



BE HE@LTHY BE MOBILE

**ANNUAL
REPORT**
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World Health
Organization



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FOREWORD



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"In September 2015 the Sustainable Development Goals (SDGs) became the new keystones for the international development community. Their aims promote many important facets of development, but two in particular stand out for the mHealth initiative: Goals 3 and 17.

Goal 3, 'Ensure healthy lives and promote well-being for all at all ages' speaks to the heart of WHO's mission. It links back as it does with its founding document, the 1948 Alma Ata Declaration, where health is defined as 'a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity'.

Yet achieving this vision of universal health coverage goes far beyond the mandate of the health sector. It requires collaboration with finance, education, agriculture, and – most importantly here – the Information and Communication Technology (ICT) sector, whose technologies are critical to communicating need and demand between populations and health providers. This is what the mHealth initiative is actively promoting, by showing that Ministries of Health and other providers can increase their outreach by partnering with sectors such as ICT.

The mHealth initiative also links to our second SDG, Goal 17, which calls for the global community

to strengthen sustainable development by promoting innovation in partnerships and tools. The International Telecommunication Union (ITU) is ideally placed to advance this aim. It tracks innovation in the public and private sectors on new tools and approaches, working to transmit the best examples to developed and developing countries in need of new resources. But true innovation lies in creating the ecosystem as much as the end product and creating the infrastructure for this requires a highly multisectoral approach.

The joint partnership between the WHO and ITU is a working example of the way in which SDGs 3 and 17 can be achieved. Innovation and collaboration sit at the heart of its work. Over the course of 2015, a close relationship between the two agencies has been maintained at the global and country level. The programme content, platforms and operations are the fruit of a concerted effort from all stakeholders and from staff across each organization. With this partnership we hope to offer an example of how true partnership can be achieved and used to deliver mHealth services for chronic diseases to anyone, anywhere, at any moment."

Geneva, December 2015

BE HE@LTHY, BE MOBILE BACKGROUND AND ORIGINS

Non-communicable diseases (NCDs) represent one of the major development challenges of the 21st century. NCDs, which include cancers, diabetes, heart and lung diseases, are responsible for 38 million deaths each year¹. This represents 68% of global deaths annually and many of these are premature and preventable².

Low and middle-income countries are particularly affected, bearing approximately 75% of the global NCD deaths² with close to 40% being premature¹. The estimated cumulative loss in economic output due to NCDs in developing countries is US\$7 trillion for 2011-2025, according to a Harvard University study³.

These diseases are largely preventable provided that effective steps are taken. This means programmes need to be developed that target the four risk factors for developing NCDs: tobacco use, unhealthy diet, physical inactivity and excessive alcohol consumption.

The global coverage of 7 billion mobile cellular subscriptions⁴ provides a reliable and inexpensive way to reach people living in even the most remote areas.

Be He@lthy, Be Mobile harnesses the power and reach of mobile phones to address the NCD risk factors by educating people to make healthier lifestyle choices to help prevent and manage NCDs via their phones.

The origins of the Initiative lie in the response to the Moscow Declaration on NCDs (resolution WHA64.11)⁵, the Political Declaration on NCDs (resolution A/RES/66/2)⁶ to identify concrete actions to be undertaken by Member States, and actions 48(c) and 49(d) of the WHO Global NCD Action Plan 2013-2020, marking when the WHO decided to scale up activities to reduce the global burden of NCDs using innovative technologies.

As the lead UN agencies for health and ICTs, the WHO and ITU are in a unique position to create a collaborative platform working

- 1 Global status report on Non-communicable diseases. Geneva: World Health Organization, Geneva, 2014.
- 2 The top 10 causes of death: Fact sheet no. 310. Geneva: World Health Organization, Geneva, 2014.
- 3 Bloom, D.E., Cafiero, E.T., Jané-Llopis, E., Abrahams-Gessel, S., Bloom, L.R., Fathima, S., Feigl, A.B., Gaziano, T., Mowafi, M., Pandya, A., Prettner, K., Rosenberg, L., Seligman, B., Stein, A.Z., & Weinstein, C., The Global Economic Burden of Non-communicable Diseases, Davos: World Economic Forum, 2011.

- 4 ICT Facts and Figures, Geneva: International Telecommunications Union, 2014.

- 5 Preparations for the High-Level Meeting of the United Nations General Assembly on the Prevention and Control of Non-communicable Diseases, World Health Assembly resolution WHA64.11, Geneva, 2011.
- 6 Political Declaration of the High-Level Meeting of the Prevention and Control of Non-communicable Disease, General Assembly resolution A/RES/66/2, New York, 2011.



Photo credit: ITU – photographer: Rowan Farrell

Dr. Oleg Chestnov, Assistant Director-General for Non-communicable Diseases and Mental Health, WHO and Brahima Sanou, Director Telecommunication Development Bureau, ITU

with all stakeholders to address many of the current mobile health (mHealth) challenges. These include complexity, systems incompatibility, under-funding, lack of a sustainable business model, or failure to show concrete evidence of their impact.

The Initiative is building on evidence based success in using mobile phones to improve access to health services, to train health workers, to strengthen treatment compliance, and to change behaviors and manage chronic diseases.

The **Be He@lthy, Be Mobile** initiative's aim is to implement mHealth strategies in eight initial countries, including at least one in each WHO region. This will be done in order to focus on the issue of prevention and management of NCDs, and support the current policies that address these diseases.

The Initiative has also developed handbooks for running mHealth national programmes to support

more traditional NCD prevention and management work.

Be He@lthy, Be Mobile is dependent on voluntary contributions from its global partners to supplement the funds that participating countries and local partners contribute domestically. **Be He@lthy, Be Mobile** aims to raise \$10 million over 4 years, in line with the signed agreement between WHO and ITU. These funds are used to support global technical work and select country operations.

Be He@lthy, Be Mobile recognizes the particular strengths of the private sector, academia and civil society – acknowledging that the resources of government and philanthropy alone are insufficient to address the world's biggest challenges, such as the NCD epidemic. Ultimately, cooperation from every sector is needed in the efforts to find sustainable and effective solutions to the prevalence and negative impact NCDs have in the world.

RESULTS IN A SNAPSHOT

	2015 Results	4 Year Target
Number of countries joining the Initiative	8 Costa Rica, India, Norway, Philippines, Senegal, Tunisia, United Kingdom & Zambia	8 With at least one from each WHO region
Partnership fundraising over 4 years	\$5.3 million	\$10 million
Handbooks in development	5 mTobaccoCessation, mDiabetes, mCervicalCancer, Monitoring and Evaluation, and Digital Health Platform	5

Note: The original objective of the Be He@lthy, Be Mobile initiative was to help 8 countries establish national mHealth programs over the first phase of four years (2013-2016), targeting a range of disease areas. The expected rate was for two additional countries to be added each year, with on average one new handbook – creating a goal of 8 countries and 5 handbooks by 2016. The reality is that the country and handbook goals were reached significantly in advance of the 2016 deadline, by the end of 2014. Since then the initiative is focusing on supporting and expanding the mHealth programs which have begun in these countries, as well as refining the existing handbooks to make them as strong as possible.

BE HE@LTHY, BE MOBILE 2015 KEY ACHIEVEMENTS

January:

- mHypertension Handbook development workshop held in Oxford, UK. This was co-hosted by the University of Oxford and brought together global experts and user-centered design to look at how mobile technology could support hypertension awareness and management in different populations.
- **Be He@lthy, Be Mobile** was referred to in a high-profile 'Green paper on mHealth' released by the European Commission, analyzing the potential of mHealth to make a meaningful contribution to health care over the next 2-3 years.

