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Progress report on the work of the geographically dispersed offices of the WHO Regional Office for Europe

This report provides an overview of the work of the geographically dispersed offices of the WHO Regional Office for Europe, in line with resolution EUR/RC54/R6.

It is submitted to the 68th session of the WHO Regional Committee for Europe in 2018.

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Introduction

1. At its 54th meeting, in 2004, the Regional Committee for Europe adopted in resolution EUR/RC54/R6 the strategy of the WHO Regional Office for Europe with regard to geographically dispersed offices (GDOs), as contained in document EUR/RC54/9. The resolution requests the Regional Director to report regularly to the Regional Committee on the work of the GDOs. Document EUR/RC63/17 Rev.1, submitted to the Regional Committee at its 63rd session in 2013, sets out a five-year time frame for such reporting. The last of these reports were presented to the Regional Committee at its 63rd session, and the present report therefore covers the next five-year period of 2014–2018.

2. As specified in document EUR/RC61/18, submitted to the Regional Committee at its 61st session in 2011, a GDO is "any technical centre or project office that is fully integrated with the regional head office in Copenhagen, supports its work by providing evidence and contributes to implementation of the work programme of the Region in key strategic priority areas". Thus a GDO is a WHO centre that is:

- located outside Copenhagen but which has a division located in the regional head office in Copenhagen from where it is directed and driven and to which it reports;
- responsible for a specific and explicit European regional technical strategic priority as approved by WHO's governing bodies, and covers the whole Region and all Member States;
- responsible for specific technical deliverables and/or research (in support of the policies of the Regional Office) that are clearly incorporated in the regional perspective of the Organization's programme budget;
- funded from the budget of the Regional Office (which receives the agreed funding for the GDO from the host country and partners); and
- staffed by WHO technical and administrative personnel who are governed by WHO rules, report directly and solely to the regional head office and are entitled to the privileges and immunities granted to United Nations staff.

3. As explained above, the activities of the GDOs are fully integrated into the work programmes of the divisions of the Regional Office and the Regional Office as a whole in terms of strategic planning and implementation. This includes establishing and contributing to the biennial collaborative agreements with Member States and working in full alignment with the Regional Office work programme. The work of these centres is driven by the GDO policy, developed in 2011 (document EUR/RC61/18), and discussed at the Regional Committee the same year. The approach to the establishment and modus operandi of GDOs in the WHO European Region has been guided by and aligned with Regional Committee deliberations, thereby ensuring that they have the trust of, and work in a way that is transparent to, the governing bodies.

4. Given the technical excellence of GDOs in their areas of work, it is becoming evident that they meaningfully contribute to the implementation of WHO global priorities and policies, particularly given the WHO transformation process and the intention to have global functions performed at the regional level. As the GDOs are fully integrated into the European Region's work programme and programme budget and are funded largely by the host country

in line with Regional Committee decisions, work performed at the global level would require negotiation, agreement and a review of the necessary resources on a case-by-case basis.

5. Unlike the previous progress reports on GDOs that were submitted to the 63rd session of the Regional Committee and that were prepared in the form of separate documents for each GDO, this single report contains information on all five GDOs. Each GDO has a designated chapter, which follows an identical structure, presenting the unique technical expertise of each GDO, achievements, lessons learned, and priorities for the current biennium and beyond. Out of five existing GDOs, two (Almaty, Kazakhstan, and Moscow, Russian Federation) started their operations during the period covered by this report and their respective chapters, therefore, cover the period since their establishment. The last chapter of this report presents the financial and human resources of the GDOs.

The WHO European Centre for Primary Health Care, Almaty, Kazakhstan

Background

6. The WHO European Centre for Primary Health Care was established in 2013 in Almaty, Kazakhstan, following approval of a new GDO on primary health care by the Regional Committee at its 63rd session. The Centre performs its activities in line with decision EUR/RC62(2), adopted at the 62nd session of the Regional Committee, on strengthening the role of the Regional Office's GDOs in programme areas geared to the needs and priorities of the Member States. The Centre has been fully operational since 2016 as both a GDO and as part of the Health Services Delivery Programme of the Regional Office.

7. As a centre of excellence on primary health care and services delivery, the Centre sets out to ensure that the Regional Office is equipped to work closely across all 53 Member States in their efforts to transform services delivery towards people-centred health systems. Its technical support is based on a primary health care approach and includes analytical work, direct country support, policy advice, and capacity building; this support is achieved partly through collaboration with academia, think tanks and a consolidated network of experts. The Centre benefits from its location in central Asia, as this context brings insights into services delivery from the perspective of Russian-speaking countries and the health systems of countries of the Commonwealth of Independent States. The work of the Centre is guided by the approach of the WHO European Framework for Action on Integrated Health Services Delivery (EFFA IHSD), which was endorsed by Member States at the 66th session of the Regional Committee in 2016, and a commitment to support its implementation.

8. The Centre has a multidisciplinary team of professional and administrative staff. The core staff consist of the Head of Office and Programme Manager, Health Services Delivery, one senior adviser on health services organization and three technical officers working in the areas of system enablers, policy development and quality improvement, respectively. The GDO also engages an extensive network of consultants, hosts interns and supervises student placements from partner organizations including the Harvard T.H. Chan School of Public Health, Kazakh Medical University and Imperial College London.

9. The Centre works in close collaboration with the other technical programmes of the Division of Health Systems and Public Health (DSP). Inter-programmatic work includes close engagement in areas such as health system response to noncommunicable diseases (NCDs), child and adolescent health and ageing, health system strengthening for tuberculosis (TB) and HIV, gender and health, and monitoring and surveillance. The Centre has also established close working modalities with other GDOs, namely the Barcelona Office, Spain, with regard to health systems strengthening and monitoring Sustainable Development Goal (SDG) target 3.8 on universal health coverage, and the European Office for Prevention and Control of NCDs, Moscow, Russian Federation, on joint data collection and surveillance systems. The Centre also works closely with country offices across the Region.

Achievements in the last two years

10. As the WHO European Centre for Primary Health Care has only been fully operational since 2016 the achievement report below covers the period 2016–2018.

11. The Centre's work is aligned with the four core pillars, namely knowledge synthesis, country support, policy analysis, and alliances and networking.

12. Analytical and applied research for evidence-informed policy action – The Centre has worked to advance and refine a conceptually sound understanding of services delivery. Following the endorsement of the EFFA IHSD in 2016, this has included exploring the future role of hospitals with the WHO interregional hospital task force, adapting the EFFA IHSD to capture the specificities of long-term care, and initiating discussions to unpack models for strengthening the integration of public health services and primary care. The Centre has also developed and applied a methodology for assessing avoidable hospitalization for ambulatory care sensitive conditions as well as other tools and instruments for collecting data on services delivery. In 2017 the Centre convened a kick-off workshop to revisit quality of care concepts and mechanisms, with a view to reinvigorating this agenda in the European Region. Through its various collaborations, the Centre has also regularly supported the application of services delivery concepts in order to explore health workforce competencies and nutrition, as well as health outcomes through the lens of men's and women's health, NCDs, HIV, TB and child health. These efforts have been documented in several resources published since 2016 as background documents, tools, applications and meeting reports, made available in English and Russian.

13. Country-specific work on primary health care and services delivery – The Centre has developed and implemented several unique approaches to priority areas of technical assistance, including services delivery assessments, quality of care, and planning and implementation of reforms and pilot projects:

- Assessing primary health care and services delivery: Rapid assessments and reviews with a focus on primary health care have been conducted at the request of several countries, including Albania, Armenia, Montenegro and the Republic of Moldova, serving as a platform of evidence for further technical assistance and policy dialogue, and as a resource for other technical units.
- Strengthening governance of quality of care and quality improvements:
  The Centre has reviewed the current system of quality of care and patient safety in several countries, including Estonia, Georgia, Kyrgyzstan and Tajikistan. These

reviews have informed further policy analysis and planning, focusing in an innovative way on quality improvement across a continuum of quality inputs, service processes, outputs and health outcomes.

- Planning and implementation of services delivery reforms: The Centre has worked closely with several countries, including Kyrgyzstan, the Republic of Moldova, Tajikistan and Ukraine, in identifying services delivery priorities and planning the development of integrated services based on a primary health care approach.
- Supporting pilot projects: The Centre took a lead role in the implementation of two regional pilot projects in Kazakhstan for improving clinical practice in primary care. The results of the final evaluation noted that there had been several changes, including an increase in newly detected cases of circulatory disease and diabetes, and progress in developing a shared understanding of quality of care across actors. The Centre has worked intensively in Belarus to support the implementation of new roles and scopes of practice for health practitioners, and in Hungary to develop a pilot project on integrated services for patients with chronic obstructive pulmonary disorder.
- Assessing ambulatory care sensitive condition hospitalizations: In its preliminary attempts to measure the performance of health services delivery, the Centre developed an approach to working with countries to identify possible performance improvement in the management of those conditions that could be treated in primary care, in order to decrease the burden of unnecessary hospitalizations. Countries assessed include Georgia (in progress), Germany, Kazakhstan, Latvia, Montenegro (in progress), Portugal, and the Republic of Moldova. The findings of these studies provided policy pointers in key areas to improve services delivery performance.
- Mapping models of integration between health and social sectors: A collaboration between the Division of Policy and Governance for Health and Well-being and the DNP was established to map models of integration focusing on long-term care in Denmark (in progress), Portugal, Romania and Turkey. These cases have provided new insights into opportunities for primary health care to support activities such as dementia care, end-of-life care and long-term care for older people.
- Documenting models for hospital, emergency and after-hours services: The Centre developed an approach to assessing the coordination and organization of emergency medical services and after-hours primary care. The approach was first applied in Greece to strengthen the potential of primary health care to effectively manage and treat the growing burden of chronic diseases while also preventing the need for acute care services, and has now been applied in Kazakhstan, Kyrgyzstan, Tajikistan and Ukraine. Illustrative country cases on hospital transformations were launched in 2017 in Germany, Greece, Portugal and Sweden. This work serves as an important input to hospital master planning and optimization of subnational services delivery networks.
- Scoping initiatives on integrated health services delivery in all 53 European Member States: The Centre documented initiatives as country case profiles across the Region, taking a snapshot of activities and lessons learned to further support services delivery transformations.

- Surveying health services delivery information platforms: The Centre conducted a survey on health record systems, disease-specific registries, databases and the existence of patient associations. The findings served as an important input to efforts to intensify monitoring in the European Region as part of the implementation of the EFFA IHSD. Additional preparatory work has included pre-testing data availability and measures in Kazakhstan.

14. Development of tools to support policy actions – To support countries in their efforts to put the EFFA IHSD into action, the Centre launched an implementation package of resources, including policy documents, background briefs, a catalogue of tools, examples of applications and lessons learned as well as a glossary of key terms in English and Russian. As part of its implementation, the Centre prepared a roadmap detailing the monitoring processes, from the adoption of the Framework to the first report to Member States at the 70th session of the Regional Committee in 2020. The Centre also actively supported intercountry policy dialogues, including the annual Baltic policy dialogue, and consultations on antenatal care, sexual and reproductive health, men's health, and the global framework on integrated, people-centred health services and patient safety.

15. Relevant partnerships and capacity-building efforts – In 2016 the WHO Regional Director for Europe established the Primary Health Care Advisory Group to support the continued advancement of primary health care. The Group met for the first time in June 2017, bringing together renowned experts to share their technical knowledge, experiences and perspectives to inform a future vision for primary health care. The Centre has also hosted several networking events in Almaty, Kazakhstan, including joint meetings of the Northern Dimension Partnership in Public Health and Social Well-being, the launch of the Global Service Delivery Network for universal health coverage and an interregional meeting of the WHO hospital task force. The Centre contributed to training and capacity-building efforts, including a local lecture series at the Kazakh National Medical University attended by over 1000 Kazakh medical students in its first year, an annual guest lecture at the European Observatory Venice Summer School and Imperial College London's Health Systems Development master seminar, as well as sponsoring various Member States to attend the International Summer School on Integrated Care. The Centre has continued to widen its network, with more than 40 partners and stakeholders engaged in events, research, technical support and training opportunities annually.

Lessons learned: enablers, success factors and challenges

16. Investing in a diverse network of partners that represent different perspectives has helped to accelerate work to close the gaps between different concepts of health services delivery held by different actors and to position the GDO as a centre of excellence in the Region. The Centre has adopted a strategy of engagement with a diverse network of partners recognizing that all play a role in services delivery transformations. The diversity of this network and the importance of such engagement is a unique feature of services delivery, given the need to establish meeting points between patients, providers, managers and policy-makers. A biannual newsletter and a regularly updated website bring these perspectives together and illustrate the diverse platforms through which the Centre works to reach its varied audiences.

17. The impact of this investment in diversified perspectives has allowed the Centre to develop an enriched understanding of services delivery concepts and unpack critical topics, including services delivery processes, a health systems approach to integrated health services delivery, key strategies for people-centredness, and quality of care as a continuum. The high level of engagement has brought clarity to each of the perspectives involved, in particular on the unique characteristics of services delivery among members of the Commonwealth of Independent States.

18. This strategy has brought benefits to the hosting country, providing increased visibility to Kazakhstan. Over the course of these first two years, the Centre has organized events with participation from all six WHO regions and all levels of the Organization, workshops, meetings of networks and advisers, and joint events with key partners. The Centre has also engaged its diverse network to increase multimedia resources, including video lectures, short films, photo stories and other innovative platforms, in order to reach an even wider audience.

19. Solidifying a dynamic team to intensify country support and deliver services locally takes time and is recognized as being part of an initial start-up phase. The Centre has developed a consolidated technical team of staff with a focus on providing direct technical support to countries. The recruitment process for full-time staff took place during most of 2017 and continues into 2018. As a new office, the Centre has also worked to establish a consolidated list of local suppliers, identifying such suppliers, engaging with them and verifying the quality of services delivered. Work in this area will decrease in the next period of work.

Priorities for 2018–2019 and the Thirteenth General Programme of Work (GPW 13) period

20. Priorities for the 2018–2019 biennium span the Centre's four core pillars of work. On knowledge synthesis, this includes a continued focus on quality of care, advancing a regional approach to measuring the performance of services delivery, and the synthesis of case studies on work streams, including transforming hospitals, long-term care and public health services. The Centre will work with its consolidated team to intensify direct country technical assistance.

21. In 2018 celebrations marking the 40th anniversary of the Declaration of Alma-Ata will take place. Year-long activities to mark the occasion include the anniversary conference itself, local events and publication of a special edition of *Public Health Panorama*. Over the next two years, one priority will be preparations for reporting to Member States on the implementation of the EFFA IHSD in 2020. The Centre will also continue to develop training and learning resources and to expand its network of partners.

