

# Small Island Developing States Health and WHO

## Country Presence Profile

### Background

Small island developing states (SIDS) are a recognized group of 58 low-lying island nations across 3 geographical divisions – Caribbean, Pacific, and Atlantic, Indian Ocean, Mediterranean, and South China Sea (AIMS), a list of the states, territories and areas in each division can be seen in table 1. Although SIDS are geographically dispersed, they face similar social, developmental, and environmental challenges. Nevertheless, economic and health statistics can vary widely across SIDS. SIDS face a unique combination of challenges due to their small size, geographical remoteness, and fragile environment and also have less resilience to natural disasters such as cyclones and earthquakes. Climate change poses both economic and existential threats to SIDS. Particularly at risk from rising sea levels are the Maldives, Tuvalu, Marshall Islands and Kiribati where over 95% of land is below five metres above sea level. This may result in population displacement and migration, bringing with it political, social, and health issues. Due to the contained nature of SIDS, the potential impact of infectious disease outbreaks on the population is severe. While numerous SIDS have universities and medical schools, a brain drain of health professionals away from these states exists. Furthermore, smaller states, territories or areas may not be able to produce the diverse variety of medical staff at the level required, and rely on other countries for training specialists.

Table 1: List of SIDS by geographical division<sup>1</sup>.

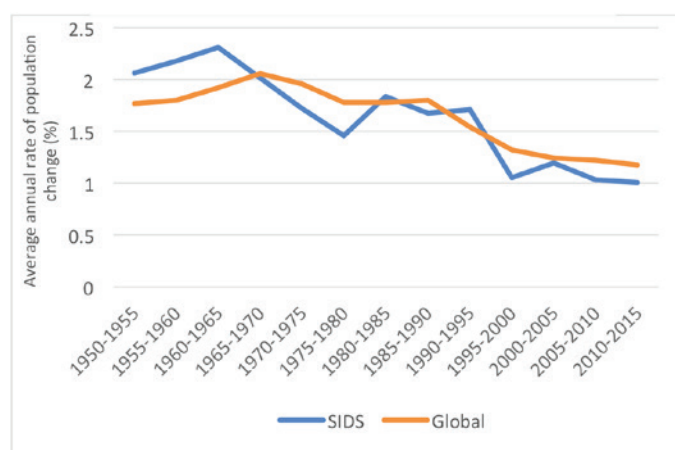
Caribbean			
Anguilla	British Virgin Islands	Guyana*	Saint Kitts and Nevis*
Antigua and Barbuda*	Cayman Islands	Haiti*	Saint Lucia*
Aruba	Cuba*	Jamaica*	Saint Vincent and the Grenadines*
Bahamas*	Curacao	Martinique	Suriname*
Barbados*	Dominica*	Montserrat	Trinidad and Tobago
Belize*	Dominican Republic*	Netherlands Antilles	Turks and Caicos Islands
Bermuda	Grenada*	Puerto Rico	United States Virgin Islands
	Guadeloupe		
Pacific			
American Samoa	Kiribati*	Northern Mariana Islands, Commonwealth of the (USA)	Timor-Leste*
Cook Islands	Marshall Islands*	Palau*	Tonga*
Federated States of Micronesia*	Nauru*	Papua New Guinea*	Tuvalu*
Fiji*	New Caledonia	Samoa*	Vanuatu*
French Polynesia	Niue	Solomon Islands*	
Guam			
AIMS			
Bahrain*	Guinea-Bissau*	Mauritius*	Seychelles*
Cabo Verde*	Maldives*	São Tomé and Príncipe*	Singapore*
Comoros*			

<sup>1</sup> \* UN members, others are non-UN members/associate members of the Regional Commissions

## Population

- The 58 SIDS are inhabited by a combined population of 69 853 190, which represents less than one percent of global population<sup>2</sup>. While population size ranges from 11 389 562 in Cuba to 1610 in Niue, SIDS are, in general, rather small in terms of population size.

Figure 1: Population change across SIDS



- The average proportion of the population aged under 15 years (27.43%) is slightly above the global figure (26.11%) but varies widely among SIDS, with Comoros, Guinea-Bissau, São Tomé and Príncipe, and Timor-Leste above 40%.
- The proportion of the population aged over 65 years lower than the current global average of 8.3%, which could be expected for a group containing many developing countries, which generally have younger populations.
- Average annual population growth is lower in SIDS than globally, as seen in figure 1, but varies within the SIDS sub-classifications. Population growth is substantially higher in the AIMS group as compared to the Caribbean and Pacific states, with the US Virgin Islands and Puerto Rico experiencing consistent negative growth between 2000 and 2015. Furthermore, average population growth between 2010 and 2015 was negative in American Samoa, Bermuda, and Niue. The current trends of low and negative population growth in many SIDS will accelerate population ageing within the next few decades.

## Economics

- The average GDP per capita in 2015 in SIDS is US\$ 12 612, increasing to US\$15 444 when least developed countries are excluded<sup>3</sup>. An outlier in this category is Singapore, with its gross domestic product (GDP) per capita over US \$30 000 higher than the next highest state, the Bahamas, at US \$22 817, reflecting Singapore's development into an international centre of commerce and finance. Of the 30 countries globally which have a GDP per capita of under US \$1 000, 3 of these are SIDS (Guinea-Bissau, Comoros, and Haiti).
- In some cases, favourable GDP per capita statistics mask ongoing resource depletion, particular of fresh water sources which are under increasing threat due to urbanisation, changing land use, and tourism. Many SIDS are reliant on industries such as tourism, agriculture, fishing, and mining for income, and are therefore vulnerable to fluctuations in market prices and tourist numbers. Due to the smaller and shallower land mass present on small islands, resource depletion through mining can occur. The economy of the island of Nauru was previously almost entirely reliant on phosphate mining, however resources have been virtually exhausted, with over 80% of the island's surface strip-mined and now infertile<sup>4</sup>.
- The total expenditure on health as a percentage of GDP varies widely, with SIDS countries, territories and areas representing the lowest expenditure globally (Timor-Leste, 1.48%) and the second highest expenditure, fractionally lower than the United States (Marshall Islands 17.14%)<sup>5</sup>. The mean expenditure of 6.94%, as seen in table 2, is lower than the global average (9.94%) and between the figures for middle income countries and high income countries (5.82% and 12.27% respectively)<sup>5</sup>.
- Of the 35 SIDS for which there is 2015 human development index data, the majority are categorised as having high human development, as found in table 2, with the block having an overall average of 0.686<sup>6</sup>.
- In terms of literacy, the average adult literacy rate for males (90.85%) and females (88.31%) is above global average, particularly for females<sup>7</sup>. There exists a double figure discrepancy between the genders

<sup>2</sup> UNPD 2015. Data from 58 SIDS.

<sup>3</sup> World Bank 2015. Data from 44 SIDS

<sup>4</sup> UN SIDS factsheet 2013

<sup>5</sup> WHO Global Health Observatory Data Repository 2014. Data from 38 SIDS

<sup>6</sup> UNDP 2015. Data from 35 SIDS.

