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Country performance in the WHO European Region

This report on country performance in the WHO European Region highlights the achievements and progress made on various aspects of WHO reform at the country level, including country-level leadership, prioritization of WHO's work through bottom-up planning processes and coordination efforts across the three levels of the Organization. It describes how country-level support by WHO – driven by global and regional workplans – is achieved and also identifies the gaps and challenges for further enhancing WHO performance in countries. The report provides a snapshot of successes in Member States with country offices and outlines work done in cooperation with those Member States without a WHO country office. An annex on budget allocation by technical area is included, providing an overview of funding at the country level and demonstrating that programme results are implemented according to plan.

Technical briefings featuring heads of WHO country offices were organized at the 65th and 66th sessions of the WHO Regional Committee for Europe, in 2015 and 2016, respectively. Both briefings presented overviews of Regional Office work at the country level and gave examples of country-specific work as well as intercountry work. Due to the positive feedback from Member States, a technical briefing on this topic, expanding on the two previous sessions, is scheduled for the 67th session of the Regional Committee.

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WHO presence in the WHO European Region

1. The WHO European Region comprises 53 countries and has a population of over 900 million people, living in an area stretching from Greenland in the north to the Mediterranean Sea in the south and from the Atlantic Ocean in the west to the Pacific shores of the Russian Federation in the east. The Region is characterized by vast diversity in its geography, people, cultures, languages and health situation. Life expectancy between countries differs by as much as 17 years (*World Health Statistics 2015*); while more than half of the countries in the Region have a high or very high human development index, others are in the group of countries with a medium human development index. Moreover, large disparities exist within countries, even in those that are the best off.

2. Headquartered in Copenhagen, Denmark, the WHO Regional Office for Europe has five technical divisions, five technical centres (known as geographically dispersed offices), 29 country offices, four sub-offices and one field office located in Kosovo (in accordance with Security Council resolution 1244 (1999)). In addition to the country offices and technical centres, the Regional Office also hosts the European Observatory on Health Systems and Policies. WHO Representation to the European Union, based in Brussels, Belgium, has been under the leadership of the Regional Director for Europe since 2011.

3. A unique characteristic of the European Region relative to the other five WHO regions is that the Organization has no in-country presence in 24 of its Member States, although two countries (Greece and Israel) have requested that a country office be set up for a period of time starting from January 2018. Support to countries without a country office is provided directly by the Regional Office and through the work of the geographically dispersed offices. WHO work in countries is also underpinned by WHO headquarters in Geneva, Switzerland.

WHO business model for the European Region

4. Regardless of whether or not WHO has a physical presence in a country, the Organization works with all Member States to support their national health development processes. Technical cooperation between the Regional Office and its Member States is based on the strategic direction outlined in the Twelfth General Programme of Work 2014–2019 and the bottom-up identification of priorities. The priority areas of WHO support to countries are outlined according to country-specific and regional deliverables in the programme budget.

5. An overview of issues relating to the delivery of programmatic results and the financing of the programme budget is regularly presented to the Standing Committee of the WHO Regional Committee for Europe. This mechanism for systematic reporting and feedback ensures that the Regional Office is accountable to its governing bodies and that it provides the platform for receiving guidance and direction from Member States.

6. Considerable efforts are made with regard to requests for technical cooperation, which are usually addressed directly to the Regional Director during her visits to Member States, during regular ministerial visits to the Regional Office or in writing. The Regional Director discusses with individual Member States possible areas of cooperation, including capacity-building, providing evidence and supporting the implementation of norms, standards and recommendations. At times, WHO assists ministers in parliamentary or other national debates, particularly on difficult issues such as health financing or the provision of vaccines,

which can then be translated into actions with the support of the technical divisions of the Regional Office.

7. The Regional Director regularly organizes country days for health ministries to enable staff to discuss interdivisional collaboration within a country. Such days allow for a greater focus on priorities for cooperation, interdivisional work, achievements and challenges, as well as for developing partnerships at the country level, for example, between heads of WHO country offices, technical units and representatives of health ministries, in order to identify WHO entry points for key policy development processes. In recent years, country days have been held in Bosnia and Herzegovina, Bulgaria, Denmark, Kyrgyzstan, Norway, the Russian Federation, Sweden and Turkmenistan and some countries of the South-eastern Europe Health Network. Moreover, visits to the Regional Office by health ministers and their delegations have taken place on average once a month in recent years.

8. In seeking to increase cooperation, transparency and efficiency with Member States, the Regional Office has formalized the process of identifying and working with national counterparts (that is, senior policy-makers appointed by their respective health ministries), who are the first and main point of contact between WHO and the health ministry. The national counterparts are supported by a network of national technical focal points, covering 12 technical areas of work: communicable diseases; equity and social determinants of health; health and the environment; health systems; leadership and governance, strategic planning, resource coordination and reporting; mental health; noncommunicable diseases (NCDs); preparedness, surveillance and response; promoting health throughout the life-course; strategic communications; subnational policies – regions and cities; and violence and injury prevention.

9. The Regional Office and country office staff are in regular contact with national counterparts, who are informed of all assistance provided to their country, including overall strategic cooperation and project implementation at the operational level, at all levels of the Organization. This mechanism of communication is particularly important for Member States without a WHO country office. Annual meetings of national counterparts have been held during Regional Committee sessions since 2013. The Regional Office also hosts online meetings for national counterparts twice a year.

Country offices in the European Region

10. The institutional framework for country offices follows a country roadmap, based on an external evaluation of the Regional Office's work within and for countries, which was reviewed a few years ago. The report presents an overview of the uniform approach to WHO presence in countries which, under the guidance of the Regional Director, aims to strengthen the capacity for and efficiency of support to country offices.

11. A revised matrix of the roles and responsibilities of heads of WHO country offices was defined in 2014, which has helped to clarify the differences in the roles, responsibilities and work of the country offices and those of the Regional Office. As a result, heads of country offices have full authority for the implementation of country-level technical assistance programmes.

12. Ensuring appropriate technical cooperation with countries, WHO country offices provide leadership in the health sector and beyond: supporting Member States in coordinating

intersectoral work with partners, including other United Nations agencies, in order to attain health objectives and to achieve national health policies and strategies that integrate the Sustainable Development Goals (SDGs) at the country level. Country offices reinforce and extend the role of the Regional Office, ensuring that the global and regional mandates are aligned with national contexts and realities. The leadership role of country offices helps to promote the continuity of public health actions during peaceful political change as well as in response to complex emergencies and natural disasters. Both the Regional Office and the country offices, particularly those in priority countries with high vulnerability and low capacity, work continuously to prevent, prepare for, respond to and recover from crises and emergencies.

13. The size and role of a country office, agreed with the Member State, are strategically adapted to the needs and contexts of the country in which it is located and depend on factors such as the population of the country and the level of operations and assistance required by the Member State. The number of staff working in country offices can vary from two people (head of office and administrative support) in countries such as Estonia and Poland to a workforce of more than 20 (staff and non-staff) in countries such as Turkey (37, including staff in the sub-office in Gaziantep) and Ukraine (43, including staff in the sub-offices in Donetsk, Luhansk and Severodonetsk). Most country offices have both internationally and nationally recruited professional staff. General services staff are recruited locally. Since 2014, the number of international professional staff working in countries has increased.

14. In June 2017, a total workforce of 347 (217 staff, 130 non-staff) staffed 29 country offices, one field office and four sub-offices in the Region (see Annex 1). Of the total workforce, 13% are international professionals, 22% are national professionals; 27% are general service staff or short-term administrative staff; and 38% are non-staff on special service agreements, consultants, agreements for performance of work, volunteers or interns. Annex 1 provides a full list of the workforce in country offices in the Region, grouped by category.

15. Human resources capacity is carefully matched to the programmatic and thematic focus of the country offices. To complement the limited full-time resources of some country offices, individuals are contracted for short-term assignments related to a specific national project or activity. As of June 2017, a total of 26 individuals in 9 country offices were on special service agreements, 10 individuals in 8 country offices were working as consultants and 15 individuals in four offices were holding staff appointments of 60 days or less.

16. Of the 29 country offices in the Region, 30% are located at United Nations common premises, 30% at health ministries, 27% at independent premises rented by WHO and 13% at independent premises owned by the Government and made available to the Organization.

17. Through detailed monthly reports shared with other Regional Office staff, heads of country offices provide regular and ad hoc feedback on relevant developments, workplan implementation and partnerships in countries within and outside the United Nations family. In addition, monthly online meetings and regular programme manager meetings serve as a means for heads of office to interact with technical units at the Regional Office on mutually agreed topics of interest.

Bringing regional and global policies to countries

18. The indicators and measurable targets that have been developed and adapted by Member States to monitor Health 2020 implementation require a more collaborative approach to working across government sectors. Being fully aligned with the 2030 Agenda for Sustainable Development, the Health 2020 framework has expanded the role of country offices to include equity, social determinants, gender and human rights values and approaches in the design of national and local health policies.

19. The Regional Office facilitates the integration of the SDGs in its networks, initiatives and partner activities thereby assisting the European Union (EU) and its member States in this process. In addition to these efforts, since 2013 all strategies, action plans, ministerial conferences and other high-level meetings of the European Region have been based on the Health 2020 policy framework, which in turn promotes the integration of Health 2020 in national policies, strategies and plans.

Supporting emergencies and crises with public health consequences

20. Under the new Health Emergencies Programme, WHO has expanded its normative function and traditional roles of technical support and standard-setting to include the design of disaster and risk management programmes, core capacity-building for health emergency preparedness and implementation of the International Health Regulations (IHR) (2005). WHO also provides effective operational support in times and places of emergencies and crises with public health consequences, supports the prevention and management of high-impact events, such as pandemics, and manages the risks associated with the day-to-day work of responding to protracted crises, outbreaks and humanitarian crises.

