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Regional plan for implementation of programme budget 2016–2017 by category in the WHO European Region

This document should be read in conjunction with the Regional plan for implementation of the programme budget 2016–2017 in the WHO European Region (document EUR/RC65/14). It contains details of each category and programme area and the European contribution to the global results chain set out in the global programme budget (PB) 2016–2017 (document A68/7) approved by the World Health Assembly in resolution WHA68.1 in May 2015.

For each of the six categories, strategic considerations in the European Region are described and budget levels by programme area are reported. These are followed by analyses of the challenges and opportunities in the Region, implementation strategies to achieve the results (including indicators) proposed, and the European Region's contribution to the global outcomes and outputs defined in PB 2016–2017, with specific indicators of achievement at the regional level. The latter forms the core of the regional implementation plan and the principal means for programmatic accountability in the Region.

WORLD HEALTH ORGANIZATION REGIONAL OFFICE FOR EUROPE
UN City, Marmorvej 51, DK-2100 Copenhagen Ø, Denmark Telephone: +45 45 33 70 00 Fax: +45 45 33 70 01
Email: governance@euro.who.int Web: http://www.euro.who.int/en/who-we-are/governance

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Regional plan for implementation of programme budget 2016–2017 by category in the WHO European Region

1. This document provides detailed information about the Regional plan for implementation of the programme budget 2016–2017 in the WHO European Region (document EUR/RC65/14). For each of the six categories and their programme areas it describes the Regional Office for Europe's contribution to the global results chain set out in the global programme budget (PB) 2016–2017 (document A68/7), which was approved by the World Health Assembly in resolution WHA68.1 in May 2015.

2. An overview of strategic considerations in the European Region are described for each category and within each category, the budget levels by programme area are discussed. Analyses of the challenges and opportunities faced in the Region are identified, along with implementation strategies to achieve the proposed results (including indicators) and the Region's contributions to the global outcomes and outputs defined in PB 2016–2017, with specific indicators of achievement at the regional level. The latter forms the core of the regional implementation plan and the principal means for programmatic accountability in the European Region.

Category 1. Communicable diseases

Regional strategic considerations

3. The 2016–2017 biennium marks the transition from the Millennium Development Goals (MDGs) to the post-2015 agenda. Recent decades have seen a significant improvement in health outcomes in the WHO European Region and progress has been made towards achievement of the health-related MDGs. However, areas remain in which action has stagnated and health inequities persist. The challenges posed by HIV/AIDS, tuberculosis (TB) and vaccine-preventable diseases continue and risk leaving behind many people who have not yet benefited from the achievements recorded in pursuing the MDGs.

4. The HIV epidemic, concentrated in socially marginalized populations, remains a serious public health challenge in the European Region, with newly reported cases of HIV continuing to increase while globally they are decreasing. With regard to TB, although progress has been made, challenges remain, particularly in relation to multidrug- and extensively drug-resistant TB (M/XDR-TB), with the majority of cases concentrated in eastern Europe and central Asia. The European Region has the highest rate of multidrug-resistant tuberculosis (MDR-TB) in the world.

5. Building on the achievements of the 2014–2015 biennium, category 1 programmes will continue to address the unfinished business of the MDGs, tackle inequities, and guide and support countries to:

- develop, implement and monitor the post-2015 development agenda and other regional and national strategies, commitments and targets aimed at tackling HIV, hepatitis, TB, malaria and neglected tropical diseases by leveraging the opportunities offered by universal health coverage (UHC) for more effective prevention, diagnosis and treatment in order to:
  - reverse the epidemiological trends for HIV/AIDS, focusing on interventions targeting key populations;

  - reduce the transmission of TB and M/XDR-TB by improving case detection and treatment;
  - address the disease burden by developing and implementing coordinated multisectoral national strategies for the prevention, diagnosis and treatment of viral hepatitis;
  - complete the elimination of malaria, providing certification and preventing reintroduction; and
  - strengthen the surveillance and control of invasive mosquito vectors and re-emerging vector-borne diseases (dengue, chikungunya and leishmaniasis);
- update and modify policies and strategies on vaccine-preventable diseases and immunization, broaden the stakeholder base supporting immunization, and strengthen capacity for outbreak communication. A major objective is to achieve and sustain regional measles and rubella elimination.

6. The budget envelope and resources for HIV/AIDS and hepatitis are limited and have been continuously reduced during the 2012–2013 and 2014–2015 bienniums. The current budget envelope, while it reflects an increase in connection with implementing resolution WHA67.6 on viral hepatitis, is not sufficient and will limit the capacity of the European Region to fully address the needs of Member States for technical support and guidance in developing and implementing coordinated multisectoral national strategies for the prevention, diagnosis and treatment of HIV/AIDS and viral hepatitis. Further pressure on the existing budget envelope for category 1 comes from its accommodation of the technical assistance component for HIV, tuberculosis and malaria of the Global Fund to Fight AIDS, Tuberculosis and Malaria, and the costing for the European vaccine action plan 2015–2020, adopted in resolution EUR/RC64/R5 by the Regional Committee at its 64th session in 2014.

7. The programme budget (PB) 2016–2017 for category 1 (Communicable diseases) is set out in Table 1.

Table 1. PB 2016–2017 for category 1 (Communicable diseases) by programme area (US$ millions)

	WHA-approved PB 2016–2017			Adjusted WHA PB 2016–2017			
Category and programme areas	**Country offices**	**Regional Office**	**Total**	**Country offices**	**Regional Office**	**Total**	**Difference approved/ adjusted**
1. Communicable diseases							
HIV and hepatitis	1.9	5.0	**6.9**	2.0	5.4	**7.4**	7%
Tuberculosis	8.0	2.8	**10.8**	6.0	5.5	**11.5**	6%
Malaria	0.2	2.9	**3.1**	–	1.0	**1.0**	-68%
Neglected tropical diseases	–	0.6	**0.6**	–	0.4	**0.4**	-33%
Vaccine-preventable diseases	3.6	8.8	**12.4**	3.9	9.6	**13.5**	9%
Category 1 total	**13.7**	**20.1**	**33.8**	**11.9**	**21.9**	**33.8**	**0%**

Source: Proposed programme budget 2016–2017 (World Health Assembly document A68/7).

1.1 HIV/AIDS and hepatitis

8. Although some progress has been made in the European Region, the HIV epidemic in eastern Europe and central Asia continues to grow and only 35% of people eligible for antiretroviral therapy (ART) actually start the treatment. In the eastern part of the Region, the number of people receiving HIV treatment increased from 137 000 in 2011 to 255 000 in 2013. Countries are increasingly revising their policies and practices in line with WHO guidance. In addition, WHO has led efforts to eliminate mother-to-child transmission of HIV in the Region. The high number of people unaware of their HIV-positive status or diagnosed late is an important public health challenge that WHO is increasingly addressing. Preventing and treating HIV in key populations in relation to structural barriers to accessing services present the greatest challenges.

9. The burden of hepatitis B and C is high in the Region, with an estimated 13.3 million people living with hepatitis B and 15 million with hepatitis C. Two thirds of those with hepatitis B and C are in eastern Europe and central Asia. The prevalence of both hepatitis B and C, and often coinfection, is considerably higher in some key populations, particularly people who inject drugs and men who have sex with men, although nosocomial transmission is also reported. With greater awareness of the disease burden, better diagnostic capacities and more effective treatment, countries are increasingly aiming to intensify efforts to prevent, diagnose and treat viral hepatitis, in line with World Health Assembly resolution (WHA67.6).

10. Through the development of a new HIV/AIDS action plan for the European Region to implement the global health sector strategy on HIV/AIDS 2016–2021 in the regional context and in the pursuit of UHC, the Regional Office will provide intensified support to Member States to significantly scale up (fast track) treatment, prevention and control of HIV/AIDS, particularly for key populations. The new action plan will accelerate the implementation of evidence-based policies, strengthen health systems and address structural barriers. Efforts will be intensified to develop and promote integrated service delivery and health systems strengthening focusing on key populations in priority countries.

11. The Regional Office will adapt, disseminate and roll out global guidelines on HIV and viral hepatitis prevention, diagnosis and treatment in priority countries, particularly those with the highest disease burden. Country work will continue to build sustainable evidence-based policies and strengthen capacities. The Regional Office will continue to track regional progress on policies and practices and to monitor HIV and viral hepatitis epidemic trends jointly with partners, including the European Centre for Disease Prevention and Control. A validation process for the dual elimination of mother-to-child transmission of HIV and congenital syphilis will be finalized.

12. The Regional Office will provide technical support and policy leadership in developing and implementing coordinated multisectoral national strategies for prevention, diagnosis and treatment of viral hepatitis. Member States will be consulted on how best to implement the global health sector strategy on viral hepatitis 2016–2021 in the European context.

1.2 Tuberculosis

13. Key opportunities for tuberculosis prevention and care in the European Region stem from the achievements related to the implementation of the Consolidated Action Plan to Prevent and Combat Multidrug- and Extensively Drug-Resistant Tuberculosis in the European Region 2011–2015 (adopted in resolution EUR/RC61/R7), for which WHO has been providing substantial technical support, especially to high-burden Member States. Progress has been observed in most of the indicators of the Consoldiated Action Plan, particularly in improved case detection and an increase in treatment coverage of notified cases, as a result of enhanced MDR-TB detection capacity, expansion of coverage for second-line drug susceptibility testing, and improvement of MDR-TB patient enrolment in adequate treatment.

14. Key challenges to be tackled are low treatment success for MDR-TB patients and ongoing transmission in some countries and (sub)populations. Population movements and an inadequate response to the social determinants of the disease are among the predisposing factors for the spread of TB.

15. A related key challenge is the considerable heterogeneity in the distribution of the TB burden across the Region, generally following a downward slope from east to west (high-incidence to lower-incidence countries) with pockets of high transmission in low-incidence countries.

16. In line with the global End TB Strategy, the Regional Office is planning to renew the regional action plan to cover the years 2016–2020. The draft plan, contained in document EUR/RC65/17 Rev.1, is being submitted for adoption by the Regional Committee at its 65th session in September 2015. Technical support will be provided to Member States to adapt their national plans for TB prevention, control and care to further reduce TB mortality and improve early detection of all forms of TB and treatment success rates.

17. The Regional Office will continue to provide technical assistance to Member States in achieving universal access to diagnosis and in ensuring universal treatment coverage, thus contributing to their efforts to prevent the emergence and reduce the transmission of TB and M/XDR-TB in the Region.

18. To that end the Regional Office will support Member States not only in scaling up quality diagnosis, but also in strengthening mechanisms for cross-border TB control and care, scaling up rational use of new medicines and improving the drug supply, working in stronger partnerships and enhancing civil society engagement, and assessing and addressing health systems challenges and the social determinants of TB, in line with Health 2020. This complementarity-oriented approach will optimize the efficiency of TB prevention and care in the Region.

19. While the focus will remain on countries with a high prevalence of TB and M/XDR-TB, the Regional Office will also assist countries with a low TB burden in developing strategies for moving towards TB elimination and for improving the diagnosis and treatment of TB among migrants and other high-risk groups. This will require further expansion of TB diagnostic capacity at the country level (laboratory capacity and quality assurance), strengthening TB monitoring and surveillance systems, introducing new TB drugs safely, adequately and efficiently, ensuring active

pharmacovigilance, avoiding secondary drug resistance and fostering integration of TB services into health systems and primary health care. It will also require increased political commitment from Member States.

1.3 Malaria

20. The European Region, in line with the Tashkent Declaration (2005), aims to interrupt the transmission of malaria and eliminate the disease from the remaining affected countries in the Region by 2015.

21. The main risk at the current stage is the reintroduction of malaria into countries in which it has been eliminated. Responding to this challenge, the Regional Office developed and published the *Regional framework for prevention of malaria reintroduction and certification of malaria elimination 2014–2020* and is continuously providing technical assistance to eligible Member States to develop their own national strategies on the prevention of malaria reintroduction.

22. In 2016–2017, the focus will be on achieving complete interruption of malaria transmission in the Region, providing certification of malaria elimination and preventing malaria reintroduction. Although the overall budget allocation for this area is decreasing slightly compared with the allocated 2014–2015 PB, the focus will be on maintaining and/or strengthening an effective surveillance system (which should be able to promptly detect and report all cases), vector control, cross-border collaboration and capacity-building. A high-level meeting on malaria is being planned with a view to reaffirming the commitment of the countries of the Region to prevent the re-establishment of malaria.

23. The Region has also contributed to and will follow up on the implementation of the global technical strategy for malaria 2016–2030, which was adopted by the World Health Assembly in resolution WHA68.2 in May 2015. The regional implementation of the strategy will be undertaken within the Health 2020 framework.

1.4 Neglected tropical diseases (including re-emerging vector-borne diseases)

24. The emergence of new vector-borne diseases in the Region and the return of diseases considered to have been eliminated is a growing problem driven by the globalization of trade and travel, increased urbanization and climate change.

25. Recent data document the increasing geographical spread of insect vectors.

26. The introduction, establishment and spread of invasive species of mosquitoes, in particular *Aedes albopictus* and *Aedes aegypti* within the Region are a cause for serious concern. *Aedes albopictus* is considered, among other things, to be a potential bridge vector of arboviruses (such as West Nile virus) from birds and mammals to humans.

27. The incidence and distribution of vector-borne diseases such as leishmaniasis, Crimean-Congo haemorrhagic fever, tick-borne encephalitis, West Nile fever, Lyme disease and imported Chagas disease are increasing significantly, particularly in the southern part of the Region.

28. These events present a clear warning signal to the Region that the emerging disease problem may spread and intensify in the years ahead.

29. Although the overall budget allocation for this area is decreasing, the Regional Office will continue to provide technical assistance to selected Member States for the implementation of the regional framework for surveillance and control of invasive mosquito vectors and re-emerging vector-borne diseases, 2014–2020, in line with their national context and needs. Other neglected tropical diseases for which technical support will be provided upon request by Member States, particularly in central Asia, the Caucasus and the Balkans, are tick-borne diseases (Lyme borreliosis, Crimean-Congo haemorrhagic fever, tick-borne encephalitis), rabies and soil-transmitted helminths (roundworm, whipworm, hookworm).

1.5 Vaccine-preventable diseases

30. Despite the wide diversity in health systems across the European Region, all 53 Member States have agreed to the priority goals of eliminating measles and rubella and maintaining polio-free status. The Region has faced serious threats to the achievement of these goals over the past few years, with large outbreaks of measles and rubella in many countries.

31. Strong vigilance, high political commitment, sufficient resources and implementation of key strategies to close immunity gaps and conduct supplemental immunization activities to address susceptible populations have all had a direct impact on reducing the numbers of un- or under-immunized infants, children and adolescents and on removing barriers to immunization.

32. With a view to establishing a life-course approach to immunization, further work is needed to address issues in adulthood, close immunity gaps resulting from past immunization schedules and practices and maximize the benefits of immunization prior to the onset of immunosenescence (the gradual deterioration of the immune system due to ageing). This work closely interacts with programme areas in category 4 (Health systems).

33. The European Vaccine Action Plan 2015–2020 (document EUR/RC64/15 Rev.1), adopted by the Regional Committee in resolution EUR/RC64/R5 in 2014, calls for activities at the regional level that include sustaining regional measles and rubella elimination programmes and supporting global elimination activities within the framework of the Global Vaccine Action Plan 2011–2020.

34. WHO will continue to provide assistance to Member States in updating and modifying policies and strategies on vaccine-preventable diseases and immunization in line with the European Vaccine Action Plan. Support will be provided in the following areas: strengthening immunization services, focusing particularly on underserved populations and identifying barriers to immunization; increasing outbreak preparedness and response and closing the immunity gaps; improving disease surveillance and laboratory networks; improving the quality and availability of the evidence for decision-making on the introduction of new vaccines; and strengthening vaccine safety and outbreak communication capacity to enable Member States to better manage crises and address anti-vaccination sentiment.

35. The countries will be supported to establish or strengthen national immunization technical advisory groups. A major area of support will be building capacity to formulate evidence-based policies and creating opportunities to exchange experiences

and foster interaction with the European Technical Advisory Group of Experts on Immunization.

36. Special emphasis will be given to broadening the stakeholder base that supports immunization and to advocating for securing and/or maintaining domestic financial support, particularly in countries graduating from donor support (for example, from the GAVI Alliance).

Table 2. Global PB 2016–2017 results structure: Category 1. Communicable diseases				Contribution of the European Region		
Results chain	Title	Global indicator: baseline	Global indicator: target	Regional indicator: baseline	Regional indicator: target	Indicator details
Outcome	**1.1. Increased access to key interventions for people living with HIV**					
Outcome indicator	**Number of new HIV infections per year**	**2.1 million (2013)**	**<500 000 (2015)**	**136 000 (2013)**	**85 000 (2017) 34 000 (2020)**	Regional targets: 38% reduction in new HIV infections by 2017 and 75% reduction in new HIV infections by 2020. Pending finalization following consultation in June 2015.
Outcome indicator	**Percentage of people living with HIV who are on antiretroviral treatment**	**37% (2013)**	**81% (2020)**	**35% (2012)**	**50% (2017) 81% (2020)**	Pending finalization following consultation in June 2015.
Outcome indicator	**Percentage of HIV-positive pregnant women provided with antiretroviral treatment (antiretroviral prophylaxis or antiretroviral treatment) to reduce mother-to-child transmission during pregnancy and delivery**	**67% (2013)**	**90% (2017 – to be confirmed)**	**95% (2012)**	**>95% (2017)**	The European Region has already reached global target of 90%.
Outcome indicator	**Cumulative number of voluntary medical male circumcisions performed in 14 priority countries**	**5.8 million (2013)**	**20.8 million (2016)**	Not relevant for European Region		
Output	1.1.1. Increased capacity of countries to deliver key HIV interventions through active engagement in policy dialogue, development of normative guidance and tools, dissemination of strategic information, and provision of technical support					
Output indicator	Number of focus countries that have national HIV/AIDS strategies that are in line with the global health sector strategy on HIV/AIDS 2016–2021	0 (2015)	58 (2017)	0 (2015)	10 (2017)	
Output	1.1.2. Increased capacity of countries to deliver key hepatitis interventions through active engagement in policy dialogue, development of normative guidance and tools, dissemination of strategic information, and provision of technical support					
Output indicator	Number of focus countries with national action plans for viral hepatitis prevention and control that are in line with the global hepatitis strategy	5 (2015)	20 (2017)	0 (2015)	3 (2017)	
Outcome	**1.2. Universal access to quality tuberculosis care in line with the post-2015 global tuberculosis strategy and targets**					

Table 2. Global PB 2016–2017 results structure: Category 1. Communicable diseases				**Contribution of the European Region**		
Results chain	Title	Global indicator: baseline	Global indicator: target	Regional indicator: baseline	Regional indicator: target	Indicator details
Outcome indicator	**Cumulative number of people with tuberculosis diagnosed and successfully treated since the adoption of the WHO-recommended strategy (1995)**	**70 million (end 2015)**	**80 million (end 2017)**	**2.33 million**	**2.73 million**	Successfully treated from all DOTS notification cohort since 1995 and DOTS+ treatment cohorts since 2012 because of the change in case definition.
Outcome indicator	**Annual number of tuberculosis patients with confirmed or presumptive multidrug-resistant tuberculosis (including rifampicin-resistant cases) placed on multidrug-resistant tuberculosis treatment worldwide**	**97 000 (2013)**	**300 000 (by 2017)**	**45 000**	**60 000**	The European Region has reached universal treatment coverage.
Output	1.2.1. Worldwide adaptation and implementation of the global strategy and targets for tuberculosis prevention, care and control after 2015, as adopted in resolution WHA67.1					
Output indicator	Number of countries that have set targets, within national strategic plans, for reduction in tuberculosis mortality and incidence in line with the global targets as set in resolution WHA67.1	0 (2015)	194 (2017)	0	53	
Output	1.2.2. Updated policy guidelines and technical tools to support the adoption and implementation of the global strategy and targets for tuberculosis prevention, care and control after 2015, covering the three pillars: (1) integrated, patient-centred care and prevention; (2) bold policies and supportive systems; and (3) intensified research and innovation					
Output indicator	Number of new and updated guidelines and technical documents supporting the global strategy developed and adopted in regions and countries	3 (2015)	12 (2017)	2	6	Baseline: 1.TB action plan 2016–2020; 2.Recording and reporting framework. Target: 1. Active TB case finding policy; 2. TB social determinants surveillance and management; 3. Drug resistance surveillance guideline; 4. EuroTB Report 2016; 5. EuroTB Report 2017; 6 European diagnostic algorithm policy.

