



WHO country presence in small island developing states (SIDS)



World Health
Organization



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Introduction

Small Island Developing States (SIDS) are a recognized group of 38 UN Member States and 20 non-Members/Associate Members of Regional Commissions, located in three geographic regions: the Caribbean; the Pacific; and the Atlantic, Indian Ocean, Mediterranean and South China Sea (AIMS) (see Annex 1).

SIDS face unique social, economic and environmental challenges. Due to their remote geography, many SIDS face high import and export trade costs as well as irregular international traffic volumes, while relying on external markets for many goods. Most of their natural resources come from the ocean. SIDS are particularly vulnerable to climate change, land degradation and biodiversity loss owing to their vulnerability to exogenous shocks and fragile land and marine ecosystems. Their remoteness and small population sizes mean high transportation costs and limited opportunity to develop economies of scale in international markets.

Climate change has an especially significant impact on SIDS, through natural disasters that destroy homes, health facilities, schools, communications, and energy and transport infrastructure. Moreover, SIDS face an existential threat from slow-onset events like rising sea levels, and the realistic prospect of drastic measures such as relocation of their populations. Biodiversity is vital for the livelihood of many SIDS, with tourism and fisheries often contributing a significant proportion of their GDP. A more robust biodiversity could help SIDS benefit in the future from a sustainable food supply, clean water, reduced beach erosion, soil and sand formation, and protection from pollution and natural disasters such as storm surges and floods. As many SIDS are tourist destinations, adolescent health—including pregnancies, drug abuse and harmful use of alcohol—also represents a special health challenge for SIDS.

These challenges—compounded by limited institutional capacity and scarce financial resources—have a considerable impact on systems, services and the health status of SIDS populations, making the role of WHO in SIDS especially important. This document provides a quick overview of health sector information and WHO's presence in SIDS in the most recent two-year period (2019–20). The information in this document is presented in the specific context of the Thirteenth General Programme of Work of the WHO (GPW13),¹ with a special section on COVID-19.

When interpreting the data presented here, it is important to keep in mind that while SIDS share common challenges and vulnerabilities, they also vary greatly in terms of population, social and cultural beliefs and practices, economic development, health status and so forth. Average figures presented for SIDS tend to mask these variations.

¹ WHO Thirteenth General Programme of Work, 2019–2023, available at <https://apps.who.int/iris/bitstream/handle/10665/324775/WHO-PRP-18.1-eng.pdf>, accessed on 19 March 2021.

D

Demography

According to the UN Statistics Division, the estimated combined population of SIDS in 2020 was 72 027 558,² which is less than one percent of the global population. Although SIDS (as the group name indicates) generally have small populations, the population size ranges from 1626 in Niue to 11 326 616 in Cuba. Average annual population growth is somewhat lower in SIDS (0.91%) than in the world (1.09%), as seen in Fig. 1.

The total fertility rate in SIDS has been steadily declining from 5.54 children per woman of reproductive age in 1950–55 to 2.45 in 2015–20; this decline is more marked than that observed globally during the same period (Fig. 2).

The proportion of the population aged below 15 years (28.9%) is higher than the global average (25.6%), and conversely the proportion of the population aged 65 years and above in SIDS is lower (6.12% vs 9.09%). The current trend of lower population growth among SIDS is likely to accelerate population ageing within the next few decades, with consequent potential health impacts.

Fig. 1. Population growth rates SIDS vs the World²

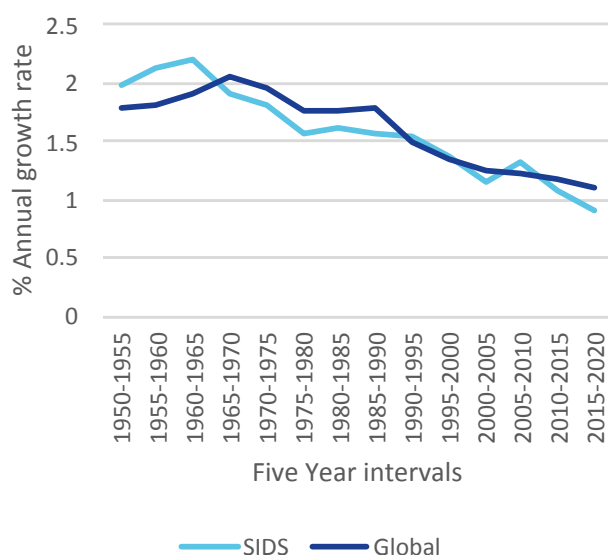
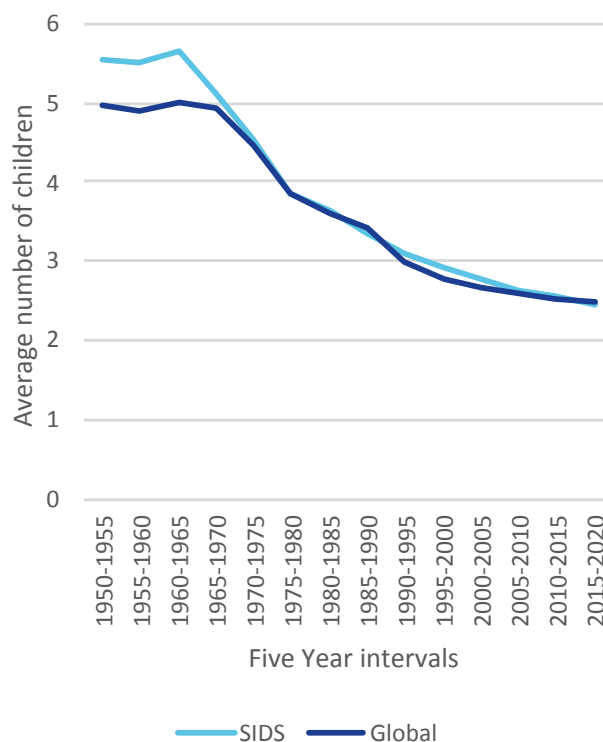


Fig. 2. Trends in total fertility rate²



² UN Data, available at <http://data.un.org/Search.aspx?q=small+island+developing+states>, accessed on 19 February 2021.



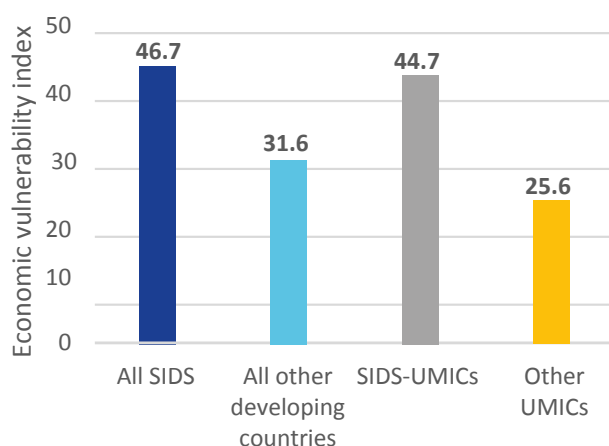
Economy

Most SIDS are either upper-middle (17) or high income (24), while nine are lower-middle and two low income status.³ The rationale for classifying them as “developing” therefore reflects the special vulnerabilities to which they are exposed.

SIDS vary in terms of their economic strength. The average per capita GDP of SIDS is US\$ 14 620.43. This figure ranges from US\$ 697.29 in Guinea-Bissau to US\$ 117 089.30 in Bermuda (2019). In 2019, half of all SIDS had a per capita GDP of less than US\$ 8000 and 15% had a per capita GDP of over US\$ 20 000.⁴

However, measuring economic growth of SIDS using the Gross Domestic Product (GDP) “does not adequately capture the unique features of SIDS that are relevant to their sustainability.”⁵ Given their geographic remoteness, small size and vulnerability to natural disasters, the economic vulnerability⁶ of all SIDS is more pronounced than that of all other developing countries as is the vulnerability of upper-middle income SIDS compared to other upper-middle income countries (Fig. 3).⁷

Fig. 3. Economic vulnerability index⁷



³ World Bank Country and Lending Groups (52 SIDS), available at <https://datahelpdesk.worldbank.org/knowledgebase/articles/906519-world-bank-country-and-lendinggroups>, accessed on 19 March 2021.

⁴ World Bank Data Bank (39 SIDS 2019), available at <https://databank.worldbank.org/>, accessed on 19 March 2021.

⁵ UNEP 2014. Emerging issues for Small Island Developing States. Results of the UNEP/UN DESA Foresight Process. United Nations Environment Programme (UNEP), Nairobi, Kenya.

⁶ The exposure of an economy to exogenous shocks, arising out of economic openness.

⁷ OECD Making Development Co-operation Work for SIDS, available at https://www.oecd-ilibrary.org/development/making-development-co-operation-work-for-small-island-developing-states_9789264287648-en, accessed on 19 March 2021.

⁸ UNDP. SIDS do not have the luxury of time, <https://www.undp.org/blogs/small-island-developing-states-do-not-have-luxury-time>, accessed on 19 March 2021.

⁹ World Resources Institute. A Sustainable Ocean Economy for 2050, available at https://oceanpanel.org/sites/default/files/2020-07/Ocean%20Panel_Economic%20Analysis_FINAL.pdf, accessed on 19 February 2021.

¹⁰ WMO. 2020 State of Climate Services, available at https://library.wmo.int/index.php?lvl=notice_display&id=21777#_YKUyuaqzaUm, accessed on 19 March 2021.