21. In order to focus on the most vulnerable and at-risk countries, in line with the IHR (2005), a list of priority countries with different priority levels has been developed, which functions across all relevant WHO health programmes with corresponding actors, sectors and partners. The list includes Turkey and Ukraine as *Priority 2* countries; Georgia, Kyrgyzstan and Serbia (including Kosovo (in accordance with Security Council resolution 1244 (1999)) as *Priority 3* countries; and Albania, Armenia, Azerbaijan, Bosnia and Herzegovina, Kazakhstan, the Republic of Moldova, Tajikistan, the former Yugoslav Republic of Macedonia, Turkmenistan and Uzbekistan in the *Other* category.

22. During 2015–2016, WHO recorded 80 health emergencies in 29 Member States in the European Region. Of these, about 20% required WHO involvement in the response. To facilitate effective coverage of WHO activities in countries facing health challenges, four sub-offices were established in the Region: one in Turkey and three in Ukraine. To strengthen capacity and assist national counterparts in improving the preparedness, response and capacity of the health sector to cope with public health challenges of large-scale migration, several national professional officer positions on migration and health have been created in selected countries (Greece, Italy, Serbia and Turkey).

Leadership, convening, representation, partnership and advocacy

23. In implementing WHO reform and aligning national health policy with the 2030 Agenda and Health 2020 provisions, the role of WHO at the country level requires

proactive engagement with diverse national and international stakeholders. Through technical and policy leadership, country presence promotes WHO's health agenda by partnering with all sectors relevant to health and by engaging with development partners, including United Nations agencies and non-State actors.

WHO country office staff as leaders for health

24. WHO country office staff act as leaders for health at the country level by guiding policy dialogue and monitoring and evaluating national policies and trends. Previously, most country offices were headed by national professional staff. However, as part of WHO reform to enhance leadership at the country level, the number of WHO representatives (WRs) heading country offices has tripled since 2014 and WR recruitment is ongoing. Human resources data from June 2017 indicate that 17 country offices in the European Region are headed by internationally recruited professional staff and three country offices are currently led by international heads of office, with confirmation to the post expected within months. This is a marked change compared to 2014 when only six country offices were led by international professional staff. Human resources data also show that 17 heads of country offices have been rotated to postings in other locations.

25. Smaller country offices are usually led by national professional officers in a primarily liaison function, although they increasingly provide technical and policy support in line with the 2030 Agenda. Their knowledge of the national language, culture and political environment is an asset when collaborating with ministries of health and other sectors.

26. The European Region has 20 country offices led by international professional staff, (Albania, Armenia, Belarus, Bosnia and Herzegovina, Bulgaria, Georgia, Hungary, Kazakhstan, Kyrgyzstan, the Republic of Moldova, Romania, the Russian Federation, Serbia, Slovakia, Slovenia, Tajikistan, the former Yugoslav Republic of Macedonia, Turkey, Uzbekistan and Ukraine), and 9 country offices led by national professional staff (Azerbaijan, Croatia, the Czech Republic, Estonia, Latvia, Lithuania, Montenegro, Poland and Turkmenistan). By the end of 2017, the Czech Republic and Turkmenistan will also have international professional staff as heads of office due to the retirement or rotation of staff. Moreover, nearly all the current heads of office (excluding six heads of country offices, two of whom are undergoing assessment for the WR roster this year) are on the global WR roster and have the possibility to apply for international positions throughout the whole Organization. Of the 29 heads of country offices, 18 are female (four of which are in acting positions) and 11 are male. The same competencies are required for all heads of country offices, who are selected on the basis of seniority, leadership and diplomatic skills. In the European Region, 90% of heads of country offices have at least five years of WHO experience and over 60% have more than 11 years of service.

27. The heads of country offices are trained regularly in the priority areas of WHO work and often accompany national delegations to governing body meetings, including the World Health Assembly and Regional Committee sessions, policy dialogues and flagship courses to ensure continuity and implementation of the principles shared with the health ministries. At retreats organized twice a year, heads of country offices discuss country work with the technical divisions as well as improvements in the management and administration of that work and of the country offices. Training sessions, traditionally held immediately following the retreats, focus on strengthening the leadership and health diplomacy skills of heads of

country offices in line with the country roadmap and improving performance at the country level. New methodologies and innovative approaches are applied to facilitate collaborative interactions, particularly the exchange of experiences and lessons learned. Over the past seven years, all heads of country offices have received professional training in leadership skills, communication, negotiation skills, health diplomacy, partnerships, resource mobilization, NCDs, health information, the IHR (2005) and risk communication. Some heads of office also attend flagship courses on health systems strengthening and on health financing organized by the WHO Barcelona Office for Health Systems Strengthening and the summer and autumn schools organized by the European Observatory and by the Division of Information, Evidence, Research and Innovation. All newly appointed heads of country offices attend induction courses at the Regional Office and at WHO headquarters.

28. WHO country-level technical staff are equipped to represent the Organization as leaders for health among stakeholders in the country. Country office staff are well integrated with the Regional Office and participate regularly in training sessions and workshops, covering areas such as global health diplomacy, negotiation skills, communication and advocacy and, more recently, leadership skills for the United Nations, as well as capacity-building activities organized by the technical divisions. Country office staff are invited and encouraged to actively participate through online meetings for programme managers and for general staff and are in frequent contact with the Strategic Relations with Countries unit, under the Office of the Regional Director.

29. The Strategic Relations with Countries unit provides guidance to the Regional Office under the policy direction of the Regional Director and in line with the Organization's corporate priorities to ensure in-house coordination of country-specific work and helps to coordinate and manage effective collaboration with all Member States of the Region. It ensures that all information flowing from the countries is collated, reviewed and shared with the Regional Director.

Convening national and international stakeholders

30. The Organization's main counterparts in countries are the health ministries. WHO country offices interact with health ministries daily in order to support national health agendas and to provide technical support and guidance in the planning, implementation, monitoring and assessment of programme activities and projects. Country office staff also represent WHO in national meetings and coordinate with national counterparts on activities at the WHO headquarters and Regional Office levels. Activities in countries are agreed and coordinated with the technical units of the Regional Office.

31. Heads of country offices provide leadership by advocating for intersectoral dialogue to ensure that health is included in all relevant policies, and that national health policies and strategies are well aligned with the Health 2020 policy framework and the 2030 Agenda. The majority of countries in the European Region have either already included the SDGs in their national health policies, strategies and plans or are in the process of ensuring their inclusion: to date, 34% of Member States have integrated the SDGs; 52% are in the process of doing so; and 14% have yet to begin integration. To support this work, the Regional Office provides technical and capacity-building assistance and has developed instruments and tools to guide the development of national health plans.

32. The most common roles played by country offices in the initiation, development and monitoring of national health policies and strategies include building national capacity for effective policy analysis, formulation, monitoring and review, and improving national health governance and inclusive, effective health sector policy dialogue. WHO country offices foster national stakeholder dialogues in order to include the SDGs in the national health agendas of more than 20 Member States, including Albania, Azerbaijan, Belarus, Bosnia and Herzegovina, Croatia, the Czech Republic, Estonia, Georgia, Lithuania, Montenegro, Poland, the Republic of Moldova, Romania, Serbia, Slovakia, Slovenia, Tajikistan, the former Yugoslav Republic of Macedonia, Turkey, Turkmenistan, Ukraine and Uzbekistan.

33. To implement Health 2020 and the relevant SDGs, country offices have increased interactions with ministries other than health, thereby expanding their traditional roles. All country offices of the Region respond to requests and work with other ministries primarily to support health promotion campaigns, participate in joint committees, missions and assessments, develop new health-relevant legislation and policies together, and mainstream health into existing projects and programmes led by other sectors. All country offices have conducted the in-country mechanisms for increased multistakeholder engagement and to advocate health-relevant SDGs by briefing partners, helping to set up national multisectoral consultations and conducting stakeholder analysis of key partners.

34. Implementation through multisectoral work and oversight bodies has provided opportunities for country offices to interact daily with parliamentarians, allowing for greater prioritization of the health-relevant SDGs, encouraging implementation of international commitments and legal instruments, increasing budget allocations and seeing the development of legislation to implement the SDGs and to establish or enhance Government accountability mechanisms.

35. In Albania, for example, the development of a new national health policy has added several new elements to traditional health policy-making in the country, including acknowledging the link between development and health as a contributor to economic growth, sustainable development and social well-being. Together with the Ministry of Health, and with the political support of the Prime Minister, WHO has expanded outreach to a number of stakeholders and sectors beyond health, and in consultation with citizens. The new policy in Albania is aligned with Health 2020 and the SDGs and complies with the EU’s accession requirements.

36. In countries without a WHO country office presence, the Health 2020 policy framework provides the impetus for the Government to revise previous public health programmes and to integrate the overarching goal of public health and social sustainability in regional development strategies. The Health 2020 framework allows countries to simultaneously comply with other EU and regional mandates, while fulfilling the SDGs. The Regional Office shares and promotes this work as examples of good practice. Detailed country studies are available for Andorra, Cyprus, Iceland, Italy, Luxembourg, Malta, Monaco, San Marino, Spain, Sweden and the United Kingdom of Great Britain and Northern Ireland.

37. The Regional Office, together with the European Observatory on Health Systems and Policies, works in close collaboration with EU countries to provide technical support for the formulation of national legislation, health systems reviews and organizing evidence, and to assist countries during their presidencies of the Council of the European Union. In Finland, for example, the European Observatory organized a panel of international experts to provide

an evidence-informed review of proposed comprehensive health and social care reform measures. In Portugal, WHO supported the development and review of the national health plan and has been a co-organizer of a policy dialogue on the national public health law.

