

Least Developed Countries Health and WHO Country Presence Profile

Background

The Least Developed Countries (LDCs) are a UN classified set of 48 countries with the lowest socioeconomic development indicators of the international community. The identification of LDCs is based on indicators within three categories: income, human assets, and economic vulnerability, further details of these are in table 1.

A country is eligible to graduate from being a LDC if it meets threshold levels for at least two of the criteria, or its gross national income (GNI) per capita must exceed at least twice the threshold level with the likelihood of sustainability being deemed as high, at two successive triennial reviews held by the Committee for Development Policy. As of May 2016, 48 countries are classified as LDCs, including nine island states and 17 landlocked countries. One country (Angola) was recommended for graduation from LDC status at the 2015 review and six others meeting eligibility criteria for the first or second time with their graduation to be considered during the 2018 triennial review.

Table 1: Criteria for identification of LDCs

1. Income criterion
The average GNI per capita over three years must be below US \$1035 for inclusion as LDC and over US \$1242 to graduate from the list
2. Human assets index
Based on indicators of: (a) nutrition: percentage of population undernourished; (b) health: mortality rate for children aged five years or under; (c) education: the gross secondary school enrolment ratio; and (d) adult literacy rate.
3. Economic vulnerability index
Based on indicators of: (a) population size; (b) remoteness; (c) merchandise export concentration; (d) share of agriculture, forestry and fisheries; (e) share of population in low elevated coastal zones; (f) instability of exports of goods and services; (g) victims of natural disasters; and (h) instability of agricultural production

Economics

The average gross domestic product (GDP) per capita in LDCs in 2015 was US \$979, less than 10% of the global average¹. LDCs accounted for 36 of the 44 countries ranked as having low human development according to the human development index (HDI) in 2015, with an average HDI of 0.48². Average adult (15 years+) literacy rates in LDCs were 69.7% and 54.8% for males and females respectively in 2015³. Literacy is highest in Equatorial Guinea for both males and females (over 90%), and lowest in Niger where 27% of males and 11% of females aged over 15 are literate. With the exception of Lesotho where literacy is 18% higher for females than males, all other LDCs exhibit higher literacy rates in adult males. This is most apparent in Yemen where the

discrepancy is 30% in favour of males, while 14 other countries have gender gaps of over 20%.

The average total health expenditure in LDCs as a percentage of GDP was 4.75% in 2014, lower than both the global average (9.94%) and that of low-income countries (5.75%). However, health expenditure in Tuvalu, Malawi, Sierra Leone, Lesotho, Djibouti, Kiribati, and Liberia was over 10% of GDP⁴.

Population

The median population size in LDCs is 11 394 293, over a third less than the mean of 19 878 287. While it is specified that LDCs must have a population of less than 75 million, Bangladesh's population, which met this

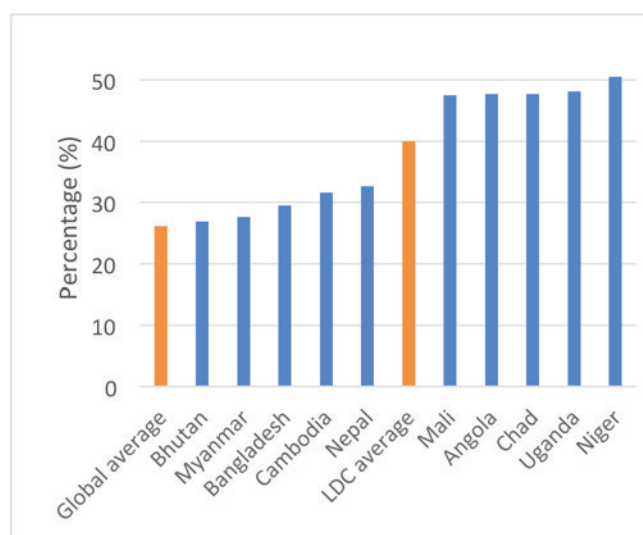
¹ World Bank 2015

² UNDP 2015

³ UNESCO data 2015

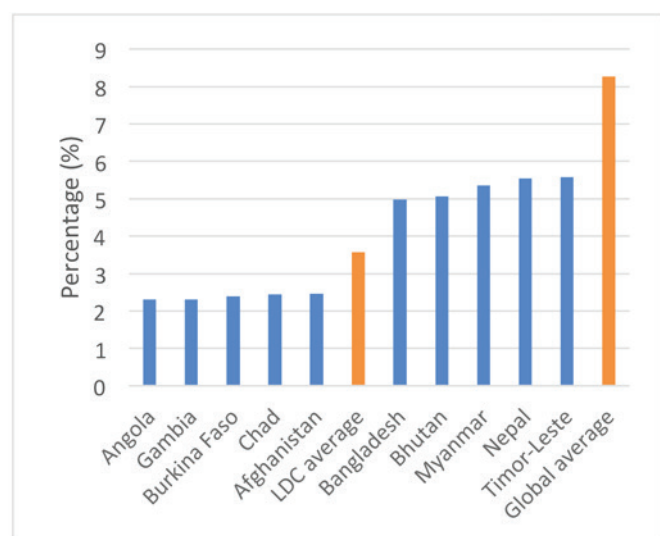
⁴ WHO Global Health Observatory Data Repository 2014

Figure 1: The proportion of populations aged under 15 years⁵



criterion upon its inclusion in 1975, has now increased to over 160 million. Bangladesh, along with Ethiopia and the Democratic Republic of the Congo (DRC), have exceeded the limit to a lesser extent, therefore distorting the average of the LDC block. The age-related population demographics are typical of developing countries with a greater proportion of the population under the age of 15 and fewer over the age of 65 than seen globally, as seen in figures 1 and 2⁵. Ten of the ten countries with the highest proportion of the population under 15 years are LDCs. Geographically, it can be seen that the five LDCs with the lowest proportion of under 15 year olds are all Asian countries, in contrary to the five African nations with the largest proportions. In terms of the population aged over 65, the average proportion in LDCs is less than half of that seen globally.

Figure 2: The proportion of populations aged over 65 years⁵

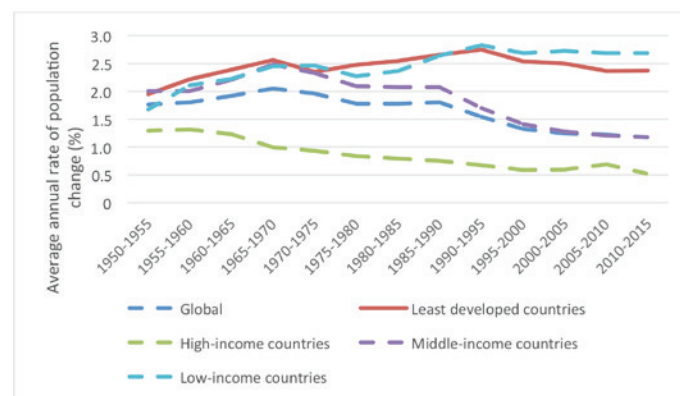


⁶ WHO Global Health Observatory Data Repository 2015. Data from 47 LDCs

⁵ UNPD 2015. Data from 47 SIDS.

