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Pillar 1: One billion more people benefitting from universal health coverage

6. Primary health care

Document EB146/5

This document is a draft operational framework for primary health care, as requested by resolution WHA72.2 (2019. The full version of the revised draft of the operational framework will be available on the WHO website. Following consultation with, and input from, Member States, the draft operational framework will be submitted for consideration by the Seventy-Third World Health Assembly in 2020.

Primary health care, as outlined in the 1978 Declaration of Alma-Ata. Member States recently reaffirmed their commitment to primary health care as a cornerstone of sustainable health systems for the achievement of universal health coverage and the health-related Sustainable Development Goals, in the Declaration of Astana, which was adopted at the Global Conference on Primary Health Care in October 2018. The document "A vision for primary health care in the 21st century: towards universal health coverage and the Sustainable Development Goals", is a whole-of-government and whole-of-society approach to health that combines the following three components: multisectoral policy and action; empowered people and communities; and primary care and essential public health functions as the core of integrated health services. Primary health care-oriented health systems are organized and operated so as to make the right to the highest attainable level of health, while maximizing equity and solidarity. They are composed of a core set of structural and functional elements that support achieving universal coverage and access to services that are acceptable to the population and that are equity enhancing. The term "primary care" refers to a key process in the health system that supports first-contact, accessible, continued, comprehensive and coordinated patient focused care.

Importance of primary health care

Despite remarkable improvements in the global population health outcomes, important gaps persist in people's ability to attain the highest possible level of health. About half of the world's population lack access to the services they need, and poor health disproportionally affects those faced with adverse determinants of health, driving health inequity both within and between countries. Health is central to the 2030 Agenda for Sustainable Development as it relates to many of the Sustainable Development Goals and is the specific focus of Goal 3. Target 3.8 on achieving universal health coverage captures commitment to equity and leaving no one behind, meaning that all individuals and communities receive the health services they need – including promotive, protective, preventive, curative, rehabilitative and palliative – of sufficient quality, without experiencing financial hardship.

To achieve universal health coverage, health systems built on the foundation of primary health care are essential, considering the demonstrated links of primary health care to better health outcomes, improved equity, increased health security and better cost-efficiency that make it the cornerstone of health systems strengthening. Primary health care-oriented health systems are required to effectively tackle WHO's current priorities including: WHO's Thirteenth General Programme of Work, 2019–2023; the global action plan for healthy lives and well-being for all, including the primary health care "accelerator" to enhance collaboration between partners in order

to accelerate progress at the country level on the health-related targets of the Sustainable Development Goals; WHO's framework on integrated people-centred health services; and WHO's framework for action for strengthening health systems to improve health outcomes, in which the principles and strategies for action are aligned with the overall approach of primary health care and the "levers" outlined in the draft operational framework.

Primary health care levers of the draft operational framework

The draft operational framework proposes 14 levers translating the global commitments made in the Declaration of Astana into actions, and interventions to accelerate progress in strengthening primary health care-oriented systems. A non-exhaustive list of proposed actions and interventions to be considered at the policy, operational, implementation and community levels is included in the draft operational framework, as well as case studies that illustrate how levers can be implemented to advance primary health care.

Actions and interventions related to each lever are interrelated, and implementation of all levers needs to take into consideration the contexts, strengths and weaknesses of the health system, and the national, subnational and local priorities based on inclusive policy dialogue that engages the community as an actor.

A framework for monitoring and evaluation of primary health care will be prepared as a separate technical document to provide decision-makers with high-quality data on all three components of primary health care, allowing them to effectively allocate resources and document progress made. It is expected that countries will select the levers and indicators that are most pertinent to their settings, based on an assessment of their needs, the capacity of their systems and their health governance models.

Enablers of success

The levers in the framework are based on evidence and experience on implementing health system reforms and align with building blocks and functions of effective health systems. The added value of this framework is that it provides guidance to countries throughout the national planning cycle on how commitment to primary health care can be translated into health for all through intersectoral actions, empowered people and communities, and integrated health services centred on people.

Health ministries should also empower actors and hold them accountable for their actions. They should steer the health sector in an inclusive manner, involving public, private and civil society actors. The integration of primary health care across a wide range of policies, strategies, activities and services will likely need a substantial transformation of the ways in which health-related policies and action are prioritized, funded and implemented. The engagement of individuals, communities, and of stakeholders from all sectors is central to primary health care, with special focus on engaging vulnerable and disadvantaged populations and promotion of social accountability will strengthen community engagement.

Many countries will still require external technical and/or financial support to bring about an improvement of primary health care for universal health coverage. In each of these countries, strong leadership and advocacy for harmonization and alignment of global donors and technical partners involved in strengthening primary health care are needed more than ever. The international community, through platforms such as the International Health Partnership for UHC 2030, should support such harmonization and alignment at the country level.

Action by the Executive Board

The Board is invited to note the report and support the implementation of the draft operational framework for primary health care, towards the commitments in the Declaration of Astana and the high level political declaration on universal health coverage.

Implications for the European Region

Strengthening primary health care has long been a priority for the countries in the European Region The 2030 Agenda for Sustainable Development and the 2018 Declaration of Astana have created renewed political commitment to this agenda in recognition of the need to more effectively address the high burden of noncommunicable diseases that impose a high cost on health systems as well as more broadly on society, as evidenced by the unanimous adoption of the Resolution on accelerating primary health care strengthening ((EUR/RC69/R8) at the 69th session of the Regional Committee for Europe in 2019.

The Operational Framework for Primary Health Care is highly relevant for the countries in the European Region and it complements the 10 policy accelerators for strengthening primary health care in the WHO European Region (EUR/RC69/13 Rev.1).

Thanks to the generous contribution of the Government of Kazakhstan, including through the WHO European Centre for Primary Health Care, the WHO Regional Office is actively supporting 34 countries in the Region through a variety of activities including assessments of national primary health care systems; technical assistance, training courses, study tours and policy dialogue; country assessments using a newly developed WHO European Primary Health Care Impact, Performance and Capacity Tool; country assessments of integrated delivery of long-term; case studies on strengthening the role of nurses in primary health care and strengthening the competences of nurses in primary health care.

7. Follow-up to the high-level meetings of the United Nations General Assembly on health-related issues

7.1 Universal health coverage: moving together to build a healthier world

Document EB146/6

Member States showed strong political commitment to ensuring universal health coverage and recognized the importance of primary health as the cornerstone of a sustainable health system for universal health coverage and health-related Sustainable Development Goals in the landmark political declaration of the high-level meeting on universal health coverage, which is the most comprehensive set of health commitments ever adopted at this level and was congratulated by the Secretary General of the United Nations. World leaders committed to leadership across policy areas within and beyond the health sector to achieve objectives for universal health coverage within SDG 3. The political declaration emphasizes the roles that governments and all stakeholders and sets out a road map of commitments, including access to safe, effective, affordable and essential medicines, vaccines, diagnostics and health technologies; and tackling the trend of catastrophic out-of-pocket

health expenditure by providing measures to ensure financial risk protection and eliminate impoverishment due to health-related expenses by 2030.

Universal health coverage and the central importance of primary health care

The essence of universal health coverage is universal access to a strong and resilient people-centred health system, with primary health care as its foundation, so that all people can obtain the nationally determined health services they need. Primary health care, which comprises primary care, community engagement and multisectoral action, is intended to provide holistic, people-centred services in communities across the life course. It is an approach to health service delivery that has the potential to address inequities in access to health care and can respond relevantly to changing epidemiological and demographic trends as well as social and cultural contexts that affect health.

Primary health care is widely recognized as the most equitable, efficient, cost-effective and sustainable platform for delivering most health services, as well as a foundation for effective, efficient and equitable health systems, being the best means to ensure universal health coverage and the Sustainable Development Goals. A commitment to people-centred primary health care as the means to move towards universal health coverage WHO's Thirteenth General Programme of Work, 2019–2023, which was reinforced by Member States in the Declaration of Astana (2018).

Universal health coverage 2019 – monitoring report: highlights, achievements and challenges

Coverage of essential health services increased from a global average of 45 (of 100) in 2000 to 66 in 2017, in all regions and income groups, but progress has slowed down since 2010 and masks gross inequities. With a continuous increase in catastrophic health expenditure between 2000 and 2015, more people are experiencing financial hardship, what pushed many of them into poverty, a situation requires action to implement evidence-based health financing measures. Despite the world's health and development efforts undertaken since 2000, most vulnerable population groups still face numerous health challenges, including preventable neonatal and maternal deaths, and ten countries account for 60% (11.7 million) of children worldwide who are not protected by vaccinations, with unprotected children disproportionately living in fragile settings.

To reach the SDG target 3.8 of achieving universal health coverage, coverage needs to at least double between 2019 and 2030, and countries will need to recruit and train 18 million health workers globally. Hence, governments, in conjunction with the global community, need to accelerate progress, including an updated and people-centred approach to primary health care and investments in strengthening health systems. so that countries are better equipped to respond to people's health needs across the life course. A sharper focus on people left behind and areas of greatest need is needed in all countries and investments in generating high-quality, disaggregated data will help to ensure accountability and provide countries with vital insights for allocation.

Investing in universal health coverage and eliminating catastrophic health expenditure

All people should be able to receive high-quality health care without financial hardship – as rights holders, citizens and taxpayers. The declaration on universal health coverage is a means of realizing people's right to the highest attainable standard of health and a sound investment for inclusive and sustainable development considering that human capital, based on people's health and education, constitutes an estimated two thirds of any nation's wealth and people are better protected in countries with higher public expenditures on health. To ensure maximum impact, these resources must be invested efficiently and equitably.

Up to five billion people risk being unable to access health care, if service coverage is not accelerated. To achieve health targets by 2030, governments need to increase spending on primary health care by at least 1% of their gross domestic product in order. An additional US$ 200 billion a year on scaling up primary health care across low- and middle-income countries could save 60 million lives, increase average life expectancy by 3.7 years by 2030 and contribute significantly to socioeconomic development and another US$ 170 billion a year is needed for a more comprehensive package to achieve universal health coverage. Most countries can raise the necessary funding from domestic resources by increasing public spending on health in general and reallocating spending towards primary health care, but currently most countries underinvest in primary health care. Countries with the lowest incomes, including many affected by conflict, will continue to require external assistance, that should be ensured by the universal solidarity embodied by the Sustainable Development Goals and international human rights.

Next steps for who

The Secretariat will respond to the high-level political declaration by redoubling its efforts to help Member States to deliver universal health coverage, including by using WHO's new special programme on primary health care to customize support for implementation to meet country-specific needs and promoting innovation and equity-, gender- and rights-based programming approaches to scale up access to health care and financial protection and reach those furthest left behind.

WHO will facilitate integration, efficiency and effectiveness through working with partners, for instance through the global action plan for healthy lives and well-being for all, and strengthen socio-political accountability and inclusive participation of all stakeholders, considering that all stakeholders play a role in identifying impediments to equity and progress, and in shaping relevant, context-specific action to drive universal health coverage and realize the rights of all people to the highest attainable standard of health.

Moreover, WHO will monitor progress on the commitments in the high-level political declaration on universal health coverage, including by supporting the Secretary General to provide a progress report during the seventy-fifth session of the General Assembly, and a report including recommendations on the implementation of the present declaration during the seventy-seventh session, which will serve to inform the high-level meeting to be convened in 2023. Monitoring can be contextualized by countries as part of national health sector planning and will be aligned with monitoring of progress towards the Sustainable Development Goals, the impact framework of WHO's Thirteenth General Programme of Work, 2019–2023, and, subject to the governing bodies' consideration, the operational framework for primary health care and Sustainable Development Goal review processes.

Action by the Executive Board

The Board is invited to note the report.

Implications for the European Region

Universal health coverage is a high priority for the countries of the European Region. Since 2015, the Regional Office for Europe is monitoring financial protection using new metrics that are more suited to high- and middle income countries and better able than other metrics (including SDG 3.8.2) to capture financial hardship among poor households. The European Region is the only WHO

region that produces equity analysis of financial hardship and unmet need for health services. This has been highlighted by the UHC2030 Civil Society Engagement Mechanism in their comments on the Global monitoring report on UHC, which includes analysis from the European Region and publishes both the SDG indicator values and the new metrics developed for Europe. There is growing interest from other WHO regions to adopt the European metrics for improving equity analysis and relevance to policy actions.

On World Health Day in 2019, the Regional Office published the first-ever WHO European regional report on financial protection 'Can people afford to pay for health care – New evidence on financial protection in Europe'. The report draws on country-specific analysis from 24 Member States and shows that there is room for improvement even in high-income countries that provide the whole population with access to a wide range of publicly financed health services

New evidence from the study finds that:

- out-of-pocket payments have the greatest impact on those least able to pay for health care: the poorest households, people with chronic illnesses and older people
- a significant share of households are impoverished or further impoverished after having to pay out of pocket; as a result, these households cannot afford to meet other basic needs – food, rent, utility bills
- the incidence of catastrophic health spending is heavily concentrated among poor households; across countries, it increases as the out-of-pocket share of current spending on health increases;
- outpatient medicines are a major source of financial hardship in many countries, especially among poorer households;
- increasing the share of public spending on health is a prerequisite for reducing out-of-pocket payments, but improving coverage policy is equally important for financial protection.

The Regional Office will continue to produce country-specific analysis with recommendations on how to make progress towards a Europe free of impoverishing out-of-pocket payments for health. The second regional report will be published in 2021 and aims to cover analyses from 37 countries of the European Region.

Strengthening primary health care has long been a priority for the countries in the European Region. The 2030 Agenda for Sustainable Development and the 2018 Declaration of Astana have created renewed political commitment to this agenda, as evidenced by the unanimous adoption of the Resolution on accelerating primary health care strengthening ((EUR/RC69/R8) at the 69th session of the Regional Committee for Europe in 2019[1].

The WHO Regional Office is actively supporting 34 countries in the Region through a variety of activities including assessments of national primary health care systems; technical assistance, training courses, study tours and policy dialogue; country assessments using a newly developed WHO European Primary Health Care Impact, Performance and Capacity Tool; country assessments of integrated delivery of long-term care; case studies on strengthening the role of nurses in primary

[1] Resolution – Accelerating primary health care strengthening.
http://www.euro.who.int/__data/assets/pdf_file/0007/413827/69rs08e_PHC_Resolution_190595.pdf?ua=1

health care (Poland, Slovenia, Ireland) and strengthening the competences of nurses in primary health care.

7.2 Political declaration of the third high-level meeting of the General Assembly on the prevention and control of non-communicable diseases

Document EB146/7 and Document EB146/7 Add.1

Document EB146/7

Resolution WHA66(8) (2013) adopted the comprehensive mental health action plan 2013-2020. Resolution WHA72(11) (2019) confirmed the objectives of this action plan and extended the period of the plan to 2030 to ensure alignment with the 2030 Agenda for Sustainable Development. This resolution requested the Director-General to prepare and update menus of policy options and cost-effective interventions to support Member States in implementing the commitments made in the political declaration of UNGA's third high-level meeting on the prevention and control of non-communicable diseases, both to promote mental health and well-being and to reduce the number of premature deaths from noncommunicable diseases attributed to air pollution, and to report to the WHA73th through the EB on the implementation of the global strategy to reduce the harmful use of alcohol.

Annex 1 outlines a menu of **policy options and cost-effective interventions to promote mental health and wellbeing** (Appendix 1), based on the WHO-CHOICE methods used for identifying the relative costs and effects of NCD prevention and control strategies. The menu of options includes both previously assessed clinical management interventions for leading causes of disease burden (such as depression, bipolar disorder and psychosis) and also newly analysed population-level interventions, specifically regulatory bans of highly hazardous pesticides to reduce suicide and school-based socio-emotional learning programmes to improve mental health and prevent suicide. WHO Secretariat convened a technical consultation in Geneva, in August 2019, to review the analyses and subsequently prepared a discussion paper containing the draft menu of options for consultation with Member States and other interested parties. In the second half of 2020, the Secretariat will prepare updated appendices to the comprehensive mental health action plan 2013-2030.

Appendix 1 provides a non- exhaustive, preliminary menu of cost effective interventions on mental health, as well population based as individual- level interventions. It highlights the importance of non-financial considerations, such as human rights and health equity to be taken into consideration. The document further stresses that the progressive expansion of service coverage is a key aspect of universal health coverage and that scaling up interventions for mental health conditions should proceed through community-based mental health and social care services. As recommended in the comprehensive mental health action plan 2013–2030, the locus of care should be systematically shifted away from long-stay mental hospitals towards non-specialized health settings with increasing coverage of evidence-based interventions and deployment of a network of linked community-based mental health services.

Annex 2 explains the current context on **premature deaths from noncommunicable diseases attributed to air pollution**. Member States identified reduction of air pollution as an integral element of global sustainable development through resolution WHA68.8 (2015), including that health impacts

related to air pollution can be a relevant health indicator for sustainable development policies, and the Health Assembly welcomed in decision WHA69(11) (2016) the road map submitted by the Director-General for an enhanced global response to the adverse health effects of air pollution.

Some 91% of the global population is exposed to pollutant levels exceeding WHO recommendations, with people living in low- and middle-income countries bearing most of the associated burden. Around three billion people still cook with solid fuels or kerosene using open fires and inefficient stoves, exposing themselves to unsafe levels of household air pollution. In 2016, WHO estimated that seven million premature deaths from acute lower respiratory infections, chronic obstructive pulmonary disease, ischaemic heart disease, lung cancer and stroke had been the result of exposure to air pollution in the outdoor and indoor environments.

The integration of strategies to mitigate air pollution into wider public health prevention and health care delivery strategies, such as the global action plans for the prevention and control of noncommunicable diseases 2013–2020 and for the prevention of communicable diseases such as pneumonia as well as other relevant existing health strategies, processes and instruments, is fundamental to an effective health sector response to air pollution.

The Secretariat will conduct an in-depth analysis of the effectiveness of existing interventions and prepare guidance on how to select population-level policy options and interventions, considering, among others, the evidence included in the WHO air quality guidelines and comprehensive reviews of other evidence. The guidance will be subject to external expert peer review. The resulting guidance will stress the need to take account of local context and will provide the necessary tools for Member States to select interventions that are effective in reducing source emissions, have co-benefits, and be are likely to be cost-effective.

Annex 3 describes the **implementation of the global strategy to reduce the harmful use of alcohol**, in response to decision WHA72(11) requesting the Director General to report on the issue to the Seventy-Third World Health Assembly in 2020, through the Executive Board. Since the endorsement of the global strategy in 2010 (resolution WHA63.13), Member States' commitment to reducing the harmful use of alcohol has been further strengthened by the adoption of the UNGA political declarations and by the adoption and implementation of the global action plan for the prevention and control of noncommunicable diseases 2013–2020, which lists harmful use of alcohol as one of the four key risk factors for major noncommunicable diseases. Furthermore, target 3.5 of Sustainable Development Goal 3 includes the objective of strengthening the prevention and treatment of substance abuse, including harmful use of alcohol, which reflects the broader impact of the latter on health beyond noncommunicable diseases, in areas such as mental health, violence, road traffic injuries and infectious diseases.

A revision of Appendix 3 to the global action plan for the prevention and control of noncommunicable diseases in 2017, included evidence on the cost–effectiveness of policy options and interventions and resulted in a new set of enabling and recommended actions to reduce the harmful use of alcohol, such as increasing taxes on alcoholic beverages, enacting and enforcing bans or comprehensive restrictions on exposure to alcohol advertising across multiple types of media, and enacting and enforcing restrictions on the physical availability of retailed alcohol. To support Member States in reducing the harmful use of alcohol by enhancing ongoing implementation of the global strategy, to protect public health-oriented policy-making against interference from commercial interests and establish strong monitoring systems to ensure accountability and track progress, the Secretariat, with partners, launched the SAFER initiative.

Since the endorsement of the global strategy, the pace of development and implementation of policies on alcohol has been uneven between the WHO regions. The presence of written national alcohol policies continues to be most common in high-income countries (67%) and least common among low-income countries (15%); most countries in the Africa Region and the Region of the Americas did not have written national alcohol policies. This underscores the need for more resources and greater priority to be given to supporting development and implementation of effective actions in low- and middle-income countries.

Between 2010 and 2016, no progress was made in reducing the total alcohol consumption per capita in the world. Despite a decrease, the highest levels of consumption per capita is observed in countries of the European Region. Levels remained stable in countries in the Region of the Americas and the African and Eastern Mediterranean regions and increased in the South-East Asia and Western Pacific regions. Although the number of drinkers declined across all WHO regions between 2010 and 2016, alcohol was consumed by more than half the population in three WHO regions: the Americas, European and the Western Pacific. Age-standardized prevalence of heavy episodic drinking decreased globally but remained high particularly in parts of eastern Europe and in some sub-Saharan African countries. In all WHO regions higher alcohol consumption rates and higher prevalence of current drinkers are associated with the economic wealth of countries, but the prevalence of heavy episodic drinking is equally distributed between higher- and lower-income countries in most regions, except for the African and European Regions, where rates are higher in lower-income countries and in high-income, respectively.

Despite improvements in the number of age-standardized alcohol-attributable deaths and disability-adjusted life years (DALY) in all regions except South-East Asia, the overall burden of disease attributable to alcohol consumption remains unacceptably high, resulting in 5.3% of all deaths and 5.1% of all DALYs worldwide, with men and younger people being the most affected. The age-standardized alcohol-attributable burden of disease and injury was highest in the African Region, whereas the proportions of all deaths and DALYs attributable to alcohol consumption were highest in the European Region (10.1% of all deaths and 10.8% of all DALYs). About 49% of alcohol-attributable DALYs are due to noncommunicable diseases and mental health conditions, and about 40% are due to injury. Projections until 2025 show that total alcohol consumption per capita in people aged 15 years and older is likely to increase in countries in the Region of the Americas and the South-East Asia and Western Pacific regions, which will increase alcohol-attributable disease and social burden if not halted.

Addressing the harmful use of alcohol needs whole-of-government and whole-of-society approaches, with appropriate engagement of non-State actors, including public health-oriented nongovernmental organizations, professional associations and civil society groups, as well as coordinated and concerted actions across organizations in the United Nations system and regional intergovernmental organizations. New partnerships and appropriate engagement of all relevant stakeholders are needed to support the implementation of practical and focused technical packages based on evidence of effectiveness and cost–effectiveness of alcohol-control measures that can ensure returns on investment by reducing the harmful use of alcohol. There is a gap between the magnitude of alcohol-attributable disease and its social burden and resources available at all levels. The Secretariat has embarked on a broad consultative process, including regional technical consultations with Member States, a web-based consultation with all stakeholders, and informal consultations with Member States on a discussion paper developed subsequently. The summary of

the findings of the consultation process are submitted as an addendum to this report (see Document EB146/7 Add.1).

Annex 4 sets out the **challenges to and opportunities for promoting access to affordable diagnostics, screening and early diagnosis as part of a comprehensive approach to the prevention and control of noncommunicable diseases**, following a meeting in November 2019 on the provisional agenda of the Executive Board at its 146th session, the Officers of the Board agreed to the request of Member States for a discussion of the early detection of noncommunicable diseases and strengthening the control of harmful use of alcohol.

The political declaration adopted at the UNGA third high-level meeting on the prevention and control of non-communicable diseases in 2018 recognizes that action to realize the commitments made [in 2011 and 2014] for the prevention and control of non-communicable diseases is inadequate and that the level of progress and investment to date is insufficient to meet target 3.4 of the SDGs and that the world has yet to fulfil its promise of implementing, at all levels, measures to reduce the risk of premature death and disability from non-communicable diseases. WHO's global action plan for the prevention and control of noncommunicable diseases 2013–2020 states that a strengthened health system directed towards addressing noncommunicable diseases should aim to improve prevention, early detection, treatment and sustained management of people with or at high risk for cardiovascular disease, cancer, chronic respiratory diseases, diabetes and other noncommunicable diseases, in order to prevent complications, reduce the need for hospitalization and costly high-technology interventions and premature deaths.

WHO has highlighted the importance of early diagnosis and screening, since late diagnosis of major noncommunicable diseases can result in higher costs of treatment, catastrophic health expenditures and impoverishment. However, countries' health systems already face significant and diverse challenges in their existing capacities. Metabolic and physiological risk factors, such as raised blood pressure and raised blood concentrations of glucose and selected lipids, can be detected and managed in primary care. The country capacity survey showed that many basic technologies for the early detection, diagnosis and monitoring of noncommunicable diseases were generally available in primary care facilities (in 50% of facilities or more) in the public health sector, but other technologies are still missing.