¹¹ WHO. Climate change and health, available at <https://www.who.int/news-room/fact-sheets/detail/climate-change-and-health>, accessed on 19 March 2021.

¹² WHO Global Health Observatory (GHO). 2018 data on 40 SIDS.

¹³ GHO. 2018 data on 34 SIDS.

Climate change and the economy

As their ocean territories are 20.7 times greater than their land area, SIDS see themselves as Large Ocean States, and are pioneering the Blue Economy paradigm which promotes the sustainable use of ocean resources while preserving and restoring ocean ecosystems and combating climate change.⁸ A recent analysis shows that every US\$ 1 invested in the sustainable ocean economy could yield as much as US\$ 5 in return.⁹ Expanding marine and coastal activities to diversify their tourist-reliant economies, accelerating the digital transformation, investing in digital infrastructure and developing innovative solutions in response to the COVID-19 pandemic are examples of the way forward.

Since 1970, it is estimated that SIDS have lost US\$ 153 billion to climate-related events.¹⁰ UNDP’s “Rising up for SIDS” is an integrated approach to support SIDS as a vehicle for green recovery and beyond.⁸ Climate change affects the social and environmental determinants of health such as clean air, safe drinking water, sufficient food and secure shelter. People living in SIDS are particularly vulnerable to the health effects that climate change—in the form of exposure to natural disasters and new patterns of water- and vector-borne diseases—can have on population health.¹¹

Health and the economy

The average total expenditure on health as a percentage of GDP in SIDS countries, territories and areas is 7%, although this percentage varies greatly from 2% GDP in Papua New Guinea to 19% in Tuvalu.¹² Variations also exist with respect to per capita health expenditure, ranging from US\$ 53 in Guinea-Bissau to US\$ 2824 in Singapore. In 2018, six SIDS spent less than US\$ 100 per capita (Guinea-Bissau, Papua New Guinea, Haiti, Comoros, Timor-Leste and Solomon Islands) while another six spent over US\$ 1000 per capita (Trinidad and Tobago, Barbados, Niue, Palau, Bahamas and Singapore).¹³ On average, out-of-pocket expenditure as a percentage of health expenditures in SIDS is 24.97%. This ranges from approximately 1% in Niue and Nauru to 75% in Comoros and Guinea-Bissau.¹³



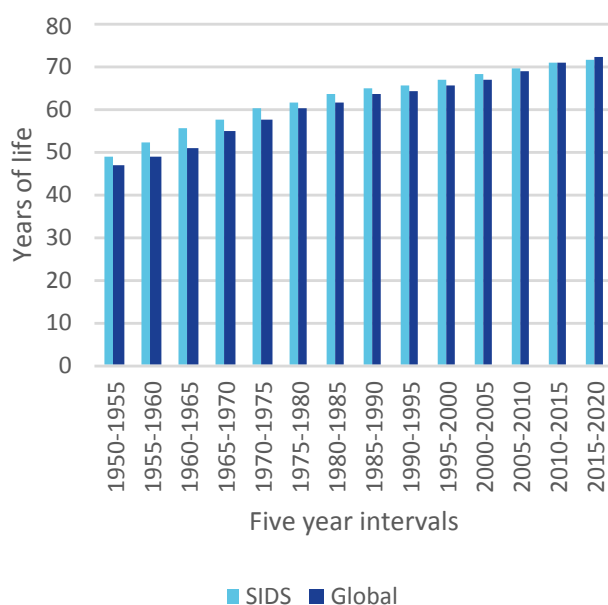
Health status

Life expectancy

Life expectancy at birth in SIDS is estimated to be 72.12 years (2015–20), which is in line with the global average of 72.60 years. While SIDS have common features, wide variations exist in health status and indicators. For example, life expectancy in SIDS ranges from 58 years in Guinea-Bissau to 83.1 years in Singapore (2018).²

Fig. 4 shows that there has been a steady improvement in life expectancy over the past seven decades, though it has been somewhat less impressive than in the rest of the world which started with a lower life expectancy than SIDS in the 1950s. Healthy life expectancy in SIDS in 2019 was approximately 87% of life expectancy, which is the same as the global standard.¹⁴

Fig. 4. Life expectancy at birth²



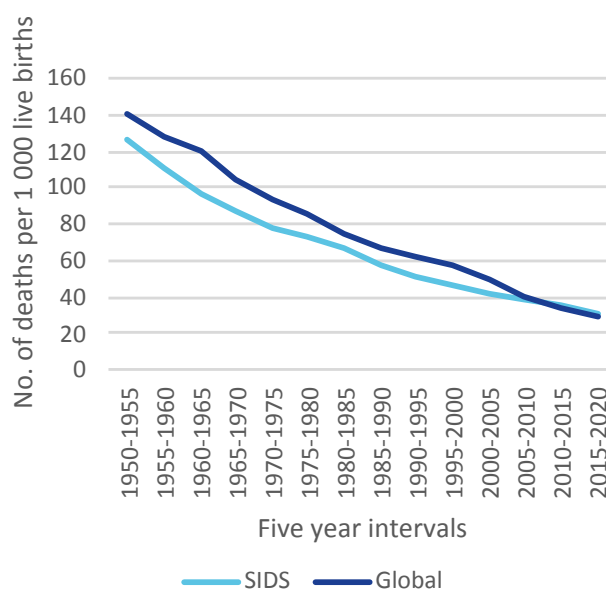
Maternal mortality, infant mortality and under-five mortality

The overall maternal mortality rate in SIDS (110.03 per 100 000 live births) is lower than the global rate (160.82 deaths per 100 000 live births). However, variations exist, ranging from 8 deaths per 100 000 live births in Singapore to over 200 deaths per 100 000 live births in Comoros, Haiti, and Guinea-Bissau.¹⁴

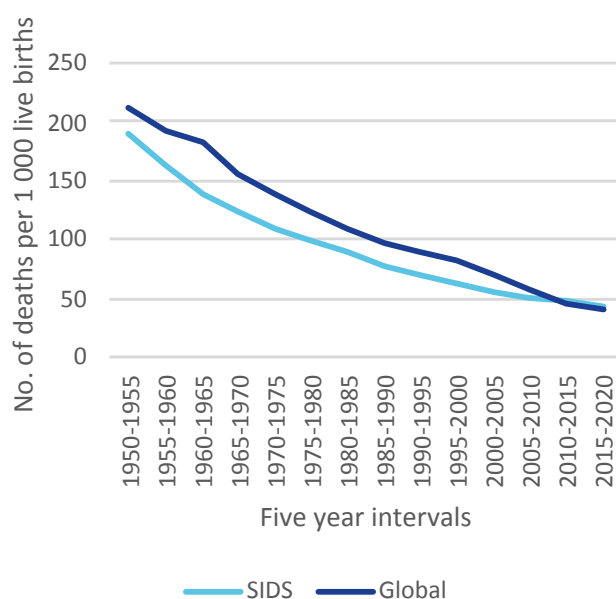
The infant mortality rate (IMR) in SIDS is 31.63 per 1000 live births in 2015-20, compared with the global average IMR of 29.26 per 1000 live births.² SIDS have seen a reduced IMR over the decades from 125.54 per 1000 live births in 1950–55 although this improvement falls short of the global decline in IMR which started at a higher level (139.6 per 1000 live births).

The under-five mortality rate shows a similar trend. It declined in SIDS from 188.90 per 1000 live births in 1950–55 to 42.33 per 1000 live births in 2015–20 compared with the global reduction from 212.75 to 39.86 per 1000 live births during the same period.²

Fig. 5. Infant mortality rate (per 1000 live births)²

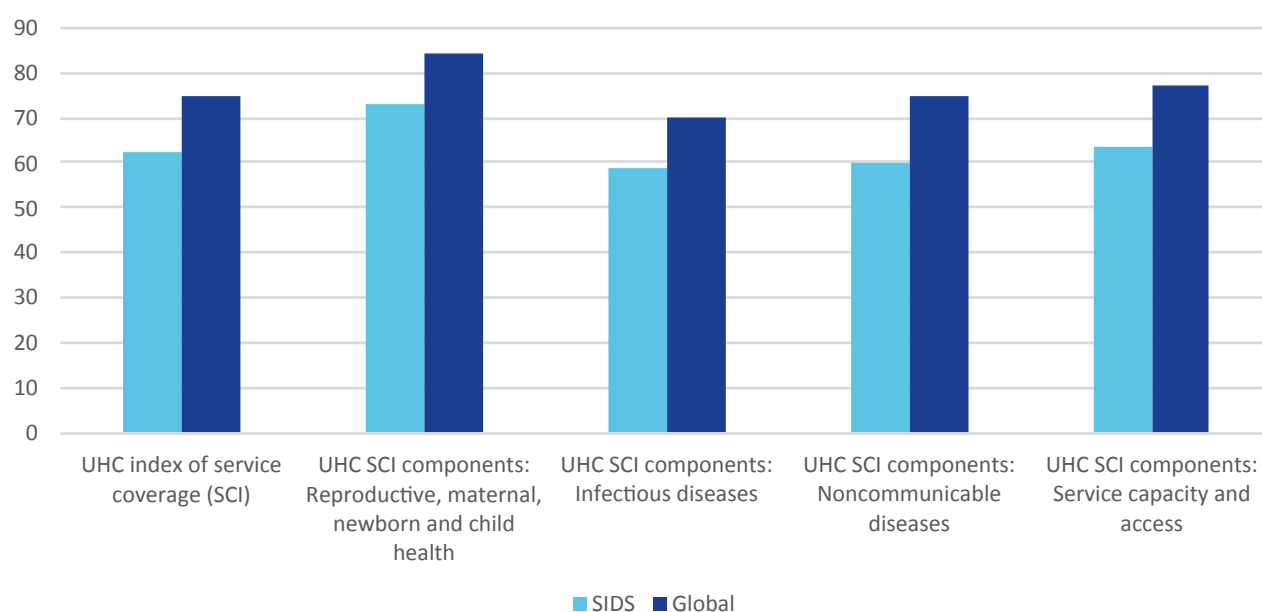


¹⁴ GHO. 2017 data on 32 SIDS.