WHO Barcelona Office for Health Systems Strengthening, Spain

Background

22. The GDO in Barcelona, Spain, began operations in 1999 with a technical focus on developing service delivery systems and particularly "integrated health care systems". This focus was modified in accordance with Regional Committee resolutions EUR/RC50/R5,

EUR/RC55/R8 and EUR/RC56/R3 and following the WHO European Ministerial Conference on Health Systems held in Tallinn, Estonia, in 2008. The name of the Barcelona GDO is now the "WHO Barcelona Office for Health Systems Strengthening", and it has a particular focus on health financing. The work of the Centre is entirely guided by the deliberations of the Regional Committee.

23. The Office is a centre of excellence in health financing for universal health coverage – a key part of WHO's work in the European Region and globally. It is responsible for monitoring progress towards universal health coverage, in particular the extent to which people are protected from facing financial hardship when they are ill. The Office is also leading the technical work of DSP on health systems strengthening for improved NCD outcomes and it organizes and hosts WHO training courses on health financing and health systems strengthening.

24. The Barcelona GDO has a balanced work programme at the regional and country levels:

(a) providing technical support to Member States in the area of health financing;

(b) monitoring progress towards universal health coverage, with a focus on financial protection (SDG indicator 3.8.2);

(c) carrying out interprogrammatic and interdivisional work on strengthening health systems with a focus on NCDs and TB; and

(d) building capacity by running the WHO Barcelona courses.

25. In terms of office structure, the technical team comprises the Head of Office (also Programme Manager for Health Financing), two senior technical staff, one part-time technical staff member shared with the European Observatory on Health Systems and Policies and two full-time consultants. In addition, an extensive network of temporary consultants supports the work of the Office. The administrative team comprises an administrative officer, three programme assistants and a receptionist/clerk, who support the technical work, financial management and other tasks related to maintaining the GDO.

26. Since January 2014 the Office has been based in new premises at the La Mercè Pavilion of the historic Art Nouveau Site of Sant Pau Hospital. This magnificent UNESCO World Heritage architectural environment provides a prestigious office location for WHO, and was generously provided by the main donor of the Office, the Government of the Autonomous Community of Catalonia, Spain.

Achievements in the last five years

27. Analysing the impact of the financial and economic crisis – The Office contributed extensively to the successful European high-level meeting on the impact of the financial crisis held in Oslo, Norway, in April 2013. In collaboration with the European Observatory on Health Systems and Policies, a major regional study entitled "Economic crisis, health systems and health in Europe: impact and implications for policy" was conducted with the findings published in two volumes. The main volume of the study was published by the Open University Press and the second volume, covering country case studies and the complete survey results from the 53 Member States, was published by WHO on behalf of the Observatory. This study was part of a wider initiative to monitor the effects of the crisis on health systems and health, to identify the policies most likely to sustain the performance of

health systems facing fiscal pressure and to gain insight into the political economy of implementing reforms during a crisis. Based on the findings of the study, a summary of the policy implications of the crisis was presented to the Regional Committee at its 64th session in 2014.

28. Developing new priorities for health systems strengthening – Under the guidance of the Director of DSP, the Office led the development of new priorities for health systems strengthening for the European Region for the period 2015–2020. The new priorities were based on a consultation process with experts and Member States, and were presented to the Regional Committee at its 65th session in September 2015. The document and related resolution received overwhelming support. The Office is responsible for the implementation of the Division's work programme on moving towards universal health coverage for a Europe free of impoverishing payments for health – one of the two priorities for health systems strengthening in the European Region.

29. Monitoring financial protection as a key component of universal health coverage – In 2014 the Office embarked on a major new work programme with the aim of strengthening the evidence base on moving towards universal health coverage in the European Region by monitoring financial protection in a wide range of health systems. A new methodology was developed for more nuanced measurement of the level of protection health systems provide against the financial burden of ill-health. The new approach addresses the weaknesses of the methodology previously used by WHO and it aims to:

(a) be relevant to all Member States in the Region, including high-income countries;

(b) generate actionable evidence for policy; and

(c) promote pro-poor policies to break the link between ill-health and poverty.

30. Since the adoption of the SDGs, including the indicator of financial protection for universal health coverage (3.8.2), the Office has been contributing to the global monitoring of universal health coverage and provided significant input to the 2017 global monitoring report, which highlights the methodological advances made by the Regional Office.

31. Regional monitoring is supported by in-depth analysis of country policies on coverage, access and financial protection. The first round of 25 reviews cover Albania, Austria, Croatia, Cyprus, Czechia, Estonia, France, Georgia, Germany, Greece, Hungary, Ireland, Kyrgyzstan, Latvia, Lithuania, the Netherlands, Poland, Portugal, the Republic of Moldova, Slovakia, Slovenia, Sweden, Turkey, Ukraine and the United Kingdom of Great Britain and Northern Ireland.

32. The policy relevance of the new methodology and policy analysis has been acknowledged by many policy-makers and international organizations, including the European Commission and the Organisation for Economic Co-operation and Development (OECD). Policy dialogue events and presentations of the findings took place in Estonia, Georgia, Kyrgyzstan, Latvia, Lithuania and Slovenia. A summary of the findings from the analysis was shared at the high-level meeting, Health Systems for Prosperity and Solidarity, held in Tallinn, Estonia, in June 2018 to celebrate the 10th anniversary of the Tallinn Charter. The first regional report will be published in 2018.

33. Strengthening health systems for better NCD outcomes – The Barcelona Office is promoting interdivisional collaboration in the Regional Office. During the past five years, the

Barcelona Office has been working closely with Member States to design and implement more effective health system policies to address noncommunicable diseases (NCDs) in a coordinated effort between DSP and DNP. By the beginning of 2018, 13 country assessments of health system responses to NCDs had been conducted, in Armenia, Belarus, Croatia, Estonia, Hungary, Kazakhstan, Kyrgyzstan, Portugal, the Republic of Moldova, Serbia, Tajikistan, the former Yugoslav Republic of Macedonia and Turkey. Following the assessments, Member States implemented recommended policies with WHO support where necessary, integrated into the regular country work by the two divisions overseeing this work. In addition, a series of good practice briefs were developed to highlight and disseminate good practices across the Region. A regional report synthesizing country work and developing an evidence-informed vision of a comprehensive and coherent health systems response to NCDs was launched at the high-level regional meeting, Health Systems Respond to NCDs: Experience in the European Region, held in Sitges, Spain, on 16–18 April 2018. The vision and conclusions of the meeting, in the form of an outcome document, will contribute to the reporting to the third United Nations high-level meeting on NCDs, to be held in 2018, and is being submitted for the consideration of the Regional Committee at its 68th session in September 2018.

34. Capacity building through training courses – WHO training courses on health financing and health systems strengthening are organized in the Barcelona Office. These annual events target policy-makers, government officials, health professionals in managerial positions and other stakeholders who influence policies and the performance of health systems in the European Region and globally. The WHO Barcelona course on health financing for universal health coverage has been delivered annually since 2011 and, for the first time in 2017, a Russian-language version was developed and delivered for the Russian-speaking countries of the European Region. The Office also hosted and contributed to the delivery of three editions of the global advanced course on health financing for universal coverage for low- and middle-income countries in 2015–2017, organized by WHO headquarters.

35. Based on the long-standing collaboration with the World Bank Institute's Flagship Program on Health Sector Reform and Sustainable Financing, the Office has developed advanced training courses on health systems strengthening to support interdivisional work programmes on NCDs and TB. The WHO Barcelona course on health systems strengthening, with a focus on NCDs, was delivered four times during 2013–2016 in English with simultaneous interpretation into Russian. Similarly, a new course was developed in 2016 to address health system challenges in responding to the TB epidemic in the European Region, focusing on 11 high-incidence countries which benefit from technical assistance through a project supported by the Global Fund, the Tuberculosis Regional Eastern Europe and Central Asia Project. With two annual courses already delivered, the WHO Barcelona course on health systems strengthening for improved TB prevention and care is the latest addition to the growing portfolio of the Barcelona-based capacity-building activities of the Regional Office.

36. During the past five years, the Office has delivered 16 courses, reaching almost 800 participants from across the Region and beyond. Standard course evaluation and informal feedback from participants provide evidence of the high quality and impact of these courses.

37. Health financing policy support to countries – Technical support is provided to Member States on a wide range of health financing policy issues. The Barcelona Office has an extensive work programme of providing technical assistance and policy advice to Member States across the European Region on a wide range of health financing policy issues. Intensive

support was provided to Cyprus, Estonia, Georgia, Greece, Kyrgyzstan, Latvia, Slovenia, Tajikistan, Turkey and Ukraine. In addition, Barcelona Office staff contributed to WHO's work in Albania, Andorra, Azerbaijan, Hungary, Ireland, Kazakhstan, the Republic of Moldova and Uzbekistan.

38. The Office has participated in technical assistance projects financed by the European Union in the Republic of Moldova and the Swiss Agency for Development and Cooperation in Kyrgyzstan. It is coordinating the European Union–Luxembourg funded universal health coverage partnership programme in the European Region, working with Georgia, Kyrgyzstan, the Republic of Moldova, Tajikistan and Ukraine. Active collaboration with the European Observatory on Health Systems and Policies and the World Bank takes place in several countries. At the regional level, the Office collaborates extensively with the OECD especially in the area of facilitating dialogue between health and finance officials.

39. The following are selected highlights of country work impact:

- Cyprus opted for a single payer system following WHO analysis, which was provided to the Government at a key point in the decision-making process for reform of the health financing system. The assessment of different options for purchasing market structure under the proposed new National Health System informed the Government's decision to launch the new system with a single purchasing agency rather than through competition between public and private insurers.
- Estonia introduced health financing policy reforms in line with WHO recommendations: The WHO Barcelona Office has provided technical support to Estonia on health financing policy in recent years, including the landmark report on the sustainability of the health financing system and the most recent report with recommendations on how to improve financial protection, coverage and access to services through better health financing policies. Estonia is now diversifying revenue sources for its health insurance fund through gradually increasing budget transfers in 2018–2021 and this will lead to a more stable and sustainable financing system, which will also allow coverage to be improved for services not currently covered (such as dental care) and partially covered medicines. Estonia is the first country in the European Region to have acted upon findings of the study produced by the WHO Barcelona Office on financial protection.
- Georgia is moving towards universal health coverage with support from WHO: In 2016, the Regional Office and the World Bank presented recommendations for the country to build on its achievements in moving towards universal health coverage. Analysis by the Barcelona Office showed how out-of-pocket payments for medicines were the most important source of financial hardship for people in Georgia. Reducing out-of-pocket payments would require actions to bring down medicine prices, encourage rational prescribing and use of medicines, extend publicly financed coverage of medicines and enhance protection, especially for poorer people. In 2017, senior officials from the Ministry of Health, Labour and Social Affairs, including the Minister, visited the Barcelona Office to discuss the challenges and opportunities for better health system performance during a two-day consultation with senior staff of the Office. Georgia has recently joined

the European Union (EU)–Luxembourg–WHO Universal Health Coverage Partnership, which allows WHO to scale up its support to the country.

- Hungary institutionalized health system performance assessment and published a first report: In close collaboration with the WHO Country Office in Hungary over the past five years, the Barcelona Office supported the country in developing capacity to produce a regular health system performance assessment (HSPA) and to set up the institutional mechanisms that secure long-term sustainability of this capacity building. Initially, the focus was on monitoring the impact of health financing reforms and developing the framework and the institutional requirements for the production of regular HSPA reports by national experts and Government officials. Following the publication of the WHO report, entitled "Strengthening HSPA in Hungary: analysis and recommendations", the Ministry of Human Capacities established the legal framework and mechanisms for producing biennial reports in line with WHO recommendations. The first report produced without any external input was published in 2017 with significant media interest and impact on national health policy-making. WHO continues to be engaged as an observer in the national working group responsible for producing regular reports that inform policy-making.
- Kyrgyzstan is transforming its health system in order to make progress towards universal health coverage: Improving financial protection and access to health care for citizens was explored in detailed technical discussions on the occasion of the 20th anniversary of the establishment of the mandatory health insurance system in 2016. The Senior Policy Forum on Moving Towards Universal Health Coverage under the Den Sooluk health care reform programme brought key messages from the technical discussions to the attention of policy-makers from the Government, parliament and regional authorities. Senior managers of the World Bank, the German Development Bank (KfW), the Swiss Agency for Development and Cooperation, WHO and other development partners participated in the forum and showed support for dialogue on intersectoral issues related to health financing. In recognition of WHO's long-standing support for health system reforms in Kyrgyzstan, three WHO staff were honoured by the Government for their many years of work and contributions to the development of the Kyrgyz health financing system.
- Slovenia is reforming its health insurance system to improve efficiency and coverage: The Office supported a major health system review in collaboration with the European Observatory on Health Systems and Policies and produced a report on options for health insurance reform. Related policy dialogue events and a series of consultations with the Minister of Health aimed at safeguarding Slovenia's excellent performance in providing financial protection for its population while reforming the health financing system.
- Ukraine is changing its health financing arrangements to trigger a full transformation of service delivery: The Office supported Ukraine in fundamentally changing the flow of funds in the Ukrainian health system. The work included analysis, technical assistance in the preparation of legislation, and high-level policy dialogue conducted at the highest levels of the Government, with parliamentarians and with civil society. The Office worked closely with the European Commission in this endeavour, to ensure that health financing reforms have a positive impact on

critical public health functions, which are relevant to the entire European Region. The work has taken place under the EU–Luxembourg–WHO Universal Health Coverage Partnership. The result of this multiyear effort was that Ukraine's parliament passed ground-breaking legislation in late 2017 and a new health purchasing agency began operations in 2018. The Office continues to provide technical assistance on implementation and evaluation of impact.

Lessons learned: enablers, success factors, challenges

40. The current level of staffing will prove insufficient to maintain the quality of technical work and respond to new challenges during the years to come. Strong technical capacity combined with an attractive venue for training events have made the Barcelona GDO a highly valued asset of the Regional Office. The WHO Barcelona courses are highly successful and demand has continued to increase over the years. The high-quality technical support provided by staff to Member States also led to increasing demand for country work, which the Office tries to meet with more extensive use of temporary consultants. While globally the health financing team of the Office is considered the strongest among regional offices, capacity needs to be further increased through recruitment of additional staff and creation of a more flexible administrative system to make better use of the wide network of consultants.