February:

- Tunisia officially joined the Initiative to create a national mTobaccoCessation programme.
- The mCervicalCancer Informal Expert Group was formed.
- A joint WHO/ERS workshop which explored how to expand the mTobaccoCessation content by adding a specialized component for tobacco smokers with TB – showing how mHealth can be used to treat multiple conditions and bridge the gap between communicable and non-communicable diseases.
- Sanofi joined the Initiative as a global partner.
- **Be He@lthy, Be Mobile** was profiled by The Economist in "Power to the patient: How mobile technology is transforming healthcare" – strengthening the initiative's association as a forerunner in the field.

March:

- India joined the Initiative and expressed their intention to launch a national mTobaccoCessation service across all 29 states by the end of the year.
- The first mDiabetes qualitative review took place in Senegal focusing on the previous mRamadan campaign and prevention campaigns.
- Costa Rica held a review workshop on their mTobaccoCessation country programme under its new joint management between the government and national health organizations.
- The core role of mTobaccoCessation in expanding access to cessation services was a major topic at the World Conference on Tobacco or Health held in Abu Dhabi. This looked at the work of **Be He@lthy, Be Mobile** in expanding global access to tobacco cessation through their programmes.
- **Be He@lthy, Be Mobile** was profiled by the Daily Mail in "Healthcare goes Hi Tech: Smart gadgets revolutionize".

April:

- **Be He@lthy, Be Mobile** released its first annual report (2013-14).
- Second stage of mDiabetes launched in Senegal with new content for nutrition and healthcare workers.
- **Be He@lthy, Be Mobile** was profiled at the WHO Global Coordination Mechanism on the Prevention and Control of NCDs in Geneva.
- **Be He@lthy, Be Mobile** was nominated and selected as runner up in the Guardian Sustainable Business Awards as an example of innovative partnerships.

BE HE@LTHY, BE MOBILE 2015 KEY ACHIEVEMENTS

May:

- Tunisia held a national planning workshop for their mTobaccoCessation programme to prepare all the main elements of the programme content, technology and management.
- Hypertension was selected by the UK as their area of interest under their partnership with **Be He@lthy, Be Mobile**.
- **Be He@lthy, Be Mobile** was the subject of a high-level panel discussion during a side event at the 68th World Health Assembly, run by LEEM and the Organisation Internationale de la Francophonie. It was attended by 200 participants and 16 Ministers of Health.
- **Be He@lthy, Be Mobile** was the month's ITU corporate cover story, profiling the work on mDiabetes in Senegal – and was showcased at the Re:publica conference in Germany.

June:

- A workshop focused on human-centered design principles gave rise to content for the mCervicalCancer Handbook.
- The second mRamadan campaign began in Senegal, with public transport being used for large advertising campaigns – a clever way for commuters to learn about the service and register interest.
- There was a great example of mHealth collaboration when Egypt borrowed the mDiabetes tools and guidance from Senegal and began planning its own autonomous programme.

July:

- The initiative was profiled by the UK as a new partnership on action against NCDs in a big report from the All-Party Parliamentary Group on Global Health.
- It was also profiled in The Economist in a feature spread on global tobacco control.

August:

- The Initiative published a review of mCancer applications on the Cancer Control journal, feeding into the ongoing work on mCervicalCancer in Zambia.
- **Be He@lthy, Be Mobile** was also highlighted in the Sustainable Development Goals' (SDGs) private sector compendium as a successful example of a UN approach to mobilizing the private sector in order to involve the world in achieving the newly agreed SDGs.

September:

- The UN General Assembly ratified 17 SDGs to be met by 2030, including a target to reduce global NCDs and a target on partnerships.
- The OECD highlighted **Be He@lthy, Be Mobile** as example of a multisectoral partnership contributing to delivering on the SDGs.
- A Digital Health Platform Handbook development workshop was held in Norway, looking at how to build country capacity in mHealth technology.

BE HE@LTHY, BE MOBILE 2015 KEY ACHIEVEMENTS

- **Be He@lthy, Be Mobile** published an article in the UN Special on the importance of intrapreneurship to helping foster new ways of working globally.
- The Initiative supported the GSMA 2015 mHealth from Paris to Geneva Cycling Grand Tour – raising global awareness of mHealth and of the importance of exercise.

October:

- **Be He@lthy, Be Mobile** participated in the CERN Hackathon where some of the brightest minds in Europe looked at how to solve challenges facing human development, including health care, using new technologies and techniques such as crowdsourcing.

November:

- A workshop was held in New Delhi, India, to develop the initial content for an mAgeing Handbook. This aims to look at how mobiles can offer remote support for all NCDs, instead of a single disease or risk factor, and focus on the specific needs of the elderly.
- **Be He@lthy, Be Mobile** was also profiled at the World Cancer Summit in Istanbul as an example of innovation in cancer control.

December:

- In Geneva, a 5-day Stakeholders Forum was held to review the first three years of country and expert work, as well as to identify lessons learned to inform work moving forward and to share with the global mHealth community.
- The Initiative's role in promoting innovation and capacity building in diabetes control was also the focus of a session at the World Diabetes Congress in Vancouver, Canada.
- On 25 December, India announced the launch of its mTobaccoCessation programme.
- In Cape Town, the Initiative's work on mTB-Tobacco and mTobaccoCessation was profiled at the International Union against TB and Lung Disease Conference.

A young woman with dark hair tied back, wearing a white and blue patterned sari with a dark blue shawl, is smiling while looking at a smartphone. She is adorned with traditional jewelry including a black choker with a gold pendant, a red thread necklace, a silver earring, and several bangles on her right wrist. The background is a textured, reddish-brown wall.

BEHE@LTHY

BE MOBILE

COUNTRIES AND IMPLEMENTATION

In 2015, the third year of the Initiative, **Be He@lthy, Be Mobile** successfully met its goal to launch or prepare mHealth programmes in all eight target countries – Costa Rica, Senegal, United Kingdom, Tunisia, Norway, India, Zambia and the Philippines. These countries were chosen because of their high burden of NCDs, technology preparedness, political commitment and their potential for generating significant results which could be replicated in other countries.

mTobaccoCessation in Costa Rica

mTobaccoCessation was launched in 2013, in Costa Rica, and was the first **Be He@lthy, Be Mobile** mHealth programme.

Smoking cessation is difficult, and only 5 -10 % of people are successful in quitting tobacco use on their own¹. This is why the **Be He@lthy, Be Mobile** programme uses mobile phones to provide support to those trying to quit.

When the sentence “I want to quit,” is sent by text message to a well-publicized number in Costa Rica, it enrolls smokers in the country’s mHealth programme. The Costa Rican service regularly sends evidence based messages, culturally adapted, that offer encouragement, advice, tips on quitting, and guidance in exploring aspects of behavior that contribute to smoking. Additionally, the interactive, toll free service allows users to seek support by sending text messages at any time of the day or night. The platform immediately responds with tailored messages, by identifying ‘trigger’ words (such as “CRAVE”), to give advice on how to cope with, confront, and resist the temptation to resume cigarette use. The programme is called “Sistema de Mensajes Saludables (SMS)”, or “healthy message system”.

The individual benefits of ending cigarette use are matched by government interest in reducing

health related problems, such as lung cancer and heart problems, and minimizing lost productivity from smoking-related issues. To raise awareness of the programme launch, a television and magazine advertising campaign was carried out over the spring and summer of 2013, featuring nationally known soccer players.

More recently, the Ministry of Health extended the phone-based effort to include cooperation with the country’s largest social security provider, the Caja Costarricense de Seguridad Social, and the national institute for Alcohol and Substance Addiction. The service will be available from the social security agency’s smoking cessation clinics in the northwest of Costa Rica, which extends programme access to smokers in rural areas, outside the capital of San Jose.

