World Health Organization

SEVENTIETH WORLD HEALTH ASSEMBLY **A70/INF./3**
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WHO presence in countries, territories and areas: 2017 report

1. The Sixty-ninth World Health Assembly in decision WHA69(8) requested the Director-General and the regional directors to provide the biennial report on WHO country presence[1] for review by the regional committees, and as an information document for the Health Assembly, through the Executive Board and its Programme, Budget and Administration Committee. This report, prepared pursuant to that request, provides information for Member States, as well as for a range of partners, including organizations of the United Nations system and staff members across the Organization.

2. This report to the Health Assembly is divided into four sections: (i) who we are as an organization; (ii) what we do to support countries, territories and areas; (iii) how we do our work at country level; and (iv) with whom we work. The full 2017 country presence report[2] contains a fifth section, which provides information on key achievements at country level. Further details are provided in a separate report on country performance.[3]

3. For the first time, the 2017 report provides trend analyses, where possible, using data from previous reports. It also highlights WHO's role in providing guidance and leadership at country level for implementation of the health-related Sustainable Development Goals.

4. The information contained in this report was obtained: through an online survey administered to the heads of WHO offices in countries, territories and areas in 2016; from the Global Management System (information on human resources and finance) and a Secretariat database on heads of WHO offices in countries, territories and areas; and external sources of data on engagement in global health initiatives.

[1] WHO country presence is the platform for effective collaboration with countries for advancing the global health agenda, contributing to national strategies, and bringing country realities and perspectives into global policies and priorities. This refers to the work of the Secretariat as a whole (WHO medium-term strategic plan 2008–2013).

[2] The full report is available on request and electronically at http://who.int/country-cooperation/publications/.

[3] Document A70/50 Add.2.

MAIN FINDINGS OF THE 2017 COUNTRY PRESENCE REPORT

Who we are: the Organization, its people and infrastructure in countries, territories and areas

5. WHO currently has 148 offices in countries, territories and areas,[1] six regional offices and the headquarters in Geneva to support its 194 Member States and two Associate Member States (Puerto Rico and Tokelau). Of those 148 offices, 146 are in countries and two are in territories and areas (namely the WHO Office in Priština and the WHO Office in West Bank and Gaza Strip). Thirty seven Member States, Associate Member States and areas do not have a WHO office; technical and normative support in this regard is provided by the respective regional offices and headquarters. Remaining Member States are supported by WHO offices in neighbouring countries or by respective regional offices and headquarters.

6. WHO's physical presence at the subnational level is mainly directed at either supporting work in very large or highly decentralized countries with specific needs, as well as in countries in fragile situations and facing humanitarian crisis, or supporting poliomyelitis eradication activities. There are 139 WHO sub-offices across 28 countries in six regions: 78 in the African Region, nine in the Region of the Americas, nine in the South-East Asia Region, five in the European Region, 36 in the Eastern Mediterranean Region, and two in the Western Pacific Region. Since 2014, the number of sub-offices has decreased from 152 to 139; sub-offices were closed in the Region of the Americas (8), the European Region (4) and Western Pacific Region (5) whereas in the Eastern Mediterranean Region the number of sub-offices increased from 32 in 2014 to 36 in 2016, because of the complex emergencies in some countries.

7. The heads of WHO offices are managers responsible for WHO offices in countries, territories and areas. As at February 2017, there were 129 full-time and 19 acting heads in countries, territories and areas. The increasing percentage of acting heads (from 12% recorded in the 2015 report[2] to 15% in the 2017 report) reflects a shortcoming in timely recruitment and weak succession planning. Although WHO is committed to mainstreaming gender equality within its workforce, since 2012 the overall male/female ratio of heads of WHO offices has remained more or less the same (2:1). The most marked discrepancy is in the South-East Asia Region where that ratio is 9:1, followed by the Western Pacific Region (3.7:1), the African Region (3.4:1), the Eastern Mediterranean Region (3.3:1) and the Region of Americas (1.4:1). In the European Region there are more female than male heads of WHO offices (1.6:1).