Mobilizing resources

38. WHO country offices have demonstrated clear leadership in the mobilization of assistance and funds at the country level. In more than half of the country offices in the Region staff have successfully assisted the health authorities in raising resources for country activities and in developing grant proposals and plans of action in all major areas of work. They are vital to fundraising for WHO activities, as demonstrated by the fact that 54% of the voluntary contributions received in 2016 were for WHO country offices. Grant agreements and voluntary donations from partners for country-level activities was derived from a variety of sources, including the Global Fund to Fight AIDS, Tuberculosis and Malaria, the EU, Gavi, the Vaccine Alliance, the United States Centers for Disease Control and Prevention and the United States Agency for International Development, as well as bilateral donors, such as the Governments of Belgium, Canada, Estonia, Finland, France, Germany, Israel, Luxembourg, Norway, Switzerland and the United Kingdom. The top nine beneficiary countries of voluntary donations to WHO were Belarus, Bosnia and Herzegovina, Greece, Kyrgyzstan, the Republic of Moldova, Tajikistan, Turkey, Ukraine and Uzbekistan.

39. In Romania, WHO supported the development of a north-east regional health services plan, which served as the basis for Romania's health care system meeting *ex ante* conditionality, which enabled the country to apply for European Structural and Investment Funds. In the Republic of Moldova, WHO initiated a tripartite meeting with the Minister of Health, the EU Ambassador and the WR to promote health as a political priority, review progress on ongoing collaboration and explore new avenues for potential joint action. It was agreed that such tripartite meetings would be organized regularly in the future. In Azerbaijan, WHO played a leading technical role in the development of proposals to the Global Fund and Gavi, the implementation of which has resulted in high immunization coverage, the elimination of malaria, measles and rubella, and significant improvements in both HIV and multidrug-resistant tuberculosis incidence. In Georgia, WHO assisted with identifying the country's potential needs during its graduation from Gavi support in 2016–2017. On the basis of a needs-assessment, a list of activities and a budget were developed into a transition grant proposal, agreed by the Ministry of Health, WHO, the United Nations Children's Fund (UNICEF) and the United States Centers for Disease Control and Prevention.

40. WHO supports former and current recipient countries in becoming donors in priority areas. There has been a major reorientation of WHO work in, for example, Kazakhstan, the Russian Federation and Turkmenistan, moving from merely technical assistance to strategic cooperation with those countries in both the national and the international arenas and to stronger engagement on global health. As development partners, they now support country-specific, as well as regional and global WHO activities.

Partnerships to promote the WHO health agenda

41. Country offices work with a variety of partners, including non-State actors, in health and other relevant sectors. Twenty-two countries of the Region have a United Nations Country Team (UNCT) in place, ensuring a coordinated in-country dialogue among United

Nations agencies in the delivery of tangible results in support of the development agenda of the Government. Through the UNCT platform, WHO country offices have the opportunity to foster a multisectoral response to health challenges and to mobilize additional resources so as to achieve national health goals.

42. In Georgia, the Government and UNCT members have signed the United Nations Partnership for Sustainable Development 2016–2020. In Belarus, WHO has partnered with the United Nations Development Programme, UNICEF and the United Nations Population Fund to establish and implement the EU-funded joint health programme on NCDs, healthy lifestyle promotion and modernization of the health system. In Croatia, WHO initiated several stakeholder dialogues on the SDGs and health reform, which addressed various topics, such as tourism and health, food safety and security, climate change and health, and environment and health, and which resulted in the Strategy for Sustainable Development of the Republic of Croatia.

43. WHO supports other partner and donor coordination mechanisms in countries. In Turkmenistan, for example, WHO is leading a United Nations health group and donor coordination health thematic group, which comprises United Nations agencies and other development partners. In Montenegro, WHO has provided input for the United Nations Development Assistance Framework (UNDAF) pillars on social inclusion and on environmental sustainability.

44. Coordination across sectors is particularly important in exceptional situations. In Ukraine, while responding to the protracted humanitarian emergency, WHO provided technical support and brought together international partners at a high-level policy forum, in which the Prime Minister, two Vice Prime Ministers, and several Cabinet ministers and regional governors participated. This resulted in the Cabinet approving the health financing and public health policies that paved the way for implementation of the global EU-Luxembourg-WHO Universal Health Coverage Partnership.

45. In order to fulfil its leadership role in global health and to act as the directing and coordinating authority on international health work, WHO proactively engages with non-State actors, including nongovernmental organizations, private sector entities, philanthropic organizations and academic institutions, on the advancement and protection of public health. The response to large-scale population movement and migration in several European countries has emerged as an area where WHO assists health ministries in coordinating with non-State actors on public health. One aspect of this assistance is the joint assessments of the capacity of the health system to adequately manage the public health implications of large-scale population movement and migration. Such assessments have been conducted in Albania, Bulgaria, Cyprus, Greece, Hungary, Italy, Malta, Portugal, Serbia, Spain and the former Yugoslav Republic of Macedonia. In addition, WHO has supported capacity-building for key health and non-health personnel involved in the response to the refugee and migrant crisis carried out in Montenegro, Serbia and the former Yugoslav Republic of Macedonia. WHO also supports Turkey in providing quality, people-centred health services to almost 3 million refugees.

46. Since 2014, WHO has provided support to address mental health issues among internally displaced persons and those in areas affected by the ongoing humanitarian crisis in Ukraine, through collaboration among the health and nutrition clusters and other partners, including the United Nations Development Programme, UNICEF, the United Nations Office

for the Coordination of Humanitarian Affairs, the International Committee of the Red Cross, the International Federation of Red Cross and Red Crescent Societies, the Department for International Development of the United Kingdom, and the Governments of Canada, Estonia, Germany and Israel.

Communication, image and visibility

47. A crucial role of country offices, and in particular of WRs, is to represent the Organization and enhance its image and visibility in the country and among partners. Effective communication is essential; examples include risk communication, participation in press conferences and media interviews, promoting country stories through the website and social media, reporting on major health topics at national events and providing leadership on health within the UNCT.

48. In 2015, WHO provided policy advice and technical support to address a cluster of adverse health effects following a mass immunization against measles in Kazakhstan. WHO provided assistance to central and local government on risk communication and supported the investigation of cases, including through the immediate deployment of high-level clinical experts and WHO epidemiologists. As a result of timely communication and the transparent and efficient investigation of the single fatal case that had been reported, the vaccination coverage in the affected area or in other regions of Kazakhstan was not adversely affected. Throughout this event, the Government of Kazakhstan, the Ministry of Health, health professionals and the media demonstrated a high level of trust in WHO.

49. WHO provided training on emergency risk communication to 30 Member States in 2014–2016; the primary purpose of the training was to provide participants with the necessary tools and guidance to develop and implement effective risk communication strategies and plans. The former Yugoslav Republic of Macedonia, one of the first countries to participate, received the training in October 2014.

50. Observance of annual WHO days and events are of special importance for the Organization; they provide opportunities to enhance WHO’s image and visibility in countries and to spotlight new collaborations and fundraising activities. For example, the 2016 World Health Day, which focused on diabetes, fostered dialogue with and joint communication by the agriculture and food sectors in Latvia, using evidence provided by WHO. This action, which strengthened the national approach to tackling diabetes, was highly regarded and received notable media attention.

51. Country profiles on the European Region’s public website promote the image and visibility of WHO work in countries and act as a medium for sharing information and knowledge with stakeholders. Each of the 53 Member States has a dedicated country profile and webpage, which includes news items, events, relevant publications, data and statistics; additional information is provided for Member States with a country office. Frequency of use statistics show that the webpages for Germany, Turkey and Ukraine received the most visits in 2016, accounting for 20% of the total number of country webpage visits.

52. An e-news item describing smoking in the presence of children as tantamount to physical abuse went viral on a social media site, resulting in 20 000 visits to Latvia’s webpage on the day the item was posted. E-news stories on Greek primary health care reform and on poliomyelitis (polio) vaccinations and mobile clinics in Ukraine were the most frequently

visited in 2016. Some webpages for small countries, such as Monaco and San Marino, showed large increases in site traffic in 2016 compared to 2015, which was attributed to web coverage of the activities of the Small Countries Initiative.

Technical cooperation, policy advice and dialogue

53. The regional plan for implementation of the Programme Budget (PB) 2016–2017 in the WHO European Region (document EUR/RC65/14) outlined the expected contribution of the Region to global results and formed a "contract" of accountability between the Regional Office and Member States. A significant difference from the previous biennium was the bottom-up planning approach: Member States set priorities for programmes at the country level, which were subsequently fed into the global process. WHO reform resulted in the strengthening of the Organization's overall performance, through the provision of high-quality technical and policy support to Member States.

Global and regional tools

54. Country work has become more efficient as a result of both advanced and bottom-up planning. Biennial collaborative agreements (BCAs) are negotiated in detail with health ministries and signed bilaterally every two years. Recent agreements have been adapted to include SDG processes and to align with global policies. The BCAs continue to be the primary vehicle for delineating technical assistance provided to Member States with country offices, as well as with some other countries, such as Malta and Portugal.

55. Country cooperation strategies (CCSs) serve as a tool for advocacy, programme planning, and alignment of WHO work with partners and provide information on country priorities for global and regional work with countries. Such strategies are often the mainstay of WHO's work in Member States without country offices and continue to be rolled out. Aligned with the Twelfth General Programme of Work 2014–2019, the CCS defines priorities for bilateral collaboration and for cooperation to improve global health governance and to promote synergies among the various national actors involved in global health. To date, CCSs have been developed with Belgium, Cyprus, Malta, Portugal, the Russian Federation and Switzerland, and strategies with Iceland and Italy are under development. Switzerland's CCS is the first of the European strategies to reach its midterm review, which is currently under way.