41. Efforts to conclude a new host agreement are still in progress and are crucial for the long-term sustainability of the Office as well as for the locally and internationally recruited staff working there.

Priorities for 2018–2019 and the GPW 13 period

42. Priorities for the 2018–2019 biennium include synthesis of the two major regional work programmes led by the Office, namely the interdivisional collaboration on health systems strengthening for better NCD outcomes and the regional monitoring of financial protection for universal health coverage, including the 25 country-specific analyses. The latter will continue to be the most important technical work on health financing at the regional level with the aim of increasing country coverage to 80% of the European Region with this analysis during 2019–2023. The Office will build on its strength in country work, which is in line with the Thirteenth General Programme of Work, and continue to support countries in moving towards universal health coverage through better health financing policies and comprehensive health system strengthening.

WHO European Centre for Environment and Health, Bonn, Germany

Background

43. The WHO European Centre for Environment and Health (WHO/ECEH) was established in 1991 in several locations, following the decision of the First Ministerial Conference on Environment and Health to tackle the most pressing health threats arising from environmental issues facing the European Region and the world. In 2012 a single office was established in Bonn, Germany, to house WHO/ECEH.

44. WHO/ECEH is the centre of technical and scientific excellence of the Regional Office for addressing environmental and work-related determinants of health and their impacts on health. The work of the Centre is entirely guided by the deliberations of the Regional Committee. Working in close cooperation with the environment and health team in the Regional Office, thereby ensuring policy coherence at regional level, the Centre focuses on providing Member States with state-of-the-art evidence on existing and emerging environmental health risks, and assists them in identifying and implementing policies to protect and promote health. It develops policy advice and international guidelines, methods and tools.

45. In 2016 an external review was commissioned to assess the work of WHO/ECEH and to identify strategies for the future direction of the Centre, its structure, and its role as a WHO centre of excellence for environment and health. The review group evaluated the performance of the Centre as outstanding in terms of technical, ethical and scientific work. Based on the results of the review, WHO/ECEH was restructured to follow the strategic foresights provided. Due to funding realities, with a decrease in voluntary contributions in the area of health and environment in the past five years, the number of staff in WHO/ECEH was also reduced to ensure the financial and technical sustainability of the office.

46. WHO/ECEH has a multidisciplinary team of 19 professional and administrative staff organized in three programmes, working under the Head of Office.

Achievements in the last five years

47. Several policy frameworks have shaped the work of WHO/ECEH in the past five years. By supporting the European Environment and Health Process (EHP), WHO/ECEH addressed the priorities set up by the Parma Declaration on Environment and Health (2010) and more recently by the Ostrava Declaration (2017). WHO/ECEH supports implementation of the Health 2020 policy framework, which provides a basis for improving health and reducing inequalities in the area of environment and health in the European Region. The work of WHO/ECEH is also driven by the 2030 Agenda for Sustainable Development and pursuit of the Sustainable Development Goals. WHO/ECEH contributes to WHO's work to prepare for, respond to and recover from emergencies by providing technical expertise in relation to all types of environmental emergencies. WHO/ECEH applies a multisectoral approach that includes research institutions, policy-makers and other stakeholders (including citizens and civil society organizations). As a result of the relevance of the technical work performed in WHO/ECEH, in 2014, 2015 and 2016 WHO/ECEH online publications had about 700 citations worldwide each year. This document contains only the main highlights of five years of achievements.

Air quality: better air for better health (preventing disease through improved outdoor and indoor air quality, Regional Priority Goal 3 of the Parma Declaration)

48. Strong support for efforts to improve health by improving air quality was provided to 51 Member States through chairing of the Joint Task Force on Health Aspects of Air Pollution (TFH) under the Convention on Long-range Transboundary Air Pollution. Annual TFH meetings have been held during the past five years, gathering the representatives of Parties to the Convention as well as the expert community. Several policy briefs were developed under the TFH, which support Member States in addressing the health effects of air

pollution, such as the publication *Health effects of particulate matter. Policy implications for countries in eastern Europe, Caucasus and central Asia.*

49. AirQ+ is a software tool that quantifies the health effects of exposure to air pollution, including estimates of the reduction in life expectancy. Since its launch in 2016, it has been downloaded in 290 cities in 70 countries, while there were 5809 views of the AirQ+ web page in 2017. WHO/ECEH supported the use of the tool and development of a solid basis for interventions in Lithuania, Montenegro, Serbia, and the former Yugoslav Republic of Macedonia. The tool is available in the English and Russian languages, and a capacity-building curriculum has been developed. WHO headquarters has organized training on AirQ+ beyond the WHO European Region, in Africa (e.g. Ghana), the Americas (e.g. Colombia), South-East Asia (e.g. India and Nepal) and the Eastern Mediterranean (e.g. Islamic Republic of Iran), reflecting the global relevance and applicability of the technical work performed in WHO/ECEH and contributing to the visibility of WHO/ECEH worldwide.

50. Work on updating the WHO global air quality guidelines started in 2016, underpinned by the results of two WHO/ECEH projects (Review of evidence on health aspects of air pollution (REVIHAAP), and Health risks of air pollution in Europe (HRAPIE)), which reviewed the scientific evidence on the health impacts of air pollution to support policy-making processes in the EU.

Chemical safety and health (preventing disease arising from chemical, biological and physical environments, Regional Priority Goal 4 of the Parma Declaration)

51. The focus of the activities in this area was to support countries in mainstreaming efforts to protect people’s health from exposure to dangerous chemicals in the context of the sustainable development agenda, to support ratification and implementation of relevant international agreements, mainly the Strategic Approach to International Chemicals Management, the Minamata Convention, and the International Health Regulations (2005), as well as implementation of the provisions of the Parma Declaration.

52. WHO/ECEH supported the strengthening of national capacities for safe chemicals management, as required to fill priority gaps in Armenia, Estonia, Georgia, Kazakhstan, Lithuania and Ukraine.

53. Support was provided to Georgia in developing the required legislative and operational framework for the collection and sharing of information on hazardous chemicals, in order to ensure development of the necessary policy on chemical safety. Activities related to mercury and the Minamata Convention performed by WHO/ECEH on behalf of WHO as a whole resulted in the inclusion of health and health sector needs in national mercury assessments and strategies in the European Region. The main outcomes of this work were developed into an educational module for health care and public health professionals on mercury and the Minamata Convention in the English and Russian languages.

Reducing noise to promote health

54. WHO/ECEH coordinated the development of WHO environmental noise guidelines for the European Region. The guidelines include a review of the evidence on the health effects of environmental noise. The WHO Guidelines Review Committee approved the guidelines in April 2018.

Environmentally sustainable health systems

55. In close cooperation with DSP, a strategic document on environmentally sustainable health systems was developed and published. A vision for an environmentally sustainable health system is put forth in the document as being a health system that improves, maintains or restores health while minimizing negative impacts on the environment and leveraging opportunities to restore and improve it. WHO/ECEH and DSP collaborated with the Government of the United Kingdom in evaluating an initiative to enhance sustainability of the National Health Service, in order to generate transferability and encourage a wider adoption of the concept.

Protecting workers' health

56. WHO/ECEH, in cooperation with the Institute of Occupational Medicine, a WHO collaborating centre in Skopje, the former Yugoslav Republic of Macedonia, developed a national programme for the elimination of asbestos-related diseases. A campaign to raise awareness of asbestos by using a whole-of-government and whole-of-society approach led to an asbestos ban in the country.

57. In July 2016, Monaco introduced a total ban on asbestos on the basis of technical advice provided by WHO/ECEH. National asbestos profiles were developed in Serbia and Ukraine.

Climate change and health

58. WHO/ECEH provides secretariat functions to the Working Group on Health in Climate Change that was established by the European Environment and Health Task Force. The main aim of the Working Group is to facilitate dialogue and communication among Member States and other stakeholders on matters related to climate change and health, and in particular to support and facilitate implementation of the relevant commitments in the Ostrava Declaration.

59. WHO/ECEH works to identify policy options to help prevent, prepare for and respond to the health effects of climate change and supports Member States (such as Croatia, Kazakhstan, Montenegro, the Republic of Moldova, Serbia and the former Yugoslav Republic of Macedonia) in selecting and implementing the most suitable policies, measures and strategies.

60. In cooperation with partners, WHO/ECEH provided projections of the effects on heat-related mortality of the 1.5°C and 2°C climate change scenarios and an assessment of the burden of disease resulting from climate change in Europe for two future periods (2035–2064 and 2071–2100), implementing the EU-funded IMPACT2C Project.

61. WHO/ECEH developed a tool which yielded an estimate that, if all WHO Member States implemented their commitments under the Paris Agreement on climate change, the annual preventable premature mortality from reduced air pollutant emissions in 2030 could be as high as 74 000 deaths for the whole European Region.

Water, sanitation and hygiene (Ensuring public health by improving access to safe water and sanitation, Regional Priority Goal 1 from the Parma Declaration)

62. WHO/ECEH, together with the United Nations Economic Commission for Europe, provides core secretariat functions for the Protocol on Water and Health to the Convention on

the Protection and Use of Transboundary Watercourses and International Lakes and supports its implementation. The Protocol is legally binding and offers an effective policy framework for translating the Parma and Ostrava commitments on water, sanitation, hygiene and health, and the aspirations of SDGs 3 and 6, into tangible national targets and action plans. The Protocol has been ratified by 26 Member States, representing about 60% of the population of the European Region.

63. WHO/ECEH supported Member States in adopting the Water Safety Plan (WSP) approach in policy and practice. WSPs are a core pillar of the WHO guidelines for drinking-water quality. The adoption of WSPs has been proven to prevent water quality incidents and results in long-term health gains. WHO/ECEH developed practical tools to support WSP uptake and provided capacity building and policy advice in more than 10 Member States. WHO/ECEH made comprehensive recommendations to the European Commission on the planned revision of the EU Drinking Water Directive. These recommendations have been incorporated in the draft of the revised Directive.

64. In response to the call in SDG 6 to ensure universal and equitable access to water, sanitation and hygiene (WASH) for all, WHO/ECEH placed due emphasis on leveraging policy attention and national action towards improving WASH in health care facilities and schools. WHO/ECEH undertook a systematic analysis of the WASH situation in schools in the European Region and brought together representatives of the education and health sectors to promote intersectoral action to ensure children's right to safe WASH in schools. WHO/ECEH also initiated a regional review of evidence, in order to substantiate and focus policy attention on WASH in health care facilities, as a tracer intervention to ensure the quality of care and universal health coverage; this included in-country activities in Kazakhstan and Tajikistan. To address persistent urban/rural inequalities in access to safely managed water and sanitation services, WHO/ECEH supported Member States in developing effective regulatory approaches to the management and public health surveillance of small water supply and sanitation systems in rural areas. WHO/ECEH provided broad capacity building in more than 15 countries, developed guidance and tools, and supported countries in systematically appraising the situation of their rural water supplies, leading to amendments of national regulatory instruments (in Serbia, for instance) or revised national targets.

Environment and health impact assessment

65. Environment and health impact assessment plays a crucial role in identifying the links between activities carried out in different sectors and their implications for human health, an area that has recently been reinforced by Health 2020, as well as in the Ostrava Declaration.

66. Effective health impact assessment of environmental health determinants requires supportive institutional arrangements, multidisciplinary expertise, access to relevant information and data, and meaningful stakeholder participation. WHO/ECEH has promoted such an approach through numerous national and international activities, including training workshops (in the Czech Republic, Kyrgyzstan, Latvia, Lithuania and Slovakia, for example), high-level policy dialogues (Romania), support for the development of services (Poland) and legislation (Portugal), and support to specific assessments (Estonia, Italy).

Environmental health economics

67. In order to strengthen the position of the health sector in a whole-of-government approach, the economic argument is invaluable. In 2015, an assessment of the economic costs of air pollution in Europe, carried out with the OECD, was presented at the Mid-Term Review of the EHP in Haifa, Israel. A collaborative assessment of the economic case for asbestos substitution was completed in 2017.

Environmental health inequalities

68. The unequal distribution of people's exposure to – and potentially of disease resulting from – environmental conditions is strongly related to a range of sociodemographic determinants. To address this gap and follow up on the commitments made in the Parma Declaration, WHO/ECEH carried out a baseline assessment of the magnitude of environmental health inequality in the European Region, based on a core set of 14 inequality indicators.

Waste and contaminated sites

69. WHO/ ECEH supports Member States in assessing the health impact of waste disposal facilities and local contamination due to present and past industrial activities. Since 2015, WHO/ECEH, with support from the EU, has facilitated an international network on industrially contaminated sites and health (ICSHNet) that currently involves 33 Member States. Activities include the development and dissemination of resources (methods, tools, guidance) for addressing the health dimension of industrial contamination, the provision of a coordination mechanism for researchers, policy-makers and stakeholders, and training.

70. Activities in this domain and the growing realization of the importance of the issue in Europe (with hundreds of thousands of contaminated sites classified by the European Environment Agency) led to the inclusion of waste and contaminated sites among the priorities of the Ostrava Declaration.

71. An assessment of the health impacts of oil shale activities in Ida-Viru County in Estonia was conducted by the national Health Board, with a team of researchers and policy-making specialists and support from WHO/ECEH. The results of the study were taken into account in the preparation of the Estonian Oil Shale Strategy 2016–2030.

Lessons learned: enablers, success factors, challenges

72. During the past five years, WHO/ECEH has adopted a more comprehensive approach and strengthened horizontal and interconnected ways of working within the Regional Office and with external partners. Working together in newly developed partnerships (especially with colleagues at the WHO European Office for Investment for Health and Development in Venice, Italy), notably the Regions for Health Network (RHN) and the Small Countries Initiative (SCI), has made WHO/ECEH more visible and led to the spread and better use of technical expertise. The first series of webinars on environment and health, developed in cooperation with the RHN, was launched in the spring of 2018. Close cooperation with the Healthy Cities Network is bringing environment and health issues to the local level, where the main interventions based on national policy frameworks are implemented. These valuable

partnerships have provided a new boost to the work of WHO/ECEH, and the new partners have shown great interest in working together.

73. On the other hand, the voluntary contributions provided by Member States for the area of environment and health are continuing to decrease. It is a paradox that, for the biennium 2018–2019, 26 Member States expressed interest in working with WHO/ECEH in different areas of environment and health (the largest number in the past five years), but voluntary contributions to this area are not following this trend.

74. WHO/ECEH benefits from its location and cooperates with the most eminent German institutions, such as the University of Bonn, the Federal Environmental Protection Agency, the Federal Institute for Occupational Safety and Health, and Dortmund Technical University.

