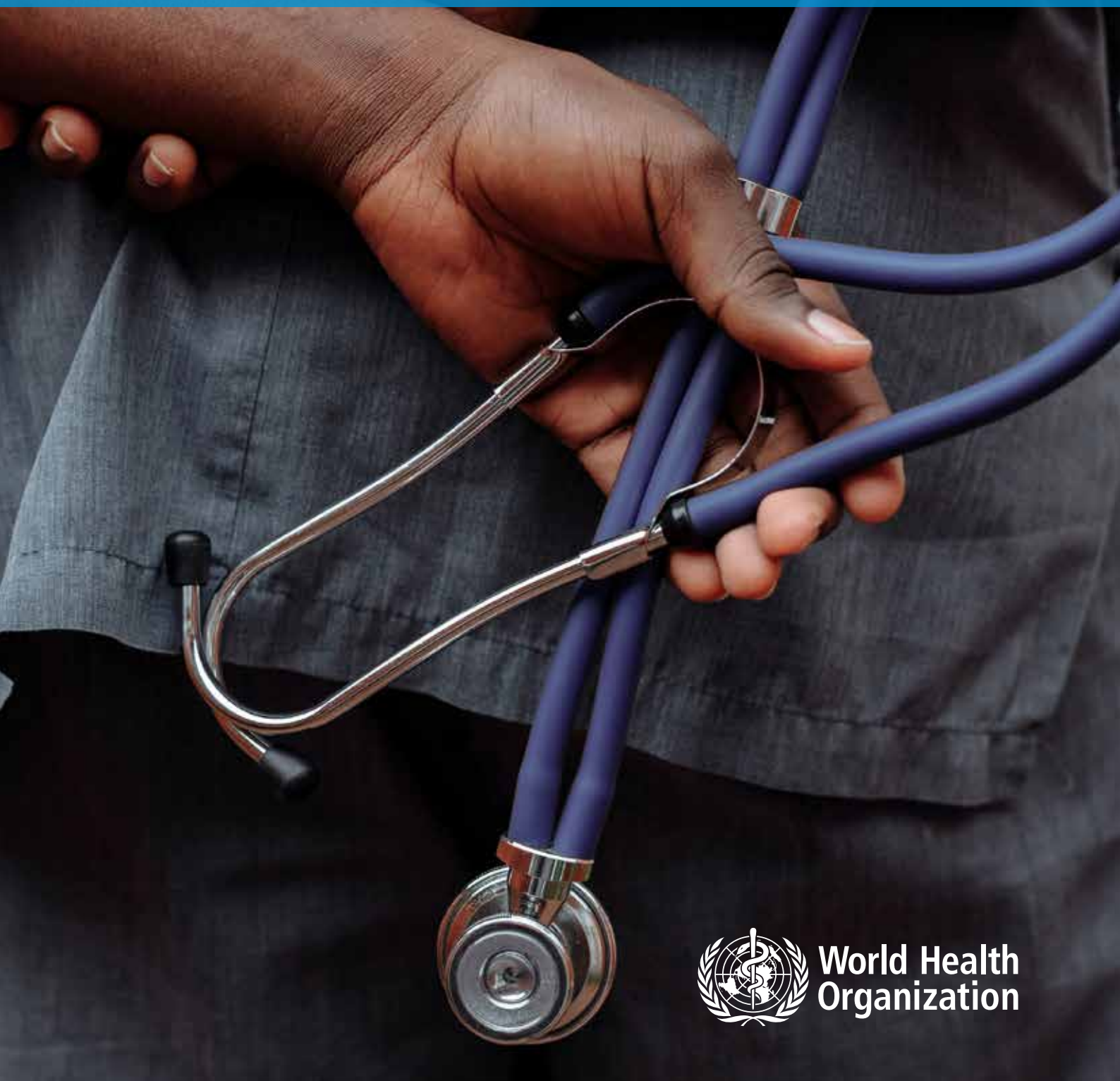
Core voluntary contributions account

2022 annual report



World Health Organization

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Cover photo: Thirdman

Contents

I. Foreword

Dr Tedros Adhanom Ghebreyesus
Director-General, World Health Organization

The COVID-19 pandemic has demonstrated why the world needs a strong, empowered and sustainably financed World Health Organization (WHO) at the centre of the global health architecture. WHO Member States have recognized the challenge of sustainable financing and taken decisive steps to address it. At the World Health Assembly in 2022, Member States committed to increased assessed contributions to 50% of the base budget over the next decade, and at this year's Health Assembly, they made a significant step towards that target by approving an initial 20% increase in assessed contributions for the 2024-25 Programme budget, and by agreeing to explore the feasibility of an investment round.

These landmark commitments to transform WHO's financing model reflect the collective commitment of Member States towards strengthening and empowering WHO to fulfil its role as the leading and directing authority on global health. They also demonstrate a shared understanding that adequate and reliable financing is essential for WHO to effectively advance global health goals.

Still, it will take some time before we reach a fully sustainably and flexibly funded WHO. Until we reach this, core voluntary contributions play a crucial role. The unwavering support of our core voluntary contributions partners in providing WHO with flexible financing underscores their commitment to WHO mission.

This report is dedicated to the core voluntary contributions and their impact in delivering Programme budget 2022-2023 with the focus on 2022. I am immensely grateful to Member States and partners for the support and trust they have demonstrated in providing core voluntary contributions, and in giving us the flexibility we need to carry out our mission and mandate. The report is also a testament to the Organization's commitment to transparency and accountability, and to building trust with partners that provide flexible funds by reporting on how those funds support delivery of the Programme budget.

I remain convinced that the increase in assessed contributions, together with a move towards more flexible funding such as core voluntary contributions, will catalyze a transformative impact on WHO and on global health, enabling us to advance towards our shared vision of a world in which all people enjoy the highest possible standard of health and well-being.

Core voluntary contributions account (CVCA) Contributors 2022

United Kingdom of Great Britain and Northern Ireland

Germany

Netherlands (Kingdom of the)

Sweden

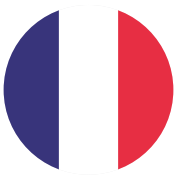
Denmark

Belgium

Norway

Spain

Switzerland



France

Ireland

In addition to the listed Member States, the WHO is grateful for CVCA support from the estates of Ms Rita Susan Cooper and Mr Jerry Lyle Baber

II. Introduction

The critical contribution of CVCA funds

The 21st century global health landscape is more complex than ever and rapidly evolving, driven by technological progress, changing demographics, climate change and health emergencies, amid a shifting picture of globalization. This places greater demands on global health governance, requiring increased investments as well as greater agility and flexibility. COVID-19 demonstrated the need to adapt quickly to changing circumstances. For WHO to fulfill its role as the leading and directing authority on global health, it is critical to ensure it has flexible and sustainable funds available that can be rapidly allocated and used when and where needed.

Since its inception in 2004, Core Voluntary Contributions Account (CVCA) have emerged as an important option for the Organization to keep pace with ever-changing global health priorities and to fulfill its mandate. CVCA offers a key pooled flexible funding modality that enables WHO to address urgent global health needs and to be agile and strategic so it can achieve its goals effectively, ensuring that the Organization can serve the best interests of global health.

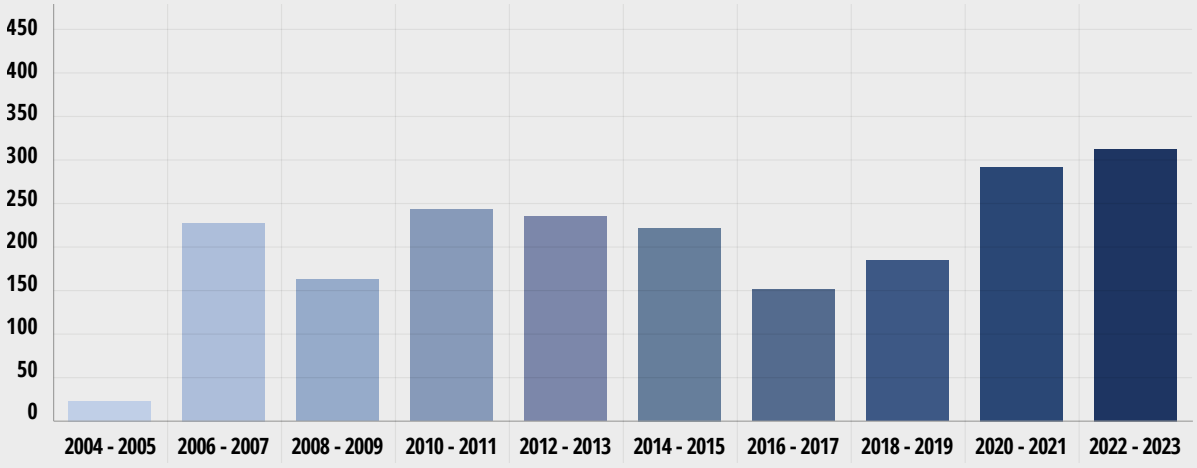
This CVCA annual report, the first of its kind, shows the wide scope and impact of flexible funding and how these funds enable WHO to effectively carry out its mission and address today's wide-ranging health challenges. As part of the mid-term review of the Programme Budget 2022-2023, the CVCA report showcases how CVCA funds, while relatively modest, play an important role in enabling WHO to meet its commitments of the Programme Budget. The report is also a testament to the Organization's commitment to transparency and accountability, and to building trust with partners that provide flexible funds by reporting on how those funds get allocated.

Through specific case studies and country stories, the impact of CVCA in addressing health needs, especially at the country level, can be seen - from strengthening disease surveillance in fragile settings, to continuing last-mile efforts to eliminate neglected diseases; from catalyzing mental health care so children thrive, to protecting lifesaving antibiotics from drug resistance; from ensuring food is safer and healthier, to providing health services in humanitarian crises; from protecting people from environmental pollution, to electrification of health facilities. Without CVCA funding, some of these areas might not have seen successful health outcomes.

WHO receives on average US$ 209 million CVCA per biennium, with a steady increase since 2019.

Graph 1.