Table 2. Global PB 2016–2017 results structure: Category 1. Communicable diseases				Contribution of the European Region		
Results chain	Title	Global indicator: baseline	Global indicator: target	Regional indicator: baseline	Regional indicator: target	Indicator details
Outcome	**1.3. Increased access of populations at risk to preventive interventions and first-line antimalarial treatment for confirmed malaria cases**					
Outcome indicator	**Percentage of confirmed malaria cases in the public sector receiving first-line antimalarial treatment according to national policy**	**70% (2013)**	**80% (2017)**	**100% (2013)**	**100% (2017)**	All cases in the European Region are confirmed microscopically and immediately treated.
Outcome indicator	**Proportion of population in need of vector control interventions that has access to them**	**53% (2013)**	**75% (2017)**	**85% (2013)**	**100% (2017)**	The data are taken from the World Malaria Report 2014 form completed by countries. The figure represents indoor residual spraying (IRS) coverage (% of population targeted by national programmes). In other countries IRS for malaria is not conducted as malaria elimination has been certified.
Outcome indicator	**Number of countries with ongoing malaria transmission in 2015 that report zero indigenous cases**	**0 (2015)**	**3 (2017)**	**1 (2015)**	**1 (2017)**	According to current information only Tajikistan had local malaria transmission in 2014 (2 cases). There had been no information on locally acquired cases in Tajikistan (or in any other country of the Region) in 2015 prior to the malaria transmission season (May to October). Considering the high receptivity of Tajikistan and its long border with Afghanistan it is possible that the country may report a few locally acquired cases in 2015.
Output	1.3.1. Countries enabled to implement evidence-based malaria strategic plans, with focus on effective coverage of vector control interventions and diagnostic testing and treatment, therapeutic efficacy and insecticide resistance monitoring and surveillance through capacity strengthening for enhanced malaria reduction					

Table 2. Global PB 2016–2017 results structure: Category 1. Communicable diseases				Contribution of the European Region		
Results chain	Title	Global indicator: baseline	Global indicator: target	Regional indicator: baseline	Regional indicator: target	Indicator details
Output indicator	Number of countries in which malaria is endemic where an assessment of malaria trends is carried out using routine surveillance systems	58/97 (2013)	70/97 (2017)	10/10 (2014)	10/10 (2017)	Malaria-endemic countries of the European Region are: Armenia, Azerbaijan, Georgia, Kazakhstan, Kyrgyzstan, Russian Federation, Tajikistan, Turkmenistan, Turkey and Uzbekistan.
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 for accelerated malaria reduction and elimination					
Output indicator	Proportion of malaria-endemic countries that are implementing WHO policy recommendations, strategies and guidelines	78/97 (2013)	85/97 (2017)	10/10 (2014)	10/10 (2017)	All endemic countries have national policies, strategies and guidelines, which were developed on the basis of WHO recommendations.
Outcome	**1.4. Increased and sustained access to neglected tropical disease control interventions**					
Outcome indicator	**Number of countries certified for eradication of dracunculiasis**	**187/194 (2015)**	**194/194 (2019)**	Not applicable to the European Region.		
Outcome indicator	**Number of countries in which diseases are endemic having achieved the recommended target coverage of the population at risk of contracting lymphatic filariasis, schistosomiasis and soil-transmitted helminthiasis**	**25/114 (2012)**	**100/114 (2020)**	**3/8 (2013)**	**6/8 (2017)**	Currently, it is considered that 8 countries in the European Region need preventive chemotherapy for treatment of soil-transmitted helminthiasis.[1] The true picture is unknown but suspected to be worse than estimated.
Output	1.4.1. Implementation and monitoring of the WHO road map for neglected tropical diseases facilitated					

[1] *Source*: Weekly Epidemiological Record. 2015;90(10):89–96. Geneva: World Health Organization; 2015 (http://www.who.int/wer/2015/wer9010/en/, accessed 14 August 2015).

Table 2. Global PB 2016–2017 results structure: Category 1. Communicable diseases				Contribution of the European Region		
Results chain	Title	Global indicator: baseline	Global indicator: target	Regional indicator: baseline	Regional indicator: target	Indicator details
Output indicator	Number of countries in which neglected tropical disease are endemic implementing neglected tropical disease national plans in line with the roadmap to reduce the burden of neglected tropical diseases	80/114 (2015)	85/114 (2017)	10/15 (2014)	14/15 (2017)	The work of the Regional Office in this area is mainly focused on leishmaniasis and soil-transmitted helminthiasis (dengue and chikungunya are not endemic). However, the true picture is not known and suspected to be worse than estimated.
Output	1.4.2. Implementation and monitoring of neglected tropical disease control interventions facilitated by evidence-based technical guidelines and technical support					
Output indicator	Number of countries in which neglected tropical diseases are endemic that have adopted WHO norms, standards and evidence in diagnosing and treating neglected tropical diseases	80/114 (2015)	84/114 (2017)	10/15 (2014)	14/15 (2017)	A number of countries have already adopted guidelines on soil-transmitted helminthiasis and leishmaniasis. In 2015, development of a regional manual on surveillance and treatment of leishmaniaisis is planned, subsequently to be adopted by the affected countries.
Output	1.4.3. New knowledge, solutions and implementation strategies that respond to the health needs of disease-endemic countries developed					

Table 2. Global PB 2016–2017 results structure: Category 1. Communicable diseases				Contribution of the European Region		
Results chain	Title	Global indicator: baseline	Global indicator: target	Regional indicator: baseline	Regional indicator: target	Indicator details
Output indicator	Number of new and improved tools, solutions and implementation strategies developed	Not applicable	8 (2017)	Not applicable	1 (2017)	New and improved tools, solutions and implementation strategies will be developed and endorsed at headquarters level. Considering that many neglected tropical diseases are not reported in the European Region, which also has the lowest burden of such diseases of the WHO regions, it is likely that the vast majority of the new tools will not be relevant. This is why only 1 tool is indicated as a target. But as soon as any tools applicable to the European Region are released, the Regional Office will make sure that they are implemented in countries.
Outcome	**1.5. Increased vaccination coverage for hard-to-reach populations and communities**					
Outcome indicator	**Global average coverage with three doses of diphtheria, tetanus and pertussis vaccine**	**83% (2015)**	**≥90% (2017)**	**96% (2013)**	**≥95% (2017)**	Regional average coverage with Diphtheria-tetanus-pertussis (DTP3) was 96% in 2013. The EVAP target (for 2017 and 2020) is a minimum of 95%. The global target has already been exceeded.
Outcome indicator	**WHO regions that have achieved measles elimination**	**1 (2015)**	**4 (2017)**	**0 (2015)**	**1 (2017)**	If the regional measles and rubella elimination target is achieved by 2017.
Outcome indicator	**Proportion of the 75 priority Member States (as per Countdown to 2015) that have introduced pneumococcal and rotavirus vaccines**	**49% (2015)**	**69% (2017)**	**3 countries (2015)**	**4 countries (2017)**	

Table 2. Global PB 2016–2017 results structure: Category 1. Communicable diseases				Contribution of the European Region		
Results chain	Title	Global indicator: baseline	Global indicator: target	Regional indicator: baseline	Regional indicator: target	Indicator details
Output	1.5.1. Implementation and monitoring of the global vaccine action plan, with emphasis on strengthening service delivery and immunization monitoring in order to achieve the goals for the Decade of Vaccines					
Output indicator	Number of Member States with DTP3 coverage <70% supported to update and implement plans to increase their immunization coverage	0/18 (2015)	12/18 (2017)	0 (2015)	1 (2017)	
Output	1.5.2. Intensified implementation and monitoring of measles and rubella elimination strategies facilitated					
Output indicator	Number of Member States supported to develop national plans to introduce measles and rubella-containing vaccine in their national childhood immunization schedule	150 (2015)	175 (2017)	53 (2015)	53 (2017)	All Member States in the European Region have already introduced two doses of measles and rubella-containing vaccines into their schedules.
Output	1.5.3. Target product profiles for new vaccines and other immunization-related technologies, as well as research priorities, defined and agreed, in order to develop vaccines of public health importance and overcome barriers to immunization					
Output indicator	Number of preferred product characteristics and policy recommendations established for priority new vaccines	1 (2015)	3 (2017)	Not applicable to the European Region as it is a global function.		

Category 2. Noncommunicable diseases

Regional strategic considerations

37. The end of the 2014–2015 biennium marks the achievement of a significant set of milestones in the area of noncommunicable diseases (NCDs), injuries and mental health.

- Five years of work to overhaul the policy mandate in these areas has come to fruition. New or renewed policies, strategies and action plans have been adopted for NCDs, tobacco control, the harmful use of alcohol, food and nutrition, physical activity, mental health, and the prevention of child maltreatment.
- The public health impact of actions by Member States, supported by WHO and other partners, is beginning to register, with more than a decade of annual declines being observed in mortality from circulatory diseases, alcohol consumption and road traffic injuries in most countries.
- Policy-level outcomes are becoming more common, with innovations and strengthened public health approaches adopted by countries, inspired by the Global Action Plan for the Prevention and Control of Noncommunicable Diseases 2013–2020 (document A66/9), endorsed by the Sixty-sixth World Health Assembly in resolution WHA66.10, and by Health 2020, the European health policy framework, endorsed by the Regional Committee in resolution EUR/RC62/R4 in 2012. These innovations range from the adoption of legislation for the standardized packaging of cigarettes in three countries in Europe (at the time of writing), to the increasing adoption of nutrient profiling models as a means of regulating the marketing of foods high in fat, sugar and salt to children, and the publication of a guide on the assessment of health systems challenges and opportunities in the prevention and control of NCDs.

38. The prevention and control of NCDs has begun to attract investment by donors. Significant support has been received from the Russian Federation (towards setting up the geographically dispersed office on NCDs), from Turkmenistan (towards the implementation of the tobacco roadmap) and from the European Commission (towards supporting action on nutrition and alcohol).

39. In 2016–2017, there will be renewed focus on deliverables at the country level. In many cases, this will be possible only if national governments increase their investment in the prevention and control of these conditions. Despite strong policy statements to the contrary, mental health programmes and violence and injury prevention remain grossly underfunded, and WHO has limited capacity to support countries in the area of illicit drugs.

40. In the 2016–2017 biennium, across all these areas, the priorities for the Regional Office will be:

- to emphasize concrete country-level deliverables in the form of effective intersectoral policies, and measurable improvements in addressing risk factors, morbidity and mortality;
- to seek ways of reducing the inequities between countries that still persist in the Region despite the overall improvements in the past decade; and

- to raise the priority, resourcing and stability of programmes on mental health and violence and injury prevention to the level achieved for NCDs.

41. The budget for NCDs has been significantly increased in response to the prioritization given to NCDs by Member States.

42. The PB 2016–2017 for category 2 (Noncommunicable diseases) is set out in Table 3.

Table 3. PB 2016–2017 for category 2 (Noncommunicable diseases) by programme area (US$ millions)

	WHA-approved PB 2016–2017			Adjusted WHA PB 2016–2017			
Category and programme areas	**Country offices**	**Regional Office**	**Total**	**Country offices**	**Regional Office**	**Total**	**Difference approved/ adjusted**
2. Noncommunicable diseases							
Noncommunicable diseases	9.7	9.5	**19.2**	9.8	10.2	**20.0**	4%
Mental health and substance abuse	2.8	2.4	**5.2**	2.6	3.2	**5.8**	12%
Violence and injuries	1.9	5.0	**6.9**	2.0	3.6	**5.6**	-19%
Disabilities and rehabilitation	0.4	0.1	**0.5**	0.4	0.1	**0.5**	0%
Nutrition	0.3	1.8	**2.1**	0.3	1.7	**2.0**	-5%
Category 2 total	**15.1**	**18.8**	**33.9**	15.1	18.8	**33.9**	0%

Source: Proposed programme budget 2016–2017 (World Health Assembly document A68/7).

2.1 Noncommunicable diseases and risk factors

43. Among the WHO regions, the European Region has the highest proportional burden of NCDs: cardiovascular diseases, cancer, respiratory diseases and diabetes (the four major NCDs) together account for 77% of the burden of disease and almost 86% of premature mortality. Premature death (before 60 years of age) or living with an NCD or related disability in the long term has socioeconomic consequences and constitutes a double burden for sustainable social and economic development.

44. The focus of the Regional Office with regard to NCDs in 2016–2017 will be development and strengthening of multisectoral plans on NCDs by supporting knowledge networks and activities across sectors in countries. Countries will be supported in: prioritizing the prevention and control of NCDs in national health planning processes and development agendas; developing and strengthening their capacity to control NCDs at the primary health care level; and developing, implementing, and evaluating integrated surveillance in line with Health 2020 targets and indicators (see Annex) and the Global Monitoring Framework on NCDs.

45. Alcohol is one of the leading risk factors for NCDs in the European Region. The Regional Office will continue to support implementation of the European action plan to reduce the harmful use of alcohol 2012–2020 (document EUR/RC61/13), adopted by the Regional Committee in resolution EUR/RC61/R4 in 2011. The focus will be on marketing, pricing and availability, but the Regional Office will also provide guidance on early identification and brief interventions in primary health care settings. Sharing of good practices among Member States is facilitated by a new timeline database, which provides information on areas such as alcohol policy, information campaigns and recent

studies. A new method of calculating alcohol-attributable death rates will be used to monitor trends and differences among Member States over time.

46. The European Region has the highest prevalence of smoking among adults and the highest rate of smoking-related mortality of all the WHO regions. Although 50 countries in the Region have ratified the WHO Framework Convention on Tobacco Control, its implementation remains poor. The Regional Office will continue to focus on attaining full implementation of the Convention following ratification, including implementation of stronger policies, use of knowledge networks and action across sectors. By 2017, countries should have prioritized implementation of the Convention as a key aspect of the prevention and control of NCDs, and should reach the global voluntary target of reducing tobacco use prevalence by 30% by 2025.

47. The Regional Office will provide technical support to countries for full implementation of the Convention in strong cross-sectoral partnerships, as part of Health 2020 priority actions. The Regional Office will also provide technical advice on tobacco control capacity building and institutional strengthening in countries with a view to achieving sustainable tobacco control policies and related health outcomes.

48. Physical inactivity has become a leading risk factor for ill health. Physical inactivity not only has substantial consequences for direct health care costs but also causes high indirect costs.

49. The Regional Office will work with governments and stakeholders to: promote physical activity and reduce sedentary behaviour; ensure an enabling environment that supports physical activity through attractive and safe built environments, accessible public spaces and infrastructure; and provide equal opportunities for physical activity regardless of gender, age, income, education, ethnicity or disability.

50. Bad diets are a serious concern in the European Region, as they lead to nutritional deficiencies and obesity and ultimately play a key role in NCDs such as cardiovascular diseases, diabetes and cancer. Furthermore, these problems have a disproportional impact on the poorest and most disadvantaged groups. The European Food and Nutrition Action Plan 2015–2020 (document EUR/RC64/14) adopted by the Regional Committee in resolution EUR/RC64/R7 in 2014 sets out the priorities for improving European diets, and calls for a comprehensive response to the problem of poor nutrition. It identifies a package of policy actions that countries can adopt, adapting the specificities to their national contexts. The ultimate aim is “to achieve universal access to affordable, balanced, healthy food” for everyone in the Region, tackling health inequalities in the process.

51. The Regional Office will support Member States in tackling NCDs in line with priorities identified and adapted to national needs and circumstances, and will monitor progress to evaluate the impact on the risk factors, burden of NCDs and improvements in health status as a result. The assistance of WHO collaborating centres and relevant networks will be called upon and implementation will take place in partnership with other agencies and experts. The project to strengthen prevention and control of NCDs supported by the Russian Federation aims to ensure a higher rate of implementation of programmes to tackle NCDs in the future.

52. The recently adopted European Food and Nutrition Action Plan 2015–2020 and the European Physical Activity Strategy 2016–2025 (document EUR/RC65/9), which will be submitted to the Regional Committee at its 65th session, will provide the framework for future priority actions. New and renewed collaboration with the European Union will ensure wider regional and national implementation.

2.2 Mental health and substance abuse

53. Mental disorders are among the greatest public health challenges in the European Region as measured by prevalence, burden of disease and disability. Mental health problems, including depression, anxiety and schizophrenia, are the main cause of disability and early retirement in many countries and a major burden to economies, demanding policy action. The well-being of their populations in these areas has become a priority for governments across the Region. In a time of economic challenges and increased unemployment in many countries, as well as ageing populations, attention is being given to effective ways of maximizing well-being across the lifespan.

54. The commitment to deinstitutionalization and the development of community-based mental health services has continued, although progress is uneven across the Region. A focus on the expanding role of primary health care, working in partnership with multidisciplinary mental health staff in community-based facilities, has become central.

55. There is strong evidence for the effectiveness of treatment and care for many mental disorders and their co-morbidities. Well-being could be improved, productivity increased and many suicides prevented. However, a large proportion of people with mental disorders either do not receive treatment at all owing to poor accessibility or experience long delays.

56. The European Mental Health Action Plan (document EUR/ RC63/11), endorsed by the Regional Committee in resolution EUR/RC63/R10 in 2013, addresses the challenges and sets out the strategic directions of the mental health programme, which aims to: improve the mental well-being of the population and reduce the burden of mental disorders, with a special focus on vulnerable groups, exposure to determinants and risk behaviours, in line with Health 2020; respect the rights of people with mental health problems and offer equitable opportunities to attain the highest quality of life, addressing stigma and discrimination; and establish accessible, safe and effective services that meet people’s mental, physical and social needs and the expectations of people with mental health problems and their families.

57. The Regional Office will continue to work closely with Member States to identify common issues and share information and good practices by collecting data, building capacity and disseminating evidence-based materials. Member States will be supported through country assessments, definition of strategies and workforce development. Several groups of countries at comparable stages of development will take part in activities related to priority areas such as suicide prevention, quality assurance and primary care development, often in partnership with other agencies and organizations

such as the European Commission and the Regional Health Development Center on Mental Health in South-eastern Europe,[2] based in Sarajevo, Bosnia and Herzegovina.

58. Substance abuse, especially use of injected drugs, is a major source of the spread of blood-borne diseases in the European Region. The Regional Office will continue to provide guidance on opioid substitution therapy and to collect information on treatment. The Regional Office will target special settings, such as prisons, and provide guidance on prison health governance.

59. A new way of estimating the implementation rate of the European alcohol action plan will guide the Regional Office and countries in the direction of a successful implementation of national strategies on alcohol.

2.3 Violence and injury prevention

60. Violence and injuries are the leading cause of death in people aged 5–44 years, and this constitutes a major public health challenge in the Region. The actions required are evidence-based and intersectoral, with a focus on equity and a life-course perspective, thereby fitting into the framework of the European Health 2020 policy. The plan outlined in Investing in children: the European child maltreatment prevention action plan (document EUR/RC64/12) adopted in resolution EUR/RC64/R6 by the Regional Committee in 2014, provides a framework for prioritizing violence prevention activities. The United Nations Decade of Action for Road Safety (2011–2020) has been embraced by most Member States and mandates delivering on the road safety targets set out in the programme budget indicators. Member States are engaged in delivering in the areas of road safety, violence prevention and child injury prevention and this represents an opportunity through a systematic public health approach to reduce these leading causes of premature death and disability.

61. The violence and injury prevention (VIP) programme will continue to work closely with Member States and will seek to achieve the results set out in the programme budget by taking advantage of the biennial collaborative agreements, in which road safety, child maltreatment prevention and child injury prevention are priority areas. Country profiles have been developed on the basis of those contained in the *Global status report on road safety 2015* (52 countries) and the *Global status report on violence prevention 2014* (41 countries). These baselines will be used to advocate for greater action, with plans to achieve the goals set out below, through monitoring, country guidance, development of regional tools and regional consultations of the VIP focal points network. The assistance of WHO collaborating centres and other VIP networks will be called upon.

2.4 Disabilities and rehabilitation

62. This is an area of importance, as demonstrated by the ratification of the Convention on the Rights of Persons with Disabilities by most Member States in the European Region. The WHO global disability action plan 2014–2021: better health for all people with disability and the European Declaration on the Health of Children and Young People with Intellectual Disabilities and their Families: Better Heath, Better Lives, demonstrate the commitment of WHO and its Member States in this area. A

[2] See: http://seehn.org/bosnia-herzegovina/ (accessed 14 August 2015).

growing number of countries are registering interest in baseline surveys using the International Classification of Functioning, Disability and Health in order to evaluate the need for improved access for people with disabilities.

63. The implementation strategy team works in close partnership with the team at WHO headquarters and provides consultants to deliver technical support. The mental health programme in the Regional Office aims to support several countries in assessing needs and providing social inclusion for people with intellectual disabilities.

2.5 Nutrition

64. Dietary factors are among the most important risk factors undermining health in every Member State in the European Region. One in every four children in the Region may already be overweight or obese, with the greatest impact among the most deprived groups of society.

65. Excess body weight (BMI > 25), excessive consumption of energy, saturated fats, *trans* fats, sugar and salt, as well as low consumption of vegetables and fruits, whole grains and other whole foods high in dietary fibre, are leading risk factors.

66. Some countries in the Region face a nutritional and demographic transition, with rapid acceleration in the rates of overweight, obesity and diet-related NCDs, and at the same time persistent and pervasive effects of micronutrient deficiencies, particularly in poor households. Stunting is prevalent in the Region, ranging from 7% to 39%. Exclusive breastfeeding rates in the Region are stalling and inappropriate complementary feeding practices are common. Micronutrient deficiencies, notably of iron and iodine, are frequent, particularly among vulnerable populations.

