World Health Organization

REGIONAL OFFICE FOR Europe

BRIEFING OF THE REGIONAL OFFICE FOR EUROPE ON TECHNICAL AGENDA ITEMS AT THE SEVENTY-SECOND WORLD HEALTH ASSEMBLY

(For Information Purposes Only)

7 May

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11.2 Public health preparedness and response

Report of the Independent Oversight and Advisory Committee for the WHO Health Emergencies Programme

Document A72/6.

Document not available on 7 May 2019

WHO's work in health emergencies

Document A72/7

This report is submitted pursuant to requests made by the governing bodies in resolution EBSS3.R1 (2015) and decision WHA68(10) (2015). It streamlines WHO's reporting on preparing for, preventing, detecting and responding to health emergencies.

Preparing for emergencies

Assessing and reporting national emergency capacities for all hazards. In 2018, WHO worked closely with countries and partners to monitor and report on their emergency preparedness capacities for all hazards. In 2018, 161 States Parties submitted annual reports under the International Health Regulations (2005), and States Parties also conducted 31 simulation exercises, 24 voluntary joint external evaluations, 18 after action reviews, and 11 International Health Regulations–public veterinary sector bridging workshops.

WHO, through health systems strengthening efforts across the Organization, worked *through* the regions, to improve capacities by developing guidance and tools, and delivering targeted training sessions to build skills and capacities in the health workforce following an all-hazards approach; strengthening Member States' laboratory and surveillance capacity through the development and dissemination of technical guidance, materials and tools, and provision of technical assistance to vulnerable and fragile States; and providing guidance, advice and technical support to countries to minimize the risk of disease spread, and advice to international travellers designed to keep them safe.

The Secretariat supported Member States in developing and implementing the wide range of capacities required to manage risk factors for emergencies associated with natural, biological, technological and societal hazards by applying prevention, preparedness, response and recovery measures and strengthening health systems. Key types of guidance and support were provided on multisectoral disaster risk management and resilience, and the integration of universal health coverage and health security.

In 2018, key areas of work included: coordinating operational readiness functions in the headquarters incident management team for the two Ebola virus disease outbreaks in the Democratic Republic of the Congo, since May 2018, and for the cholera outbreak in Zimbabwe, since September 2018; supporting the operational readiness of the four countries neighbouring the Democratic Republic of the Congo deemed to be at high risk from the spread of Ebola virus disease by improving border screening of travellers, and by enhancing surveillance and contact tracing, and the vaccination of frontline and health care workers.

Preventing epidemics and pandemics

WHO fostered research and information sharing for high-threat hazards prevention and control, including developing and coordinating expert technical networks and advisory groups. WHO continued to coordinate global expert networks in developing and implementing the research and development blueprint (R&D Blueprint), a global strategy and preparedness plan that triggers the rapid activation of research and development activities during outbreaks.

WHO, with partners, continued to develop global strategies to counter high-threat infectious hazards, such as yellow fever, cholera and influenza, including:

- the strategy to Eliminate Yellow Fever Epidemics (EYE), under which 61 million people were vaccinated in 24 African countries;
- the Ending Cholera Global Roadmap to 2030, which enabled nearly 21 million doses of oral cholera vaccine to be shipped to 10 countries;
- the Global Influenza Strategy 2019–2030, under which more than 500 million people worldwide are estimated to have been vaccinated and more than 400 million doses of pandemic vaccine secured through the Pandemic Influenza Preparedness (PIP) Framework; and
- the Ebola virus disease outbreak response, which enabled 60 000 people at high-risk of contracting the virus to be vaccinated in the Democratic Republic of the Congo.

WHO worked with its network of partners from a broad range of technical areas to reduce the risk of re-emergence of high-threat pathogens and the emergence of new and unknown high-threat pathogens, such as viral haemorrhagic fevers, vector-borne diseases, respiratory pathogens, biosecurity threats and antimicrobial resistance.

Rapid detection and response

WHO's global surveillance system currently picks up approximately 7000 public health threat signals every month. If, following a field investigation and a formal risk assessment, the threat is determined to be a potential outbreak with a high risk of spreading, action is triggered within 48 hours.

In 2018, WHO detected, monitored and carried out risk assessments and field investigations for more than 170 health events each month, while providing full support to two Ebola virus disease outbreaks in the Democratic Republic of the Congo, since 8 May, and to the protracted cholera outbreak in Yemen, and the cholera outbreak in Zimbabwe.

Emergency response

During 2018, WHO responded to 36 graded emergencies in more than 30 countries and territories. The Director-General has made no new declaration of a public health emergency of international concern in 2018. At the beginning of 2018, WHO's operations were targeting 75 million people for humanitarian assistance, although that number has progressively risen with new outbreaks and emergencies throughout the year. Among the acute (graded and ungraded) emergencies, eight were classified as Grade 3 emergencies.

In accordance with the principles of the Emergency Response Framework, WHO activated the Incident Management System to fulfil its six critical functions and scaled up its operational and technical support in order to address immediately the health needs of, and risks facing, the affected population.

Working with partners, the Secretariat supported national governments' efforts in life-saving interventions to increase the quality and coverage of health services, strengthen primary and secondary health and hospital care by operating mobile teams and health facilities, improve surveillance and early warning systems, conduct vaccination campaigns, distribute medicines and supplies, and train health

workers. WHO also led or jointly led health sector coordination, including 25 activated health clusters. Those actions were supported by the rapid release of funds from WHO's Contingency Fund for Emergencies: about US$ 37.6 million have been disbursed in 2018 in order to ensure rapid expansion of WHO's response in 29 graded emergencies.

ACTION BY THE HEALTH ASSEMBLY

The Health Assembly is invited to note the report

Implication for the European Region

At the time of writing this briefing, 91% of European Member States (50/55) submitted their State Party Annual Report for 2018.

To be ready for a new season of west-Nile virus Serbia, supported by WHO and ECDC, is conducting an After-Action Review (AAR) of the 2018 West Nile virus (WNV) transmission. Surrounding countries have been updated through the process. Targeted support to strengthen the laboratory systems in priority countries have been provided through the Better Labs for Better Health (BLBH) initiative implemented by the WHE in the Regional Office for Europe.

With the ongoing measles outbreak in many European countries, preventive (e.g. vaccination) and readiness support (clinical management, hospital care, infection-prevention and control, AMR) is being provided.

Out of the 484 Public Health Events recorded in the EMS in 2018 globally, 52 (11%) were in the European Region. While globally, 13% of recorded events were originally reported by national government institutions, including the National IHR Focal Points, in EURO this share was 65% (more information in A72/8).

Based on the latest surveillance data shared by member-states, during January and February 2019 (data as of 28 March 2019), 34 300 measles cases have been reported in 42 countries (79.3%) of the WHO European Region, including 13 measles-related deaths in three countries. WHO risk assessment conclude that measles disease generally poses a moderate risk to the European Region as a whole. Additionally, measles outbreaks continuing for more than 12 months pose a risk for countries that interrupted endemic transmission in the Region. Measles also serves as a sentinel indicator for gaps in the overall national immunization programmes. Since the herd immunity needed for measles is at least 95%, it is expected that measles is the first disease for which outbreaks occur. However, if gaps continue to persist, other vaccine preventable disease outbreaks may begin to emerge. An internal WHO emergency grading call was held on 6 May 2019 and declared multi-country grade 2 emergency for the WHO European Region.

Emergency Response in Ukraine

The conflict in Ukraine enters its fifth year with 3.4 million people affected in eastern Ukraine. Over 800 000 residents along the 457 kilometres 'contact line' are in need for humanitarian support. Continued shelling, limited freedom of movement, shortage of medicines and medical supplies and shortage of safe water significantly affect their life and health. Due to an impaired access to health services people are exposed to increased health risks.
Ukraine is a WHO Protracted Emergency Grade 2, and to ensure direct impact of the emergency operations on the improvement of the health system and quality care services towards universal health

coverage, an emergency preparedness team has joined the office and is led by the IMS., through its main office in Kyiv and four field offices in Donetsk, Kramatorsk, Luhansk and Severodonetsk.

In 2018, Health and Nutrition Cluster partners reached some 336,000 people through direct service provision, cash and voucher assistance, health education and provision of medical supplies (medicines, reagents, materials).

- WHO scaled up support to the selected health facilities in the conflict-affected regions of Donetsk and Luhansk in eastern Ukraine to reduce the risk of infections acquired in hospitals.
- WHO trained over 30 health workers to improve the quality of health care services and reduce health risks for over 40 000 people in need in non-government-controlled areas of Ukraine's Luhansk region.
- More than **500,000** children and adults have access to safer secondary and tertiary health care services due to the WHO's efforts on Infection prevention and control
- Over **1 000 000** people living on both sides of the contact line are better protected from the diseases outbreaks through laboratory systems strengthening.
- WHO supported the Ministry of Health of Ukraine in implementation of the Mental Health Gap Action Programme (mhGAP) that will allow expansion of the provision of mental health services at community level.
- About **1000** consultations were provided to people with moderate and severe mental disorders were performed through WHO supported mobile community mental health teams in Donetsk region.
- **34** trauma care specialists, surgeons, emergency doctors and anaesthesiologists in Luhansk (NGCA) completed the training on Advanced Trauma Care.
- Disease Surveillance
    - WHO continued implementing "Better Labs for Better Health" to improve disease detection. Within this initiative, in 2018, WHO conducted ten mentoring visits to the laboratories in the conflict affected areas.
    - Successful application of Ukraine to the Global Fund to Fight AIDS, TB and Malaria (GFATM) enabled both GCA and NGCA to have all critical lab equipment, basic medical consumables, modern drugs and funds committed for the next three years for TB and HIV.
- WHO procured live-saving medicines, medical supplies and medical equipment for the selected primary, secondary and tertiary health care facilities to serve the needs of over 200,000 people on both sides of the contact line.
- Over **200,000** people are supported with medicines and medical supplies for trauma care, surgery and blood transfusion.

Whole of Syria Operations (in and from Turkey) (para 18):

The continuing conflict in the Syrian Arab Republic has affected millions of lives, causing one of the world's largest and most dynamic displacement crises. Over half of all Syrians have been displaced from their homes: 40% of internally displaced people are living in north-west Syria and over 3.6 million are refugees in Turkey.

Under the Whole-of-Syria Initiative, as dictated by the UN Resolutions, WHO Emergency Programme operations in Turkey are twofold: supporting Turkey's efforts to include the refugees in the universal health coverage of the country, and a cross-border response, providing life-saving support to people in need in areas in northern Syria that are not accessible through WHO Country Office in Syria.

In Turkey: The Ministry of Health of Turkey, with WHO support, has been implemented a flag-ship model of culturally and linguistically sensitive health services that are accessible to the Syrian 3.6 million refugees that are hosted by Turkey. Comprehensive training courses are being provided to Syrian health care professionals to qualify them to work in the Turkish health care system and to provide services to their fellow nationals.

WHO trained an additional 731 Arabic/Turkish interpreters in 2018 to serve as guides for Syrian patients, adding to a total of 1193 since the beginning of the programme. Over 427 Syrian refugees were trained to serve as community health support staff for the provision of home care and social services to older and disabled fellow nationals.

Cross border: As health cluster lead agency, WHO coordinates all health-related cross-border activities, overall priority-setting, contingency planning and provision of health information in order to support an effective humanitarian response. Over 100 health partners are currently responding to the needs in north-west Syria, coordinated by the health cluster in Gaziantep.

WHO advocates an end to attacks on health care, which shatter the already fragile health system. In 2018, WHO called for the guaranteed medical evacuation of critically ill patients and their families from besieged and hard-to-reach areas. Advocacy for the protection of health workers in the face of a growing threat of kidnap also became increasingly important.

Maintaining close relationships with donors to ensure accountability and transparency about the activities implemented and advocacy for health needs are key priorities.

In 2018, WHO and the United Nations shifted from a response by geographical location to one based on a detailed assessment of the severity of needs in all 270 subdistricts in Syria. This allowed for a more targeted delivery of assistance, complementing the sector specific assessments and improving coordination with partners working from the operational hubs in Iraq, Jordan and Turkey.

WHO supports the Early Warning Alert and Response Network, which covers over 486 sentinel sites monitoring the trends for 13 high-priority diseases including acute flaccid paralysis, measles, cholera and leishmaniasis. WHO regularly provides capacity-building activities, laboratory support and coordination of international testing of samples. The network has proved effective in detecting epidemic-prone diseases, which has triggered response and monitoring trends over time.

Before the crisis, it was estimated that 95% of children had been immunized but this had dropped to approximately 60%, resulting in more outbreaks of vaccine-preventable diseases. In 2018 a vaccine-derived poliomyelitis outbreak was declared over. In 2018, together with UNICEF, through five poliomyelitis campaigns 2 442 054 doses were administered and during two measles campaigns 1 641 186 children were vaccinated.

In 2018, the reported number of people affected by cutaneous leishmaniasis in northern Syria increased by up to 30% compared to the same period in 2017. Increased transmission can be explained by the environmental conditions related to overcrowded settlements, poor sanitation and inadequate waste management which expose people to the sandflies that are the vector transmitting the disease. Moreover, in 2018, there was a shortage of leishmaniasis medications on the world market as well as lack of experts in this field. WHO will scale up its activities in 2019 for a greater response.

Spread of tuberculosis (TB) is imminent. Treatment options for diagnosed patients were limited, with severe shortages of TB drugs, use of expired drugs, weak laboratory capacities and lack of qualified staff as contributory factors. WHO has accelerated its support to fight TB.

There is an increased risk of cholera outbreaks due to the poor water and sanitation conditions in the area. WHO has been preparing health partners to respond to outbreaks through the provision of training for early detection, control measures and treatment for patients.

WHO's hub in Gaziantep coordinated and supported a network of 38 primary health care centres in Idlib in adopting common standards and strengthening the quality of care in order to increase health coverage. By the end of 2018, the primary health care network provided on average close to 150 000 consultations per month. On the basis of this network's experiences, and with the technical and operational support of WHO, a larger network for referrals linking 62 primary and secondary health care structures was initiated. By the end of 2 018 4400 patients were being referred through the referral network each month. To mitigate severe shortages of health care staff and ease the pressure on health care professionals, certain tasks formerly handled by physicians were transferred to health care support staff. In the past year WHO trained 23 503 people to address the lack of skilled health workers.

In 2018, WHO supported on average 16 mobile teams per month to address urgent health needs and adjusted outreach activities based on needs reported by the partners. On average, each mobile team carried out around 100 consultations per day. WHO has provided capacity-building activities for mental health staff, psychotropic medicines for 4000 patients, salaries for two psychiatrists and the running costs for four mobile teams and one specialized hospital. WHO has funded 68 ambulances and has tailored training courses for the first responders to facilitate the best possible conditions for trauma care.

WHO shipped during 2018 over 60 truckloads of emergency health kits, medicines, surgical kits, laboratory supplies and medical equipment with a total weight of approximately 500 tons and valued at US$ 5 million to hospitals and clinics in north-west Syria. These supplies are enough for an estimated 4.2 million treatment courses.

Operational Partnerships in Emergencies:

In the European Region there are 13 WHO classified EMTs (5 – Type 1; 7 – Type 2; and 1 – Type 3). In 2019 WHO European Regiono with the support of EMT Secretariat in HQ/Geneva has deployed four EMTs to support emergency response to Cyclone Idai in Mozambique:

There 103 GOARN partner institutions in the WHO European Region. Twenty of them have been deployed during 2018-2019 to provide support in 7 missions through 81 deployments. Rospotrebnadzor (Russia) has been accepted as a new GOARN partner institution in 2018. Other non-English speaking countries from EURO are keen to join. Tier 1 online module of the GOARN training was translated into Russian in 2018 and is now available. Tier 2 GOARN training package is being tailored to the regional needs.

Health Clusters continue activities in the two graded emergencies in EURO: Grade 2 protracted emergency in Ukraine and Grade 3 Whole of Syria.

International Health Regulations (2005)

Document A72/8

In response to decision WHA71.15 (2018), this report from the Director General provides an update on progress made in implementation of the International Health Regulation (2005). Overall, in 2018, States Parties made encouraging progress in preparing for and responding to public health emergencies under the framework of the International Health Regulations (2005). Many States Parties recorded laudable achievements in building and maintaining IHR core capacities particularly in respect of surveillance, laboratory and IHR coordination. However, significant gaps still remain, particularly with regard to capacities in the most vulnerable countries with weak health systems and in conflict-affected and fragile settings, as well as States Parties' capacity to manage all-hazards health emergencies.

Throughout 2018, altogether 484 public health events were recorded in WHO's event management system (a 16% increase from 2017), of which 352 (73%) were attributed to infectious diseases, 47 (10%) to disasters and 19 (4%) to food safety. During the same period, WHO posted 120 updates on the Event Information Site for National IHR Focal Points, relating to 82 public health events. Events were reported from the African Region (40%), the Western Pacific Region (20%), the Region of the Americas (16%), the European Region (12%), the Eastern Mediterranean Region (11%) and the South-East Asia Region (1%). Most event updates concerned influenza, Middle East respiratory syndrome, cholera, polio and yellow fever. In addition, WHO published 91 updates as disease outbreak news on its official website in 2018.

In 2018, WHO continued to work closely with partners in the Global Outbreak Alert and Response Network, through weekly operational calls for information sharing and coordination of alert, risk assessment and response activities, in order to support public health preparedness and response operations for diphtheria and the monsoon in Bangladesh, listeriosis in South Africa, Lassa fever in Nigeria, cholera in the Democratic Republic of the Congo, cholera in Angola, and Ebola virus disease in the Democratic Republic of the Congo. During the two outbreaks of Ebola virus disease in the Democratic Republic of the Congo in 2018, the Secretariat provided intensive support to the nine priority neighbouring countries identified as being at high risk based on public health risk assessment.

1. Emergency committee

The Emergency Committee has been meeting every three months since 2014, when the international spread of poliovirus was declared a public health emergency of international concern. In addition, the Director-General convened an Emergency Committee for the two distinct outbreaks of Ebola virus disease occurring in the Democratic Republic of the Congo in 2018. These meetings were convened, on 18 May 20183 and 17 October 2018, and the committees, while issuing public health advice, did not consider either event to constitute a public health emergency of international concern.

2. Strengthening national core capacities

A preliminary analysis of the data collected under the IHR monitoring and evaluation framework shows that almost all the States Parties are overall performing better in the detection capacities, such as surveillance and laboratory, with the average scores on the State Party Annual Reporting questionnaire and joint external evaluations above 65% globally. Gaps in capacities at the points of entry and for chemical safety and radiation emergencies are observed, with the global average scores at about 45–49% in both the State Party Annual Reporting and Joint External Evaluation results.

3. Compliance with requirements of the regulations

Since May 2018, the secretariat has held structured dialogues with six States Parties that had implemented additional health measures that significantly interfered with international traffic and movement of people. As a result, two of the six States Parties lifted the restrictions. The Secretariat will continue to monitor systematically additional health measures in relation to public health events. The Secretariat is also exploring approaches for reporting and presenting such information to States Parties. In order to better inform States Parties about the effectiveness of additional health measures, the Secretariat is drafting evidence-based guidelines on the effectiveness of exit/entry screening in reducing international spread of infectious diseases.

Several WHO regional offices, including those for Africa, the Americas and Europe, have embarked on systematic monitoring and reporting of States Parties' compliance with obligations under the Regulations with regard to event notification and verification. To support States Parties in fulfilling relevant obligations, the Secretariat has been developing guidance documents and tools and is assessing the experiences and needs of National IHR Focal Points in conducting their functions.