CVCA income trend since 2004 (US$ million)



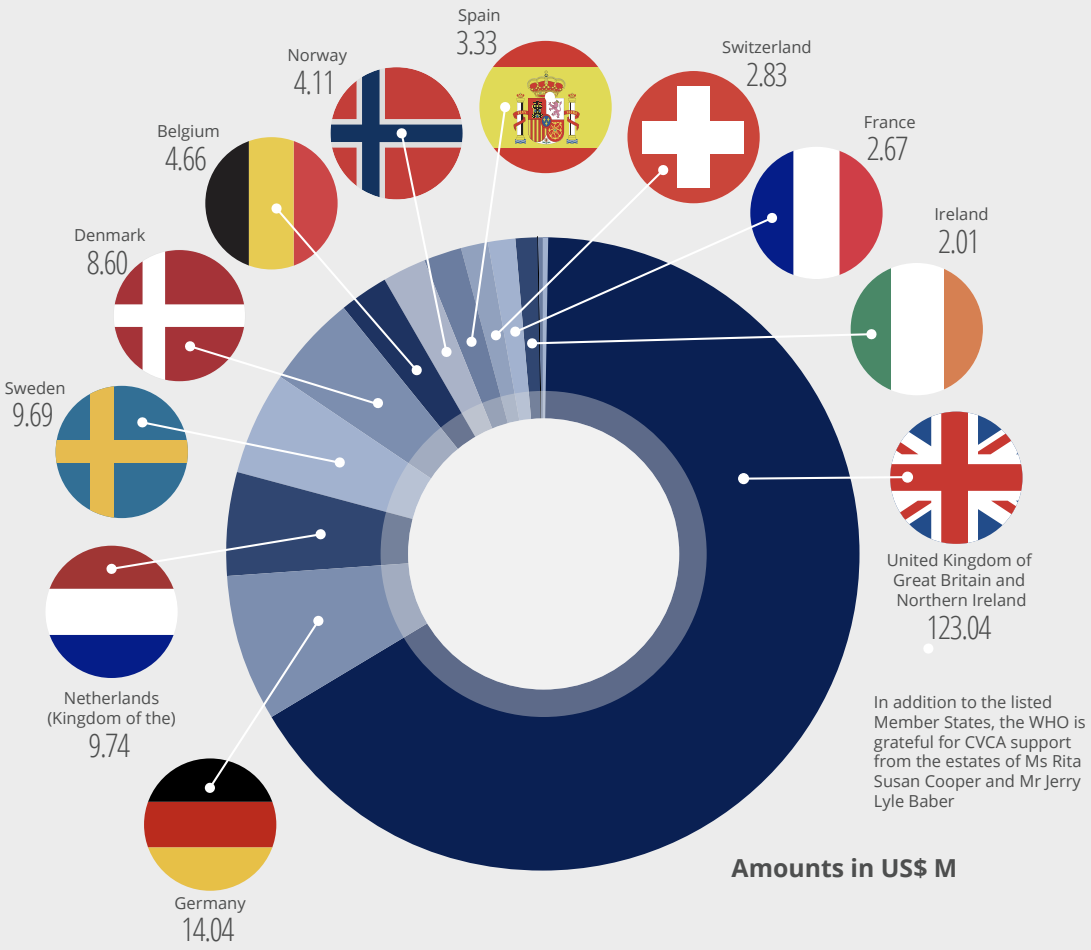
CVCA funding in 2022

As of 31 December 2022, CVCA revenue was US$ 184.9 million, coming from 13 CVCA donors. Even though this constituted just 6% of the total base Programme budget financing, together with the assessed contributions and programme support costs - which together are known as flexible funds - CVCA represents a crucial part of WHO's funding structure. Being flexible, it can be fully aligned with the priorities set by Member States in the Programme budget. CVCA represented 14% of the total available flexible funds as at the end of 2022.

At the start of 2022-2023 biennium, flexible funds envelopes, which included CVCA funds projected to be received in 2022-2023, were determined for the six WHO regional offices and headquarters based on a set of geographic, historic, and economic criteria. Actual cash transfer to the regional offices and headquarters takes place in 3 tranches throughout the biennium, depending on the cash flow. The proper pipeline management is, therefore, of utmost importance to best plan the availability of the major office flexible funds to fill the envelopes, making predictability and multi-year funding agreements paramount.

Once the flexible funds envelopes to regional offices and headquarters are agreed upon, the Director-General delegates authority to the regional directors to allocate flexible funds within their respective Regional Office and country offices according to strategic allocation of resources to ensure an equitable balance in the funding of Programme budget.

The utilization of flexible funds is closely monitored during the biennium to ensure that (i) funds are shifted towards underfunded priority areas and away from areas that benefit from other sources of funds and (ii) funds are implemented in a timely fashion.



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Principles for the Strategic Allocation of Resources

- CVCA grouped with the assessed contributions and programme support costs to represent flexible funds to strategically fund the Organization based on priorities set out in the Programme budget
- Flexible funds are allocated before the new biennium starts based on the best estimate of funds to be received
- The Director-General decides on allocation to every major office in consultation with the Global Policy Group
- Flexible funds are used to ensure operational capacity for staff costs and critical activities within the approved Programme budget
- Flexible funds are used strategically: during the biennium they are shifted towards underfunded priority areas and away from areas that benefit from other sources of funds
- Flexible funds may be used as catalytic funds in priority areas to attract other resources; the use of flexible funds to subsidize projects that are meant to be fully funded by voluntary contributions is discouraged.

CVCA has a “cash-basis” conditionality and for most agreements, funds can only be allocated once received. When biennium 2022-2023 started, US$57.5 of CVCA were available and could be allocated in the first tranche for implementation in 2022. Of these, US$ 36.8 million of CVCA funds were implemented (Table 1) with over 65% of CVCA supporting activities of polio transition (Programme budget outcomes 1.1 Improved access to quality essential health services and 2.3 Health emergencies rapidly detected and responded to). Over 60% of CVCA implementation was at country and regional level with 70% of expenditures to support staff cost. Further expenditure details can be found in the Annex.

Table 1.

CVCA expenditure as of 31 December 2022 by outcome, in US$ millions

Programme budget outcome		Expenditure
1.1	Improved access to quality essential health services	18.4
1.2	Reduced number of people suffering financial hardship	1.0
1.3	Improved access to essential medicines, vaccines, diagnostics and devices for primary health care	1.5
2.1	Countries prepared for health emergencies	0.1
2.3	Health emergencies rapidly detected and responded to	5.7
3.1	Safe and equitable societies through addressing health determinants	2.3
3.2	Supportive and empowering societies through addressing health risk factors	2.1
3.3	Healthy environments to promote health and sustainable societies	2.1
4.1	Strengthened country capacity in data and innovation	1.3
4.2	Strengthened leadership, governance and advocacy for health	0.3
4.3	Financial, human, and administrative resources managed in an efficient, effective, results-oriented and transparent manner	0.1
14.1	Special Programme for Research and Training in Tropical Diseases (TDR)	1.0
14.2	Special Programme of Research, Development and research Training in Human Reproduction (HRP)	1.0
Grand Total		**36.8**

As part of the mid-term review of the Programme budget 2022-2023, country offices, regional offices and headquarters reported both progress towards achieving Programme budget outcomes and the impacts that have already been achieved, to which CVCA have contributed.

This report synthesizes these inputs and shows how the flexibility that these funds offer allows the Secretariat to strategically act in programmatic and geographic areas where there are opportunities for impact while other resources are not readily available or are highly specified, such as areas of neglected tropical diseases, polio transition, mental health, antimicrobial resistance and many more.

The following chapter, through case studies and country stories, illustrates the progress achieved. Although the progress and achievements showcased cannot be solely attributed to CVCA alone, these catalytic funds have played a critical role in making them possible. Without CVCA, this impact at the country level may not have been possible.

Looking forward, CVCA revenue already recorded as of end April 2023 (further US$ 103.6 million, see Annex), as well as financial projections backed up by signed CVCA agreements (US$ 28 million), show the prospect of an all-time high in CVCA contributions supporting the implementation of the Programme budget 2022-2023 of US$ 316.5 million. This is a welcome step forward.

III. Driving public health impact at country level

i. Moving forward to integrate polio activities with other health programmes

Polio transition refers to the process of transferring the expertise and assets of WHO's polio eradication programme to other health programmes, and ultimately national health systems, in countries now polio-free. The polio transition initiative fully contributes to Programme budget outputs "1.1.3 Countries enabled to strengthen their health systems to address population-specific health needs and barriers to equity across the life course" and "2.3.1 Potential health emergencies rapidly detected, and risks assessed and communicated".

Overview

In 2022, over 50 countries transitioned out of Global Polio Eradication Initiative (GPEI) resources, integrating essential polio functions under other programme areas. For the first time, country offices, many in fragile settings, worked to integrate and sustain critical functions – such as immunization, disease surveillance and emergency response – using alternative resources. To support this, WHO allocated CVCA funds as a 12-month "polio transition" guarantee to sustain essential functions in countries no longer receiving GPEI funds.

Country offices in WHO's Eastern Mediterranean Region, African Region and South-East Asia Region, where most polio infrastructure is located, utilized these funds to bolster routine immunization, maintain and strengthen sensitive surveillance systems for polio and other diseases, support capacity building, strengthen laboratory networks, and operationalize Integrated Public Health Teams, with a view to strengthening functions for the long term.

In WHO's Region of the Americas, Western Pacific Region, and European Region, which have long been polio-free, the focus has been on strengthening essential immunization and disease surveillance. In the context of a backslide in essential immunization, post-COVID-19 recovery, and ongoing risk of polio outbreaks, the CVCA funds have been catalytic to sustain polio essential functions and to ensure their utilization for broader health impact.

Surveillance and municipality staff in Iraq were trained on sewage sample collection for effective environmental surveillance and early detection of possible polioviruses. https://photos.emro.who.int/preview/40399

Country-level impact

In the **Eastern Mediterranean Region**, the focus was on sustaining polio assets and infrastructure to strengthen essential immunization coverage, vaccine-preventable disease surveillance systems, and to respond to health emergencies. Countries also worked in 2022 to operationalize Integrated Public Health Teams (IPHTs), which aim to repurpose the skills of the polio network to deliver on broader public health goals. For instance, in Sudan, these teams enabled stronger disease surveillance and rapid response to public health emergencies, especially in border areas and amongst high-risk and hard-to-reach populations. In Iraq, polio outbreak risk was mitigated through building the capacity of several hundred national Expanded Programme on Immunization (EPI) and surveillance officers on outbreak response and Acute Flaccid Paralysis (AFP) surveillance, as well as through the establishment of nine new environmental surveillance sites.