56. To increase coherence with United Nations organizations in Member States and to ensure more coordinated and integrated support to countries in the implementation of the 2030 Agenda, WHO country offices play a key leadership role in the development and implementation of UNDAFs – the United Nations mechanism for intersectoral cooperation. Eighteen Member States in the European Region have UNDAFs. In the past three years, all have been renewed and WHO has ensured that health and the health-related SDGs are well represented. Three countries (Albania, Kyrgyzstan and Montenegro) participate in the Delivering as One programme, Bosnia and Herzegovina and the Republic of Moldova have adopted most of the pillars of the Delivering as One programme and numerous countries are taking part in the One United Nations programme. WHO participates in United Nations thematic or results groups on health in 22 Member States in the European Region.

Financing

57. The budget for country-level work under the global PB 2016–2017 is US$ 147.8 million, which, in comparison to the Region-level budget, means just over 50% is allocated to country offices. This is in comparison to PB 2014–2015, when 35% was allocated to country offices and 65% to the Regional Office. Of this amount, as shown in Annex 2, US$ 58.6 million is allocated for base programmes, US$ 56.3 million for outbreak and crisis response in Turkey and Ukraine, and 6% (US$ 7.6 million) for the WHO Health Emergencies Programme and polio eradication.

58. The newly launched WHO Programme Budget Portal is the Organization's central source for detailed information on the work, financing and implementation of country offices by category, programme and output. With quarterly updates, the Programme Budget Portal presents a transparent breakdown of WHO's performance in countries. It provides Member States and other partners with a common understanding of available and projected income and outlines how the work is funded and who the main contributors are. Annex 2 provides an overview of the distribution of country-level funds by technical area. More detailed information may be found on the Programme Budget Portal (http://open.who.int/2016-17/home).

59. Although spending under the BCAs is a very specific type of collaboration with health ministries, there are also a number of other funding sources, such as intercountry funding by the Regional Office and WHO headquarters, direct financial contributions and the Pandemic Influenza Preparedness Partnership Contribution. Annex 3 sets out a summary of the areas of work that are addressed by the different country offices based on funding provided through assessed contributions.

60. Direct financial cooperation – WHO grants made to ministries of health or government agencies – is a form of payment made by WHO to cover the cost of items or activities that would otherwise be borne by governments in order to strengthen their health development capacity and ability to participate more effectively in, or to meet their commitments to, WHO technical cooperation at the country level. It is based on technical cooperation agreed through a BCA and approved workplans. In the 2016–2017 biennium, only two countries – Tajikistan and Croatia – have received such financial cooperation to date. In Tajikistan, it has been used to implement the national switch plan for polio vaccination (US$ 99 600), to launch a nationwide measles–rubella campaign (US$ 780 900) and to conduct subnational immunization days in selected districts of the country (US$ 26 400). In Croatia, a vector control campaign to eliminate mosquito breeding has been conducted (US$ 25 900).

Technical in-country support

61. As a result of Health 2020 implementation, numerous country achievements and best practices in Member States of the European Region support the regional and global progress made towards achieving SDG 3 and the health-related targets of the other SDGs. Specific examples of how WHO technical in-country support has contributed to the integration of SDGs in national health agendas in the four priority areas of Health 2020 are described below.

Priority area 1: investing in health through a life-course approach and empowering people

62. Adapting regional action plans to the 2030 Agenda and Health 2020 goals has triggered the process of revision of existing national health policies. In Azerbaijan, Kyrgyzstan, Montenegro, the Republic of Moldova, Spain, Tajikistan, Ukraine and Uzbekistan, WHO has supported the development of national policies on sexual and reproductive health, including maternal and newborn health.

63. An analytic report on the uptake of Investing in Children: the European Child and Adolescent Health Strategy 2015–2020 by Member States in the Region identified gaps and actions that governments could take to make children's lives more visible, particularly among vulnerable groups, thereby addressing the SDGs and ensuring children's and adolescents' survival, development and well-being.

64. The WHO European Childhood Obesity Surveillance Initiative and the Health Behaviour in School-aged Children survey have assisted Member States in developing national systems that monitor obesity trends. Data from more than 300 000 children aged 6–9 years in 36 Member States in the Region are registered in the system.

65. The multisectoral National Programme on Rehabilitation of Persons with Disabilities in Tajikistan seeks to improve health, rehabilitation and social protection for people with disabilities and to create an enabling environment with equal opportunities for all. Launched in October 2016, the National Programme's development was part of a disability rehabilitation programme implemented by Tajikistan's Ministry of Health and Social Protection, undertaken with technical support from WHO and financial support from the United States Agency for International Development and the United Nations Partnership to Promote the Rights of Persons with Disabilities.

Priority area 2: tackling Europe's major health challenges: noncommunicable and communicable diseases

66. A government proposal to implement tax on sugar-sweetened beverages to be launched in 2018 in Estonia is the key outcome of the comprehensive and continuous WHO support to Estonia in promoting action on overweight and obesity. This support encompasses capacity-building, technical assistance, policy advice and advocacy, and involves working across different sectors and government departments, including the Ministries of Social Affairs, Finance, Rural Affairs and their sub-agencies.

67. On 20 April 2016, the Regional Director announced the interruption of indigenous transmission of malaria in the European Region – the first WHO Region to achieve this Millennium Development Goal. By 2016, 37 countries had interrupted measles and/or rubella transmission, and the European Regional Verification Commission for Measles and Rubella Elimination is strengthening its advocacy activities and providing more intensive support to malaria-endemic countries.

68. In 2016, Armenia validated elimination of mother-to-child transmission of HIV, the Republic of Moldova validated elimination of syphilis and Belarus achieved both. Kyrgyzstan received the official WHO certification of malaria elimination in November 2016. Country offices have facilitated technical cooperation and delivery of WHO technical guidance on the diagnosis and treatment of tuberculosis, HIV and viral hepatitis, with particular attention to

people-centred integrated care and leaving no one behind, in line with the Health 2020 policy framework. WHO has assisted countries in developing national tuberculosis, HIV and/or viral hepatitis action plans in line with global strategies and regional action plans, and has provided support for monitoring, surveillance and data collection.

69. The Regional Office, in its role as the WHO IHR Contact Point for all Member States in the Region, continues work on detecting, verifying and assessing public health events of potentially serious national and international consequences. This work is carried out through daily cooperation with National IHR Focal Points in all 53 States Parties to the IHR (2005) in the Region. WHO regularly organizes multisectoral, national IHR external evaluations, assessments, after-action reviews and exercises. Joint external evaluations were carried out in 2016 in Albania, Armenia, Kyrgyzstan and Turkmenistan.

70. In Turkmenistan, the merging of tabletop, field and functional exercises and mass gathering preparedness for the 5th Asian Indoor and Martial Arts Games was successfully undertaken by a team comprising all three levels of WHO.

71. A series of intersectoral food safety workshops were conducted for Albania, Croatia, Romania, Tajikistan, Turkmenistan, Ukraine and Uzbekistan in 2016 in collaboration with the Food and Agriculture Organization of the United Nations and the European Food Safety Authority, with an emphasis on intersectoral cooperation and collaboration between public health and agriculture sectors, consistent with the One Health approach, to strengthen capacity on the epidemiology, surveillance, prevention and control of foodborne pathogens.

72. The Regional Office and country offices have organized antimicrobial resistance stakeholder meetings in Albania, Armenia, Azerbaijan, Bulgaria, Kazakhstan, the Republic of Moldova, the Russian Federation, Serbia, Tajikistan, Turkey, Turkmenistan, Ukraine and Uzbekistan to establish an intersectoral coordination mechanism and to develop national antimicrobial action plans.

73. In Uzbekistan, WHO helped establish a national intersectoral working group to support the Ministry of Health in its stewardship role on health reform and to pilot an NCD-integrated approach in two areas of the country. The working group included representatives of the Ministry of Health, the Ministry of Agriculture, the veterinary department, clinical and research institutions, sanitary epidemiology surveillance centres and medical academia.

74. In Sweden and the United Kingdom, The Guide to Tailoring Immunization Programmes, a behavioural insights tool and approach developed by the Regional Office, has been used to improve the reach and rates of vaccination in marginalized and hard-to-reach communities by applying a people-centred approach with equity as a core principle and objective.

Priority area 3: strengthening people-centred health systems, public health capacity, and emergency preparedness, surveillance and response

75. At the national level in Greece, the Regional Office had identified a historical bias limiting the role of stakeholders in planning and implementing reform initiatives, which had prevented the introduction of primary health care reform for over three decades. High-level international experts were mobilized by WHO to work with local teams and to share relevant experience and good practice from across the Region. More than 200 participants engaged

actively in the intersectoral policy dialogue, including representatives of the Prime Minister's Office, the Ministry of Health, other ministries and state agencies, local authorities, professional and patients' associations, academia and nongovernmental organizations. The policy dialogue generated the highest possible commitment for moving towards universal health coverage and people-centredness. As a result, a detailed roll-out plan was put in place, new legislation on primary health care was developed, and significant financial resources were mobilized, including resources from the State budget.

76. In Azerbaijan, WHO facilitated the first ever bilateral meeting between Azerbaijan and Iran on the IHR (2005). Co-organized in partnership with the International Organization for Migration, the dialogue focused on cross-border collaboration on surveillance, capacity at border-crossings, emergency response, people movements, health system capacity, prison health and prevention and treatment of infectious diseases.

77. WHO continues to support two large-scale, protracted crises affecting the Region: the crisis in the Syrian Arab Republic and its spill-over effects to Turkey with its nearly 3 million refugees, and the ongoing conflict in eastern Ukraine. Since the beginning of the respective conflicts, WHO has been jointly leading the health clusters with Save the Children in the northern Syrian Arab Republic through a whole-of-Syria approach, and with the Ministry of Health in Ukraine. In addition to coordinating the health response of all stakeholders, WHO provides essential medical drugs and supplies to health facilities in the conflict areas, trains local health-care providers and ensures strategic planning with regard to immediate needs and early recovery. Attacks on health-care facilities and health-care workers are monitored and reported. WHO and its partners undertake regular health needs assessments and monitor health services delivery to affected populations. In Ukraine, WHO and its partners supported the nationwide immunization response to a vaccine-derived poliovirus and assisted the Ministry of Health in interrupting its transmission.