The Government of Costa Rica also used funds collected from tobacco taxes to finance the national smoking cessation campaign, which has proven to be an innovative financing mechanism, and a key step in ensuring the programme’s sustainability.

mTobaccoCessation in Tunisia

Following in the footsteps of Costa Rica, Tunisia also launched an mHealth programme aimed at helping Tunisians quit the use of cigarettes and shisha. The WHO estimates that up to 50% of the adult male population in Tunisia smoke tobacco².

The programme titled “Yezzi!” (“Enough!”) will be launched for users in early 2016 and will use interactive, two-way SMS communication to provide continuous support to smokers, in addition to traditional clinical support. This **Be He@lthy, Be Mobile** programme will be the first to be undertaken in the North Africa and Middle East region.

¹ Mpower: A Policy Package to Reverse the Tobacco Epidemic, World Health Organization, Geneva, 2008.

² Tunisia: Non-communicable Diseases Country Profiles, World Health Organization, Geneva, 2014.



ENVOYEZ YEZZI AU 85 ...

Image credit: WHO

'Yezzi' logo for
mTobaccoCessation in
Tunisia

Once a person is enrolled in "Yezzi", supportive text messages are sent to the person at regular intervals. Messages are also sent in response to user requests for information and help.

To make the system as relevant and effective as possible, the content of the messages are tailored to different target audiences, including adolescents, young adults, and middle-aged smokers. The programme's emphasis is on providing support during the first six months of smoking cessation, when the process is the most stressful and relapses often occur. The phone-based system is being complimented by mass-media campaigns and other promotions.

Expansion of the Ministry of Health's cessation effort is anticipated, along with the creation of a larger portfolio of mHealth services to address other chronic diseases. An mDiabetes programme is also scheduled for development in 2016.

mHealth for NCDs in Norway

The mCOPD initiative in Norway aims to foster behavioral change via health promotion and empower patients to manage their own diseases via their daily use of mobile phones and tablet computers. The goal is to enhance the quality of life for patients, and reduce instances of hospital re-admittance.

Norway's advanced health system and telecommunications network will be utilized nationally to develop and implement a series of phone-based tools. These tools will be used to help reduce rates of emphysema, bronchitis, and other related ailments known as chronic obstructive pulmonary disease (COPD).

COPD damages lung tissue and progressively interferes with breathing. However, in most cases, it can be prevented or diminished by changes in behavior and lifestyle. Effective information campaigns and support programmes, via mobile phones, can alert people to the dangers of smoking and can help smokers to quit.

All of Norway's tools and information will also be fed into the **Be He@lthy, Be Mobile** Global Toolkit, which can then be adapted for use by other countries with similar high rates of these illnesses.

In addition to rolling out its domestic programme, Norway also supports **Be He@lthy, Be Mobile** institutionally with funding for global programmes and a secondment to the Secretariat.

mHypertension in the United Kingdom

One in four adults in England suffers from hypertension, or high blood pressure. The diseases caused by high blood pressure, such as stroke, heart disease and vascular dementia cost their National Health Service (NHS) over £2bn each year. Evidence from the Global Burden of Disease Study demonstrate that high blood pressure remains to be one of the principle risk factor for premature death and disability for many countries. Yet simple behavioural changes have the potential to save numerous lives, by raising public awareness about the importance of blood pressure on overall health and of controlling risk factors such as smoking, diet and exercise.³

In 2014 Public Health England published their national action plan focusing on this area: "Tackling High Blood Pressure: From Evidence into Action". Over the past year they have been working with **Be He@lthy, Be Mobile** and national partners to deliver on their commitment to this by looking at digital opportunities for improving hypertension prevention, detection and management. Work has focused on digital solutions for gaining and sustaining population engagement in blood pressure control. This includes tools such as an online Heart Age calculator which helps people understand their risk of heart disease and encourages them

³ Study: Newton J, Briggs A, Murray C et al. Changes in health in England, with analysis by English regions and areas of deprivation, 1990–2013: a systematic analysis for the Global Burden of Disease Study 2013. *Lancet* 2015 386:10010; 2257–227

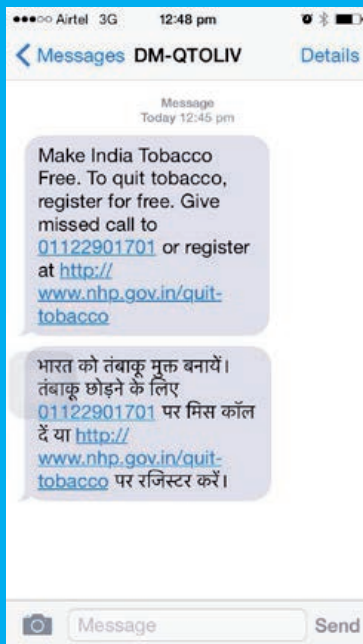


Image credit: WHO

SMS from India launch

Over 180,000 people registered in the first month of the **mTobaccoCessation** programme in India

to be more aware of their blood pressure and how it is affected by lifestyle choices.

The work has strengthened links with the broader digital health innovations community for hypertension. It also supports the beginnings of a broader conversation between health policy and patients on how to manage behaviour change, under the new national One You campaign focusing on promoting healthy behaviours amongst adults in England. The experiences with digital hypertension form part of the England's contribution to the mHypertension Handbook under development by **Be He@lthy, Be Mobile**.

mTobaccoCessation in India

India, the world's second most populous country, is facing a growing epidemic of tobacco consumption. Nearly 35% of Indians over the age of 15, or some 275 million people, use tobacco. Most (206 million) take the substance in smokeless form⁴. Chewing tobacco causes heightened rates of mouth, tongue, cheek, gum, esophageal, stomach, and pancreatic cancer, and is suspected of raising risks of heart disease and stroke.

In 2015, India's Ministry of Health and Family Welfare and the Ministry of Communication and Information Technology partnered with **Be He@lthy, Be Mobile** to create an mHealth programme to initially focus on TobaccoCessation. The programme is part of the Government of India's Digital India Initiative.

The programme will provide evidence-based behavioral change messages, including health information, tips on quitting, and encouragement for those attempting to do so. Different content libraries have been developed, consisting of

messages for smokeless users, for those who smoke, and for those who consume tobacco in both ways. The nationwide programme commenced in December 2015, and approximately 180,000 people registered in the first month of the programme. The unique feature of the programme in India is that tobacco users who want to quit, can register by giving a missed call to (011 22 901 701), or by registering at: <http://www.nhp.gov.in/quit-tobacco>. The progress is monitored in real time by key policy people, through an online dashboard, which details the number of registrations, stratified by various factors such as gender, geography, tobacco use type, etc. The programme is currently available in English and Hindi, and more languages are being added.

mCervicalCancer in Zambia

Cervical cancer is the most common cancer among females globally and Zambia has the second highest prevalence rates in Sub-Saharan Africa⁵. Worldwide, 85% of deaths from cervical cancer occur in low- and middle-income countries, and cervical cancer kills more women in Africa than any other form of cancer⁶. However, cervical cancer is highly preventable and can be cured if diagnosed and treated early.

The Zambian Ministry of Health, in cooperation with **Be He@lthy, Be Mobile**, is developing a mobile-based system focusing on reducing rates of cervical cancer.

In 2015, the government with support from the Initiative, developed a work plan for mCervicalCancer which included plans for the mobile-based

4 Global Adult Tobacco Survey: GATS India 2009-2010, World Health Organisation, Geneva, 2009-2010.

5 Katai Kapambwe S., Review of cervical cancer screening program in Zambia, 44th International Course in Health Development, University of Amsterdam, 2008.