In the **African Region**, many countries worked to strengthen integrated disease surveillance, as part of bolstering broader public health and reaching underserved communities. In Tanzania, 13 National Integrated Active Search (NIAS) teams were recruited, trained and deployed to serve 38 districts with poor disease surveillance. NIAS activities included vaccine-preventable disease surveillance trainings and sensitization of local health workers and traditional healers.

In Tanzania, active search teams stepped up disease surveillance, such as this team at Seliani Lutheran Hospital in Arusha District Council, Tanzania. Credit: WHO / Tanzania

Meanwhile in Sierra Leone, WHO provided capacity building support on comprehensive vaccine-preventable disease surveillance to over 2000 surveillance officers. This integrated training approach led to an improvement in polio surveillance indicators and the response to measles outbreaks. In Uganda, WHO provided technical support and resources for active surveillance of poliovirus and vaccine-preventable diseases such as measles. To improve surveillance sensitivity and performance, WHO introduced a new system for managing surveillance activities: the Open Data Kit system, used by the polio eradication programme to accurately track surveillance site visits. This led to over 1200 active case searches conducted in health facilities in 2022, with staff more frequently reaching hard-to-reach-areas, as well as cost savings.

The **South-East Asia Region** stepped up efforts to expand the scope of the integrated network of surveillance and immunization, working closely with the governments of five priority countries.

In Bangladesh, the WHO Surveillance Immunization Medical Officer (SIMO) network supported COVID-19 pandemic recovery, working to increase parental confidence in routine immunization, and built capacity among 26,000 community health workers on infection prevention and control, to ensure safe practices in routine immunization. In India, the government increased financing and the scope of the National Public Health Support network, which covers emergency response and measles and rubella elimination, alongside routine immunization. In Indonesia, the government worked to increase surveillance, laboratory and immunization capacities with WHO support, whilst the Government of Myanmar developed a draft roadmap for the next stage of transition. In Nepal, the national transition plan has been revised to align with the federalized structure and post COVID-19 priorities.

WHO staff inspect a vaccine vial in Bangladesh, where WHO is working to increase confidence in routine immunization. ©WHO Bangladesh. Polio Workforce (who.int)

Sustaining a polio-free African Region

Sustainability is at the core of polio transition efforts. Although Africa was declared wild polio-free in 2020, the region remains at risk of poliovirus importation and potential outbreaks. WHO country offices are committed to sustaining essential polio functions, including sensitive poliovirus surveillance and high polio vaccine coverage, as part of the essential immunization programme.

In 2022, poliovirus surveillance efforts were improved in several countries:

In Mozambique, capacity building of 60 Ministry of Health staff was undertaken, aligned with the intensification of polio surveillance to ensure the swift detection of all poliovirus isolates. This rapidly improved surveillance sensitivity in the response to circulating vaccine-derived poliovirus outbreaks.

In South Africa, three surveillance officers were recruited to support integrated surveillance for polio and measles in nine provinces. Environmental surveillance was established at 18 sites, and 1570 specimen/cooler boxes were procured for shipment of samples to laboratories.

In the Central African Republic, capacity building and a revised approach to sample shipment led to an increase in AFP stool adequacy rate from 67% in 2018 to 86% in 2022. In the Gabon, technical support and trainings enhanced case classification, environmental surveillance and active surveillance site visits. In Mali, 16 consultants were deployed in districts with poor disease surveillance to ramp up surveillance to swiftly detect and respond to any suspected poliovirus cases.

Strengthening integrated public health in the Syrian Arab Republic

In 2022, WHO Syria took significant steps towards a more integrated approach to public health, aligned with a sustainable polio transition. Dedicated Integrated Public Health Teams (IPHTs) at the sub-national level have improved coordination with local health authorities to better serve high-risk populations.

The IPHTs supported COVID-19 surveillance and vaccination, undertook cholera and measles outbreak response efforts, and assisted with integrated EPI vaccination activities in high-risk areas. Integration with the EWARS system led to the enhancement of case reporting and outbreak readiness. In October 2022, an integrated polio and measles vaccination activity targeted 2.7 million children under 5 years.

In addition, WHO strengthened integrated disease surveillance, and supported costs associated with accredited laboratories.

These efforts resulted in hundreds of thousands of children under one year of age being reached with routine vaccinations, enhanced disease surveillance, all polio indicators being met at state level, and improved coordination with local partners.

Staff with the Early Warning Alert and Response network, which monitors outbreaks of infectious diseases such as polio, cholera, measles and influenza. The network has improved outbreak readiness. © WHO / EWARN / Muhamed Shahin

ii. Dramatic progress towards eliminating neglected tropical diseases

Neglected tropical diseases (NTDs) are a diverse group of diseases historically neglected on the global health agenda. Mostly affecting people living in poverty, they cause much suffering and have devastating social and economic consequences. A concerted effort to scale-up interventions against NTDs in recent years has led to their significant decline – at least 100 countries have eliminated at least one NTD. In 2022 for example, trachoma was certified as eliminated in 4 more countries and sleeping sickness in 3 countries. The work around Neglected Tropical Diseases is mainly contributing to Programme budget output "1.1.2 Countries enabled to strengthen their health systems to deliver on condition- and disease-specific service coverage results"

Getting closer to global eradication of dracunculiasis

In the mid-1980s, there were an estimated 3.5 million cases across 20 countries of dracunculiasis (Guinea-worm disease), a crippling parasitic disease that causes burning pain. Over the last 20 years, endemicity has plummeted. Cases have fallen consistently in recent years, with 54 cases in 2019 and 27 in 2020. In 2022, only 13 cases were reported to WHO – the lowest count ever.

The disease, spread by parasite-infected water fleas, now remains in just five African countries: Angola, Chad, Ethiopia, Mali and South Sudan. A sixth country, Sudan, has not reported cases for several years and is due to be certified as free from the disease soon by WHO.

CVCA funds have supported disease control and surveillance activities in affected countries, thus continuing the critical work towards global eradication of this debilitating disease. Efforts have focused on actively searching for cases and stopping disease transmission through interventions targeting both the water fleas transmitting the infection and the animal reservoir hosts (dogs).

The parasitic worm normally emerges from the foot, causing burning pain. Credit: WHO.

Programmes for neglected tropical diseases were among the most frequently and severely affected by the COVID-19 pandemic, but country-level activities on dracunculiasis have been largely maintained, thus keeping progress towards global eradication on track.

Extensive surveillance also enabled WHO to certify the Democratic Republic of the Congo as free of dracunculiasis transmission in November 2022, bringing the number of countries that have eliminated at least one NTD to 47. Dracunculiasis is the first parasitic disease set for eradication.

Turning around neglected tropical diseases in Timor-Leste

A decade ago, neglected tropical diseases NTDs) were widespread in Timor-Leste. A 2012 national survey found the prevalence of soil-transmitted helminthiases (STH) for example, ranged from 4 to 55 percent among schoolchildren (aged 7 to 16 years), while the prevalence of lymphatic filariasis (LF), also known as elephantiasis, ranged from 10 to 35 percent. LF causes pain and disfigurement, and due to stigma, can have a mental, social, and financial impact. Another endemic disease was yaws.

Since 2014, the WHO has provided technical and financial support to Timor-Leste's government to eliminate NTDs through Mass Drug Administration (MDA) targeted at LF and STH (with one drug also active against scabies), which reached 100 percent of schools. WHO also supported efforts to build health provider capacity to detect and treat NTDs and to monitor and care for LF patients through community health centres.

Considerable progress has since been made: LF is down to near elimination level, while scabies prevalence has declined to about 0.5 percent, a large decrease from 22 percent prevalence in 2016. No yaws cases have been found since 2018. STH is also under control.

However, advancing NTDs further towards elimination requires sustained technical and financial support from WHO and donors. The contribution of CVCA funds provided a boost to continuing this work. Sustained funding from other development partners will be critical for successfully sustaining the programme going forward.

Rizky Martins Pinto was one of 90,000 schoolchildren who received deworming tablets in October 2022 in Timor-Leste. Ricky later passed out a worm 15cm long. WHO Photo/ Emilia

iii. Catalysing change for child mental health in countries

Mental health is a large and growing problem among children and adolescents – among 10 - 19-year-olds globally, 1 in 7 experiences a mental disorder such as depression, anxiety and behavioral disorders. The WHO-UNICEF Joint Programme aims to address this. The technical work around mental health is mapped as a contribution to output "1.1.2 Countries enabled to strengthen their health systems to deliver on condition- and disease-specific service coverage results"

Awareness on the impact of mental health issues on the well-being of young people has increased exponentially in countries over the past 3 years. The COVID-19 pandemic has exposed the extent and severity of the global mental health crisis and the dire lack of services. Countries are now ready to invest in child and adolescent mental health, and are seeking support to strengthen systems, transform policy, and boost community inclusion.

Recognizing the urgent need to accelerate action , WHO and UNICEF have come together to co-create and deliver a Joint Programme on the mental health and psychosocial well-being and development of children and adolescents. This ambitious, phased 10-year action plan (2020-2030) aims to expand capacity in countries in child mental health promotion, prevention and care. The commitment of CVCA funding has been critical in laying the foundations for this important work.

A first step has been the development of context-specific multi-sectoral plans in 12 countries – Albania, Bhutan, Colombia, Côte d'Ivoire, Egypt, Guyana, Jordan, Maldives, Mozambique, North Macedonia, Papua New Guinea, and Serbia – which once implemented could benefit an estimated 98 million children and adolescents.

The complementary strengths of WHO and UNICEF are being leveraged to create new modalities and support cross-ministerial coordination and accountability mechanisms for child mental health. An inter-ministerial approach will serve to promote multidisciplinary, integrated strategies.

CVCA funding as seed contribution to the Joint Programme enables WHO to provide timely and strategic technical support in countries. The flexibility of the funding also provides countries more opportunities to define priorities for implementation, and thus align with stakeholders' efforts and identify underfunded activities. Initial outputs include the joint development of workplans (which will involve different government sectors), establishing country-level coordination mechanisms (on child and adolescent development, mental health and psychosocial wellbeing) and strengthening capacities in countries.

A strong focus is being given to strengthening care systems within the health sector and beyond, and promoting enabling environments for young people's mental health in schools, homes and elsewhere in the community. Key aspects of the implementation approach are youth engagement and parent training, as well as workforce development for mental health promotion, care and psychosocial support.

Another priority will be the integration of mhGAP guidelines (on early identification and management of mental, neurological and substance use conditions in young people) at primary health care and community levels.

