

# WHO presence in countries, territories and areas

## 2023 Report





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WHO presence in countries, territories and areas: 2023 report

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# Foreword



Since the Organization was founded 75 years ago, WHO's mission has been "the attainment by all people of the highest possible level of health". Our success in achieving that objective stands or falls by our ability to deliver results in countries. Over the past three years, COVID-19 has caused immense suffering, in the death and disease caused by the virus itself, as well as the severe disruption to health services, and the social and economic impacts of the pandemic. This once-in-a-century crisis illustrates the urgent need to support all countries to strengthen their defences against health emergencies, including the health systems that are the bedrock of healthier populations, universal health coverage and health security.

This report provides an overview of the WHO Secretariat's work in countries to implement the now-extended Thirteenth General Programme of Work, 2019–2025 and the health-related targets of the Sustainable Development Goals (SDGs). It outlines how the Secretariat implements the priorities of Member States across the triple billion targets, the current country capacities in place to do so, and the modalities employed in facilitating that delivery. Key to our work are the critical partnerships established in countries with United Nations agencies, bilateral and multilateral partners, and other entities with which WHO works to deliver results.

While there are many positives, the outcomes and challenges reported here must be addressed as a matter of priority. This means **equipping** country offices with the financial and human resources to match country needs, based on a core predictable country presence and a fit-for-purpose workforce that strives for gender parity; it means **enabling** country offices with capacity-building and training; it means **empowering** country offices with more delegation of authority and scaling up multisectoral partnerships; and it means **engaging** country offices, with more participation in decision-making, bottom-up prioritization and enhanced visibility.

WHO's 152 country offices are at the forefront of ensuring that we deliver effective and timely support to Member States. This report will enable the global community to better understand the role of the WHO Secretariat in countries: how it works, with whom it works, and the barriers that hinder our work. It also indicates where improvements are needed and what it will take to make them.

I remain committed to steering WHO's continued transformation towards an organization that is focused on delivering an impact where it matters most – in the lives of the people we serve.

Dr Tedros Adhanom Ghebreyesus  
Director-General  
World Health Organization

# Abbreviations

ADB	Asian Development Bank
AfDB	African Development Bank
AFR	African Region
AMR	Region of the Americas
ARG	Action for Results Group
AWaRe	Access, Watch, Reserve
BCA	Biennial Collaborative Agreement
CCA	Common Country Analysis
CCS	Country Cooperation Strategy
COVAX	COVID-19 Vaccine Global Access
COVID-19	coronavirus disease
EMR	Eastern Mediterranean Region
EUR	European Region
FENSA	Framework of Engagement with Non-State Actors
GLASS	Global Antimicrobial Resistance and Use Surveillance System
GPW13	Thirteenth General Programme of Work, 2019–2025
GS	General Service
HEPR	health emergency preparedness, response and resilience
ICT	information and communications technology
IDB	Inter-American Development Bank
IHR	International Health Regulations
IMF	International Monetary Fund
NAPHS	national action plan for health security
NGO	nongovernmental organization
NHPSPs	national health policies, strategies and plans

NPO	National professional officer
PAHO	Pan American Health Organization
PRSEAH	Prevention and Response to Sexual Exploitation, Abuse and Harassment
RCCE	risk communication and community engagement
SDGs	Sustainable Development Goals
SEAR	South-East Asia Region
SPAR	State Party Self-Assessment Annual Reporting Tool
SPRP	Strategic Preparedness and Response Plan
SSTC	South-South and triangular cooperation
TrACSS	tracking antimicrobial resistance country self-assessment survey
UHC	universal health coverage
UN	United Nations
UNCT	United Nations country team
UNICEF	United Nations Children's Fund
UNSDCF	United Nations Sustainable Development Cooperation Framework
WHO	World Health Organization
WHO FCTC	WHO Framework Convention on Tobacco Control
WPR	Western Pacific Region
WR	WHO representative



# Introduction

## Overview

This publication is the latest edition of WHO's biennial report providing an overview of the Organization's work in countries,<sup>1</sup> in accordance with World Health Assembly decision WHA69(8). This edition builds on previous country presence reports and captures the value that WHO's presence delivers in countries, as well as highlighting areas for improvement. The *2023 report* covers the period from January 2021 to December 2022 and complements WHO's end-of-biennium (2021) and mid-term results (2022) reports.

This report aims to capture the diversity of work undertaken by WHO country offices to provide technical support and cooperation to WHO Member States. However, the data in this report also leave no doubt that without strengthening WHO's presence through human and financial resources, the organizational gains made thus far may be lost, derailing the achievements towards the already off-track Sustainable Development Goals. In line with the long-standing tradition of partnership, this report aims to accelerate dialogue between WHO and its Member States on the urgency of addressing such matters, so that WHO country offices are strengthened and fully equipped to deliver meaningful and valuable support to Member States.

The structure of the *2023 report* emphasizes WHO's focus on driving public health impact in every country, as envisioned in the Thirteenth General Programme of Work (GPW13).

- [Chapter 1](#) presents the structure and governance of WHO, as well as findings on the differentiated approaches to WHO's cooperation.
- [Chapter 2](#) describes WHO's strategic work in health and development through Country Cooperation Strategies, Common Country Analyses and the United Nations Sustainable Development Cooperation Framework.
- [Chapter 3](#) describes the role of WHO country offices and the country-level capacity of the Organization to deliver on priorities, such as healthier populations; universal health coverage; health emergencies; and data, delivery and innovation.
- [Chapter 4](#) covers enabling mechanisms and describes the leadership and staffing levels of WHO country offices. It also discusses enhancement of capacities to support the country offices to remain at the forefront of public health work in countries, and provides funding information pertinent to WHO country offices.
- [Chapter 5](#) provides an overview of WHO country offices' partnerships for health at the country level to deliver results in the GPW13 priorities.

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<sup>1</sup> In the present report, the word "countries" refers to "countries, territories or areas" without distinction.

- **Chapter 6** provides information on the premises of WHO country offices in countries, territories and areas, accessibility of those offices for people with disabilities, and availability of parent-friendly facilities, with a focus on creating an inclusive workplace.
- **Chapter 7** describes the approaches of WHO country offices for corporate communications, and their collaboration with the communications sector.
- **Chapter 8** summarizes the challenges, opportunities and lessons learned by WHO country offices in the two-year period.
- **Chapter 9** presents a brief outlook for the years to come.

## Methodology

The primary source of data for this report was a dedicated survey sent to the 152 WHO country offices in the six WHO regions.<sup>2</sup> The survey (provided in English, French and Spanish) was conducted from September to November 2022 and received a 100% response rate. The data collected pertain to the period between 1 January 2021 and 31 August 2022. The survey design built on previous editions, adapted to reflect the changing context in which WHO country offices operated and the updated strategic vision of the Organization through the extended GPW13. New and revised questions were developed in collaboration with technical teams at WHO headquarters, and the Country Support Unit Network and a sample of WHO representatives were consulted. Efforts were made to ensure that questions gathered quantitative data so that the results could be compared across WHO regions.

In addition to the survey findings, this report drew on other sources, including:

- WHO's Global Management System, for data on human and financial resources;<sup>3</sup>
- databases of the Department of Country Strategy and Support and of various technical divisions at WHO headquarters;
- conclusions from the Eleventh WHO Global Management Meeting, held in December 2022; and
- input from the United Nations Development Coordination Office and external sources on engagement in global health initiatives.

WHO works with, and provides technical cooperation to, its 194 Member States and three Associate Members (Annex 1). In most cases, one WHO country office covers technical cooperation with one country, territory or area (Annex 2). Where countries do not have a physical country office, technical cooperation is covered by an office in a nearby country (a WHO multi-country office; Annex 3) or by a WHO regional office (Annex 4). **It is important to note that the survey and findings, as presented in this report, reflect the number of WHO country offices (152) and not the number of countries, territories and areas.** In addition to country offices, which is the main focus of this report, WHO has liaison offices, project offices, sub-offices, technical offices, warehouses and service centres. The analysis and conclusions would probably be affected if other types of WHO offices were included.

<sup>2</sup> In January 2023, the 153rd WHO country office was established in Cyprus. This report covers the period 2021–2022.

<sup>3</sup> Unless otherwise indicated, the data pertain to December 2022.



## Limitations of the report

Although efforts were made to collect quantitative data for comparability between country offices, there are limitations to the report. The report is mostly based on self-reported information, and survey respondents might not have interpreted the questions uniformly. To address this, WHO headquarters and a focal point from the Country Support Unit Network in the six WHO regional offices reviewed the response of country offices and, when needed, contacted them for further clarification.

When appraising the results presented in this report, limitations related to the unit of measurement (number of WHO country offices) and the size of the WHO regions should be considered. Specifically, the workforce of multi-country offices is tasked with responding to the needs of multiple countries, territories or areas. However, in this report, answers pertaining to those offices' capacity or role in providing technical cooperation to Member States were not disaggregated by the countries, territories or areas with which they worked. Furthermore, for the purposes of interregional comparability, the report presents findings as a percentage of WHO country offices per region. The denominators of regional analyses thus range from 11 (South-East Asia Region) to 47 (African Region), such that the answers of a country office carry different weight in interregional comparisons.



# 1. WHO country offices supporting Member States



This chapter describes the structure and governance of WHO, focusing on WHO country offices and their relationship with other levels of the Organization. The differentiated approaches (policy dialogue, strategic support, technical assistance and service delivery) are also presented to provide context for subsequent chapters.

## 1.1. WHO's structure and governance

Since the Organization was founded 75 years ago, WHO presence in countries, territories and areas has been the primary mode of delivering technical cooperation to Member States. WHO, as a specialized agency of the United Nations system, has a convening, directing and coordinating role in international health.

The WHO Secretariat – which comprises 152 WHO country offices,<sup>4</sup> six WHO regional offices and WHO headquarters in Geneva, Switzerland – is led by the WHO Director-General (Fig. 1). The Organization is governed by 194 Member States and three Associate Members (Annex 1).



*Fig. 1. WHO Secretariat: the three levels of the Organization*

<sup>4</sup> In January 2023, the 153rd WHO country office was established in Cyprus. This report covers the period 2021–2022.

## Regional offices

WHO Member States are grouped into six WHO regions, each with its own regional office (Table 1). Member States that do not have a WHO country office or are not covered by a neighbouring multi-country office receive direct technical and normative support from the relevant regional office and from headquarters. WHO headquarters and regional offices help countries and regions to exchange evidence, experiences and expertise promptly. The Member States of each region elect its regional director at its regional committee meetings.

*Table 1. WHO regional offices, location and Member States*

Regional offices	Location	No. of Member States	No. of WHO country offices
Regional Office for Africa	Brazzaville, Congo	47	47
Regional Office for the Americas (also Pan American Sanitary Bureau*)	Washington, DC, United States of America	35	27
Regional Office for the Eastern Mediterranean	Cairo, Egypt	21	21
Regional Office for Europe	Copenhagen, Denmark	53	31
Regional Office for South-East Asia	New Delhi, India	11	11
Regional Office for the Western Pacific	Manila, Philippines	27	15
<b>Total</b>		<b>194</b>	<b>152</b>

\* The Pan American Sanitary Bureau is the executive arm of the Pan American Health Organization (PAHO); it simultaneously serves as the WHO Regional Office for the Americas.

## Country offices

In the United Nations system, WHO has one of the most significant field presences. WHO presence in 152 countries, territories and areas serves as the Organization's central platform for effective collaboration with Member States to advance the global health agenda; contribute to national strategies and priorities; and incorporate country realities and perspectives into global policies and priorities. WHO's presence enables Member States to build national capacity for health service delivery and effective participation in global health debates.

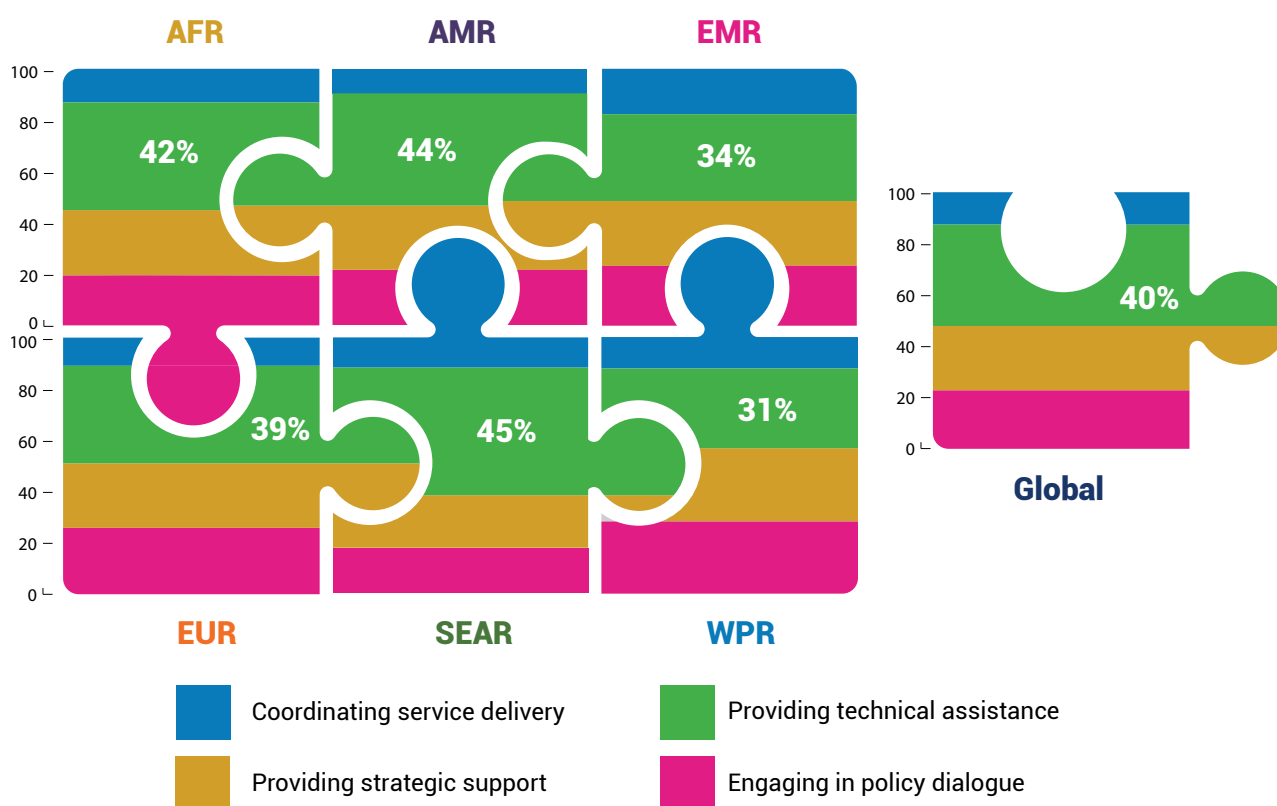
## Sub-offices in countries

In some countries, sub-offices are established as subsidiaries of a country office to provide support for implementing field activities for a programme, or to facilitate effective coverage of WHO activities in geographically large countries, countries facing complex emergencies or countries experiencing polio outbreaks. Typically, a sub-office is placed at the subnational level and is directed by a senior staff member. In the six WHO regions, 200 sub-offices have been established. The African Region has the most sub-offices (104), followed by the Eastern Mediterranean Region (45), the South-East Asia Region (26), the Region of the Americas (13) and the European Region (12). There are no sub-offices in the Western Pacific Region.

## 1.2. Differentiated support to Member States

Effective and efficient country offices are critical for WHO's work towards the Sustainable Development Goals (SDGs). Over time, however, countries' needs change. As a result, tailored responses from WHO are critical for addressing the various challenges faced by Member States. The increased focus on country-level action highlights the need for greater delegation of authority and accountability systems to the country level by WHO.

Previous editions of this report have demonstrated that WHO's country presence plays a crucial and catalytic role in advancing national health plans, SDGs and health goals. The principal types of cooperation with countries, which frequently intertwine and reinforce one another, are: policy dialogue to develop future systems; strategic support to build high-performing systems; technical assistance to build national institutions; and service delivery to fill critical gaps in emergency situations. Depending on their particular needs, contexts and complexities, countries could adopt all four types of support or a subset pertinent to their specific context at any given time. On average, around a quarter of WHO country offices' time and resources have been spent on engaging in policy dialogue, a quarter on providing strategic support, 40% on technical assistance and 13% on coordinating service delivery<sup>5</sup> (Fig. 2). The differentiated approaches adopted by WHO country offices can serve to identify what workforce a core WHO country presence could include.



**Fig. 2.** Average resources and time WHO country offices spent on types of differentiated cooperation by WHO region

<sup>5</sup> Thirty-five WHO country offices reported not engaging in coordinating service delivery at all (two in the Western Pacific Region, three in the South-East Asia Region, three in the African Region, four in the Eastern Mediterranean Region, 11 in the Region of the Americas and 12 in the European Region).

### Size of WHO country offices

As the context of countries varies (such as population size and sociopolitical background), so do the size of WHO country offices. For example, country offices in the African Region, the Eastern Mediterranean Region and the South-East Asia Region generally have more staff members than in other WHO regions, owing to the greater need of the populations. In those three regions, half of the offices have at least 26, 29 and 25 staff members, respectively. In contrast, half of the offices in the Region of the Americas have 11 staff members or fewer, half of the offices in the European Region have eight or fewer staff members, and half of the offices in the Western Pacific Region have 17 staff members or fewer.

### Backstopping support from other WHO offices

In its planning and operations, WHO aims to have seamless three-level alignment to optimize impact and results in countries. In cases where WHO country offices need additional support, they can request backstopping support from other WHO offices. In 2021–2022, 95% of WHO country offices received backstopping support from a regional or subregional office, and 70% from WHO headquarters. Most backstopping support received in this period focused on health emergencies (91% from a regional office; 45% from headquarters) – reflecting WHO's three-level support to address the coronavirus disease (COVID-19) pandemic. This was followed by healthier populations (82% from a regional office; 33% from headquarters) and universal health coverage (82% from a regional office; 30% from headquarters). Over two thirds of country offices also received support for data, delivery and innovation (74% from a regional office; 22% from headquarters) and WHO leadership and management (62% from a regional office; 17% from headquarters).

### Backstopping example: WHO's Internal Boost initiative

In line with WHO's country focus, the Organization has provided support to over 32 countries<sup>6</sup> since 2020 through its Internal Boost initiative, to respond to the disruption of essential health services caused by the COVID-19 pandemic. Internal Boost fast-tracks technical and programmatic support (such as communications and resource mobilization, policy and strategy, and data management) to country offices that have identified specific tasks and projects for which they need support. Through Internal Boost, selected staff from headquarters dedicate up to 50% of their time to support a specific project or task in a country office. As COVID-19 travel restrictions eased, Internal Boost shifted from a virtual modality to a hybrid one and has contributed to the development of over 60 high-level technical products.

<sup>6</sup> As at June 2022, Guinea, Mali, Nigeria, Rwanda, Sao Tome and Principe, Togo and Zimbabwe (AFR); Bahrain, Djibouti, Jordan, Kuwait, Morocco and Oman (EMR); Belarus, Kazakhstan, the Republic of Moldova and Tajikistan (EUR); Bangladesh, India, Indonesia and Timor-Leste (SEAR); Cambodia and the Philippines (WPR); and Paraguay, Suriname and seven Caribbean countries under the PAHO/WHO subregional office in Barbados (AMR).

### Chapter key message: WHO country offices' work with Member States

- WHO's differentiated country-level approaches to cooperation can provide insight into the type of skills and competencies needed in the offices to optimally provide technical support to Member States. In collaboration with Member States, and through applying Country Cooperation Strategies, WHO should define and establish a core country presence that reflects country priorities, one that should be funded by predictable WHO financing and should ensure that the right and sufficient capacities are in the right places.



# 2. Strategic cooperation for health and development



WHO presence in 152 countries, territories and areas is one of the Organization's central platforms for collaborating effectively with Member States to advance the global health agenda, contribute to national strategies and priorities, and incorporate country realities and perspectives into global policies and priorities. WHO's primary and strategic instruments for the planning process and engagement with governments at the country level are the Country Cooperation Strategies (CCSs). Where CCSs were not used, many WHO country offices and Member States reported that they used Biennial Collaborative Agreements (BCAs) to guide their cooperation. This chapter explores the uses of CCSs by WHO country offices, as well as the role country offices had in engaging with the United Nations Sustainable Development Cooperation Framework (UNSDCF) and national development plans.

## 2.1 Country Cooperation Strategies

One of the primary functions of WHO country offices is to assist in the development and implementation of national health policies, strategies and plans (NHPSPs) (see Chapter 3 for more on engagement with NHPSPs). The priorities identified in NHPSPs are then used to define WHO technical cooperation with a Member State, such as CCSs.

As at September 2022, just over two thirds of all WHO country offices had a CCS that was valid or under development in their country of operation, with variations across WHO regions (Fig. 3). The South-East Asia Region (82%) and the Western Pacific Region (67%) had the largest proportion of valid CCSs. Of the country offices that reported not having a valid CCS, this was either due to the use of a BCA instead of a CCS (as was the case for country offices in the European Region) or due to external factors such as political instability and protracted emergencies (in which case they followed a humanitarian response plan).

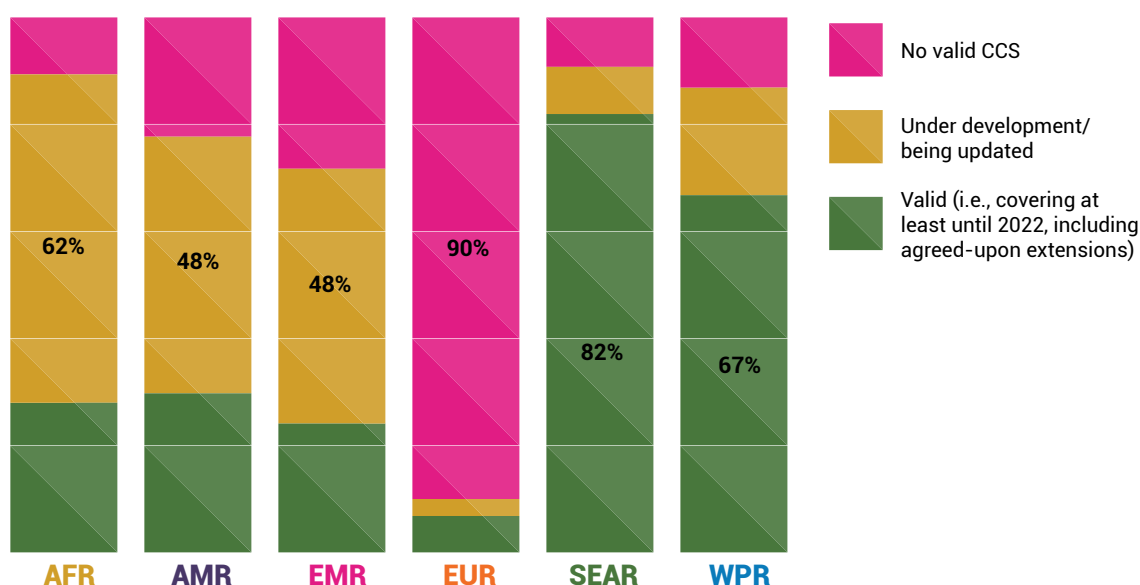
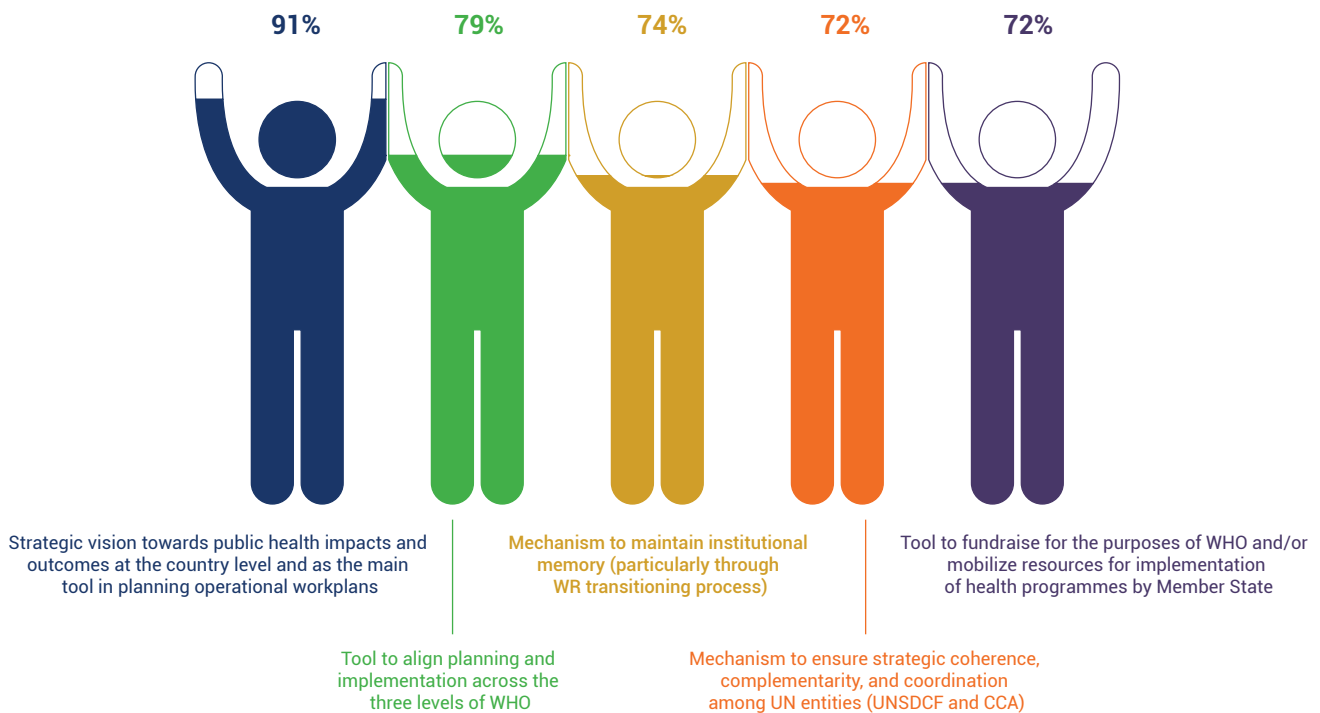


Fig. 3. Status of CCSs with Member States by WHO region

Of the 57 WHO country offices that reported having a CCS under development, 39% reported being in the final stages of development and 23% reported being in the stage of situation analysis. The remaining were also being advanced through consultations, joint design of priorities and evaluations.

The 47 country offices that reported having a valid CCS as at September 2022 used it for an array of strategic and operational purposes. Almost all of them used it for the “strategic vision towards public health impacts and outcomes at the country level and as the main tool in planning operational workplans”. The top five uses of CCSs across country offices, which demonstrate the value that the document and its development bring to the process, are shown in Fig. 4.



**Fig. 4.** Main uses of CCSs by the 47 WHO country offices with a valid CCS

A very different number of country offices had a valid CCS in each WHO region, and the usage purposes of CCSs varied across regions; this may reflect regions' different priorities (Table 2). For example, all the country offices with a valid CCS in the African Region, the Eastern Mediterranean Region and the European Region reported using CCSs for resource mobilization or fundraising, compared with two thirds or below in the other regions. Of the 48 country offices that reported not having a valid CCS or one under development, half indicated that they had a BCA instead. Over 40% stated that external factors – such as health emergencies like the coronavirus disease (COVID-19) or political instability – had created delays in the development of a new CCS, and the remaining few reported that they used another United Nations strategy instead.

**Table 2.** Uses of CCSs by WHO region

Areas where CCSs are used (n=47)	AFR (13)	AMR (8)	EMR (5)	EUR (2)*	SEAR (9)	WPR (10)
Strategic vision towards public health impacts and outcomes at the country level and as the main tool in planning operational workplans	100%	75%	100%	100%	89%	90%
Political instrument to promote national ownership and intersectoral approaches to achieve all health-related SDGs	77%	63%	80%	100%	67%	60%
Mechanism to ensure strategic coherence, complementarity and coordination among United Nations entities (UNSDCF and CCAs)	77%	63%	80%	100%	78%	60%
Tool to fundraise for the purposes of WHO and/or mobilize resources for implementation of health programmes by Member State	100%	50%	100%	100%	67%	40%
Platform for increasing WHO's visibility (communication and advocacy) at the country level	85%	50%	80%	100%	67%	20%
Tool to contribute to internal and external assessments (audits, evaluations)	54%	63%	60%	0%	89%	40%
Tool to align planning and implementation across the three levels of WHO	92%	38%	100%	50%	89%	80%
Mechanism to maintain institutional memory (particularly through WHO representative transitioning process)	92%	50%	100%	100%	56%	70%
Informing actions to advance gender, equity, human rights and disability inclusion in the health sector	69%	25%	60%	100%	33%	10%

\* In the European Region, 86% of the country offices used a BCA instead of a CCS, which explains the low number of CCSs.

CCSs have proved to be an effective instrument for supporting Member States in their systematic pursuit of national health goals and the Sustainable Development Goals (SDGs). Considering the lag in the implementation of the SDGs, it is imperative that CCS agreements at various stages of development be concluded expeditiously, and where they are no longer valid, new agreements should be concluded through an accelerated mechanism. The absence of a valid CCS may make it more difficult for WHO to provide the most contextualized technical cooperation and to forge multisectoral actions, which are fundamental to accelerating progress towards WHO's triple billion targets and the SDGs.

### Engagement with countries where WHO has no physical presence

The COVID-19 pandemic has highlighted that the dichotomy of countries receiving support versus countries providing support has become increasingly outdated. In the past few years, WHO's engagement and cooperation with Member States, where no country office is in place, have significantly expanded, including in some cases having CCSs with such countries in addition to biennial workplans.