Average population growth in LDCs between 2010 and 2015 was double that of global growth (2.4% and 1.2% respectively)¹. As can be seen in figure 3, population growth is falling in high and middle income countries, but remains high in low income countries and the LDCs. Wide fluctuations have been seen in LDCs at particular points in history, such as -4.11% between 1990-1995 in Rwanda and -4% between 1970-1975 in Equatorial Guinea due to genocide, and below -2% in Afghanistan, Timor-Leste, and Cambodia during periods of conflict.

Figure 3: Population change from 1950-2015

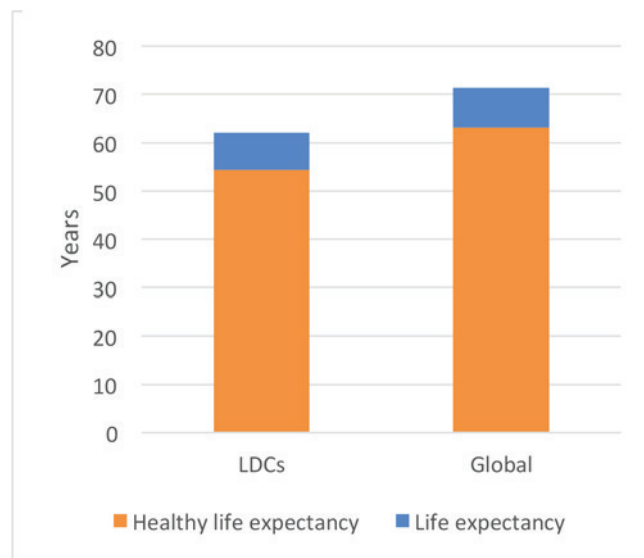


Health

Life expectancy

Life expectancy in LDCs has been increasing gradually since 1950, and stood at 62.1 years in 2015, almost a decade less than the global average of 71.4, as seen in figure 4⁶. Bangladesh and Vanuatu have life expectancies of over 70, while Lesotho, Chad, Central African Republic,

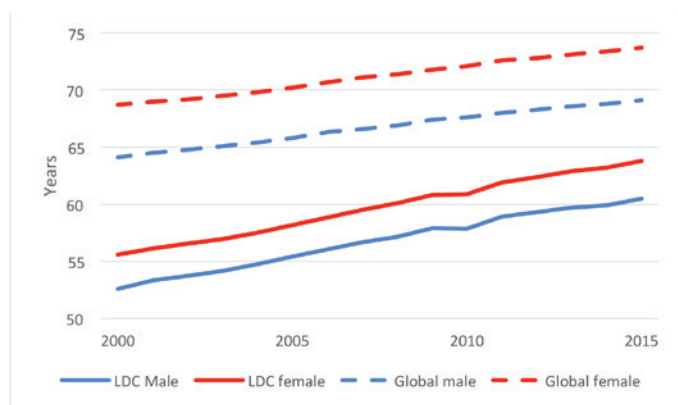
Figure 4: Average life expectancy and healthy life expectancy in LDCs and globally



Angola, and Sierra Leone have overall life expectancies of under 55 years. Healthy life expectancy in LDCs is around 87% of life expectancy, similar to global levels.

As seen in figure 5, life expectancy for males and females has been gradually increasing since 2000, with a plateau observed during 2010 due to the loss of life which occurred as a result of the Haitian earthquake in January of that year. Life expectancy for males in Haiti halved in 2010, and was cut by over a third for females, before returning to the previous level in 2011. Despite increases, and a lower gender disparity in life expectancy is evident than generally seen globally. Life expectancy for males and females in LDCs still lags around ten years below average global levels.

Figure 5: Male and female life expectancy in LDCs and globally



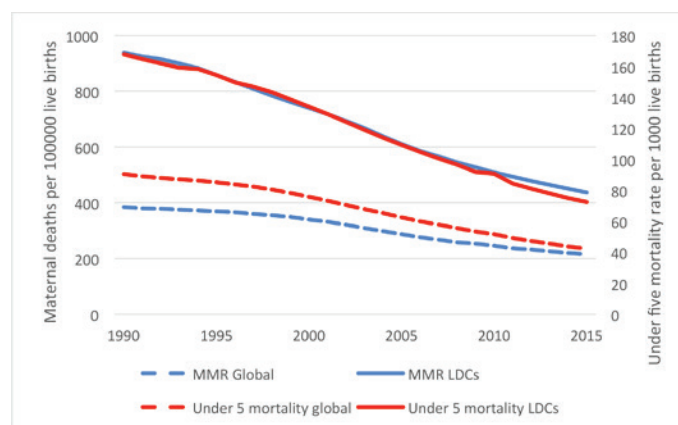
Under five and maternal mortality

Maternal mortality rates (MMR)⁷ and under five mortality⁸ have been steadily decreasing over past decades, as can be seen in figure 6, although both remain around double that of global average. Of the 20 countries with the highest MMR globally, 15 are LDCs, though the rate has decreased at a quicker pace in LDCs than globally. While Sierra Leone's MMR has decreased from 2630 in 1990 to 1360 in 2015, it is still far greater than the next highest – the Central African Republic (882). LDCs account for 17 of the 20 countries with the highest under five mortality rates, though these have more than halved since 1990 in part due to successful public health campaigns, such as childhood immunisation.

Health service coverage

Coverage of the measles, hepatitis B, and diphtheria

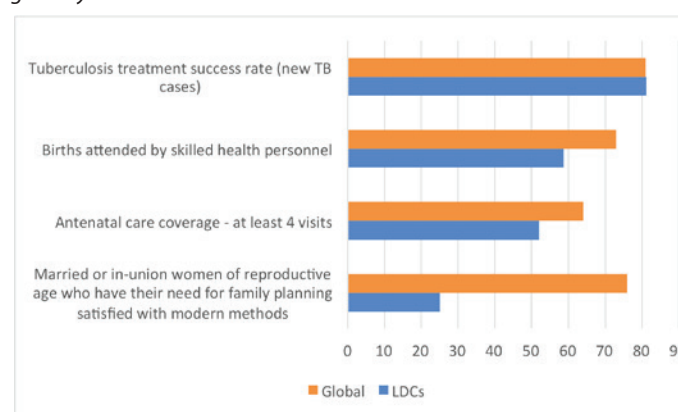
Figure 6: Maternal and under five mortality rates in LDCs and globally



tetanus toxoid and pertussis vaccinations are lower in LDCs than globally (by 10%, 6%, and 8% respectively). The percentage of births attended by skilled health personnel⁹ and women receiving at least four antenatal visits¹⁰ is lower than LDCs than globally by around 14% and 12% respectively, as seen in figure 7, and varies widely across LDCs. Over 90% of births are attended by skilled health personnel in Tuvalu, São Tomé and Príncipe, and Rwanda, while attendance is less than 50% in 19 LDCs, with South Sudan and Ethiopia under 20%.