Several WHO publications highlight the appropriateness of screening for cancer in countries with different health system capacities and WHO's initiative to eliminate cervical cancer as a public health problem will boost the momentum for cervical cancer screening and treatment. WHO also provides guidance on cardiovascular disease risk assessment, on screening for diabetes, on hypertension and diabetes diagnosis and management in primary care. The Second WHO Model List of Essential In Vitro Diagnostics (2019) provides a comprehensive reference for programme managers for the prevention and early detection of noncommunicable diseases and builds on the WHO list of priority medical devices required for cancer management. In 2018–2019, the Secretariat provided support for implementation of cardiovascular disease and cancer programmes, including early diagnosis, screening and treatment, in more than 30 Member States and consultations on cancer screening were conducted in the European and Eastern Mediterranean region.

Regarding the Secretariat response, it will generate technical packages and service delivery models that support the scaling up of early diagnosis and screening, through technical consultations and a global policy dialogue starting in 2020. Regional offices will further advance this work by providing guidance and support to Member States for implementing these packages and models. To support Member States in fulfilling their commitments to the early detection of noncommunicable

diseases, the Secretariat is producing a guide for cancer screening, taking account of a variety of perspectives and the potential harms and benefits and enhancing the capacity of the One Health Tool. The Secretariat will also update its guidance on screening for metabolic and physiological risk factors (hypertension, diabetes and an unfavourable blood lipid profile) and selected cancers, taking into account global evidence as well as local capacity and feasibility. Considering that strengthened information systems are required for safe and effective implementation of early detection programmes for noncommunicable diseases, WHO has produced guidance on the indicators that should be used to monitor programme performance in cervical cancer and is working on a clinic-based register of noncommunicable diseases.

Several organizations in the United Nations system are supporting the work in this area. Professional societies have a major role in promoting a standardized approach, and development partners and non-State actors, including civil society and other stakeholders seeking to support implementation of early detection programmes, should consider both the guidance of intergovernmental agencies and the feasibility of screening for noncommunicable diseases giving due recognition to the potential harm of diverting resources towards programmes that have high costs and minimal population benefit. To support monitoring, reporting and accountability, all partners should consider using an agreed set of performance indicators and report on progress on closing the gap on early treatment to the appropriate public health authorities.

Action by the Executive Board

The Board is invited to note the report and to provide guidance on the way forward to (1) consider the menu of policy options and cost-effective interventions in Annex 1 to promote mental health and well-being; (2) finalize the work of the Secretariat described in Annex 2 to prepare a menu of policy options and cost-effective interventions to reduce the number of premature deaths from noncommunicable diseases attributed to air pollution; and (3) strengthen the implementation of the global strategy to reduce the harmful use of alcohol.

Document EB146/7 Add.1

This document summarizes the findings of a consultative process undertaken by the Secretariat on the implementation of WHO's global strategy to reduce the harmful use of alcohol during the first decade since its endorsement and the way forward, in response to the request of the Health Assembly to the Director-General in decision WHA72(11) (2019).

The consultative process was conducted and included: (a) multi-stakeholder discussions at the Second WHO Forum on alcohol, drugs and addictive behaviours (173 participants of 53 countries); (b) regional technical consultations with Member States in all six WHO regions; (c) a multi-stakeholder web-based consultation on a discussion paper (191 submissions); (d) an informal consultation with Members States (52 Member States and the European Commission). Furthermore, the Secretariat conducted the global survey on progress towards health target 3.5 (Strengthening the prevention and treatment of substance abuse, including narcotic drug abuse and harmful use of alcohol) of Sustainable Development Goal.

Challenges

Considerable challenges remain for the development and implementation of effective alcohol policies, such as the complexity of the problem, the intersectoral nature of cost-effective solutions and limited levels of political commitment of stakeholders to effective measures in the context of international economic and commercial interests. Drinking alcoholic beverages is strongly embedded in social norms and cultural traditions in many societies, which may encourage alcohol consumption, delay appropriate health-seeking behaviour and weaken community actions. Awareness and acceptance of the overall negative impact of alcohol consumption on a population's health and safety among decision-makers and the public remain low. Competing interests across the whole of government at country level, including those related to the production and trade of alcohol, often result in policy incoherence and the weakening of alcohol control efforts.

Alcohol is not controlled at the international level by legally-binding regulatory instruments, which limits the ability of national and subnational governments to regulate the distribution, sales and marketing of alcohol within the context of trade negotiations, as well as to protect the development of alcohol policies from interference by commercial interests. This calls for discussions about the feasibility and necessity of a global normative law on alcohol at the intergovernmental level, modelled on the WHO Framework Convention on Tobacco Control.

Informally- and illegally-produced alcohol amounts to an estimated 25% of total alcohol consumption per capita worldwide, exceeding 50% in some jurisdictions, and are often embedded in cultural traditions and socioeconomic fabrics of communities. The capacity to deal with these informal or illicit practices, including safety issues, is limited or inadequate, particularly in jurisdictions where unrecorded alcohol consumption is high. Satellite and digital marketing presents a growing challenge for the effective control of alcohol marketing and advertising. Since they cross borders, they are not easily subjected to national-level control. Delivery systems are evolving rapidly, challenging the ability of governments to control sales of alcohol to minors and intoxicated people.

Limited technical capacity, human resources and funding hinder efforts in developing, implementing, enforcing and monitoring effective alcohol control interventions at all levels, including in the WHO Secretariat. Few civil society organizations prioritize alcohol as a health risk and prod governments into action, as has been common for tobacco control. In the absence of philanthropic funding and limited resources in WHO and other intergovernmental organizations, there has been little investment in capacity-building in low- and middle-income countries. The lack of sufficiently developed national systems for monitoring alcohol consumption and the impact of alcohol on health reduces the capacity for advocacy of effective alcohol-control policies and monitoring their implementation and impact.

Opportunities

Alcohol use has been increasingly recognized as a factor in health inequality, both within and among societies, as its health and social harm are greater for the poorer and it can exacerbate health and social inequalities between genders. Policies and programmes to reduce health inequalities and promote sustainable development need to include alcohol policies and programmes.

In recent years, alcohol consumption by young people has been dropping in many countries throughout Europe and in some other high-income societies and capitalizing on this trend offers a considerable opportunity for public health policies and programmes. Increasing awareness of negative health and social consequences of the harmful use of alcohol, particularly regarding some types of cancer, liver and cardiovascular diseases, and infectious diseases such as tuberculosis and HIV/AIDS

and increasing the health literacy and health consciousness of people provides an opportunity for strengthened prevention activities.

Evidence for the effectiveness and cost–effectiveness of alcohol-control measures has been significantly strengthened, demonstrating high returns on investment for "best buys" in alcohol control: every additional United States dollar invested in the most cost-effective interventions per person per year will return US$ 9.13 by 2030, which is higher than for a similar investment in tobacco control (US$ 7.43) or prevention of physical inactivity (US$ 2.80).

The way forward

Priority areas for strengthening implementation of the global strategy

Concerted actions are needed to at least stabilize the currently increasing trends in alcohol consumption in several WHO regions and to accelerate the decreasing trends in others. Priority areas include preventing children and adolescents from starting to drink alcohol, actions to reduce drinkers' levels of alcohol consumption, measures to protect non-drinkers from pressures to drink, and support for non-drinking behaviour.

Developing goals and targets in line with global and regional monitoring frameworks, but reflecting global, regional, national or subnational public health priorities, trends, contexts and opportunities and action plans or implementation road maps with specified objectives, indicators and time frames can help to accelerate implementation. Strengthening monitoring and surveillance functions and systems on alcohol and health can support the evaluation of alcohol policies and generate data in support of alcohol-control measures.

Public health advocacy, partnership and dialogue

An international "World no alcohol day" could help to increase public attention and provide high-level advocacy to accelerate implementation of the global strategy to reduce harmful use of alcohol.

New partnerships and appropriate engagement of all relevant stakeholders building capacity and supporting implementation of practical and focused technical packages can ensure returns on investments, including the new WHO-led SAFER initiative. Economic operators in the areas of alcohol production and trade are encouraged to contribute to reducing the harmful use of alcohol in their core areas, and to take concrete steps towards eliminating marketing, advertising and sales of alcoholic products to minors. The global dialogue with economic operators should focus on the industry's contribution to reducing the harmful use of alcohol within their roles and to be centred on areas of: traditional and online or digital marketing (including sponsorship); sales, e-commerce, and delivery; production and labelling; and data on production and sales.

Technical support and capacity-building

Implementation of alcohol policy measures at country level may require strong technical assistance, particularly in less-resourced countries and such technical areas such as taxation, legislation or consideration of health protection from alcohol-related harm in trade negotiations.

Global and regional networks of country focal points for alcohol policies and technical experts will facilitate country cooperation, knowledge transfer and capacity-building, particularly in challenging technical areas such as control of digital marketing and social media advertising.

A comprehensive repository of practical examples of good implementation and evaluation of alcohol-policy options linked to or integrated with WHO's Global Information System on Alcohol and Health, strengthening national monitoring systems on alcohol and health, and technical tools to improve the data generated at country level are some of the main requests.

Production and dissemination of knowledge

Compared with 2010, more countries are able to collect, collate and disseminate reliable information on alcohol use, its health and social consequences, and policy developments, but their number is still limited. All countries are encouraged to include alcohol modules in data collection tools used in population-based surveillance activities.

Research is needed on various elements such as the role of alcohol consumption in the transmission, progression and treatment outcomes of some infectious diseases, on harm to others from drinking, as well as on the consumption of informally and illegally produced alcohol and its health consequences, on effective ways to increase the health literacy of people , on costs and benefits of alcohol-control measures and development of investment cases.

International standards on the labelling of alcohol beverages must be developed and implemented including the update of WHO's lexicon of alcohol and drug, to ensure "common language" in this area among different cultures and jurisdictions. Strategic and well-developed communication and advocacy are needed to raise awareness among decision-makers and the general public, mobilize different stakeholders for coordinated actions to protect public health, and foster political commitment to reduce harmful use of alcohol.

Resource mobilization

Lack of resources presents a primary barrier to introducing or accelerating global and national actions to reduce the harmful use of alcohol.

Several innovative approaches that combine evidence-based knowledge with more unorthodox ideas have been reported, and there are examples of revenues from taxes on alcoholic beverages being used to fund health-promotion initiatives, health coverage of vulnerable populations, prevention and treatment of alcohol and substance use disorders, as well as, in some cases, supporting international work in these areas. Earmarked funding for prevention and treatment of alcohol use disorders and related conditions is provided with funds generated from: State-owned retail monopolies; a levy on profits across the value chains for alcohol beverages; taxing alcohol advertising; or imposing earmarked fines for noncompliance with alcohol regulations. Consideration should be given to an intergovernmental commitment to a global tax on alcohol to support this effort, with the use of the money so raised to be governed internationally.

Action by the Executive Board

The Board is invited to note the report and to provide further guidance on the way forward.

Implications for the European Region

Mental health

Mental health conditions are one of the most significant public health challenges in the WHO European Region. A substantial number or proportion of Member States are seeking to develop evidence-informed policies and approaches to the development or reconfiguration of mental health

services and systems. Identification of intervention strategies that are supported by evidence on cost-effectiveness, affordability and feasibility can help to guide policy-makers towards a more efficient and equitable use of resources, not only in relation to currently delivered care but also new or untapped strategies for mental health promotion and protection at the population level. Several countries in the WHO European Region are making use of WHO's mental health gap action programme (mhGAP), which provides clinical guidance on the identification and management of priority conditions in non-specialist settings; the cost-effectiveness analyses that has been carried out provides economic evidence that can be used alongside other considerations including accessibility, equity and human rights protection.

Air pollution

Despite improvements in air quality in parts of the European Region, ambient and household air pollution is responsible for more than 550 000 premature deaths in the WHO European Region. Reducing air pollution and the associated burden of disease requires intersectorial cooperation and targeting different sources of air pollution.

In the WHO European Region, air pollution remains one of the priorities of the European Environment and Health Process. The Declaration of the Sixth Ministerial Conference on Environment and Health (Ostrava, Czechia, 2017), sets the objective to 'improve outdoor and indoor air quality as one of the most important environmental risk factors in the Region through actions towards meeting the WHO air quality guideline values in a continuous process of improvement'. Several actions are proposed to be considered by Member States, which are urged to develop national portfolios of actions according to their specific needs. In resolution EUR/RC67/R4, the 67th session of the WHO Regional Committee for Europe endorsed the Ostrava Declaration.

The WHO Regional Office, through the European Centre for Environment and Health (, develops tools, such as AirQ+ software to quantify the health impact of air pollution, and works with Member States to strengthen capacities in the health and environment sector to calculate the estimates to support decision-makers to develop actions to protect public health.

The Task Force on the Health Aspects of Air Pollution, established within the UNECE Convention on Long-range Transboundary Air Pollution, and chaired by WHO Regional Office provides a well-established platform that gathers experts designated by countries that are parties to the Convention.

Alcohol

Despite some progress, the WHO European Region continues to have the highest level of per capita alcohol consumption in the world. In 2016, more than 1 million people died as a result of harmful use of alcohol in the Region. Reducing the harmful use of alcohol requires understanding that alcohol is not an ordinary commodity and increase implementation of cost-effective policies. As the WHO European Action Plan on reducing harmful use of alcohol 2012-2020, is coming to an end and Member States requested discussions on the way forward at global and regional levels, the WHO Regional Office hosted two consultations with Member States and civil society organizations in 2019. Member States requested The WHO Regional Office to develop a "Framework for action to strengthen implementation of the WHO European Action Plan to Reduce the Harmful Use of Alcohol 2020-2025", aligned with the Global Strategy but focusing on the following priority areas: pricing, availability,

marketing, health information, health service response and community action. The intention is to boost implementation in these areas for which implementation is lagging behind despite very strong evidence that such measures are effective. Discussions on the way forward of the WHO Global Strategy to reduce the harmful use of alcohol are important to further inform the new framework for action to be developed.

Early detection of noncommunicable diseases and risk factors

Within the WHO European Region, early diagnosis and timely treatment of noncommunicable diseases or their risk factors is of key importance. Early detection of noncommunicable diseases should be managed in a more cost-effective way. Currently, to often resources are invested in launching screening programs but with low participation, and there are inadequate quality assurance measures and insufficient health infrastructure to deliver organized services. Furthermore, in some countries screening is done for people at a too early age or for disease where screening has no impact and can even be harmful. Such nonevidence-based practices result in wasting of resource and may harm healthy people.

With the "WHO Europe Technical Consultation on Screening" that took place in February 2019 and the "WHO Europe conference on screening" to be held in February 2020, the Regional Office has stepped up efforts on screening for noncommunicable diseases and health checks throughout the life-course. The 2019 consultation provided evidence on various screening practices, including harms and benefits, and identified cross-cutting issues and possible solutions. Guidance and publications build on this evidence and finding will be made available at the 2020 Conference.

8. Global vaccine action plan

Document EB146/8

This document provides the relevant updates to the global vaccine action plan and identifies the lessons learned from its implementation and additionally explores the feasibility of eradicating measles and rubella and defeating meningitis, both by 2030.

Immunization in the next decade

The global vaccine action plan provides a comprehensive global strategy spanning both disease elimination/eradication initiatives and national immunization programme activities. The regional vaccine action plans have played a key role in bridging the gap in strategy and planning between global and country levels. Progress towards the intended objectives of better integrating immunization into primary health care and of building linkages outside the health sector has been limited. The opportunities for non-State actors to establish closer ties with emerging health priorities, such as global health security, have not been fully grasped. The innovative and comprehensive framework for monitoring, evaluation and accountability allows a common set of metrics to assess progress and to enable Member States to benchmark their achievements. The Strategic Advisory Group of Experts on immunization, at its meeting in October 2019, proposed that a post-2020 immunization strategy should ensure more timely and comprehensive implementation at global,

regional, national and subnational levels with focus on countries, establish a governance model to turn strategy into action, promote long-term planning for the development and implementation of novel vaccine and other preventive innovations, to ensure that populations benefit as rapidly as possible, promote the use of data to stimulate and guide action and to inform decision-making and, strengthen monitoring and evaluation at the national and subnational levels in order to promote greater accountability.

The Feasibility of Eradicating Measles and Rubella

All regions have set a measles elimination goal and four out of six have set a rubella elimination goal, but regions and countries are at different stages of achieving those goals. Implementation of current strategies in some countries is not sufficient to achieve these goals in the foreseeable future without a substantial shift in country, regional and global commitments. Eradication of measles and rubella is considered technically feasible and the Strategic Advisory Group of Experts on immunization has already stated that these diseases can and should be eradicated. Progress relies critically on delivery of primary health care and universal health coverage, increased commitment to achieving high, equitable immunization coverage, identifying and filling immunity gaps, robust surveillance, and effective outbreak response. Efforts to achieve and maintain elimination of measles and rubella are critical to strengthening immunization and primary health care services, advancing the global health security agenda and achieving equitable health coverage for all.

Defeating Meningitis by 2030

In 2018, the report by the Director-General acknowledges defeating meningitis by 2030 as one of the four flagship global strategies to prevent high-threat infectious hazards. A new immunization strategy for meningitis could provide an overarching framework for a global vision and strategy for meningitis prevention and control thereby acting as a potentially powerful lever to strengthen immunization programmes, reinforce primary health care, improve control of infectious disease, tighten global health security and broaden access to disability support.

Action by the executive board

The Board is invited to note the progress report and focus its deliberations on how to take forward the work on immunization and meningitis, thus ensuring the succession from the global vaccine action plan and framework for meningitis prevention and control.

Implication for the European Region

The European Vaccine Action Plan 2015–2020 (EVAP) was drafted to complement, regionally interpret and adapt the Global Vaccine Action Plan 2012-2020 (GVAP) in harmony with key regional health strategies and policies. The goals and objectives outlined in EVAP remain valid and pertinent to achieving equitable immunization in the Region. With EVAP coming to an end in 2020, a discussion with the Member States in the Region to outline the 2030 European Regional Immunization Agenda & framework for action for the next decade will start soon. It is anticipated that Region-specific strategic focus areas, guided by the national priorities, will serve as the foundation of the regional immunization framework and the basis for the WHO European Region to realize the vision and goals of the Immunization Agenda 2030 (IA2030).

The European Technical Advisory group of experts on Immunization (ETAGE), at its meeting in October 2019, agreed that a post-2020 immunization strategy in the WHO European Region should

be aligned with IA2030, build on the direction set by EVAP and take into account the regional specificities. The following guiding principles will define the 2030 Regional immunization framework:

- Equity-based: national policies, programme design and provision of services aim to provide equitable access to vaccination across the life-course in every community.
- People-focused: the design, management and delivery of high-quality immunization services are shaped by and tailored to the needs of individuals and communities.
- Country-owned: national stakeholders are in the "driver's seat", being responsible for developing and implementing operational plans shaped by the local context and achieving the targets they set.
- Data-enabled: high-quality data from disease surveillance and programme monitoring serve as the basis for policy and strategy formulation and for operational planning.
- Partnership-based: partnerships are strengthened and amplified at all levels both within and outside the domain of the health sector.
- Innovation and research-driven: appropriate technological and programmatic innovations are developed, evaluated and scaled up, including the use of implementation science and operational research to improve programme design.

Measles and rubella elimination remains a priority in the WHO European Region and all the Member States in the Region have committed to address the challenges towards achieving and sustaining measles and rubella elimination. Increasing number of measles cases in recent years indicates the fragility imbedded in the success and calls for a holistic approach to address the challenges of un and/or under-vaccinated subnational populations.

As per data available with the WHO European Region, the total number of measles cases in the Region for the year 2019 (as of 29 November 2019) amounts to 101,280 in comparison to 88,693 in 2018. The number of people who have died from measles related complications in 2019 (as of 29 November 2019) is 44 in comparison to 75 in 2018. 49 out of the 53 Member States reported measles outbreaks (case counts range from 2 to 56986) in 2019.

The number of rubella cases in the WHO European Region showed a decline in the number of reported cases from 838 in 2018 to 575 in 2019 (as of 29 November 2019). This decline has been primarily contributed by lesser number of reported cases in 2019 from Poland, Ukraine, Turkey and Germany.

The European Regional Verification Commission for Measles and Rubella Elimination (RVC) concluded in 2019 that by the end of 2018, the elimination status of measles and rubella elimination in the Region is as follows:

a. 37 Member States have demonstrated that endemic transmission of measles was interrupted.
b. 35 Member States have been verified of having eliminated endemic measles.
c. 42 Member States have demonstrated that endemic rubella transmission was interrupted.
d. 39 Member States have been verified of having eliminated endemic rubella.

e. 12 Member States were measles endemic, 11 Member States were rubella endemic and nine Member States were endemic for both measles and rubella.
f. 4 countries (Albania, Czech Republic, Greece and the UK) were verified to have re-established measles transmission.

Following a risk assessment of the situation and in line with the WHO Emergency Response Framework (ERF), in May 2019, WHO activated a Grade 2 emergency response to measles circulation in the Region. Being proactive to respond to the demands of the Member States for the required technical and operational support to the affected countries, WHO European Region initiated an internal procedure laid out in the ERF to inform the Organization of the extent, complexity and potential duration of the required response. This allowed WHO to mobilize the needed technical, financial and human resources in support of the affected countries.

The WHO Strategic Response Plan (SRP) for measles emergency outlines the actions needed including to bring the outbreaks under control, provide safe care to patients, increase high-level commitment, strengthen vaccine acceptance and demand, increase preparedness and risk mitigation, and review outbreak response.

Based on the health system characteristics and the need, the activities supported by the Regional Office was primarily to accelerate tailored interventions, as appropriate, in measles-affected and at-risk countries. The support provided by the WHO European Region to the measles affected countries ranged from direct technical and operational support for containment of the outbreak and decrease the spread, to addressing health system issues and better understanding of the social determinants and community behaviours. This is in line with the strategies to eliminate both measles and rubella outlined in the European Vaccine Action Plan 2015–2020 to enhance immunization and disease surveillance systems in the affected countries.

The actions undertaken by the Ministries of Health in the Region ranged from age-wide supplementary immunization activities, intensified routine immunization to vaccination in schools and special vaccination campaign for adults and adolescent. In this process, some of the Ministries of Health also conducted operational research on identifying the root causes of low vaccination coverage and devise ways to strengthen the routine immunization programme. In addition to immunization activities, measles surveillance with laboratory confirmation of the cases to supplement a timely outbreak investigation was also strengthened by the national immunization programme in the affected countries.

9. Accelerating the elimination of cervical cancer as a global public health problem

Document EB146/9

As requested in decision EB144(2) (2019), a draft global strategy to accelerate cervical cancer elimination 2020–2030, was developed, in consultation with Member States, regional offices and other relevant stakeholders, for consideration by the Seventy-Third World Health Assembly in 2020.

Current status of prevention and control of cervical cancer

Cervical cancer is the fourth most common cancer among women globally, with an estimated 570 000 new cases and 311 000 deaths in 2018. Without bolder action, inequalities will grow, due to in the burden of cervical cancer in high- and low-income countries, as well as within countries, reflecting the limited access to health services for women who are disadvantaged. Cervical cancer and HIV co-morbidity is significant, with women living with HIV being six times as likely to develop cervical cancer and at a younger age and making up over 50% of cervical cancer cases in some countries with high HIV prevalence. Up-front investments are especially important to set those countries on the path towards elimination.

Targets, timeline and impact of the draft strategy on the path to cervical cancer elimination

Data for 2018 show that age-standardized cervical cancer incidence rates varied from 75 per 100 000 women in the highest-risk countries to less than 10 per 100 000 women in the lowest-risk countries. To achieve cervical cancer elimination, all countries must reduce cervical cancer incidence below a defined threshold. WHO established, based on scientific evidence, that cervical cancer should no longer be considered a public health problem when the age-standardized incidence rate is less than four per 100 000 women.

To achieve elimination this century, the following “90-70-90” targets need to be met by 2030: 90% of girls fully vaccinated with a human papillomavirus vaccine by 15 years of age; 70% of women screened using a high-performance test by 35 and 45 years of age; and 90% of women identified with cervical disease are treated, with 90% of women screening positive treated for pre-cancerous lesions and 90% of invasive cancer cases managed. Modelling projections estimated that meeting the 90-70-90 targets would reduce the median cervical cancer incidence rate by over 90% in 78 low- and lower-middle-income countries, averting more than 70 million cases over the next century, as well as on mortality due to cervical cancer, with a 10% reduction by 2030 and a 39% reduction by 2045.

Strategic actions to accelerate elimination

To achieve elimination in the shortest period and with maximum impact, intensive vaccination against human papillomavirus, screening for and treatment of pre-cancerous lesions and management of invasive cervical cancer must be pursued in combination. Social mobilization strategies that are context specific and culturally appropriate are important to ensure that communities are empowered to drive demand for all interventions. Referral pathways and people-centric linkages throughout the continuum of care will be required to provide effective services. Innovations in service delivery, testing, treatment and data systems, together with new and expanded training methods, will be crucial for scaling up interventions and meeting the targets.