In the **European Region**, the 22 Member States without a country office have appointed a "national counterpart", as well as technical focal points to steer collaboration on policy and strategic and technical issues, as per the strategy for collaboration between WHO and Member States.<sup>7</sup> Of those, three have CCSs. The strategy reaffirmed good practices of collaboration and proposed new modalities aimed at strengthening collaboration with Member States without country offices. These include building a network of national counterparts; matching national counterparts with senior "WHO counterparts" in the Regional Office for Europe as a sustainable point of access to WHO's offer; conducting national health stocktaking and developing more medium-term collaborative agreements; and developing mechanisms to deploy short-term response teams to provide targeted support with a specific programmatic focus upon the request of Member States. Some countries have initiated focused in-country collaboration, such as public health policy reviews in Belgium and Malta and establishing a primary health care demonstration site in Sweden. Other countries have expressed interest in opening a permanent country office; Cyprus made a commitment to open a new country office in October 2022.

In the **Region of the Americas**, cooperation with countries and territories that do not have a WHO country office is done through the Regional Office for the Americas and through multi-country offices. In the case of Canada and the United States of America, the biennial workplans are implemented through technical teams at the Regional Office and mostly focus on triangular cooperation activities. Puerto Rico has a biennial workplan that is implemented through the Liaison Office. The multi-country offices have different modalities for technical cooperation, with some islands having a staff member in the country or territory, reporting back to the main country offices. For example, some of the islands that are served by the PAHO/WHO Office for Barbados and the Eastern Caribbean Countries have a staff member in the country or territory, who reports back to the PAHO/WHO Representative to Barbados. Each country or territory under this type of cooperation has its own biennial workplan.

In the **Western Pacific Region**, the Regional Office for the Western Pacific established the Division of Pacific Technical Support in Fiji in 2010, to coordinate and provide timely, tailored and backstopping support to 21 Pacific island countries and areas. The Division also includes six other WHO offices: WHO representative offices in Samoa and in the Solomon Islands; and country liaison offices in the Federated States of Micronesia, Kiribati, Tonga and Vanuatu. WHO's engagement with other countries, outside of the Pacific, that have no physical WHO presence is managed through the Regional Office.

In the **Eastern Mediterranean Region**, cooperation with the United Arab Emirates (the only country in the region without a WHO country office) is done through cooperation with a desk officer at the Regional Office for the Eastern Mediterranean.

<sup>7</sup> Delivering United Action for Better Health – a strategy for collaboration between the WHO Regional Office for Europe and Member States in the WHO European Region. Copenhagen: WHO Regional Office for Europe; 2022 (EUR/RC72/14; <https://apps.who.int/iris/handle/10665/362022>, accessed 18 March 2023).

## 2.2. Cooperation for development and health through the United Nations development system

Involving partners outside of the health sector and adopting a whole-of-government and whole-of-society approach are essential for making progress towards the health-related SDGs, especially at the country level.

### Common Country Analyses and the UNSDCF

Through multisectoral and interagency engagement with United Nations partners, WHO contributes to health under all 17 SDGs. WHO country offices have actively incorporated key areas of work under the Thirteenth General Programme of Work, 2019–2025 (GPW13) into the UNSDCF outcomes framework, to promote coherence across all agencies of the United Nations system with mandates pertinent to health at the country level. In this context, WHO country offices across regions have had a leadership role in developing, implementing, monitoring and evaluating health-related matters in the UNSDCF and in developing Common Country Analyses (CCAs) (Fig. 5). Nearly half of the country offices led the development of health-related inputs for CCAs, and almost a third were active contributing partners with other agencies. The trend was almost in reverse with respect to the development of the UNSDCF.

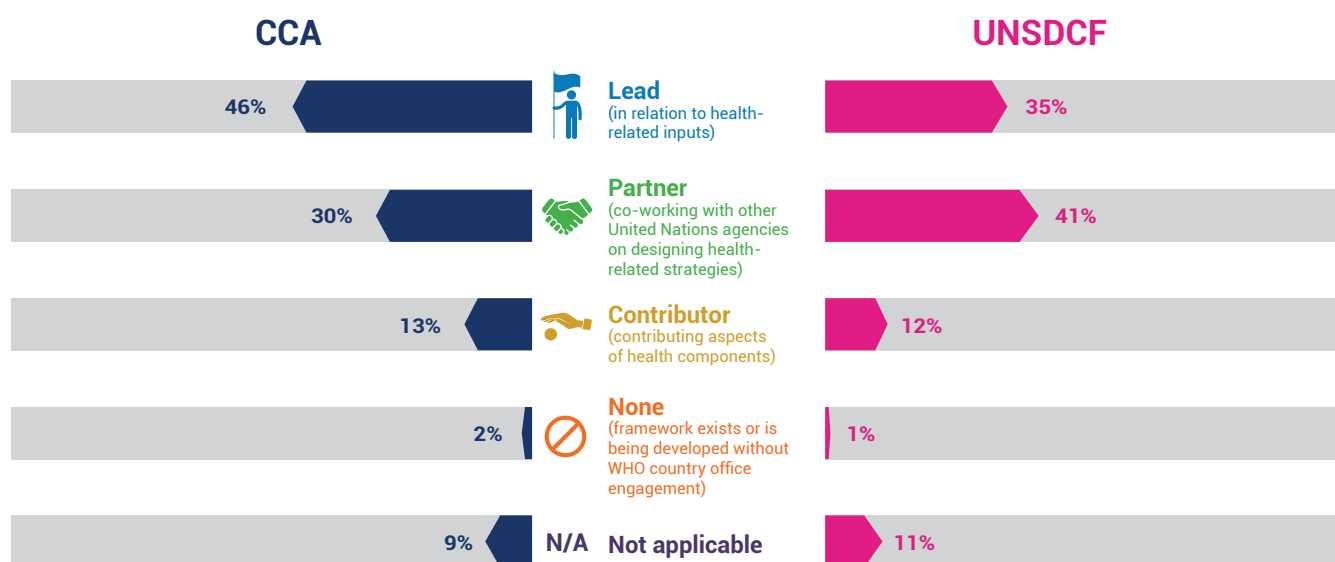


Fig. 5. Role of WHO country offices in developing CCAs and the UNSDCF

In the Eastern Mediterranean Region and the African Region, a majority of country offices had a leadership role in developing health-related inputs for CCAs (81% and 55%, respectively). In the European Region, 16% of country offices took on such a role,<sup>8</sup> and 48% in the Region of the Americas had this role. The proportion of country offices having a partnership role with other agencies of the United Nations system for CCAs was highest in the South-East Asia Region (64%), followed by the Western Pacific Region (40%).

<sup>8</sup> The lower figure for the European Region may be attributable to the fact that several nations lacked a United Nations country team (UNCT) and/or the UNSDCF.

The regional variations of roles for the UNSDCF were similar to the variations of roles for the CCAs. With regard to the role of WHO country offices in the UNSDCF, the Eastern Mediterranean Region and the African Region were also the WHO regions with the highest proportion of country offices that had taken a leadership role in developing health-related inputs (62% and 45%, respectively), with 13–36% of country offices in the other WHO regions having this role. Three quarters of the offices in the Western Pacific Region and two thirds of those in the South-East Asia Region played a partnership role for the UNSDCF, a role that 19–39% of country offices in the other WHO regions had.

Of all the WHO country offices, 89% stated that the COVID-19 pandemic had allowed them to exert greater influence in UNCTs beyond matters of health emergencies, suggesting that WHO country offices have maintained a relevant role in development matters with UNCTs. Of those who indicated greater influence, 97% attributed it to WHO's increased visibility, and 91% attributed it to the country offices' increased coordination role during the pandemic. A total of 77% of WHO country offices cited a broader scope of work as a reason for their increased influence. Of the ten country offices that reported not having increased influence in the work of UNCTs in the past two years, most stated that this was due to the limited capacity of the country office to engage in such work because of the focus on the COVID-19 response; three mentioned that this was due to low interest in health by UNCTs, and two mentioned that their country office already had strong influence before the pandemic.

### Integrating GPW13 priorities into the UNSDCF

Over three quarters of WHO country offices reported that they had integrated the priorities of healthier populations (mostly determinants of health and multisectoral work to address risk factors); universal health coverage (UHC; mostly access to essential health services); and health emergencies (mostly preparedness) into the UNSDCF or equivalent. Less than half (43%) of the country offices had integrated work on data, delivery and innovation.

- In the **African Region**, all the country offices had integrated UHC, and almost all had integrated health emergencies (94%) and healthier populations (89%) into the UNSDCF or equivalent; 51% had integrated data, delivery and innovation.
- In the **Region of the Americas**, 93% of country offices had integrated healthier populations and health emergencies, 89% UHC and 41% had integrated data, delivery and innovation into the UNSDCF or equivalent.
- In the **Eastern Mediterranean Region**, 90% of country offices had integrated health emergencies, 90% UHC and 86% healthier populations. Almost two thirds (62%) had integrated data, delivery and innovation.
- In the **European Region**, 55% of country offices had integrated UHC and health emergencies into the UNSDCF or equivalent, and 52% had integrated healthier populations. About a quarter (23%) had integrated data, delivery and innovation. As many of the European Region's country offices were in countries that did not have a United Nations Resident Coordinator Office to develop the UNSDCF, the percentage of country offices integrating GPW13 work was lower than in other WHO regions.
- In the **South-East Asia Region**, 82% of country offices had integrated healthier populations, UHC and health emergencies into the UNSDCF, and 55% had integrated data, delivery and innovation.

- In the **Western Pacific Region**, all the country offices had integrated UHC, 93% health emergencies and 87% healthier populations into the UNSDCF or equivalent. One third of offices had integrated data, delivery and innovation.

The success of WHO country offices in integrating GPW13 priorities into the UNSDCF and CCAs paves the way for the multiplication and amplification of health goals to reach the SDG targets. In conjunction with the many effective multisectoral and UNCT partnerships that have been formed, this presents an excellent opportunity to implement accelerated health initiatives across all sectors in the countries utilizing, among other things, locally available United Nations multi-partner trust funds.

## Role of WHO country offices in national development plans

Many WHO country offices, as partners in health and development, are involved in the development, implementation, monitoring or review of national development plans, in alignment with their engagement in the UNSDCF. National development plans provide a long-term perspective on a country's sustainable development by designating a desired destination and identifying the role that various sectors of society must take on to accomplish this goal. As long-term strategic objectives, national development plans establish overarching goals, assist in building consensus on the key goals, create a common long-term strategy framework within which more refined planning can occur, and provide a basis for making decisions regarding the most efficient use of resources.

It is notable that nearly two thirds of WHO country offices reported that they had an active role in initiating, developing, implementing, monitoring or reviewing **national development plans**, with about a quarter serving as leaders and 41% as active partners (Fig. 6). A total of 45% of WHO country offices in the African Region and 33% of country offices in the Eastern Mediterranean Region reported a leadership role in developing national development plans, compared with less than 20% of country offices in other WHO regions, where they were mostly active partners (building national capacity for effective policy analysis, formulation, implementation, monitoring and review) or contributors (one of the partner agencies but not providing active support) for the development of national development plans.



Fig. 6. Role of WHO country offices in the national development plan process



The importance of mainstreaming health across sectors to address the root causes of diseases through a whole-of-society approach has been underscored by the extension of GPW13 and strategies relevant to its accelerated implementation. The importance of WHO country offices taking an active role in national planning forums is thus self-evident. However, participation in engagement with national development plans is typically contingent on an invitation from the government to a WHO country office, which may be influenced by a number of variables, such as whether a government invites solely the United Nations Resident Coordinator Office or the United Nations Development Programme. It can also depend on how tasks are distributed in UNCTs, a government's openness to consulting multilateral organizations or a government's perception of WHO country offices' expertise in matters of development beyond health. The latter is particularly important, because in countries where WHO's work is perceived as only relevant for disease or emergency response, progress towards sustainable development and healthier populations could be hindered.

### Chapter key messages: strategic cooperation for health and development

- CCSs are the most important instrument for WHO's country-level cooperation, with about two thirds of WHO country offices engaged in CCS development or application. However, almost one third of country offices did not have a valid CCS, and over one third were in the development or validation process in 2021–2022. CCS development should be streamlined to increase the number of countries with a valid CCS, which can guide bottom-up planning and prioritization focused on driving impact in every country. Innovative cooperation agreements with countries that do not have a physical WHO presence should also be encouraged.
- Country offices have shown that they play an active role in processes related to CCAs and the UNSDCF, including the integration of GPW13 priorities into the UNSDCF. Where this is not the case, CCSs should be proactively used to lead the health component of CCA and UNSDCF discussions. Strengthening links between these strategic processes and documents could create opportunities for the mobilization of United Nations multi-partner trust funds or other locally available resources that could support the accelerated implementation of GPW13 and the SDGs.
- Although ministries of health are the main counterparts of WHO, inviting and enabling WHO country offices to engage with other sectors, especially those that work in development, will be essential to ensuring that health and its determinants are considered and integrated across strategic areas of the development plans of countries.



# 3. Promote, provide, protect and power health



The extension of the Thirteenth General Programme of Work (GPW13) provides a unique and timely opportunity for WHO and its Member States to renew their commitment and efforts towards achieving the triple billion targets. This chapter outlines the role of WHO country offices in shifting towards a paradigm that promotes health and prevents diseases through multisectoral action; advancing universal health coverage (UHC); addressing health emergencies; and enhancing data, delivery and innovation. Information on staffing capacity for those areas of work will be discussed in Chapter 4.

## 3.1. Promoting health: healthier populations

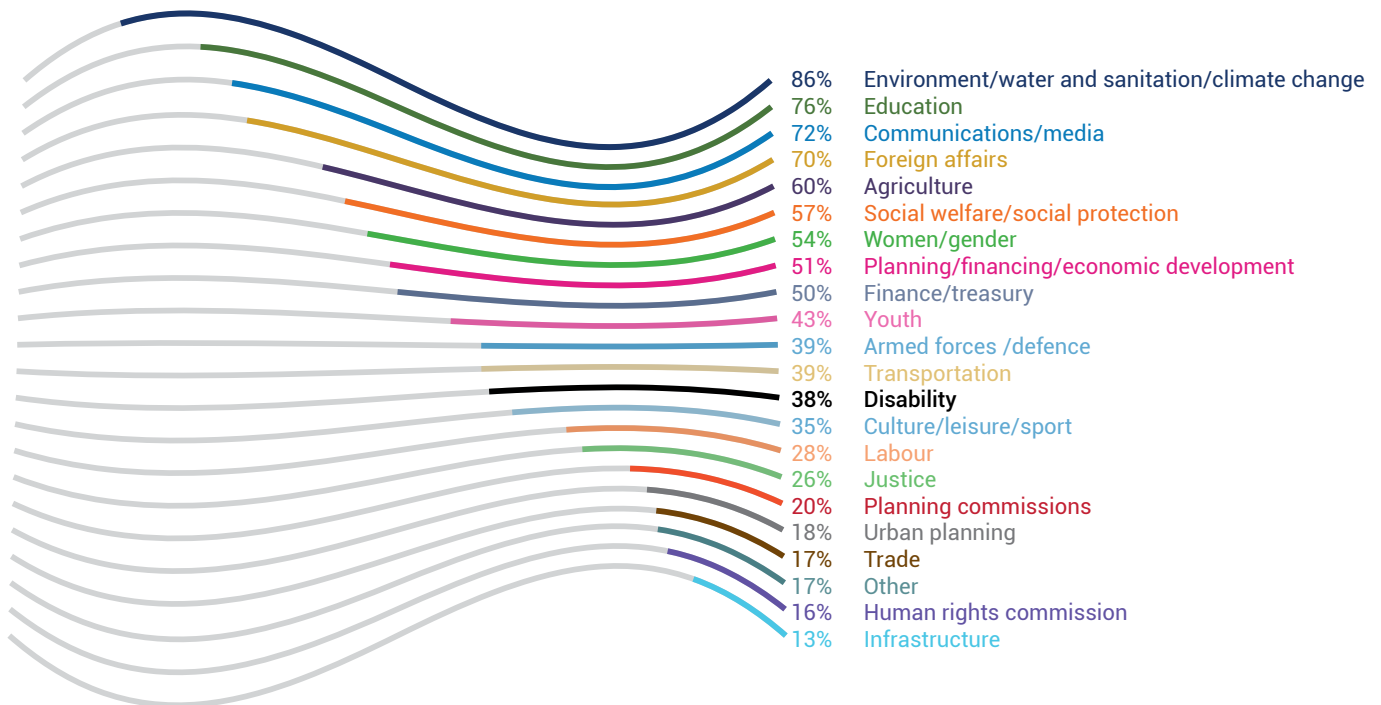
The onset of the coronavirus disease (COVID-19) pandemic has revealed dire health inequities, highlighting the importance of enabling people across the socioeconomic strata to live healthy lives and the need to address the social, economic, environmental and commercial determinants of health.<sup>9</sup> WHO country offices play an integral role in enabling, implementing and promoting cross-sectoral work for health in response to the billion target of healthier populations outlined in GPW13. This section provides an overview of WHO's multisectoral collaborations and workforce capacity for healthier populations. More information on WHO country offices' partnerships in general is provided in Chapter 5.

### Multisectoral work

In 2021–2022, WHO country offices engaged widely with multiple sectors, fostering strong partnerships for health, a key mechanism identified by WHO for accelerating efforts towards achieving the Sustainable Development Goals (SDGs), especially at the country level.<sup>10</sup> In addition to technical cooperation with the health sector, all WHO country offices reported to have worked with at least one other sector, mainly environment/water and sanitation/climate change; education; communications/media; foreign affairs; and agriculture (Fig. 7). Compared with 2019–2020, in 2021–2022 there was a 20-percentage-point increase in country offices that worked with the foreign affairs sector, reflecting in part WHO's engagement in supporting Member States with the acquisition of COVID-19 vaccines, in response to humanitarian crises in 2021–2022, and in their participation in meetings of governing bodies.

<sup>9</sup> Social determinants of health. Geneva: World Health Organization; 2021 (WHA74.16; [https://apps.who.int/gb/ebwha/pdf\\_files/WHA74/A74\\_R16-en.pdf](https://apps.who.int/gb/ebwha/pdf_files/WHA74/A74_R16-en.pdf), accessed 26 March 2023).

<sup>10</sup> Programme budget 2022–2023: revision. Geneva: World Health Organization; 2022 (A75/8; [https://apps.who.int/gb/ebwha/pdf\\_files/WHA75/A75\\_8-en.pdf](https://apps.who.int/gb/ebwha/pdf_files/WHA75/A75_8-en.pdf), accessed 26 March 2023).



*Fig. 7. Percentage of WHO country offices that worked with sectors other than the health sector*

Regional variations exist with regard to the most engaged sectors, which may reflect the different priorities of WHO's cooperation in countries (Table 3).

- In four of the six WHO regions (the African Region, the Eastern Mediterranean Region, the South-East Asia Region and the Region of the Americas), the most commonly engaged sector was the **environment/water and sanitation/climate change sector**; this was the second most engaged sector in the other two regions.
- The **women/gender sector** was among the top five engaged sectors for WHO country offices in the Region of the Americas and the Eastern Mediterranean Region. Moreover, two thirds of country offices in the African Region engaged with this sector.
- The **social welfare/social protection sector** was among the top five engaged sectors for country offices in the Region of the Americas, the European Region and the Western Pacific Region.
- The **finance/treasury sector** was among the five most engaged sectors for country offices in the African Region. Moreover, more than half of the country offices in the South-East Asia Region also engaged with this sector.
- The **planning/financing/economic development sector** was among the top five sectors engaged by offices in the Eastern Mediterranean Region and the South-East Asia Region.

**Table 3.** Most common cross-sectoral collaboration for WHO country offices

AFR (n=47)	AMR (n=27)	EMR (n=21)	EUR (n=31)	SEAR (n=11)	WPR (n=15)
Environment/ water and sanitation/ climate change (98%)	Environment/ water and sanitation/ climate change (85%)	Environment/ water and sanitation/ climate change (81%)	Foreign affairs (84%)	Environment/ water and sanitation/ climate change (91%)	Education (87%)
Communica- tions/media (87%)	Education (81%)	Communica- tions/media (76%)	Environment/ water and sanitation/ climate change (74%)	Foreign affairs (82%)	Environment/ water and sanitation/ climate change (73%)
Education (83%)	Women/gender (74%)	Women/gender (71%)	Communica- tions/media (61%)	Education (82%)	Foreign affairs (73%)
Agriculture (68%)	Agriculture (70%)	Foreign affairs (71%)	Education (61%)	Communica- tions/media (64%)	Social welfare/ social protection (60%)
Finance/ treasury (68%)	Social welfare/social protection Foreign affairs (70%)	Planning/ financing/ economic development (67%)	Social welfare/ social protection (52%)	Planning/ financing/ economic development (64%)	Communica- tions/media (53%)

In addition to interministerial collaborations, 83% of country offices worked with municipal-level governments, 80% with communities or villages, 78% with subnational governments (such as provinces or states) and 72% with legislators or parliamentarians. Notably, over 90% of country offices in the African Region reported to have worked with communities/villages or subnational governments for the implementation of GPW13. Likewise, over 90% of country offices in the Western Pacific Region worked with communities and municipal governments, and 90% of country offices in the Eastern Mediterranean Region also worked with municipal governments.

Since promoting health is done by working beyond the health sector – thus requiring WHO to engage with other sectors, civil society, communities, nongovernmental organizations, academia and the private sector – it will be important for ministries of health to enable cross-sectoral cooperation for WHO country offices.

## Implementation of the WHO Framework Convention on Tobacco Control and its Protocol to Eliminate Illicit Trade in Tobacco Products

The year 2023 marks the 20th anniversary of the adoption by the World Health Assembly of the WHO Framework Convention on Tobacco Control (WHO FCTC). The treaty responds to the global tobacco epidemic and reaffirms the right of all people to the highest standard of health. **As at 31 December 2022, WHO FCTC had 182 Parties.**<sup>11</sup>

In the past two decades, WHO FCTC has made a remarkable impact on public health. The global prevalence of current tobacco use dropped from an estimated 29% in 2005 to around 22% in 2019, with the downward trend being seen across all World Bank income groups.<sup>12</sup> Strengthening the implementation of WHO FCTC in all countries was explicitly included in the SDGs (target 3.a), and the Convention has been recognized as an accelerator for sustainable development.<sup>13</sup>

On 25 September 2018, the Protocol to Eliminate Illicit Trade in Tobacco Products, the first protocol to WHO FCTC and a treaty in its own right, entered into force. The Protocol seeks to eliminate all forms of illicit trade in tobacco products, in accordance with the terms of Article 15 of WHO FCTC. **As at 31 December 2022, the Protocol had 66 Parties,<sup>14</sup> a number that is expected to continue increasing in the coming period.**

**The Secretariat of WHO FCTC and its Protocol<sup>15</sup> leads on treaty matters and works jointly with WHO to provide support to Parties.** Such support includes facilitating policy dialogue, providing technical assistance to further tobacco control at the country level (for example by conducting in-country technical missions and needs assessment missions to support Parties to implement both treaties) and supporting and encouraging Parties to the Convention to become Parties to the Protocol. The Convention Secretariat also coordinates with WHO country offices to promote the integration of WHO FCTC into WHO Country Cooperation Strategies, as well as the country work of United Nations funds, programmes and agencies, and to provide support for the inclusion of SDG target 3.a into voluntary national reviews of progress towards the 2030 Agenda for Sustainable Development. WHO country offices facilitate outreach and advocacy efforts of the Convention Secretariat at the country level; assist in communication with governments should support be requested; and support the Convention Secretariat with the collection of mandatory assessed contributions from Parties.

The 10th session of the Conference of the Parties to WHO FCTC and the third session of the Meeting of the Parties to the Protocol (the governing bodies of the treaties) are set to take place in Panama in November 2023.<sup>16</sup>

<sup>11</sup> For a list of Parties to WHO FCTC, see: WHO Framework Convention on Tobacco Control ([https://treaties.un.org/pages/ViewDetails.aspx?src=TREATY&mtdsg\\_no=IX-4&chapter=9&clang=\\_en](https://treaties.un.org/pages/ViewDetails.aspx?src=TREATY&mtdsg_no=IX-4&chapter=9&clang=_en), accessed 26 March 2023).

<sup>12</sup> 2021 global progress report on implementation of the WHO Framework Convention on Tobacco Control. Geneva: World Health Organization; 2022 (<https://apps.who.int/iris/handle/10665/351735>, accessed 26 March 2023).

<sup>13</sup> The WHO Framework Convention on Tobacco Control: an accelerator for sustainable development. New York: United Nations Development Programme; 2017 (<https://fctc.who.int/publications/m/item/the-who-framework-convention-on-tobacco-control-an-accelerator-for-sustainable-development>, accessed 26 March 2023).

<sup>14</sup> For a list of Parties to the Protocol, see: Protocol to Eliminate Illicit Trade in Tobacco Products ([https://treaties.un.org/Pages/ViewDetails.aspx?src=TREATY&mtdsg\\_no=IX-4-a&chapter=9&clang=\\_en](https://treaties.un.org/Pages/ViewDetails.aspx?src=TREATY&mtdsg_no=IX-4-a&chapter=9&clang=_en), accessed 26 March 2023).

<sup>15</sup> For more information on the Secretariat, see: Who we are [webpage]. Geneva: Secretariat of the WHO Framework Convention on Tobacco Control; 2023 (<https://fctc.who.int/secretariat/about>, accessed 26 March 2023).

<sup>16</sup> Global tobacco control conferences to take place in November 2023. Geneva: Secretariat of the WHO Framework Convention on Tobacco Control; 20 January 2023 (<https://fctc.who.int/newsroom/news/item/20-01-2023-global-tobacco-control-conferences-to-take-place-in-november-2023>, accessed 26 March 2023).

## 3.2. Providing health: universal health coverage

UHC<sup>17</sup> is firmly grounded in the WHO Constitution, which stipulates that the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being. GPW13 outlined UHC as one of the three pillars of the triple billion targets, emphasizing the importance of having access to a “strong and resilient people-centred health system with primary care as its foundation”.<sup>18</sup> Although the UHC service coverage index has increased in the past decades, 30% of the world’s population still cannot access essential health services, almost 2 billion people face catastrophic spending on health, and health systems worldwide have been affected by the COVID-19 pandemic.<sup>19,20</sup> WHO is a key partner in addressing such challenges, working towards a radical reorientation of health systems that have primary health care as the foundation of UHC. This section provides an overview of WHO country offices’ cooperation towards UHC by means of involvement in the national health plans of the countries with which they work, with special consideration for the countries in the UHC Partnership.

### Engagement with national health plans

National health policies, strategies and plans (NHPSPs) play a crucial role in defining countries’ vision, policy goals and strategies for maintaining the health of populations. NHPSPs provide a framework for addressing the vast array of challenges to enhancing health outcomes. WHO has a long history of working with its Member States in developing NHPSPs through technical cooperation at the country level, facilitation of national policy debate and intercountry interaction, as well as normative work and high-level international policy frameworks.<sup>21</sup> As at 2021, 142 Member States had a NHPSP updated within the last five years, including 126 that received cooperation from WHO country offices.

In the current reporting period, almost all WHO country offices (regardless of the status of their national health plan) were involved in initiating, developing, implementing, monitoring and reviewing national health plans, either by building national capacity for effective policy analysis, formulation, implementation, monitoring and review as active partners (48%), or by leading, such as co-chairing or co-leading NHPSP mechanisms (42%). Another 5% had a contributing role as a partner agency, but not providing active support, and 5% were not involved.<sup>22</sup>

<sup>17</sup> Universal health coverage [webpage]. Geneva: World Health Organization; 2023 ([www.who.int/health-topics/universal-health-coverage#tab=tab\\_3](http://www.who.int/health-topics/universal-health-coverage#tab=tab_3), accessed 26 March 2023).

<sup>18</sup> Thirteenth General Programme of Work 2019–2023. Geneva: World Health Organization; 2019 (<https://apps.who.int/iris/bitstream/handle/10665/324775/WHO-PRP-18.1-eng.pdf>, accessed 26 March 2023).

<sup>19</sup> Universal health coverage (UHC) [webpage]. Geneva: World Health Organization; 12 December 2022 ([https://www.who.int/news-room/fact-sheets/detail/universal-health-coverage-\(uhc\)](https://www.who.int/news-room/fact-sheets/detail/universal-health-coverage-(uhc)), accessed 26 March 2023).

<sup>20</sup> Programme budget 2022–2023: revision. Geneva: World Health Organization; 2022 (A75/8; [https://apps.who.int/gb/ebwha/pdf\\_files/WHA75/A75\\_8-en.pdf](https://apps.who.int/gb/ebwha/pdf_files/WHA75/A75_8-en.pdf), accessed 26 March 2023).

<sup>21</sup> Supporting national health policies, strategies, plans [webpage]. Geneva: World Health Organization; 2023 ([www.who.int/activities/supporting-national-health-policies-strategies-plans](http://www.who.int/activities/supporting-national-health-policies-strategies-plans), accessed 26 March 2023).

<sup>22</sup> WHO country offices that were not involved with NHPSPs provided strategic support to authorities across different levels of government, in accordance with the sociopolitical context.



Regional variations reveal that a larger proportion of country offices in the African Region, the Western Pacific Region and the Eastern Mediterranean Region had a leadership role in NHPSPs than in other WHO regions (Fig. 8). This may reflect the type of cooperation requested by Member States across regions.