4. Activities by the Secretariat in support of States Parties to implement the regulations

The Secretariat has provided sustained support to States Parties to enhance preparedness for all hazards, with country-level activities focusing on evidence-based planning and implementation. In 2018, 19 countries were supported in developing their public health risk profiles, based on which 16 countries developed contingency plans; 16 countries expanded their readiness capacities to respond to imminent risks; and four countries implemented safety programmes in their priority health facilities. With the support of the Secretariat, 27 countries finalized national action plans for health emergency preparedness. Moreover, a WHO high-level conference on preparedness in public health emergencies (Lyon, France, 3 and 4 December 2018) focused on multisectoral approaches for effective leadership in preparedness for public health emergencies in urban areas.

ACTION BY THE HEALTH ASSEMBLY

The Health Assembly is invited to note the report

Implication for the European Region

The numerous activities related to IHR (2005) implementation in the European Region are quite well represented in the document. The good functioning of IHR NFPs in the European region, as indicated by high compliance by IHR NFPs to IHR verification requests (84% response in 24 hours in 2018) is highlighted in the report (para 11).

The development, implementation and advocacy for the European Action Plan - including the High-level and Ministerial meeting in Istanbul in February 2019 - is also well noted (para 33).

Strengthening national core capacities

As prescribed by the *Action plan to improve public health preparedness and response in the WHO European Region 2018–2023*, the WHO Emergency Programme in the European Region has intensified its work with priority countries. Through diversified activities, the countries are supported to improve their assessments and implementation of the IHR (2005), address their weakest IHR core capacities through the development of national plans and concrete actions; and prepare for all-hazard health emergencies. The actions are imbedded in their efforts to improve public health and health system

functions to ensure as access to people-centered public and clinical health services, towards universal health coverage.

In the European Region, progress has been made in specific IHR Core Capacities, such as early detection of infectious hazards, including those related to food safety, but further work need to be done to improve, such as the quality of surveillance data collected, particularly in eastern and south eastern Europe. At the time of writing this briefing, 91% of European Member States (50/55) submitted their State Party Annual Report for 2018. Overall the analysis of the information provided by the State Parties, shows a high level of capacity in the Region. The average implementation score across all 13 technical areas in the Region is 3.7 (74%) with an average implementation score of 3.0 (60%) in priority countries and 3.9 (78%) in the other countries in the region. The two strongest technical areas overall in the region are: Laboratories (average regional implementation score: 4/80%) and IHR Coordination and National IHR Focal Point Functions (4/79%). The following five technical areas have the highest potential for further strengthening: Points of entry (with an average score of 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%). In addition, European priority countries have shown to have a greater potential for strengthening of their capacity in the technical area of Food Safety (2.6/52%). A total of 14 Member States in the region have conducted voluntary joint external evaluation and five additional are planned for 2019.

Preparedness activities

In November 2018, the WHO Regional Office for Europe conducted a functional simulation exercise called Joint Assessment and Detection of Events (JADE) with participation of 27 EURO Member States. WHO is supporting an After-Action Review (AAR) of the 2018 West Nile virus (WNV) transmission in Serbia in close coordination with ECDC. Targeted support to strengthen the laboratory systems have been provided to countries through the Better Labs for Better Health (BLBH) initiative implemented in WHO Regional Office for Europe.

The IHR National Focal Point Knowledge Network has been developed in the region. In 2018, in addition to the Istanbul meeting mentioned in the WHA report, WHO Regional Office for Europe organised a High-level meeting for IHR National Focal Points in Munich and a IHR National Focal Point Workshop in Copenhagen. The next workshops will be held on 12-14 June 2019 (for Russian speaking NFPs) and in October 2019.

WHO Regional Office for Europe contributed the organization of the Seventh Meeting of the Collaborative Arrangement for the Prevention and Management of Public Health Events in Civil Aviation held in Finland, 10-12-12 April 2019, and presented WHO guidelines on aircraft disinfection products and methods.

Of the four countries indicated who underwent Hospital Safety Index assessments, two were in EURO. Teams of professionals were trained in an additional two countries to undertake this work in 2019.

Four of the WHO Emergency Programme priority have completed their strategic risk assessments to prioritize their health risks, which consequently informs the development of contingency plans and the strengthening of early warning, laboratory and surveillance systems.

To date, three National Action Plans for Health Security/Emergency Preparedness(NAPHS) have been completed in the European Region and one is expected to be completed soon. Six more countries are in the process of developing a NAPHS or adapting national plans.

In the European Region, National Bridging Workshops (NBW) on the IHR (2005) and the OIE Performance of Veterinary Pathway were successfully organized in Kyrgyzstan (2-4 October 2018), Kazakhstan (21-23 November 2019) and Albania (5-7 December 2018). National Bridging Workshops are planned in Armenia (May 2019), Serbia (October 2019) and Tajikistan (TBC).

Moreover, in terms of cross-sector cooperation, the Regional Office participated in the European Aviation Crisis Coordination Cell (EACCC) table top simulation exercise on a pandemic-prone respiratory infection, conducted in Brussels in February 2019 with involvement of national authorities and international organizations from the fields of public health and civil aviation, further strengthening the strategic collaboration on IHR related issues between the two sectors.

WHO Regional Office for Europe plays an important role in European travel-associated legionnaires' disease (TALD) surveillance, led by the ECDC-managed European Legionnaires' Disease Surveillance Network (ELDSNet).

Public Health Events in the European Region

Out of the 484 Public Health Events recorded in 2018 globally, 52 (11%) were in the European Region. While globally, 13% of recorded events were originally reported by national government institutions, including the National IHR Focal Points, in European Region this share was 65%.

Of the 120 Event Information Side postings globally in 2018, 12 were for the European Region. By far, ***measles*** dominated the notifications in the European Region since 2018. Two formalized rapid risk assessments (RRA) have been conducted since 2018 and as of mid-April 2019 (West Nile in Serbia, measles in North Macedonia) and one in May 2019 (multi-county measles outbreak).

Based on the latest surveillance data shared by member-states, during January and February 2019 (data as of 28 March 2019), 34 300 measles cases have been reported in 42 countries (79.3%) of the WHO European Region, including 13 measles-related deaths in three countries.

The risk assessment conclude that measles disease generally poses a moderate risk to the European Region as a whole. Additionally, measles outbreaks continuing for more than 12 months pose a risk for countries that interrupted endemic transmission in the Region. Measles also serves as a sentinel indicator for gaps in the overall national immunization programmes. Since the herd immunity needed for measles is at least 95%, it is expected that measles is the first disease for which outbreaks occur. However, if gaps continue to persist, other vaccine preventable disease outbreaks may begin to emerge.

An internal WHO emergency grading call was held on 6 May 2019 and declared multi-country grade 2 emergency for the WHO European Region.

11.3 Polio

Eradication

Document A72/9

The Executive Board, at its 144th session, considered an earlier version of this report

Pursuant to resolution WHA71.16 (2018) this report provides an update on the status of the Polio Eradication and Endgame Strategic Plan 2013–2018 (Endgame Plan)[1]'s objectives, summarizing programmatic, epidemiological and financial challenges to achieving a lasting polio-free world.

Because the circulation of the wild poliovirus (WPV) has not yet been interrupted, it has become necessary to assess the Endgame Plan's strategies beyond 2018 and adapt them in a 2019–2023 plan. There is an urgent need to eradicate WPVs as soon as possible, both to prevent global re-emergence and to enable the rapid cessation of oral polio vaccine (oPV) use, thereby preventing long-term risks of outbreaks of circulating VDPVs.

The Polio Endgame Strategy 2019-2023[2]: Eradication, integration, certification and containment was recently finalized and highlights which activities need to be undertaken and what needs to be done differently to certify the eradication of polio, particularly in the context of recent detections of circulating vaccine-derived poliovirus (VDPV). There was extensive stakeholder engagement and an independent evaluation of eradication strategies in endemic areas [3] that helped to inform this extended plan. After eradication of polio has been certified, the Post-Certification Strategy (71rst WHA[4]) will guide the activities and functions that must be sustained to maintain a world free of polio. The Secretariat will continue to report to the Health Assembly, through the Executive Board, until global polio eradication has been certified.

Global polio eradication can be considered a dual emergency in respect of WPV and VDPV in certain areas:

5. Wild poliovirus transmission

The last reported case of poliomyelitis due to WPV type2 was in 1999, WPV type2 was officially certified as eradicated in September 2015. WPV type 3 has not been detected globally since November 2012. Since that time, all cases have been caused by WPV type1, which continues to circulate in 3 countries in which the disease is endemic: Afghanistan, Nigeria and Pakistan.

Afghanistan and Pakistan continue to be treated as a single epidemiological block. In 2018, eight cases of paralytic poliomyelitis due to wild poliovirus type 1 were reported in Pakistan, the same number as in 2017, while in Afghanistan, 21 cases were reported, compared with 12 in 2017. Both countries continue to coordinate immunization and surveillance activities. Virus transmission is now primarily restricted to 2 cross-border corridors, from eastern Afghanistan with Khyber Pakhtunkhwa to Federally Administered Tribal Areas in Pakistan, and from southern Afghanistan (Kandahar and Hilmand) to the Quetta block, Balochistan province, in Pakistan, and Karachi (Pakistan).

6. Circulating VDPV transmission, which continues to take on added significance

Inadequate routine immunization levels coupled with subnational gaps in surveillance in high-risk countries continue to be the main risk factors for the circulation of VDPV. Strengthened efforts are required to tackle both risk factors; however, the only and surest way to prevent circulation is to stop oral polio vaccine (oPV) use rapidly, which can only occur after the successful eradication of WPV. In 2018, outbreaks due to circulating VDPV newly emerged or continued in Democratic Republic of Congo, the Horn of Africa (Kenya & Somalia), Mozambique, Niger, Nigeria, the Syrian Arab Republic and Papua New Guinea.

[1] Although the Endgame Plan was formulated to cover the period 2013–2018, a midterm review conducted by the Polio Oversight Board of the GPEI in 2015 formally extended the plan to 2019 (see document EB138/25).
[2] http://polioeradication.org/wp-content/uploads/2019/03/stakeholder-consultation-report-20191004-1.pdf
[3] Recommended by the Independent Monitoring Board of the Global Polio Eradication Initiative (GPEI), implemented third quarter of 2018
[4] See 71rst WHA summary records Committee B, fourth meeting, section 3, fifth meeting, section 1 and sixth meeting, section 3.

Public Health Emergency of International Concern

The declaration in 2014 of the international spread of WPV as a Public Health Emergency of International Concern (PHEIC) and the temporary recommendations promulgated under the International Health Regulations (IHR 2005) remain in effect. All countries currently affected have declared such events to be national public health emergencies and are implementing national emergency action plans. This PHEIC designation has now been in place for 4 years (an exceptional use of the declaration) and at its most recent meeting in March 2019, the Committee unanimously agreed that the risk of international spread of polioviruses remains a PHEIC and recommended a 3-month extension of the temporary recommendations[5].

Phased removal of oral polio vaccines (oPV):

The first phase took place with the switch from trivalent to bivalent oral polio vaccine between April and May 2016. Once all remaining foci of WPV transmission have been eradicated, all use of oPV will be stopped. Until then, Member States (MS) are encouraged to minimize risks and consequences of potential VDPV by ensuring high routine immunization coverage, conducting surveillance for any emergence of circulating VDPV, and maintaining strong outbreak response capacity. In the lead-up to the switch to bivalent oPV, global supply constraints of the inactivated poliovirus vaccine had emerged owing to technical difficulties encountered by manufacturers in scaling up production. As a result, some countries experienced delays, however the supply situation has improved, and all countries have now access to supplies for their routine immunization programmes. The global supply situation was further improved thanks to Member States increasingly adopting dose-sparing strategies. GAVI made a commitment in June 2018 to support priority countries until 2021.

Containment of polioviruses (PVs):

Efforts to contain PV type 2 were implemented progressively starting in 2016 and will continue through 2019 and are guided by the WHO global action plan to minimize PV facility-associated risk after type-specific eradication of WPVs and sequential cessation of oral oPV use (GAPIII)[6]. To assist facilities, WHO has published guidance to minimize risks for facilities collecting, handling or storing materials potentially infectious for PVs. The 71rst WHA in May 2018 adopted resolution WHA71.16 urging Member States to intensify efforts to accelerate the progress of poliovirus containment certification. Member States are urged to complete inventories for type 2 PVs and destroy unneeded type 2 materials, and to begin inventories for types 1 and 3 materials; to reduce to a minimum the number of facilities designated for PVs retention, to appoint before the end of 2018 a competent national authority for containment; and to request facilities planning to retain PV type 2 to engage formally in the GAPIII Containment Certification Scheme by the end of 2019. The Global Commission for the Certification of the Eradication of Poliomyelitis has countersigned a first certificate of participation. The Containment Advisory Group, established to address technical issues related to GAPIII, has made recommendations to be read in conjunction with the GAPIII. The Secretariat continues to support the strengthening of technical capacities of national authorities for containment.

As of January 2019, all countries and territories that reported that they no longer hold WPV or VDPV type 2 are updating their inventories. In total, 78 poliovirus-essential facilities have been officially designated by the governments of 26 countries to retain type 2 PV materials. Inventory of materials will have to be repeated after global interruption of transmission, in all countries affected. Of the 26

[5] https://www.who.int/news-room/detail/01-03-2019-statement-of-the-twentieth-ihr-emergency-committee, accessed 24 April 2019).

[6] 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. Geneva: World Health Organization; 2015 (http://apps.who.int/iris/handle/10665/208872, accessed 3 October 2018).

countries planning to retain type 2 PVs, 20 have made significant progress with the establishment of national authorities for containment and are preparing to certify their designated poliovirus-essential facilities.

Recognizing that poliovirus transmission levels are currently at the lowest point in history and the feasibility of eradication in the short-term is a realistic expectation, all parties need urgently to intensify containment activities. The Health Assembly's call in resolution WHA71.16 (2018) to accelerate implementation of poliovirus containment has received strong commitment from all MS, so that the certification of poliovirus eradication can be achieved and sustained.

Financing the global polio eradication initiative:
Thanks to the generous continuing support of the international development community including Member States, multilateral and bilateral organizations, development banks, foundations and Rotary International, public- and private-sector partners, the budget for planned activities for 2018 was fully financed. Throughout 2018, leaders of the G7, Commonwealth and G20 countries pledged their continued support to the effort. MS are strongly encouraged to fulfil their pledges and commitments as rapidly as possible and continue to make their best efforts to provide flexibility in their allocations so as to ensure uninterrupted programme operations. To ensure transparency and cost-effectiveness, the GPEI continually assesses its financial resource requirements, in the face of evolving programmatic and epidemiological developments.

Most recently, the Polio Oversight Board adopted new financial scenarios in September 2018. The key to achieving and sustaining a world free of both WPV and VDPV will be the full and rapid mobilization of these financial requirements. The global budget for implementing the Strategic Plan 2019–2023 is projected to be US$ 4.2 billion, of which US$ 3.27 billion still needs to be mobilized. Continued support will therefore be needed from longstanding partners, along with ministers and leaders of the G7, Commonwealth and G20 countries, to ensure the uninterrupted programme operations necessary to achieve eradication by 2023. The Global Polio Eradication Initiative continues to demonstrate value for money, and its sound financial management practices have been confirmed in positive programme reviews and audits.

ACTION BY THE HEALTH ASSEMBLY

The Health Assembly is invited to note the report.

Implication for the European Region

The WHO European Region was certified polio-free in 2002 after the last case of indigenous WPV was detected in 1998. Since certification, the European Regional Certification Commission has been meeting on annual basis to review national polio reports, preparedness plans, and assess risk. All Member States are requested to ensure that polio outbreak preparedness plans are updated and tested.

By the end of April 2016, all 20 Member States in the European Region that used oral polio vaccine (OPV) successfully discontinued trivalent polio vaccine (tOPV) and switched to bivalent oral polio vaccine (bOPV) or inactivated polio vaccine (IPV) only. All switched countries introduced at least one dose of IPV. Until all use of oral polio vaccine has ceased, Member States are encouraged to minimize

the risks and consequences of potential vaccine-derived polioviruses by ensuring high routine immunization coverage, conducting surveillance for any emergence of circulating vaccine-derived poliovirus, and maintaining strong outbreak response capacity. Five Member States in the European Region had to delay introduction of IPV for nearly two years due to supply constraints[7] . They must ensure that the cohorts missed in 2016-2018 are immunized against type 2 polio virus once additional IPV is available in sufficient quantities.

The WHO European Region has the largest number of Member States and facilities retaining polioviruses. The Region has made substantial progress in 2018 towards in implementing the containment requirements to minimize poliovirus facility-associated risk after type-specific eradication of wild polioviruses and sequential cessation of oral polio vaccine. The Regional Office is providing technical support to Member States retaining or considering retaining polioviruses in order to meet global milestones.

Since the WHO European Region was certified polio-free in 2002, WHO Regional Office for Europe has been providing support to Member States to maintain the Region's polio-free status until global eradication is achieved. The Region received minimal but critical funding from global partners to support polio surveillance, laboratory and certification activities essential for keeping the Region polio-free.

Transition

Document A72/10

Document not available on 7 May 2019

[7] Kyrgyzstan, Republic of Moldova, Tajikistan, Turkmenistan, and Uzbekistan.

11.4 Implementation of the 2030 Agenda for Sustainable Development

Document A72/11

The Executive Board, at its 144th session, considered an earlier version of this report. The report provides a further update on progress towards the Sustainable Development Goals (SDGs) as requested in resolution WHA69.11 on Health in the 2030 Agenda for Sustainable Development Part I summarizes global and regional progress made by Member States towards achieving Goal 3 (Ensure healthy lives and promote well-being for all at all ages), as well as other health-SDGs and targets. Part II describes the progress made in implementing resolution WHA69.11.

I. Progress Towards Health-Related SDGs And Targets

The status of more than 30 health and health-related indicators are reported in World Health Statistics 2018. While remarkable progress has been made in some areas, especially in reducing under-5 mortality, increasing the coverage of HIV treatment and reducing cases of and deaths from tuberculosis, it has stalled in other areas such as malaria, drug-resistant tuberculosis, alcohol use and air pollution. In many countries, weak health systems remain an obstacle to progress and lead to gaps in the coverage of even the most basic health services, as well as poor preparedness for health emergencies.

Reproductive, maternal and child health, and nutrition
Main targets: 3.7, 3.1, 3.2, and 2.2

The most recent estimates suggest that 77% of women of reproductive age who are married, or in-union had their family planning needs met with a modern contraceptive method. There is an estimate of 12.8 million births amongst adolescent girls (15-19 years) annually. In 2015, an estimated 303 000 women worldwide died during pregnancy and childbirth ,99% occurred in low- and middle-income countries and almost 64% occurred in the African Region. Having access to high-quality care before, during and after childbirth is crucial in reducing maternal mortality.

Global under-five mortality rate dropped from 93 per 1000 live births in 1990 to 39 per 1000 live births in 2017. Nevertheless, 5.4 million children died in 2017 before reaching their fifth birthday. Among children aged 1-59 months, acute respiratory infections, diarrhoea and malaria are the leading death causes in 2016.

In 2017, 151 million children under the age of five (22%) were stunted, three quarters of them living in the South-East Asia Region or African Regio. In 2017, 51 million children under the age of five (7.5%) were to light for their height (wasted), while 38 million (5.6%) were overweight. Wasting and overweight can coexist in the same populations – so-called “double burden of malnutrition”.

Infectious diseases
Main target: 3.3.

Globally, HIV incidence declined from 0.40 per 1000 uninfected population in 2005 to 0.25 per 1000 uninfected population in 2017. The African Region remained the most heavily impacted region (1.22 per 1000). A record 21.7 million people were receiving treatment by end-2017, however, 41% of people living with HIV were still not receiving treatment.