Children run on the sand
https://photos.afro.who.int/preview/9350

iv. Boosting online resources for antimicrobial resistance national action plans

Antimicrobial resistance kills an estimated 1.3 million people globally every year. The problem is at alarming levels in many countries and growing. Today, 170 countries have national action plans on antimicrobial resistance (AMR) and this cross-cutting work is linked to output "1.3.5 Countries enabled to address antimicrobial resistance through strengthened surveillance systems, laboratory capacity, infection prevention and control, awareness-raising and evidence-based policies and practices"

Amid travel restrictions during the COVID-19 pandemic, Member States requested WHO develop and deliver virtual technical support and tools to expedite the implementation and monitoring of their national action plans on antimicrobial resistance (AMR). While most countries have developed these plans, only about 24% are effectively implementing them, a recent country self-assessment survey showed.

CVCA funds were utilized to support the development of:

- a practical implementation handbook accompanied by two e-learning modules;
- a global webinar series to share new guidance, tools and best practices; and
- an online community of practice platform to enhance peer-to-peer learning at the country level.

In addition, targeted virtual technical support was provided.

The uptake has been significant. The implementation handbook, translated into multiple languages, has been downloaded 5,700 times. About 5,600 learners have enrolled in the two e-learning modules – on implementing AMR national action plans and on the WHO costing and budgeting tool for these plans – between their launch in late 2022 and March 2023.

The 17 global webinars with multiple language interpretation attracted close to 14,000 participants from 120 countries. The new online "AMR Community Exchange" platform currently has more than 800 members from 48 countries who are using the platform to share information, request assistance, and learn from each other. The increased knowledge is expected to increase the rate of implementation of AMR national action plans in the near term.

Assessing national action plans virtually

To help countries conduct virtual assessments of the implementation of their national action plans, the Secretariat worked closely with a WHO Collaborating Centre – One Health Trust – to develop a protocol that included a desk review of published and gray literature and data; a structured questionnaire for remote interviews; data analysis; and an assessment document and recommendations, which were reviewed by all 3 levels of WHO and national authorities. This process was used to conduct assessments in Burkina Faso, Kenya, Malawi and Mali. A similar process was also used to ascertain the technical needs of 10 countries for monitoring and evaluating their AMR national action plans.

v. New strategies and reports mark significant steps in food safety

Food safety is a growing issue. Each year, an estimated 600 million people fall ill after eating contaminated food, resulting in 420 000 deaths. The technical work around Food safety mainly contributes to output "3.2.1 Countries enabled to address risk factors through multisectoral actions"

In 2022, the WHO Secretariat made significant strides towards addressing foodborne risks by launching the Global Food Safety Strategy 2022-2030, (adopted by the World Health Assembly in May). With CVCA funds, WHO ran a successful World Food Safety Day campaign on 7 June 2022, with over 450 events and 1.2 billion people viewing the #foodsafety hashtag. The Secretariat also linked the nutrition agenda to sports and with climate change, through the launch of the I-CAN initiative at COP27.

A WHO report looks at how digital technologies are used to promote breast-milk substitutes

Abusive formula milk marketing was exposed through multiple reports, including one revealing the shocking exploitative marketing of mothers through personalized social media content. Also with CVCA funds, a successful advocacy campaign for World Breastfeeding Week (1-7 August) was launched. And the Global Breastfeeding Scorecard 2022 was released calling for protecting breastfeeding through further investments and policy actions which kickstarted the development of WHO Donor Human Milk Banking Guidelines.

A tangible impact on global food safety standard setting emerged through the joint Food and Agriculture Organization of the United Nations (FAO)/WHO CODEX Alimentarius programme. The team provided sound scientific advice on a major number of substances through seven expert meetings while empowering 40 low-income countries, to actively engage in Codex and attend related meetings, including 9 regional and country training workshops.

With CVCA support, WHO monitored data for the UN State of Food Security and Nutrition in the World report 2022, released the COVID-19 impact on nutrition analytical framework with the Analytical Framework Visualizer tool, launched the new WHO Nutrition Data Portal and migrated all food safety databases. The Healthy Diets and Global Initiatives took significant steps forward in addressing the global obesity epidemic through a successful World Obesity Day campaign, the new WHO Global Acceleration Plan to stop obesity and the publication of six STOP Policy Briefs, which offer governments key policy measures to address childhood obesity.

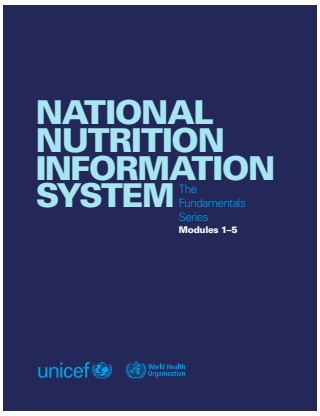
Healthy diets were further enforced by the publication of several guidelines addressing the use of non-sugar sweeteners, carbohydrate intake, fiscal policies to promote healthy diets, and protecting children from harmful food marketing, informed by related evidence reviews and public consultations.

Enhancing country preparedness for food safety emergencies

Investing CVCA funding, the International Food Safety Authorities Network (INFOSAN) convened 8 national workshops to support Member States in enhancing their preparedness to respond to food safety emergencies in 2022. A thorough analysis was conducted of existing indicators, such as the International Health Regulations (IHR) State Party Self-Assessment Annual Report (IHR-SPAR), and customized multi-level strategies were implemented to improve national coordination for risk communication.

To further reinforce global food safety efforts, the INFOSAN Secretariat continues to work closely with countries to strengthen the multi-sectoral collaboration mechanisms between food safety agencies at national, regional, and international levels. This is being done through targeted workshops aimed at mitigating risks associated with the consumption of unsafe food. In the GPW13 results structure, this work is anchored to output “2.1.3 Countries operationally ready to assess and manage identified risks and vulnerabilities”, with a strong cross-cutting element to output “3.2.1 Countries enabled to address risk factors through multisectoral actions”.

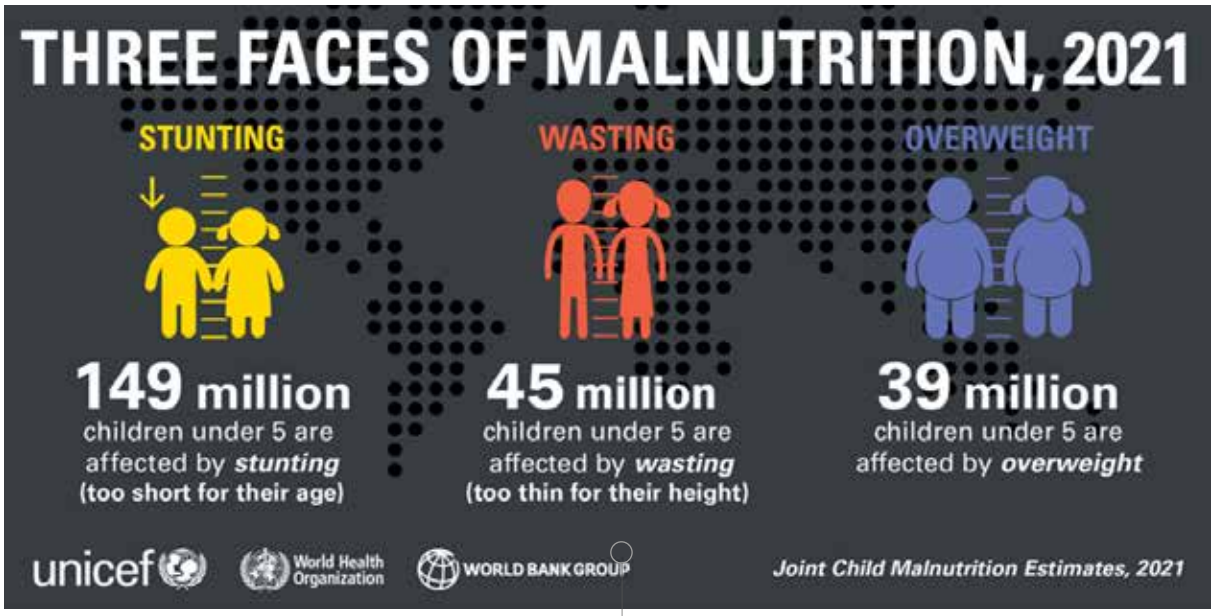
Updating and enhancing malnutrition data



WHO has developed guidelines to strengthen nutrition surveillance systems and data analytical capacities of countries, to enhance data quality and monitoring for malnutrition targets of the Sustainable Development Goal (SDG) 2.2. The document, National nutrition information systems: modules 1-5, aims to strengthen the capacity of countries to collect data on nutrition indicators that will feed into SDG 2.2 targets.

The interagency UNICEF-WHO-World Bank Joint Child Malnutrition Estimates (JME) group jointly updates estimates on child malnutrition from available data. The group reviewed over 150 surveys and 1063 primary sources from 158 countries in the joint database to derive estimates for the 2023 edition, to be launched in May 2023, for indicators on childhood stunting (SDG 2.2.1), overweight (SDG 2.2.2(1)) and wasting (SDG 2.2.2(2)).

The Micronutrients Database continues to be updated. It contains 1457 primary sources that will feed into the estimates for anaemia in women of reproductive age (SDG 2.2.3). The UNICEF-WHO Joint Low Birthweight estimates were derived for 195 countries. The updates were obtained from WHO-related policy surveys and regional office reports, as well as from thematic peer reviews of country policies and from the websites of ministries of health.



The new estimates, available in May 2023, will supersede former estimates.

vi. Delivering essential health services to the vulnerable in Myanmar

A **political and humanitarian crisis in Myanmar** – including escalating armed conflicts in multiple areas– as well as the COVID-19 pandemic has disrupted the health situation. Some 10 million people are in need of health assistance. Health systems are struggling to maintain functionality, with critical shortages of health commodities and staff. WHO and partners have scaled up operations to address the health needs of the most vulnerable.

Scaling up epilepsy services

In Myanmar, an estimated 500 000 people live with epilepsy, a common neurological condition. In 2014, an estimated 95% of them were not receiving the care required. With only 18 neurologists in public health services, there was a clear rationale for supporting efforts to strengthen community-based care for epilepsy. Epilepsy can impact a person's physical, mental and psychosocial ability if left untreated.