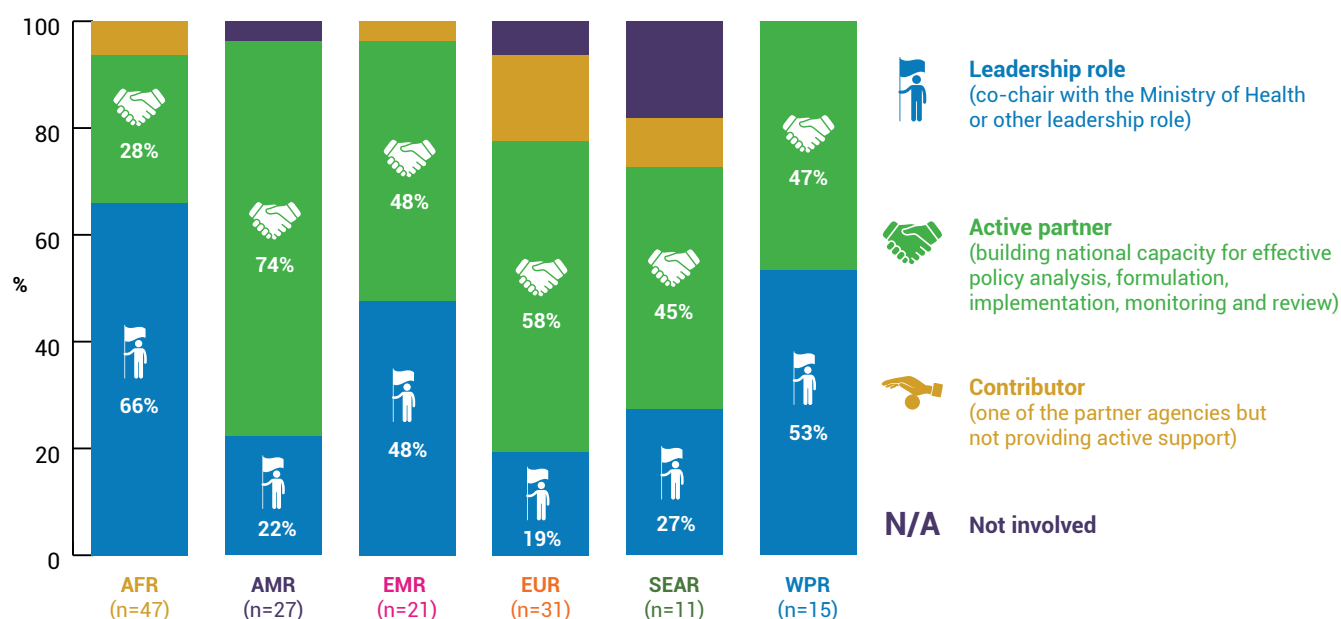


Fig. 8. Role of WHO country offices in the national health plan process by WHO region

## Countries in the UHC Partnership

Since 2011, the UHC Partnership – a multi-donor partnership and one of WHO’s largest platforms for international cooperation on UHC and primary health care – has been supporting policy dialogue and providing technical assistance for strategic planning, health system governance, health financing strategies and effective development cooperation in countries.<sup>23</sup> As at October 2022, WHO, through the UHC Partnership, had placed policy advisers in 115 countries across the six WHO regions (Table 4). A full list of countries in the UHC Partnership as at 2021 is provided in Annex 5.

Table 4. Number of countries in the UHC Partnership by WHO region

AFR	AMR	EMR	EUR	SEAR	WPR	Total
46	23	13	12	4	17	115

<sup>23</sup> Universal Health Coverage Partnership [webpage]. Geneva: World Health Organization; 2023 ([extranet.who.int/uhcpartnership/about](https://extranet.who.int/uhcpartnership/about), accessed 26 March 2023).

To enhance WHO's country-level capacity to support work towards UHC in the 115 countries, 121 health policy advisers were deployed in 2021 to country offices to support health priorities towards UHC (in some countries, more than one policy adviser was deployed). These included 39 in the African Region, 14 in the Region of the Americas, 13 in the Eastern Mediterranean Region, six in the European Region, 18 in the South-East Asia Region and 31 in the Western Pacific Region.

Of the 115 countries in the UHC Partnership, 88 had a valid NHPSP and received enhanced cooperation from WHO. Compared with countries without policy advisers, a much larger percentage of WHO offices in countries participating in the UHC Partnership reported that they had a lead role in national health plan processes (such as co-chairing with health ministries) (Fig. 9). This suggests the added value of WHO support to Member States for their national health strategies through the UHC Partnership.

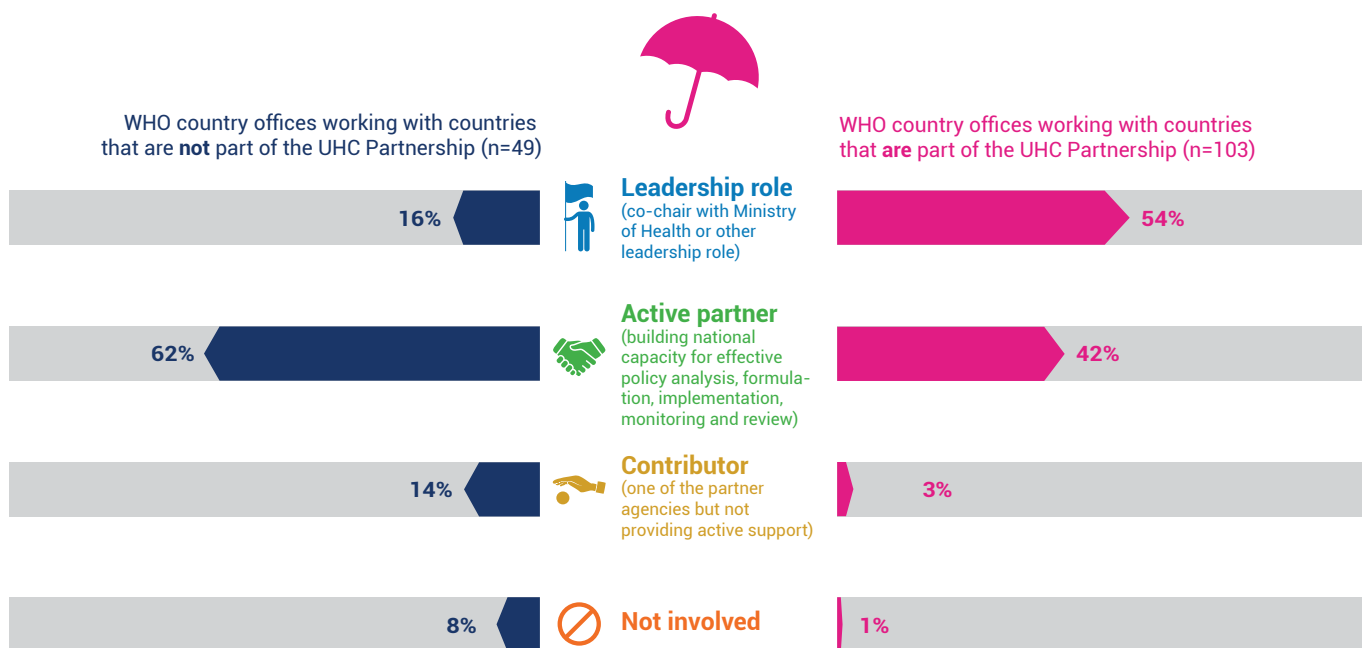


Fig. 9. Role of WHO country offices in the national health plan process by UHC Partnership status

## Addressing antimicrobial resistance

### *National action plans on antimicrobial resistance*

Multisectoral actions that integrate health into other sectors and that consider other sectors within the delivery of health services are required to respond to antimicrobial resistance and protect population health. The global action plan on antimicrobial resistance, adopted in 2015 by the World Health Assembly and then endorsed by the Food and Agriculture Organization of the United Nations (FAO) and the World Organisation for Animal Health (founded as the Office International des Epizooties), provides a blueprint for countries to develop and implement their own national action plans on antimicrobial resistance. In 2022, the United Nations Environment Programme officially joined the partnership.

Implementation of the national action plans is being supported by WHO through specific guidance, tools, capacity-building technical workshops, e-learning modules, global webinars and the establishment of communities of practice through an online platform. Significant progress has been achieved in the development of national action plans on antimicrobial resistance. As at November 2022, 169 WHO Member States had developed their national action plan on antimicrobial resistance, and 134 of them had a WHO country presence to guide and support this effort (Table 5).

**Table 5.** Member States with national action plans on antimicrobial resistance and WHO country presence

WHO region and Member States	With antimicrobial resistance national action plan	With antimicrobial resistance national action plan and WHO country presence
African Region (47)	42	42
Region of the Americas (35)	27	23
Eastern Mediterranean Region (21)	20	19
European Region (53)	46	27
South-East Asia Region (11)	11	11
Western Pacific Region (27)	23	12
Total (194)	169	134

### *Tracking antimicrobial resistance country self-assessment survey (TrACSS)*

Since 2016, TrACSS<sup>24</sup> has been monitoring the implementation of national action plans on antimicrobial resistance annually.<sup>25</sup> A total of 166 WHO Member States responded to the 2022 survey, and 133 of those had WHO country offices to support the completion of the annual survey (Table 6). The global trend analysis shows increases in several indicators monitored by the survey in the past few years, including: countries with antimicrobial resistance national action plan development, countries with functional multisectoral coordination mechanisms on antimicrobial resistance, countries offering training on antimicrobial resistance for health care workers, countries with national surveillance systems on antimicrobial resistance, and countries adopting the Access, Watch, Reserve (AWaRe) classification of antibiotics into their national essential medicines list. This indicates that there has been some global improvement in implementing the objectives of the global action plan on antimicrobial resistance, although the progress has not been

<sup>24</sup> Previously known as the tripartite antimicrobial resistance country self-assessment survey.

<sup>25</sup> All results are available at: Global database for tracking antimicrobial resistance (AMR) country self-assessment survey (TrACSS) [database]. Geneva: World Health Organization; 2022 ([www.amrcountryprogress.org](http://www.amrcountryprogress.org), accessed 26 March 2023).

consistent across all objectives of the global action plan. In the past five years, there has been less progress on indicators measuring government-supported antimicrobial resistance awareness-raising campaigns, having a national monitoring system for antimicrobial consumption, nationwide implementation of national infection, prevention and control programmes or policies to optimize use of antimicrobials in human health.

**Table 6.** Member States that responded to TrACSS in 2022

WHO region and Member States	Responded to TrACSS	Responded to TrACSS with WHO country presence
African Region (47)	42	42
Region of the Americas (35)	24	21
Eastern Mediterranean Region (21)	21	20
European Region (53)	52	29
South-East Asia Region (11)	11	11
Western Pacific Region (27)	16	10
Total (194)	166	133

Based on the latest survey data, 102 countries reported to have implemented practices in ensuring appropriate antimicrobial use in at least some health care facilities, as well as the availability of guidelines on their appropriate use. Of those, 42 countries had guidelines implemented nationwide in most health care facilities. Of the 102 countries with at least some antimicrobial use practices and guidelines for optimizing use in human health, 73 had WHO country presence to support this effort.

### *Appropriate use of antibiotics*

WHO published the AWaRe antibiotic handbook in 2022,<sup>26</sup> which provides guidance based on WHO's classification of antibiotics into three groups: Access, Watch and Reserve. Countries can adopt the AWaRe classification in their national essential medicines list to guide the optimal use of antibiotics and carefully manage the availability and use of last-resort drugs. Evidence shows that to optimize the use of antibiotics and reduce resistance, countries should increase the proportion of using Access antibiotics to correspond to at least 60% of total national consumption. Data from TrACSS showed that 70 countries reported to have adopted the AWaRe classification in their national essential medicines list. Of those, 57 had WHO country presence to provide support and technical assistance.

### *Global Antimicrobial Resistance and Use Surveillance System (GLASS)*

As at December 2022, 127 countries had enrolled in GLASS. In 2022, 87 countries provided data on antimicrobial resistance and 55 provided data on antimicrobial consumption. WHO country offices, regional and subregional offices and headquarters have provided strong support for establishing and strengthening in-country antimicrobial resistance surveillance systems. This support has been critical for tracking the emergence and spread of antimicrobial resistance, especially as all WHO Member States are expected to collect and report relevant data for SDG indicator 3.d.2 (Proportion of bloodstream infections due to selected antimicrobial-resistant organisms).

<sup>26</sup> The WHO AWaRe (Access, Watch, Reserve) antibiotic book. Geneva: World Health Organization; 2022 (<https://apps.who.int/iris/handle/10665/365237>, accessed 26 March 2023).

### 3.3. Protecting health: health emergencies

The COVID-19 pandemic has underscored the importance of WHO's work across levels, especially with respect to preparedness and response to health emergencies at the country level. As the global health architecture evolved in 2021 and 2022, WHO remained a core partner for its Member States, especially for preparedness and response to health emergencies, such as COVID-19. This section presents information on WHO support during the COVID-19 pandemic in 2021–2022; the work of WHO country offices in health emergency preparedness, response and resilience (HEPR); and Member States' engagement in preparedness and prevention of health emergencies and pandemics.

#### Addressing the COVID-19 pandemic in 2021–2022

Since the outbreak of the COVID-19 pandemic, WHO country offices worldwide have been essential partners for the COVID-19 response.<sup>27</sup> The years 2021 and 2022 were marked by, among other things, the emergence of SARS-CoV-2 variants, the development and deployment of tools (testing, treatments and vaccines) and global efforts to shift from acute management to longer-term management of COVID-19. The focus of the 2021 Strategic Preparedness and Response Plan (SPRP) was to accelerate equitable access to new COVID-19 tools and protect the vulnerable through vaccines, and the 2022 SPRP sought to reduce and control incidence of SARS-CoV-2 infections and to prevent, diagnose and treat COVID-19.

Guided by the strategic objectives of SPRP, WHO has supported Member States to suppress transmission, reduce exposure, counter misinformation, protect the vulnerable, reduce mortality and morbidity from all causes, and accelerate equitable access to COVID-19 tools.<sup>28</sup> To that end, the Organization has played a role in strengthening surveillance, laboratories and public health intelligence capacities in countries; implementing vaccination campaigns, public health interventions and community engagement; addressing health systems' weaknesses and leveraging the opportunity for resilient health systems and safe and scalable clinical care; and advancing research and development, and equitable access to countermeasures and essential supplies.<sup>29</sup> The provision of WHO support across its levels to Member States in the context of COVID-19 has enabled the Organization to respond rapidly and strategically to other health emergencies, including mpox, which was declared a public health emergency of international concern in May 2022.<sup>30</sup>

<sup>27</sup> WHO presence in countries, territories and areas: 2021 report. Geneva: World Health Organization; 2021 (<https://apps.who.int/iris/handle/10665/341308>, accessed 26 March 2023), p. 25.

<sup>28</sup> COVID-19 Strategic Preparedness and Response Plan (SPRP 2021). Geneva: World Health Organization; 2021 (<https://apps.who.int/iris/handle/10665/340072>, accessed 26 March 2023).

<sup>29</sup> Responding to health emergencies in 2022: annual report of the World Health Organization. Geneva: World Health Organization; in press.

<sup>30</sup> Mpox (monkeypox) outbreak [webpage]. Geneva: World Health Organization; 2022 (<https://www.who.int/emergencies/situations/monkeypox-oubreak-2022>, accessed 26 March 2023).

## Supporting equitable access to COVID-19 vaccines

Across its levels, WHO has played an important role in making COVID-19 vaccines available and accessible to priority groups and the general population. In 2021–2022, WHO country offices were instrumental in supporting countries with countermeasures specific to COVID-19. Most country offices helped to ensure that people got vaccinated, and many supported with acquisition or capacity-building for the development of vaccines, for example by providing support to countries with agreements for access to vaccines (such as COVAX<sup>31</sup>), with equitable redistribution of vaccines (such as the COVID-19 Vaccine Delivery Partnership<sup>32</sup>) and with capacity-building for local production of vaccines.<sup>33</sup> Table 7 lists WHO support across the WHO regions.

*Table 7. Types of support provided by WHO country offices in COVID-19 vaccine access and deployment in 2021–2022*

WHO country office support	Regional variation
<b>90%</b> Demand generation for COVID-19 vaccines, including community engagement and misinformation management regarding vaccines.	From 82% of country offices in the South-East Asia Region, to 98% in the African Region.
<b>87%</b> COVID-19 immunization campaigns for the general population.	From 71% of country offices in the European Region, to 100% in the Region of the Americas.
<b>86%</b> COVID-19 immunization campaigns for health workers, older persons and other priority groups.	From 71% of country offices in the Eastern Mediterranean Region, to 93% in the Region of the Americas and the Western Pacific Region.
<b>68%</b> Supply or access agreements for COVID-19 vaccines for governments, such as local or international manufacturing agreements.	32% of country offices in the European Region; 67–78% in the Eastern Mediterranean Region, the South-East Asia Region, the Western Pacific Region and the Region of the Americas; 85% in the African Region.
<b>65%</b> Advocacy for vaccine procurement, such as donation of excess vaccines and consumables.	39% of country offices in the European Region; 55–63% in the South-East Asia Region, the Eastern Mediterranean Region and the Region of the Americas; 80–83% in the Western Pacific Region and the African Region.
<b>33%</b> Investment in research and development activities for vaccines, including local development of new COVID-19 vaccines.	From 20% of country offices in the Western Pacific Region, to 48% in the Eastern Mediterranean Region.

<sup>31</sup> COVAX [webpage]. Geneva: World Health Organization; 2023 (<https://www.who.int/initiatives/act-accelerator/covax>, accessed 26 March 2023).

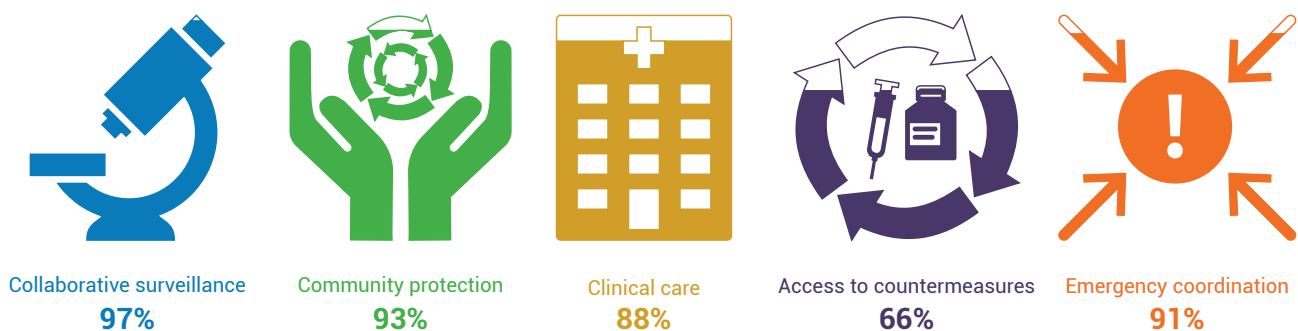
<sup>32</sup> COVID-19 Vaccine Delivery Partnership [webpage]. Geneva: World Health Organization; 2023 (<https://www.who.int/emergencies/diseases/novel-coronavirus-2019/covid-19-vaccines/covid-19-vaccine-delivery-partnership>, accessed 26 March 2023).

<sup>33</sup> Strengthening local production of medicines and other health technologies to improve access. Geneva: World Health Organization; 2021 ([https://cdn.who.int/media/docs/default-source/medicines/local-production/a74\\_r6-resolution\\_published.pdf](https://cdn.who.int/media/docs/default-source/medicines/local-production/a74_r6-resolution_published.pdf), accessed 26 March 2023).

## Work of WHO country offices in HEPR

At the Seventy-fifth World Health Assembly, in 2022, the WHO Director-General presented WHO's proposals to strengthen the global architecture for HEPR. An updated draft was presented at the 152nd session of the WHO Executive Board, in January 2023.<sup>34,35</sup> WHO country offices provide HEPR support through available expertise or coordination to address health emergencies. Notably, in 2022, WHO responded to more than 70 graded emergencies.<sup>36</sup> As at December 2022, there were 31 active Health Clusters of the Inter-Agency Standing Committee.<sup>37</sup>

The HEPR proposals rely on five interconnected subsystems: collaborative surveillance, community protection, clinical care, access to countermeasures and emergency coordination (a description of the five core subsystems is provided in Annex 6). In 2021–2022, all WHO country offices reported to have supported Member States in at least one of the five subsystems, especially collaborative surveillance, community protection and emergency coordination (Fig. 10).



**Fig. 10.** Percentage of WHO country offices worldwide providing support across HEPR subsystems in 2021–2022

Support provided by country offices in 2021–2022 followed a similar pattern across most WHO regions, with some variations (Table 8). A larger percentage of country offices in the African Region provided support across all subsystems. Conversely, a smaller percentage of country offices in the European Region provided support across the subsystems (except for community protection), which may reflect countries relying on the European Centre for Disease Prevention and Control or may be influenced by the relatively smaller size of many country offices in that Region.

<sup>34</sup> Strengthening the global architecture for health emergency preparedness, response and resilience: report by the Director-General. Geneva: World Health Organization; 2022 (A75/20; [https://apps.who.int/gb/ebwha/pdf\\_files/WHA75/A75\\_20-en.pdf](https://apps.who.int/gb/ebwha/pdf_files/WHA75/A75_20-en.pdf), accessed 26 March 2023).

<sup>35</sup> Strengthening WHO preparedness for and response to health emergencies. Geneva: World Health Organization; 2022 (EB152/12; [https://apps.who.int/gb/ebwha/pdf\\_files/EB152/B152\\_12-en.pdf](https://apps.who.int/gb/ebwha/pdf_files/EB152/B152_12-en.pdf), accessed 26 March 2023).

<sup>36</sup> Responding to health emergencies in 2022: annual report of the World Health Organization. Geneva: World Health Organization; in press.

<sup>37</sup> Health Cluster countries and regions [webpage]. Geneva: World Health Organization; 2023 (<https://healthcluster.who.int/countries-and-regions>, accessed 26 March 2023).

**Table 8.** Percentage of WHO country offices providing support across HEPR subsystems by WHO region

	AFR (n=47)	AMR (n=27)	EMR (n=21)	EUR (n=31)	SEAR (n=11)	WPR (n=15)
Collaborative surveillance	100%	100%	100%	87%	100%	93%
Community protection	98%	93%	86%	90%	91%	93%
Clinical care	98%	89%	86%	71%	91%	87%
Access to countermeasures	74%	67%	71%	45%	73%	73%
Emergency coordination	100%	96%	86%	77%	82%	100%

Despite all WHO country offices working in at least one of the HEPR subsystems, only 44% reported to have sufficient workforce (somewhat or to a great extent) across all five subsystems, indicating a need to increase capacity for health emergency preparedness and response at the country level. At the subsystem-level specifically, 47% of country offices reported that they had limited or completely insufficient workforce for access to countermeasures, 31% reported as much for clinical care and 23% stated the same for community protection. More information on sufficiency of staffing in health emergencies is presented in Chapter 4.

Three quarters (74%) of country offices reported that risk communication and community engagement (RCCE) was one of the top priorities for the implementation of HEPR, emphasizing the importance given by country offices to ensuring that populations are informed and involved. RCCE was the top priority across all WHO regions – 87% of country offices in the European Region and the Western Pacific Region – except the South-East Asia Region, where most offices (64%) prioritized enabling HEPR to focus on respiratory pathogen pandemic preparedness. Adopting a One Health approach was the second priority for the implementation of HEPR, reported by 58% of all country offices. While One Health was the second priority in most WHO regions, in the Region of the Americas and the Western Pacific Region genomic surveillance and forging strategic partnerships were reported as the second priorities for HEPR implementation, respectively.

The ability of country offices to support actions in the interconnected core subsystems for HEPR will continue to play an important role in WHO's health emergency work in countries.

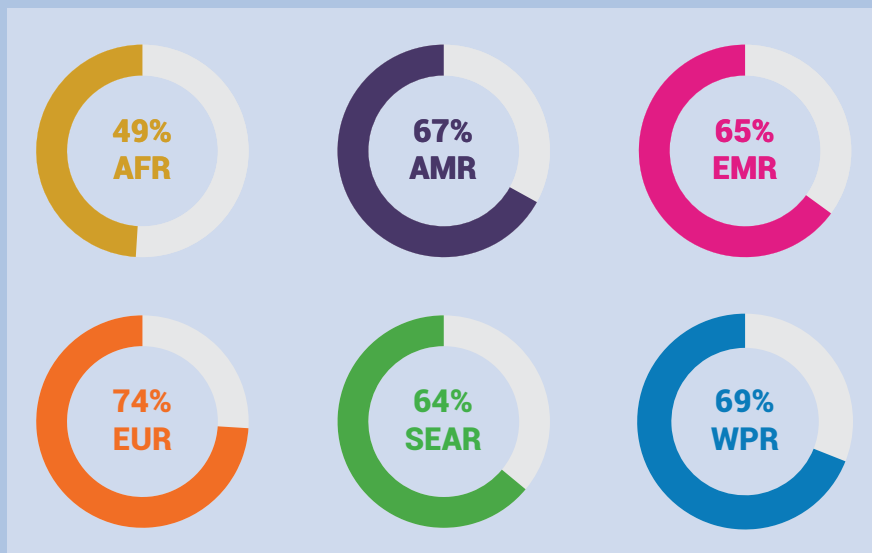


## Engaging with Member States for pandemic prevention, preparedness and response

### International Health Regulations (IHR) core capacities

All WHO Member States have the responsibility to build and maintain effective and functioning capacities and systems to prevent, detect, protect against, control and provide a public health response to public health emergencies and to comply with relevant international treaties or agreements, including the 2005 IHR. Since 2010, all States Parties to the IHR have been expected to report annually on the status of implementation of the IHR, in accordance with Article 54. The State Party Self-Assessment Annual Reporting Tool (SPAR) is intended to support States Parties to fulfil these obligations, assessing through 35 indicators the 15 IHR core capacities needed to detect, assess, notify and respond to public health risks and acute events. The second edition of the tool,<sup>38</sup> which takes into account the lessons learned from the COVID-19 pandemic, was first used in 2021.

Throughout the years, there has been a steady increase in submission by States Parties to SPAR. In 2021, 184 States Parties (94%) submitted self-assessment reports, the highest for a SPAR reporting cycle.<sup>39</sup> That year, all the States Parties in the African Region (47), the Eastern Mediterranean Region (21) and the South-East Asia Region (11) submitted their reports, as did 93% of countries in the European Region, 91% in the Region of the Americas and 81% in the Western Pacific Region. The SPAR average of capacities across all WHO regions was 64% (Fig. 11).



*Fig. 11. Average of SPAR core capacities for all WHO regions in 2021 (184 States Parties)*

<sup>38</sup> International Health Regulations (2005): State Party Self-Assessment Annual Reporting Tool, 2nd edition. Geneva: World Health Organization; 2021 (<https://apps.who.int/iris/handle/10665/350218>, accessed 26 March 2023).

<sup>39</sup> States Parties can submit their report through an online platform (<https://extranet.who.int/e-spar>) or by email.

Globally, more than half of the States Parties that reported to SPAR in 2021 achieved over 60% of the core capacities, which was also the case within each WHO region except the African Region, where most States Parties achieved between 41% and 60% of the IHR core capacities (Fig. 12). However, while the averages provided insight into strengths and weaknesses of core capacities, they did not consider the influence of any low scores in capacities that were not of relevance for the respective State Party. Therefore, averages should be carefully interpreted.<sup>40</sup>

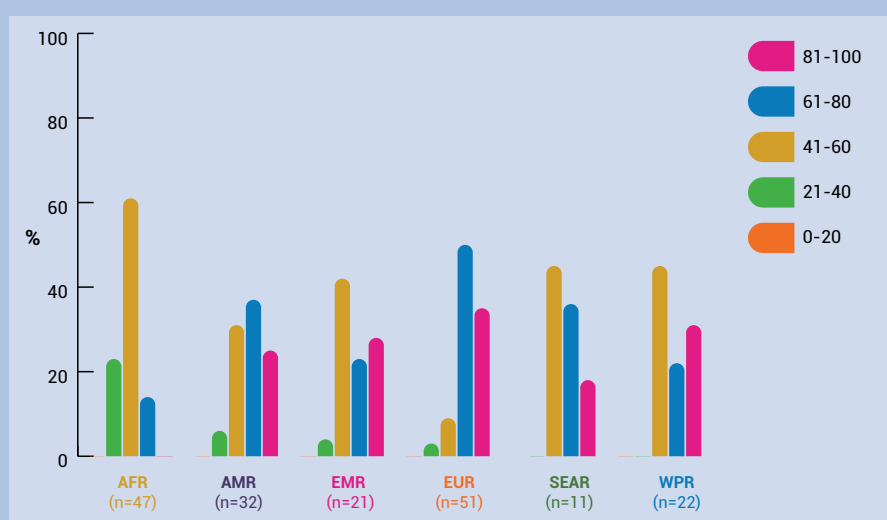


Fig. 12. Average of SPAR core capacities by WHO region in 2021 (184 States Parties)<sup>41</sup>

The overall average scores of 2021 suggest that States Parties are generally performing better in surveillance, laboratory, health service provision and health emergency management, as the majority of States Parties achieved over 70% in those core capacities. On average, States Parties achieved between 60% and 69% of the core capacities of RCCE, IHR coordination and national IHR focal point functions and advocacy, zoonotic diseases, financing, food safety, points of entry and border health, and infection prevention and control. Core capacities requiring further efforts are those in which States Parties achieved less than 60% (human resources, radiation emergencies, chemical events, and policy, legal and normative instruments to implement the IHR).