6 Ferlay J, Bray F, Pisani P, Parkin DM. GLOBOCAN 2002; Cancer Incidence, Mortality and Prevalence Worldwide. CancerBase No.5, version 2.0., International Agency for Research on Cancer (IARC), Lyon, France: IARC Press 2004.

mCervical Cancer programme in Zambia
– Undertaking a needs assessment to determine women's knowledge about cervical cancer.



Image credit: WHO

programme to be incorporated in its National Cancer Control Strategic Plan for 2017-2021. This step will help ensure the programme's sustainability as a core health provider for cervical cancer services.

In preparation, the government with WHO and ITU, has developed a systematic evidence-based content library and algorithm.

The programme is expected to be launched nationally in 2016 and will aim to reach out to women and immediate family members of those at risk, as well as improving patient contact with local health workers.

The mobile system will alert and educate women most at risk of developing the disease – those between 25 and 59 years old. It will urge them to be screened for cervical cancer, to increase the chance that early symptoms are spotted in time to prevent the disease, and also remind them of scheduled appointments to help minimize missed screenings. Health workers in rural locations will also be able to use mobile technology to consult with experts, increasing patient access to specialists' knowledge, and helping to decrease the incidence of serious consequences from the disease and/or secondary conditions.

mTobaccoCessation in the Philippines

A mTobaccoCessation programme is currently being developed in consultation with **Be He@lthy, Be Mobile**.

In the Philippines, 28.3% (17.3 million) of the population over the age of 15 years use tobacco⁷. The health consequences are significant, and several smoking cessation programmes already exist in the country. However, the government recognizes that the high rate of mobile phone subscribers creates an innovative channel to provide information, regarding the risks of tobacco use and the benefits of quitting, directly to those who need it.

The effort will be aimed at helping smokers aged 15 and older to quit. It is intended initially to be launched in two counties and then expanded nationally by the third quarter of 2016. The programme will be part of a broader strategy to reduce national tobacco consumption. It will complement existing efforts to increase the domestic supply of services and tools for smoking cessation. It will also raise people's awareness about the possibility

⁷ The 2009 Philippines' Global Adult Tobacco Survey: Country Report, Department of Health, National Statistics Office, contribution from World Health Organization, U.S. Centre for Disease Control and Prevention, the Philippine Government, 2010.

of using their phones to obtain information and support for giving up tobacco.

mDiabetes in Senegal

The mDiabetes programme in Senegal was launched in November 2014. In Senegal, over 74% of the country's estimated 498,000 cases go undiagnosed⁸, prompting the Government of Senegal to focus on influencing individual awareness of the disease. **Be He@lthy, Be Mobile** is working with Senegal to make use of mobiles in four areas:

1. To increase awareness about diabetes through SMS messages
2. To train health workers through a mTraining programme using SMS and smartphone based educational programmes
3. To provide remote consultation services, and
4. To provide management support for people with diabetes.

The first phase of mDiabetes launched in time for the month of Ramadan, a period of high sugar consumption and dietary irregularity where health authorities witness a peak in the urgent hospitalization of people with uncontrolled diabetes. Members of the country's diabetes patient association, health professionals and the general public are encouraged to sign up to receive free text messages that aim to increase awareness and help people with diabetes to avoid the complications that can be triggered by fasting and feasting. Typical messages include:

- "Drink one liter of water every morning before you begin fasting."
- "Take care not to overeat and watch out for foods high in sugar such as dates."
- "Ask your doctor to adapt the dose and timing of your diabetes medication before you fast."

mDiabetes logo
in Senegal



⁸ Diabetes in Senegal: 2015, International Diabetes Federation - Africa, Senegal, 2015.



2015 mRamadan campaign for mDiabetes in Senegal

During the initial mRamadan phase in 2014, 80,000 SMS messages were sent to more than 2,000 people. An evaluation conducted by the “Image 4” agency on behalf of the patient association ASSAD (“Association Sénégalaise de Soutien et d’Assistance aux Diabétiques”), revealed that more than 70% of the recipients had read the messages and over 90% were satisfied with the messages. This phase was used to evaluate the cost of running the system as well as the efficacy of the programme.

In 2015, the second year of the programme, subscriptions rose sharply to over 12,000 people and included individuals from the general public, people with diabetes and health professionals. Over 430,000 SMS messages have been sent out since the beginning of the programme.

Results from the 2015 campaign are currently undergoing independent evaluation and will be used to develop a long term sustainable business model for the Diabetes mHealth programme and other chronic diseases. Plans are also underway for future campaigns to possibly incorporate voice messages to help target illiterate users.

The common use of the technology platform shows how investment in mobile health is a way to improve overall population health as quickly and efficiently as possible. This was demonstrated in Senegal in 2014 when it utilized the mDiabetes programme infrastructure to develop a public health awareness campaign for the Ebola virus.

mDiabetes in Egypt

In addition to the official 8 countries, others have started to use the tools that **Be He@lthy, Be Mobile** are developing to create their own national programmes.

Egypt is an impressive example of country autonomy, and is an early example of the way in which it is hoped all countries will be able to use the handbooks and Global Toolkit once they are published.

In 2015, the Government of Egypt, with a bare minimum of technical support from the Initiative, utilized the mDiabetes Handbook to successfully create the foundations of their own national mDiabetes programme. The program target is substantial: an initial program for 10,000 diabetics by the end of May, an mRamadan campaign for 150,000 users by the end of July, and a final phase for 300,000 users by the end of 2016. This reflects the government’s commitment to the program and their dedication to creating an effective, sustainable program using their own resources.

By copying the global structure, following the necessary steps, learning from the experiences of Senegal, and garnering support from local and international mDiabetes experts, they have been able to adapt the content for use in Egypt and are working with national partners to promote user uptake. In this instance the Ministry of Communications took the lead, showing again that mHealth is a field extending beyond the health sector alone. The national programme is expected to officially launch the service to users in April 2016.

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PARTNERSHIPS



Photo credit: ITU

ITU Deputy Secretary General Mr Malcom Johnson welcomes Dr Pierre Chancel, Senior Vice President, Global Diabetes at Sanofi as a new **Be He@lthy, Be Mobile** partner.

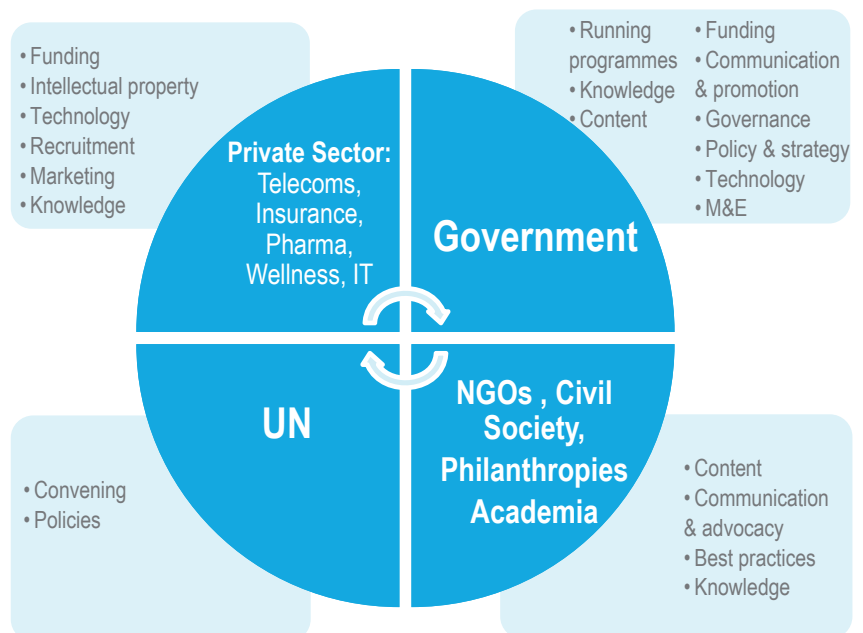
In 2015, **Be He@lthy, Be Mobile** welcomed a new partnership with Sanofi. **Be He@lthy, Be Mobile** also partnered with the University of Oxford on the mHypertension Workshop and the All India Institute of Medical Sciences on mAgeing. The Initiative also continues to work with individual academics from the world's leading institutions who support the handbooks and Global Toolkit development.