The Myanmar Epilepsy Initiative (MEI) started in 2013 with the aim to tackle the epilepsy burden and to scale up integrated epilepsy care into primary health care. The Initiative's rollout was supported by the WHO Country Office in Myanmar. However, the country's political and humanitarian crisis has disrupted the Initiative.

With CVCA funding and through engagement with partners, WHO has sustained the MEI to meet the needs of vulnerable patients during these difficult times. Epilepsy services were resumed in 37 out of 61 project townships achieving 56% coverage. By 2021, the MEI had 1904 people with epilepsy registered and had provided more than 11 000 follow-up consultations.

In 2022, MEI was scaled up to include an additional 10 townships in Bago Region. Training based on WHO mhGAP guidelines was conducted in these townships, with more than 2000 basic health staff trained. In total, 2,573 people with epilepsy have been registered for treatment at health facilities and more than 15 000 follow-up consultations have been provided through the MEI.

A health assistant providing epilepsy services at a primary health care facility in Myanmar. Credit: Myanmar Epilepsy Initiative

Scaling up services for noncommunicable diseases

In Myanmar, an estimated 71% of all deaths are due to the four major noncommunicable diseases (NCDs) –cardiovascular diseases, cancers, chronic respiratory diseases and diabetes.

The political and humanitarian crisis in the country and COVID-19 has strained health systems and disrupted services for the prevention and treatment of NCDs in the public health sector, further widening already existing NCDs service gaps at the community level.

To address this, WHO Myanmar scaled up services for NCD prevention and management through non-governmental organizations and implementing partners in 2022. A people-centered integrated NCD services delivery approach was taken, with a focus on seven townships (including hard-to-reach areas). Resources from CVCA funds and the NORAD flagship programme were used to deliver NCD services, including prevention of NCDs risk factors through health education and awareness raising campaigns. Low-cost solutions exist to reduce the common modifiable risk factors.

Screening of hypertension among people above 40 years of age in Kyaungon township, Myanmar. Credit: People Health Foundation Myanmar

In addition, 610 community volunteers and 18 healthcare workers (including medical doctors) received training on NCD care using the WHO Package of Essential Noncommunicable disease interventions (PEN) guidelines. More than 25,000 people above 40 years have now been screened for hypertension and diabetes, which can have few initial symptoms. Screening enables early detection of diseases and timely treatment, which can reduce the need for more expensive treatment at later stages. Around 3700 cases of hypertension, 789 cases of diabetes and 1588 cases of both hypertension and diabetes were newly diagnosed. Subsequently, 4377 patients were put on antihypertensive and oral hypoglycemic agents.

Restoring malaria control

Myanmar has targeted *P. falciparum* malaria elimination by 2025 and all human malaria elimination by 2030. There has been progress in driving down cases caused by *P. falciparum* malaria parasites across the Greater Mekong sub-region but cases of *P. vivax* malaria have risen in Myanmar in 2020 and 2021, due to a political and humanitarian crisis that has strained health systems.

In February 2021, the National Malaria Control Programme (NMCP) faced a huge human resources crunch which led to a breach in treatment and prevention services. In response to the situation and the country's political instability, WHO Myanmar stepped in to provide support for human resources and essential malaria services, working with the NMCP, partners and volunteers.

WHO personnel training Integrated Community Malaria Volunteer on malaria testing, recording and reporting. Credit: WHO Myanmar

Thanks to CVCA funds, malaria control has been reestablished, and about 306 000 bed nets have since been distributed, 1.8 million tests conducted, and 100% of malaria cases detected were treated, despite COVID-19 and humanitarian emergencies. In addition, WHO has supported training of 100 staff from the NMCP and partners and an external independent review of the NMCP, which provided recommendations that are now being used to revise national plans and mobilize resources for the 2024-2026 period.

vii. Investing in overlooked areas

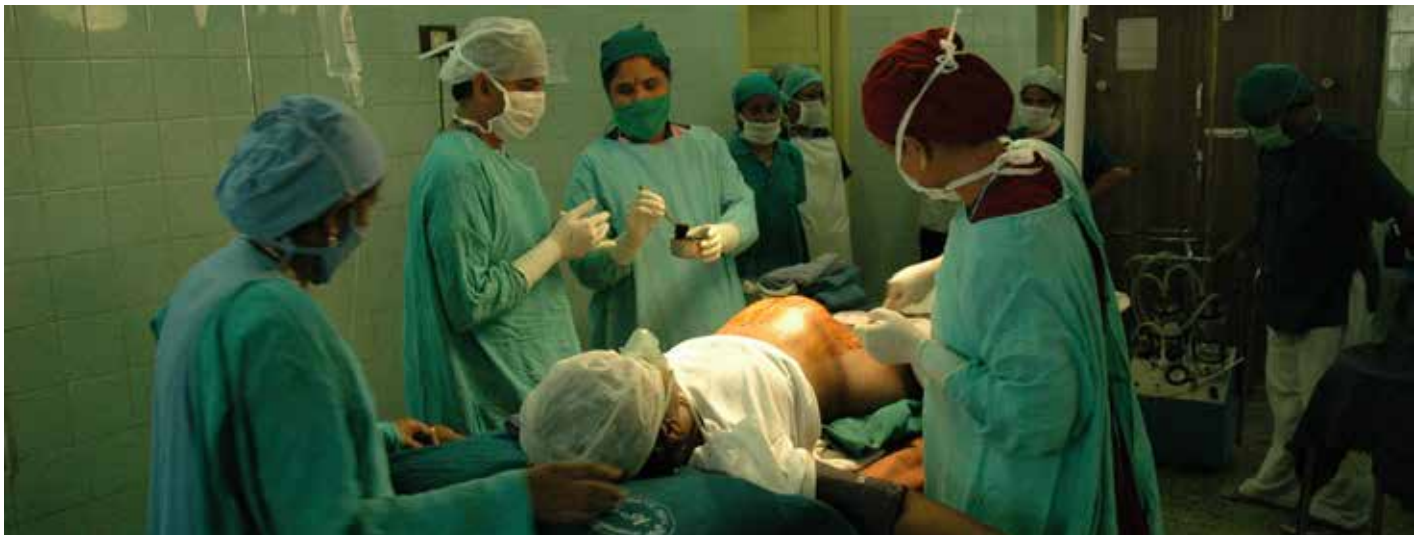
WHO / Panos Pictures / Saiyna Bashir

Nepal steps up fight against dengue

Nepal has seen a recurring pattern of dengue outbreaks every year, with outbreaks increasing in frequency and severity. In a severe outbreak in 2022, 54,000 cases and 88 deaths were reported – more than triple the number of cases in the previous largest outbreak in 2019. Limited entomological expertise and resources to manage vector control, particularly at sub-national levels, has hindered efforts to prevent such outbreaks in recent years.

In response, the Ministry of Health And Population (MOHP) introduced a range of interventions at sub-national levels, in collaboration with key stakeholders. With CVCA funds, the WHO Country Office provided technical and financial support for vector surveillance in districts with high-case incidence. This confirmed the widespread presence of Aedes mosquitoes and suggested a very high risk of dengue transmission. On-site demonstrations by entomologists on how to destroy potential vector breeding sites led to local levels revamping vector control activities with their own funds. The “10 Minutes Every Saturday at 10:00 am” campaign encouraged communities to spare time every week to destroy mosquito breeding sites.

WHO also provided technical assistance for risk assessments in high-incidence districts. With GIS technology, visual maps of dengue case incidence and spatial distribution were generated, pinpointing high-risk areas. This enabled local governments to prioritize interventions and resources. However, challenges remain in ensuring broader community engagement and ownership of these efforts. WHO continues to work closely with the MOHP to improve resilience and readiness and to enhance capacity for early detection and effective response to outbreaks.



WHO / Pallava Bagla

Training for effective emergency care in India

Effective emergency care systems save lives. In the South-East Asia region, 90% of deaths are caused by conditions with emergency manifestations, including cardiovascular diseases, injuries, and maternal and child health. In India, a 2019 study found fragmented services and system gaps impaired critical care.

Responding to a request from the Government of Uttar Pradesh to strengthen the emergency care system, WHO India and the regional WHO Collaborating Centre for Emergency and Trauma Care (WHOCCET) , based in New Delhi, developed a five-day training module for preparing "Champions of Change" in emergency care with CVCA funds. The aim was to pilot the module before scaling it across the state and to other states.

Three-member teams, comprising a lead administrator, doctor in charge of emergency and trauma care and senior nurse, were selected from 11 state medical colleges as "Champions of Change" for a 5-day training at the WHOCCET Trauma Centre in New Delhi. The training covered setting up of emergency care facilities (including governance and planning), and major interventions in emergency clincal care.

Following the pilot, the training was provided to all medical colleges in the state and implemented in medical college hospitals, which will serve as nodal centres to guide other major hospitals in the state and to build emergency care. In addition, casualty was redesignated to emergency departments in medical colleges, and the State drafted policy on human resources for emergency department.

WHO / Pallava Bagla

Electrification of health facilities in Somalia

WHO has been supporting countries in the electrification of health care facilities, which is crucial for the functionality of facilities and to deliver quality services reliably. In sub-Saharan Africa, an estimated one in four health care facilities lack electricity.

WHO supported Somalia's Ministry of Health on the electrification of 100 health care facilities through solar systems. Somalia is looking to solar power to rebuild a health system recovering from a conflict that took a toll on public health infrastructures.

WHO supported the techno-economical analysis of the project. Procurement of the solar system is currently ongoing and will be completed within the first half of 2023. Electrification will greatly improve safety and quality of care in health care facilities, allowing the use of essential power-dependent medical devices.

WHO wishes to acknowledge the invaluable support from all its CVCA contributors for this flexible funding, which is vital for the achievement of the WHO's vision of a world in which all peoples attain the highest possible level of health. CVCA continues to be key to facilitating WHO's mission to promote health, keep the world safe and serve the vulnerable, with measurable impact for people at country level.

IV. Accountability and transparency

Programmatic and geographic focus

In employing an allocation mechanism that is inspired by the Development Assistance Committee's mandate and principles[1] - and in committing to maintain an Official Development Assistance (ODA) coefficient[2] of 100% - WHO defined corporate principles to ensure CVCA funds prioritize country work or the work around global public health goods.

The corporate principles stipulate that CVCA, to the extent possible, cannot be used to carry out activities linked to the enabling functions of the Organization. Equally, CVCA should be mostly used for the Base segment (the core mandate of the Organization) of the Programme budget.

