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Overview of the implementation of programme budget 2014–2015 in the WHO European Region

This document presents the WHO Regional Office for Europe perspective on the delivery of programmatic results as specified in the approved programme budget for 2014–2015.

The report consists of two parts. Part one provides an overall executive review of the biennial performance assessment, including technical and financial implementation, resources, challenges and lessons learned. Part two provides a more in-depth view on the technical implementation of each of the six categories and their respective programme areas, including a detailed account of the contribution made by the Regional Office for Europe towards the achievement of overall outputs.

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Glossary of terms

Assessed contributions (AC)	Regular contributions made by all Member States, calculated on the basis of an assessment key determined by the United Nations..
Allocated budget	The programme budget as revised and approved by the WHO Director-General, subsequent to World Health Assembly approval.
Administrative support costs (AS)	Part of the programme support costs. These funds can be used to fund only category 6.
Base programmes	The part of the PB for which WHO has full, exclusive managerial control.
Biennial collaborative agreement (BCA)	An agreement between a Member State and the WHO Regional Office, which outlines the focus of work during a specific biennium.
Corporate resources	Financial resources that can be managed by the Organization with a high degree of flexibility; this includes allocating, spending, according priority and filling budget funding gaps. These include AC, AS, CVCA and POC funds.
Country-specific (CS) mode	A mode of delivery used for outputs that are specifically tailored to an individual country.
Core voluntary contributions account (CVCA)	A mechanism to receive, allocate and manage resources provided to WHO by donors and which are flexible at the level of the PB (across categories 1–5) or within a category.
European Observatory on Health Systems and Policies (OBS)	A collaborative arrangement within the PB's SPA segment and located in Brussels, Belgium.
Event Management System (EMS)	An online WHO application tool designed to provide timely information for event monitoring, iterative risk assessment and to support decisions about response operations during outbreaks and other acute public health events in accordance with the International Health Regulations (2005)
Geographically dispersed office (GDO)	An office of the WHO Regional Office for Europe, with a specific technical focus, that is located outside Copenhagen.
Health impact	The final achievement of the value chain, defined as improvements in both the level and the distribution of health in European populations
Intercountry (IC) mode	A mode of delivery used for outputs that will benefit all countries in the Region.
Multicountry (MC) mode	A mode of delivery used for outputs that will benefit a group of countries in the Region.
Multiple indicator cluster survey (MICS)	United Nations Children's Fund-assisted survey for monitoring progress toward national goals and global commitments, including 20 of the MDGs as the target year (2015) approaches.
Output	An element in the value chain representing deliverables by the Secretariat, such as guidelines, norms and standards, policy options, capacity-building packages and technical advice, required by Member States to achieve a health impact.

Post occupancy charge (POC)	Part of staff costs charged to each project or workplan to recover any direct costs associated with project staff who are not otherwise covered. This is an Organization-wide charge that applies to all salaries. In order to avoid double-counting, the POC is applied outside the PB.
Priority outcome	Element in the value chain deemed to be a priority by Member States. The measure of achievement of a priority outcome is "the number of Member States that have … ."
Programme budget (PB)	The WHO global programme budget as presented to the World Health Assembly before the start of the biennium. Budget envelopes are often adjusted during the biennium, resulting in the allocated budget.
Secretariat	The staff and organizational, managerial and physical structures of the World Health Organization.
Special programmes and collaborative arrangements (SPA)	Activities that are fully within WHO's results hierarchy and over which WHO has executive authority.
Specified voluntary contributions (VCS)	Voluntary contributions closely earmarked by the donor as to what and how they can be used.
Strategic Budget Space Allocation (SBSA)	Methodology based on bottom-up planning, the use of realistic costing and the roles and functions of the three levels of the Organization, used to allocate the global programme budget.
Twelfth General Programme of Work	The strategic vision for the work of WHO for the period 2014–2019. It reflects the three main components of WHO reform: programmes and priorities, governance and management.
United Nations Development Assistance Framework (UNDAF)	The planning framework for the development operations of the United Nations system at the country level.
Value chain	Describes and illustrates the transformation of inputs (money, staff, information, etc.) into public health impacts, expressed in terms of the overarching goal of improving the level and distribution of health in the European population
Voluntary contributions (VC)	Contributions received from donors. "Other VC" are VC other than AS, CVCA and OBS.
WHO collaborating centre (WHO CC)	There are 285 officially designated centres in the European Region, of which 112 are designated by the Regional Office and the remainder by WHO headquarters or other regions.

Introduction

1. This document is presented to the 66th session of the Regional Committee for Europe to provide a regional perspective by the WHO Regional Office for Europe on the delivery of programmatic results as specified in the approved programme budget 2014–2015.

2. The report at hand consists of two parts. Part one provides an overall executive perspective on the WHO 2014–2015 end-of-biennium performance assessment report, including technical and financial implementation, resource situation, and challenges and lessons learned. Part two provides a more in-depth view on the technical implementation of each of the six categories, including a detailed account of the contribution by the Regional Office to the overall output achievements.

3. The extensive section on the technical implementation by category uses selected programmes or initiatives to illustrate work done under each of the six categories, including: zero indigenous malaria cases; multidisciplinary cross-programme collaboration between noncommunicable diseases (NCDs) and health systems, with 12 country assessments of health systems responses to NCDs; the small countries initiative; 13 cross-border polio and measles immunization campaigns reaching more than 1.3 million Syrian children; 36 missions, involving 25 staff and amounting to 1302 staff days, in the regional support to the global the Ebola outbreak response; the high-level meeting on refugee and migrant health; children's nutritional status surveillance implemented and enlarged for 32 countries of the Region; the growing number of intersectoral action plans put in place for creating age-friendly, supportive environments at various levels of governance; publication of *The European health report 2015* in two formats and all four official languages; publication of core health indicators in 2014 and 2015 for monitoring progress towards Health 2020 targets; and many other technical highlights of the Regional Office's work and achievements in 2014–2015.

Regional contribution to WHO leadership priorities

4. The 2014–2015 biennium marked the start of implementation of the WHO Twelfth General Programme of Work. It was also the first full biennium since adoption of the Health 2020 policy framework by the 62nd session of the Regional Committee in 2012. Health 2020 addresses the special requirements and experiences of the Regional Office for Europe and is aligned with the six global leadership priorities:

- advancing universal health coverage;
- accelerating the health-related Millennium Development Goals (MDGs) up to and beyond 2015;
- addressing the challenges of noncommunicable diseases and mental health, violence and injuries, and disabilities;
- implementing the provisions of the International Health Regulations (IHR) (2005);
- increasing access to high-quality, safe, effective and affordable medical products; and
- addressing the social, economic and environmental determinants of health as a means of promoting health outcomes and reducing health inequities within and between countries.

5. This document highlights the progress made by the Regional Office towards achieving the global leadership priorities.

6. All of the Regional Office's strategies, action plans, and high-level meetings have been based on the Health 2020 policy framework since its adoption in 2012 and have served as important vehicles for the development of national health policies, strategies and plans in the European Region. Strategies and action plans adopted in the years just prior to the adoption of Health 2020 have been implemented in alignment with the vision and strategic objectives of the policy framework.

Universal health coverage

7. At the national level, the Regional Office supported health officials engaging with other sectors and civil society in policy dialogue to prepare, develop and implement national health policies, strategies and plans that promote universal health coverage (UHC), taking into consideration social determinants of health and other cross-cutting issues, values and principles. The Regional Office continuously advocated for and supported high-level national/local policy dialogue for health systems development to support UHC. During the 2014–2015 biennium, UHC was at the forefront of the approaches taken to reducing health inequalities across national health policies, followed by gender equity and vulnerability reduction.

MDGs

8. The Regional Office continued to pursue implementation of the health-related MDGs as well as to review and document the achievements made and lessons learned, in order to inform the regional preparations and negotiations for the post-2015 development agenda.

9. The life-course approach to improving reproductive, maternal, newborn, child and adolescent health remained high on the political agenda of the WHO European Ministerial Conference on the Life-course Approach in the Context of Health 2020, held in October 2015 in Minsk, Belarus. Improvement of the quality of maternal, newborn and child health care has been achieved in a number of countries as a result of technical support from WHO, implementation of WHO tools and guidelines, and close collaboration with United Nations partners.

10. Assistance was provided to Member States in implementation of the WHO European Action Plan for HIV/AIDS 2012–2015, including wide dissemination and monitoring of the priority actions and targets contained therein. Antiretroviral treatment (ART) was made widely available in the western part of the Region, with coverage estimated to be at around 75% on average at the end of 2015. ART also become more accessible in eastern Europe and central Asia, yet only 21% of those requiring it were receiving ART at the end of 2015. The reduction in mother-to-child transmission of HIV is also one of Europe's successes in its response to the HIV/AIDS epidemic. Significant HIV transmission, however, continues in the Region. A 23% increase in the annual number of people newly diagnosed with HIV during the four years since the European Action Plan for HIV/AIDS was developed (2010–2015) emphasizes the continuing public health challenge of HIV in the Region. This change is largely driven by the high and increasing number of new cases in eastern Europe and central Asia, where population groups at highest risk of HIV infection often do not receive the comprehensive HIV services they need. The number of new infections is decreasing in

some Member States, notably in western Europe where overall rates of newly diagnosed HIV infections decreased by 10% between 2010 and 2014. However, only 12 countries in the Region have decreased rates of newly diagnosed infections by 10% or above since 2010. Much needs to be done to halt and reverse the spread of HIV/AIDS. Support and technical assistance will continue to be provided to Member States to adopt evidence-informed policies for treating and preventing HIV infection, particularly among key populations, and to implement harm reduction interventions and programmes for the prevention of sexual transmission in national HIV plans.

11. The year 2015 marked the end of the Consolidated Action Plan to Prevent and Combat Multidrug- and Extensively Drug-Resistant Tuberculosis (M/XDR-TB) in the WHO European Region 2011–2015. Much progress has been made in the fight against TB in the Region during implementation of the Consolidated Action Plan. TB incidence has been decreasing by about 5% annually, which is the fastest rate of decline among all WHO regions. More than a million TB patients, including 53 000 multidrug-resistant (MDR)-TB patients have been cured and more than 2.6 million lives have been saved. With the support of the Regional Office and partners, Member States managed to increase MDR-TB case detection from one third to 60%, and about 200 000 cases of MDR-TB were averted. However, despite notable progress, TB, and particularly its drug-resistant forms, remains one of the major public health concerns in the Region. Drug-resistant TB is still ravaging the Region, making it the most affected area of the world. Due to high resistance rates and the increasing burden of TB/HIV coinfection in the eastern part of the Region, the mortality rate has not decreased enough to reach the MDG target. In central and western European countries, TB is concentrated among vulnerable population groups, such as people of foreign origin and prisoners. In order to move forward and address the challenges of TB and M/XDR-TB prevention and care, Member States at the 65th session of the Regional Committee in September 2015 endorsed a new Tuberculosis Action Plan for the WHO European Region 2016–2020.

12. For the first time, in 2015 the Region reported zero indigenous malaria cases, in line with goal of the Tashkent Declaration on the elimination of malaria from the Region by 2015. The work on neglected tropical diseases, as dengue and chikungunya are not endemic in the Region, mainly focused on leishmaniasis and soil-transmitted helminthiasis. Historic milestones were achieved in the global effort to eradicate all wild polioviruses, but maintaining the Region’s polio-free status and preparing for the post-eradication period became critical and require constant vigilance.

13. Several health targets in the newly adopted Sustainable Development Goals (SDGs) follow on from the unfinished agenda of the MDGs.

NCDs, mental health, violence and injuries

14. The Regional Office spearheaded the United Nations’ thematic group on social determinants and the prevention and control of NCDs, and through intensive collaboration with other United Nations agencies, 10 new United Nations Development Assistance Frameworks (UNDAFs) were developed – for the first time to include NCD-related results and outcomes. A new project on the development of a geographically dispersed office on NCDs in Moscow, Russian Federation, was launched. The prevention and control of cardiovascular diseases in Europe was the theme of a major international conference, and further new STEPwise approach to Surveillance of NCDs (STEPS) risk factor surveys were

completed in four countries. Technical contributions were provided to support: national mental health policy and legislation development; capacity-building to strengthen primary health care in addressing mental conditions and suicide prevention; and facilitation of changes in the configuration of community-based mental health services.

15. **Investing in children: the European child maltreatment prevention action plan 2015–2020** was developed by the Regional Office and adopted by the Regional Committee at its 64th session in 2014 in resolution EUR/R64/R6. Capacity-building efforts were systematically conducted: training in TEACH-VIP e-learning, national policy dialogues on road safety and national policy dialogues on child maltreatment prevention. Databases on violence and injury were updated, resulting in three new publications: *European facts and the global status report on violence prevention 2014; Injuries in Europe: a call for public health action*; and *European facts and the global status report on road safety 2015*.

IHR (2005)

16. The Regional Office strengthened the use of the IHR (2005) to prevent and respond to emergencies. Joint work with other sectors and international organizations during the response to the Ebola virus disease outbreak was enhanced, culminating in the development of an overview of response capacities at European airports. Alert and response operations continued, with event-based surveillance throughout the biennium on a 24/7 basis recording 80 public health events in the WHO Event Management System out of more than 1500 signals reviewed and assessed per year.

17. In the European Region, the majority of States Parties to the IHR have established the required IHR capacities. However, in several countries the IHR need more cross-sectoral commitment and operational relevance. The Regional Office provided support to countries in revising their legislation to: empower National IHR Focal Points to share information and reports; enhance specific national critical functions and capacities, such as surveillance, laboratory networks and risk communication; and strengthen the peer network and mutual support within the WHO European Region.

Access to medical products

18. Access to specific medical products continued to be an important focus in several programme areas, including, access to antiretroviral drugs for HIV treatment; TB diagnostic tests and treatment drugs; and immunization vaccines and contraceptives. In emergencies, such as those experienced in Ukraine, southern Turkey and northern Syria, access to medical products played a critical role.

19. A WHO flagship publication, *Access to new medicines: technical review of policy initiatives and opportunities for collaboration*, was developed and published in early 2015 with several partners including the Organisation for Economic Co-operation and Development (OECD) and the London School of Economics. The Observatory Venice Summer School in 2014 was conducted with the theme: Re-thinking pharmaceutical policy – optimizing decisions in an era of uncertainty. Three pharmaceutical pricing and reimbursement information (PPRI) network meetings and a PPRI conference were carried out with the PPRI WHO collaborating centre to update Member States on pricing and reimbursement policies and discuss current challenges.

Social, economic and environmental determinants of health outcomes and health inequities

20. Sustaining the multisectoral policy commitment to reducing health inequities required a balance between high-level political advocacy by the Regional Office and new partnerships for action. These have been a strong feature of the work developed in 2014–2015. The evidence base and promising practices in cross-sectoral policies and approaches continued to be strengthened through five national inequity policy reports, three social determinants/equity guidance documents, and new mainstreaming tools such as the *Toolkit on social participation: methods and techniques for ensuring the social participation of Roma populations and other social groups in the design, implementation, monitoring and evaluation of policies and programmes to improve their health*. Four multicountry partnerships, involving 23 Member States, were active in advancing common policy objectives and building capacity to reduce inequities through addressing social determinants of health. There has also been increased interest from Member States in learning exchange and support of innovative approaches to scaling up action on social determinants, vulnerability, migration and health equity (see Box 1).

Box 1. Health 2020 and working across categories and programme areas

A main tenet of Health 2020 is that different health issues and actions cannot be seen in isolation from each other and from the social and physical environments. Therefore collaboration among programmes and with other sectors has been encouraged in 2014–2015. Some examples include:

The **European Ministerial Conference on Life-course Approach in the Context of Health 2020** in Minsk, Belarus, in October 2015 resulted in the signing of the Minsk Declaration and clear plans for further life-course approach actions. These actions not only provide guidance to category 3 (Promoting health through the life-course), but also to categories 2 (Noncommunicable diseases) and 4 (Health systems).

A multidisciplinary collaboration between the NCD and health systems teams has developed a guide and conducted country assessments on health system strengthening with a focus on NCDs in 10 countries: Armenia, Belarus, Croatia, Estonia, Hungary, Kyrgyzstan, Republic of Moldova, Tajikistan, the former Yugoslav Republic of Macedonia and Turkey. The assessments were followed up by policy dialogues, policy development and building of political support.

Challenges remain, though, in getting countries to acknowledge: the role of social determinants; the importance of intersectoral action; the preventability of diseases and injuries; and the need to mobilize political will, which itself includes countering the disinvestment in policies that have a positive influence on UHC and health equity.

21. Activities in regard to climate change, sustainable development and environmentally-friendly health systems were conducted in several Member States and work on prevention and control of water-related diseases was revitalized with a focus on strengthening capacities for surveillance systems. Work on water, sanitation and hygiene in schools commenced in 2014, while activities continued in relation to environmental exposures and risk capacity-building.

Preparation of the post-2015 development agenda

22. Throughout 2014–2015, as part of the United Nations Development Group Team for Europe and Central Asia (ECA R-UNDG) and the Regional Coordination Mechanism (RCM), the Regional Office has closely followed and been engaged with the post-2015 process.

23. The work has been guided by the priorities and key messages agreed upon among regional policy-makers and other stakeholders at the regional consultation, Inclusive and Sustainable Development: Perspectives from Europe and Central Asia on the Post-2015 Development Agenda, held in Istanbul, Turkey, in November 2013, which highlighted the critical role of health in the new development agenda and recognized Health 2020 as being a crucial regional framework for health and well-being in terms of laying the groundwork and implementing the new vision for health after 2015.

24. The priorities and key messages formulated at the regional consultation also fed into the global negotiation process, including the work of the Open Working Group on the SDGs, and were promoted through various channels at the national and international levels.

25. Regular briefings, guidance and technical support on the post-2015 development agenda have been provided to staff, especially at the country level, where heads of WHO country offices have played a crucial role in supporting national consultations and ensuring the central role of health in national development priorities.

26. The post-2015 development agenda has featured regularly in briefings to the Regional Committee and the Standing Committee of the Regional Committee, under agenda items on matters arising from resolutions and decisions of the World Health Assembly and the Executive Board.

27. In December 2015, the RCM and the ECA R-UNDG organized a retreat, with the aim of defining joint priority actions among United Nations agencies for implementing the SDGs. One outcome of the retreat was that health was identified as one of the “issue-based coalitions”, serving as a platform for the implementation of health across the SDGs, advocacy, partnerships and resource mobilization, and monitoring and evaluation.

28. The countries of the European Region have been important advocates of health and its central role in the new development agenda throughout the negotiations. Following the launch of the 2030 Agenda for Sustainable Development, preparations have started for the “localization” of the Agenda at the country level, with the integration of the SDGs and their targets into national development plans, policies and strategies, as well as into programming and budgeting, and resource mobilization strategies.

29. This represents a unique opportunity to renew national commitments to health, seek intersectoral synergies and implement the priorities already endorsed by European Member States through the adoption of Health 2020.

30. The United Nations system as a whole, and WHO in particular, will play an important role in supporting the implementation of the 2030 Agenda. UNDAFs, country cooperation strategies, biennial collaborative agreements (BCAs), and their alignment, will all be important means of implementation at national and local levels.

31. The multiplicity and complexity of the health targets that run through most of the SDGs will enable WHO, as well as the broader United Nations system, to think and act more broadly on the determinants of health, through an integrated approach to sustainable development, with policy coherence across different sectors as well as good governance and whole-of-government and whole-of-society efforts.

32. The totality of the health targets under the SDGs address most national health concerns, all the main priorities of the Twelfth General Programme of Work, as well as the majority of WHO's programme areas. Therefore, an approach to national health development that focuses on individual programmes in isolation will be counterproductive and will fail to address the many cross-cutting issues that do not fit neatly into single programme areas.

33. Achieving the new health targets will require WHO to maintain and strengthen its core functions as set out in the Twelfth General Programme of Work, particularly in terms of:

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

34. The integrated nature of the SDGs provides additional legitimacy and an opportunity for WHO to take a fresh look at the institutional arrangements that are required to improve and maintain people's health. There is now an opportunity to start thinking about what is needed in terms of institutional arrangements for financing and producing global public goods; for improving cross-border health security; for improving the relevance and coherence of United Nations bodies in the field of health; for addressing the causes of NCDs; and for enhancing standardized measurement and accountability.

Programme budget 2014–2015

Changes to budget levels for the European Region

35. In May 2013, the Sixty-sixth World Health Assembly approved the programme budget (PB) 2014–2015 before the completion of operational planning (during which every output and deliverable was costed). During the 2014–2015 biennium, the following adjustments were made to the regional budget:

(a) after completion of operational planning for PB 2014–2015, programme area budgets were adjusted to reflect detailed costings, while budgets by category were kept at the levels approved in resolution WHA66.2 (referred to as the WHA-approved budget);

(b) budget level increases and decreases were made in all technical categories based on updated funding and implementation projections at the end of 2014; and

(c) several ad hoc budget increase requests were submitted for the outbreak and crisis response programme area of category 5 for the crisis response operations carried out by the Regional Office: operations in Turkey related to the situation in the Syrian Arab Republic, specifically in connection with the Gaziantep field presence in southern

Turkey; the humanitarian crisis response related to the situation in Ukraine; and the emergency response to the Balkan floods (as large-scale outbreaks or crises requiring a response cannot be planned for, their budgets are rapidly adjusted based on the scale of operations and available funding);

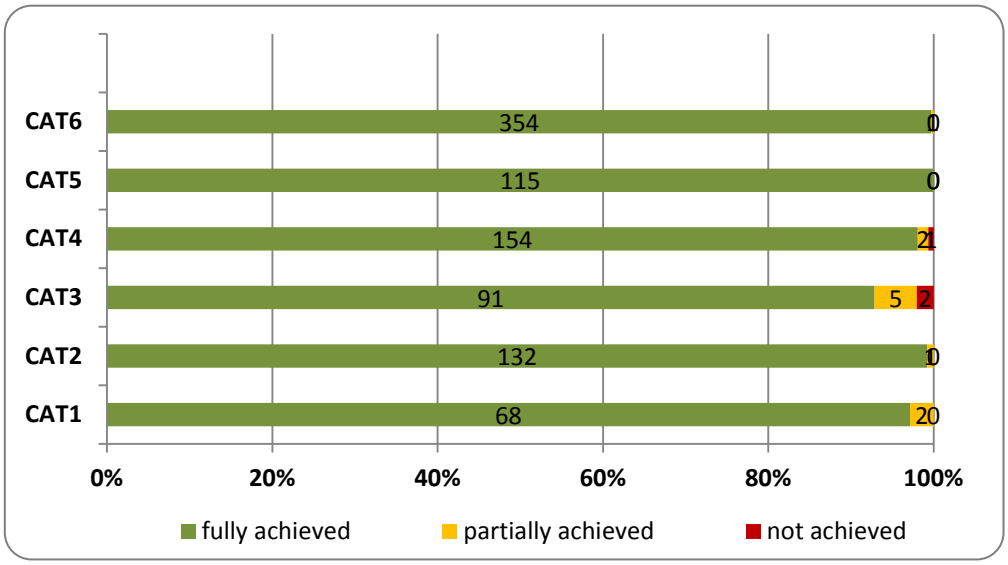
(d) when implementation projections could be made with certainty and the level of funding was known with relatively high precision in the second half of 2015, the base PB (excluding outbreak and crisis response and the polio eradication programme) was carefully reviewed and brought into line with implementation and funding projections in order to align the total allocated budget for the Regional Office with the level of the WHA-approved budget of US$ 216 million. This resulted in some realignment of the budget envelopes for categories 1, 2, 3 and 5.

36. The above-mentioned adjustments to programme areas and categories resulted in an allocated budget of US$ 239 million for 2014–2015 for the Regional Office, a 6% increase over the WHA-approved budget of US$ 225 million, the entire increase being in outbreak and crisis response.