78. Country offices in central Asia and the Caucasus played a leading role in health clusters in national emergency preparedness activities and simulation exercises organized by the United Nations Office for the Coordination of Humanitarian Affairs and held jointly with other United Nations organizations and national stakeholders. Sixteen country offices have applied the targets of the Sendai Framework for Disaster Risk Reduction 2015–2030 through Hospital Safety Index by training national teams. To date, 122 hospitals have been assessed. Kyrgyzstan and the Republic of Moldova are currently the standard-bearers having assessed many of their public hospitals and provided assistance to the ministries of health in implementing action plans for improving hospital safety.

Priority area 4: creating resilient communities and supportive environments

79. WHO supported the development of national health and environment action plans in Georgia and the former Yugoslav Republic of Macedonia. The plans follow whole-of-government and whole-of-society approaches to governance for health and are linked to SDG targets and indicators.

80. WHO supported the implementation of national targets in Serbia, established in line with the Protocol on Water and Health to the 1992 Convention on the Protection and Use of Transboundary Watercourses and International Lakes. The aim is to improve rural water supply as an essential component of achieving SDG target 6.1 and to formulate supportive

policies and improve interventions to strengthen safety, reliability and resilience of rural water services, which protect public health.

81. In Kazakhstan, WHO provided technical support to implement a project funded by the Kazakh Government to promote sustainable environmental development, including piloting water and energy efficiency in housing and communal sectors, environmentally oriented and adapted usage of land and other natural resources and disaster risk reduction practices in the Kyzylorda Region. Local authorities were trained in addressing key environment and health issues related to climate change.

Mobilizing and developing regional synergies

Health networks and regional initiatives

82. WHO brings together countries and stakeholders through various regional platforms to promote nationally owned processes to develop, implement and monitor national health plans and strategies and to localize the SDGs. In partnership with other United Nations agencies and development partners, the Regional Office has supported the development and implementation of several networks and local and regional initiatives, whose activities are aligned with Health 2020. These include the Regions for Health Network (20 countries, 26 regions), the WHO European Healthy Cities Network (34 countries, 94 cities, and 22 national networks, 1500 municipalities or approximately 150 million people across the Region), the South-eastern Europe Health Network (9 countries) and the Small Countries Initiative (8 countries).

83. The European Healthy Cities Network represents the most important partnership for many activities related to the SDGs and the Health 2020 agenda in the Czech Republic, including community planning and public engagement through community forums, roundtables and campaigns. This community-based approach promotes intersectoral cooperation at all levels of public administration.

84. Membership of the Regions for Health Network and the endorsement of Health 2020 has played a crucial role in the development of the Regional Health Plan 2015–2025 in Italy.

85. The Small Countries Health Information Network, established in 2015 within the framework of the Small Countries Initiative, provides coordination of data requests to Member States by the Regional Office, supports analysis and joint reporting of indicators and discusses potential relevant developments. The Network is considering whether to establish a joint indicator data set for small countries.

Geographically dispersed offices

86. The five geographically dispersed offices of the European Region support the Regional Office with specialized expertise and facilitate focused technical support to Member States and the exchange of relevant experience across the Region.

87. The WHO Barcelona Office for Health Systems Strengthening, under the Division of Health Systems and Public Health, and the WHO Country Office in Riga have been crucial in convening sectors and partners to secure sustainable health financing for the planned introduction of a compulsory health insurance in Latvia. The WHO European Office for

Investment for Health and Development in Venice, Italy, has provided substantial cooperation and support in producing an evidence-based resource tool for linking the SDGs for health with health equity in Lithuania.

88. The WHO European Office for the Prevention and Control of Noncommunicable Diseases in Moscow, Russian Federation, has developed a country-based package of 15 interventions for the prevention and control of NCDs, consistent with evidence and global and regional mandates, adapted to national needs and circumstances and implemented using national resources in a sustainable fashion. The project has created a platform for sharing best practice, national achievements and setbacks, and for developing communities of decision-makers and high-level specialists in their individual fields.

89. The WHO European Centre for Environment and Health located, in Bonn, Germany, and the WHO European Office for Investment for Health and Development jointly supported a case in drinking water contamination in northern Italy by contributing to two public events and press conferences and advising on communication needs and the design of epidemiological studies.

WHO collaborating centres

90. WHO collaborating centres strengthen the role of WHO by supporting the integration of the SDGs in national research and educational programmes. Acting as sources of information, services and expertise to WHO, the 279 collaborating centres of the European Region help to enhance national capacity for health development at the local level with relevant stakeholders and institutions.

91. In 2016, the WHO Country Office in the Russian Federation attained a de facto network of the 22 WHO collaborating centres. The Country Office organizes regular seminars on major issues of public health for the centres.

Administration and management

92. As part of WHO reform, the Regional Office has undertaken significant reorganization, ensuring transparency and accountability for resources and results. Efforts to further strengthen internal controls in the European Region have advanced through the implementation of key performance indicators. Managerial key performance indicators have been included in the performance appraisal of directors of divisions and heads of WHO offices, and the matrix of roles and responsibilities has been updated to guide planning, monitoring and oversight. The risk register and internal control framework checklist by budget centres were fully implemented in 2015 and 2016.

93. The Regional Office is currently briefing programme managers and heads of country offices on full compliance with the International Aid Transparency Initiative (IATI), including the degree of transparency that will be required at each level. Heads of country offices will play a crucial role in preparing and informing Member States on the IATI framework and in utilizing the information for building stronger partnerships with stakeholders and potential resource mobilization opportunities. The Regional Office participated in reviewing the new Programme Budget Portal with respect to this when it was under development. WHO staff, particularly at the country level, must be familiar with

country-specific information when they participate in regional and global WHO meetings. Additional intelligence is being sought out to determine whether there are changes that could be applied during operational planning to facilitate IATI reporting.

94. Monthly retreats of executive management and online meetings between programme managers and remotely connected heads of country offices promote synergies and sharing of information at the technical level, and allow for open discussions on how to accelerate implementation and optimize the use of resources. A programme budget monthly performance dashboard is being prepared and disseminated, which will serve as the backdrop for discussions during these meetings. Ad hoc analyses and information are provided, which guide periodic special sessions fully dedicated to monitoring implementation.

95. Biannual (six-month) reviews of outputs, progress and achievements are well established at the Regional Office. Careful assessment of country and regional contributions to the achievement of outputs, feedback on compliance and quality, and managerial feedback are part of such reviews. In the past few years, the Regional Office has undergone several audits. The results confirm the overall effectiveness of risk management and internal controls of administration and finance.

Resource allocation

96. Better alignment between allocation of the budget to programme areas and priority setting by Member States has been evident in the financing of PB 2016–2017. At the country level, the BCAs budgets are aligned to the contract agreed with Member States, thereby reflecting, to the extent possible, the prioritization made by Member States. For the Region-wide budget, this alignment is consistent with the fact that budget reviews of base programme areas were not needed in the first 12 months of the biennium.

97. At the corporate level, allocation of flexible funding has been geared towards programme areas given the highest priority by Member States. Early establishment of workplans allows continuity of programmes from one biennium to the next, resulting in increased efficiency in the use of available financial resources.

98. To promote predictability and transparency in the allocation of flexible resources at the country level, the Regional Office has utilized a strategic budget space allocation approach to distribute its resources. This methodology has added a needs-based element to resource distribution and decisions on resource amounts are clearly set out. Seventy-five per cent of the resources were distributed at the beginning of the biennium and the remaining 25% were distributed in accordance with satisfactory implementation of flexible funds and voluntary contributions, considering country level needs.

99. The Regional Office is currently analysing potential synergies and current collaboration arrangements between offices and with other partners to further the allocation agenda while utilizing resources in an efficient manner.

Management of human resources

100. There has been a marked increase in the voluntary rotation and mobility of heads of country offices and in the movement of internationally recruited professional staff between

the regional and country levels and between country offices within and outside the European Region. The majority of country offices in the Region have changed from being led by national professional officers to being led by international professional staff.

101. All performance management evaluations (100%) were completed by February 2017. Key performance indicators have been institutionalized and monitored for all professional and general service category staff. Priority recruitment and the introduction of several electronic tools, such as performance management and travel reports, have increased work efficiency.

Next steps

102. The Regional Office is committed to strengthening support to all Member States – those with and those without a country office presence. To achieve this, the Regional Office will work:

(a) to incorporate SDGs as expected deliverables in PB 2018–2019, giving greater clarity to country offices about their contributions towards achieving the SDGs through work at the country level;

(b) to provide further training to heads of country offices and to continue upgrading heads of country offices from the national professional to the international professional level to strengthen the capacity of country offices to deliver at the country level;

(c) to improve reporting mechanisms to ensure accountability and transparency for resources and results with all 53 Member States, those with and those without a country office presence, and to report on outputs, contributions to national health outcomes and progress towards achieving the SDG goals; and

(d) to include the global, regional and country levels of the Organization in WHO reform processes, with a particular focus at the country level, taking into account the country perspective in terms of the challenges faced on a daily basis to mitigate potential impacts of reform implementation.