8. In 2015, in order to ensure rotation and mobility, the Director-General in consultation with the Director-General's Global Policy Group, decided that at least 30% of heads of WHO offices should come from outside their region of origin. Over the years, in increasing numbers, heads of WHO offices are being appointed from a region different than that of their origin; between the issuing of the 2010 and 2017 country presence reports, the proportion of heads of WHO offices working outside their region of origin rose by 7% (from 18% to 25%). In the Eastern Mediterranean Region, 62% of heads of WHO offices are from the other regions, followed by the South-East Asia Region (60%), the

[1] In the 2017 country presence report, the Office of Caribbean Program Coordination has been excluded from the list of WHO country offices as it serves as a subregional office and not a country office.

[2] WHO presence in countries, territories and areas: 2015 report. Geneva: World Health Organization; 2015 (http://www.who.int/country-cooperation/publications/who-presence-report-2015/en/, accessed 18 April 2017).

Western Pacific Region (57%), the Region of the Americas (27%) and the African Region (8%). In the European Region, no head of a WHO office is from another region.

9. WHO country offices' workforces vary with the size, complexity and priorities of the country office. As at 31 December 2016, WHO had a total of 4009 staff at country level (11% more than at the same date in 2015). Of this total workforce 19% were international professional officers, 28% national professional officers and 53% general service staff. Between the 2010 and 2017 reports, there has been an 8% increase in the number of international professional officers and a reduction of 3% in national professional and general staff at country level.

10. Some WHO offices often hire non-staff contractors to support the implementation of specific time-limited projects and activities such as polio eradication and emergencies. As at 31 December 2016, altogether 4631 non-staff contractors were hired by WHO offices in countries, territories and areas: 44% working in the African Region, 34% in the South-East Asia Region, 8% in the Eastern Mediterranean Region, 6% in Region of the Americas, and 4% each in the European and Western Pacific regions. The number of non-staff contractors at country level decreased by 14% compared to 2015 owing to the transition from polio eradication activities in several countries.

What we do: provision of support to countries, territories and areas

11. WHO country staff members provide crucial support to health ministries in developing, implementing and monitoring national health policies, strategies and plans. A total of 105 (71%) countries, territories and areas in which WHO has a physical presence reported having an up-to-date national health policy, strategy or plan; for the 2015 report, 91% of countries, territories and areas had reported the availability of such a policy, strategy or plan. The lower percentage for the present report is because many countries are in the process of updating their national health policies, strategies or plans in order to mainstream the Sustainable Development Goals.

12. The country cooperation strategy is a medium-term strategic vision to guide WHO's work in a country, territory or area, in support of its health policies, strategies or plans, and to strengthen bottom-up planning processes. A total of 109 of the 148 countries, territories or areas in which WHO is physically present[1] reported the existence of, or undertaking work on, country cooperation strategies. Of these 109, 63 reported having a valid country cooperation strategy. The number of countries, territories or areas with valid country cooperation strategies has declined by 15% compared with the figure in the 2015 country presence report because of the ongoing process in many countries of renewing their strategies so that they are aligned with the Sustainable Development Goals. In 46 countries, territories or areas, country cooperation strategies were reported to be under development or being finalized.

13. To enhance implementation, monitoring and reporting of WHO's technical cooperation, an increasing proportion of WHO offices in countries, territories and areas is using a joint WHO/government mechanism (83% in the period covered by the 2017 report compared to 77% in the 2015 report). WHO country offices are also enhancing collaboration with non-health ministries to promote multisectoral approach to health: reported by 75% offices. One factor contributing to enhanced collaboration with other sectors is the increasing demand for work towards the Sustainable

[1] The Regional Office for Europe uses an alternative tool (biennial collaborative agreements) instead of country cooperation strategies as a basis to guide WHO's work in countries.