After unprecedented global gains in malaria control, progress has slowed. All regions experienced reductions in mortality in 2016 compared with 2010, with the exception of the Eastern Mediterranean Region, where mortality rates remained unchanged.

Globally, the tuberculosis incidence rate declined by 1.5% per year since 2000. In 2017, an estimated 10 million people fell ill with tuberculosis, 87% of them in the 30 high-burden countries in all six WHO regions. Drug-resistant tuberculosis is a continuing threat. In 2017, there were 560 000 new cases of the disease that were resistant to rifampicin (the most effective first-line drug), of which 460 000 were multidrug-resistant.

In 2015, an estimated 325 million people worldwide were living with hepatitis B virus (HBV) or hepatitis C virus (HCV) infection. Most of the burden of disease due to HBV infection results from infections acquired before the age of five. The widespread use of hepatitis B vaccine in infants has considerably reduced the incidence of new chronic HBV infections, with prevalence falling from 4.7% in the pre-vaccine era to 1.3% in 2015. Unsafe health-care procedures and injection-drug use are the major routes of HCV transmission. To reduce this risk, screening, diagnosis and treatment also need to be expanded.

1.5 billion people required mass or individual treatment and care for neglected tropical diseases in 2016, down from 2 billion people in 2010. Progress has been driven by steady elimination of such diseases at the country level. In 2017, more than 1 billion people were treated during mass administration campaigns for at least 1 of 5 neglected tropical diseases.

Noncommunicable diseases, tobacco control, substance abuse and mental health
Main targets: 3.4, 3.5 and 3.a.

In 2016, an estimated 41 million deaths occurred due to noncommunicable diseases (NCDs), accounting for 71% of the overall total of 57 million deaths worldwide. The majority of such deaths were caused by the four main NCDs: cardiovascular disease (44% of all deaths from NCDs); cancer (22%); chronic respiratory disease (9%); and diabetes (4%). Globally, the risk of dying from any one of the four main NCDs between ages 30 and 70 decreased from 22% in 2000 to 18% in 2016.

The worldwide level of alcohol consumption in 2016 was 6.4 litres of pure alcohol per person aged 15 years or older, a level that remained stable since 2010. Consumption in the South-East Asia Region increased by almost 30% since 2010, while that of the European Region decreased by 12% but remained the highest in the world.

In 2016, globally more than 1.1 billion people aged 15 years or older smoked tobacco. To date, the WHO Framework Convention on Tobacco Control has been ratified by 181 Parties, representing more than 90% of the global population. While the status of implementation has improved since the Convention’s entry into force in 2005, progress towards implementation of the various articles remains uneven.

Almost 800 000 deaths by suicide occurred in 2016. Men are 75% more likely than women to die as a result of suicide, which occur in adolescents and adults of all ages. Suicide mortality rates were highest in the European Region (15.4 per 100 000 population) and lowest in the Eastern Mediterranean Region (3.9 per 100 000 population).

Injuries and violence
Main targets: 3.6, 5.2, 13.1, 16.1 and 16.2.

Road traffic crashes killed 1.25 million people worldwide in 2013 and injured up to 50 million more. The death rate due to road traffic injuries was 2.6 times higher in low-income countries than in high-income countries, despite lower rates of vehicle ownership in low-income countries.

Latest estimates indicate that up to 1 billion children aged 2–17 years (50%) have experienced physical, sexual or emotional violence or neglect in the past year, and about one third (35%) of women have experienced either physical and/or sexual intimate partner violence or non-partner sexual violence at some point in their life. An estimated 477 000 murders occurred globally in 2016, with four fifths of all homicide victims being male. Men in the Region of the Americas suffered the highest rate of homicide deaths.

Over the period 2012–2016, on average there were 11 000 deaths globally each year due to natural disasters. Low- and lower-middle-income countries typically have higher mortality rates and struggle to meet financial, logistical and humanitarian needs for recovery from disasters.

It is estimated that in 2016, 180 000 people were killed in wars and conflicts, not including deaths due to the indirect effects of war and conflict such as the spread of diseases, poor nutrition and collapse of health services. The Eastern Mediterranean Region had the highest conflict death rate in 2012–2016.

Universal health coverage (UHC) and health systems
Main targets: 3.8, 3.b, 3.c, 17.19 and 1.a.

Globally, the average national percentage of total government expenditure devoted to health was 9.9% in 2015, ranging from 6.9% in the African Region to 12.5% in the European Region. This measure indicates the level of government spending on health from domestic sources within the total expenditure for public sector operations in a country and could constitute part of SDG indicator 1. a.2.

The service coverage index for UHC, a single indicator computed from tracer indicators of the coverage of essential services, varies widely across countries from 22 to 86 (out of a maximum index score of 100), with at least half of the world's population not having full coverage of essential health services. Among those who did have access to services, many suffered undue financial hardship. In 2010, an estimated 11.7% of the world's population spent at least 10% of their household budget paying out of their own pocket for health services. An estimated 1.4% of the world's population were impoverished by out-of-pocket health-care spending in 2010.

According to the latest available data for the period 2007–2016, 76 countries reported having less than one physician per 1000 population, with 87 countries reporting having fewer than three nursing and midwifery personnel per 1000 population. In many countries, nurses and midwives constitute more than half of the national health workforce.

Research and development into new or improved health products and processes, ranging from medicines to vaccines to diagnostics are often poorly aligned with global public health needs. Countries with comparable levels of income and health needs receive different levels of official development assistance for medical research and for basic health sectors. In 2015, low-income countries received only 0.3% of direct grants for health research.

Environmental risks
several targets relating to environmental sustainability and human health under Goals 3, 6, 7, 9, 11, 12 and 13.

Access to clean fuels and technologies for cooking has marginally improved and in 2016 reached 59% globally, but coverage levels vary greatly between countries. While over 90% of the population in the Region of the Americas and the European Region used clean fuels and technologies for cooking, less than 17% in the African Region did.

In 2016, 91% of the world's population did not breathe clean air, while more than half of the global urban population were exposed to outdoor air pollution levels at least 2.5 times above the safety standard set by WHO. It is estimated that in 2016, outdoor air pollution in both cities and rural areas caused 4.2 million deaths worldwide.

Unsafe drinking water, unsafe sanitation and lack of hygiene also remain important causes of death. The African Region suffered a disproportionate burden, with a mortality rate four times the global rate. Available data from fewer than 100 countries indicate that safely managed drinking-water were enjoyed by only 71% of the global population in 2015, whereas safely managed sanitation services were available to only 39%.

Unintentional poisonings were responsible for more than 100 000 deaths in 2016, with relative high mortality rates in low-income countries due to household chemicals, pesticides, carbon monoxide and medicines, environmental contamination or occupational chemical exposure.

Health risks and disease outbreaks
Main target: 3.d.

Under the International Health Regulations (2005), all States Parties are required to have or develop minimum core public health capacities to implement the Regulations effectively. In 2017, 167 States Parties (85%) responded to the monitoring questionnaire. The average core capacity score in 2017 was 71%.

II. Progress in Implementing Resolution Wha69.11

Promoting a multisectoral and coordinated approach to implementation of the 2030 Agenda

WHO's Thirteenth General Programme of Work (GPW), 2019–2023 recognizes that multisectoral approaches are needed to respond to the social, environmental and economic determinants of health. WHO supports "whole-of-government", "whole-of-society" and "Health in All Policies" approaches that deal comprehensively with all health determinants.

WHO has been involved in several intersectoral initiatives to address SDG3 such as the Global Strategy for Women's, Children's and Adolescents' Health (2016–2030) ,the Report of the Commission on Ending Childhood Obesity (2017) ,the Nurturing Care for Early Childhood Development Framework, the Partnership for Maternal, Newborn and Child Health and the Early Child Development Action Network, the Third Global Conference on Climate and Health (2018). In line with resolution WHA70.15 (2017), WHO made an online global call for evidence on practices of dealing with migration and health, receiving responses from 52 Member States and international partners. The United Nations General Assembly Declaration, "United to end tuberculosis: an urgent global response to a global epidemic", to provide leadership in order to treat all 40 million people in need of care by 2022 and at the Third United Nations High-level Meeting on NCDs Heads of State committed to WHO-recommended fiscal, information and legislative measures, including restricting alcohol advertising, nutrition labelling and marketing, banning smoking, taxing sugary drinks, public education, vaccinations, treating hypertension and diabetes, promoting regular physical activity, reducing air pollution and improving mental health and well-being.

WHO regional offices have developed plans to support countries in taking multisectoral action. For example, in the European Region, the road map to implement the 2030 Agenda for Sustainable Development, building on Health 2020, the European policy framework for health and well-being, was adopted, 3 highlighting five strategic priorities (governance, health determinants, healthy places,

leaving no one behind and universal health care) and four enabling measures. Using the roadmap, 20 European Member States have been supported in their implementation of the 2030 Agenda. Through one of the enabling measures, namely, multi-partner cooperation, the WHO Regional Office for Europe calls on the Issue-based Coalition on Health and Well-being, a partnership of multiple United Nations agencies and other intergovernmental organizations and stakeholders, led by the Regional Office for Europe, to jointly implement the health-related targets. One of the first achievements was recorded when 14 regional United Nations agencies joined forces to end HIV infection, tuberculosis and viral hepatitis through coordinated approaches. In 2018, the Regional Committee for Europe decided to adopt a set of indicators for the joint monitoring framework for the Sustainable Development Goals, Health 2020 and the Global Action Plan for the Prevention and Control of Noncommunicable Diseases 2013–2020.4 In the same year, members of the WHO European Healthy Cities Network adopted the Belfast Charter for Healthy Cities, which defines new bold health roles for city mayors and local government.

WHO engaged with other partners on health-related issues beyond SDG3, including with FAO and other partners around an ambitious 6-pronged work programme aimed at ending hunger; with ILO and OECD launching A Five-Year Action Plan for Health Employment and Inclusive Economic Growth (2017–2021) and established the Working for Health Multi-Partner Trust Funds. In 2018, WHO released its first global guidelines on sanitation and health to help countries to invest in safe, culturally and gender-appropriate sanitation (SDG 6). WHO and ILO have established a global occupational safety and health coalition to promote health and well-being in the working environment (SDG 8) and are developing their first joint methodology and joint estimates of the work-related burden of disease and injury.

Engaging in United Nations (UN) system-wide strategic planning, implementation and reporting

WHO is an active member of the UN Development Group and the Inter-Agency Standing Committee and is committed to supporting the UN Secretary-General's proposal to work as "one United Nations" to improve the efficiency and effectiveness of operational activities at the country level. WHO engages as part of UN country teams and aims to strengthen the health capacity of countries, while recognizing its constitutional mandate to act as the directing and coordinating authority on international health work.

The Thirteenth GPW, 2019–2023 sets out WHO's strategic direction, outlines how the Organization will proceed with its implementation and provides a framework to measure progress. A major shift will be to create a seamless organization, in which all three levels of the Organization will work closely together, with a clear focus on country impact, results and accountability.

WHO has advised the Inter-Agency and Expert Group on Sustainable Development Goal Indicators (IAEG-SDG) on refining and reclassifying indicators. A comprehensive review of SDG indicators is expected in 2020 based on the criteria set out in the IAEG-SDG's most recent report to the Statistical Commission.

Supporting comprehensive and integrated national plans for health

All regional offices have developed strategies to advance UHC. WHO country offices have been supporting governments and partners in the implementation of SDGs, including providing advice, facilitation, coordination on setting national targets and indicators (130 country offices), providing advocacy for mainstreaming the Goals in national plans (139), providing technical support to mainstreaming the Goals into national plans (133), providing support on measuring and reporting (104), promoting the establishment of alliances and multisectoral approach (110), providing support on resource mobilization (76) and providing capacity-building for a multisectoral approach (110).

Supporting Member States in strengthening research and development of new technologies and tools

The 2018 review of the WHO Research and Development Blueprint for action to prevent epidemics identified an urgent need for accelerated research and development on nine diseases. WHO is engaged in activities to promote research availability and transparency, such as the International Clinical Trials Registry Platform. WHO provides technical support to countries to enhance clinical trial oversight, especially in low- and middle-income countries, including by facilitating the acceleration of clinical trial and market approvals through work with national regulatory authorities and regulatory and other networks, such as the African Vaccine Regulatory Forum.

Under the umbrella of the global strategy and plan of action on public health, innovation and intellectual property, WHO has set up the Global Observatory on Health Research and Development, a centralized and open-data platform that will monitor and analyse what health research and development is being conducted globally, where it is being conducted, by whom and how.

Supporting Member States to develop more effective approaches to ensuring and delivering universal access to health services

Along with other departments, the Alliance for Health Policy and Systems Research, a partnership hosted by WHO, is working to strengthen the capacity of policy-makers to better engage with research to improve health systems. WHO is working directly with Ethiopia, India and Nepal to identify health systems research priorities as they work to achieve universal health care.

Facilitating enhanced North–South, South–South and triangular regional and international cooperation

Globally, half of the WHO offices in the six regions reported supporting a total of 241 South–South and/or triangular cooperation (SSTrC) initiatives mostly on communicable diseases (68%) and health systems and universal health care (47%). The major focus of the initiatives varied by region; Region of the Americas initiatives related to health systems, universal health care and communicable diseases; African Region on communicable diseases and health emergencies/international health regulations; Western Pacific, South-East Asia and Eastern Mediterranean regions on communicable diseases and in the European Region on noncommunicable diseases.

Supporting thematic reviews of progress on the SDGs

In 2016, WHO launched the technical handbook The Innov8 approach for reviewing national health programmes to leave no one behind, involving an 8-step pathway to review who is left behind, why and what can be done to respond within the health sector and beyond. The role of health promotion in improving health equity was reinforced at the 9th Global Conference on Health Promotion and WHO issued three information products in this area: (a) Health Equity Assessment Toolkit Plus (HEAT Plus), allowing Member States to assess within-country inequalities in health using their own data; (b) National health inequality monitoring: a step-by-step manual, designed to help countries embed health inequality monitoring in their health information systems and create the statistical codes needed to analyse household survey data to reveal where inequalities lie; and (c) AccessMod, a tool for modelling physical accessibility to health care and geographic coverage.

Supporting Member States in strengthening national statistical capacity

WHO has worked with partners in the Health Data Collaborative to develop a technical package of health information standards and tools to strengthen country health information systems. The number of countries interested in adopting the Collaborative's approach is increasing. WHO regional offices support a variety of activities to improve vital statistics, including cause of death, as well as routine health information systems. By strengthening health information systems, the Health Data Collaborative is undertaking a critical role in improving country systems for planning and monitoring of the health-related Sustainable Development Goals, including universal health coverage.

In collaboration with Health Data Collaborative partners, WHO has developed the SCORE[8] technical package, which helps countries to strengthen country data systems and their capacity to track progress towards the health-related Sustainable Development Goals and other national and subnational health priorities and targets. In addition, SCORE provides a framework for development partners to better align funding and technical support for countries.

Taking the 2030 Agenda into consideration in the development of the programme budget and general programme of work

WHO has based the Thirteenth General Programme of Work on the Sustainable Development Goals. Its three strategic priorities – universal health coverage, health security and improved health and well-being – encapsulate each of the health-related targets encompassed by Goal 3 and are accompanied by an impact framework to enable WHO to measure progress and remain focused on outcomes rather than outputs. While Goal 3 is devoted to good health and well-being, WHO's work indirectly influences, and is influenced by, other Sustainable Development Goals.

The programme budget is the primary instrument for the translation of the Thirteenth General Programme of Work into concrete plans for implementation. The development of the Programme budget 2020–2021 will be guided by the following principles, outlined in the Thirteenth General Programme of Work: (a) it will be based on the Sustainable Development Goals; (b) WHO will measure its impact, especially on the implementation of those Goals relating to improvements in people's health; and (c) WHO will prioritize its work to drive impact in every country.

ACTION BY THE HEALTH ASSEMBLY

The Health Assembly is invited to note this report.

Implication for the European Region

Following the adoption of the SDG roadmap at the Regional Committee, in 2017, WHO Europe has been working with Member States to support the implementation of the SDGs, through four key support mechanisms:

> Policy guidance in the development of national development strategies and the alignment of national health policies with the SDGs

[8] SCORE: survey, count, optimize, review, enable.

- Partnerships through sub regional (South East European Health network, Small country initiative, regions for health and the healthy cities network) thematic (e.g. public health coalition) and UN networks (e.g. IBC-health and gender)
- Technical support through a technical resource package and support in key strategic areas, such as UHC, health financing, NCDs and health equity
- Advocacy and communication, through high level events, targeted information material (e.g. for the youth)

35 European Member States have reported on SDG implementation at the High-level Political Forum since 2016. Some key considerations regarding the further implementation of the SDGs in the WHO European region:

- There are still major inequities in health and well-being between and within countries.
- The Region has seen a considerable reduction in under five mortality and infant mortality; however, a few countries are still over the threshold and the variation between countries remains high.
- The Region needs to continue to keep its malaria- and polio-free status.
- The highest political commitment on immunization to achieve the goals established in the European Vaccine Action Plan and avoid disease outbreaks, needs to be provided.
- MDR-TB needs to be addressed. Scale up of implementation of evidence-based interventions and take urgent collective actions to curb the HIV epidemic.
- Further multisectoral national action plans to combat AMR need to be implemented and further developed.
- Cost-effective NCD interventions need to be further implemented and the pockets of avoidable high mortality among men under 70 years, addressed. Building blocks and actions to be taken, as well as on the need for leapfrogging. Mental health remains a growing persistent problem.
- Environment, behavioural and commercial risk factors and determinants need to be addressed: Tobacco use, alcohol consumption, overweight and obesity, air pollution and climate change.
- Further implementation of the regional action plan of migrants and refugee health and contribution to the establishment of a global action plan on the health of refugees and migrants for consideration by the WHA in 2019.
- There is a need for continued efforts to address emergencies.
- Implementing the Tallinn and Sitges resolution, including health systems that are inclusive, leaving no one behind, and that no one should become poor because of ill-health. We still have a long way to go to achieve our target of a maximum of 15% impoverishing out-of-pocket payments for health. Improving access to affordable, effective, quality medicines requires multidimensional interventions, with comprehensive national policies, together with supportive legal and regulatory frameworks and efficient supply chains.

11.5 Universal health coverage

Primary health care towards universal health coverage

Documents A72/12 and EB144/2019/REC/1, resolution EB144.R9

The Executive Board, at its 144th session, considered an earlier version of this report. The Executive Board also adopted resolution EB144.R9.

The year 2018 marked the fortieth anniversary of the Declaration of Alma-Ata celebrated during the Global Conference on Primary Health Care (PHC) in Astana.

In the Declaration of Astana[9], Member States called for a renewal of PHC, reaffirming their commitment to the fundamental right of every human being to the enjoyment of the highest attainable standard of health without distinction of any kind and to the values and principles of justice and solidarity, underlining the importance of health for peace, security and socioeconomic development. There is a recognition that elements of PHC need to be updated to respond adequately to ongoing and new health and health system challenges, as well as to take advantage of new resources and opportunities for success in the 21st century and mobilize all stakeholders around national policies, strategies and plans across all sectors, to take joint actions to build stronger and sustainable PHC towards achieving UHC.

Renewing PHC is critical for three reasons: (a) the features of PHC allow the health system to adapt and respond to a complex and rapidly changing world; (b) with its emphasis on promotion and prevention, addressing determinants and a people-centred approach, PHC has proven to be a highly effective and efficient way to address the main causes of, and risk factors for, poor health, as well as for handling the emerging challenges that may threaten health in the future; and (c) universal health care and the health-related SDGs can only be sustainably achieved with a stronger emphasis on PHC.