67. The European Food and Nutrition Action Plan 2015–2020 is the framework for identifying the challenges in this area, and for underscoring the opportunities and priorities for addressing those challenges. The Action Plan includes a portfolio of options from which countries may choose those appropriate to their national context. In addition, the Action Plan includes a set of existing good practices for countries to share, adopt and adjust to their national circumstances.

68. The Regional Office will support several countries in the revision and development of their food and nutrition action plans in line with the European Action Plan. High-level meetings with policy-makers and/or capacity-building workshops will be organized in countries, focusing on intersectoral action for better nutrition.

69. The Regional Office will continue to develop guidance in several domains, particularly those related to the creation of healthier food environments.

70. A revision of nutrition policies will be undertaken in several countries with WHO support. Price policies and nutrient profiling will continue to be implemented and evaluated. Support to countries and progress will be evaluated in relation to breastfeeding, complementary feeding, and school food and nutrition initiatives.

71. WHO will support Member States in the evaluation of their national plans and the use of data for policy-making. Examples of what works will be translated into a policy adopted to a specific country context. This endeavour will include updates on *trans* fat

elimination, salt and sugar reduction as well as situation analyses around undernutrition and micronutrient deficiencies in some countries. Updates and knowledge sharing on marketing of foods to children, salt reduction, nutrition surveillance and food policies will be prepared; addressing nutrients, by expanding national reformulation strategies and targets, will be the focus.

Table 4. Global PB 2016–2017 results structure: Category 2. Noncommunicable diseases.				Contribution of the European Region		
Results chain	Title	Global indicator: baseline	Global indicator: target	Regional indicator: baseline	Regional indicator: target	Indicator details
Outcome	**2.1. Increased access to interventions to prevent and manage noncommunicable diseases and their risk factors**					
Outcome indicator	**At least a 10% relative reduction in the harmful use of alcohol, as appropriate, within the national context**	**6.2 litres (2010)**	**At least 10% reduction (2025)**	**10.9 litres (2010)**	**10.0 litres (2017)**	Total average alcohol consumption per capita.
Outcome indicator	**A 30% relative reduction in prevalence of current tobacco use in persons aged 15+ years**	**22% (2010)**	**30% reduction (2025)**	**29% (2010)**	**27% (2017)**	
Outcome indicator	**A 10% relative reduction in prevalence of insufficient physical activity**	**25% (2010)**	**10% reduction (2025)**	**25% (2010)**	**5% reduction (2017)**	
Outcome indicator	**A 25% relative reduction in the prevalence of raised blood pressure, or contain the prevalence of raised blood pressure, according to national circumstances**	**40% (2008)**	**25% relative reduction (2025)**	**45% of persons 25 years and over (2008)**	**34% relative decrease (if a 2% per year relative reduction is kept) (2025)**	Raised blood pressure or under treatment.
Outcome indicator	**Halt in the rise in diabetes and obesity**	**10% diabetes/fasting plasma glucose (2008); 12% obesity (2008)**	**0% increase (2025)**	**10% diabetes/fasting plasma glucose (2008); 12% obesity (2008)**	**0% increase (2017)**	
Outcome indicator	**At least 50% of eligible people receiving drug therapy and counselling (including glycaemic control) to prevent heart attacks and strokes**	**Unknown**	**At least 50% coverage (2025)**	**Unknown from current data**	**At least 50% coverage (2025)**	
Outcome indicator	**A 30% relative reduction in mean population intake of salt/sodium**	**10 grams (2010)**	**30% reduction by 2025.**	**10 grams (2010)**	**15% reduction (2017)**	
Outcome indicator	**An 80% availability of the affordable basic technologies and essential medicines, including generics, required to treat major noncommunicable diseases in both public and private facilities**	**Unknown**	**At least 80% (2025)**	**Unknown with current data**	**At least 50% (2025)**	
Output	2.1.1. Development and/or implementation of national multisectoral policies and plans to prevent and control noncommunicable diseases accelerated					

Table 4. Global PB 2016–2017 results structure: Category 2. Noncommunicable diseases.				Contribution of the European Region		
Results chain	Title	Global indicator: baseline	Global indicator: target	Regional indicator: baseline	Regional indicator: target	Indicator details
Output indicator	Number of countries with at least one operational multisectoral national policy/strategy/action plan that integrates several noncommunicable diseases and shared risk factors	110/194 (2015)	134/194 (2017)	25/53 (2013)	39/53 (2017)	
Output indicator	Number of countries incorporating noncommunicable diseases in national development agenda, including in United Nations Development Assistance Frameworks, as appropriate	30/194 (2015)	42/194 (2017)	27/53 (2013)	30/53 (2017)	
Output	2.1.2. Countries enabled to implement strategies to reduce modifiable risk factors for noncommunicable diseases (tobacco use, diet, physical inactivity and harmful use of alcohol), including the underlying social determinants					
Output indicator	Number of countries that have strengthened and expanded their implementation of population-based policy measures to reduce the harmful use of alcohol	50/194 (2015)	60/194 (2017)	38/53 (2015)	48/53 (2017)	Adopted national alcohol plan.
Output indicator	Number of countries with an operational policy, strategy or action plan to reduce physical inactivity and/or promote physical activity	100/194 (2015)	130/194 (2017)	19/53 (2012)	35/53 (2017)	
Output indicator	Number of countries implementing policies that promote a reduction in salt consumption in the population	70/194 (2015)	100/194 (2017)	32/53 (2012)	45/53 (2017)	
Output indicator	Number of countries with an operational obesity prevention policy, strategy or action plan	98/194 (2015)	128/194 (2017)	30/53	45/53	
Output indicator	Number of countries that have made significant progress (increased by at least one category level in the Report on the global tobacco epidemic) in implementing at least one MPOWER measure (tobacco taxes, smoke-free environments, tobacco advertising, promotion and sponsorship ban or health warnings as defined in Appendix 3 of the global action plan for the prevention and control of noncommunicable diseases 2013–2020)	0/194 (2015)	10/194 (2017)	20/53 (2015)	35/53 (2017)	Global data needs verification.
Output	2.1.3. Countries enabled to improve health care coverage for the management of cardiovascular diseases, cancer, diabetes and chronic respiratory diseases and their risk factors through strengthening health systems					
Output indicator	Number of countries that have recognized/government approved evidence-based national guidelines/protocols/standards for the management of cardiovascular diseases, cancer, diabetes and chronic respiratory diseases, including emergency and palliative care	96/194 (2015)	111/194 (2017)	40/53 (2013)	48/53 (2017)	

Table 4. Global PB 2016–2017 results structure: Category 2. Noncommunicable diseases.				Contribution of the European Region		
Results chain	Title	Global indicator: baseline	Global indicator: target	Regional indicator: baseline	Regional indicator: target	Indicator details
Output indicator	Number of countries that have incorporated risk factor detection and disease management into national primary health care systems	156/194 (2015)	166/194 (2017)	48/53 (2013)	50/53 (2017)	
Output indicator	Number of countries that have included the following essential noncommunicable disease medicines (aspirin, statins, angiotensin converting enzyme inhibitors, thiazide diuretics, long-acting calcium channel blockers, metformin, insulin, bronchodilators and steroid inhalants) and technologies (blood pressure measurement devices, weighing scales, blood sugar and blood cholesterol measurement devices with strips and urine strips for albumin assay) in their national essential medicines lists and which are generally available in the public health sector	101/194 (2015)	116/194 (2017)	40/53 (2013)	45/53 (2017)	
Output	2.1.4. Monitoring framework implemented to report on the progress made on the commitments contained in the Political Declaration of the High-Level Meeting of the United Nations General Assembly on the Prevention and Control of Non-communicable Diseases and in the WHO global action plan for the prevention and control of noncommunicable diseases 2013–2020					
Output indicator	Number of countries with noncommunicable disease surveillance and monitoring systems in place to enable reporting against the nine voluntary global noncommunicable disease targets	38/194 (2015)	55/194 (2017)	43/53 (2013)	46/53 (2017)	
Outcome	**2.2. Increased access to services for mental health and substance use disorders**					
Outcome indicator	**Percentage of persons with a severe mental disorder (psychosis, bipolar affective disorder, moderate-severe depression) who are using services**	**30% (2015)**	**35% (2017)**	**0.50 (2015)**	**0.55 (2017)**	National survey data.
Outcome indicator	**Suicide rate per year per 100 000 population**	**11.1 per 100 000 (2015)**	**10.8 per 100 000 (2017)**	**13.0 per 100 000 (2015)**	**12.5 per 100 000 (2017)**	Health for All database country returns.
Output	2.2.1. Countries' capacity strengthened to develop and implement national policies, plans and information systems in line with the comprehensive mental health action plan 2013–2020					

Table 4. Global PB 2016–2017 results structure: Category 2. Noncommunicable diseases.				Contribution of the European Region		
Results chain	Title	Global indicator: baseline	Global indicator: target	Regional indicator: baseline	Regional indicator: target	Indicator details
Output indicator	Number of countries with a national policy and/or plan for mental health that is in line with the comprehensive mental health action plan 2013–2020	85 (2015)	100 (2017)	30 (2015)	35 (2017)	WHO biannual ATLAS survey.
Output	2.2.2. Countries with technical capacity to develop integrated mental health services across the continuum of promotion, prevention, treatment and recovery					
Output indicator	Number of countries with functioning programmes for intersectoral mental health promotion and prevention	83 (2015)	100 (2017)	30 (2015)	35 (2017)	WHO biannual ATLAS survey.
Output	2.2.3. Expansion and strengthening of country strategies, systems and interventions for disorders caused by alcohol and other psychoactive substance use enabled					
Output indicator	Number of countries with prevention and treatment strategies, systems and interventions for substance use disorders and associated conditions expanded and strengthened	70 (2015)	80 (2017)	25 (2015)	30 (2017)	
Outcome	**2.3. Reduced risk factors and improved coverage with interventions to prevent and manage unintentional injuries and violence**					
Outcome indicator	**Percentage of countries with comprehensive laws tackling the five key risk factors for road safety**	**15% (2010)**	**50% (2020)**	**48%**	**52%**	
Outcome indicator	**Percentage of countries implementing six or more interpersonal violence prevention programmes**	**48% (2014)**	**53% (2017)**	**48%**	**55%**	
Output	2.3.1. Development and implementation of multisectoral plans and programmes to prevent injuries, with a focus on achieving the targets set under the United Nations Decade of Action for Road Safety 2011–2020					
Output indicator	Number of countries with funded road safety strategies	119/194 (2010)	153/194 (2017)	40/53	44/53	
Output	2.3.2. Countries and partners enabled to develop and implement programmes and plans to prevent child injuries					
Output indicator	Number of countries receiving an assessment of their child injury prevention policies during the 2016–2017 biennium	0 (2015)	10 (2017)	Not applicable	2 (2017)	
Output	2.3.3. Development and implementation of policies and programmes to address violence against women, youth and children facilitated					

Table 4. Global PB 2016–2017 results structure: Category 2. Noncommunicable diseases.				Contribution of the European Region		
Results chain	Title	Global indicator: baseline	Global indicator: target	Regional indicator: baseline	Regional indicator: target	Indicator details
Output indicator	Number of countries implementing at least half of the interpersonal violence prevention programmes surveyed by the global status report on violence prevention 2014	42/194 (2015)	52/194 (2017)	20/53	23/53	
Outcome	**2.4. Increased access to services for people with disabilities**					
Outcome indicator	**Number of countries reporting increased access to services for persons with disabilities**	**30 (2014)**	**53 (2021)**	**6**	**7**	
Outcome indicator	**Number of countries reporting implementation of national plans for eye and ear care**	**20 (2014)**	**30 (2021)**	**Not applicable to the European Region.**		
Output	2.4.1. Implementation of the WHO global disability action plan 2014–2021: better health for all people with disability, in accordance with national priorities					
Output indicator	Number of countries that have comprehensive policies/programmes on health and rehabilitation	30/152 (2015)	53/152 (2017)	5	7	
Output	2.4.2. Countries enabled to strengthen prevention and management of eye and ear diseases in the framework of health systems					
Output indicator	Number of countries that have completed an eye care service assessment	6/194 (2015)	30/194 (2017)	**Not applicable to the European Region.**		
Outcome	**2.5. Reduced nutritional risk factors**					
Outcome indicator	**Number of stunted children below five years of age**	**165 million (2011)**	**102 million (2025)**	**7.2%**	**6%**	
Outcome indicator	**Proportion of women of reproductive age (15–49 years) with anaemia**	**30% (2014)**	**15% (2025)**	**20%**	**15% (2017)**	
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, which takes into consideration the double burden of malnutrition					
Output indicator	Number of countries that are implementing national action plans consistent with the comprehensive implementation plan on maternal, infant and young child nutrition	54/194 (2015)	74/194 (2017)	30/53	40/53	

Table 4. Global PB 2016–2017 results structure: Category 2. Noncommunicable diseases.				Contribution of the European Region		
Results chain	Title	Global indicator: baseline	Global indicator: target	Regional indicator: baseline	Regional indicator: target	Indicator details
Output	2.5.2. Norms and standards and policy options for promoting population dietary goals and cost-effective interventions to address the double burden of malnutrition, and their adoption by countries in developing national guidelines and legislation supporting effective nutrition actions					
Output indicator	Number of countries adopting, where appropriate, policies, legislation and regulatory measures and guidelines on dietary goals and effective nutrition actions for addressing the double burden of malnutrition	68/147 (2015)	90/147 (2017)	35/53	50/53	

Category 3. Promoting health through the life-course

Regional strategic considerations

72. Category 3 programmes are at the core of the life-course approach and cross-cutting priorities of the Organization. Category 3 is the only category in the European Region with a budget reduction in comparison with the approved PB 2014–2015 budget ceiling (a decrease of 4.5% or US$ 1.8 million). This reduction reflects the reality that funding for category 3 has been a challenge; the approved PB 2014–2015 had already been reduced by 6% (US$ 2.3 million) to arrive at a more realistic current allocated PB 2014–2015 (US$ 37.8 million). Thus, the US$ 38.3 million PB 2016–2017 is a de facto 1.5% increase over the allocated PB 2014–2015.

73. In 2016–2017, the strategy outlined in Investing in children: the European child and adolescent health strategy 2015–2020, supported by all 53 European Member States, requires adequate funding to be fully implemented in countries. A new European sexual and reproductive health strategy is planned for submission to the Regional Committee at its 66th session in 2016, which will require active country involvement and implementation in all Member States in 2017. The new United Nations Secretary-General's Global Strategy on Women's, Children's and Adolescents' Health (expected to be approved by the United Nations General Assembly in September 2015) and the sustainable development goals require the full involvement of child and adolescent health and sexual and reproductive health programmes in countries that are being assisted and require funding – both for activities and human resources.

74. The budget for programme area 3.3 – gender, equity and human rights – has been reduced, but this does not mean that work in these cross-cutting themes is not a priority for the Regional Office. Other technical programmes are mainstreaming these priorities in order to move the agenda forward within the Secretariat. Funding for activities at the country level in 2014–2015 has depended on voluntary contributions raised by headquarters, a situation that is likely to continue in 2016–2017.

75. The European Region has made notable progress on environmental and health issues. However, significant cause for concern remains. Environmental determinants of health are estimated to account for approximately 20% of total mortality and up to 25% of the total burden of disease, much of it unevenly distributed across geographic, demographic, sociocultural and socioeconomic subgroups. This generates large costs, consumes important resources, prevents the attainment of optimal health and well-being, and undermines societal and economic development. Air pollution is the largest single environmental health risk. In addition, growing evidence of the health impacts of climate change, and chemical and physical agents suggests that the significance of such environmental factors is greater than was previously thought to be the case.

76. The European Environment and Health Process (EHP) will continue to be an important international and regional technical and policy framework for advancing WHO's objectives of improving well-being and promoting health. The Regional Office and EHP will continue to provide support – financial, technical, policy and other kinds – to national governance processes and platforms, and will actively support the development and renewal of national environment and health action plans. The work of the Regional Office on environmental health inequalities will provide evidence of the

current situation, quantify its magnitude for selected environmental health risks (such as second-hand smoke, housing conditions, injuries, noise and sanitation) and continue to identify country-specific priorities for national action.

77. PB 2016–2017 for category 3 (Promoting health through the life-course) is set out in Table 5.

Table 5. PB 2016–2017 for category 3 (Promoting health through the life-course) by programme area (US$ millions)

	WHA-approved PB 2016–2017			Adjusted WHA PB 2016–2017			
Category and programme areas	**Country offices**	**Regional Office**	**Total**	**Country offices**	**Regional Office**	**Total**	**Difference approved/ adjusted**
3. Promoting health through the life-course							
Reproductive, maternal, newborn, child and adolescent health	3.0	3.5	**6.5**	3.2	3.7	**6.9**	6%
Ageing and health	0.4	1.0	**1.4**	0.4	1.0	**1.4**	0%
Gender, equity and human rights mainstreaming	0.1	0.9	**1.0**	0.1	1.0	**1.1**	10%
Social determinants of health	2.0	5.9	**7.9**	2.0	5.8	**7.8**	-1%
Health and the environment	4.1	17.4	**21.5**	4.0	17.1	**21.1**	-2%
Category 3 total	**9.6**	**28.7**	**38.3**	**9.7**	**28.6**	**38.3**	**0%**

Source: Proposed programme budget 2016–2017 (World Health Assembly document A68/7).

3.1 Reproductive, maternal, newborn, child and adolescent health

78. The aim of the child and adolescent health (CAH) programme is to enable children and adolescents in the European Region to realize their full potential for health, development and well-being, and to reduce the burden of avoidable disease and mortality. The CAH programme in the Regional Office supports governments in developing strategies for children and adolescents that ensure access to quality care and the creation of a health-literate generation who can address their own health risks throughout their lifespan.

79. The European CAH strategy (document EUR/RC64/12), adopted by the Regional Committee in resolution EUR/64/R6 in 2014, provides the opportunity to move work in this area forward. Child health is a high priority in most of the countries in the Region; adolescent health, less so.

80. There is a more than 40 times difference in several sexual and reproductive health indicators among countries of the Region, including the maternal mortality ratio and contraceptive prevalence. This and other issues will be addressed in the new regional sexual and reproductive health strategy.

81. A major challenge is the limited amount of financial and human resources in WHO in this programme area, both in the Regional Office and in country offices, to support implementation of the approved agenda, as outlined in WHO's Twelfth General Programme of Work, Health 2020 and other regional strategic documents, as well as to respond to the requests for technical assistance from Member States.

82. WHO will continue to support governments in developing effective national strategies and policies on CAH with tools and guidance for their implementation and monitoring that provide clear direction and clarify the contributions to be made by different social and economic sectors. The Regional Office will monitor implementation of the strategy and trends.

83. Priorities include making children's lives visible through documentation of the burdens and risks they face, particularly in neglected groups; promoting quality care in line with the United Nations Convention on the Rights of the Child, thus addressing the unfinished agenda of preventable deaths and infectious diseases; and ensuring mechanisms for supporting healthy growth and development in childhood and adolescence, including through schools that create a health-literate and health-competent generation who can move into adulthood to enjoy a productive, healthy, happy life.

84. The sexual and reproductive health (SRH) programme in the Regional Office supports countries in decreasing SRH inequalities between and within countries, with a special focus on the prevention of maternal and newborn mortality and morbidity as well as reducing the unmet needs in family planning. Technical assistance includes development of new national policies, monitoring, and improvement of access and quality of SRH services.

85. An analysis of sexual and reproductive and women's health in the European Region will be carried out in 2015, in line with the objectives set by Health 2020, and will be presented to the Regional Committee at its 65th session as part of the technical briefing on women's health in the WHO European Region. This work will involve a broad network of partners and stakeholders, including policy-makers, relevant sectors, United Nations agencies and civil society. They will be actively engaged in the development of goals and objectives of the new European sexual and reproductive health strategy as well as in assisting countries in improving the sexual and reproductive health of the population.

86. Meanwhile, technical assistance will continue to be provided to countries in improving access to quality sexual and reproductive health services, monitoring progress and improving the research capacity of national experts.

87. The outcomes of the European Ministerial Conference on the Life-course Approach in the Context of Health 2020 (to be held in October 2015 in Minsk, Belarus) will guide countries and the Regional Office in setting priorities for 2016–2017 in this programme area.

3.2 Ageing and health

88. Ageing and health has become increasingly important on policy agendas in a majority of countries in the Region, due to current demographic and socioeconomic trends towards ageing populations in Europe, with Member States implementing a growing number of national (and subnational) strategies and intersectoral policy approaches. However, progress in the health and living situations of older people remains uneven: while more countries now provide public support to informal care givers of frail persons, coverage rates of influenza vaccination for older people have generally been falling in recent years.

89. The strategy and action plan for healthy ageing in Europe, 2012–2020 (document EUR/RC62/10 Rev.1), adopted by the Regional Committee in resolution EUR/RC62/R6 in 2012, continues to provide a sound mandate and framework for supporting Member States in the implementation of existing or the design of new national strategies and action plans on ageing and health. A global strategy and action plan that is planned to be submitted to the World Health Assembly in 2017 will contribute to raising the profile of WHO's work on ageing and health globally.