Development Goals. Key areas of collaboration include funding, missions, joint committees for intersectoral work, and joint implementation of activities.

14. The 2030 Agenda for Sustainable Development presents a major opportunity to place health in all sectors of policy-making. Sixty countries, territories or areas (41%) with a WHO office reported that the health-related Sustainable Development Goals were reflected in their health policies, strategies or plans by October 2016. Some 43% reported the in-progress status of inclusion of Sustainable Development Goals in policies, strategies or plans, whereas 13% reported not having initiated the process.

15. As the Sustainable Development Goals are owned and led by national governments, WHO's action in this area is driven by its country offices, with regional and global coordination. By the end of 2016, among the 60 countries that have incorporated the Goals into their national policies, strategies or plans, the main thrust of the Secretariat's support has been in the provision of leadership, advocacy and technical advice to enhance multisectoral collaborations, strengthen health information systems with contextualization of indicators, and mobilize domestic resources.

How we do our work at country level

16. To provide effective support, WHO country teams received reinforcement from staff in regional offices and headquarters, contributing to enhanced national capacity and strengthening country teams. Almost two thirds (64%) of backstopping missions in 2015–2016 were staffed from regional offices, 27% from headquarters and 9% jointly with regional and headquarters teams. Most of these missions were initiated by the country offices (70% of the regional staff missions and 44% of the visits by headquarters).

17. The purpose of most backstopping missions to country offices was to provide support for implementation of work in the following Programme budget categories: communicable diseases (33%), health systems (including universal health coverage) (20%), noncommunicable diseases (16%), health emergencies (14%), promoting health through the life course (13%), and other areas (4%).

18. In addition to technical cooperation, WHO provides financial support as a catalyst for normative work and, in case of emergencies, technical support and operations. As at 31 December 2016, the total funds available to support WHO's work in countries, territories and areas were US$ 2 064 561 131, which represents 84% of the total planned costs for the biennium 2016–2017, an 11% increase compared to 2014–2015. Of the total funding for WHO country-level work 16% came from assessed contributions and 84% from voluntary contributions. Over the past three bienniums, the distribution between assessed contributions and voluntary contributions has remained reasonably consistent.

19. Of the total funds made available as at end-2016, base programmes received 41% whereas polio, outbreak and crisis response and special programmes (combined) received 59% of funds. From the total base programme funds (US$ 847 510 952), WHO country offices in the African Region received 46% of these funds followed by 54% distributed among country offices in the other five regions. Higher funding for the African Region is consistent with previous biennium, and reflects the Organization's commitment to tackle the higher burden of disease and the challenge of fragile health systems.

20. Whereas in the case of polio, outbreak and crisis response and special programmes (US$ 1 217 050 179) country offices in the African Region received 45% and those in the Eastern Mediterranean Region 44%, the offices in the other four regions received 11% of these funds. The

significant amount of funding allocated to the African and Eastern Mediterranean regions is due to the fact that they include three countries in which poliomyelitis is endemic[1] and 11 priority countries facing grade 2 and 3 emergencies.[2] These funds were instrumental in providing support to countries in which polio is endemic for eradication of the disease as evident by the reduction in the number of cases due to wild polio virus in only three countries from 213 in 2013 to 10 as at February 2017.

With whom we work: partnerships at country level

21. WHO offices in countries, territories and areas play a key role in supporting governments to coordinate partners in the health sector. Of the 113 (76%) WHO offices that reported taking part in these coordinating mechanisms, 60 (53%) chaired or co-chaired them and the others (53) mentioned participation in such activities. The number of countries, territories and areas in which WHO has a leadership role in health sector coordination has slightly increased (by 5%) since the 2015 country presence report, suggesting a growing role of the Organization in coordinating health development partners at country level.