In addition to reporting on the IHR through SPAR, States Parties can prepare a national action plan for health security (NAPHS) and can request a joint external evaluation (a voluntary, collaborative and multisectoral process to assess country capacities to prevent, detect and rapidly respond to public health). The NAPHS and its equivalent are critical for ensuring that “national capacities in health emergency prevention, preparedness, response and recovery are planned, built, strengthened and sustained in order to achieve national, regional and global health security”.<sup>42</sup> Since NAPHS guidance was introduced in late 2016, 79 countries have developed a five-year strategic NAPHS, including 11 countries<sup>43</sup> that developed a national action plan in 2021–2022. In the same period, 22 (20 in the African Region and two in the Eastern Mediterranean Region) of the 79 countries also developed a one-to-two-year operational plan, which complement the strategic NAPHS. In 2021–2022, five joint external evaluations were completed (in Algeria, Nepal, Thailand, Ukraine and Uzbekistan).

<sup>40</sup> The score levels need to be analysed according to each country's risk analysis and capacities needed to deal with existing risks in the national context and potential public emergency of international concern affecting the territory.

<sup>41</sup> e-SPAR State Party Annual Report [web portal]. Geneva: World Health Organization; 2019 (<https://extranet.who.int/e-spar/>, accessed 26 March 2023).

<sup>42</sup> World Health Organization strategy (2022–2026) for the national action plan for health security. Geneva: World Health Organization; 2022 (<https://apps.who.int/iris/handle/10665/365581>, accessed 26 March 2023).

<sup>43</sup> Five in the African Region (Togo, Uganda, United Republic of Tanzania, Zambia, Zimbabwe); one in the Region of the Americas (United States of America); two in the Eastern Mediterranean Region (Tunisia, United Arab Emirates); two in the South-East Asia Region (Thailand, Timor-Leste); and one in the Western Pacific Region (Viet Nam).

## Intergovernmental Negotiating Body

In view of the unprecedented challenges presented by the COVID-19 pandemic, the special session of the World Health Assembly in December 2021 concluded with decision SSA2(5) to establish the Intergovernmental Negotiating Body to strengthen pandemic prevention, preparedness and response. The Body started its work in 2022 to draft and negotiate a WHO convention, agreement or other international instrument under the WHO Constitution to strengthen pandemic prevention, preparedness and response, considering the need for coherence and complementarity with regard to implementation and strengthening of the 2005 IHR. The development of the pandemic accord is a Member State-led process that aims to address gaps and challenges in managing COVID-19 and other recent disease outbreaks (such as timely and equitable access to pandemic-related products; global preparedness and response arrangements to help to anticipate and prevent future pandemics; sustainable and predictable funding for health emergency, preparedness and response; and governance and oversight mechanisms that foster trust, accountability and transparency). Member States decided that the accord should be legally binding, signalling their commitment to building resilience to pandemics; supporting prevention, detection and response for outbreaks with pandemic potential; ensuring equitable access to pandemic countermeasures; and supporting global coordination through a stronger and more accountable WHO. This will thus influence the country-level work of the Organization.<sup>44</sup>

## 3.4. Powering health: data, delivery and innovation

### WHO action to strengthen delivery at the country level

Tracking progress made, scaling up delivery and staying on top of innovation enable WHO to achieve the targets of GPW13. To accelerate much-needed progress in the triple billion targets, WHO is rolling out the Delivery for Impact approach, which brings a systematic, data-driven and sustained focus on the SDGs, while providing countries with analytical and implementation tools to boost their capacity for country-level impact.

Through three-level cooperation, WHO has provided dedicated delivery support to 47 countries across all WHO regions (Table 9). This cross-cutting support included areas of work such as road safety, obesity, maternal and child health, primary health care, essential health services, as well as strategic planning, delivery of capacity-building and analytics that complement Country Cooperation Strategies. Delivery supports countries on their journey to impact: it encourages the use of data to set ambitious yet measurable targets, identifies strategies to accelerate progress for measurable and meaningful results, and activates the three levels to leverage the support.

<sup>44</sup> Pandemic prevention, preparedness and response accord. Geneva: World Health Organization; 24 February 2023 (<https://www.who.int/news-room/questions-and-answers/item/pandemic-prevention--preparedness-and-response-accord>, accessed 26 March 2023).

**Table 9.** Countries that received dedicated delivery support

WHO region	AFR	AMR	EMR	EUR	SEAR	WPR	Total
No. of countries in which WHO has provided dedicated delivery support	11	11	10	9	3	3	47

Among those initiatives, WHO started to pilot an innovative single prioritization process in nine country offices to explore alignment of various planning processes (GPW13 data, Country Cooperation Strategies, operational and strategic planning) around the needs and priorities of the countries. Two of the pilots were in the African Region, one in the Region of the Americas, two in the Eastern Mediterranean Region, two in the European Region, one in the South-East Asia Region and one in the Western Pacific Region.

### Chapter key messages: strategic priorities of WHO country offices

- WHO country offices have demonstrated a capability to work with diverse sectors beyond the health sector, customizing context-relevant approaches and addressing the determinants of health. Ensuring that Member States, especially ministries of health, create an enabling environment and encourage WHO to work across sectors will be important if the Organization is to meet its billion target of healthier populations.
- A larger percentage of country offices with health policy advisers of the UHC Partnership played a leadership role in national health plan processes, showing the added value of technical expertise in health policy and system for WHO's country-level cooperation to realize UHC through a reorientation of health systems. Sustainable and predictable funding that increases WHO's country-level capacity should be prioritized and sustained in order to optimize WHO's country-level role and impact across strategic priorities of work (in UHC and beyond).
- All WHO country offices have provided cooperation for HEPR actions in the past two years, with priority given to RCCE.
- WHO has made efforts to optimize its three-level coordination to support country offices and countries to address staff shortage in this area of work. Such three-level alignment cooperation should be documented and replicated across other areas of work. The WHO Secretariat should identify ways to enhance capacity in data, delivery and innovation at the country level.

# 4. Perform for health



As WHO prepares to embark on the two-year extension of the Thirteenth General Programme of Work, 2019–2025 (GPW13), it will be crucial for the Organization to ensure that its country offices are well capacitated to lead and to be a directing authority on health, in order to remain at the centre of the global health architecture. In this context, this chapter describes the leadership and staffing levels of WHO country offices – including enhancement of country offices’ capacities to ensure that WHO remains at the forefront of public health in countries – as well as funding information pertinent to the offices. Staffing data pertain to December 2022 (unless otherwise stated).

## 4.1. Leadership of WHO country offices

Efforts to cultivate effective leaders to work as WHO representatives (WRs) at the country level are consistent with the goals of GPW13. A key objective for preserving organizational credibility at the national level is to ensure that WHO has strong and capable leaders in country offices and that WR positions do not remain vacant for extended periods of time. This section presents information on WRs, including gender balance in appointments and percentage of WRs from outside the WHO region of their origin.

### WRs

WRs are the designated representatives of the WHO Director-General and the respective Regional Director to Member States. WRs use their expertise, experience and acumen in health diplomacy to lead WHO’s strategic and operational functions in their assigned country. They are selected using a merit-based global talent management system. In 2021–2022, some WRs had the opportunity to participate in skills-building programmes. Fifty-four WRs participated in the induction programme for newly appointed WRs, and five participated in the United Nations System Staff College leadership course on United Nations country teams (UNCTs). Some areas that will continue to present a challenge to WRs worldwide include managing the growing expectations of WHO, sustaining the capacities developed during the coronavirus disease (COVID-19) pandemic and advocating for (or mobilizing) flexible funds.

As at December 2022, there were 152 WR positions<sup>45</sup> in countries, territories and areas, with 133 (88%) posts filled (Table 10).

*Table 10. Number of countries with full-time WRs, acting WRs or officers-in-charge*

	No. of countries with full-time WRs	No. of countries with acting WRs or officers-in-charge
AFR	36	11
AMR	25	2
EMR	19	2
EUR	29	2
SEAR	11	0
WPR	13	2
Global	133	19

<sup>45</sup> This includes WRs, PAHO/WHO representatives, heads of country offices, heads of offices, liaison officers and country liaison officers.

## Gender distribution of leadership positions in WHO country offices

Ensuring that the number of female WRs continues to increase is in line with WHO's commitment to inclusion, diversity and gender parity in WHO leadership at the country level. Although some WHO regions have progressed in that regard, as at December 2022, the percentage of WR posts occupied by women worldwide remained at 38%, the same as at the last reporting in December 2020.<sup>46</sup> The regional distribution is shown in Table 11. Compared with the last reporting, WR posts held by women increased in the South-East Asia Region, the Western Pacific Region (where the proportion of female WRs nearly doubled) and the Region of the Americas.

**Table 11.** Percentage of female WRs from 2015 to 2023

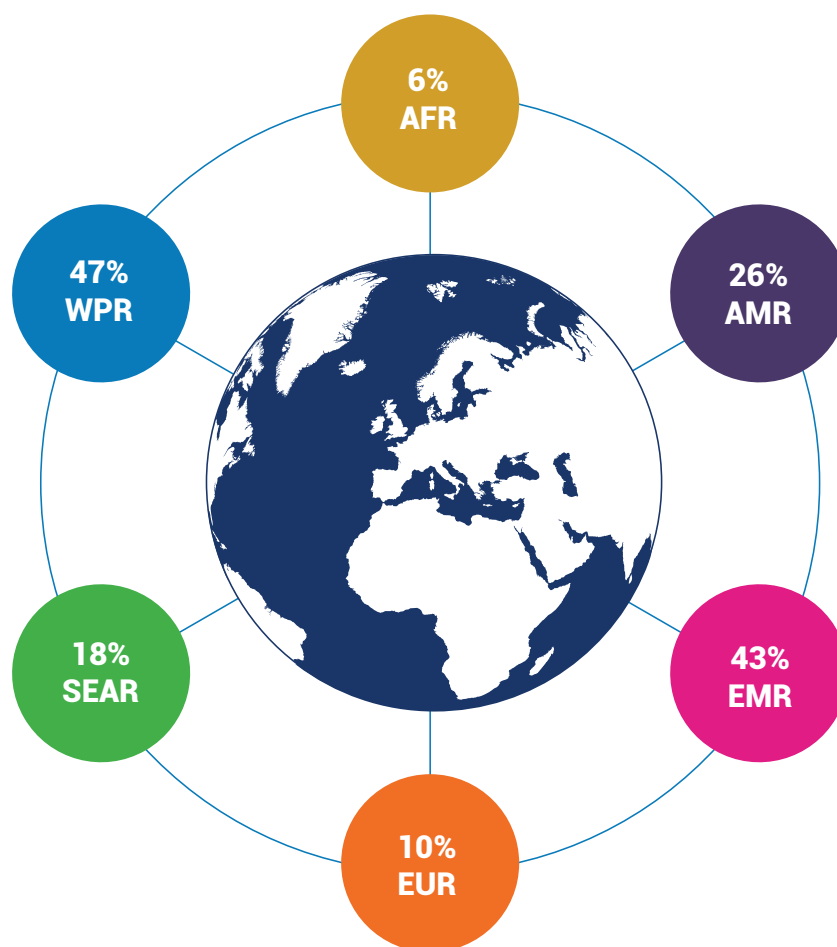
	2015 report	2017 report	2019 report	2021 report	2023 report
AFR	26%	23%	32%	30%	21%
AMR	46%	42%	48%	50%	52%
EMR	21%	23%	40%	38%	38%
EUR	55%	62%	59%	52%	48%
SEAR	30%	10%	9%	10%	18%
WPR	23%	21%	23%	36%	60%
<b>Total</b>	<b>36%</b>	<b>33%</b>	<b>39%</b>	<b>38%</b>	<b>38%</b>



<sup>46</sup> WHO presence in countries, territories and areas: 2021 report. Geneva: World Health Organization; 2021 (<https://apps.who.int/iris/handle/10665/341308>, accessed 26 March 2023), p. 78.

## Region of origin of WRs

In 2012, the WHO leadership determined that at least 30% of WR positions must be filled by personnel from outside the duty station's region. As at December 2022, the Western Pacific Region and the Eastern Mediterranean Region had met this threshold, and the Region of the Americas was close to target (Fig. 13). More efforts towards this target must be made in other WHO regions.



*Fig. 13. Percentage of WRs serving outside their WHO region of origin*

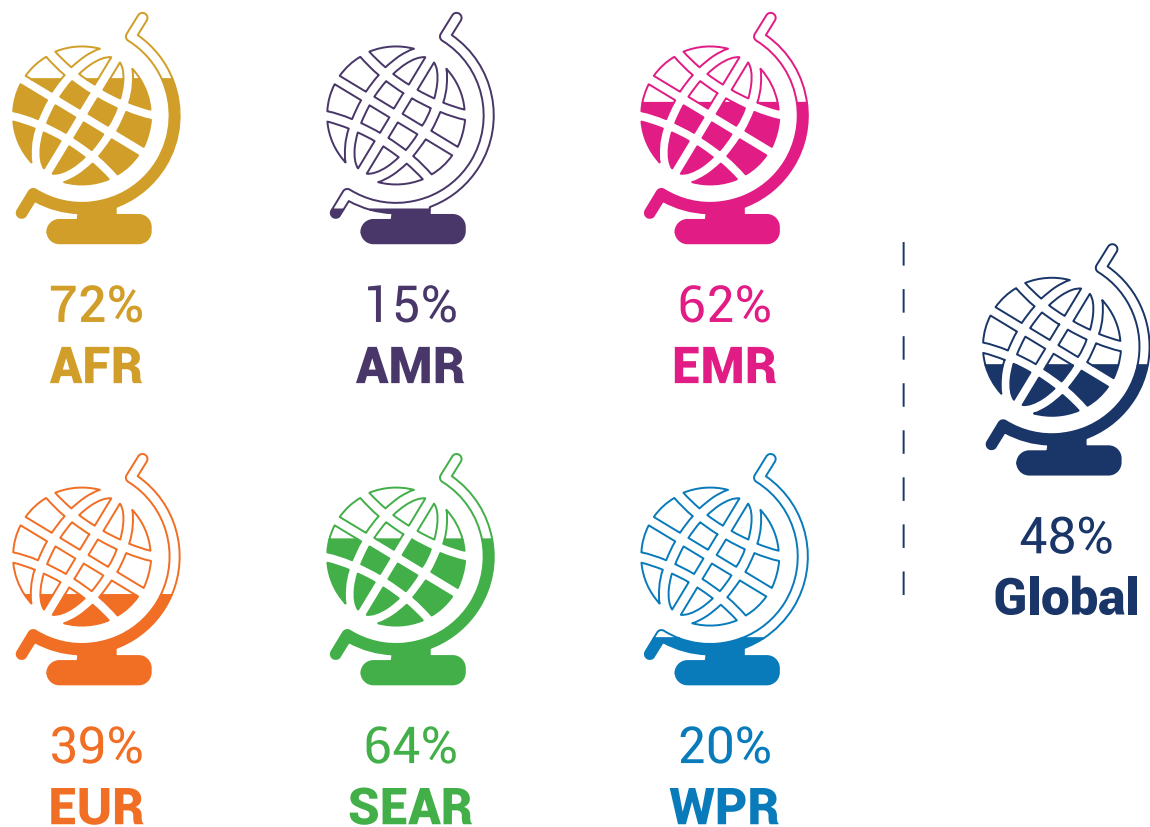
## WR vacancies

While a variety of factors may contribute to a WR position remaining vacant, WHO is committed to ensuring that this does not occur for extended periods of time. Vacant positions can disrupt and derail strategic work, jeopardizing WHO's reputation. As at December 2022, there were 19 vacant WR positions globally (Table 10). Of those, nine had been vacant for six months or less, eight had been vacant for 7–12 months and two (both in the African Region) had been vacant for over a year. Transitions, succession plans and other processes should continue to be designed to ensure continuity in country-level leadership.



## WHO leadership in the United Nations Resident Coordinator system

The opportunity to lead UNCTs exposes WRs to the complexities of United Nations interagency work. It also provides access to the country's highest levels of government, diplomatic corps and national media. A total of 73 (48%) WHO country offices reported that their WR served as the acting United Nations Resident Coordinator between January 2021 and September 2022, 91% of them for less than three months. This was the highest in the African Region, the South-East Asia Region and the Eastern Mediterranean Region (Fig. 14). Three WRs acted as the United Nations Resident Coordinator for longer than three months (two from the Eastern Mediterranean Region and one from the African Region). There were no full-time permanent United Nations Resident Coordinator from WHO (as at early 2023, there were four active senior WHO staff members on the United Nations Resident Coordinator roster).



**Fig. 14.** Percentage of WRs who acted as United Nations Resident Coordinator between January 2021 and September 2022

## 4.2. Staffing of WHO country offices

### Staff members

As at December 2022, 4154 WHO staff members were working at the country level across the six WHO regions. This represented 46% of the Organization's total staff workforce of 8983, a 1-percentage-point increase from the last reporting. Of WHO's total international professional (P-level) staff, 25% worked in country offices, representing a 3-percentage-point increase from the last reporting.<sup>47</sup> This suggests that WHO is steadily strengthening technical capacity at the country level. Meanwhile, 49% of all WHO General Service staff worked in country offices, as well as 92% of all national professional officers (NPOs). A description of the staff categories is provided in Annex 7.

In 2022, the highest proportion of all country-level staff worked in the African Region (42%). The Region has 47 country offices, comprising almost one third of all country offices. The remaining country-level staff were distributed as follows: 20% in the Eastern Mediterranean Region, 12% in the South-East Asia Region, 10% in the European Region, 8% in the Western Pacific Region and 8% in the Region of the Americas. However, when considering the distribution of staff across WHO regions, it is important to note that the size of WHO country offices varies widely within and between regions. Table 12 shows the size of country offices, from a minimum of one WHO staff member<sup>48</sup> to over 300.

*Table 12. Size of WHO country offices shown by minimum and maximum values and quartiles by WHO region\**

Size of WHO country office	AFR	AMR	EMR	EUR	SEAR	WPR
Minimum	6	1	1	1	1	2
Q1	16	7	11	3	21	8
<b>Median<sup>†</sup></b>	<b>26</b>	<b>11</b>	<b>29</b>	<b>8</b>	<b>25</b>	<b>17</b>
Q3	42	14	59	14	70	35
Maximum	308	54	129	128	97	51

\* In this table, only WHO staff members were included. Non-staff, such as Special Service Agreements and consultants, were not included.

† Given outliers in the size of country offices, the median is provided in the table. For reference, the average numbers of staff per country office across WHO regions are as follows: 37 in AFR, 12 in AMR, 40 in EMR, 13 in EUR, 45 in SEAR and 21 in WPR.

<sup>47</sup> WHO presence in countries, territories and areas: 2021 report. Geneva: World Health Organization; 2021 (<https://apps.who.int/iris/handle/10665/341308>, accessed 26 March 2023), p.82.

<sup>48</sup> In some cases, there was only one WHO staff member, and the office workforce was complemented by secondments from the government.

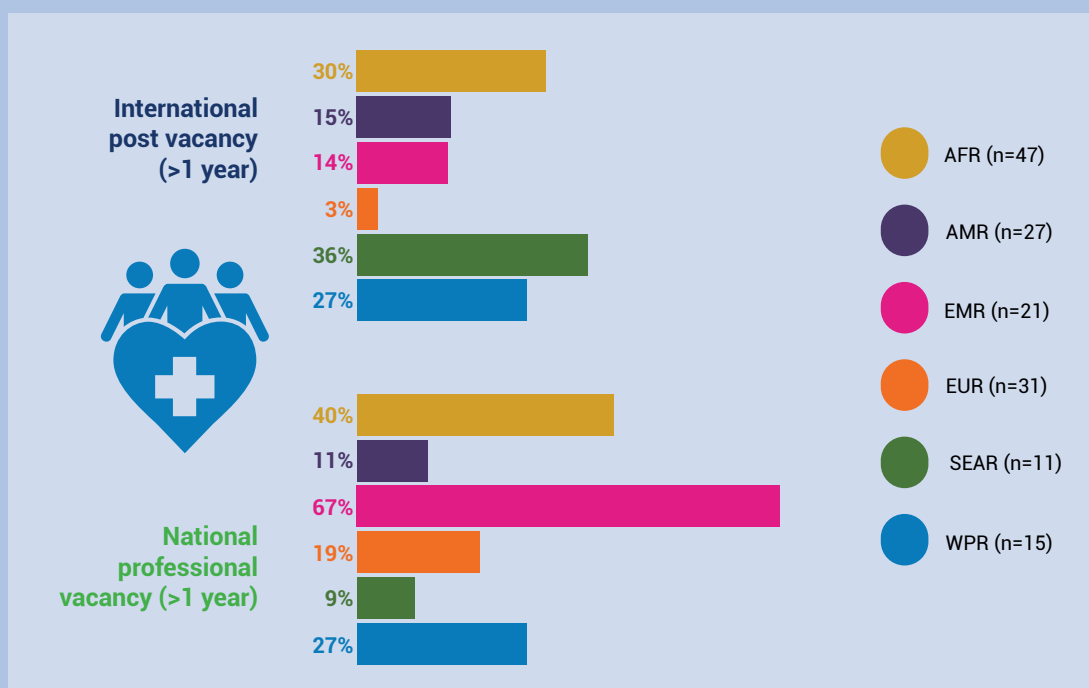
## Human resources to promote, provide, protect and power health

### *Human resources for healthier populations*

Of all country-level technical staff, including national professional and international professional staff, 6% were assigned to work in the strategic area of healthier populations as at December 2022,<sup>49</sup> the majority of which were NPOs (73%).

Despite the small proportion of technical staff assigned to the healthier populations workstream, over two thirds of country offices reported that they had somewhat sufficient (47%) or fully sufficient (21%) staff for the delivery of results vis-à-vis the healthier populations needs of the countries with which they worked. This may be due to staff assigned to other strategic workstreams concurrently contributing to health promotion and disease prevention efforts. Across all the country offices, 32% reported a workforce insufficiency for healthier populations. This proportion was greater in the Eastern Mediterranean Region, the African Region and the Western Pacific Region (43%, 40% and 40%, respectively).

In 2021–2022, one fifth of all WHO country offices reported that they had a vacant international post in healthier populations for more than one year, and 30% had a vacant national post for more than a year, with notable regional differences (Fig. 15).



**Fig. 15.** Percentage of WHO country offices with a vacancy in healthier populations for more than a year in 2021–2022 by WHO region

Two thirds of the country offices that reported at least one long healthier populations vacancy said that this was due to lack of funding for an existing position, and close to one third attributed vacancies to slow recruitment processes. Lack of funding for an existing position was the leading reason for the long-term vacancies across all WHO regions, including for around three quarters of country offices in the African Region and the Eastern Mediterranean Region.

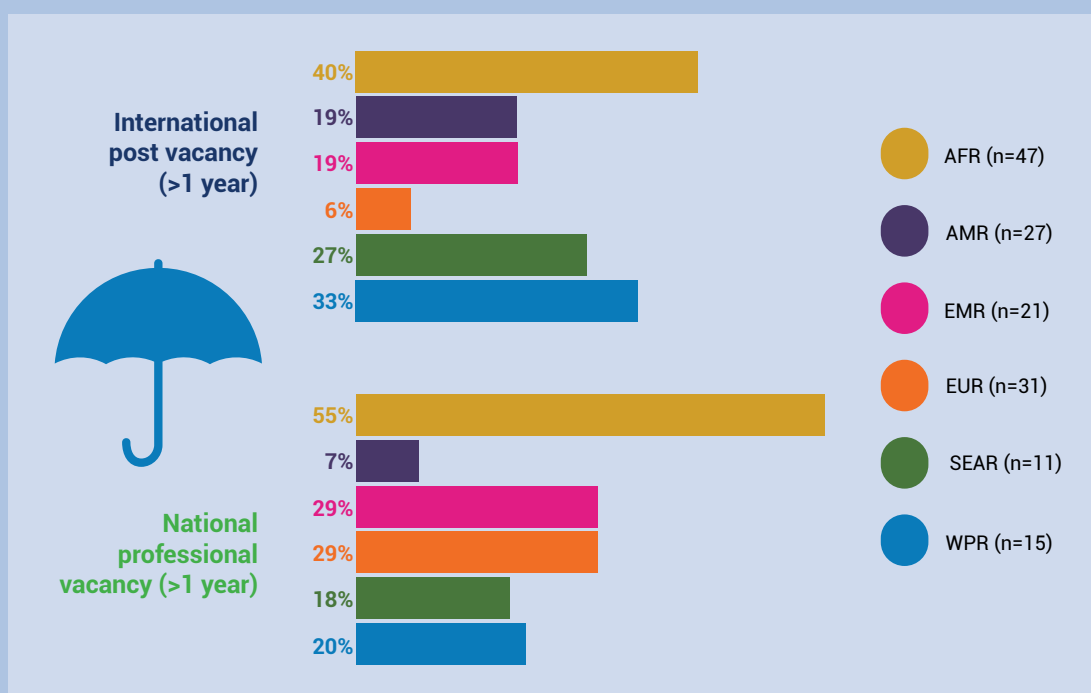
<sup>49</sup> The rest of the international staff worked in universal health coverage (UHC), health emergencies and enabling mechanisms.

**Human resources for UHC**

One third (33%) of technical staff in country offices, both national and international, were assigned to work on UHC. Of those, 63% were national professional staff.

Similar to healthier populations, two thirds of country offices reported that they had somewhat sufficient (41%) or sufficient (25%) staff to meet the UHC needs of the countries with which they worked. UHC-workforce insufficiency was more strongly felt by the country offices in the African Region (40%), the Western Pacific Region (40%), the Eastern Mediterranean Region (38%) and the South-East Asia Region (36%).

Across all country offices, 25% reported that they had at least one international UHC vacancy for more than a year, and 32% reported that they had at least one UHC vacancy for a national professional post. Compared with the other WHO regions, the African Region had the highest percentage of WHO country offices with extended UHC vacancies (both international and national posts), whereas one third or less of country offices in other WHO regions reported extended UHC vacancies (Fig. 16).



**Fig. 16.** Percentage of WHO country offices with a vacancy in UHC for more than a year in 2021–2022 by WHO region

Of the country offices with long UHC vacancies, 62% said that these were due to lack of funding for an existing position and 33% due to slow recruitment processes, although the main reasons differed across regions. Lack of funding and difficult recruitment were cited as the primary reasons in the African Region, the Eastern Mediterranean Region and the European Region. In contrast, in the South-East Asia Region and the Western Pacific Region, lack of suitable candidates was the main reason, and in the Region of the Americas slow recruitment processes was the main reason.

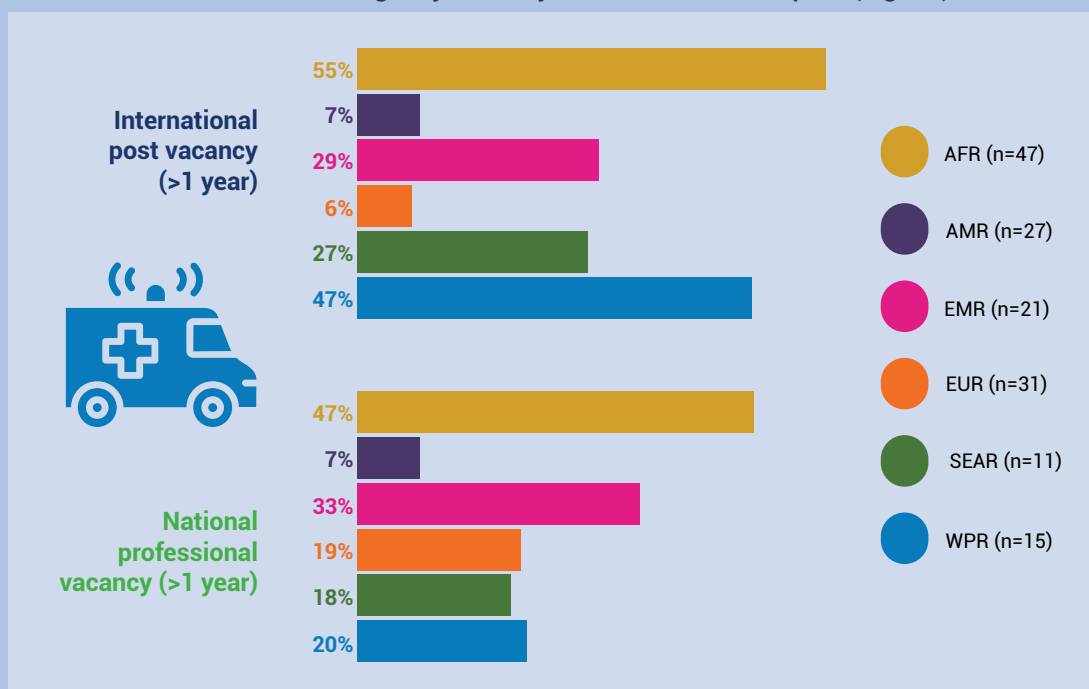
### Human resources for health emergencies

Of the technical professional staff at the country level, 43% were assigned to health emergencies, outbreak and crisis response, and polio, of which 35% were international professional staff.

Over three quarters of WHO country offices reported that they had sufficient (31%) or somewhat sufficient (45%) workforce for the delivery of health emergency needs relevant to their countries. Only 24% of all country offices reported insufficiency for health emergency staffing, and this was more strongly felt in the Western Pacific Region and the South-East Asia Region (53% and 36%, respectively).

However, less than half of the country offices reported that they had sufficient workforce across all five subsystems of health emergency preparedness, response and resilience (HEPR), so ensuring that those gaps are filled in country offices where such skillsets are needed will be critical for health emergency preparedness and response.