90. At the Regional Office for Europe, ageing and health is a cross-cutting programme that is implemented in cooperation with relevant programmes across divisions. The ageing and health programme in the Regional Office supports Member States in the implementation of the strategy and action plan for healthy ageing in Europe. WHO works with an increasing number of countries that are putting in place intersectoral action plans in order to improve the health and well-being of ageing populations. In 2016, a regional progress report will take stock of the status of implementation and relevant health and policy trends in recent years.

91. The resources required to fully support Member States in this policy area are potentially significantly greater than the modest budget allocated, which could pose challenges, in particular because the demand from Member States and international partners will continue to increase and there will be a substantially larger number of countries with corresponding activities under biennial collaborative agreements.

92. Policies for healthy ageing require strong intersectoral approaches and action on the social determinants of health of older people, creating important synergies with Health 2020 implementation, and WHO will continue to focus on this aspect.

93. The situation assessment conducted in 2015 and the regional progress report on ageing and health, which will be published in 2016, will provide the basis for future priority setting for the 2016–2017 programme of work on ageing and health. The report will also review progress, and gather evidence and lessons learned in implementation of the strategy and action plan for healthy ageing in Europe.

94. The publication in 2015 of a toolkit on age-friendly environments in Europe will be used to strengthen the impact of the Regional Office in supporting intersectoral actions to create age-friendly environments at various levels. This work will continue in cooperation with a broad range of partner organizations in Europe, such as the European Innovation Partnership on Active and Healthy Ageing of the European Commission.

95. While work on age-friendly environments has consumed a large part of the resources in 2014–2015, the 2016–2017 workplan will shift the focus to implementing other pillars of the healthy ageing strategy as well. This will include country work under a substantially larger number of biennial collaborative agreements. Cooperation on NCDs and their risk factors will be strengthened under the strategic pillar "Healthy ageing across the life-course". Close links will be maintained with health systems strengthening, in particular for joint work on coordinated/integrated care and long-term care reform.

3.3 Gender, equity and human rights mainstreaming

96. Reducing inequities and strengthening intersectoral action are crucial for implementation of Health 2020 and supporting actions across government and society for health and well-being. Cross-cutting programme areas enable programmes in other categories to address determinants of health, including social determinants, and tackle gender inequalities that affect health and use a human rights approach in the technical assistance provided to countries.

97. The focus of the Regional Office is twofold: to mainstream gender equality, equity and human rights approaches throughout the work of the Secretariat and programme areas of the Regional Office as part of the WHO reform process; and to strengthen country capacity to integrate gender equality, equity and human rights into their health policies and monitor implementation of those policies.

98. Programme budget output 3.3.1 (Gender, equity and human rights) will be delivered within the framework of the global mainstreaming reform process, following the results of the exercise on the United Nations System-wide Action Plan on Gender Equality and the Empowerment of Women, and the gender, equity and human rights marker criteria established during 2015 in the Regional Office.

99. Under output 3.3.2 (Countries enabled to integrate and monitor gender, equity and human rights in national health policies and programmes) assistance to Member States focuses on developing local, national and subregional policies that systematically address the social determinants of health and equity. Strengthening collaboration with other sectors on how to integrate health equity into government policies for inclusive growth and sustainable development will continue to be a priority. Particular attention will be devoted to migrants and Roma groups; intersectoral work and adequate health system capacity will be required to address public health issues related to mobile populations. The Regional Office is responding to increasing requests for assistance from Member States to address the public health aspects of migration.

100. The Regional Office will assist countries to: integrate gender equality and human rights into the development and implementation of national health policies and programmes guided by Health 2020; strengthen intersectoral collaboration for health; and address the results of gender inequalities and human rights violations such as gender-based violence.

101. Other opportunities to strengthen WHO's work to mainstream gender equity and human rights at the regional and country levels include: *The impact of gender and socioeconomic inequalities on women's health* – a report produced by the Regional Office; the reporting process for the Beijing+20; and the development of a WHO global plan of action on strengthening the role of the health systems as part of a national multisectoral response to address interpersonal violence, in particular against women and girls, and against children planned for submission to the 138th session of the WHO Executive Board in January 2016 and for consideration by Member States at the Sixty-ninthWorld Health Assembly in May 2016.

3.4 Social determinants of health

102. Improving health for all and reducing health inequities are two strategic objectives of the Health 2020 policy framework. Health 2020 strongly advocates for upstream policy-making to address interrelationships between social and economic factors and health opportunities and gaps, which are essential for the achievement of goals for sustainable and inclusive development. The social determinants of health are located in all major policy domains of government and cut across all programme areas. The review of social determinants of health and the health divide undertaken by the Regional Office in 2012 sets out the evidence and policy options for acting on the pathways from social determinants to better health and reduced inequities. WHO will provide support to countries, as outlined in the report, highlighting the priority sectors and governance arrangements through which intersectoral action for health and well-being are required, alongside opportunities for building common interests and joint action for health and equity as objectives within broader development agendas.

103. Strong emphasis will be placed on combining universal and targeted policies to advance overall levels of health while accelerating improvements for those most excluded and vulnerable to health, social and economic risks. Effective implementation requires governance approaches at the local and national level that enable, provide incentives and hold accountable all sectors involved in dealing with the determinants of health and health equity, and these will be the focus of the work.

104. Beyond national borders, governance of the social determinants of health needs new forms of political and policy alliances between health and non-health sectors, with public and private actors and with citizens. This resonates strongly with the dialogues around the proposed sustainable development goals and is recommended in various World Health Assembly and Regional Committee resolutions. Across the European Region there is strong demand for WHO support, with policy guidance, assessment tools and direct technical support, for the development of local, national and subregional policies, health systems capacity and collaboration between health and non-health sectors that systematically address the social determinants of health and equity. WHO will support Member States in structured capacity-building for implementing cross-sectoral policies that address social determinants of health, together with ongoing platforms for sharing policy experiences and strengthening approaches to integrating health equity into government policies for inclusive growth, sustainable development and vulnerable groups.

105. In this regard, WHO will respond to the requests emerging across the Region for scaling up technical assistance to address the public health aspects of migration that are challenging Member States in diverse ways, confronting the health system with influxes of migrants in irregular situations, asylum seekers and labour migrants, each with diverse access to health services. The variety of governmental and nongovernmental, health and non-health, actors managing migration requires the establishment of intersectoral mechanisms for a participatory and effective impact on the social determinants of health of migration. These developments have indicated – also through the Standing Committee of the Regional Committee for Europe (SCRC) – a growing need in the Region for a more comprehensive and intersectoral approach in order to address country needs and specificities, identify regional priorities and agree on a common strategy for addressing the political sensitivities involved. The precariousness

of keeping health and equity on the political, policy and public agendas is an ongoing challenge amid the continuing financial crisis, and WHO will continue to advocate for and facilitate mechanisms that will enable dialogue and strengthen partnerships across social and economic sectors. The work of WHO in this area will continue to aim at strengthening the synergies between gender, human rights and social determinants of health towards achieving equity.

3.5 Health and the environment

106. WHO addresses the environmental determinants of health and well-being through a structured intersectoral process – the EHP – which began in 1989 and has been governed through periodic ministerial conferences. It provides overall strategic guidance and sets implementation priorities in the Region. It is supported by WHO for its Secretariat and by the European Centre on Environment and Health in Bonn, Germany, for evidence to inform policy-making. Within a wide partnership of Member State and non-Member-State stakeholders, the Regional Office links its core functions of normative work, technical guidance and technical support with policy leadership in international public health.

107. The European Region has made notable progress on environmental and health issues. However, significant cause for concern remains. The environmental burden of disease has persisted in some geographic areas, and is either newly emerging or re-emerging in others. Environmental determinants of health are estimated to account for approximately 20% of total mortality and up to 25% of the total burden of disease, much of it unevenly distributed across geographic, demographic, sociocultural and socioeconomic subgroups. This generates large costs, consumes important resources, prevents the attainment of optimal health and well-being, and undermines societal and economic development.

108. Air pollution is the largest single environmental health risk. In addition, growing evidence on the health impacts of climate change, and chemical and physical agents, suggests that several environmental factors have greater significance than had previously been thought. Resolution WHA68.8, adopted at the Sixty-eighth World Health Assembly in 2015, has expanded the mandate of WHO to address air quality across all seven major offices.

109. Many public health challenges of modern life, including the increasing incidence of NCDs, have complex connections to the physical environment. The environment must be recognized as not only a source of potential hazards, but also a health-promoting and health-protecting asset that can extend life, improve its quality and increase overall well-being.

110. The Regional Office supports its Member States and partners in understanding and navigating through this complexity and in identifying policies and actions in different sectors, nationally and internationally, that can benefit the environment and human health and are underpinned by the best available evidence. Great opportunities for progress lie in changing consumption patterns and fostering healthy and environmentally friendly developments in energy, transport, housing, urban management and agriculture, as well as in the health sector itself.

111. Health 2020 recognizes that the environmental determinants of health are of equal importance for creating, maintaining and restoring health as biological, social and behavioural determinants and identifies the creation of resilient communities and supportive environments as one of the four priority areas for action in the European Region.

112. Addressing the environmental determinants of health through multiple pathways – from monitoring, assessing and responding to health hazards to health promotion and protection and advancing public health research – is among the key functions and domains of public health services.

113. The EHP will continue to be an important international and regional technical and policy framework for advancing WHO's objectives to improve well-being and promote health.

114. An important mechanism for addressing regional challenges in relation to environmental and health issues is working with Member States under the framework of multilateral environmental agreements and other cross-border intersectoral platforms, such as the Protocol on Water and Health to the 1992 Convention on the Protection and Use of Transboundary Watercourses and International Lakes, the 1979 Convention on Long-range Transboundary Air Pollution, or the Transport, Health and Environment Pan-European Programme (THE PEP). Under implementation of the Convention, WHO activities will be performed through cooperation with Member States in joint work within the UNECE Task Force on Health.

115. The EHP, as an intersectoral platform, is a suitable avenue for presenting, explaining and advocating for Health 2020 and its principles to the environment and health sectors, as well as to other relevant sectors, such as transport, land management, planning, and energy. The main EHP forums – the European Environment and Health Ministerial Board and the European Environment and Health Task Force – have already been introduced to Health 2020 and consider it to be one of the main policy reference frameworks for the EHP.

116. The key non-health sectors that are engaged in the EHP – environment, transport, land and water management, labour and employment (in particular regarding occupational health), industry, trade and others – are a part of an all-of-government response to the environmental determinants of health.

117. At the national level, the EHP promotes the establishment and maintenance of an intersectoral process/structure that involves all profiles of stakeholders, including civil society. This has been in place since the Second Ministerial Conference on Environment and Health in Helsinki, Finland, in 1994 when Member States started the practice of establishing national environment and health action plans and the required multistakeholder and cross-sectoral implementing bodies. The Regional Office and EHP will continue to provide support – financial, technical, policy and other kinds – to national governance processes and platforms and will actively support the development and renewal of national environment and health action plans. The work of the Regional Office on environmental health inequalities will provide evidence of the current situation, quantify the magnitude of selected environmental health risks (such as

second-hand smoke, housing conditions, injuries, noise, sanitation) and will continue to identify country-specific priorities for national action.

118. The EHP focuses on strengthening the institutional and knowledge infrastructure for monitoring and evaluation in the area of environment and health, primarily at the national level, but also at the regional level. Regular and frequent workshops and network meetings will continue to be organized every year for participants from all 53 Member States in the Region, as well as country-level activities in countries with biennial collaborative agreements in place.

119. This area of work faced a shortfall of funding in 2014–2015. While the budget for 2016–2017 corresponds to the work expected by the Regional Office, the key issue for delivery will be the availability of funding for environment and health.

120. In the 2016–2017 biennium, the EHP will focus on preparations for the Sixth Ministerial Conference on Environment and Health, to be held in 2017. The preparatory process started with the EHP Mid-term Review (MTR), which took place in Haifa, Israel, on 28–30 April 2015. At the MTR, Member States and EHP stakeholders reviewed achievements and challenges encountered in the implementation of the commitments taken at the Fifth Ministerial Conference, held in Parma, Italy, in 2010. They decided to focus their work on achieving the time-limited targets set in Parma, to address the challenges that still persist in the Region, while at the same time starting to identify the priorities that will define the environment and health political agenda of the 21st century. To this effect, the MTR endorsed a roadmap that sets out the preparatory process for the 2017 Ministerial Conference. It consists of technical and political components and is framed within the Health 2020 and post-2015 sustainable development agenda.

Note on indicators

121. In general, indicators under outcome 3.5 (Reduced environmental threats to health) are framed for developing countries and do not necessarily reflect European regional priorities. The European Region has its own political process on health and the environment, with different priorities and existing political commitments made by the Member States in the Region, with accompanying targets and indicators. The global PB 2016–2017 targets and indicators are therefore of limited value to the European Region.

122. The outcome indicator for programme area 3.5 – the "proportion of the population relying primarily on solid fuels for cooking" – is of limited relevance to the European Region. This is evidenced by data for 2013 obtained by the WHO Global Observatory,[3] which show that less than 1% of the population in 35 Member States and less than 15% of the population in 44 Member States use solid fuels. In the Region, eight Member States (Albania, Bosnia and Herzegovina, Georgia, Kyrgyzstan, Montenegro, Serbia, Tajikistan and the former Yugoslav Republic of Macedonia) meet the criteria of having more than 25% of the population use solid fuels.

[3] See:http://gamapserver.who.int/gho/interactive_charts/phe/iap_exposure/atlas.html (accessed 14 August 2015).

123. The household use of solid fuels in the European Region is particularly important given its contribution to ambient air pollution. However, more relevant proxies for air quality and health could feature as output indicators under output 3.5.1. They are relevant to Health 2020, as they relate to intersectoral policy and interventions informed by health sector data, and could be formulated as follows:

- number of countries that have established population-relevant exposure monitoring for outdoor air pollution (as represented by PM2.5 monitoring);
- number of countries with annual population exposure for PM2.5 below WHO air quality guidelines (for WHO guideline value and interim targets 1, 2 and 3).

124. These indicators would be useful in assessing progress and providing evidence for policy development and health impact assessments of air pollution. Similar indicators are being considered for inclusion in the post-2015 sustainable development goals.

Table 6. Global PB 2016–2017 results structure: Category 3. Promoting health through the life-course				Contribution of the European Region		
Results chain	Title	Global indicator: baseline	Global indicator: target	Regional indicator: baseline	Regional indicator: target	Indicator details
Outcome	**3.1. Increased access to interventions for improving health of women, newborns, children and adolescents**					
Outcome indicator	**Contraceptive prevalence rate (world, any modern method)**	**20% (2015)**	**64% (2017)**	**50% (2015)**	**64% (2017)**	Data not available or out of date for a number of Member States.
Outcome indicator	**Number of targeted countries that have reduced the wealth quintile gap for demand satisfied for modern contraception by at least 10%**	**Not applicable**	**25/75 (2017)**	**Not applicable**	**2/5 (2017)**	
Outcome indicator	**Skilled attendant at birth (percentage of live births attended by skilled health personnel)**	**75% (2015)**	**80% (2017)**	**90% (2015)**	**95% (2017)**	
Outcome indicator	**Postnatal care for mothers and babies (percentage of mothers and babies who received postnatal care visit within two days of childbirth)**	**60% (2015)**	**65% (2017)**	**Not applicable in the European Region; visits already higher, but concern remains about content.**		
Outcome indicator	**Exclusive breastfeeding for six months (percentage of infants aged 0–5 months who are exclusively breastfed)**	**40% (2015)**	**45% (2017)**	**28% (2014)**	**35% (2017)**	
Outcome indicator	**Antibiotic treatment for pneumonia (percentage of children aged 0–59 months with suspected pneumonia receiving antibiotics)**	**60% (2015)**	**65% (2017)**	**Not applicable**	**Not applicable**	
Outcome indicator	**Adolescent birth rate (per 1000 girls aged 15–19 years)**	**45 per 1000 (2015)**	**43 per 1000 (2017)**	**Not applicable**	**Not applicable**	
Output	3.1.1. Countries enabled to further expand access to, and improve quality of, effective interventions for ending preventable maternal, perinatal and newborn deaths, from pre-pregnancy to postpartum, focusing on the 24-hour period around childbirth					
Output indicator	Number of targeted countries that have plans with targets for ending preventable maternal and neonatal deaths by 2030	0/75 (2015)	50/75 (2017)	0/5 (2015)	3/5 (2017)	
Output	3.1.2. Countries enabled to implement and monitor integrated strategic plans for newborn and child health, with a focus on expanding access to high-quality interventions to improve early childhood development and end preventable newborn and child deaths from pneumonia, diarrhoea and other conditions					
Output indicator	Number of targeted countries that are implementing an integrated plan to end preventable newborn deaths (e.g. Every Newborn action plan)	4/75 (2014)	50/75 (2017)	0/5	2/5	

Table 6. Global PB 2016–2017 results structure: Category 3. Promoting health through the life-course				Contribution of the European Region		
Results chain	Title	Global indicator: baseline	Global indicator: target	Regional indicator: baseline	Regional indicator: target	Indicator details
Output indicator	Number of targeted countries that are implementing an integrated plan to end preventable child deaths due to pneumonia and diarrhoea (e.g. Global Action Plan for the Prevention and Control of Pneumonia and Diarrhoea)	4/75 (2014)	50/75 (2017)	0/5	2/5	
Output	3.1.3. Countries enabled to implement and monitor effective interventions to cover unmet needs in sexual and reproductive health					
Output indicator	Number of countries able to implement WHO strategies and interventions to cover unmet needs in family planning	20/194 (2013)	40/194 (2017)	6/53	12/53	
Output	3.1.4. Research undertaken and evidence generated and synthesized for designing key interventions in maternal, newborn, child and adolescent health, and other conditions and issues linked to it					
Output indicator	Number of scientific publications reporting new and improved tools, solutions and strategies in maternal, newborn, child and adolescent health within the biennium	Not applicable	80 (2017)	Not applicable	5 (2017)	
Output	3.1.5. Countries enabled to implement and monitor integrated policies and strategies for promoting adolescent health and development and reducing adolescent risk behaviours					
Output indicator	Number of countries with a comprehensive adolescent health component in the national health programme	47/194 (2013)	60/194 (2017)	13/53 (2014)	18/53 (2017)	
Output	3.1.6 Research undertaken and research capacity strengthened for sexual and reproductive health, including in family planning, maternal and perinatal health, adolescent sexual and reproductive health, sexually transmitted infections, preventing unsafe abortion, infertility, sexual health, female genital mutilation, violence against women and sexual and reproductive health in humanitarian settings					
Output indicator	Number of scientific publications reporting new and improved tools, solutions and strategies in sexual and reproductive health	N/A	240 (2017)	Not applicable	3 (2017)	Lack of resources in the Regional Office prevents higher expectations.
Output indicator	Number of research capacity strengthening grants awarded to research centres	N/A	50 (2017)	Not applicable	2 (2017)	Lack of resources in the Regional Office prevents higher expectations.

Table 6. Global PB 2016–2017 results structure: Category 3. Promoting health through the life-course				Contribution of the European Region		
Results chain	Title	Global indicator: baseline	Global indicator: target	Regional indicator: baseline	Regional indicator: target	Indicator details
Output indicator	Number of systematic reviews of key questions in sexual and reproductive health	Not applicable	60 (2017)	Not applicable	2 (2017)	Lack of resources in the Regional Office prevents higher expectations.
Outcome	**3.2. Increased proportion of older people who can maintain an independent life**					
Outcome indicator	**Number of countries producing high quality reports, including on healthy life expectancy**	**112/194 (2015)**	**122/194 (2017)**	**28 (2015)**	**30 (2017)**	
Output	3.2.1. Countries supported in developing policies and strategies that foster healthy and active ageing					
Output indicator	Number of countries with national health plans (policies, strategies, plans) that explicitly include actions to address the health needs of older people	40/194 (2015)	54/194 (2017)	15 (2015)	20(2017)	
Output indicator	Number of countries with at least one municipality implementing the WHO Age-friendly Environments Programme	26 (2015)	45 (2017)	15 (2015)	22(20017)	
Output	3.2.2. Countries enabled to deliver integrated person-centred services that respond to the needs of older women and men in low-, middle- and high-income settings					
Output indicator	Number of countries supported to deliver integrated person-centred services that respond to the needs of older women and men in low-, middle- and high-income settings	2 (2015)	21 (2017)	1 (2015)	4 (2017)	
Output	3.2.3. Evidence base strengthened, and monitoring and evaluation mechanisms established to address key issues relevant to the health of older people					
Output indicator	Number of countries that are quantifying and monitoring the diverse health needs of older people as per WHO recommended measures and models	0 (2015)	14 (2017)	0 (2015)	4 (2017)	
Outcome	**3.3. Gender, equity and human rights integrated into the Secretariat's and countries' policies and programmes**					
Outcome indicator	**Evaluation processes in place to ensure gender, equity and human rights are measured in Secretariat programmes**	**0 (2014)**	**2 (2017)**	**Not applicable**	**Not applicable**	Global indicator.
Output	3.3.1. Gender, equity and human rights integrated in WHO's institutional mechanisms and programme deliverables					

Table 6. Global PB 2016–2017 results structure: Category 3. Promoting health through the life-course				Contribution of the European Region		
Results chain	Title	Global indicator: baseline	Global indicator: target	Regional indicator: baseline	Regional indicator: target	Indicator details
Output indicator	Number of WHO programme areas that have integrated gender, equity and human rights	10/24 (2015)	15/24 (2017)	6	12	Regional baseline and targets being defined through the gender, equality and human rights criteria. These are estimates.
Output	3.3.2. Countries enabled to integrate and monitor gender, equity and human rights in national health policies and programmes					
Output indicator	Number of countries implementing at least two WHO-supported activities to integrate gender, equity and human rights in their health policies and programmes	63 (2015)	84 (2017)	12	16	
Outcome	**3.4. Strengthened intersectoral policies and actions to increase health equity by addressing social determinants of health**					
Outcome indicator	**Number of countries showing an increase in the percentage of households living in durable housing**	**0/139 (2012)**	**8/139 (2018)**	**Indicator not relevant for the European Region** The global and regional outcome indicators need to be reviewed as they are not considered by Member States to be relevant to the European Region.		
Outcome indicator	**Number of countries showing a decrease in the difference between highest and lowest income quintiles in the percentage of households using solid fuels for cooking**	**0/139 (2013)**	**8/139 (2018)**	**Indicator not relevant for the European Region** The global and regional outcome indicators need to be reviewed as they are not considered by Member States to be relevant to the European Region.		
Output	3.4.1. Improved country policies, capacities and intersectoral actions for addressing the social determinants of health and reducing health inequities through “health-in-all-policies”, governance and universal health coverage approaches in the proposed sustainable development goals					
Output indicator	Number of countries implementing WHO tools and guidance to strengthen “health-in-all-policies” capacities and actions	21/139 (2015)	35/139 (2017)	18	25	The European Region includes high-income countries in the baseline and targets while the global figures include only low- and middle-income countries.