The importance of partnership in advancing human development is made explicit in Goal 17 of the SDGs, with its call to "Strengthen the means of implementation and revitalize the global partnership for development".⁹ Collaborating with other organizations who are working towards the same overarching development aims, maximizes overall impact and achievement.

The partnership model selected by the **Be He@lthy, Be Mobile** is explicitly multisectoral, reflecting

the need for collaboration between many different stakeholders in order to build a robust mHealth system. By encouraging contributions from different sectors and groups, the Initiative enables its programmes to maximize the quality of technical, financial and political support they receive, all of which are vital for ensuring sustainability in the longer term.

There are four main groups whose input is critical to creating and sustaining mHealth interventions. These are the national governments, multilateral organizations, academia and civil society, and certain areas of the private sector. The Initiative ensures that the private sector organizations it partners with are companies with experience relevant to mHealth or related areas. This includes technology, mobile operators, health care, health insurance, and wellness groups.



⁹ Sustainable Development Goals, Sustainable Development Knowledge Platform, United Nations, 2015.

THE MULTINATIONAL PHARMACEUTICAL FIRM JOINED BE HE@LTHY, BE MOBILE IN FEBRUARY 2015.

NORWAY PARTNERSHIP

Norway officially joined the **Be He@lthy, Be Mobile** initiative in November 2014. The objectives of the Norway Programme are to scale up mHealth programmes in the country and promote the sharing of technical content and expertise by working towards health system strengthening.

By promoting a structure which allows the skills of each sector to be incorporated fully, **BeHe@lthy, Be Mobile**'s model avoids the traditional donor-recipient relationship which has typically earmarked public-private partnerships in development. It is a unique approach for the UN and an example of how the

Initiative is fostering innovation which goes beyond just individual interventions: this innovative approach contributes towards the broader mHealth ecosystem, and will provide the long-term structure needed for institutionalization and sustainability.

“ Mobile phones are increasingly becoming additional tools in the global quest to improve health-care delivery systems. This partnership reinforces our commitment to work with industry to harness the power of ICTs to promote sustainable economic development around the world. ”

Mr Brahima Sanou,
Director of the ITU Telecommunication Development Bureau

“ Sanofi's global reach and diabetes knowledge will help expand the excellent pilot work undertaken in Senegal. Through Sanofi's support, the **Be He@lthy, Be Mobile** initiative will employ successful mobile strategies for people with diabetes and their caregivers, and provide access to training for health workers in additional countries around the world, furthering our aim of bringing about far-reaching improvements in diabetes management, treatment and care. ”

Mr. Pierre Chancel,
Senior Vice President, Sanofi

“ Norway is a prime example of everything this initiative hopes to achieve. By partnering with **Be He@lthy, Be Mobile**, the pioneering work done in Norway on mHealth will be recognized by and bring benefit to the world. In return the Initiative can accelerate Norway's expertise by sharing knowledge from programmes across the world with them. This kind of feedback loop will allow Norwegian programmes to expand to other areas, and will support both developed and developing countries to achieve the best health care systems possible. ”

Oleg Chestnov,
WHO Assistant Director-General –
Non-communicable Diseases and Mental Health

“ The WHO and ITU are co-leading this amazing initiative which puts together governments, NGOs, private sector, development agencies and other key actors. **Be He@lthy, Be Mobile** is unique in the world of mHealth and cross-sectoral collaboration. It is one of the few initiatives which can tangibly demonstrate the journey to outcomes in tackling NCDs by embracing the use of technology.

We have just started to see the rapid expansion of the Initiative in terms of country involvement – with over 50 countries now wanting to join – and the expansion of the diversity of partners getting involved from different sectors. This is great news, as it will continue to strengthen the sustainability and impact of the Initiative globally. ”

Andrés Martin Diana,
Global Partnerships Lead for mHealth - Centre Medical, BUPA

“ I think that **Be He@lthy, Be Mobile** is a perfect example of policy concepts being put into action. **Be He@lthy, Be Mobile** is using existing technology to find ways to go directly to patients and the general population, to help empower them on their own disease management. These types of programmes can potentially have a huge impact. ”

Martin Bernhardt,
Vice President, Relations with International Institutions, Sanofi

“ It is clear that through these **Be He@lthy, Be Mobile** country programmes, governments are being able to access patients and the general population in ways that hasn't been done in the past. It is evident from the number of patients registering for these programmes, that the need is there, and the information and feedback that the patients get through these systems actually benefit them. ”

Sarah Pasternack,
Director Market Access Programmes, Global Health Programmes, GSK

“ **Be He@lthy, Be Mobile** is one of the very active forces which keep NCDs in their rightful place within the political agenda. It inevitably brings together partnerships which will lead to better, more holistic and effective solutions for patients on the ground with NCDs and other chronic diseases. ”

Andrew Bushell,
Global Programme Head, Galvus Group, Novartis

HANDBOOKS

mHypertension
Workshop held in
Oxford, UK



Be He@lthy, Be Mobile supports countries and governments by providing technical expertise to implement mobile health interventions as part of their national health systems. It also helps countries adapt delivery mechanisms of mHealth programmes based on guidelines, best practice, evidence based research and existing system capacity.

Handbooks for each mobile intervention are developed by the Secretariat together with academic and technology partners. These documents contain business and technology rules and operation guides, as well as content for the specific disease intervention.

The Secretariat compiles a handbook for each disease which provides guidance and technical assistance to governments to implement national mHealth interventions. Handbooks include information on:

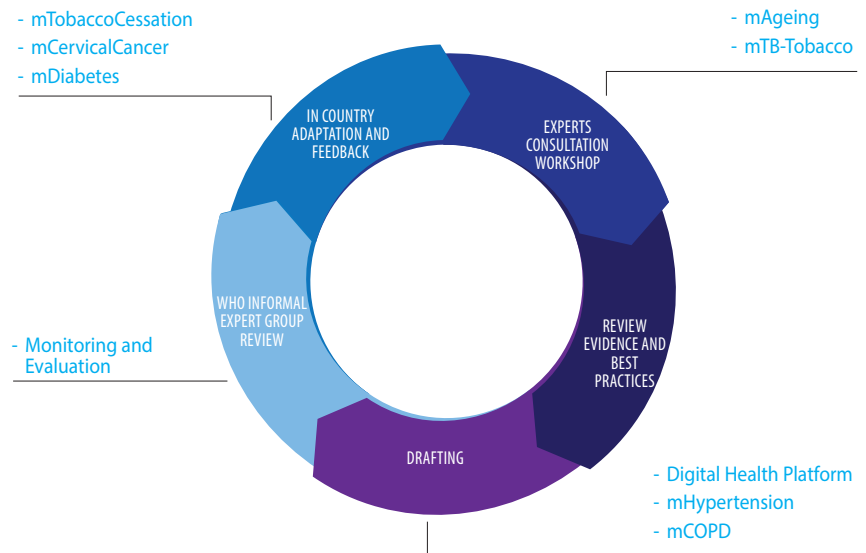
- Overall programme management including stakeholder engagement, programme structure and operations;

- Technology specifications for implementation of services;
- Content creation and adaptation, including: example libraries of validated message content based on WHO guidelines and evidence based interventions;
- Programme promotion and recruitment, strategies;
- Monitoring and evaluation methodology.