Bhutan, São Tomé and Príncipe, and Comoros have the highest prevalence of antenatal care visits (4+) at over 80%, with 19 LDCs again having 50% or below. The prevalence of both these indicators is under 50% in the LDCs of Afghanistan, Yemen, Bangladesh, Laos, Niger, Somalia, Chad, South Sudan, and Ethiopia.

Figure 7: Prevalence of health service coverage indicators in LDCs and globally



⁷ World Bank data 2015. Data from 48 LDCs.

⁸ World Bank data 2015. Data from 47 LDCs.

⁹ UNICEF data 2016. Data from 48 LDCs, latest available year 2006-2015

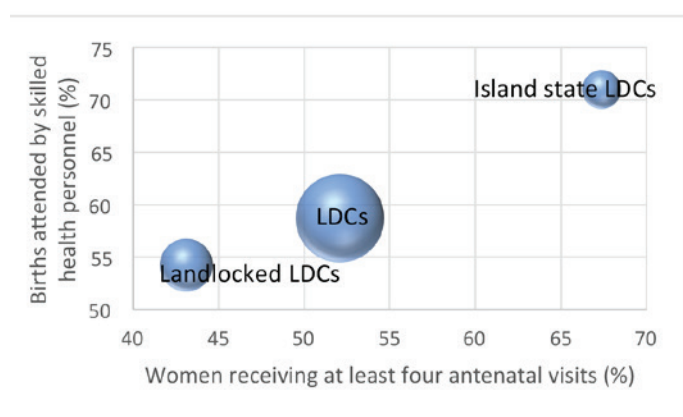
¹⁰ UNICEF data 2016. Data from 47 LDCs

Access to modern methods of contraception among married or in-union women of reproductive age is substantially lower in LDCs than globally¹¹. The lowest prevalence is seen in South Sudan at 1.7%, while seven other countries are also below 10%.

The success rate of treating new tuberculous cases compares favourably to global standards, with 26 LDCs having a success rate of over 85%¹².

The geographical discrepancy between landlocked and island countries, compared with LDCs overall is shown in figure 8. Maternal services are seen to be more prevalent in island states, which tend to be wealthier than LDCs on average, and a stark difference can be seen when comparing island and landlocked states.

Figure 8: Maternity service coverage in landlocked LDCs, island state LDCs, and LDCs overall



Risk factors for non-communicable disease

Although trends of global trends of ageing populations are not evident in LDCs to extent seen in countries which are more advanced in their epidemiological transition, LDCs are not immune from non-communicable diseases (NCD) or the prevalence of their risk factors.

The prevalence of various risk factors for NCD are shown in figures 9 to 12. A downward gradient with decreasing economic status can be observed for the

prevalence of raised blood glucose¹³, obesity¹⁴, and the smoking of tobacco¹⁵. However, the prevalence of raised blood pressure¹⁶ was not seen to follow this trend, and was highest for those in low income LDCs with Niger, Chad, Mali, Somali, and lower-middle income country Mauritania in the ten countries with the highest raised blood pressure for both males and females. A systematic analysis of population-based studies from 90 countries published in 2016 found a higher prevalence of hypertension in low and middle income countries (LMIC) than high-income countries (HIC), and also indicated

Figure 9: Prevalence of raised blood glucose (%)¹³

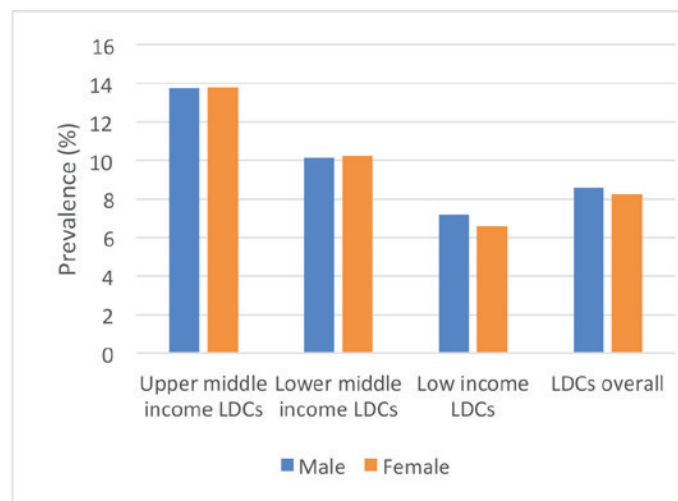
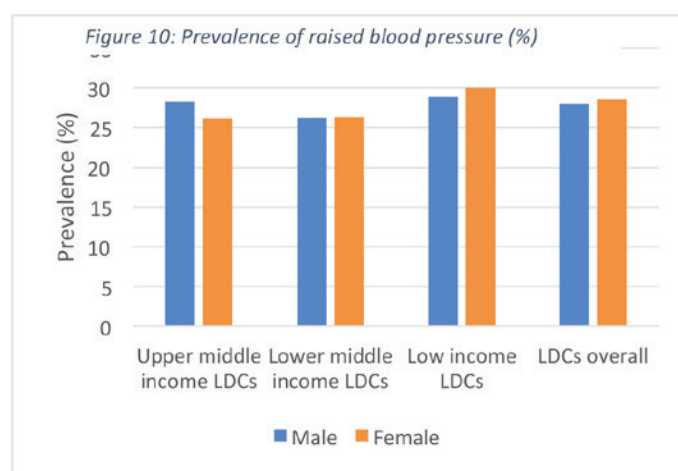


Figure 10: Prevalence of raised blood pressure (%)



¹¹ United Nations, Department of Economic and Social Affairs, Population Division (2016). World Contraceptive Use 2016. Data from 47 LDCs from latest available year 2006-2015

¹² WHO Global Health Observatory Data Repository. Data from 48 LDCs latest available year 2013-2014. latest available year 2006-2016.

¹³ WHO Global Health Observatory Data Repository 2014. The prevalence of raised fasting blood glucose (≥ 7.0 mmol/L or on medication, age-standardized estimate) in LDCs by World Bank income classification. Data from 46 LDCs

¹⁴ WHO Global Health Observatory Data Repository 2014. Prevalence of obesity (BMI ≥ 30) (age-standardized estimate) in LDCs by World Bank income classification. Data from 46 LDCs.