Overall, the CVCA enables WHO to attain the greatest impact for countries and strengthen its leadership role in the global public health arena by:

- Securing expert staff across all programmatic and geographic areas;
- Scaling up proven results and best practices for better health globally;
- Leading and pioneering new ideas to respond effectively to complex global health's issues.

Transparency

Traceability throughout the financial flows is key to contributors' accountability to their national constituencies. To support them in this recurring exercise, WHO places accountability and transparency as a foundation of its business model. It plays a growing role in promoting the usage of the International Aid Transparency Initiative (IATI) publication standard and regularly contributes to its further refinement.

As a result of its continued efforts to enhance its transparency framework, WHO was first assessed as part of the 2022 Aid Transparency Index and received a "Good" rating. Preparation works have already started towards the 2024 Aid Transparency Index, with the prospect of increasing the overall score.

Additionally, the Secretariat moved to monthly updates of programme budget funding and implementation across programmatic and geographic dimensions, and maintained the yearly performance assessment, which are published on WHO's Programme Budget web portal. Additionally, the web portal features a CVCA-dedicated section, acknowledging contributors' support and displaying how the funding flows across the organizational and result structures, to deliver the biennial programme budget. Financial data reported under this CVCA-dedicated section is based on funds available net of support cost and therefore differ from the revenue data presented in this report.

CVCA expenditures are also reported yearly to the OECD Creditor Reporting System and the Total Official Support for Sustainable Development (TOSSD) exercises and have maintained a coefficient of 100% towards development assistance. This coefficient means that the totality of the CVCA expenditures - whether incurred at country, regional or headquarters level – contribute to development assistance, as defined by the Development Assistance Committee.

1 The Development Assistance Committee's Mandate, OECD, 2023
2 Annex 2 List of ODA-eligible international organisations, OECD, 2023

V. Looking ahead

Much of the work showcased in this report would not have been possible without the generosity of our donors, who have recognised that to empower WHO to lead global health, the Organization needs to be sustainably financed, with a pool of flexible funds on hand, if needed. Insufficient investments impede the Organization's ability to perform, and limit its capacity to step in and address a health challenge in a timely manner.

The report of the Working Group on Sustainable Financing to the World Health Assembly and the subsequent decision in 2022 on sustainable financing represent a significant step forward in enabling WHO to better equip itself and enhance its technical excellence to address the 21st century challenges facing global public health. The report's consensus that the base segment of the Programme budget should be fully flexibly funded is a crucial development that will enable the Organization to deliver on its mandate more effectively.

Flexible funds, such as CVCA, are critically important for WHO to deliver on the Programme budget commitments, to respond to emerging global health issues and to strengthen its leadership role in global health. While flexible funds still represent only 40% of the available base segment of the Programme budget funding , these funds provide the Organization with much needed financial resources to capacitate the Organization to lead global health and deepen its impact in countries, at a time when there is an exceptional need for global health leadership.

As global public health challenges continue to mount, CVCA funds will be instrumental in enabling WHO to continuously deliver at the highest standards. This will help to ensure that the Organization remains at the forefront of efforts to promote health and well-being globally, and its call for equity in health will lead the way among the many actors in the global health community.

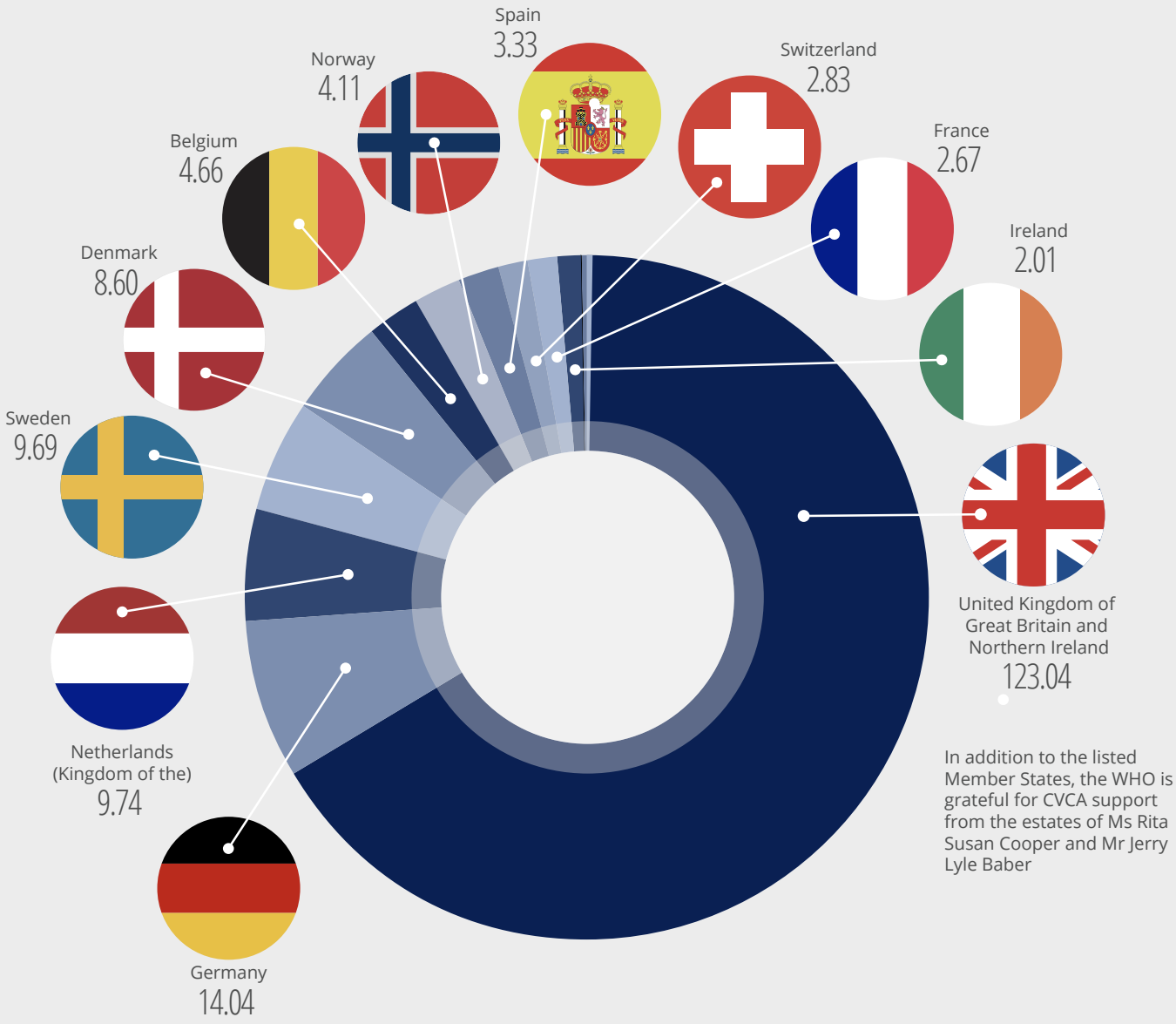
Prioritizing these funding mechanisms will help ensure a stronger, more agile and flexible WHO, one that is fit for purpose in the 21st century to work and able to navigate health challenges, ultimately contributing to a healthier and more resilient world.

VI. Annex: Core voluntary contributions account revenue and implementation

Fig. A1.

2022 Contributions to the Core Voluntary Contributions Account

Amounts in US$ million



In addition to the listed Member States, the WHO is grateful for CVCA support from the estates of Ms Rita Susan Cooper and Mr Jerry Lyle Baber

Fig. A2.