Across all country offices, close to a third reported that they had at least one international health emergency vacancy for more than a year, and 28% reported that they had at least one vacancy for a national professional post. Around half of WHO country offices in the African Region reported at least one long health emergency vacancy (both international and national). Likewise, 47% of country offices in the Western Pacific Region had at least one extended health emergency vacancy for an international post (Fig. 17).



**Fig. 17.** Percentage of WHO country offices with a vacancy in health emergencies for more than a year in 2021–2022 by WHO region

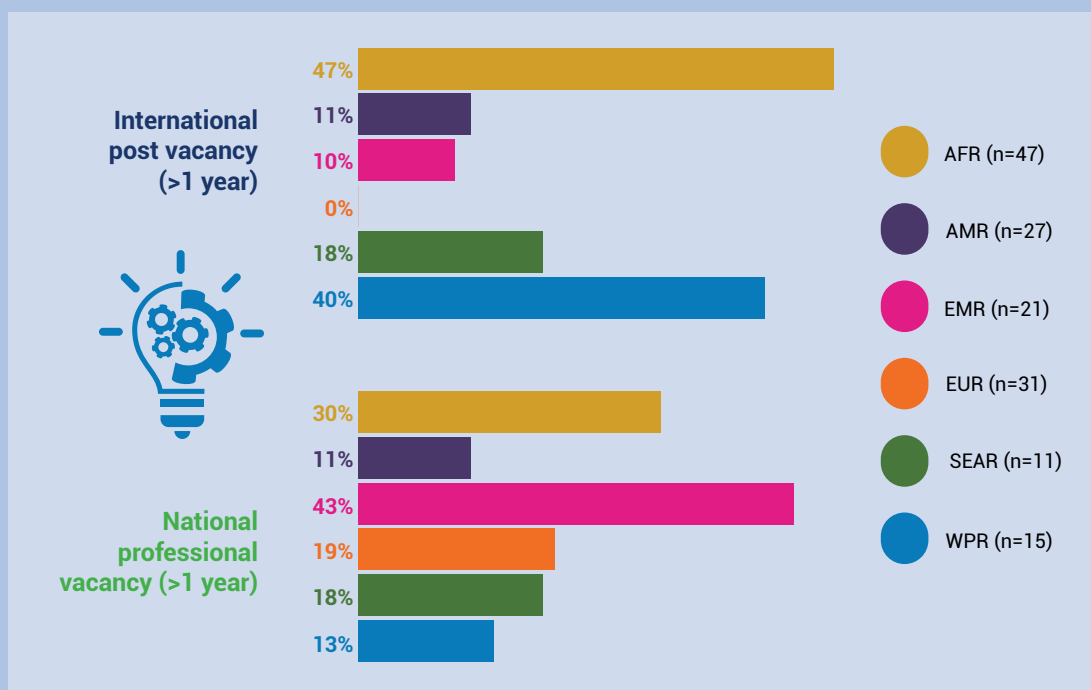
Approximately half (51%) of the country offices with long-term health emergency vacancies reported that these were due to lack of funding for an existing position and 45% due to slow recruitment processes. In the African Region and the European Region, lack of funding for an existing position was the reason behind most vacancies, while in the Region of the Americas, the Eastern Mediterranean Region and the South-East Asia Region, these were due to long and slow recruitment processes. Notably, three quarters of offices in the Western Pacific Region said that their extended health emergency vacancies were due to a lack of suitable candidates.

**Human resources for data, delivery and innovation**

While WHO has leveraged its three levels to support data, delivery and innovation, capacity in this area of work must be strengthened at the country level. Less than 2% of all technical staff in country offices were assigned to work on data, delivery and innovation, of which two thirds were national professional staff. This is a low percentage of staff, given the importance of this work at the country level.

Overall, 43% of country offices reported that they had insufficient staff for this area of work, more than for the above-mentioned areas of work. The WHO regions with the highest levels of staff insufficiency for data, delivery and innovation to meet the needs of countries were the African Region (57%), the Western Pacific Region (53%) and the Eastern Mediterranean Region (48%). Most WHO country offices did not have full-time staff assigned solely to data, delivery and innovation, but rather such work was done across technical areas. WHO country offices reported that they met data, delivery and innovation needs with recruitment of non-staff members and through backstopping support from other WHO offices.

Approximately one quarter of all WHO country offices reported that they had a vacancy for data, delivery and innovation for more than a year in both the international (23%) and the national (24%) staff categories (Fig. 18).

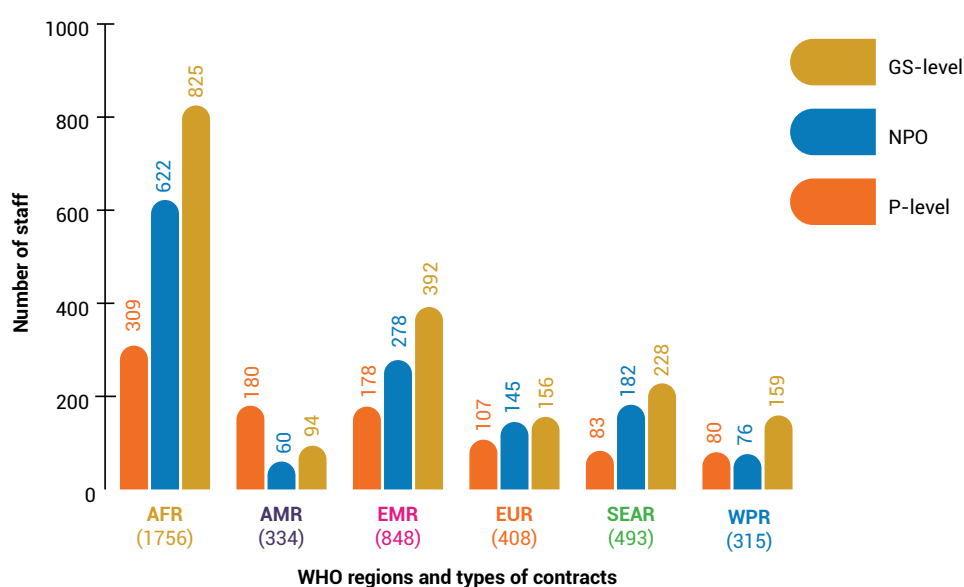


**Fig. 18.** Percentage of WHO country offices with a vacancy in data, delivery and innovation for more than a year in 2021–2022 by WHO region

Of the country offices with long vacancies for data, delivery and innovation, 67% indicated that this was due to lack of funding for an existing post. This was consistently the main reason for vacancies across the WHO regions.

## Types of staff contracts

As at September 2022, 45% of the workforce in country offices were General Service staff, 32% were NPOs and 23% were international professional staff, with regional differences (Fig. 19). It should be noted that several country offices in the European Region had only two staff members, which explains the pattern.



**Fig. 19.** Contract types of WHO staff at the country level as at September 2022 (n=4154)

The proportion of international professional and national professional staff in WHO country offices had increased steadily (Table 13).

**Table 13.** Percentage of international professional and national professional staff in WHO country offices

	2015 report	2017 report	2019 report	2021 report	2023 report
P-level	18%	19%	20%	22%	23%
NPO	28%	28%	30%	32%	32%

## Gender distribution of staff

WHO has reached overall gender parity for staff across all appointment types and post categories, as reported at the 152nd session of the WHO Executive Board. However, at the country level there is still room for improvement. Progress towards gender parity among international professional staff can be seen across some WHO regions: the Region of the Americas inched closer, and the African Region, the South-East Asia Region and the Western Pacific Region made modest progress (Table 14). However, overall gender parity among international professional staff in country offices declined from 39% at the last reporting to 37%. Given that the African Region and the Eastern Mediterranean Region – where men made up over two thirds of international professional staff – jointly accounted for over 60% of country office staff, their gender distribution greatly affected the global gender balance compared with other WHO regions with a smaller workforce. Enhancing efforts towards gender parity of international technical staff remains a challenge that WHO needs to address at the country level.

Table 14. Percentage of female international professional staff in WHO country offices

WHO region	2015 report	2017 report	2019 report	2021 report	2023 report
AFR	24%	25%	26%	28%	30%
AMR	62%	50%	45%	43%	46%
EMR	33%	30%	29%	32%	29%
EUR	51%	54%	33%	43%	43%
SEAR	38%	37%	32%	30%	34%
WPR	48%	50%	48%	55%	64%
<b>Global</b>	<b>33%</b>	<b>35%</b>	<b>38%</b>	<b>39%</b>	<b>37%</b>

## Non-staff members

Non-staff members, retained through a variety of contract types, support WHO efforts around the world by guaranteeing the continuity of critical programmes, working alongside country-level staff. In 2021–2022, WHO country offices engaged the services of 6979 non-staff members,<sup>50</sup> which was slightly lower than the number in 2019–2020. The decrease may reflect maintenance by WHO country offices of some, but not all, non-staff roles recruited for surge capacity at the onset of the pandemic.<sup>51</sup>

Most non-staff contracts at the country level were issued in the African Region and the South-East Asia Region (Fig. 20). Importantly, in some WHO regions there was more reliance on non-staff than staff, with non-staff comprising more than 50% of the workforce. This was the case in 82 country offices, including 89% of the offices in the Region of the Americas, 67% in the Western Pacific Region and 64% in the African Region.

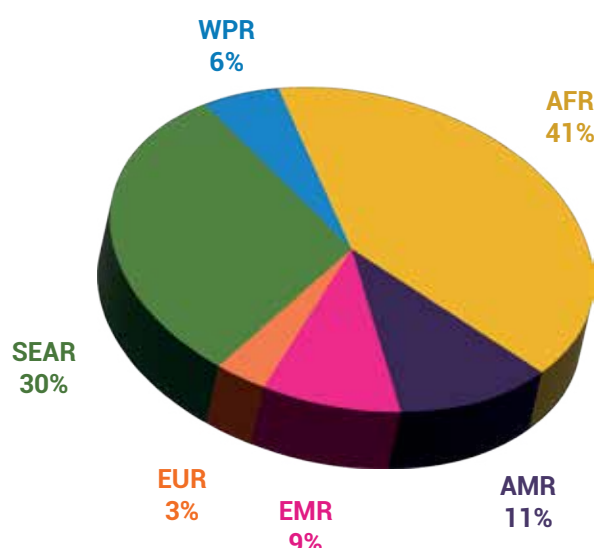


Fig. 20. Distribution of the 6979 non-staff members across WHO regions

<sup>50</sup> This included the following contractual arrangements: Special Service Agreements, long-term consultants (over six months), United Nations Volunteers and interns. In addition to those contract types, WHO country offices also reported 2912 agreements of performance of work.

<sup>51</sup> There were 7589 non-staff members at the last reporting, influenced by a rapid surge in capacity needs to address the COVID-19 pandemic. See: WHO presence in countries, territories and areas: 2021 report. Geneva: World Health Organization; 2021 (<https://apps.who.int/iris/handle/10665/341308>, accessed 26 March 2023), p. 86.

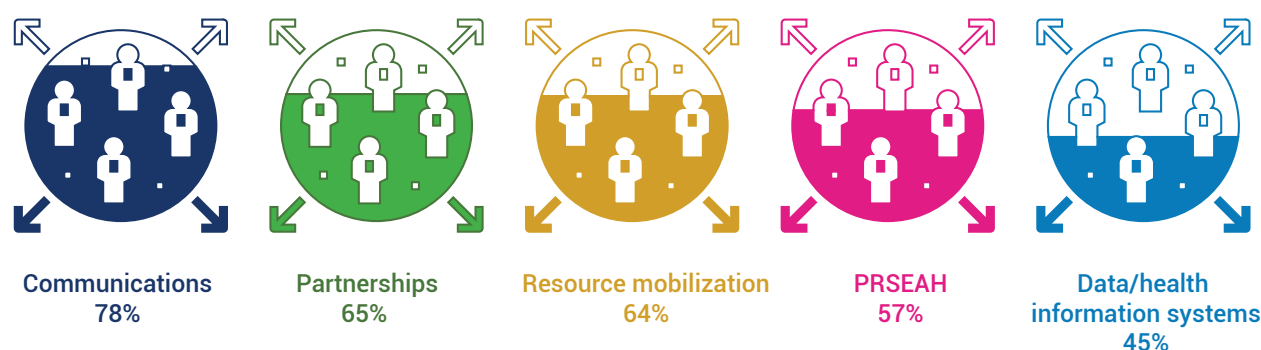


Across all WHO country offices, women comprised 35% of non-staff personnel, with regional variations. In the Region of the Americas, the European Region and the Western Pacific Region, women comprised the majority of non-staff members (66%, 64% and 55%, respectively), whereas they comprised less than 35% in the other WHO regions.

A majority (93%) of non-staff contracts were done through Special Service Agreements, consultancies and other types of service provision contracts. WHO country offices also welcomed United Nations Volunteers (218); secondments from governmental organizations, intergovernmental agencies, nongovernmental organizations, philanthropic foundations and academic institutions (240); and interns (59). This reflects WHO's country-level capacity to leverage partnerships with external institutions, which could be further expanded.

### 4.3. Enhancement of capacities in WHO country offices

Over the years, different strategies and evaluations have highlighted the need to strengthen WHO's capacities at the country level.<sup>52</sup> In line with such recommendations, WHO country offices have made efforts to enhance capacities to ensure that WHO remains a leading public health authority in countries and that WHO works effectively at the country level towards the achievement of results and impact. WHO country offices reported that they had enhanced various types of capacities in 2021–2022. The top five were communications; partnerships; resource mobilization; Prevention and Response to Sexual Exploitation, Abuse and Harassment (PRSEAH); and data and health information systems (Fig. 21). In addition, around one third of country offices reported enhanced capacities in community engagement (36%) and mainstreaming of gender, equity and rights (29%). COVID-19 was an important contributing factor for increased capacities in communications, partnerships, resource mobilization, and data and health information systems, showing that country offices exerted additional efforts to strengthen their capacities to respond to health priorities during the pandemic.



**Fig. 21.** Areas in which WHO country offices worldwide enhanced their capacities in 2021–2022 (% average)

<sup>52</sup> WHO Transformation [webpage]. Geneva: World Health Organization; 2018 ([www.who.int/about/transformation](http://www.who.int/about/transformation), accessed 26 March 2023).

## Communications

In 2012–2022, 118 of the 152 country offices reported that communications (including risk communications) was one of their top five enhanced capacities. This was largely accomplished by recruiting new WHO non-staff members specifically for this purpose (61%), followed by backstopping support from other WHO offices (47%) and training the existing workforce (46%). The enhanced communications capacity in country offices may be a result of the Organization's role during the COVID-19 pandemic. To ensure sustainable and predictable enhancement of the communications capacity in country offices, the expertise acquired through training should be further sustained. WHO communications is further discussed in Chapter 7.

Although recruitment of non-staff members was the most common way to enhance this capacity across most WHO regions, there were regional differences. Notably, in the South-East Asia Region, 67% of country offices enhanced this capacity this way, but also through recruitment of staff specifically for this purpose and training the existing workforce. Meanwhile, in the European Region, training the existing workforce was the primary means of improving the communications capacity (52%), followed by hiring of non-staff members (48%).

## Partnerships

Of all WHO country offices, 99 reported that building partnerships was one of their top five enhanced capacities in 2021–2022. Task-shifting of the existing WHO workforce to fill gaps was the most common method to enhancing the partnerships capacity across WHO country offices (52%), followed by requesting and receiving backstopping from other WHO offices (39%) and training the existing country office workforce (38%).

Reprofiling was the most common in the Western Pacific Region (86%), the Eastern Mediterranean Region (67%) and the South-East Asia Region (67%). Meanwhile, an equal percentage of country offices in the European Region enhanced their partnerships capacity through task-shifting or backstopping support from other WHO offices (both 57%). Backstopping was the main method for enhancing this capacity in the Region of the Americas (65%). Unlike in other WHO regions, most country offices in the African Region enhanced this capacity by recruiting staff specifically for this purpose (65%). WHO partnerships is further discussed in Chapter 5.

## Resource mobilization

Resource mobilization at all levels of the Organization is an important aspect of WHO's efforts towards country-level transformation. As at September 2022, 24% of WHO country offices reported that they had a dedicated resource mobilization specialist to support this area, all of which were in the African Region, the Eastern Mediterranean Region and the South-East Asia Region. In offices without dedicated specialists, resource mobilization was done by technical, programmatic and administrative staff or non-staff (such as consultants), or through backstopping support from other subregional or regional offices.

### Challenges in resource mobilization for WHO country offices

- 50% of country offices reported inadequate resource mobilization capacity and specialized donor engagement skills.
- 40% of country offices found the availability of tools to understand the overall funding landscape and to identify prospective donors to be insufficient.
- 27% of country offices reported the need to strengthen capacity to articulate WHO comparative advantage at the country level and insufficient visibility for country-level donor discussions or decision-making.
- Other challenges included a lack of staff dedicated to resource mobilization, competing priorities in (small) country offices, disincentive to applying due to limited staff available to implement potential funds, competition with other agencies of the United Nations system, donor fatigue, donors' decreasing interest in health development, scarce donor interest in supporting upper-middle income or high-income countries, and complex political situation in countries.

As Fig. 21 shows, 98 of the 152 WHO country offices (64%) made concerted efforts to improve their resource mobilization capacity as one of their top five enhanced capacities. A large part did so by requesting and receiving backstopping from other WHO offices (44%), task-shifting or reprofiling the existing WHO workforce (42%), and recruiting WHO staff specifically for resource mobilization (41%).

In the Western Pacific Region, the most common intervention for resource mobilization was task-shifting or reprofiling the existing WHO workforce (83%), while in the African Region and the Eastern Mediterranean Region, the most common intervention was to recruit staff specifically for this purpose (69% and 75%, respectively). The most common intervention in the Region of the Americas was training the existing country office workforce (58%).

As WHO works towards strengthening its country focus, it should find innovative ways to rapidly enhance country-level capacity for resource mobilization, especially as 63% of country offices indicated that an increase in flexible funding would influence their resource mobilization capacity (such as by being enabled to recruit people). While reviewing WHO country offices' fundraising ambitions, capacity limits already reported by country offices in resource mobilization should be kept in mind.

### United Nations multi-partner trust funds

Despite challenges in resource mobilization, WHO country offices have made continuous efforts to mobilize funds. In 2021–2022, two thirds of all country offices reported that they had applied to the United Nations multi-partner trust funds.<sup>53</sup> Of the 100 country offices that applied, 81 reported that they were successful and received the funds (10 of 14 offices in the European Region; 10 of 10 in the South-East Asia Region; three of three in the Western Pacific Region; 33 of 40 in the African Region; 15 of 20 in the Region of the Americas; and 10 of 13 in the Eastern Mediterranean Region).

Of the 52 country offices that did not apply for United Nations multi-partner trust funds, 44% indicated that this was due to lack of information about the available funds and the application procedure, 29% cited a lack of resource mobilization capacity and 21% stated that they did not need the United Nations multi-partner trust funds. WHO country offices in high-income countries did not apply as they were not eligible. Others noted that competing priorities and lack of capacity to implement funds (if received) were the reasons for not applying.

<sup>53</sup> Such as the One Fund/multi-donor trust fund, the Joint SDG Fund, the Central Emergency Response Fund or country-based pooled funds.

## PRSEAH

WHO is implementing a strong risk-based approach to ensure that policies, practices and interventions for preventing and responding to sexual misconduct – including sexual exploitation, abuse and harassment and other forms of sexual violence – by WHO workforce are centred on the needs, preferences and rights of those at risk.<sup>54</sup> As at early 2023, the first building blocks of a comprehensive policy framework centred around the new WHO Policy on Preventing and Addressing Sexual Misconduct, implementation guidance and new procedures were being put in place. The efforts of country offices towards PRSEAH in 2021–2022 have already produced concrete outputs.

As at September 2022, all country offices reported to have taken concrete and positive steps towards zero tolerance for sexual exploitation, abuse and harassment. Notably, 95% ensured that all country office personnel had completed the mandatory training on iLearn on sexual exploitation, abuse and harassment, and 94% had appointed or identified a PRSEAH focal point.

Moreover, 89% reported to have conducted a meeting with all personnel at least once on PRSEAH, 84% had provided instructions to all members of the workforce on how to directly contact the WHO integrity hotline or investigation services to raise complaints or concerns related to sexual exploitation, abuse and harassment, 72% had ensured that newly appointed and deployed personnel received a briefing on PRSEAH, and 66% had collaborated with UNCTs or the humanitarian country teams on PRSEAH work.

In 2021–2022, PRSEAH was one of the top five capacities enhanced at the country office level, with 57% of country offices worldwide reporting an increase in the PRSEAH capacity. Training of the existing workforce was cited by 85% of WHO country offices as the primary solution for increasing this capacity, followed by task-shifting or reprofiling the current WHO workforce (67%) and backstopping support from other WHO offices (38%). Across the WHO regions, those were also the three main ways for enhancing the PRSEAH capacity.

## Data and health information systems

Sixty-nine WHO country offices worldwide (45%) reported an increase in data and health information systems capacity. This was achieved mainly by recruitment of WHO non-staff members specifically for this purpose (68%), likely owing to emerging needs for surveillance and monitoring/evaluation during COVID-19; backstopping from other WHO offices (46%); and training the existing country office workforce (46%). Recruitment of non-staff members was the main way for country offices across all WHO regions to enhance their capacity in data and health information systems.

<sup>54</sup> Our work tackling sexual exploitation, abuse and harassment at WHO [webpage]. Geneva: World Health Organization; 2023 ([www.who.int/initiatives/preventing-and-responding-to-sexual-exploitation-abuse-and-harassment/our-work](http://www.who.int/initiatives/preventing-and-responding-to-sexual-exploitation-abuse-and-harassment/our-work), accessed 26 March 2023).

## 4.4. WHO's financial resources at the country level

WHO's ability to make an impact at the country level is contingent on the availability of dependable, adequate and flexible funds. As at 30 December 2022, US\$ 3.8 billion was available for WHO country-level activities under the WHO programme budget for 2022–2023, representing 54% of WHO funds available (Table 15).

*Table 15. Funding available for country-level work as a percentage of planned cost and of total available funds*

	Available funds for WHO country offices as % of planned cost	Available funds for WHO country offices as % of total available WHO funds
2016–2017	88%	54%
2018–2019	89%	58%
2020–2021	81%	55%
2022–2023	85%	54%

Country offices in the Eastern Mediterranean Region received the largest part of the Organization's funds by the end of 2022 (38%), followed by the African Region (36%), the European Region and the South-East Asia Region (10% each), the Western Pacific Region (4%) and the Region of the Americas (2%). The Eastern Mediterranean Region and the African Region also received the largest share of country-level funds at the last reporting. The European Region received a slightly higher percentage (by 2 percentage points) than at the last reporting, which may reflect the health and humanitarian crises that emerged in the European Region in the past two years. The Region of the Americas and the Western Pacific Region received a slightly smaller share than at the last reporting.

### Sources of funding

WHO's programme budget is funded primarily through two sources: (1) flexible funds, which include assessed contributions, core voluntary contributions and programme support costs; and (2) specified voluntary contributions, which include funds designated for specific programmes (a list of funding sources is provided in Annex 8). At the midpoint of the biennium, flexible funding accounted for only 13% of total distributed funds across the 152 country offices, representing a 3-percentage-point increase from the last reporting. A low proportion of core and flexible funding hinders WHO efforts to offer Member States enduring, predictable and high-quality support through WHO country offices. Therefore, the slight increase of flexible funds made available to country offices shows that WHO is working towards more flexible funds at the country level. The allocations of funds are detailed on the WHO programme budget portal.<sup>55</sup> The Director-General is committed to allocating more resources to countries and enhancing the capacities of WHO country offices. To that end, in February 2023, he announced that an additional US\$ 100 million would be allotted to country offices, as part of the Organization's commitment to increasing focus on WHO country-level action.

<sup>55</sup> The WHO programme budget portal [webpage]. Geneva: World Health Organization; n.d. (<https://open.who.int/2022-23/home>, accessed 26 March 2023).

## Chapter key messages: performing for health

- The WHO Secretariat prioritizes gender parity and interregional mobility of WRs. Given the lower representation of women and uneven interregional mobility of WRs in most WHO regions, the Secretariat will make concerted efforts to address this. To ensure uninterrupted WHO leadership at the country level, WHO should continue to design and implement succession plans.
- Because women comprise only 37% of international staff in WHO country offices, more efforts should be made to achieve gender parity; this should be considered in the recruitment strategies of country offices.
- There are significant international professional and national professional staffing gaps in country offices due to a lack of funds or time-consuming recruitment procedures. The WHO Secretariat, with support from Member States, will need to fund vacant posts, simplify recruitment processes at the country level and make mobility mandatory after completion of the standard duty assignment period. This will be particularly important for core posts in country offices. Following the Eleventh WHO Global Management Meeting, in December 2022, the Action for Results Group, comprising a group of six WRs, has started to make concerted efforts to enable the Organization to address those matters.
- Country offices have shown adaptability to enhance technical and corporate capacities (communications; partnerships; resource mobilization; PRSEAH; and data and health information systems). This was done through non-staff recruitment, training existing workforce and backstopping support from other WHO offices. Efforts should be sustained and further enhanced.
- Flexible funding at the country office level, while still low, has increased from 10% to 13% in the past two years. The Secretariat will continue to make concerted efforts to further increase flexible funding for country offices to ensure strong and predictable country presence and country-level work through implementing suggested actions from the Action for Results Group.

# 5. Partner for health



To deliver results at the country level, WHO engages with a wide range of stakeholders. This chapter emphasizes the importance of country-level partnerships in achieving the health-related Sustainable Development Goals (SDGs). It starts by examining collaboration with the United Nations system at the country level and participation in South-South and triangular cooperation (SSTC), followed by a profile of WHO's development partners, especially bilateral and multilateral organizations. Lastly, cooperation with WHO collaborating centres and non-State actors is discussed.

### 5.1. The United Nations system

In total, there are 137 WHO country offices in countries that engage with United Nations country teams. This entails collaborating with United Nations partners at the country level to identify shared health priorities and approaches for the United Nations Sustainable Development Cooperation Framework (UNSDCF). Moreover, WHO actively participates in common business operations as part of the United Nations.

#### United Nations thematic groups

WHO country offices participate in several United Nations thematic groups to promote country-level interagency and multisectoral collaboration on health and its determinants. In many cases, they chair or co-chair different health-related groups. In 2021–2022, 70% of WHO country offices chaired or co-chaired the United Nations thematic group on preparedness, response and resilience to health emergencies – such as the coronavirus disease (COVID-19) – in addition to 12% of country offices that participated in this group (Fig. 22).

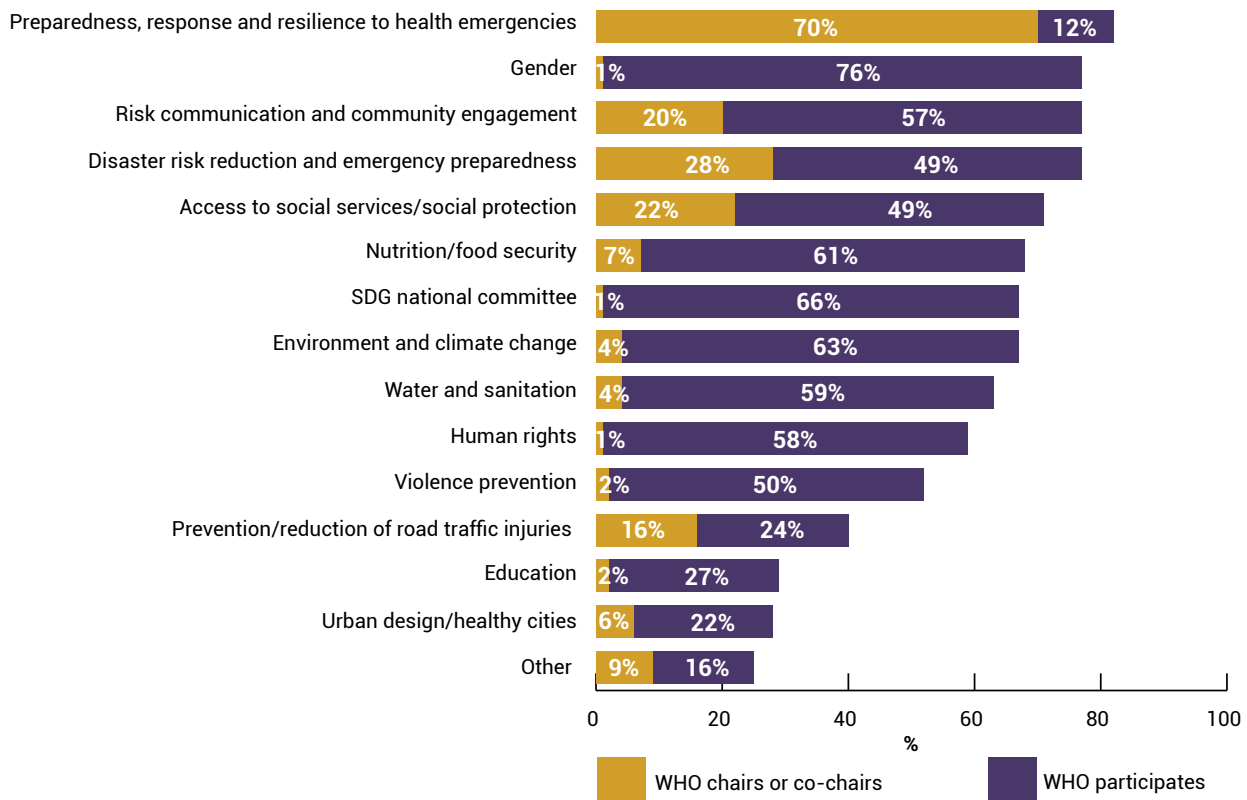
A total of 28% of WHO country offices chaired or co-chaired the thematic group on disaster risk reduction and emergency preparedness (a slight increase from 25% at the last reporting<sup>56</sup>), in addition to 49% that participated in this group. Moreover, 22% of WHO country offices chaired or co-chaired the thematic group on access to social services or social protection (more than a twofold increase from the last reporting<sup>57</sup>), in addition to 49% that participated in this group.