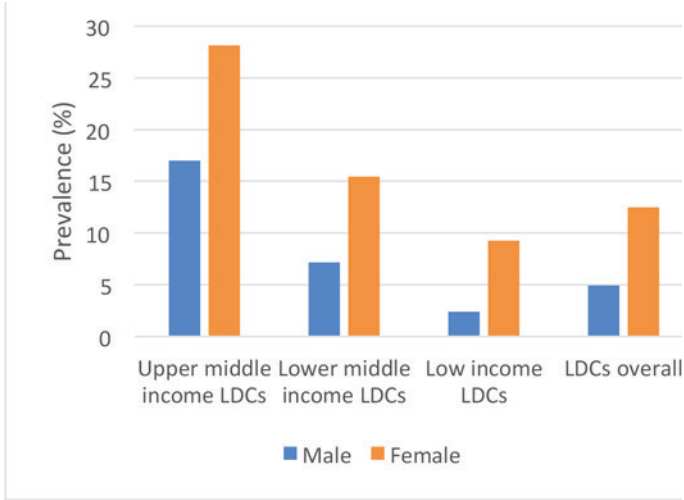
¹⁵ WHO Global Health Observatory Data Repository 2013. Prevalence of tobacco use (current smoking of any tobacco product age-standardized rate) in LDCs by World Bank income classification. Data from 24 LDCs

¹⁶ WHO Global Health Observatory Data Repository 2015. The prevalence of raised blood pressure (SBP ≥ 140 OR DBP ≥ 90) (age-standardized estimate) in LDCs by World Bank income classification. Data from 46 LDCs

that awareness, treatment, and control were much lower in LMIC than HIC¹⁷. The changing lifestyles associated with economic development, and phenomena such as urbanization, are contributing to unhealthier diets and the subsequent onset of obesity and raised blood glucose, a precursor for type 2 diabetes mellitus. The Western Pacific island states of Tuvalu, Kiribati, Vanuatu, and the Solomon Islands have the highest prevalence of raised blood glucose for both males and females in LDCs, while Sub-Saharan countries dominate the lower placed countries. These four island states also represent four of the five countries with the highest prevalence of obesity in both males and females among LDCs, reflecting geographical differences in lifestyle. While questions remain over the role of genetics in the onset of obesity, South Asians have been identified as genetically predisposed to development of diabetes mellitus type 2, and also tend to have a higher percentage of body fat than other individuals of the same body mass index. Seven of the eight countries with the lowest level of obesity in females are Asian, six of which are in South East Asia (Myanmar, Nepal, Bangladesh, Laos, Cambodia, Timor-Leste, and Afghanistan).

Marked gender disparities in obesity and tobacco consumption in LDCs are in line with what is observed globally in LMIC. Smoking prevalence of above 50% in males is seen in Kiribati, Lao DPR, Sierra Leone, and Lesotho, while the only countries where female smoking prevalence is above 10% are Lao DPR, Sierra Leone, Nepal, and Kiribati, though 42.2% of females in Kiribati smoke tobacco.

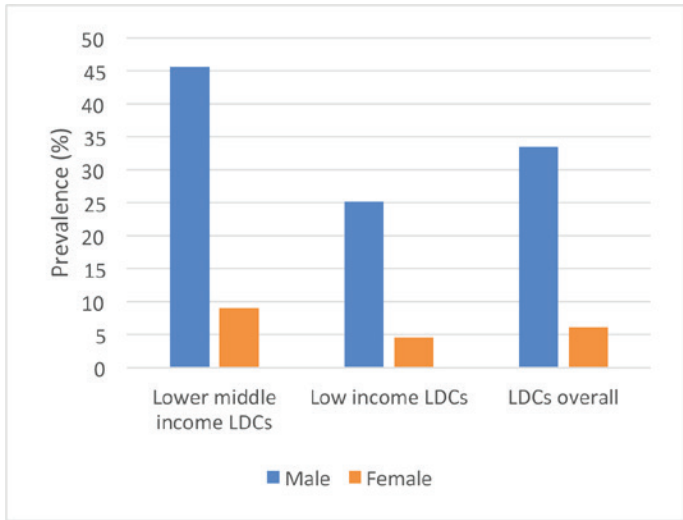
Figure 11: Prevalence of obesity (%)



¹⁷ Mills, K.T., Bundy, J.D., Kelly, T.N., Reed, J.E., Kearney, P.M., Reynolds, K., Chen, J. and He, J., 2016. Global Disparities of Hypertension Prevalence and Control Clinical Perspective. *Circulation*, 134(6), pp.441-450.

¹⁸WHO 2015

Figure 12: Prevalence of tobacco consumption (%)



Causes of death and disability

An estimated 47% of deaths in LDCs overall are caused by communicable, maternal, perinatal, and nutritional conditions, compared to 22% globally, as seen in figure 13¹⁸. This figure is 53% for low income LDCs and 38% for middle income LDCs, reflecting the tendency of low income countries to have a high communicable disease burden, as the epidemiological transition is not as advanced. The proportion of deaths caused through injury is largely consistent across LDCs, with countries affected by conflict showing higher rates, e.g. Afghanistan (18%) and Yemen (14%). A higher than average proportion of 15% is also seen in Rwanda. As seen in table 2, maternal, neonatal, nutritional causes and communicable disease representing the three highest causes of DALYs across LDCs in 2015, the combined total higher than the sum of the six other non-injury related causes.

Figure 13: Percentage of deaths by cause (%)

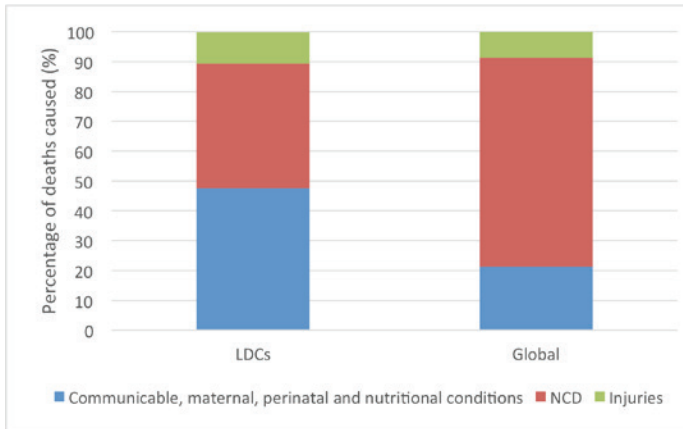


Table 2: Top 10 causes of DALYs in LDCs

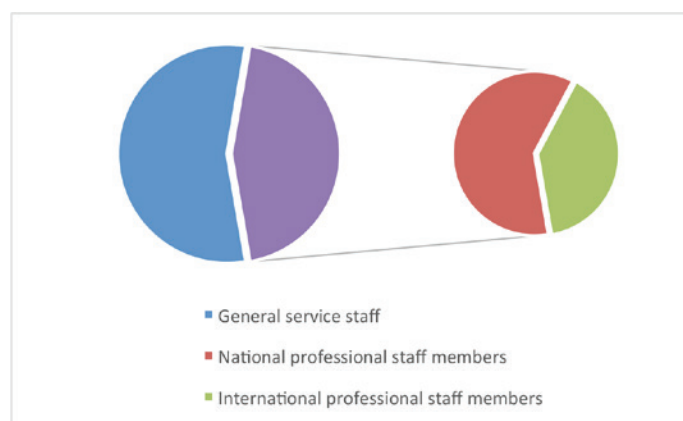
Cause of DALYs	Number of DALYs caused in 2015
Maternal, neonatal, nutritional	98 230
HIV, TB and malaria	55 569
Lower respiratory infections	46 084
Unintentional injuries	45 547
Other NCDs ¹⁹	43 591
Cardiovascular diseases	38 557
Diarrhoeal diseases	32 025
Malignant neoplasms	19 868
Mental and substance use disorders	18 220
Digestive diseases	13 290