Health and health system challenges

Although considerable progress has been made in improving health and well-being over the past 40 years, this progress has been uneven across and within countries.

Many countries are still working on the unfinished agenda of the MDGs: addressing the burdens of communicable, maternal, neonatal and childhood diseases and malnutrition while, at the same time, there has been a dramatic shift in the global patterns of disease and demographics. Across all countries, the proportion of disability-adjusted life years lost to noncommunicable diseases grew from 47% to 60% between 2000 and 2016. People are living longer, and the coexistence of multiple conditions in a single individual, presents a clear challenge, because of the significant burden on the individual concerned and because of the relative lack of evidence available to guide the complex management of simultaneous conditions. The burden of disease related to mental health has been growing and is increasingly recognized as a major and largely untreated epidemic. Additional challenges are presented by increasing health emergencies, including violent conflict and natural disasters resulting in the largest population migrations in history. There are new pathogens and pathogens resistant to current forms of treatment and an increasing prevalence of antimicrobial resistance. Addressing these often chronic and increasingly complex health needs calls for PHC, including a multisectoral approach that integrates

[9] Declaration of Astana. Geneva: World Health Organization/United Nations Children's Fund; 2018 (https://www.who.int/docs/default-source/primary-health/declaration/gcphc-declaration.pdf, accessed 15 November 2018).

health-promoting and disease-preventing policies, solutions that are responsive to communities and health services that are people-centred.

Global conference on primary health care

WHO, UNICEF and the Government of Kazakhstan organized the Global Conference on PHC in Astana, October 2018 to reaffirm high level commitment to the PHC approach in order to reach global targets for UHC and other health-related SDGs.

The sharing of best practices, discussions and the Declaration of Astana adopted by the Conference will all contribute to the debates of the high-level meeting of the General Assembly on UHC, due to be held in 2019. It is expected that this Conference will generate the following outcomes: strengthened political commitment to PHC and UHC; appropriate financing and resource allocations to primary care and essential public health functions; appropriate health workforce development; increased investment in relevant research and health system innovation; increased appropriate use of technology; and improved assessment of progress on PHC as countries periodically review the implementation of the Declaration, in cooperation with stakeholders.

A vision of primary health care in the 21th century: towards Universal health coverage and sustainable development goals.

PHC is a whole-of-society approach to health that aims to ensure the highest possible level of health and well-being and equitable distribution through action on three levels: meeting people's health needs through comprehensive and integrated health services throughout the life course, prioritizing primary care and essential public health functions; systematically addressing the broader determinants of health through evidence-informed policies and actions across all sectors; empowering individuals, families and communities to optimize their health as advocates for policies that promote and protect health and well-being, as co-developers of health and social services and as self-carers and caregivers.

PHC increases efficiency by improving access to preventive and promotive services, early diagnosis and treatment and by ensuring people-centred care foussing on the needs of the whole person and reduces avoidable hospital admissions and readmissions. PHC also indirectly achieves wider macroeconomic benefits through its capacity to improve population health in both low and middle-income countries and high-income countries. Health and well-being related SDG targets rely on the implementation of PHC through multisectoral policies and actions.

The model of service delivery and package of services offered through primary care should vary according to local needs and health priorities. Priority services may vary between urban centres and remote, hard to reach populations even within the same country or region. One of the essential functions of primary care is to coordinate service delivery across the whole spectrum of health and social care services, including sub-specialized medical care, long-term care and social care, through integrated, functional, and mutually supportive arrangements (including referral systems) for transitions and information sharing along evidence-based care pathways. It should also ensure seamless transitions between the public and private sectors – both profit and non-profit – as necessary.

Currently, one of the major areas of focus of the global community is achieving UHC, and primary health coverage is a necessary foundation for this effort. PHC plays a key role in reducing household expenditure on health by addressing the underlying determinants of health and by emphasizing population-level services that prevent illness and promote well-being. PHC is a cost-effective way of delivering services and the involvement of empowered people and communities as co-developers of services improves cultural sensitivity and increases patient satisfaction and ultimately improves health

outcomes. Adopting approaches for health workforce development based on multidisciplinary teams with a diverse skill mix and optimal scopes of practice increases workforce productivity while responding to a wide range of population and community needs.

Transforming vision into action

The global commitment to PHC in the Declaration of Astana, when fully implemented, has the potential to bring about demonstrable change. Two related UNICEF/WHO documents[10][11] , launched at the Global Conference on PHC, provides a set of evidence-based levers[12] to help countries to make progress across the three components of PHC.

The levers and their related actions are intended to provide options for countries at different levels of social and economic development and with different degrees of PHC orientation and health status. The selection and prioritization of specific actions should be informed by evidence, both local and global, as well as by the values and preferences of a diverse range of stakeholders.

Sessions at the Conference and WHO senior leadership meetings on the post-Astana agenda identified the need to describe a clear plan for the Organization's support to Member States on PHC and to align with existing initiatives, including the Global Action Plan for healthy lives and well-being for all.[13] Alignment is important in order to streamline efforts and increase coordination, particularly in the preparatory process for the high-level meeting on UHC, due to be held in September 2019.

ACTION BY THE HEALTH ASSEMBLY

The Health Assembly is invited to adopt the draft resolution recommended by the Executive Board in resolution EB144.R9.

DRAFT RESOLUTION EB144.R9

The Executive Board recommends the World Health Assembly to adopt a resolution welcoming the Declaration of Astana adopted at the Global Conference on Primary Health Care in Astana on 25 October 2018 and urging Member States to take measures to implement the vision and commitments of the Declaration of Astana according to national contexts. The resolution calls on stakeholders to align actions to support national policies, strategies and action plans and support Member States in the implementation. The resolution also request the Director General to support Member States and to develop, in consultation with Member States, by the Seventy-third World Health Assembly an operational framework for primary health care, to ensure that WHO promotes the vision and commitments in the Declaration of Astana in its work and overall organizational efforts, and to report regularly through the Executive Board to the Health Assembly on progress made in strengthening primary health care, including implementation of the vision and commitments of the Declaration of Astana, as part of all reporting on progress towards achieving universal health coverage by 2030.

[10] A vision for primary health care in the 21st century: towards universal health coverage and the Sustainable Development Goals. Geneva: World Health Organization/United Nations Children's Fund; 2018 (https://www.who.int/docs/default-source/primary-health/vision.pdf, accessed 29 November 2018).

[11] Operational Framework. Primary health care: transforming vision into action. Draft for consultation. Geneva: World Health Organization/United Nations Children's Fund; 2018 (http://www.who.int/docs/default-source/primary-health-careconference/operational-framework.pdf?sfvrsn=6e73ae2a_2, accessed 29 November 2018).

[12] Background documents. Global Conference on Primary Health Care (https://www.who.int/primaryhealth/conference-phc/background-documents, accessed 29 November 2018).

[13] See https://www.who.int/sdg/global-action-plan (accessed 11 December 2018).

Community health workers delivering primary health care: opportunities and challenges

Documents A72/13, resolution EB144.R4

The Executive Board, at its 144th session, considered an earlier version of this report. The Executive Board also adopted resolution EB144.R4.

The Thirteenth General Programme of Work (GPW) 2019–2023 recognizes that the "delivery of safe and good-quality services calls for a fit-for-purpose, well-performing and equitably distributed health and social workforce". The Declaration of Alma Ata (1978) led to a generational paradigm shift in the health sector, with a call for strengthening investments in the primary health care system and the recognition of an interdisciplinary health workforce. The Declaration of Astana (2018) commits to "promote multisectoral action and universal health coverage " and recognizes that the success of primary health care will also be driven by human resources for health, with a call to "create decent work and appropriate compensation for health professionals and other health personnel working at the primary health care level to respond effectively to people's health needs in a multidisciplinary context".

The WHO investment case 2019–2023[14] similarly highlights that investments in universal health coverage, including a substantial portion towards developing the workforce, will generate up to a 40% return over a five-year period. The WHO Global Strategy on Human Resources for Health: Workforce 2030 (resolution WHA69.19 (2016)) presents a range of policy options for Member States to maximize benefits from health workforce investments, including optimizing the composition of the health workforce, with a priority emphasis on the planning, education and employment of an interdisciplinary workforce configured to meet primary health care needs.

Community health workers are part of the interdisciplinary workforce in many countries and provide particular roles in primary health care and essential public health functions. The Global Strategy calls for a more sustainable and responsive skills mix through inter-professional primary care teams, harnessing opportunities from the education and deployment of community-based and mid-level health workers in order to address population needs for the achievement of SDGs and universal health coverage.

Challenges for programmes for community health workers.

Evidence across and within countries indicates that support for community health workers and their integration into the health system and the communities they serve is uneven. Examples of good practices exist but are not necessarily replicated and the performance of community health worker programmes is highly variable. Common shortcomings identified include: poor planning; unclear roles, education and career pathways; lack of certification hindering credibility and transferability; multiple competing actors; disease-specific training; donor-driven management and funding; inadequate coordination, quality control and support; and lack of recognition. Many community health worker initiatives fail to be properly integrated into health systems and remain pilot projects or small-scale initiatives.

Opportunities and policy options.

[14] A healthier humanity: the WHO investment case for 2019–2023. Geneva: World Health Organization; 2018 (http://apps.who.int/iris/bitstream/handle/10665/274710/WHO-DGO-CRM-18.2-eng.pdf, accessed 9 November 2018).

Consolidated evidence of the policy options is available to improve the design, implementation, performance and evaluation of community health worker programmes; the evidence and recommendations and published in a WHO guideline on health policy and system support to optimize community health worker programmes,[15] launched at the Global Conference on Primary Health Care, 25-26 October 2018.

The development of this guideline included analysis of the available evidence (including 16 systematic reviews), a stakeholder perception survey and the deliberations of a Guideline Development Group, comprising representation from policy-makers and planners from Member States, experts, labour unions, professional associations and community health workers. The guideline establishes key principles and provides policy recommendations to optimize the design and performance of community health worker programmes.

Key principles for countries to optimize the design and performance of community health worker programmes include: the use of a combination of policies adapted according to the objectives, context and architecture of each health system; the monitoring and evaluation of programmes and policies including the transparent sharing of data on community health workers performance; the perception of community health workers as element of integrated primary health care teams; allowing the contribution of community health workers to the provision of integrated, people-centred health services in the design and organization of health care; the consideration of their perspectives in the policy dialogue when setting policies that affect community health workers; the consideration of health workers' labour rights, including safe and decent working conditions and freedom from all forms of discrimination, coercion and violence, in identifying the optimal features of a community health worker programme.

Policy recommendations

The design, implementation, performance and impact of community health worker programmes can be optimized by: selecting community health workers for pre-service education; using competency-based formal certification for workers who have successfully completed pre-service training; adopting supportive supervision strategies; providing practicing workers with an adequate financial package; providing paid workers with a written agreement specifying role and responsibilities, working conditions, remuneration and workers' rights; offering a career ladder to those well-performing; adopting service delivery models in which workers are assigned general tasks as part of integrated primary health care teams, in which they can play a complementary role.

Key actions at national level for optimal design and implementation of community health workers programmes

The starting point should be an analysis of population needs and health system requirements, including with regard to the objectives of the programme and the roles of the workers within a holistic approach that considers optimal service delivery modalities in a country and the corresponding workforce implications; planning for their health workforce as a whole rather than segmenting planning including the formal integration of community health workers into national health, education, labour and economic development strategies and policies; progressively incorporate and include collation, analysis and reporting of data on community health workers in national health workforce information systems

[15] Available at http://www.who.int/hrh/community/guideline-health-support-optimize-hw-programmes/en/ (accessed 9 November 2018).

(disaggregated by age and sex. The financial implications of embedding community health worker programmes in the formal health system should be factored into financing strategies, mechanisms and resource allocation decisions and finally, the role of community health workers should be considered within a long-term perspective as it might need to evolve over time, in parallel with changes in the epidemiological profile of the population and health system requirements, and it should be considered in the education, certification and career ladder of the workers.

Key actions at international level to optimize support for community health workers programmes

The key determinant of success in securing adequate levels of investment and the adoption of appropriate policy decisions is the political will of countries to prioritize approaches and strategies that are most likely to lead to improved population health outcomes and enhanced working and living conditions for community health workers. However, in some contexts development partners can provide an important complementary role, by aligning external support to domestic policy needs and health system mechanisms in low-income countries where the domestic resource envelope is unlikely to allow self-reliance in the short term. Furthermore, managers and implementers of community health worker programmes supported by development partners and global health initiatives should strive to adopt the recommendations of the WHO guideline and ensure that their programmes align with national policies and mechanisms rather than establish parallel ones. Finally, international agencies, including WHO, ILO and the World Bank, should adopt, in their technical and financial cooperation activities, the health, labour and financing policies required to ensure that effective support is provided to the implementation of evidence-based community health worker policies, as part of and in alignment with broader health, labour and development policies.

The Secretariat, through the Global Health Workforce Network and the Working for Health programme, has convened representatives of Member States, other UN agencies, partners and relevant stakeholders to strengthen the dissemination and uptake of the guideline throughout 2019.

ACTION BY THE HEALTH ASSEMBLY

The Health Assembly is invited to adopt the draft resolution recommended by the Executive Board in resolution EB144.R4.

DRAFT RESOLUTION EB144.R9

The Executive Board recommends the World Health Assembly to adopt a resolution, taking note of the WHO guideline on health policy and system support to optimize community health worker programmes, urges all Member States, as appropriate to local and national contexts, to align the design, implementation, performance and evaluation of community health worker programmes, including through greater use of digital technology, to adapt as appropriate and support implementation of the WHO guideline on health policy and system support to optimize community health worker programmes at national level , to strengthen the relevance, effectiveness and implementation of the WHO Global Code of Practice on the International Recruitment of Health Personnel, to allocate adequate resources from domestic budgets and from a variety of sources, as appropriate, to the capital and recurrent costs required for the integration of community health workers into the health workforce, to improve and maintain the quality of health services provided by community health workers and to strengthen voluntary collection and sharing of data, based on national legislation, on community health workers and community health worker programmes,. The resolution invites international, regional, national and local partners, including financing agencies and development banks, to support implementation of the

WHO guideline on health policy and system support to optimize community health worker programmes, taking into account national context, and to contribute to monitoring and evaluation of implementation.

The resolution further requests the Director-General to continue to collect and evaluate data on community health worker performance and impacts, to integrate and monitor the implementation of the WHO guideline on health policy and system support to optimize community health worker programmes, to provide support to Member States, upon request, with respect to implementation of the WHO guideline including for information exchange and technical cooperation and implementation research between Member States and relevant stakeholders and to recognize the role of community health workers in an emergency, and support Member States on how to integrate them within emergency response. The Director General is further requested to strengthen WHO's capacity and leadership on human resources for health at all levels of the Organization and to submit a report every three year to the Health Assembly on progress made in implementing this resolution, integrated with the regular progress reporting on resolution WHA69.19 (2016) on the global strategy on human resources for health: workforce 2030.

Preparation for the high-level meeting of the United Nations General Assembly on universal health coverage

Documents A72/14, resolution EB144.R10

The Executive Board, at its 144th session, considered an earlier version of this report The Executive Board also adopted resolution EB144.R10.

The present report is submitted for the consideration of the World Health Assembly in keeping with the request made in paragraph 24 of resolution 72/139, adopted in 2017[16] in which the United Nations General Assembly decided to hold a high-level meeting on universal health coverage.

More than a decade into the 21st century, the health community is grappling with epidemiological transition, game-changing statistics and technological trends.
A number of key statistics are cited – notably that:

- at least half the world's population lack access to essential services; as would, presumably, be covered under UHC.
- approximately 800 million people spend more than 10% of their household budget on health care; UHC seen in the context, primarily of health financing and service coverage, would help to address this percentage spend on health care.
- almost 100 million people are pushed into extreme poverty yearly on account of out-of-pocket health expenses (UHC, by expanding coverage, has the reduction of OOPS as a key target; and while this figure reflects "extreme poverty", the document differentiates between catastrophic spending on health – which reflects out-of-pocket spending beyond a household's ability to pay – and impoverishing spending on health – which diverts household spending away from crucial items such as food, shelter and clothing and towards health, resulting in below the poverty line living).
- out-of-pocket payments represent, on average, 32% of every country's health expenditure.

[16] See http://undocs.org/A/RES/72/139 (accessed 21 February 2019).

In terms of the latter, the document provides a brief summary of key issues around UHC in the context of the Sustainable Development Goals (SDGs), where SDG 3 on ensuring health lives and promoting well-being for all at all ages is the point of focus.
Here, reference to target 3.8 (achieve universal health coverage, including financial risk protection, access to quality essential health care services and access to safe, effective, quality and affordable essential medicines and vaccines for all) is made. This is seen as the "key to attaining Goal 3 in its entirely, as well as the health-related targets of other Sustainable Development Goals". In this regard, working towards UHC serves the two indicators under target 3.8: coverage of essential services (3.8.1) and expenditure on health (3.8.2).

Regarding service coverage, the document notes the wide regional variation according to the UHC service coverage index under the SDGs, with Europe reflecting the highest level (77) along with North America and East Asia. The index relies on the use of nine tracers which show an average of 20% increase between 2000-2015 (approximately 1.3% per year), for which coverage of antiretroviral treatment for HIV is the tracer most relevant to the European Region which has shown the highest rate of increase. Nonetheless, the document notes that notwithstanding data limitations, "it is clear that at least have of the world's population do not have full coverage of essential services".

As to health spending, catastrophic spending is reported in terms of two thresholds: out-of-pocket expenditures that exceed 10% of household total income or consumption and those that exceed 25% – this is used under the SDGs monitoring framework. For impoverishing spending, while this is not part of goal 3.8, its importance to not just understanding the impact of health costs on households, and thus UHC, but also working towards the other SDGs is clear. Variation between regions remains stark, but overall impoverishment rates are increasing. As such, the document notes a need for strong, continuous political commitment and support, more government fiscal space specifically dedicated to health, more investment in health delivery systems, primary health care and a committed health workforce, and strengthened implementation capacities; all of which are crucial to UHC as recognised under the 13th GPW.

In terms of the high-level UN GA meeting on UHC, the document notes the overall theme as "Universal health coverage: Moving together to build a healthier world". It will be a one-day event (09:00-18:00) before the opening of the general debate at ait's 74th session, consisting of four segments: opening, plenary, two multi-stakeholder panels and a closing. The panels will take into account earlier and current relevant health initiatives and processes and will focus on sharing experiences and lessons to address implementation gaps. The meeting will be supported by a political declaration "agreed in advance by consensus through intergovernmental negotiations."

Preparations for the meeting will follow usual protocol through governing bodies with the aim to allow Member States to engage and support the political declaration development process; translate existing commitments on UHC into concrete actions and call up on stakeholders to harmonise their support for Member States to realise UHC progressively.

ACTION BY THE HEALTH ASSEMBLY

The Health Assembly is invited to note the report. It is also invited to focus its discussions on providing strategic directions that will enable the global community to make a coordinated effort towards achieving universal health coverage.

The Health Assembly is further invited to adopt the draft resolution recommended by the Executive Board in resolution EB144.R10.

DRAFT RESOLUTION EB144.R10

The Executive Board recommends to the World Health Assembly to adopt a resolution urging Member States to accelerate progress towards achieving Universal Health Coverage (UHC SDG target 3.8) and support the preparation, including the development of an action-oriented political declaration, of the UN General Assembly High Level meeting in September 2019. The resolution also urges Member States to ensure adequate and sustainable resources and collaboration across all sectors for UHC; to encourage systematic use of new technologies and prioritize efficient and evidence-based decision making; to continue investing in primary health care as a cornerstone for a sustainable health system as well as in the public health functions envisioned in the Astana Declaration; to invest in gender-sensitive health care services and in adequate and competent health workforce; to promote access to and research and development of affordable, safe, efficient and quality medicines, vaccines and diagnostics; to promote inclusive approaches for safeguarding UHC in emergencies: to promote health literacy and strengthen prevention and health promotion, monitor and evaluation platforms and to make best use of the UHC Day.