<sup>7</sup> UNESCO data most recent year available between 1999-2015. Data from 21 SIDS

Table 2: Categorisations of human development according to human development index. Source: UNDP data 2014. Data from 35 SIDS.

Very high human development	High human development		Medium human development	Low human development
Bahrain Singapore	Antigua and Barbuda Bahamas Belize Cuba Dominica Dominican Republic Fiji Grenada Jamaica Maldives	Mauritius Palau Samoa Seychelles St Kitts and Nevis St Lucia St Vincent and the Grenadines Suriname Trinidad and Tobago	Cabo Verde Guyana Kiribati Micronesia (Federated States of) São Tomé and Príncipe Timor-Leste Vanuatu	Comoros Guinea-Bissau Haiti Papua New Guinea Solomon Islands

in favour of males in two countries: Guinea-Bissau (23.5%) and the Solomon Islands (14.7%, data from 1999). Of the 32 countries where data was available, there was a higher rate of adult female literacy in 13 countries, with Jamaica representing the country with the greatest difference of 9.13%.

expectancy – the number of years a person can expect to live in “full health” without disease or injury, is 88% of life expectancy – in line with the global standard. Again, there is a substantial gap of over 20 years between the highest and lowest figures, but most SIDS lie at or above global average.

## Health

### Life expectancy

Average life expectancy at birth in the majority of SIDS is 70 or above, though it can vary between countries by over twenty years, as can be seen when comparing Singapore and Guinea-Bissau in figure 2. Healthy life

Life expectancies for males and females are increasing steadily, as shown in figure 3, however in 2010 the trend was affected by the Haitian earthquake which reduced life expectancy nearly halved male life expectancy and reduced female life expectancy by a third due to the number of deaths. There is around a 5 year gender gap in life expectancy, increased from 4 in 2000, which is similar to the global average.

Figure 2: Overall life expectancy and healthy life expectancy across SIDS

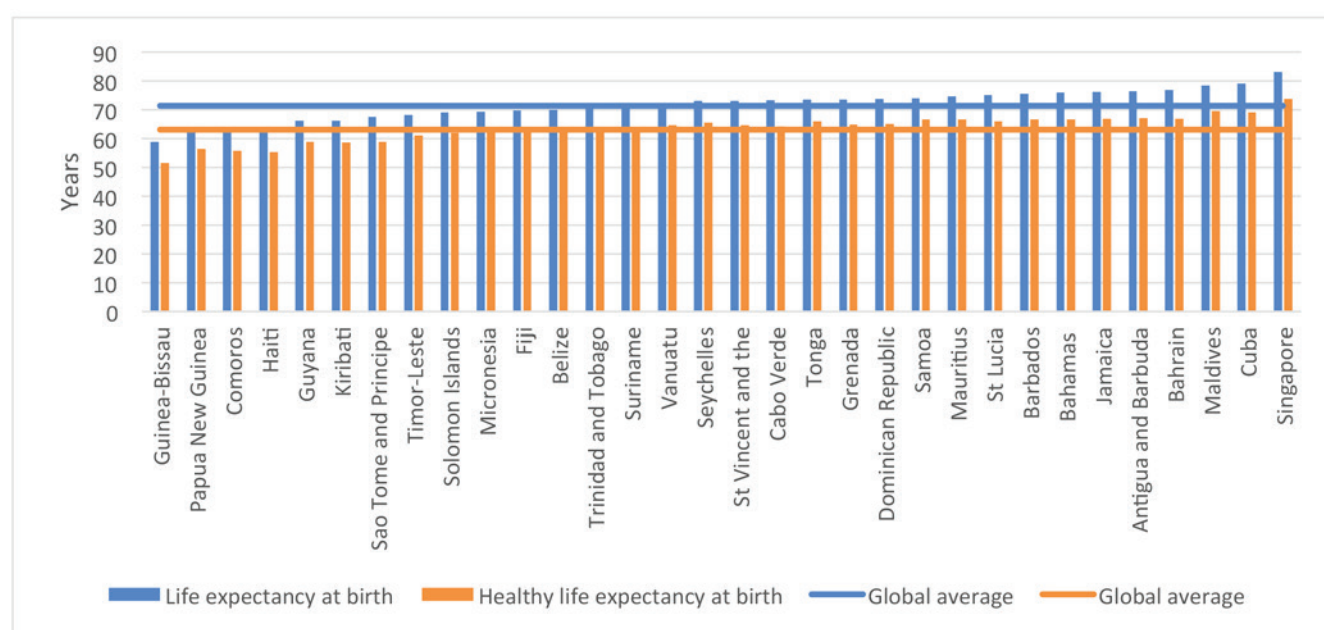
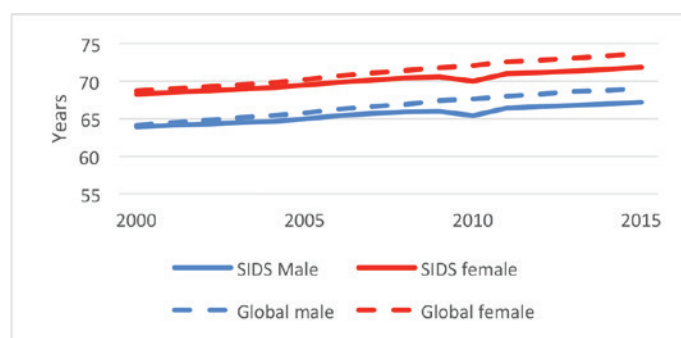


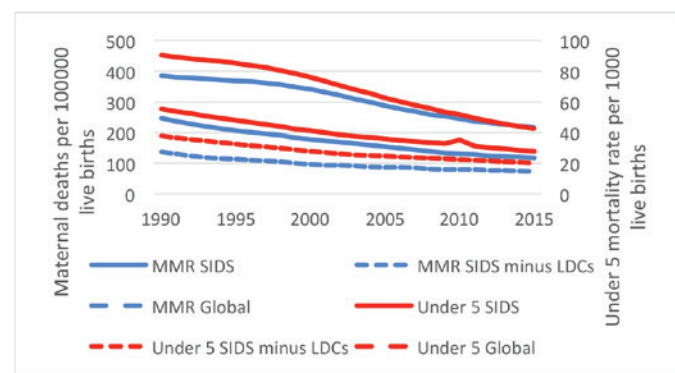
Figure 3: Life expectancy for males and females in SIDS and globally



### Maternal mortality and under five mortality

Similar to global trends, maternal mortality ratio (MMR)<sup>8</sup> in SIDS have fallen over the past few decades, as seen in figure 4, from 247 per 100 000 live births in 1990 to 117 in 2015, which drops to 73.5 if SIDS which are also classified as least developed countries (LDCs) are excluded. Between 1990 and 2015, MMR has dropped in 23 SIDS, with an over 80% decrease seen in Timor-Leste, Cabo Verde, and the Maldives. However, it has risen overall in six states, with an increase of 46 to 80 seen in the Bahamas<sup>9</sup>. The gap between SIDS overall and SIDS minus LDCs has fallen though the latter remains over a third below.