In 2015, one of the **Be He@lthy, Be Mobile** objectives was to incorporate a more human-centered approach to the mHealth programmes and handbook content. This approach focuses on the individuals affected by the diseases, their stories, circumstances, and risk factors. By placing people at the center of the programmes, interventions, strategy and guidelines can be better tailored to achieve successful outcomes.

Using these human centered design techniques, **Be He@lthy, Be Mobile** brings together groups of international experts for multi-day content development workshops. Here, they present the evidence, discuss gaps and solutions, and create a first draft.

Figure 1: Handbook Development Process



Four of these workshops were held globally throughout 2015.

A smaller “informal expert group” of leaders in the field, with experience in the particular disease area (smoking cessation, diabetes, etc.), is then selected to review and finalize the content. Once this process is complete, the official handbook is published and added to the Global Toolkit for countries to draw on.

Be He@lthy, Be Mobile works with countries who request support, to adapt the content of the handbooks into a context-specific framework for a national mHealth intervention. The results and experiences of each country are then fed back into the Global Toolkit, increasing the mHealth evidence base and supporting programmes in yet more countries. The process is

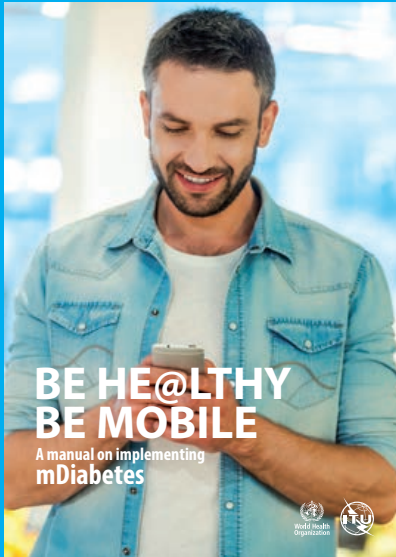
iterative to continually enhance the handbooks and Toolkit content.

In addition to the handbooks, the Toolkit content includes a range of other information including mobile tools, apps, and project management strategy.

The mTobaccoCessation, mCervicalCancer, mDiabetes, Monitoring and Evaluation and Digital Health Platform handbooks have been created and are in the final development stages. The aim is for these to be made available during 2016. Further mHealth handbooks are currently under development including: mHypertension, mCOPD and mSmartlife. Other future areas of focus include mAgeing and mTB-Tobacco (a joint programme targeting tobacco users who also suffer from Tuberculosis).

- JAN 2015 - mHYPERTENSION WORKSHOP HELD IN OXFORD, UK
- JUNE 2015 - mCERVICALCANCER WORKSHOP IN ZAMBIA
- SEPTEMBER 2015 - DIGITAL HEALTH PLATFORM WORKSHOP IN NORWAY
- NOVEMBER 2015 - mAGEING WORKSHOP IN INDIA

mDiabetes Handbook

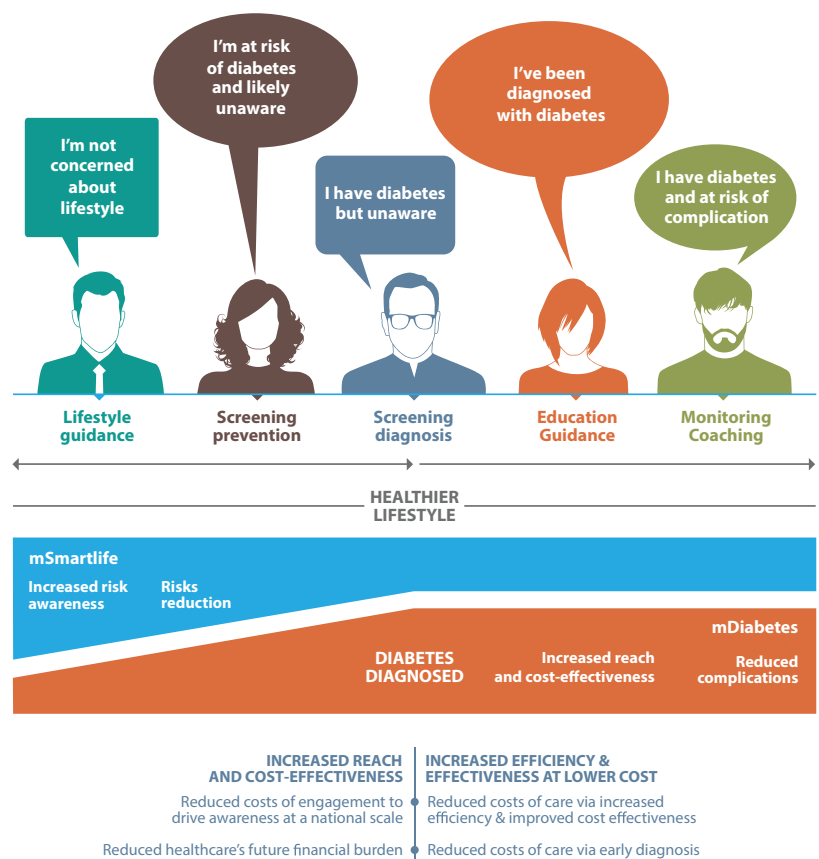


The mDiabetes handbook provides guidance on how mHealth can be integrated into all levels of prevention, management and care, and targeted towards different segments of the population (Figure 2). Specifically, it details the main areas where mDiabetes initiatives can be used within a broader, structured national diabetes programme: prevention, long-term management, secondary prevention of complications, and for specific conditions (e.g. gestational diabetes and type 1 diabetes) (Figure 3). Senegal's government has been using the **Be He@lthy, Be Mobile** mDiabetes handbook to develop and implement successful mDiabetes programmes for prevention, long-term management, secondary prevention, specific conditions, and healthcare worker training. Egypt has replicated this model for their population and will be launching an mDiabetes programme in 2016. Feedback from these countries is being used to improve the handbook, which will then be used by additional countries to implement national mDiabetes programmes in the future.

Figure 2: Segmenting the diabetes population



Figure 3: The mDiabetes continuum of interventions



MONITORING AND EVALUATION MEASURING PERFORMANCE

There is a critical need for robust evidence to make the health and investment case for the scale-up and integration of mHealth programmes, and to demonstrate the potential role mHealth can play in strengthening national health services. To address this need, the **Be He@lthy, Be Mobile** initiative, in collaboration with a range of global experts, is developing a monitoring and evaluation handbook, including a monitoring and evaluation framework, to measure the success of **Be He@lthy, Be Mobile** mHealth country programmes as they are implemented as well as the global programme as a whole. Monitoring and evaluation are fundamental elements of country programmes which help track an intervention's performance using input, process and outcome information. While monitoring routinely gives information on where a project is at any given time relative to respective targets for implementation, evaluation provides evidence for why targets and outcomes are or are not being achieved or the extent to which changes can be attributed to the intervention.

The **Be He@lthy, Be Mobile** Monitoring and Evaluation Handbook draws on emerging evidence from WHO-supported initiatives and from globally published peer-reviewed studies on best practices in monitoring and evaluation of mHealth, offering countries a suggested pathway for monitoring and evaluation, evaluation tools, and suggested evaluation questions and indicators. Examples of evaluation questions include:

- Are users improving their knowledge, behaviour or

attitudes due to the mHealth application?

- Are users increasing their access of health services?
- Are health workers improving their performance?

Once these questions are in place, a set of indicators can be tailored to the specific mHealth intervention to collect data to answer the questions, thus providing an objective methodology for assessing demonstrable impact and outcomes. Examples of indicators include:

- Percentage of users who report satisfaction with the content received through the mobile device;
- Percentage of users retained for the entire duration of the programme;
- Percentage of users who changed targeted behaviour;
- Cost per user.