The resolution calls upon development cooperation partners and stakeholders to harmonize and enhance their support to countries' objectives in achieving UHC.

The Director General is requested to support Member States efforts to achieve UHC including through facilitating learning from and sharing of best practices and experiences, in close collaboration with the UN system and the Inter-Parliamentary Union; to produce a report on UHC as technical input to the High- level meeting of the UN General Assembly; to make best use of the International UHC Day and to submit biennial progress reports on the implementation of the resolution from 73th Health Assembly onwards until 83th Health Assembly in 2030.

Implication for the European Region

UHC continues to be high on the political agenda, many previous resolutions and activities across the Regional Office are focused on UHC.

In 2018, three high-level events reflected this sentiment and generated increased political commitment to UHC in the Region:

1. In April, the regional meeting **Health Systems Respond to Noncommunicable Diseases (NCDs)** brought together 200 experts and policy-makers from 43 countries to examine how various components of a health system can be aligned to respond to NCDs. The most effective and affordable NCD interventions – known as the best buys – must be implemented if WHO's goal of ensuring better health and well-being for 1 billion more people is to be achieved.
2. Equity, a key tenet of UHC, was the central theme of the June 2018 high-level meeting **Health Systems for Prosperity and Solidarity: leaving no one behind.** Organized in Estonia on the occasion of the 10th anniversary of the Tallinn Charter, the event concluded with countries of the Region expressing clear commitment to building health systems based on solidarity. The meeting noted 3 concrete ways in which countries can take action on this commitment: redouble efforts to advance UHC; work harder to provide people-centred health services; and plan ahead to make sure that health systems are prepared to deal with crises.

3. Primary health care plays a vital role in bringing health services closer to people's homes and communities, thereby improving access. In October this year, 1200 delegates from more than 120 countries around the world gathered in Astana, Kazakhstan, for the **Global Conference on Primary Health Care.** Together they adopted the Declaration of Astana, vowing to strengthen their primary health care systems as an essential step towards UHC. In the coming years, WHO will support countries to implement the Declaration of Astana, which provides direction for the development of primary health care as the basis of health care systems. This support will form part of WHO's ongoing work to help countries move towards UHC, including efforts to better understand the causes of financial hardship and to make a strong case for investment in health systems.

The WHO European Centre for Primary Health Care in Almaty, Kazakhstan supports Member States in reforming systems to deliver PHC. European Member States have made great progress in translating policies, plans and strategies in the European Region into action, beginning to pave the way for the development of comprehensive PHC towards UHC.

In 2018, the regional report, *From Alma-Ata to Astana: primary health care – reflecting on the past, transforming for the future*, explored innovations across the health system in the Region. Country experiences are wide-reaching, and include innovations in organizational design and governance, devolved decision-making, enhancement of local accountability and management, innovations in the financing of provider payment schemes as well as improvements in performance and outcomes and reduction of inequalities in access. Good practices in training and education, the roles and responsibilities of health workers and the use of technology, especially information solutions, are a testament to the strong evidence and knowledge that has accumulated in Europe.

With regard to community health care workers, in the WHO European Region, a number of policies and resolutions have looked to strengthen health systems by strengthening the health workforce. More recently, the European Regional Committee has endorsed a number of resolutions calling on Member States to develop national health workforce policies and plans, urging Member States to improve information and the knowledge base on their health workforces; to develop national health workforce policies, plans and strategies as a critical component of health systems strengthening, particularly in view of the changing demographics and health care needs in the Region and to accelerate efforts towards achieving a sustainable health workforce by optimizing the performance, quality and impact of health workers by transforming education and training. The Tallinn Charter, endorsed by all European Member States calls for investment in the health workforce. This requires alignment of investment in HRH with the current and future needs of the population and of health systems and building institutional capacity for effective policy stewardship and governance of human resources. It also necessitates improvements to the evidence base and strengthening of data, as well as the application of analytical approaches to health workforce dynamics, policy and planning. Resolution EUR/RC67/10 expands on this by offering a framework for action towards a sustainable health workforce by translating the Global Strategy on Human Resources for Health: Workforce 2030 to the European regional context.

At regional level, in September 2019 at the 69th session of the WHO Regional Committee for Europe, Member States are also expected to discuss a way forward to accelerate primary health care and the implementation of the Declaration of Astana. In line with the 10 policy levers of the operational framework developed at global level, 10 evidence-based policy accelerators have been identified to

support organizational and technological innovations for strengthening primary health care. These are cross-cutting, interconnected and compelling high-impact entry points for policy action. They are the best buys for allocating time and resources to the transformation of services delivery. Most importantly, tested research and practice show that they improve performance and, ultimately, health outcomes.
Importantly, this effort continues to be informed by the approach of the European Framework for Action on Integrated Health Services Delivery. Intensifying work on primary health care in Europe is expected to build on existing structures including the Issue-based Coalition on Health and Well-being (IBC-Health), offering a platform to collaboratively define a joint agenda in countries. In 2018 the regional directors of the participating United Nations agencies established a workstream dedicated to primary health care, given its paramount importance for accelerating progress in advancing the universal health coverage agenda.

11.6 Health, environment and climate change

Documents A72/15 and A72/16

An earlier version of this document was noted by the Executive Board at its 144th session in January 2019. The draft WHO global strategy on health, environment and climate change, which the Board broadly supported, was subject to further consultations by Member States in March 2019 and has been updated in the light of comments made.

A previous drat was submitted to WHO's regional committees for input and comments by Member States.

Scope

This draft strategy aims to provide a vision and way forward on how the world needs to respond to environmental health risks and challenges until 2030, and to ensure safe, enabling and equitable environments for health by transforming our way of living, working, producing, consuming and governing. Environmental risks to health are defined as all the physical, chemical, biological and work-related factors external to a person, and all related behaviours. It focuses especially on the part of the environment that can reasonably be modified.

Challenge

The current situation and the challenges ahead call for a transformation in the way we manage our environment with respect to health and well-being. Known avoidable environmental risks cause about one quarter of all deaths and disease burden worldwide, amounting to at least a steady 13 million deaths each year. Air pollution alone is responsible for 7 million preventable deaths per year and more than half the world's population are still exposed to unsafely managed water, poor sanitation and hygiene. Climate change increasingly affects people's health, through more frequent heat waves, extreme rainfall and severe cyclones in many areas, and modifying the transmission of food/water-borne and zoonotic infectious diseases.

There are gaps in institutional capacities for health protection through legislation, management of chemical and other hazards, and emergency response. The effects of human actions on the environment also rise ethical and human rights issues, as they will be felt by future generations and will continue to disproportionally affect populations in situations of vulnerability.

New environmental, climatic and health issues are emerging and require rapid identification and response. Recent examples include the management of electronic waste, nanoparticles and endocrine-

disrupting chemicals. To face these new challenges, stakeholders, health authorities and communities should be more active in shaping the energy transition, guiding urbanization and ameliorating other major development trends. Health is rarely central to decisions affecting these trends, resulting in missed opportunities for health protection and promotion.

The sustainability of health systems is put at risk if the root causes of disease are not seriously tackled. About 10% of global gross domestic product is being spent on health care, but very little goes to prevention. Financial and human resources allocated to health promotion and primary prevention remain poor to reduce the burden of disease caused by environmental risks to health. Approaches that focus on treatment of individual diseases rather than improvement of determinants of health will be insufficient to tackle modern environmental health challenges. Current governance mechanisms, including those at the local level, are failing to effectively deal with the cross-cutting nature of environmental health issues.

Vision: a world in which sustainable development has eliminated the almost one quarter of the disease burden caused by unhealthy environments, through health protection and promotion, good public health standards, preventive action in relevant sectors and healthy life choices, and which manages environmental risks to health. Key sectors fully integrate health into their decision-making process and maximize societal welfare

Strategic objectives for the transformation needed

To address the challenges in health, environment and climate change, governments and society will need to rethink the way we live, work, produce, consume and govern. This transformation requires focusing action on upstream determinants of health, environment and determinants of climate change in an integrated and mainstreamed approach across all sectors.

Strategic objective 1. Primary prevention: to scale up action on health determinants for health protection and improvement in the 2030 Agenda for Sustainable Development

The 2030 Agenda for SDGs calls for tackling environmental risks at their root through a shift towards primary preventive actions and the promotion of healthy choices. Reducing the 13 million deaths resulting from environmental risks each year requires efficient scale-up of primary preventive action involving all key stakeholders.

Strategic objective 2. Cross-sectoral action: to act on determinants of health in all policies and in all sectors

Policies across sectors will systematically consider health perspectives and evidence and gain the health co-benefits of environmental protection. An example is ensuring healthy energy and transport transitions. Substantial transitions in energy, transport and other major systems are under way, which should lead to profound impacts on population health.

Strategic objective 3. Strengthened health sector: to strengthen health sector leadership, governance and coordination roles

The health sector will play leadership and coordination roles, working together with other sectors with relevance to health, environment and climate change to improve lives. Incremental changes to deal with individual environmental risks are not sufficient. To address the environmental contribution to the global burden of disease, which is beginning to worsen after remaining almost static for a decade, the

health sector needs to be equipped and strengthened to assume its obligations in shaping a healthy and sustainable future.

Strategic objective 4. Building support: to build mechanisms for governance, and political and social support

Governance mechanisms and political support at high level will enable work across sectors and maintain public goods for health. Citizens' demands for healthier environments will shape policy choices. Multilateral and other high-level agreements will tackle major driving forces of risks to health and global threats to health.

Strategic objective 5. Enhanced evidence and communication: to generate the evidence base on risks and solutions, and to efficiently communicate that information to guide choices and investments

Sufficient evidence-based information will be available in all critical areas to support choices in health-protective actions based on health impacts, economic implications, their effectiveness and co-benefits. Enhanced cross-sectoral action, high-level support and scaled-up primary prevention will all require a solid and expanded evidence base on health impacts, costs, effectiveness and wider societal benefits of solutions, and will need to be informed by regular monitoring.

Strategic objective 6. Monitoring: to guide actions by monitoring progress towards the SDGs

Actions will be guided by monitored progress in the implementation of primary prevention through healthier and safer environments. Monitoring will aim at closely tracking changes in determinants of health and their impacts, as well as their distribution across and within population groups.

Implementation platforms

Specific entry-points will be used to deliver scaled-up action on environmental upstream determinants of disease using integrated approaches. The response to the challenges of persistent and emerging health risks goes beyond the formal health sector. The response can only meet the scale of the challenges if it is led by the health community, participating in key strategies and planning, working with others to implement health-promoting multisectoral policies. A range of implementation mechanisms and platforms is required to achieve this vision. These are outlined below.

An empowered health sector

The formal health sector represents a significant fraction of the global economy. It is therefore ideally placed: to implement environmental health interventions at the community level; to lead by example in demonstrating good practice in sustainability, by reducing the environmental impact of health care practice; and to act as leaders and advocates for health and sustainable development.

Stronger national and subnational platforms for cross-sectoral policy-making

A few countries have formal institutional structures that provide direct policy guidance on health and environment challenges or that mandate intersectoral assessments of the health implications. Health in All Policies approach needs to have broader coverage, upstream policies that include strategic assessments rather than individual projects, and more direct influence on policy. High-level regional forums have also been contributing to advancing the health and environment agenda.

Key settings as sites for interventions

Key settings present opportunities to deal with environmental health risks and reduce health inequalities, while responding to demographic, social, economic, technological and lifestyle changes. The main settings and the objectives of interventions are: households, schools, workplaces, businesses, health care facilities, and cities.

Partnerships for a social movement for healthier environments

An essential requirement for action is political will. This can only come about through broad societal awareness of the fundamental health threats posed by environmental risks and climate change, and their potential solutions. Individual advocates, health professional associations and civil society organizations are crucial for mobilizing public support for health-promoting development choices.

Multilateral environmental, health and development agreements

Most global and regional environmental agreements cite threats to health as a major concern. However, the mechanisms for implementing these agreements do not always adequately include consideration of these health threats, at national, regional or international levels. Stronger engagement of the health sector would promote synergies and optimize any necessary trade-offs between health, environmental and economic objectives. Such integration would advance the holistic approach articulated in the 2030 Agenda for SDGs.

Platforms for the Sustainable Development Goals

The adoption of the 2030 Agenda has led to the creation of high-level political forums that are strengthening the means of implementation and follow-up on commitments made. Such forums therefore constitute key platforms for triggering progress towards action on upstream environmental causes of disease and equitable health promotion.

Evidence and monitoring

A limited number of countries have advisory bodies with the mandate and capacity to set national research agendas, generate syntheses of available evidence, track national progress on health and the environment, and provide this information directly to policy-makers. At the international level, the Intergovernmental Panel on Climate Change carries out this function in relation to the implication of climate change for health but institutionally similar functions for other environmental challenges are less comprehensively covered and more fragmented. National and international institutions, such as research institutes, universities, and sources such as peer-reviewed journals could also play a significant role in the definition of national strategies.

WHO's role and leadership in global health

The Secretariat's actions under the proposed global strategy on health, environment and climate change are based around the three strategic priorities of WHO's Thirteenth General Programme of Work, 2019–2023. The basic health, environment and climate change activities fall under the strategic priority "Promoting healthier populations", but the contribution to "Addressing health emergencies" has also proven to be substantial. WHO's strategic priority of "Achieving universal health coverage" should underlie mechanisms for implementing basic environmental health services. The three strategic priorities, with a description of how health and environment contribute to each of them, are: Achieving universal health coverage; Addressing health emergencies; Promoting healthier populations. Within these three strategic priorities, WHO is contributing to the global agenda on health, environment and

climate change through (a) leadership and policies; (b) evidence synthesis and advocacy; and (c) provision of direct country support.

The document provides further detail of the WHO activities.

Measuring progress towards SDGs.

The main targets for measuring progress, aligned with WHO's Thirteenth General Programme of Work, are listed below (for the period 2019–2023).

Within Goal 3 (Ensure healthy lives and promote well-being for all at all ages)
• Reduce the mortality rate from air pollution by 5%.

Within Goal 6 (Ensure availability and sustainable management of water and sanitation for all)
• Provide access to safely managed drinking water services for 1 billion people.
• Provide access to safely managed sanitation services for 0.8 billion people.
• Reduce by 40–50% the number of people in low- and middle-income countries served by hospitals without reliable electricity and basic water and sanitation services.

Within Goal 13 (Take urgent action to combat climate change and its impacts)
• Double the amount of climate finance for health protection in low- and middle-income countries.
• Reduce by 10% mortality from climate-sensitive diseases (through climate change action rather than other drivers

The draft strategy also lists the main health-related Sustainable Development Goals and indicators

ACTION BY THE HEALTH ASSEMBLY

The Health Assembly is invited to consider a draft decision:

1. to note the WHO global strategy on health, environment and climate change, and
2. to request the Director-General to report back on progress in the implementation of the WHO global strategy on health, environment and climate change to the Seventy-Fourth World Health Assembly.

Health, environment and climate change - Draft global plan of action on climate change and health in small island developing States

Document A72/16

In 2018, the Executive Board adopted decision EB142(5) on health, environment and climate change. In that decision, the Director-General was requested to develop "a draft action plan for the platform to address the health effects of climate change initially in small island developing States, and to submit the draft action plan for consideration by the Seventy-Second World Health Assembly in May 2019, through the Executive Board at its 144th session in January 2019". This draft global plan of action on climate change and health in small island developing States was developed following the recommendations of the Third Global Conference on Climate and Health 2018, which was organized as a series of three separate events dispersed across three regions with a focus on small island developing States.

In line with the Thirteenth General Programme of Work, the focus of this draft global plan of action is a targeted effort to rapidly scale up support for a group of countries with unique and severe challenges; it provides a response to the call for urgent action made by the health ministers of the small island developing States.

Vision

This draft global plan of action has a vision that by 2030, all health systems in small island developing States will be resilient to climate variability and change. 8. This vision must be realized in parallel with the steps taken by countries around the world to reduce carbon emissions, both to protect the most vulnerable from climate risks and to gain the health co-benefits of mitigation policies.

Scope

The draft global plan of action aims to provide national health authorities in small island developing States with the political, technical and financial support and the evidence needed to: better understand and address the effects of climate change on health; improve the climate resilience and environmental sustainability of health services; promote the implementation of climate change mitigation actions by the most polluting sectors. The draft global plan of action also aims to lead the way in transforming health services in small island developing States away from a model of curative services with escalating costs and towards a model based on disease prevention, climate resilience and sustainability. In addition, it aims to promote working in a more integrated way across different health programmes and with other partners.

The draft global plan of action is designed to support WHO's the special initiative on climate change and health in, which is a voluntary grouping that includes small islands irrespective of their constitutional status, i.e. it includes the participation of independent States, overseas departments, dependencies and territories. 1

Strategic action

The draft global plan of action has four interlinked and mutually reinforcing strategic lines of action; each has two associated actions and two indicators for monitoring progress.

Strategic line of action 1 – Empowerment: Supporting health leadership in small island developing States to engage nationally and internationally

Health is increasingly recognized in climate discussions; nevertheless, it is still not routinely and formally identified as a priority, resulting in missed opportunities. There is a need to ensure that connections between health and climate change are effectively incorporated into the official positions. Small island developing States constitute about one fifth of United Nations and WHO Member States and could leverage their strength in numbers to advocate more effectively for global action.

Action 1.1 – Establish at WHO a small island developing States hub or alternative coordination mechanism on small island developing States to provide support to climate change, environment rand other priority health issues. Progress will be monitored against the following indicator:

Indicator 1.1 – Small island developing States coordination mechanism established in WHO for climate change, environment and other priority health issues.

Action 1.2 – Provide health sector inputs to the United Nations Framework Convention on Climate Change and stakeholders leading relevant national climate change processes. To implement this action,

WHO will work to strengthen the monitoring of health issues within international conventions and agreements on the environment and will put in place regional risk assessment and risk communication mechanisms. Progress will be monitored against the following indicator:

Indicator 1.2 – Number of small island developing States that include health as a priority in their most recent national communications, national adaptation plans or nationally determined contributions to the United Nations Framework Convention on Climate Change.

Strategic line of Action 2 – Evidence: Building the business case for investment

The global evidence base for the impacts of climate change on health is comparable to that for any other climate-sensitive outcome. However, this information is often not presented in an easily accessible form at the national or subnational levels where most policy decisions are made. It also often lacks the systematic economic evidence base that is necessary to make the case to potential investors. Finally, there is a lack of operational research on the implementation of climate change and health programmes. There is therefore a need to ensure that existing evidence is connected as directly as possible to policy and to build capacity and strengthen the connections of national research institutions in small island developing States with each other, with research institutions outside such States and with policy-makers.

Action 2.1 – In collaboration with the UN Framework Convention on Climate Change, develop or update national climate and health country profiles for every small island developing State. WHO has already produced country profiles for 45 countries, including six small island developing States. Progress will be monitored against the following indicator:

Indicator 2.1 – Number of small island developing States that have completed climate and health country profiles supported by WHO and the United Nations Framework Convention on Climate Change

Action 2.2 – Identify, support and build on existing centres of excellence for increasing capacity, conducting assessments, data analysis, research and implementation of actions, including with organizations and universities that have regional mandates. Progress will be monitored against the following indicator: Indicator 2.2 – Number of collaborating centres actively engaged in supporting the platform to address the health effects of climate change in small island developing States.