Table 6. Global PB 2016–2017 results structure: Category 3. Promoting health through the life-course				Contribution of the European Region		
Results chain	Title	Global indicator: baseline	Global indicator: target	Regional indicator: baseline	Regional indicator: target	Indicator details
Output	3.4.2. A social determinants of health approach to improving health and reducing health inequities integrated in national, regional and global health programmes and strategies, as well as in WHO					
Output indicator	Number of countries improving planning, implementation and monitoring of health programmes by integrating social determinants of health and health equity in line with WHO-supported tools and guidance	22/139 (2015)	41/139 (2017)	21	26	The European Region includes high-income countries in the baseline and targets while the global figures include only low- and middle-income countries
Output	3.4.3. Trends in, and progress on, action on social determinants of health and health equity monitored, including under the universal health coverage framework and the proposed sustainable development goals					
Output indicator	Regional and global trends in, and progress on, action on social determinants of health and health equity monitored and reported	0 (2015)	2 (2017)	1		Baseline is the *Review of social determinants and the health divide in the WHO European Region. Final report* (Copenhagen: WHO Regional Office for Europe; 2013).
Outcome	**3.5. Reduced environmental threats to health**					
Outcome indicator	**Proportion of the population without access to improved drinking-water sources**	**9% (2015)**	**7% (2017)**	**1% (2015)**	**1% (2017)**	Monitored by the WHO/UNICEF Joint Monitoring Programme (JMP); baseline data are unpublished data for 2015; due to high overall coverage in the European Region, this target area is not meaningful at regional level; the percentage is likely to remain the same in 2017; the target could be meaningful at subregional level.
Outcome indicator	**Proportion of the population without access to improved sanitation**	**32% (2015)**	**30% (2017)**	**7% (2015)**	**6% (2017)**	Monitored by the JMP; baseline data are unpublished data for 2015.

Table 6. Global PB 2016–2017 results structure: Category 3. Promoting health through the life-course				Contribution of the European Region		
Results chain	Title	Global indicator: baseline	Global indicator: target	Regional indicator: baseline	Regional indicator: target	Indicator details
Outcome indicator	**Proportion of the population relying primarily on solid fuels for cooking**	**40.4% (2015)**	**39.8% (2017)**	**Not relevant for the European Region**		
Output	3.5.1. Countries enabled to assess health risks and develop and implement policies, strategies or regulations for the prevention, mitigation and management of the health impacts of environmental and occupational risks					
Output indicator	Number of countries that have undertaken a national assessment or status review of water and sanitation drawing on WHO data, analysis or technical support	45/194 (2015)	55/194 (2017)	10/53	12/53	Monitoring at global level by UN-Water Global Analysis and Assessment of Sanitation and Drinking-Water (GLAAS); baseline refers to number of countries participating in the GLAAS 2014 cycle that reported latest national assessment since 2012; for the European Region, monitoring by GLAAS is to be complemented by reporting under the Protocol on Water and Health.
Output indicator	Number of countries that have developed health adaptation plans for climate change	28/194 (2015)	40/194 (2017)	22	28	Number of countries that have developed health adaptation plans or included health in national multisectoral action plans with WHO support.
Output indicator	Number of countries that have developed national policy instruments for workers' health with support from WHO	87/194 (2015)	145/194 (2017)	38/53 (2013)	41/53 (2017)	
Output	3.5.2. Norms and standards established and guidelines developed for environmental and occupational health risks and benefits associated with, for example, air and noise pollution, chemicals, waste, water and sanitation, radiation, nanotechnologies and climate change					

Table 6. Global PB 2016–2017 results structure: Category 3. Promoting health through the life-course				Contribution of the European Region		
Results chain	Title	Global indicator: baseline	Global indicator: target	Regional indicator: baseline	Regional indicator: target	Indicator details
Output indicator	Number of WHO norms, standards and guidelines on environmental and occupational health risks developed or updated	0 (2015)	3 (2017)	0	1 (2017)	WHO Environmental Noise Guidelines for the European Region (Update of the WHO Community Noise Guidelines) finalized and published.
Output	3.5.3. Public health objectives addressed in implementation of multilateral agreements and conventions on the environment and in relation to the proposed sustainable development goals and the post-2015 development agenda					
Output indicator	Number of countries that have included public health considerations within their national strategies to support the ratification and implementation of the Minamata Convention, based on WHO input	0 (2015)	7 (2017)	0 (2015)	3 (2017)	

Category 4. Health systems

Regional strategic considerations

125. Strategic priorities in health system strengthening in 2015–2020 follow the direction of Health 2020 – the European health policy framework – which along with developing priorities and actions for health improvements more widely, sets out a comprehensive vision for the Regional Office to improve health and reduce health inequalities.

126. People-centred health systems reflect the values of solidarity and equity. They do not leave anyone behind; they minimize social exclusion and promote financial protection. The socioeconomic realities in the European Region are sobering, especially in the wake of the financial and economic crisis. Millions of people experience financial hardship when accessing the health services that they need. Some are impoverished or are pushed further into poverty by having to make out-of-pocket payments for health care. Others face catastrophic levels of out-of-pocket payments.[4] A commitment to health gains and reduced inequalities in health requires moving towards UHC. Targeted approaches may be necessary to reach the most vulnerable groups of people.

127. In 2016–2017, the Regional Office will strengthen its technical support to Member States in developing national health policies and intersectoral governance at all levels, as well as health financing strategies and policies aimed at moving towards UHC. One of the key indicators for monitoring progress is the measure of financial risk protection. A major new programme will support this joint effort with Member States aiming at a Europe free of impoverishing health expenditures.

128. Strengthening health systems that put people at the centre involves trade-offs, especially at times of economic hardship. There are no ready-made solutions to the need to balance social goals and prioritize limited resources. The Regional Office will continue to provide tailored support to Member States, helping them to address problems and assess policy options through context-specific analytical work that draws on international experience, policy dialogue, knowledge brokering and direct technical assistance.

129. Health systems need to adapt to changing needs in the 21st century: this means putting NCDs, chronic conditions, multimorbidity, M/XDR-TB and a number of other health threats (such as HIV and antimicrobial resistance) at the top of the health policy agenda. Population-based interventions and individual services are equally important and these will be among the priorities of the work of the Secretariat.

130. To strengthen health systems in working towards a people-centred focus in line with the values outlined above, the Regional Office will work intensively with Member States over the 2016–2017 period on two priority areas:

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[4] Thomson S, Figueras J, Evetovits T, Jowett M, Mladovsky P, Maresso A et al. Economic crisis, health systems and health in Europe: impact and implications for policy. Copenhagen: WHO Regional Office for Europe on behalf of the European Observatory on Health Systems and Health Policies; 2014 (Policy summary 12; http://www.euro.who.int/en/about-us/partners/observatory/publications/policy-briefs-and-summaries/economic-crisis,-health-systems-and-health-in-europe-impact-and-implications-for-policy, accessed 14 August 2015).

- strategic priority 1: transforming health services to meet the health challenges of the 21st century;
- strategic priority 2: moving towards UHC for a Europe free of impoverishing out-of-pocket payments.

131. In order to implement these priorities, complex transformational changes in health systems require a long-term horizon and proactive management. For transformational changes to be sustainable, solutions must be contextualized and linked to broader development and social policies with the participation of a wide range of stakeholders and partners, including the education, social sphere and employment, and transport sectors among others. Moreover, sustainable and resilient health systems are likely to be those that also take environmental considerations into account and that work closely with the environment sector. A tailored approach to policy work will be combined with global and regional guidance, standards and evidence.

132. The Regional Office will provide support to Member States in these areas in an effective, integrated and evidence-informed manner, working closely with key partners such as patient organizations, the European Commission, the European Observatory on Health Systems and Policies, the GAVI Alliance, the Organisation for Economic Co-operation and Development (OECD), the Global Fund to Fight AIDS, Tuberculosis and Malaria, the World Bank, WHO collaborating centres and bilateral cooperation agencies, among others.

133. In line with bottom-up planning to define country priorities, category 4 was in high demand and the proposed figures initially entailed an increase in excess of 20%. Through a process of prioritization, these proposals were honed into the most high-impact programmes and projects that are included in the substantial 7.6% increase approved for category 4 in the European Region.

134. Although there is an overall increase in category 4, programme area 4.1 (National health policies and plans), is reduced by 15% compared with PB 2014–2015, reflecting a realistic assessment of current funding prospects. Nonetheless, increased demand is expected for support in developing Health 2020-aligned national health policies, strategies and plans, and many countries are embarking on whole-of-government and whole-of-society approaches to support the development and implementation of these policies. With a decreased budget in PB 2016–2017 for this area as compared with 2014–2015, the Regional Office will seek innovative ways to leverage limited resources to respond to the demands of Member States for increased support.

135. PB 2016–2017 for category 4 (Health systems) is set out in Table 7.

Table 7. PB 2016–2017 for category 4 (Health systems) by programme area, US$ millions.

	WHA-approved PB 2016–2017			Adjusted WHA PB 2016–2017			
Category and programme areas	**Country offices**	**Regional Office**	**Total**	**Country offices**	**Regional Office**	**Total**	**Difference approved/ adjusted**
4. Health systems							
National health policies, strategies and plans	5.2	9.8	**15.0**	5.6	10.5	**16.1**	7%
Integrated people-centred health services	6.3	9.1	**15.4**	6.6	9.5	**16.1**	5%
Access to medicines and other health technologies	1.1	6.0	**7.1**	0.8	4.4	**5.2**	-27%
Health systems information and evidence	2.7	8.0	**10.7**	2.7	8.1	**10.8**	1%
Category 4 total	**15.3**	**32.9**	**48.2**	**15.7**	**32.5**	**48.2**	**0%**

Source: Proposed programme budget 2016–2017 (World Health Assembly document A68/7).

4.1 National health policies and plans

136. Member States in the European Region are strengthening and broadening the scope of their intersectoral national health policies and strategies in line with Health 2020, providing direction and coherence to efforts to improve health, equity and well-being for all. Health 2020 has provided a strong political impetus to efforts to take forward the Health 2020 national policies vision across the Region. In the 2014–2015 biennium, more than two thirds of the 53 Member States of the Region had embarked on or completed a Health 2020 national policy process. It is expected that the vast majority of Member States will be engaged in such processes in the 2016–2017 biennium.

137. The Regional Office supports Member States and provides advice on the development and implementation of intersectoral national health policies, strategies and plans, and capacity-building in the areas of: leadership for health and health diplomacy; addressing health inequalities and the social determinants of health; whole-of-government and whole-of-society and health-in-all-policies approaches; and gender, human rights and vulnerability. The Regional Office will put special emphasis on further developing tools for policy implementation and analysis and tools and platforms to facilitate intersectoral dialogue and cooperation. The Regional Office also coordinates the European Healthy Cities Network and the Regions for Health Network, recognizing the importance of involving all levels of government in efforts to achieve population health and well-being.

138. A movement towards UHC has been growing around the world, and even the most advanced economies of the European Region face challenges in ensuring that everyone who needs health services (including promotion, prevention, treatment, rehabilitation and palliation) is able to obtain them without undue financial hardship. The recent financial and economic crisis reminded all Member States that UHC is relevant to all countries regardless of their level of economic development and that every country can improve its national health financing strategies and policies aimed at moving towards UHC. One of the key indicators for monitoring progress is the measure of financial risk protection. However, data on catastrophic and impoverishing levels of health expenditures by households in the European Region are outdated and regular

monitoring is lacking in most countries despite the relatively good capacity available to conduct household budget surveys and produce analyses. Most countries in the Region need technical and financial assistance to be able to measure and monitor financial protection against the costs of ill health. An increasing number of Member States request WHO's support in improving their health financing strategies and policies, including the monitoring and assessment of financial protection, and WHO will provide this support by increasing its capacity to respond to the above-mentioned challenges.

139. The Regional Office has launched a major new programme to strengthen the evidence base on UHC and to monitor progress in providing financial protection for the population of the European Region. This includes:

- improving the methodology used to measure financial protection to ensure that it is relevant to all Member States and the specifics of the European context;
- commissioning new estimates of catastrophic and impoverishing out-of-pocket spending on health in around 20 countries in the European Region; and
- documenting progress in individual country reports as well as in a regional report to be presented to the Regional Committee in 2018.

140. Therefore, the bulk of the work will take place in the 2016–2017 biennium and it is reflected in the programme budget and related staff development plans.

4.2 Integrated people-centred health services

141. The shortcomings in the delivery of health services include an increasing unmet need for health promotion, health protection and disease prevention, low quality of care, and lack of continuity of care and coordination of providers, leading to elevated rates of hospital readmission and inflated waiting times. Furthermore, factors compromising the adequacy of attempted responses, characterized as barriers to change, include: a lack of leadership that fosters synergies and orients a systems-approach to transformations; a limited focus on health-in-all policies; inadequate financing systems and financial incentives; an insufficient focus on primary health care; human resources constraints; inadequate information systems; insufficient investment in public–private partnerships; insufficient investment in research that targets integrated health service delivery; health services primarily conceptualized from the provider perspective; and budgetary restrictions.

142. New opportunities adding impetus to efforts to transform health services include advances in research, technology, manufacturing and medicines presenting, for example, new means of health status self-monitoring, sharing information across organizational boundaries, and providing services at a distance. Moreover, increased patient mobility across European Union member states holds the promise of new opportunities to promote access and develop centres of excellence. In addition, improved health literacy and greater awareness of health-related rights have served to significantly change the role of patients in health care, promoting a more significant role for patients in the management of their own health.

143. While there is a shared sense of urgency both globally and across the European Region to ensure that health systems are fit for purpose in the 21st century, there remains a degree of variability in reforming delivery of services that renders many

efforts small-scale and context-specific, often with preset time frames and funding limits, and ultimately constraining the potential to tackle broader health system bottlenecks. Initiatives that take shape as siloed or isolated interventions in the health system itself fundamentally contradict the principles of people-centred and integrated services delivery and pose a major barrier to sustained change.

144. A vision of service delivery that is linked more closely to outcomes in its approach and that analyses transformations through systems-thinking is considered to be a prerequisite for more robust reforms that are equipped with a mindfulness of the range of determining factors for people-centred services delivery and, ultimately, that best contribute to optimal performance and health gains.

145. Progress in people-centred health gains can be made by moving away from reactive, disease-based, episodic service delivery towards a proactive approach involving better coordination of health promotion, prevention and condition management throughout the life-course. As the burden of chronic illnesses increases, prevention and care take place in different settings, including the home, with increasing frequency. This demands stronger systems of public health, primary and community care, the development of specialist networks, and integrated models of care in relation to prevention and promotion. It also demands greater unity between public health and individual services; for example, by integrating Essential Public Health Operations into primary health care services and hospitals. Importantly, greater health literacy and a more engaged public in health protection, disease prevention, and self-management of disease add value to system changes and improve outcomes.

146. In order for health service delivery reforms to advance further towards integrated care and to address the challenges to system-wide change, there is a need to generate a shared vision of the transformations required, in direct alignment with the values of people-centred health systems. This will take precedence in the development of a framework for action for coordinated/integrated health service delivery to scale up initiatives in countries and develop sustainable models of care.

4.3 Access to medicines and health technologies and strengthening regulatory capacity

147. Pharmaceutical policies are embedded in a framework with many stakeholders, a dynamic environment and variations across the Region in terms of the political and social context. Generally speaking, resources are always limited but related to pharmaceutical expenditure; given the resource constraints that many countries are facing, it is important to prioritize and obtain best value for money both in terms of public and individual health.

148. Support to countries in strengthening their systems for providing access to medicines is part of the engagement of, and assistance provided to, countries by the Regional Office in moving towards UHC. Transparency increases understanding of the challenges health systems are facing in the medicines and health technology area. Today there is a lack of transparency in many Member States' systems for selection of medicines. The aim of achieving value for money invites discussion and debate, and many European countries seek reform in their public pharmaceutical sector, using transparency as the underlying principle in creating sustainable, healthy markets for medicines and other health technologies for the benefit of people and societies. The

health technologies and pharmaceuticals (HTP) team will support Member States in the process of pursuing greater value for money in the medical product area by supporting policy and strategy development as well as process and systems reform.

149. Access to essential medicines and basic health technologies for the treatment of NCDs is poor in many areas of the Region. The establishment of resilient health care systems to prevent and control chronic diseases requires mechanisms to ensure access to affordable medicines and technologies. Strengthening primary health care by ensuring the availability of well-functioning public and private medicine supply chains to improve access to care and medicines to treat and prevent NCDs will be the focus of the work of the Secretariat.

150. It is estimated that up to 50% of medicines are not taken as intended, with immense costs to patients' health, as well as to the health economy. There is a clear relationship between medication adherence and improved outcomes. If adherence were to be improved, better results could be achieved and savings could be made. Improving adherence is crucial for the future sustainability of the European health system. Appropriate use of antimicrobial medicines is a current priority area in which HTP will provide substantial country support.

151. Convergence in regulation of medical products is desirable and WHO establishes norms and standards that can be implemented at the country level. The HTP team provides country-specific support as well as support to the Prequalification of Medicines Programme, managed by WHO, that facilitates the regulatory work of manufacturers from the European Region. Medical device regulation is lagging far behind medicines regulation, and this area will require more attention.

152. The HTP programme will continue its multicountry activities on key topics including capacity-building in methodology and systems development (including health technology assessment (HTA), drug utilization, and risk-based assessment of supply chains); managed introduction of new medicines using HTA; pricing and reimbursement policy and systems development; antimicrobial medicines consumption surveillance; and issues relating to convergence in medical product regulation and enforcement.

153. Through biennial collaborative agreements, HTP will assist Member States in their efforts to develop and update medical policy and related systems to, for example: tackle problems relating to poor access, including to medical products for the treatment of NCDs; monitor the use of medicines; work towards appropriate use of antibiotics; strengthen pharmacovigilance systems; and improve regulation of the supply chain.

4.4 Health systems information and evidence

154. Information and evidence are the foundations of sound public health policies and programmes. Allocation of resources and development of national policies, activities and decision-making should be guided by accurate, up-to-date and complete information on health situations and trends, including population health status and health system resources, and on evidence of what works at what cost. However, health information systems are still inadequate in many countries.

155. Routine collection, processing and dissemination of health-related information in many countries is difficult due to a lack of intersectoral coordination between national institutions. The reasons for weak and/or uncoordinated national health information systems vary, ranging from understaffed and inadequately resourced health and statistics departments, to a lack of the strategies and legal frameworks that facilitate the exchange of statistics.

156. It is WHO's constitutional mandate to collect, analyse and report health information, including cause of death and epidemiological information, from Member States in an internationally comparable format. Regular reporting is carried out through the Health 2020 monitoring framework for targets and indicators, which is reported through the annual report of the Regional Director. Further and more detailed evaluations will continue to be carried out in the European health reports, the annual Core Health Indicator series, the revitalized highlights on health country profiles (compiled in direct collaboration with Member States) as well as the new health information and evidence web portal hosted by the Regional Office, which includes the European Health for All database.

157. The interest of Member States concerning investments in eHealth continues to grow rapidly within the European Region and this is leading to greatly increased demand for regional engagement in direct support of country activities. Within the scope of national eHealth strategy development, additional effort is being made to promote adoption of eHealth standards and to utilize the interoperability frameworks developed by the European Union. Electronic health record development continues to be a key driver of eHealth activity in Europe, in particular the coalescence with mobile health platforms for personal access to health information. Two countries in the European Region are also participating in the WHO–ITU Mobile Health for NCDs Initiative, with a third likely to join in 2015. A regional report based on the third global eHealth survey will also be produced in 2015. This work will continue during the 2016–2017 biennium.