Priorities for 2018–2019 and the GPW 13 period

75. WHO/ECEH will continue to provide technical expertise for the Regional Office's work in the priority areas of the Ostrava Declaration. Increasing impetus for the work of WHO/ECEH is given by the 2030 Agenda for Sustainable Development, in which health and well-being linked to environmental and work-related factors are both determinants, enablers and outcomes of sustainable development. The post-Ostrava thematic work will contribute to further progress and stronger cross-cutting support to Member States to tackle the challenges of the 2030 Agenda.

76. GPW 13 places due emphasis on the environment, climate change and health, and its Platform 5 specifically addresses the health effects of climate change in small island developing States and other vulnerable States, highlighting the interlinkages between air quality and access to water. WHO/ECEH has significant expertise in this area of work, with a history of success and well-developed methodologies and tools ready for use by Member States to strengthen the integration of health aspects into national adaptation strategies. After negotiations and agreement, and depending on the provision of additional human and financial resources, WHO/ECEH will further support global activities in this area of work, in alignment with and in support of implementation of GPW 13. Such activities are considered on a case-by-case basis at the top management level, depending on the capacity of the GDO.

WHO European Office for the Prevention and Control of Noncommunicable Diseases, Moscow, Russian Federation

Background

77. The last four years have seen a transformation in the field of NCDs in Europe. Since the project for the development of a GDO on NCDs was launched on 1 December 2014, collaboration between the Russian Government, Russian experts and institutions, WHO and its European Member States has led the European Region to become a leader in the field globally. The GDO has been working since its inception as part of WHO/Europe and in coordination with all three levels of the Organization, and it has transformed the way in which the European Region is preventing and controlling the NCD epidemic. This transformation has affected four dimensions of the work:

- Impact: the GDO has contributed to reduction of the risk of NCDs, to the overall decline in premature mortality and to the changing patterns of NCD causes of death.
- Process: the GDO has managed its funds and human resources to ensure full implementation and sustainable patterns of investment, expanding its funding basis and donor pool and optimizing its impact on countries in greatest need.
- Innovation: the GDO has generated new tools and instruments for NCD surveillance, prevention and control and found novel ways of disseminating established, evidence-based interventions.
- Partnership: the GDO has effectively developed a network of partners composed of Russian experts and institutions, as well as collaborators and donors in other countries, and nurturing its network of collaborating centres.

78. The NCD Office is part of DNP, and the Head of Office reports directly to the Director, DNP, based in Copenhagen. The vision for the GDO in Moscow is that of a structure that serves as the powerhouse for NCDs in Europe and beyond, prioritizing innovation and the deployment of effective interventions at country level, with the aim of supporting attainment of the SDGs. The work of the NCD Office follows the guidance given by the governing bodies of WHO, based on the deliberations of the Regional Committee.

79. The NCD Office regards an innovation as being a useful new tool or activity if it meets four criteria:

- It is a low-cost, affordable action that can help advance NCD policies or outcomes particularly in a low- to middle-income country.
- It solves or addresses a common problem in implementation of the “best buys” for NCDs in a way that is new or different from approaches used elsewhere.
- It has been tried out successfully and with positive impact in the European Region and notably in countries of eastern Europe and central Asia.
- It has been designed with the collaboration of Russian experts or institutions.

80. During the life of the NCD Office, several such innovations have been developed and are ready for dissemination elsewhere, including:

- The NCD Office has developed a system for assessing the composition of foods sold in markets in central Asia and other eastern European countries.
- In collaboration with DSP, a framework has been devised for assessing a health system in terms of its strengths and weaknesses with regard to NCDs. WHO has supported these assessments in 14 countries, using funds from the NCD Office as well as other regular budget sources and staff support from Copenhagen.
- The NCD Office has contributed to compilation of a set of evidence to counteract the claims of the tobacco industry when it opposes effective tobacco legislation. This is a tool for augmenting the capacity of tobacco control advocates, who may be isolated in their fight for effective legislation.
- The NCD Office first proposed the idea of a multisectoral investment case for national action on NCDs. The draft of the methodology was developed in Europe and it has since been taken up and refined and is being globally implemented by

the United Nations Interagency Task Force on the Prevention and Control of NCDs.

- The NCD Office successfully adapted the Childhood Obesity Surveillance Initiative (COSI) to the countries of eastern Europe and central Asia, transforming it into a tool that more comprehensively analyses nutritional status, diet quality and physical activity in school-age children. At the same time, these countries are already incubators for the expansion of COSI to children under five years old. This is the only data source worldwide that has measured data on the prevalence of overweight and obesity in primary school children. The NCD Office's project has shown that it can be extended to low- and middle-income countries, an essential finding at a time when the obesity epidemic is hitting children in even the poorest countries and will affect their health in adult years, and when policy-makers at the highest level, such as the G20, are already taking up this issue in their discussions.

81. There are many other examples of innovation, including interventions on alcohol pricing, extending the success of the Russian Federation over the last 10 years, trans-fat elimination, salt reduction, digital marketing of foods to children, innovations in data warehousing and visualization, the use of electronic health records, data mining and predictive analytics. The activities of the NCD Office are fully integrated into the work programme of the Division and the whole Regional Office in terms of strategic planning and implementation.

Achievements in the last four years

82. The establishment of the NCD Office allowed for an unprecedented scaling up of coordinated activities across the European Region, which will undoubtedly have an impact on countries' trajectories towards decisively reducing the number of deaths and years lived with disability caused by diabetes, cancer, cardiovascular diseases and chronic respiratory diseases.

83. The impact of the NCD Office has been outstanding. This is highlighted by more than 230 events and/or country missions involving many Member States, in which more than 6000 specialists from major scientific institutions and academics from the Russian Federation and elsewhere have participated. More than 60 landmark documents have been produced, primarily in Russian. All Member States in the Region have benefitted from the project in one way or another, while targeted approaches have been applied for countries more in need, notably those in the eastern part of the Region. The project and its main deliverables have also generated significant interest on the Internet and social media, with some publications from the GDO surpassing previous download records.

Selected highlights of the impact of country work

84. Delivery of the NCD country package – A core concept behind this work plan is the promotion of a country-based package of interventions for the prevention and control of NCDs. The package consists of evidence and guidance, adapted to national needs and circumstances, implemented using national resources in a sustainable fashion. These outputs have been evaluated as showing that WHO's contribution has had a significant impact on the risk factors and burden of NCDs and the resulting improvement in health status. Whether through intercountry interventions led by the Regional Office or country-specific deliverables

by national teams and WHO country offices, each country has made significant progress in its priority areas, which were agreed to and aligned with their bilateral agreements with WHO.

85. For the past four years, the NCD Office has been actively working with countries of the European Region in four main areas: policy, surveillance, prevention and disease management. During this time, significant work has been done in cooperation with local communities, NCD experts, and ministries of health, social affairs, education, economics, finance and others. This has made it possible to achieve significant results and raise the issue of NCDs at a high political level. Individual countries not only conducted training courses for decision-makers and provided reliable data on NCD risk factors but also managed to take concrete policy steps towards reducing the burden of NCDs.

Partnerships

86. Russian experts and institutions – The NCD Office has been working closely with experts from the Russian Federation in its efforts to provide technical support to Member States in the Region. These experts make a crucial difference to the task of combating NCDs throughout Europe.

87. The experts come from leading Russian institutions and join the NCD Office team in a wide range of activities, either in missions to individual countries or in meetings, conferences or workshops that bring countries together. The institutions are regarded as leaders in their field in the Russian Federation: they all conduct fundamental and applied research and carry out scientific, academic and medical training, while also providing treatment. Some of them are already WHO collaborating centres; others have collaborated for the first time with the NCD Office and could potentially become collaborating centres.

88. Roster of experts, collaborating centres and cooperation with Russian regions – The network of Russian experts, combined with the network of WHO collaborating centres for NCDs, has created an unprecedented critical mass in Europe. At present, whether in policy-making, public health in general, epidemiology, research, surveillance, NCD risk factors and prevention, or treatment of specific NCDs, the NCD Office provides, through these mechanisms and platforms, a pool and range of experience, knowledge and skills that countries would not otherwise be able to access with ease. The NCD Office has also worked, at the request of the Ministry of Health of the Russian Federation, with several regions of the country.

89. Community of practice, collaboration across countries, networks and meetings of NCD directors – The NCD Office has contributed significantly to energizing the community of practice around NCDs in Europe and to the global agenda on NCDs by bringing together different actors in the field to attend major summits, such as the annual meetings of NCD programme managers and directors and the high-level conference that took place in Montevideo, Uruguay, in November 2017, in preparation for the High-level Meeting of the United Nations General Assembly on NCDs that will be held in late September 2018. The Regional Office, through its NCD Office, has been the force behind the push for ambitious goals in reducing premature NCD mortality. This bold vision was discussed by NCD programme managers and directors from all WHO major offices at their meeting in Moscow and has provided inspiration for the work of the High-level Commission on Noncommunicable Diseases.

90. Increasing the visibility of the NCD Office – The NCD Office has ensured the provision of cross-platform communications support (web, print, social media) to its programmes, projects and events, disseminating information about the Office's products and achievements in a timely manner to relevant partners and stakeholders. The Office has successfully used WHO's communications channels, and has collaborated strategically with partners to increase outreach. Some of the NCD Office's launches and social media campaigns were among the top performers in the European Region during recent years, and particularly in 2017.

91. Working closely with the Russian-speaking media within the Region and identifying key media contacts to enhance its communications efforts, the NCD Office has continued to support the training of journalists to report on NCD issues and to use WHO NCD datasets. After the first successful training of journalists in reporting on tobacco issues, held in Moscow in 2016, the NCD Office supported a similar training course for 30 journalists in Dushanbe, Tajikistan, in 2017.

92. In 2017, the NCD Office held two press events in Moscow in collaboration with the Ministry of Health of the Russian Federation. The first took place in June 2017 to launch the Russian version of the Health Behaviour in School-aged Children report on adolescent obesity trends. Fifty guests attended the event, including 30 media representatives, while additional media representatives from 15 regions of the Russian Federation attended the event virtually. The event resulted in 140 news items published by print and digital media outlets in the Russian Federation and abroad. Five federal channels released special reports on adolescent obesity, with the NCD Office's experts as invited speakers. The second event, held in Moscow on 13 December 2017, took the form of a round-table discussion on the initiative of the Ministry of Health of the Russian Federation to introduce a law on salt fortification with iodine. Over 70 Russian bloggers, media representatives, academicians, health practitioners and policy-makers attended the event, which supported public and scientific discussion of the importance of sufficient iodine intake, as well as the overall importance of healthy behaviours during pregnancy. Twenty-five news items and a number of social media posts published by bloggers encouraged continued virtual discussion of the issue for two weeks after the event.

93. The social media campaign launched by the NCD Office, in which pregnant women were invited to share their personal stories of how they had led a healthy pregnancy, resulted in over 200 stories shared on digital media. On the Regional Office's English-language Twitter channel, this social media campaign performed on a par with or better than some other WHO global health campaigns in 2017. To further increase its outreach, the NCD Office has been seeking opportunities to involve celebrities in its communications efforts. A former Olympic figure skater, Irina Slutskaya, participated in the round-table event as a guest speaker, drawing additional attention from the media and the public to the discussion.

94. The NCD Office's communications work also focused on development and maintenance of its website (www.euro.who.int/en/NCDOffice) in English and Russian, to ensure that relevant and up-to-date information is available and accessible and reaches the intended audience in a timely manner. The number of news items published on the website in 2017 increased more than 2.5-fold in comparison with the previous reporting period (2016).

Lessons learned: enablers, success factors, challenges

95. One of the most significant enablers of the success of the NCD Office has been the proximity factor. Being located in the eastern part of the Region, the Office is at the epicentre of the NCD epidemic; its readiness to take immediate action and its detailed knowledge of the situation on the ground and at the political level are not to be underestimated.

96. Sustainable funding has been instrumental in the steady growth of the NCD Office's business portfolio, as well as in building up a young and dynamic team composed of a mix of Russian Federation nationals and a large number of international experts. This group of scientists and experts has been carefully selected to ensure that the Office becomes, and sustains its role as, an innovation laboratory and a powerhouse for NCDs in Europe and beyond.

97. Another important positive element has been the interaction with highly competent Russian experts in the field of cardiovascular diseases, cancer, diabetes and other NCDs which, in combination with new collaborating centres and institutions, has significantly increased the potential outreach of the NCD Office.

98. The main challenges at present are to increase the pool of donors and to ensure that the NCD Office continues to attract the attention of the international public health community, so that its vision of being a centre of excellence is indeed achieved.

Priorities for 2018–2019 and the GPW 13 period

99. While the work of the GDO only partly accounts for the success in reducing NCD mortality, it will nonetheless be an essential component in accelerating these trends in the next decade leading to 2030, and a critical contributor to implementation of the Organization's priorities for 2018–2019 and the forthcoming GPW 13. The work of the GDO (and of NCD prevention and control activities in the Region) will contribute decisively to implementation of the above-mentioned priorities. The main priorities fall into four domains, as defined below with a summary of the achievements so far and the main future directions:

- Governance: this includes collaboration with regional economic organizations (such as the Eurasian Economic Union and the EU), action across borders to address multinational determinants of health, developing investment cases and addressing the financing of NCD programmes, and establishing a system for the dissemination of innovations, together with WHO's global programme on NCDs.
- Surveillance: this includes the reinforcement of specialized sources of information on NCDs, technical assistance to countries for the implementation of integrated and specialized risk factor surveys, cancer registration, innovations and improved quality in the area of population health surveys, and more detailed reporting on health inequalities within and between counties.
- Risk reduction: this includes efforts to address tobacco and alcohol, unhealthy diets and physical inactivity, with a focus on regulation and policy change alongside more traditional efforts aimed at behaviour change. Special emphasis will be placed on what might be termed "fast buys", i.e. cost-effective interventions that return the most rapid results.

- Disease management: this includes scaling up the work to strengthen health systems and increase capacity to detect and manage diabetes, hypertension, cancer, asthma and chronic lung diseases. In the context of the SDGs, the people who are going to die of NCDs in the years leading to 2030 are already suffering from early stages of these conditions. Universal health coverage and evidence-based primary health care interventions (i.e. screening and brief interventions) are essential tools in this domain.