Introduction of human papillomavirus vaccine into national immunization programmes is imperative, which will require sound communication, social mobilization efforts, and engagement with parents, teachers and health providers to disseminate appropriate information and counter misinformation. To achieve high coverage, it is necessary to secure a sufficient supply of affordable vaccines, delivered through cost-effective platforms, more efforts are needed to be optimize the price and supply of health products (“market shaping”), and more manufacturers should be encouraged to bring new products to market. Although there are currently only two suppliers of human papillomavirus vaccines, new manufacturers have already brought three new products to advanced stages of development.

Considering that effective screening for and treatment of pre-cancerous lesions can prevent women from developing invasive disease, affordable, accessible quality screening and treatment services must be in place, including through new innovations, such as artificial-intelligence-based technologies for screening and portable ablative devices. This includes building screening into the basic package of services at the primary health care level, promoting a single-visit approach to reduce loss to follow-up, and generating demand for services. Referral linkages to higher-level facilities are critical to ensure timely management of women who require complex treatment of pre-cancerous lesions and those with advanced disease. Integration of cervical cancer prevention and care with existing health services will create operational efficiencies.

To meet the 90-70-90 targets, investment is needed to improve access to diagnostic services, particularly anatomical pathology. Task sharing and building the competencies of health care professionals will help countries to scale up services. Combating cancer stigma is critical for removing social barriers to care. Universal health coverage will ensure that women and their families are protected from financial catastrophe due to out-of-pocket expenditures.

Considerations for implementation of the strategy

The draft strategy is based on a public health approach that focuses on: health promotion; primary and secondary prevention through vaccination, screening for and treatment of pre-cancerous lesions; and prolonging life through timely management of early cancers. Meeting the 90-70-90 targets will require robust primary health care systems that adopt an integrated disease management approach.

Data across the three pillars of the strategy (vaccination, screening and treatment, and cancer management and palliative care) are critical to track progress made towards meeting the targets, to ensure accountability and provide the foundation for advocacy, coordinated action and reinforced political commitment. Primary prevention programmes need to be able to track young girls (aged 9–14 years) who have been vaccinated. To ensure links between different health services and continuity of care, patient information must be captured and transferable for follow-up and referral to treatment and integrating vaccination and school health services may simplify this follow-up. The health system must be able to identify novel ways of ensuring that women return for the most appropriate care. Monitoring and surveillance will need to be able to capture longitudinal services delivered over the life course.

Investments in cervical cancer programmes are expected to save over 250 000 lives and avoid over 100 000 cases of cervical cancer in low- and lower-middle-income countries by 2030, and 4.5 million deaths and 4.1 million cases by 2050. US$ 10.50 billion need to be mobilized by 2030 to implement the cervical cancer prevention and care strategies across all the 78 low- and lower- middle-income countries modelled, with an average of US$ 0.40 and US$ 0.20 per person per year, respectively. Interventions would also be cost-effective in a majority of these countries, with every US dollar returning US$ 3.20 to the economy. In addition, the benefits to the lives of girls, women and society are incalculable.

Multisectoral partnerships at the global, regional and national levels need to extend beyond the health sector to encompass non-traditional sectors. The global action plan for healthy lives and well-being for all provides a strategic platform to help to support country-led implementation. Regional-level partnerships can support strategies such as pooled procurement, market shaping and innovative programmes to improve access to health services. North–South and South–South partnerships can build capacity to develop core competency in policy, planning and management of

human resources for health. At the national level, a whole-of-government and whole-of-society approach – including public–private partnerships – will be crucial for successful implementation of the strategy.

Action by the Executive Board

The Board is invited to note the report. It is also invited to consider the draft strategy and provide further guidance regarding the next steps to be taken to accelerate cervical cancer elimination.

Implication for the European Region

Cervical cancer poses significant burden on public health in many countries of WHO European Region. It is the fifth most common cancer in women. It is estimated that there are around 69 100 new cases of cervical cancer annually and in 2018, 30 200 deaths related to cervical cancer, mostly in low- and middle- income countries. Incidence varies significantly across the Region, from 3-5 cases per 100,000 women in Malta, Switzerland, Finland for example to 20-25 cases per 100,000 women in Serbia, Moldova, Latvia, Estonia, Bosnia & Herzegovina. These differences are primarily the result of difference in cervical cancer screening practices, with inadequate implementation and lack of quality assurance in some parts of the Region.

By 2019, 38 countries of WHO European Region have introduced HPV vaccines into their routine immunization programmes. However, due to high price of HPV vaccines, middle-income countries that do not receive donor support are lagging behind. Strengthening decision-making on immunization policy in middle-income countries plays a critical role in mobilizing political will and financing. Additional efforts should be undertaken to improve access to affordable and timely vaccine supply. Many countries face challenges in reaching high coverage with HPV vaccines in target populations. Available data show that vaccine hesitancy has contributed to low uptake of HPV vaccines and can exacerbate inequitable coverage. Further in-depth analyses of data at the country level may provide insights into the root causes. Application of the Tailoring Immunization Programmes (TIP) approach helps in achieving a better understanding of the reasons for low uptake and in designing a tailored approach to correcting the problem.

Cervical cancer screening is one of the most cost-effective health interventions to reduce mortality by non-communicable diseases. The cervical cancer elimination initiative provides a unique opportunity to strengthen secondary prevention of cervical cancer. The priority is to improve processes and quality assurance of screening. However, establishing an organized screening and reaching high coverage will require additional human and financial resources. This work is being supported by the Regional Office broader initiative to improve effectiveness of screening of noncommunicable diseases and through the life-course with WHO European Conference on Screening scheduled for February 2020.

Among WHO regions, the European Region has the highest rate of adults in need of palliative care: 562/100,000, 25% of which attributable to cancer (WHO - WHPCA, Global Atlas of Palliative care at the end of life, 2014). But provision of palliative care remains under-developed with only 13 countries out of 53 where hospice-palliative services are at a stage of advanced integration into mainstream service provision.

10. Ending Tuberculosis

Document EB146/10 and Document EB146/11

Document EB146/10

This document is the second report on progress in implementation of the End TB Strategy and describes actions taken on the commitments made in declarations, in resolution WHA71.3 (2018) and in related regional committee resolutions and documents. It builds on the 2019 report of the Director-General on the outcomes of the high-level meeting of the General Assembly and includes key findings of the Global tuberculosis report 2019, with data provided by over 200 countries representing 99% of the world's population.

A summary of the targets, milestones, principles, pillars and associated components of the End TB Strategy is available at https://www.who.int/tb/post2015_TBstrategy.pdf?ua=1 and the table on the original document provides additional global targets adopted by the United Nations General Assembly in the high-level meeting on the fight against tuberculosis in 2018.

The report concludes that the world is still not yet on track to end the tuberculosis epidemic by 2030 and investments are insufficient for full acceleration, whereas progress in some regions and high burden countries is promising. A global milestone was reached in 2018 for the number of people diagnosed and registered for treatment, and there is progress in reducing the gaps in access to treatment for children, for people ill with drug-resistant tuberculosis, and people coinfected with HIV and tuberculosis. Some countries are already strengthening multisectoral accountability including high-level mechanisms, engaging civil society and affected persons, and improving legislation. The introduction of new technologies and innovative integrated care delivery approaches is being supported. New partnerships towards accelerating research and development are showing results. The progress report to the United Nations General Assembly in 2020 should demonstrate whether there is impact, and what remedial action may be required.

Progress against targets

Progress in reduction in tuberculosis incidence and mortality is notable in two regions: the WHO European Region is on track to achieve the 2020 milestones for reductions in incidence and mortality, which are also falling relatively fast in the WHO African Region. Yet most WHO regions and many countries with a high tuberculosis burden are not yet on track to reach the 2020 milestones of the End TB Strategy.

National surveys conducted from 2016 to 2019, between 27% and 83% of tuberculosis patients and their households were estimated to face catastrophic expenses, with a higher proportion for drug-resistant tuberculosis cases (between 67% and 100%).

The 2018 milestone towards the global target of 40 million people notified and treated by 2022 was achieved. However, a gap of 3 million cases in relation to the estimated 10 million incident (new) cases still exist due to underreporting and underdiagnoses, since 7.0 million new cases of tuberculosis were notified in 2018. Ten countries accounted for 80% of the gap and children

represented 8% of the cases notified. Increases in case reporting are largely attributable to two countries (India and Indonesia), suggesting that further advances can be achieved. Regarding drug-resistant tuberculosis, 186 772 cases of multidrug resistant tuberculosis or rifampicin-resistant tuberculosis were notified in 2018, up from 160 684 in 2017, but the number of people with drug-resistant tuberculosis enrolled for treatment in 2018 was equivalent to only a third of the nearly half a million-people estimated in need of care. Therefore, multidrug-resistant tuberculosis remains a public health crisis.

In 2018, 1.8 million people living with HIV were reported to have initiated preventive treatment, up from under 1 million in 2017, which suggests that the target of 6 million people living with HIV treated to prevent tuberculosis in the period 2018–2022 can be achieved. Still, far more needs to be done to identify child and adult contacts, and to initiate preventive treatment for those eligible.

Despite an increase of US$ 400 million from 2018, the US$ 6.8 billion in 2019 for implementation of tuberculosis care and prevention were well below the US$ 13 billion needed annually by 2022. Of the total available in 2018, 87% was from domestic sources.

Progress in implementing the principles, pillars and components of the End TB Strategy

In 2019, the Director-General communicated with Heads of State and Government of 48 high burden countries urging them to undertake accelerated action to meet End TB targets and missions were undertaken by WHO to 12 high burden countries to discuss targets and strategies for acceleration and strengthening of multisectoral accountability. WHO finalized its multisectoral accountability framework for tuberculosis, launched a platform for multisectoral and multi-stakeholder collaboration and continued to support Member States to strengthen surveillance and impact assessment.

WHO launched, with youth leaders, the 1+1 Initiative and is supporting the formation of a Civil Society Task Force on TB. Several countries with a high burden of tuberculosis are formalizing forums with civil society. The Stop TB Partnership, the Global Fund and bilateral partners are helping to mobilize, and to secure resources for, civil society and affected people.

In 2019 a new declaration on the human rights of people affected by tuberculosis was launched. Countries are implementing WHO guidance on ethics in tuberculosis care and prevention. National assessments of legal environments related to tuberculosis care and prevention, and of gender-sensitive tuberculosis care and prevention, are under way.

Pillar 1: Integrated patient-centred care and prevention. New guidelines were issued for the diagnosis and treatment of drug-sensitive, drug-resistant tuberculosis, and to prevent disease and for infection prevention and control. In 2018, WHO launched, with partners, new road maps for private sector engagement, and for scaling up tuberculosis care and prevention for children and countries are now giving more priority to locally effective approaches. Care for tuberculosis and HIV comorbidity has continued to improve and, in 2018, eighty-six per cent of known patients coinfected with HIV and tuberculosis were on antiretroviral therapy. Overall progress towards targets is slow. In 2018, 113

countries reported coverage of at least 90% for bacille Calmette-Guérin, the vaccine recommended to prevent severe forms of tuberculosis in children.

Pillar 2: Bold policies and systems. High-level actions have been taken to enhance political commitment and financing for health including for tuberculosis control and efforts are ongoing to strengthen community-based care. Prioritization of private sector engagement and novel partnerships have contributed to increased case notifications and to implementing new essential packages of care and strategic purchasing arrangements. However, most of the 30 countries with the highest tuberculosis burden still have below-average index levels for health service coverage. The Secretariat is supporting countries to engage with national social protection platforms, and to assess the status of tuberculosis-specific social support. In 2018, 2.3 million tuberculosis cases were attributable to undernourishment, 0.9 million to smoking, 0.8 million to alcohol abuse, 0.8 million to HIV infection and 0.4 million to diabetes.

Pillar 3: Intensified research and innovation. In response to resolution WHA71.3, the Secretariat has developed a global strategy for tuberculosis research and innovation that will be considered by the Executive Board at its 146th session (see document EB146/11). The WHO Secretariat, in collaboration with partners including bilateral agencies, foundations and the UNICEF/UNDP/WHO/World Bank Special Programme for Research and Training in Tropical Diseases, continues to support expanded national tuberculosis research planning and capacity-building, and WHO is providing support to the secretariat of the tuberculosis research network of the BRICS countries (Brazil, Russian Federation, India, China and South Africa).

Action by the executive board

The Board is invited to note the report, and to advise on what further actions are required to reach the Sustainable Development Goal and End TB targets for 2030 and 2035.

Document EB146/11

This document is a summary of the global strategy for tuberculosis research and innovation developed by the Director-General of WHO as requested by the resolution WHA71.3 on preparation for a high-level meeting of the General Assembly on ending tuberculosis adopted in May 2018.

The drafting of the strategy was guided by the target of ending the tuberculosis epidemic by 2030, as defined in the Sustainable Development Goals and the WHO End TB Strategy. Extensive consultation, including through the WHO Regional Committees, were held with Member States and multiple stakeholders. A set of proposed activities, and suggestions for monitoring and evaluating progress have been incorporated into the strategy, but additional planning at the country level will be required to ensure appropriate implementation.

Background and context

Tuberculosis is the leading cause of death from a single infectious agent globally and is one of the leading causes of death from antimicrobial resistance. The Sustainable Development Goals include a target for tuberculosis that builds on historic gains made under the Millennium Development Goals, to “end the epidemic” by 2030. More specific targets for 2030, set in WHO’s End TB Strategy, include ensuring that no family is burdened with catastrophic expenses due to tuberculosis, and achieving a

90% reduction in tuberculosis deaths and an 80% reduction in tuberculosis incidence compared with 2015 levels, with targets for further reductions (95% and 90%, respectively) by 2035. However, there is still an enormous gap between current reality and the vision of the Sustainable Development Goals.

Robust efforts are needed to sustain and improve on the gains made to date, and to address persistent challenges that have led to uneven progress in the fight against tuberculosis. The End TB Strategy stipulates that major technological breakthroughs are needed by 2025, so that the rate at which tuberculosis incidence falls can be accelerated dramatically compared with historic levels. Delivering on these targets requires a multisectoral approach to developing and equitably diffusing the right medical innovations and strategies as a top priority. However, there are multiple challenges and gaps to be addressed in research, innovation and access to tuberculosis vaccines, medicines, technologies and services.

The global strategy aimed primarily at the Member States, particularly ministries of health, science and technology, finance and education. By aligning their national health research and innovation strategies and actions (and related investments) to the framework presented in the strategy, all countries can accelerate progress towards the milestones and targets of the End TB Strategy. Member States may also consider developing a comprehensive national strategy or a road map for tuberculosis research and innovation, to coordinate the implementation of the global strategy at national level.

A prerequisite for successfully accelerating efforts to end tuberculosis is that all stakeholders make concerted efforts and collaborate. Hence, the global strategy also makes the case for a unified and aligned response in which key relevant national and international partners and affected communities support Member States by undertaking the investments or partnerships (or both) necessary for accelerating innovation.

Objectives and Recommendations

The global strategy for tuberculosis research and innovation will support efforts by governments and partners to accelerate tuberculosis research and innovation, and to improve equitable access to the benefits of research.

Objective 1: *Create an enabling environment for high-quality tuberculosis research and innovation to increase the capacity for conducting and using research outcomes equitably in a sustained and effective manner.* Recommendations are:

- to streamline and harmonize regulatory processes to enable efficient review of research protocols and products, and to reduce trade and distribution mark-ups on the prices of essential tuberculosis medicines and technologies;
- to strengthen public–private partnerships and integrate civil society's expectations, needs, interests and values into the research and development process;
- to develop and implement country-specific tuberculosis research agendas that are aligned with national health research strategic plans in order to expand and accelerate tuberculosis research at the country level through capacity-building and collaboration among other actors in the innovation system;
- to increase the number and profile of local researchers engaged in tuberculosis research and to provide the necessary incentives to retain researchers in employment, in order to deliver

the research training, infrastructure and incentives required to stimulate innovation and increase the capacity to make use of innovations.

Objective 2: *Increase financial investments in tuberculosis research and innovation by increasing overall contributions for tuberculosis research funding.* Recommendations are:

- to set a target contribution for the conduct of the social, health system and operational/implementation research that is vital to support effective scale-up of innovative strategies and tools and
- to develop innovative and collaborative financing mechanisms to facilitate the timely development and diffusion of appropriate and affordable biomedical tools and technologies.

Objective 3: *Promote and improve approaches to data sharing to advance scientific discovery and dissemination of findings, reduce duplication of effort and facilitate the translation of evidence to national and global policies on tuberculosis prevention, diagnosis, treatment and care, including by making use of new and existing scientific academic forums.* Recommendations are:

- to develop or strengthen a policy of open access to and open data for scientific research (both nationally and globally) that receives public funds;
- to establish or strengthen national health information and vital registration systems for the collection of high-quality data that allow for reliable tracking of the tuberculosis epidemic (in terms of absolute numbers and trends in incidence and deaths), so that subnational, national, regional and global trends can be detected and monitored and can inform decision-making;
- to foster voluntary technology-transfer policies that enable the development and diffusion of knowledge, and the wider transfer of evidence to policy and practice.
- publicly searchable patent databases also promote the diffusion of knowledge by facilitating access to the information disclosed in a patent.

Objective 4: *Promote equitable access to the benefits of research and innovation by strengthening global access initiatives for tuberculosis prevention and care.* Recommendations are:

- to support the replenishment of global financing mechanisms such as Unitaid and the Global Fund to Fight AIDS, Tuberculosis and Malaria;
- to provide appropriate governance structures that foster research and innovation as a shared responsibility that is needs driven, evidence based and guided by the core principles of affordability, effectiveness, efficiency and equity;
- to ensure the availability of the most recent guidelines on the prevention, diagnosis and treatment of tuberculosis at all levels of the health system; including tuberculosis technologies and medicines in national essential medicine and technology lists, while retaining effective supply-chain management to facilitate the procurement and use of high-quality medicines and technologies;
- to develop policies on trade, health and intellectual property through multisectoral collaborative frameworks, to help address access and innovation simultaneously
- to develop regulatory frameworks and foster partnerships across sectors to reduce trade and distribution mark-ups on the prices of essential tuberculosis medicines and technologies
- to support policies that promote transparency in the public disclosure of clinical trial data

Action by the Executive Board

The Board is invited to recommend to the Seventy-Third World Health Assembly the adoption of a draft decision: (1) to endorse the global strategy on tuberculosis research and innovation; and (2) to request the Director-General to submit a report on progress made in the implementation of the global strategy to the Health Assembly in 2023.

Implication for the European Region

To advance tuberculosis-related research in the WHO European Region is part of the Regional Office's priority actions in supporting of the implementation of the Tuberculosis Action Plan for the WHO European Region 2016-2020, the Regional Office established the European Tuberculosis Research Initiative (ERI-TB).2,3 The ERI-TB secretariat at the Regional Office defined TB research priority areas for the Region and in collaboration with the WHO Special Programme for Research and Training in Tropical Diseases (TDR) launched a series of workshops on Structured Operational Research Training to End TB (SORT-TB) in the WHO European Region.

To accelerate the implementation of the global strategy and utilizing the existing network of European Tuberculosis Research Initiative, the Regional Office in collaboration with partners will assist Member States in conducting multicounty operational research studies to accumulate evidence on prevention and care of drug-resistant TB, TB/HIV and latent TB. Specifically, the WHO Regional Office is launching the Operational research for 11 countries on introduction of fully-oral shorter treatment regimens for MDR/RR-TB, which will contribute to generation of new strong recommendations by the WHO on drug-resistant TB and improve treatment success for MDR-TB.

The year of 2020 makes a first milestone set by the End TB Strategy to report interim results. Countries in the WHO European Region have made substantial progress towards ending TB, in line with the implementation of the Regional Action Plan. The Region has the fastest decline of TB incidence and mortality (5.1% and 9.7% annual decrease respectively between 2014-2018). Despite the fastest decline of TB incidence and mortality, the Region has the highest rates of drug resistant TB. Treatment success for MDR-TB is steadily increasing but yet below the regional target of 75% and was 57.4 in 2018 (cohort of patients started treatment in 2016). DR-TB and TB/HIV remain the main challenges calling for urgent actions. The WHO Regional Office in collaboration with the key partners and the civil society organizations is assisting the Member States to implement the people-centred integrated models of care and new WHO recommendations with inclusion of new medicines and shorter and more effective treatment regimen.

[2] Roadmap to implement the tuberculosis action plan for the WHO European Region 2016–2020. Towards ending tuberculosis and multidrug-resistant tuberculosis (2016). Available at http://www.euro.who.int/en/health-topics/communicable-diseases/tuberculosis/publications/2016/roadmap-to-implement-the-tuberculosis-action-plan-for-the-who-european-region-20162020.-towards-ending-tuberculosis-and-multidrug-resistant-tuberculosis-2016

[3] The European Tuberculosis Research Initiative (ERI-TB). Terms of reference available at http://www.euro.who.int/en/health-topics/communicable-diseases/tuberculosis/areas-of-work/the-european-tuberculosis-research-initiative-eri-tb

11. Epilepsy

Document EB146/12

The document responds to a decision from the Executive Board at its 144th session to include the subject of epilepsy on the agenda of the 146th Executive Board.

Epidemiology and burden of epilepsy

Epilepsy is one of the most common serious chronic neurological conditions affecting people of all ages globally, with peaks in incidence rates in children and in adults over the age of 60. It is characterized by abnormal electrical activity in the brain, causing seizures or unusual behaviour, sensations and sometimes loss of awareness. Common causes include prenatal or perinatal injuries, congenital abnormalities or brain malformations, head injuries, stroke, neurological infections such as meningitis, encephalitis and neurocysticercosis, and brain tumours. In some cases, there is an underlying genetic reason for the condition; in about half of the cases, however, there is no identifiable cause.

Nearly 80% of the estimated 50 million people who have epilepsy live in low- and middle-income countries and more than 5 million new cases diagnosed annually. Epilepsy accounts for more than 0.5% of the total global burden of disease and the risk of premature death is three times higher than in the general population. They are often subjected to stigmatization and discrimination, leading to human rights violations and social exclusion. Epilepsy can also constitute a significant financial burden. For example, the cost of epilepsy has been estimated at €20 billion per year in the WHO European Region.

Challenges and gaps in epilepsy care

Up to 70% of people with epilepsy could live seizure-free, if treated with antiseizure medicines, which are cost-effective and included in the WHO Model List of Essential Medicines. However, the treatment gap (percentage of people with epilepsy whose seizures are not being appropriately treated at a given point in time) is estimated at 75% in low-income countries and is substantially higher in rural than in urban areas due to a combination of lack of capacity in health care systems, inequitable distribution of resources and low priority accorded to epilepsy care. Approximately 25% of epilepsy cases could be prevented by broader public health responses in maternal and new-born health care, communicable disease control, injury prevention and cardiovascular health.

International commitments for dealing with epilepsy

Multiple commitments have been undertaken through Health Assembly and UNGA resolutions, including the resolution WHA68.20 adopted in May 2015 on the global burden of epilepsy and the need for coordinated action at the country level and to integrate epilepsy into action on noncommunicable diseases and mental health.

Principal WHO response

Together with the International League Against Epilepsy and the International Bureau for Epilepsy, WHO has been leading the Global Campaign Against Epilepsy since 1997 and they jointly published the global report “Epilepsy: a public health imperative” in June 2019, which summarizes the available evidence on the burden of epilepsy and the public health response required at the global,

regional and national levels. A high-level side event on epilepsy as a political priority was organized by Member States during the Seventy-Second World Health Assembly in May 2019.

Since 2008, the WHO Mental Health Gap Action Programme (mhGAP), which includes epilepsy, has been using innovative and multifaceted approaches to expand services in more than 100 low- and middle-income countries. The WHO Programme on Reducing the Epilepsy Treatment Gap mobilizes nongovernmental organizations and community groups to raise epilepsy awareness and support people with epilepsy and their families, supports efforts to ensure sustainable access to antiseizure medicines, reinforce referral systems and enable better monitoring of epilepsy. Pilot initiatives have been launched (in Ghana, Mozambique, Myanmar and Viet Nam) resulting in a considerable increase in access: epilepsy treatment is now accessible for 6.5 million more people.

Improving epilepsy care

Promoting epilepsy as a public health priority, strengthening effective leadership and governance, integrating care for people with epilepsy into national policies on health, and providing adequate funding can contribute to reduce the burden of epilepsy.

Actions, involving community leaders, grassroots public health workers and people with epilepsy and their families, are needed to improve public attitudes, reduce stigma and protect the rights of people with epilepsy to correct misconceptions and negative attitudes and legislation should protect the rights of people of epilepsy.