158. Member States also face challenges related to the lack of equitable and sustainable access to health knowledge, and in developing capacity for engaging in research following globally-accepted ethical principles, knowledge generation and its translation into policy and practice, and the strategic use and seamless integration of information and communications technology into health systems. The Regional Office will help Member States to strengthen their health research systems and promote the ethical conduct of research and adherence to ethical governance of public health practices.

159. Implementation of the Evidence-informed Policy Network (EVIPNet) Europe will be expanded. The Regional Office will develop key strategic and operational guidance documents to support Member States to strengthen their capacity to generate, share and apply knowledge. Several initiatives have been implemented and will be continued to provide technical assistance to countries: EVIPNet Europe, the HINARI Access to Research in Health Programme and the Global Information Full Text (GIFT) project. A new Russian–English bilingual public health journal, *Public Health Panorama*, was launched to furnish implementation research across all Member States and share good practices in the Region. The Secretariat will develop a roadmap that will propose actions for accelerated progress towards, and implementation of, improved evidence-informed policy-making.

160. The annual flagship course organized by the Regional Office – the Autumn School on Health Information and Evidence for Policy-making – builds capacity in Member States to strengthen health information collection, analysis and reporting mechanisms. As a result of a petition from Member States to the Regional Director, additional advanced courses are being organized throughout the year. Subregional health information networks have been established, including the Central Asian Republics Information Network. Such networks promote harmonization and standardization of health reporting. The Health Evidence Network has several new evidence syntheses, including on the integration of health information systems and chronic disease management; a series on migration and health is to be launched at the Regional Committee in 2015. In addition, WHO gives direct technical support to the strengthening of national health information and reporting systems as well as eHealth strategies and activities for the purpose of public health monitoring. WHO's monitoring and evaluation efforts, including harmonization and standardization, are guided by the overarching WHO European Health Information Initiative which has the support of Member States, WHO collaborating centres, the European Commission and the OECD as well as foundations. A recent Steering Group meeting has cemented this initiative and developed a workplan.

161. Based on country assessment missions and in accordance with biennial collaborative agreement commitments, Member States are being offered assistance in developing national eHealth strategies through multi-stakeholder workshops based on the curriculum of the WHO–ITU National eHealth Strategy Toolkit. Additional effort is also being made to launch a big data trial in the European Region to examine the possibilities for new and innovative mechanisms for health information analysis.

162. In parallel with efforts to support and strengthen the ability of Member States to generate, share and apply knowledge, the capacity of the Regional Office to increase the effectiveness and efficiency of information management will also be improved. This will be done using a four-pronged approach:

- developing an internal information management and information systems strategy for health information;
- developing a framework for information ownership and curation within the Regional Office;
- developing tools to enable easy access to information available in-house, including through interactive visualisations;
- implementing a common technical infrastructure to collate and bring together data and information handled by the Regional Office.

Table 8. Global PB 2016–2017 results structure: Category 4. Health systems				Contribution of the European Region		
Results chain	Title	Global indicator: baseline	Global indicator: target	Regional indicator: baseline	Regional indicator: target	Indicator details
Outcome	**4.1. All countries have comprehensive national health policies, strategies and plans aimed at moving towards universal health coverage**					
Outcome indicator	**Number of countries with a comprehensive national health sector policy/strategy/plan with goals and targets updated within the last five years**	**103/194 (2015)**	**115/194 (2017)**			Clarification sought from HQ – pending.
Output	4.1.1. Improved country governance capacity to formulate, implement and review comprehensive national health policies, strategies and plans (including multisectoral action, and "health in all policies" and equity policies)					
Output indicator	Number of countries enabled to monitor the progress of their national health policy/strategy/plan during the biennium	0	25/115 (2017)	0	15	
Output	4.1.2. Improved national health financing strategies aimed at moving towards universal health coverage					
Output indicator	Number of countries monitoring and reporting their progress in financial protection	24/194 (2015)	50/194 (2017)	5	15	
Outcome	**4.2. Policies, financing and human resources in place to increase access to integrated, people-centred health services**					
Outcome indicator	**Number of countries implementing integrated services**	**65/194 (2015)**	**80/194 (2017)**			Clarification sought from HQ – pending.
Outcome indicator	**Number of countries reporting on national health workforce disaggregation (by top 10 cadres, place of employment, urban/rural, subnational administrative area (second level))**	**0/194 (2015)**	**50/194 (2017)**	**0/53 (2015)**	**25/53 (2017)**	Data reported by Member States on health workforce employment and education to the Joint OECD/Eurostat/WHO Europe database (excluding second-level data).
Output	4.2.1. Equitable integrated, people-centred service delivery systems in place in countries and public health approaches strengthened					

Table 8. Global PB 2016–2017 results structure: Category 4. Health systems				Contribution of the European Region		
Results chain	Title	Global indicator: baseline	Global indicator: target	Regional indicator: baseline	Regional indicator: target	Indicator details
Output indicator	Number of countries enabled to implement integrated, people-centred health service strategies through different models of care delivery matched with their infrastructure, capacities and other resources	48/194	83/194	15/53	16/53	
Output	4.2.2. Health workforce strategies oriented towards universal health coverage implemented in countries					
Output indicator	Number of countries that are implementing national health workforce accounts during the biennium	0/194 (2015)	30/194 (2017)	0/53	10/53 (2017)	Health workforce accounts do not exist in the European Region. Target indicator is estimated, but it may be higher.
Output	4.2.3. Countries enabled to improve patient safety and quality of services, and patient empowerment within the context of universal health coverage					
Output indicator	Number of countries enabled to develop and implement strategies for improving patient safety and quality of health services at the national level within the context of universal health coverage	47/194 (2015)	77/194 (2017)	17/53	11/53	
Outcome	**4.3. Improved access to, and rational use of, safe, efficacious and quality medicines and other health technologies**					
Outcome indicator	**Availability of tracer medicines in the public and private sectors**	**60% (2015)**	**65% (2017)**	**60%**	**65%**	
Output	4.3.1. Countries enabled to develop or update, implement, monitor and evaluate national policies on better access to medicines and other health technologies; and to strengthen their evidence-based selection and rational use					
Output indicator	Number of countries with national policies on medicines and other health technologies updated within past five years	133/165 (2015)	159/194 (2017)	16	20	
Output	4.3.2. Implementation of the global strategy and plan of action on public health, innovation and intellectual property					

Table 8. Global PB 2016–2017 results structure: Category 4. Health systems				Contribution of the European Region		
Results chain	Title	Global indicator: baseline	Global indicator: target	Regional indicator: baseline	Regional indicator: target	Indicator details
Output indicator	Number of countries that report data on product research and development investments for health	71/194 (2015)	100/194 (2017)	Not applicable to the European Region.		
Output	4.3.3. Improved quality and safety of medicines and other health technologies through norms, standards and guidelines, strengthening of regulatory systems, and prequalification					
Output indicator	Number of national regulatory authorities ensuring essential regulatory functions for vaccines	56/194 (2015)	66/194 (2017)	17	19	
Outcome	**4.4. All countries having well-functioning health information, eHealth, research, ethics and knowledge management systems to support national health priorities**					
Outcome indicator	**Number of countries that have annual good quality public analytical reports for informing regular reviews of the health sector strategy**	**85 (2015)**	**120 (2016, 2017)**	**28**	**34**	
Output	4.4.1. Comprehensive monitoring of the global, regional and country health situation, trends, inequalities and determinants, using global standards, including data collection and analysis to address data gaps and system performance assessment					
Output indicator	Number of countries that have produced a comprehensive health situation and trends assessment during 2016–2017	119 (2015)	156 (2017)	37	47	
Output	4.4.2. Countries enabled to plan, develop and implement an eHealth strategy					
Output indicator	Number of countries that have developed an eHealth strategy	90/194 (2015)	110/194 (2017)	23	24	
Output	4.4.3. Knowledge management policies, tools, networks and resources developed and used by WHO and countries to strengthen their capacity to generate, share and apply knowledge					

Table 8. Global PB 2016–2017 results structure: Category 4. Health systems				Contribution of the European Region		
Results chain	Title	Global indicator: baseline	Global indicator: target	Regional indicator: baseline	Regional indicator: target	Indicator details
Output indicator	Number of visits to WHO's electronic knowledge assets and resources by low-income and lower-middle-income countries (annual)	50 million (2015)	60 million (2017)	Not applicable for the European Region.		
Output	4.4.4. Policy options, tools and technical support provided to promote research for health and address ethical issues in public health and research					
Output indicator	Number of countries that have an explicit national policy requiring all research involving human subjects to be registered in a recognized public registry	66 (2015)	76 (2017)	Not relevant at regional level.		

Category 5. Preparedness, surveillance and response

Regional strategic considerations

163. Category 5 focuses on strengthening institutional, international and country capacities in prevention, preparedness, response and recovery for all types of hazards, risks and emergencies that pose a threat to human health. The category also provides for rapid and effective response operations in acute and protracted emergencies with health consequences. Furthermore, under this category, WHO continues to provide guidance and technical support to countries in sustaining their polio-free status.

164. The work of the Regional Office under this category provides direct input to the reform of WHO's work in emergencies with health consequences (see resolution EBSS3.R.1 on Ebola virus disease (EVD) adopted by the Executive Board at its special session in January 2015; documents A68/24, A68/25, and A68/26; and decision WHA68(10) endorsed by the Sixty-eighth World Health Assembly in May 2015).

165. Since 2010, the Regional Office has taken an all-hazards approach with joint procedures, logistics and human resources for all emergencies with health consequences. This approach has proved to be valuable and was endorsed by the Regional Committee at its 63rd session in decision EUR/RC63(2) in 2013 through the establishment of a geographically dispersed office (GDO) on humanitarian crises, the Europe Centre for Preparedness for Humanitarian and Health Emergencies (document EUR/RC63/Inf.Doc./11), which will provide additional resources.

166. The EVD outbreak in Western Africa, which triggered a massive response globally, including by the European Member States and by the Regional Office for Europe, focused the work in category 5 on supporting the global response and, simultaneously, strengthening preparedness for potential Ebola importation or outbreak(s) in Europe, as well as other public health threats of international concern.

167. Furthermore, experience from major emergencies in the European Region during 2014–2015, ranging from natural disasters to humanitarian crises (the spillover effect of the protracted crisis in the Syrian Arab Republic affecting Turkey, the crisis in Ukraine, and the Balkan floods) highlighted the need for generic core capacity, required to effectively prevent, mitigate and manage humanitarian and/or health emergencies and the fact that all-hazards preparedness is more efficient than a series of parallel preparedness measures for specific risks.

168. Enhancing the limited capacity of the Regional Office in this area requires significant investment, given the increasing Region-wide demand for health security. This is particularly true as the new WHO global Emergency Response Framework (ERF) sets out the roles and responsibilities (with expanded capacity requirements) of WHO regional offices and country offices with regard to meeting country-level performance standards during emergencies.

169. In addition to expanding human resources capacity, functional improvements in standard operating procedures will also have to be considered and introduced, in line with the global reforms in WHO's emergency management systems and procedures.

170. Building on the achievements and lessons learned from the previous biennium, the work of category 5 programmes during 2016–2017 will focus on:

- strengthening preparedness in a wider context, by addressing numerous and diverse public health threats, especially those of cross-border and international concern, including not only communicable diseases, but also chemical and radionuclear, and natural threats and disasters (all-hazards and multisectoral approach);
- building on synergies between the capacity required to prepare for humanitarian and public health emergencies and the core capacity required for surveillance and response under the International Health Regulations (IHR) (2005);
- strengthening national capacities for outbreak response and pandemic preparedness, including prevention and control of influenza and other respiratory pathogens;
- building national capacity, supporting implementation of multisectoral national plans, and developing national networks for antimicrobial resistance surveillance;
- building national capacity in food safety and management of zoonotic risks at the animal–human interface; participating in work related to the Codex Alimentarius; and promoting collaboration between the agriculture, animal health, and human health sectors;
- ensuring implementation of the Polio Eradication and Endgame Strategic Plan 2013–2018 as it relates to the regional context, including cessation of trivalent oral polio vaccine and introduction of bivalent vaccine in selected Member States;
- developing comprehensive health emergency risk management policies and programmes with an all-hazards approach, and responding in an effective and timely manner to acute and protracted emergencies with public health consequences.

171. Human resources capacity for work in relation to category 5 in the European Region has been limited and often overwhelmed by the high number of public health events requiring substantial technical support to Member States and prolonged response in the Region and beyond. The increased budget allocation for category 5 (an increase of US$ 7.6 million or 55% over that of PB 2014–2015) will enhance the Regional Office’s ability to support Member States in line with the expected demands in this area of work.

172. The increased budget allocation will facilitate the regional implementation of actions called for in the Executive Board’s resolution on EVD (EBSS3.R1) and particularly the strengthening of preparedness and response capacities.

173. The budget increase will also allow for successful implementation of the European action plan on antibiotic resistance 2011–2016 (document EUR/RC61/14), endorsed by the Regional Committee in resolution EUR/RC61/R6 in 2011, which significantly raised awareness of antimicrobial resistance and has resulted in increased requests for support from Member States. Similarly, the newly developed global action plan on antimicrobial resistance (document A68/20), adopted by the World Health Assembly in resolution WHA68.7 in 2015, calls for accelerated efforts, which has been reflected in the costing of that resolution.

174. Additional pressure on the budget allocation for category 5 comes from the following commitments and respective resources expected to be received during the biennium:

- inclusion of Pandemic Influenza Preparedness (PIP) Framework funds (still under discussion);
- establishment of a new GDO for preparedness for humanitarian and health emergencies.

175. PB 2016–2017 for category 5 (Preparedness, surveillance and response) is set out in Table 9.

Table 9. PB 2016–2017 for category 5 (Preparedness, surveillance and response) by programme area (US$ millions)

	WHA-approved PB 2016–2017			Adjusted WHA PB 2016–2017			
Category and programme areas	**Country offices**	**Regional Office**	**Total**	**Country offices**	**Regional Office**	**Total**	**Difference approved/ adjusted**
5. Preparedness, surveillance and response							
Alert and response capacities	3.2	5.0	**8.2**	2.8	4.3	**7.1**	-13%
Epidemic- and pandemic-prone diseases	2.5	5.5	**8.0**	2.3	5.1	**7.4**	-8%
Emergency risk and crisis management	1.7	2.4	**4.1**	2.4	3.4	**5.8**	41%
Food safety	0.3	0.7	**1.0**	0.3	0.7	**1.0**	0%
Category 5 total	**7.7**	**13.6**	**21.3**	**7.8**	**13.5**	**21.3**	**0%**
Polio	1.4	6.0	**7.4**	1.4	6.0	7.4	0%
Outbreak and crisis response	0.7	2.3	**3.0**	0.7	2.3	**3.0**	0%

Source: Proposed programme budget 2016–2017 (World Health Assembly document A68/7).

5.1 Alert and response capacities

176. Following the EVD outbreak, the demand from Member States for technical assistance from WHO in this area will increase even further beyond the high current level. Implementing resolution EBSS3.R1 will require additional resources and renewed structures. Besides enhanced preparedness efforts and strengthening of IHR core capacities, many countries continue to find it challenging to apply the IHR in an operative manner on a day-to-day basis. Human resources capacity in the Regional Office has to be adjusted and increased in order to enable it to respond effectively to requests for support. Although funding has generally increased, it is still not available on a sustainable basis, posing challenges to human resources planning and long-term projects such as the Better Labs for Better Health initiative.

177. The European Union decision on serious cross-border health threats (decision No. 1082/2013/EU of the European Parliament and of the Council) adopted in 2013 is a unique opportunity to identify synergies and strengthen overall health security in parts of the European Region.

178. Event-based surveillance activities and the functions of the IHR Regional Contact Point will be continued, so that all public health events with potential international

implications can be detected and assessed. Rapid surge capacity to respond to public health events caused by any hazard will need to be further strengthened in the Region, in line with global efforts to improve surge capacity in terms of health emergency workforce and contingency funds, allowing for immediate mobilization of appropriate and sufficient response when and where needed. Many Member States in the Region require further support in improving their capacities for timely detection, assessment and response to all types of public health events.

179. In general, the EVD outbreak has created a momentum that will be used to incorporate health and preparedness into all national policy areas. In addition to overall strengthening of national IHR core capacities, special emphasis will be given to supporting Member States in addressing specific challenges, such as at ports, airports and ground crossings, in multisectoral coordination, and in risk communication. The overall rapid response capacities and mechanisms for well-coordinated mobilization of national and international responses need to be further strengthened. The European Region has extensive capacities in terms of Global Outbreak Alert and Response Network (GOARN) partners and foreign medical teams, which will be utilized in a rational and coordinated manner. This also includes laboratory services and networks for emerging pathogens. The Better Labs for Better Health initiative is the foundation on which this work will be conducted. Support will be provided to countries to develop national laboratory policies and strategic plans and to achieve accreditation of their national public health laboratories.

5.2 Epidemic-prone and pandemic-prone diseases

180. The Regional Office assists Member States in revising their pandemic plans, facilitates the exchange of best practices, develops guidance and provides support in outbreaks. The PIP Framework Partnership Contribution Implementation Plan 2013–2016 provides the opportunity to enhance regional and country activities, aiming at strengthening laboratory and surveillance capacities, and will continue during the biennium. The assessment of the risk and severity of influenza epidemics and pandemics, and coordination of the response at the regional level, in line with global activities, are major challenges, mainly related to intercountry work.

181. The European action plan on antibiotic resistance is fully in line with the new global action plan on antimicrobial resistance. There is an increased demand from Member States for technical support, as well as the need for closer coordination among technical programmes within WHO. As a consequence, WHO will need to substantially strengthen its capacity across the three levels of the Organization. The proposed antimicrobial resistance budget allocation, as a result of the costing of the World Health Assembly resolution, requires an increase in the budget envelope if all of the activities supporting requests from Member States' are to be implemented.

182. The Regional Office, in close collaboration with key partners, will continue its work to reduce influenza-related morbidity and mortality by: monitoring and strengthening virological and epidemiological surveillance for mild and severe influenza; using surveillance data to estimate the burden of influenza in order to prioritize national influenza vaccination programmes; and maintaining and strengthening pandemic preparedness activities at the national level.

183. Five countries will be targeted for intensive support under the PIP Framework. Outbreak investigation and response guidelines will be generic and will benefit other disease-control activities. In 2016–2017, PIP funds will also be used to target countries with more advanced surveillance systems in order to enhance the establishment of national and regional burden estimates that will benefit other countries as well as contributing to global estimates.

184. The Regional Office will continue to provide support to countries in developing national antimicrobial resistance action plans, and in defining the roles and responsibilities of all national stakeholders for the implementation of coordinated multisectoral activities. In addressing the cross-border nature of antimicrobial resistance and the threat to global health security, progress in all countries in the Region will be tracked and shared. Regional data reporting through the Central Asian and Eastern European Surveillance of Antimicrobial Resistance network will be expanded and data will be published periodically so that trends can be followed and the effect of interventions on antimicrobial resistance development can be monitored. In addition, a growing alliance of agencies, institutions and networks are joining the Regional Office in providing support to efforts to gather data on antibiotic use, improve antibiotic stewardship for the prudent use of antibiotics, promote infection prevention and control, and raise awareness of the problem in both the human and veterinary sectors in an integrated “one health” approach.

5.3 Emergency risk and crisis management

185. Member States in the Region are increasingly confronted by public health risks associated with natural disasters, conflicts and other humanitarian emergencies, often affecting millions of people. Recent events inside and outside the Region, including the EVD outbreak in West Africa, the humanitarian crisis in Ukraine, the spillover effects of the crisis in the Syrian Arab Republic that caused a large influx of refugees into Turkey, the crises in northern and central Africa that have led to an increasing flow of migrants and asylum seekers into the Region, and the frequent natural disasters – especially floods – in the Region, highlight the importance of the Regional Office’s work on preparedness and response for humanitarian emergencies, regardless of the underlying hazards. This work will be undertaken in close interdivisional collaboration, including with the Public Health Aspect of Migration in Europe project of the Division of Policy and Governance for Health and Well-being, linkages with health systems and the Essential Public Health Operations activities of the Division of Health Systems and Public Health.

186. More resources are needed for this programme area if the requests from Member States are to be met with regard to: increased support in developing comprehensive health emergency risk management policies and programmes with an all-hazards approach; enhancing prevention and preparedness efforts in high-risk countries; and providing essential surge capacity to assist Member States affected by emergencies or humanitarian crises.

187. The Regional Office’s work on preparedness will continue to focus on providing support to Member States following an all-hazards, multisectoral approach. The regional strategy to address the above-mentioned challenges includes the development of national preparedness plans and strengthening of national emergency and risk

management capacities. Other activities include assessing the capacity of countries' health systems for crisis management, evaluating the resilience of hospitals to disasters, mapping the geographic distribution of hazards, vulnerabilities and capacities, conducting capacity-building in public health and emergency management and supporting health systems planning for mass gatherings.