Fig. 6. Under-five mortality rate (per 1000 live births)²

UHC service coverage

The achievement of Universal Health Coverage is central to GPW13 and the health-related targets of the SDGs. In 2017, the average UHC index of service coverage in SIDS—which uses tracer indicators relating to (1) reproductive, maternal, newborn and child health; (2) infectious diseases; (3) NCDs; and (4) service capacity and access—was 61.53 (out of 100), which is lower than the global average of 74.66 (Fig. 7).¹⁵ Of 32 SIDS with available data, eight had an index of 74 or above (Dominican Republic, Trinidad and Tobago, Bahamas, Bahrain, Barbados, Cuba, and Singapore). Seven SIDS had an index below 50 (Guinea-Bissau, Papua New Guinea, Kiribati, Federated States of Micronesia, Solomon Islands, Vanuatu and Haiti).¹⁵

Fig. 7. UHC service coverage index (SCI)¹⁵

¹⁵ GHO. 2017 data on 32 SIDS.



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NCDs in the Pacific SIDS

NCDs are behind 75% of all deaths in the Pacific, including much higher rates of premature (below age 60) deaths in many Pacific countries than the comparable global average. The top 10 countries with the highest overweight and obesity rates in the world are Pacific island countries and areas. This is due to the limited local availability of fruits and vegetables, high importing costs and the effects of climate change, and the comparably low cost of heavily processed, calorie-rich and nutrient-poor foods. In addition, three of the top ten worst rates of adult smoking in the world are found in the Pacific region.¹⁶

Risk factors and noncommunicable diseases (NCDs)

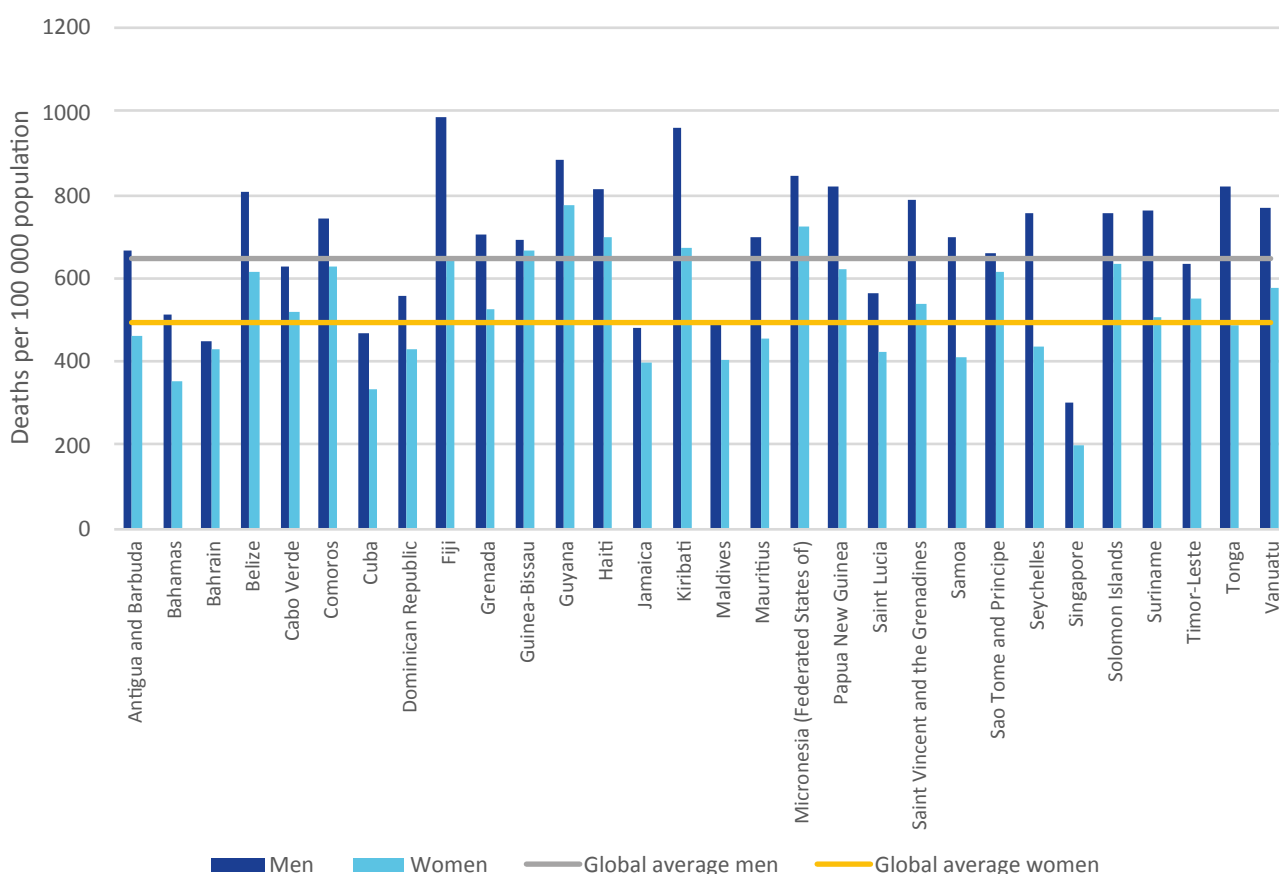
In 2014, heads of state and government, ministers and other relevant SIDS stakeholders launched the “Pacific NCD Partnership for a Multi-sector Approach to Prevent and Control”, and adopted the SIDS Accelerated Modalities of Action (SAMOA) Pathway¹⁶. The Samoa Pathway specifically emphasizes NCDs as a priority area for sustainable development in SIDS, with action needed to empower responses in SIDS worldwide.

Noncommunicable diseases represent an important health issue for SIDS. The average NCD mortality rate of SIDS (600.2 per 100 000 population) is higher than the global average (561.6 per 100 000 population), with higher average NCD mortality rates among men than women and variations from one country to the next (Fig. 8).¹⁷

The four main risk factors driving NCDs are tobacco use, harmful use of alcohol, physical inactivity and unhealthy diets.¹⁸

- The estimated prevalence of tobacco use is slightly higher in SIDS than globally (25% vs 22%), with a higher prevalence among men in SIDS (33%) than women (12%).¹⁹
- The prevalence of harmful consumption of alcohol is the same globally and in SIDS (3%), with a higher prevalence among men (5%) than women (1%).²⁰
- The average prevalence of insufficient physical activity is similar in SIDS (27%) and globally (28%), with slight differences among men (21% of men in SIDS vs 24% globally) and women (34% of women in SIDS vs 33% globally).²⁰
- Overall, the prevalence of obesity in SIDS (28%) is higher than globally (20%). This difference is more marked among women (23% globally vs 33% in SIDS) than among men (26% globally vs 32% in SIDS).²⁰

Fig. 8. Age-standardized NCD mortality rate (per 100 000 population)¹⁷



¹⁶ NCD Alliance. NCDs and SIDS, available at <https://ncdalliance.org/ncds-and-small-island-developing-states>, accessed on 19 March 2020.

¹⁷ GHO. 2016 data on 30 SIDS.

¹⁸ WHO Noncommunicable diseases, available at https://www.who.int/health-topics/noncommunicable-diseases#tab=tab_1, accessed on 19 March 2021.

¹⁹ GHO. 2018 data on 23 SIDS.

²⁰ GHO. 2016 data on 39 SIDS.



WHO country presence and country-level action on GPW13

WHO presence in SIDS countries is covered either through a dedicated WHO office, a multicountry WHO office (WHO office in a neighbouring country) or by a respective WHO regional office.

African Region

- Cabo Verde, Comoros, Guinea-Bissau, Mauritius, Sao Tomé and Príncipe, and Seychelles have their dedicated WHO country offices.

Region of the Americas

- Anguilla, Antigua and Barbuda, Barbados, British Virgin Islands, Dominica, French Guyana, Grenada, Guadeloupe, Martinique, Montserrat, Saint Kitts and Nevis, Saint Lucia, and Saint Vincent and the Grenadines are covered by the **WHO Office of Eastern Caribbean Countries in Barbados**, which oversees technical cooperation with the largest number of SIDS in the region.²¹
- Bahamas and Turk and Caicos Islands are covered by the **WHO office in Bahamas**.
- Bermuda, Cayman Islands and Jamaica are covered by the **WHO office in Jamaica**.
- Aruba, Curacao, Sint Martin, and Trinidad and Tobago are covered by the **WHO office in Trinidad and Tobago**.
- Belize, Cuba, Dominican Republic, Guyana, Haiti and Suriname have their dedicated WHO country offices.
- Puerto Rico is directly covered by the Regional Office.