Figure 4: Maternal mortality and under 5 mortality in SIDS and globally



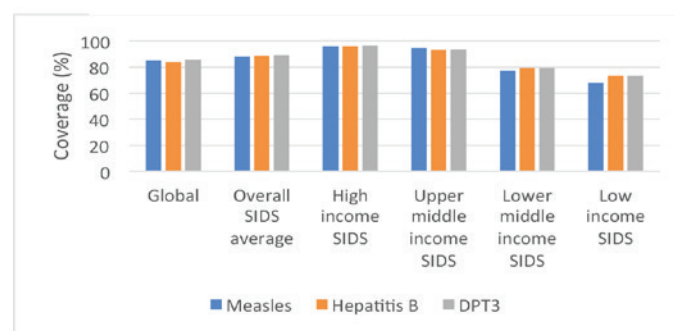
The under 5 mortality rate<sup>10</sup> has likewise fallen since 1990 in SIDS overall and stood at two third of the global figure in 2015, as can be seen in figure 4. When SIDS

LDCs are excluded, the under 5 mortality rate is less than half of that globally. The downward trend was interrupted in 2010 when the figure increased from 81.2 to 208.8 in Haiti due to the earthquake in February 2016. Under 5 mortality fell in each individual state except Dominica Republic which has seen a 23% increase since 1990 despite a rapid drop from 139 in 1960 to 19.8 in 1980. Decreases of over 70% were seen in Timor-Leste, Bahrain, and the Maldives.

### Health service coverage

The coverage of immunization for measles, hepatitis B and diphtheria tetanus toxoid and pertussis (DPT3) compares positively to the global rate, with an average of above 88% for all 3 vaccinations, as can be seen in Error! Reference source not found.<sup>11</sup>. When stratifying the countries, territories and areas by World Bank Country Classifications, an economic gradient can be observed with vaccination coverage decreasing from high income countries to low income countries.

Figure 5: Immunization coverage among 1-year olds in SIDS (%)



When considering indicators of health service coverage, as noted in Error! Reference source not found., SIDS excel in comparison to the global average in terms of maternal care, namely antenatal coverage of at least 4 visits<sup>12</sup>, and births attended by skilled personnel<sup>13</sup>. However, even when statistics from SIDS which are also LDCs are removed, the block falls behind global standards of contraceptive prevalence<sup>14</sup> and TB treatment success<sup>15</sup>.

### Risk factors for non-communicable disease

As countries develop economically, there are changes in food consumption towards highly processed foods and lifestyles become increasingly sedentary. These and other factors contribute to the increasing prevalence

<sup>8</sup> World Bank data. Data from 30 SIDS.

<sup>9</sup> The Bahamas, Tonga, Guyana, Suriname, Jamaica, and St Lucia

<sup>10</sup> World Bank data. Data from 37 SIDS.

<sup>11</sup> WHO Global Health Observatory Data Repository 2015. Data from 38 SIDS.

<sup>12</sup> WHO Global Health Observatory Data Repository, most recently available year 2005-2014. Data from 31 SIDS.

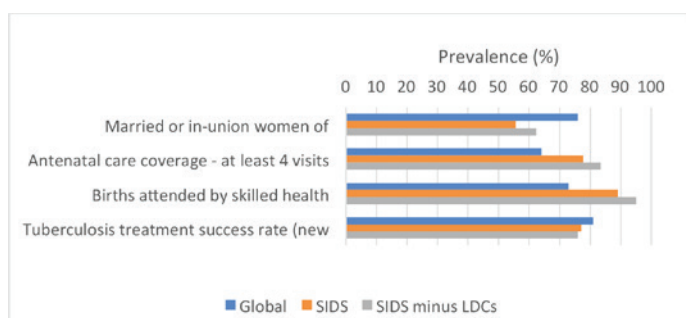
<sup>13</sup> WHO Global Health Observatory Data Repository, most recently available year 2006-2014. Data from 38 SIDS.

<sup>14</sup> WHO Global Health Observatory Data Repository, most recently available year 2005-2014. Data from 26 SIDS.

<sup>15</sup> WHO Global Health Observatory Data Repository, most recently available year 2011-2014. Data from 38 SIDS.



Figure 6: Percentage coverage of health service indicators globally, in SIDS, and in SIDS minus LDCs



of risk factors for NCD such as cancer, diabetes, and cardiovascular diseases.

Figure 7: Prevalence of raised fasting blood glucose in SIDS

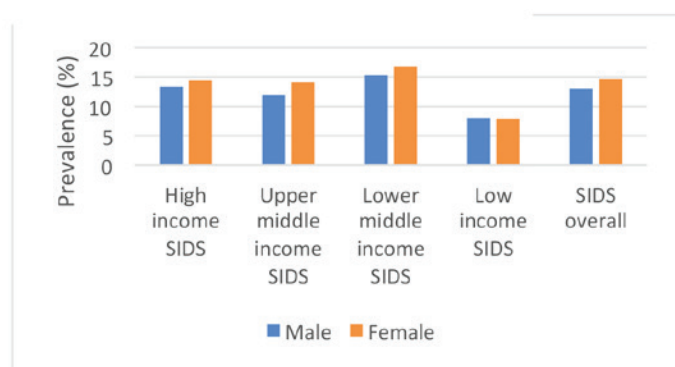
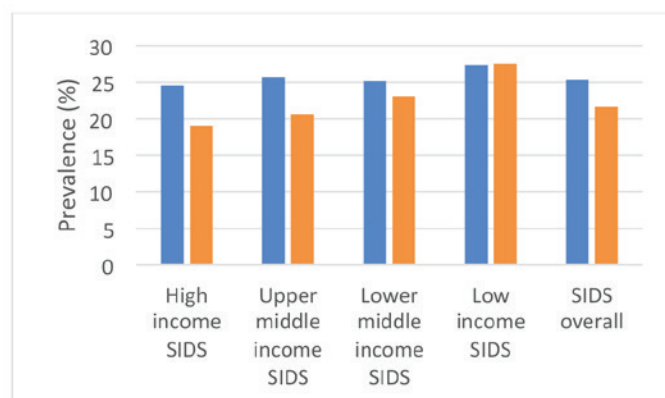


Figure 7 shows the highest prevalence of raised fasting blood glucose – a precursor to diabetes, as highest in the lower-middle income SIDS, followed by high income and upper-middle income<sup>16</sup>. Prevalence in low income countries, territories and areas is markedly less, and only in this classification do females not have higher prevalence. When considering raised blood pressure in females<sup>17</sup> (figure 8), an economic gradient can be seen where the prevalence of raised blood pressure increases with decreasing World Bank income classification. Such a clear pattern cannot be observed for males, who overall are more likely to have raised blood pressure, though those in low income countries also have the highest prevalence.