To reduce epilepsy treatment-gap, non-specialist health care providers should be trained, and a strong referral system should be made available so that epilepsy management can be integrated into primary health care. Access to cost-effective antiseizure medicines should be enhanced globally by making them more available, accessible and affordable. Extending the coverage of antiseizure treatment to 50% of epilepsy cases would reduce the current burden between 13% and 40%.

Health information systems should be strengthened and metrics for collecting and reporting incidence and prevalence of epilepsy on the disaggregate level should be improved and harmonized to better understand the burden of epilepsy. Attention given to epilepsy in research agendas should be increased through capacity building, investment and training for epilepsy research.

Action by the Executive Board

The Board is invited to note the report and may wish to focus on ways to close the treatment gap and/ or on actions that will be taken by Member States, the Secretariat and other partners to tackle the health, social and public impact of epilepsy.

Implication for the European Region

In the WHO European Region, it is estimated that there are at least 3.5 million cases and the cost of epilepsy has been estimated at €20 billion per year.

Epilepsy is highly amenable to effective and cost-effective treatment. Up to 70% of people with epilepsy can live seizure-free if treated with antiseizure medicines. The provision of anti-epileptic medication in non-specialised care settings has a favourable ratio of costs to effects: an extra year of healthy life can be achieved for less than $500 international dollars. For these reasons, epilepsy forms part of WHO's mental health gap action programme (mhGAP) intervention guide for use in non-specialist settings, which is now being taken up in several countries in the WHO European Region such as Kazakhstan, Turkey, Turkmenistan and Ukraine.

12. Integrated, people-centred eye care, including preventable blindness and impaired vision

Document EB146/13

Drawing on WHO's World report on vision published on 9 October 2019, the document sets forth the rationale for integrating the delivery of people-centred eye care services into the health system, describes how to reduce inequities in access to such services and considers how to enable health systems to respond to the projected increase in eye conditions.

Opportunity: raising the priority accorded to putting vision impairment on national agendas

Effective interventions covering the continuum of care address the needs associated with eye conditions and vision impairment, some of which are among the most cost-effective and feasible health care interventions. These efforts have yielded considerable dividends, with an ongoing reduction in the global prevalence of distance vision impairment from 3.83% in 1990 to 2.90% in 2015 and a substantial reduction in the number of children and adults with eye infections and blindness due to vitamin A deficiency, onchocerciasis and trachoma in all regions. Nevertheless, at least one billion people globally have a vision impairment that could have been prevented or is yet to be addressed.

Vast inequities exist in the prevalence of vision impairment, which is estimated to be four times higher in low- and middle-income than in high-income regions. Eye conditions and vision impairment pose a significant personal and societal burden, being ranked as the third cause among all impairments for years lived with disability by the Global Burden of Disease Study 2017 and posing a global financial burden of estimated annual productivity losses associated with uncorrected myopia and presbyopia of US$ 244 billion and US$ 25.4 billion, respectively.

Global challenges for meeting eye care needs

Global demographic trends, including population ageing and growth, and behavioural and lifestyle factors will cause a substantial increase in the number of people with eye conditions and vision impairment. New strategies are needed to meet the challenges related to the rapid emergence of noncommunicable chronic eye conditions such as diabetic retinopathy, glaucoma, age-related macular degeneration, complications of high myopia and retinopathy of prematurity.

Addressing challenges through the implementation of integrated people-centred eye care

On 9 October 2019, WHO published the first World report on vision which proposed to make integrated people-centred eye care the care model of choice and to ensure its widespread implementation.

Integrated people-centred eye care has the potential to facilitate approaches to service delivery that respond to emerging health challenges in the eye care sector, including unhealthy lifestyles and ageing populations, and the need to address a range of noncommunicable eye conditions. To redress inequities, eye care must be an integral part of universal health coverage. Achieving integrated people-centred eye care requires Member States to adopt four key strategies:

- empowering and engaging people and communities,
- reorienting the model of care towards strengthening eye care in primary health care,
- coordinating services within and across sectors,

- creating an enabling environment.

Action by the Executive Board

The Board is invited to note the report and to provide guidance on next steps.

Implication for the European Region

In the WHO European Region, over 30 million people experience visual impairment, including 2.7 million who are blind. Blindness can be avoided in 8 out of 10 cases with appropriate treatment or early prevention. Leading causes of visual impairment and blindness within the WHO European Region the noncommunicable chronic eye conditions such as diabetic retinopathy, glaucoma, age-related macular degeneration, complications of high myopia and retinopathy of prematurity.

Consequently, within the WHO European Region, multiple programmes contribute to prevention of blindness, including noncommunicable diseases; child and adolescent health programme; sexual and reproductive health programmes and health service delivery. The WHO NCD Best/Good Buys include 'Diabetic retinopathy screening for all diabetes patients and treatment (if available, laser photocoagulation) for prevention of blindness'. This will be an area of focus within the upcoming WHO European Screening Conference with takes place on 11-12 February 2020.

The WHO European Region has also initiated a disability and rehabilitation programme in June 2019. The programme also covers eye care. Efforts has been initiated for integration of comprehensive eye-care services into existing health systems as well as secure access to low-vision and rehabilitation services for those in need.

13. Neglected tropical diseases

Document EB146/14

Neglected tropical diseases (NTD) are a diverse set of currently 20 bacterial, viral, parasitic, fungal and noncommunicable diseases and disease groups that disproportionately affect populations living in poverty, predominantly in tropical and subtropical areas. They remain a public health problem that affects populations left behind in the most vulnerable countries and communities. They impose a devastating human, social and economic burden on more than one billion people worldwide.

In 2013, in resolution WHA66.12 the Health Assembly urged Member States "to expand and implement, as appropriate, interventions against NTDs in order to reach the targets agreed in the Global Plan to Combat NTDs 2008–2015, as set out in WHO's road map for accelerating work to overcome the global impact of NTDs".

Progress against NTDs demonstrates the impact of aligning the work of Member States and partners, which during the past eight years has established that interventions against NTDs are one of the best buys in development, given their contribution to human and economic well-being.

Important advances have been made since the road map was published in 2012. Today, an estimated 500 million fewer people than in 2010 need interventions against NTDs. Some 40 countries, territories and areas have eliminated at least one of 20 NTDs. Dracunculiasis is on the verge of eradication, with 28 human cases reported in three countries in 2018. Lymphatic filariasis and trachoma have been eliminated as a public health problem in 16 and 9 countries respectively. Onchocerciasis has been eliminated in four countries in the Region of the Americas. The annual

number of reported cases of human African trypanosomiasis has fallen from more than 7000 in 2012 to fewer than 1000 in 2018, eclipsing the original target of 2000 cases by 2020. In 2019, Mexico became the first country in the world to be validated for elimination of dog-mediated human rabies. Since 2012, the number of reported cases of visceral leishmaniasis has reduced significantly in Bangladesh, India and Nepal, where the disease is targeted for elimination as a public health problem.

The range of people who are not covered by services has been further narrowed by the progressive expansion of interventions against NTDs in the field. In 2016, for the first time, the number of people who received treatment for one or more disease exceeded one billion. The number further increased in 2017 and peaked in 2018 when more than 1.13 billion people were delivered a cumulative total of 1.7 billion doses of medicines, including more than one million life-saving treatments delivered through specialized individual case management.

Between 2017 and 2019, donors committed more than US$ 1 billion, including pharmaceutical companies, which donate an average of nearly three billion tablets or other formulations of safe, quality-assured medicines annually to support control and elimination in countries where NTDs are endemic. Some 45 WHO collaborating centres support activities on NTDs. Capacity has been strengthened to achieve greater impact and ownership of interventions in more than 60 countries in 2019 alone.

Despite these important advances, not all the targets set in the road map are likely to be met and efforts will need to continue. At its twelfth meeting in Geneva in April 2019, the Strategic and Technical Advisory Group for NTDs considering that the current road map would end in 2020, noted with concern the emergence of some diseases in settlements for refugees and internally displaced people as well as in conflict zones, and recommended that the situation be closely monitored; that cross-sectoral collaboration be continued and reinforced at all three levels of the Organization; that reduced efficacy to medicines and insecticides be monitored to prevent and address any possible emergence of resistance; that equity, gender and human rights be included in all activities, particularly with regard to women; that the role of women and women's groups in public health interventions be reflected in strategies to prevent, eliminate and eradicate NTDs; and that surveillance and health systems be strengthened. Climate change is likely to lengthen the transmission season of mosquito-borne diseases, such as dengue and those caused by other arboviruses.

In light of the current challenges and needs, WHO's Strategic and Technical Advisory Group for NTDs recommended in 2018 that the Secretariat consider the development of a subsequent road map for 2021–2030. The Advisory Group also provided further guidance at its meeting in 2019, on strategic direction towards the targets set in the 2030 Agenda for Sustainable Development and WHO's Thirteenth General Programme of Work, 2019–2023.

Action by the Executive Board

The Board is invited to note the report and provide guidance on the next steps to advance global action on neglected tropical diseases

Implication for the European Region

Since 2015 the Regional office is steadily scaling-up activities on NTDs and significantly accelerated its support to countries to strengthen national capacities on surveillance and

management of NTDs. The work of the Regional office in NTDs is mainly focused on emerging/re-emerging vector- borne diseases (dengue, chikungunya, Zika), leishmaniasis, soil-transmitted helminthiasis and neglected zoonotic diseases such as rabies and echinococcosis.

The introduction and spread of invasive mosquito species Aedes aegypti and Aedes albopictus which are effective vectors of dengue, chikungunya and Zika is a growing problem for the European region driven by the globalization of trade and travel and increased urbanization, as well as climate change. Local and small-scale outbreaks of dengue and chikungunya in countries of Mediterranean basin as well as the first ever autochthonous vector-borne transition of Zika reported this year in the European region serve as a stern reminder of the potential burden these developments may cause.

A Regional framework for surveillance and control of invasive mosquito vectors and re-emerging vector-borne diseases in the WHO European Region 2014-2020 was adopted by the 63rd session of the WHO Regional Committee for Europe. During the 68th session of the WHO Regional Committee for Europe the Member States welcomed the Secretariat's report on the progress with implementation of the Regional Framework and expressed their concerns regarding the rise in vectors and increasing threat of vector-borne diseases in the Region. Expansion of the scope of the Regional Framework by inclusion of other vector-borne diseases of concern such as West Nile fever, Lyme borreliosis, Zika and Congo-Crimean Haemorrhagic Fever was recommended.

Half of Europe's countries are considered endemic for leishmaniasis and the regional incidence of leishmaniasis is estimated at less than 2% of the global burden. However, the regional epidemiology of leishmaniasis is complex, since it comprises various diseases that are caused by distinct Leishmania species adapted to various hosts and transmitted by different phlebotomine vectors. The Regional Office is providing technical assistance to countries to develop/update their national strategies and protocols on surveillance and case management of leishmaniasis. Countries in need are regularly provided by diagnostic tests and medicines for treatment of the disease.

According to WHO estimates over 4 million school-aged children are affected by soil-transmitted helminthes (STH) in the WHO European Region with the highest prevalence in countries of central Asia and the southern Caucasus. During 2018-19 over four million tablets of Albendazole was provided to countries for mass deworming campaigns among school-aged children. As access to basic drinking water sources, adequate sanitation facilities and appropriate hygiene practices are essential to breaking the cycle of STH transmission, cooperation with other sectors (water, sanitation and hygiene) was established.

The Strategic framework for leishmaniasis control 2014–2020 and Framework for control and prevention of soil-transmitted helminthes in the WHO European region, 2016-2020 created a solid foundation and provided clear guidance to countries for the development of national strategies and programmes based on their epidemiological, socioeconomic and environmental context. As a result of implemented activities, the situation on STH in countries in WHO European Region has significantly improved and the prevalence of STH has remarkably decreased.

The new roadmap for 2021-2030 which was developed through an extensive global consultation process will serve as a solid platform for the Regional Offices and Members States to accordingly plan and implement activities and contribute to achievement of the global targets and milestones.

14. Global strategy and plan for action on public health, innovation and intellectual property

Document EB146/15

This document presents progress as requested in decision WHA71(9) (2018). An implementation plan for 2020–2022 is under development, with a draft version available online which will be further refined with inputs from Member States, to be completed before the 73rd World Health Assembly.

Progress made in implementing the recommendations of the overall programme review panel

Prioritizing research and development needs

Since 2014-2015, implementation of the global strategy and plan of action has been harmonized with the WHO strategy on research for health, and particularly the work on the Global Observatory on Health Research and Development. During the biennium 2018–2019, US$ 1.12 million was received or pledged to the Observatory coming from the European Commission, the Government of France and the Government of Switzerland. Despite a new grant of US$ 456 244 from the European Commission in 2020–2021, the funding gap for the Observatory's projected budget for 2020, 2021 and 2022 is US$ 330 818, US$ 781 094 and US$ 781 094, respectively.

The Observatory, in collaboration with the WHO Global Malaria Programme, has developed a methodology for the prioritization of research and development for malaria, including a report that will inform decisions about how best to monitor product development pipelines and prioritize public health needs as well as research and development activities. In view of the suspension of the establishment of an Expert Committee on Health Research and Development, the Observatory has been working with WHO technical units to identify global strategic directions and research priorities for each disease or health-related field, with information being made available and regularly updated for malaria, tuberculosis, HIV, neglected tropical diseases, WHO research and development blueprint pathogens, antimicrobial resistance, mental health, target product profiles and digital health research.

Promoting research and development

The Observatory is the authoritative WHO source of global information and strategic direction on research for health, by serving as a global analytical and information-sharing mechanism to promote and disseminate relevant information and analyses on health research and development investments, activities and capacities. Together with the Secretariat's engagement with stakeholder groups, it promotes evidence-informed decisions on new investments in health research based on public health needs in a coordinated and equitable manner. WHO is taking initiatives to guarantee open-access to publicly funded research, including by making all research supported or published by WHO available for immediate access and reusable under the terms of a free public copyright licence by 2021 and encouraging all Member States to adopt a similar approach for the dissemination of publicly funded research.

Building and improving research capacity

The WHO research and development blueprint has facilitated collaboration between research and development centres in all regions of the world so that they can be better prepared for and more rapidly respond to serious outbreaks of high-threat pathogens, including through the strengthening

of regional networks and the development of a mapping visualization tool. Moreover, the UNICEF/UNDP/World Bank/WHO Special Programme for Research and Training in Tropical Diseases has supported research capacity strengthening for over 40 years through a variety of training programmes, fellowships and its six regional training centres, and as a direct outcome of the research projects it supports.

WHO has been undertaking actions regarding traditional and complementary medicine, including by adding a chapter on traditional medicine in the 11th International Classification of Diseases (ICD-11), and publishing a global report in May 2019. The report traces global trends and presents knowledge on best practices and developments to support countries in generating evidence-based policies and strategic plans to strengthen the role of traditional and complementary medicine in their health systems. To provide continuous support in the future, the WHO Secretariat also asked Member States to define their collaboration needs, which included requests for support and general technical guidance for research and evaluation of traditional and complementary medicine, information sharing on regulatory issues, workshops on national capacity-building and the provision of research databases.

Promoting transfer of technology

WHO has a normative role in setting guidelines or best practices to support technology transfer for health product and has been involved in technology transfer projects and has used innovative mechanisms, including by facilitating contact between potential partners; maintaining a presence during negotiations, mapping and review of technologies; supporting the development of business plans; providing funding and technical cooperation; creating technology transfer hubs or centres to facilitate technology transfer; and establishing public–private partnerships. The WHO, UNCTAD, UNIDO, UNICEF, UNAIDS and the Global Fund inter-agency statement signals the six organizations' aim to work in a strategic, holistic and collaborative manner in partnership with governments and other stakeholders in the promotion of sustainable local production of quality-assured medicines and other health technologies.

Managing intellectual property to contribute to innovation and public health

To help Member States to devise ways to safeguard public health interests, while adhering to their obligations under international trade agreements, WHO provided technical advice and policy support in the framing of national policies, laws and regulations to favour the application and management of intellectual property in a manner that maximizes health-related innovation and promotes access to health products and services, considering the impact on public health of adopting provisions that go beyond the requirements of the Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS Agreement). WHO works with WIPO and WTO to foster a better understanding of the linkage between public health and intellectual property policies and to enhance a mutually supportive implementation of those policies. Since 2017, WHO has requested and strongly promoted the further development of patent status information and licensing databases for health products and facilitated greater access to such information by public health actors, in particular, procurement agencies. MedsPaL, the Medicines Patents and Licences Database of the Medicines Patent Pool, encouraged by WHO, has expanded its scope to include all patented essential medicines in the 21st WHO Model List of Essential Medicines (2019).

Improving delivery and access

The WHO Secretariat has provided support to countries in developing national lists of essential medicines and frameworks for coverage and prioritization systems for benefit packages and the WHO Model List of Essential Medicines formed the basis for pooled procurement mechanisms to improve affordability. It is updating the 2015 WHO guideline on country pharmaceutical pricing policies to include evidence-informed recommendations for the promotion of price transparency of pharmaceutical products.

The Secretariat has also implemented a digital tool and methodology to more efficiently measure the availability and affordability of medicines, which enabled the Secretariat to provide technical support to several Member States in monitoring the prices of medicines, assessing the conformity of policy implementation with policy scopes, and formulating appropriate policy responses. Medicines-pricing databases have been established in two WHO regions to promote and monitor transparency in medicines prices and availability and the WHO Secretariat has established mechanisms to monitor patient out-of-pocket expenditure on health services and products.

Promoting sustainable financing mechanisms

G-Finder3 is a project that tracks public, private, and philanthropic funding of basic research and product development for global health priorities and has a core focus on funding for neglected disease research and development. For fiscal year 2018, G-Finder reported an increase in both Member State and total funding for product development partnerships, with 11 Member States providing funding and accounting for 56% of the total.

Establishing a monitoring and accountability mechanism

In September 2019, the Secretariat launched a questionnaire to gather baseline information from Member States to monitor progress on implementing decision WHA71(9), of which responses will be included in the report to be submitted to the 73rd World Health Assembly and inform the further development of the draft implementation plan for 2020–2022. In 2018, 30 Member States reported data to G-Finder, with further seven Member States being identified as funders by the funding recipients, which was an increase compared to 28 and 4 Member States in 2017, respectively.

Action by the Executive Board

The Board is invited to take note of the report and to comment on progress reported, including the development of the draft implementation plan for 2020–2022; and take stock of further discussions and actions that have taken place to implement decision WHA71(9), in particular operative paragraph (2) in which Member States were urged to further discuss the recommendations of the review panel not emanating from the global strategy and plan of action on public health, innovation and intellectual property.

Implication for the European Region

The WHO European Region has established the European Advisory Committee on Health Research (EACHR) as highest-level scientific advisory body of EURO, with a mandate to provide guidance to the Regional Director on shaping the research agenda in the Region, provide new findings on priority public health issues, as well as facilitate exchange of information on evidence gaps. In 2018, it offered advice on a range of research topics, including the joint monitoring framework and its potential impact on research agenda setting, early childhood development, the cultural contexts of health and well-being, the European Food and Nutrition Action Plan 2015-20, big data, and primary health care.

The Regional Office is strengthening the health research agenda through its Health Evidence Network (HEN) synthesis report series, which synthesizes the available evidence and makes information on high-priority health issues (such as health and migration, nutrition, cultural context of health) comparable across the 53 countries of the WHO European Region. Recently, further work has been done on developing new research agendas such as on tuberculosis (published in 2019 within the scope of the European Tuberculosis Research Initiative (ERI-TB)), health and migration, non-communicable diseases in the eastern part of the European Region, primary health care, environment and health, and on implementation research priorities for HIV/AIDS.

In the WHO European Region, the 'Global strategy and plan of action on public health, innovation and intellectual property' is to a large extent aligned with the 'Action plan to strengthen the use of evidence, information and research for policy-making in the WHO European Region' (EUR/RC66/12)'. Within the implementation period 2018-19:

1. Regional cooperation in science, technology and innovation to enhance knowledge sharing and translation has been fostered by the European Health Research Network (EHRN), which was formally launched and operationalized to assist Member States in strengthening their national research systems and strategies for health. This includes building sustainable capacity, structures and resources in research systems in Member States, and encouraging Member States to share best practices and experiences on research systems issues and strategies.
2. The Evidence-informed Policy Network (EVIPNet) Europe has, with its 21member countries, become the most dynamic knowledge translation network globally. The network aims to increase Member States' capacity in systematically and transparently using research evidence in policy formulation and implementation. The network is supporting countries in creating and institutionalizing innovative, multisectoral and multidisciplinary country partnerships and teams in view of strengthening the science–policy interface and foster mutual learning across the Region.

Pillar 2: One billion more people better protected from health emergencies

15. Public health emergencies: preparedness and response

15.1 Independent Oversight and Advisory Committee for the WHO Health Emergencies Programme

Document EB146/16

In 2016, the WHO Director-General established an Independent Oversight and Advisory Committee for WHO Health Emergencies Programme (IOAC), to provide oversight and monitoring of the development and performance of the Programme and to guide the Programme's activities. The Committee consists of 7 members drawn from national governments, NGOs, the UN system, with extensive experience in a broad range of disciplines. Committee members will end their current term in 2020. The Committee advises the Director-General on issues within its mandate, reports its findings annually through the WHO Executive Board to the World Health Assembly. Its main functions include:

- Assessing the performance of the key functions in health emergencies.
- Determining the appropriateness and adequacy of financing and resourcing.
- Providing advice to the Director-General.
- Reviewing reports on WHO's actions in health emergencies.
- Reviewing reports on the state of health security developed by the Director-General for submission to the World Health Assembly through the Executive Board and to the United Nations General Assembly.
- Preparing an annual report on its activities, conclusions, recommendations.

This document transmits the report submitted by the Chair of the Independent Oversight and Advisory Committee (IOAC) for the WHO Health Emergencies Programme (WHE), includes observations from the IOAC's monitoring of the WHO transformation agenda process and a follow-up to the special report on diversity presented to the Director-General in April 2019.

Main findings from the report include that remarkable progress has been noted in terms of WHO's leadership in disease outbreaks, country preparedness, research, and the Organization's increasingly visible role in managing health in protracted crises. However, WHO cannot do everything alone and needs to work together with partners and with political and operational support and the IOAC will continue to monitor WHO's performance in light of this multiplicity of roles and the constraints of financing.

Progress, challenges and opportunities

The IOAC recognizes the significant progress WHO has made in its leadership in health emergency situations despite the simultaneous challenges of enacting the transformation agenda and the increased numbers of global crises, particularly in managing the Ebola outbreak in the Democratic Republic of Congo, its critical role in coordination efforts and as last-resort provider of health services, for instance in protracted crisis such as in Somalia. The IOAC notes this has led to a good progress with respect to donors' trust in, and support of, WHO's management of outbreaks.

The IOAC emphasises the importance of the United Nations Security Council in providing an enabling environment for WHO's health operation, since security is of paramount importance, especially in conflict settings. It recognizes the importance of the transformation agenda for WHO, but says to be cautiously optimistic about the transformation's added value to addressing health emergencies, considering it has the potential to disrupt existing emergency response systems during the transitional period as capacities move out of the WHE Programme and into centralized WHO structure.

WHO leadership and health emergency management

The IOAC perceives the ERF to be the most effective for managing disease outbreaks and will explore whether it is equally functional in protracted crises.

WHO has performed well in responding to the health needs in north-western Syrian Arab Republic, noting excellent coordination and communication within WHO and with partners, with clear delegation of authority and definition of roles and responsibilities, as well as autonomy in running the operations. The IOAC recommends that WHO document its work under the Whole of-Syria approach – an operational approach to a complex humanitarian and health crisis – to inform future responses.

WHO's support for the Turkish Government in the provision of health services to Syrian populations living in Turkey, including the training of more than 2600 Syrian health care workers and the provision and support of services in paediatrics, obstetrics, gynaecology, mental health in refugee training centres, has been impressive in the face of a complex health workforce challenge. IOAC found this to be an innovative and sustainable approach to managing a high demand for services and observes that this model also could ease cultural and linguistic barriers in other refugee settings.

Despite the strong commitment by United Nations leadership, the IOAC remains concerned about access to security as well as scale-up for non-Ebola interventions. It points out to the progress with Ebola vaccination, welcoming the European Medicines Agency's approval of Merck's rVSV-ZEBOV-GP Ebola vaccine on 11 November 2019, and WHO's announcement on 12 November that the vaccine meets WHO's standards, since these timely actions pave the way for enhanced distribution and stockpiling of this vital resource. It also notes WHO's progress with its research and development blueprint, which is a high-level strategic conveying mechanism under WHE Programme Executive Director leadership that enables prioritization of research and development required for high threat pathogens, coordinated efforts to develop solutions and operational capacity to deploy, test and scale-up, and has, for instance, ensured the timely access to Ebola vaccines in DRC.