188. As part of the plan for regional implementation of the resolution adopted by the Executive Board on EVD, particularly in relation to the establishment of a more extensive global health emergency workforce, WHO readiness work will focus on establishing and maintaining adequate numbers of dedicated and trained WHO staff with an appropriate range of skills and experience in the management of emergency response activities (see also Section 5.6).

189. In order to strengthen institutional capacity in this area, WHO is establishing a GDO on humanitarian crises, the Europe Centre for Preparedness for Humanitarian and Health Emergencies, in Turkey. The GDO, which is expected to be operational by 2016, will increase the support provided to Member States in developing comprehensive health emergency risk management policies and programmes with an all-hazards approach, and will allow crucial prevention and preparedness efforts in high-risk countries to be enhanced. While the establishment of the GDO and the support that it will provide to Member States is necessary, consideration should be given to the fact that, in an unchanged budget envelope, it is not possible to include this new commitment without putting pressure on, and scaling down, other existing initiatives within the programme area or at the category level.

5.4 Food safety

190. The Regional Office sees an increasing interest and engagement, especially from the eastern part of the Region, in work related to the Codex Alimentarius, which can partly be attributed to active work undertaken by WHO and the Food and Agriculture Organization (FAO) of the United Nations. Participation of countries in Codex work is also encouraged and welcomed by the rest of the Region as it strengthens the European voice in Codex work. For several newly independent states and Balkan countries, continued financial support from the Codex Trust Fund is needed if they are to maintain efficient participation in Codex work. Ensuring the use of the Russian language in all relevant Codex meetings and the translation of all Codex texts into Russian are important if Russian-speaking countries are to be fully engaged.

191. Proper surveillance of foodborne and zoonotic diseases is crucial. Furthermore, there is a need for the monitoring of relevant hazards in the food chain, data from which should be linked to human data to provide a basis for risk assessment and risk management, and also for risk communication. WHO will continue to guide appropriate policy-making and support capacity-building in these areas. It is essential that the health sector be fully involved in regard to the establishment and maintenance of national food safety systems.

192. Intersectoral and interdisciplinary collaboration is crucial for prevention and control of foodborne diseases and for cost-efficient and successful interventions, but there are often obstacles in ensuring intersectoral cooperation and information sharing. Food safety is by its nature a health area that requires health-in-all-policies, whole-of-

government and whole-of-society approaches. The Regional Office will support Member States, with a special emphasis on the newly independent states and Balkan countries, in building mechanisms for intersectoral cooperation and information sharing in the area of foodborne and zoonotic diseases, in particular between the health and agriculture sectors where WHO can play an important role at the regional and national levels, and where there is already an effective collaboration with FAO. The World Health Day 2015 campaign was important in facilitating the understanding of food safety as a shared responsibility.

193. Promoting and supporting Codex work in the Region is a priority. The Regional Office will facilitate and support the involvement of Member States, particularly newly independent states and Balkan countries in Codex work, through capacity-building funded by the Codex Trust Fund. The Secretariat will continue to promote the use of the Russian language in all Codex work.

194. The establishment and strengthening of risk-based and holistic food safety systems with intersectoral collaboration and information sharing will be promoted through country work. The Regional Office will continue capacity-building work in the newly independent states and Balkan countries, with particular focus on surveillance of foodborne diseases and the importance of linking such data with data on the occurrence of food safety hazards in the food chain. Here again, the Regional Office will build on its effective collaboration with FAO, the World Organization for Animal Health, the European Food Safety Authority, the European Centre for Disease Prevention and Control, the European Medical Agency and the European Commission in regard to food safety and zoonotic issues, including antimicrobial resistance-related aspects.

5.5 Polio eradication

195. To ensure that the objectives of the global Polio Eradication and Endgame Strategic Plan 2013–2018 are met, the Regional Office will support Member States in completing the introduction of inactivated polio vaccine (IPV), with withdrawal of all stocks of trivalent oral polio vaccine (tOPV) and introduction of the bivalent vaccine, monitoring of vaccine uptake and vaccine management, surveillance of any safety issues, including risk management of the newly introduced products and concurrent use of bivalent vaccine with other vaccines, and following up on any issues faced by national immunization programmes.

196. All 11 countries in the European Region that have used an OPV-only schedule will have introduced IPV before 31 December 2015. This gives sufficient time to plan for the 21 countries with IPV/OPV sequential schedules to switch from tOPV to bivalent oral polio vaccine (bOPV; containing types 1 and 3 poliovirus) during a two-week period in April 2016.

197. Additional challenges include the following:

- Planned introduction of other vaccines during the same year may jeopardize successful introduction of IPV and dilute capacity-building and communication efforts. Technical assistance is being provided to the three countries thus affected in rationalizing planned activities and synergizing efforts.
- Having a low target population in some introducing countries makes multi-dose presentation of IPV unsuitable due to anticipated high wastage. Additional

training activities need to be planned with multi-dose vial policy, which recently has been recommended for IPV.

- Specific communication support needs to be provided to Member States in which adverse events following past immunization programmes have compromised trust in injectable vaccines.
- Low immunization coverage for polio in Ukraine poses the threat of an explosive outbreak in case of continued transmission following an importation.

198. In 2016–2017, the Regional Office will continue to support the work of the Regional Certification Commission for Poliomyelitus Eradication in estimating the risk of outbreaks after introduction of polioviruses and will use its oversight capacity to monitor and support national authorities in biocontainment or destruction of type-2 viruses at vaccine production, research, diagnostic or vaccine utilization level.

199. Additional activities will be initiated to prepare national polio certification committees for the biocontainment of remaining poliovirus types, an essential step towards global certification of polio eradication, but which is a substantial task. Long-established activities, such as support to Member States in maintaining highly sensitive surveillance for polio, annual accreditation of national and regional polio laboratories, provision of laboratory supplies and proficiency testing panels, monitoring of surveillance performance and polio outbreak simulation exercises, will continue.

200. These activities will be delivered in close collaboration with programme areas 1.5 and 4.3. Technical support will be given to licensing and post-marketing surveillance of new products containing inactivated poliovirus or bOPV.

5.6 Outbreak and crisis response

201. Member States in the European Region are increasingly confronted by public health risks associated with natural disasters, conflicts and other humanitarian emergencies, often affecting millions of people. In addition, in line with the ERF and the concept of “one WHO”, the Regional Office will increasingly be expected to contribute actively to rapid and high-quality responses to public health emergencies in other regions.

202. This response work will include mobilizing rapid response teams, able to fulfil WHO’s critical functions in public health and humanitarian emergencies, leading the health cluster, and implementing the ERF. This will ensure that the necessary support is provided to national health authorities and other key stakeholders, including health cluster partners, in the provision of health services appropriate to the needs of the affected population, aiming to minimize mortality and morbidity in line with the ERF.

Table 10. Global PB 2016–2017 results structure: Category 5. Preparedness, surveillance and response				Contribution of the European Region		
Results chain	Title	Global indicator: baseline	Global indicator: target	Regional indicator: baseline	Regional indicator: target	Indicator details
Outcome	**5.1. All obligations under the International Health Regulations (2005) met**					
Outcome indicator	**Number of countries meeting and sustaining International Health Regulations (2005) core capacities**	**80 (2013)**	**196 (2017)**	**0**	**53**	
Output	5.1.1. Implementation monitoring of the International Health Regulations (2005) at country level and training and advice for Member States in further developing and making use of core capacities required under the Regulations					
Output indicator	Number of countries supported that have met and sustained International Health Regulations (2005) core capacities within the biennium	63 (2015)	196 (2017)	0	53	Countries that received technical assistance through a country-specific or a subregional approach.
Output	5.1.2. Standing capacity to provide evidence-based and timely policy guidance, risk assessment, information management, response and communications for all acute public health emergencies of potential international concern					
Output indicator	Percentage of public health emergencies of international concern for which information is made available under the International Health Regulations (2005) to International Health Regulations national focal points within the first 48 hours of completing the risk assessment	80% (2015)	100% (2017)	80% (2015)	100% (2017)	The Regional Office will use the IHR Event Information Site to share information, thereby making information available to all 196 IHR national focal points globally, not just the 55 in the European Region.
Outcome	**5.2. Increased country capacity to build resilience and adequate preparedness for mounting a rapid, predictable and effective response to major epidemics and pandemics**					
Outcome indicator	**Percentage of countries with a national strategy in place covering resilience and preparedness for major epidemics and pandemics**	**40% (2011)**	**60% (2017)**	**0 countries**	**4 countries**	
Outcome indicator	**Number of countries with a national antimicrobial resistance action plan**	**34/194 (2013)**	**56/194 (2017)**	**21/53 (2013)**	**30/53 (2017)**	

Table 10. Global PB 2016–2017 results structure: Category 5. Preparedness, surveillance and response				Contribution of the European Region		
Results chain	Title	Global indicator: baseline	Global indicator: target	Regional indicator: baseline	Regional indicator: target	Indicator details
Output	5.2.1. Technical assistance to Member States to strengthen preparedness and response capacities for epidemic and pandemic threats, with a specific focus on implementing the Pandemic Influenza Preparedness Framework					
Output indicator	Number of countries registering a significant improvement in detecting and monitoring influenza outbreaks	26 (2015)	43 (2017)	0	5	
Output	5.2.2. Standing capacity to provide expert guidance and lead global networks and systems to anticipate, prevent and control epidemic and pandemic diseases					
Output indicator	Number of functioning global and regional expert networks available to contribute to global health security	16 (2015)	22 (2017)	2	4	The regional influenza network will be maintained and a regional emerging pathogens network established; networks will also include the European Mobile Laboratory project, and GOARN's European partners.
Output	5.2.3. Implementation oversight of the draft global action plan on antimicrobial resistance, including surveillance and development of national and regional plans					
Output indicator	Number of countries with a national surveillance system contributing data on global trends and to the burden of antimicrobial resistance	22 (2015)	29 (2017)	31 (2013)	39 (2017)	
Outcome	**5.3. Countries with the capacity to manage public health risks associated with emergencies**					
Outcome indicator	**Percentage of countries with minimum capacities to manage public health risks associated with emergencies**	**To be determined**	**80% (2019)**	**66%**	**90%**	
Output	5.3.1. Technical assistance to Member States for the development and maintenance of core capacities to manage risks to health associated with disasters and conflicts using an all-hazards approach					

Table 10. Global PB 2016–2017 results structure: Category 5. Preparedness, surveillance and response				Contribution of the European Region		
Results chain	Title	Global indicator: baseline	Global indicator: target	Regional indicator: baseline	Regional indicator: target	Indicator details
Output indicator	Number of target countries in which minimum performance standards are met for emergency and disaster risk management for health	52 (50%) (2015)	73 (70%) (2017)	14 (52%)	20 (74%)	
Output	5.3.2. Standing capacity to respond to natural disasters and conflict, and to lead networks and systems for effective humanitarian action					
Output indicator	Number of target countries in which minimum readiness requirements are met	37 (50%) (2015)	56 (75%) (2017)	8 (70%)	10 (85%)	
Output	5.3.3. Health-sector leadership and coordination for needs-based programme planning, monitoring and reporting in countries with protracted humanitarian emergencies, or those in recovery or transition					
Output indicator	Number of target countries with protracted humanitarian emergencies, or which are in recovery or transition, in which minimum performance standards are met	12 (50%) (2015)	17 (70%) (2017)	2 (66%)	3 (100%)	
Outcome	**5.4. All countries are adequately prepared to prevent and mitigate risks to food safety**					
Outcome indicator	**Number of countries that have adequate mechanisms in place for preventing or mitigating risks to food safety**	**97/194 (2015)**	**123/194 (2017)**	**28**	**35**	
Output	5.4.1. Technical assistance to enable Member States to control risk and reduce the burden of foodborne diseases					
Output indicator	Number of countries having a food safety system with an appropriate legal framework and enforcement structure	137/194 (2015)	149/194 (2017)	34	38	
Output	5.4.2. International standards and scientific advice, as well as a global information exchange platform, for effectively managing foodborne risks, in addition to the coordination needed to harness multisectoral collaboration					
Output indicator	Number of countries with mechanism for multisectoral collaboration on reducing foodborne public health risks	132/194 (2015)	152/194 (2017)	41	44	
Outcome	**5.5. No cases of paralysis due to wild or type-2 vaccine-related poliovirus globally**					

Table 10. Global PB 2016–2017 results structure: Category 5. Preparedness, surveillance and response				Contribution of the European Region		
Results chain	Title	Global indicator: baseline	Global indicator: target	Regional indicator: baseline	Regional indicator: target	Indicator details
Outcome indicator	**Number of countries reporting cases of paralysis due to any wild poliovirus or type-2 vaccine-related poliovirus in the preceding 12 months**	**8 (2012)**	**0 (2019)**	**Not applicable**	**Not applicable**	The European Region is already certified as polio-free.
Output	5.5.1. Technical assistance to enhance surveillance and raise population immunity to the threshold needed to stop polio transmission in affected and at-risk areas					
Output indicator	Number of polio-infected and high-risk countries supported to conduct polio vaccination campaigns and surveillance	83	83	3 (2015)	3 (2017)	There are 3 high-risk countries in the European Region; no country is polio-infected.
Output	5.5.2. Use of oral poliovirus vaccine type 2 stopped in all routine immunization programmes globally					
Output indicator	Number of countries in which use of oral poliovirus vaccine type 2 in routine immunization has been stopped	49 (2015)	156 (2016)	33 (2015)	20 (2017)	As of 2015, 33 out 53 countries use only IPV. By 2017 (if not earlier), the remaining 20 countries will have stopped using OPV type2.
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					
Output indicator	Containment phase of type 2 poliovirus fully implemented globally and verified by end of 2017	7 (2015)	7 (2017)	0 (2015)	1 (2017)	The containment phase of type 2 poliovirus in the European Region will be fully implemented by 2017.
Output	5.5.4. Polio legacy work plan finalized and under implementation globally					
Output indicator	Polio legacy work plan finalized and under implementation in all regions	0 (2015)	7 (2017)	0 (2015)	1 (2017)	European Region polio legacy work plan will be finalized and be under implementation by 2017
Outcome	**5.6. All countries adequately respond to threats and emergencies with public health consequences**					

Table 10. Global PB 2016–2017 results structure: Category 5. Preparedness, surveillance and response				Contribution of the European Region		
Results chain	Title	Global indicator: baseline	Global indicator: target	Regional indicator: baseline	Regional indicator: target	Indicator details
Outcome indicator	**Percentage of countries that demonstrated an adequate response to an emergency from any hazard with a coordinated initial assessment and a health sector response plan within five days of onset**	**Not available**	**100% (2017)**	N/A	**100% (2017)**	
Output	5.6.1. In acute/unforeseen emergencies and disasters with public health consequences, Emergency Response Framework implemented					
Output indicator	Percentage of emergencies from any hazard with public health consequences, including any emerging epidemic threats, where the Emergency Response Framework has been fully implemented	Not available	100% (2017)	100%	100% (2017)	
Output	5.6.2. In protracted emergencies, gap-filling, life-saving activities as “provider of last resort” implemented, and included in the health sector response plans and appeals					
Output indicator	Percentage of countries with protracted emergencies in which health targets are met and gap-filling, life-saving health service are provided	Not available	80% (2017)	100%	100% (2017)	
Output	5.6.3. In countries recovering from major emergencies and disasters, early recovery health activities implemented as defined in the health sector recovery plans and in appeals					
Output indicator	Percentage of countries recovering from acute or protracted emergencies in which minimum early recovery activities for the health sector are implemented	Not available	80% (2017)	100%	100%	

Category 6. Corporate services/enabling functions

Regional strategic considerations

203. Category 6 contains a mix of leadership, management and administrative functions. The nature of these functions is expected to be similar to the 2014–2015 biennium. However, the budget required will increase by 11% as a result of two main factors:

- an increase in country presence in the form of additional WHO representatives and a small number of administrative officers in non-European Union countries (in line with the recommendations of the Joint Inspection Unit); and
- strengthening management through the recruitment of key experts. The WHO country representatives fall under programme area 6.1, the administrative officers under 6.4 and senior management under 6.3.

204. PB 2016–2017 for category 6 (Corporate services/enabling functions) is set out in Table 11.

Table 11. PB 2016–2017 for category 6 (Corporate services/enabling functions) by programme area (US$ millions)

	WHA-approved PB 2016–2017			Adjusted WHA PB 2016–2017			
Category and programme areas	**Country offices**	**Regional Office**	**Total**	**Country offices**	**Regional Office**	**Total**	**Difference approved / adjusted**
6. Corporate services/enabling functions							
Leadership and governance	20.1	13	**33.1**	20.1	13.0	**33.1**	0%
Transparency, accountability, risk management	0.4	2.4	**2.8**	0.4	2.4	**2.8**	0%
Strategic planning, resource coordination, reporting	1.2	3.4	**4.6**	1.2	3.4	**4.6**	0%
Management and administration	7.1	9.3	**16.4**	7.1	9.3	**16.4**	0%
Strategic communications	0.9	2.1	**3.0**	0.9	2.1	**3.0**	0%
Category 6 total	**29.7**	**30.2**	**59.9**	**29.7**	**30.2**	**59.9**	**0%**

Source: Proposed programme budget 2016–2017 (World Health Assembly document A68/7).

6.1 Leadership and governance

205. This programme area has been a key part of governance reform in WHO. In 2016–2017, the Regional Office will focus on further strengthening WHO country offices in the Region. The aim is to increase the number of WHO representative positions (international posts) in at least four more country offices. Furthermore, the Regional Office aims to strengthen the core capacity of the country offices by reviewing the regional country roadmap, which has guided human resources planning in the regional country offices since the external evaluation of the work in countries that took place in 2010. The plan is also to open other key positions, such as administrative officer posts, in line with the new strengthened accountability framework, as well as general public health National Professional Officer posts, as a means of ensuring cross-divisional and general public health approaches to country work.

206. The Regional Office will continue to create closer and more regular interactions with its Member States through the national counterparts and national technical focal points. Visits by ministers of health and country delegations to the Regional Office have proved to be productive, and will continue as a means of ensuring a bottom-up approach to planning and delivery of country work. The development of biennial collaborative agreements and country cooperation strategies are the key instruments guiding the work of the Regional Office in countries.

207. The Regional Office will support the strategic subregional country networks, such as the South-eastern Europe Health Network, as a means of addressing the particular needs of subregions.

208. Governing body meetings, at both global and regional levels, are a high priority for the Regional Office. The strong involvement of the SCRC in the preparation of sessions of the Regional Committee has been crucial and will continue. Implementing WHO reform, including governance reform, is expected to continue to be an important part of the oversight function of the SCRC. The Regional Office provides support to its Member States in their preparations for both global and regional governing body sessions. This includes preparation of technical briefing documents, holding briefing meetings before the sessions, and organizing a yearly technical/financial consultation.

209. Since 2010, the Regional Office has put great effort into building and maintaining partnerships. In 2016–2017, the Regional Office will continue to foster its cooperation with partners such as the European Union and its institutions, the OECD, the Global Fund to Fight AIDS, Tuberculosis and Malaria, the GAVI Alliance, the World Bank and United Nations agencies. In addition, it will be important to find ways of increasing collaboration with regional entities.

210. Joint efforts with United Nations agencies through the United Nations Development Group Team (formerly known as Regional Directors' Team) and the Regional Coordination Mechanism will continue, particularly in regard to the post-2015 process, social determinants of health, NCDs and supporting efficient United Nations country teams. Many new United Nations Development Assistance Frameworks will start in 2016–2017; the inclusion of health priorities has already been ensured and WHO will support their proper implementation and follow up.

211. The main challenge will be to implement the framework for engagement with non-State actors pending approval by the World Health Assembly. This may include implementing the revised and new policies as regards working with the main categories of non-State actors – nongovernmental organizations, academia, the private sector and foundations – as well as the development and maintenance of tools to enable the transparent and efficient management of engagement with non-State actors in the European Region, at both regional and country levels.

6.2 Transparency, accountability and risk management

212. Building on a strong foundation and in the context of WHO reform, the Regional Office has made good progress in the area of transparency and accountability, and in 2016–2017 increased emphasis will be given to making further progress. This work is supported and informed by the high level of the satisfactory assessments given in past operational audits.

213. In 2016–2017, the key mechanisms for ensuring the transparency and accountability of the Regional Office to Member States include the present document, oversight reports to the SCRC, and performance reports on achievement of the objectives (financial and technical) set out herein. Individual donor reports also form an integral part of donor accountability. As the Regional Office continues to strengthen these mechanisms, it is hoped that they will translate into increased funding in alignment with the priorities set out in the regional plan.

214. To further strengthen WHO's global accountability and transparency, the 2006 WHO Accountability Framework has been revised. It operates in parallel with WHO's Risk Management Framework and its Internal Control Framework. The Regional Office is committed to continuing to function in an accountable and transparent manner, and one of the ways of doing so is through implementation of the Accountability Framework. In this regard, corporate risks have been identified at the regional and country levels, with the aim of finalizing the risk validation before the start of the new biennium, in cooperation with the Office of Compliance, Risk Management and Ethics at WHO headquarters.