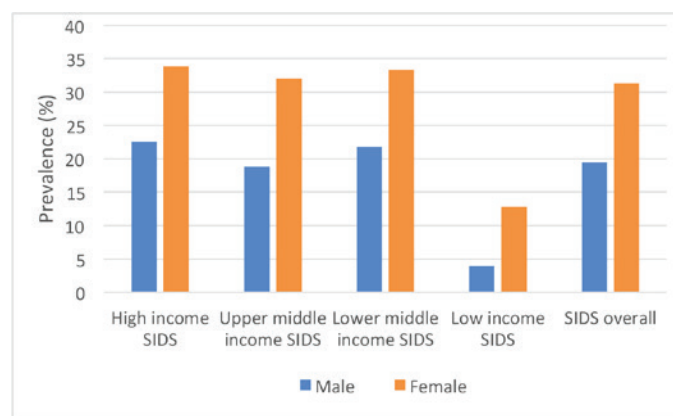
Obesity is highest for both males and females in high income SIDS, with slightly lower rates for the middle-income country classifications, as seen in figure 9<sup>18</sup>.

Figure 8: Prevalence of raised blood pressure in SIDS



Figures are substantially lower in low income countries, territories and areas this could be expected as their epidemiological transition is not as advanced.

Figure 9: Prevalence of obesity in SIDS



The consumption of tobacco does not follow the same patterns as risk factors related to diet and lifestyle. On a global scale, smoking rates in high income countries have been decreasing for decades, while the tobacco industry seeks to create new markets in countries where there are less regulations and lower awareness of the risks. Figure 10 shows an incremental gradient exists with increasing prevalence of tobacco use from high income to lower-middle income countries, territories or areas<sup>19</sup>. Low income countries display usage prevalence as being much lower than other classifications. Men in SIDS are almost three times as likely to smoke tobacco than females, generally reflecting trends seen globally.

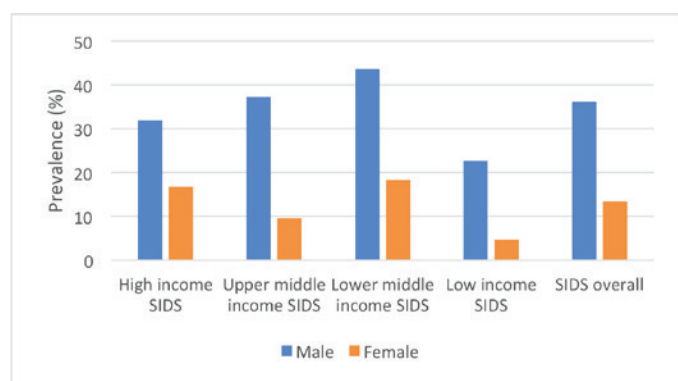
<sup>16</sup> WHO Global Health Observatory Data Repository 2014. Prevalence of raised fasting blood glucose ( $\geq 7.0$  mmol/L or on medication, (age-standardized estimate) in those aged 18 years and above. Data from 38 SIDS.

<sup>17</sup> WHO Global Health Observatory Data Repository 2015. Prevalence of raised blood pressure (SBP  $\geq 140$  OR DBP  $\geq 90$ , age-standardized estimate) of those aged 18 years and above. Data from 38 SIDS.

<sup>18</sup> WHO Global Health Observatory Data Repository 2014. Prevalence of obesity (BMI  $\geq 30$ , age-standardized estimate) in those aged 18 and above. Data from 38 SIDS.

<sup>19</sup> WHO Global Health Observatory Data Repository 2013. Prevalence of current smoking of any tobacco product (age-standardized rate) in those aged 15 years and above. Data from 16 SIDS.

Figure 10: Prevalence of tobacco smoking in SIDS



## Causes of death and the burden of disease

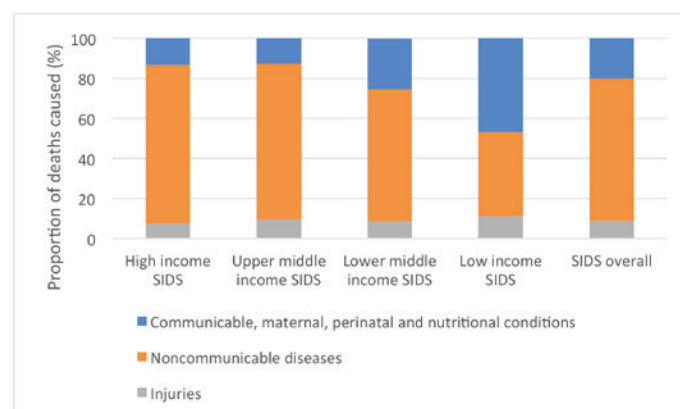
The burden of diseases is measured in terms of disability-adjusted life-years (DALYs). One DALY is equivalent to a year of healthy life lost and are calculated as the sum of years lost due to premature mortality in a population and years lost to disability for people living with a health condition or its consequences. The top 10 causes of DALYs in SIDS can be seen in table 3, with the highest burden due to cardiovascular diseases, typical of more developed countries<sup>20</sup>. However, the next highest burden is of maternal, neonatal and nutritional DALYs, the majority of which are related to neonatal conditions, generally more commonly associated with developing countries.

Table 3: Top ten causes of DALYs in SIDS and the number of resultant DALYs in 2015

Condition	DALYs caused in 2015
Cardiovascular diseases	3326
Maternal and neonatal conditions, and nutritional deficiencies	2800
Other NCDs	2369
Malignant neoplasms	1961
Unintentional injuries	1755
Lower respiratory infections	1433
Mental and substance use disorders	1372
HIV/AIDS, TB and malaria	1222
Intentional injuries	915
Diabetes mellitus	891

In 2015, 71% of deaths in SIDS overall were caused by NCD, as seen in figure 11, with 20% of deaths due to communicable, maternal, perinatal and nutritional conditions, and 9% from injuries. These proportions varied depending on income status, with low income SIDS having a far greater proportion of deaths caused by communicable, maternal, perinatal and nutritional conditions than higher income SIDS. This pattern is consistent with that seen worldwide, as the disease burden of countries transitions from communicable to NCD with increasing wealth.

Figure 11: The proportion of deaths by cause in SIDS in 2015



## WHO presence in SIDS

The WHO has a country office in 43% of SIDS, with 55% of SIDS are covered by either a representative office (as listed below) or another country's office. Bahrain and Guam were covered by the respective regional offices.

- Barbados and Eastern Caribbean Country (BECC) Office** which represents WHO in Antigua and Barbuda, Barbados, Dominica, Grenada, St Kitts and Nevis, St Lucia, St Vincent and the Grenadines, and the territories of Anguilla, British Virgin Islands, Montserrat, Guadeloupe, and Martinique.
- Northern Micronesia** as a representation of WHO to the Marshall Islands, Federated States of Micronesia and Palau.
- South Pacific:** WHO Representative office acts as a sub-regional office in South Pacific and represents WHO to Fiji, French Polynesia (France), Commonwealth of the Northern Marian Islands (USA), New Caledonia (France), New Zealand, Nauru, Palau, Tuvalu, Wallis and Futuna (France), Pitcairn Islands (United Kingdom). It also represent WHO to those countries covered by WHO Country Liaison Officers namely, Kiribati, Federated States of Micronesia, Marshall Islands, Palau, Tonga and Vanuatu.
- Samoa,** WHO representative office in Samoa also represents American Samoa, Cook Islands, Tokelau and Niue.