WHO Presence in LDCs

Finance and staffing

WHO country offices are present in all LDCs, with the exception of Tuvalu which is represented under the South Pacific office. In total these offices employ 2005 staff personnel and 1970 non-staff personnel²⁰. Staff personnel in LDCs account for 50% of the total global staff workforce in WHO country offices. As seen in figure 14, 44% of country office personnel are professional staff members, of which 61% are national professionals and 39% are international. Four countries have staff numbers higher than 100 (Guinea, DRC, Sierra Leone, and Ethiopia), and the proportion of professional staff in these offices ranges from 17% in Guinea to 54% in Ethiopia. South Sudan has the highest proportion of professional staff (80% of its 50-strong workforce), just over half of these (57%) being international staff. The

Figure 14: Staffing breakdown in LDC country offices



three countries at the centre of the 2014-2015 Ebola epidemic (Guinea, Liberia, and Sierra Leone) are among the seven LDCs with the greatest staffing level. Sierra Leone has a higher proportion of professional staff than the other two (51% compared to 17%), although the proportion of national professionals is far lower (13% compared to 47% in Liberia, and 61% in Guinea). Professionals in LDCs represent 47% of the WHO professional workforce in country offices globally.

The 2016-2017 planned costs for these offices was US \$ 1 107 100 288, and a total of US \$943 009 749 of funds were distributed as of 31st December 2016. Distributed funds in LDCs account for 46% of total distributed funds globally. Of the available funds, 84% are specified voluntary contributions and 16% are flexible funds, as shown in figure 15. Flexible funds mostly consisted of assessed contributions (87%), with lesser proportions of programme support costs (12%) and core voluntary contributions (<1%).

Figure 15: Breakdown of available funds for LDCs

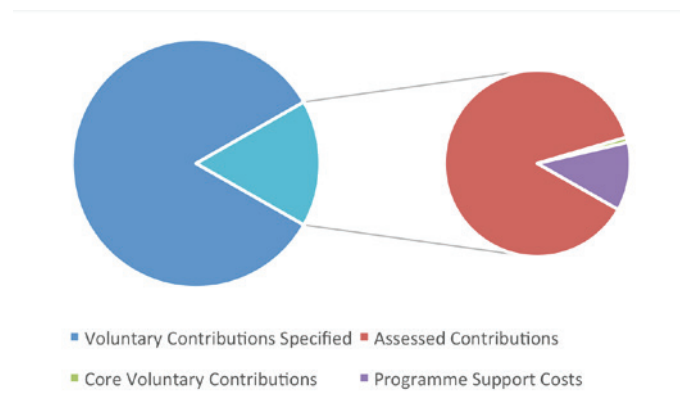


Table 3 shows the LDCs with the highest and lowest levels of WHO funds available. The five countries receiving the most funds all experienced conflict or humanitarian crisis between January 2015 and 31st October 2016, and received funds between 2.7 and 5 times the LDC average. Almost 60% of Afghanistan's funds are devoted to the ongoing polio eradication effort, while three quarters of funds in Yemen are assigned for outbreak and crisis response, as the country faces conflict and humanitarian crisis. Guinea, Liberia, and Sierra Leone, receive a combined total of US \$ 135 058 739, 45% of which were outbreak and crisis response (OCR) funds, 14% are WHO's Health Emergencies Programme, and 13% are for health systems.

¹⁹ Includes non-malignant neoplasms, endocrine, blood and immune disorders, sense organ disorders, digestive disease, genitourinary diseases, skin diseases, oral conditions and congenital anomalies

²⁰ Non staff personnel data missing for country offices of Djibouti, Kiribati, Somalia, and Sudan

Table 3: WHO funds available in LDCs

Country	Funds available (US\$)
Total	943 009 749
Afghanistan	99 915 735
Yemen	81 565 668
DRC	62 180 994
Ethiopia	53 991 638
South Sudan	53 902 917
LDC average	19 646 036
Comoros	2 385 404
Lesotho	2 108 167
São Tomé and Príncipe	1 647 192
Kiribati	1 053 631
Tuvalu	128 621

Thirty two percent of available funds are assigned for polio eradication across 23 LDCs, with the highest proportion of this going to Afghanistan (20%), followed by the DRC (13%). The next highest funding category is for outbreak and crisis response, which accounts for 22.5% of available funds, with 35 LDCs receiving a proportion. Table 5 shows the five countries which receive the highest share of OCR funds, including Guinea and Liberia which were heavily affected by the Ebola epidemic in 2014-2015. Communicable disease receives 13.4% of available funds, over half of which is for vaccine preventable diseases, and 38% for HIV, TB, and malaria combined.

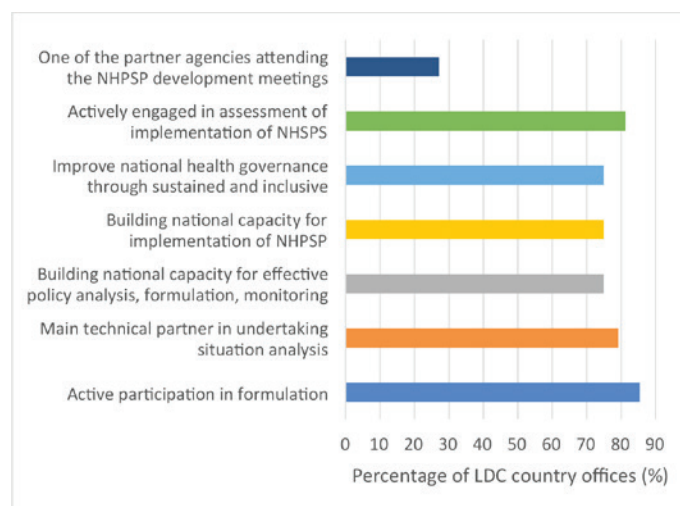
Table 4: The proportion of total OCR funds received by LDCs

Country	Share of outbreak and crisis response funds (%)
Yemen	29
Guinea	14
Liberia	12
Afghanistan	10
Sudan	8

Government policies, strategies, and plans²¹

An up-to-date National Health Policy, Strategy and Plan (NHPSP) is present in 31 countries, and is currently under development in 14, Yemen which does not have, and is not developing an up-to-date NHPSP. In all countries with, or developing, a NHPSP, WHO was involved in some aspect. The roles played by WHO in the initiation, development, implementation, and monitoring of the NHPSP are detailed in figure 16.