Strategic line of action 3 – Implementation: Preparedness for climate risks, adaptation, and health-promoting mitigation policies

The draft global plan of action will build on the experience gained in climate and health adaptation projects around the world, increasing coverage of evidence-based interventions within a comprehensive approach based on WHO's operational framework for building climate resilient health systems. It also aims to strengthen the role of the health sector in promoting health co-benefits of climate change mitigation actions implemented by those sectors more responsible for global warming, both within and outside small island developing States.

Action 3.1 – Support small island developing States through regional frameworks to build climate resilient health systems. This action includes preventive measures, such as integrating into the implementation of universal health coverage the protection of the environmental determinants of health. It also includes a specific focused effort on climate resilient and environmentally sustainable health care facilities. Progress will be monitored against the following indicator: Indicator 3.1 – Number of small island developing States that have initiated actions for climate resilient, environmentally sustainable health care facilities.

Action 3.2 – Develop and implement programmes to raise awareness and build capacity for adaptation and disease prevention both by people and by the health system. To implement this action, WHO will support small island developing States to implement national and subnational health adaptation plans and facilitate information-sharing, stocktaking and research, and will conduct advocacy and awareness campaigns for health leaders, policy-makers, key stakeholders and the general public. Progress will be monitored against the following indicator: Indicator 3.2 – Number of small island developing States that have begun implementation of climate change and health national and subnational adaptation plans or actions to achieve health co-benefits described in their nationally determined contributions to the UN Framework Convention on Climate Change.

Strategic line of action 4 – Resources: Facilitating access to climate and health finance

A significant change in the current health vulnerability of the populations of small island developing States will not be possible without access to sufficient financial resources. Health ministers have prioritized the need to expand and diversify the funding streams potentially available to build health resilience to climate change. This strategic line of action aims to facilitate access to climate finance, development assistance and domestic resources so as to triple the current level of investment in climate change and health in small island developing States over the period 2019–2023.

Action 4.1 – Lead a process to identify new and innovative forms of funding and resource mobilization mechanisms. This action will entail advocacy to facilitate equity and transparency in accessing funds, including supporting simplified funding mechanisms. Progress will be monitored against the following indicator: Indicator 4.1 – Special fund on climate and health for small island developing States established (Small Island Developing States Climate and Health Fund).

Action 4.2 – WHO will pursue the process to become an accredited agency for the Green Climate Fund and facilitate support to small island developing States. Small island developing States have advocated for WHO to facilitate mechanisms and overcome current complexities in obtaining funding for adaptation and mitigation in the health sector.

Indicator 4.2 – Total funds received for the health sector as a percentage of total climate funds

Monitoring and reporting progress

Progress in implementation of the Global plan of action will be monitored against the indicators defined above, based primarily on survey information collected in consultation with countries, which also form the basis of the climate and health country profiles supported by WHO and the United Nations Framework Convention on Climate Change. It is proposed that progress be reported biennially to the Health Assembly, over the period 2019–2025.

ACTION BY THE HEALTH ASSEMBLY

The Health Assembly is invited to consider a draft decision:

- to note the plan of action on climate change and health in small island developing States,
- to request the Director-General to report back on progress in the implementation of the plan of action on climate change and health in small island developing States to the Seventy-Fourth World Health Assembly.

Implication for the European Region

The European Region welcomes the Global Strategy and actively contributed to its development, as well as to the consultations with Member States. Initial information on the development of the Strategy was shared with Member States in March 2018 at the eighth meeting of the European Environment and Health Task Force. The European Office facilitated consultations with Member States in the framework of the RC68 in September 2018 and mobilized the European Environment and Health Task Force in the consultation held in March 2019. This has facilitated the full alignment and consistency between the objectives, scope and monitoring framework of the Global Strategy and the commitments taken by European Member States at the Sixth Ministerial Conference on Environment and Health held in Ostrava in 2017. This will ensure that, by implementing the Ostrava commitments, Member States will at the same time contribute to the achievement of the Global Strategy. In turn, this will maximize outcomes and efficiency in the use of resources.

In the WHO European Region, environmental determinants of health, including climate change, remain of utmost importance. They cause 1.4 million annual premature deaths, which corresponds to 15% of Europe's total deaths. There is accumulating evidence about the significant health impacts of climate change in European Region. Direct health impacts result through progressive temperature increases, heat waves, storms, forest fires, floods or droughts, in addition to many indirect health impacts.

The Paris Agreement, endorsed by all Member States of the WHO European Region, sets ambitious aims to curb greenhouse gas emissions but also commits countries to strengthen adaptation (prevention, protection and response measures), which urgently needs to be scaled up. 18% of the 53 WHO European Member States referred to health in their list of intended nationally determined contributions (INDCs) to Paris Agreement, when outlining commitments to achieving climate-related policy goals and targets, compared with 67% of countries globally.

The physical and economic consequences for human health achieved through improvements in country-level air quality from domestic carbon reductions, specifically policy mitigation actions and measures as reported in a country's INDCs amount to 138 000 annual preventable premature mortality from 2030 and beyond across the whole Region. In economic terms, the benefit of reduced emissions is equivalent to a savings of US$ 244 billion to US$ 564 billion, or 1–2% of the WHO European Region's gross domestic product at purchasing power parity. The saved cost from reduction in illnesses (US$ 34.3 billion) amounts to 6–14% of the total economic benefit. This includes implementing plans that should protect human health from the impacts of climate change. 24 out of the 53 Member States of the WHO European Region had included health in their national adaptation strategies.

The 2017 Ostrava Declaration, adopted at the Sixth Ministerial Conference on Environment and Health, provides an effective policy framework for the WHO European Region to address environmental determinants, including climate change adaptation and mitigation. Through the Ostrava Declaration, WHO European Member States have committed to develop national portfolios of action on environment and health, which prioritize key intervention areas of national relevance.

EUR/RC67/8 Resolution on Improving environment and health in the context of Health 2020 and the 2030 Agenda for Sustainable Development: outcomes of the Sixth Ministerial Conference on Environment and Health was adopted at the 67th Regional Committee for Europe in September 2017. It sets the strategic direction in the European Region on health and environment issues until 2030 and provides an actionable plan to move forward and implement political commitments through the

European Environment and Health Process as a regional platform for the implementation of the 2030 Sustainable Development Agenda in Europe.

In the WHO European Region, multilateral environmental agreements, such the WHO/UNECE Protocol on Water and Health and the WHO/UNECE Transport, Health and Environment Pan-European Programme (THE PEP), and the Task Force on Health Aspects of Air Pollution under the UNECE Convention on Long-Range Transboundary Air Pollution (CLRTAP) provide effective frameworks to address environmental determinants of health.

11.7 Access to medicines and vaccines

Document A72/17

The Executive Board, at its 144th session, considered an earlier version of this report. The draft road map has been revised and a new Appendix 2 has been added to indicate the linkage between the Thirteenth General Programme of Work, 2019-2023 and the activities, actions, deliverables and milestones set out in the road map. The milestones have been updated to reflect the global goods planning process, and information has been added on the Organization's mandate with regard to the actions required by the road map and on the distribution of road map activities across the programme budget. The revised draft also reflects issues raised by the Executive Board relating to providing health products for primary health care, monitoring access, optimizing the use of biosimilars, addressing the challenges faced by small island States, and supporting countries transitioning from donor funding.

In May 2018, the Seventy-first World Health Assembly considered a report by the Director-General on addressing the global shortage of, and access to, medicines and vaccines.[17] Having considered the report, the Health Assembly adopted decision WHA71(8), in which it decided to request the Director-General to elaborate a road map report, in consultation with Member States, outlining the programming of WHO's work on access to medicines and vaccines for the period 2019–2023, including activities, actions and deliverables. The Health Assembly also requested the Director-General to submit the road map report to the 72nd WHA, through the Executive Board at its 144th session.

In July 2018, the Secretariat initiated a process to consult Member States and an online consultation with Member States on the zero-draft road map was conducted in the period July–September 2018, during which 62 countries provided feedback. In addition, a consultation with Member States on the zero draft was conducted on 10 and 11 September 2018 in Geneva, preceded by an informal discussion with representatives of the United Nations and other international organizations and non-State actors in official relations with WHO. The draft report was updated based on the feedback obtained by these consultation processes, including broadening of the scope to include medicines, vaccines and health products.

The revised draft road map for access to medicines, vaccines and other health products, 2019–2023, based on existing WHO mandates in key Health Assembly resolutions of the last 10 years related to access to safe, effective and quality medicines, vaccines and health products, and also reflecting the Thirteenth Global Programme of Work, 2019–2023, is contained in Annex.

SUMMARY OF THE ANNEX

The planning framework for the Thirteenth General Programme of Work provides a structure for identifying priorities at the country level and for the planning and budgeting of the work of WHO. It

[17] Document A71/12

will ensure that the programme budget reflects the needs of the countries and that work at all three levels of the Organization is geared towards delivering country impact. This road map for access to medicines, vaccines and other health products, 2019–2023, aligns with the following outputs that have been identified within this framework:

- provision of authoritative guidance and standards on the quality, safety and efficacy of health products, including through prequalification services, essential medicines and diagnostics lists;
- access to essential medicines, vaccines, diagnostics and devices for primary health care improved;
- country and regional regulatory capacity strengthened, and supply of quality-assured and safe health products improved;
- research and development agenda defined, and research coordinated in line with public health priorities; countries enabled to address antimicrobial resistance through strengthened surveillance systems, laboratory capacity, infection prevention and control, awareness-raising and evidence-based policies and practices.

Structure of the road map

The road map[18] outlines the principles of WHO's work on access to health products, including essential health system components. It is structured around two interlinked strategic areas that are necessary to support access to health products: ensuring the quality, safety and efficacy of health products and improving equitable access to health products. Under each strategic area, the road map describes activities and puts forward the specific actions and deliverables for the period 2019–2023. Thus, ensuring quality, safety and efficacy of health products include the following activities: regulatory system strengthening; assessment of the quality, safety and efficacy / performance of health products through prequalification; market surveillance of quality, safety and performance. Improving equitable access includes the activities of research and development that meets public health needs and improves access to health products; application and management of intellectual property to contribute to innovation and public health; evidence-based selection and fair and affordable pricing; procurement and supply chain management; and finally, appropriate prescribing, dispensing and rational use.

A health systems approach to improving access to health products

Four of the six key components of a well-functioning health system[19] are addressed in the roadmap for improving access to health products, with specific actions under the two strategic areas. The key components are the financing of health products; the governance of health products; the health workforce that ensures access to health products; and the information on health products for decision-making.

Inadequate financing of health products, high prices of new health products and ineffective policy interventions and processes to manage expenditure, such as the ineffective use of generic policies, contribute to the challenges facing the health system in achieving universal health care. Activities in this road map support countries' ability to allocate resources more effectively through evidence-based decisions to ensure that cost-effective health products are included in a country's essential medicines

[18] More information on how the road map was developed can be found in the original document.
[19] The six components of a well-functioning health system outlined in the WHO document "Key components of a well-functioning health system"1 include: Leadership and governance, health information systems, health financing, human resources, essential medical products and technologies, and service delivery. http://www.who.int/healthsystems/publications/hss_key/en/ (accessed 11 November 2018).

list, essential diagnostics lists or reimbursement lists and through more efficient procurement and supply processes and rational use of medicines. Support for fair pricing[20] and policy implementation to reduce out-of-pocket expenditures will also be provided.

The need for good governance is increasingly recognized as a major hurdle on the road to achieving universal health coverage. Weak governance complicates access to health products by fuelling inefficiencies, distorting competition and leaving the system vulnerable to undue influence, corruption, waste, fraud and abuse. As unbiased information free of any conflict of interest is vital for the sound selection, incorporation, prescription and use of health products, activities in the road map address the transparency of clinical trials enabling support for clinical trial registries and address price transparency through the Market Information for Access to Vaccines (MI4A platform)[21], for example. Moreover, the relationship between government and the private sector, such as pharmaceutical companies and medical device companies, requires particular attention and in this regard, WHO supports improving practices in both the public and private sectors to ensure that national policies reflect the central role of access to health products in achieving universal health coverage and in contributing to improved accountability.

Part of the workforce shortage[22] concerns pharmacists (one of the specialized workforces required to ensure access to medicines and vaccines) and biomedical engineers (who play a crucial role in supporting the best and most appropriate use of medical technologies), essential to the development, production, procurement, distribution and appropriate use and maintenance of health products. The WHO Global Strategy on Human Resources for Health: Workforce 2030 addresses health workforce challenges. In addition, activities provided in the road map include support to ensure that the workforce is fit-for-purpose in key areas such as regulatory capacity, where specific competencies are required to ensure the quality, safety and efficacy of health products. Another key area is procurement and supply chain management, for which particular skills are required to forecast needs, procurement processes, warehousing and distribution, stock management and maintenance (of medical devices), for example.

Information is essential for decision-making, monitoring policy implementation and establishing accountability. Monitoring access to health products is a complex endeavour that requires gathering information from multiple sources and ensuring the interoperability of various data collection systems. Within the framework of the Health Data Collaborative, WHO is supporting countries to improve their capacity to collect, organize, analyse and use quality data for policy-making, to create standards of reference for data compatibility and to advance the harmonization of data collection tools. WHO is working to develop an agreed list of indicators across all areas involved in improving access to quality health products. This list will contribute to the measurement of a SDG indicator on access to medicines, also under development. Activities provided in the road map include support for platforms in collecting a wide variety of data such as the Global Observatory on Health Research and Development, the Global Surveillance and Monitoring System for substandard and falsified medical products, the shortages notification system and the global programme on surveillance of antimicrobial consumption.

[20] A fair price is one that is affordable for health systems and patients and at the same time provides sufficient market incentive for industry to invest in innovation and the production of medicines.
[21] MI4A: Market Information for Access to Vaccines (http://www.who.int/immunization/programmes_systems/procurement/v3p/platform/en/, accessed 11 November 2018).
[22] Working for health and growth: Investing in the health workforce. Report of the High-Level Commission on Health Employment and Economic Growth. Geneva: World Health Organization; 2016 (http://www.who.int/hrh/com-heeg/reports/en/, accessed 11 November 2018).

Strategic areas and activities

For further details, each strategic areas and related activities, as presented in the structure of the roadmap section, is developed in the original, long version of this briefing[23].

How WHO will collaborate and measure progress on access to health products

As described in the document Towards access 2030,[24] the key stakeholder groups with whom collaboration will be strengthened and sustained include UN and other international partners, research institutions and academia, donors, civil society and the private sector. Collaboration with each provides an opportunity for WHO to synergize action and to be a more active and effective partner. Collaboration with UN and other international agencies will focus on optimizing information flows, sharing information and implementing mechanisms to ensure coordination in the field. Collaboration with academia will continue to leverage each entity's comparative advantages so as to achieve faster and better impact on access, while collaboration with donors will focus on enhanced advocacy to enable funding partners to contribute to the agenda described in this road map. The growing importance of civil society's role in influencing health leads WHO to engage civil society in policy and advocacy processes and help channel their expertise and experience in countries. Lastly, WHO will seek to engage with the private sector to find solutions to health challenges, such as the need for public health-driven research and development, pricing and affordability of health products, and leveraging innovative technologies and solutions for health.

WHO's impact framework for the GPW and its targets and indicators are aligned with the SDGs and Health Assembly-approved resolutions and action plans. The present road map aligns with the 13th GPW's outcome 1, with a focus on primary health care measured with a universal health coverage index; it also considers the other outcomes ensuring its indirect contribution to reaching them. The road map will be guided by the 13th GPW's related high-level targets/indicators and those that may be developed to complement them.

ACTION BY THE HEALTH ASSEMBLY

The Health Assembly is invited to note the draft road map for access to medicines, vaccines and other health products, 2019–2023, as contained in the Annex.

Implication for the European Region

WHO Europe is already taking concrete actions in most of the activities outlined in the Road Map for Access. WHO Europe supports currently the self- assessment of countries regulatory function and benchmarking of the National Regulatory Authorities (NRA) have taken place in Kazakhstan and Serbia in 2018. These assessments also lead to creation of an Institutional Development Plan to strengthen their regulatory functions and WHO Europe is providing technical guidance to facilitate its implementation. Further support is provided in Georgia and Kyrgyzstan through a full revision of the regulatory framework. Tajikistan has also requested support in this area. Early 2019, a WHO conference was held on regulatory activities for Balkan countries.

[23] EB 144/17 http://apps.who.int/gb/ebwha/pdf_files/EB144/B144_17-en.pdf (accessed December 12th)

[24] WHO Essential medicines and health products. Annual Report 2017. Towards Access 2030. Geneva: World Health Organization; 2018. Available at: http://apps.who.int/iris/handle/10665/272972 (accessed 11 November 2018).

WHO Europe contributes to the expansion of the prequalification program to eastern Europe and central Asia manufacturers so to foster access to affordable and quality assured medicines and diagnostic technologies. Two international conferences were held in recent times in Minsk, Belarus, on this topic.

Albania, Armenia, Kyrgyzstan are currently included in trainings and capacity building activities to develop and reinforce of pharmacovigilance functions. Trainings and policy dialogues on the enforcement of TRIPS flexibilities were held in Ukraine and the Republic of Moldova and technical guidance was given on the revisions of patent laws. WHO/Europe has supported the installation and training of Essential Medicines List committees in countries of the region: Greece, Kosovo, Kyrgyzstan, the Republic of Moldova and Ukraine. The office is also conducting a study in collaboration with PAHO and EMRO on the role of HTA in middle income countries.

From 25 to 27th June 2019, WHO EURO will co-organize with UNICEF in Copenhagen the second edition of the Medicines Practitioners Procurement' s exchange forum as part of the UN Issue Based Coalition (IBC) on Health activities. The Forum will convene public procurement practitioners from the European Region, but also from other region, s to exchange knowledge, practical experiences & challenges, best practices in procurement of HIV, TB- and hepatitis-related medicines as well as NCD medicines and medical devices. Other international partners as UNDP, UNFPA, GFATM, GDF, MPP and MSF are actively supporting the organization of this event.

In addition, a joint UNICEF, UNFPA & WHO consultation meeting will be organised in December 2019 in UN City in Copenhagen with manufacturers and suppliers of contraceptive devices, in vitro diagnostic products, vaccines, finished pharmaceutical products, active pharmaceutical ingredients and vector control products, advocating for WHO prequalification of these products and combining efforts to bring needed health products to vulnerable populations.

WHO Europe is conducting a study on cross country voluntary collaboration to improve access to medicines. The first results of the study were presented already during various workshops but the final paper summarizing best practices and normative guidance to guide MS to conduct regional approaches is under development.

Annually WHO Europe organises a summer school on pricing and reimbursement policies-, with the support of the WHO collaborating centre sited in Vienna. A network of competent authorities on pricing and reimbursement in CIS countries was established in 2017; direct technical assistance for the introduction of pricing and reimbursement policies was also provided in Kyrgyzstan and Ukraine.
To help Member States further to maintain sustainable access to affordable pharmaceuticals and medical devices, the Regional Office organized several training events 2018 including on strategic procurement and enhancement of negotiations skills of public sector medicines procurement staff from more than 20 countries in the Region.

Finally, numerous publications were released in recent times on this question, among others a recent WHO report on "medicines reimbursement policies in Europe" and a summary on "access to HIV, hepatitis and TB medicines in eastern Europe and central Asia" The latter highlights challenge that countries will face when graduating from GFATM support which 12 countries in the Region will go through in the next few years..

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

Antimicrobial resistance

Document A72/18

The Executive Board, at its 144th session, considered an earlier version of this report. The current version of the report reflects the latest developments and takes account of Member States' comments.