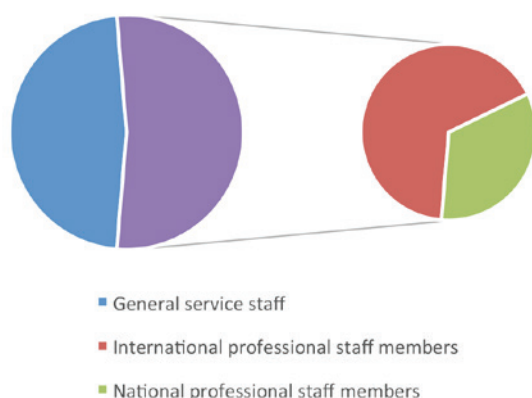
## Staffing and finance

WHO offices in SIDS are staffed by a total of 317 staff personnel and 133 non-staff personnel. WHO Staff in SIDS account for 8% of total country office staff globally. Just over half of staff personnel (53%) are professional staff members while 47% are general service staff, as shown in figure 12. The ratios of professional staff to general service staff is skewed by the composite offices listed

<sup>20</sup> WHO 2015. Data from 32 SIDS.

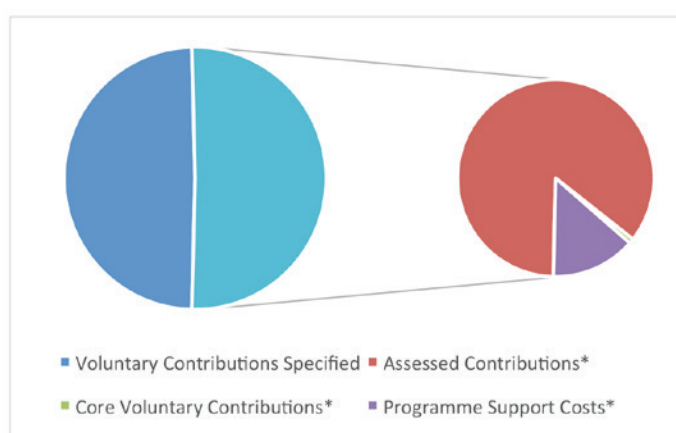
above, where a single individual can present a country, territory or areas without the need for a dedicated service staff member. The professional workforce in SIDS represents 9% of global WHO professional staff working in country offices. Seven SIDS covered from the BECC offices are covered by a single National Professional staff member each. Due to the small size of country offices, the proportion of professional personnel who are international professionals varies widely – from 0% in nine SIDS<sup>21</sup> (seven Caribbean states and two African states) to 100% in five SIDS<sup>22</sup> (one Caribbean states and four Pacific states), with an average of 51%.

Figure 12: Breakdown of staff personnel in SIDS



SIDS have a combined 16-17 planned costs total of US \$125 847 777, with US \$90 447 259 of funds available. The distributed funds comprise 4% of total distributed funds globally. Just over half (51%) of the available funds are flexible funds, as in figure 13, with 49% being specified voluntary contributions. Flexible funds largely consist of assessed contributions (85%), with a smaller proportion of programme support costs (14%), and less

Figure 13: Available funds breakdown



<sup>21</sup> Anguilla, Antigua and Barbuda, Dominica, Grenada, Sao Tome and Principe, the Seychelles, St Kitts and Nevis, St Lucia, St Vincent and the Grenadines

<sup>22</sup> Cuba, Kiribati, Micronesia (Fd. States of), Solomon Islands, and Tonga

<sup>23</sup> Palau, Guam, Marshall Islands, Tuvalu, Grenada, Jamaica, Timor-Leste, Nauru, Cook Islands, and Niue

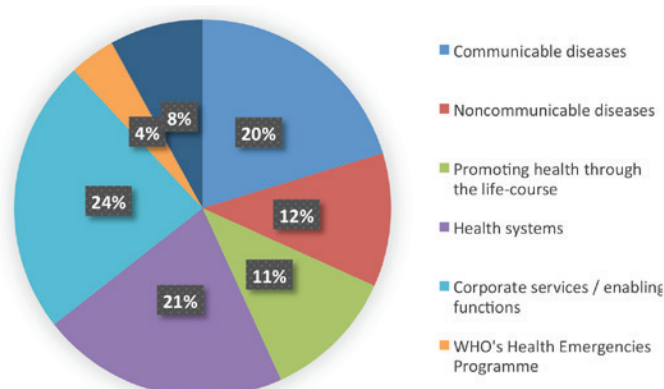
than 1% of core voluntary contributions. The five SIDS with the largest proportion of available funds can be seen in table 4, collectively accounting for almost 60% of all available funds in SIDS.

Table 4: SIDS receiving the highest proportion of available funds

Country	Proportion	Amount (US\$)
Papua New Guinea	17.6	15 947 296
Fiji	16.3	14 777 566
Solomon Islands	10.5	9 464 809
Timor-Leste	8.7	7 859 494
Haiti	6.5	5 880 651

The category of corporate services/enabling functions received the greatest proportion of distributed funds in SIDS, as seen in figure 14, followed closely by health systems and communicable diseases.

Figure 14: Distributed funds by category



- At 45%, Haiti is the country with the highest available funds for communicable disease, with 96% of these funds for vaccine preventable disease programmes. Papua New Guinea, Dominican Republic, Vanuatu, and Guinea Bissau each assigned over 25% of available funds for communicable disease.
- The Solomon Islands and Suriname devote the most available funds for promoting health through the life course, each 40%+.
- Ten SIDS<sup>23</sup> assigned over 40% of distributed funds for health systems, with this representing 100% of Palau's funds.
- Funds for WHO's Health Emergencies Programme were at or below 10% in all SIDS bar 6, though

represented the largest category of funding in Dominica (43%).

- Corporate services/enabling functions constituted the largest proportion of available funds, and accounted for over 70% of distributed funds in the Seychelles and São Tomé and Príncipe. Almost two quarters of this was assigned for leadership and governance in the Seychelles, and split 52/48 between leadership and governance and management and administration in São Tomé and Príncipe.
- Haiti and Cuba designate over 40% of distributed funds for polio, outbreak and crisis response (OCR), and special programmes. Haiti is the largest recipient of funds for OCR across SIDS, accounting for 42% of overall funds for OCR.