Eastern Mediterranean Region

- Bahrain was directly covered by the Regional Office.²²

South-East Asia Region

- Maldives and Timor-Leste have their dedicated WHO country offices.

Western Pacific Region²³

- Fiji, French Polynesia, Nauru, New Caledonia, the Commonwealth of the Northern Mariana Islands, and Tuvalu are covered by the **WHO Office in the South Pacific (located in Fiji)**.
- American Samoa, Cook Islands, Niue and Samoa are covered by the **WHO Office in Samoa**.
- Singapore is covered by the **WHO Office in Malaysia**.
- Marshall Islands, Federated States of Micronesia and Palau are covered by the **WHO Country Liaison Office in the Federated States of Micronesia**.
- Kiribati, Papua New Guinea, Tonga, Solomon Islands and Vanuatu have their dedicated WHO country (or country liaison) offices.
- Guam is directly covered by the Regional Office.

²¹ The PAHO/WHO Representative in Barbados is responsible for general administration of these SIDS. Each independent state of the Eastern Caribbean also has an office with a Country Programme Specialist who manages country-level work.

²² A process to establish a WHO country office in Bahrain was initiated in 2020.

²³ Some offices in the Western Pacific cover territories and areas that are not part of the list of Small Island Developing States (Annex 1).



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Subregional support in the Caribbean and Pacific islands

PAHO/WHO Subregional Program for the Caribbean

The Region of the Americas counts with the PAHO/WHO Subregional Program for the Caribbean, which works with major subregional political integration entities and institutions such as the Caribbean integration mechanism CARICOM, the University of the West Indies, and the Caribbean Development Bank. Through this programme, PAHO/WHO provides technical cooperation and political inputs in the health sector and areas related to the social determinants of health, thus helping to achieve the national health development objectives of PAHO/WHO and its Member States.

Division of Pacific Technical Support

The WHO Western Pacific Regional Office established the Division of Pacific Technical Support (DPS) in Fiji in 2010 to coordinate and provide timely, tailored support and backstopping to 21 Pacific island countries and areas. The Division also includes six other WHO offices in the Pacific: country offices in Samoa and the Solomon Islands and country liaison offices in Kiribati, the Federated States of Micronesia, Tonga and Vanuatu.



WHO human resources in SIDS

As of 31 August 2020, there were a total of 310 WHO staff members across the 27 WHO country offices in SIDS, representing 7% of all WHO staff at the country level.²⁴ On average, country offices in SIDS are smaller than those in non-SIDS (11 staff per WHO country office vs 31 staff per WHO country office). While half of all WHO country offices in SIDS had less than 10 staff, this was the case for only one quarter of non-SIDS offices. The percentage of women staff in WHO country offices in SIDS is significantly higher (58%) than that in non-SIDS offices (37%).

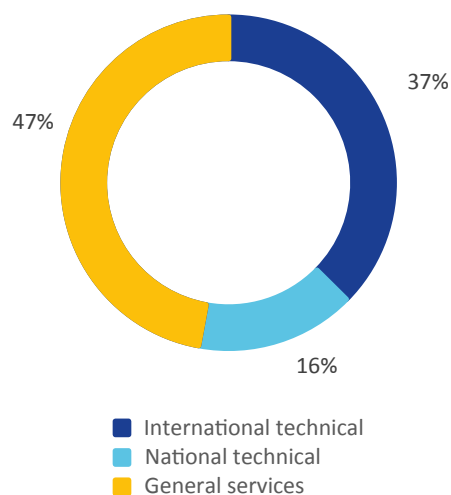
International professional (IP) staff in SIDS accounted for 13% of the overall international staff across all 149 WHO country offices and national professional officer (NPO) staff in SIDS made up 4% of the national technical staff across all country offices.

Of the 310 staff working in SIDS, over one third (37%) were international professional, less than one fifth (16%) were national professional office, and 47% were general services staff (Fig. 9). The distribution of IP and NPOs in SIDS differs from the global distribution of international (22%) and national (32%) technical staff in all WHO country offices. Across the board (in WHO country offices in SIDS and non-SIDS alike), general services staff comprise 47% of all staff in country offices.

Over 40% of technical staff in SIDS worked on healthier populations and UHC (compared to 33% of staff in non-SIDS), reflecting health priorities in SIDS. In addition, there were 397 technical non-staff working in SIDS WHO country offices, with almost half (49%) dedicated to healthier population and UHC and close to one third (31%) to the COVID-19 response.

WHO country offices across SIDS strengthen their technical capacity by working with non-staff, including full-time special service agreement non-staff, full-time consultants, UN volunteers, secondments from the Ministry of Health (or other governmental agencies), UN agencies or other intuitions, as well as interns. In addition to having staff and non-staff at the country level, WHO country offices also receive backstopping from WHO regional and subregional offices²⁵.

Fig. 9. Distribution of staff in SIDS with WHO Country Offices



²⁴ Information from here onwards is taken from the survey of the WHO presence in countries, territories and areas: 2021 report. The report is available at <https://apps.who.int/iris/handle/10665/341308>, accessed on 18 May 2021.

²⁵ In this document, where backstopping by WHO regional offices is mentioned, this also includes subregional offices.

S

Sustainable Development Goals

WHO country offices play an important role in supporting Member States to implement GPW13 and the health-related SDGs.

44% of WHO country offices

in SIDS reported playing a **lead role** in national mechanisms for the implementation of health-related SDGs and 40% reported being partners.

52% of WHO country offices

in SIDS played a **partner role** in national mechanisms for monitoring health-related SDGs, with 30% playing a lead role.

41% of WHO country offices

were **contributors** to the annual voluntary review at the UN High-Level Political Forum and 36% reported playing a partner role.



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Addressing health emergencies

One of the main pillars of the GPW13 is addressing health emergencies. In view of the predominance of the COVID-19 pandemic in 2020, the response to that emergency is presented separately first.

COVID-19 pandemic

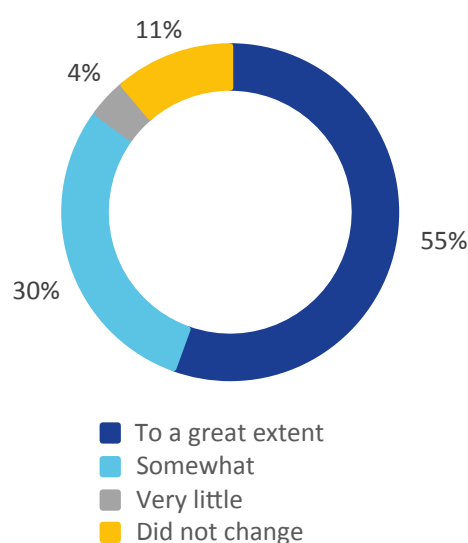
The geographic remoteness of many SIDS influenced how the COVID-19 pandemic impacted the country. Border closures restricting the deployment of international technical assistance and impacting the distribution of supplies, low resource availability, limited human resource capacity as well as geographic challenges for surveillance in archipelagos or hard-to-reach areas were some of the challenges faced by SIDS and WHO country offices during the COVID-19 pandemic. Other factors were crucial in rising to these challenges and providing support to SIDS: WHO country offices' strong relationships with their national counterparts, rapid technical and financial support received from WHO regional offices and headquarters, repurposing of human resources in WHO country offices and being able to leverage existing national infrastructure for infectious diseases.

Role of WHO in coordination mechanisms

Most WHO country offices in SIDS played a lead role in supporting Member States in their response to the COVID-19 pandemic.

- **85%** of WHO country offices in SIDS experienced an increase in their UNCT coordination role somewhat or to a great extent (Fig. 10).²⁶
- **78%** of WHO country offices in SIDS played a lead role in 2020 Strategic Preparedness and Response Plan coordination versus 82% of WHO country offices in non-SIDS.
- **67%** of WHO country offices in SIDS played a lead role in UN framework for the immediate socio-economic response to COVID-19 "Health First" pillar coordination versus 59% of WHO country offices in non-SIDS.
- **54%** of WHO country offices in SIDS played a lead role in the health donors' coordination mechanisms versus 61% of WHO country offices in non-SIDS.

Fig. 10. Increase of WHO country offices' UNCT coordination role in SIDS in the context of COVID-19



COVID-19 response capacity

WHO country offices spared no effort in responding to the unprecedented challenges posed by the COVID-19 pandemic. Although WHO country offices in SIDS were not able to deploy a comparable level of human resources as WHO country offices in non-SIDS, similar percentages of country-level staff were working on the COVID-19 response on 31 August 2020.

Repurposing and recruitment

- WHO country offices in SIDS **repurposed a larger proportion of their international technical staff²⁷ (70%) and a smaller percentage of national technical staff²⁸ (40%)** than WHO country offices in non-SIDS (56% and 55% respectively). This indicates the important role played by international staff, especially in relation to the human resources shortages commonly seen in SIDS (Fig. 11). The same proportion of general services staff was repurposed in WHO country offices in SIDS and non-SIDS.