End-of-biennium overview of technical implementation

37. For 2014–2015, the Regional Office had a portfolio of 1161 outputs. These are outputs for the global PB 2014–2015 that are specified at the regional and country levels. Achievement of outputs is monitored and analysed through reviews at six-month intervals at the regional level. In the end-of-biennium assessment, 97% of outputs were reported to be achieved, 1% partially achieved and 2% not achieved (see Fig. 1).

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



38. For the partially and not achieved outputs the main challenges continue to be the lack of financial and human resources, which prevented completion of the relevant deliverables, despite efforts by the country offices and national counterparts. Political changes that affected decisions within ministries of health also resulted in delays or postponement of some programmed activities. Lastly, some public health actions involved limited implementation of WHO-recommended evidence-based policies, which resulted in technical challenges to advance them and required increased advocacy at higher levels.

39. Category 3 has the highest percentage of partially or not achieved outputs. The major issue for this category for the European Region is that resource mobilization efforts were less successful than expected in this biennium. In particular, programme areas 3.4 (Social determinants of health) and 3.5 (Health and the environment) are highly dependent on voluntary contributions (VC) raised by the programmes themselves, and these VC funds are for the most part highly specified. While the Regional Office received more flexible funds in 2014–2015 than in previous bienniums and these funds were strategically distributed internally, it was not possible to fill all the funding gaps. This underfunding in turn prevented the achievement of several outputs, most prominently in programme area 3.1 (Reproductive, maternal, newborn, child and adolescent health).

40. The analysis of the achieved outputs also highlighted a number of factors that at times slowed down technical implementation. These challenges must be considered as lessons learned from this biennium and will be considered in risk mitigation plans for 2016–2017. By far the most common challenges were the need to strengthen technical capacities at the country level and to ensure the sustainability of actions to maintain achievements, followed by the lack of resources and political changes that delayed implementation.

41. Many WHO country offices in the European Region as well as several technical programmes have a relatively low number of staff, and these offices and programmes often experienced challenges in meeting various technical, administrative and political demands. Therefore, building technical capacity and developing strong collaboration with key partners continued to be the main success factors to advance the regional health agenda in 2014–2015.

42. The European Region has been making good progress in a number of public health areas, and questions have been raised as to how to sustain the progress achieved. For categories 1 and 5, for instance, the progress achieved in many programmes is shifting the focus of donors towards other countries or regions in higher need, leaving full responsibility to Member States to continue their financing. Category 2 sustainability demands are more oriented towards the implementation of strategies, policies and plans that have recently been adopted and require appropriate follow-up for their success. Categories 3 and 4 focused more on sustainability needs in terms of staff and continuity of programmes at the country level.

43. An important challenge this biennium was also the budget level pressures in categories 1, 4 and 5. Although budget levels were revised for these categories, the process was lengthy and eventually delayed implementation. As mentioned earlier, the Regional Office was able to review and readjust the total budget towards the end of the biennium to bring it into line with the approved level, but interim increases had allowed the needed flexibility to accommodate funding and continue implementation.

44. Several technical and administrative programme areas also felt a direct impact on progress in delivery due to the deployment of staff members to support the Ebola outbreak response. Between April 2014 and June 2015, the Regional Office organized 36 missions for the Ebola response, involving 25 staff, amounting to 1302 staff days and close to US$ 700 000 in staff salary expenses.

45. The full end-of-biennium assessment of PB 2014–2015 is a global exercise. The Regional Office's programme area and category leads contributed to the process with assessment reports, focusing on main achievements, challenges and risks for implementation. These reports were consolidated into a global document[1] presented to the Sixty-ninth World Health Assembly in May 2016. A high-level summary of technical and administrative lessons learned by the Regional Office stemming from the end-of-biennium assessment is presented in this document.

End-of-biennium overview of funding and financial implementation

By category

46. The Regional Office's WHA-approved budget for 2014–2015 was US$ 225 million. Distribution of the budget by category is shown in Table 1 and Fig. 2. Among the technical categories, category 4 (Health systems) had the largest share of the budget (20%), followed by category 3 (Promoting health through the life-course).

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

Category	WHA-approved budget	Allocated budget	Increase/decrease	
1	30.6	36.2	5.6	18.3%
2	32.8	29.2	-3.6	-11.0%
3	40.1	36.0	-4.1	-10.3%
4	44.8	45.0	0.2	0.4%
5	13.7	15.5	1.8	12.8%
6	54.0	54.0	0.0	0.0%
Total Base	216.0	215.8	-0.2	-0.1%
Emergencies	9.0	23.0	14.0	155.6%
Total European Region	**225.0**	**238.8**	**13.8**	**6.1%**

Note: Category 5 refers to programme areas 5.1, 5.2, 5.3, 5.4; Emergencies refers to programme areas 5.5, 5.6.

47. As noted above, the European Region's WHA-approved budget had been adjusted for various reasons, resulting in the final increase of US$ 14 million (6%) to US$ 239 million; the entire increase being in the Emergencies part of the budget. The base budget of categories 1, 2, 3 and 5 had been adjusted (see Table 1) with a net zero increase. The new budget level is referred to as the current allocated budget or allocated PB.

48. At the end of the biennium, the approved budget of the Regional Office was funded at 95% (Table 2), with base programmes funded at 90% and Emergencies at 232%, as the approved PB 2014–2015 for Emergencies was established on the basis of the situation in the

[1] Document A69/45, WHO programmatic and financial report for 2014–-2015 including audited financial statements for 2015.

previous biennium and therefore underestimated. The level of PB funding was adjusted towards the end of the biennium when implementation projections could be made with certainty; projected surplus of VC was transferred to the next biennium, whenever donor agreements allowed such a transfer.

Table 2. Implementation and financing of PB 2014–2015 by category

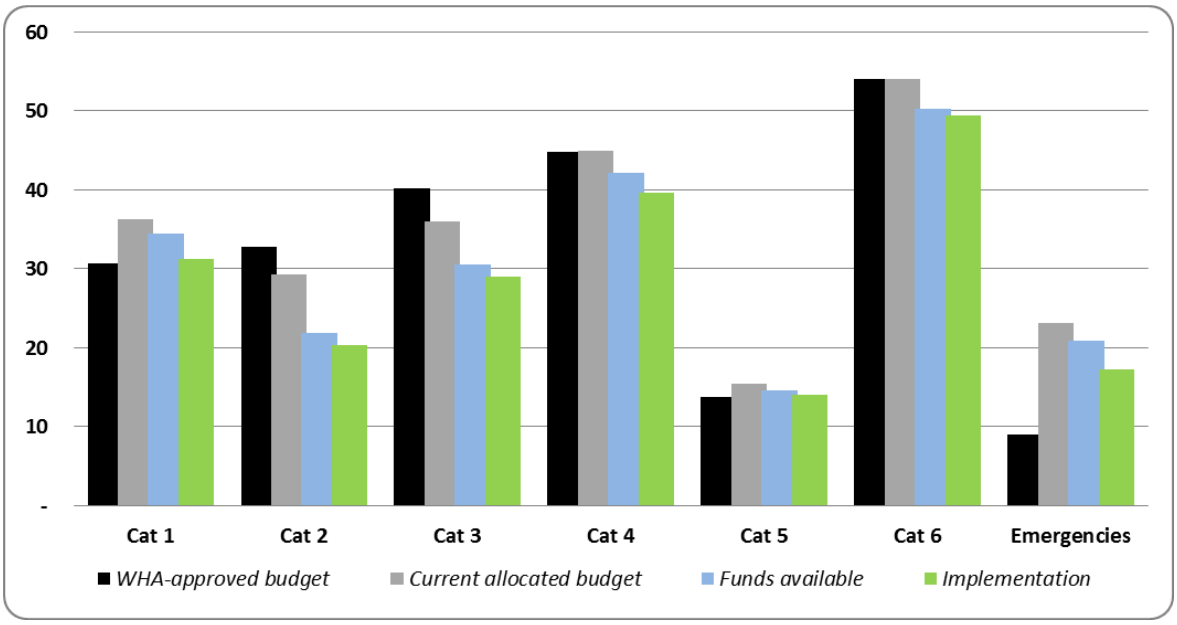
Category	% funds available of WHA-approved PB	% funds available of allocated PB	% implementation of WHA-approved PB	% implementation of allocated PB	% implementation of funds available
1	113%	95%	102%	86%	91%
2	67%	75%	62%	69%	93%
3	76%	85%	72%	81%	95%
4	94%	94%	88%	88%	94%
5	106%	94%	103%	91%	97%
6	93%	93%	91%	91%	98%
Subtotal Base	90%	90%	85%	85%	95%
Subtotal Emergencies	232%	91%	192%	75%	83%
Total European Region	**95%**	**90%**	**89%**	**84%**	**94%**

Note: Category 5 refers to programme areas 5.1, 5.2, 5.3, 5.4; Emergencies refers to programme areas 5.5, 5.6.

49. Biennial implementation of the WHA-approved budget was 89%, which is in line with the commitment made at the 65th session of the Regional Committee in September 2015. This level of implementation was achieved despite several impeding factors, in addition to the ones already mentioned in the section on technical implementation. The most important reasons behind the uneven implementation pattern were: availability of resources at a later stage of the biennium than earlier; capacity issues, especially at the country level; redirection of staff to support the responses to regional and global crises; budget ceiling restrictions; the impact of a stronger US dollar (budget and expenditures are expressed in US dollars while regional expenditures are to a great extent in euros). The approximately 90% implementation, despite these factors, was possible through coordinated efforts by all staff at the regional and country levels, which were also boosted by a number of operational measures implemented during 2015. The Secretariat carefully monitored and analysed the implementation level on a monthly basis, with closer follow-up in the second half of 2015. Lessons learned from this process included the need to maintain close monitoring in the early days of the 2016–2017 biennium in order to mitigate implementation risks proactively and in a timely manner.

50. Analysis of funding by category (Table 2 and Fig. 2) shows a great variation in available funding as a percentage of the WHA-approved PB: between 67% in category 2 and 113% in category 1. There is a more even funding of the allocated PB (between 75% and 95%), that is, when available funding is compared to the adjusted levels of the budget. Implementation of available funds, on the other hand, is very even across all base categories (Table 2), at between 91% and 98%, indicating great absorption capacity. More detailed analysis of funding and implementation within categories, by programme area, is presented in the next section.

Fig. 2. PB 2014–2015: WHA-approved and allocated budget, available funds and implementation by category, as of 31 December 2015 (US$ million)



By programme area

51. The six categories of the PB are divided into 30 programme areas as shown in Annex 2. Table 3 summarizes the financial situation and budget implementation by programme area.

52. Table 3 shows that 20 of the 30 programme areas had more than 80% of their WHA-approved PB funded, a positive development in comparison with the situation in past bienniums, which demonstrates the effectiveness of the financing dialogue. Despite this overall positive trend, most of the underfunded programme areas are in categories 2 and 3 (the same is true globally), which are high-priority areas both regionally and globally. The Regional Office offset this imbalance with flexible corporate resources, but only to the extent possible.

53. There is a direct correlation between implementation of the WHA-approved PB and available funding (Table 3, marked in red). This underlines the issue that the underfunded programme areas continue to have aspirational budget levels, which are not supported by allocated funding. As a consequence, these areas show low implementation against the approved budget. All programme areas without exception show high biennial implementation of available resources.

By staff and activity costs

54. Overall spending on staff constituted 53% of total biennial expenditure, which is about 12% less than in the last biennium when the Regional Office started to implement its sustainability plan, whereby administrative/support staff levels were reduced. Lower staff cost expenditures are directly related to overall staffing levels (Fig. 3) as well as the impact of a stronger US dollar. Towards the end of 2015, there was a slight increase in staff numbers – in line with the Regional Office's strategy to strengthen technical capacity.

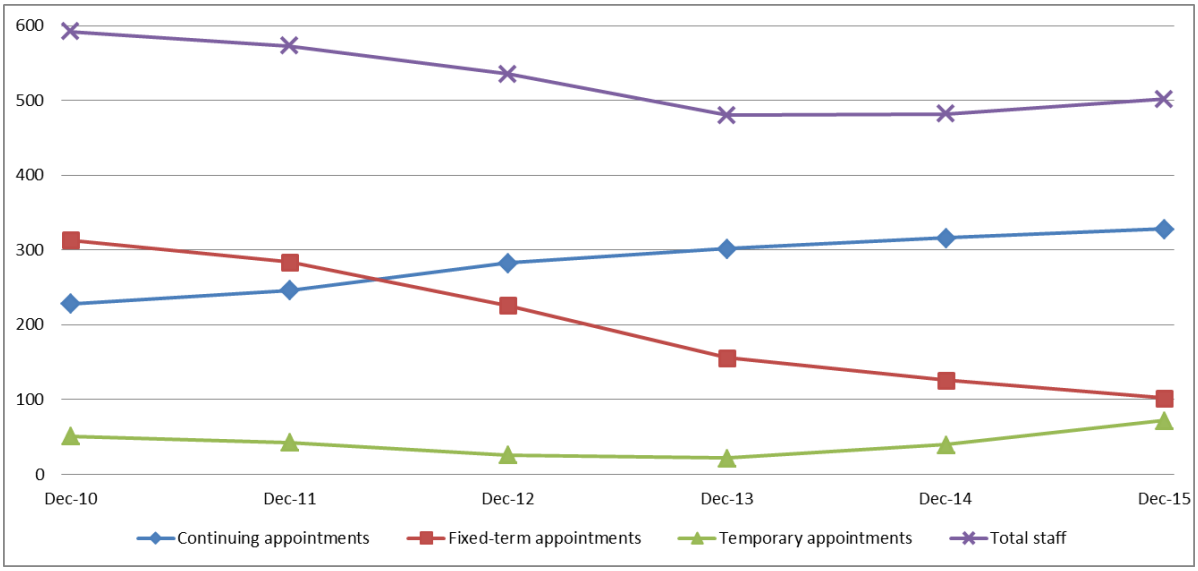
Further strengthening of technical capacity at both regional and country levels is planned for 2016–2017.

Table 3. PB 2014–2015 by programme area: budget, available resources and implementation, as of 31 December 2015 (US$ 000)

Programme area	WHA-approved PB	Allocated PB	Funds available (awards budgeted + to be budgeted)	Implement-ation	% funds available of WHA-approved PB	% funds available of allocated PB	% implement-ation WHA-approved PB	% implement-ation of allocated PB	% implement-ation of available funds
1.1 HIV	5,800	7,033	6,607	6,026	114%	94%	104%	86%	91%
1.2 TUB	11,000	14,062	13,248	11,153	120%	94%	101%	79%	84%
1.3 MAL	1,100	1,055	1,049	1,049	95%	99%	95%	99%	100%
1.4 NTD	400	409	376	384	94%	92%	96%	94%	102%
1.5 VPD	12,300	13,566	13,213	12,617	107%	97%	103%	93%	95%
Subtotal Cat 1	**30,600**	**36,125**	**34,493**	**31,229**	**113%**	**95%**	**102%**	**86%**	**91%**
2.1 NCD	16,400	15,501	11,778	10,434	72%	76%	64%	67%	89%
2.2 MHS	7,200	4,936	4,266	4,152	59%	86%	58%	84%	97%
2.3 VIP	6,700	5,215	3,408	3,413	51%	65%	51%	65%	100%
2.4 DIS	500	967	869	841	174%	90%	168%	87%	97%
2.5 NUT	2,000	2,584	1,595	1,443	80%	62%	72%	56%	90%
Subtotal Cat 2	**32,800**	**29,202**	**21,916**	**20,283**	**67%**	**75%**	**62%**	**69%**	**93%**
3.1 RMC	7,000	6,997	6,622	6,356	95%	95%	91%	91%	96%
3.2 AGE	1,500	1,500	1,072	988	71%	71%	66%	66%	92%
3.3 GER	1,300	1,129	945	931	73%	84%	72%	82%	99%
3.4 SDH	7,600	7,498	6,546	5,999	86%	87%	79%	80%	92%
3.5 HEN	22,700	18,856	15,322	14,758	67%	81%	65%	78%	96%
Subtotal Cat 3	**40,100**	**35,981**	**30,507**	**29,032**	**76%**	**85%**	**72%**	**81%**	**95%**
4.1 NHP	17,600	16,522	15,078	14,106	86%	91%	80%	85%	94%
4.2 IPH	11,700	14,981	13,860	12,660	118%	93%	108%	85%	91%
4.3 AMT	7,000	3,708	3,707	3,667	53%	100%	52%	99%	99%
4.4 HSI	8,500	9,780	9,491	9,179	112%	97%	108%	94%	97%
Subtotal Cat 4	**44,800**	**44,991**	**42,136**	**39,612**	**94%**	**94%**	**88%**	**88%**	**94%**
5.1 ARC	7,500	5,962	5,363	5,173	72%	90%	69%	87%	96%
5.2 EPD	1,400	5,430	5,382	5,113	384%	99%	365%	94%	95%
5.3 ERM	3,400	3,084	2,876	2,839	85%	93%	84%	92%	99%
5.4 FOS	1,400	974	943	931	67%	97%	67%	96%	99%
Subtotal Cat 5	**13,700**	**15,451**	**14,564**	**14,056**	**106%**	**94%**	**103%**	**91%**	**97%**
6.1 GOV	25,300	27,631	25,461	25,372	101%	92%	100%	92%	100%
6.2 TAR	1,100	2,310	1,944	1,970	177%	84%	179%	85%	101%
6.3 SPR	3,400	3,248	2,735	2,729	80%	84%	80%	84%	100%
6.4 ADM	21,400	16,629	15,979	15,240	75%	96%	71%	92%	95%
6.5 COM	2,800	4,182	4,055	4,052	145%	97%	145%	97%	100%
Subtotal Cat 6	**54,000**	**54,000**	**50,173**	**49,363**	**93%**	**93%**	**91%**	**91%**	**98%**
Subtotal Base	**216,000**	**215,749**	**193,790**	**183,575**	**90%**	**90%**	**85%**	**85%**	**95%**
5.5 POL	4,000	6,933	5,478	4,557	137%	79%	114%	66%	83%
5.6 OCR	5,000	16,137	15,430	12,728	309%	96%	255%	79%	82%
Subtotal Emergencies	**9,000**	**23,070**	**20,908**	**17,285**	**232%**	**91%**	**192%**	**75%**	**83%**
Total European Region	**225,000**	**238,819**	**214,698**	**200,860**	**95%**	**90%**	**89%**	**84%**	**94%**

55. In 2014–2015, the funding of staff costs was regularly monitored and there was no risk of shortfall with the exception of programme area 3.5 (Health and environment) as a result of decreased funding of this programme area and tightly earmarked funds, which could predominantly be used only for activities. Flexible corporate resources were provided to this programme area to bridge the gap and a sustainability plan is being implemented to ensure that this programme area operates within its projected means in 2016–2017.

Fig. 3. Number of staff employed by the Regional Office during the past five years by type of contract



56. The level of planned activities had to be adjusted during the biennium, depending on the availability of funds as signified by the overall programme area funding (Table 3). Despite this fact, and as shown in the technical implementation section, the majority of planned outputs have been delivered during the biennium; often, alternative ways of implementation had to be found, such as greater reliance on technical capacity at the country level, on partner organizations and on collaborating centres.

Outbreak and crisis response

57. As the 2014–2015 biennium saw the highest ever number of emergencies globally as well as in the European Region, significant efforts of the Regional Office were directed towards emergency preparedness and response operations. The Regional Office assisted Member States in dealing with three WHO-graded emergencies in the European Region, as well as the refugee influx into Europe. As a part of corporate efforts, the Regional Office deployed a significant number of senior staff to support global emergencies like the fight against the Ebola outbreak in West Africa, the consequences of the earthquake in Nepal in April 2015 and the response to the crisis in Yemen.

58. The most prominent emergency affecting the European Region is the conflict in the Syrian Arab Republic, with 6.5 million people internally displaced and 4.5 million people fleeing the country. Close to 3 million refugees are hosted by Turkey alone. In 2013, WHO established a field presence in Gaziantep, southern Turkey, which has since been coordinating the health sector response jointly with the Turkish Government for the refugees residing in Turkey and also in northern Syria, taking the whole of Syria approach and leading the Health Cluster for northern Syria jointly with Save the Children. In southern Turkey, the main achievements of the WHO field presence with regard to Syrian refugees in Turkey in 2014–2015 were: training 175 doctors and 74 nurses to be able to obtain licences to treat Syrians in Turkey; mental health assessments among refugees; scaling up the national public health laboratory to enable analysis of an increasing amount of samples from the Syrian Arab Republic; training outbreak alert and response staff of the Turkish Ministry

of Health on communicable diseases; providing medical equipment and supplies to health clinics to improve health services for Syrian refugees; organizing and monitoring an immunization campaign of 44 000 Syrian children according to the Turkish vaccination schedule; raising health awareness among refugees; and prepositioning 86 emergency health kits.

59. WHO works under United Nations resolution 2258, which authorizes cross-border humanitarian aid delivery into the Syrian Arab Republic; activities are coordinated through the WHO whole of Syria approach, which unites the Gaziantep, Jordan and Damascus hubs to ensure the widest possible coverage. The WHO field presence in Gaziantep serves non-government controlled areas in the northern part of the Syrian Arab Republic, in collaboration with partner organizations. The main achievements were: the organization, training and monitoring of 12 cross-border polio immunization and one measles campaign (each immunization round reached more than 1.3 million children under five years of age); undertaking a needs assessment on mental health; developing mental health training materials as well as creating an essential mental health drug list; providing technical assistance, capacity-building and procurement of laboratory supplies for the Early Warning Alert and Response Network (EWARN) system (comprising 995 sentinel sites); delivering essential medical supplies and drugs to hospitals and health care facilities; and providing technical assistance and guidance to Health Cluster partners. WHO, in collaboration with health partners, also maintains a real-time database on attacks against health-care facilities and health-care workers. Based on the material collected in the database, monthly reports were prepared, in collaboration with the United Nations Office for the Coordination of Humanitarian Affairs, to be presented to the United Nations Security Council.

60. The second major protracted emergency affecting the European Region is the conflict in eastern Ukraine, with an estimated 3.1 million people in need of humanitarian assistance, mainly in the regions of Lugansk and Donetsk. The crisis has internally displaced more than 1.4 million people and more than 120 health facilities are reported to have been damaged. WHO leads the Health and Nutrition Cluster at national and subnational levels to plan, coordinate and execute the health response activities of actors on the ground.

61. The WHO Country Office in Kiev and five subnational offices in Kharkiv, Dnipropetrovsk, Severodonetsk and in the de facto authorities of Lugansk and Donetsk, worked with partners to deliver high-quality primary and secondary health care, as well as medications and consumables for people living in the conflict zones and for those displaced. The main WHO activities included procurement of medical drugs, including 5 tonnes to Donetsk's nongovernment controlled areas, and 16 tonnes to nongovernment controlled areas in Lugansk. In addition, trauma kits and laboratory tests were delivered to health authorities. Furthermore, WHO established 37 mobile emergency primary care units active in the contact zone in eastern government controlled areas, and supervised and trained the required staff. The mobile units conducted medical and mental health consultations for internally displaced people and members of host communities using a unique software system for collecting real-time, web-based information on the health situation. An EWARN system with 72 sentinel sites has been established by WHO and partners to reinforce the national surveillance system, covering internally displaced people and other vulnerable population groups. WHO carried out nutritional assessments, outbreak and syndromic surveillance, and an assessment of the use of pharmaceuticals. In October and December 2015, polio outbreak response immunization campaigns were conducted in response to the circulating vaccine-derived poliovirus outbreak that was confirmed in Ukraine on 28 August

2015. Since then, no other polio cases have been reported and the transmission of the poliovirus is considered likely to have been interrupted.

62. In May 2014, the Regional Office led a large-scale response to heavy rainfall in the Balkans, which caused flooding and landslides across Bosnia and Herzegovina, eastern Croatia and Serbia that disrupted public services for weeks, and damaged or destroyed health facilities in all three countries. The response included the deployment of several technical experts from the Regional Office and WHO headquarters. WHO led the national health sector meetings to coordinate the initial health response by the United Nations and other partner organizations, procured emergency health supplies for all three affected countries, and advised on a common strategy to fight infectious diseases in flood-affected areas and to tackle emerging environmental health risks.