Figure 16: WHO role in the initiation, development, implementation and monitoring stages of NHPSPs in LDCs (%)

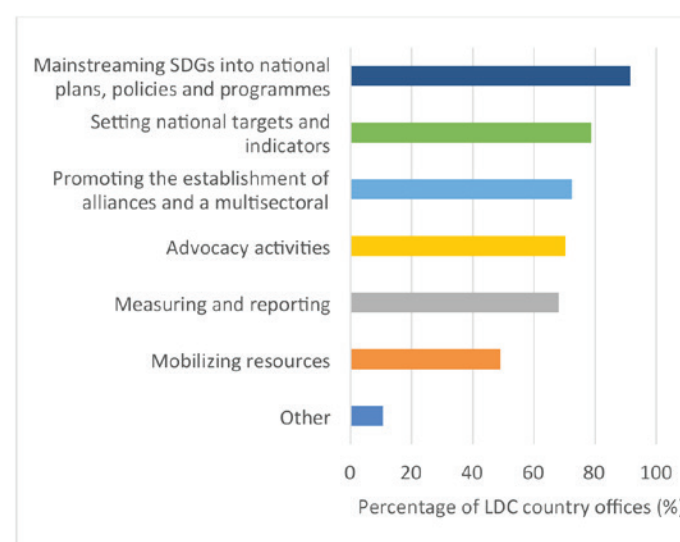


Of the 42 countries which have ever developed a Country Cooperation Strategy (CCS), there is an up-to-date and valid CCS in 23. The countries of Chad, Kiribati, Mali, Myanmar, and Togo are currently developing a CCS.

Sustainable Development Goals

Country offices in 46 LDCs have been supporting with the implementation of the Sustainable Development Goals (SDGs), with figure 17 detailing the activities they were engaged in. Twenty seven country offices have been involved in five or six of the highlighted activities. Additional activities have also been carried out such as developing a SDG policy brief in Rwanda, building capacity on new indicators and issues in Bhutan, working

Figure 17: The percentage of country offices engaging in highlighted activities to support countries with the implementation of the SDGs (%)

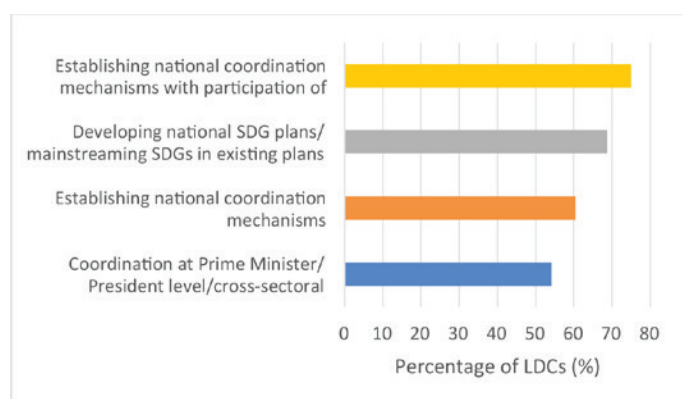


²¹ Due to incomplete data, Haiti is excluded from the country office presence survey results

with other UN agencies in Cambodia, formulating situational analysis in Djibouti, and sharing successful stories from other countries and regions in Sudan.

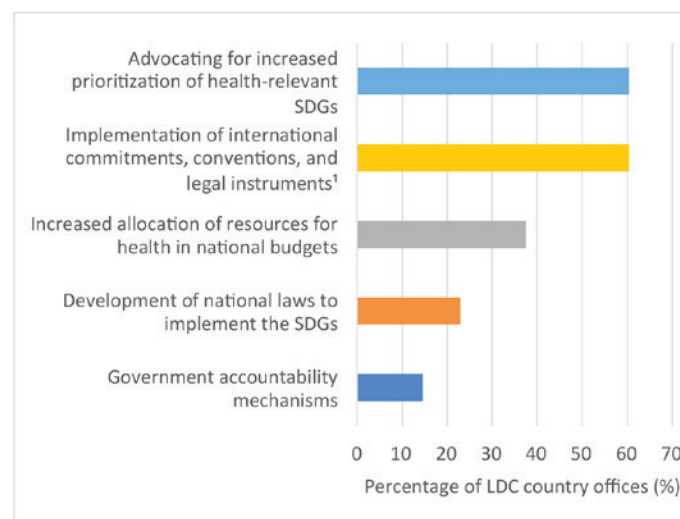
Figure 18 below shows how the governments of LDCs are approaching the implementation of the Sustainable Development Goals (SDGs). Of the 45 countries where the relevant discussions have begun, over 70% are involved in either establishing national coordination mechanisms with participation of other partners or developing national SDG plans or integrating SDGs into existing plans. Governments in eighteen LDCs are reported to be involved in all four highlighted activities. The discussion on implementing SDGs has not started in South Sudan or Yemen. The SDGs are integrated in the NHPSP's of 25 LDCs, with the process of integration ongoing in 87. Seventeen LDCs have integrated SDGs into either their CCSs or workplans/BCA between WHO and the government, with 25 in the process of integration. Only Yemen had integration neither occurred or was in progress for its NHPSP or and CCS.

Figure 18: The percentage of LDC governments which are engaging in the highlighted activities in approaching the implementation of SDGs



All country offices, are involving in leading processes or mechanisms for increased multi-stakeholder engagement and advocating for health-relevant SDGs. Twenty eight of the country offices are engaged in at least two of the following: helping set up national multi-stakeholder consultations on SDGs, conducting stakeholder analysis of key partners, and briefing partners about SDGs and links between MDGs and SDGs. The latter was the most widespread activity with 73% of country offices engaging. Figure 19 details the percentage of country offices which are working with Parliament towards attainment of health specific SDGs. The country offices in Cambodia, Mauritania, and Tanzania participate in all five highlighted areas. Fifteen LDC country offices are not working in Parliament for the attainment of health specific SDGs.