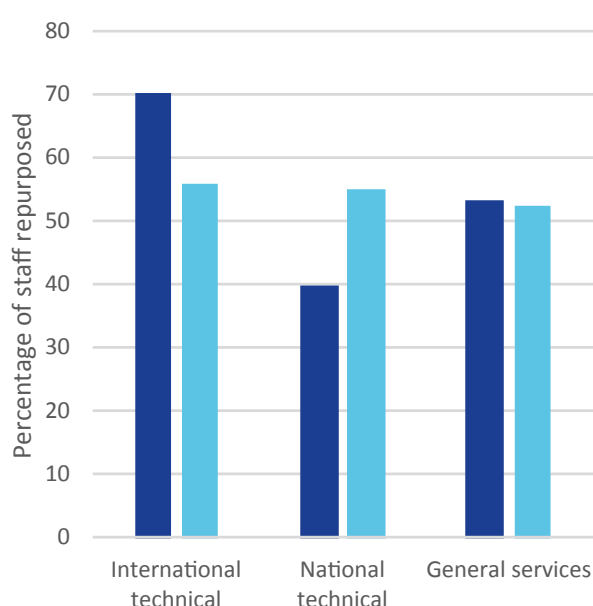
²⁶ Of the 27 WHO country offices working with SIDS, 19 are in countries, territories and areas with a single-country UNRC office, and eight in countries covered by a neighbouring multicountry UNRC office.

²⁷ Also referred to as international professional staff.

²⁸ Also referred to as national professional officers.

- **Over 40% of non-staff in SIDS were also repurposed** to COVID-19.
- While WHO country offices reported expressly on the percentage of staff repurposed from their planned area of work to deal with COVID-19, it is important to note that in 2020 **the pandemic affected all of WHO's areas of work**, with programmes having to adjust to the new socioeconomic contexts resulting from the pandemic response.
- Of the 59 staff recruited for COVID-19²⁹ across all WHO country offices, only one staff member was recruited in a WHO country office in a SIDS (Vanuatu).
- WHO country offices in SIDS reported recruiting 144 non-staff for COVID-19. On average, this represents 5.3 non-staff per office, although this number ranged from 0 recruits in nine country offices to over 20 non-staff recruits in two country offices (Haiti and South Pacific). Approximately half of WHO country offices in SIDS recruited less than two new non-staff.

Fig. 11. Average percentage of staff repurposed for COVID-19 in WHO country offices

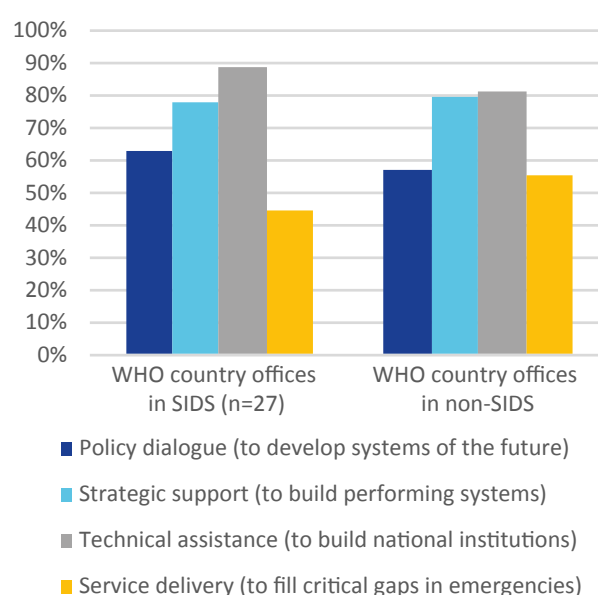


²⁹ As of 31 August 2020.

Backstopping

- Fig. 12. shows that most COVID-19 backstopping support received by WHO country offices in SIDS from WHO regional offices or subregional offices was for technical assistance, strategic support, and policy dialogue. A larger percentage of WHO country offices in SIDS than those in non-SIDS received backstopping for technical assistance. A larger percentage of WHO country offices in non-SIDS (56%) than in SIDS (44%) received backstopping for service delivery.
- Just over a quarter (26%) of WHO country offices in SIDS received backstopping from WHO headquarters for policy dialogue compared to 32% of WHO country offices in non-SIDS. Over one third (37%) of WHO country offices in SIDS received backstopping from WHO headquarters on strategic support and technical assistance (48%). This is a smaller proportion than for WHO country offices in non-SIDS (46% and 61%, respectively). For service delivery, 15% of WHO country offices in SIDS and 30% of WHO country offices in non-SIDS received backstopping from WHO headquarters.

Fig. 12. Distribution of COVID-19 backstopping received from WHO regional or subregional offices



Health emergencies

WHO country offices in SIDS reported far fewer non-COVID health emergencies (2.3 per WHO country office) compared with non-SIDS (11.8).³⁰ A comparison of the types of non-COVID-19 emergencies shows that disease outbreaks constituted the greatest proportion (56%) of non-COVID-19 emergencies in SIDS, whereas natural disasters were most common in non-SIDS (36% floods, 35% other causes). However, discounting data from one outlier country³¹ shifted the distribution of health emergencies in non-SIDS, with disease outbreaks/epidemics becoming the most common reason (41%). WHO country offices in SIDS reported zero (0%) conflict/humanitarian crises, compared to 104 (17%) by WHO country offices in non-SIDS.

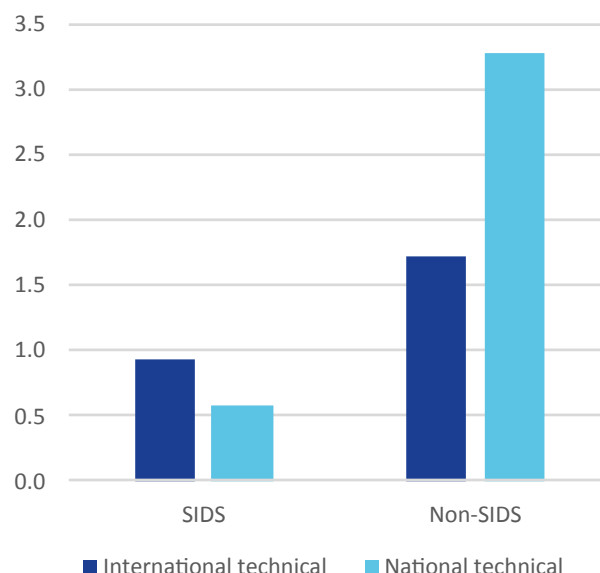
Capacity for health emergencies

WHO country offices in SIDS reported a lower level of deployment of health emergencies staff than those in non-SIDS. In terms of relative allocation of human resources, WHO country offices in SIDS have assigned 25% of their technical staff and technical non-staff to health emergencies compared with 30% of technical staff and 31% of technical non-staff in WHO country offices in non-SIDS.

Staff

- The equivalent of 40 full-time technical WHO country office staff were deployed in SIDS for health emergencies.³² This is equivalent to **25% of all technical staff in SIDS** and is equivalent to an average of 1.5 full-time technical staff per WHO country office.
- In comparison, there were 609 full-time technical staff in WHO country offices in non-SIDS working on health emergencies,³³ representing approximately 30% of total technical staff in non-SIDS. On average, this is equivalent to 5.0 full-time staff per WHO country office (Fig. 13).
- Most technical health emergencies work was done by international technical staff (62%) in SIDS, compared with only one third (34%) in non-SIDS.

Fig. 13. Average number of WHO technical staff working on health emergencies per country office



Non-staff

- As of 31 August 2020, WHO country offices in SIDS had an equivalent of 144 technical non-staff working on health emergencies (of which 124 focused on COVID-19) or **25% of all technical non-staff in SIDS**. On average, this is equivalent to approximately 5 full-time technical non-staff per WHO country office working on health emergencies.
- In comparison, there were 2161 health emergencies technical non-staff in the WHO country offices in non-SIDS (of which 1631 focused on COVID-19),³⁴ which represents 31% of all technical non-staff in SIDS. On average, this is equivalent to just over 18 full-time non-staff per WHO country office.

³⁰ When discounting a strong outlier among non-SIDS countries, the average number of health emergencies per WHO country office is 4.9

³¹ Calculated after excluding one WHO country office reporting a disproportionate number of natural disasters.

³² This excludes work and capacity on polio health emergencies, which do not occur in SIDS.

³³ This excludes an additional 372 full-time staff equivalent working in polio in WHO country offices in non-SIDS.

³⁴ This excludes an additional 1405 full-time technical non-staff equivalent working in polio in WHO country offices in non-SIDS.

Decentralized health emergencies support in the Caribbean and Pacific Islands

PAHO/WHO counts with a decentralized unit of the PAHO Emergency Team based in Barbados to act as a quick response team to provide support if any disasters that take place in the Caribbean.

The WPRO Division of Pacific Technical Support, a subregional office located in Fiji, has a health emergency team to support all the Pacific Island countries, with a Pacific Health Cluster coordinator working closely with the UN Pacific Humanitarian Team.