As Fig. 22 shows, three quarters of WHO country offices participated in the United Nations thematic group on gender, two thirds participated in the SDG national committee, and more than half participated in the groups on environment and climate change; nutrition and food security; water and sanitation; human rights; and risk communication and community engagement.

<sup>56</sup> WHO presence in countries, territories and areas: 2021 report. Geneva: World Health Organization; 2021 (<https://apps.who.int/iris/handle/10665/341308>, accessed 26 March 2023), p. 108.

<sup>57</sup> In the 2021 report (see previous footnote), less than 10% of WHO country offices co-chaired or chaired this group.





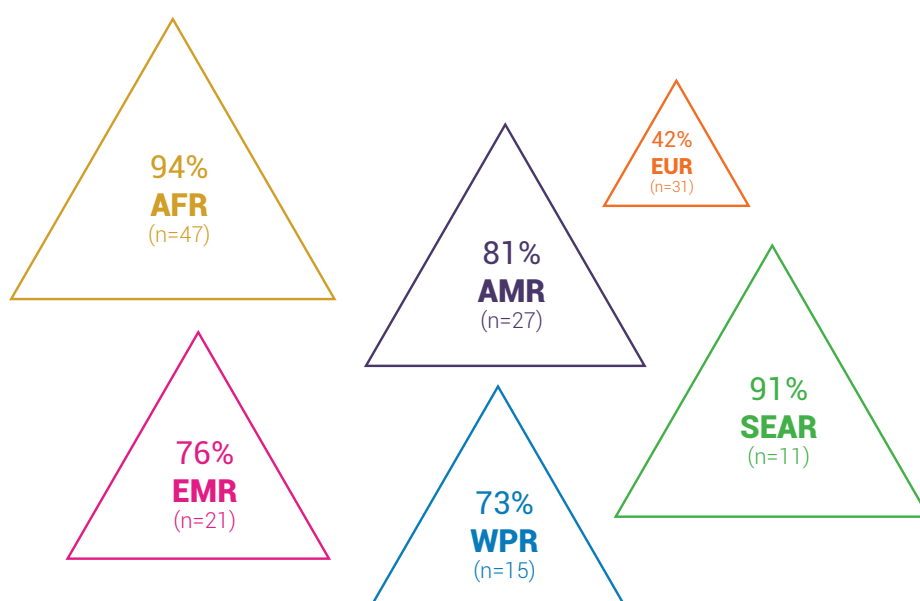
**Fig. 22.** United Nations thematic groups in which WHO country offices participated in 2021–2022

Furthermore, WHO country offices chaired or co-chaired United Nations thematic groups on migration (migrants and refugees), disability, HIV/AIDS, United Nations health facility management, mental health and psychosocial support, health cooperation, health cluster, communications, donor coordination, as well as the Ebola leadership team.

The participation of WHO country offices in the United Nations thematic groups shown in Fig. 22 is an example of country offices embracing the “One United Nations” approach towards multisectoral collaboration as a core business agenda in support of the implementation of the Thirteenth General Programme of Work, 2019–2025 (GPW13) and the achievement of the SDGs.

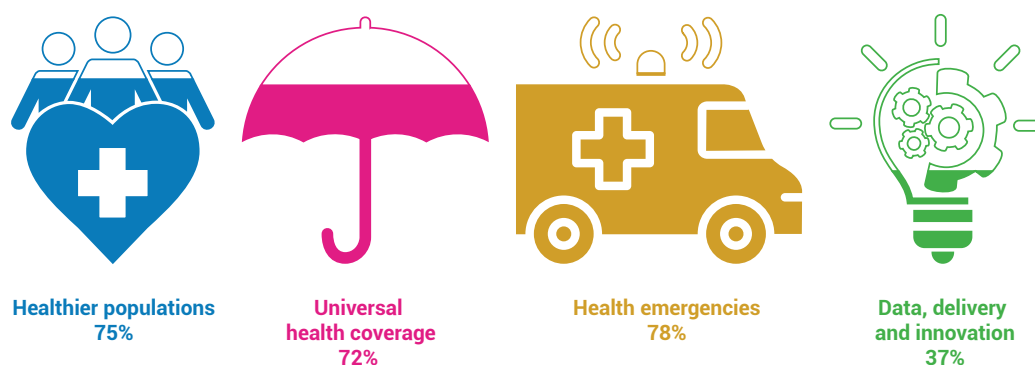
## Joint United Nations programmes

WHO country offices participate in joint United Nations programmes. Participation rose from 62% in 2019–2020 to 76% in 2021–2022. Almost all country offices in the African Region (94%) and the South-East Asia Region (91%), as well as 81% of offices in the Region of the Americas, participated in joint United Nations programmes (Fig. 23). The percentage of WHO country offices in the European Region that engaged in joint United Nations programmes was low owing to the small number of countries that had a United Nations Resident Coordinator system. However, when considering only the offices in countries that had such a system, 72% participated in joint United Nations programmes.



**Fig. 23.** Participation of WHO country offices in any joint United Nations programme since 1 January 2021, by WHO region

Of the 116 WHO country offices that participated in joint United Nations programmes, engagement was almost evenly distributed among the strategic priorities of healthier populations, universal health coverage (UHC) and health emergencies (Fig. 24).



**Fig. 24.** Strategic priorities of the 116 WHO country offices that participated in joint United Nations programmes

*Areas of collaboration:*

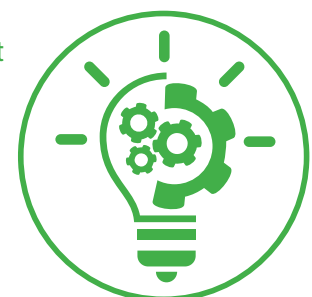
Collaboration with joint United Nations programmes that supported **health emergencies** was the most reported in the African Region (91%), the European Region (62%), the South-East Asia Region (90%) and the Western Pacific Region (91%). Health emergencies was the second most reported area of collaboration in the Eastern Mediterranean Region (75%). This may reflect the United Nations-wide efforts in those regions to address ongoing health emergencies and humanitarian crises since 2021. A little over half (55%) of country offices in the Region of the Americas participated in joint United Nations programmes on health emergencies.

**Healthier populations** was the most reported joint United Nations programme collaboration in the Region of the Americas (82%) and the second most reported collaboration in the South-East Asia Region (80%) and the Western Pacific Region (82%), which may reflect a strong joint United Nations focus on promoting health and well-being and preventing noncommunicable diseases in those regions. Still, three quarters of country offices in the African Region and the Eastern Mediterranean Region also participated in such joint United Nations programmes. Only 54% of the country offices in the European Region participated.



**UHC** was the most reported collaboration in the Eastern Mediterranean Region and the European Region (81% and 62%, respectively) and the second most reported collaboration in the African Region (89%). This may reflect the priority given by the United Nations in those regions to ensure that people have equitable access to health and health care coverage. In contrast, 60% of the country offices in the South-East Asia Region and 55% of those in the Western Pacific Region and the Region of the Americas participated in joint United Nations programmes on UHC.

Although less than half of the country offices in most WHO regions reported joint United Nations programmes focusing on **data, delivery and innovation**, 69% of the offices in the Eastern Mediterranean Region and 55% in the African Region reported such collaborations; the collaborations in those regions could be examined and scaled up to other regions.



## United Nations common business operations

The most used United Nations business operations and support systems by WHO country offices worldwide was security services (71%; up slightly from 65% at the last reporting), followed by information technology and ICT combined (52%), local procurement (45%), administrative services (37%) and logistics and travel (each 32%). Fig. 25 shows significant regional variation in shared service uptake, which may reflect local operational circumstances.

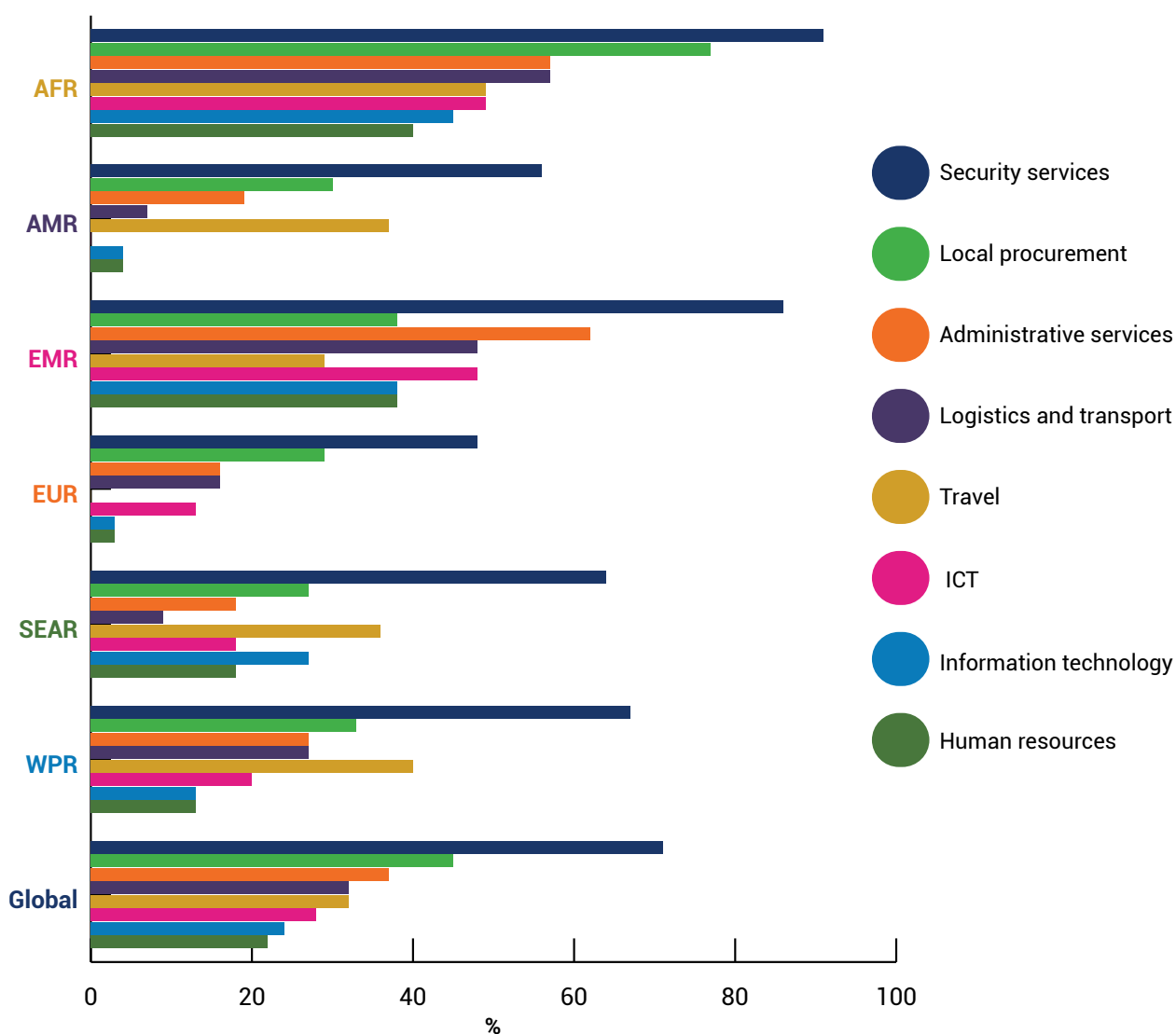


Fig. 25. WHO country offices' uptake of United Nations common business operations and support systems by WHO region

## 5.2. South-South and triangular cooperation

To achieve the SDGs, the 2030 Agenda for Sustainable Development emphasizes regional and international cooperation. SSTC allows two or more developing countries (sometimes with support from developed countries or multilateral organizations) to pursue individual and/or shared national capacity development through knowledge, skills and capacities exchange to deliver development solutions that harness innovation and capabilities of diverse partners across different countries.

Half (51%) of WHO country offices reported to have engaged in SSTC in 2021–2022, the same percentage as at the last reporting. The WHO regions with the highest percentage of country offices that contributed to any SSTC were the African Region (72%) and the Region of the Americas (63%). Although 47% of the offices in the Western Pacific Region and 45% in the South-East Asia Region reported to have contributed to SSTC, only 33% of the country offices in the Eastern Mediterranean Region and 26% in the European Region reported this.

Of the SSTC initiatives that WHO country offices have supported, the larger part contributed to addressing health emergencies (42%), followed by UHC (27%), healthier populations (20%) and data, delivery and innovation (11%), with variations across WHO regions (Fig. 26). Notably, the SSTC initiatives in the European Region were more evenly distributed across strategic priorities than those in other WHO regions. About one third of SSTC initiatives in the Region of the Americas and the South-East Asia Region focused on healthier populations, a larger percentage than in other WHO regions.

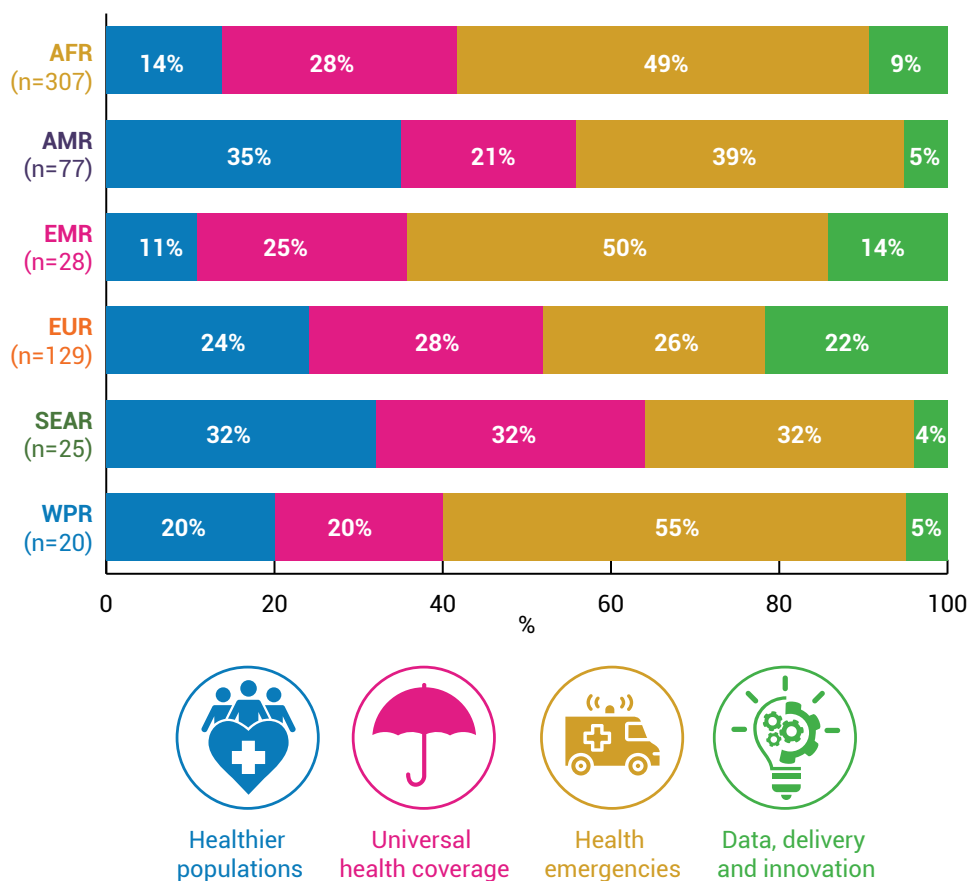


Fig. 26. Percentage of SSTC initiatives across strategic priorities by WHO region

Most (89%) of the 78 country offices that contributed to SSTC said that the initiatives enabled them to deliver on commitments in their Country Cooperation Strategy or Biennial Collaborative Agreement. Country offices found SSTC useful for meaningful expertise exchange for programme learning, planning and course correction. According to others, international collaboration strengthened health security. Working in geographical proximity and in similar linguistic and cultural contexts allowed more efficient use of WHO country offices' resources.

### “ Reflections on SSTC from WHO country offices

*“SSTC enables a better understanding of relevant policy reforms undertaken by another [lower-middle-income country] towards universal health coverage.” – A WHO country office in the South-East Asia Region*

*“SSTCs enhance the reach of joint technical support to the small island developing states.” – A WHO country office in the Western Pacific Region*

*“National counterparts like to get evidence of what works and does not, listen to peers and see with their own eyes. It is motivating.” – A WHO country office in the European Region*

*“It is essential to promote the exchange of good practices and knowledge among the countries in the region, for example on approaches to mental health services across levels of care.” – A WHO country office in the Region of the Americas*

*“The WHO Country Office supported a ministerial visit including five mayors to travel to another country in the region to exchange on city cleanness and affordable housing, contributing to the healthier populations strategic priority.” – A WHO country office in the African Region*



Regardless of whether WHO country offices have contributed to SSTC, 74% of WHO country offices worldwide stated that SSTC would help them to achieve their strategic deliverables and commitments. This appreciation for the value of SSTC may help those country offices to forge such collaborations in the future.

### 5.3. Bilateral, multilateral and other partnerships

As the global health architecture evolves, WHO's partnerships with national and multilateral partners, as well as financial, technical and philanthropic organizations at the country level, enable the Organization to be a more effective public health leader in countries, territories and areas. In addition to being strategic financial partners, bilateral and multilateral actors can also work with WHO at the country level as technical partners. Fig. 27 shows technical cooperation partnerships in 2021–2022.

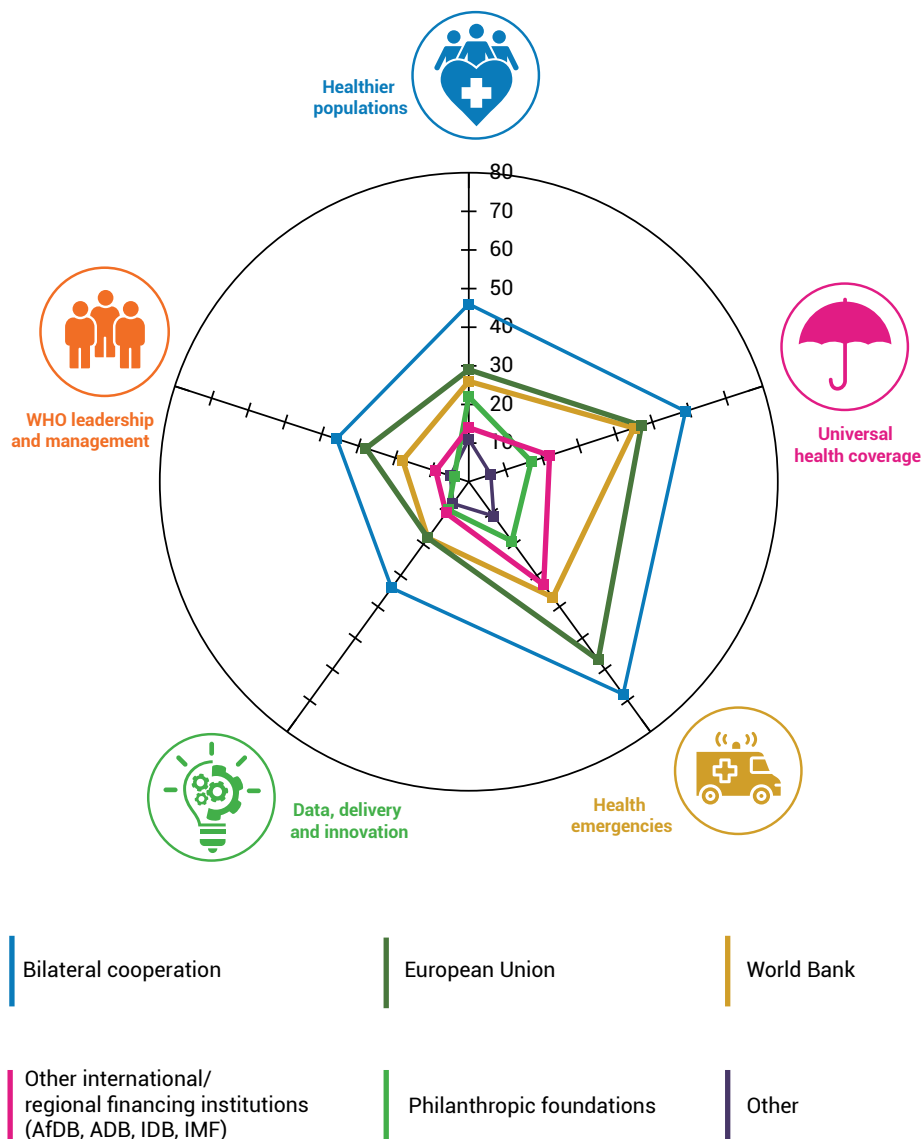


Fig. 27. WHO country offices' collaboration with partners in 2021–2022

- Of all the WHO country offices, 68% worked with bilateral partners in their technical capacity (beyond a financial one) towards health emergencies, 59% reported technical cooperation for UHC, and 46% reported engaging with bilateral partners for technical cooperation on healthier populations.
- Over half (57%) of WHO country offices reported technical cooperation with the European Union for health emergencies, and 47% reported such cooperation for UHC.
- Close to half (45%) of WHO country offices reported cooperating with the World Bank in their technical capacity towards UHC, and 37% did so towards health emergencies.
- Other types of technical cooperation was leveraged with other international or regional financing institutions, such as the African Development Bank (AfDB), the Asian Development Bank (ADB), the Inter-American Development Bank (IDB) and the International Monetary Fund (IMF), including one third of country offices cooperating with those institutions to address health emergencies.
- Almost one quarter (22%) of country offices reported that they had worked with philanthropic foundations in their technical capacity towards healthier populations, 19% towards health emergencies and 17% towards UHC.



## WHO country offices' technical cooperation with the Global Fund and Gavi, the Vaccine Alliance

- Of the 132 country offices that work with countries, territories or areas that receive support from the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund) 55% of conducted activities for UHC, 40% for healthier populations and 35% for health emergencies.
- WHO has offices in 54 Gavi-eligible countries. More than three quarters (76%) of the WHO country offices reported working with Gavi on UHC technical issues and 63% on health emergencies.

### Providing support to governments for their resource mobilization: some examples

A crucial aspect of the partnerships that WHO country offices forge is providing support to Member States in resource mobilization for their public health efforts. WHO country offices across the globe have provided significant support to their counterpart health authorities in mobilizing resources. Nearly three quarters of country offices reported that they had provided support to governments through advocacy and dialogue facilitation with bilateral partners and donors. On behalf of Member States, 93% of WHO country offices in the Western Pacific Region, 91% in the African Region and 78% in the Region of the Americas supported international resource mobilization efforts for the government.

By engaging with ministries of finance and other national institutions, nearly one third of WHO country offices provided support to health authorities in securing domestic funding. The following examples show the dedication of country offices in maximizing WHO's role as the world's leading health actor to provide support to governments and attract new and non-traditional donors to support health.

- **Armenia:** The WHO Country Office for Armenia supported the mobilization of funding for mental health from a European Union delegation and agencies of the United Nations system.
- **Botswana:** The WHO Country Office for Botswana mobilized funds from the German Embassy and British High Commission, which were then provided to the Ministry of Health for COVID-19 support, and mobilized funds from the Arab Bank for Economic Development in Africa.
- **Haiti:** The WHO Country Office for Haiti participated in negotiations on the use of IDB funds (already available within the government) for health and also facilitated Gavi funds for COVID-19 and routine vaccinations.
- **Jordan:** WHO co-chaired a high-level health development coordination platform (which included the Ministry of Health, donors and agencies of the United Nations system) to align external support with national priorities. WHO advocated for sustained financial support for public health.
- **India:** WHO coordinated the development of the proposal for activities around antimicrobial resistance from the Fleming Fund and provided input for the country's Global Fund proposal through the country coordinating mechanism for HIV, tuberculosis and malaria.
- **Solomon Islands:** WHO supported the government and partners' dialogue with Gavi. The government prepared and applied successfully for multiple Gavi budget streams. Moreover, technical support was provided by the WHO Country Office in the Solomon Islands for proposal writing and coordination.

## 5.4. National collaborations and partnerships with academia, research institutions and non-State actors

WHO promotes health-advancing scientific and professional collaboration with diverse organizations. WHO country offices collaborate with non-State actors including national and international nongovernmental organizations (NGOs), international and regional networks, the media, and subregional and regional organizations. They also work with non-State actors such as community and civil society organizations to further extend the reach of WHO's work.

### WHO collaborating centres

WHO collaborating centres strengthen institutional capacity in countries and regions and increase national participation in WHO activities by providing strategic support to implement the Organization's mandated work. WHO programmes are supported by WHO's work with over 800 WHO collaborating centres in 80 countries (Table 16).

*Table 16. Number of WHO collaborating centres by WHO region*

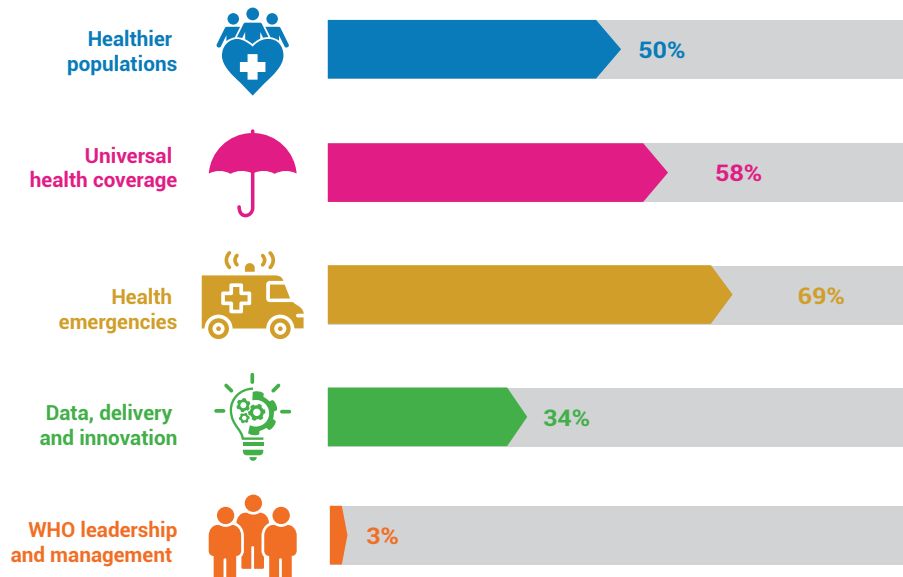
AFR	AMR	EMR	EUR	SEAR	WPR	Global
28	178	57	268	95	198	824

Globally, 62 WHO country offices reported receiving support from a WHO collaborating centre in 2021–2022 (Table 17). Although 63% of country offices in the Region of the Americas received support from a WHO collaborating centre, a smaller percentage did so in other WHO regions: 45% in the South-East Asia Region, 47% in the Western Pacific Region, 35% in the European Region and 30% in the African Region. WHO country offices, in liaison with their respective regional offices, could further increase partnerships with WHO collaborating centres to work towards achieving the GPW13 objectives.

*Table 17. Number of country offices that received support from a WHO collaborating centre in 2021–2022 by WHO region*

AFR	AMR	EMR	EUR	SEAR	WPR	Global
14 (30%)	17 (63%)	8 (38%)	11 (35%)	5 (45%)	7 (47%)	62 (41%)

Of the country offices that received support from a WHO collaborating centre, globally, most did so for the areas of health emergencies and UHC, and half did so for healthier populations (Fig. 28), with regional variations.



*Fig. 28. Areas of work in which the 62 WHO country offices received support from WHO collaborating centres*

- **Health emergencies:** Of the 43 WHO country offices that received WHO collaborating centre support for health emergencies, most were in the African Region (all 14) and the Region of the Americas (11 of 17). In the South-East Asia Region, 4 (of 5) also received such support for health emergencies.
- **UHC:** Four of the five (80%) country offices that received support from collaborating centres in the South-East Asia Region, 75% in the Eastern Mediterranean Region and 73% in the European Region did so for UHC.
- **Healthier populations:** Of the country offices receiving support from WHO collaborating centres, 64% in the European Region, 57% in the Western Pacific Region and 53% in the Region of the Americas did so for healthier populations.

## Non-State actors

In response to a call for collaboration with civil society, local communities, philanthropic foundations and private sector entities, WHO works with non-State actors to strengthen country-level leadership. Collaborations follow WHO's Framework of Engagement with Non-State Actors (FENSA).

WHO country offices reported engagement with local, international, media and professional associations across the priority areas (Fig. 29).