This report provides an update on the implementation of resolution WHA68.7 (2015), the global action plan on AMR and UNGA resolution 71/3 (2016) "Political declaration of the high-level meeting of the General Assembly on AMR", and key ongoing challenges and emerging threats. It provides a summary of WHO's actions at all three levels of the Organization, as well as through collaboration with FAO, OIE and other stakeholders.

Country-level progress in combating AMR

Based on guidance and tools jointly developed by WHO/FAO/OIE, Member States have developed and started implementing their national action plans for combating AMR. As of January 2019, 117 countries have finalized their national action plans and another 62 are in the process of developing theirs; these countries represent all regions and all levels of income and development.

Since 2016, an annual country self-assessment survey has been jointly administered by WHO/FAO/OIE. In 2018, 154 out of WHO's 194 MS, representing 91% of the world's population, responded to the survey.
Nearly 40% have progressed to implementing their action plans after receiving government approval, establishing monitoring arrangements, engaging all relevant sectors and identifying specific funding for implementation. Responses from the surveys are published in an open-access database.

Key findings of the AMR country self-assessment survey 2017-2018 include:

- Some 50% of responding countries (53) have established a multisectoral AMR working group with representatives from the human, animal and plant health, food safety, food production and environment sectors;
- 125 countries have conducted awareness campaigns about the risks of AMR in human health, but more efforts are needed on animal and non-human health sectors. Although 105 countries (68%) report that they have a national AMR surveillance system, not all of these countries are currently enrolled in the Global Antimicrobial Surveillance System (GLASS);
- although 105 (68%) countries report that they have a national antimicrobial resistance surveillance system for some common bacterial pathogens in humans, not all are currently enrolled in the Global Antimicrobial Surveillance System (GLASS); close to 40% of countries are conducting surveillance in the animal and food sectors;
- a total of 90 countries report that they have a national infection prevention and control programme for health care facilities, with national guidelines; in the animal and food production sectors, far fewer countries report national programmes for infection prevention and control;
- While 123 countries have policies requiring a prescription for antibiotic use in humans, 64 countries have limited the use of critically important antimicrobials (human and animal) for growth promotion in animal food production.

Although these self-assessment surveys have limitations, when their results are compared with data from the Joint External Evaluations of the International Health Regulations (2005) conducted between 2016 and 2018, the scores are broadly consistent.

Progress in implementing the global action plan

Objective 1. Improve awareness and understanding of AMR through effective communication, education and training. Among the events organised, the World Antibiotic Awareness Week has been a major campaign in all regions (in 2017, 131 countries participated). Technical consultations with behavior change experts to share knowledge on changing behavior around the use of antibiotics were held in 2017 and 2018, resulting in country-based pilot projects to be developed in 2019. WHO is also liaising with FAO and OIE to develop, adapt and disseminate cross-sectoral educational materials that address AMR at the human–animal interface.

Objective 2. Strengthen the knowledge and evidence base through surveillance and research. Launched in October 2015, GLASS provides a standardized approach to the collection, analysis and sharing of AMR data by countries for selected bacteria. The second annual GLASS report was issued in January 2019, including information from 68 enrolled countries as at 31 July 2018, (10 low-income countries, 16 lower-middle-income countries, 15 upper-middle-income countries, 27 high-income countries). Sixty-seven countries provided information on their national antimicrobial resistance surveillance systems, while 48 also provided antimicrobial resistance data. Compared with 2017, GLASS has seen a 57% increase in country enrolment in 2018 and almost twice the number of countries has submitted antimicrobial resistance data. The GLASS Emerging Antimicrobial Resistance Reporting (GLASS-EAR) component was launched in 2018 to support the detection, early warning and risk assessment capacities of national antimicrobial resistance surveillance programmes and to strengthen global health security.

In 2019, GLASS will be revised. New targets and datasets, including data from molecular testing, will be included, while emerging threats will be addressed in a more comprehensive manner.

WHO is also engaged in developing, promoting and coordinating the implementation of a global protocol for integrated surveillance of antimicrobial resistance in humans, the food chain and the environment, using appropriate indicators WHO, in collaboration with other relevant United Nations agencies, is engaged in improving the understanding of the role of inadequate water, sanitation and hygiene (WASH) facilities and environmental contamination with residues and resistant bacteria as drivers of antimicrobial resistance and its impact on health. In this regard, WHO supports the Global Sewage Surveillance Project and the publication of results. Technical assistance is also being provided to facilitate the integration of environmental surveillance modalities into GLASS.

Objective 3. Reduce the incidence of infection through effective sanitation, hygiene and infection prevention measures. Prevention of infections is critical to reducing the need for antibiotics and controlling the spread of resistant microorganisms. Over the last year, intensive support has been provided through collaboration across the three levels of WHO to more than 40 countries for the assessment and implementation of core components of infection prevention and control WHO is providing technical support on strengthening environmental components within national action plans for tackling AMR, with a focus on monitoring and strengthening the availability of basic WASH services in health care facilities, wastewater treatment, health care waste management and surveillance.

Based on the WHO/UNICEF Joint Monitoring Programme Report in 2017 on WASH services in health care facilities and other studies, the linkage between WASH and antimicrobial resistance has been highlighted in the new WHO WASH Strategy 2018–2025. There will be greater collaboration with UNEP and other United Nations agencies on these issues.

Objective 4. Optimize the use of antimicrobial medicines in human and animal health. In its most recent Model List of Essential Medicines (2017), WHO adopted a new classification for antibiotics, comprising three groups:

- Access antibiotics (for common infections): available at all times, affordable and quality-assured;
- Watch antibiotics: recommended only for specific, limited indications;
- Reserve antibiotics: for situations when all alternative antibiotics have failed.

The first WHO Report on Surveillance of Antibiotic Consumption (November 2018) presents data on the consumption of systemic antibiotics from 65 countries and describes WHO's approach to monitor antimicrobial consumption, the methodology for data collection and the challenges and future steps in monitoring antimicrobial consumption. WHO has developed a toolkit to implement antimicrobial stewardship in hospitals, covering the core elements needed to enable stewardship activities, options for hospital interventions and education and training.

During a second consultation with MS, relevant international organizations and non-State actors (October 2018), it was noted that in order to advance the establishment of a Global Framework for Development and Stewardship to Combat AMR, MEMBER STATES additional consultations are needed. WHO updated and published the WHO list of Critically Important Antimicrobials for human medicine and will also disseminate guidelines for the appropriate use of the antimicrobials important for human medicine in food producing animals.

Objective 5. Develop the economic case for sustainable investment that takes account of the needs of all countries and increases investment in new medicines, diagnostics tools, vaccines and other interventions. The Global Antibiotic Research and Development Partnership Aid Member States to develop new treatments for bacterial infections. The Partnership has launched programmes addressing sepsis in newborns through an observational study in 11 countries. WHO published:

1) a global priority list of antibiotic-resistant bacteria that pose the greatest threat to human health, to guide research, discovery and development of new antibiotics and is a factor in prioritizing new vaccine development,
2) a comprehensive analysis of the clinical antibacterial and anti-tuberculosis pipeline reviewing all new antibacterial treatments currently developed and assesses to what extend they are expected to have some activity against at least one WHO priority pathogen;
3) is encouraging the development of new diagnostics tools relevant to antimicrobial resistance.
4) is formulating models that will enable evidence-based prioritization of research into and the development of new vaccines to address pathogens associated with antibiotic resistance, as well as those associated with high levels of antibiotic consumption.

AMR: Tuberculosis, malaria, HIV, neglected tropical diseases and sexually transmitted infections

Tuberculosis. According to the Global Tuberculosis Report 2018, drug-resistant tuberculosis continues to be a public health crisis. In 2017, 558 000 people developed tuberculosis that was resistant to rifampicin, the most effective first-line drug, of whom 82% had multidrug resistant tuberculosis and

8.5% extensive multidrug resistant tuberculosis. In August 2018, a rapid communication on key changes to recommendations for the treatment of multidrug tuberculosis was issued by WHO.

Malaria. The Global Technical Strategy for Malaria 2016–2030 calls on countries and global malaria partners to monitor the efficacy of antimalarial medicines so that the most appropriate treatments can be selected for national policies. WHO continues to update the Global database on antimalarial drug efficacy and resistance database.

AIDS. The elimination of AIDS as a public health threat calls for expansion of the coverage and quality of treatment. This expansion needs to be balanced by efforts to ensure that the risks and impact of HIV drug resistance (HIVDR) are minimized. WHO's HIVDR report 2017 highlights concerning trends. The Global Action Plan on HIV drug resistance 2017–2021 outlines key actions for country and global stakeholders to prevent, monitor and respond to HIV drug resistance and to protect ongoing progress towards achieving the global targets for epidemic control by 2030. In July 2018, WHO released a report summarizing progress and remaining challenges in implementing the Global Action Plan achieved during the first year (2017 to 2018).

Tropical diseases. Established in 2011, the Working Group on Monitoring of Neglected Tropical Diseases Drug Efficacy is expected to eventually contribute to the emergence of resistance to anthelminthic medicines. The Working Group's seventh meeting in 2018 articulated such concerns in relation to resistance to treatment for soil-transmitted helminthiases.

Sexual transmitted infections. Each year, 357 million new infections occur of the following four curable sexually transmitted infections. Resistance of sexually transmitted infections to antibiotics has increased rapidly in recent years. WHO has issued new treatment guidelines for syphilis, gonorrhoea and chlamydia to address the problem of resistance to antibiotics.

Multisectoral collaboration: FAO, OIE, WHO (the Tripartite)

The members of the Tripartite (FAO, OIE, WHO) have worked together since 2010. To formalize and strengthen the collaboration, the heads of agencies of the Tripartite signed a memorandum of understanding in May 2018. This was followed by the development of a joint Tripartite workplan for 2019–2020, which has five focus areas and about 20 specific outputs. The joint workplan also recognized the need for the UNEP to join the collaboration (known as "Tripartite Plus"). To finance the implementation of the joint workplan for 2019–2020, the Tripartite Plus is exploring the establishment of a trust fund mechanism. Without sustained and reliable additional resources, the majority of the outputs listed in the workplan cannot be effectively implemented.

WHO and the Tripartite support the work of the WHO Secretariat in managing the activities of the ad hoc inter-agency coordination group established by United Nations General Assembly resolution 71/3 on antimicrobial resistance.

In 2019, the Tripartite Plus will work together to deliver the first biennial global AMR report, as well as contribute to the Secretary General's report to the UN General Assembly on the implementation of the commitments made in the high-level meeting on AMR.

Ongoing challenges

The challenges to the effective implementation of national action plans to combat AMR are:

- Prioritization and implementation.
- Multisectoral working and the One Health approach.
- Monitoring. A global monitoring and evaluation framework was publishes in 2018.
- Maintaining country-level political buy-in.
- Enhancing civil society, private sector and stakeholder engagement.

Emerging threat

One of the most significant threats to public health associated with AMR is the carbapenem-resistant gram-negative bacteria. These bacteria are very difficult to treat due to extremely limited remaining treatment options. They also have the potential for widespread transmission of resistance via mobile genetic elements. Addressing this emerging threat will require that AMR be considered a cross-cluster platform, as highlighted in the Thirteenth General Programme of Work, 2019–2023. This threat necessitates the engagement and coordination of relevant departments within WHO, at all three levels, including by strengthening health system in Member States in the context of UHC, strengthening core country capacity to identify and deal with emerging high-threat infectious as a health emergency, and addressing the social and environmental determinants of health.

ACTION BY THE HEALTH ASSEMBLY

The Health Assembly is invited to adopt the draft resolution recommended by the Executive Board in resolution EB144.R11.

DRAFT RESOLUTION EB144.R11

The Executive Board recommends to the Health Assembly the adoption of a resolution welcoming the new tripartite agreement on antimicrobial resistance and encouraging WHO, FAO, OIE and UNEP to establish clear coordination and align reporting to their governing bodies. The resolution urges Member States to remain committed to the One Health approach and increase efforts to implement actions to attain the objectives of the global action plan and strengthen national plans; to enhance the prudent use of antimicrobials and enhance collaboration with all sectors toward combatting antimicrobial resistance; conduct post market surveillance of antimicrobials and provide technology transfer on voluntary and mutual agreed terms to control and prevent antimicrobial resistance. The resolution invites all partners and stakeholders to support Member States, coordinate and increase efforts of multistakeholder coordination to address antimicrobial resistance in a One Health approach and consider mainstreaming activities in existing international development financing. The Director General is requested to accelerate the implementation of the global action plan on antimicrobial resistance, enhance support an technical guidance to countries in collaboration with relevant UN agencies, including in developing integrated surveillance systems and mobilizing predictable and sustainable funding including through collaboration with the World Bank, OECD and other relevant partners; to keep Member States informed on WHO's work with the tripartite and UNEP and consult Member States on the global development and stewardship framework; to facilitate the development of a process to allow Member States to consider the Secretary General's report requested in UNGA resolution 71/3 (2016); to maintain and update WHO list of Critically Important Antimicrobials for human medicine and to submit consolidated biennial reports on the implementation of this resolution and WHA68.7 (2015) to the 74th,76th,78 WHA.

Implication for the European Region

WHO/Europe coordinates activities with the Regional Offices of FAO and OIE to support Member States with national action plan development and implementation, and to provide campaign materials and messages for a One Health approach. Sub-regional Tripartite meetings were held in Bishkek, Kyrgyzstan in 2017 and in Almaty, Kazakhstan in 2018. Good progress is being made at country level in the European region on the implementation of each of the objectives of the European and global AMR action plans, which is apparent from the results of the 2nd global self-assessment survey of 2017-2018. Fifty out of 53 Member States of the European region responded to the survey. Results can be

reviewed through an open-access database on the WHO website: https://www.who.int/antimicrobial-resistance/global-action-plan/database/en/.

There is a long tradition of awareness raising for AMR in Europe, starting with the European Antibiotic Awareness Day in 2008, which WHO/Europe joined and expanded throughout the region since 2012. In 2018, WHO/Europe and the European Center for Disease Prevention and Control (ECDC) launched a joint media toolkit, as in previous years, and made awareness campaign materials available for all 53 Member States. During the 2018 World Antibiotic Awareness Week, WHO/Europe highlighted the One Health approach to combating AMR, together with the Regional Offices of FAO and OIE, with joint messages and materials.

There is close collaboration between WHO/Europe and ECDC on surveillance of antimicrobial medicines consumption and resistance. In 2018, a joint ECDC–WHO/Europe meeting was organized in Copenhagen, Denmark, of the Antimicrobial Resistance, Healthcare-Associated Infections and Antimicrobial Medicines Consumption (ARHAI) networks of the European Region. The 3-day meeting was attended by ca. 300 delegates from 47 European Member States, as well as representatives from the EC, WHO HQ and WHO Country Offices (10). Currently, surveillance data is gathered from 47 out of 53 European Member States on antimicrobial medicines consumption and from 40 Member States on antimicrobial resistance through the combined surveillance networks of ECDC (ESAC-Net and EARS-Net) and WHO/Europe (WHO AMC network and CAESAR). In 2020, ECDC and WHO/Europe will publish a joint report on antimicrobial resistance surveillance in the European region. ECDC and WHO/Europe work closely together with GLASS, hosted at WHO headquarters, to share experience, expertise and data, and have put procedures in place to avoid the additional burden of double-reporting for Member States of the European region that are part of regional surveillance networks and wish to enrol in GLASS.

Efforts to strengthen Member States capacity in catalysing evidence-informed policy change and action related to high-priority AMR issues, were initiated in 2017 through the establishment of a strategic partnership between the regional AMR Programme and the WHO Evidence-informed Policy Network (EVIPNet) Europe. This partnership supports country-led processes to develop sound evidence briefs for policy on AMR, through the provision of technical advice and quality assurance for outputs and assists countries in the development of strategies for dissemination and policy outreach. It has been suggested to replicate this innovative approach in other WHO Regions to accelerate and scale-up evidence-informed efforts against the growing public health threat of AMR.

Despite steady progress, much work still needs to be done throughout the region. Country responses of the self-assessment survey indicated that 16 countries of the European region did not have or were still developing a multisectoral AMR action plan in May 2018. Though a number of countries have completed and adopted their national action plans since then, collaboration across sectors remains a challenge and many countries indicated that they have no formal or functional multi-sectoral governance or coordination mechanism. The training of healthcare workers and the veterinary workforce in AMR-related subjects still needs to be institutionalized in many countries. Policies for infection prevention and control and antimicrobial stewardship need to be strengthened and enforced in healthcare facilities across the region.

As most European countries have gone through the planning process of a national action plan, involving all relevant sectors and defining strategic objectives and goals for the coming years, WHO/Europe and partners are ready to support the implementation of action plans. Therefore, in addition to strengthening national surveillance capacities, the focus of support activities will be on the implementation of infection prevention and control programmes in healthcare facilities, the introduction of the AWaRe

classification and promotion of antimicrobial stewardship to improve prescription habits, development and dissemination of educational and awareness materials, as well as driving behaviour change through targeted campaigns.

Prevention and control of noncommunicable diseases (NCDs)

Document A72/19

This document is an update of the document EB144/20 presented and discussed during the last 144th Executive Board in January 2019. The updated report contains additional text in Annex 1 (all paragraphs), Annex 2 (paragraphs 1–2, 5–13, 20 and 25) and Annex 5 (paragraphs 4 and 5), and two new annexes (Annex 6 and 7) in response to comments received from Member States. Document EB144/20 Add.1 has been integrated into this document as Annex 4.

The report is submitted in response to resolution WHA71.2 (2018), which "requests the Director-General to report to the Seventy-Second World Health Assembly, through the Executive Board, on the outcomes of the third High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases and its follow-up"

Outcomes

The Political Declaration of the third High-level Meeting entitled "Time to deliver: Accelerating our response to address NCDs for the health and well-being of present and future generations" was accepted in the opening segment of the High-level Meeting and adopted by the General Assembly on 10 October 2018. The overall theme of the high-level meeting was "Scaling up multi-stakeholder and multisectoral responses for the prevention and control of non-communicable diseases in the context of the 2030 Agenda for Sustainable Development". The plenary segment of the third high-level meeting was addressed by 11 Heads of State, 12 Heads of Government, 55 Ministers, four Vice-Ministers and two senior representatives of Member States, representing a total of 84 Member States.

The Political Declaration recognizes (paragraph 4) that the progress and the investment made are inadequate to meet target 3.4 of the Sustainable Development Goals 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. Moreover, it broadens the scope of the commitments from the four major NCDs and four main risk factors (the so-called "4 x 4 NCD agenda") to include commitments to reduce air pollution and promote mental health and well-being (the so-called "5 x 5 NCD agenda").

The Political Declaration includes also 14 new commitments (Annex 1) and requests (paragraph 50) the Secretary-General, in consultation with Member States, and in collaboration with WHO and relevant funds, programmes and specialized agencies of the UN system, to submit to the General Assembly, by the end of 2024, a report on the progress achieved, in preparation for a fourth high-level meeting to be held in 2025. In preparation for the fourth high-level meeting on the prevention and control of non-communicable diseases in 2025, the Secretariat will convene global meetings of national NCD directors and programme managers on a regular basis.

To support Member States in realizing their commitment, in paragraph 21 of the Political Declaration, to promote fiscal measures, as appropriate, aiming at minimizing the impact of the main risk factors for NCDs, and promote healthy diets and lifestyles, the Secretariat has provided in Annex 2 a note on current scientific knowledge, and a review of international experience for one of the three fiscal measures included in the set of best buys and other recommended interventions.