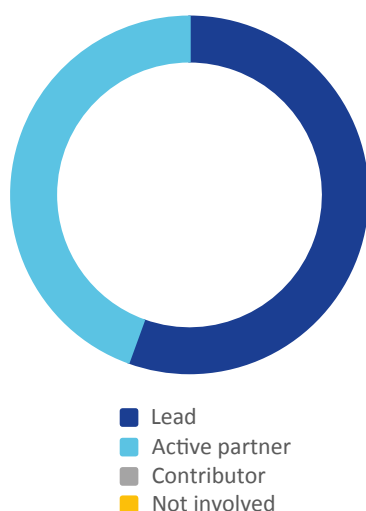
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Achieving universal health coverage (UHC)

Universal health coverage (UHC) is the first strategic priority of GPW13. Achieving UHC poses challenges in many SIDS which are short of medicines, health workers and health facilities, and where the small population size fails to allow economies of scale. Analyses of publicly accessible data for 14 SIDS, covering health-related travel and health indicators for the period 2003–13,³⁵ showed that these SIDS generally lacked health infrastructure and technologies, and that most had less than the recommended number of physicians per population, thus limiting their capacity to achieve UHC. As a result, some SIDS such as Tuvalu, Maldives and Seychelles have adopted innovative approaches to progress towards achieving UHC,³⁶ providing overseas medical treatment schemes as a measure to increase access to health services that are not locally available.

Fig.14 Main role played by WHO in the initiation, development, implementation, monitoring and review of the national health plan



WHO coverage and role in achieving UHC

Besides being one of the key pillars of WHO's GPW13, achieving UHC is an important part of the SDGs. As such, WHO prioritizes support to Member States in making progress towards UHC. A special initiative in this regard is the UHC Partnership (UHC-P), which supports 115 countries financially and technically. Of the 58 countries in the SIDS group, 33 (57%) are part of the UHC-P.

All WHO country offices in SIDS were involved in the initiation, development, implementation, monitoring and review of the national health plan, either taking on a lead role (56%)—co-chair with MOH, other health leadership role or main technical partner—or acting as active partner (44%). In addition to enhancing national capacity for effective policy analysis, formulation and implementation, they helped to improve national health governance through sustained, inclusive and effective health sector policy dialogue. WHO has also supported country offices in SIDS to help them address key obstacles such as procuring medicines and supplies through pooled procurement, given the disproportionate costs of purchasing supplies in the small quantities required per country, territory, and area.

Capacity for UHC

Considerable resources are deployed by WHO country offices in supporting Member States in their efforts towards achieving UHC. WHO country offices in SIDS and non-SIDS alike allocated approximately one fifth (21%–22%) of their technical staff to UHC issues. WHO country offices in SIDS, however, allocated a larger proportion of their technical non-staff to UHC (23%) than offices in non-SIDS (14%).

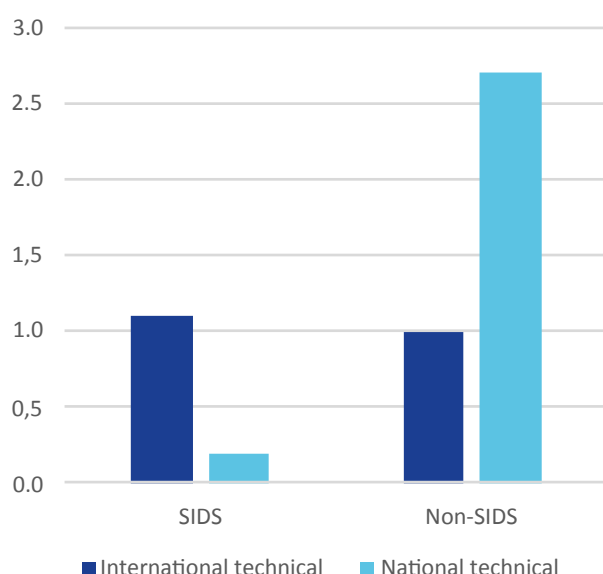
³⁵ Suzana M, Walls H, Smith R et al. Achieving universal health coverage in small island states: could importing health services provide a solution? *BMJ Global Health* 2018;3:e000612.

³⁶ World Bank. Who Needs Big Health Sector Reforms Anyway? Seychelles' Road to UHC Provides Lessons for Sub-Saharan Africa and Island Nations. <https://documents.worldbank.org/en/publication/documents-reports/documentdetail/971671550219065057/who-needs-big-health-sector-reforms-anyway-seychelles-road-to-uhc-provides-lessons-for-sub-saharan-africa-and-island-nations>, accessed on 7 April 2021.

Staff

- As of 31 August 2020, the equivalent of 35 full-time technical staff were working on UHC in WHO country offices in SIDS, representing **21% of the total technical staff in SIDS**. This is equivalent to an average of 1.3 full-time staff per WHO country office.
- In WHO country offices in non-SIDS, 455 full-time staff were working on UHC, representing 22% of all WHO country office technical staff in non-SIDS. This is equivalent to an average of 3.7 full-time technical staff per WHO country office.
- On average, there were more national technical staff working on UHC per WHO country office in non-SIDS than in SIDS (Fig. 15). This may reflect the impact of the low SIDS populations on nationally available human resources, and WHO's efforts to strengthen international cooperation to mitigate that constraint in these countries.
- Given that WHO country offices in SIDS are smaller on average than those in non-SIDS, international technical staff accounted for 81% of technical staff working on UHC in WHO country offices in SIDS versus 27% in WHO country offices in non-SIDS.

Fig. 15. Average number of WHO technical staff working on UHC per country office



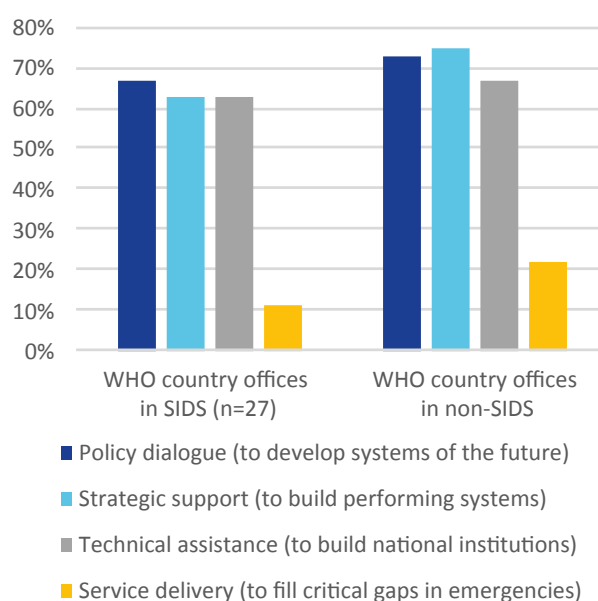
Non-staff

- As of 31 August 2020, WHO country offices in SIDS had 90 full-time non-staff working on UHC. This is equivalent to an average of just over 3 full-time non-staff per WHO country office or **23% of all technical non-staff in SIDS**.
- In comparison, there were 657 non-staff across the other country offices. On average, this is just over 5 full-time non-staff per WHO country office or 14% of all technical non-staff in non-SIDS.

Backstopping

- Fig. 16. shows that over 60% of WHO country offices in SIDS received UHC backstopping from WHO regional offices on policy dialogue to develop systems for the future, strategic support to build up performing systems and technical assistance to build up national systems. This proportion is smaller than for WHO country offices in non-SIDS.
- Over one third (37%) of WHO country offices in SIDS received backstopping from WHO headquarters on policy dialogue, while 26% received strategic support backstopping and 19% received technical assistance. These percentages are lower than for WHO country offices in non-SIDS (39%, 43% and 36%, respectively).

Fig. 16. Distribution of UHC backstopping received from WHO regional or subregional offices



Promoting healthier populations

Another strategic priority of GPW13 is promoting healthier populations by addressing the social, environmental and commercial determinants of health through multisectoral cooperation to improve human behavioural and lifestyle factors. The impact of climate change is of relevance to SIDS; by extension, therefore, the health impact of climate change turns out to be a critical focus of attention under healthier populations. This factor is even more significant in SIDS where NCDs are growing in importance.

As SIDS become increasingly integrated into the global economy and culture, SIDS populations are threatened by many of the same health concerns facing the rest of the world.³⁷ Noncommunicable diseases including diabetes, obesity, and heart disease affect SIDS as they adopt unhealthy dietary habits and nutrition choices that put them at risk of these conditions. In addition, violence, road safety, natural disasters and exposure to respiratory diseases due to environmental pollution are on the rise in SIDS.³⁷ The health care infrastructure in many SIDS, including preventive health care, is not always adequate to meet these challenges.³⁷ In terms of policy implications, SIDS can explore regional cooperation and share expertise and best practices in order to address these new health care challenges. Traditional and indigenous knowledge can be integrated into forthcoming responses.³⁷

Working towards healthier populations

WHO country offices in SIDS have placed great emphasis on multisectoral actions with a view to promoting healthier populations.

- 24 WHO country offices (88%) in SIDS reported working with the education sector to promote healthy lifestyles, nutrition, physical activity, mental health and prevent NCDs. In comparison, only 72% of WHO country offices in non-SIDS reported working with the education sector, with less focus on healthy lifestyles.
- Of 27 WHO country offices in SIDS, 23 (85%) reported working with the environment/water and

sanitation/climate change sector and 22 (81%) with the agriculture sector on matters such as climate change, AMR, One Health, food safety and nutrition. In comparison, 81% of WHO country offices in non-SIDS collaborated with the environment/water and sanitation/climate change sector and 59% with the agriculture sector.

- 19 WHO country offices (70%) in SIDS worked with the social protection/welfare sector to protect and promote the health of persons with disability, prevent violence (gender-based, domestic), and promote healthy ageing, among other actions.