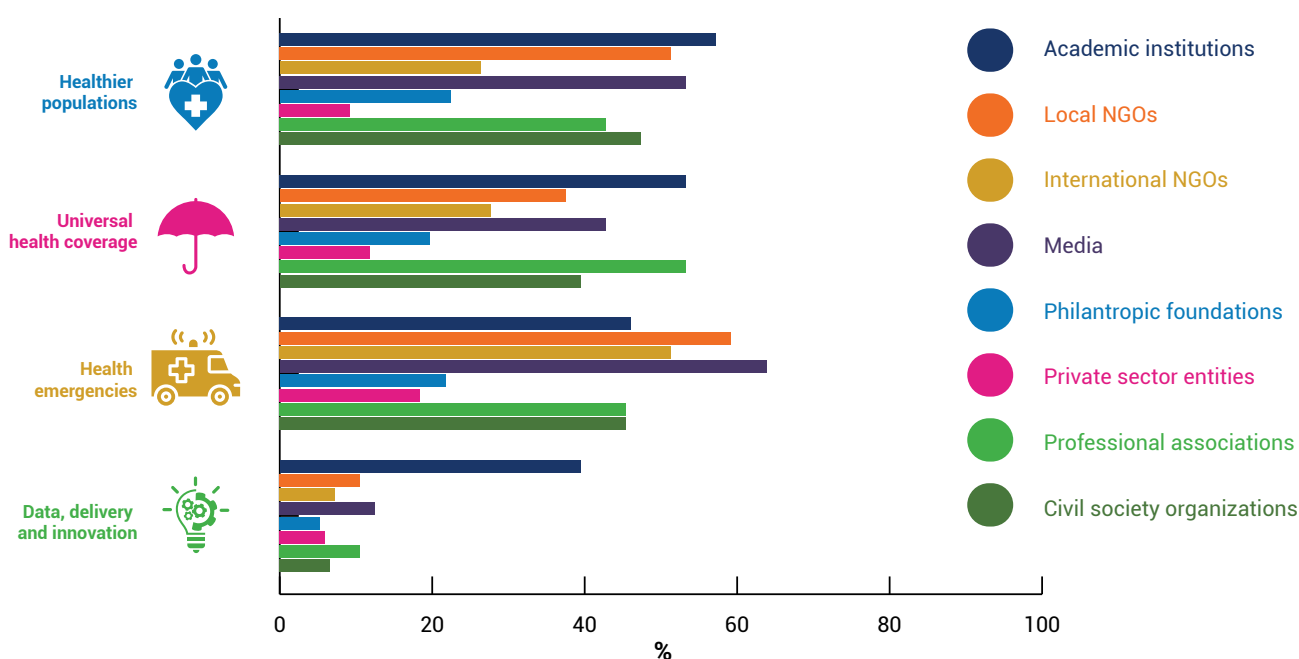
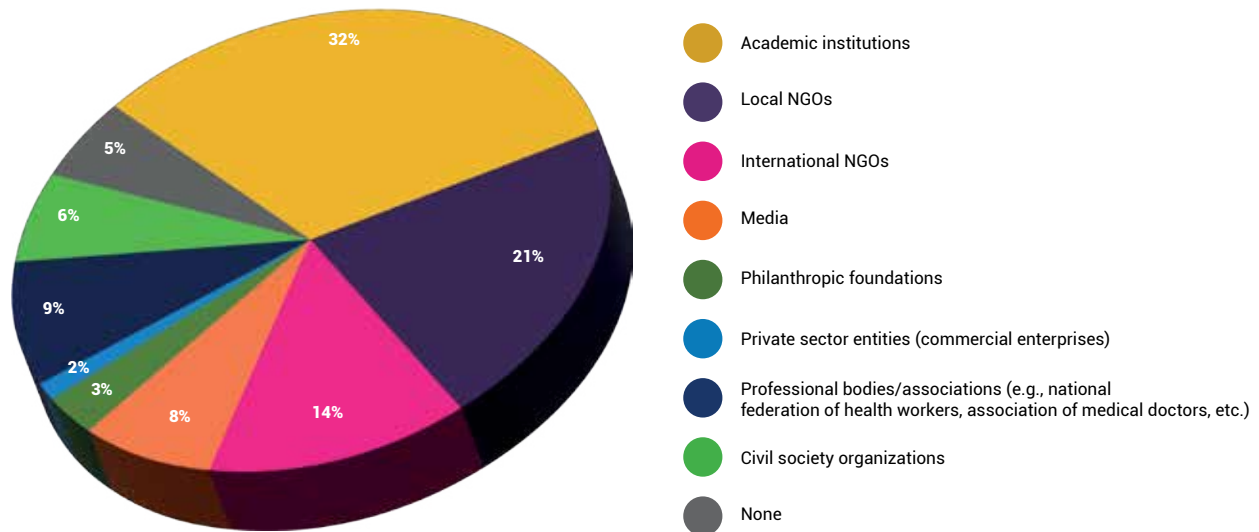


Fig. 29. Types of non-State actors with which WHO country offices cooperated across priority areas

- **Health emergencies:** A majority (64%) of WHO country offices reported working with the media to address health emergencies, followed by collaboration with local NGOs (59%).
- **UHC:** To strengthen UHC, a high percentage of WHO country offices worked with academic institutions and professional associations (53% each).
- **Healthier populations:** 57% of country offices worked with academic institutions towards healthier populations, the third most common collaboration across all non-State actors and across all areas of work. More than half of the country offices also worked with local NGOs (51%) and the media (53%).

Globally, a majority of WHO country offices reported that their collaborations with academia (32%), local NGOs (21%) and international NGOs (14%) were the most effective in helping WHO to achieve its country-level objectives, followed by partnerships with the media and with professional bodies or associations (such as national federation of health workers, association of medical doctors, etc.) (Fig. 30).



*Fig. 30. WHO country offices' most effective non-State actor partnerships for delivery of WHO objectives, globally*

Partnerships with academia were reported as the most effective by most WHO regions: the Eastern Mediterranean Region (33%), the South-East Asia Region (36%), the Western Pacific Region (40%) and the Region of the Americas (41%). This is followed by partnerships with local NGOs: the Eastern Mediterranean Region (19%), the South-East Asia Region (36%), the Western Pacific Region (27%) and the Region of the Americas (22%).

In the African Region, a larger percentage of country offices reported partnerships with international NGOs (32%) as being the most effective for delivering WHO country-level objectives, followed by academic institutions (28%) and local NGOs (13%).

In the European Region, a larger percentage of country offices reported partnerships with professional bodies or associations as the most prevalent (29%). Around a quarter (26%) of country offices in the European Region indicated that partnerships with academic institutions and local NGOs (23%) were the most effective for WHO's work.

For the delivery of results, a significant proportion of WHO country offices reported that their engagement with non-State actors was guided by FENSA. However, WHO country offices also reported issues with the application of FENSA, including that it could be a lengthy, cumbersome and difficult process to manage alongside other work priorities; finding the delay in FENSA approval challenging; and having low awareness of FENSA requirements and procedures among country offices' technical staff. To understand and expedite the process to enable WHO to increase and enhance country-level partnerships, support and training from WHO headquarters and regional offices (as well as simplifying and digitizing the approval process) could help.

### Chapter key messages: WHO country offices and partnerships

- Increasing proactive participation of country offices in the United Nations Resident Coordinator system, especially in the formulation of Common Country Analyses and the UNSDCF, presents an opportunity to optimize interagency collaboration to achieve the SDGs and accelerate GPW13 targets, including addressing the social and commercial determinants of health, as well as demonstrating WHO leadership at the country level.
- By collaborating with donors at the country level in common technical priority areas, WHO country offices are leveraging international collaborations, notably bilateral cooperation, at the country level. This shows WHO's country-level ability to convene key partners and funders, such as Member States or international agencies, to work on technical goals and GPW13 implementation. Such efforts should be sustained.
- SSTC can advance national priorities and WHO strategic commitments, while creating mutual learning opportunities. Such engagements strengthen not only collaboration between countries, but also cross-regional collaboration.
- Less than half of the country offices used WHO collaborating centres in 2021–2022. To leverage the centres' technical expertise and build national capacities, WHO country offices could increase their engagement and involve them in activities.
- Scaling and achieving the SDGs require rapidly expanding high-quality partnerships with all actors within and outside government institutions at the country level, such as civil society, communities, academia and local NGOs. This can be further facilitated through training and simplification of FENSA application and establishing an online electronic approval process. WHO, through backstopping from headquarters and regional offices, could provide further training and briefings to country offices and country-level non-State actors.
- In 2021 and 2022, given that many country-level partnerships focused on health emergencies related to the COVID-19 pandemic, lessons learned from these can be used to establish partnerships across the other GPW13 strategic priorities.

# 6. WHO country offices' facilities



This chapter provides information on the premises of WHO country offices in countries, territories and areas, accessibility of those offices for people with disabilities and availability of parent-friendly facilities, with a focus on creating an inclusive workplace.

## 6.1. Premises of WHO country offices

To fulfil the ambition from the extended Thirteenth General Programme of Work, 2019–2025 (GPW13)<sup>58</sup> of placing countries at the core of WHO's work and driving public health impact in every country, the premises of WHO country offices must be healthy work environments. WHO, through its country offices, delivers its technical cooperation and acts as a convenor and coordinator of many partners in support of achieving the health objectives of national authorities. Attracting and retaining a diverse, motivated and fit-for-purpose workforce underpin WHO's transformation objectives; therefore, creating a welcoming and appropriate workplace for people with diverse needs remains important.<sup>59</sup>

The geographical proximity of the premises of WHO country offices to partners, including ministries of health, United Nations entities or others, varied from country to country. Around a third of country offices were housed in independent premises rented by WHO, and a quarter were housed in Ministry of Health or national agency premises. Similar to the last reporting, close to one fifth of WHO country offices were housed in United Nations common premises (Fig. 31).<sup>60</sup> WHO encourages its country offices to be housed in United Nations common premises when they can benefit from economies of scale. Having premises on United Nations common premises enhances collaboration and coherence within the United Nations system.

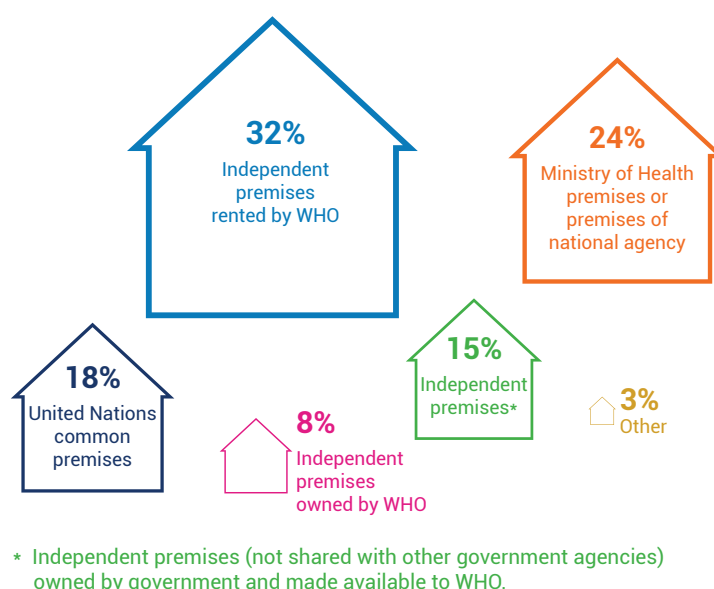


Fig. 31. Types of premises housing WHO country offices globally as at September 2022

<sup>58</sup> Thirteenth General Programme of Work 2019–2023. Geneva: World Health Organization; 2019 (<https://apps.who.int/iris/handle/10665/324775>, accessed 26 March 2023).

<sup>59</sup> WHO Transformation [webpage]. Geneva: World Health Organization; 2018 ([www.who.int/about/transformation](http://www.who.int/about/transformation), accessed 26 March 2023).

<sup>60</sup> WHO presence in countries, territories and areas: 2021 report. Geneva: World Health Organization; 2021 (<https://apps.who.int/iris/handle/10665/341308>, accessed 26 March 2023).



The arrangement of country offices' premises varied considerably across WHO regions (Table 18).

- In the **South-East Asia Region**, 45% of country offices were housed in independent premises rented by WHO. This type of premises also housed 42% of country offices in the **European Region** and 30% in the **African Region**.
- More than half (60%) of country offices in the **Western Pacific Region** and 33% of offices in the **Eastern Mediterranean Region** were housed in Ministry of Health or national agency premises, compared with less than 30% in the other WHO regions.
- In the **African Region**, 34% of country offices were housed in United Nations common premises, compared with 18% globally.
- Almost one third (30%) of country offices in the **Region of the Americas** were housed in WHO-owned premises, compared with 8% globally.

**Table 18.** Types of premises housing country offices by WHO region and globally as at September 2022

Types of premises	AFR (n=47)	AMR (n=27)	EMR (n=21)	EUR (n=31)	SEAR (n=11)	WPR (n=15)	Global (n=152)
Ministry of Health premises or premises of national agency	11%	22%	33%	23%	27%	60%	24%
Independent premises (not shared with other government agencies) owned by government and made available to WHO	21%	19%	5%	16%	9%	7%	15%
Independent premises owned by WHO	4%	30%	10%	0%	0%	0%	8%
Independent premises rented by WHO	30%	22%	29%	42%	46%	27%	32%
United Nations common premises	34%	7%	14%	13%	9%	7%	18%
Other	0%	0%	10%	6%	9%	0%	3%

## 6.2. Accessibility for persons with disabilities

The year 2021 was the International Year of Health and Care Workers,<sup>61</sup> as well as the Year of the WHO Workforce, and WHO made diversity, equity and inclusion a key pillar of its operations, with a view to helping the Organization build a truly inclusive and respectful work culture and environment. To fulfil its commitment to putting the United Nations Disability Inclusion Strategy into action,<sup>62</sup> and to fostering an inclusive work environment that considers staff with diverse needs, WHO implemented a new policy on flexible work arrangements and updated its policy on the employment of people with disabilities.<sup>63</sup> Making WHO country offices accessible to people with disabilities can serve to put the policy into practice, among other things, and may help WHO to harness the benefits of inclusive workplaces as articulated by the International Labour Organization.<sup>64</sup>

### Accessibility of premises

Although there are complexities in ensuring all premises of WHO country offices are accessible for people with disabilities, there remains significant room for improvement in disability accessibility in country offices. In 2021–2022, 30% of the 152 WHO country offices were fully accessible<sup>65</sup> (Fig. 32). This represents a steady increase from percentages reported in 2017 (18%)<sup>66</sup> and in 2021 (26%).<sup>67</sup> Similar to the last reporting, approximately half of the country offices reported that they were partially accessible for people with disabilities. Notably, the percentage of offices that were not accessible had decreased since the last reporting (from 19% to 16%). Some factors that affected accessibility included building additional floors to existing buildings, sharing the premises with other institutions and limited resources for office building maintenance.

<sup>61</sup> Year of Health and Care Workers 2021 [webpage]. Geneva: World Health Organization; 2023 (<https://www.who.int/campaigns/annual-theme/year-of-health-and-care-workers-2021>, accessed 26 March 2023).

<sup>62</sup> United Nations Disability Inclusion Strategy [webpage]. New York: United Nations Secretariat; 2022 (<https://www.un.org/en/content/disabilitystrategy/>, accessed 26 March 2023).

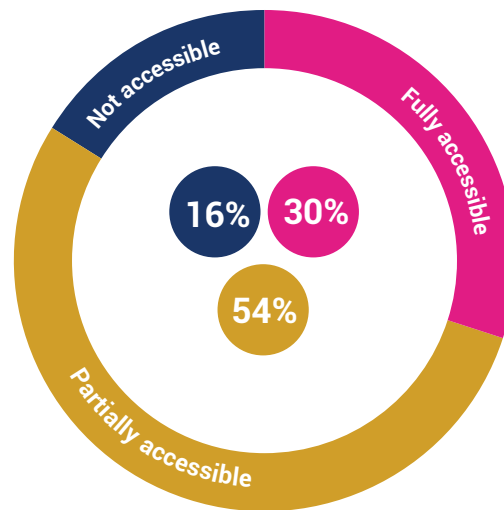
<sup>63</sup> Director-General's remarks at the WHO Town Hall on 4 October 2021. Geneva: World Health Organization; 4 October 2021 ([www.who.int/director-general/speeches/detail/director-general-s-remarks-at-the-who-town-hall-on-4-october-2021](http://www.who.int/director-general/speeches/detail/director-general-s-remarks-at-the-who-town-hall-on-4-october-2021), accessed 26 March 2023).

<sup>64</sup> The win-win of disability inclusion [webpage]. Geneva: International Labour Organization; 2016 ([www.ilo.org/infostories/en-GB/Stories/Employment/The-win-win-of-disability-inclusion#the-benefits-of-inclusive-workplaces](http://www.ilo.org/infostories/en-GB/Stories/Employment/The-win-win-of-disability-inclusion#the-benefits-of-inclusive-workplaces), accessed 26 March 2023).

<sup>65</sup> In the present report, offices that are considered "fully accessible" provide access to all floors and have an adapted bathroom for persons with disabilities. Offices that are considered "partially accessible" may be accessible on all floors but without adapted bathrooms or may be accessible on the ground floor with or without an adapted bathroom.

<sup>66</sup> WHO presence in countries, territories and areas: 2017 report. Geneva: World Health Organization; 2017 (<https://apps.who.int/iris/handle/10665/341308>, accessed 26 March 2023).

<sup>67</sup> WHO presence in countries, territories and areas: 2021 report. Geneva: World Health Organization; 2021 (<https://apps.who.int/iris/handle/10665/341308>, accessed 26 March 2023).



*Fig. 32. Disability access of WHO country offices worldwide in 2021–2022*

Forty-one per cent of the offices in the Region of the Americas, as well as one third of offices in the Eastern Mediterranean Region, the European Region and the Western Pacific Region, reported that they had fully accessible premises. This is followed by the South-East Asia Region (27%) and the African Region (19%). However, 27% of country offices in the Western Pacific Region and 35% of offices in the European Region were not accessible to people with disabilities.

Dedicated parking spaces were made available at 29% of WHO country offices worldwide, with regional differences. In the Eastern Mediterranean Region, 52% of country offices reported that they had parking spaces for people with disabilities, followed by 37% in the Region of the Americas and 36% in the South-East Asia Region. In addition, 3% of offices reported to have assisted accessibility for people with visual or hearing impairment, showing that such accessibility measures could be implemented at the country level.

## Awareness-raising and flexible arrangements for country-level workforce

Raising awareness about disability at WHO country offices is a work in progress, with 33% of country offices reporting that they had completed disability awareness training for the workforce. In the Region of the Americas, 48% of country offices completed awareness-raising activities, followed by the Western Pacific Region (47%) and the South-East Asia Region (45%).

Globally, 34% of WHO country offices offered flexible work arrangements for persons with disabilities, with significant variance among WHO regions. The Region of the Americas reported the highest percentage of country offices with flexible work arrangements for persons with disabilities (59%), followed by the Eastern Mediterranean Region (52%), the European Region and the South-East Asia Region (each 45%). In the Western Pacific Region and the African Region, 13% and 9% of country offices, respectively, offered flexible work arrangements.

The coronavirus disease (COVID-19) pandemic has underlined the importance of mental health, not only for the people who the Organization serves, but also for those working in WHO offices. To support persons with psychological disorders, 28% of WHO country offices worldwide provided services by mental health professionals on-site or on-call. In the Eastern Mediterranean Region, this support was available in 38% of country offices, followed by the South-East Asia Region (36%) and the African Region (34%).

## 6.3. Breastfeeding facilities and supporting workers across the life course

In the past several decades, WHO has urged Member States to support, protect and promote breastfeeding, acknowledging the importance of adequate breastfeeding policies at the workplace.<sup>68, 69, 70</sup> Therefore, and in the spirit of the “walk the talk” motto, WHO’s commitment to making offices breastfeeding-friendly is thus important. In the United Nations system, the United Nations Children’s Fund (UNICEF) and WHO were the first to increase maternity leave to six months, to ensure alignment with their recommendation on exclusive breastfeeding for the first six months of a child’s life.<sup>71</sup>

The percentage of WHO country offices with breastfeeding facilities remained close to one third (32%), the same percentage as at the last reporting (Fig. 33). The Region of the Americas had the most offices with available facilities (67%), followed by the Western Pacific Region (53%) and the South-East Asia Region (45%). Availability of breastfeeding facilities may change over time for various reasons. Country offices that reported not having such facilities as at September 2022 noted that space constraints (such as having to use the facilities as office space following a surge in capacity due to the COVID-19 response) affected availability. Others mentioned that although not permanently available, breastfeeding facilities could be made available as needed. Therefore, not having an immediate need for breastfeeding facilities may influence availability and may partly explain low accessibility to such facilities over time. Notably, 32% of WHO country offices worldwide provided awareness-raising training to their staff about breastfeeding policies, and 39% of offices had access to refrigeration for pumped breast milk.

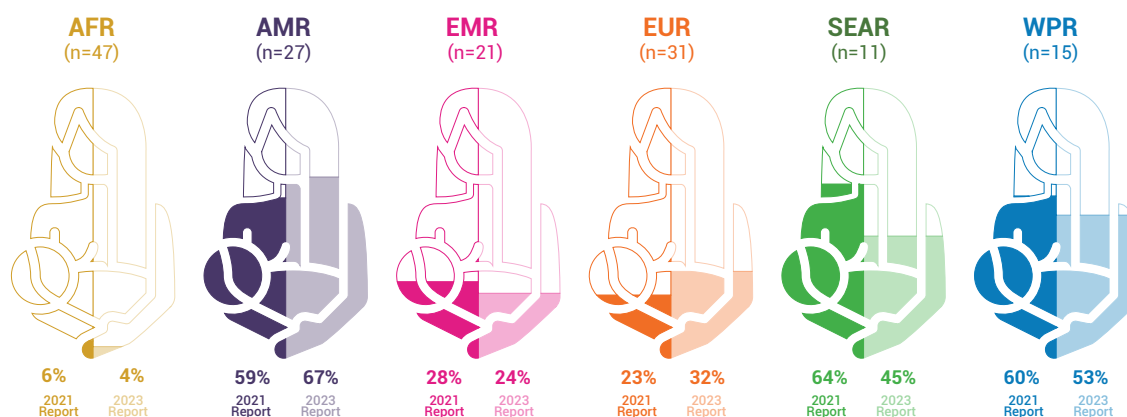


Fig. 33. Percentage of WHO country offices with breastfeeding facilities by WHO region, compared with the 2021 report<sup>72</sup>

<sup>68</sup> Comparative analysis of implementation of the Innocenti Declaration in WHO European Member States: monitoring Innocenti targets on the protection, promotion and support of breastfeeding. Geneva: World Health Organization/United Nations Children’s Fund; 1999.

<sup>69</sup> Comprehensive implementation plan on maternal, infant and young child nutrition. Geneva: World Health Organization; 2014 (<https://apps.who.int/iris/handle/10665/113048>, accessed 24 March 2023).

<sup>70</sup> Global nutrition targets 2025: breastfeeding policy brief. Geneva: World Health Organization/United Nations Children’s Fund; 2014 (<https://apps.who.int/iris/handle/10665/149022>, accessed 24 March 2023).

<sup>71</sup> Enabling environment guidelines for the United Nations system. New York: UN-Women; 2019.

<sup>72</sup> Owing to different denominators in each WHO region, a change in one country office may be proportionately different from one WHO region to another.

### Chapter key messages: WHO country offices' facilities

- A majority of WHO country offices are located in independent premises (including premises made available to WHO by the government at no cost, premises rented and those owned by WHO). Almost a quarter are on Ministry of Health (or national agency) premises and less than one fifth are housed in United Nations common premises. Depending on the location of the premises, WHO country offices can leverage different benefits that enhance WHO's independent work or relationships with national or United Nations counterparts. In cases where they can benefit from economies of scale, WHO country offices should take advantage of opportunities to be on United Nations common premises.
- WHO has a global commitment to inclusion of persons with disabilities, as shown by the adoption of the revised WHO policy on employment of persons with disabilities, in 2022. Country offices adopted various measures to accommodate people with disabilities. However, while more than half of country offices' premises were partially accessible, less than one third were fully accessible. In the coming years, the WHO policy may enable more country offices to adopt more comprehensive and appropriate measures to include workers with disabilities, such as flexible work arrangements, dedicated parking spaces, assisted accessibility measures for people with sensory impairment, as well as mental health support.
- As part of the maternity leave policy, the Organization supports new mothers by providing them time to breastfeed and nurture their child (two hours per day). However, considering that less than one third of WHO country offices reported having breastfeeding facilities on premises, and in view of further assisting mothers who return to the office from maternity leave, more WHO country offices should prioritize ensuring that breastfeeding facilities are available on premises when additional resources become available.



# 7. WHO's communications



WHO places great importance on effective, coordinated and integrated health messaging and communications across the three levels of the Organization, to ensure the effective delivery of its technical cooperation to achieve results and impact in countries, which are essential for building a safer and healthier future for the world's population. In accordance with the Thirteenth General Programme of Work, 2019–2025 (GPW13), strategic communications constitute an important part of WHO's efforts to enhance leadership, governance and external relations to drive impact in countries. WHO country offices are tasked with communicating with the public, national counterparts, partners and donors, as well as communicating on country-specific issues.<sup>73,74</sup> The role of country offices is therefore instrumental to strengthening leadership, governance and advocacy for health.

This chapter outlines the notable strides that WHO country offices made in this direction in 2021–2022, including cross-sectoral work with the communications sector, enhancing of the communications capacity (including risk communications) in country offices and the use of various media to reach a wide range of audiences.

## 7.1. External communications: leveraging multisectoral work with the communications sector

**In the past two years, most country offices across the WHO regions have reported that they worked with the communications sector.** A larger percentage of country offices, globally, reported that they had worked with ministries of communication (72% in 2021–2022, compared with 58% in 2019–2020). This meant that (apart from health) communications was the third most engaged sector with WHO country offices, after the environment-related sector and the education sector (Fig. 34). The increase in engagement with the communications sector may reflect the importance of effective communication during health and humanitarian crises, such as the coronavirus disease (COVID-19) pandemic and conflicts. The expansion of this intersectoral collaboration may also have been influenced by the increased visibility of WHO country offices at the onset of the pandemic.<sup>75</sup> The abundance of information (and misinformation) was one of the pandemic's hallmarks, so the urgency of evidence-based communication was acute.

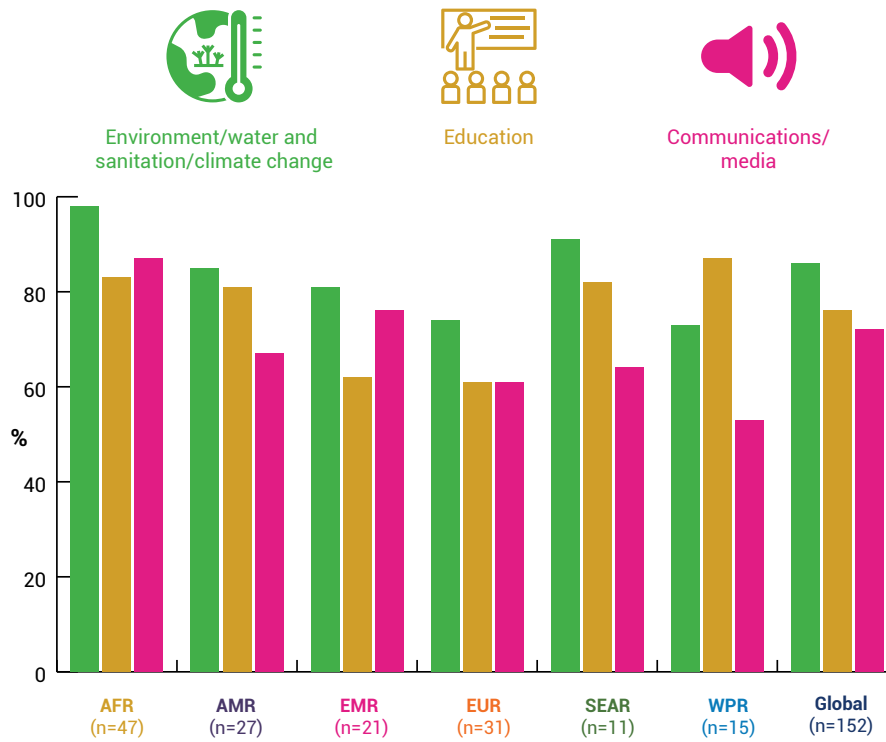
Although the communications sector was the third most engaged sector for all WHO country offices, engagement varied across the WHO regions: from 53% in the Western Pacific Region to 87% in the African Region (Fig. 34).

<sup>73</sup> Over 90 stories across the six WHO regions are presented in: WHO delivering results and making an impact: stories from the ground. Geneva: World Health Organization; 2022 (<https://apps.who.int/iris/handle/10665/365138>, accessed 26 March 2023).

<sup>74</sup> For country reports, see: Results report 2020–2021 [webpage]. Geneva: World Health Organization; 2023 (<https://www.who.int/about/accountability/results/who-results-report-2020-2021#country-profiles>, accessed 26 March 2023).

<sup>75</sup> According to the 2021 report, 96% of WHO country offices working with countries that have a United Nations country team reported that their visibility increased in the context of COVID-19 (83% to a large extent; 13% somewhat). See: WHO presence in countries, territories and areas: 2021 report. Geneva: World Health Organization; 2021 (<https://apps.who.int/iris/handle/10665/341308>, accessed 26 March 2023).