2023 Contributions to the Core Voluntary Contributions Account (as of 30 April 2023)

Amounts in US$ million

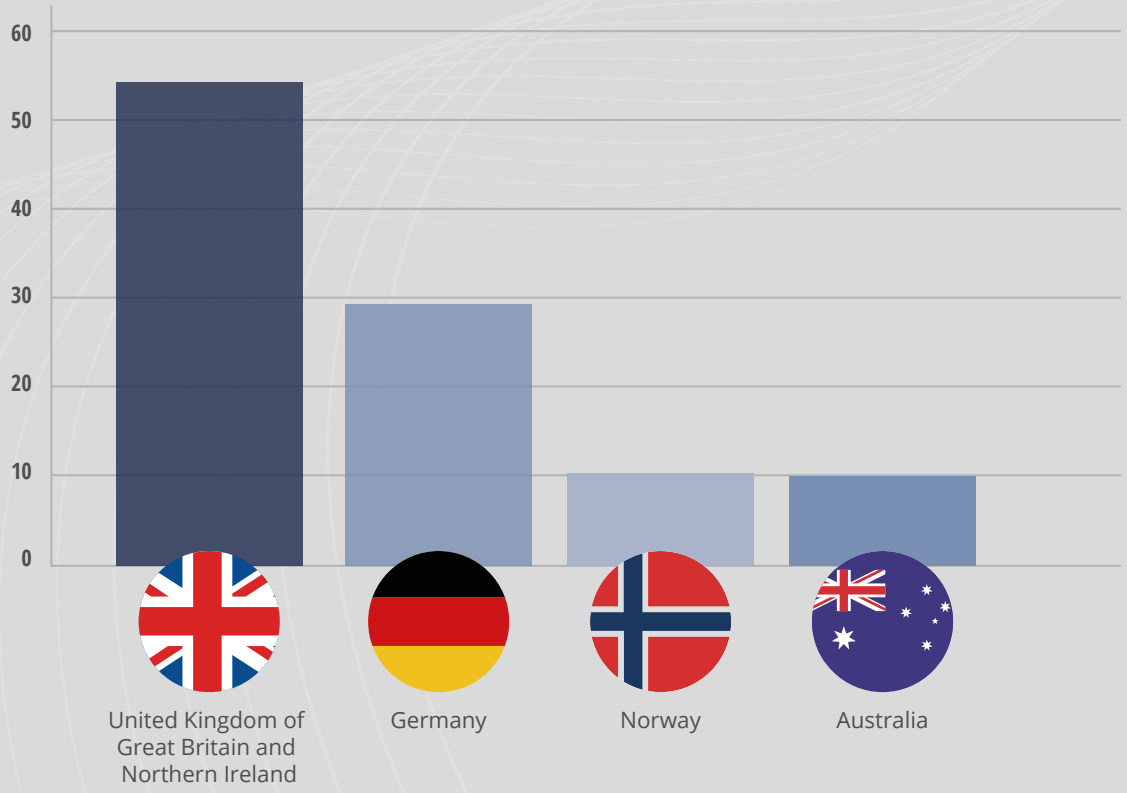
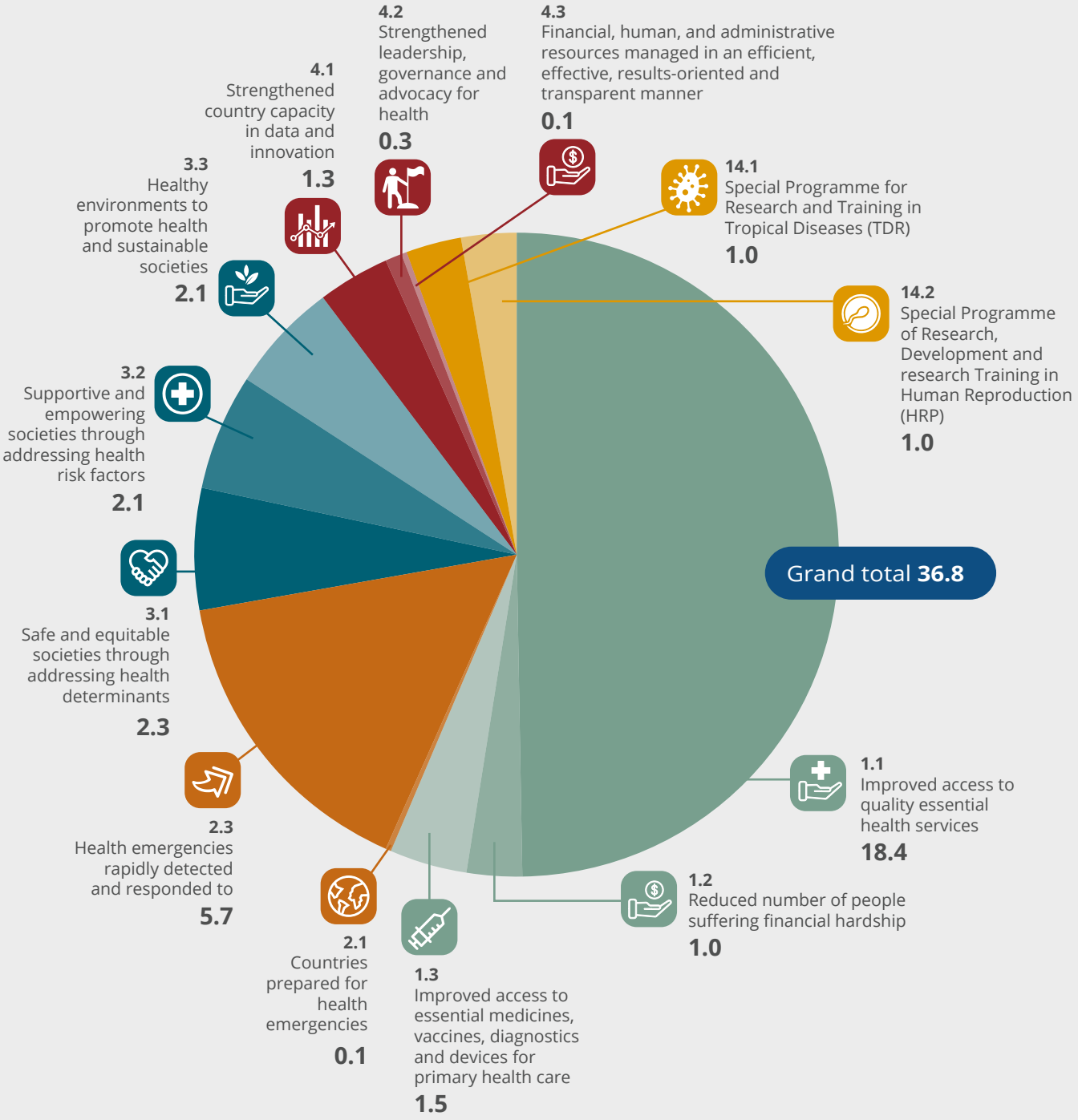
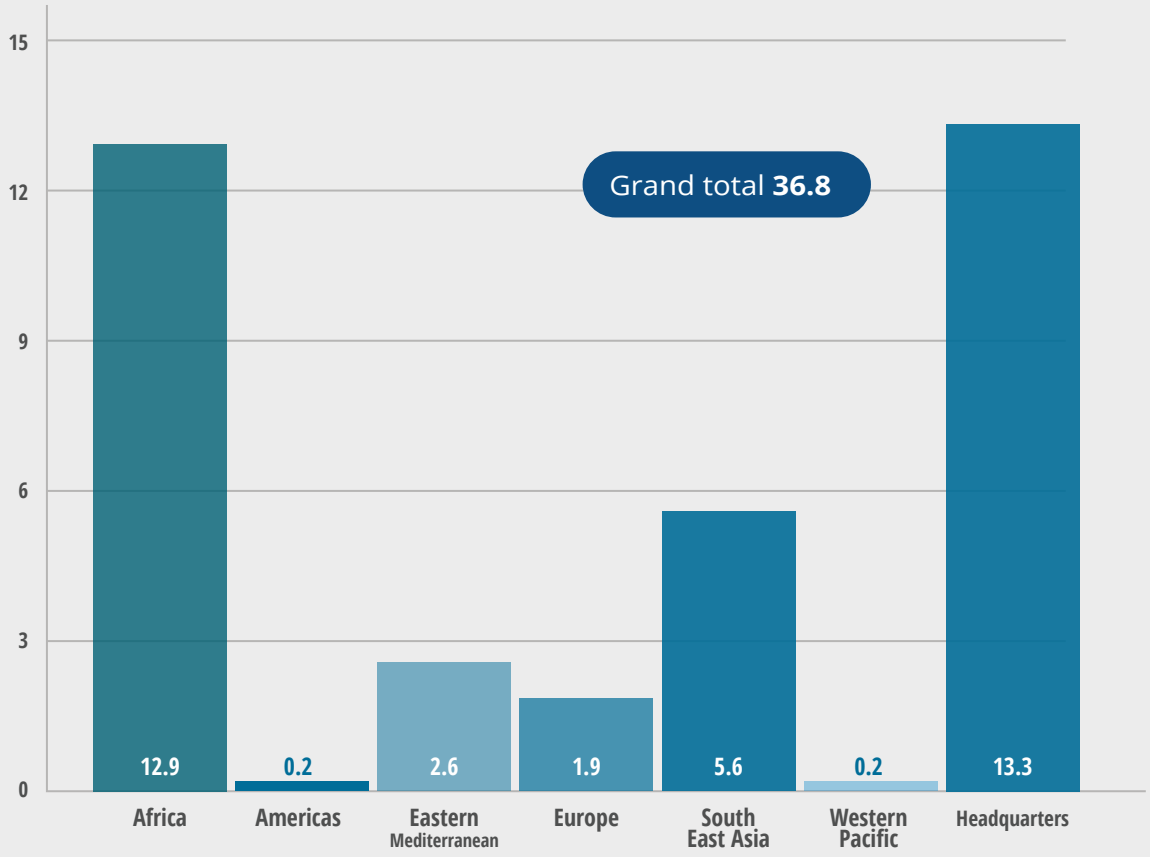


Fig. A3.

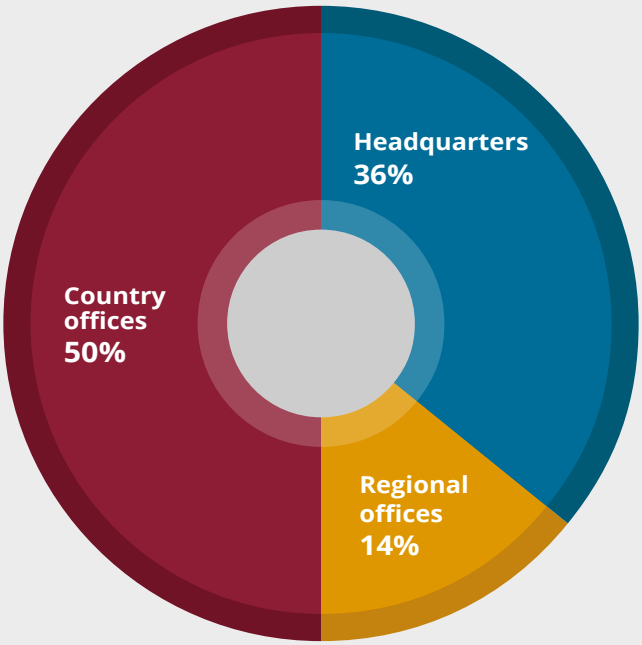
1. Expenditures by outcome as of 31 December 2022 (US$ million)



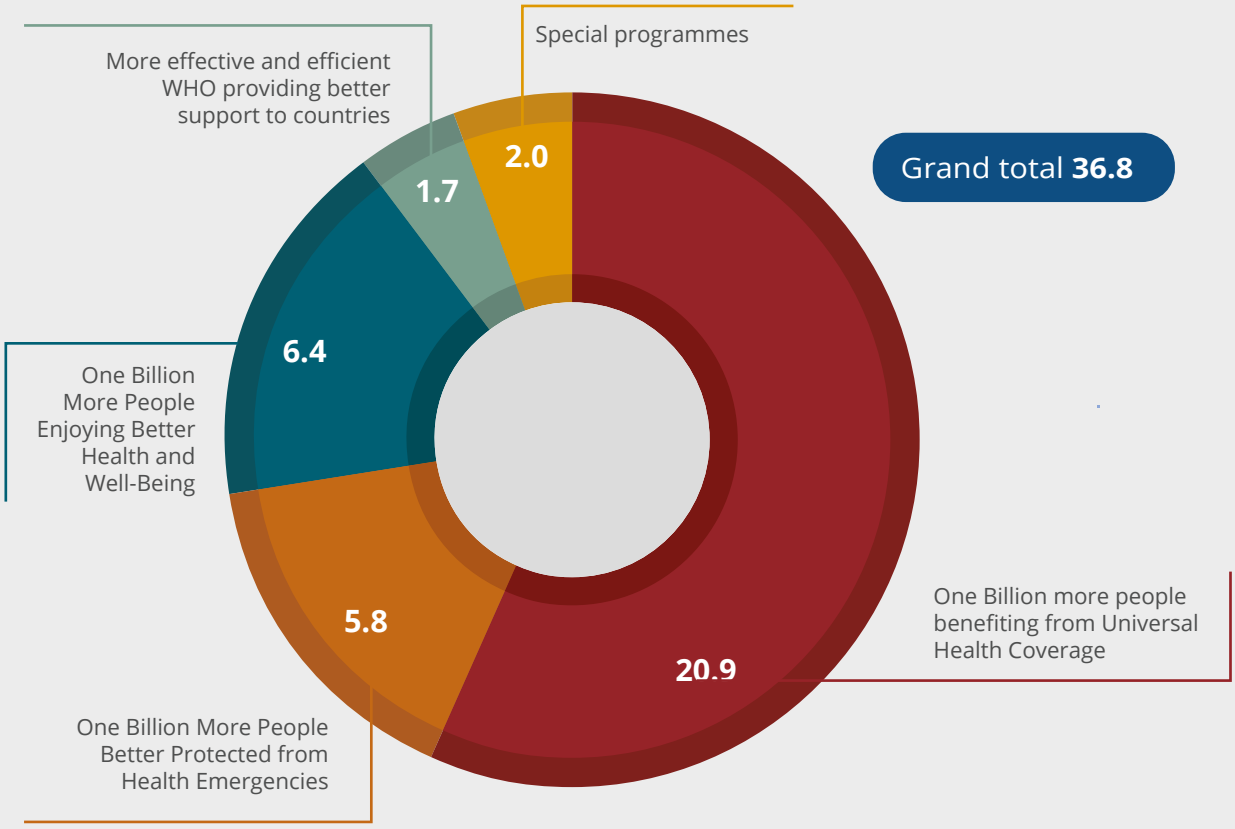
2. Expenditures by major office as of 31 December 2022 (US$ million)