Capacity for healthier populations

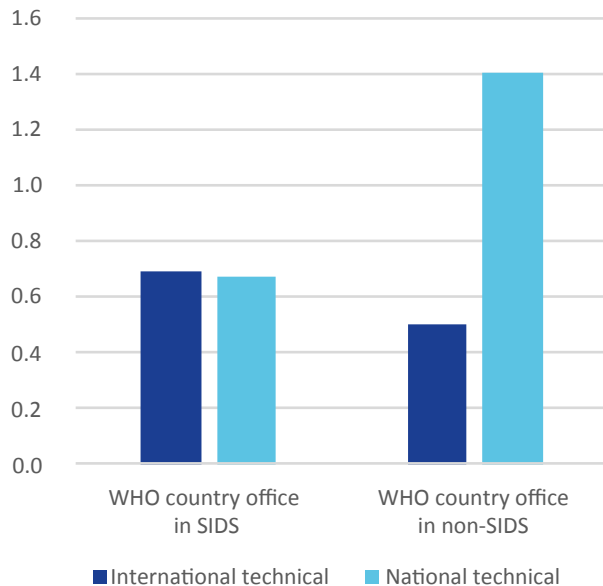
In terms of their relative allocation of human resources, WHO country offices in SIDS have assigned a larger percentage of their total technical staff and technical non-staff to healthier populations compared to WHO country offices in non-SIDS.

Staff

- As of 31 August 2020, 36 full-time staff were working on healthier populations in WHO country offices in SIDS, representing **22% of the total technical staff in SIDS**. On average, this is equivalent to 1.4 full-time staff per WHO country office in SIDS.
- In non-SIDS, 225 full-time staff were working on healthier populations, representing 11% of all WHO country office technical staff. On average, this is equivalent to 1.8 full-time staff per WHO country office in SIDS (Fig. 17).
- In WHO country offices in SIDS, most healthier populations work was covered by international technical staff (51%), whereas international technical staff only represented 26% of staff working on healthier populations in WHO country offices in non-SIDS.

³⁷ UNEP 2014. Emerging issues for Small Island Developing States. Results of the UNEP/UN DESA Foresight Process. United Nations Environment Programme (UNEP), Nairobi, Kenya.

Fig. 17. Average WHO technical staff working on healthier populations per country office



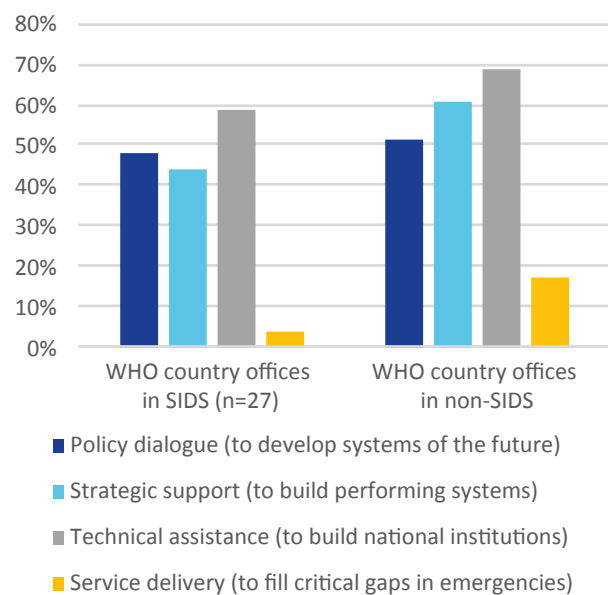
Non-staff

- WHO country offices in SIDS deployed 103 full-time technical non-staff on healthier populations (26% of all technical non-staff in SIDS). This is equivalent to an average of 3.8 full-time non-staff per WHO country office.
- In comparison, WHO country offices in non-SIDS deployed 343 full-time technical non-staff (7% of all technical non-staff). This is equivalent to an average of 2.8 full-time non-staff per WHO country office.

Backstopping

- WHO country offices in SIDS obtained backstopping support from WHO regional offices as well as from WHO headquarters, though in a smaller proportion compared with WHO country offices in non-SIDS (Fig. 16).
- The highest demand for regional or subregional backstopping from WHO country offices in SIDS was for technical assistance to build up national institutions (59%), followed by policy dialogue to develop systems for the future (48%) and strategic support to develop performing systems (44%) (Fig. 18). Less than 30% of WHO country offices in SIDS received backstopping support for healthier populations from WHO headquarters.

Fig. 18. Distribution of backstopping for healthier populations received from WHO regional or subregional office





Data And delivery for impact

Measuring and delivery for impact in countries

To measure progress on the advancement of GPW13, timely, reliable, and actionable data is essential. Four SIDS (Mauritius, Maldives, Timor-Leste and Vanuatu) are pilot countries in the GPW13 Impact Framework which aims to track progress and solve problems while learning and sharing best practices.

Most WHO country offices in SIDS reported that they had identified the key interventions making the greatest impact and largest contribution to the GPW13 Triple Billion targets based on their Country Support Plans (CSPs) or equivalent (96%).³⁸ Of these, 80% reported having a data system in place to routinely review progress made with these interventions, compared to 71% of WHO country offices in non-SIDS.

Data and delivery for impact capacity

As a cross-cutting area of work, data analysis, monitoring and innovation is partly covered by staff generally focused on a different strategic priority. In WHO country offices in both SIDS and non-SIDS, data and delivery for impact has the smallest proportion of technical staff allocated to this topic.

Staff

- As of 31 August 2020, there were 4 full-time technical staff working on data analysis, monitoring and innovation in all WHO country offices in SIDS, representing **2% of all technical staff in SIDs**. On average, this is equivalent to 0.1 full-time technical staff per WHO country office in SIDS (10% of one full-time staff time).
- In comparison, 96 full-time technical staff were working on this area in WHO country offices in non-SIDS, or 5% of all WHO country office technical staff in non-SIDS. On average, this is equivalent to 0.8 full-time technical staff per WHO country office in non-SIDS (80% of full-time staff time).
- Of the available capacity for this area of work, 88% was provided by international technical staff in WHO country offices in SIDS versus 24% in WHO country offices in non-SIDS.

Non-staff

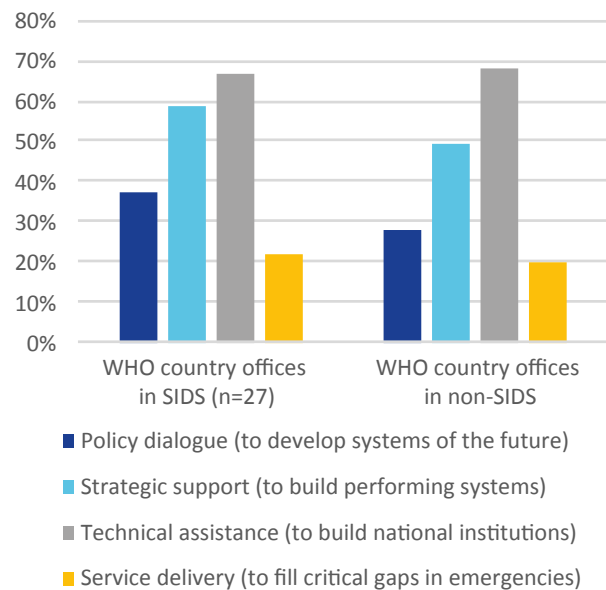
- WHO country offices in SIDS had 26 full-time technical non-staff working on data analysis, monitoring and innovation (7% of all technical non-staff in SIDS), which is equivalent to an average of 1.0 full-time non-staff per WHO country office.
- In comparison, WHO country offices in non-SIDS had 112 full-time technical non-staff working on this topic (2% of all their technical non-staff). This is equivalent to an average of 0.9 full-time non-staff per WHO country office.

³⁸ Such as Biennial Work Plans (BWP), Biennial Collaborative Agreement (BCA).

Backstopping

- Similar proportions of WHO country offices in SIDS and non-SIDS received backstopping from the WHO regional or subregional offices for data analysis, monitoring and innovation (Fig. 19). The most common area of backstopping was for technical assistance to build up institutions (67% in SIDS) and strategic support to develop performing system (59% in SIDS).

Fig. 19. Distribution of data analysis, monitoring and innovation backstopping received from WHO Regional Office





WHO internal enabling functions

Facilities of the WHO country offices

The most common location of WHO offices in SIDS are Ministry of Health or national agency premises (44%), unlike WHO country offices in non-SIDS which are primarily housed in independent sites rented by WHO. Only 11% of WHO country offices in SIDS used UN common premises (compared to 20% of WHO country offices in non-SIDS) largely because, in many SIDS, WHO may be the only—or one of few—UN resident agencies.

A quarter of all WHO country office premises in both SIDS and non-SIDS countries were accessible on all floors with adapted bathrooms. However, while other country offices were partially accessible, 26% of premises in WHO country offices in SIDS were not accessible, with 11% planning to increase access in the near future.

Only a third of WHO country office premises in SIDS reported having breastfeeding facilities whereas 69% of WHO country offices in non-SIDS already have such facilities.

Finances

WHO country offices in SIDS received 80% of funding for their planned costs, which follows the trend in all WHO country offices. Over a quarter of funding (27%) derived from WHO's flexible funds, which is three times higher than in WHO country offices in non-SIDS. Most funding was allocated to programmes on outbreaks and crisis response, including COVID-19 (39%), UHC (30%) and a more effective and efficient WHO (18%). The lowest amount of funds was allocated to activities for a healthier population (4%) which also had the lowest proportion of its planned costs funded. This trend follows the allocation of resources across all WHO country offices in both SIDS and non-SIDS.