WHE Programme in the context of the WHO transformation agenda

The transformation agenda has afforded an opportunity to review the WHE Programme, to optimize the workforce, and to define clear roles and responsibilities across the Organization. The IOAC emphasizes the importance of close collaboration and coordination between the WHE Programme Executive Director and the Regional Directors for major emergencies management and recruitment of key senior staff such as the Regional Emergency Directors to ensure coherent work as "One Programme".

The IOAC recommends the development of a policy on the waiving of due diligence processes for implementing partners with a proven record as a part of streamlining the implementation of the framework of engagement with non-State actors (FENSA) and a systematic workflow applicable to all, and that staff should be made aware of it and encouraged to use it to facilitate critical emergency responses.

IOAC notes that WHO did not bring the findings of its internal audit and follow-up actions on the corruption allegations in Yemen to the attention of all donors in a proactive and constructive manner. In this sense, WHO must assess risks proactively when managing large operations in fragile

contexts, develop mitigation strategies in advance to address these risks, and transparently share its risk analysis and mitigation measures with donors as standard procedure in order build shared awareness. The IOAC recommends strengthening WHO country offices with appropriate capacity in the areas of administration, finance, human resources, emergency response, operational partnerships and procurement, and implementing systematic risk assessment and prevention measures in the context of the transformation agenda.

Human resource management

As of November 2019, 1583 positions (1064 existing staff and 519 vacant positions) are planned for the WHE Programme, with a distribution of 46% in country offices, 30% across the six regional offices and 24% at headquarters. IOAC recommends implementing the human resources plans to strengthen the WHO country offices of priority countries. It also recommends that WHO review the degree of hardship in offices working for emergencies, especially cross-border posts such as Gaziantep, and make a management decision to compensate staff based on workload, following the identification of such an issue for cross-border workers in Turkey-Syria.

The WHE Programme is working with the Department of Human Resources Management to pilot incentives to encourage staff to take positions in hardship duty stations, but IOAC states that in the absence of a clear mobility policy and Organizational commitment, such incentives would not be sufficient to attract experienced senior staff who hold longer-term contracts. The IOAC recommends that the experience of the WHE Programme should be leveraged in finalizing WHO's geographic mobility policy. Evidence from the field missions in the Democratic Republic of the Congo and Turkey suggests that an internal surge capacity policy, including back-filling posts that are left vacant due to emergency deployments or delays in contracting, is not yet in place, but IOAC was informed that such a global policy is in the final stage of revision and will be presented to the Global Policy Group for decision.

The WHE Programme has launched a new incident management system (IMS) leadership training programme to identify and train staff with demonstrated or potential leadership abilities. An in-depth internal roster validation process has now been completed and human resources standards of practice for emergencies are being restructured and further developed, including for selection and placement from the emergency roster. The IOAC will look into the roster management to ensure it is cost-effective and fit for purpose.

As part of the transformation agenda, WHO envisions a shift to a long-term and strategic human resources plan, and away from heavy reliance on short-term contracts with multiple extensions, consultancies and agreed programmes of work. Whilst the IOAC acknowledges the good intentions behind the change, this transition could negatively affect the speed of the emergency response because staff might be left without a possibility of immediately available solutions, as noted in the Gaziantep office. The IOAC recommends that WHO identify staffing gaps and provide flexibility to minimize the disruption during the transitional period.

Staff security, protection and welfare

The IOAC recommends that the transformation agenda ensure a sustainable and functional security apparatus within WHO given that the Organization is increasingly operating in hostile and insecure environments. Despite the intensification of United Nations efforts for prevention of sexual harassment, sexual exploitation and abuse and the fact that more than 90% of WHE Programme staff have completed mandatory training, there could be potential risks in an environment where many external consultants are being hired. The IOAC recommends that WHO conduct systematic risk assessments, implement preventive measures and put in place risk mitigation procedures, including lessons learned and benchmarking with other United Nations agencies.

The IOAC recognizes the provision by medical services of psychological support to the staff working in the Democratic Republic of the Congo on the Ebola crisis and recommends that this practice should be institutionalized for other emergencies.

Partnerships and coordination

Continuous progress has been noted in terms of global partnerships and the IOAC endorses the Director-General's vision to build south–south cooperation by empowering deployable national rapid response teams, working towards the establishment of a global health workforce. As part of its leadership role, WHO has successfully advocated for political support for the Ebola virus disease outbreak in the Democratic Republic of the Congo and for partner mobilization as well as played a successful coordination role is its Gaziantep-based cross-border operations in response to the Syrian crisis. Findings from the field visits in Turkey indicate that operational partnerships on the ground have also improved greatly.

WHO's continuous investment and innovation in technology for health information and epidemiological data management has been fruitful. Go.Data is a unique software tool for outbreak data management to support field operations, codeveloped by WHO and GOARN partners over the period 2017–2018, which was recently deployed in the Ebola response. The IOAC recommends that WHO work closely with Member States, GOARN partners, and stakeholders to ensure a rapid roll-out of the Go.Data tool.

IAOC notes that WHO's performance in the health cluster is heavily dependent on the ability of health cluster coordinators (HCC) supported by an Information Management Officer (IMO). Although national HCC positions have been included in the country business model, recruitment has been slow, mainly due to a funding gap but also because of a lack of qualified candidates. Securing IMOs continues to be challenging. The IOAC recommends reaching out to potential candidates for recruitment, improving roster management and training, and implementing a policy for retention and reward.

WHE Programme finance

The WHE Programme core budget of US$ 533 million was 89% funded as of November 2019 and is composed of US$ 200 million of WHO core flexible funds, US$ 100 million of WHE Programme flexible funds and US$ 233 million of WHE Programme specified funds. The IOAC emphasized the importance of WHO core flexible funding and recommends that the proportion of this component of funding should be increased. The outbreak and crisis response budget of US$ 1.5 billion and the Contingency Fund for Emergencies (CFE) budget of US$ 100 million were 87% and 92% funded as of November 2019. However, due to continued drawdown of the CFE in 2019, especially for the Ebola response, has left the Fund well below an acceptable threshold (balance of around US$ 8 million as of September 2019). The IOAC reiterates that it is critical for Member States to ensure sustainability of the CFE.

WHO continues to target humanitarian funding and is strengthening country-level capacity to tap into country-based pooled funds such as the United Nations Central Emergency Response Fund (CERF). The IOAC recommends that WHO empower WHO representatives and acquire adequate capacity for resource mobilization at the country level. The strategic response plan (SRP) for the period July–December 2019, with a total budget of about US$ 460 million, has received positive feedback from donors. For the Ebola response component, WHO was fully funded as of December 2019, but investment in Ebola preparedness is critically low.

Country preparedness and International Health Regulations (2005)

While acknowledging the impressive progress in terms of volume of activities undertaken under joint external evaluations (JEE) and National Action Plans for Health Security (NAPHS), the IOAC cautions that their impact on strengthening International Health Regulations (2005) core capacities is still unclear. The IOAC reiterates that WHO should make further efforts in streamlining the process and supporting countries in developing simplified and impact-oriented national action plans and welcomes the joint scope of work around universal health coverage for delivery of health services in fragile settings.

Preparedness within and beyond the Democratic Republic of the Congo continues to be a critical component of the Ebola response, but low donor interest has may indicate investment in preparedness is generally undervalued. Without country preparedness and International Health Regulations (2005) core capacity strengthening, there will be more dangerous and costly emergencies in future. The IOAC acknowledges WHO's campaign to raise the profile of preparedness, but more is needed to translate of political commitments into funding allocation. The IOAC endorses WHO's support and vision regarding post-Ebola rebuilding efforts in the Democratic Republic of the Congo and recommends using key points from the operational reviews of the outbreaks to build national capacity and strengthen International Health Regulations (2005) core capacities for the future.

Implication for the European Region

The objective of the IOAC mission to Turkey was to review WHO's work in assisting the Government's response to the Syrian crisis under the whole-of-Syria operations cross border from Gazientep and in Turkey – inclusion of the refugees into the Turkish health system as well as the efforts done on strengthening Turkey's preparedness. The IOAC's field visit to Gaziantep, Turkey, suggests that WHO has performed well in responding to the health needs in north-western Syrian Arab Republic, under the auspices of United Nations Security Council Resolution 2165 (2014).

The IOAC commends WHO on its cross-border operations in Gaziantep, noting excellent coordination and communication between WHO headquarters, the European and Eastern Mediterranean Regional Offices, and the Gaziantep hub in Turkey, with a clear delegation of authority throughout. The supportive WHO Representative in Turkey and the team leader in the Gaziantep office have clear roles and responsibilities and are running operations with autonomy. The IOAC recommends that WHO document its work under the Whole-of-Syria approach – an operational approach to a complex humanitarian and health crisis – to inform future responses.

WHO's support for the Turkish Government in the provision of health services to Syrian populations living in Turkey has been impressive in the face of a complex health workforce challenge. The Organization assisted the Ministry of Health in the training of more than 2600 Syrian health care workers who were later employed by the Ministry of Health to provide primary care services to fellow Syrians living in Turkey. The IOAC observes that this model also could ease cultural and linguistic barriers in other refugee settings.

WHO's work in Turkey has been highly appreciated by the Government, United Nations Country Teams, other United Nations agencies and national and international nongovernmental organizations. The IOAC commends WHO for its Health Cluster leadership in Gaziantep, where it provides strong coordination, and technical and operational support to the implementing partners on the ground. The IOAC notes the receipt of positive recognition for the Early Warning, Alert and Response System

(EWARS),1 the Health Resources Availability Monitoring System (HeRAMS),2 and the Surveillance System of Attacks on Healthcare (SSA) from partners in Gaziantep.

As mentioned above, the Country Office in Turkey has successfully raised US$ 3 million for 2018–2021 for health security and is pushing the agenda for country preparedness. The IOAC recommends that WHO empower WHO representatives and acquire adequate capacity for resource mobilization at the country level.

The IOAC recommends that WHO review the degree of hardship in offices working for emergencies, especially cross-border posts such as Gaziantep, and make a management decision to compensate staff based on workload.

Evidence from the field missions in the Democratic Republic of the Congo and Turkey suggests that an internal surge capacity policy, including back-filling posts that are left vacant due to emergency deployments or delays in contracting, is not yet in place. The IOAC was informed that a global surge policy is in the final stage of revision and will be presented to the Global Policy Group for decision. The IOAC will monitor progress on this issue.

The countries are at the front and the canter of the WHE work in the European Region. The Country Business model is fully functional and proved to be effective and efficient in preventing, preparing and responding to emergencies, and linking with development and UHC efforts.

15.2 WHO's work in health emergencies

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The report provides an overview on WHO's response and coordination in severe, large-scale emergencies in the period of 1 January – 30 September 2019. WHO responded to 51 graded emergencies in more than 40 countries, of which 14 were new graded emergencies and six were classified as Grade 3 (given their scale, complexity and the operational difficulties inherent to them, these six emergencies require the highest level of Organization-wide support). The Ebola virus disease outbreak in the Democratic Republic of the Congo was declared a public health emergency of international concern in July 2019.

The majority of WHO higher-graded public health emergencies are occurring in the African Region (the Democratic Republic of the Congo, South Sudan, Nigeria), which continued to experience prolonged disease outbreaks, population displacements, escalating long-term humanitarian crisis and devastating tropical Cyclone Idai. The Eastern Mediterranean Region continued to face unprecedented humanitarian and health emergencies in several countries (the Syrian Arab Republic, Yemen and Somalia). In the South-East Asia Region, the Grade 3 emergency in Bangladesh was downgraded to a Protracted Grade 2 emergency in April 2019.

For all graded and protracted emergencies WHO Health Emergencies Programme (WHE) developed strategic response and joint operational plans with national health authorities and partners. All higher-graded emergencies have been managed through the WHO Incident Management System allowing incident management structures to be rapidly established at country, regional and headquarters levels. Funds for these structures were released within 24 hours from the WHO

Contingency Fund for Emergencies. About US$ 66.5 million was disbursed from the Contingency Fund, to fast-track support for WHE's response in 17 graded emergencies.

As the Inter-Agency Standing Committee Cluster lead Agency for Health, WHO has led health coordination through 29 Health Clusters, targeting the health and humanitarian needs of 65 million people, in partnership with over 700 national and international partners.

Constraints to WHO's emergency responses and its partners at country level in 2019 included: the scale and magnitude of simultaneously occurring crises, accompanied by mass population movements; ongoing insecurity; limited humanitarian access; insufficient funding for sustainable and continuous life-saving health services to crisis-affected and vulnerable populations; limited human resources; looting; attacks on health care workers and facilities; and escalating field costs.

The report also summarizes progress achieved on health security preparedness. WHE expanded the monitoring and evaluation of International Health Regulations (2005) capacities in all six regions, obtaining the highest number of national responses to the State Parties' self-assessment annual reporting tool since 2010 (191 out of 196 States Parties). This was complemented with significant progress in use of voluntary evaluation instruments (over 100 Joint External Evaluations, 15 after-action reviews and 25 simulation exercises were implemented during the reporting period) and the input from the human-animal interface (28 national bridging workshops). Sixty-four countries used these findings to develop national action plans for health security. WHE also supported countries in building operational readiness to mitigate the impact of imminent public health threats.

WHE contributed and supported the preparation of the first annual report of the Global Preparedness Monitoring Board, which was launched at the UN General Assembly in September 2019. WHE also supported Inter-Parliamentary Union's efforts to advance universal health coverage by 2030.

WHO continued to develop global strategies with its partners to prevent and control high-threat infectious hazards and scale these strategies to regional and country level. The report provides details regarding the progress on status and implementation of several global strategies and plans. Under the Global Strategy to Eliminate Yellow Fever Epidemics, estimated 125 million people in Africa have been protected through vaccination campaigns. An Ending Cholera: A Global Roadmap to 2030 galvanized a number of at-risk countries to launch comprehensive plans for cholera elimination and 58 million doses of oral cholera vaccines have been shipped to 25 countries by mid-2019. Under the Defeating Meningitis by 2030: Roadmap, a platform for integrated surveillance has been set up and implementation is starting in the African Region. EpiBrain, an epidemic forecasting tool that harnesses the power of artificial intelligence, has been developed under the WHO Global Strategy on Digital Health 2020-2024.

WHO's Global Influenza Strategy 2019-2030 provides a framework to approach influenza holistically through tailored national programmes with the goal of strengthening seasonal, zoonotic, and pandemic preparedness. Eight new National Influenza Centers have been recognized by WHO taking the total number to 147 in 124 countries. Through the implementation of the Pandemic Influenza Preparedness Framework, more than 400 million doses of pandemic vaccine have been secured. WHO raised US$ 200 million from the Pandemic Influenza Preparedness Contributions, and those funds have been used to strengthen national preparedness capacities in 72 countries.

The WHO Health Emergency Programme continued to manage a global event-based surveillance system. In 2019, 440 events occurring in 138 countries and territories were investigated, risks were assessed and followed up. Of these, 73% were infectious events, 14% were natural disasters, 10% were events related to chemical, radiological or nuclear products or food safety events, and the remaining 3% were other or undetermined. A formalized rapid risk assessment was conducted for 58 of these events occurring in 33 countries. Surveillance, epidemiology and health information management support was provided through field deployments in several countries as well as through remote support to all other graded emergencies. As part of strengthening early detection of all hazards that have the potential to become acute public health event, the Epidemic Intelligence from Open Sources initiative has been launched and will be initially deployed to 10 countries. The Health Resources Availability Monitoring System has been deployed in eight new countries and reinforced in six others. The Early Warning, Alert and Response System was enhanced or implemented during emergencies in four countries. An analysis of the public health situation was prepared for 16 countries. A method of mapping emergencies and presenting the details in the form of maps of infographics has been developed. A Global WHO Surveillance and Early Warning Strategy was developed in order to better support Member States in fulfilling their obligations under the IHR (2005).

Action by the Executive Board

The Board is invited to note the report and to provide further guidance.

Implication for the European Region

Response:

In the European Region, WHO strives to respond rapidly to acute emergencies, leveraging relevant national and international capacities and provide essential health services and health system strengthening in fragile, conflict-affected and vulnerable settings.

WHO Regional Office has responded to 102 acute public health events in the European Region under IHR and the Emergency Response Framework during the biennium. During 2019, WHO Regional Office responded to four Graded emergencies under WHO's Emergency Response Framework:

- A **Grade 3 Whole-of-Syria response** two **border crossings from southern Turkey**, led and coordinated by WHO Office in Turkey and its Field Office in Gaziantep ensuring access to life saving and health services in northwest Syria (NWS). The recent military escalation in northwest Syria resulted in loss of lives, injuries and exacerbated suffering of civilians, displacing more than 299,000 (as of 02 January 2020), including women, children and elderly; 2.7 million of the 12 million people in need of humanitarian health services are in northwest Syria. WHO estimates that 600,000 people depend on access to primary health care if cross-border operations from Turkey. Among them, lifesaving TB services for 1,200 patients, immunization for children; access to essential packages of medicines and care for non-communicable diseases as well as care for people with mental health disorders; Secondary health services in six major hospitals are maintained through the cross-border operations; 633 patients received haemodialysis services; Life-saving trauma caseload is currently increasing with escalation of hostilities; Emergency obstetric care and pediatric care are provided at all levels.

WHO continues supporting the Turkish Ministry of Health in their efforts to provide universal health care to the **3.6 million refugees** from Syria, through cultural and linguistic sensitive health services. The **refugees health programme** is in the WHO Country Office in Turkey. Mental health care needs continue to exceed treatment capacities. To respond to the specific health needs of the refugees specific programmes have been tailored (e.g. mental health and conflict-related injuries including rehabilitation services). The prevention and management of NCDS are priority areas for intervention at the primary health care level. The services are provided in Arabic by Syrian health care workers that were trained and integrated into the Turkish health system.

- A **Grade 2 multi-country measles** emergency was declared to respond to health system gaps leading to current outbreaks, and its response is led by the Regional Office and guided by the WHO's Strategic Response Plan for the measles emergency in the European Region.
- A **Grade 2 protracted crisis in Ukraine** where 5.2 million people are currently directly affected in eastern Ukraine, with around 1.3 million people within 20 km of the "contact line" and almost 1.5 million people displaced in need of life-saving and essential health services.
- A **Grade 1 earthquake in Albania** that led to 51 deaths, 943 injured and over 13,000 displaced in November 2019. Hundreds of buildings, including health facilities and public health infrastructure, have serious structural damages. The recovery process and Post Disaster Needs Assessment (PDNA) was formally launched by the Government of Albania in December 2019 with the support of the UN, EU and World Bank. WHO and Ministry of Health of Albania are working closely to build the Albanian health system back.

During non-emergency phase, WHO Regional Office works to strengthen the implementation of WHO standards including those set by the Health Cluster, Emergency Medical Teams (EMTs), the Global Outbreak and Response Network (GOARN), and Stand-by Partners. 105 GOARN partner institutions are located in the WHO European Region. In 2018-2019, 20 GOARN partners were deployed to provide support to seven responses, through 81 deployments. Through GOARN, WHO established a Mobile Labs (ML) Initiative and collaboration between WHO Regional Office; Robert Koch Institute in Germany; and Rospotrebnadzor in Russian Federation on Mobile Lab Classification and Standardization.

Four WHO classified EMTs from the European Region deployed in 2019 to respond to Cyclone Idai in Mozambique (Johanniter International; Regione Piemonte (Italy); Spanish Agency for International Development Cooperation; and Instituto Nacional de Emergência Médica (INEM). A new Regional Governance Structure v. 2.0 for EMTs in the European region has been adopted in 2019.

WHO Regional Office is strengthening People-Centered Emergency Care Systems (PECs) that are well organized, safe and of high quality which are key for ensuring provision of emergency services and for achieving a range of SDGs targets – including those on UHC, road safety, maternal and child health, noncommunicable diseases, mental health, and communicable disease, and is working with relevant programmes to develop a regional toolkit.

Preparedness:

Guided by the GPW13, the IHR (2005) provisions, European Action Plan to improve public health preparedness and response in the European Region 2018-2023 and other relevant strategic and policy frameworks, WHO Regional Office is supporting countries to evaluate the status of national preparedness capacities, monitoring areas of work, developing strategies and documenting best practices, while ensuring continuum from assessment to national planning and implementation by providing operational guidance for national action plans and country capacity-building, as described below.

The 2018's self-assessment from 53/55 (95%) State Parties in WHO European Region records generally high capacities with an average score of 3.7 (74%) across all 13 IHR technical areas. The 2019 reporting is under way and so far 32 countries submitted State Party Annual Report. The two strongest technical areas overall in the European Region are: Laboratories (average score: 4/80%) and IHR Coordination and National IHR Focal Point Functions (4/79%). The five technical areas in the region with the highest strengthening potential are: Points of entry (average score 2.9/58%), Risk Communication (3.4/69%), Chemical Events (3.4/69%), Human Resources (3.5/71%), and National Health Emergency Framework (3.6/72%).

By December 2019, 18 countries in the European Region – eight priority countries - requested WHO support and completed Joint External Evaluation (JEE). Two countries are already in the pipeline for 2020. Six after action reviews (AARs) were conducted with the Regional office support and three AARs are planned for 2020. In 2019, six country-level simulation exercises were supported by WHO, one sub-regional and one region-wide simulation exercise (Joint Detection and Assessment of Events (JADE) exercise with participation of 46 Member States. Preparations for JADE 2020 have already started. One Health approach has also been addressed and eight national bridging workshops (NBW) were organized in 2019.

WHO Regional Office provides support and technical assistance to Member States for the development of comprehensive public health emergency management systems through promotion of preparedness programmes and plans at national, subnational, local and health facility levels. Nine countries were supported to conduct national strategic risk assessment using WHO Strategic Tool for Assessing Risks (STAR), as a starting point of the emergency preparedness cycle. Training on the concept of hazard specific contingency planning and WHO methodology on developing a contingency plan using high priority risks identified by strategic risk assessment as case scenario was undertaken in six countries.

Seven European Member States have developed or are in the process of developing national action plan for health security. The Regional Office will scale up its support during 2020-21 and will provide a comprehensive support to the national action planning processes transforming recommendations from various evaluations into actions that strengthen the ability of countries to prepare and be operationally ready to manage major public health risks or events. Determined political leadership is of critical importance for prioritizing health emergency preparedness and the full implementation of legally binding obligations under the IHR (2005).

Achieving high levels of preparedness and readiness have a cost but this is also an investment in health, safety, security and development. WHO Regional Office promotes provision of an adequate

and consistent levels of domestic financing for the full implementation of the IHR (2005) and comprehensive preparedness programs in Member States that will ensure long-term sustainability for the health emergency preparedness and response capacities.

Preventing epidemics and pandemics

Global strategies have been developed for 4 high threat infectious hazards so far: Cholera, Meningitis, Yellow Fever and Influenza. In the European Region, the focus is on Influenza. Strategies for other diseases of priority in our Region, such as Crimean-Congo haemorrhagic fever (CCHF), are under development.

WHO Regional Office contributed to the development of the WHO's Global Influenza Strategy 2019–2030 and conducts a range of activities at the Regional level (in particular the joint EURO-ECDC influenza surveillance platform Flu News Europe) as well as in multiple countries (particularly in 5 PIP PC priority countries, Armenia, Kyrgyzstan, Tajikistan, Turkmenistan and Uzbekistan) to support its' implementation with tangible results: four of the new National Influenza Centres recognized by WHO in 2019 are in the EURO Region (Cyprus, North Macedonia, Turkmenistan and Ukraine). In addition, Turkmenistan endorsed its' national pandemic preparedness plan in 2019.

In addition to CCHF, WHO Regional Office has defined other high threat infectious hazards and has analysed historical data submitted by Member States to WHO since 2006. The analysis will be finalized in 2020 and inform where additional strategies are needed to prevent or mitigate the impact of these pathogens, and where there are gaps in indicator-based surveillance. The 2019 launch of the Laboratory Task Force to improve diagnostic capacities for High Threat Pathogens in 15 WHE priority countries will contribute to this work. Member States are encouraged to continue to invest in maintaining and strengthening their surveillance systems for high threat pathogens. 15.3 Influenza preparedness

15.3 Influenza preparedness

Document EB146/18

This document reports on progress in strengthening influenza preparedness, notably the implementation of the Global Influenza Strategy, which was launched in March 2019 by WHO and provides an overarching framework for the Secretariat, Member States and partners to approach influenza preparedness holistically through the establishment and strengthening of capacities to prevent, control and prepare for influenza at the global, regional and national levels. It also reports on the Pandemic Influenza Preparedness Framework for sharing of influenza viruses and access to vaccines and other benefits, as requested by the decision WHA72(12) from May 2019.