3. Expenditures by Organizational level as of 31 December 2022 (US$ million)



4. Expenditures by Strategic priority as of 31 December 2022 (US$ million)



5. Expenditures by type as of 31 December 2022 (US$ million)

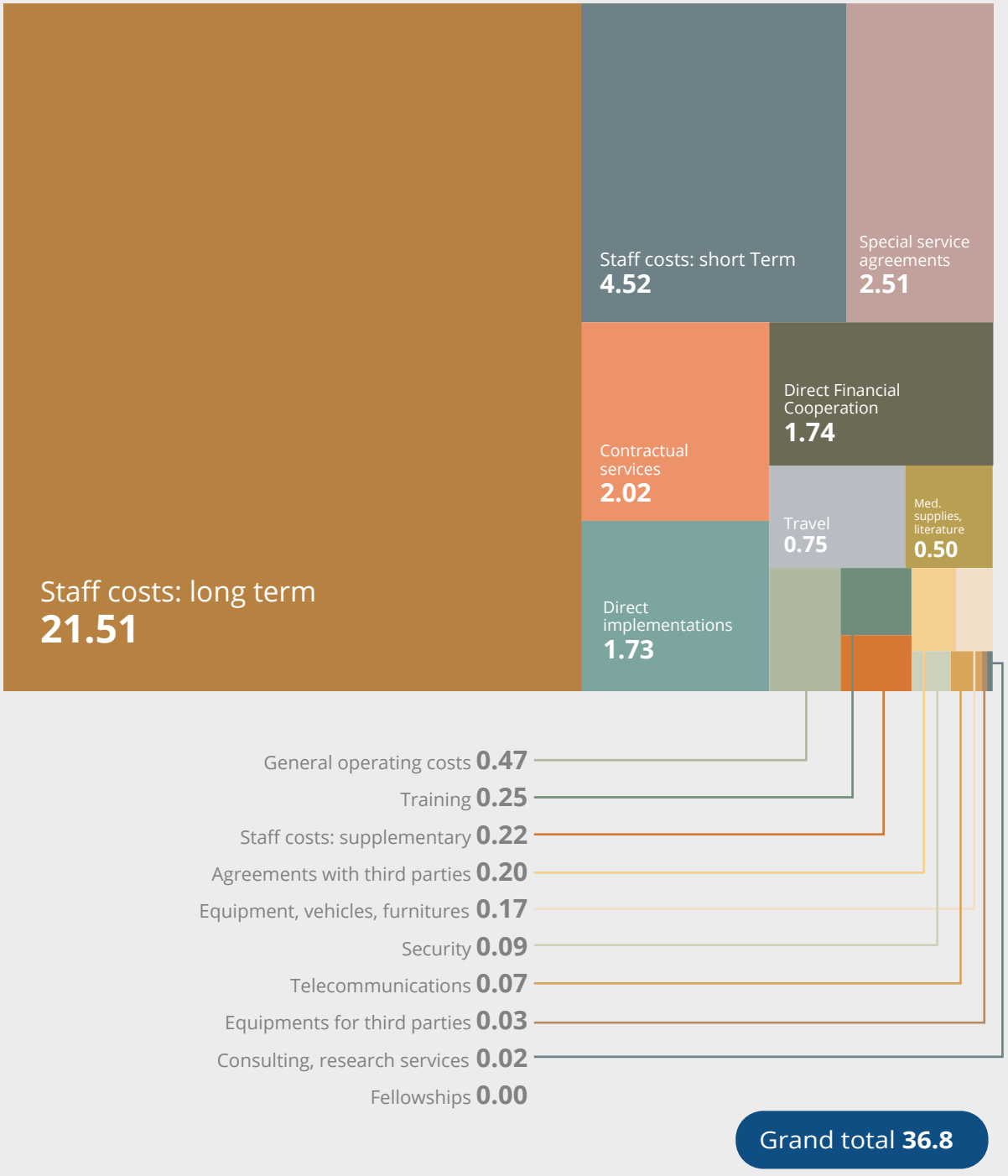


Table A1.

6. Expenditures by output as of 31 December 2022 (US$ million)

	Output	2022 Expenditures
1.1.1	Countries enabled to provide high-quality, people-centred health services, based on primary health care strategies and comprehensive essential service packages	1.75
1.1.2	Countries enabled to strengthen their health systems to deliver on condition- and disease-specific service coverage results	2.51
1.1.3	Countries enabled to strengthen their health systems to address population-specific health needs and barriers to equity across the life course	13.45
1.1.4	Countries' health governance capacity strengthened for improved transparency, accountability, responsiveness and empowerment of communities	0.38
1.1.5	Countries enabled to strengthen their health workforce	0.31
1.2.1	Countries enabled to develop and implement more equitable health financing strategies and reforms to sustain progress towards universal health coverage	0.34
1.2.2	Countries enabled to produce and analyse information on financial risk protection, equity and health expenditures and to use this information to track progress and inform decision-making	0.47
1.2.3	Countries enabled to improve institutional capacity for transparent decision-making in priority-setting and resource allocation and analysis of the impact of health in the national economy	0.15
1.3.1	Provision of authoritative guidance and standards on quality, safety and efficacy of health products, including through prequalification services, essential medicines and diagnostics lists	0.20
1.3.2	Improved and more equitable access to health products through global market shaping and supporting countries to monitor and ensure efficient and transparent procurement and supply systems	0.20
1.3.3	Country and regional regulatory capacity strengthened, and supply of quality-assured and safe health products improved	0.25
1.3.4	Research and development agenda defined and research coordinated in line with public health priorities	0.09
1.3.5	Countries enabled to address antimicrobial resistance through strengthened surveillance systems, laboratory capacity, infection prevention and control, awareness-raising and evidence-based policies and practices	0.76
14.1.1	TDR - Strengthened evidence base, prioritization and uptake of WHO generated norms and standards and improved research capacity and the ability to effectively and sustainably scale up innovations, including digital technology, in countries	1.00
14.2.1	HRP - Strengthened evidence base, prioritization and uptake of WHO generated norms and standards and improved research capacity and the ability to effectively and sustainably scale up innovations, including digital technology, in countries	1.00
2.1.1	All-hazards emergency preparedness capacities in countries assessed and reported	0.03
2.1.2	Capacities for emergency preparedness strengthened in all countries	0.02
2.1.3	Countries operationally ready to assess and manage identified risks and vulnerabilities	0.10

	Output	2022 Expenditures
2.2.2	Proven prevention strategies for priority pandemic-/epidemic-prone diseases implemented at scale	0.00
2.3.1	Potential health emergencies rapidly detected, and risks assessed and communicated	5.68
2.3.2	Acute health emergencies rapidly responded to, leveraging relevant national and international capacities	0.00
2.3.3	Essential health services and systems maintained and strengthened in fragile, conflict and vulnerable settings	0.03
3.1.1	Countries enabled to address social determinants of health across the life course	1.52
3.1.2	Countries enabled to strengthen equitable access to safe, healthy and sustainably produced foods through a One Health approach	0.74
3.2.1	Countries enabled to address risk factors through multisectoral actions	1.99
3.2.2	Countries enabled to reinforce partnerships across sectors, as well as governance mechanisms, laws and fiscal measures	0.07
3.3.1	Countries enabled to address environmental determinants, including climate change	1.77
3.3.2	Countries supported to create an enabling environment for healthy settings	0.34
4.1.1	Countries enabled to strengthen data, analytics and health information systems to inform policy and deliver impacts.	1.02
4.1.2	GPW 13 impacts and outcomes, global and regional health trends, Sustainable Development Goal indicators, health inequalities and disaggregated data monitored	0.16
4.1.3	Strengthened evidence base, prioritization and uptake of WHO generated norms and standards and improved research capacity and the ability to effectively and sustainably scale up innovations, including digital technology, in countries.	0.09
4.2.1	Leadership, governance and external relations enhanced to implement GPW 13 and drive impact in an aligned manner at the country level, on the basis of strategic communications and in accordance with the Sustainable Development Goals in the context of United Nations reform	0.06
4.2.2	The Secretariat operates in an accountable, transparent, compliant and risk management-driven manner including through organizational learning and a culture of evaluation	0.02
4.2.3	Strategic priorities resourced in a predictable, adequate and flexible manner through strengthening partnerships	0.03
4.2.4	Planning, allocation of resources, monitoring and reporting based on country priorities, carried out to achieve country impact, value-for-money and the strategic priorities of GPW 13	0.14
4.2.5	Cultural change fostered and critical technical and administrative processes strengthened through a new operating model that optimizes organizational performance and enhances internal communications	0.03
4.3.1	Sound financial practices and oversight managed through an efficient and effective internal control framework	0.13
4.3.3	Effective, innovative and secure digital platforms and services aligned with the needs of users, corporate functions, technical programmes and health emergencies operations	0.00
	Grand total	**36.82**