63. The public health aspects of the crisis caused by the influx of migrants and refugees from the Middle East and north Africa to Europe was handled by the Public Health and Migration Programme of the Regional Office and included assessments of the preparedness activities of the health sectors of affected countries, support in training and provision of technical advice to health-care workers at borders and in reception camps, as well as the delivery of medical supplies and drugs to affected countries for the treatment of affected migrants and refugees. Health assessment missions to border areas and migrant centres were undertaken jointly with national health authorities to identify needs and provide support.

64. The Regional Office, both at the regional and country levels, engaged in extensive resource mobilization activities to fund emergency responses during the biennium. Table 4 summarizes the budget, funding and implementation figures of the outbreak and crisis response operations.

Table 4. Summary of budget, funding and implementation of the outbreak and crisis response activities of the Regional Office in 2014–2015, as of 31 December 2015 (US$ 000)

Outbreak and crisis response	
WHA-approved budget	5000
Funds available	**15430**
Funds available as % of WHA-approved budget	309%
Activity costs	10600
Staff costs	2128
Total expenditure	**12728**
Expenditure as % of WHA-approved budget	255%
Expenditure as % of funds available	82%

65. Staff across the Region, both from the Regional Office in Copenhagen and from geographically dispersed offices and country offices, were deployed during the biennium to support global and regional emergency response operations. As mentioned earlier in this report, in support of the Ebola response alone the Regional Office organized 36 missions involving 25 staff, amounting to 1302 staff days. Therefore, the main challenge throughout the biennium was finding a balance between the planned core activities of the Region and responses to acute and protracted emergencies, which was not an easy task given the limited

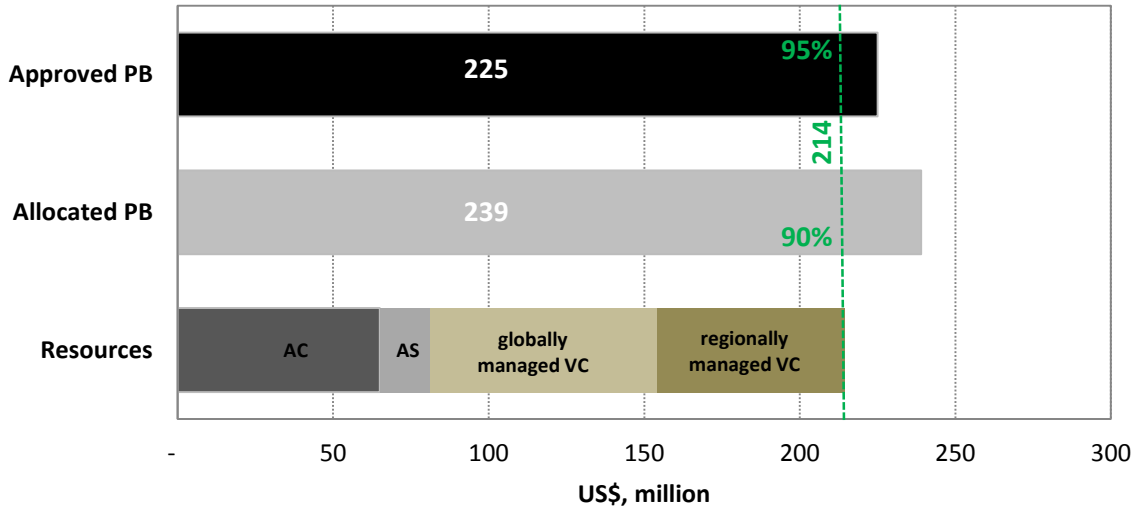
human resources of the Regional Office involved in programmes and in country offices. This inadvertently led to delayed implementation of some planned core activities.

Resources

Financial resources of the Regional Office

66. At the end of 2014–2015, the approved budget of the Regional Office was funded at 95% (Fig. 4), excluding VC funds, which have been transferred to 2016–2017 based on projected levels of implementation. About 48% of the Regional Office's financial resources are fully or highly flexible funds. Assessed contributions (AC) make up 63% of the flexible funds, the core VC account (CVCA) 21%, and administrative support (AS) funds 16%. The other 52% of the Regional Office's financial resources consists of VC that are highly specified for a project, country or disease or a combination of the three.

Fig. 4. PB 2014–2015 funding and composition of available resources, as of 31 December 2015



AC = assessed contributions; AS = administrative support costs; VC = voluntary contributions

Resource mobilization coordination and donor analyses

67. In 2014, the Regional Office introduced a new donor proposal/agreement tracking system, which strengthens compliance with the global coordinated resource mobilization processes and alignment with the PB. The process is coordinated by the Strategic Partnerships and Resource Mobilization unit in cooperation with the teams involved in clearing donor proposals and agreements, such as administration and finance, legal services, programme and resource management, human resources, and country relations, as well as the respective technical divisions.

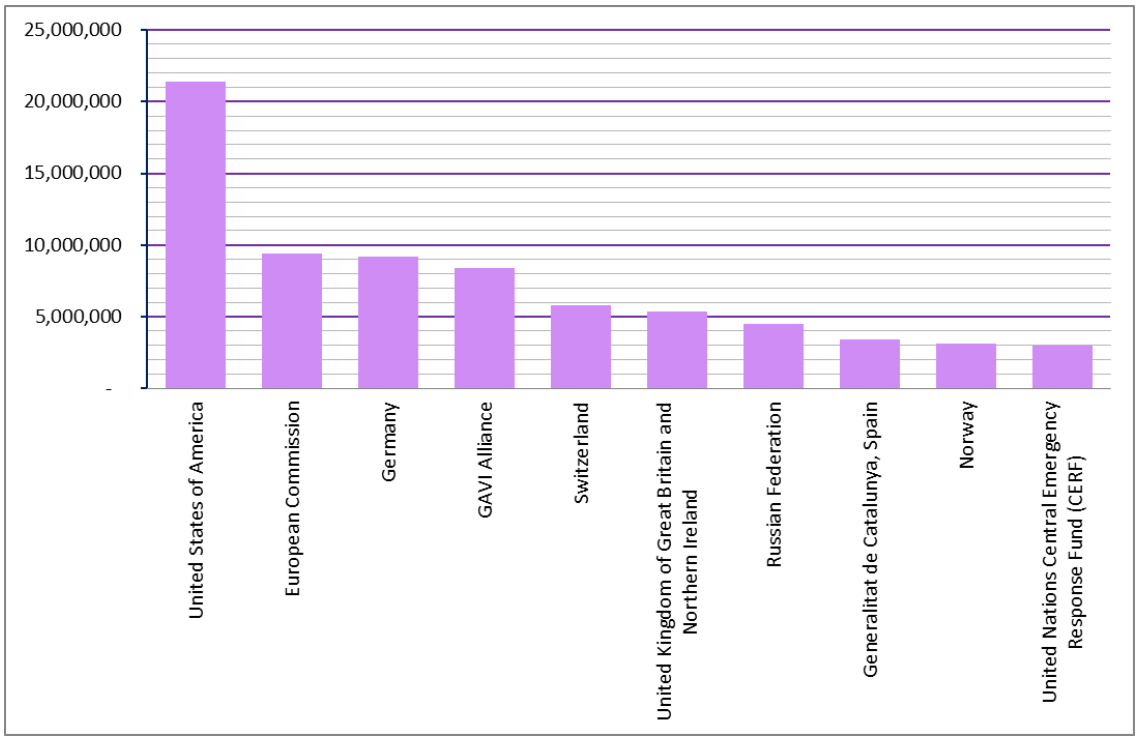
68. Following the introduction of the coordinated resource mobilization process, technical units submit information on opportunities for resource mobilization to PAR, which conducts a first review and allocates a reference number that allows the proposal to be taken forward.

69. In 2015, approximately 100 proposals, agreements and no-cost extensions were initiated by programmes and country offices and reviewed through the coordinated resource mobilization process led by PAR.

70. The introduction of the new system supported alignment with global processes, increased compliance with WHO rules and regulations, and alignment with the PB.

71. As a result of considerable resource mobilization efforts both at the global and regional levels, approximately US$ 116 million of VC were received by the Regional Office in 2014–2015. Of this amount, approximately US$ 74 million (63%) came from the top 10 donors (Fig. 5).

Fig. 5. Top 10 donors of the Regional Office in 2014–2015 (US$ million)



72. The United States of America was the European Region's major single donor, with 19% of the entire share of VC, followed by the European Commission and Germany with 8% each. Together, European Member States contributed over US$ 50 million through VC to the Regional Office, or 22% of the regional approved budget, in addition to their AC and core voluntary contributions.

73. Fig. 5 clearly illustrates WHO's, and more specifically the Regional Office's, vulnerability caused by having a limited donor base. Globally, the Organization still relies on 20 contributors for about 76% of its funding. Broadening the donor base is one of the objectives of the financing dialogue and is the area which has made the least progress to date. Efforts to explore new avenues of financing from traditional and non-traditional donors, including Member States that have not been donors until now and development banks, will be further enhanced globally as well as regionally in 2016–2017.

74. The Regional Office strongly believes in coordinated resource mobilization and is committed to aligning funds with the approved PB. That being said, it is recognized that there is still misalignment between strategic prioritization and the financial resources that are being mobilized, and more work needs to be done to enhance flexibility on the part of donors, such as the flexibility clause in the agreement with Sweden.

75. The bottom-up planning exercise that informed the development of PB 2016–2017 provided a snapshot of programme areas that were prioritized by Member States, both those with and those without BCAs. These priorities were summarized in document EUR/RC64/17[2] presented to Member States at the 64th session of the Regional Committee in September 2014. The programme areas ranked highest overall were:

2.1 Noncommunicable diseases

2.2 Mental health and substance abuse

4.2 Integrated people-centred health services

4.1 National health policies, strategies and plans

4.4 Health systems information and evidence

3.5 Health and the environment

1.1 HIV/AIDS

2.3 Violence and injuries

3.1 Reproductive, maternal, newborn, child and adolescent health

1.2 Tuberculosis

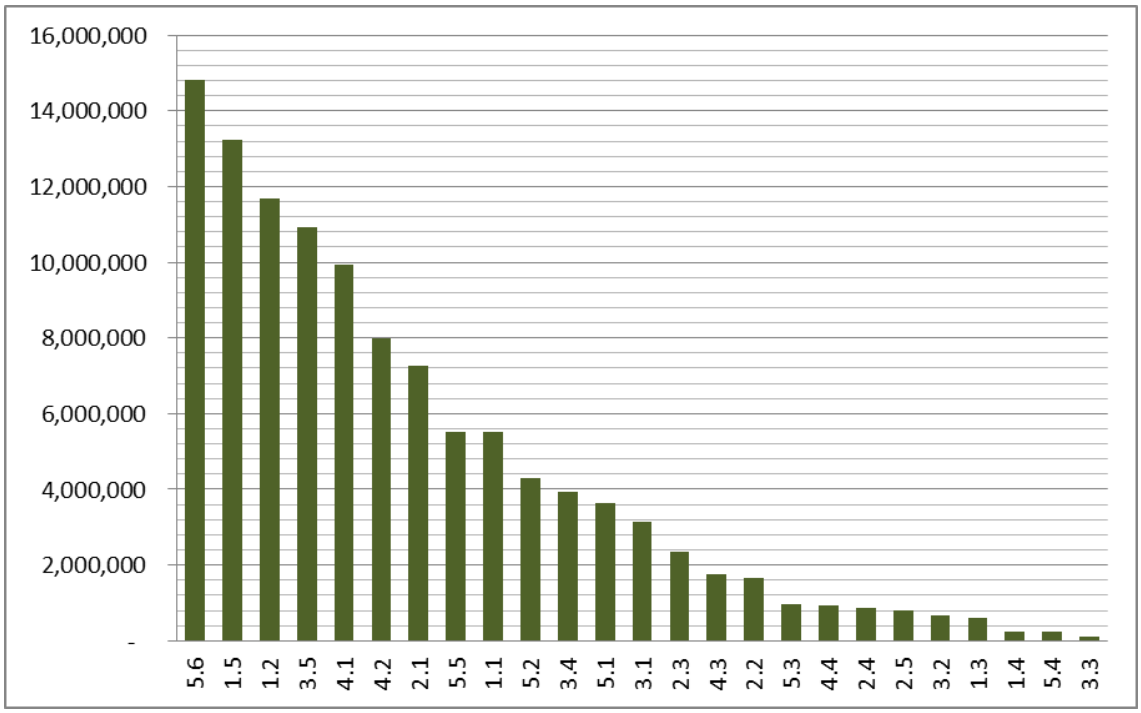
4.3 Access to medicines and other health technologies and strengthening regulatory capacity.

76. Fig. 6 shows VC distribution by programme area in 2014–2015. Using the prioritization of 2016–2017 as a proxy for 2014–2015, based on an overall continuity of priorities, it can be noted that all prioritized programme areas received VC financing, although the proportion of contributions varied dramatically among the prioritized areas.

77. This analysis shows that further efforts are needed to better respond to the strategic priorities of Member States. As pointed out earlier in this report, the matter can be looked at from the perspective of the approved budget, and further work is needed to arrive at more realistic budgets.

[2] Draft proposed WHO programme budget 2016–2017: the European Region's perspective. Copenhagen: WHO Regional Office for Europe; 2014 (EUR/RC64/17; http://www.euro.who.int/en/about-us/governance/regional-committee-for-europe/past-sessions/64th-session/documentation/working-documents/eurrc6417-draft-proposed-who-programme-budget-20162017-the-european-regions-perspective, accessed 3 August 2016).

Fig. 6. Programme areas* and their financing by voluntary contributions in the WHO Regional Office for Europe in 2014–2015 (US$)



* For a full list of programme areas by category, see Annex 1.

Main challenges at the technical level

78. While, as reported, there have been many achievements across all categories and programme areas, the 2014–2015 biennium also posed some challenges, the main ones including:

- sustainability of progress;
- development of intersectoral action;
- changing political landscapes;
- migration; and
- implementing preparedness for health emergencies and the IHR (2005).

79. The Region faced significant challenges in addressing the growing number of new HIV/AIDS infections, inadequate treatment coverage with antiretrovirals, unmet needs for treatment of hepatitis C and inadequate treatment success of M/XDR-TB. As a result of limited domestic resources, due to budget cuts and the reduction of international funding, particularly through the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund), national programmes faced challenges in sustaining their interventions, particularly in reaching out to the most vulnerable and hard-to-reach populations. For immunization, funding through the GAVI Alliance has been following the same trend, while vaccine-preventable diseases are re-emerging in the Region. The sustainability of work in relation to the Codex Alimentarius on food safety at the national level is also a challenge in countries that are no longer eligible for Codex Trust Fund support. Despite the efforts being made,

health system barriers and stigma, along with social determinants, are leading to ongoing transmission of communicable diseases.

80. A great challenge is ensuring that countries acknowledge the importance of intersectoral action, the preventability of diseases and injuries, and the need to mobilize political will. Due to the complexity of developing and implementing the multisectoral policies and interventions required to effectively address the risk factors and social determinants underlying many diseases, including those causing the NCD epidemic, sustained political commitment and certainty of resources are paramount. Intersectoral collaboration is essential for some technical areas like health emergencies, antimicrobial resistance (AMR) and food safety, including foodborne and zoonotic diseases, where a holistic, multifaceted and "One Health" approach is crucial for effective and efficient risk assessment and risk management. This is well recognized at the international and regional levels, but not always at the country level. Furthermore, accountability with respect to intersectoral action is not yet clearly defined and needs to be better developed, communicated and institutionalized within countries.

81. The changing political landscape in some countries with respect to contraception and abortion poses considerable challenges to the work in reproductive, maternal, newborn, child and adolescent health, as well as in gender, equity and human rights. The ongoing effects of the financial crisis and related austerity measures present a risk of disinvestment in policies that directly influence the move towards UHC, the determinants of health and health equity. While the Region is on track to achieve the target to reduce premature mortality, it still has the highest levels of alcohol consumption and tobacco use in the world. While the range between the highest and lowest levels of health measured by life expectancy and infant mortality rates in the Region has narrowed, the absolute differences between countries remain substantial.

82. Migration to Europe has brought several challenges to the health policy arena and national health systems at the pan-European level. The impact of political unrest has also increased the need to convene stakeholders to agree on modalities and priorities of cooperation across countries and across agencies in order to protect against social, economic and health risks. The Regional Office's role as advocate and convener has been key to mitigating political and policy instability with a view to developing sound national policies, strategies and plans.

83. The current modality of IHR monitoring and evaluation, based largely on self-assessments, is being revised based on requests from Member States, so that more accurate baselines for future planning can be set. The revised IHR monitoring and evaluation approach requires further consultation with Member States and regional adaptation. With regard to influenza, challenges include lack of reporting to WHO of data on seasonal influenza vaccine policies and uptake, while in a number of countries there is insufficient human resource capacity to drive technical improvements. The main challenges for strengthening AMR surveillance in many countries of the Region include limited laboratory capacity, lack of standardized methodologies and guidelines, lack of routine sampling and use of diagnostics to inform treatment, and paper-based recording of laboratory results.

Lessons learned

84. The following are some of the most relevant lessons learned from the 2014–2015 biennium, from the technical and strategic perspectives, as a result of this self-assessment exercise.

(a) The Health 2020 policy and adopting national Health 2020 strategies have proved to be important tools for formulating and implementing effective policies and interventions for all the programme and thematic areas. This is due to the intersectoral approach of Health 2020 and its focus on equity and the life-course. In addition, the Minsk Declaration, resulting from the European Ministerial Conference on the Life-course Approach in the Context of Health 2020, has underlined the importance of preventive actions in critical life periods. There is a need to further exploit the synergies between different frameworks to convince governments of the benefits and necessity of intersectoral action for health.

(b) WHO networks of Health 2020 implementation have proved to be effective and cost-efficient vehicles for providing technical support around Health 2020 core themes, approaches and practices at the subnational level of governance for health. Good examples of such networks, which have been strengthened in the reporting biennium, are the Regions for Health Network and the Healthy Cities Network targeting the regional (subnational) and local/municipal levels of governance, respectively.

(c) The work on national health policies and health systems is subject to political (in)stability in countries, and the effects of austerity and migration to Europe call for increased consensus-building among Member States in the context of the SDGs and the scale-up towards UHC. This offers a unique opportunity for WHO to play out its comparative advantage: normative work and country assistance based on values, with the aim of achieving better health and well-being and decreased inequities for the people of the Region, which is the core of Health 2020.

(d) WHO is in a transformative moment in the history of the fight against communicable diseases and towards embedding efforts under the SDGs, which calls for important strategy adjustments in Member States in line with global strategies, regional frameworks and action plans. Strengthening political commitment and vigilance are crucial to ending communicable diseases as public health concerns and potential cross-border health threats. There are good examples of countries improving their responses to communicable diseases. However, for those interventions to be successful, they need to be part of multidisciplinary and whole-of-society approaches. To this end, integrated and people-centred care for communicable and noncommunicable diseases is essential. The countries with the highest burdens of TB and HIV need to move fast to improve service delivery models and/or finance mechanisms to sustain effective responses through health systems strengthening.

(e) Lessons learned show that continuing long-term investment is needed to decrease the burden of communicable diseases and that these efforts would save significant resources in the long term. WHO guidance and technical leadership, as well as mechanisms for exchange of good practices among countries, are crucial. Migration, with the exchanges of labour, commerce and skills that it entails, also comes with the risk of cross-border spread of infectious diseases, including TB. TB has no borders. Yet borders often hinder the effective diagnosis and care of those with the disease. In order to achieve the elimination of TB, cross-border collaboration between national

health authorities is needed to ensure early diagnosis, uninterrupted treatment and the support of patients and families alike. This also includes equity in access to care among vulnerable populations, such as migrants, or those who travel temporarily to other countries. To reach the targets of the Tuberculosis Action Plan for the WHO European Region 2016–2020, intensified research (ranging from basic science to operational research) is needed to develop more effective interventions for detecting, curing and preventing TB.

(f) The Regional Office and country offices worked intensively to make sure that funding was available for technical assistance and human resources; in this way the risk of insufficient support by the Secretariat was mitigated. This was particularly relevant in the areas of TB, immunizations, HIV, violence and injury prevention, nutrition, reproductive health, environment and health, health information systems, and emergency preparedness.

(g) Several programmes, such as TB, HIV, malaria, immunizations, and food safety, are paying specific attention to Member States that are becoming ineligible for support through global mobilization mechanisms such as the Global Fund, the GAVI Alliance and the Codex Trust Fund or that are facing the withdrawal of other donors in the Region as they are considered to have lower needs. The Secretariat took active steps to help countries in the transition to prepare costing and financial gap analyses, and organized high-level visits to discuss financial sustainability.

(h) Addressing the practical implementation of standards and requirements in the area of health security and IHR (2005) turned out to be critical to scaling up preparedness in the Region. In particular, training courses and exercises for a multisectoral audience have proved to be effective means of achieving national cross-sectoral, multilevel coordination and communication and for operationalizing the IHR for day-to-day use.

(i) During the Ebola outbreak, the Regional Office strengthened the expert network and facilitated expert exchanges and support. Several Member States could benefit from experts visiting and advising on preparing for threats from highly infectious diseases.

(j) In general, the notion that the “job is done” in the European Region is inaccurate and more work needs to be done to advocate for attention by Member States to better reach the underserved and marginalized populations of the Region, not only in relation to diseases, but also in terms of their access to quality health services. Other cross-cutting topics, such as gender, equity and human rights, and social determinants of health, also remain at the top of the agenda. It must be considered that the migrant crisis experienced this biennium will continue and will represent a challenge, particularly for a vulnerable population group.

(k) Strong commitment at the country level has been reported as the most important success factor that contributed to the achievement of outputs and programmes in the Region. Strengthening the capacity, knowledge and skills of national health staff with regard to preparedness, prevention, control, surveillance, and the provision of high-quality interventions in countries of the Region has been key for programmes such as neglected tropical diseases, health information systems, influenza, emergency preparedness, and food safety. This has been particularly important in an environment of unpredictable resources, competing priorities, and emerging new priorities.

(l) Close collaboration with United Nations partners has been critical for the success of many programmes and initiatives. The inclusion of health-related topics, such as

health emergencies, life-course approaches, NCDs, and quality and affordable health care, in UNDAFs and the work of the United Nations Committee for Development Policy provides a unique opportunity to work together on common agendas, particularly in the context of the SDGs.

(m) The whole-of-society and whole-of-government approach is better understood by national counterparts as the approach required to achieve better health. Collaboration with ministries and departments, intergovernmental organizations and institutions, civil society, other non-State actors, and other United Nations agencies has been enhanced and is rendering positive results in many public health programmes.

(n) For programmes in areas such as alcohol control, mental health, social determinants of health, health information systems, the IHR (2005), and food safety, it is necessary to maintain close collaboration with other areas in the Organization, and also with WHO collaborating centres and with other major actors in the field (nongovernmental organizations, professional associations, etc.).

(o) It is important to strengthen tools, guidance and the capacity of the health sector and agencies to engage with non-health sectors around common agendas and policy priorities that have strong repercussions for health.

(p) There is a need for more technical human resources at both country and regional levels. The Regional Office implemented a sustainability plan in 2012–2013 with a view to strengthening technical capacity across priority areas. However, resource uncertainties in 2014–2015 did not allow full implementation of this plan and appropriate actions will need to be taken in 2016–2017.

(q) Difficulties in implementation due to staff scarcities were overcome, whenever possible and feasible, in partnerships at the regional and national levels with national and international organizations and authorities, and more work was done in partnership with WHO collaborating centres. This was particularly relevant for work on nutrition and the IHR (2005). Collaborative work with other programme areas has been the answer to implementation of areas of work that are underfunded and understaffed. For instance, activities on prevention and management of sexually transmitted infections are carried out by the Division of Communicable Diseases alongside the TB, HIV/AIDS and hepatitis programmes. Other examples are the synergies between work on social determinants of health and NCDs, and NCDs and health systems.