### Government policies, strategies, and plans<sup>24</sup>

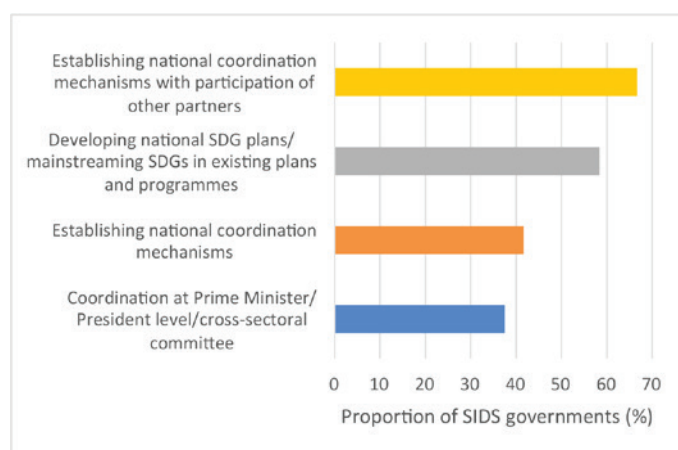
- Fifteen states/representative offices had an up-to-date National Health Policy, Strategy and Plan (NHPSP), with 6 currently under development.
  - WHO offices were actively participating in the formulation, the main technical partner in undertaking situation analysis, and building national capacity for effective policy analysis, formulation, monitoring and review in over two thirds of SIDS.
  - WHO was also active in building national capacity for implementation of the NHPSP, improving national health governance through sustained and inclusive effective health sector policy dialogue, and engaging in assessment of implementation of the NHPSP in over half of the countries.
- All of SIDS country, territory or area offices had ever developed a Country Cooperation Strategy (CCS), with the exception of Kiribati where it is currently under development.
  - Thirteen of these countries, territories and areas have an up-to-date CCS and in 9, it is currently under development. The number of strategic priorities in the up-to-date CCS ranges between 3 (Guinea-Bissau) and 10 (Cuba) with an average of 5.5.
- When considering the extent to which the WHO office is supporting the Ministry of Health (MoH) to ensure cross-sector collaboration and/or ways to work more effectively with other ministries, five

countries reported this to be extensive – Cuba, Dominica, Guyana, Seychelles, and Suriname - while the lowest rating for this was given by Mauritius (2 out of a possible 5).

### Sustainable Development Goals

The sustainable development goals (SDGs) are a set of goals adopted by countries in 2015 to end poverty, protect the planet, and ensure prosperity for all, with each goal having specific targets to be achieved over the following 15 years. Figure 15 shows how governments are approaching the implementation of the SDGs, with over half having established national coordination mechanism and developed national SDG plans or mainstreamed SDGs in existing plans and programmes. The governments of Timor-Leste and Vanuatu are the most active, participating in all four of the highlighted roles. The discussion on SDGs had not yet started in 2 countries (the Bahamas and Mauritius).

Figure 15: SIDS governments approaches to the implementation of the SDGs



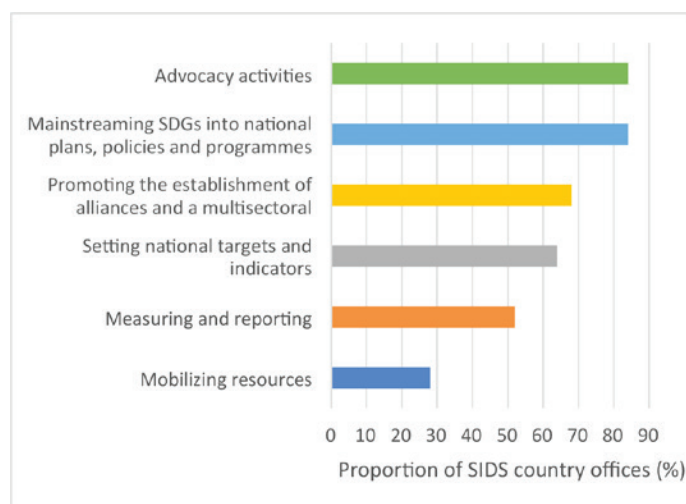
WHO offices have been active in all but one (the Bahamas) of the countries, territories or areas in supporting the implementation of the SDGs. This work has mostly taken the form of advocating activities, promoting a multi-sectoral approach, setting targets and mainstreaming the SDGs into policy as opposed to supporting the mobilization of resources. WHO offices in Belize, Guinea-Bissau, Trinidad and Tobago, and Vanuatu have been the most active, reportedly supporting implementation in all 6 areas of figure 16.

- WHO offices are working with the Parliament towards the attainment of health-relevant SDGs in some way in all SIDS except Barbados and Eastern Caribbean, Belize, the Solomon Islands and Mauritius. The areas in which WHO offices in countries, territories

<sup>24</sup> Information from here onwards taken from 2016 WHO Country Presence Survey. Completed by three representative offices as detailed above, covering 22 SIDS.



Figure 16: Roles played by country offices in supporting SIDS in implementing the SDGs



national multi-stakeholder consultations on SDGs, while briefing partners about SDGs has occurred in 13 and conducting stakeholder analysis of key partners in 4. Guinea-Bissau, Suriname, and Trinidad and Tobago partook in all 3 of the above activities, with 7 others indicating that other activities related to this aim occurred.

### Emergency preparedness

According to reported data by WHO offices, a health emergency or outbreak was experienced by 22 of the 25 countries, territories, areas/groupings between January 2015 and the 31st of October 2016<sup>25</sup>, with the nature of these shown in table 5. The majority of countries, territories or areas can be seen to have experienced disease outbreaks or epidemics during this time, natural disasters also affecting 7 of them, plus another 4.

Table 5: Types of health emergencies or outbreaks experienced by SIDS between January 2015 and the 31st of October 2016 (as reported by WHO offices)

Natural disasters only	Disease outbreaks/epidemics only	Both natural disasters and disease outbreaks/epidemics
Barbados Cuba Northern Micronesia Vanuatu	Guinea-Bissau Guyana Jamaica Kiribati Mauritius Samoa São Tomé and Príncipe Seychelles Solomon Islands Suriname Tonga	The Bahamas Belize Cabo Verde Dominican Republic Maldives Papua New Guinea South Pacific

and areas were most active were advocating for increased prioritization of health-relevant SDGs (73%), implementing of international commitments, conventions, and legal instruments (e.g. Framework Convention for Tobacco Control) (57%). To a lesser extent, the SIDS WHO offices were involved in increasing allocation of resources for health in national budgets (38%) development of national laws to implement the SDGs (19%), government accountability mechanisms (11%). Suriname was the only state in which the country office worked with Parliament in all areas.

- Leading the processes and/or mechanisms for increasing multi-stakeholder engagement (including with NGOs, private sector, academics, institutions etc.) and advocating for health-relevant SDGs are key activities for implementation. Fifteen country offices in countries, territories or areas have helped set up

All WHO offices in SIDS provided support to MoH for emergency preparedness and response during the survey period, regardless of whether the country, territory or area had undergone a health emergency or outbreak. This support was most likely to have consisted of:

1. Providing logistics support and supplies, equipment and/or commodities (e.g. emergency health kits, lab supplies, etc.) (92%)
2. Technical, material, or financial support for an Early Warning Alert and Response System or Integrated Disease Surveillance and Response (88%)
3. Implementing, capacity building, and monitoring & evaluation of International Health Regulations (IHR) (84%)
4. Preparedness/readiness & core capacity building

<sup>25</sup> Hereafter referred to as the "survey period"

(e.g. through training, stakeholder analysis, national staff roster, drills, and field simulation exercises) (80%)

WHO offices provided support to the government on mobilizing resources for health at country level (including from Gavi and/or the Global Fund) during the survey period in all SIDS except in Kiribati, Micronesia (Federated States of), Tonga, and Trinidad and Tobago.