Figure 19: The percentage of LDC country offices working with Parliament towards attainment of health-related SDGs through selected activities

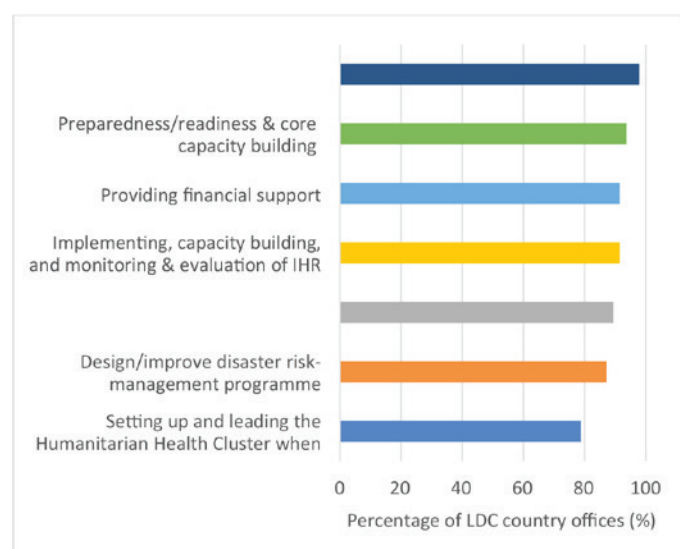


Emergency preparedness

Forty four LDCs experienced a health emergency of outbreak between January 2015 and the 31st of October 2016. This was due to natural disasters in 26 countries, conflict or humanitarian crisis in 16 countries and disease outbreaks or epidemics in 40 countries. Eleven countries experienced all three of these (Afghanistan, Burundi, DRC, Mali, Myanmar, Niger, Somalia, South Sudan, Sudan, Tanzania, and Yemen).

Country offices provided support to the MoH for emergency preparedness and response between January 2015 and 31st October 2016 in 47 LDCs. Figure 20 shows the different types of support provided, with the provision of logistical support and supplies, equipment and/or commodities almost universal at 98% of LDCs.

Figure 20: Support provided to MoH by country offices for emergency preparedness and response



Backstopping missions

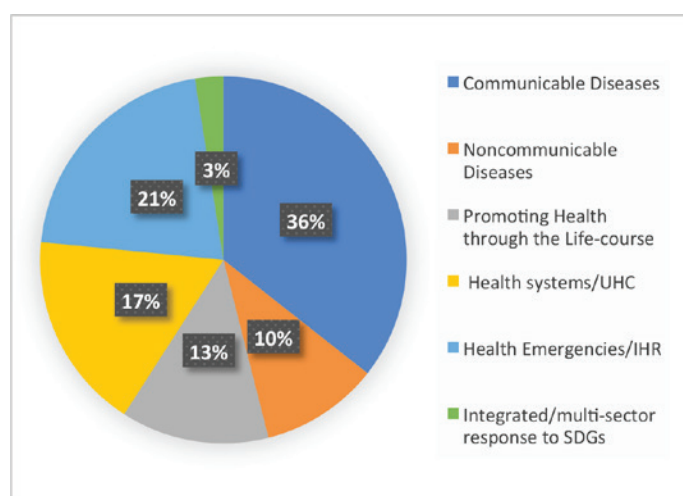
LDCs received a total of 2053 backstopping mission from different levels of WHO staff between January 2015 and 31st October 2016, as displayed in table 5, with the largest proportion from staff at regional office level. Thirty one percent of all WHO backstopping missions were to LDCs during this time. Guinea, heavily affected by the Ebola epidemic, was the most visited country during this period with a total of 266 missions, all of which were initiated by the country office. Laos was the most visited country at sub-regional level, and second most visited country overall with 209 missions, the vast majority of which were initiated by the country office.

Table 5: The number of backstopping missions to LDCs by different levels of WHO staff and the percentage of these missions which were initiated by the country office

	Number of missions	Percentage of missions initiated by the country office
Sub-regional office	544	85
Regional office	901	76
Headquarters	457	81
Joint visit by HQ & RO (and/or sub-regional office)	151	85

The largest proportion of backstopping missions related to communicable diseases, as seen in figure 21, followed by health emergencies. Communicable disease missions compromise over 50% of all backstopping missions in Afghanistan, Burkina Faso, Lao DPR, Mali, Myanmar, Somalia, Sudan, and Timor-Leste, in line with the predominant disease burden in developing countries. However, missions pertaining to NCD represent over 60% of all missions in Equatorial Guinea and Ethiopia.

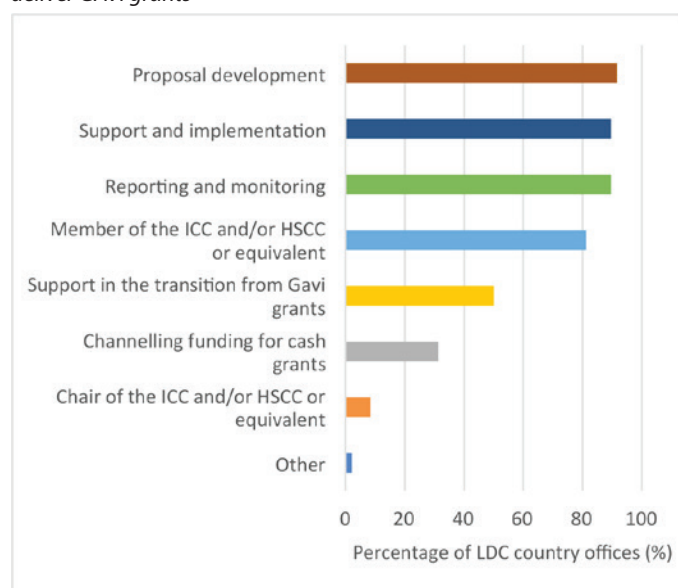
Figure 21: Proportion of backstopping missions by topic



Donor coordination mechanisms

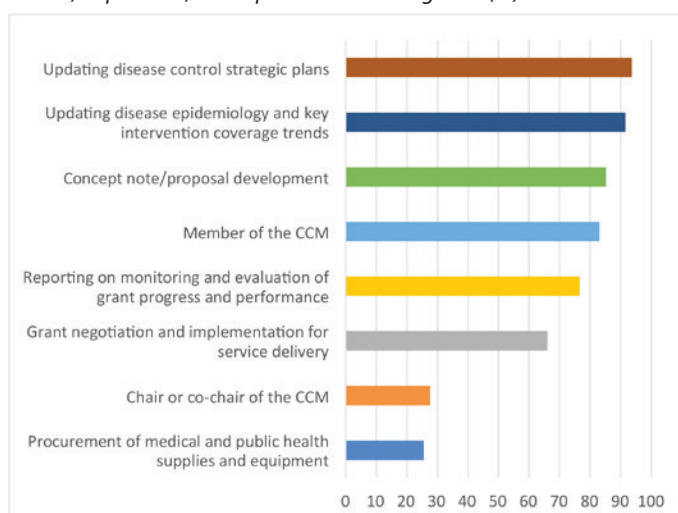
A donor coordination mechanism for health exists in 83% of LDCs. Of these, 38% of country offices act as co-chairs with the MoH, 40% are chairs or rotational chairs, and 35% are the Secretariat. Figure 22 shows the percentage of GAVI eligible countries where country offices played roles in supporting the country to access, implement, and deliver GAVI grants. Over 90% of country offices were involved in proposal development, support and implementation, and reporting and monitoring roles. The country offices in Guinea-Bissau and Benin participated in 7 of the highlighted roles in figure 22.