Strengthening influenza preparedness

The Global Influenza Strategy 2019–2030 was developed using a consultative process with Member States and relevant stakeholders and supports the achievement of two outcomes: (1) better global tools for the prevention, detection, control and treatment of influenza; and (2) stronger country capacities such that every country has an evidence-based influenza programme that meets national

needs and is integrated within health security and universal health coverage efforts. Its indicators of success will be finalized by the Secretariat in 2020.

A core principle of the Strategy is that influenza capacity-building has spill-over benefits for broader health systems strengthening and preparedness for other infectious disease threats through the International Health Regulations (2005). Since countries cannot build new systems at the time of an influenza pandemic or an health emergency, overall preparedness can be realized through building routine systems. It builds on the success of the WHO Global Influenza Surveillance and Response System, which is a mechanism of alert and response for seasonal, zoonotic and pandemic influenza, by integrating broader goals for influenza prevention, control and preparedness for all countries. The System has represented the commitment of Member States to global health for more than 70 years, serving as the foundation of surveillance, preparedness and response to influenza epidemics and pandemics.

To begin implementation towards the first high-level outcome of better global tools, the Secretariat hosted in June 2019 a multi-stakeholder technical consultation on influenza product research and innovation, which allowed participants to review the product landscape and current trends in production and use for influenza vaccines, antivirals and other treatments; and to identify concrete actions and opportunities for WHO and partners to accelerate research and innovation. To support countries in strengthening pandemic preparedness, the Secretariat developed a package of tools for use by countries in developing and updating their national influenza pandemic preparedness plans and in conducting simulation exercises. In 2020, the Secretariat will host a consultation on the second high-level outcome of stronger country capacities to identify opportunities and challenges for strengthening capacities for influenza surveillance, monitoring and data utilization; seasonal influenza prevention and control; and pandemic influenza preparedness and response.

Implementing decision WHA72(12)

A webinar was held on 7 October 2019 to update Member States and stakeholders on progress in implementing decision WHA72(12) (the recording and slides are available online). An information session on implementation of the decision was held on 1 November 2019.

Operative paragraph 1(a): Data and analysis related to influenza virus sharing

The Health Assembly requested the Director-General to work with the Global Influenza Surveillance and Response System and partners to collect, analyse and present data on influenza virus sharing to enable a deeper understanding of the challenges, opportunities and implications for public health associated with virus sharing under the Global Influenza Surveillance and Response System, including by identifying specific instances where influenza virus sharing has been hindered, and how such instances may be mitigated.

The Secretariat is aware of four specific instances to date providing evidence on the effects of national regulation, legislation or other administrative measures on virus sharing or other aspects of the work of the Global Influenza Surveillance and Response System. In these instances, Influenza Centres hosted by parties of the Nagoya Protocol or by countries that are not parties but have put into place domestic access and benefit-sharing sharing legislation asked for additional requirements and procedures, such as obtaining a registration number for use of the virus or signing a transfer agreement, which led to delays and uncertainties in a time-sensitive process. Additional instances were reported during an information meeting in connection with the southern hemisphere influenza vaccine composition in late September 2019.

To develop a more systematic approach that will gather comprehensive information and allow

a thorough analysis and presentation of data on influenza virus sharing under the Global Influenza Surveillance and Response System in a way that enables a deeper understanding of the challenges, opportunities and implications for public health, including identifying specific instances where influenza virus sharing has been hindered and how such instances may be mitigated, the Secretariat will work in close collaboration with the Global Influenza Surveillance and Response System, using appropriate tools and mechanisms – including a questionnaire to Global Influenza Surveillance and Response System laboratories and relevant partners – .

Operative paragraph 1(b): Legislation and regulations related to influenza virus sharing

The Health Assembly requested the Director-General to prepare a report on the influenza virus sharing and the public health considerations thereof by existing relevant legislation and regulatory measures, including those implementing the Nagoya Protocol, with inputs from Member States and stakeholders and in consultation with the Secretariat of the Convention on Biological Diversity as appropriate. To address this request, the Secretariat will conduct a desk review of available existing legislation and regulations that may impact the sharing of influenza viruses, including by using information available on the Convention on Biological Diversity Access and Benefit-Sharing Clearing-House; and, based on the desk review, prepare a document summarizing the key components of available national legislation or regulatory measures that are relevant to influenza virus sharing and the public health considerations thereof. A pilot of the desk review, covering 10 countries, has been completed. The methodology for the desk review was reviewed and updated to consider lessons learned from the pilot.

Operative paragraph 1(c): Functioning, usefulness and limitations of search engine

Following a request by the Health Assembly for the Director-General, the Secretariat will collaborate closely with relevant partners to provide more information on three key aspects of the prototype search engine: (1) functioning, including which databases are searched, the search terms used, how data are processed and presented, and who owns the data; (2) usefulness, including results obtained from piloting the search engine to identify uses of genetic sequence data from influenza viruses with pandemic potential and how information generated could potentially be used in the future; and (3) limitations, including information and data that cannot be obtained from the search engine, such as information for monitoring access to genetic sequence data at the point where the data are distributed, and where human intervention is needed.

Operative paragraph 1(d): Databases and initiatives, data providers and data users

In response to a request by the Health Assembly that the Director-General explore possible next steps in raising awareness of the PIP Framework among relevant databases and initiatives, data providers and data users, and in promoting the acknowledgment of data providers and collaboration between data providers and data users, the Secretariat will gather information from Member States and relevant stakeholders, building on previous work done by the PIP Framework Advisory Group. The results of this information gathering will form the basis of a report on possible next steps in raising awareness of the PIP Framework and in promoting acknowledgment of data providers and collaboration between data providers and data users.

Operative paragraph 1(e): New developments

The Health Assembly requested the Director-General to continue providing information on new challenges and opportunities from new technologies in the context of the PIP Framework for the

sharing of influenza viruses and access to vaccines and other benefits and possible approaches to them. Since the Health Assembly in May, the Secretariat has organized several events to advance its work to harness the challenges and opportunities presented by new technologies. In June 2019, WHO held a technical consultation on better global tools: product research and innovation for influenza prevention control and treatment and organized an internal seminar on universal influenza vaccine. The Secretariat plans to collect information on new developments from all three levels of the Organization and will continue to share such information.

Operative paragraph 2: Amendment to Annex 2, Footnote 1 of the PIP Framework

The Health Assembly decided to revise Footnote 1 in the Standard Material Transfer Agreement 2, in Annex 2 of the PIP Framework with effect from the closure of the Seventy-Second World Health Assembly. The Secretariat has taken the following steps to implement this decision:

(a) In 2011, following adoption of the PIP Framework, WHO developed a notice to be included with all shipments of PIP Biological Materials to alert recipients that acceptance of such materials would trigger benefit-sharing obligations under the PIP Framework. The document has been revised to alert recipients of the amendment and is in use as of 1 November 2019.

(b) Templates for the three categories of the Standard Material Transfer Agreement 2 have been updated and signatories of existing agreements are being contacted to inform them of the amendment and its applicability to their agreement.

(c) The Secretariat is in the process of publishing an updated edition of Pandemic Influenza Preparedness Framework for the sharing of influenza viruses and access to vaccines and other benefits, which is expected to be available in all official WHO languages by the end of 2019.

(d) The PIP webpage has been updated to inform stakeholders of the amendment.

Action by the Executive Board

The Executive Board is invited to note this report and may wish to focus on suggestions for further sensitizing Member States to the importance of timely influenza virus sharing and on ways to promote influenza prevention and control strategies, including seasonal vaccination.

Implication for the European Region

WHO European Region has provided technical input to both the Global Influenza Strategy and the implementation of the WHA (72)12 – contributing to documents and attending relevant technical meetings.

Key outstanding questions for the region relate to the implications of the Nagoya protocol on virus sharing for Member States in the region. The WHO European Regional office is supporting the dissemination of the WHO questionnaire on this issue.

Based on experience with some countries in our Region (particularly those of Eastern Europe, the review of existing legislation that may impact sharing of influenza viruses is expected to uncover prohibitive legislation which will need to be discussed at the highest level. This pertains to the sharing of all infectious substances and associated data, not just influenza.

15.4 The public health implications of implementation of the Nagoya Protocol

Document EB146/19

This report is submitted pursuant to the Health Assembly request in decision WHA72(13) (2019) for the Director-General to provide information on current pathogen-sharing practices and arrangements, the implementation of access and benefit-sharing measures, as well as the potential public health outcomes and other implications; and to provide an interim report to the Executive Board at its 146th session, in order to broaden engagement with Member States, the secretariat of the Convention on Biological Diversity and relevant international organizations and stakeholders. This document has been prepared in close consultation with the Secretariat of the Convention on Biological Diversity and provides background information on WHO's work to date on access and benefit-sharing arrangements; an update on the Secretariat's work in implementing decision WHA72(13) and a proposed workplan for the period February 2020 to March 2021.

Background

Pathogen-sharing and the Nagoya Protocol

The Nagoya Protocol to the Convention on Biological Diversity is an international agreement whose objectives are to create legal certainty and mechanisms that promote fair and equitable sharing of the benefits arising from the utilization of genetic resources through the establishment of national legal frameworks. Under the Protocol, genetic resources may be accessed subject to the "prior informed consent" of the country providing the resources and once "mutually agreed terms" have been reached that include the fair and equitable sharing of benefits arising from the utilization of the concerned resources.

Currently, pathogen-sharing occurs on an ad hoc basis; bilaterally, as the need arises; and through existing networks of institutions and researchers. In the case of seasonal influenza, virus-sharing is systematic through the WHO Global Influenza Surveillance and Response System, an international network of influenza laboratories that conducts year-round surveillance of influenza. For influenza viruses of pandemic potential, sharing occurs under the terms of the Pandemic Influenza Preparedness Framework. Pathogen samples are shared to advance surveillance and diagnostic activities or to determine, for example, epidemiological changes or the development of resistance.

WHO's relevant work on biodiversity and health and on access and benefit-sharing

WHO and the Secretariat of the Convention on Biological Diversity have a strong history of collaboration on access and benefit-sharing and have worked closely on several activities, particularly since the establishment in 2012 of the joint work programme on biodiversity and health. WHO and the Secretariat of the Convention on Biological Diversity signed in 2015 a memorandum of understanding to strengthen collaboration, and co-convened regional capacity-building workshops, and have prepared joint guidance to support the consideration of biodiversity and ecosystem management in the One Health approach.

A study conducted by the WHO Secretariat and presented to the Executive Board in January 2017 concluded that the Nagoya Protocol has implications for the public health response to infectious diseases. In a visit from WHO delegation to the Secretariat of the Convention on Biological Diversity in March 2017, they agreed on mutual areas of work and future collaboration and identified key linkages between the Nagoya Protocol and WHO's work on access and benefit-sharing for human pathogens, including (a) implementation of the Nagoya Protocol in the context of health emergencies

(b) reference to specialized international access and benefit-sharing instruments under the Nagoya Protocol; (c) digital sequence information and access and benefit-sharing under the Convention on Biological Diversity/Nagoya Protocol and the Pandemic Influenza Preparedness Framework; and (d) linkages with other provisions of the Nagoya Protocol, especially as they may apply to the sharing of pathogens.

In May 2018, WHO, the Secretariat of the Convention on Biological Diversity, FAO and the OIE collaborated on the development of a question-and-answer document on the implementation of the Nagoya Protocol in the context of human and animal health and food safety regarding access to pathogens and fair and equitable sharing of benefits. The Health Assembly requested the Secretariat to prepare a report on how existing relevant legislation and regulatory measures, including those implementing the Nagoya Protocol, treat influenza virus-sharing and the public considerations, as mentioned in document EB146/18.

Progress in implementing decision WHA72(13)

As at 1 October 2019, WHO has advanced its internal coordination on pathogen-sharing, particularly in the context of the Nagoya Protocol, across all three levels of the Organization and with several stakeholders. Regarding internal coordination, WHO is coordinating across its divisions and actively reaching out to all technical units that may have experience with or knowledge of pathogen-sharing, including the Secretariat of the Pandemic Influenza Preparedness Framework, focal points for the International Health Regulations (2005) and food safety and communicable disease teams.

In collaboration with the Secretariat of the Convention on Biological Diversity and in consultation with other international organizations, including the FAO and the OIE, WHO has developed a survey to collect information on current pathogen-sharing practices and arrangements and on implementation of access and benefit-sharing measures as well as to gather perspectives on potential public health outcomes and other implications. The survey for Member States, international and national agencies, WHO collaborating centres, non-State actors in official relations with WHO, the private sector and other relevant stakeholders will be made available on the WHO website and, as appropriate, on the Convention on Biological Diversity website as well.

WHO will analyse the results of the initial survey, conducting further research if gaps in the knowledge base become evident, and the final report that will be submitted to the Health Assembly in 2021.

Analysis of existing data is also being carried out, including via the Access and Benefit-Sharing Clearing-House (ABSCH), a platform for exchanging information on access and benefit-sharing that contains country profile information relating to, inter alia, the competent national authority and legislative, administrative or policy measures under the Protocol, as well as the reports submitted by the Parties to the Protocol on progress made in implementing obligations under the Nagoya Protocol, including information on the development of access and benefit-sharing measures and progress made. This information will supplement the survey analysis.

Next steps in implementing decision WHA72(13)

To ensure the completeness and thoroughness of this WHO Director-General report to the 74th World Health Assembly, as outlined by decision WHA72(13), the Secretariat has developed a workplan for the period between February 2020 and March 2021.

Continued research and analysis

Based on the outcomes of the initial survey and subsequent in-depth research, the Secretariat, in collaboration with the Secretariat of the Convention on Biological Diversity and in consultation with other partners, may issue a secondary survey to stakeholders to address any gaps in data collection or in stakeholder response. Should this be necessary, the survey would be made available on the WHO website and, as appropriate, on the Secretariat of the Convention on Biological Diversity's websites.

Further engagement with Member States and stakeholders

Throughout the course of 2020, the Secretariat will convene regular Member State briefings at WHO headquarters in Geneva and at other Member State meetings, as requested, and stakeholder briefings to ensure that all interested parties are kept apprised of progress in implementing decision WHA72(13).

The WHO Secretariat will also provide a briefing of its progress to the Conference of the Parties serving as the meeting of the Parties to the Nagoya Protocol at its next (fourth) meeting, currently scheduled for the last quarter of 2020, as part of its collaboration with the Secretariat of the Convention on Biological Diversity and the States party to the Nagoya Protocol.

The full report by the WHO Secretariat will be made available in advance of the 148th session of the Executive Board, on the WHO website. A summary of the final report will be made available in mid-2020 to help Member States in their consideration of the full report.

Action by the Executive Board

The Executive Board is invited to note this report and to endorse the proposed next steps presented above. The Board is also invited to provide any further guidance considered necessary.

Implication in the European Region

A key focus in our Region is to ensure that all Member States have a National Influenza Centre recognized by WHO (NIC) as recognition is only achieved when NICs have proven to regularly share seasonal influenza viruses with WHO. Currently, 46/53 MS have a WHO-recognized NIC.

15.5 Cholera prevention and control

Document EB146/20

The document reports, as requested by resolution WHA71.4 (2018) on the global cholera situation and evaluate efforts made in cholera prevention and control.

Cholera is an extremely virulent and acute diarrhoeal infection caused by ingestion of food or water contaminated with the bacterium Vibrio cholerae and can lead to severe dehydration, possibly killing within hours if untreated.

Global cholera situation

In 2018, 499447 cholera cases and 2990 deaths resulting from cholera were reported worldwide to WHO, showing a 59% decrease when compared to 2017 and the fewest number of cases since 2004. Excluding cases reported from Yemen (where reporting is imprecise), numbers were 128 121 cases and 2485 deaths, a respectively 34% and 27% decrease compared with those in 2017. This

global decrease mirrored a reduced cholera incidence in the WHO African Region where the reduction was of 37% in cases and a 25% in deaths for the period.

Efforts made in cholera prevention and control

The movement to end cholera has made significant progress since the launch of the Global Roadmap. Several cholera-affected countries have demonstrated strong leadership and determination to stop cholera outbreaks and develop multisectoral cholera control plans. Unprecedented use of oral cholera vaccines has resulted in a significant reduction of the disease burden in countries in which cholera is endemic and outbreaks in multiple settings have been controlled. The Global Task Force partnership continues to support countries in their efforts. However, challenges remain and ending cholera as a public health issue by 2030 will require sustained collaboration and commitment from cholera-affected countries, technical partners and international donors.

Since 2018, several countries have made remarkable gains in overall cholera control and prevention. South Sudan, Haiti, Somalia, and Yemen are countries showing objectives set by the *Global Task Force on Cholera Control's strategy* of reducing the number of deaths resulting from cholera by 90% and eliminating cholera in 20 of the 47 countries currently affected by 2030 is achievable and on track. The Global Roadmap, which was launched in October 2017 and recognized by the World Health Assembly in 2018, was developed to leverage and reinforce efforts to advance the 2030 Agenda (specifically SDGs 3, 6 and 11). It outlines three main axes for cholera prevention and control: early detection and quick response to contain outbreaks at an early stage; a multisectoral approach to prevent cholera in endemic countries targeting hotspots; and an effective mechanism of coordination for technical support, resource mobilization and partnership at the local and international levels.

Early detection and rapid response are critical to contain cholera outbreaks and reduce mortality. For instance, Mozambique and Zimbabwe were able to rapidly control cholera outbreaks through the decision to employ oral cholera vaccines and the development of multi-sectoral responses. Oral cholera vaccine is being increasingly used and serves as a critical bridge to longer-term efforts like sustainable water, sanitation and hygiene solutions.

The recognition in 2018-2019 that control and elimination of cholera requires governments to acknowledge and report the disease, such as by specifying cholera by name, was important to favour the introduction of specific multisectoral control programmes targeting known risk factors and launching specific control measures. Several countries and areas have made a commitment to, and are making significant progress in, developing multisectoral cholera control plans that are tailored to the specific context of the country while retaining the strategic framework of the Global Roadmap.

The partners of the Global Task Force on Cholera Control have since 2018 developed several tools and guidance to support countries on comprehensive and coordinated cholera control activities, including a framework for the development of national cholera plans for control or elimination. For instance, the International Federation of Red Cross and Red Crescent Societies have engaged with the Islamic Development Bank in seeking to raise up to US$ 150 million globally to support, in line with the Roadmap, projects on sustainable water, sanitation and hygiene (contributing to SDGs 3 and 6) in cholera hotspots in the most affected Member States of the Organization of Islamic Cooperation over the next 10 years.

Several challenges remain and need to be overcome in all countries to fully control cholera and achieve the objectives of the Global Roadmap. More robust epidemiological and laboratory surveillance data are needed to precisely identify cholera hotspots and detect outbreaks at an early

stage and the detection, confirmation and reporting of outbreaks should be accelerated everywhere, to ensure immediate control. Moreover, interventions that separate water, sanitation and hygiene efforts from immunization activities should be avoided and vaccine supply should cover the increasing demand.

Action by the Executive Board

The Board is invited to note the report. The Board may wish to focus its discussions on how to ensure that surveillance and early reporting of cholera is strengthened in line with the International Health Regulations (2005) and that cholera prevention and control measures are developed and implemented in affected countries, in accordance with resolution WHA71.4.

Implication for the European Region

Several European organizations are partners of the Global Task Force on Cholera Control and continue to provide support for comprehensive and coordinated cholera control activities and technical guidance to countries. Their work and achievements are to be commended.

There has been no autochthonous cholera outbreak in WHO European Region since 2011, when there was a limited outbreak in Mariupol, Ukraine.

Every year, there are imported cases of cholera in Europe and since these cases usually fulfil only one of the four IHR Annex 2 criteria (1. serious public health impact, 2. unusual or unexpected, 3. risk of international spread of disease and 4. interference with international travel and trade)only some of those imported cases are notified to WHO, either under IHR or through the EU Early Warning and Response System (EWRS).

.WHO European Region also receives annual data on cholera cases from Member States. The latest data is from 2018 and includes zero (0) autochthonous laboratory confirmed cholera case and a total of 13 imported lab confirmed cholera cases, by **B**elgium, France, Kazakhstan, Spain, Sweden and United Kingdom two imported from Bangladesh, Cuba and India.

The risk for further transmission of cholera from these imported cases in Europe is considered to be very low.

16. Poliomyelitis

16.1 Polio eradication

Document EB146/21

This report provides an update on the status of polio eradication against the three key goals of the Global Polio Eradication Initiative Polio Endgame Strategy 2019–2023 presented at the 72 WHA and summarizes the remaining challenges to securing a lasting polio-free world.

Eradication

Wild poliovirus transmission

Cases of wild poliovirus type 2 were last reported in 1999 and of type 3, in November 2012. Since then, all cases of paralytic poliomyelitis due to wild poliovirus have been caused by wild poliovirus type 1, which can still be detected in parts of Afghanistan and Pakistan, where a cross-border endemic virus transmission is happening. No wild poliovirus has been detected in Africa since September 2016 and the certification of the eradication of wild poliovirus in the WHO African Region could occur as early as 2020.

An increase in newly-reported cases in 2019, particularly in Pakistan, highlights the continued geographic spread of the virus. Gaps in strategic implementation of vaccination activities mean a high likelihood that this scenario will continue. In-depth analysis of the programme and the establishment of new emergency measures by the start of the low transmission season will be needed, and a high-level commitment to polio eradication by the authorities will be key to find the solutions. The Global Polio Eradication Initiative partnership has launched a “hub” of experts based in Amman, Jordan, to provide dedicated, rapid and coordinated support and expertise to these national governments. The polio programme has also strengthened its integration efforts, launching a more systematic collaboration with routine immunization programmes and fostering new partnerships with broader health initiatives.

Circulating vaccine-derived polioviruses

In Africa, several outbreaks due to genetically-distinct circulating vaccine-derived poliovirus type 2 continue to spread in 2019. The continued spread of existing outbreaks due to circulating vaccine-derived poliovirus type 2 as well as the emergence of new type 2 circulating vaccine-derived polioviruses point to insufficient quality of outbreak response with monovalent oral polio vaccine type 2 and gaps in routine immunization coverage. This situation is aggravated by an increasing mucosal-immunity gap to type 2 poliovirus, following the switch from trivalent to bivalent oral polio vaccine in 2016. Monovalent oral polio vaccine type 2 is currently the best available tool to respond to outbreaks of type 2 vaccine-derived polioviruses, but if outbreak response with this vaccine is not of high quality, and coverage targets are not met, or vaccine management is substandard, there is an increased risk of both ongoing transmission and emergence of future vaccine-derived polioviruses type 2.

The polio programme is continuously evaluating existing and new strategies to address the situation, including by: evaluating modelling data, closely monitoring vaccine supply, assessing the geographic scope for the use of monovalent oral polio vaccine type 2 and quality of operations, and supporting the development and rapid licensure of a novel oral polio vaccine type 2 that would have a lower risk of seeding new type 2 vaccine-derived polioviruses.

In Asia, coordinated, cross-regional, cross-border outbreak response activities have been conducted to address two outbreaks due to genetically-distinct circulating vaccine-derived poliovirus type 1 in border areas of Indonesia and Papua New Guinea. This has likely been a successful approach since no new viruses have recently been detected. An assessment of the outbreak response in Papua New Guinea noted the strong coordination between the Government, WHO, UNICEF and Gavi, the Vaccine Alliance, in using the outbreak response as an opportunity to reinvigorate routine immunization in a sustainable manner. This experience is helping to inform similar activities in other outbreak settings. Cases of circulating vaccine-derived poliovirus have been identified or are under investigation in Myanmar (type 1), China (type 2) and Philippines (type 1 and type 2).

Integration

Integration is one of the three key goals of the new strategy and highlights the importance the Global Polio Eradication Initiative is placing on working together with other actors in a systematic and sustained way. Polio staff on the ground spend approximately 50% of their time working on other disease intervention areas and the polio infrastructure and planning capacity are frequently used to implement supplementary immunization activities with other interventions and antigens (e.g. doses of vitamin A, vaccines of measles, yellow fever and tetanus toxoid, deworming tablets and insecticide-treated bed-nets).

In the new strategy, the focus on integration calls on the polio programme to ensure a systematic approach to integration and a closer collaboration with other partner programmes, including by providing support to the implementation of interventions aimed at tackling broader community health needs and fostering strengthened engagement for polio and broader vaccination uptake. This will leverage the Global Polio Eradication Initiative's human and physical assets, systems and expertise to protect populations through strengthened immunization services and enhanced emergency response. Collaboration with routine immunization, surveillance and emergencies groups ensures that core capacities are maintained and strengthened and helps mitigate risks of new outbreaks in areas of weak routine immunization.