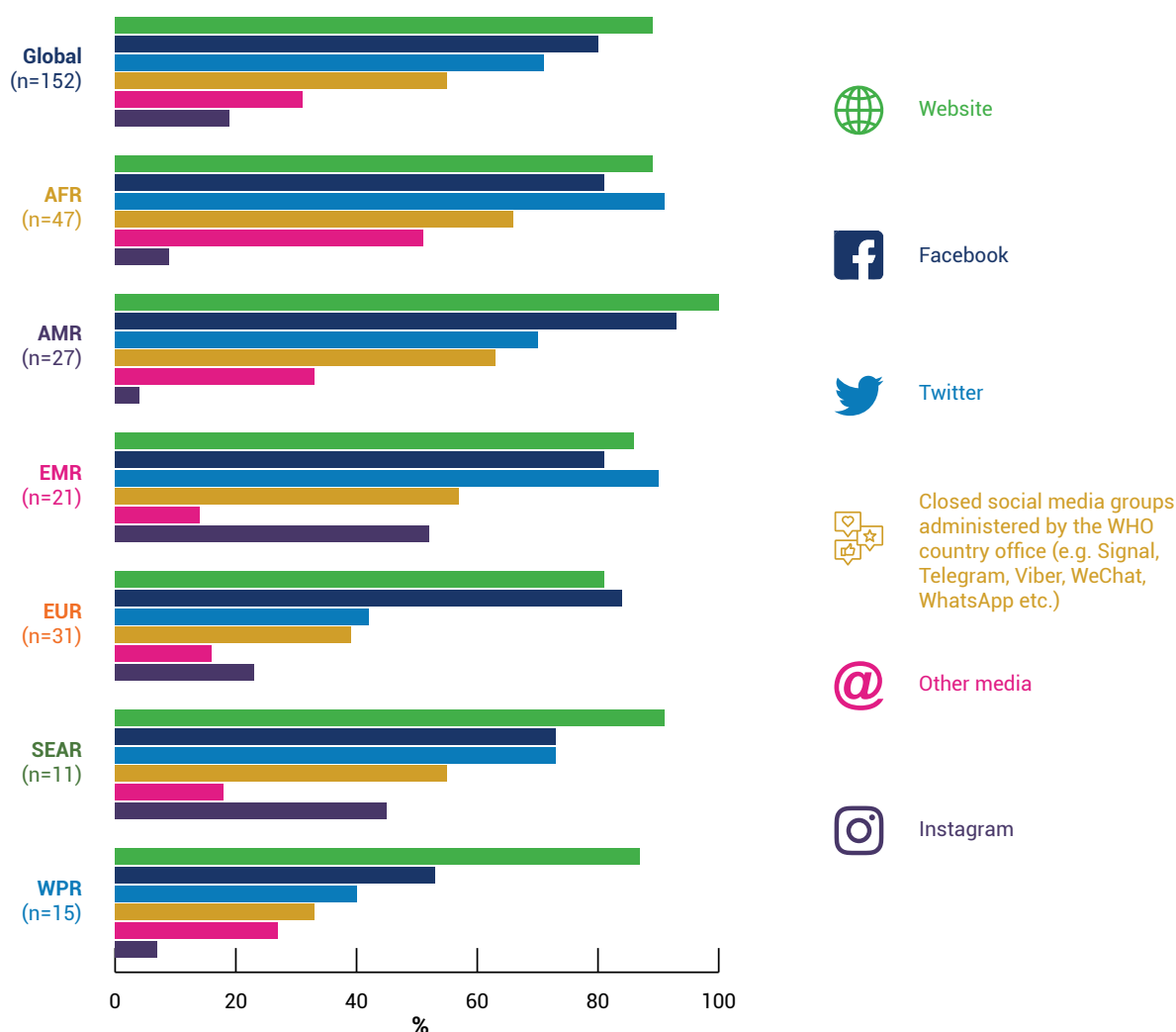




**Fig. 34.** WHO country offices' collaboration with the three most engaged sectors (other than health) in 2021–2022 by WHO region

## 7.2. Media platforms for corporate communications at the country level

**Most WHO country offices used their website, Facebook and Twitter for corporate communications.** Across the WHO regions, 135 (89%) country offices reported that they used their website, representing the most common communications platform at the country level, with regional variability (Fig. 35). This was followed by Facebook (80%) and Twitter (71%), which were the most frequently updated platforms at the last reporting.<sup>76</sup>



**Fig. 35.** Platforms used by WHO country offices for corporate communications in 2021–2022 by WHO region

<sup>76</sup> WHO presence in countries, territories and areas: 2021 report. Geneva: World Health Organization; 2021 (<https://apps.who.int/iris/handle/10665/341308>, accessed 26 March 2023)

The reason websites were the most commonly used communication platform may be because they required less frequent updating, compared with social media platforms (which translates into less human resource effort and time). Websites also carry greater familiarity and authority with local government and stakeholders. As Fig. 35 shows, over 80% of country offices in each WHO region relied on their website (from 81% of offices in the European Region, to 100% in the Region of the Americas), whereas the use of Facebook and Twitter varied across regions. Although Facebook was used by a larger percentage of country offices in the Region of the Americas, the European Region and the Western Pacific Region, Twitter was used more in the African Region and the Eastern Mediterranean Region. Facebook and Twitter were used equally in the South-East Asia Region. Other media reported by WHO country offices included newsletters and bulletins, press conferences on local television and radio, press releases, publication in peer-reviewed articles, Zoom, Microsoft Teams and YouTube.

**In addition to online platforms, WHO country offices leveraged closed social media groups (which they administered) for their corporate communications.** In 2020, WHO launched a global partnership with Facebook, Viber and WhatsApp for dedicated messaging services in Arabic, English, French and Spanish (among other local languages) to deal with the COVID-19 infodemic, reaching people on their mobile phones.<sup>77</sup> WHO's corporate partnerships with those platforms may have contributed to the relatively high reported use of the platforms by the country offices, despite these being new forums of engagement with WHO audiences. Of the 83 WHO country offices that reported using a closed social media group, most used WhatsApp (81%), followed by Signal (47%). The use of closed social media groups reported by WHO country offices may correspond to the geographical characteristics of audience popularity and preferences (Table 19).

**Table 19.** Closed social media platforms used by 83 WHO country offices for corporate communications

Closed social media platform	AFR (n=31)	AMR (n=17)	EMR (n=12)	EUR (n=12)	SEAR (n=6)	WPR (n=5)	Global (n=83)
Signal	61%	41%	17%	50%	67%	20%	<b>47%</b>
Viber	0%	0%	8%	17%	0%	40%	<b>6%</b>
WeChat	3%	0%	0%	0%	0%	20%	<b>2%</b>
WhatsApp	74%	100%	83%	83%	83%	40%	<b>81%</b>
Telegram	0%	6%	0%	17%	0%	0%	<b>4%</b>

Although the use of some platforms by WHO country offices may appear low in global percentage, its audience penetration may be significant. The diversity of closed social media platforms that country offices use warrants reflection in country-level social media strategies for corporate communications.

<sup>77</sup> WHO Health Alert brings COVID-19 facts to billions via WhatsApp [webpage]. Geneva: World Health Organization; 2021 (<https://www.who.int/news-room/feature-stories/detail/who-health-alert-brings-covid-19-facts-to-billions-via-whatsapp>, accessed 26 March 2023).

## Chapter key messages: WHO's country-level communications

- The trend of increasing engagement and cooperation with the media and communications sector in general needs to be sustained and further encouraged to ensure that WHO is visible, trusted and relevant as a leader in public health in countries and worldwide.
- The COVID-19 pandemic has largely enabled WHO country offices to enhance, through concerted efforts, their communications capacity through recruitment of non-staff and staff, training existing staff and receiving backstopping from other offices. As the pandemic subsides, country offices should continue to build their communications capacity by linking it with their country priorities and allocating resources to communications so as to strengthen WHO's ability to reach more people in countries through various forms of communication.
- By adopting different types of communication approaches in 2021–2022, WHO country offices have shown versatility in their approach to reaching public audiences. The use of popular and appropriate channels of communication should be further encouraged, especially media platforms that communicate reliable information in real time.

# 8. Challenges and opportunities for WHO country offices



This chapter captures the challenges reported by WHO country offices in establishing a strong and meaningful country presence. The challenges and opportunities are also discussed throughout the report.

The challenges and opportunities outlined are in the context of WHO's accelerated efforts to implement the Thirteenth General Programme of Work, 2019–2025 (GPW13) and to make up for lost ground on achieving the targets of the Sustainable Development Goals (SDGs). The coronavirus disease (COVID-19) pandemic has highlighted WHO's role as the global leader in health, raising awareness and expectations for continued stewardship. The unprecedented and societal nature of the pandemic necessitated cross-sectoral action and pooling of resources. Although some challenges may be unique to those circumstances, other challenges have continued to persist. In view of the commitments made by WHO to double its efforts in the next two years to achieve the health-related SDGs, the need to address chronic challenges is now more pressing than ever.

The foremost challenges and opportunities for WHO country offices can be broadly categorized as follows:

- **Ensuring core predictable WHO country presence**

In 2021–2022, WHO country offices continued to support Member States to advance the implementation of GPW13. The overarching challenge that country offices faced across geographies and strategic priorities was insufficient resources to fund core country presence to attract and retain talent. The skillsets and profiles needed in country offices varied depending on the type of cooperation required, ranging from high-level policy advice to operational health systems and services on the ground.

- **Sustaining a fit-for-purpose workforce that includes core staff positions and considers gender parity of international staff and global mobility**

WHO country offices vary widely in size. Having a fit-for-purpose workforce that is capable of delivering on the priorities of the country will continue to be essential at the country office level. Given the limited number of WHO staff to deliver results at the country level, particularly international country-based staff, there is an opportunity to boost technical country-level capability by activating mechanisms such as mobility and rotation policies and career pathway plans. Improving gender parity among WHO leadership at the country level will continue to be an important aspect of WHO's country-level work, which requires increasing the proportion of female WHO representatives (it has stagnated at 38% since the last reporting). Likewise, to reach gender parity among international professional staff, WHO's country offices will need to increase the recruitment and retention of women, as they comprised 37% of all international professional staff in country offices as at December 2022.

- **Securing flexible funds congruent with core predictable WHO country presence**

The excessive reliance on voluntary donations for country-level activities puts support for Member States at risk. A greater proportion of flexible and predictable resources is essential for WHO country offices.

- **Maintaining and scaling up multisectoral partnerships by ensuring that country offices are encouraged to work across sectors and with different actors**

The focus of the extended GPW13 and the five WHO priorities is to “accelerate progress”. One of the five priorities is to support countries to make a paradigm shift towards promoting health and well-being and preventing disease by addressing its root causes. Implementing the priorities at the country level requires further strengthening of multisectoral partnerships. However, WHO country offices often face challenges from ministries of health, which discourage the Organization from working with other sectors. Therefore, it is essential to ensure that ministries of health enable WHO country offices to engage in cross-sectoral work, including development of national development plans. Such engagement requires the availability

of expertise in policy-making and diplomacy at WHO country offices and support from the local United Nations Resident Coordinator Office. Similarly, the SDG3 Global Action Plan has recommended closer collaboration with the equity cluster of accelerators (including gender, determinants and civil society). This implies that a realistic, costed and funded plan for robust engagement with partners is required, including engagement with non-State actors at the country level by applying the Framework of Engagement with Non-State Actors mechanism.

- **Sustaining advocacy and communication gains to improve the efficiency and efficacy of WHO country work**

The majority of WHO country offices associated WHO's increased visibility and coordination role during the COVID-19 pandemic with their growing influence in United Nations-driven processes. When combined with the communications capacity gains reported by many country offices around the world, this is a critical expertise to sustain. Therefore, country offices should leverage the increased visibility to enhance health advocacy for resource mobilization. Several country offices have effectively mobilized funds from a variety of stakeholders at the national level and have shown interest in further enhancing their fundraising capacities.

### Working towards enhanced country presence for country-level impact

WHO has already started to leverage the above opportunities. In December 2022, participants of the Eleventh WHO Global Management Meeting developed several recommendations on how WHO could better support Member States by strengthening its country presence. To take forward the recommendations, the Action for Results Group (ARG) was established, comprising a WHO representative from each of the six WHO regions. Building on the recommendations of the Eleventh WHO Global Management Meeting, the ARG has developed a plan of action to strengthen WHO presence at the country level to drive measurable impact. The ARG will be reporting to the six WHO regional directors and the WHO Director-General and is expected to meet quarterly to monitor the Secretariat's implementation of the plan of action.





# 9. The way forward



The COVID-19 pandemic propelled WHO country offices to perform at the highest level of coordination on public health matters, given the increased visibility and scope of WHO's work. WHO country offices have had to adjust their work in the past two years by enhancing capacities (such as reprofiling staff, training staff and hiring non-staff) in order to meet the health needs of countries. Moreover, they have been given an opportunity to expand partnerships with United Nations entities, civil society, academia, the private sector and the media. To sustain progress in these settings – and to promote, provide, protect, power, partner and perform for health – there is a need for enhanced country staff presence and better predictability of funds for country offices, adjusted to the types of cooperation provided.

The findings of this report are congruent with the results from the Eleventh WHO Global Management Meeting, held in December 2022, at which WHO representatives, as well as regional directors and staff at headquarters, renewed their commitment to refocusing WHO work on country impact.

### Measures to advance WHO's country presence

The Eleventh WHO Global Management Meeting recommendations and the Action for Results Group (ARG) plan of action focus on strengthening WHO's country-level presence to drive impact. The ARG plan of action aims to transform country offices to better engage with all stakeholders to influence the health agenda and determinants of health, while bolstering WHO's leadership position in health. The plan harnesses the capacities of the entire Organization (all three levels) to support country offices in delivering measurable results. It has been developed in discussion with relevant divisions and departments across the three levels of the Organization and is based on the country-level needs as identified by WHO representatives.

Foundational to strengthening WHO country offices is the core predictable country presence model that is based on the differentiated approaches of WHO support proposed in the Thirteenth General Programme of Work, 2019–2025 (GPW13) and tailored to country context and needs. According to the model, the typologies of country offices could range from country offices that primarily provide (a) policy support; (b) targeted technical support; (c) moderate technical support; (d) full technical support with emergency response; and (e) full support including field operations. The ARG plan of action covers the following main areas: ensuring WHO has appropriate and sufficient capacities in the right places, especially at the country level; ensuring WHO country offices have access to sufficient and predictable finances to provide responsive support; empowering WHO country offices to make decisions that drive impact in countries; allowing WHO to leverage bottom-up planning and prioritization focused on driving impact in every country; enabling WHO to work across sectors effectively; and ensuring WHO country offices have effective and efficient ways of working across the three levels.

Although some actions in the ARG plan are expected to be completed within the framework of a "100-day challenge" (by mid-year), others will be completed over the medium term with necessary accountability and monitoring mechanisms in place.

As the world transitions out of the COVID-19 pandemic, the work of the Organization is needed more than ever. The WHO Secretariat maintains its commitment to working hand in hand with Member States towards the achievement of the objectives of GPW13 and the Sustainable Development Goals. WHO must continue to play a leadership role in matters of public health cooperation, especially with the countries, territories and areas that receive support from a WHO country office.

# Annexes



# Annex 1. Member States and Associate Members of WHO

## Member States

Afghanistan	Chad	Germany
Albania	Chile	Ghana
Algeria	China	Greece
Andorra	Colombia	Grenada
Angola	Comoros	Guatemala
Antigua and Barbuda	Congo	Guinea
Argentina	Cook Islands	Guinea-Bissau
Armenia	Costa Rica	Guyana
Australia	Côte d'Ivoire	Haiti
Austria	Croatia	Honduras
Azerbaijan	Cuba	Hungary
Bahamas	Cyprus	Iceland
Bahrain	Czechia	India
Bangladesh	Democratic People's Republic of Korea	Indonesia
Barbados	Democratic Republic of the Congo	Iran (Islamic Republic of)
Belarus	Denmark	Iraq
Belgium	Djibouti	Ireland
Belize	Dominica	Israel
Benin	Dominican Republic	Italy
Bhutan	Ecuador	Jamaica
Bolivia (Plurinational State of)	Egypt	Japan
Bosnia and Herzegovina	El Salvador	Jordan
Botswana	Equatorial Guinea	Kazakhstan
Brazil	Eritrea	Kenya
Brunei Darussalam	Estonia	Kiribati
Bulgaria	Eswatini	Kuwait
Burkina Faso	Ethiopia	Kyrgyzstan
Burundi	Fiji	Lao People's Democratic Republic
Cabo Verde	Finland	Latvia
Cambodia	France	Lebanon
Cameroon	Gabon	Lesotho
Canada	Gambia	Liberia
Central African Republic	Georgia	Libya
		Lithuania

Luxembourg	Paraguay	Switzerland
Madagascar	Peru	Syrian Arab Republic
Malawi	Philippines	Tajikistan
Malaysia	Poland	Thailand
Maldives	Portugal	Timor-Leste
Mali	Qatar	Togo
Malta	Republic of Korea	Tonga
Marshall Islands	Republic of Moldova	Trinidad and Tobago
Mauritania	Romania	Tunisia
Mauritius	Russian Federation	Türkiye
Mexico	Rwanda	Turkmenistan
Micronesia (Federated States of)	Saint Kitts and Nevis	Tuvalu
Monaco	Saint Lucia	Uganda
Mongolia	Saint Vincent and the Grenadines	Ukraine
Montenegro	Samoa	United Arab Emirates
Morocco	San Marino	United Kingdom of Great Britain and Northern Ireland
Mozambique	Sao Tome and Principe	United Republic of Tanzania
Myanmar	Saudi Arabia	United States of America
Namibia	Senegal	Uruguay
Nauru	Serbia	Uzbekistan
Nepal	Seychelles	Vanuatu
Netherlands (Kingdom of the)	Sierra Leone	Venezuela (Bolivarian Republic of)
New Zealand	Singapore	Viet Nam
Nicaragua	Slovakia	Yemen
Niger	Slovenia	Zambia
Nigeria	Solomon Islands	Zimbabwe
Niue	Somalia	
North Macedonia	South Africa	<b>Associate Members</b>
Norway	South Sudan	Faroe Islands
Oman	Spain	Puerto Rico
Pakistan	Sri Lanka	Tokelau
Palau	Sudan	
Panama	Suriname	
Papua New Guinea	Sweden	

## Annex 2. Countries, territories and areas with WHO offices

### WHO African Region

1. Algeria
2. Angola
3. Benin
4. Botswana
5. Burkina Faso
6. Burundi
7. Cabo Verde
8. Cameroon
9. Central African Republic
10. Chad
11. Comoros
12. Congo
13. Côte d'Ivoire
14. Democratic Republic of the Congo
15. Equatorial Guinea
16. Eritrea
17. Eswatini
18. Ethiopia
19. Gabon
20. Gambia
21. Ghana
22. Guinea
23. Guinea-Bissau
24. Kenya
25. Lesotho
26. Liberia
27. Madagascar
28. Malawi
29. Mali
30. Mauritania
31. Mauritius
32. Mozambique
33. Namibia
34. Niger
35. Nigeria
36. Rwanda
37. Sao Tome and Principe
38. Senegal
39. Seychelles
40. Sierra Leone
41. South Africa
42. South Sudan
43. Togo
44. Uganda
45. United Republic of Tanzania
46. Zambia
47. Zimbabwe

### WHO Region of the Americas

1. Argentina
2. Bahamas
3. Barbados
4. Belize
5. Bolivia (Plurinational State of)
6. Brazil
7. Chile
8. Colombia
9. Costa Rica
10. Cuba
11. Dominican Republic
12. Ecuador
13. El Salvador
14. Guatemala
15. Guyana
16. Haiti
17. Honduras
18. Jamaica
19. Mexico
20. Nicaragua
21. Panama
22. Paraguay
23. Peru
24. Suriname
25. Trinidad and Tobago
26. Uruguay
27. Venezuela (Bolivarian Republic of)

### WHO Eastern Mediterranean Region

1. Afghanistan
2. Bahrain
3. Djibouti
4. Egypt
5. Iran (Islamic Republic of)
6. Iraq
7. Jordan
8. Kuwait
9. Lebanon
10. Libya
11. Morocco
12. Oman
13. Pakistan
14. Qatar
15. Saudi Arabia
16. Somalia
17. Sudan
18. Syrian Arab Republic
19. Tunisia
20. Occupied Palestinian territory, including east Jerusalem
21. Yemen

### WHO European Region

1. Albania
2. Armenia
3. Azerbaijan
4. Belarus
5. Bosnia and Herzegovina
6. Bulgaria
7. Croatia
8. Cyprus\*
9. Czechia
10. Estonia
11. Georgia
12. Greece
13. Hungary
14. Israel†
15. Kazakhstan
16. Kyrgyzstan
17. Latvia
18. Lithuania
19. Montenegro
20. North Macedonia
21. Poland
22. Republic of Moldova
23. Romania
24. Russian Federation
25. Serbia
26. Slovakia
27. Slovenia
28. Tajikistan
29. Türkiye
30. Turkmenistan
31. Ukraine
32. Uzbekistan
33. Kosovo†

### WHO South-East Asia Region

1. Bangladesh
2. Bhutan
3. Democratic People's Republic of Korea
4. India
5. Indonesia
6. Maldives
7. Myanmar
8. Nepal
9. Sri Lanka
10. Thailand
11. Timor-Leste

### WHO Western Pacific Region

1. Cambodia
2. China
3. Kiribati
4. Lao People's Democratic Republic
5. Malaysia
6. Micronesia (Federated States of)
7. Mongolia
8. Papua New Guinea
9. Philippines
10. Samoa
11. Solomon Islands
12. South Pacific (Fiji)
13. Tonga
14. Vanuatu
15. Viet Nam

\* In January 2023, a new country office was established in Cyprus.

‡ Host agreement being finalized

† All references to Kosovo in this document should be understood to be in the context of the United Nations Security Council resolution 1244 (1999).

## Annex 3. Countries, territories or areas covered by a WHO multi-country office

WHO region	WHO office	Countries, territories or areas
African Region	WHO Country Office in Madagascar	Réunion
Region of the Americas	PAHO/WHO Office for Barbados and the Eastern Caribbean Countries* (Barbados)	Anguilla Antigua and Barbuda British Virgin Islands Dominica French Guiana Grenada Guadeloupe Martinique Montserrat Saint Kitts and Nevis Saint Lucia Saint Vincent and the Grenadines
	PAHO/WHO Country Office in Trinidad and Tobago	Aruba Bonaire Curaçao Saba Sint Eustatius Sint Maarten
	PAHO/WHO Country Office in Jamaica	Bermuda Cayman Islands
	PAHO/WHO Country Office in the Bahamas	Turks and Caicos Islands
Western Pacific Region	WHO Representative Office for Malaysia, Brunei Darussalam and Singapore (Malaysia)	Brunei Darussalam Singapore
	WHO Representative Office for Samoa, American Samoa, Cook Islands, Niue and Tokelau (Samoa)	American Samoa Cook Islands Niue Samoa Tokelau
	WHO Representative Office in the South Pacific (Fiji)	French Polynesia Nauru New Caledonia Northern Mariana Islands Pitcairn Islands Tuvalu Wallis and Futuna
	Country Liaison Office for the Federated States of Micronesia, Republic of the Marshall Islands and Republic of Palau (Federated States of Micronesia)	Marshall Islands Micronesia (Federated States of) Palau

\* The countries, territories and areas that are covered by this Office have a physical WHO office (the WHO office in Anguilla covers the British Virgin Islands and Montserrat). Each of these WHO offices has a resident country programme specialist; however, the offices are under the credentialed WHO Representative with residence in Barbados.



# Annex 4. Countries, territories or areas covered through a focal point from a WHO regional office

## Regional Office for the Americas

Canada  
Puerto Rico  
United States of America

## Regional Office for Europe

Andorra  
Austria  
Belgium  
Cyprus  
Denmark  
Finland  
France  
Germany  
Iceland  
Ireland  
Italy  
Luxembourg  
Malta  
Monaco  
Netherlands (Kingdom of the)  
Norway  
Portugal  
San Marino  
Spain  
Sweden  
Switzerland  
United Kingdom of Great Britain and Northern Ireland

## Regional Office for the Eastern Mediterranean

United Arab Emirates

## Regional Office for the Western Pacific

Australia  
Macao Special Administrative Region (China)  
Hong Kong Special Administrative Region (China)  
Guam  
Japan  
Republic of Korea

## Annex 5. Countries and areas in the UHC Partnership\*

### WHO African Region

1. Angola
2. Benin
3. Botswana
4. Burkina Faso
5. Burundi
6. Cabo Verde
7. Cameroon
8. Central African Republic
9. Chad
10. Comoros
11. Congo
12. Côte d'Ivoire
13. Democratic Republic of the Congo
14. Equatorial Guinea
15. Eritrea
16. Eswatini
17. Ethiopia
18. Gabon
19. Gambia
20. Ghana
21. Guinea
22. Guinea-Bissau
23. Kenya
24. Lesotho
25. Liberia
26. Madagascar
27. Malawi
28. Mali
29. Mauritania
30. Mauritius
31. Mozambique
32. Namibia
33. Niger
34. Nigeria
35. Rwanda
36. Sao Tome and Principe
37. Senegal
38. Seychelles
39. Sierra Leone
40. South Africa
41. South Sudan
42. Togo
43. Uganda
44. United Republic of Tanzania
45. Zambia
46. Zimbabwe

### WHO Region of the Americas

1. Antigua and Barbuda
2. Bahamas
3. Barbados
4. Belize
5. Bolivia (Plurinational State of)
6. Colombia
7. Cuba
8. Dominica
9. Dominican Republic
10. Grenada
11. Guyana
12. Haiti
13. Honduras
14. Jamaica
15. Paraguay
16. Peru
17. Saint Kitts and Nevis
18. Saint Lucia
19. Saint Vincent and the Grenadines
20. Suriname
21. Trinidad and Tobago

### WHO Eastern Mediterranean Region

1. Afghanistan
2. Djibouti
3. Egypt
4. Iran (Islamic Republic of)
5. Iraq
6. Jordan
7. Lebanon
8. Morocco
9. Pakistan
10. Somalia
11. Sudan
12. Tunisia
13. Yemen
14. Occupied Palestinian territory, including east Jerusalem

\* As at 2021.

### WHO European Region

1. Azerbaijan
2. Georgia
3. Kyrgyzstan
4. Republic of Moldova
5. Tajikistan
6. Ukraine
7. Uzbekistan

### WHO Western Pacific Region

1. Bangladesh
2. India
3. Indonesia
4. Myanmar
5. Nepal
6. Sri Lanka
7. Timor-Leste

### WHO Western Pacific Region

1. Cambodia
2. Cook Islands
3. Fiji
4. Kiribati
5. Lao People's Democratic Republic
6. Malaysia
7. Marshall Islands
8. Micronesia (Federated States of)
9. Mongolia
10. Nauru
11. Niue
12. Palau
13. Papua New Guinea
14. Philippines
15. Samoa
16. Solomon Islands
17. Tonga
18. Tuvalu
19. Vanuatu
20. Viet Nam

## Annex 6. Five core subsystems of HEPR\*

- **Collaborative surveillance:** Strengthened national integrated disease, threat and vulnerability surveillance; increased laboratory capacity for pathogen and genomic surveillance; and collaborative approaches for risk forecasting, event detection and response monitoring.
- **Community protection:** Proactive risk communications and infodemic management; community engagement to co-create interventions; and multisectoral action to address community concerns such as social welfare and livelihood protection.
- **Clinical care:** Supported with safe and scalable emergency care; infection prevention and control that protect patients, health workers and communities; and resilient health systems that can maintain essential health services during emergencies.
- **Access to countermeasures:** Fast-tracking of research and development, with pre-negotiated benefit-sharing agreements; scalable manufacturing platforms and agreements for technology transfer; coordinated procurement and emergency supply chains to ensure equitable access.
- **Emergency coordination:** Trained workforce that is interoperable, rapidly deployable and scalable; coherent National Action Plan for Health Security for preparedness, prevention, risk reduction and readiness; and application of the Emergency Response Framework to a health emergency.

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\* The descriptions were included in the WHO country presence survey and were adapted from: Strengthening the global architecture for health emergency preparedness, response and resilience: report by the Director-General. Geneva: World Health Organization; 2022 (A75/20; [https://apps.who.int/gb/ebwha/pdf\\_files/WHA75/A75\\_20-en.pdf](https://apps.who.int/gb/ebwha/pdf_files/WHA75/A75_20-en.pdf), accessed 26 March 2023).

## Annex 7. Categories of WHO staff

Category	Description
International professional officers (P-level)	<ul style="list-style-type: none"><li>• Recruited internationally in accordance with WHO Staff Rules and may be assigned to any official duty station outside their home country.</li><li>• Perform functions of a professional nature requiring global knowledge, expertise and experience of an international dimension.</li></ul>
National professional officers (NPO)	<ul style="list-style-type: none"><li>• Nationals of the country in which they are recruited and serve.</li><li>• Perform functions of a professional nature requiring local knowledge, expertise and experience of a local dimension.</li></ul>
General service staff (GS-level)	<ul style="list-style-type: none"><li>• Perform clerical, custodial and subprofessional tasks in accordance with WHO Staff Rule 1310.</li><li>• All positions in this category are subject to local recruitment and must be filled, as far as possible, by people recruited in the local community area of each office.</li></ul>
Non-staff members	<ul style="list-style-type: none"><li>• Hired on a temporary basis to perform programme-specific and time-limited activities.</li><li>• The status does not fall either under "staff members" under WHO Staff Regulations or "officials" for the purposes of the 1947 Convention on the Privileges and Immunities of the Specialized Agencies.</li></ul>

## Annex 8. Sources of funding

**Assessed contributions:** The dues countries pay in order to be a WHO member. The amount each Member State must pay is calculated relative to the country's wealth and population.

**Core voluntary contributions:** Donations received by WHO from donors. These funds are earmarked at the highest level and allow for flexibility in their use.

**Voluntary specified contributions:** Donations received by WHO from donors. These funds are earmarked to specific type of work and do not allow for flexibility in their use.

**Programme support costs:** A percentage taxed on voluntary contributions received from donors for the cost of required administrative support.

**Base budget:** The largest component of WHO's budget. Its scope is set by WHO, covering work done across all three strategic priorities, as well as the enabling functions – by country office, regional office and headquarters.

**Special programmes:** Work done with additional governance structures (United Nations partners, intergovernmental agencies, philanthropic foundations, etc.).

**Emergency operations and appeals:** Funds that respond to acute and protracted emergencies and disasters from any hazard with public health consequences, such as the coronavirus disease (COVID-19) pandemic.



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