WHO European Office for Investment for Health and Development, Venice, Italy

Background

100. The WHO European Office for Investment for Health and Development in Venice, Italy, is a centre of excellence of the Regional Office, with a focus on promoting health through addressing the social and economic determinants of health and health equity, and on advocating for investments for health in the context of the 2030 Agenda for Sustainable Development using a gender- and rights-based, Health in All Policies approach. The Venice Office builds its programme on priorities that:

- best reflect demands and needs within the European Region (at regional and country levels) and among Member States (at national and subnational levels);
- anticipate future dynamics in the policy environment of health and development and address them by developing cutting-edge innovations today;
- offer strong synergies with other programme areas and their networks and partners within and beyond WHO; and
- realistically reflect the Office's own capacities and resources, in order to ensure high-quality products and services for clients and final beneficiaries, which provide evidence of added value and are a testimony for the mobilization of further resources.

101. The programme of the Venice Office encompasses three closely interrelated areas: social determinants of health (SDH) and health equity; investment approaches for health and well-being; and healthy settings networks (the SCI and the RHN). The Centre's activities are fully in line with decisions taken by the Regional Committee.

Achievements in the last five years

Social determinants of health and health equity

102. Direct support to countries in implementing and evaluating multisectoral policies for health and equity – The Venice Office's SDH/Health Equity Programme provides tailored policy support to countries to design, implement and evaluate multisectoral policies for health and health equity. Between 2014 and 2017, direct support was provided to 13 Member States across the Region.

103. Flagship course – The equity in Health in All Policies flagship course addresses the demand from WHO's European Member States to develop and shape intersectoral policies, and specifically to influence and work in partnership with other sectors – putting Health in All Policies into practice. To date, participants from 16 Member States have participated in the flagship course, which has been running since 2015. Five countries have adapted the course and are using it to cascade training as part of a mainstreaming service and continuing professional education for cross-sectoral and public health planners and policy-makers. In 2018–2019, two further flagship courses covering eight Member States are planned. In 2019, an advanced flagship course will be launched.

104. The Health Equity Status Report Initiative is producing the first European Region atlas of health equity status within countries and a situation report on policy progress to increase equity in health. These will directly support WHO, Member States and partners in better targeting resources and actions to reduce gaps in health and well-being by strengthening health sector responses and multisectoral policies. The Initiative is launching a suite of online interactive tools to guide decision-makers and practitioners in selecting the most effective policy options and interventions that work at the national and local levels to increase equity in health at key stages across the life course.

105. The Health System Social and Economic Footprint Initiative supports dialogue between the health, finance and economy sectors, underlining how the health sector contributes to resilient communities and inclusive economies. The WHO Venice Office's SDH/Health Equity Programme has developed a new methodology that allows a country to calculate the contribution (in terms of gross domestic product, jobs and household consumption) of the health sector to the national and subnational (regional) economy. The methodology has been used in Slovenia and the United Kingdom (England) and is being translated into an online tool that all countries can access and use.

106. Making health a goal and an investment sector in regional growth and development strategies: Economic growth and social sustainability are high priorities for the governments of all Member States. The Venice Office has been working intensively to support the health ministries and public health organizations of the South-eastern Europe Health Network (SEEHN) to ensure that health is part of the regional growth and development strategy, SEE2020. The Venice Office was the main partner supporting SEEHN in using evidence to make the case, together with regional economic and development organizations, for investing in health for growth. This contributed to health targets and measures being included in the SEE2020 growth and development strategy, which was formally endorsed by all economy ministers of countries in the western Balkans and south-eastern Europe.

107. Multicountry alliances for health equity – The Nordic–Baltic Health 2020 Social Determinants and Health Equity Collaboration is an ongoing collaboration between Nordic and Baltic States (Denmark, Estonia, Finland, Iceland, Latvia, Lithuania, Norway and Sweden) and the Regional Office. The Collaboration has been active since its launch in Helsinki, Finland, in June 2014 and supports governments and societies by providing politicians and policy-makers with the opportunity for a subregional learning exchange on emerging evidence, policy experiences and good practices. In December 2016 Sweden hosted a three-day policy exchange which brought together over 100 policy-makers from the sectors of health, development and welfare with representatives of private institutions and the social economy, as well as academic experts, to enrich the European knowledge base and sustain the commitment to act to increase equity in health. The event was co-chaired by the Minister of

Health of Sweden and the WHO Regional Director for Europe. Lithuania will host the next three-day policy exchange in 2019.

108. Evidence and support tools for policy-makers – There is a continuing demand for evidence-informed tools and resources to support decision-makers in implementing policies and approaches that will reduce socially determined health inequities. Guidance focuses on the evidence and practical options for working with policies relating to social protection, income and taxation, family and community, education, and employment and working conditions. In parallel, the tools include case studies, syntheses of promising practices and lessons learned.

109. Between 2014 and 2017, 14 resources were launched and are now being used by countries and partners. These resources include guidance on policy options, implementation approaches and governance mechanisms that can support the health sector and wider government to tackle social inequities in health.

Investment approaches for health and well-being

110. The Framework for Investment for Health and Sustainable Development – The people-centred approach is at the core of this Framework, which advocates for investment for health and well-being throughout the life course. All investments should be guided by the value systems, goals and targets as agreed in the Health 2020 policy framework and the 2030 Agenda.

111. The life-course approach suggests that the health outcomes of individuals and the community depend on the interaction of multiple protective and risk factors throughout people's lives, and particularly in their early years. Consequently, investment must occur throughout the life course: ensuring a good start in life while leaving no child behind; building lifelong skills, resilience and healthy behaviours; supporting learning, employment and opportunities for young people; ensuring good living and working conditions; and ensuring a safe, healthy and active older age.

112. The Framework also reflects the wider determinants of health, both of individuals and the planet. These social, economic and environmental factors are multiple and interactive, taking into consideration equity, gender and human rights and supporting security and peace.

113. The practical investment mechanisms are used in developing human capital and procuring sustainable infrastructure, goods and services, on the one hand; and in implementing Health in All Policies using participatory governance and achieving sustainable systems, on the other. It is on this level of practical investment and procurement decisions that policy commitments have to be translated into coherent action.

114. Most importantly, investment for health and well-being is made in a whole-of-government and whole-of-society manner. The Framework applies to investments in all sectors, by positioning health as a driver of sustainability and as an enabler of governance and regulatory processes that steer investment in other sectors to meet their own goals and to contribute to sustainable development, health and well-being.

115. Building on the Framework, the Venice Office has made strong contributions to the synthesis of evidence on the social return on investment in public health policies and to

advancement of social return on investment concepts in the context of Health 2020 and the 2030 Agenda at national and subnational levels. These contributions shaped regional strategies such as the WHO roadmap to implement the 2030 Agenda for Sustainable Development, building on Health 2020, and are in increasing demand at the national level, for example in Italy, Poland and Slovenia (also in the context on advancing the agenda of health and inclusive and sustainable growth), and at the subnational level (in regions and cities).

Healthy settings networks

116. SCI: beyond the European – High-level meetings of representatives of small countries were held in San Marino (July 2014), Andorra (July 2015), Monaco (October 2016) and Malta (June 2017), attended by ministers and high-level delegates of the eight small countries in the Region and with the participation of the ministers of health of Mauritius, Barbados and the Maldives. Ministers from outside the Region praised the initiative and expressed interest in launching it in other WHO regions.

117. Commitments of small countries to key global priorities – In Monaco (October 2016), ministers and high-level delegates of small countries endorsed a statement calling for joint action on the new 2030 Agenda and, in particular, for special attention to be paid to the issue of climate change, an appeal that resonates with the priorities in GPW 13. In Malta (June 2017), the small countries committed to stepping up action to counteract childhood obesity, anticipating the global discussions on the same topic that will take place in the United Nations General Assembly in September 2018. Small countries are proving to be fully aligned with and committed to global and European priorities.

118. Small countries at the forefront of knowledge generation – Small countries have contributed substantially to advancing knowledge and practical know-how in three areas, thanks to thematic, case story-based publications: intersectoral action for health and well-being, practical application of the life-course approach, and resilience. With regard to the latter theme, the illustrative case stories from small countries clearly identified three levels at which resilience can be strengthened: individuals, communities and the system. Knowledge generated in this field was also disseminated to the large audiences attending the annual European Public Health Conference in 2014–2017.

Important milestones in the Regions for Health Network

119. SDGs: from global to local – The RHN is an important platform for gaining a better understanding of how the 2030 Agenda can be applied at the various levels of governance. Some of the implementation practices being followed at the subnational level are actually boosting implementation at the central level of governance, in a virtuous cycle.

120. Study visits: understanding how outstanding practices are born – Two study visits took place in 2016–2017, to Austria (Lower Austria) and the United Kingdom (Wales). These activities allowed members to understand two very different and notable facts first-hand. In Wales, participants learned how the Future Generation Act was conceived and is being implemented by means of a “sustainable development in all policies” approach, which remains a unique and forward-looking example at global level. In Lower Austria, participants were able to learn how cross-border health care can be boosted. This experience highlighted the fact that ensuring that people obtain equal treatment across borders is a priority shared by all EU countries.

121. RHN regions are pioneers in many ways. The RHN has produced numerous publications to demonstrate this fact: the RHN case story series has been well received by public health professionals, far beyond the "borders" of the Network. The latest RHN publication on sustainable development, based on the Welsh example, is the first WHO publication to offer readers practical examples from across Europe of how to implement the recently endorsed SDG roadmap. The Network is also active in communications, including social media activities.

122. Including subnational experiences in ministerial forums – Thanks to the RHN, the subnational (regional) level of governance now has access to ministerial forums to which they previously did not have access. For example, a successful subnational event was held during the Sixth Ministerial Conference on Environment and Health (Ostrava, Czechia, June 2017). Additionally, the RHN continues to be represented at the Regional Committee, and in 2017 subnational examples were featured in the plenary sessions of the Committee and in all major meetings organized by the Regional Office.

123. Expanding collaboration – The RHN has intensified its collaboration with the Healthy Cities Network. This has ranged from participating in the Healthy Cities Conference (and inviting Healthy Cities to participate in RHN events) to the organization of joint events, such as the Sixth Ministerial Conference on Environment and Health and other international public health forums.

124. An authoritative voice in the international public health arena – In the past four years, the RHN has been successful in expanding its presence during the annual European Public Health Conference, the largest technical public health forum in Europe. In Glasgow, United Kingdom (2014), Milan, Italy (2015), Vienna, Austria (November 2016), and Stockholm, Sweden (November 2017), the RHN organized thematic workshops on innovative themes such as subnational implementation of SDGs and gender stereotypes, which were attended by large audiences.

Lessons learned: enablers, success factors, challenges

125. The combination of a strong downstream portfolio (healthy settings networks and country support) and upstream initiatives (driving regional and global innovations that shape policies and strategies and scale-up of implementation) is a great asset for the Venice Office as a centre of excellence and a learning institution. It enables timely identification of the challenges that are most relevant for Member States, and the development of solutions and capacity building based on evidence, cutting-edge knowledge and contextual relevance. In addition to highly skilled professionals at the Venice Office, a strong network of external experts and WHO collaborating centres enables it to meet demands with high-quality outputs.

Priorities for 2018–2019 and the GPW 13 period

126. During the GPW 13 period, the Venice Office will play a leading role in building policy-making capacity to reduce health inequities, putting the European Region in the driving seat of efforts to leave no one behind in tackling poor health and vulnerability. Interactive tools will enable all Member States across the Region to analyse the most important health equity gaps as measured by mortality, morbidity and well-being, and to review and implement the most effective policy options that are tailored to country-specific

needs and priorities. A Region-wide health equity policy progress report will be used to ensure that decisions outside the health sector within a country and at supranational level do not undermine the attainment by all people of the ability to live a healthy life.

127. The Venice Office's Health Sector Economic Footprint Initiative has done ground-breaking work on capturing the economic and social impacts of good health policies and systems. In 2018–2019, the evidence and tools will be made available online and through capacity-building activities, making it easier for more countries to regularly quantify and demonstrate how the health sector is a key engine for creating inclusive, sustainable and prosperous communities and societies.

128. The RHN and the SCI aim to become the most prominent technical networks globally for promoting the 2030 Agenda at subnational level and in small countries by:

- identifying, documenting and disseminating best practices in implementation of the 2030 Agenda;
- functioning as an extensive repository of practical know-how;
- being a dynamic platform for peer-to-peer learning;
- being an essential node for the dissemination of WHO policies at global and regional levels;
- proposing cutting-edge tools for strengthening technical capacity around the 2030 Agenda;
- contributing to the creation of a critical mass of professionals (in the health and non-health sectors) who are enthusiastic about promoting WHO's principles, core values and proposed strategies, policies and plans.

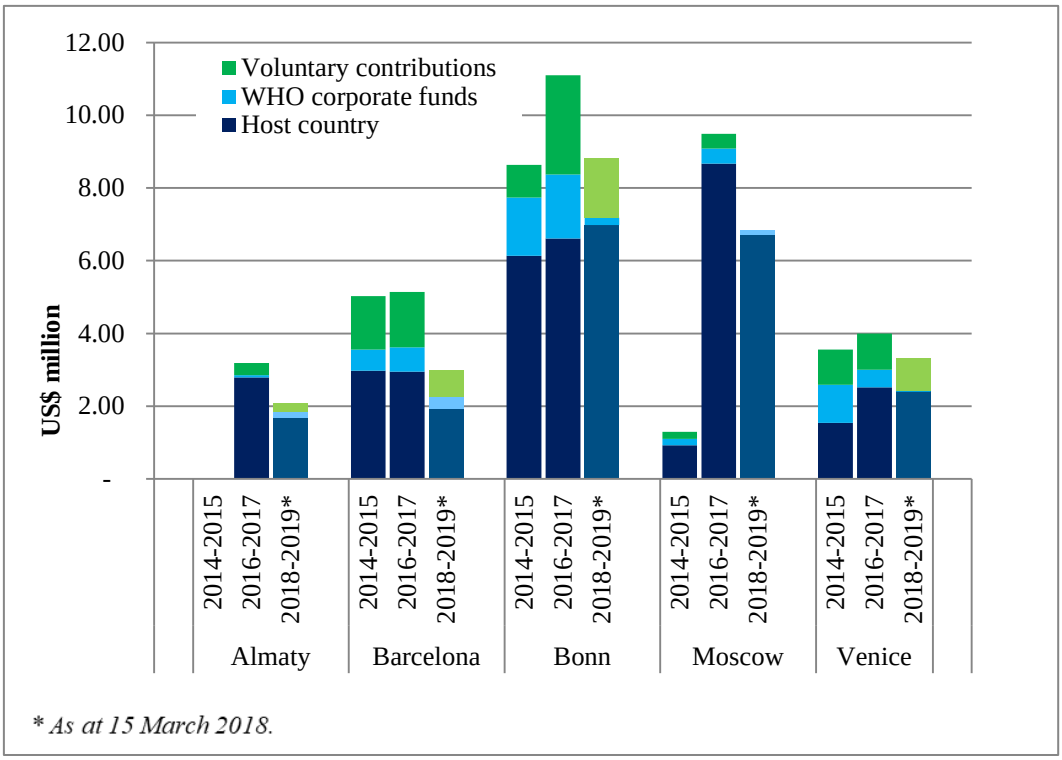
Financing and staffing of GDOs

129. The host governments ensure generous, sustainable and predictable core funding for the respective GDOs. This funding covers the salaries of core GDO staff, as well as the activities and running costs of each office. In the case of some GDOs, premises are also provided on an in-kind basis.