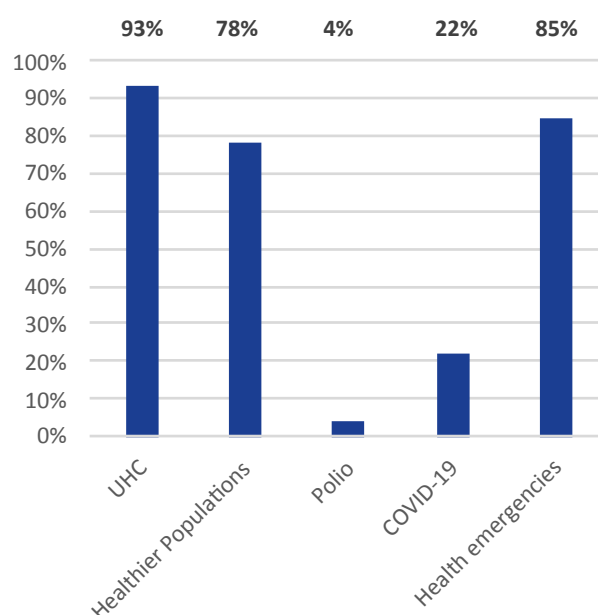
Country strategic and operating processes

Of all WHO country offices in SIDS, 22 (81%) reported having a valid Country Cooperation Strategy (CCS), two having a CCS under development and three not having any at all. The most common functions (81%) of the CCS

in WHO country offices in SIDS are for advocacy with other sectors, donors and stakeholders; aligning WHO financial and human resources to country priorities; and briefing new Ministry of Health authorities.

Almost all WHO country offices in SIDS were involved in supporting the development, implementation or monitoring health-related matters of the United Nations Sustainable Development Cooperation Framework/ United Nations Development Assistance Framework (UNSDCF/UNDAF), either as lead (48%) or partner (44%). Most WHO country offices in SIDS reported that UHC, health emergencies and healthier populations were integrated in the UNSDCF/UNDAF (Fig. 20). Close to three quarters (74%) of WHO country offices in SIDS reported that health is integrated at the outcome level of the UNSDCF/UNDAF and 67% reported it at the output level.

Fig. 20. Percentage of WHO country offices in SIDS WHO country offices that reported integration of GPW13 priorities in UNSDCF/UNDAF or equivalent



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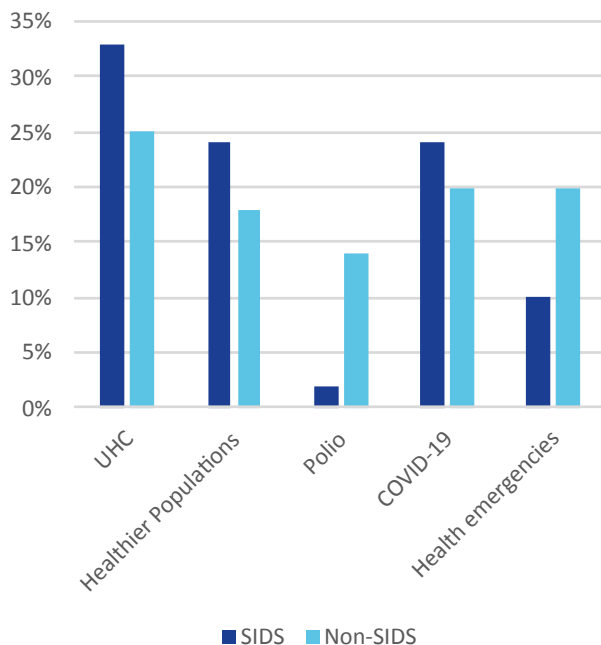
Partnerships

National partnerships and collaborations

Approximately three fifths of WHO country offices in SIDS reported collaborating with local NGOs (81%) and with academic institutions (78%) on GPW13 strategic priorities.

A little over half (55%) of WHO country offices in SIDS reported working with WHO collaborating centres on matters such as NCD prevention, addressing environmental health, support for infectious diseases and strengthening research, communications and epidemiology capacities.

Fig. 21. Percentage of WHO country offices that worked on South-South Triangular Cooperation (SSTC) initiatives for GPW13 priorities



International development partners

Four SIDS (Haiti, Jamaica, Papua New Guinea and Timor-Leste) are implementing the Stronger Collaboration, Better Health: The Global Action Plan for Healthy Lives and Well-being for All (GAP).

A larger percentage of WHO country offices in SIDS (74%) than in non-SIDS (65%) reported participating in Joint UN programmes. Similarly, a larger proportion (59%) of WHO country offices in SIDS reported participating in South-South Triangular Cooperation (SSTC) initiatives than in non-SIDS (49%). Of the 43 SSTC initiatives supported by WHO country offices in SIDS, two thirds focused on UHC and close to one quarter (24%) on healthier populations and COVID-19, respectively (Fig. 21).

With respect to bilateral and multilateral partners, a greater proportion of WHO country offices in SIDS reported collaborating on UHC and COVID-19 with different partners like the European Union, World Bank Group, other inter-governmental institutions, international financing agencies, bilateral partners and philanthropic foundations versus WHO country offices in non-SIDS. However, the reverse pattern was observed for healthier populations, polio and the other emergencies.

Approximately 85% of WHO country offices (in SIDS and non-SIDS) reported having mobilized resources from partners. The larger portion (33%) of WHO country offices in SIDS mobilized less than US\$ 1 million, followed by 22% mobilizing between US\$ 1 and US\$ 5 million and 19% between US\$ 6 and US\$ 10 million (Fig. 22).

Of the 10 SIDS that engaged with Gavi, the Vaccine Alliance, most WHO country offices were involved with proposal development (80%), supported with monitoring and evaluation (70%), advised on or supported preparation of a proposal for repurposing funding to COVID-19 (70%) or were members of the ICC and/or HSCC (60%). Of these, 80% are subrecipients. Gavi funds supported vaccines and immunization programmes in all (100%) eligible countries as well as programmes for health systems strengthening in most countries (70%).

Of the 19 WHO country offices that support SIDS with the Global Fund to Fight AIDS, Tuberculosis and Malaria (the Global Fund), most supported proposal development (84%), acted as Members of the Country Coordination Mechanism (CCM) (74%), advised on or supported preparation of a proposal for repurposing funding to COVID-19 (68%) or supported with monitoring and evaluation (63%). Of those, all (100%) reported that Global Fund backing was used for HIV/AIDS programmes, and most reported that the funds supported programmes for tuberculosis (74%) and malaria (58%).

T

The way forward

Despite variations in terms of economic development and health indicators, SIDS as a group face unique challenges related to combating climate change and its influence on natural disasters, preventing noncommunicable diseases and continuing to exist with weak health systems. WHO provides technical support to SIDS through its country offices, subregional offices and regional offices to address these challenges. Concerted efforts to continue supporting SIDS through technical cooperation adapted to their specific needs will be crucial in ensuring that the health benefits reaped from progress in global health are seen in SIDS.

This informational document was developed in preparation for the Small Island Developing States Summit for Health (28–29 June 2021) using data from the WHO Global Health Observatory, data collected through the WHO Country Presence Survey (2019–20) collected in 2020, and other sources cited throughout.





Annex. List of Small Island Developing States³⁹

WHO African Region	WHO Region of the Americas	WHO Eastern Mediterranean Region	WHO South-East Asia Region	WHO Western Pacific Region
1. Cabo Verde 2. Comoros 3. Guinea-Bissau 4. Mauritius 5. Sao Tomé and Príncipe 6. Seychelles	1. Anguilla* 2. Antigua and Barbuda 3. Aruba* 4. Bahamas 5. Barbados 6. Belize 7. Bermuda* 8. British Virgin Islands* 9. Cayman Islands* 10. Cuba 11. Curaçao* 12. Dominica 13. Dominican Republic 14. Grenada 15. Guadeloupe* 16. Guyana 17. Haiti 18. Jamaica 19. Martinique* 20. Montserrat* 21. Puerto Rico** 22. Saint Kitts and Nevis 23. Saint Lucia 24. Saint Vincent and the Grenadines 25. Saint Maarten* 26. Suriname 27. Trinidad and Tobago 28. Turks and Caicos* 29. U.S. Virgin Islands*	1. Bahrain	1. Maldives 2. Timor-Leste	1. American Samoa* 2. Northern Marianas (Commonwealth of the) * 3. Cook Islands*** 4. Fiji 5. French Polynesia* 6. Guam* 7. Kiribati 8. Marshall Islands 9. Micronesia (Federated States of) 10. Nauru 11. New Caledonia* 12. Niue*** 13. Palau 14. Papua New Guinea 15. Samoa 16. Singapore 17. Solomon Islands 18. Tonga 19. Tuvalu 20. Vanuatu

* Countries, territories and that areas are Non-UN Members/Associate Members of regional commissions.

** Associate Member State of the WHO as well as non-UN Members/Associate Members of regional commissions.

*** Member State of the WHO, but non-UN Members/Associate Members of regional commissions.

³⁹ UN SIDS, available at <https://sustainabledevelopment.un.org/topics/sids/list>, accessed on 19 March 2021.



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