### Backstopping missions

The number of backstopping missions made to SIDS by different levels of WHO staff is detailed in table 6. SIDS received 546 missions during the survey period, 8% of total backstopping missions globally. The country most visited at sub-regional office level was Vanuatu with 30 missions during the survey coverage period. The most visited SIDS overall was Papua New Guinea with 68 missions, including 54 at regional office level, with all countries, territories or areas receiving at least 2 missions at this level. Sub-regional office missions were most likely to have been initiated by the WHO country, territory or area office (76%) and missions from the headquarters were least likely (54%).

Table 6: The number of backstopping missions by WHO staff to SIDS the survey period <sup>26</sup>

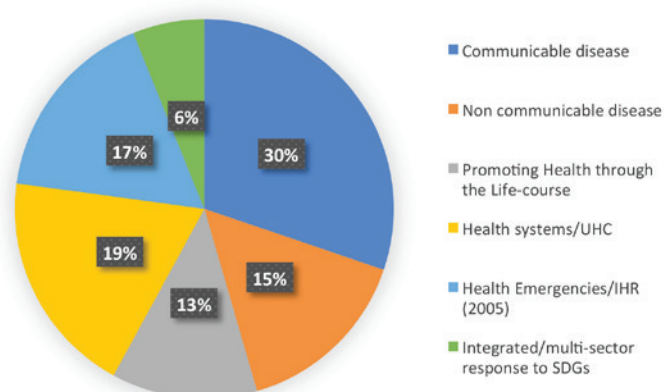
	Number of backstopping missions	Proportion of missions initiated by the country office(%)
Sub-regional office	172	76
Regional office (RO)	294	69
Headquarters (HQ)	48	54
Joint visit by HQ & RO (and/or sub-regional office)	32	63

The highest proportion of backstopping missions were related to communicable disease, as shown in figure 17, followed by health systems and universal health coverage (UHC). Communicable disease accounted for over half of missions in Cabo Verde, Cuba, Mauritius, Suriname, and Timor-Leste, while Tonga was the only SIDS with over half of missions related to NCD. Sixty percent of backstopping missions to Vanuatu (n=30) were pertaining to Health Emergencies/IHR 2005, after the country was hit by Cyclone Pam in March 2015 – the largest cyclone in recorded history to make landfall in the Pacific<sup>27</sup>.

### Donor coordination mechanisms

A donor coordination mechanism for health exists in 9 SIDS<sup>28</sup>, the majority of which either lower-middle or low

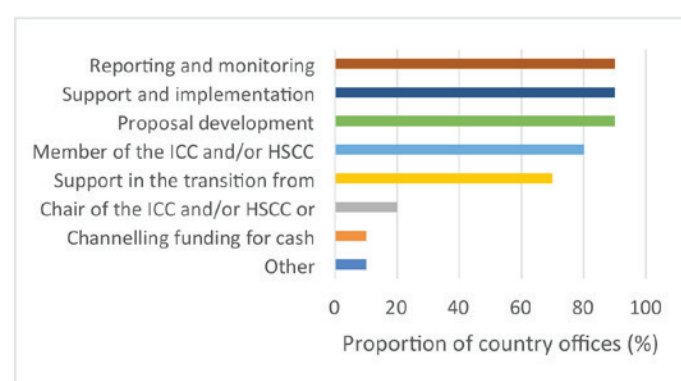
Figure 17: Proportion of backstopping missions relating to each area of work



income countries, territories or areas. The WHO office co-chairs this with the MoH in Comoros, Guyana, and Kiribati where it is also function as the Secretariat, and is a chair or rotational chair in Papua New Guinea, Solomon Islands, Timor-Leste and Vanuatu. Only the country offices in Samoa and Suriname are not in leadership or coordination position.

Of the 10 SIDS which are linked with Gavi, the majority of country, territory or areas offices (80%) are involved in proposal development, support and implementation, reporting and monitoring, and are a member of the Inter-agency Coordinating Committee (ICC)/and or Health Sector Coordination Committee (HSCC) or equivalent, as shown in figure 18. Over 6 of the stated roles are played by the WHO offices in Guinea-Bissau, Guyana, and Papua New Guinea.

Figure 18: Roles played by country offices in Gavi eligible countries



When considering how WHO office in SIDS support the 17 eligible countries in relation to Global Fund grants, it can be seen from figure 19 that they are most active in developing concept notes or proposals,

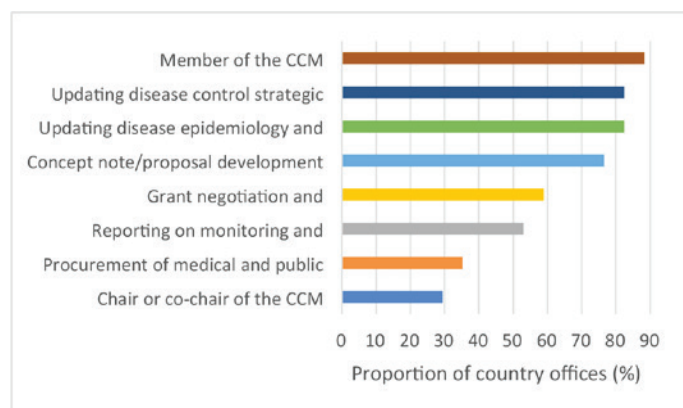
<sup>26</sup> South Pacific country office data is excluded due to data anomalies

<sup>27</sup> World Bank News: <http://www.worldbank.org/en/news/feature/2015/09/29/vanuatu-six-months-after-cyclone-pam>

<sup>28</sup> Comoros, Guyana, Kiribati, Papua New Guinea, Solomon Islands, Suriname, Timor-Leste, and Vanuatu

updating disease control strategic plans and updating disease epidemiology and key intervention coverage trends. Fifteen (88%) are also members of the Country Coordination Mechanism (CCM). All of the eight highlighted roles are played by WHO offices in Guinea-Bissau and Vanuatu, and seven in Comoros, Guyana, Papua New Guinea, and the Solomon Islands.

Figure 19: Country offices playing supportive roles in relation to Global Fund grants



Country offices act as sub-recipients of Global Fund grants in four SIDS, over three programmes, as detailed in table 7.