On-going monitoring and evaluation allows for identification of programme strengths and weaknesses as well as development of action plans to address problems and improve efficacy. These lessons can then be translated to help other countries overcome obstacles and improve their mHealth programmes.

This type of work is already being implemented in Senegal where preliminary results from a qualitative evaluation of the mRamadan campaign in 2014 indicated that the programme enhanced diabetes services in the country and was popular among users. The campaign achieved a high rate of implementation of SMS recommendations by participants. Initial results from a survey demonstrated significant



dietary changes, in particular increased hydration before and after fasting and reduced consumption of soft drinks and sweets. Ninety percent of interviewed participants declared they want to receive m-Diabetes messages during the next Ramadan campaign. A number of limitations and recommendations were also identified which will be used to improve the efficacy of future phases of the Initiative.

Another example is India's mTobaccoCessation programme, which has already created a real time dashboard for monitoring some of the operational process and performance indicators. The dashboard will also use its real time database to help with the evaluation processes.

In addition to the formal monitoring and evaluation work of the country programmes, the secretariat captures lessons learnt within the broader initiative through stories, interviews and videos. This information is shared at the annual stakeholders forum and will be published in the form of short case studies which will be useful information for other digital and partnership initiatives.

The secretariat also applies the same approach to its own work planning: quarterly lessons learnt meetings feed into quarterly work plans, to ensure that the small team stays as agile and responsive as possible.

COMMUNICATIONS AND ADVOCACY

High-level side event during the 68th World Health Assembly, run by Les Entreprises du Medicament (LEEM) and the International Organization of La Francophonie.

From left to right:
Luc Dandurand,
Hani Eskandar,
Sameer Pujari,
Virginia Arnold,
Susannah Robinson,
Surabhi Joshi



In 2015 **Be He@lthy, Be Mobile** was profiled in a number of articles and global events, reaching a large audience across mHealth related sectors and stakeholders. These outreach activities and media coverage have been critical in raising awareness of the Initiative and generating interest from

participating countries and potential partners.

This year's activities included **Be He@lthy, Be Mobile** being: named as runner up in The Guardian's Business Awards, profiled in the Daily Mail and twice in The Economist, as well as being the



Be He@lthy, Be Mobile session at the NCD Café, hosted by supporters of the NCD Alliance at the World Diabetes Congress in Canada

From left to right:
Maimouna Ndour, Line
Kleinebreil, Catherine Levy,
Fiona Adshead

focus of sessions at the World Diabetes Congress and a high-level side event run by Les Entreprises du Medicament (LEEM) and the International Organization of La Francophonie at the 68th World Health Assembly attended by 200 participants and 16 Ministers of Health. A full list of the 2015 communication and advocacy events is included in the Key Achievements section of this report.

Be He@lthy, Be Mobile is quickly becoming recognized as a pioneer

in the successful scale-up of national mHealth programmes. Currently over 50 countries (in addition the eight target countries) have expressed interest in joining or utilizing the **Be He@lthy, Be Mobile** resources.

Currently phase two of **Be He@lthy, Be Mobile** is being considered. It is expected that the Initiative will extend past 2016 and be sustained into the future.

GOVERNANCE AND PROGRAMME MANAGEMENT

Secretariat and Steering Committee with Assistant Director-General WHO and Director ITU

Front Row:
Oleg Chestov,
Brahima Sanou

Back Row:
Sameer Pujari,
Vinayak Prasad,
Hani Eskandar,
Douglas Bettcher,
Kemal Huseinovic,
Yushi Torigoe,
Eun-Ju Kim,
Nick Banatvala,
Luc Dandurand



Two bodies coordinate the **Be He@lthy, Be Mobile** initiative: the Secretariat and the Steering Committee.

The mHealth Secretariat, staffed by WHO and ITU, is responsible for operations, fundraising, technical development of handbooks, country coordination and implementation and partnership outreach. The WHO and ITU each have full and part time staff members dedicated to **Be He@lthy, Be Mobile** from the headquarters in Geneva, as well as the regional and country offices.

The Steering Committee, made up of senior staff from the WHO and ITU, meet at least once every quarter and provide the Secretariat with guidance and oversight.

Informal Expert Groups (IEGs) are established by the Steering Committee for each mobile intervention area. The role of IEGs is to review the successes and failures of existing projects, provide advice and adapt best practices

from existing projects to different countries, develop a generic framework for monitoring and evaluation, and develop a campaign and costing model for mobile health interventions at national scale.

Partners and countries who join **Be He@lthy, Be Mobile** meet at regular events and meetings.

In December 2015, **Be He@lthy, Be Mobile** held its annual Stakeholders Forum which focused on sharing information on the progress of the Initiative, as well as identifying and capturing lessons learned for the key areas of: Communications, Governance and Innovation, Countries and Toolkit, Monitoring and Evaluation, and Partnerships.

The stakeholders' ideas and lessons learned will be used to improve the efficiency of all aspects of the **Be He@lthy, Be Mobile** initiative, to help ensure its continued success in this important work.

[illegible]

A group of four people, two men and two women, are standing in front of a banner for the Ashabi Telemedicine Centre. The banner features a logo of a stylized head with a brain and Arabic text. The individuals are dressed in professional attire, including suits and blazers.

**BE HE@LTHY
BE MOBILE**

REPORT
JANUARY 2013 TO NOVEMBER 2014

150 



December 2015: global consultation on mHealth, Geneva

SUMMARY OF LESSONS LEARNED STAKEHOLDERS MEETING (DECEMBER 2015)

Partnerships

- Personal engagement with partners is the best way to develop shared values
- Need to involve partners in global and national work
- First-hand experience is a core value driver

Communications

- Make communications two-way between initiative and stakeholders
- Offer a repository of materials for stakeholder reference and/or dissemination
- Evaluate communication effectiveness

Governance and Innovation

- Consider an Advisory Board for governance
- More information from the global BHBM to all stakeholders about strategic decisions
- Focus innovation on sustainability and scalability

Countries and Handbooks

- Create a practical toolkit that is accessible to stakeholders
- Create a more collaborative approach to sharing country experiences across stakeholders

Monitoring and evaluation

- Work on implementing mHealth evaluations led by countries that measure key indicators and respond to stakeholders' questions
- Consider design and cost of national evaluation frameworks

ANNEX 1

STEERING COMMITTEE

Dr Nicholas Banatvala,

Senior Adviser to the Assistant Director General, Non-communicable Diseases and Mental Health, WHO

Dr Douglas Bettcher,

Director, Prevention of Non-communicable Diseases, WHO

Dr. Edward Kelley,

Director, Service Delivery and Safety, World Health Organization

Dr. Najeeb Al-Shorbaji,

Director, Department of Knowledge Management & Sharing, WHO (retired from committee in Aug 2015)

Dr. Kemal Huseinovic,

Chief of the Infrastructure, Enabling Environment and E-Applications, ITU

Dr Eun-Ju Kim,

Chief of Partnership and Innovation Department, ITU

Mr Yushi Torigoe,

Deputy to the Director and Chief of Administration & Operations Coordination, ITU

INFORMAL EXPERT GROUPS

1. mTobaccoCessation:

Dr. Lorien Abrams,

Associate Professor and Director of Public Health Communication and Marketing, George Washington University, Washington DC, USA

Dr. Erik Auguston,

Program Director in Tobacco Control Research, National Cancer Institute, Bethesda, MD, USA

Dr. Caroline Free,

Senior Lecturer in Epidemiology, London School of Hygiene and Tropical Medicine, London, UK

Dr. Pratima Murthy,

Chief of De-addiction Services, National Institute of Mental Health and Neurosciences, Bangalore, India