215. The Regional Office will continue to follow up on implementation of the observations contained in audits (both internal and external) and apply the lessons learned through improvement of the current procedures, in order to continue to achieve positive assessments.

6.3 Strategic planning, resource coordination and reporting

216. This programme area has been a key part of the programmatic reform effort in WHO. In 2016–2017, the challenge will be to build on the solid foundations of the programme budget for 2016–2017 (bottom-up planning, costed outputs, realistic budgeting against expected funding) during the funding and implementation phases. The goal established in the financing dialogue is a "fully funded budget" in which funding lines up exactly with the priorities and budgets approved by Member States at the World Health Assembly; considerable progress has been made in this direction. A trend of increasingly flexible funding presents an opportunity to improve funding alignment. As noted above, increased accountability and more visibility/transparency of implementation of the programme budget globally and regionally will be crucial in supporting this trend.

217. The Regional Office mobilizes resources and cooperates with donors in line with the principles and objectives of the global coordinated resource mobilization policy. Procedures are in place to help Regional Office staff in the development of high-quality proposals and well-planned projects and agreements. Methods will be established to facilitate information sharing, compliance with timelines and reporting requirements.

218. The finance, compliance and procurement unit of the Regional Office will continue to ensure full integrity of accounting throughout the Region and timely recording of income, in keeping with International Public Sector Accounting Standards (IPSAS).

219. Preparation for the 2018–2019 biennium will begin, with the opportunity to build on the significant progress made during the 2016–2017 planning process.

220. The outcome and outputs, and especially the indicators, in this programme area focus on the alignment of funding with the programme budget ceilings. The Regional Office will aim to achieve these results by means of the following strategies:

- ensuring that the budget ceilings for the Region are realistic in terms of funding and implementation capacity across programme areas and budget centres;
- closely monitoring the funding gaps in all programme areas on a monthly basis, with follow-up in support of fundraising where gaps are identified;
- full participation in the coordinated global resource mobilization effort;
- close liaison with counterparts at WHO headquarters to ensure that they are informed in a timely manner about funding gaps (and also about potential "over-funding") and proactively seeking to fill such gaps;
- participation in the global process to allocate flexible resources where they are needed most, and ensuring that this is also done at the regional and country levels;
- using flexible funding strategically to support those programme areas in the Region that have difficulty in raising voluntary contribution funds but that are priorities for the Region.

221. The monitoring and reporting mechanisms of the Regional Office have evolved to a high level in the 2014–2015 biennium, providing intelligence to senior management on the programmatic and financial situation in the Region on which action may be taken. These mechanisms will continue to enable management to respond effectively to issues as they arise during 2016–2017.

6.4 Management and administration

222. This programme area covers the bulk of the administrative functions at regional and country levels that enable the technical work in the Region to be carried out. The overall priority for this programme area in 2016–2017 will continue to be delivery of administrative services, as efficiently and effectively as possible, in full compliance with WHO rules and regulations.

223. The Regional Office will aim to achieve the outcome and outputs at the regional level in 2016–2017 by the following strategies:

- Strengthening procurement, especially in view of the increased level of emergency operations seen recently in the European Region, namely, overspill from the crisis in the Syrian Arab Republic, the humanitarian crisis in Ukraine, and seasonal emergencies in the Balkans. The additional resources and continuous efforts to optimize the utilization of existing resources will create favourable conditions to achieve the planned outputs.
- Continuing to ensure the integrity of the imprest accounting, as well as mitigation of the risks related to financial and procurement transactions.
- Implementation of full alignment with IPSAS procedures in the area of fixed assets and inventories management.
- Undertaking human resources planning that will be instrumental in focusing organizational design and staffing needs so as to best meet the objectives of the regional plan for implementation of the programme budget.

- Maintaining the overall female/male ratio of staff and continuing to closely monitor selections for unrepresented and under-represented nationalities in order to improve geographical distribution.
- Actively participating in the voluntary mobility scheme and encouraging international staff in the Regional Office to express interest in positions across the Organization.
- Continuing to improve the recruitment process and carrying out targeted outreach to attract high-quality talent.
- Implementation of mechanisms for more effective staff performance management and accountability.
- Modernization, implementation and harmonization of global information technology solutions and increasing staff productivity.
- Strengthening information management, automation, business intelligence, and service delivery to country offices.
- Strengthening information and communications technology for work related to health emergencies.
- Striving to maintain a high level of compliance with United Nations Minimum Operating Security Standards, especially in emergency- and crisis-affected Member States with country presence.
- Streamlining and strengthening service delivery of conferences, infrastructure, security and printing to the Regional Office, country offices and other out-posted offices, with a view to optimizing the use of resources.
- Further strengthening the core capacity of country offices by opening administrative officer positions in several country offices in line with the new, strengthened accountability framework.

6.5 Strategic communication

224. In 2016–2017, strategic communications will demonstrate the work that the Regional Office does for and with Member States. In that respect, the implementation phase of Health 2020 creates opportunities to illustrate intersectoral work in the Region at both country and regional levels. The Regional Office will also ensure that information and messages are available and accessible. In alignment with the global communications strategy, stronger emphasis will be placed on web and social media, on internal communications and on training staff in the Regional Office and country offices to communicate better and use different communications channels. The new iLearn platform will create opportunities to deliver this training more effectively and to develop the knowledge base for all staff.

225. Communications staff in the Regional Office and country offices, like those in other regions, will continue to be trained in risk communication, and prepared for rapid global deployment in health crises and emergencies.

226. Another proposed change in the next biennium, pending adequate funding, is that the Regional Office plans to strengthen its support to Member States by enriching the country web sites with information about biennial collaborative agreements and their

implementation in the respective national languages. The work of governing bodies will be made more easily accessible through searchable online databases of resolutions and other documents.

227. Networks of national technical focal points for communications and of journalists are being strengthened. This is being ensured through establishment of clear terms of reference, regular meetings (by videoconference) and training courses, which will allow capacity across the Region to be increased and the impact of communications from the Organization to be strengthened.

228. Finally, the capacity of the Regional Office in internal communications is expected to grow through the development of an internal communications strategy, closely aligned to the global communications strategy. This will be accompanied by further improvements to the Intranet, which will play a leading role in keeping staff informed while providing a global platform for internal communications.

Table 12. Global PB 2016–2017 results structure: Category 6. Corporate services/enabling functions				Contribution of the European Region		
Results chain	Title	Global indicator: baseline	Global indicator: target	Regional indicator: baseline	Regional indicator: target	Indicator details
Outcome	**6.1. Greater coherence in global health, with WHO taking the lead in enabling the different actors to play an active and effective role in contributing to the health of all people**					
Outcome indicator	**Extent to which WHO leadership priorities are reflected in the resolutions and decisions of the governing bodies (World Health Assembly, Executive Board and regional committees) adopted during the biennium**	**Not applicable**	**At least 80%**	**Not applicable**	**90% (for Regional Committee sessions in 2016 and 2017)**	
Output	6.1.1. Effective WHO leadership and management in accordance with leadership priorities					
Output indicator	Up-to-date gender equality policy and plan, including gender mainstreaming and the equal representation of women, approved and being implemented	No (2015)	Yes (2017)	To be implemented and measured globally.		
Output	6.1.2. Effective engagement with other United Nations agencies and non-State actors in building a common health agenda that responds to Member States' priorities					
Output indicator	Number of non-State actors and partnerships for which information on their nature and WHO's engagement is available	100	1000	To be implemented and measured globally.		
Output	6.1.3. WHO governance strengthened with effective oversight of governing body sessions and efficient, aligned agendas					
Output indicator	Percentage of governing bodies' documentation that is provided within agreed timeline	60% (2015)	90% (2017)	85% submitted on time for the Regional Committee session in 2014	90% submitted on time for Regional Committee sessions in 2016 and 2017	
Output	6.1.4. Integration of WHO reform in the work of the Organization					
Output indicator	Percentage of reform outputs in the implementation phase	65% (2015)	100% (2017)	To be implemented and measured globally.		
Outcome	**6.2. WHO operates in an accountable and transparent manner and has well-functioning risk management and evaluation frameworks**					
Outcome indicator	**Percentage of operational audits issuing a "satisfactory" or "partially satisfactory" assessment**	**Not applicable**	**100% (2017)**	**Not applicable**	**100% in the Regional Office for 2016–2017**	For Regional Office audits only.

Table 12. Global PB 2016–2017 results structure: Category 6. Corporate services/enabling functions				Contribution of the European Region		
Results chain	Title	Global indicator: baseline	Global indicator: target	Regional indicator: baseline	Regional indicator: target	Indicator details
Output	6.2.1. Accountability ensured and corporate risk management strengthened at all levels of the Organization					
Output indicator	Proportion of corporate risks with response plans approved and implemented	0% (2015)	50% (2017)	0% in the Regional Office for 2014	50% in the Regional Office for 2016–2017	
Output	6.2.2. Organizational learning through implementation of evaluation policy and plans					
Output indicator	Proportion of recommendations in corporate evaluations implemented within the specific timeframe	Not applicable	At least 80%	Not applicable (no evaluations in EURO in 2014–2015)	100% for future evaluations	For EURO evaluations only
Output	6.2.3. Ethical behaviour, decent conduct and fairness promoted across the Organization					
Output indicator	Proportion of staff to have completed training in ethical behaviour during the biennium	Not applicable	To be provided by CRE	Not applicable	100% for applicable EURO staff	This is a new training course, not available in 2014–2015.
Output indicator	Proportion of eligible staff who have completed annual declaration of interests	100% (2015)	100% (2017)	100% of applicable EURO staff in 2015	100% of applicable EURO staff in 2017	
Outcome	**6.3. Financing and resource allocation aligned with priorities and health needs of Member States in a results-based management framework**					
Outcome indicator	**Proportion of programme budget funded at the beginning of the biennium**	**70% (2014)**	**75% (2016)**	**49% (February 2014 for PB 2014–2015)**	**55%**	European Region portion of the PB only.
Outcome indicator	Percentage of programme areas at least 75% funded at midpoint of biennium across all major offices	**20/28**	**26/28**	**36% (10/28)**	**57% (16/28)**	For the European Region only.
Output	6.3.1. Needs-driven priority-setting in place and resource allocation aligned to delivery of results					

Table 12. Global PB 2016–2017 results structure: Category 6. Corporate services/enabling functions				Contribution of the European Region		
Results chain	Title	Global indicator: baseline	Global indicator: target	Regional indicator: baseline	Regional indicator: target	Indicator details
Output indicator	Percentage of outputs (by programme area) fully achieved	To be determined from the value indicated in the performance assessment of PB 2014–2015	At least 80%	To be decided at the at end of 2015 (for PB 2014–2015)	100%	For the European Region only.
Output	6.3.2. Predictable, adequate and aligned financing in place that allows for full implementation of WHO's programme budget across all programme areas and major offices					
Output indicator	Percentage of funding proposals prepared through an Organization-wide system	0% (2015)	70% (2017)	To be implemented and measured globally.		
Outcome	**6.4. Effective and efficient management and administration consistently established across the Organization**					
Outcome indicator	**Level of performance of WHO management and administration**	**To be determined**	**Strong (2019)**	To be measured globally.		
Output	6.4.1. Sound financial practices managed through an adequate control framework					
Output indicator	Percentage of country offices compliant with imprest reconciliations	80% have "A" rating (2015)	100% have "A" rating (2017)	92% have "A" rating as at the end of 2014	100% (as of end of 2017)	
Output indicator	Number of audit findings of high significance associated with financial transactions processing and operations	44	33	0 in 2014, to be determined for 2015	Reduced by 50% in the Regional Office at the end of 2017	
Output	6.4.2. Effective and efficient human resources management and coordination in place					
Output indicator	Overall male/female ratio of staff	58:42 (2015)	55:45 (2017)	48.4% Male 51.6% Female (2014)	50:50	
Output indicator	Proportion of international staff changing duty station	15%	Double the number	8% (2014)	Double the number	For the European Region, moves counted in line with mobility policy.

Table 12. Global PB 2016–2017 results structure: Category 6. Corporate services/enabling functions				Contribution of the European Region		
Results chain	Title	Global indicator: baseline	Global indicator: target	Regional indicator: baseline	Regional indicator: target	Indicator details
Output indicator	Percentage of unrepresented and under-represented countries (List A) in Organization's staffing	38% (2015)	28%	3% of the 184 P staff (fixed term and continuing appointment) are from A countries (2014)	6%	
Output indicator	Percentage reduction in audit findings associated with human resources processing and operations during the biennium	Not applicable	25%	Not applicable	25% reduction	
Output	6.4.3. Efficient and effective computing infrastructure, corporate and health-related systems and applications					
Output indicator	Percentage of locations with essential information technology infrastructure and services aligned with agreed Organizational standards, including corporate and health systems applications	50% (2015)	80% (2017)	60%	80%	Continuing implementation of global/shared solutions.
Output	6.4.4. Provision of operational and logistics support, procurement, infrastructure maintenance and asset management, and of a secure environment for WHO staff and property					
Output indicator	Percentage of WHO offices at security level 3 worldwide that are compliant with United Nations Minimum Operating Security Standards	90% (2015)	100% (2017)	Not applicable (no phase 3 for Regional Office	100% for any new phase 3 offices	
Output indicator	Number of audit findings of high significance associated with procurement transactions processing and operations	8 (2015)	2 (2017)	1 in Regional Office in 2014, to be determined for 2015.	Reduced by 50% in Regional Office as at the end of 2017	
Outcome	**6.5. Improved public and stakeholders' understanding of the work of WHO**					
Outcome indicator	**Percentage of public and other stakeholder representatives evaluating WHO's performance as excellent or good**	**77% (2015)**	**88% (2017)**	To be measured globally.		
Output	6.5.1. Accurate and timely health information accessible through a platform for effective communication and related practices					

Table 12. Global PB 2016–2017 results structure: Category 6. Corporate services/enabling functions				Contribution of the European Region		
Results chain	Title	Global indicator: baseline	Global indicator: target	Regional indicator: baseline	Regional indicator: target	Indicator details
Output indicator	Proportion of public and other stakeholders who rate the timeliness and accessibility of WHO's public health information as "good" or "excellent"	66% (2015)	75% (2017)	To be measured globally.		
Output	6.5.2. Organizational capacity enhanced for timely and accurate provision of internal and external communications in accordance with WHO's programmatic priorities, including during disease outbreaks, public health emergencies and humanitarian crises					
Output indicator	Number of offices that have completed global communications strategy workshops (headquarters, regional and country offices)	12 (2015)	20 (2017)	10 (2015)	15 (2016–2017)	For the European Region, individual country offices, GDOs, field offices and the Regional Office are counted separately.

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Annex. Targets and indicators for Health 2020

Area/target	Quantification	Core indicators	Additional indicators
Area 1. Burden of disease and risk factors	1.1. A 1.5% relative annual reduction in overall (four causes combined) premature mortality from cardiovascular diseases, cancer, diabetes and chronic respiratory diseases until 2020	(1) 1.1.a. Age-standardized overall premature mortality rate (from 30 to under 70 years) for four major noncommunicable diseases (cardiovascular diseases (ICD-10a codes I00–I99), cancer (ICD-10 codes C00–C97), diabetes mellitus (ICD-10 codes E10–E14) and chronic respiratory diseases (ICD-10 codes J40–47)) disaggregated by sex; diseases of the digestive system (ICD-10 codes K00–K93) also suggested but to be reported separately	(1) 1.1.a. Standardized mortality rate from all causes, disaggregated by age, sex and cause of death
Target 1. Reduce premature mortality in Europe by 2020		(2) 1.1.b. Age-standardized prevalence of current (includes both daily and nondaily or occasional) tobacco use among people aged 18 years and over	(2) 1.1.b. Prevalence of weekly tobacco use among adolescents
		(3) 1.1.c. Total (recorded and unrecorded) per capita alcohol consumption among people aged 15 years and over within a calendar year (litres of pure alcohol), reporting recorded and unrecorded consumption separately, if possible	(3) 1.1.c. Heavy episodic drinking (60 g of pure alcohol or around 6 standard alcoholic drinks on at least one occasion weekly) among adolescents
		(4) 1.1.d. Age-standardized prevalence of overweight and obesity in people aged 18 years and over (defined as a body mass index (BMI) ≥25 kg/m² for overweight and ≥30 kg/m² for obesity), where possible disaggregated by age and sex, reporting measured and self-reported data separately	(4) 1.1.d. Prevalence of overweight and obesity among adolescents (defined as BMI-for-age value above +1 Z-score and +2 Z-score relative to the 2007 WHO growth reference median, respectively)
	1.2. Achieved and sustained elimination of selected vaccine preventable diseases (poliomyelitis [polio], measles and rubella) and prevention of congenital rubella syndrome	(5) 1.2.a. Percentage of children vaccinated against measles (1 dose by second birthday), polio (3 doses by first birthday) and rubella (1 dose by second birthday)	
	1.3. Reduction of mortality from external causes	(6) 1.3.a. Age-standardized mortality rates from all external causes and injuries, disaggregated by sex (ICD-10 codes V01–V99, W00–W99, X00–X99 and Y00–Y98)	(5) 1.3.a. Age-standardized mortality rates from motor vehicle traffic accidents (ICD-10 codes V02– V04, V09, V12–V14, V19–V79, V82–V87 and V89)
			(6) 1.3.b. Age-standardized mortality rates from accidental poisoning (ICD-10 codes X40–X49)
			(7) 1.3.c. Age-standardized mortality rates from alcohol poisoning (ICD-10 code X45)

Area/target	Quantification	Core indicators	Additional indicators
			(8) 1.3.d. Age-standardized mortality rates from suicides (ICD-10 codes X60–X84)
			(9) 1.3.e. Age-standardized mortality rates from accidental falls (ICD-10 codes W00–W19)
			(10) 1.3.f. Age-standardized mortality rates from homicides and assaults (ICD-10 codes X85–Y09)
Area 2. Healthy people, well-being and determinants	2.1. Continued increase in life expectancy at current rate (the annual rate during 2006–2010), coupled with reducing differences in life expectancy in the European Region	(7) 2.1. Life expectancy at birth, disaggregated by sex	(11) 2.1.a. Life expectancy at ages 1, 15, 45 and 65 years, disaggregated by sex
Target 2. Increase life expectancy in Europe			(12) 2.1.b. Healthy life years at age 65, disaggregated by sex
Area 2. Healthy people, well-being and determinants	3.1. Reduction in the gaps in health status associated with social determinants within the European population	(8) 3.1.a. Infant mortality per 1000 live births, disaggregated by sex	
Target 3. Reduce inequities in Europe (social determinants target)		(7) 3.1b. Life expectancy at birth, disaggregated by sex	
		(9) 3.1.c. Proportion of children of official primary school age not enrolled, disaggregated by sex	
		(10) 3.1.d. Unemployment rate, disaggregated by age and sex	
		(11) 3.1.e. National and/or subnational policy addressing the reduction of health inequities established and documented	
		(12) 3.1.f. GINI coefficient (income distribution)	
Area 2. Healthy people, well-being and determinants		(13) 4.1.a. Life satisfaction, disaggregated by age and sex	4.1.a. Indicators of subjective well-being, either in different domains or by eudaimonia or by affect; to be developed
Target 4. Enhance the well-being of the European population		(14) 4.1.b. Availability of social support	(13) 4.1.b. Percentage of people aged 65 years and over living alone

Area/target	Quantification	Core indicators	Additional indicators
		(15) 4.1.c. Percentage of population with improved sanitation facilities	(14) 4.1.c. Household final consumption expenditure per capita
		(12) 4.1.d. GINI coefficient (income distribution)	(15) 4.1.d. Educational attainment of people aged 25 years and over who have completed at least secondary education
		(10) 4.1.e. Unemployment rate, disaggregated by age and sex	
		(9) 4.1.f. Proportion of children of official primary school age not enrolled, disaggregated by sex	
Area 3. Processes, governance and health systems **Target 5. Universal coverage and the "right to health"**	5.1. Moving towards universal coverage (according to the WHO definition) by 2020	(16) 5.1.a. Private household out-of-pocket expenditure as a proportion of total health expenditure	(16) 5.1.a. Maternal deaths per 100 000 live births (ICD-10 codes O00–O99)
		(5) 5.1.b. Percentage of children vaccinated against measles (1 dose by second birthday), polio (3 doses by first birthday) and rubella (1 dose by second birthday)	(17) 5.1.b. Percentage of people treated successfully among laboratory confirmed pulmonary tuberculosis (TB) cases who completed treatment
		(17) 5.1.c. Total expenditure on health (as a percentage of gross domestic product (GDP))	(18) 5.1.c. Government (public) expenditure on health as a percentage of GDP
Area 3. Processes, governance and health systems **Target 6. National targets/goals set by Member States**	6.1. Establishment of processes for the purpose of setting national targets (if not already in place)	(18) 6.1.a. Establishment of process for target-setting documented (mode of documenting to be decided by individual Member States)	
		(19) 6.1.b. Evidence documenting: (a) establishment of national policies aligned with Health 2020; (b) implementation plan; (c) accountability mechanism (mode of "documentation" to be decided by individual Member States)	

Source: Targets and indicators for Health 2020. Version 2. Copenhagen; WHO Regional Office for Europe: 2014.

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