Annex 1. Total workforce (staff and non-staff) in WHO country offices by category

	Staff					Non-staff					Total
Country	**IP**	**NP**	**GS**	**60+**	**LTA**	**SSA**	**CON**	**APW**	**UNV**	**VOL**	
Albania	1	1	2	0	0	0	0	4	0	0	8
Armenia	1	3	3	0	0	0	0	0	0	0	7
Azerbaijan	0	2	3	0	0	0	0	3	0	0	8
Bosnia and Herzegovina	2	1	5	0	0	0	0	0	0	0	8
Belarus	1	2	2	0	0	1	1	0	0	0	7
Bulgaria	1	1	1	0	0	0	0	0	0	0	3
Croatia	0	1	1	0	0	0	0	2	0	0	4
Czech Republic	0	2	0	0	0	0	0	2	0	0	4
Estonia	0	1	1	0	0	0	0	0	0	0	2
Georgia	1	3	2	0	0	0	0	11	0	0	17
Hungary	1	0	1	0	1	0	1	0	0	1	5
Kazakhstan	1	1	2	8	0	0	0	14	0	0	26
Kyrgyzstan	1	4	4	0	0	0	2	1	0	0	12
Latvia	0	1	1	0	0	0	0	1	0	0	3
Lithuania	0	1	1	0	0	0	0	1	0	0	3
Poland	0	1	1	0	0	0	0	0	0	0	2
Republic of Moldova	2	7	4	0	0	0	0	0	0	0	13
Romania	0	1	1	0	1	0	1	10	0	2	16
Montenegro	0	1	1	0	0	0	0	15	0	0	17
Russian Federation	3	4	4	0	0	2	0	0	0	0	13
Serbia	1	2	3	0	0	1	0	0	0	0	7
Field Office Pristina, Kosovo[1]	0	2	3	0	0	2	0	1	0	0	8
Slovakia	1	0	1	2	0	0	0	4	0	0	8
Slovenia	1	0	1	4	0	0	1	4	0	0	11
Tajikistan	2	6	6	0	0	0	1	2	0	0	17
The former Yugoslav Republic of Macedonia	1	1	1	0	1	1	0	0	0	0	5
Turkey	3	6	0	0	0	3	0	4	0	0	16
Sub-office Gaziantep	12	1	6	0	0	0	2	0	0	0	21
Turkmenistan	0	3	4	0	0	1	0	1	0	0	9
Ukraine	6	6	6	0	0	7	1	9	1	1	37
Sub-office Severodonetsk	1	1	1	0	0	0	0	0	0	0	3
Sub-office Donetsk	0	1	1	0	0	0	0	0	0	0	2
Sub-office Luhansk	0	1	0	0	0	0	0	0	0	0	1
Uzbekistan	1	7	7	1	0	8	0	0	0	0	24
Total	**44**	**75**	**80**	**15**	**3**	**26**	**10**	**89**	**1**	**4**	**347**

APW: agreement for performance of work; CON: consultant; GS: general service staff; IP: international professional staff; LTA: long-term acting head of office; NP: national professional staff; SSA: special service agreement; UNV: United Nations volunteer; VOL: international volunteer or intern; 60+: staff contract of 60 days or more.

[1] In accordance with Security Council resolution 1244 (1999).

Annex 2. Financial resources at the country level by category and programme area for PB 2016–2017

Fig. A2.1. Percentage of PB 2016–2017 categories selected as a BCA priority by countries

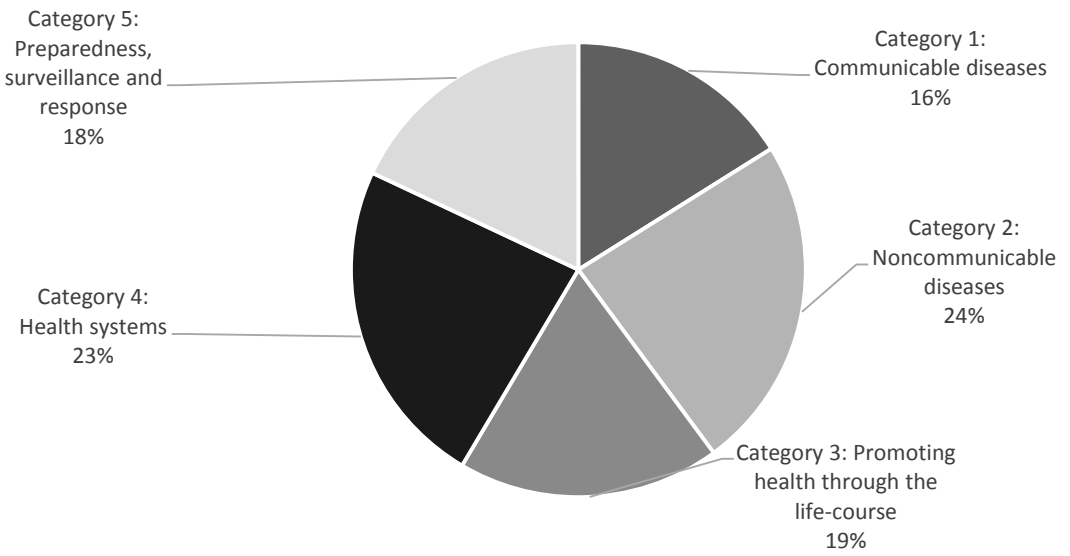


Fig. A2.2. PB 2016–2017 by category in US$

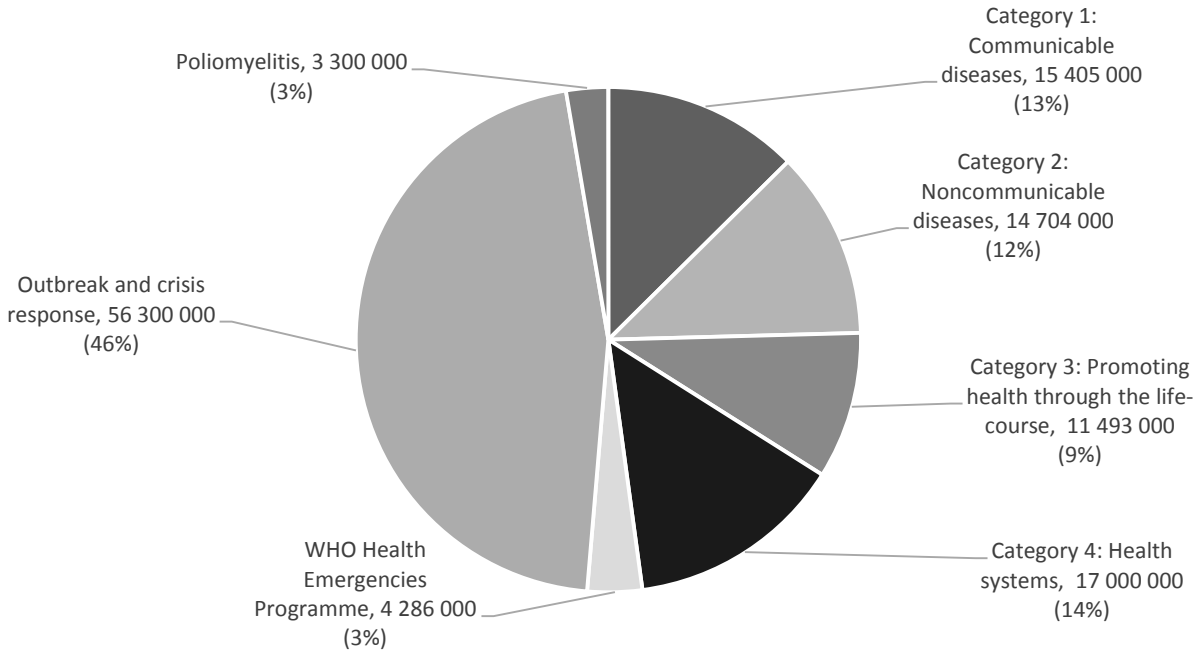


Fig. A2.3. PB 2016–2017 for category 1 (communicable diseases) by programme area in US$

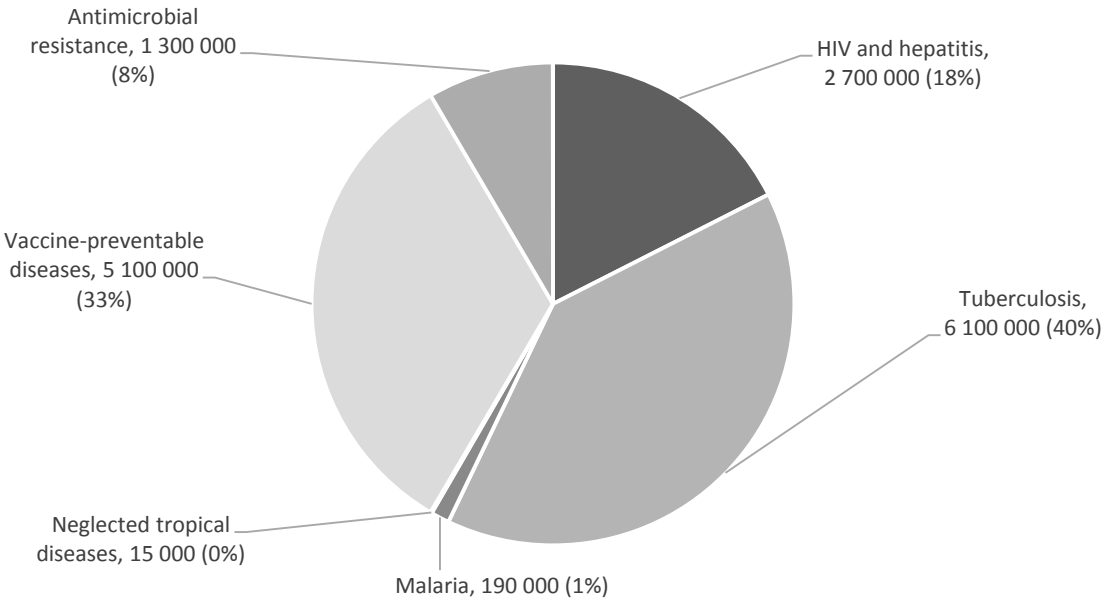


Fig A2.4. PB 2016–2017 for category 2 (noncommunicable diseases) by programme area in US$