(r) New policy support tools and multistakeholder platforms have been developed and established to address the social determinants of health. This has enabled stronger action across sectors to be taken and involved a wider-society-approach to reducing socially determined health inequities. There has also been increased interest from Member States regarding learning exchanges and support for innovative approaches to scaling up action on social determinants of health, including on vulnerability, migration and health equity. This requires a more diverse partnership base and team structure to match the changing demands and needs of Member States and this trend is envisaged to continue into the next biennium.

(s) Improved surveillance and reporting have revealed countries' achievements, gaps and areas requiring improvement, thus enabling a more targeted response in a range of areas, such as vaccine-preventable diseases and nutrition.

(t) For priorities such as NCDs, nutrition and AMR, implementation is crucial to achieving agreed targets. Member States will continue to require more direct support in terms of developing national guidelines and approaches to support their actions.

(u) Language barriers cannot be overlooked. Translation of tools and transfers of expertise in the language of the countries that are receiving technical support have delayed actions in some countries in regard to reproductive health and health information systems, among others.

(v) Country demand has been boosted by Health 2020 and by the evidence produced to support it, especially in the area of equity and social determinants of health, and gender, equity and human rights.

(w) Political changes often delay and risk the implementation of agreed programmes, and mitigation actions must be considered from the onset of activities.

(x) Coordinated resource mobilization needs to be further strengthened and oriented towards strategic prioritization.

85. The following are lessons learned from the managerial and administrative perspectives.

(a) Bottom-up planning needs to continue driving the strategic planning process. Better timing and processes need to be established to maximize the potential of this process. Regional priorities set out in Health 2020 will be reflected in regional and country operational plans.

(b) Operational planning that allows for workplan approval and implementation in a timely manner has had a very positive impact on technical implementation, giving technical offices flexibility and continuity in their technical activities. Several internal processes linked to the closure and start of consecutive bienniums have supported this process, such as early transfer of unutilized VC to the next biennium so that these funds were ready for implementation on 1 January 2016.

(c) As part of WHO reform, the Regional Office has clarified and strengthened roles and responsibilities at the country level by adopting a newly developed country matrix of roles and responsibilities, which will need to be fully implemented in the Regional Office in 2016–2017 to strengthen clarity and transparency of actions between the regional and country levels.

(d) Monitoring of the PB indicators must be considered as an integral part of technical implementation at all levels of the Organization, in order to facilitate a better coordination of delivery, including at the country level and with Member States. This is particularly relevant as the Organization approaches the final stages of the Twelfth General Programme of Work (2014–2019).

(e) Better predictability in allocation of corporate resources to major offices both in timing and amounts is necessary. Late availability of flexible corporate funding in 2014–2015 led to delays in activities, in starting implementation and the need for a significant effort in the second half of the biennium to boost implementation.

(f) At the same time, unpredictable streams of VC create an incentive to hold on to flexible resources available for activities and to use them when other sources of income have been completely exhausted. This creates a trend of low implementation of corporate contributions at the start of the biennium and peak implementation

towards the end of the biennium. Mechanisms to overcome this trend must be put in place from the start of the new biennium.

(g) It is important to recognize that funding realities and priorities may change during a biennium. Some flexibility is needed to adapt to these changes within the approved priorities. It is important to ensure that adequate and timely PB space is available so that fundraising activities and implementation can continue accordingly in these programmes. This is particularly important for areas that traditionally receive significant support from external donors. At the same time, there are programme areas that, despite best efforts, are less successful in attracting VC, which in turn translates into lower implementation rates when compared with approved budgets. The Regional Office will continue offsetting this imbalance with flexible resources, but this can only be done to a certain extent.

Summary by category

Category 1: Communicable diseases

86. The category comprises five programme areas: 1.1 HIV/AIDS; 1.2 Tuberculosis; 1.3 Malaria; 1.4 Neglected tropical diseases; and 1.5 Vaccine preventable diseases.

Major achievements

87. Efforts with partners to implement the **European Action Plan for HIV/AIDS 2012–2015** have led to progress in the availability of HIV testing and counselling services: the number of people receiving ART reached 1 million in 2015. The sharpest increase was evident in eastern Europe and central Asia, where the number of people receiving ART increased by 187%, from 112 000 in 2010 to 321 800 in 2015. Significant progress towards regional elimination of mother-to-child HIV transmission and congenital syphilis has been made. Twelve (of 15) countries of eastern Europe and central Asia adopted WHO recommendations on prevention of mother-to-child transmission Option B+ and 21 countries expressed the interest in obtaining validation.

88. Throughout the biennium, the Regional Office engaged in the global response to viral hepatitis by strengthening collaboration with regional partners, raising awareness and promoting partnerships at the national level. The Regional Office began to strengthen regional hepatitis surveillance. In 2015, 13 countries were supported in developing national strategies and plans on viral hepatitis. Two regional HIV/AIDS surveillance reports, covering 53 countries, were prepared and published jointly with the European Centre for Disease Prevention and Control (ECDC), in 2014 and 2015. All 15 priority countries adopted/adapted the WHO 2013 guidelines on the use of antiretroviral medicines for the treatment and prevention of HIV infection. The Regional Office also started to work on the development of the first ever action plan for the health sector response to viral hepatitis in the WHO European Region, setting the ambitious goal of eliminating viral hepatitis as a public health threat by 2030 in the Region. The action plan is aligned with the Global Health Sector Strategy on Viral Hepatitis 2016–2021, which was adopted by the Sixty-ninth World Health Assembly in May 2016.

89. The implementation of the Consolidated Action Plan to Prevent and Combat Multidrug- and Extensively Drug-Resistant Tuberculosis in the WHO European Region 2011–2015 has resulted in the achievement of most of the milestones for its seven areas of action: prevent the development of cases of M/XDR-TB; scale up access to testing for resistance to first- and second-line anti-TB drugs and to HIV testing and counselling among TB patients; scale up access to effective treatment for all forms of drug-resistant TB; scale up TB infection control; strengthen surveillance of drug-resistant TB and monitor treatment outcomes; expand countries' capacity to scale up the management of drug-resistant TB; and address the needs of special populations. Over the last five years, more than a million TB patients, including 53 000 MDR-TB patients, were cured. About 200 000 cases of MDR-TB have been averted and more than 2.6 million lives have been saved. However, the proportions of MDR-TB among new cases and retreatment TB cases in the WHO European Region remain the highest in the world (15% and 48%, respectively).

90. The TB work in the Region focused on the 18 high-priority countries, with 85% of TB reported cases, resulting in a substantial decrease in the incidence of TB in those countries. Countries have made major progress in case detection and treatment coverage, which increased to 95%, although the rate of treatment success, at 48% – the same as the global level – is still lower than expected. In September 2015, the Regional Committee at its 65th session in resolution EUR/RC65/R6 adopted the new **Tuberculosis Action Plan for the WHO European Region 2016–2020**, which builds on the achievements of the Consolidated Action Plan for 2011–2015 and aims to prevent the emergence and transmission of TB and drug-resistant TB by guiding actors to integrate their efforts and to centre care on patients' needs. This should enable the Region to cure some 1.4 million TB patients, including 130 000 M/XDR-TB patients, prevent 1.7 million new cases of all forms of TB, and save more than 3.1 million lives and US$ 48 billion.

91. Remarkable progress has been achieved in the Region towards eliminating malaria – indigenous transmission of malaria was interrupted in 2015. Countries that have eliminated malaria need to make every effort to prevent reintroduction of the disease, in conditions in which – although imported cases may continue to be reported – local malaria cases are no longer registered (see also Box 2). In 2014, the **Regional framework for prevention of malaria reintroduction and certification of malaria elimination 2014–2020** was developed and published in response to requests from the countries that have become malaria-free. This framework outlines the key ways to avoid the resurgence of malaria in countries where it has been eliminated and methodological aspects of the process of certifying countries as being free from malaria.

92. The Regional Office's work on neglected tropical diseases mainly focused on providing guidance and technical support to Member States to implement the **Regional framework for surveillance and control of the invasive mosquito vectors and re-emerging vector-borne diseases 2014–2020** (dengue, and chikungunya); the **Strategic framework for leishmaniasis control in the European Region 2014–2020**; and on soil-transmitted helminthiasis (STH).

Box 2. Malaria (programme area 1.3)

In 2015, for the first time, the European Region reported zero indigenous malaria cases, thereby achieving the goal of the Tashkent Declaration to eliminate malaria from the Region by 2015. The European Region is the first WHO region to achieve a malaria-free status.

This success is a fragile one. Lessons learned from the past highlight the continuous threat of malaria reintroduction and accentuate the need for sustained political commitment, vigilance and investment in health systems strengthening to ensure that any resurgence could be rapidly contained.

To meet this challenge, the Regional Office provides technical assistance, in line with the Regional framework for prevention of malaria reintroduction and certification of malaria elimination 2014–2020, and convened the first High-level Consultation on prevention of malaria reintroduction in Ashgabat, Turkmenistan, on 21–22 July 2016.

93. Although dengue and chikungunya are not endemic, the introduction, establishment and spread of invasive species of mosquitoes, in particular *Aedes albopictus* and *Aedes aegypti*, within the European Region, assisted by globalization in trade, travel and climate change, are a cause for serious concern. The vector of dengue, *Aedes albopictus*, has rapidly spread to more than 25 countries, mainly through global trade. The threat of dengue outbreaks now exists in Europe after a lapse of 55 years. In recent years, *Aedes albopictus* has been implicated as the vector responsible for outbreaks of chikungunya in France and Italy, and has been responsible for local transmission of dengue in Croatia and France. This mosquito species has also been considered as a potential bridge vector of other arboviruses (such as West Nile virus) from birds and mammals to humans.

94. The work of the Regional Office on neglected tropical diseases was mainly focused on leishmaniasis and STH. Albania, Armenia, Azerbaijan, Georgia, Israel, Italy, Kazakhstan, Kyrgyzstan, Republic of Moldova, Romania, Spain, Tajikistan, Turkey, Turkmenistan and Uzbekistan have been identified as endemic for STH and/or leishmaniasis. Leishmaniasis is a neglected and poorly reported disease with an underestimated or undetermined burden in most countries of the Region. Countries in central Asia and the Caucasus are considered to have the highest burden of STH in the Region. Recent surveys have demonstrated that the proportion of children infected with STH ranges from 15% to 70% in some countries.

95. In 2014, the 64th session of the Regional Committee, in resolution EUR/RC64/R5, adopted the **European Vaccine Action Plan 2015–2020** (EVAP) (document EUR/RC64/15 Rev.1), which is designed to complement the Global Vaccine Action Plan 2011–2020 and regional policies and strategies, such as Health 2020, the European Action Plan for Strengthening Public Health Capacities and Services, and the European Strategy for Child and Adolescent Health. EVAP envisions a Europe free of vaccine-preventable diseases, where all countries provide equitable access to high-quality, safe, affordable vaccines and immunization services throughout the life-course. The plan proposes innovative strategies to meet these goals and defines five objectives, priority action areas and a framework to evaluate and monitor progress towards them. The Regional Office has therefore scaled up technical support, training and the development of guidance documents to build capacity in national immunization programmes. Additionally, through EVAP, and the forthcoming action plan for the health sector response to viral hepatitis in the WHO European Region, the Regional Office commits itself to preparing a programme and action plan for the control of hepatitis B infection and to identify targets for 2020.

96. The Regional Office assisted Member States in pursuing equitable access to vaccines of assured quality, including new immunization products and technologies. Several received assistance in preparing for and in some cases evaluating the success of programmes to introduce vaccines into national routine immunization schedules. The number of countries that have introduced rotavirus, pneumococcal and HPV vaccines reached 15, 18 and 28, respectively. In line with the Global Polio Endgame Strategy, assistance was also provided to countries (using only oral polio vaccines) in adding at least one dose of inactivated polio vaccine to their routine schedules. The Regional Office scaled up technical support, training and development of guidance documents to build capacity in national immunization programmes, focusing on helping the programmes address vaccine safety concerns and thereby drive demand for immunization; respond to safety crises and disease outbreaks; and protect and build immunization budgets (particularly for middle-income countries) through the development of multi-year planning for immunization and stronger advocacy efforts (see also Box 3).

Box 3. Measles and rubella (programme area 1.5)

The projected end-date for measles and rubella in the European Region was 2015. Through accelerated efforts undertaken since 2013, over half of the Member States of the Region have successfully interrupted transmission of endemic measles and rubella; 20 countries eliminated measles and 21 countries eliminated rubella. The Regional Office implemented a new mobilization strategy for measles and rubella elimination in 2015 and the Regional Verification Commission for Measles and Rubella Elimination gauged the progress towards elimination.

Outbreaks of measles and rubella in 2014–2015 indicate that the 2015 elimination goal has not yet been met and that pockets of susceptible populations continue to be affected, particularly by measles. While some countries lag behind, the verification process led by the Regional Office has facilitated tremendous progress. Improvements in surveillance and reporting has revealed those countries that have interrupted transmission, and has also identified the remaining obstacles to elimination, thereby enabling a more targeted response.

The Regional Office called for stronger political commitment and partnerships to implement the package for accelerated action and scaled-up vaccination. Action taken with partners included supporting national vaccination campaigns and helping countries to strengthen their responses through the Regional Verification Commission for Measles and Rubella Elimination, the European Technical Advisory Group of Experts on Immunization, the Measles and Rubella Initiative, the Sabin Vaccine Institute and Lions Clubs International.

Impediments and challenges

97. The European Region has made good progress in tackling communicable diseases and is now faced with the challenge of sustaining the progress achieved and investments made, while facing the highest proportion of multidrug resistance among new and retreatment TB cases in the world, and when vaccine-preventable diseases are re-emerging in the Region.

98. Two countries account for the majority of all new HIV diagnoses (71% in 2014). Treatment coverage is not increasing fast enough to keep pace with new infections and in eastern Europe and central Asia it remains low. Many countries in southern and eastern Europe and central Asia suffer from an intermediate to high burden of chronic viral hepatitis. However, reliable epidemiologic data are largely still not available; and despite the fact that new, highly effective treatment options have been developed in the last few years, these treatments are not accessible to or affordable by the majority of people in need due to

high costs. Countries in eastern Europe and central Asia still suffer from high rates of TB and MDR-TB and a growing burden of TB/HIV coinfection, while in central and western European countries TB is concentrated among vulnerable population groups such as people of foreign origin and prisoners.

Lessons learned

99. Building on the lessons learned from the implementation of the European Action Plan for HIV/AIDS 2012–2015, a new action plan for the health sector response to HIV in the European Region is being developed. The action plan is aligned with the Global Health Sector Strategy on HIV/AIDS, 2016–2021, which was adopted by the Sixty-ninth World Health Assembly in May 2016, and with the outcome document of the United Nations General Assembly 2016 High-level Meeting on Ending AIDS. In Europe, ending the AIDS epidemic as a public health threat by 2030 will be accomplished only through a renewed and reinvigorated political commitment, accelerated implementation of evidence-based policies, and technical and programmatic innovations. The new action plan will put greater emphasis on concrete and intensive actions at the country level, developing and mobilizing high-level commitment and support, and providing tools to turn back the epidemic in this new phase of the response.

100. In addition, a focus on building new and reinvigorating existing political commitment to, and public awareness of, TB, malaria and vaccine-preventable diseases will be of paramount importance in sustaining achievements and funding, and in making further progress. In October 2015, the Regional Verification Commission for Measles and Rubella Elimination met for the first time to review documentation for the period 2012–2014 to determine Member States' elimination status. While the Region did not meet the goal of stopping transmission of measles and rubella by the end of 2015, there has been significant progress towards achieving measles and rubella elimination. The diversity of challenges across the Region will require customized national and subnational strategies in order to interrupt indigenous transmission of measles and rubella. A focus on high-level political support and technical innovations will be required during the next biennium to meet the elimination goal as quickly as possible.

Outlook for 2016–2017

101. Building on the work done in the context of the MDGs, category 1 work will mainly contribute to the achievement of SDG3 (Ensure healthy lives and promote well-being for all at all ages), specifically SDG targets 3.1, 3.2, 3.3, 3.8, 3.b, 3.c and 3.d, as well as SDG10 (Reduce inequalities within and among countries), with a particular focus on reducing inequalities with regard to vulnerable population groups. In addition to its direct impact on the achievement of SDG3 targets, work in category 1 will also indirectly have an impact on ending poverty (SDG1), achieving gender equality and empowering women and girls (SDG5), managing water and sanitation (SDG6), reducing inequality in access to services and commodities (SDG10), promoting inclusive societies that promote non-discrimination (SDG16), and financing and capacity-building for implementation (SDG17). The implications of the SDGs for the work of category 1 are considerable and require collaboration across programme areas that promote intersectoral actions consistent with whole-of-society and whole-of-government approaches and Health 2020.

Output indicators and achievement ratings[3]

Programme area 1.1: HIV/AIDS

Output 1.1.1. Implementation and monitoring of the global health sector strategy on HIV/AIDS 2011–2015 through policy dialogue and technical support at global, regional and national level			**Achieved**
Output indicator	**Baseline**	**Target**	**Achieved value:**
Number of countries that have developed and are implementing national HIV/AIDS strategies in line with the global health sector strategy on HIV/AIDS	20/57	57/57	9 priority countries have developed and are implementing national HIV/AIDS strategies in line with the global health sector strategy on HIV/AIDS (*ARM, AZE, BLR, GEO, KAZ, KGZ, TJK, UKR, UZB*)
Output 1.1.2. Adaptation and implementation of most up-to-date norms and standards in preventing and treating paediatric and adult HIV infection, integrating HIV and other health programmes, and reducing inequities			**Achieved**
Output indicator	**Baseline**	**Target**	**Achieved value:**
Number of countries that have adopted/adapted 2013 guidelines on the use of antiretroviral medicines for the treatment and prevention of HIV infection	NA	57/57	15 priority countries have adopted/adapted 2013 guidelines on the use of antiretroviral medicines for the treatment and prevention of HIV infection (*ARM, BUL, EST, GEO, KAZ, KGZ, MDA, POL, ROM, RUS, SRB, SVK, TJK (partially), UKR, UZB (partially)*)

Programme area 1.2: Tuberculosis

Output 1.2.1. Intensified implementation of Stop TB Strategy to scale up care and control, with focus on reaching vulnerable populations, strengthening surveillance, and alignment with health sector plans facilitated			**Achieved**
Output indicator	**Baseline**	**Target**	**Achieved value:**
Number of priority countries that have up-to-date tuberculosis strategic plans	54/95 (2012)	85/95 (2015)	18/18 (*ARM, AZE, BLR, BUL, EST, GEO, KAZ, KGZ, LTU, LVA, MDA, ROM, RUS, TJK, TKM, TUR, UKR, UZB*)
Output 1.2.2. Updated policy guidance and technical guidelines on HIV-related tuberculosis, delivery of care for patients with multidrug-resistant tuberculosis, tuberculosis diagnostic approaches, tuberculosis screening in risk groups and integrated community-based management of tuberculosis			**Achieved**
Output indicator	**Baseline**	**Target**	**Achieved value:**
Number of countries in which the WHO-recommended rapid diagnostic for tuberculosis and drug-resistant tuberculosis is being implemented	77/145 (2012)	110/145 (2015)	18/18 (*ARM, AZE, BLR, BUL, EST, GEO, KAZ, KGZ, LTU, LVA, MDA, ROM, RUS, TJK, TKM, TUR, UKR, UZB*)

[3] For this section: NA: not applicable; Full list of country abbreviations: Annex 2.

Programme area 1.3: Malaria

Output 1.3.1. Countries enabled to implement malaria strategic plans, with focus on improved diagnostic testing and treatment, therapeutic efficacy monitoring and surveillance through capacity strengthening			**Achieved**
Output indicator	**Baseline**	**Target**	**Achieved value:**
Number of malaria-endemic countries where an assessment of malaria trends is done using routine surveillance systems	58/99 (2013)	68/99 (2015)	10/10 (*ARM, AZE, GEO, KAZ, KGZ, RUS, TJK, TKM, TUR, UZB*)
Output 1.3.2. Updated policy recommendations, strategic and technical guidelines on vector control, diagnostic testing, antimalarial treatment, integrated management of febrile illness, surveillance, epidemic detection and response			**Achieved**
Output indicator	**Baseline**	**Target**	**Achieved value:**
Proportion of malaria-endemic countries that have adapted policy recommendations, strategic and technical guidelines in their implementation of malaria strategies and plans	81/99 (2011)	89/99 (2015)	10/10 (*ARM, AZE, GEO, KAZ, KGZ, RUS, TJK, TKM, TUR, UZB*)

Programme area 1.4: Neglected tropical diseases

Output 1.4.1. Implementation and monitoring of the WHO road map for neglected tropical diseases facilitated			**NA**
Output indicator	**Baseline**	**Target**	**Achieved value:**
Number of disease-endemic countries adopting and implementing neglected tropical disease national plans in line with the road map to reduce the burden of priority neglected tropical diseases	40/125 (2013)	100/125 (2015)	NA
Output 1.4.2. Implementation and monitoring of neglected tropical disease control interventions facilitated by evidence-based technical guidelines and technical support			**Achieved**
Output indicator	**Baseline**	**Target**	**Achieved value:**
Number of disease-endemic countries that have adopted WHO norms, standards and evidence to implement neglected tropical disease diagnosis and treatment	20/125 (2013)	100/125 (2015)	10 (*ARM, AZE, GEO, KAZ, KGZ, MDA, TJK, TKM, TUR, UZB*)
Output 1.4.3. New knowledge, solutions and implementation strategies that respond to the health needs of disease-endemic countries developed through strengthened research and training			**NA**
Output indicator	**Baseline**	**Target**	**Achieved value:**
Number of new and improved tools, solutions and implementation strategies developed and successfully applied in disease-endemic countries	NA	8 (2015)	NA

Programme area 1.5: Vaccine preventable diseases

Output 1.5.1. Implementation and monitoring of the global vaccine action plan as part of the Decade of Vaccines Collaboration strengthened with emphasis on reaching the unvaccinated and under-vaccinated populations			**Achieved**
Output indicator	**Baseline**	**Target**	**Achieved value:**
Number of countries with immunization coverage <70% that develop and implement strategies within their national immunization plans to reach unvaccinated and under-vaccinated populations	5/19 (2013)	7/19 (2015)	NA (*None of the 19 countries are in the European Region. European countries are achieving high coverage at national level but equitable coverage at subnational level still remains a challenge. In order to address this challenge, the European Vaccine Action Plan 2015–2020 has been developed, translating GVAP to the regional context.*)
Output 1.5.2. Intensified implementation and monitoring of measles and rubella elimination, and hepatitis B control strategies facilitated			**Achieved**
Output indicator	**Baseline**	**Target**	**Achieved value:**
Number of priority countries that have conducted supplementary immunization activities to achieve their measles elimination or control goal	0/68 (2013)	34/68 (2015)	1/1 (*TJK*)
Output 1.5.3. Target product profiles for new vaccines and other immunization-related technologies defined and research priorities to develop vaccines of public health importance and overcome barriers to immunization agreed			NA
Output indicator	**Baseline**	**Target**	**Achieved value:**
Number of new preferred product characteristics for new vaccines and policy recommendations for their use	NA	At least one	NA (*Output indicator (on vaccines research and development) belongs to the global function. Not applicable to the Regional Office for Europe.*)

Category 2: Noncommunicable diseases

102. The category comprises five programme areas: 2.1 Noncommunicable diseases; 2.2 Mental health and substance abuse; 2.3 Violence and injuries; 2.4 Disabilities and rehabilitation; and 2.5 Nutrition.

Major achievements

103. The Regional Office has spearheaded a **United Nations thematic group on social determinants and the prevention and control of NCDs**, and has, through an intensive collaboration with other United Nations agencies, led the development of 10 new UNDAFs that for the first time include NCD-related results and outcomes.