130. In line with the business model of the Regional Office, the technical staff of GDOs, like their colleagues in the head office in Copenhagen, are responsible for delivering both country and regional work. As part of this responsibility, GDO staff are engaged in resource mobilization activities to raise further voluntary contributions, in order to deliver on commitments outlined in the Organization's programme budget.

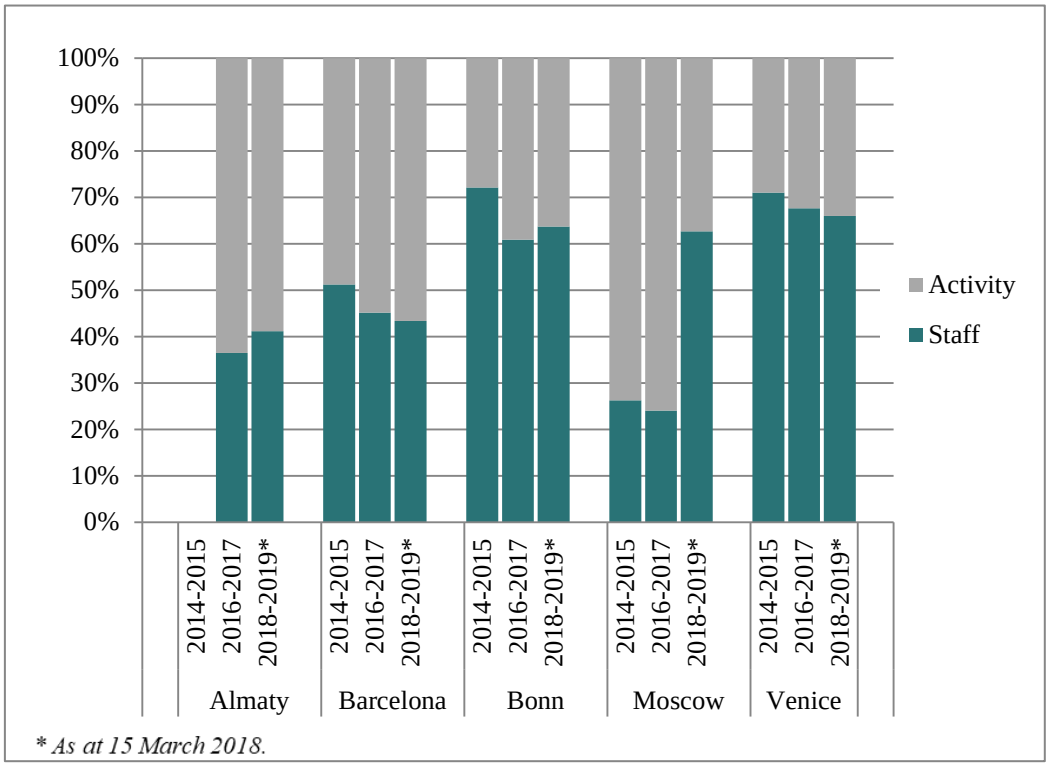
131. Fig. 1 shows funding from countries hosting GDOs in the context of total funding implemented by GDO staff, which includes funds from various donors as well as the flexible corporate resources used to cover activities led by GDO staff in countries as part of biennial collaborative agreements with Member States. Activities include all those under the responsibility of GDO staff, both in regional and country workplans. It should be noted that for 2018–2019, only currently available funding is shown, therefore its comparison with the two previous bienniums should be viewed with caution.

Fig. 1. Funding of GDO staff salaries and activities, by source of funding, 2014–2018
(for 2018–2019, data are based on the first three months of the biennium and therefore the bars are shaded in a different colour)



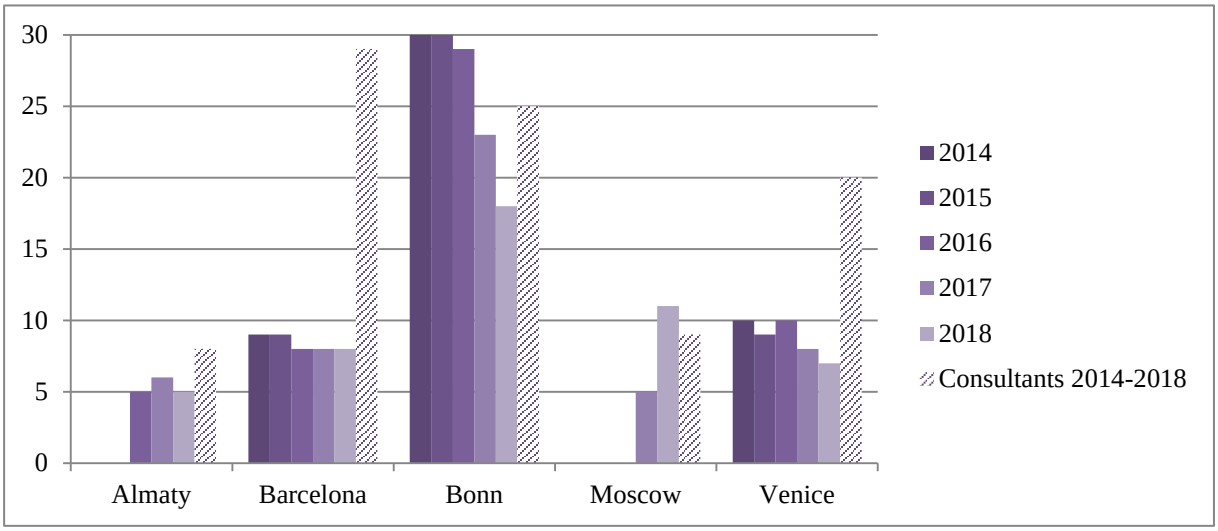
132. The split between the funding of activities and salaries in the GDOs closely follows the overall regional and global trends of approximately 60% of funding (and expenditures) being for staff costs (Fig. 2). A different trend for the GDO in Moscow is explained by the recent appointment of the Head of Office and accelerated recruitment of staff. In previous years, activities were implemented mostly by staff located at the Regional Office or regional staff temporarily located in the GDO on travel status.

Fig. 2. Activity/salary split of GDO funding, 2014–2018



133. As shown in Fig. 3, the GDO in Bonn is the largest of the five GDOs in terms of number of staff. However, in response to the decrease in funding of the health and environment area from voluntary contributions, the number of staff had to be reduced to ensure the sustainability of that GDO. All GDOs rely on external consultants to supplement technical capacity and to deliver on ever-increasing demands.

Fig. 3. GDO staff numbers 2014–2018, including consultants



Annex. Details of the financing of geographically dispersed offices

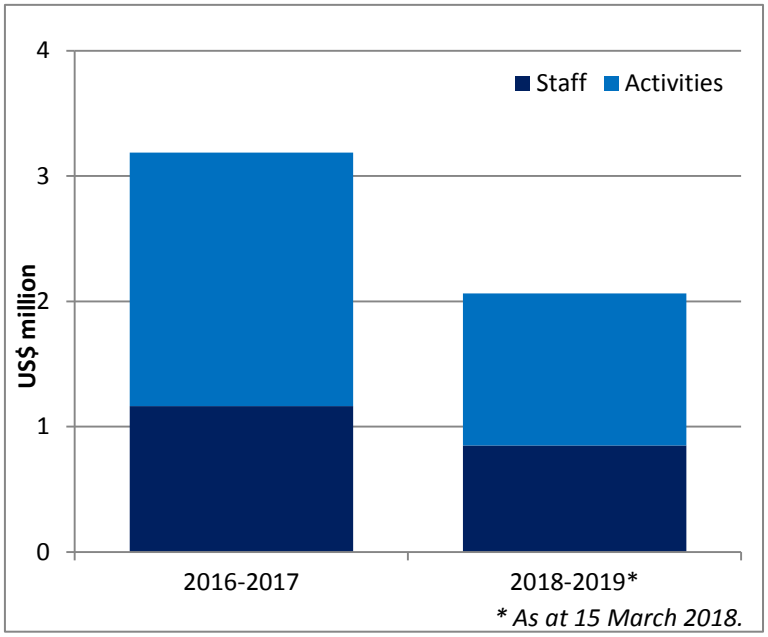
1. This Annex gives details of the financing and scope of expenditures of every geographically dispersed office (GDO). The data presented are for the five years 2014–2018, detailed on a biennial basis in line with the WHO budgeting period. Data for 2018–2019 are based on the information available on 15 March 2018. Therefore, comparisons with the two previous bienniums should be undertaken with due care.

2. Financing of the GDOs includes all funding implemented by and with the support of GDO staff at both country and regional level and captured across all relevant workplans of the WHO Regional Office for Europe.

The WHO European Centre for Primary Health Care, Almaty, Kazakhstan

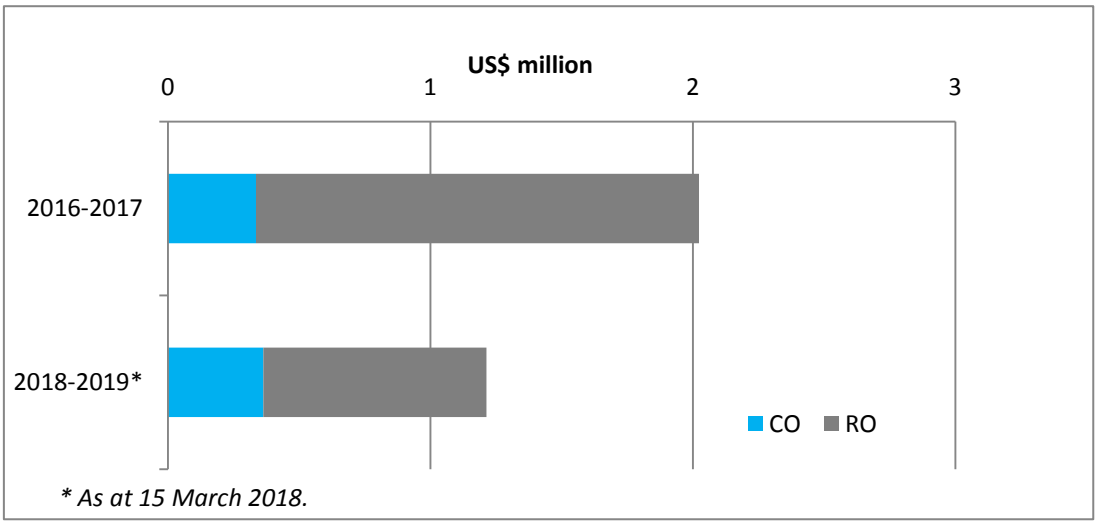
3. The most recently established of the GDOs, which started operating in 2016, it is still in the process of team building and thus the staff costs share is slightly lower than in the other GDOs (Fig. A1).

Fig. A1. Funding for staff and activities of the WHO European Centre for Primary Health Care in Almaty



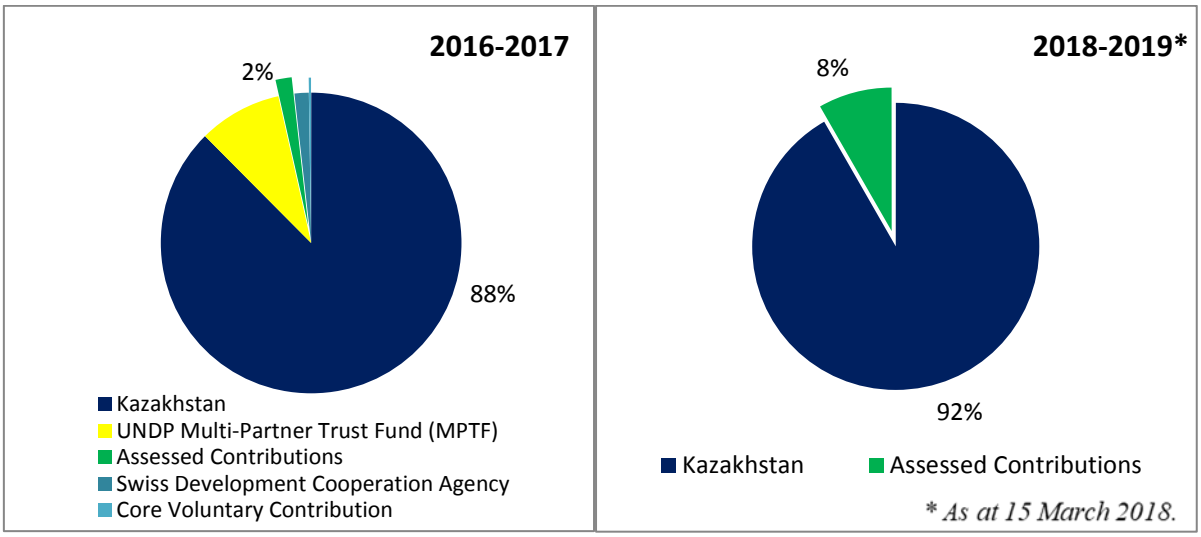
4. In line with the GDO mandate, i.e. being responsible for a specific and explicit European regional technical strategic priority as approved by WHO's governing bodies, and covering the whole Region and all Member States, GDOs contribute to both country and regional work. As the Almaty GDO builds capacity and increases visibility, it is expected that the country activity component will increase in 2018–2019 and beyond (Fig. A2).

Fig. A2. Activity funding distribution of the WHO European Centre for Primary Health Care in Almaty



5. Fig. A3 summarizes the funding of the GDO in Almaty in the two bienniums in which it has been operating (2016–2017 and 2018–2019), showing that host funding by Kazakhstan accounts for the majority of the GDO's funding. WHO's flexible funds and voluntary contributions represent investments made by country offices in the work supported by the GDO's staff. The two main donors reflect the ongoing support that the GDO has provided to health systems projects in several countries.