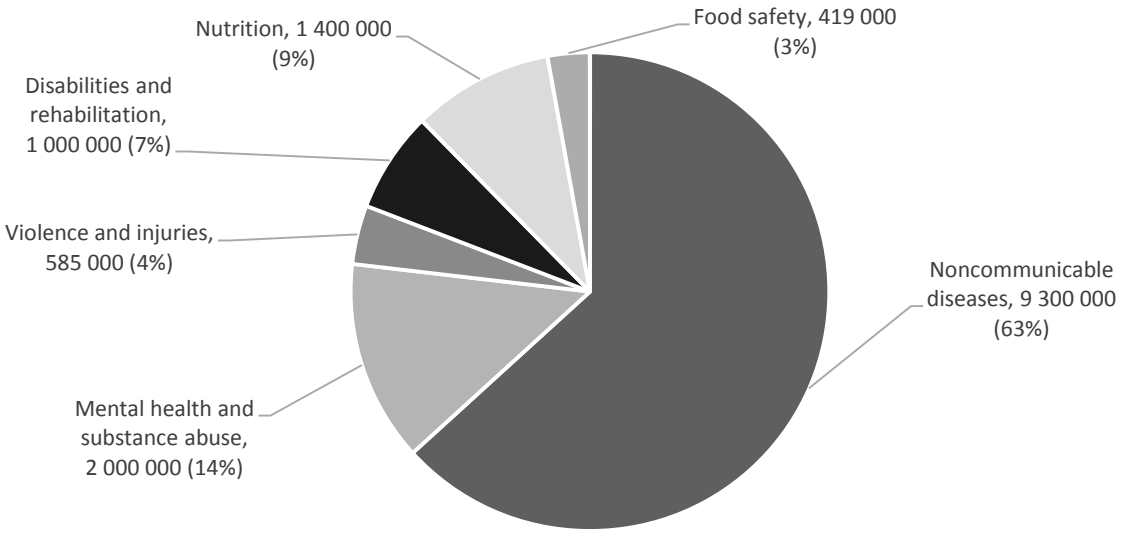


Fig. A2.5. PB 2016–2017 for category 3 (promoting health through the life-course) by programme area in US$

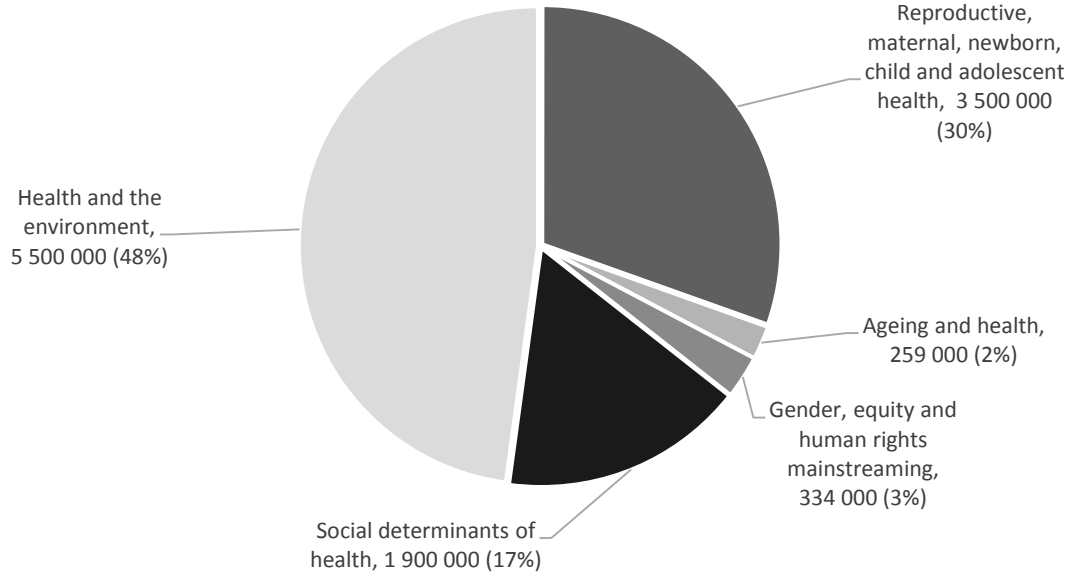


Fig. A2.6. PB 2016–2017 for category 4 (health systems) by programme area in US$

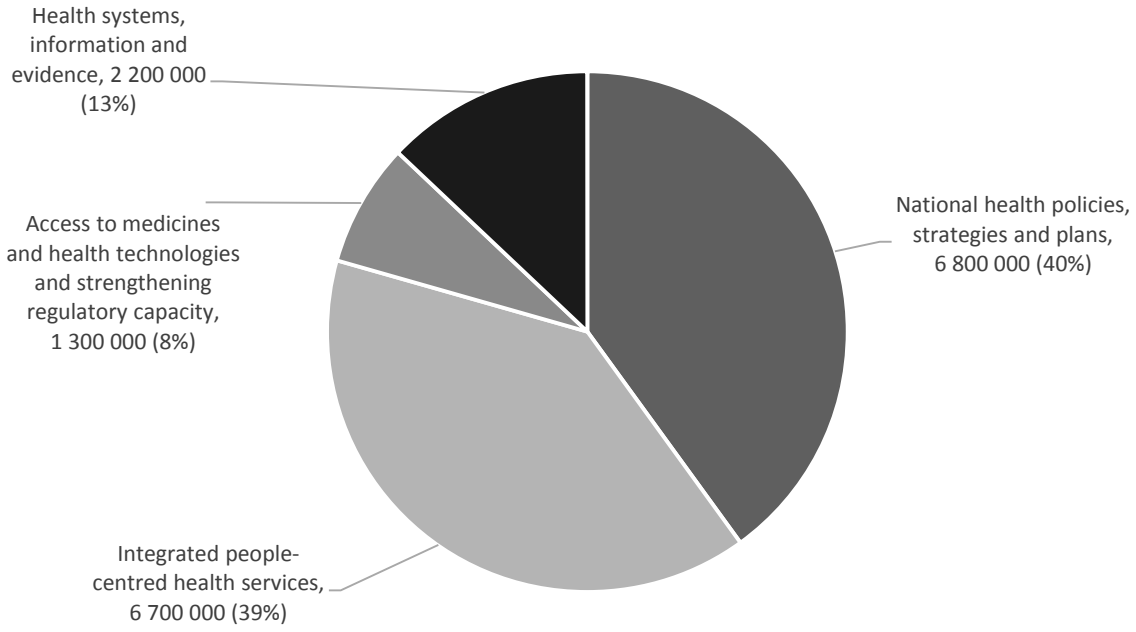
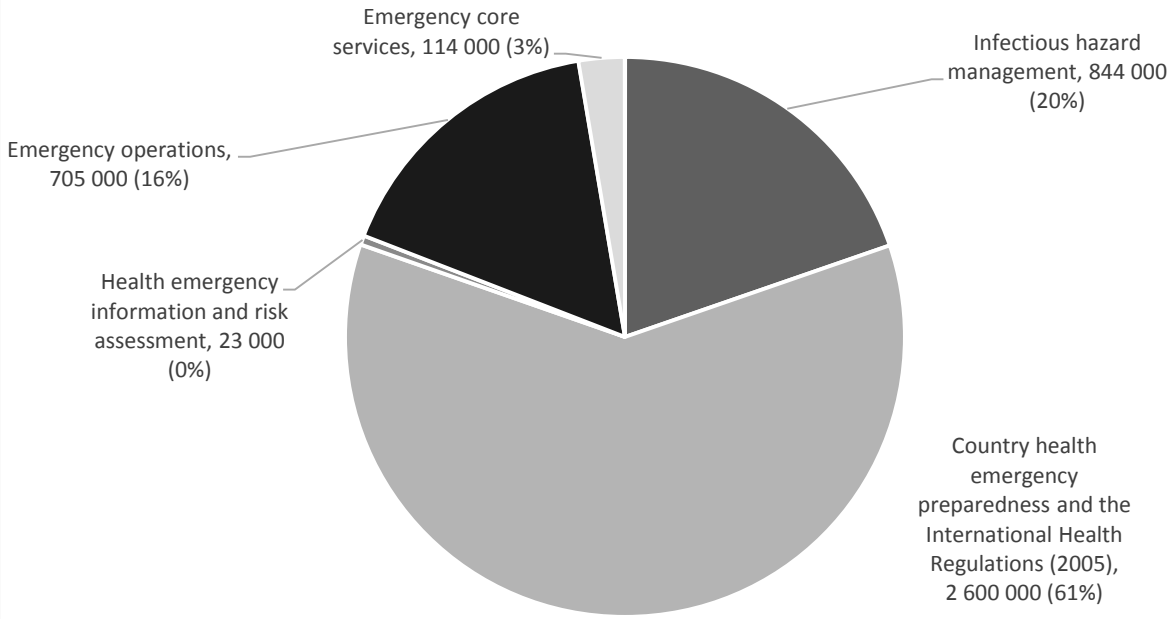


Fig. A2.7. PB 2016–2017 for WHO Health Emergencies Programme by programme area in US$