104. The greatest development in capacity in the European Region arises from the renewed interest among Member States in supporting the work on NCDs at the country level (see also Box 2.1). The grant from the Russian Federation for establishing the geographically dispersed office in Moscow has led to packages of technical support being provided to 23 countries, as well as funding for many of the activities at the regional level. Other donors

are showing a strong interest and are supporting individual country programmes, in particular in eastern Europe and central Asia.

Box 4. Tobacco (programme area 2.2)

The European Union's Tobacco Products Directive (Directive 2014/40/EU) was adopted requiring the 28 Member States of the European Region that are also members of the European Union to strengthen their tobacco control policies, effective from May 2016.

The Republic of Moldova adopted a new tobacco control law fully compliant with the WHO Framework Convention on Tobacco Control (FCTC). Kyrgyzstan and Turkmenistan started using large pictorial warnings on tobacco products. Bosnia and Herzegovina, Estonia, Hungary and Ukraine raised their tobacco tax closer to the level set by the FCTC. Romania and the Russian Federation became smoke-free and Belarus adopted a point-of-sale display ban. France, Ireland and the United Kingdom implemented plain packaging making the European Region the global leader of this initiative.

In 2015, ministers of health of the 53 Member States endorsed the Roadmap of actions to strengthen implementation of the WHO Framework Convention on Tobacco Control in the European Region 2015–2025 that will make it possible to achieve the global voluntary target in tobacco use by 2025 and to make tobacco a thing of the past for future generations.

105. The WHO, Turkey and European Union project in Turkey to develop **community-based mental health services** has matured, focusing on the rights, inclusion and quality of life of people with mental disabilities – success indicators include the establishment of residential homes and community centres. The project now serves as a model for other countries in the Region that face similar challenges, for example, the central Asian republics and Albania.

106. New STEPS NCD risk factor surveys were completed in four countries and technical contributions were provided to national mental health policy and legislation development in six countries, capacity-building to strengthen primary health care in addressing mental conditions and suicide prevention in seven countries, and facilitation of changes in configuration of community-based mental health services in 10 countries.

107. The WHO **global strategy to reduce the harmful use of alcohol** and the **European action plan to reduce the harmful use of alcohol 2012–2020** have provided a solid base for policy-making in countries and have been the guidance tools for implementing evidence-based policies to reduce alcohol consumption and harm. Forty countries in the European Region have adopted national plans on alcohol. The majority of remaining countries are in the process of evaluating national substance abuse policies and are expecting to update these policies in the coming years. Overall, there is a decrease in alcohol consumption of around 2% per year in Europe – but some countries, mainly situated in central and eastern Europe, are experiencing an increase and are the priority countries for WHO in the coming period.

108. In 2015, a new collection of alcohol policy data started to be made to populate a new alcohol database presenting milestones on alcohol policy in Member States. The database includes information on good practices, shares alcohol policy work among Member States of the Region and contributed to the *Global status report on alcohol and health 2014*.

109. **Investing in children: the European child maltreatment prevention action plan** was adopted by the Regional Committee in 2014. The plan highlights a critical but much ignored area of public health and advocates that violence prevention should be a mainstream policy area for Europe, as it has strong synergies with Health 2020, equity, and the life-course approach.

110. Since 2010, there has been a reduction in **road accident mortality** of 8.1%. This means that efforts need to be scaled up to achieve the Decade of Action for Road Safety (2011–2020) target of reducing mortality by 30% by 2020.

111. However, gains are being made by strengthening health systems in Member States through improved injury surveillance, capacity-building using TEACH-VIP, and national policy dialogues, often attended by high-level officials/ministers, on road safety, child injury prevention and child maltreatment prevention. One result of these policy dialogues is that the barriers to intersectoral action are slowly being overcome in some Member States.

112. Databases on violence and injury were updated for 52 Member States and resulted in three publications: *European facts and global status report on violence prevention 2014*; *Injuries in Europe: a call for public health action*; and *European facts and the global status report on road safety 2015*.

113. During the 2014–2015 biennium, **disabilities and rehabilitation** was not selected as a priority area for most Member States that have signed up to the United Nations Convention on the Rights of Persons with Disabilities. However, several countries have shown support for and interest in the **WHO global disability action plan 2014–2021**. A project for the rehabilitation of polio victims has been completed in Tajikistan and documents highlighting project successes and lessons are being produced. The Republic of Moldova and Ukraine have applied for United Nations Partnership on the Rights of Persons with Disabilities funds. Projects on intellectual disability have been completed in the Republic of Moldova and Turkey.

114. A **Food and Nutrition Action Plan 2015–2020** (see Box 5) and a **Physical Activity Strategy for the WHO European Region for 2016–2025** (as contained in document EUR/RC65/9, and adopted by the Regional Committee in resolution EUR/RC65/R3 in 2014), were developed and adopted. Successful implementation and impacts have been achieved in some areas, including: promotion of healthier food environments, nutrition throughout the life-course, food and nutrition governance, and surveillance.

Impediments and challenges

115. The greatest challenges in category 2, however, are ensuring that countries acknowledge the intersectorality and preventability of diseases and injuries, and mobilize the required political will and financial resources. Due to the complexity of developing and implementing the multisectoral policies and interventions required to effectively address the risk factors and social determinants underlying the NCD epidemic, sustained political commitment and certainty of resources are of paramount importance. While the political and financial environments have generally posed challenges and sometimes delayed the start of the process of implementing effective policies, there are also recent examples of countries that have changed attitudes towards, for example, developing more effective alcohol policies, including Czech Republic, Georgia, Kyrgyzstan, Russian Federation and Serbia.

The political changes in several countries have influenced time frames for delivery as well as raising new priorities and opportunities. The financial crises affecting several Member States have meant that there are increasingly fewer offers to host network meetings and, as a result, opportunities for capacity-building and experience exchange are being foregone.

116. Accountability with respect to intersectoral action is not yet clearly defined and needs to be better developed, communicated and institutionalized within countries.

Box 5. Nutrition (programme area 2.5)

The European Food and Nutrition Action Plan 2015–2020, which is aligned with the Global Strategy, was adopted at the 64th session of the Regional Committee for Europe, prior to the Second International Conference on Nutrition in Rome, Italy, in 2014. A majority of Member States, with the support of the Regional Office, are implementing actions relating to food environments, leadership, monitoring and surveillance, the life-course approach to nutrition and improvements in health systems responses, particularly at the primary health care level.

The surveillance of children's nutritional status has been implemented and enlarged in 32 countries in the Region. The majority of countries have developed guidelines and recommendations for nutrition during pregnancy and the first 1000 days of life. A world-leading childhood obesity surveillance initiative has been established, collecting nationally representative, nationally measured and internationally comparable data on overweight and obesity among primary school children in 31 Member States. The Region has published unique work in the area of childhood obesity surveillance, nutrient profiling and marketing, and price policies for healthy diets.

Difficulties in implementation due to staff scarcity were overcome with partnerships at the regional and national levels with various national and international organizations and authorities and with more work done through WHO collaborating centres.

Lessons learned

117. The Health 2020 policy and adopting national Health 2020 strategies have also proved to be important tools for formulating and implementing effective policies and interventions for all the programme and thematic areas of category 2. This is due to the intersectoral approach of Health 2020 and its focus on equity and the life-course. In addition, the Minsk Declaration (2015), resulting from the European Ministerial Conference on the Life-course Approach in the Context of Health 2020, has underlined the importance of preventive actions in critical life periods as well as the need to work across budget categories, in particular budget categories 2, 3 and 4, in order to make headway in preventing and controlling NCDs (see also Box 10). There is a need to further exploit synergies with the different policy frameworks in order to convince governments of the cost–effectiveness of intersectoral action for health.

Outlook for 2016–2017

118. Countries of the Region have recognized the need to develop and implement systems directed at monitoring and evaluation of the impacts, risk factors, determinants, and policies and programmes for the prevention and control of NCDs and related conditions across multiple sectors. Many information resources are available, including large amounts of data and many indicators, some requiring quality improvements and some further development, while others need to be made suitable for disaggregation. Capacity-building needs to be

enhanced and even more importantly coordinated and integrated into functional systems that can generate the information and evidence required for policy-making across sectors. Such capacity- and systems building will be a direct response to SDG17.

119. Maintaining and further gathering momentum in 2016 – during times of resource constraints – will be achieved through reprioritizing, maximizing the effective use of resources, and successful fundraising. This will require support from Member States, WHO headquarters, and senior management at the Regional Office in order to exploit synergies across the divisions of the Regional Office and different levels of WHO more fully. With the SDGs as a context, various non-traditional actors are supporting countries in addressing NCD issues. However, while potentially facilitating a comprehensive, multisectoral view of NCD risk factors and social determinants, without due coordination and definition of roles, this may lead to confusion and inefficiency. Political will, clear strategies and the establishment of multisectoral agreements and mechanisms will be necessary.

Output indicators and achievement ratings[4]

Programme area 2.1: Noncommunicable diseases

Output 2.1.1. Development of national multisectoral policies and plans for implementing interventions to prevent and control noncommunicable diseases facilitated			**Achieved**
Output indicator	**Baseline**	**Target**	**Achieved value:**
Number of countries that have established national multisectoral action plans for the prevention and control of noncommunicable diseases	NA	NA	33 (*BEL, BIH, BUL, CYP, CZH, DEN, DEU, EST, FIN, FRA, GRE, HUN, IRE, ITA, KAZ, KGZ, LTU, LVA, MAT, MDA, MON, MNE, NET, NOR, POL, RUS, SPA, SVK, SWE, TJK, TKM, UNK,UZB*)
Output 2.1.2. High-level priority given to the prevention and control of noncommunicable diseases in national health planning processes and development agendas			**Achieved**
Output indicator	**Baseline**	**Target**	**Achieved value:**
Number of countries that have integrated work on noncommunicable diseases into their United Nations Development Assistance Framework (UNDAF)	NA	NA	15 (*ALB, ARM, AZE, BIH, BLR, FYROM, GEO, KAZ, MNE, SRB, TJK, TKM, TUR, UKR, UZB (although not a Member State, Kosovo[5] also agreed with the United Nations to include NCDs in the UNDAF; if counted, this would add up to 16 countries)*

[4] For this section: NA: not applicable; TBC: to be confirmed; Full list of country abbreviations: Annex 2.
[5] In accordance with Security Council resolution 1244 (1999).

Output 2.1.3. Monitoring framework implemented to report on progress in realizing the commitments made in the Political Declaration of the High-level Meeting of the General Assembly on the Prevention and Control of Noncommunicable Diseases and the global action plan for the prevention and control of noncommunicable diseases (2013–2020)			**Achieved**
Output indicator	**Baseline**	**Target**	**Achieved value:**
Number of countries with NCD surveillance and monitoring systems in place to enable reporting against the nine voluntary global NCD targets	43/53 (in 2013)	46/53 (in 2017)	**43** (*ARM, AUT, BEL, BIH, BLR, BUL, CRO, CYP, CZH, DEN, DEU, EST, FIN, FRA, GEO, GRE, HUN, IRE, ISR, ITA, KAZ, KGZ, LTU, LUX, LVA, MAT, MDA, NET, NOR, POL, POR, ROM, RUS, SPA, SRB, SVK, SVN, SWE, SWI, TKM, TUR, UKR, UNK*)

Programme area 2.2: Mental health and substance abuse

Output 2.2.1. Countries' capacity to develop and implement national policies and plans in line with the 2013–2020 global mental health action plan strengthened			**Achieved**
Output indicator	**Baseline**	**Target**	**Achieved value:**
Number of countries with a national policy and/or plan for mental health that is in line with the 2013–2020 global mental health action plan	60/194 (2013)	70/194 (2015)	5 (*ISR, ITA, LTU, SRB, TUR*)
Output 2.2.2. Mental health promotion, prevention, treatment and recovery services improved through advocacy, better guidance and tools on integrated mental health services			**Achieved**
Output indicator	**Baseline**	**Target**	**Achieved value:**
Number of countries with functioning programmes for intersectoral mental health promotion and prevention	70/194 (2013)	90/194 (2015)	5 (*CRO, ISR, ITA, MDA, TUR*)
Output 2.2.3. Expansion and strengthening of country strategies, systems and interventions for disorders due to alcohol and substance use enabled			**Achieved**
Output indicator	**Baseline**	**Target**	**Achieved value:**
Number of countries with prevention and treatment strategies, systems and interventions for substance use disorders and associated conditions	60/194 (2013)	70/194 (2015)	26 (*ALB, BEL, CRO, CZH, DEU, EST, FIN, ICE, IRE, ISR, LTU, LVA, MDA, MNE, NOR, POL, RUS, SMR, SWE, SWI, TJK, TKM, TUR, UKR, UNK, UZB*)

Programme area 2.3: Violence and injuries

Output 2.3.1. Development and implementation multisectoral plans and programmes to prevent injuries, with a focus on achieving the targets set under the Decade of Action for Road Safety (2011–2020)			**Achieved**
Output indicator	**Baseline**	**Target**	**Achieved value:**
Percentage of countries with comprehensive laws tackling five key risk factors for road safety	15% (2013)	20% (2015)	30% (*ALB, AUT, BEL, CRO, CZH, FRA, GRE, HUN, IRE, ITA, LUX, NOR, POR, SPA, SWE*)
Output 2.3.2. Countries and partners enabled to develop and implement programmes and plans to prevent child injuries			**Achieved**
Output indicator	**Baseline**	**Target**	**Achieved value:**
Number of countries implementing policies addressing the prevention of at least one mechanism of child injuries consistent with WHO guidance (*There has not been a formal assessment as the tool has not yet been developed.)*	Baseline survey under develop-ment in 2013	TBC	6 (*Countries with national evidence-based policies and programming include: CZH, DEN, NET, POR, SWE, UNK*)
Output 2.3.3. Development and implementation of policies and programmes to address violence against women, youth and children facilitated			**Achieved**
Output indicator	**Baseline**	**Target**	**Achieved value:**
Number of countries that have submitted a complete assessment of their national violence prevention status to WHO	60/194 (2013)	120/194 (2015)	40 of the 53 countries did a baseline assessment (*ALB, ARM, AUT, AZB, BEL, BLR, BUL, CRO, CYP, CZH, DEU, EST, FIN, FYROM, GEO, ICE, ITA, KAZ, KGZ, LTU, LVA, MDA, MNE, NET, NOR, POL, POR, ROM, RUS, SMR, SPA, SRB, SVK, SVN, SWE, SWI, TJK, TUR, UNK, UZB*)

Programme area 2.4: Disabilities and rehabilitation

Output 2.4.1. Implementation of the recommendations of the *World report on disability* and the High-level Meeting of the General Assembly on Disability and Development			**Achieved**
Output indicator	**Baseline**	**Target**	**Achieved value:**
Number of countries that have comprehensive policies on health and rehabilitation	7/130 (2012)	31/130 (2020)	6 (*FYROM, ITA, MDA, TJK, UKR, UNK*)
Output 2.4.2. Countries are able to strengthen the provision of services to reduce disability due to visual impairment and hearing loss through more effective policies and integrated services			NA
Output indicator	**Baseline**	**Target**	**Achieved value:**
Number of countries implementing eye and ear health promoting policies and services that are in line with WHO recommendations	96/194 (2013)	117/194 (2015)	NA

Programme area 2.5: Nutrition

Output 2.5.1. Countries enabled to develop, implement and monitor action plans based on the maternal, infant and young child nutrition comprehensive implementation plan			**Achieved**
Output indicator	**Baseline**	**Target**	**Achieved value:**
Number of countries that are implementing national action plans consistent with the comprehensive implementation plan on maternal, infant and young child nutrition	Currently being developed	TBC	41 (*ALB, AUT, BEL, BIH, BUL, CRO, CZH, DEN, DEU, EST, FIN, FRA, FYROM, GRE, HUN, ISR, ITA, KAZ, LTU, LUX, LVA, MAT, MDA, MNE, NET, NOR, POL, POR, ROM, RUS, SPA, SRB, SVK, SVN, SWE, SWI, TJK, TUR, UKR, UNK, UZB*)
Output 2.5.2. Norms and standards on maternal, infant and young child nutrition, population dietary goals, and breastfeeding updated, and policy options for effective nutrition actions for stunting, wasting and anaemia developed			**Achieved**
Output indicator	**Baseline**	**Target**	**Achieved value:**
Number of countries adopting, where appropriate, guidelines on effective nutrition actions for stunting, wasting and anaemia	Currently being determined	TBC	43 (*ALB, ARM, AUT, BEL, BIH, BLR, BUL, CRO, CZH, DEN, DEU, EST, FIN, FRA, FYROM, GRE, HUN, ISR, ITA, KAZ, LTU, LUX, LVA, MAT, MDA, MNE, NET, NOR, POL, POR, ROM, RUS, SPA, SRB, SVK, SVN, SWE, SWI, TJK, TUR, UKR, UNK, UZB*)

Category 3: Promoting health through the life-course

120. The category comprises five programme areas: 3.1 Reproductive, maternal, newborn, child and adolescent health; 3.2 Ageing and health; 3.3 Gender, equity and human rights mainstreaming; 3.4 Social determinants of health; and 3.5 Health and the environment.

Major achievements

121. The European policy framework, Health 2020, supports the work set out in the scope of category 3 through the first of its four priority areas: investing in health through a life-course approach and empowering people. Health 2020 also provides the framework for implementation of cross-cutting technical issues within the other four technical categories. The European Ministerial Conference on the Life-course Approach in the Context of Health 2020, held in Belarus in October 2015, resulted in the signing of the Minsk Declaration, indicating political commitment and clear plans for further life-course approach actions.

122. The tools for implementing the European Child and Adolescent Health Strategy 2015–2020, adopted in resolution EUR/R64/R6 by the Regional Committee at its 64th session in 2014, have been updated. The development of the Action plan for sexual and reproductive health and the Strategy on women's health and well-being in the WHO European Region were triggered during technical briefings at the 64th and 65th sessions of the Regional Committee and will be presented for consideration at the 66th session. With technical assistance from the Regional Office, implementation of WHO tools and guidelines, and

close collaboration with United Nations system and other partners, improvement of the quality of maternal, newborn and child health care has been achieved in 20 countries in the Region.

123. Progress in Member States in adoption of elements of the **Strategy and action plan for healthy ageing in Europe, 2012–2020** remains strong (see also Box 6). Evidence published in 2014–2015 shows that more countries now address often neglected policy interventions, such as improved services for those living with dementia and for their families, and the prevention of maltreatment of elderly people. However, some neglected areas for action remain in the implementation of the action plan, such as greater awareness of the benefits of vaccination for older people, which is needed to reverse the trend in recent years of declining influenza vaccination rates (for countries where data are available).

Box 6. Healthy ageing (programme area 3.2)

Two important milestones for the implementation of the Strategy and action plan for healthy ageing in Europe, 2012–2020 were reached: a handbook on age-friendly environments in Europe was drafted in a joint project with the European Commission; and a report on the midterm progress of implementation of the European action plan for healthy ageing was prepared, along with a proposal on indicators to monitor future progress.

An important success story is the growing number of intersectoral action plans that have been put in place to create age-friendly, supportive environments at various levels, including work at the country level, evidenced by the growing movement of cities and communities implementing action plans based on the WHO framework of supportive age-friendly environments.

In a number of countries, this is directly supported by governments at a higher level, including at the national level (Finland, France, Ireland, and the United Kingdom of Great Britain and Northern Ireland). For example, local action has been acknowledged as a key element in addressing issues such as physical inactivity, loneliness and social isolation of older people.

124. In cooperation with WHO headquarters, more than 170 cities in 19 European countries were by the end of 2015 member cities of the **Global Network of Age-friendly Cities and Communities**, and available for mutual exchange of experiences on the new ePortal of the Network. During 2014–2015 direct support to countries focused on: long-term care reform, palliative care, quality and equity of access to (long-term care) services and integrated services delivery.

125. The piloting and finalization of the **gender, equity and human rights** criteria to assess the level of mainstreaming across programme areas was a key achievement (the results of the assessment are reported in the first part of this report). Another important achievement was the first analysis of the impact of gender and socioeconomic inequalities on women's health (beyond the mortality advantage) discussed at a technical briefing at the 65th session of the Regional Committee in 2015. This triggered the development of the Strategy on women's health and well-being in the WHO European Region (see above). Due to limitations of human resources, country support in 2014–2015 focused on specific requests from the Republic of Moldova, Serbia, Ukraine and Uzbekistan, and responding to ad hoc requests from various countries and networks. These requests were primarily to integrate gender, equity and human rights into policy development processes and to provide feedback on UNDAFs and joint country initiatives.

126. Sustaining the multisectoral policy commitment to reduce **socially determined health inequities** requires a balance between high-level political advocacy by the Regional Office and new partnerships for action. These have been a strong feature of the work in 2014–2015 through examples such as decision EUR/RC65(1), Promoting intersectoral action for health and well-being in the European Region: health is a political choice, taken by the Regional Committee at its 65th session in 2015. During the biennium, work to strengthen the evidence base and scientific partnerships to develop tools and resources for policy action on social determinants of health at the local, national and regional levels continued to evolve. The 2014–2015 biennium saw the launch of 15 new publications and other resources on social determinants of health, including guidance documents, promising practices and policy syntheses. As work at the country level matures through ongoing policy support over successive bienniums, requests for support are increasing in number and diversity, while also becoming more specific in nature. There has also been a marked increase in interest among Member States for learning exchange and for support to innovative approaches to scaling up action on social determinants, vulnerability, migration and health equity (see also Box 7).

Box 7. Small Countries Initiative (programme areas 3.4 and 4.1)

There is an increased demand for tailored approaches and intercountry learning exchange from Member States with common policy contexts and priorities in addressing issues relating to equity and the social determinants of health. The Small Countries Initiative involves eight countries (Andorra, Cyprus, Iceland, Luxemburg, Malta, Monaco, Montenegro, San Marino), with a population of less than 1 million, that collaborate to share knowledge and ensure the voice and perspectives of small countries are heard in European and global fora.

At the Second High-Level Meeting of the small countries held in Andorra in July 2015, the high-level representatives from the small countries united their voice in the Andorra statement, *Health promotion and disease prevention throughout the life-course*. Small countries acknowledged that a life-course approach to health means that the health outcomes of individuals and the community rely on the interaction of multiple protective and risk factors that occur throughout people's lives. They acknowledged the importance of intergenerational processes and how what happens today affects what happens tomorrow and heavily influences the possibility of living in fair and sustainable societies.

Through the Andorra statement, countries called for adoption of the life-course approach in national health plans to provide a more comprehensive vision of health and its determinants and to lead to the development of health services based on the needs of users at each stage of life.

127. Supporting the European Environment and Health Process – for which the Regional Office is the Secretariat – is one of the main areas of focus for health and environment work in the Regional Office. Major achievements in the 2014–2015 biennium include the High-level, midterm review meeting in April 2015, which critically assessed progress achieved since the Fifth Ministerial Conference on Environment and Health (2010) and defined the priorities for continued policy attention until the development and adoption of the roadmap for the preparations towards the Sixth Ministerial Conference on Environment and Health (2017), defining the political process and the thematic areas that will be addressed in order to inform the process of negotiation of the political outcomes. Additional major achievements include: further review of the global WHO air quality guidelines and noise guidelines; a new economic evaluation of the health effects of air pollution in Europe; a review of policies for elimination of asbestos-related diseases; the continued implementation

of the Protocol on Water and Health with the United Nations Economic Commission for Europe; the publication of a book on industrially contaminated areas; the development of national climate change adaptation plans and the Fourth High-level Meeting on Transport, Health and Environment (2014); and extending the Health Economic Assessment Tool (HEAT) for cycling and walking – which produces estimates of the economic value of reduced total mortality from changes to levels of cycling and walking – to include an air pollution module, which will be launched in 2016.