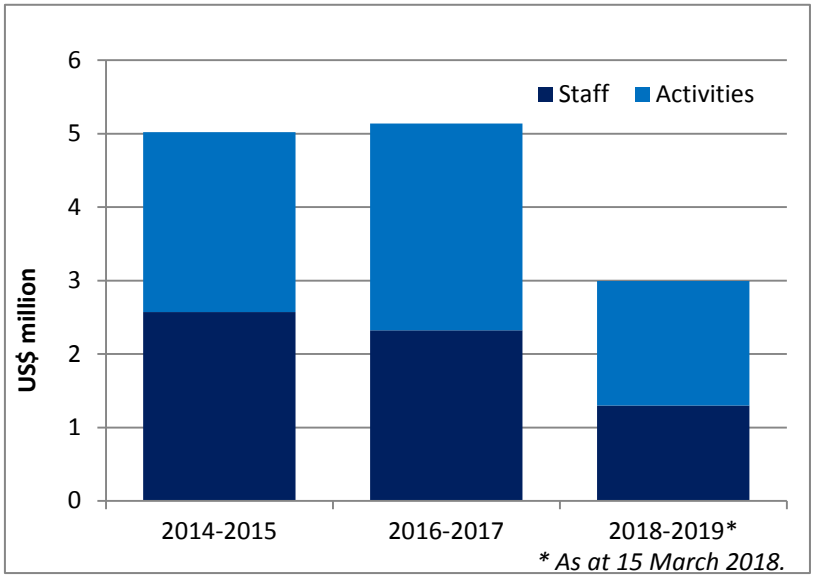
Fig. A3. Sources of funding of the WHO European Centre for Primary Health Care in Almaty



WHO Barcelona Office for Health Systems Strengthening, Spain

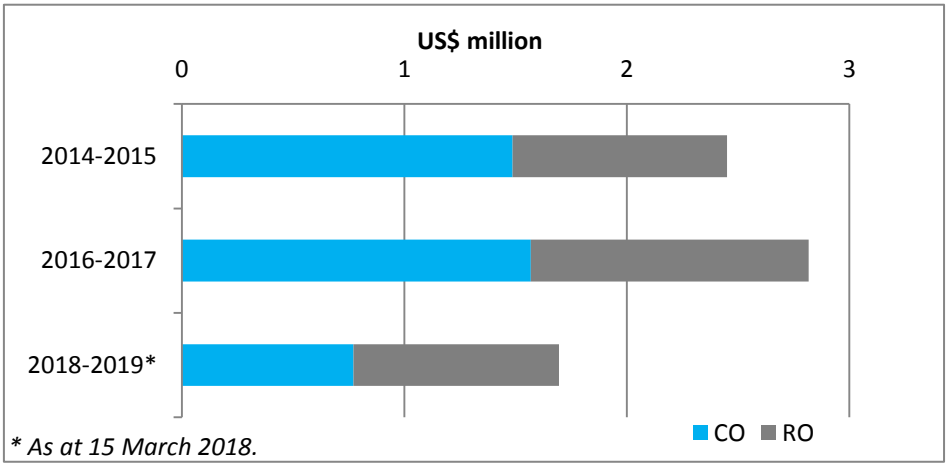
6. A longstanding and well-established GDO, the Barcelona GDO has reached a good balance of funding for staff and activities that is similar to the organizational average (50/50) (Fig. A4).

Fig. A4. Funding for staff and activities of the WHO Barcelona Office for Health Systems Strengthening



7. In comparison with other GDOs, more than half of the activities of the Barcelona GDO (55%) are funded and implemented at the country level, supplemented by WHO corporate funds and various voluntary contributions (Fig. A5).

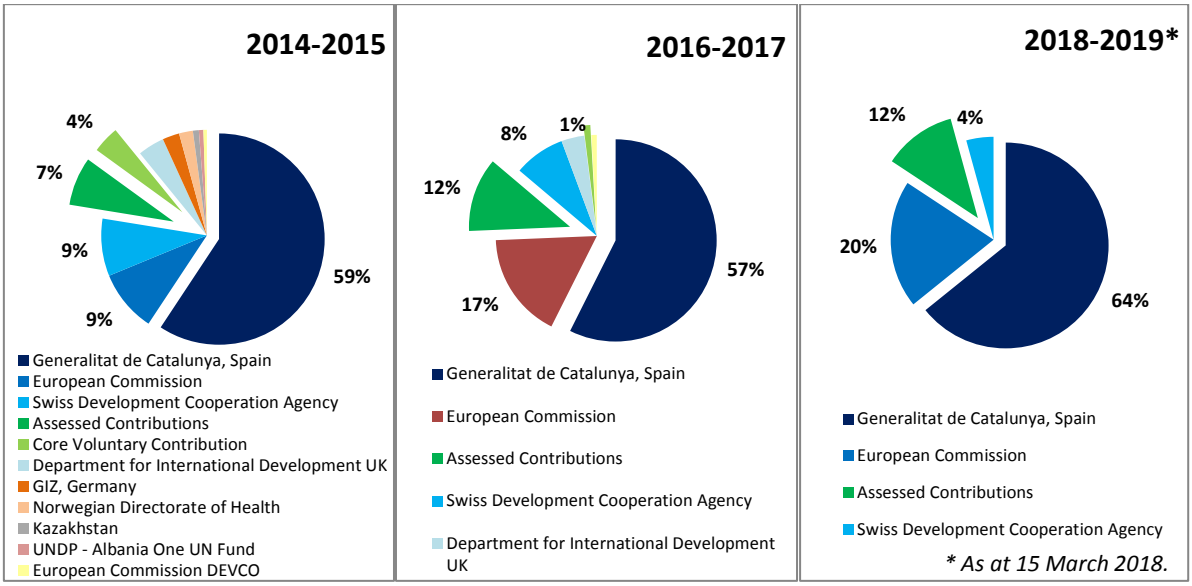
Fig. A5. Activity funding distribution of the WHO Barcelona Office for Health Systems Strengthening



8. In 2014, the funding of the Office was put on a stable footing after the Government of the Autonomous Community of Catalonia, Spain, transferred arrears accumulated during the years of the financial crisis. Since then, annual budget agreements and transfers of funds have been made in a timely manner, which secured funding for staff, the running of the Office and

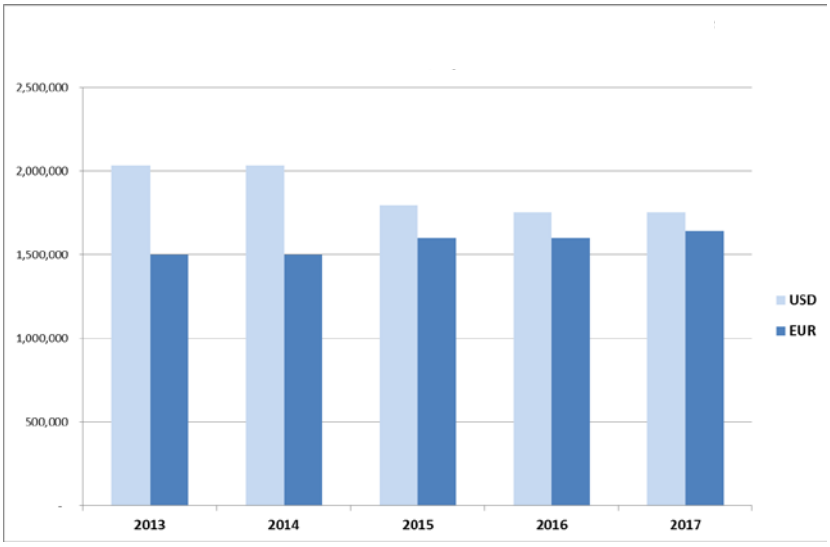
part of the technical work portfolio of the health financing programme. Additional funding has been received from a wide range of donors supporting both country and regional levels of work delivered by the GDO. Country work led by GDO staff is also funded from flexible funds through biennial collaborative agreements with Member States. Diversification of sources of funds proved to be an excellent strategy to increase funding for activities, while the stable funding from Spain enables the Regional Office to deliver more than would be feasible without this GDO (Fig. A6).

Fig. A6. Sources of funding of the WHO Barcelona Office for Health Systems Strengthening



9. Fluctuations of US dollar/euro exchange rates conceal the fact that there has been a slight increase in the financial support provided by the Government of the Autonomous Community of Catalonia, Spain, when defined in euros (Fig. A7).

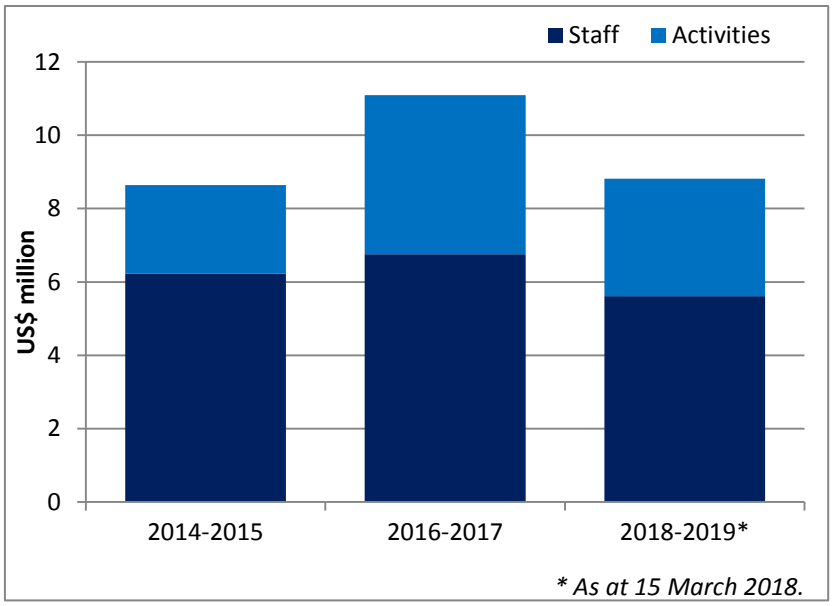
Fig. A7. Funding from the Government of the Autonomous Community of Catalonia, Spain 2013–2017



WHO European Centre for Environment and Health, Bonn, Germany

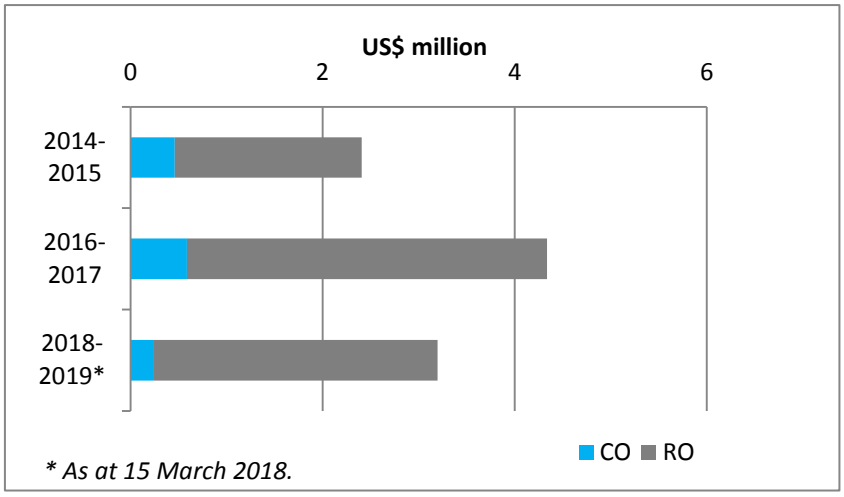
10. Programme area 3.5 (Health and environment) has seen a significant decrease in funding from voluntary contributions, starting from 2014–2015, and projections indicate a similar trend for 2018–2019. Due to these funding realities, the number of staff in the WHO European Centre for Environment and Health (WHO/ECEH) was also reduced to ensure the financial and technical sustainability of the office (Fig. 3). As a result, there is a decrease in the share of the total funding allocated to staff costs (from 72% to 61%) in 2018–2019 (Fig. A8).

Fig. A8. Funding for staff and activities of the WHO/ECEH, Bonn



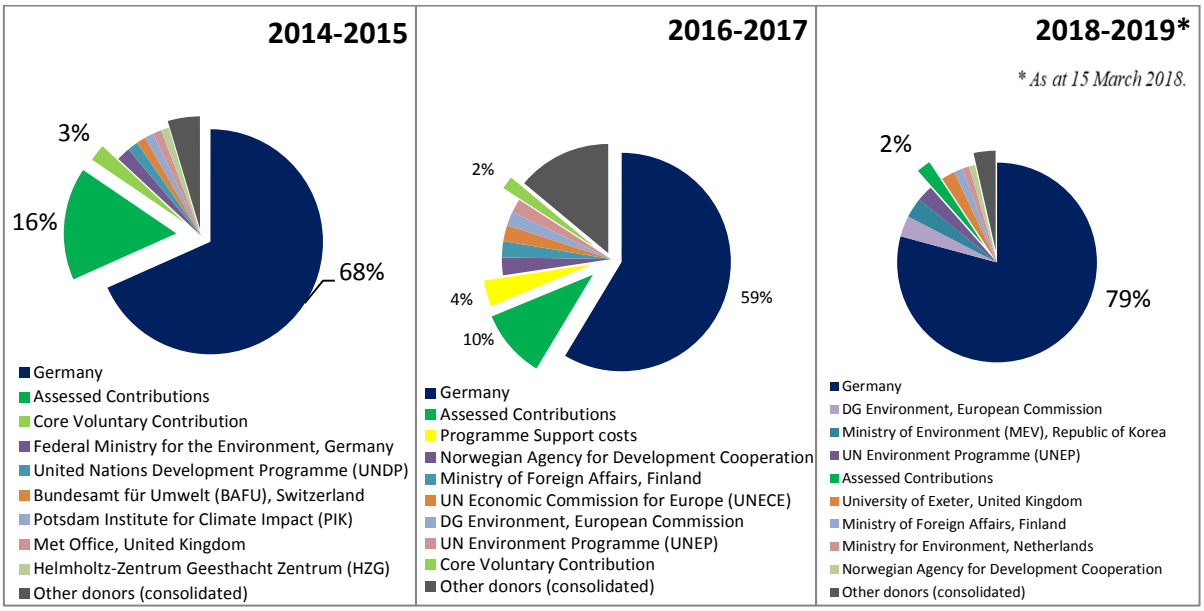
11. The share of the investments in activities at country level in 2014–2015 and 2016–2017 was approximately 20% of the total (Fig. A9); the current 2018–2019 share is smaller but there is a great demand for technical support at country level and investment in activities at country level will grow as 2018–2019 advances.