Annex 3. Topical focus of work in WHO country offices in the European Region

Country	Main areas of technical assistance
Albania	HIV, TB, hepatitis B and C; NCDs, including risk factors such as tobacco control, violence and injury prevention, mental health and nutrition; SDGs, including activities linked to gender equity, and maternal and child health, social determinants of health, health and the environment – particularly water and sanitation; national policies, strategies and plans, health systems strengthening, including health financing and public health services, medicines and health technologies, health information; IHR (2005); AMR, emergency and disaster risk management, pandemic influenza preparedness, food safety
Armenia	TB, hepatitis, vaccine-preventable diseases; health systems strengthening with a focus on primary health care; IHR (2005); disaster preparedness; mental health
Azerbaijan	HIV, TB, vaccine-preventable diseases; NCDs; promoting health through the life-course; integrated people-centred health services; emergency risk and management, polio eradication, alert and response capacities
Bosnia and Herzegovina	80% of resources are directed toward the NCD project, including setting up, integrating, implementing and assessing a comprehensive quality-assurance programme for cardiovascular risk assessment and management
Belarus	NCD prevention and control, particularly cardiovascular diseases and cancer, risk factors, tobacco control; integrated people-centred health services with a focus on primary health care; TB, MDR-TB, changing the model of TB services financing, HIV/AIDS, viral hepatitis; AMR; mother and child health, child injury prevention
Bulgaria	NCDs with a focus on tobacco control, nutrition and food reformulation, mental health, health behaviour in school-aged children; integrating SDGs in national health policies and strategies; strengthening IHR (2005); pandemic preparedness plan; formulating a national plan on AMR; integrating TB services with primary health care
Croatia	Hepatitis C, TB, vaccine-preventable diseases; NCDs with a focus on mental health, alcohol use and nutrition; health through the life-course; health systems, particularly regulation and access to medical products; alert and response capacities, food safety
Czech Republic	NCDs with a focus on implementing strategies to reduce modifiable risk factors, integrated mental health services with development and implementation of primary, secondary and tertiary prevention; violence and injuries, systems for monitoring nutrition outcomes, development, adaptation and implementation of national guidelines and legislation on nutrition; reproductive, maternal, newborn, child and adolescent health with an emphasis on interventions for adolescent health, multisectoral policies and plans to foster healthy and active ageing, provision of long-term, palliative and end-of-life care, assess and manage the health impacts of environmental risks; national health policy, health-promoting hospitals, national e-health strategy, support in using evidence-informed policy-making
Estonia	NCDs and their risk factors; AMR; HIV, TB; health systems strengthening with a focus on primary health care, health financing, pharmaceuticals and health technologies
Georgia	HIV, hepatitis, TB, vaccine-preventable diseases – advancing the vaccination rate; NCDs and their risk factors, including tobacco control; promoting health through the life-course, environment and health; health systems strengthening with a particular focus on health financing, UHC, integrated people-centred health systems, national health policies, strategies and action plans; preparedness, surveillance and response, polio eradication
Hungary	Vaccine-preventable diseases, in particular HIV and hepatitis; NCDs and their risk factors, including tobacco, mental health, diabetes and nutrition; social determinants of health; health systems and evidence-based policy-making, including integrated services delivery and people-centred, integrated care; advancing the AMR policy agenda
Kazakhstan	TB with a focus on children; assessment of health systems performance for NCD control, violence and injury prevention; child and adolescent health, environment and health with a focus on chemical safety; health systems strengthening; IHR (2005) capacity-building
Kyrgyzstan	Health systems strengthening, UHC; NCDs; health security, including communicable diseases and immunization

Country	Main areas of technical assistance
Latvia	Health financing, including policy dialogues, health systems strengthening, including primary health care, hospital payment systems, procurement of medicines, e-health; NCDs with a focus on nutrition, physical activity; maternal and child health
Lithuania	Communicable diseases, TB, vaccine-preventable diseases; NCDs and their risk factors, including tobacco and alcohol control and nutrition; health through the life-course, including healthy ageing, social determinants of health and health equity, environment and health; health systems strengthening and human resources for health, national capacity-building on evidence-informed health policy-making; influenza preparedness
Montenegro	Effective control of NCDs and related risk factors, including alcohol control, child maltreatment; vaccine-preventable diseases and immunization; development of an action plan for health system adaptation to climate change, strengthening primary health care performance and capacities; IHR (2005) core capacities; AMR surveillance
Poland	Health 2020 through the new public health policy, renewal of the national health programme with a focus on social determinants of health; a main focus on NCDs with specific actions on nutrition and risk factors, including obesity and physical inactivity, violence and child maltreatment; other themes include improving patient safety, quality of services, patient empowerment in the context of UHC
Republic of Moldova	Communicable diseases, especially HIV, sexually transmitted infections, viral hepatitis and TB, vaccine-preventable diseases and immunization; NCDs and risk their factors with a particular emphasis on cancer registry, implementation of a package of essential NCD interventions for primary health care and tobacco control; promoting health through the life-course, including reproductive health, violence and injury prevention, healthy ageing; health systems strengthening focusing on integrated people-centred health services, quality of care, improving access to medicines, national health policies, strategies and action plans; preparedness, surveillance and response to disasters and health emergencies, particularly polio; AMR; IHR (2005)
Romania	Health systems strengthening with a strong focus on management of communicable diseases and outbreaks, vaccine-preventable diseases and immunization, TB, hepatitis; the life-course approach, including child, adolescent and maternal health; NCD risk factors; human resources for health
Russian Federation	TB, HIV; NCDs through policy dialogues; development of national strategies and plans, monitoring health systems, capacity-building, piloting WHO methodologies for assessing public health effectiveness, communication and advocacy for behavioural change, strengthening essential public health operations; preparing for major national health-related events
Serbia	Communicable diseases, particularly HIV, hepatitis, TB, vaccine-preventable diseases and immunization with piloting of tailored immunization programmes; health systems strengthening to improve outcomes of NCDs and related risk factors with a focus on tobacco and alcohol control through assessment and capacity-building, mental health, road safety, violence and injury prevention; child and adolescent health, environment and health through policy dialogue, intersectoral and local capacity-building in the SDG context; EVIPNet, health systems strengthening and public health capacities related to migrant health; preparedness, surveillance and response to disasters and health emergencies, improved risk communication
Field office Pristina	HIV, hepatitis, TB; NCDs, including tobacco control, mental health, substance abuse; promoting health through the life-course, social determinants of health, environment and health; national health policies, strategies and plans, integrated people-centred health services, health systems strengthening, information and evidence; emergency risk and crisis management, food safety
Slovakia	Health systems strengthening with a focus on management of the main NCDs from primary to tertiary care, development and implementation of long-term care strategy/legislation, reform of public health services; effective control of NCD risk factors focusing on obesity and physical activity; full implementation of IHR (2005); elimination of TB; establishment of a knowledge translation platform to support evidence-based policy-making, applying principles of Health 2020 and SDG implementation to promote health as a whole-of-society responsibility

Country	Main areas of technical assistance
Slovenia	Reform of public health services, strengthening primary health care, support of actions and policies to reduce harmful effects of tobacco and alcohol use, implementation of healthy ageing strategy and plans, drafting and implementation of a long-term care strategy/legislation, establishment of a knowledge translation platform to support evidence-based policy-making; strengthening infrastructure and the workforce for full implementation of IHR (2005) using recommendations from the joint external evaluation; applying principles of Health 2020 and SDG implementation to promote health as a whole-of-society responsibility
Tajikistan	Service delivery, including promoting primary health care, integrated patient-centred care, development of a strategic plan for family medicine, health financing reform and UHC by strengthening the evidence base and holding informed policy dialogues, targeting public funds and capacity-building around UHC; communicable diseases, vaccine-preventable diseases
The former Yugoslav Republic of Macedonia	Communicable diseases, especially HIV/AIDS; NCDs, including nutrition; promoting health through the life-course, healthy ageing, social determinants of health, environment and health; health systems strengthening, particularly people-centred health services, health information system strengthening; preparedness, surveillance and response, including IHR (2005); emergency risk and crisis management
Turkey	NCD prevention and control strategies; health systems strengthening for more sustainable NCD management, health systems performance assessment, strengthening the capacity of community mental health services, strengthening health system capacity in the area of ageing with a focus on long-term care; scaling up evidence-based road safety interventions
Sub-office Gaziantep	Emergency operations responding to the needs of the refugee communities in Turkey and cross-border emergency operations in the northern Syrian Arab Republic
Turkmenistan	TB and viral hepatitis; NCD risk factors, including tobacco, nutrition, physical inactivity and mental health; promoting health through the life-course; human resources for health, national policies on medicines, health information; IHR (2005) capacity-building; AMR; emergency and disaster management, food safety, polio eradication, pandemic influenza preparedness; strengthening laboratory services for communicable disease control
Ukraine	Health system reforms, including health financing and health insurance, human resources for health decentralization, primary health care, e-health for primary health care, family medicine, integrated service delivery, health systems strengthening for UHC (SDGs), national medicines policy, national list of essential medicines, reference pricing for medicines, NCD medicines reimbursement scheme, reform of public health laboratories network, establishment of public health policy dialogue and governance centre; NCDs with a focus on risk factors, including alcohol, sugar and salt intake, *trans* fats, tobacco control; environment and health (asbestos); communicable diseases, particularly TB, MDR-TB, HIV/AIDS, hepatitis C, vaccine-preventable diseases and immunization, including polio eradication; pandemic influenza preparedness, AMR; laboratory surveillance, strengthening laboratory services for communicable disease surveillance, detection and control; IHR (2005) capacity-building; food and chemical safety, blood safety system
Sub-offices in eastern Ukraine	Health and nutrition cluster lead; emergency health assistance, emergency preparedness and response plan, emergency medical supplies, emergency surgical and trauma care, mobile medical clinics with psychosocial support
Uzbekistan	Communicable diseases; NCDs; promoting health through the life-course, environment and health; health systems strengthening; emergency preparedness and response; SDGs

AMR: antimicrobial resistance; EVIPNet: Evidence-informed Policy Network; IHR (2005): International Health Regulations (2005); MDR-TB: multidrug-resistant tuberculosis; NCDs: noncommunicable diseases; Polio: poliomyelitis; TB: tuberculosis; SDGs: Sustainable Development Goals; UHC: universal health coverage.

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