128. Specific country-level highlights in the area of health and the environment include: an assessment of the quality of school environments in Albania, Croatia, Estonia, Latvia, Lithuania and Serbia; capacity strengthening on chemical safety/chemical risk assessment in Estonia, Kazakhstan, Latvia, Lithuania and Ukraine; facilitation of uptake of the water safety plan in national policies and regulations in Kyrgyzstan, Republic of Moldova, Tajikistan, Ukraine and Uzbekistan; and support for the development of national adaptation strategies, green health services, and sharing of best practices and policy advice regarding policies that reduce greenhouse gas emissions in Croatia, Kazakhstan, Kyrgyzstan, Lithuania, Republic of Moldova, Serbia, Tajikistan, the former Yugoslav Republic of Macedonia, Turkmenistan and Uzbekistan.

Impediments and challenges

129. The changing political landscape in some countries with respect to contraception and abortion poses considerable challenges to the work in reproductive, maternal, newborn, child and adolescent health as well as in gender, equity and human rights.

130. There is also room for improvement of cooperation among international organizations that are active in the area of ageing and health in order to overcome the risk of fragmentation of work with countries, including monitoring of policy progress.

131. The ongoing effects of the financial crisis and related austerity measures present a risk of disinvestment in policies that directly influence the determinants of health and health equity. The impact of political unrest has increased the need to convene stakeholders to agree on modalities and priorities of cooperation across countries and agencies in order to protect against social, economic and health risks. This was exemplified by the process leading up to the high-level, multi-country and multi-agency meeting on refugee and migrant health held in Rome, Italy, in November 2015 and the adoption of the outcome document, **Stepping up action on refugee and migrant health – towards a WHO European framework for collaborative action** (see also Box 8).

Box 8. Migration and health (programme area 3.3)

Around 75 million international migrants are estimated to be living in the European Region, accounting for one third of all international migrants worldwide. Above and beyond this long-term phenomenon, in 2015 alone, over 1 million refugees and migrants arrived in European countries; this number is in addition to approximately 2.5 million who had taken shelter in Turkey by the end of that year. These numbers, along with the ongoing conflict in the Middle East, suggest that large arrivals may continue to arrive in the future.

In this context, European countries have increasingly requested technical assistance and policy advice to improve the response to the health needs of these mobile populations and the public health implications of the migration phenomenon. A good response requires health system preparedness and capacity, including robust epidemiological data and intelligence on migration, careful planning, training and, above all, adherence to the principles of equity and solidarity and to human rights and dignity. In addition, high-quality care for refugee and migrant groups cannot be addressed by health systems alone. Social determinants such as education, employment, social security and housing have a considerable impact on the health of refugees and migrants.

In August 2015, the WHO Regional Office for Europe scaled-up its response to the refugee and migrant crisis with the creation of an interdivisional Task Force on Migration and Health. The Regional Office conducted joint assessment missions with ministries of health to improve the health-system capacity and public health response to large-scale migration; provided assistance on contingency planning and intersectoral action for migrant health; delivered training on migrant health for health and non-health workers; and so on.

After an initial discussion at the 65th session of the Regional Committee in September 2015, the Regional Office and the Ministry of Health of Italy organized a High-level meeting for Refugee and Migrant Health in Rome in November 2015. The outcome document of that meeting, Stepping up action on refugee and migrant health, contributed to the development of the Strategy and action plan on refugee and migrant health in the WHO European Region, which addresses the short, medium and longer-term public health challenges of migration, and which will be submitted for consideration by the 66th session of the Regional Committee in September 2016.

132. In the environment and health area, the lower mobilization of resources resulted from a combination of different factors. While to some extent this was attributable to a shift in many governments' priorities, resulting in lower priority being afforded to addressing environmental and health challenges, a significant reduction of funds resulted from the high dependence on voluntary donations made in euros. In addition, the prolonged negotiations of new contractual agreements between the European Commission and the United Nations had an impact on the resources mobilized through the European Commission, which is one of the main donors in this area of work. A sustainability plan was developed and put in place to address this issue for the longer term. For all programme areas, more investment would be warranted, especially in the case of programme areas 3.1, 3.2, and 3.5, where important funding gaps exist. Several of the programme areas in category 3 were stretched in 2014–2015 due to demands and work programmes that surpassed the available financial and human resources. Besides putting more effort into resource mobilization, there is a need for sharper priority-setting in countries and in the Regional Office. In a scenario of competing priorities, achievements are at risk across the board.

Outlook for 2016–2017

133. By its nature, the work of category 3 cuts across the different PB categories and requires a multisectoral approach to policy and actions – at the country, intercountry and regional levels. Most of the SDGs are therefore directly relevant to the programme areas of category 3. The Regional Office established a team focusing on coordination of the work on the SDGs across the European Region, synergizing all the work and consolidating reporting of target achievements.

134. A regular Health 2020 equity status report (HESR) will be prepared, using dialogue-based methods to gather and analyse qualitative information specifically on policies and actions undertaken by Member States (and the Regional Office) to address health equity. This will support the monitoring of progress on achieving the commitments and policy innovations for Health 2020 and the SDGs. It will also serve as a valuable tool for keeping health equity, gender, human rights, and social and environmental determinants of health on local, national and Region-wide agendas. The HESR will also help to guide action to reduce health gaps between and within countries in the roll-out of the SDGs as well as providing an up-to-date context analysis that can inform stronger integration and coordination in countries and among international organizations.

Output indicators and achievement ratings[6]

Programme area 3.1: Reproductive, maternal, newborn, child and adolescent health

Output 3.1.1. Further expansion enabled of access to and quality of effective interventions from pre-pregnancy to postpartum focusing on the 24-hour period around childbirth			**Achieved**
Output indicator	**Baseline**	**Target**	**Achieved value:**
Number of countdown countries that have expanded access to skilled attendance at birth	0/75 (2013)	75/75 (2015)	5 (*AZE, KGZ, TJK, TKM, UZB*)
Output 3.1.2. Countries' capacity strengthened to expand high-quality interventions to improve child health and early child development and end preventable child deaths, including from pneumonia and diarrhoea			**Achieved**
Output indicator	**Baseline**	**Target**	**Achieved value:**
Number of countdown countries that are implementing an integrated plan for the prevention and control of pneumonia and diarrhoea	5/75	20/75 (2015)	4 (integrated child health plans, not specific to pneumonia and diarrhoea) (*KGZ, TJK, TKM, UZB*)
Output 3.1.3. Countries enabled to implement and monitor effective interventions to cover the unmet needs in sexual and reproductive health and to reduce adolescent risk behaviour			**Achieved**
Output indicator	**Baseline**	**Target**	**Achieved value:**
Number of countries that are implementing and monitoring effective interventions to cover the unmet needs in family planning	0/69 (2013)	25/69 (2015)	1 (*UZB*)

[6] For this section: NA: not applicable; TBC: to be confirmed: Full list of country abbreviations: Annex 2.

Output 3.1.4. Research undertaken, and evidence generated and synthesized to design key interventions in reproductive, maternal, newborn, child and adolescent health, and other conditions and issues linked to it			**Partly achieved**
Output indicator	**Baseline**	**Target**	**Achieved value:**
Number of new and improved tools, solutions, and implementation strategies successfully applied to reproductive, maternal, newborn and child health	NA	8 (2015)	1 (*KGZ*)

Programme area 3.2: Ageing and health

Output 3.2.1. Countries enabled to develop policies and strategies that foster healthy and active ageing, and improve access to, and coordination of, chronic, long-term and palliative care			**Achieved**
Output indicator	**Baseline**	**Target**	**Achieved value:**
Number of national plans that include strategies to promote active and healthy ageing or access to an integrated continuum of care	30/194 (2013)	40/194 (2015)	6 (*CZH, DEU, NET, SVK, SVN, UNK*)
Output 3.2.2. Technical guidance and innovations that identify and address the needs of older people for improved health care			**Achieved**
Output indicator	**Baseline**	**Target**	**Achieved value:**
Number of countries that are monitoring and quantifying the diverse health needs of older people as per WHO recommended measures and models	0/194 (2013)	20/194 (2015)	6 (*BEL, DEU, NET, POL, SWE, UNK*)
Output 3.2.3. Policy dialogue and technical guidance provided to countries focusing on the health of women beyond the reproductive age			**Achieved**
Output indicator	**Baseline**	**Target**	**Achieved value:**
Number of countries that have developed national health-related policies, legislation or plans on the health of women beyond the reproductive age	NA	5 (2015)	4 (*DEU, FIN, POL, UNK*)

Programme area 3.3: Gender, equity and human rights mainstreaming

Output 3.3.1. Gender, equity and human rights are incorporated in routine strategic and operational planning and monitoring of Secretariat programmes			**Achieved**
Output indicator	**Baseline**	**Target**	**Achieved value:**
Percentage of WHO offices and programmes that have integrated gender, equity and human rights (GER) into routine strategic and operational planning	Baseline survey TBC in 2013	100% (2015)	This is not relevant for countries and the indicator reflects the work of the global GER network and the introduction of GER in 2014–2015 reporting and 2016–2017 planning
Output 3.3.2. Countries' capacity strengthened to integrate and monitor gender, equity and human rights in their health policies			**Achieved**
Output indicator	**Baseline**	**Target**	**Achieved value:**
Number of countries that are providing key health data disaggregated by two or more social stratifiers[7]	120 (2013)	140 (2015)	6 *(ALB, AUT, MDA, SRB, TJK, UZB) as reported by WHO headquarters*

Programme area 3.4: Social determinants of health

Output 3.4.1. Increased country capacity to implement a health-in-all-policies approach, intersectoral action and social participation to address the social determinants of health			**Achieved**
Output indicator	**Baseline**	**Target**	**Achieved value:**
Number of countries implementing technical guidance on a health-in-all-policies approach and intersectoral action	9/194 (2012)	21/194 (2015)	18 (*ALB, BIH, CRO, BUL, DEN, EST, FIN, FYROM, ICE, LTU, LVA, MDA, MNE, NOR, ROM, SRB, SVN, SWE*)
Output 3.4.2. Effective guidance to countries to mainstream social determinants of health in all WHO programmes			**Achieved**
Output indicator	**Baseline**	**Target**	**Achieved value:**
Percentage of WHO offices and programmes that have integrated social determinants of health into planning, implementation and monitoring	Baseline survey TBC (2013)	25	25 (*ALB, AUT, BUL, CRO, DEN, DEU, EST, FIN, FRA, FYROM, ICE, ITA, KAZ, LTU, MNE NOR, POL, ROM, SRB SWE, SVN, SVK, UKR, UNK, and Kosovo*[5])

[7] Note: This output indicator is measured by the number of countries contributing data to WHO's health equity monitor, with the baseline reflecting the number of countries contributing data to the monitor as of the beginning of 2014. This measurement does not reflect the total number of countries advancing in gender-responsive, equity-enhancing and rights-focused health systems, which is a more accurate measure of the impact made in category 3.3 work at all levels of WHO. Therefore, to better reflect regional and country level work, the 2014–2015 indicator for output 3.3.2, that is, the number of countries implementing at least two WHO-supported activities to integrate gender, equity and human rights in their health policies and programmes, is reported here. The total number of countries meeting the measurement criteria, as per the 3.3.2 indicator for 2016–2017, is 52 countries.

Programme area 3.5: Health and the environment

Output 3.5.1. Country capacity strengthened to assess health risks, develop and implement policies, strategies or regulations for the prevention, mitigation and management of the health impacts of environmental risks			**Achieved**
Output indicator	**Baseline**	**Target**	**Achieved value:**
Number of countries with national health monitoring systems in place to assess the health risks from the lack of water and sanitation	31/194 (2013)	45/194 (2015)	3/3 (*AZE, SRB, UZB*)
Output 3.5.2. Norms, standards and guidelines to define environmental and occupational health risks and benefits associated with air quality, chemicals, water and sanitation, radiation, nanotechnologies, and climate change			**Achieved**
Output indicator	**Baseline**	**Target**	**Achieved value:**
Number of countries that have developed new or revised existing policies or national standards based on WHO guidelines for environmental and occupational health risks	20/194 (2013)	30/194 (2015)	6/53 (*BEL, FYROM, HUN, LTU, NET, UZB*)
Output 3.5.3. Public health issues incorporated in multilateral agreements and conventions on the environment and sustainable development			**Achieved**
Output indicator	**Baseline**	**Target**	**Achieved value:**
Degree to which public health issues are recognized in the post-2015 sustainable development agenda	NA	Meets expectations (2015)	Meets expectations

Category 4: Health systems

135. The category comprises four programme areas: 4.1 National health policies, strategies and plans; 4.2 Integrated people-centred health services; 4.3 Access to medicines and health technologies and strengthening regulatory capacity; and 4.4 Health systems, information and evidence.

Major achievements

136. All the Regional Office's strategies, action plans, and activities have been based on **Health 2020** since its adoption by the Regional Committee in 2012, and have contributed to developing national health policies, strategies and plans in the Region. Strategies and action plans adopted just before 2012 were implemented in alignment with the vision and strategic objectives of Health 2020.

137. At the national level, the Regional Office facilitated the development and implementation of one-country health plans in line with the principles of the International Health Partnership (IHP+); supported health officials to engage with other sectors and civil society in policy dialogue to promote UHC, taking into consideration social determinants of health and other cross-cutting issues, values and principles; and advocated for and supported high-level national/local policy dialogue for health system development in support of UHC. The new national health strategies and policies covered primary care and quality of care, among other relevant topics, to operationalize the concepts of integrating all types of

services, up to tertiary specialized services, across the life-course, including health promotion and protection and disease prevention (see Box 9).

Box 9. San Marino national health policy (programme area 4.1)

In 2012, San Marino started developing a new national health plan (2015–2017). In contrast to its previous health plan (2006–2008), the new plan integrated key components of Health 2020, such as the reduction of health inequities through action on the social determinants of health, and the promotion of intersectoral work through whole-of-government and whole-of-society approaches.

Once general ideas were agreed within the State Secretariat for Health and Social Security, an extensive consultative process was started with numerous intersectoral stakeholders (environment and education ministries; community councils and local citizens; voluntary associations representing health and social welfare issues; and WHO). Then the plan was approved in a step-wise process. Enabling factors in the process were shared political will, use of existing intersectoral mechanisms and a high level of trust among the partners.

The challenges included internal coordination, definition of the roles of the various entities involved and engaging with a long-term vision while acting in the short term. San Marino, a small country, faced the challenge of avoiding isolation while maintaining a leadership role in the international community.

138. In line with the Regional Office's operational approach, "people centred health systems: innovations for better health outcomes", which translates the vision of Health 2020 into reality, health systems strengthening has underpinned an increasing number of work programmes throughout the Regional Office, including:

- capacity-building and flagship courses on health systems strengthening/NCDs;
- country systems reviews using the health systems barriers and NCDs framework (see Box 10);
- data and monitoring (on SDGs, NCDs and Health 2020 indicators, among others);
- multicountry work, in collaboration with the Global Fund, on tuberculosis control and health financing (such as the TB Regional Eastern Europe and Central Asia Project for Health System Transformation and Financing Reform to Scale up Drug-resistant TB Control (TB-REP);
- health systems, essential public health operations and IHR (2005); and
- environmentally sustainable health systems.

139. Externally, the Regional Office has also positioned its work in partnership with the OECD, the European Union, the European Observatory on Health Systems and Policies and other relevant institutions, calling on stakeholders from professional associations, providers and civil society to contribute to the development of a regional framework for action on integrated health services delivery in line with the global WHO framework that was submitted to the Sixty-ninth World Health Assembly in May 2016.

Box 10. Health systems and NCDs (programme areas 4.1 and 4.2)

An outstanding example of multidisciplinary cross-programme collaboration at the Regional Office has been the work to strengthen health systems that focuses on NCDs. A country assessment guide on health systems strengthening with a focus on NCDs was developed and implemented at the country level. Participating countries strengthen their policies through the entry point of a country assessment based on multidisciplinary consensus (http://www.euro.who.int/en/health-topics/Health-systems/health-systems-response-to-ncds).

To date, 12 countries (Armenia, Belarus, Croatia, Estonia, Hungary, Kazakhstan, Kyrgyzstan, Portugal, Republic of Moldova, Tajikistan, the Former Yugoslav Republic of Macedonia and Turkey) assessed their health systems' response to NCDs. Many launched their reports at high-profile public events, to build momentum among multiple stakeholders and to gain political and public support.

Many countries have taken action on a range of topics, benefiting from WHO technical assistance: governance, intersectoral action, models and continuity of care, incentives, and access to high-quality medicines. For example, Estonia and Turkey started to move towards multiprofile team-based primary health care, integrating population and individual services.

Good practice briefs were published sharing information on effective policies such as Hungary's tax on food high in salt, fat and sugar; Estonia's pay-for-performance instrument in primary health care; and Kyrgyzstan's community-based health promotion work within primary health care teams.

The Regional Office integrated experience from this cross-cutting programme in its annual course on strengthening health systems, which takes a systematic approach and attracts over 50 participants from about 20 countries.

140. Information gathered highlighted key approaches to reducing **health inequalities** in national health policies:

- UHC;
- gender equity; and
- reductions in vulnerability, including health differences experienced by different ethnic groups.

141. Most Member States have explicitly included equity and social determinants of heatlh, gender and human rights in the design of national and local health policies and some have established specialized agencies or committees to ensure implementation. Still, the area of disaggregated data partially affects the setting of targets and indicators for reducing health inequalities, with many targets being rather generic.

142. Prompted by the financial crisis in Europe and the global demand for monitoring progress towards UHC, the Regional Office started major work to strengthen the evidence base by monitoring financial protection in a wide range of health systems. A new methodology was developed for more detailed measurement of the protection that health systems provide against the financial burden of ill-health on households. Twenty country reports were commissioned to generate new evidence in the Region, and a regional report on financial protection is due next biennium.

143. Countries have greater knowledge of their **health workforces** and stronger capacity to monitor and analyse health workforce dynamics. The quality of data on health workforce employment and education provided by Member States to the joint

OECD/Eurostat/Regional Office database, which includes a new section on migration flows, has improved (see Box 11).

Box 11. Health statistics (programme area 4.4)

The annual collection of health statistics from European Member States include: cause-of-death and population data, Health for All (HFA) indicators and joint data collection on non-monetary health care statistics with Eurostat and OECD. Joint data collection has been extended to include data on health-workforce migration. The HFA databases are updated several times per year and their data are also available in the new European Health Information Gateway and the European Health Statistics mobile application.

In addition, the Regional Office conducted a monitoring exercise for qualitative Health 2020 indicators in 2014. On request, it supported countries in developing monitoring frameworks (Czech Republic and Georgia), assessing health information systems (Bulgaria and the Republic of Moldova) using a support tool to assess health information systems and develop and strengthen health information strategies elaborated in the context of EHII, beginning and improving the use of the International Classification of Diseases and International Classification of Functioning, Disability and Health (Albania, Bulgaria, Georgia, Latvia, Montenegro, Serbia, Slovakia, Uzbekistan), building national health observatories/data-dissemination platforms (Germany, Italy, Republic of Moldova, Serbia and United Kingdom), assessing systems for civil registration and vital statistics (Tajikistan) and building capacity in health information and statistics (Georgia, Kazakhstan and Slovakia).

The Regional Office was also instrumental to the creation of various subregional health information networks such as the Central Asian Republics Health Information Network (CARINFONET) and the Small Countries Health Information Network (SCHIN).

Challenges in countries are related to fragmented health information systems, lack of cooperation between sectors, lack of resources for health information, non-use/lack of updated standards and classifications, low quality of data and poor governance in some parts of the European Region. Even if available, information is often not shared, made public or acted upon.

144. The WHO Global Code of Practice on the International Recruitment of Health Personnel continues to be highly relevant in the Region, due to growing regional and interregional labour mobility and the need to achieve sustainable workforces and effective health systems. To monitor its implementation, the Regional Office presented a report, *Making progress towards a sustainable health workforce in the WHO European Region*, to the 65th session of the Regional Committee in 2015. Some of the activities supported at the country level are exemplified in the results achieved by the Republic of Moldova in regard to the project for better managing health professionals' mobility: stronger technical capacity to assess, monitor and plan human resources for health; a new national strategy on human resources for health; and a legal framework for international recruitment of health personnel aligned with the principles of the Global Code of Practice.

145. In response to resolution WHA64.7 on strengthening nursing and midwifery, and in line with Health 2020, the technical programme, in close collaboration with governmental and civil society stakeholders, launched the European strategic directions for strengthening nursing and midwifery towards Health 2020 goals, accompanied by a compendium of good nursing and midwifery practice. Joint efforts focused on supporting Member States in conducting self-assessments of essential public health operations, and in public health workforce development through national and regional courses and workshops and through advice on workforce planning, education and training.

146. A key part of a well-functioning health system is access to essential medicines and medical devices. Executive Board resolution EB134.R16 on **access to essential medicines** provides a renewed mandate for WHO to support Member States in improving access to medical products in line with UHC and the global action plan on NCDs. In 2014, the Regional Office started work on medicines policy and appropriate use in 13 countries (Albania, Armenia, Belarus, Croatia, Cyprus, Estonia, Greece, Hungary, Kyrgyzstan, Republic of Moldova, Russian Federation, Tajikistan and Ukraine). During the biennium, Kyrgyzstan adopted its first medicines policy, the culmination of several years of work.

147. In March 2014, Regional Office staff published an article in *Lancet Infectious Diseases* showing a fourfold difference in antibiotic consumption among countries of the European Region. The Regional Office requested data to follow up this study in 19 countries, and expects to publish an analysis late in 2016.

148. In line with the Tallinn Charter and the Health 2020 policy framework, countries were supported in formulating evidence-informed policies and in ensuring good practices and governance throughout the health technologies supply chain, from selecting the right products to using them correctly. The programme addressed access to medicines and medical devices for current and emerging health priorities, and developed tools to assess situations and monitor and measure progress on access to quality health products. In emergencies, such as those experienced in Ukraine, substantial support was provided and access to medical products played a critical role.

149. Guidance in medical product regulation continued to be a crucial element of the work of the Regional Office, with support provided to countries to strengthen regulation, including post-marketing surveillance, and to eliminate substandard and falsified medicines. To promote convergence in the regulation of medical products, support was provided to countries to implement the WHO Prequalification Programme, which enables participating European medicines manufacturers to facilitate their regulatory affairs work. In terms of responsible use of medicines, the focus was on the use of antimicrobial medicines and supporting countries in setting up registers to monitor the use of medicines.

150. The Regional Office report, *Access to new medicines in Europe: technical review of policy initiatives and opportunities for collaboration and research*, highlighted the challenges faced by governments in purchasing the rising number of new, high-priced medicines being introduced in Europe. National health authorities have to be sure, when making decisions on purchasing new medicines, that the price paid matches the therapeutic benefits to be gained by using them. To further support Member States in this area, the Observatory Venice Summer School 2014 was conducted with the theme – Re-thinking pharmaceutical policies – optimizing decisions in an era of uncertainty. In addition, several PPRI activities were carried out with the PPRI WHO collaborating centre to update Member States on pricing and reimbursement policies and discuss current challenging issues.

151. The Regional Office also enhanced access to and dissemination of health information and evidence. As a result, Regional Office publications increased in popularity in the biennium: downloads of PDFs rose by 11% from 2014 (376 714) to 2015 (416 819). The Regional Office also conducted a monitoring exercise for qualitative Health 2020 indicators in 2014, and produced the Region's annual **core health indicators**. Moreover, several well-received Health Evidence Network synthesis reports were published, two in collaboration with the European Commission.

152. *The European health report 2015: targets and beyond –reaching new frontiers in evidence*, the main corporate health information publication, was published in 2015 in two formats and in all four official languages of the Region. It summarized regional health trends, provided updates on challenges in measuring and reporting progress in regard to Health 2020, and proposed new sources of qualitative evidence to describe and monitor well-being, and stronger international collaboration to advance the agenda for health information research and development. Essential health statistics from the report were published in the European Health Statistics mobile application.

153. The Regional Office also updated its systems for the integration and presentation of health information and evidence, and launched the WHO European Health Information Gateway (portal.euro.who.int) in October 2015, along with its underlying integrated data warehouse.