Table 7: Country offices acting as sub-recipients of Global Fund grant programmes

HIV/AIDS	Tuberculosis	Malaria
Cuba South Pacific	Solomon Islands South Pacific Vanuatu	Solomon Islands

### Cooperation with the United Nations system

A Joint National/UN Steering Committee exists in 11 of the countries, territories, areas/groupings, with the MoH participating in 45% of these, and the WHO office participating in 100%. The MoH and the WHO office both participate in the committees in Guinea-Bissau, Guyana, Jamaica, Kiribati, and Trinidad and Tobago. The head of the WHO office has acted as the Resident Coordinator (RC) at some point during the survey period in 15 SIDS, all of these for less than three months. There is no RC office in Micronesia (Federated States of) or Vanuatu.

There is an Integrated Strategic Framework present in three countries – Cuba, the Dominican Republic, and Guinea-Bissau – with the country office participating in all of these. A UNDAF or equivalent is present in all SIDS besides Mauritius, Suriname and Vanuatu, as in table 9. Health is most commonly incorporated at outcome level (90%), and in incorporated at all four levels highlighted

Table 8: The number and percentage of countries which have a UNDAF or equivalent and how health is incorporated into these

	N (of 24)	%
Countries where there is a UNDAF or equivalent	21	87.5
How is health incorporated		
	N (of 21)	%
Outcome level	19	90
Output level	11	53
Results group	14	67
Joint work	7	33

in table 8 in Barbados and Eastern Caribbean Countries, Cabo Verde, Papua New Guinea, Samoa, and Trinidad and Tobago.

Table 9 shows the frequency of health issues being included in the UNDAF of countries, territories or areas/groupings which have included certain health issues in their UNDAF. NCDs and reproductive, maternal, newborn, child and adolescent health (RMNCH) issues were those most often included in the UNDAF. Three countries, territories or areas/groupings - Cuba, Guyana and the South Pacific - included 8 or more issues in their UNDAF, with the South Pacific including all 10 identified issues.

Thematic/results groups participated in and chaired/

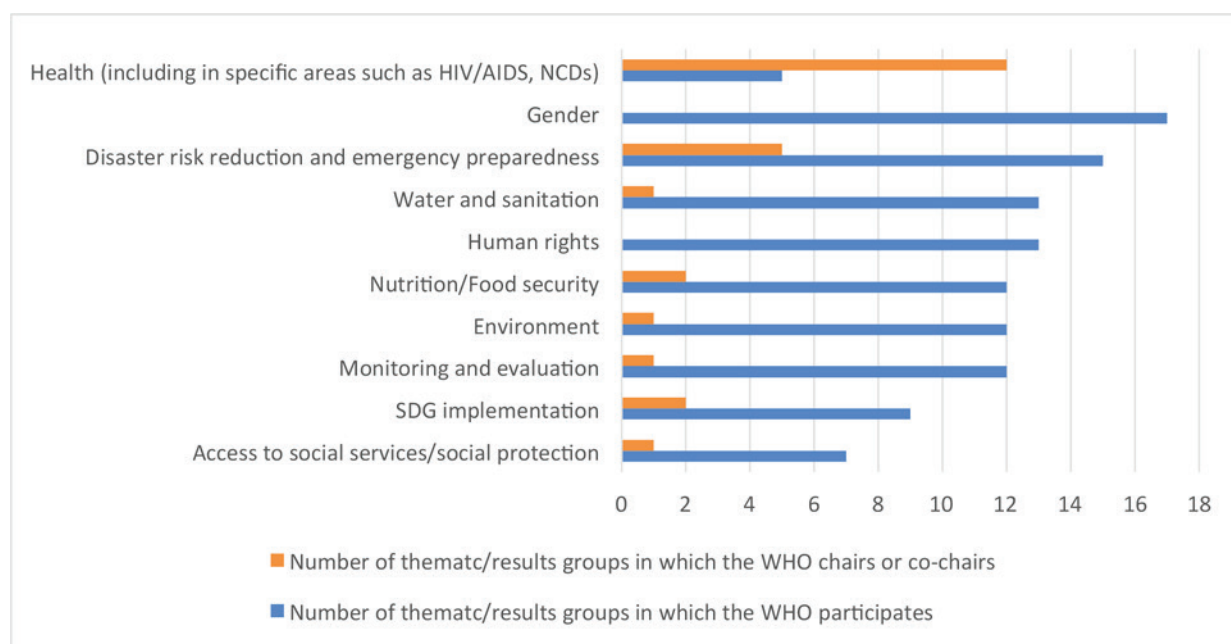
Table 9: The number and percentage of countries which included different health issues into their UNDAF

Health Issue	n (of 21)	%
Non-communicable diseases	17	81
Reproductive, Maternal, Newborn, Child and Adolescent Health	17	81
Health systems/Universal health coverage	16	76
Communicable diseases	15	71
Social Determinants of Health/Health and the environment	14	67
Nutrition and/or Food safety	13	62
Health Emergencies/International Health Regulations (2005)	11	52
Implementation of Framework Convention on Tobacco Control	7	33
Ageing and population	4	19
Anti-Microbial Resistance	3	14
Other	1	5

co-chaired by WHO are shown in figure 20. The WHO participates in or chairs/co-chairs the health thematic/results group in all SIDS bar the Bahamas, Haiti, Mauritius, Suriname, and Vanuatu. WHO was involved in all 10 groups in Comoros, Guinea-Bissau, Guyana, Maldives and Micronesia (Federated States of).

WHO offices participated Joint Programmes and Joint

Figure 20: Thematic/results groups chaired by and participated in by WHO



Resource Mobilisation Strategies in just over 40% of countries, territories or areas and to a lesser extent participated in One Fund/Multi donor trust funds (17%), as seen in table 10. Participation in all 3 occurs in Maldives and Papua New Guinea, and no participation was reported in seven countries, territories or areas.

states, territories or areas have the highest burden of non-tobacco related lifestyle risk factors for NCD. It is important to mitigate sudden changes in lifestyle and diet, such as increasing access to highly processed foods, as countries develop economically. WHO offices support SIDS in addressing health challenges through

Table 10: The number and percentage of WHO country offices which participate in different programmes

WHO country office participation					
Joint Programmes		Joint Resource Mobilisation Strategy		One Fund/Multi Donor Trust Fund	
N (of 22)	%	N (of 24)	%	N (of 24)	%
9	41	10	42	4	17

The SIDS are a block facing considerable barriers to progression in development and health from largely external factors. However, these countries, territories and areas have shown progress as well. There have been continual improvements in maternal and under 5 mortality, even in the least developed countries, though a substantial gap exists between countries at either end of the spectrum. This gap is also evident when considering life expectancy and healthy life expectancy. Immunisation coverage and health service indicators compare favourably to global standards although an economic gradient exists concerning immunisation coverage. Lower-middle income SIDS, particularly Pacific

in country staff, backstopping from WHO regional and headquarter teams and experts who are deployed need based. Between January 2015 and the 31st of October 2016, there was widespread experience of natural disasters, disasters outbreaks/epidemics, or both among SIDS. All WHO country, territory or area offices provided emergency preparedness support to SIDS, most commonly in the form of logistical support. Lack of resilience to natural disasters may be mitigated by the ongoing investment in health systems, positive progress in health service indicators (i.e. maternal care coverage) must be maintained through building robust infrastructure.



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