22. In line with the principles of global partnership for development cooperation effectiveness, WHO country teams play an active role in joint annual health sector reviews to monitor the effective implementation of national health policies, strategies and plans. During the survey coverage period, 84 joint annual health sector reviews, including those in IHP+ countries, with governments and partners were reported in countries, territories and areas in which WHO teams participated. This figure reflects an increase of 7% compared to the 2015 country presence report.

23. One of most crucial roles of WHO in countries, territories and areas is to provide support in mobilizing resources to implement their health policies, strategies or plans. A total of 117 (79%) WHO offices in countries, territories and areas reported being involved in resource mobilization processes for health, mainly through the development of funding proposals. Most of the mobilized funds were for communicable diseases (including HIV, tuberculosis, malaria and vaccination), health emergencies, and strengthening of health systems. However, among countries that reported mobilizing resources, 83% raised less than US$ 500 000 and only 17% more than US$ 1 million. These figures indicate that greater investment in the WHO country offices is needed in order to strengthen in-country capacities to mobilize more resources, taking into account that most funds from major donors have been decentralized to country level.

24. Recognizing the major role of financing from the Global Fund to Fight AIDS, Tuberculosis and Malaria in the prevention and control of diseases and strengthening health systems, WHO country offices work closely with governments and partners to access, implement and report on this funding. In the case of 43 grants, WHO country offices act as sub-recipients. WHO representation in the Global Fund's Country Coordinating Mechanism was reported in 84 countries, territories and areas. In 11 of these, WHO co-chaired this coordinating mechanism.

25. WHO is a key partner in The GAVI Alliance. WHO country teams reported contributing to the application for and delivery and implementation of the Alliance's grants in 73 (49%) countries, territories and areas. This engagement has decreased by 9% compared to that reported in the 2015

[1] Afghanistan, Nigeria and Pakistan.

[2] Cameroon, Central African Republic, Democratic Republic of the Congo, Ethiopia, Iraq, Libya, Niger, Nigeria, South Sudan, Syrian Arab Republic, and Yemen.

report because of a reduction in the number of countries eligible for support from the Alliance and/or countries phasing out its support. WHO staff members supported health ministries and partners in developing proposals, implementing grants, reporting and monitoring, or participating in interagency coordination committees.

26. WHO's engagement with the United Nations as part of United Nations Country Teams is becoming more important, especially in the context of the Sustainable Development Goals. WHO is actively engaged in (a) the activities of the United Nations Resident Coordinator system, (b) the interagency thematic groups and (c) the United Nations Development Assistance Framework process. Increasingly, WHO offices are participating in Country Team activities; examples include heads of WHO offices acting as the United Nations Resident Coordinator (64% of offices), participation in at least one of the common United Nations services (70%), and joint resource mobilization (51%).

27. WHO office staff members in countries, territories and areas increasingly contribute to interagency thematic groups in order to promote coordination among organizations in the United Nations system at country level (67% in the 2015 report to 92% in the 2017 report). In 98 countries, territories or areas WHO provides leadership by chairing or co-chairing health thematic groups. WHO teams led health clusters in 20 out of the 23 countries in which a health cluster was activated, a pattern consistent with that in the 2015 report. Other than health, WHO teams reported participation in thematic groups on gender, human rights, nutrition, monitoring and evaluation, water and sanitation, and implementation of the Sustainable Development Goals.

28. The United Nations Development Assistance Framework provides strategic support for the collective response of the United Nations system to development priorities in countries. It exists in 126 countries, territories and areas where WHO has an office. In 125 of these (98%, an increase of 7% compared to the figure in the 2015 report), where the health component is part of the Framework, WHO country teams played a leadership role in the development of this component. In 54 countries, WHO was reported to be part of the United Nations' Delivering as One initiative. Out of 31 countries for which an Integrated Strategic Framework exists, WHO country offices have participated in the developing and implementation process in 28 countries. Similar statistics were reported in the 2015 report.

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