Fig. A9. Activity funding distribution of the WHO/ECEH, Bonn



12. While corporate flexible funds in other GDOs come largely from the biennial collaborative agreements for the country work led by staff of the respective GDO, due to the decreasing share of voluntary contributions as a source of funding of the Bonn GDO's operations, corporate flexible funds have been advanced to sustain the operations of the Office both in 2014–2015 and 2016–2017 (Fig. A10).

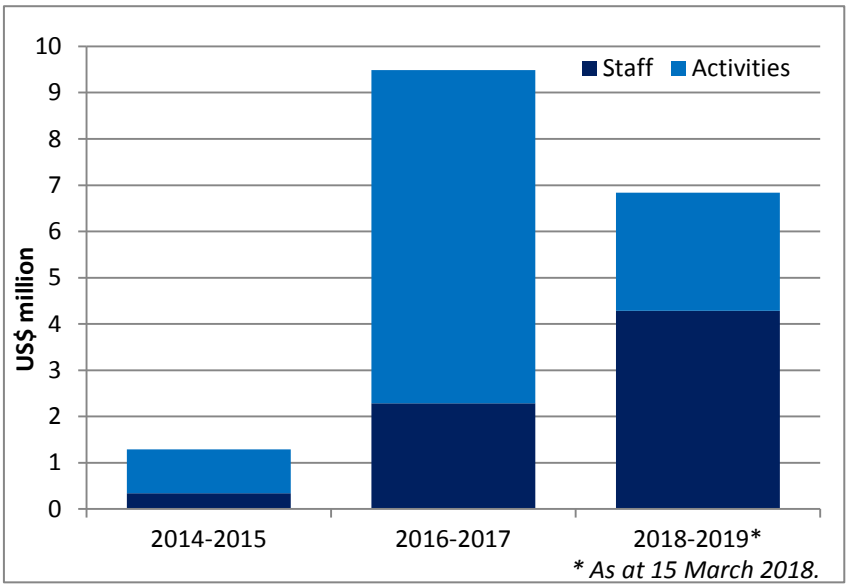
Fig. A10. Sources of funding of WHO/ECEH, Bonn



WHO European Office for the Prevention and Control of Noncommunicable Diseases, Moscow, Russian Federation

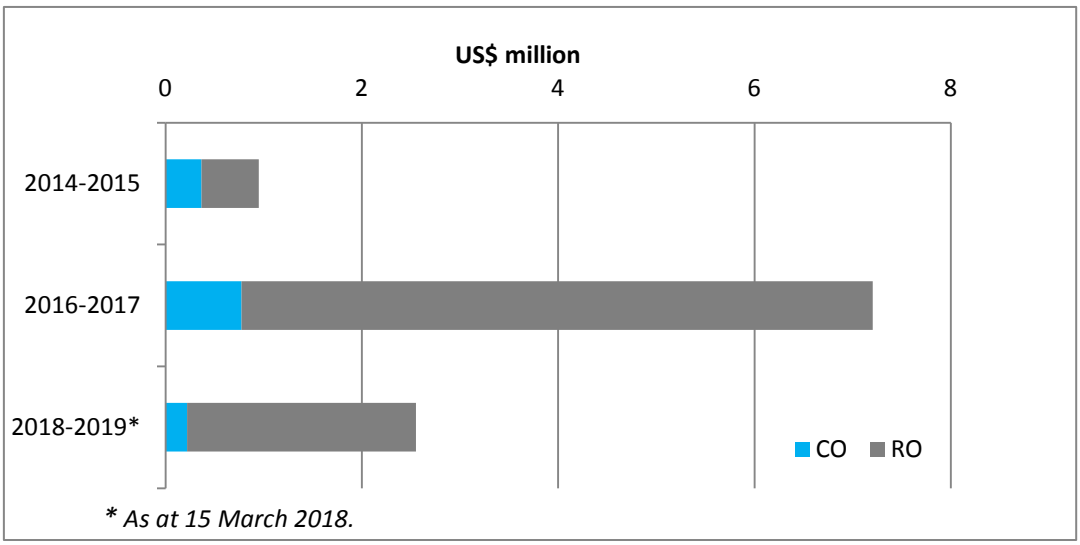
13. The WHO European Office for the Prevention and Control of Noncommunicable Diseases (NCDs), Moscow was launched on 1 December 2014, therefore there was only one year of operations in the biennium 2014–2015. Throughout 2016–2017, the great efforts made to strengthen the team determined the shift in the staff/activity funding breakdown that is seen in 2018–2019 (Fig. A11).

Fig. A11. Funding for staff and activities of the WHO European Office for the Prevention and Control of Noncommunicable Diseases, Moscow



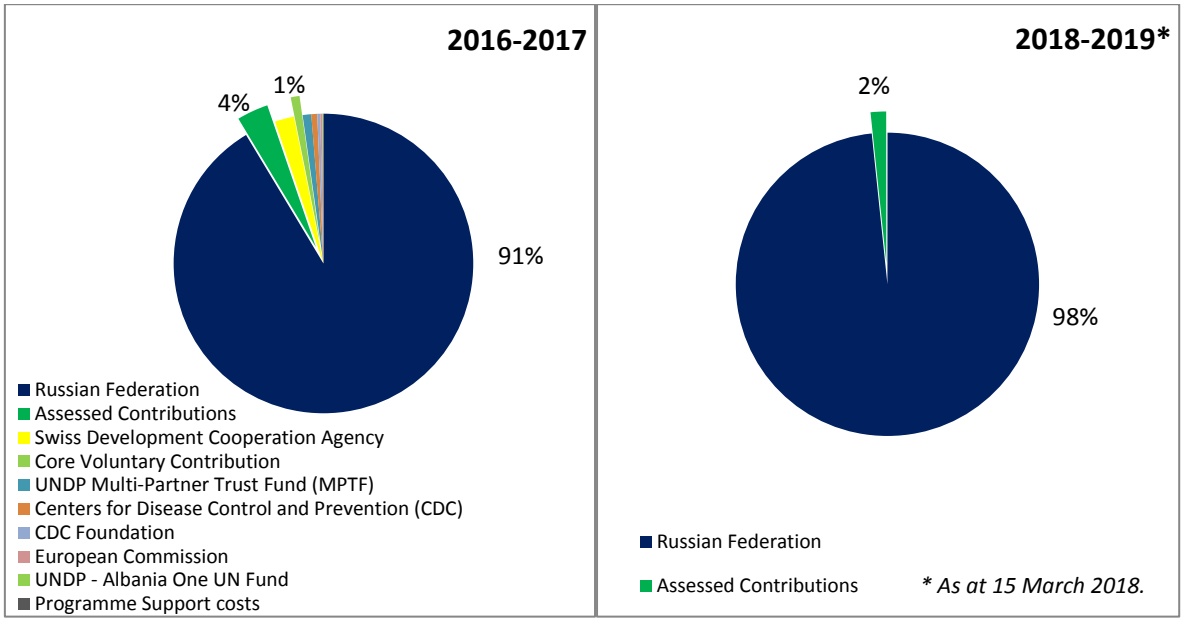
14. As with other more recently established GDOs, the funding of activities was concentrated at the intercountry level and direct country investment remained sub-optimal (Fig. A12). The breakdown is likely to change towards greater investment at the country level in 2018–2019.

Fig. A12. Activity funding distribution of the WHO European Office for the Prevention and Control of Noncommunicable Diseases, Moscow



15. The NCD Office is already attracting significant interest from other donor countries, namely Switzerland, Turkey and Turkmenistan, as well as the EU and global philanthropists and foundations. The NCD Office is using the support from the Russian Federation as a catalyst for consolidating this growing interest and diversifying sources of funding (Fig. A13). The vision is to increase the attractiveness of the NCD Office, aiming for greater volumes of funding and more donors while investing more at country level.

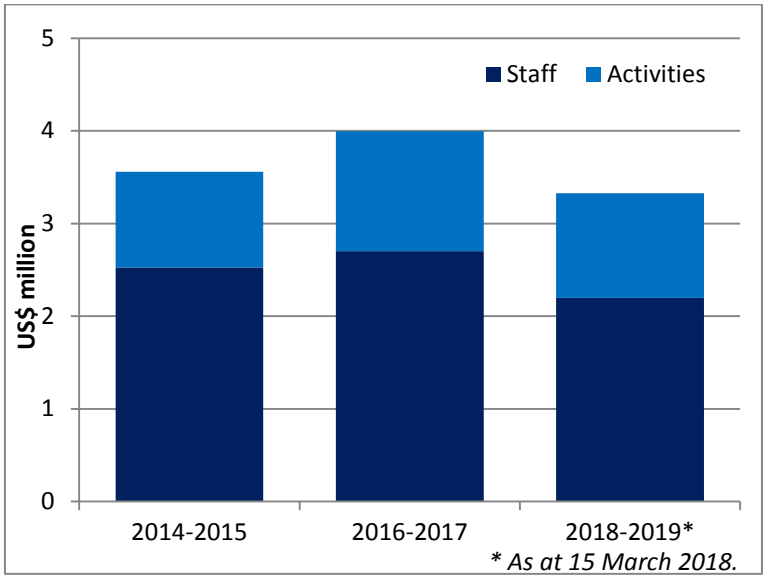
Fig. A13. Sources of funding of the WHO European Office for the Prevention and Control of Noncommunicable Diseases, Moscow



WHO European Office for Investment for Health and Development, Venice, Italy

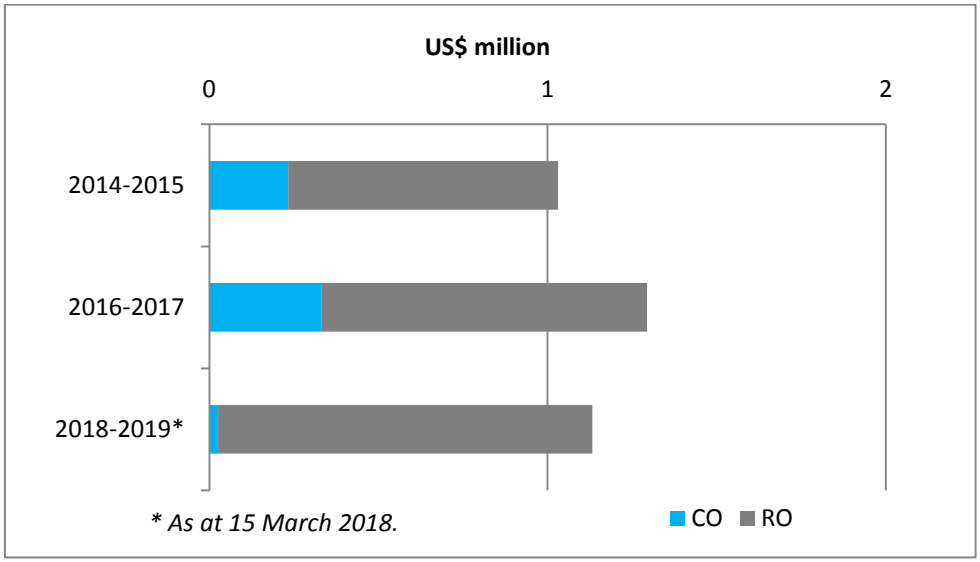
16. The WHO European Office for Investment for Health and Development, Venice, has showcased a steady funding trend throughout the period of analysis (2014 to March 2018), whereby staff costs represent approximately two thirds of the overall operation, which is slightly higher than the organizational average of a 50/50 split (Fig. A14).

Fig. A14. Funding for staff and activities of the WHO European Office for Investment for Health and Development, Venice



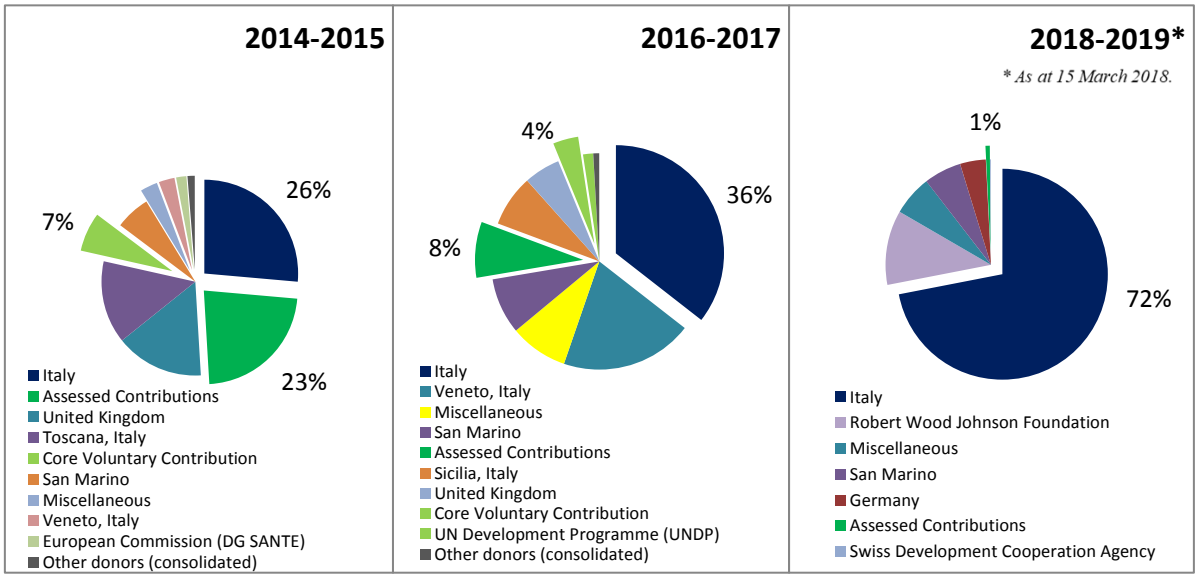
17. Approximately 20% of the funding of Venice GDO activities represent direct country activities with a slight increase in the country share in 2016–2017 and a likely further increase in 2018–2019 as the biennium progresses (Fig. A15).

Fig. A15. Activity funding distribution of the WHO European Office for Investment for Health and Development, Venice



18. The Venice GDO team has mobilized various voluntary contributions at the regional level to support their work, and a number of voluntary and flexible contributions are being implemented with the support of the Venice GDO staff at country level from the various biennial collaborative agreement funds (Fig. A16).

Fig. A16. Sources of funding of the WHO European Office for Investment for Health and Development, Venice



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