154. In 2014–2015, the Regional Office continued its **European Health Information Initiative** (EHII) to develop a single, integrated health information system for the entire European Region by supporting the integration and sharing of existing knowledge, expertise and good practices in the area of health information. The number of participants – spanning Member States, WHO collaborating centres, the European Commission, the OECD, Public Health England, the Wellcome Trust, and health information networks – doubled, from 11 to 22, during the biennium. As part of EHII, the Regional Office organized capacity-building in regard to collecting, analysing, reporting and using health information, including through the Evidence-informed Policy Network (EVIPNet) and the annual Autumn School on Health Information and Evidence for Policy. Moreover, it introduced a new annual capacity-building event, the Advanced Health Information Workshop, in 2015, targeting around 100 people. The capacity-building work of EVIPNet also expanded, with a record number of 16 countries participating.

155. The Regional Office continued its commitment to multilingual health information dissemination and use. A new bilingual (English and Russian) scientific journal, *Public Health Panorama*, was launched. Three issues were published, addressing a wide range of topics, including communicable diseases, intersectoral action for health and children's rights to health. The Regional Office also developed a bilingual (English and Russian) glossary of life-course terms and there are plans to expand the work on terminology.

156. The Regional Office convened two meetings of the European Advisory Committee on Health Research, which gave valuable advice on the Regional Office's strategies and activities. Subgroups of the Committee identified research topics on migration and health, and agreed to help the Regional Office to draft an action plan to strengthen the use of evidence, information and research for policy-making in the Region, for consideration by the 66th session of the Regional Committee in 2016.

157. The area of technology and innovation in health was significantly strengthened with the establishment of the eHealth & Innovation (EIN) unit to meet the increasing demand from European Member States for support to national e-health strategy development and guidance on implementation of e-health standards and interoperability. The unit was responsible for achieving the highest response rate of any Region in the 2015 global e-health survey (89%) and subsequently produced the successful European e-health report, *From innovation to implementation*.

158. In close collaboration with the United Nations Educational, Scientific and Cultural Organization, the Regional Office launched a new initiative to assess the impact of culture on health and well-being through the work of a specially dedicated expert group. The expert group will be reporting on its findings, including the development of a new tool kit, in due course.

Impediments and challenges

159. The effects of the financial crisis and related austerity measures challenge the pursuit of UHC. The consequences might not be noticed for some time, owing to fragmented health information systems and low availability of high-quality and appropriately disaggregated data in countries. Migration to Europe has brought several challenges to the health policy arena and national health systems at the pan-European level. Furthermore, the impact of political unrest has increased the need to convene stakeholders to agree on modalities and priorities for cooperation across countries and agencies to protect against social, economic and health risks. The Regional Office has played a key role as an advocate and convener to mitigate political and policy instability in the development of sound national policies, strategies and plans.

Lessons learned

160. The Regional Office's work on national health policies, systems and services is expected to support Member States facing the increased challenges posed by rising inequalities, the burden of chronic conditions and migration, and to support increased consensus among Member States to achieve the SDGs, particularly those on health and well-being. This offers WHO a unique opportunity to employ its comparative advantage: normative work and country assistance, based on the core values of Health 2020, to secure better health and well-being and to decrease inequity in health for the people in the Region. A key to WHO's credibility is its ability to attract and retain high-calibre staff.

Outlook for 2016–2017

125. While pursuing the achievement of the health-related MDGs, and contributing to the implementation of the MDG agenda, the Regional Office continuously advocated for and contributed to the implementation of the Health 2020 policy framework at the regional, national and subnational levels. Following the launch of the 2030 Agenda for Sustainable Development, it started work to "localize" the Agenda in countries, integrate it into national development planning and adapt national targets. The 2030 Agenda represents a unique opportunity to renew countries' commitment to health and seek intersectoral synergies to advance the SDGs and implement the priorities already endorsed by European Member States through the Health 2020 policy framework.

Output indicators and achievement ratings[8]

Programme area 4.1: National health policies, strategies and plans

Output 4.1.1. Advocacy and policy dialogue to support countries to develop comprehensive national health policies, strategies, plans			**Achieved**
Output indicator	**Baseline**	**Target**	**Achieved value:**
Number of countries that conducted reviews of their national health strategy including the financing component during the biennium	0 (2013)	25 (2015)	25 (*ALB, AND, ARM, AZE, BUL, CRO, CZH, FYROM, HUN, ICE, ITA, KAZ, KGZ, LTU, LVA, MAT, POL, POR, ROM, SMR, SPA, SVK, SVN, UKR, UZB*)
Output 4.1.2. Country capacity to develop and implement legislative, regulatory, and financial frameworks strengthened by generation and use of evidence, norms and standards, and robust monitoring and evaluation			**Achieved**
Output indicator	**Baseline**	**Target**	**Achieved value:**
Number of countries that have institutionalized tracking of health resources	49/194 (2013)	65/194 (2015)	34 (*AUT, BEL, BUL, CRO, CYP, CZH, DEN, DEU, EST, FIN, FRA, GRE, HUN, ICE, IRE, ISR, ITA, LTU, LUX, LVA, MAT, NET, NOR, POL, POR, ROM, SPA, SVK, SVN, SWE, SWI, TJK, TUR, UNK*)

Programme area 4.2: Integrated people-centred health services

Output 4.2.1. Policy options, tools and technical support to countries for equitable people-centred integrated service delivery and strengthening of public health approaches			**Achieved**
Output indicator	**Baseline**	**Target**	**Achieved value:**
Number of countries routinely assessing the costs and impact of different service delivery options and the related expenditures	45/194 (2013)	80/194 (2015)	23 (*ALB, AUT, BIH, BLR, CRO, CYP, EST, DEU, FYROM, GRE, ITA, KAZ, KGZ, LVA, MAT, MDA, POR, SRB, SVK, SVN, TJK, UKR, UZB*)
Output 4.2.2. Countries enabled to plan and implement strategies that are in line with WHO's global strategy on human resources for health and the WHO Global Code of Practice on the International Recruitment of Health Personnel			**Achieved**
Output indicator	**Baseline**	**Target**	**Achieved value:**
Number of countries that have an investment plan for scaling up and/or improving training and education of health workers in accordance with national health needs	30/57 (2013)	35/57 (2015)	The output indicator applies to 57 countries with critical shortages of health workers, as defined by WHO. The European Region has no countries with critical shortages, but ensuring an appropriate, trained and sustainable workforce is clearly one of the key challenges for European health policy-makers now and in the future

[8] For this section: NA: not applicable; Full list of country abbreviations: Annex 2.

Output 4.2.3. Guidelines, tools and technical support to countries for improved patient safety and quality of services, and for patient empowerment			**Partly achieved**
Output indicator	**Baseline**	**Target**	**Achieved value:**
Number of countries with official engagement in new patient safety initiatives	20 (2013)	40 (2015)	4 (*LVA, MDA, MNE, POL*)

Programme area 4.3: Access to medicines and health technologies and strengthening regulatory capacity

Output 4.3.1. Countries enabled to develop or update, implement, monitor and evaluate national policies on better access to health technologies; and to strengthen evidence-based selection and rational use of health technologies			**Achieved**
Output indicator	**Baseline**	**Target**	**Achieved value:**
Percentage of countries with official national policies on access, quality and use of medicines and health technologies updated within past five years	80% (2013)	82% (2015)	2 (*FIN, KGZ*)
Output 4.3.2. Implementation of the global strategy and plan of action on public health, innovation and intellectual property			**Achieved**
Output indicator	**Baseline**	**Target**	**Achieved value:**
Number of countries that report data on research and development investments for health	71/194 (2010)	100/194 (2015)	45 (*ALB, ARM, AUT, AZE, BLR, BEL, BUL, CRO, CYP, CZH, DEN, DEU, EST, FIN, FRA, FYROM, GRE, HUN, ICE, IRE, ISR, ITA, KAZ, KGZ, LTU, LUX, LVA, MAT, NET, NOR, POL, POR, MDA, ROM, RUS, SPA, SRB, SVK, SVN, SWE, SWI, TJK, TUR, UKR, UNK*)
Output 4.3.3. Strengthening national regulatory authorities facilitated; norms, standards, guidelines for medical products developed; and quality, safety and efficacy of health technologies ensured through prequalification			**Achieved**
Output indicator	**Baseline**	**Target**	**Achieved value:**
Number of new medicines and health technologies prequalified	NA	100 (2015)	NA *(Prequalification is a global effort)*

Programme area 4.4: Health systems, information and evidence

Output 4.4.1. Comprehensive monitoring of the global, regional and country health situation, trends and determinants, using global standards, and leadership in the new data generation and analyses of health priorities			**Achieved**
Output indicator	**Baseline**	**Target**	**Achieved value:**
Number of countries (among the 75 countries in the Commission on Information and Accountability for Women's and Children's Health report) that have good-quality public analytical reports for informing regular reviews of the health sector strategy	30/75 (2013)	50/75 (2015)	1 (*KGZ*)
Output 4.4.2. Countries enabled to plan, develop and implement an eHealth strategy			**Achieved**
Output indicator	**Baseline**	**Target**	**Achieved value:**
Number of countries that have developed an eHealth strategy	80/194 (2013)	100/194 (2015)	46 (*ALB, ARM, AUT, AZE, BLR, BEL, BIH, BUL, CRO, CYP,*

			CZH, DEN, DEU, EST, FIN, FRA, FYROM, GEO, GRE, HUN, ICE, IRE, ITA, LTU, LUX, LVA, MAT, MDA, MNE, NET, NOR, POL, POR, ROM, RUS, SPA, SRB, SVK, SVN, SWE, SWI, TJK, TUR, UKR, UNK, UZB)
Output 4.4.3. Knowledge management policies, tools, networks, assets and resources developed and fully utilized by WHO and countries to strengthen their capacity to generate, share and apply knowledge			**Achieved**
Output indicator	**Baseline**	**Target**	**Achieved value:**
Number of visits to the WHO electronic knowledge assets and resources from low-income and lower-middle-income countries (annual)	20 million (2013)	30 million (2015)	NA (*global indicator*)
Output 4.4.4. Policy options, tools and support provided to define and promote research priorities, and to address priority ethical issues related to public health and to research for health			**Achieved**
Output indicator	**Baseline**	**Target**	**Achieved value:**
Number of global and regional Advisory Committees on Health Research convened at least once during the biennium, and whose recommendations have been synthesized, published and disseminated	4 (2013)	7 (2015)	2

Category 5: Preparedness, surveillance and response

161. The category comprises six programme areas: 5.1 Alert and response capacities; 5.2 Epidemic-prone and pandemic-prone diseases; 5.3 Emergency and crisis management; 5.4 Food safety; 5.5 Polio eradication; and 5.6 Outbreak and crisis response.

Major achievements

162. During 2014–2015, the Regional Office provided assistance to Member States in strengthening IHR (2005) core capacities, including the Better Labs for Better Health initiative, strengthening surveillance and response to pandemic influenza and other emerging pathogens, addressing the challenge of AMR, building national capacity on risk-based food safety systems, and increasing capacities to prepare for and respond to outbreaks and health emergencies. As part of corporate efforts, a significant number of staff were deployed to support global emergencies: the Ebola outbreak in West Africa, the consequences of the earthquake in Nepal in April 2015, and the response to the crisis in Yemen.

163. The **alert and response** operations continued to perform event-based surveillance throughout the 2014–2015 biennium on a 24/7 basis. During the biennium, out of the hundreds of signals reviewed and assessed, 81 public health events were recorded in the WHO Event Management System. All of these events led to communication with the respective National IHR Focal Points, WHO country offices (where present), technical units in the Regional Office and headquarters, IHR Contact Points in other WHO regions and with partners, especially the European Commission Directorate-General for Health and Food Safety and the ECDC. Daily exchanges of operational information took place between the Regional Office and the ECDC on epidemiological intelligence.

164. The Regional Office worked to reduce the burden of **seasonal influenza** on European countries by providing evidence on the disease burden, promoting vaccination, providing surveillance data jointly with the ECDC through the new Flu News Europe bulletin and seeking to improve the care of patients with severe forms of influenza. It also worked to enhance the representativeness of viruses shared with WHO for the composition of the annual influenza vaccine: 28 European countries shared viruses for the composition of the vaccine for the northern hemisphere 2015–2016 influenza season.

165. At the 64th session of the Regional Committee in 2014, the Regional Office reported on its most recent accomplishments with partners and Member States in combating **AMR** using a "One Health" approach. Throughout 2014–2015, the Regional Committee supported Member States, including on the formation of intersectoral coordination mechanisms, surveillance of antimicrobial consumption and resistance, infection prevention and control, antibiotic stewardship, AMR from an agricultural and food safety perspective, and awareness raising.

166. In addition, the Regional Office and partners provided assistance in the development of countries' capacity for laboratory surveillance, through the efforts of the Central Asian and Eastern European Surveillance of Antimicrobial Resistance (CAESAR) network; and in setting up a sustainable network of national surveillance systems on antimicrobial medicines consumption (the AMC Network) in non-European Union countries, to complement the European Union's European Surveillance of Antimicrobial Consumption Network, coordinated by the ECDC.

167. In 2014–2015, the Regional Office continued to support Member States in preparing for and responding to **public health threats and emergencies**, taking a multihazard and multisectoral approach, and in using the IHR (2005) on a day-to-day basis in an operational way. Senior health care workers of eastern European ministries of health and ministries of emergencies gained additional knowledge of public health in emergencies through training courses and workshops. Assessment missions on health system capacities, hospital safety and mass gathering preparedness were carried out and support in the updating of national emergency preparedness plans was provided.

168. The importance of intersectoral approaches to increase **food safety** and strengthen prevention, surveillance and control of foodborne diseases, in particular between the public health sector and the agriculture and veterinary sectors, has been emphasized, encouraged and stimulated; this includes promotion and facilitation at the regional and national levels of work in relation to the Codex Alimentarius and the role of the Codex Trust Fund. A policy brief on intersectoral collaboration, **Health 2020: agriculture and health though food safety and nutrition**, was published in March 2015. During the biennium, support was provided to countries in building capacity for the prevention, surveillance, reporting and control of foodborne and zoonotic diseases, and in addressing the food safety and "One Health" aspects of AMR critical to the development and implementation of national action plans on AMR. Technical support was provided during outbreaks and emergencies that concerned the food-chain. The Regional Office used World Health Day 2015, which had the theme of food safety, to recognize the roles of all those involved in food production and to strengthen collaboration and coordination among them in order to prevent, detect and respond to foodborne diseases

169. After the WHO Director-General declared the spread of poliovirus to be a public health emergency of international concern under the IHR (2005) in May 2014, the Regional Office worked with Member States and partners to support implementation of the temporary recommendations by the **IHR Emergency Committee** and the **Polio Eradication and Endgame Strategic Plan 2013–2018**, which guides intensified global efforts to complete the eradication of polio and certify the remaining WHO regions polio-free by the end of 2018. With wild poliovirus type 2 now eradicated and a three-year absence of type 3 celebrated in November 2015, historic milestones have been achieved in the global effort to eradicate all wild polioviruses. Maintaining the European Region's polio-free status and preparing for the post-eradication period have now become more critical than ever before and require constant vigilance. At the 64th session of the Regional Committee, Member States discussed the current European and global situations, and noted that the oral polio vaccine had been withdrawn and inactivated polio vaccine had been introduced in the Region (see also Box 12).

170. The Regional Office **responded to four graded emergencies** in the biennium: the Syrian Arab Republic (classified as a Grade 3 emergency – see Box 12); Ukraine (Grade 2); the Balkan floods, affecting Bosnia and Herzegovina, Croatia and Serbia (Grade 2 until August 2014); and the Ebola response (Grade 3). The **conflict in eastern Ukraine**, with an estimated 5 million people affected in the regions of Lugansk and Donetsk, has led to more than 1.4 million people being internally displaced and more than 120 health facilities being damaged. WHO leads the Health and Nutrition Cluster in Ukraine at the national and subnational levels to plan, coordinates and execute the health response activities of different actors on the ground.

Box 12. The Syrian Arab Republic conflict (programme area 5.3)

The most prominent emergency affecting the European Region is the Syrian Arab Republic conflict, which has caused a migration crisis; almost 3 million refugees are currently hosted by Turkey. Since 2013, through its field presence in Gaziantep, southern Turkey, and jointly with the Turkish Government, WHO has coordinated the health response for refugees residing in Turkey. Achievements include: training of 175 doctors and 74 nurses to obtain a license to treat Syrians in Turkey; mental health assessment among refugees; up-scaling of the national public health laboratory to analyse increasing numbers of samples from the Syrian Arab Republic; training staff of the Turkish Ministry of Health on communicable diseases outbreak alert and response; provision of medical equipment and supplies to the health clinics to improve health services for Syrian refugees; raising health awareness among refugees and prepositioning 86 emergency health kits.

In collaboration with the Regional Office for the Eastern Mediterranean, the Regional Office for Europe – jointly with Save the Children – leads the health cluster for the northern part of the Syrian Arab Republic. Implemented through partners, this has included: organizing 12 cross-border polio immunization campaigns and one measles campaign each reaching more than 1.3 million children; development of mental health training materials and an essential mental health drug list; and technical assistance, capacity building and procurement of laboratory supplies for the Early Warning and Alert Response Network (EWARN) system with 995 sentinel sites.

WHO, in collaboration with Syrian health partners, is also maintaining a real-time database on attacks against health-care facilities and health-care workers. Based on that data, a report was prepared in November 2015 in collaboration with the Office for the Coordination of Humanitarian Affairs to be presented to the United Nations Security Council.

171. In May 2014, the Regional Office led a large-scale response to **heavy rainfall in the Balkans** that caused flooding and landslides across Bosnia and Herzegovina, eastern Croatia and Serbia. The flooding disrupted public services for weeks and damaged or destroyed health facilities in all three countries. WHO led the national health sector meetings to coordinate the initial health response from the United Nations and other partner organizations, procured emergency health supplies for all three affected countries, and advised on a common strategy to fight infectious diseases in flood-affected areas and to prevent emerging environmental health risks.

172. WHO's involvement with the public health aspects of the **migration and refugee crisis**, with people moving from the Middle East and north Africa to Europe, included assessments of the preparedness activities of the health sectors of affected countries, support in training and advice to health-care workers in border and reception camps, as well as the delivery of medical supplies and drugs to affected countries to treat migrants.

173. As a part of corporate efforts, the Regional Office deployed a considerable number of staff to support global emergencies such as the fight against the Ebola outbreak in West Africa, the consequences of the earthquake in Nepal in April 2015 and the response to the crisis in Yemen. In support of the Ebola response alone, the Regional Office organized 36 missions by 25 staff, amounting to a total of 1302 staff days. Both the regional and the global crises diverted capacity from the Region's workplans and budgets and contributed to either delayed or postponed implementation of some planned activities.

Impediments and challenges

174. The current modality of IHR (2005) monitoring and evaluation, based largely on self-assessments, is limited and does not provide an adequate reflection of country capacities. This is an important challenge, as the information and scoring received from countries cannot fully be used for planning. For influenza, challenges include lack of reporting to WHO on surveillance data and, in a number of countries, insufficient human resources capacity to drive technical improvements. The main challenges to strengthening AMR surveillance in many countries of the Region include limited laboratory capacity, lack of standardized methodologies and guidelines, lack of routine sampling and use of diagnostics to inform treatment, and paper-based recording of laboratory results. The sustainability of work in relation to the Codex Alimentarius at the national level is a challenge for countries that are no longer eligible for Codex Trust Fund support. Intersectoral collaboration is essential for cost-efficient prevention, surveillance and control of foodborne and zoonotic diseases. This is well recognized at the international and regional levels, but not always at the country level.

Lessons learned

175. Efforts are ongoing to revise the IHR (2005) monitoring and evaluation framework in favour of a multifaceted approach oriented towards capturing the functionality of the IHR, which will include independent evaluations and real-time exercises, while moving away from self-assessments only. Language barriers (many members of National IHR Focal Point institutions in the eastern parts of the Region are not English speakers) and a relatively frequent turnover of National IHR Focal Point staff necessitate extra resources for translation, interpretation and for the continuous training of new staff. Efforts are being made to meet these challenges, but not in a systematic manner, owing to limited capacity

and resources at the Regional Office. To meet the challenges related to AMR surveillance, the Regional Office and partners have developed a proof-of-principle study protocol to stimulate routine sampling, improve laboratory capacity and skills, and start up surveillance.

176. Even though the Region has been certified free of wild poliovirus for more than a decade, the recent circulating vaccine-derived poliovirus outbreak in Ukraine provided some important regional lessons. It showed that sustained, high population immunity against polio and regional outbreak preparedness will be vital for achieving global polio eradication by 2018.

Outlook for 2016–2017

177. The outlook for 2016–2017 will be guided by the results of the **reform of WHO's work in outbreaks and emergencies**. In line with the reform, the Regional Office will implement one programme, one budget, one health workforce, one line of accountability, one set of business processes and one set of benchmarks, which will require adjustments to the work, as well as increased resources and human capacity at both the regional and country levels to fulfil the new mandate and achieve key expected results. It is expected that this will assist in making WHO an operational organization which is capable, predictable, accountable, independent, etc. in responding to outbreaks and other public health emergencies and strengthening the ability of its Member States to manage public health events in a timely and appropriate manner, as stipulated in the IHR (2005). Continued strengthening of interregional cooperation, especially between the Regional Offices for Europe and the Eastern Mediterranean in the areas of preparedness and response at the technical, operational and political levels, is also of great importance.

Output indicators and achievement ratings[9]

Programme area 5.1: Alert and response capacities

Output 5.1.1. Countries enabled to develop core capacities required under International Health Regulations (2005)			**Partly achieved**
Output indicator	**Baseline**	**Target**	**Achieved value:**
Proportion of countries supported that have met and sustained International Health Regulations (2005) core capacities within the biennium	50% (2013)	100% (2015)	80% (*ALB, AND, ARM, AUT, AZE, BEL, BLR, BUL, CRO, CZH DEN, DEU, EST, FIN, FYROM, GEO, HUN, ICE, IRE, ISR, ITA, KAZ, LTU, LUX, LVA, MAT, MDA, MNE, NOR, POL, POR, ROM, RUS, SMR, SPA, SVK, SVN, SWE, SWI, TKM, TUR, UKR, UNK*).
Output 5.1.2. WHO has the capacity to provide evidence-based and timely policy guidance, risk assessment, information management and communications for all acute public health emergencies			**Achieved**
Output indicator	**Baseline**	**Target**	**Achieved value:**
Proportion of WHO offices fully meeting standards for event-based surveillance and risk assessment	60% (2013)	100% (2015)	70%

[9] For this section: NA: not applicable; Full list of country abbreviations: Annex 2.