The current polio surveillance infrastructure has also played an important role in expanding and strengthening vaccine-preventable disease surveillance beyond polio. The new strategy supports the integration of polio field and laboratory surveillance with other surveillance systems. Under the leadership of the WHO immunization programme, a joint accountability framework across the Global Polio Eradication Initiative and the immunization community is being developed to support the monitoring and implementation of the integration goal of the strategy. The framework will define roles and responsibilities, identify critical activities for timely implementation and track progress.

Containment and certification

In 2019, the Global Commission for the Certification of the Eradication of Poliomyelitis continued to intensify its work and review the criteria that will need to be met to achieve the global certification of wild poliovirus eradication. The Commission recommended a process of sequential certification of wild poliovirus eradication (following the global certification of wild poliovirus type 2 eradication in 2015), and confirmation of the absence of vaccine-derived polioviruses, which would occur after the global certification of wild polioviruses and after the global withdrawal of bivalent oral polio vaccine.

The Commission concluded at its meeting in October 2019 that wild poliovirus type 3 has been globally eradicated as it has not been detected since 2012. Efforts to contain type 2 poliovirus were intensified in 2019, guided by the WHO global action plan to minimize poliovirus facility-associated risk after type-specific eradication of wild polioviruses and sequential cessation of oral polio vaccine use (GAPIII) and by WHO guidance on minimizing risks for facilities collecting, handling or storing materials potentially infectious for polioviruses. The Containment Advisory Group continues to provide advice on issues related to the interpretation and implementation of GAPIII.

Following the initiation of the global Containment Certification Scheme in 2018, Global Certification Commission-endorsed certificates have been granted to vaccine manufacturing facilities in Indonesia and Sweden and to laboratories in South Africa and the United States. Additional applications are under review by the Commission. In resolution WHA71.16 (2018), Member States committed to intensifying efforts to accelerate progress towards poliovirus containment. 25 of the 26

countries hosting facilities planning to retain type 2 poliovirus material have established national authorities for containment. Poliovirus essential facilities have until 31 December 2019 to enter the Containment Certification Scheme by submitting applications for participation in the scheme to their national authorities for containment.

As a result of training sessions and webinars on GAPIII and the risks and costs of poliovirus type 2 material retention organized by the Global Polio Eradication Initiative partners, two designated poliovirus-essential facilities have opted to destroy or transfer these materials. WHO is helping to build capacity for GAPIII auditing countries with facilities planning to retain type 2 poliovirus materials, by providing auditor training sessions and opportunities for trained auditors to become qualified as lead GAPIII auditors by performing supervised facility audits.

National efforts to complete inventories for types 1 and 3 wild poliovirus materials have continued in 2019, prioritizing type 3 inventories due to the Commission's certification of the eradication of wild poliovirus type 3. The inventory, destruction or transfer of type 3 wild and vaccine-derived poliovirus infectious and potentially infectious material will be the initial focus for containment following certification. Countries planning to retain these materials within a poliovirus essential facility must have established a national authority for containment and should enrol all facilities in the Containment Certification Scheme.

Strengthening partnerships and new enabling factors

The Global Polio Eradication Initiative partnership continues to strengthen its governance and management structures and is working to advance key universal health coverage priorities, by improving the delivery of health services, developing and scaling health infrastructure, and effectively mobilizing domestic resources to confront key health issues. Coordination with GAVI has been formalized and GAVI officially joined the Polio Oversight Board in 2019. This enhanced collaboration will be at the centre of the integration goal of the new strategy. In 2019, G7 and G20 leaders demonstrated continued political will for polio eradication by focusing on the implementation of the 2030 Agenda and universal health coverage through the G7 Health Ministers' meeting in May in Paris and the G20 Heads of State Summit in Osaka.

In November 2019, Reaching the Last Mile Forum in United Arab Emirates, focused international attention on tackling infectious diseases and provided an opportunity for world leaders and civil society organizations to contribute to the last mile of polio eradication. The Global Polio Eradication Initiative 2019–2023 Investment Case defines that impacts of investing in polio eradication include savings made of more than US$ 27 billion in health costs since 1988 and a generation of US$ 14 billion in expected cumulative cost savings by 2050 in a sustained polio free world.

Another enabling factor in polio eradication is the increased focus on gender as a determinant of health-seeking behaviours and a critical variable in vaccination outcomes. The programme is committed to identifying and addressing gender-related barriers to immunization, communication and disease surveillance and to advancing gender equality. The Global Polio Eradication Initiative Gender Equality Strategy 2019–20231 and implementation plan provide a clear framework for action to guide the programme's work on gender-responsive programming.

Action by the Executive Board

The Executive Board is invited to note the report.

Implication for the European Region

In line with the Global Polio Eradication Initiative Polio Endgame Strategy 2019–2023, the WHO European Region has maintained its polio-free status. Containment of polioviruses and preventing any containment breach at a vaccine manufacturer or research laboratory is a priority for the WHO European Region.

All 53 Member States in the WHO European Region have completed their national inventories of facilities and designation of Polio Essential Facilities (PEF) including activities conducted in line with the poliovirus containment certification is ongoing.

The global eradication of wild poliovirus of type 3 was certified in October 2019, and the WHO Regional Office for Europe is preparing appropriate communication to Member States to update their National Inventories of facilities retaining wild type 3 poliovirus and to proceed with appropriate measures in accordance with the Global Action Plan on poliovirus containment (GAPIII)

Progress to date in the WHO European Region: Poliovirus containment activities are currently focused on containment of poliovirus type 2 (both of wild and vaccine origin) and type 3 (wild) and preparation made for containment of polioviruses type 1 and type 3 (vaccine).

i. All WHO European Region Member States have completed their National Inventories of facilities
ii. 42 Member States decided not to designate PEFs and destroyed type 2 polioviruses
iii. 11 Member have formally confirmed nomination of PEFs (43 PEFs, final figures might change) and plan to proceed with poliovirus containment certification
    - 10 of these Member States have established NACs
    - 3 Member States submitted applications for the Certificate of Participation (CP) for a review by the Containment Working Group of the Global Certification Commission for Polio Eradication (CWG-GCC)
    - 1 Member State obtained the CP

Within the domain of global health security and strengthening routine immunization programme in the Region including ensuring robust comprehensive disease surveillance and adequate data management, the polio programmatic activities are well-integrated within the routine immunization system.

16.2 Polio transition planning and polio post-certification

Document EB146/22

Following the 2017 World Health Assembly decision on polio transition planning (WHA70(9)), the Secretariat submitted a strategic action plan to the Seventy-first World Health Assembly in May 2018 that has three main objectives: (a) to sustain a polio-free world after eradication of polio virus; (b) to strengthen immunization systems, including surveillance for vaccine-preventable diseases, to achieve the goals of the WHO Global Vaccine Action Plan 2011–2020; and (c) to strengthen emergency preparedness, detection and response capacity in countries to fully implement the International Health Regulations (2005). The Health Assembly noted the strategic action plan, which included

identification of the capacities and assets, particularly at country level, required to sustain progress in other polio-funded programmatic areas and to maintain a polio-free world after eradication.

The Secretariat has since then been working with 20 countries prioritized for transition planning, either because of the substantial polio programme investments they have received or based on their high-risk status for sustaining polio eradication, focusing on reviews of and appropriate support for the development and implementation of national plans for polio transition. The country planning process has revealed the need to sustain or selectively re-purpose essential functions currently funded by the polio programme, particularly in fragile and conflict-affected countries and those with poor health systems, where essential functions depend heavily on the polio eradication programme and other international donor funding.

This report provides an update on progress made since the 72nd WHA regarding the strategic action plan and outlines the approaches to be taken and milestones up to May 2020.

Progress on transition activities since May 2019

As announced at the 72nd World Health Assembly in May 2019, the Deputy Director-General is leading and overseeing WHO's polio transition efforts at the request of the Director-General, including by coordinating measures across the three levels of the Organization and by chairing the high-level Polio Transition Steering Committee. Additionally, in recent months, regional steering committees overseeing polio transition in the African, South-East Asia and Eastern Mediterranean regions have been established or reactivated.

A corporate workplan to enhance coordination and facilitate the implementation of the plan was designed by the Secretariat in response to requests from Member States at the Seventy-First World Health Assembly. It covers an initial period of 12 months starting from June 2019 and defines roles, responsibilities and activities to be performed by the technical departments across the three levels of the Organization. A summary of the outcomes of the eight joint country support visits carried out to date has been prepared and posted on the WHO website.

Consultations with regional offices and country support

Advocacy for polio transition remains a priority and high-level regional consultations involving key stakeholders have been initiated at three levels of the Organization. To date, one consultation has taken place in Eastern Mediterranean Region, and another is planned to take place in the African Region before the 146th session of the Executive Board. The consultation held in Cairo in September 2019 aimed to agree on the polio transition leadership role for regional and country offices, produce a workplan mainstreaming polio transition into workplans for 2020–2021; conduct a full mapping of polio-funded positions currently supporting immunization or emergencies functions at the regional and country levels; agree on the modalities of establishing "integrated public health teams" at country level; and to agree a joint corporate country-by-country workplan. As an outcome, joint country support visits are planned to Iraq and Sudan by January 2020 and to Somalia and Syria before May 2020. The table on the original document provides a list of priority countries and completed or planned related country missions.

Cross-departmental progress

The 2021–2030 global vaccine and immunization vision and strategy currently under development integrate the need for sustainability of polio eradication and strengthening of country immunization and vaccine-preventable disease surveillance capacities, focusing on effective, efficient

and resilient immunization programmes as part of primary health care. It calls for mainstreaming the essential functions so far implemented, managed and funded by partners and the Global Polio Eradication Initiative into the programmes of national governments, preferably by domestic funding.

WHO has prepared a global strategy on comprehensive vaccine-preventable disease surveillance, based on the Thirteenth General Programme of Work (2019–2023) and extensive consultation with regional offices and partners. The strategy will be finalized in May 2020, together with the 2021–2030 global vaccine and immunization strategy, of which it will constitute an integral part. It intents that all countries are equipped with sustainable, high-quality surveillance systems for vaccine-preventable diseases, supported by strong laboratory systems that detect and confirm cases and outbreaks and generate useful data, thereby decreasing the burden of vaccine-preventable diseases as efficiently and effectively as possible. It also aims to guide countries in integrating acute flaccid paralysis surveillance into vaccine-preventable disease surveillance, and in mitigating the negative implications of the decline in resources from the Global Polio Eradication Initiative, giving the heavy reliance on polio funding for disease surveillance in many countries in the African, South-East Asia and Eastern Mediterranean regions.

WHO is working with partners to cost the global implementation and maintenance of comprehensive vaccine-preventable disease surveillance, focusing on lower income countries, and established a working group to define surveillance capacity needs and gaps and determine how to expand polio surveillance infrastructure and combine it with other disease and outbreak surveillance activities. A guidance note is being prepared on implementing comprehensive vaccine-preventable disease surveillance while maintaining strong polio surveillance. At the regional level, the investment case for vaccine-preventable disease surveillance in Africa 2020–2030 was launched in Abu Dhabi in November 2019. Certification and containment, progress reporting and management will remain the same, is one of the three goals of the new Global Polio Eradication Initiative's Polio Endgame Strategy 2019–2023. The future location of Containment is under consideration since it will be sustained post-eradication and then eventually absorbed into another WHO programme.

Operational planning guidance for regional and country offices have been developed for the Programme budget 2020–2021, including programmatic deliverables and activities to foster integration and transition. A separate polio transition base budget workplan will facilitate the mainstreaming of polio-funded functions where required, increase transparency and accelerate integration. Consultations at all three levels of the Organization on different approaches to mobilizing funding for immunization activities affected by polio transition are planned to take place after the operational planning process. In consultation with regional offices, this will involve the selection of two pilot countries in the African Region, with the objective of securing resource mobilization support for immunization activities, consistent with the relevant regional plan. An initial mapping has been completed of potential countries and lessons learned.

A joint accountability framework across the immunization community and Global Polio Eradication Initiative partners is being developed under the leadership of the Secretariat department for immunization. It defines roles and responsibilities, identifies critical activities for timely implementation, and tracks progress as part of the "integration" goal of the Initiative's Endgame Strategy.

WHO country offices are determining based on national capacities the programme support required by countries, particularly in the subnational level, to maintain key immunization, surveillance, and emergency-related functions. The support for these functions from WHO will be accounted for in the WHO polio transition base budget. Specific deliverables under the related workplans would

include, at a minimum, support for: assessment of capacities and gaps for vaccine-preventable disease and health emergencies functions; case-based, active surveillance for high-risk diseases and broader passive surveillance for vaccine-preventable diseases and other priority diseases; verification and case investigation for signals and alerts for polio and other high-risk diseases; rapid response and health emergency coordination through emergency operations centres or equivalent mechanisms; and support for immunization campaigns and risk communication as required.

For the purposes of effective and efficient independent monitoring of the polio transition process, the terms of reference of the Transition Independent Monitoring Board have been amended, to streamline its membership and extend its role, initially for an additional two years.

Transition activities planned until May 2020

The Secretariat will continue to implement the polio transition corporate workplan described above, with a focus on enhancing the role of regional offices and strengthening country capacities. In the African Region in particular, additional guidelines for non-priority countries will also be developed. All polio activities in endemic countries and polio campaigns in non-endemic countries will continue to be located in the non-base Global Polio Eradication Initiative workplans to ensure that eradication remains the overarching priority. Planning activities for ongoing outbreaks of circulating vaccine-derived polio viruses will be aligned with the most recent epidemiological situation, especially in the African Region where outbreaks are occurring in six out of seven priority polio transition countries. Collaboration with health systems units will be further enhanced in support of cross-Organization universal health coverage goals.

Action by the Executive Board

The Board is invited to note the report and to provide advice on the best way to support the development, finalization, implementation of national polio transition plans for the various countries concerned.

Pillar 3: One billion more people enjoying better health and well-being

17. Decade of Healthy Ageing

Document EB146/23

This document outlines a summary of the proposal for a Decade of Healthy Ageing 2020-2030, following the adoption of the Global strategy and action plan on ageing and health by resolution WHA69.3 (2016), which comprises five strategic objectives; a framework for action across the 15-year period of the Sustainable Development Goals and the mandate to, inter alia, establish the global evidence and partnerships needed to set up a decade of concerted global action, the Decade of Healthy Ageing 2020–2030.

Preparations for the proposal

In 2018, the Secretariat conducted a mid-term review of country progress on implementing the Global strategy and action plan on ageing and health against 10 indicators as well as an analysis of six past and current health-related Decades to ascertain factors for, and barriers to, successful Decades of action and some regional offices have reviewed progress, gaps and lesson learned. In January 2019, the Secretariat conducted an internal review of the contributions of WHO headquarters to the implementation of the Action plan on ageing and health (2016–2020). An independent evaluation is currently under way and its report will be available in January 2020. The Secretariat is preparing a Global status report on healthy ageing reflecting agreed standards and metrics to provide baseline data for the Decade of Healthy Ageing 2020–2030, which will be submitted as information to the Seventy-Third World Health Assembly and launched on 1 October 2020.

Identifying priorities

From October to November 2018, with United Nations entities and partner organizations, the Secretariat ran a survey to determine country priorities for the Decade of Healthy Ageing. Improved engagement with older people; better understanding of older peoples' needs; developing and strengthening health and long-term care, specifically in communities; and improved multisectoral action were the main issues identified, whereas the priority support options were capacity-building; evidence-based guidance; support to connect, convene and exchange knowledge with relevant stakeholders; and data and innovation. The support options were further discussed and refined in a meeting in November 2018, held in partnership with the United Nations Population Fund, on developing a platform to support the Decade. Healthy life expectancy; age-friendly cities and communities; and reduced number of older people who are care dependent were the main outcomes identified. Ten progress indicators related to the Global strategy have already been used to track progress and other possible indicators were discussed during the process of consultation.

From concept note to draft proposal

The proposal for the Decade of Healthy Ageing 2020–2030 has been developed through a broad consultative process led by Member States, while engaging United Nations entities and several stakeholders. Building on the concept note, the results from the survey and the meeting on developing a platform to support the Decade, a preliminary draft proposal for the Decade of Healthy Ageing was

developed by the Secretariat, which was further refined through a series of consultations, including with regional committees, and a global public online survey from May to October 2019. Based on the feedback received, a revised draft is proposed for consideration by the Executive Board.

As of September 2019, a total of 89 Member States, across all six regions and at different administrative levels, and the European Union have provided inputs. Nineteen United Nations entities and international organizations provided comments and inputs, including under the Inter-Agency Group on Ageing, and an estimated 300 non-State actors working on ageing and with older people engaged in the development of the proposal for the Decade of Healthy Ageing.

The draft proposal for a decade of healthy ageing 2020–2030

Vision

The vision for the Decade of Healthy Ageing is a world in which everyone can live a longer and healthier life.

Action areas

The Decade of Healthy Ageing is proposed as a global collaboration that will bring together diverse sectors and stakeholders including governments, civil society, international organizations, professionals, academic institutions, the media and the private sector. This global collaboration has the potential to build on and strengthen existing synergies, align with United Nations reform, contribute to the progressive realization of the rights of all older people everywhere to the enjoyment of the highest attainable standard of health, and harness the social and economic opportunities that population ageing provides.

The collaboration focuses on four strongly interconnected action areas that are intended to improve the lives of older people, their families and their communities, namely: changing how we think, feel and act towards age and ageing; developing communities in ways that foster the abilities of older people; delivering person centred integrated care and primary health services responsive to older people; and providing older people who need it with access to long-term care. To promote health and address the environmental and social determinants of healthy ageing, multisectoral action is important and combating ageism needs to take place across all policies, settings and practices.

Activities

The activities will take place at the local, national, regional and global levels, with a focus on improving the lives of older people, their families and their communities; and tackle the current challenges that older people face, while anticipating the future for those who will journey into older age. Moreover, it will take a life course approach, recognizing the importance of multisectoral actions that focuses on healthy lives and targets the needs of people throughout their life, but focuses on the second half of life, given the unique issues that arise in older age, and the limited attention this period has received compared with other age groups. Actions will also be crafted in ways that overcome, rather than reinforce, inequities linked to individual and social factors and to specific, multiple or complex health conditions; since policies and programmes would otherwise risk widening the gaps and leaving some older people behind.

The proposal for the Decade of Healthy Ageing promotes multisectoral and multi-stakeholder engagement and collaboration and a platform used for the development of the proposal will be

further expanded to support collaboration and focus on four enablers across the four action areas of the Decade of Healthy Ageing: hearing diverse voices and enabling the meaningful engagement of older people, family members, caregivers and communities; nurturing leadership and building capacity at all levels to take appropriate action that is integrated across sectors; connecting diverse stakeholders around the world to share and learn from the experience of others; and strengthening data research and innovation to accelerate implementation.

Underpinning this work, there is a framework to track progress in implementing the Decade of Healthy Ageing which builds on progress indicators used for the Global strategy and action plan on ageing and health and uses existing indicators (such as those of the Sustainable Development Goals), where possible, by disaggregation of data by age. This framework prioritizes the role of national and subnational leadership and ownership of results; building strong capacity including to monitor and evaluate; and a reduction in reporting burden by aligning multi-stakeholder efforts with the systems countries use to monitor and evaluate their national policies and strategies on ageing; and recognizes the critical role of strengthening people's voice and of civil society engagement to responsive governance and service delivery.

Mechanisms to manage the Decade of Healthy Ageing will initially be led by WHO with support from key United Nations entities and are expected to evolve to ensure that actions remain country led, drawing on the leadership of governments at different levels and across sectors, in partnership with civil society and continue to strengthen the United Nations system delivering as one on ageing.

Action by the Executive Board

The Executive Board is invited to note the report and to recommend to the Seventy-third World Health Assembly a draft decision which: (1) endorses the proposal for a Decade of Healthy Ageing 2020–2030; and (2) requests the Director-General to report back on progress in the implementation of the Decade of Healthy Ageing to the Seventy-sixth World Health Assembly, the Seventy-ninth and the Eighty-second World Health Assembly.

Implication for the European Region

The European Region has the highest median age of all WHO Regions. Progress with life expectancy in Europe is increasingly due to gains in life expectancy among the higher age groups. Political awareness of ageing as a demographic trend that needs policy response is high in all parts of the Region, more recently also in countries of Central Asia. A large majority of countries have policies/strategies/plans for healthy ageing.

Work in the European Region has been based on the Strategy and action plan for healthy ageing in Europe, 2012-2020 and will be reported on at the Regional Committee in 2020.

In the 2020-2021 work programme of the WHO Regional Office, topics of healthy ageing will be addressed in more than 10 country cooperation agreements. There is a strong demand for broadening of WHO toolbox (guidance and policy briefs) from European countries. The European Region has been asked to take a leading role to address some of these, such as the area of integrated, person-centred long-term care. These activities are backed by a high-level of inter-programmatic cooperation in the WHO Regional Office for Europe on healthy ageing: Healthy ageing has been addressed in around 20 programmes and been included in relevant strategies and action plans across the organization.

The Regional Office has cooperated with Member States on all four action areas of the proposed Decade. Demand from Member States for WHO cooperation often had a focus on topics of long-term

care and age-friendly environments (the later in the framework of the WHO European Healthy Cities Network, and the WHO Global network of age-friendly cities and communities).

Key deliverables for 2020-2021 will include a package of guidance for long-term care reform (financing of long-term care and the investment case for long-term care; quality of long-term care; qualification, skill mix and sustainability of long-term care work force) and the implementation of the Age-friendly environments in Europe handbook and policy tools.

18. Maternal, infant and young child nutrition

Document EB146/24

The report describes the progress made in carrying out the comprehensive implementation plan on maternal, infant and young child nutrition (endorsed by the Health Assembly in resolution WHA65.6 (2012)) and updates on the related Global Nutrition Monitoring Framework as requested by decision WHA68(14) (2015).

It also provides information on national measures to give effect to the International Code of Marketing of Breastmilk Substitutes, adopted through resolution WHA34.22 (1981) and updated through subsequent related Health Assembly resolutions, and describes the progress made in drawing up technical guidance on ending the inappropriate promotion of foods for infants and young children.

Progress made in carrying out the comprehensive implementation plan on maternal, infant and young child nutrition

Overall, only slow progress has been made in reducing stunting and low birth weight and increasing breastfeeding. Wasting and anaemia are still largely unaddressed, and overweight has continued to increase. This means that, in the absence of a substantial scale up in response actions, it is likely that the 2025 targets will not be met, and neither will the targets under Sustainable Development Goal 2, target 2.2 on ending all forms of malnutrition by 2030.

Global target 1: stunting

The global number of stunted children aged under 5 years dropped from 166 million in 2012 to 149 million 2019, more than half of whom lived in Asia and one third in Africa. In 2018, 36 of the 85 countries with sufficient data to estimate progress were on track and 31 presented some progress in reaching the 40% reduction target in the global number of stunted children by 2025.

Global target 2: anaemia

The global prevalence of anaemia among women of reproductive age in 2016 was 32.8% (compared with 30.3% in 2012), which equates to 613.2 million women according to latest population estimates by the United Nations. The highest rates of anaemia are found in the WHO South-East Asia, Eastern Mediterranean and African regions.

Global target 3: low birth weight

The global, regional, and national low birth weight estimates updated between 2000 and 2015 by WHO and UNICEF, together with academia, show slow progress in the decrease on low weight births, with an average annual reduction of only 1% in the period from 2010 to 2015, as opposed to the 2.74% since 2012 required to reach the target of 30% reduction by 2025.

Global target 4: overweight

By 2018, there were an estimated 40 million overweight under-fives in the world, 10 million more than in 2000, almost half of whom lived in Asia and one quarter in Africa. This represents a slight but persistent increase both in terms of prevalence and of numbers.

Global target 5: exclusive breastfeeding

In the period 2013–2018, an estimated 41% of infants aged under 6 months were exclusively breastfed. Of 73 countries with sufficient data to estimate current trends, 34 are on track to reach the 50% target by 2025, 16 present insufficient progress and 23 present no improvement or are worsening.

Global target 6: wasting

In 2018, there were an estimated 49.5 million under-fives with wasting, of whom 16.6 million had severe wasting and 68% lived in Asia and 28% in Africa. Worldwide, of the 74 countries with recent data, 35 have already reached or are on track to meet the 2025 target of reducing childhood wasting rates to below 5%, while 15 present insufficient progress, and 24 show no improvement or worsening trends.

Action 1: create a supportive environment for the implementation of comprehensive food and nutrition policies

Nutrition is increasingly being included on foreign policy agendas. For instance, the G20 has made commitments on childhood overweight and obesity, hunger, access to safe and nutritious food and the Foreign Policy and Global Health Initiative focussed its work on nutrition. The UNGA resolution 73/132 (2018) on global health and foreign policy calls on Member States to address hunger and malnutrition and scale up activities under the United Nations Decade of Action on Nutrition (2016–2025).