Dr. Robyn Whittaker,

Public Health Physician, Waitemata District Health Board, New Zealand

2. mDiabetes:

Dr. Line Kleinebreil,

Primary Care Physician, Paris, France

Dr. Marc-Andre Raetzo,

Primary Care and Public Health Expert, Onex, Switzerland

Dr. Ambady Ramachandran,

Researcher, Indian Diabetes Research Foundation, Chennai, India

Dr. Nalini Saligram,

CEO, Arogya World, Napierville, IL, USA

Dr. Nikhil Tandon,

Professor, All India Institute of Medical Sciences, New Delhi, India

Dr. Nigel Unwin,

Professor of Public Health and Epidemiology, University of the West Indies, Cave Hill, Barbados

Dr. Josefien Van Olmen,

Institute of Tropical Medicine, Antwerp, Belgium

Dr. Robyn Whittaker,

Public Health Physician, Waitemata District Health Board, New Zealand

3. mCervicalCancer:**Dr. Surendra S. Shastri,**

Professor and head of the Department of Preventive Oncology, Tata Memorial Centre in Mumbai, India, and head of the World Health Organization's (WHO's) Collaborating Centre for Cancer Prevention, Screening and Early Detection

Dr. Rengaswamy Sankaranarayanan,

Special Advisor and Group Head of Screening at the International Agency for Research on Cancer

Prof. Groesbeck Parham,

Director of the CIDRZ Cervical Cancer Prevention in Zambia, and Professor of Gynecologic Oncology, Department of Obstetrics and Gynecology, University of North Carolina

Ms Raveena Chowdhury,

Deputy Director, Cervical Cancer Prevention, Marie Stopes International

Dr. Achim Schneider,

MD, MPH, Professor and Chairman, Department of Gynecology and Gynecologic Oncology, Charité University Medicine Berlin

Dr. Patrick Petignat,

Head of Surgical Gynecologic Oncology Unit, University Hospitals of Geneva

Dr. Dan Murokora, MD,

Clinical Director of the Uganda Women's Health Initiative and former Director of Obstetrics, Masaka Regional Hospital, Uganda

Dr. Mauricio Maza,

Medical Director, Basic Health International

Dr. Karen Yeates,

Associate Professor, Department of Medicine, Queen's University, and Co-Director, Office of Global Health, Queen's University School of Medicine, and Director, Pamoja Tunaweza Research Centre, Tanzania

Ms Janet Matemu,

Technology Manager, Jacaranda Health Kenya

REGIONAL FOCAL POINTS

The World Health Organization and International Telecommunications Union gratefully acknowledge the contributions made to Be He@lthy, Be Mobile by the following regional focal points from both organizations:

From WHO Regional Offices: Benoit Varenne, Elisa Prieto, Nyo Nyo Kyaing, Clayton Hamilton, Ahmed Mohamed Amin Mandil, Heba Fouad, Hani Farouk Abdel Hai Mohamed, Angela Pratt, Kelvin Khow, Mark Landry and David Novillo Ortiz.

From ITU Regional Offices: Karim Abdelghani and Cleveland Thomas

ANNEX 2

FINANCIAL OVERVIEW: INCOME AND EXPENSES

TABLE 1.
FUNDS RAISED BY
SECTOR FOR 2013-2016
(IN US DOLLARS)

Financial highlights

Fundraising for **Be He@lthy, Be Mobile** is carried out across 5 industry groups, targeting \$2 million per group across pharma, insurance, sporting goods, technology and bilaterals/foundations sectors for the four years of the Initiative. Partners give donations to ITU directly, and the Steering Committee

allocates funds to countries and for technical work.

By December 2015, partners have committed \$5.3 million for the four years of the Initiative.

	2013	2014	2015	2016+	4year+ total	Funding gap 2013-2016
Pharmaceutical IFPMA, GSK, Novartis and Sanofi	\$104,895	\$150,000	\$648,006	\$750,000	\$1,652,901	\$347,099
Health insurance/wellness Bupa	\$150,000	\$350,000	\$500,000	\$1,000,000	\$2,000,000	-
Sporting goods	-	-	-	-	-	\$2,000,000
Telecoms/technology Verizon	\$71,429	-	\$71,429	-	\$142,858	\$1,857,142
Bilaterals/foundations African Development Bank, WHO, WDF, Norway	-	\$140,959	\$545,354	\$830,000	\$1,516,313	\$483,687
All Sectors	\$326,324	\$640,959	\$1,764,789	\$2,580,000	\$5,312,072	\$4,687,928

IN-KIND CONTRIBUTIONS
NON-FINANCIAL SUPPORT FROM
PARTNERS, COUNTRIES AND ACADEMIC
INSTITUTIONS INCLUDE:

Donor	In-kind support
WHO	Additional Staff to Secretariat & Steering Committee
ITU	Additional Staff to Secretariat & Steering Committee; support for Telecoms 2012
IFPMA	Publication "Health at your fingertips"
The NCD Alliance	Advocacy support, support to mDiabetes Handbook
University of Cambridge	Financial modeling seminar and Monitoring & Evaluation Framework, March 2013
University of Southern California	Workshop on mSmartlife, February 2014
University of Oxford	Workshop on mHypertension, January 2015
AIIMS, University College of Medical Sciences	Workshop on mAgeing, November 2015
Norwegian Directorate of eHealth	Additional Staff to Secretariat

TABLE 2.
SECRETARIAT OPERATING
INCOME & EXPENSES,
2013 – 2015
(IN US DOLLARS)

INCOME	2013-2014	2015	2013-2015
Total Income	\$967,283	\$1,764,789	\$2,732,072
Voluntary contributions	\$826,032	\$1,560,440	\$2,386,472
Cash contributions	\$140,959	\$203,354	\$344,313
Interest earned	\$292	\$994	\$1,286

EXPENSES	2013-2014	2015	2013-2015
Total Expenses	\$770,314	\$1,104,327	\$1,874,641
Global Activities	\$422,740	\$674,043	\$1,096,783
Programme Coordination and Management (staff to support global and country activity)	\$282,528	\$348,700	\$631,228
Toolkit Development	\$119,163	\$236,071	\$355,234
Promotion & Partnership	\$41,050	\$69,271	\$110,321
Country Activities	\$256,630	\$383,298	\$639,928
Programme Planning and Implementation Support			
Costa Rica	\$131,377	\$35,174	\$166,551
Norway	\$12,853	\$51,399	\$64,252
Philippines	\$22,559	\$31,817	\$54,376
Senegal	\$52,030	\$113,068	\$165,098
Tunisia	-	\$27,551	\$27,551
UK	\$13,500	\$6,604	\$20,104
Zambia	\$17,023	\$21,240	\$38,263
India	-	\$76,894	\$76,894
Others	\$7,289	\$19,550	\$26,839
Operations	\$70,943	\$66,988	\$137,931
Administrative and Operations Services (AOS) 10% (ITU), 13% (WHO)	\$54,244	\$59,237	\$113,481
ITU Administrative Agent's Cost (1%)	\$8,237	\$12,199	\$20,436
Bank Charges	\$8,463	\$(4,450)	\$4,013

Exchange Losses/Gains			
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Total Surplus for the year 2015	\$196,969	\$660,461	\$857,430
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Note: All figures are unaudited. Expenses for 2014 include commitments as at December 11th 2014. The 2015 figures include commitments as at December 31st 2015. Where applicable, figures in Swiss Francs (CHF) have been converted to United States Dollars (USD) using the average UN operational rate of exchange for the relevant financial period.

ITU PARTNERS

BE HE@LTHY, BE MOBILE
WOULD LIKE TO EXPRESS
SINCERE APPRECIATION
AND THANKS TO ALL ITS
PARTNERS INCLUDING:



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