Programme area 5.2: Epidemic-prone and pandemic-prone diseases

Output 5.2.1. Countries are enabled to develop and implement operational plans, in line with WHO recommendations on strengthening national resilience and preparedness covering pandemic influenza and epidemic and emerging diseases			**Achieved**
Output indicator	**Baseline**	**Target**	**Achieved value:**
Number of countries that have developed or updated since the end of the 2009 influenza pandemic their operational plans on strengthening national resilience and preparedness for pandemic influenza and epidemic and emerging diseases	10/194 (2013)	40/194 (2015)	14 (*BUL, CZH, DEN, FIN, FRA, FYROM, LVA, NET, NOR, SVK, SWE, SWI, TJK, UNK*)
Output 5.2.2. Expert guidance and systems support in place for disease control, prevention, treatment, surveillance, risk assessment and risk communications			**Partly achieved**
Output indicator	**Baseline**	**Target**	**Achieved value:**
Number of countries with routine and event based surveillance reporting based on international standards for epidemic diseases	100/194 (2013)	120/194 (2015)	7 (*ARM, AZE, CYP, FYROM, TJK, UKR, UZB*)

Programme area 5.3: Emergency and crisis management

Output 5.3.1. Global Health Cluster and country health clusters reformed in line with the United Nations Inter-Agency Standing Committee's transformative agenda			**Achieved**
Output indicator	**Baseline**	**Target**	**Achieved value:**
Percentage of health clusters that meet the minimum requirements for a satisfactory performance	40% (2013)	70% (2015)	70%
Output 5.3.2. Health established as a central component of global multi-sectoral frameworks for emergency and disaster risk management; national capacities strengthened for all-hazard emergency and disaster risk management for health (*not applicable to the WHO Regional Office for Europe*)			**NA**
Output indicator	**Baseline**	**Target**	**Achieved value:**
Percentage of countries conducting a capacity assessment for all-hazard emergency and disaster risk management for health	40% (2013)	80% (2015)	NA
Output 5.3.2. Guidance and tools for disaster risk reduction including mass gathering, hospital resilience and safety and roll out of hospital emergency response (*WHO Regional Office for Europe Output*)			**Achieved**
Output indicator	**Baseline**	**Target**	**Achieved value:**
Percentage of countries conducting a capacity assessment for all-hazard emergency and disaster risk management for health	40% (2013)	80% (2015)	80% (2015)
Output 5.3.3. Organizational readiness successfully realized for full implementation of WHO's Emergency Response Framework (*not applicable to the WHO Regional Office for Europe*)			NA
Output indicator	**Baseline**	**Target**	**Achieved value:**
Percentage of WHO offices that fully comply with WHO's readiness checklist	20% (2013)	80% (2015)	NA

Output 5.3.3. Training and capacity-building packages for Public Health and Emergency Management and surge training adapted, including roll out of ERF and the CO readiness checklist in line with IHR procedures and requirements (*WHO Regional Office for Europe Output*)**.**			**Achieved**
Output indicator	**Baseline**	**Target**	**Achieved value:**
Percentage of WHO offices that fully comply with WHO's readiness checklist	20% (2013)	80% (2015)	80% (2015)
Output 5.3.4. Health sector strategy and plan developed, implemented and reported on in all targeted protracted-emergency countries by an in-country network of qualified and trained WHO emergency staff			**Achieved**
Output indicator	**Baseline**	**Target**	**Achieved value:**
Percentage of protracted-emergency countries that meet the performance standards	25% (2013)	70% (2015)	70%

Programme area 5.4: Food safety

Output 5.4.1. Support the work of the Codex Alimentarius Commission to develop, and for countries to implement, food safety standards, guidelines and recommendations			**Achieved**
Output indicator	**Baseline**	**Target**	**Achieved value:**
Percentage of high priority requests for international guidance, standards or recommendations on food hazards successfully dealt with	80% (2013)	90% (2015)	100%
Output 5.4.2. Multisectoral collaboration to reduce foodborne public health risks, including those arising at the animal–human interface			**Achieved**
Output indicator	**Baseline**	**Target**	**Achieved value:**
Number of countries with mechanism for multisectoral collaboration on reducing foodborne public health risks	118/194 (2013)	132/194 (2015)	45*/53 (* Measured as the number of countries that currently have an International Food Safety Authorities Network (INFOSAN) Emergency Contact Point registered on the INFOSAN Community Website) (*ALB, AND, ARM, AUT, AZE, BLR, BEL, BIH, BUL, CRO, CYP, CZH, DEN, DEU, EST, FIN, FRA, FYROM, GEO, GRE, HUN, ICE, IRE, ISR, ITA, LTU, LUX, LVA, MAT, NET, NOR, POL, POR, MDA, ROM, RUS, SPA, SRB, SVK, SVN, SWE, SWI, TUR, UKR, UNK*) ** TKM and UZB are in the process of formally registering an INFOSAN Emergency Contact Point

Output 5.4.3. Adequate national capacity to establish and maintain risk-based regulatory frameworks to prevent, monitor, assess and manage foodborne and zoonotic diseases and hazards			**Achieved**
Output indicator	**Baseline**	**Target**	**Achieved value:**
Number of countries with a food safety system that has an appropriate legal framework and enforcement structure	116/194 (2013)	137/194 (2015)	31*/53 (* Measured as the number of countries with a food safety system that has appropriate legal framework and enforcement structure as self-reported by Member States on the IHR monitoring questionnaire) (*AND, ARM, AUT, BEL, CZH, DEU, EST, FIN, FRA, GEO, HUN, ICE, IRE, KAZ, LTU, LUX, LVA, MAT, MON, MNE, NET, NOR, POL, MDA, SPA, SVK, SVN, SWE, SWI, TJK, TUR*)

Programme area 5.5: Polio eradication

Output 5.5.1. Direct support to raise population immunity against polio to the required threshold levels in affected and high-risk areas			**Partly achieved**
Output indicator	**Baseline**	**Target**	**Achieved value:**
Number of polio-infected and high-risk countries supported to conduct polio vaccination campaigns and surveillance	72/72 (2013)	72/72 (2015)	3/3 (*BIH, ROM, UKR*)
Output 5.5.2. International consensus established on the cessation of the use of oral polio vaccine type 2 in routine immunization programmes globally			**Achieved**
Output indicator	**Baseline**	**Target**	**Achieved value:**
Number of countries (those using oral polio vaccine) where there is an agreed timeline for cessation of use of oral polio vaccine type 2 in routine immunization	0 (2013)	130 (2015)	20 (*ALB, ARM, AZE, BIH, BLR, FYROM, GEO, ISR, KAZ, KGZ, MDA, MNE, POL, RUS, SRB, TJK, TKM, TUR, UKR, UZB*)
Output 5.5.3. Processes established for long-term poliovirus risk management, including containment of all residual polioviruses, and the certification of polio eradication globally			**Achieved**
Output indicator	**Baseline**	**Target**	**Achieved value:**
Number of fully functional certification processes for polio eradication at global and regional levels	4 (2013)	7 (2015)	WHO European Regional Certification Commission fully functional
Output 5.5.4. Establishment of the polio legacy plan			**Achieved**
Output indicator	**Baseline**	**Target**	**Achieved value:**
Plan for the polio legacy established	No (2013)	Yes (2015)	Yes

Programme area 5.6: Outbreak and crisis response

Output 5.6.1. Implementation of the WHO's Emergency Response Framework in acute emergencies with public health consequences			**Achieved**
Output indicator	**Baseline**	**Target**	**Achieved value:**
Percentage of emergencies from any hazard with public health consequences, including any emerging epidemic threats, where WHO's Emergency Response Framework has been fully implemented	0% (2013)	80% (2015)	80%

Category 6: Corporate services/enabling functions

178. The category comprises five programme areas: 6.1 Leadership and governance; 6.2 Transparency, accountability and risk management; 6.3 Strategic planning, resource coordination and reporting; 6.4 Management and administration; and 6.5 Strategic communications.

Major achievements

179. The two annual sessions of the Regional Committee and the 10 sessions of the Standing Committee of the Regional Committee in 2014–2015 have put great emphasis on implementation of **WHO reform** in the Region, including dedicated discussions on reform and Standing Committee subgroups on governance and resource allocation. In particular, the Standing Committee subgroup on governance made concrete recommendations for ways to improve the functioning of WHO's governing bodies and associated processes in the European Region.

180. The Regional Office's **leadership role** and effective coordination with partners have been strengthened at both the regional and country levels (see also Box 13). Implementation of a joint action framework with the United Nations Children's Fund and the United Nations Population Fund, focusing on both regional and country collaboration, is moving forward; and past cooperation with the European Commission was reviewed and a new framework of cooperation was endorsed at the 65th session of the Regional Committee in 2015.

Box 13. Country collaboration (programme area 6.1)

Leadership and performance of WHO country offices has been strengthened and coordination of technical delivery at the country level has been improved through clarification of management roles and responsibilities and lines of authority for country offices and by increasing accountability. Head of country office positions in non-European Union countries have been upgraded to international level posts (for example, in Bosnia and Herzegovina and Kyrgyzstan; selection is under way for Albania, Armenia, Azerbaijan and Georgia; an international post for deputy head of country office is being established at the WHO country office in the Russian Federation).

All Member States have nominated National Counterparts and 44 countries have appointed National Technical Focal Points. This has greatly improved coordination and information exchange with Member States, providing robust mechanisms for technical collaboration, also with countries without a WHO country presence.

Fifteen UNDAFs were rolled out in 2014–2015 (Albania, Armenia, Azerbaijan, Belarus, Bosnia and Herzegovina, Georgia, Kazakhstan, Montenegro, Serbia, Tajikistan, the former Yugoslav Republic of Macedonia, Turkey, Turkmenistan, Uzbekistan; and in Kosovo (in accordance with Security Council resolution 1244 (1999)) even though it is not a Member State). All country offices and the Regional Office are actively engaged in the development process, including with evaluation of the Common Country Assessments (CCAs). This has improved coherence of WHO work with United Nations and other development partners at the country level.

Remaining challenges for country collaboration include insufficient human resources/capacity in ministries and country offices, lack of support for collaboration in some Member States, and political turmoil.

181. **Internal control** continues to be strong in the Regional Office, as evidenced by the results of internal and external audits. A step forward in the implementation of the internal control framework was achieved with the roll-out of the internal control checklist. Although no evaluations were planned or conducted in 2014–2015, European members of the **WHO Global Network on Evaluation** reviewed and provided input to the first draft of a framework on strengthening the evaluation function and organizational learning, which was developed by WHO headquarters.

182. At its 65th session in 2015, the Regional Committee adopted the **regional plan for implementation of programme budget 2016–2017 in the WHO European Region**, which specifies the contribution of the European Region to the global outcomes and outputs defined in PB 2016–2017, with specific indicators of achievement at the regional level. This is a new iteration of the contract between Member States and the Regional Office Secretariat and will be used as a strategic tool for accountability.

183. The Regional Office developed a new **country matrix of roles and responsibilities**, which brings clarity to the roles and responsibilities of country offices and the Regional Office as regards implementation of country technical assistance programmes, especially the **BCAs**. The matrix will be implemented in 2016–2017 and will facilitate greater accountability for results. The Regional Office has further developed a new approach to **strategic allocation of corporate resources to countries** with BCAs, based on the strategic budget space allocation methodology. This was welcomed by country offices and technical programmes, as it adds more objective health needs-based elements to the distribution of resources, while not losing sight of historical allocations.

184. The human resources team in the Regional Office continued to provide advice and guidance to staff and managers at regional and country office level on **human resource**s planning, organizational development, recruitment, staff performance management, career management, and staff development and well-being.

185. The **information technology** focus in 2014–2015 was on implementing corporate solutions, in particular the standardized workspace environment (“Synergy” project) and the corporate standard security solution (managed firewalls). In addition, the focus was on a new, harmonized approach to service delivery (in the Regional Office and country offices) in order to standardize and improve service levels across the Region. Along with the rest of WHO, the Regional Office launched the **new integrated records management system** in 2015, which is expected to increase transparency and compliance with administrative rules and procedures. The Regional Office has continued to support its country offices and geographically dispersed offices in their efforts to remain **compliant with the Minimum Operating Security Standards (MOSS)**, and all are fully MOSS compliant except one (the country office in Turkmenistan). After a tender for travel services for all United Nations agencies based at UN City Copenhagen, a new travel agent began work with the Regional Office in 2015, providing travel services to all offices of the Region, which has already demonstrated savings in terms of travel costs. As part of the contract, a new online booking tool has been made available to staff.

186. Progress in achieving **better understanding of WHO’s public health priorities and work** by key national and international actors in public health and governance as a whole was reinforced at the regional level through strengthened and intensified interagency and regional cooperation with the European Commission, the ECDC, the European Food Safety

Authority and the European Medicines Agency, and in partnership with other United Nations agencies in UN City Copenhagen. This was also achieved at the country level through the launch of the WHO **Regional Network for National Technical Focal Points for Communications** mapping and actively deploying the communication capacities of WHO country offices in Europe. Communication capacity in 28 Member States has been improved though a series of needs-based interactive subregional training courses in Kazakhstan, Republic of Moldova and Serbia. Communication skills of WHO staff in the Regional Office and country offices were enhanced through training courses on communications without jargon and social media.

Impediments and challenges

187. The delay in distribution of **global corporate funds** at the start of 2014 created some impediments to implementation at regional and country levels. While there has been a better **alignment of resources with strategic prioritization**, this alignment has been driven by the use of flexible resources to cover strategic gaps. Coordinated resource mobilization focused on highly prioritized areas remains a challenge and is expected to improve with the financial dialogue that is ongoing at the global level.

188. Despite the global guidance on **bottom-up planning for the 2016–2017 biennium** being somewhat delayed, consultations between country offices and their Member State counterparts and with Member States that do not have country offices took place early in the biennium. Due to a significant time gap between bottom-up planning and operational planning, there was a need to revisit priorities during operational planning at the end of the 2014–2015 biennium. **Monitoring of PB indicators** must be considered to be an integral part of technical implementation at all levels of the Organization and there is a need for better definition and guidance from WHO headquarters in terms of monitoring PB indicators from the start of implementation. This includes a reassessment of the suitability and feasibility of outputs, indicators, and achievement targets of the new PB 2016–2017 in order to facilitate a better coordination of delivery, including at the country level and with Member States. The feasibility of reporting on PB indicators is particularly important for PB 2018–2019, in light of the closing of the Twelfth General Programme of Work by the end of 2019.

189. Prevention and resolution of **harassment** cases is still a challenge. Investing in prevention and mediation, empowering staff and creating a respectful workplace environment with zero tolerance should be a priority.

Lessons learned

190. Delayed availability of financial resources at the start of 2014 was seen as one of the main impeding factors in delayed implementation. The decision to keep the process of **transfer of voluntary contributions** into 2016–2017 open until late in 2015 will help to reduce delays in implementation in the new biennium. Technical programmes and country offices were able to have resources available for implementation from the start of 2016, giving much needed continuity to their actions over the closing of the biennium and the start of the new one. However, the problem of **better predictability in allocation of corporate resources** to major offices both in timing and amount still persists. Likewise, the **global budget reviews** need to be more flexible and adapted to regional specifities. In order to prevent organizational results from being driven by resources, **coordinated resource**

mobilization at global and regional levels needs to be more strongly oriented towards strategic priorities.

191. Bottom-up planning should continue to drive the overall **regional and global strategic planning**, including PB processes. However, better timing and processes need to be developed in order to more fully exploit the potential of this process. This must include better coordination between the technical programmes at the regional level and country offices in preparation for and development of BCAs with countries. Operational planning that allows for timely workplan approval and thus implementation has a positive impact on technical implementation, giving technical units and countries flexibility and continuity in their actions.

Outlook for 2016–2017

192. The Regional Office has started linking its **strategic planning process** with the **SDGs**, including in the development of BCAs, by establishing a correspondence between each programme area and the SDG to which it contributes. More specific linkage is still needed and will be incorporated into strategic and operational planning for 2018–2019. A **WHO-led regional United Nations thematic working group on NCDs and social determinants of health** contributes to implementing Health 2020 and the global NCD action plan. The Regional Office has requested for this to be turned into an issues-based coalition on SDGs in 2016 and a guidance note on the inclusion of Health 2020, NCDs and social determinants of health has been developed by WHO and was shared with all United Nations country teams through the United Nations Development Programme. A review of the draft roll-out of UNDAFs showed a high level of inclusion of Health 2020, the objectives of the global NCD monitoring framework and the SDGs in the UNDAFs and of linkages between them.

193. In 2016–2017, the Regional Office plans to be closely involved with **corporate evaluations** in order to gain evaluation experience and develop evaluation competencies. But equally importantly, the Regional Office looks forward to learning from the results of the corporate evaluations in order to remain relevant.

Output indicators and achievement ratings[10]

Programme area 6.1: Leadership and governance

Output 6.1.1. Effective WHO leadership and management in place			**Achieved**
Output indicator	**Baseline**	**Target**	**Achieved value:**
Proportion of country cooperation strategies that are up to date and aligned with national health policies strategies and plans	88% (2013)	95% (2015)	98% (*ALB, ARM, BEL, BIH, BLR, BUL, CRO, CYP, CZH, EST, FYROM, GEO, HUN, KAZ, KGZ, LTU, LVA, MAT, MDA, MNE, POL, POR, ROM, RUS, SRB, SVK, SVN, SWI, TJK, TKM, UZB*)

[10] For this section: NA: not applicable; TBD: to be determined; Full list of country abbreviations: see Annex 2.

Output 6.1.2. Effective engagement with other stakeholders in building a common health agenda that responds to Member States' priorities			**Achieved**
Output indicator	**Baseline**	**Target**	**Achieved value:**
Percentage of countries where WHO is perceived as providing the main support to government/partner coordination for health	80%	85%	82% (global figure) (*AZE, BIH, BUL, GEO, KGZ, MDA, TJK, TUR, TKM, UKR, UZB and Kosovo*[5])
Output 6.1.3. WHO governance strengthened with effective oversight of the sessions of the governing bodies, and efficient, aligned agendas			**Achieved**
Output indicator	**Baseline**	**Target**	**Achieved value:**
Extent of the alignment of the governing bodies' agendas with the general programme of work and the programme budget, and their harmonization	NA	Progressive improvement	Progressive improvement
Output 6.1.4. Integration of WHO reform into the work of the Organization			**Achieved**
Output indicator	**Baseline**	**Target**	**Achieved value:**
Percentage of outputs in the WHO implementation plan being completed or on track	25% (2013)	100% (2015)	84% (global figure)

Programme area 6.2: Transparency, accountability and risk management

Output 6.2.1. Accountability ensured though strengthened corporate risk management and evaluation at all levels of the Organization			**Achieved**
Output indicator	**Baseline**	**Target**	**Achieved value:**
Organization-wide risk management framework implemented	No (2013)	Yes (2015)	Yes
Output 6.2.2. Implementation of WHO's evaluation policy across the Organization			**Achieved**
Output indicator	**Baseline**	**Target**	**Achieved value:**
WHO programmes regularly evaluated according to established policy, with follow-up actions initiated within 6 months from the date of the final recommendations	NA	Yes (2015)	**0**
Output 6.2.3. Ethical behaviour, decent conduct and fairness promoted across the Organization			**Achieved**
Output indicator	**Baseline**	**Target**	**Achieved value:**
Proportion of the complaints and/or allegations reported that are assessed within 6 months of registration	TBD	100% (2015)	100% for informal complaints For formal complaints – this is global measurement at the WHO headquarters level

Programme area 6.3: Strategic planning, resource coordination and reporting

Output 6.3.1. Results-based management framework in place including an accountability system for WHO's corporate performance assessment			**Achieved**
Output indicator	**Baseline**	**Target**	**Achieved value:**
Organizational performance measured through a consolidated assessment of delivery of planned outputs	NA	Yes	Yes (*77% of outputs is reported on 31 January 2016*)

Output 6.3.2. Alignment of WHO's financing with agreed priorities facilitated through strengthened resource mobilization, coordination and management			**Achieved**
Output indicator	**Baseline**	**Target**	**Achieved value:**
Percentage of programme budget by category and major office funded at the beginning of biennium	55% (2013)	At least 70% (2015)	40% (*January 2014*)

Programme area 6.4: Management and administration

Output 6.4.1. Sound financial practices managed through an adequate control framework, accurate accounting, expenditure tracking and the timely recording of income			**Achieved**
Output indicator	**Baseline**	**Target**	**Achieved value:**
An unqualified audit opinion	Yes (2013)	Yes (2015)	Yes
Output 6.4.2. Effective and efficient human resources management in place to recruit and support a motivated, experienced and competent workforce in an environment conducive to learning and excellence			**Achieved**
Output indicator	**Baseline**	**Target**	**Achieved value:**
Percentage of recruitment processes completed within 180 days	65% (2013)	90% (2015)	2014: 88% 2015: 80%
Output 6.4.3. Efficient and effective computing infrastructure, network and communications services, corporate and health-related systems and applications, and end-user support and training service provided			**Achieved**
Output indicator	**Baseline**	**Target**	**Achieved value:**
Number of IT infrastructure and services delivered according to common accepted standards	6 IT infra-structure and services (2013)	10 IT infra-structure and services (2015)	10 is a global figure. In the Regional Office, four services were implemented (harmonized service desk support, global synergy deployment, storage services and back-up system, telephony and conferencing system upgrade)
Output 6.4.4. Provision of operational and logistics support, procurement, infrastructure maintenance and asset management, and of a secure environment for WHO's staff and property (in compliance with United Nations Minimum Operating Security Standards (MOSS) and Minimum Operating Residential Security Standards (MORS))			**Achieved**
Output indicator	**Baseline**	**Target**	**Achieved value:**
Percentage of WHO facilities worldwide that are MOSS/MORS compliant	85% (2013)	95% (2015)	97%

Programme area 6.5: Strategic communications

Output 6.5.1. Improved communication by WHO staff leading to a better understanding of the Organization's action and impact			**Achieved**
Output indicator	**Baseline**	**Target**	**Achieved value:**
Number of WHO offices that have completed the communications capacity-building programme and assessed to be effective communicators of WHO's work	0 (2013)	40 (2015)	18
Output 6.5.2. Development and efficient maintenance of innovative communication platforms			**Achieved**
Output indicator	**Baseline**	**Target**	**Achieved value:**

Percentage of stakeholders who say WHO communicates public health information in timely and accessible ways	66% (2013)	75% (2015)	NA (*global indicator*)

Annex. PB 2014–2015 by category and programme area

Category		Programme area	
1	**Communicable diseases**	1.1	HIV/AIDS
		1.2	Tuberculosis
		1.3	Malaria
		1.4	Neglected tropical diseases
		1.5	Vaccine-preventable diseases
2	**Noncommunicable diseases**	2.1	Noncommunicable diseases
		2.2	Mental health and substance abuse
		2.3	Violence and injuries
		2.4	Disability and rehabilitation
		2.5	Nutrition
3	**Promoting health through the life-course**	3.1	Reproductive, maternal, newborn, child and adolescent health
		3.2	Ageing and health
		3.3	Gender, equity and human rights mainstreaming
		3.4	Social determinants of health
		3.5	Health and the environment
4	**Health systems**	4.1	National health policies, strategies and plans
		4.2	Integrated people-centred health services
		4.3	Access to medicines and health technologies and strengthening regulatory capacity
		4.4	Health systems, information and evidence
5	**Preparedness, surveillance and response**	5.1	Alert and response capacities
		5.2	Epidemic- and pandemic-prone diseases
		5.3	Emergency risk and crisis management
		5.4	Food safety
6	**Corporate services/ enabling functions**	6.1	Leadership and governance
		6.2	Transparency, accountability and risk management
		6.3	Strategic planning, resource coordination and reporting
		6.4	Management and administration
		6.5	Strategic communications
	Emergencies	5.5	Poliomyelitis eradication
		5.6	Outbreak and crisis response

Annex 2. Country abbreviations used in the tables on output indicators and achievement ratings

ALB	Albania
AND	Andorra
ARM	Armenia
AUT	Austria
AZE	Azerbaijan
BEL	Belgium
BIH	Bosnia and Herzegovina
BLR	Belarus
BUL	Bulgaria
CRO	Croatia
CYP	Cyprus
CZH	Czech Republic
DEN	Denmark
DEU	Germany
EST	Estonia
FIN	Finland
FRA	France
FYROM	The former Yugoslav Republic of Macedonia
GEO	Georgia
GRE	Greece
HUN	Hungary
ICE	Iceland
IRE	Ireland
ISR	Israel
ITA	Italy
KAZ	Kazakhstan
KGZ	Kyrgyzstan
LTU	Lithuania
LUX	Luxembourg
LVA	Latvia
MAT	Malta
MNE	Montenegro
MON	Monaco
NET	Netherlands
NOR	Norway
POL	Poland
POR	Portugal
MDA	Republic of Moldova
ROM	Romania
RUS	Russian Federation
SMR	San Marino
SPA	Spain
SRB	Serbia
SVK	Slovakia
SVN	Slovenia
SWE	Sweden
SWI	Switzerland
TJK	Tajikistan
TKM	Turkmenistan
TUR	Turkey
UKR	Ukraine
UNK	United Kingdom of Great Britain and Northern Ireland
UZB	Uzbekistan

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