WHO and FAO have jointly published a resource guide, inspiring countries to translate the 60 recommended policies and actions of the Second International Conference on Nutrition (ICN2) Framework for Action into more binding country specific commitments and the United Nations. The Security Council recognized in 2018 (resolution 2417) that 75% of all stunted children under five years of age lived in countries affected by armed conflict and that the use of starvation as a weapon of war against civilians must be strongly condemned.

Multisectoral and multi-stakeholder collaboration is promoted by the Scaling Up Nutrition movement and, as of August 2019, 125 out of the 172 WHO Member States that had national nutrition policies and strategies in place had elaborated multisectoral policies. A further 16 Member States have incorporated nutrition-related goals and policy actions into relevant sectoral strategies as well as in national development plans. Regarding coordination, 148 WHO Member States reported that they have nutrition coordination mechanisms in place, 37 of which had them at the highest level of government.

Action 2: include all required effective health interventions with an impact on nutrition in national nutrition plans

Among the 172 WHO Member States with national nutrition policies, 134 have policies that cover action areas related to maternal, infant and young child nutrition, 122 cover nutrition in schools, 134 cover promotion of healthy diet and prevention of obesity and diet-related NCDs, 125 cover vitamin and mineral nutrition, 82 cover acute malnutrition, and 70 cover nutrition and infectious disease.

However, nutrition interventions are often not part of benefit packages and when they are, their coverage tends to be insufficient and even if quality services are delivered, nutrition interventions may be neglected. Despite clear guidance of the Emergency Nutrition Network on infant feeding in emergencies and commitments undertaken by Member States on resolution WHA71.9, few Member States have policies (26%) and protocols (37%) that cover the nutritional needs of infants and young children during emergencies, even if a quarter of the world's children live in countries affected by disasters or wars.

WHO, using its One Health Tool and its repository of interventions for universal health coverage, is supporting Member States in enhancing the integration of nutrition into their national health policies and programmes by including all essential nutrition actions in health sector planning and the costing of health sector strategic plans. The WHO list of essential nutrition actions has recently been updated.

Action 3: stimulate development policies and programmes outside the health sector that recognize and include nutrition

According to the United Nations Intergovernmental Panel on Climate Change's report on climate change and land, meeting the challenges of our climate crisis requires urgent changes in our food systems. In response to this, FAO and WHO have developed guiding principles for sustainable, healthy diets, designed to guide action taken in the context the Decade of Action on Nutrition.

Better alignment and coordination of efforts to strengthen food safety systems across sectors and borders is crucial. For instance, opportunities and challenges of strengthening food safety systems, particularly through trade, were explored at WTO by the International Forum on Food Safety and Trade in April 2019, where FAO, WHO and WTO emphasized consumers' right to expect that locally produced and imported food are safe. The FAO Committee on World Food Security is developing voluntary guidelines on food systems and nutrition, which are intended to give guidance on appropriate policies, investments and institutional arrangements and improve alignment of food, agriculture and health sectors.

WHO is currently analysing existing school food and nutrition policies, guidelines and standards in about 100 countries to see how countries are ensuring healthy food and nutrition environments in schools. School programmes have the potential to deliver double-duty actions by addressing all forms of malnutrition among children and adolescents, but currently only 55 of the 122 WHO Member States including actions on nutrition in schools in their national nutrition policies are planning to regulate the types of foods and beverages in schools.

Although 73 Member States are implementing excise or special sales taxes for sugar-sweetened beverages at the national level, many such tax laws still do not cover all relevant beverages systematically or equally tax beverages with and without sugars. Moreover, legal measures are being taken to limit quantities of industrially produced trans-fatty acids in foods in all settings in 31 Member States and recommended best practice policies have been developed in 12 of those. In a further 26 Member States, adopted best practice legal measures are yet to be put into effect.

Action 4: provide sufficient human and financial resources for the implementation of nutrition interventions

An additional US$ 7 billion additional per year would be needed from 2016 to 2025 to reach the global nutrition targets on stunting, anaemia, breastfeeding and wasting, according to estimations from the Investment Framework for Nutrition produced by the World Bank. An increasing number of

countries have costed investment plans and data from OECD countries show that funding levels remain volatile despite a 11% increase in donor financing for nutrition from 2015–2017 (from US$ 1.1 billion to US$ 1.4 billion). Health accounts data taken in 2016 from 35 low- and middle-income WHO Member States shows a median domestic general government expenditure on "nutritional deficiencies" of US$ 0.21 per capita, which is the lowest among all disease categories. A nutrition summit (Nutrition for Growth) will be hosted by the Government of Japan in 2020 inviting governments and development actors in nutrition to make new financial and specific SMART policy commitments.

Action 5: monitor and evaluate the implementation of policies and programmes

Nutrition data systems are fragmented and incomplete even though the availability of good quality data is recognized as being necessary for understanding progress towards reducing malnutrition in all its forms, which negatively impacts governments' capacity to plan and prioritize investments. To address this issue, initiatives have been established, such as Data for Decisions to Expand Nutrition Transformation (DataDENT) and the European Commission's National Information Platforms for Nutrition.

The joint WHO-UNICEF Technical Expert Advisory Group on Nutrition Monitoring provides guidance on indicators and issues recommendations on data collection, analysis and reporting. It supported the development and validation of indicators in the Global Nutrition Monitoring Framework, on which information is included in the WHO Nutrition Landscape Information System. Several collaborations have been formed to report annually on national, regional and global estimates. Considering that improving routine data collection is crucial for increasing the volume and frequency of data and allowing better geographical disaggregation, WHO and UNICEF together with other partners are developing a nutrition module to enhance national health management information systems (District Health Information System – DHIS2).

Progress in implementing the international code of marketing of breastmilk substitutes and guidance on ending the inappropriate promotion of foods for infants and young children

In 2018–2019, WHO Member States and partners and the Secretariat implemented a variety of actions to improve infant and young child feeding. According to the latest assessment, 35 out of the 136 countries that have enacted legal measures related to the International Code of Marketing of Breastmilk Substitutes have instituted measures reflecting all or most of the provisions in the Code. Despite WHO guidance that companies marketing foods for infants and young children should not sponsor meetings for health professionals, 38% of national paediatric associations continue to receive funding for their conferences from the manufacturers of breastmilk substitutes. This is increasingly being addressed at the national level through regulations and legislation.

National systems are increasingly being developed and more than 20 countries have pursued the establishment of monitoring systems to identify Code violations and implement enforcement actions. Eight countries were able to document inappropriate promotion of breastmilk substitutes by using the NetCode toolkit for ongoing monitoring and periodic assessment, which examines Code violations in health care, retail, communities, and mass media. The widespread use of digital marketing strategies for the promotion of breastmilk substitutes is a cause of growing concern, since modern marketing methods that were still unknown when the Code was written are now used regularly.

WHO has developed a methodology for identifying commercial baby foods available in retail settings and collecting data on their nutritional content, as well as various aspects of their packaging, labelling and promotion, and has outlined a nutrient profile model for commercially-available complementary foods marketed as suitable for infants and young children (aged 6–36 months). A study conducted in four countries high levels of total sugars in baby foods.

In 2018, WHO published a new guideline recommending breastfeeding counselling for all pregnant women and new mothers and describing the frequency, timing, mode and providers of such counselling and, together with UNICEF, issued a revised version of their Ten Steps to Successful Breastfeeding and guidance on breastfeeding support in neonatal intensive care units. The 2019 Global Breastfeeding Scorecard, introduced by the Global Breastfeeding Collective led by WHO and UNICEF, documents that considerable gaps remain regarding the national implementation of key priority policies and programmes that protect, promote, and support breastfeeding.

Action by the Executive Board

The Executive Board is invited to note the report. In its discussions, the Board is invited to:

• comment on progress made in relation to: the comprehensive implementation plan on maternal, infant and young child nutrition, implementation of the International Code of Marketing of Breastmilk Substitutes and the guidance on ending the inappropriate promotion of foods for infants and young children;

• identify areas for Secretariat action in support of Member States (involving the provision of for example, guidance, technical support and data);

• discuss how the Secretariat may best support the preparation of Member States' financial and policy commitments at the nutrition summit, planned for 2020;

• consider the a draft decision requesting the World Health Assembly to adapt a decision to streamline future reporting requirements on maternal, infant and young child nutrition, through biennial reports until 2026 (to be issued in 2022, 2024 and 2026, respectively).

Implication for the European Region

Many challenges persist in the WHO European Region in terms of mother, infant and young child nutrition. Exclusive breastfeeding is on average low in the Region although there are countries showing an interesting increase. WHO European Region does not suffer the same problems with stunting, wasting and low birth weight as in other parts of the globe. In a few countries while going down steadily in the last years there are still some groups in the population suffering from these issues. Childhood obesity is affecting more than one in every four children and does not show significant signs of improvement in spite of some sporadic country successes.

Member States of the WHO European Region have been implementing specific actions on nutrition guided by the European Food and Nutrition Action Plan 2015-2020 and the Global Implementation Plan developed as part of WHO's Twelfth General Programme of Work, 2014–2019.

The European Food and Nutrition Action Plan 2015–2020 has placed the WHO European Region at the forefront of global discussions regarding policy development, evaluation and

surveillance in the field of nutrition including on maternal, infant and young children nutrition which is one of the main pillars of this action plan.

Several success stories are associated with the nutrition area in the WHO European Region notably the significant expansion of the WHO European Childhood Obesity Surveillance Initiative that highlights the importance of improved surveillance to inform effective policies for better food and nutrition.

Both the Global Implementation Plan and the European Action Plan have enabled the WHO Regional Office for Europe to bring together Member States of the Region in action networks for reducing food marketing pressure on children and for salt reduction. Through these networks, the Regional Office could develop tools such as regional nutrient profile models, which provide guidance on how to classify foods to restrict the marketing of “unhealthy” foods.

19. Accelerating efforts on food safety

Document EB146/25

At a meeting of the Officers of the Board, it was recommended to add this item to the provisional agenda of this session of the Board. In 2019, in collaboration with the African Union and the World Trade Organization (WTO), respectively, WHO and FAO contributed to convening the First International Conference on Food Safety and the International Forum on Food Safety and Trade, which reviewed the status of food safety in the world and identified new and emerging challenges.

The six WHO/FAO Regional Coordinating Committees, subsidiary bodies of the Codex Alimentarius Commission, the executive organ of the joint WHO/FAO food standards programme, are discussing follow up actions and have highlighted to date the need to mainstream food safety to advance public health goals, raise the profile of food safety in the governing bodies of both WHO and FAO and ensure sustainable funding for scientific advice to the Commission. The relevant role of the Codex Commission in developing new and revised standards on food safety and nutrition was noted in a recent evaluation of WHO’s normative functions and reaffirmed in the Codex Strategic Plan 2020–2025. WHO and FAO provide technical support to Member States in effectively engaging in the Codex discussion and in implementing its adopted standards at the national level.

Food safety has been part of the WHO Constitution (Article 2(u)) since its adoption. Over the past decades, major food safety crises have profoundly influenced or reshaped food safety policies and national food control systems whereas increasing global trade in food and animal feed have likewise highlighted the importance of managing food safety at the international level. Member States have requested the WHO Secretariat to implement activities to promote and strengthen food safety worldwide through Health Assembly resolutions resulting in the WHO global strategy for food safety: safer food for better health (2002) and the WHO strategic plan for food safety, including foodborne zoonoses (2013–2022). Commitments to acting on food safety have also been undertaken at regional levels in the Western Pacific, Americas and South-East Asia.

Burden of foodborne diseases

Foodborne diseases are caused by hazardous physical, chemical, microbial and radioactive agents in food. Microbial hazards include prions, viruses, bacteria and parasites. The nature of such

illnesses ranges from acute (e.g. diarrhoea, allergy, meningitis, miscarriage) and sub-acute (e.g. arthritis, renal failure) to chronic (e.g. cancer, epilepsy) symptoms and sequelae.

According to WHO first estimates from 2015, foodborne hazards cause 600 million cases of foodborne illnesses and 420 000 deaths yearly, resulting in the loss of 33 million disability-adjusted life years and presenting a particularly high risk for children under five years of age, who represent 30% of global mortality. The burden is unevenly distributed across regions, and the African, South-East Asia and Eastern Mediterranean regions carry the highest disease burden per population, having diarrhoeal diseases as leading cause of are.

Total productivity loss in low- and middle-income countries and the cost of treating foodborne illnesses are estimated to be respectively US$ 95.2 and US$ 15 billion per year, according to the World Bank, and additional costs include losses of farm and company sales, foregone trade income, the health repercussions of consumer avoidance of perishable yet nutrient-rich foods and the environmental burden of food waste. A large proportion of those public health burden and economic costs can be avoided by the adoption of preventive interventions in the food chain by all stakeholders (governments, local authorities, private sector and consumers). Interventions include actions from primary food production, storage and processing through to the point of final preparation and consumption combined with improved food safety management at the national, regional and global levels, including contamination monitoring, disease and outbreak surveillance, laboratory diagnoses and food traceability and recall systems.

Foodborne disease generally is subject to huge underreporting. Food safety interventions contribute to attaining multifactorial targets and indicators of the Thirteenth General Programme of Work and the SDGS. Lack of specific indicators to measure progress and prioritize areas for action in food safety is seen as a challenge to quantifying the magnitude of the foodborne disease burden and building up the necessary investments in food safety systems.

WHO's response to reduce the burden of foodborne diseases

WHO is working to protect the health of consumers by providing (i) normative frameworks, (ii) science-based policy guidance, (iii) consolidated health-related data, (iv) technical assistance and cooperation and (v) public health leadership.

WHO, jointly with FAO, provides resources and strategic and technical guidance to the Codex Alimentarius Commission, whose standards and related texts have become international benchmarks for food safety under the WTO Agreement on the Application of Sanitary and Phytosanitary Measures. WHO contributes approximately 20% of the budget of the joint WHO/FAO food standards programme administered by FAO and Joint WHO/FAO Committees conduct international risk assessments used both by Codex and Member States. In order not to impede or delay the Commission's standards-setting work to protect the health of consumers, the issue of how to ensure sustainable and predictable funding for scientific advice has been discussed, since these resources are identified and managed by WHO and by FAO separately

International risk assessments must be supported by the collection of food contamination data that are representative of different regions and diets. WHO is home to the Global Environment Monitoring System – Food Contamination Monitoring and Assessment Programme (GEMS/Food) which informs governments, the Codex Alimentarius Commission and other relevant institutions on the levels and trends of chemical contaminants in food and their contribution to total human exposure. The Directors-General of WHO and FAO established the Codex Trust Fund, to ensure that developing and transition economy countries were able to participate in the work of the Commission

and better understand its importance, contributing to make Codex standards global and relevant. The successor initiative, launched in 2016, supports countries in strengthening their national Codex structures to engage fully, effectively and sustainably in the establishment and use of international food standards

WHO published in 2018 a new manual on strengthening the surveillance of, and response to, foodborne diseases, which is also a prerequisite for effectively combating antimicrobial resistance in the food chain, and, in collaboration with FAO, it has developed a national food control system assessment tool to assist countries to identify the areas for improvement and prioritize their investment. WHO is finalizing a country tool to estimate the national foodborne disease burden. Recognizing that food safety responsibilities at the national level are often split among different ministries and that managing food safety emergencies often requires a rapid exchange of information across borders, WHO and FAO launched the International Network of Food Safety Authorities (INFOSAN) in 2004, which is complementary to the International Health Regulations (2005) and collaborates with several external partners.

WHO is playing a global leadership role in advocating for food safety at the policy and technical levels, including by organizing the World Health Day 2015 on the theme of food safety, being designated by UNGA to facilitate, jointly with FAO, the celebration of the annual World Food Safety Day and launching the Five Keys to Safer Food initiative as a universal food hygiene campaign.

WHO is delivering its products and services through a collaborative effort that cuts across all three levels of the Organization. The joint WHO/FAO secretariats for INFOSAN and for the Codex Trust Fund are located at headquarters, which is where normative products are generated, including Codex standards, the scientific advice, global guidance manual and tools, and where interagency collaboration takes place, for instance with FAO, IAEA, WFP and WTO. The regional and country offices are taking a lead in identifying priority areas for action and supporting countries to strengthen their capacity to prevent, detect and respond to foodborne disease outbreaks through risk-based food control regulations and enhanced surveillance and information exchange, thus reinforcing the implementation of international standards.

New and emerging challenges

The outstanding challenges facing food safety were identified by the above-mentioned International Conference on Food Safety and International Forum on Food Safety and Trade and include: (i) providing timely support to the Codex Alimentarius Commission in developing or revising international standards that take new scientific evidence and methodologies and addressing emerging hazards into account; (ii) providing support to Member States to effectively participate in the Codex work and implement adopted Codex standards at the national level; (iii) making use of new technologies to improve food safety, such as whole genome sequencing, processing of big data using artificial intelligence, blockchain and other innovations in product-tracing, while harnessing potential risks from the application of novel technologies such as genome editing; and (iv) addressing the food safety risks driven or influenced by climate change and building sustainable and resilient food systems. Among those innovations, whole genome sequencing has the potential to revolutionize the foodborne disease outbreak investigations and product recalls, which would benefit all high-, middle- and low-income countries.

Collecting quality data, building evidence and connecting these to concrete actions that are given a clear priority are essential to build effective food safety systems at the national, regional and

global levels. Sharing expertise, knowledge and information on existing and emerging food safety challenges will inform forward-looking policies, regulations and programmes. Finally, a clear understanding by policy-makers that food safety is an important pillar of public health is critical to mobilizing appropriate resources towards food safety, following the “One Health” approach.

Action by the Executive Board

The Board is invited to note the report and to provide advice on how Member States can strengthen: the development and implementation of Codex Standards; food safety legislation and regulations; other components of national food safety systems; and information exchange operations during food safety events.

Implication for the European Region

Foodborne diseases are a significant public health concern. In the WHO European region. every year, an estimated 23 million people fell ill and approximately 4,700 people died from consuming contaminated food.

Unsafe food also plays a fundamental role in the socio-economic development of countries. In 2016, it was estimated that the total productivity loss associated with foodborne diseases in low- and middle-income countries cost approximately US$ 95.2 billion a year, excluding the cost of treatment of foodborne diseases. Of this, countries in the Middle East, North Africa, Europe and Central Asia accounted for approximately 8%, corresponding to US$ 7.6 billion. There are no figures available specifically for the WHO EURO Region.

WHO European Region positions food safety as an important component of health security and sustainable development and supports countries in achieving the core capacities for food safety required under the IHR (2005) including strengthening the linkages between National IHR Focal Points and Emergency Contact Points for the International Food Safety Authorities Network (INFOSAN).

The work is guided by the ‘Action plan to improve public health preparedness and response in the European Region 2018-2023’ and national health security action plans using One Health approach. Work related to antimicrobial resistance in the food chain is guided by the European strategic action plan on antibiotic resistance.

Pillar 4: More effective and efficient WHO providing better support to countries

20. Data and innovation: draft global strategy on digital health

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In May 2018, the Seventy-First World Health Assembly adopted resolution WHA71.7 on digital health requesting the Director-General to develop a global strategy on digital health identifying priority areas in close consultation with Member States and with inputs from stakeholders. The WHO Secretariat developed a first draft of the global strategy through internal consultation that was made available online for global public consultation. The full draft strategy is available for review at the following link: https://www.who.int/DHStrategy.

Purpose

The purpose of the global strategy on digital health is to advance and apply digital technologies towards the vision of health for all. It sets out a vision, mission, strategic objectives and a framework for action to advance digital technologies for health, globally and in countries and aims to encourage international collaboration, support countries in their national digital health enabled programmes, promote research, improve evidence and share information as well as best practices on digital health to assure its solid foundation. The global strategy is expected to lead to concrete actions within the five-year time frame (2020 – 2024), but it aims to set the overall direction for the development of digital health in Member States for a longer period. The draft global strategy acknowledges that the institutionalization of digital health in the national health system requires a decision and commitment by countries; recognizes that successful digital health initiatives require a unified strategy; promotes the appropriate use of digital technologies for health; and recognizes the urgent need to address major impediments faced by least-developed countries implementing digital health technologies.

Vision

The vision of the draft global digital health strategy is to improve health for everyone, everywhere by accelerating the development and adoption of appropriate digital health solutions and its mission is to use digital health solutions to achieve the health-related Sustainable Development Goals and the triple billion targets of the Thirteenth General Programme of Work (2019–2023). Advancing appropriate digital health solutions has the potential to support equitable and universal access to quality health services; increase health systems sustainability and accessibility and the affordability of care; strengthen health promotion, disease prevention, diagnosis, management, rehabilitation and palliative care. Global collaboration on digital health encourages action on common opportunities and challenges that are relevant to all countries and stakeholders, regardless of the quality and level of development of their digital systems.

The draft strategy identifies four strategic objectives: (1) promote global collaboration and advance the transfer of knowledge on digital health, including developing partnerships at national, regional and global levels to align resources and investments that will ensure sustainability and growth of digital health; (2) advance the implementation of national digital health strategies, by stimulating and supporting every country to adopt, own, evolve and strengthen its digital health strategy in a way that best suits its vision, health situation, available resources and core values; (3) strengthen

governance for digital health at global and national levels, focusing on creating sustainable and robust governance structures and capacity for digital health and (4) advocate for people-centred health systems that are enabled by digital health, placing people at the centre of digital health through the adoption and use of digital health technologies in scaling up and strengthening health service delivery.

Framework for action

The framework for action aims to facilitate the implementation of the global strategy by providing an organized environment for collaboration where partners accommodate diversity and consider methodologies, funding and other resources and support countries in the development, utilization and evaluation of digital technologies as a means of promoting equitable, affordable and universal access to health for all. It proposes the creation of an international convening mechanism for validation of artificial intelligence and digital health solutions, which will enshrine the value of health data and associated digital health products as a global public health good and call for action to safeguard the anonymity of health data providers, mitigate challenges and ensure universal access to digital health products and technology.

It focuses on four major actions, namely, (1) commit - encourage countries, partners and other stakeholders to commit to the global digital health strategy; (2) catalyse – create and sustain an environment and processes that will facilitate and induce collaboration towards implementing the global digital health strategy; (3) measure – create processes for monitoring and evaluating the effectiveness of the strategy; and (4) Enhance and iterate – undertake a new cycle of action based on what has been experienced, measured and learned.

Strategy implementation

The Secretariat will work closely with Member States, other bodies of the United Nations system, international partners and other stakeholders to implement the global strategy. Financing for implementation of the global digital health strategy will require specific action in the area of resource mobilization. For Member States, this implies developing investment strategies to allow for new capital expenditures, national digital health governance, enterprise architectures, capacity-building and solution development, in addition to reprogramming existing funds for maintenance and periodic updating of operating environments. The Secretariat will support the activities outlined within the global strategy through the establishment of a Department of Digital Health and Innovation and coordination of digital health activities across all departments and levels of the Organization (countries, regions, headquarters). This will be further coupled with resource mobilization at national level to support Member States in their implementation of the strategy

Action plan

To meet the needs of Member States expressed during the consultative process, the draft global strategy on digital health includes an action plan that will allow for adaptation and continuous enhancements over time, accommodate changes that may arise due to the rapidly changing world of digital health and offer a mechanism to incorporate experience gained from practical implementation in countries. The action plan aims to facilitate the development and implementation of effective strategies and policies on digital health and achieve the objectives set out in national health policies, strategies and plans. The action plan builds on the framework for action with impact targets, key policy options and a proposed set of actions by Member States, the Secretariat and partners.

Action by the Executive Board

The Executive Board is invited to recommend to the Seventy-third World Health Assembly the adoption of a draft decision : (1) to endorse the global strategy on digital health; and (2) to request the Director-General to report back on progress in the implementation of the strategy to the World Health Assembly in 2023.

Implication for the European Region

Digital Health is an area that has been identified as one of the key emerging priorities of the EURO Region. Member States have expressed a clear interest in having WHO's increased support and leadership for digital health regionally and globally. Until now, work in the European Region has been progressing under the *Digitalization of Health Systems initiative* which, through 5 key focus areas, has taken the initial approach of addressing the developing role of digital health in health systems operation and health services delivery.

A Regional action for accelerating digital health adoption is being further articulated in the forthcoming *European Roadmap for the digitalization of health systems*. This roadmap will constitute implementation of the Global Strategy on Digital Health in Europe and provide Member States with in-depth technical guidance in addressing the "how" in digitalizing health systems. The roadmap will also offer a European vision of the future of the digitalization of health systems and address the need for a transition from systems of reactive health care to preventive health.

A 2nd Symposium on the Future of Digital Health Systems, will be held on 4-5 March 2020, in UN City, Copenhagen will be a chance to further garner input to the development of the roadmap and to further capitalize upon the discussions raised in the 1st symposium on key digital health topics.

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