Figure 22: The percentage of LDC country offices which have played selected roles in supporting the country to access, implement, and deliver GAVI grants



In relation to Global Fund grants, figure 23 shows the percentage of country offices in Global Fund eligible countries which played roles in providing technical

Figure 23: The percentage of LDC country offices which have played roles in providing technical support and/or capacity building for countries to access, implement, and report Global Fund grants (%)



support and/or capacity building for countries to access, implement, and report these grants. Guinea-Bissau, Lao People's Democratic Republic (Laos PDR), Myanmar, Vanuatu, and Yemen's country offices participated in all the highlighted roles in figure 21, compared to an average of 5.5 roles played by LDC country offices.

The country offices acted as sub-recipients for Global Fund grants in the following programmes: HIV/AIDS (7), tuberculosis (12), malaria (8), RMNCH (2), and health system strengthening (5). The offices of Cambodia, Madagascar, Somalia, and South Sudan each acted as sub-recipients of four of the aforementioned Global Fund programmes.

All country offices except Kiribati provided support to the government on mobilizing resources for health at country level (including from Gavi and/or Global Fund) for the period January 2015 - 31st October 2016.

Cooperation with the United Nations system

There is a Joint National/UN Steering Committee with MoH participation in 17 countries, and country office participation in 27 countries, while no Joint National/UN Steering Committee is present in 18 countries. Between January 2015 and the 31st of December 2016, the head of the WHO country office had acted as the Resident Coordinator in 34 LDCs.

There is an Integrated Strategic Framework present in 17 countries, with country office participation in 15 of these. A UNDAF was reported in all countries except Central African Republic, Myanmar, and Vanuatu. Health is most commonly incorporated in the UNDAF at outcome level (69%), with half of countries also incorporating it at output level and results group, as seen in table 6. In 11 countries, health is incorporated into the UNDAF in all highlighted means.

Table 6: The number and percentage of LDCs which have a UNDAF or equivalent, and which incorporate health at different levels of the UNDAF.

	N (of 48)	%
Countries where there is a UNDAF or equivalent	44	92
How is health incorporated		
Outcome level	33	69
Output level	28	58
Results group	25	52
Joint work	22	46

The three health issues most frequently included in the UNDAF, seen in table 7, reflect the main causes of DALYs in LDCs shown earlier in table 2. Over 77% of countries

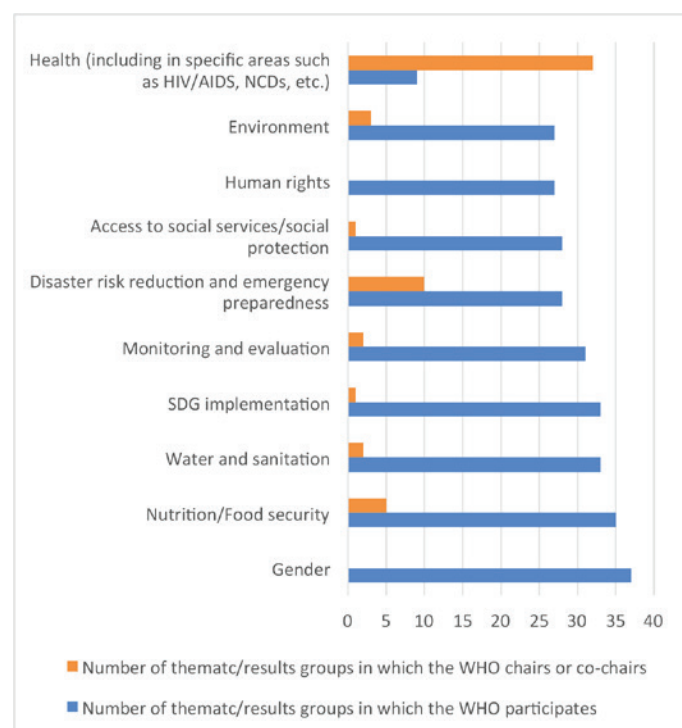
include RMNCH, communicable disease and nutrition and/or food safety as part of their UNDAF. All ten of the highlighted health issues are included in the UNDAF in South Pacific, Sudan, Tanzania, and Zambia.

Table 7: The number and percentage of countries which include selected health issues in their UNDAF

Health Issue	n (of 48)	%
Reproductive, Maternal, Newborn, Child and Adolescent Health	42	88
Communicable diseases	41	85
Nutrition and/or Food safety	37	77
Health systems/Universal health coverage	36	75
Noncommunicable diseases	33	69
Social Determinants of Health/Health and the environment	31	65
Health Emergencies/International Health Regulations (2005)	29	60
Implementation of Framework Convention on Tobacco Control	16	33
Ageing and population	10	21
Anti-Microbial Resistance	5	10
Other	4	9

The number of LDC country offices which participate in and chair/co-chair a range of thematic/results groups is shown in figure 24. Participation or chairing/co-chairing of at least 1 thematic/results group occurs in all LDCs except Central African Republic, Myanmar, and Vanuatu. Nineteen country offices are involved in all 10 highlighted groups, and over half are involved in at least 8 groups.

Figure 24: The number of LDC country offices which participate in and chair or chair a range of thematic/results groups



Over half of country offices participated in Joint Programmes (71%) or Joint Resource Mobilisation Strategy (58%), while 29% participated in the One Fund/Multi Donor Trust Fund, as shown in table 8. Lesotho,

Liberia, Madagascar, Niger, Tanzania, and Zambia participated in all of three of these while 27 countries participated in at least 2.

Table 8: The number and percentage of countries participating in selected programmes

Joint Programmes		Joint Resource Mobilisation Strategy		One Fund/Multi Donor Trust Fund	
n	%	n	%	n	%
34	71	28	58	14	29

Appendix

http://www.un.org/en/development/desa/policy/cdp/ldc/ldc_list.pdf

Afghanistan	Gambia	Rwanda
Angola	Guinea	São Tomé and Príncipe
Bangladesh	Guinea-Bissau	Senegal
Benin	Haiti	Sierra Leone
Bhutan	Kiribati	Solomon Islands
Burkina Faso	Lao People's Dem. Republic	Somalia
Burundi	Lesotho	South Sudan
Cambodia	Liberia	Sudan
Central African Republic	Madagascar	Timor-Leste
Chad	Malawi	Togo
Comoros	Mali	Tuvalu
Dem. Rep Of The Congo	Mauritania	Uganda
Djibouti	Mozambique	United Rep. of Tanzania
Equatorial Guinea	Myanmar	Vanuatu
Eritrea	Nepal	Yemen
Ethiopia	Niger	Zambia

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