On the margins of the third High-level Meeting, the WHO Secretariat sponsored 12 side events and released the following global goods: WHO non-communicable diseases country profiles 2018; WHO Global status report on alcohol and health; WHO SAFER alcohol control initiative; WHO Global Initiative for Childhood Cancer; WHO tool to highlight investment opportunities for preventing and treating NCDs; WHO/World Obesity report on taking action on childhood obesity; Accountability consortium of institutions to measure the contribution of the food and non-alcoholic beverage industries towards target 3.4 of the Sustainable Development Goals (see Annex 2); Worldwide trends in insufficient physical activity from 2001 to 2016; WHO-led United Nations Inter-Agency Task Force on NCDs policy briefs on what government ministries need to know about NCDs.

Where do we stand today?

WHO estimates that, in 2016, 15.2 million people between the ages of 30 and 70 years died from noncommunicable diseases. The total number of these premature deaths is increasing owing to population growth. Globally, the probability of dying from cardiovascular disease, cancer, diabetes and chronic lung disease between the ages of 30 and 70 years continues to decline from 22% in 2000 to 18% in 2016. However, this rate of decline is insufficient to meet Sustainable Development Goal target 3.4. There is slow progress towards most of the voluntary global targets for 2025 for the prevention and control of noncommunicable diseases, with the exception of the prevalence of obesity and diabetes.

Follow up

To support governments in fulfilling their commitments made in the 2018 Political Declaration on NCDs and accelerate their response over the next 3–5 years, the WHO Secretariat is working to identify a specific subset of "NCD accelerators" within the overall set of interventions included in the WHO list of best buys and other recommended interventions for the prevention and control of NCDs.

Moreover, to provide support to Member States in their efforts to implement paragraph 44 of the Political Declaration, the Secretariat will convene the following dialogues: every six months with representatives from international business associations representing the food and non-alcoholic beverage industries, pharmaceutical industries, and sport industries; and every 12 months with representatives of the economic operators in the area of alcohol production and trade. The dialogues will focus on specific "asks" from the Secretariat to relevant private sector entities.

To fast-track health outcomes in specific areas in selected countries, the Secretariat will scale up four special initiatives launched in 2018: (a) Bringing mental health out of the shadows (London, 2 May 2018); (b) the Global Hearts Initiative to prevent premature deaths from noncommunicable diseases, including the global initiative to eliminate industrially-produced trans-fat from the global food supply (Geneva, 14 May 2018); (c) cervical cancer elimination (Geneva, 20 May 2018); and (d) the Global Initiative on Childhood Cancer (New York, 27 September 2018). These initiatives provide opportunities for synergy, as do existing mechanisms to forge multi-stakeholder partnerships and alliances with civil society and the private sector.

To fast-track health outcomes in specific areas in selected countries, WHO will scale up four special initiatives launched in May 2018: (a) Bringing mental health out of the shadows; (b) Global Hearts Initiative to prevent premature deaths from NCDs, including the global initiative to eliminate industrially-produced trans-fat from the global food supply; (c) Cervical cancer elimination.; and (d) the Global Initiative in Childhood Cancer.

Political championing at the highest levels of government to address NCDs and mental health is viewed as invaluable in advancing policies on these matters. In that regard, a number of Heads of State and

Government have emphasized the value of promoting informal collaboration among interested counterparts in order to intensify their efforts over the next three to five years to put their countries on a sustainable path to reaching Sustainable Development Goal target 3.4 by 2030.

Pursuant to paragraph 50 of the 2018 Political Declaration on NCDs and building on decision EB136(13) (2015), the Secretariat has set out in Annexes 4 and 6 how WHO will report in 2024 to the United Nations General Assembly on the national commitments included in the 2011 Political Declaration on NCDs, the 2014 outcome document on NCDs and the 2018 Political Declaration on NCDs, using existing survey tools and taking into account existing indicators at the global and regional levels. Annex 7 gives an analysis by the Secretariat of implementation of the WHO framework for national NCD surveillance, the lessons learned, and future support to be provided.

Pursuant to paragraph 31 of the 2018 Political Declaration on NCDs, WHO and partners convened the first Global Conference on Air Pollution and Health on 29 October–1 November 2018 to raise awareness and to share information and tools.

Pursuant to paragraph 8 of resolution 2018/13 of the United Nations Economic and Social Council, WHO will, through the WHO-led United Nations Inter-Agency Task Force for the Prevention and Control of Noncommunicable Diseases, develop new partnerships to achieve Sustainable Development Goals target 3.4 on NCDs and mental health with Governments, nongovernmental organizations, relevant private-sector entities, academic institutions and philanthropic foundations.

Statutory reporting requirements

In response to paragraph 15 of the terms of reference of the Global Coordination Mechanism on the Prevention and Control of Noncommunicable Diseases, the proposed workplan for the Mechanism, covering the period until the end of its lifespan, is submitted for consideration by Member States. The proposed workplan takes into account the recommendations of the preliminary evaluation of the Global Coordination Mechanism, as well as the outcomes of its general meeting held in Geneva on 5 and 6 November 2018.

Evaluations

In accordance with paragraph 60 of the Global Action Plan for the Prevention and Control of Noncommunicable Diseases 2013–2020 and in conformity with the evaluation workplan for 2018–2019, the Secretariat will convene a representative group of stakeholders, including Member States and international partners, that will work during the second quarter of 2019 to conduct a mid-point evaluation of progress on the implementation of the Global Action Plan. The results will be reported to the Seventy-Third World Health Assembly, through the Executive Board. The evaluation has been delayed due to financial constraints.

ACTION BY THE HEALTH ASSEMBLY

The Health Assembly is invited to note the report.

Implication for the European Region

Numerous Resolutions in the WHO European Region were endorsed by the Regional Committee related to this topic in the previous years.

The WHO European Region is likely to achieve SDG target 3.4 earlier than 2030 and will most probably exceed it. Furthermore, within the WHO European Region implementation of progress monitoring indicators has improved significantly over the last two years. Between 2015 and 2017 the proportion of full implementation of indicators in countries increased on average from 34% to 42%.

Many of the side events at the UNHLM3, including those sponsored by WHO Secretariat, were co-sponsored by Member States from the WHO European Region and showcased their remarkable leadership and achievements: for example 'Tobacco Control at the heart of the Preventing NCDs (Netherlands), Food Systems Approaches to the Prevention of NCDs (Norway, Sweden), Time to Act on Global Mental Health: Building Momentum on Mental Health in the SDG Era (Belgium, Netherlands), Addressing Childhood Obesity in Europe (Portugal), The Power of Partnerships to Implement the Commitments Made in the 2018 Political Declaration on NCDs (Israel), Alcohol, NCDs and Sustainable Development: Where do we stand and where do we go? (Slovenia, Sweden, Estonia). Russia and Finland are in addition co-chairing the HLC on NCDs.
The WHO European Regional Office convened a high-level technical meeting on NCDs during 9-10 April 2019 as part of its follow up to the UNHLM3, and as a review of progress since the 'Ashgabat Declaration on the Prevention and Control of NCDs in the Context of Health 2020' in 2013. This was hosted by the Government of Turkmenistan with the participation of 44 Member States, UN and international agencies, non-state actors and technical experts.

Expansion of the main NCD risk factors and diseases to also include air pollution and mental health echoes the Action Plan for the prevention and control of NCDs in the WHO European Region endorsed in 2016 which already included these. There is a Mental Health Action Plan for the WHO European Region and air Pollution and health is a well-established priority in the European Environment and Health Process - an important inter-sectorial platform to facilitate action in Member States, directly relevant to addressing the NCD burden. In the recent Ministerial Declaration (Ostrava, 2017) a list of potential actions was put forward to reduce ambient and indoor air pollution to better protect health; these actions, framed into national portfolios of action are a suitable mechanism to facilitate inter-sectorial action to act upon this risk factor towards reducing the NCD burden; continued implementation of the tools to support decision making, such as AirQ+ (to quantify the health impacts of AP as well as the health gains of reducing AP), and sustained efforts to strengthen the capacities in the health sector will also contribute.

Ending tuberculosis

Document A72/20

The Executive Board, at its 144th session, considered an earlier version of this report.

The 77th WHA adopted the global strategy and targets for tuberculosis prevention, care and control after 2015,[25] known as the End TB Strategy, with the goal of ending the global tuberculosis epidemic. The 2030 Agenda for Sustainable Development has the same target.[26] The End TB Strategy high-level targets include the reduction in the number of deaths due to TB by 90% and the TB incidence rate by 80% compared with 2015, between 2016 and 2030. A report submitted to the 70th WHA in May 2017

[25] Resolution WHA67.1 (2014).

[26] Target 3.3 (By 2030, end the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases and combat hepatitis, waterborne diseases and other communicable diseases of the Sustainable Development Goals.

on the progress made in implementing resolution WHA67.1,[27] cautioned that, on the basis of national data reported to WHO, current actions and investments are falling far short. It signals that the world is not on track to end the epidemic by 2030[28], and that some high TB-burden countries were able to drive down incidence and/or mortality at a faster rate, suggesting that greater progress is possible, even in resource-constrained countries.

TB is the leading cause of death worldwide from a single infectious agent, the 10th global cause of death, the leading cause of death of people with HIV infection, and a major cause of death due to antimicrobial-resistant infections. In 2017, TB was responsible for an estimated 1.3 million deaths and additional 300 000 deaths among HIV-positive people worldwide. An estimated 10.0 million people globally fell ill with TB in 2017 within which 3.6 million were not included in national TB case notification reports and may therefore have missed out on being diagnosed and receiving quality care. Globally, TB mortality and incidence rates are decreasing far too slowly, at 3% and 2%, respectively each year. By 2020, these rates need to reach 4–5% and 10% to meet the targets of the End TB Strategy. The ongoing burden of and poor access to treatment for drug-resistant TB represents a public health crisis and health security threat. In 2017, about 558 000 people were in need of treatment for drug-resistant TB, but only 1 in 4 of them were enrolled in care, and treatment success globally remains low at only 55%, versus a target of 90%.

In December 2016, the UNGA decided to hold a high-level meeting in 2018 on the fight against TB.[29] WHO, jointly with the Government of the Russian Federation, organized the first WHO global ministerial conference on "Ending tuberculosis in the sustainable development era: a multisectoral response", in November 2017. The resulting Moscow Declaration to End TB set out commitments notably: advancing the response to TB within the 2030 Agenda; ensuring sufficient and sustainable financing; pursuing science, research and innovation; and developing a multisectoral accountability framework.[30]

The Executive Board at its 142nd session in January 2018 adopted resolution EB142.R3 on preparation for the high-level meeting of the General Assembly on ending tuberculosis. In it, the Board requested the Director-General to develop, working in close collaboration with all relevant partners as recommended in the Moscow Declaration to End TB, a draft multisectoral accountability framework that enables the monitoring, reporting, review and actions needed to accelerate progress to end TB, and to submit the draft for consideration by the 71rst WHA in May 2018.

The reports outlines the outcomes of the global ministerial conference in Moscow and the work of WHO and its partners to support the General Assembly in preparing for the high-level meeting.[31] In resolution WHA71.3 (2018), the Health Assembly welcomed the Secretariat's report on a draft multisectoral accountability framework[32] and urged Member States to pursue the implementation of all the commitments. It also requested the continued development of the draft multisectoral accountability framework, and the provision by the Director General of technical support to Member States, including for national adaptation and use of the draft framework.

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[27] Document A70/38, section E.

[28] Global tuberculosis report 2018. Geneva: World Health Organization; 2018 (https://www.who.int/tb/publications/global_report/en/, accessed 26 November 2018).

[29] See United Nations General Assembly resolution 71/159 (2016).

[30] Moscow Declaration to end TB. Geneva: World Health Organization; 2017 (http://www.who.int/tb/Moscow_Declaration_MinisterialConference_TB/en/, accessed 6 November 2018).

[31] Document A71/15.

[32] Documents A71/16 and A71/16 Add.1. EB144/21

The Secretariat, together with the Stop TB Partnership, supported the President of the 73rd session of the General Assembly in holding a successful interactive civil society hearing on 4 June 2018 at UN headquarters with a wide range of stakeholders in preparation for the high-level meeting, in September 2018. The Secretariat supported the two co-facilitators from Antigua and Barbuda and Japan, appointed by the President of the General Assembly, in the preparation for and the conduct of intergovernmental consultations and negotiations on the outcome document of the high-level meeting.

Outcomes

The first high-level meeting of the General Assembly on the fight against TB was held on 26 September 2018, with over 1000 participants. The theme was "United to end tuberculosis: an urgent global response to a global epidemic". It resulted in an action-oriented political declaration, which the delegations approved by acclamation and the General Assembly adopted on 10 October 2018.[33] At the meeting, statements of commitment were made by 65 high-level national representatives, including 15 Heads of State and Government. More than 100 high-level national delegations attending expressed interest in speaking. Also attending were representatives of 10 entities of the UN system and over 360 external stakeholders including representatives from affected communities and civil society, nongovernmental organizations, private sector entities, philanthropic foundations, academic institutions and other agencies.

The Heads of State and Government and representatives reaffirmed their commitment to end the TB epidemic globally by 2030 as the disease requires a comprehensive response, including towards achieving UHC, and one that addresses the social and economic determinants of the epidemic and protects / fulfils the human rights and dignity of all people. Thus, they pledged to provide leadership and to work together to accelerate collective actions, investments and innovations urgently.

Among new commitments, the declaration set numerical targets to be met by 2022:
(Paragraph 24) Commit to providing diagnosis and treatment with the aim of successfully treating 40 million people with TB from 2018 to 2022 bearing in mind varying degrees of the burden of TB among countries, and recognizing the constrained health system capacity of low-income countries, and thereby aiming to achieve effective universal access to quality diagnosis, treatment, care, and adherence support, without suffering financial hardship, with a special focus on reaching those who are vulnerable and marginalized among the 4 million people each year who have been most likely to lack quality care;

(Paragraph 25) Commit to preventing TB for those most at risk of falling ill through the rapid scaling up of access to testing for TB infection, according to the domestic situation, and the provision of preventive treatment, with a focus on high-burden countries, so that at least 30 million people receive preventive treatment by 2022, with the vision of reaching millions more, and further commit to the development and provision of new vaccines and other TB prevention strategies, and to enacting measures to prevent TB transmission in congregate settings;

(Paragraph 46) Commit to mobilize sufficient and sustainable financing for universal access to quality prevention, diagnosis, treatment and care of TB, with the aim of increasing overall global investments and reaching at least 13 billion US$ a year by 2022, according to each country's capacity and strengthened solidarity, including through contributions to the WHO as well as voluntary mechanisms; and to align within overall national health financing strategies, including by helping developing

[33] United Nations General Assembly resolution 73/3 (2018) (http://www.un.org/en/ga/search/view_doc.asp?symbol=A/RES/73/3, accessed 8 December 2018).

countries to raise domestic revenues and providing financial support bilaterally, at regional and global levels, towards achieving UHC and social protection strategies, in the lead-up to 2030;

(Paragraph 47) Commit to mobilize sufficient and sustainable financing, with the aim of increasing overall global investments to 2 billion dollars to close the estimated 1.3 billion dollar gap in funding annually for TB research, ensuring that all countries contribute appropriately to quality research and development, to support the effective implementation of recently approved health technologies and strengthen the academic, scientific, public health and laboratory capacity needed inter alia through the engagement of national, international and innovative financing mechanisms.

In addition, the political declaration included the following requests:
(Paragraph 49) Request WHO Director-General to continue developing the multisectoral accountability framework in line with WHA resolution 71.3 and ensure its implementation no later than 2019;
(Paragraph 52) Request the Secretary-General, in close collaboration with WHO Director-General, to promote collaboration and implement the present declaration, with Member States and relevant entities;
(Paragraph 53) Also request the Secretary-General, with the support of the WHO, to provide a progress report in 2020 on global and national progress, across sectors, in accelerating efforts to achieve agreed TB goals, including on the progress and implementation of the present declaration at the national, regional and global levels, which will serve to inform preparations for a comprehensive review by Heads of State and Government at a high-level meeting in 2023.

Actions being taken by the Director General

As of 2019, these efforts will be taken up as part of the 13th GPW as approved by the 71rst WHA in 2018.[34]

(a) **finalizing in 2019 the multisectoral accountability framework (MAF)**, ahead of the 72nd WHA in 2019. This process includes consultations with Member States and relevant partners. In response to resolution WHA71.3, the Secretariat is working to provide technical support for adaptation and use of the draft framework. Its 4 components are: commitments, actions, monitoring and reporting, and review. The WHO Regional Office for Europe shared available MAF information, including its draft version, with Member States in early January 2019 for their possible comments and input and similarly, encouraging external partners, including Civil Society Organizations, to provide input within the frame of a public online consultation. Furthermore a regional adaptation in order to guide EUR MS is under development, and framework of which was presented, discussed and reviewed recently at two major TB prevention and care relevant EUR events: a) at the 13th meeting of the Technical Advisory Group for Tuberculosis (TAG-TB) for the WHO European Region on 9-10 April, 2019, and b) at the 7th meeting of the Regional Collaborating Committee on accelerated response to TB, HIV and Viral Hepatitis (RCC-THV), 11 April 2019, including technical experts of various partner organizations and (ex)patient and Civil Society Organization representatives.

(b) **strengthening collaboration between all stakeholders** and implementing the political declaration, with Member States and relevant partners, with a special focus on acceleration of efforts, strengthening country capacity and multisectoral response.

(c) **continuing all WHO core functions to support delivery on commitments and impact,** including via WHO country support plans, enabling strengthened and updated national strategic plans and targets;

[34] See resolution WHA71.1

providing support to enable effective, integrated, people-centred TB prevention and care; policy revision and resource mobilization; monitoring and evaluation; and research promotion. Throughout, efforts will include enabling meaningful engagement of civil society. Underpinning this work is the updating and consolidating of technical guidance to enable rapid access to effective new tools, innovations and information on best practices. A special focus is on supporting dissemination and use of new guidelines on treatment of multidrug-resistant TB and on treatment of latent TB infection. The commitments, country progress and WHO actions will be accompanied by advocacy and communication;

(d) **supporting the Secretary-General to provide a progress report in 2020**. This includes ongoing support for the preparation of the Organization's annual global TB report. Support will also be provided to Member States to strengthen the generation, analysis and use of data that are needed to accelerate progress and measure impact. In addition, the Director-General plans to submit a report to the 73rd WHA in May 2020, through the Executive Board, on progress achieved in implementing resolution WHA67.1.

Important initiatives are under way to support accelerated implementation of actions at the country level to reach the 2022 targets and the End TB Strategy and the SDGs TB-related targets for 2030, including:
(a) A WHO flagship initiative FIND.TREAT.ALL#ENDTB launched – a joint initiative with the Stop TB Partnership and the Global Fund to Fight AIDS, Tuberculosis and Malaria. The work is complementary to bilateral support provided to Member States, and other partners are encouraged to join the initiative. It aims to provide support for scaled-up access to high-quality diagnosis and treatment for TB and multidrug-resistant TB, monitoring and evaluation, with the aim of treating 40 million people ill with TB between 2018 and 2022. The initiative was launched in March 2018. Its main focus is on the 30 highest TB-burden countries[35], and it provides support such as defining/setting targets; mobilizing resources; engaging stakeholders; scaling up testing and treatment; and measuring results and impact.
(b) A strategic initiative agreement between WHO and the Global Fund, and a related strategic initiative agreement between the Stop TB Partnership and the Global Fund are being implemented to enhance the capacity of 13 high TB-burden countries to reach ambitious targets in diagnosing and treating all persons ill with TB with a focus on groups most at risk of missing out on quality prevention and care.
(c) The Secretariat is collaborating with Unitaid to provide support to Member States: for effective introduction of innovations, including through ensuring that evidence to inform policy is generated, and effective use of WHO guidelines.
(d) High-level missions are being undertaken to support target setting, strategic planning and multisectoral actions, including with partner agencies, as well as missions of a WHO-UHC accelerator flagship initiative.
(e) In line with the research and development and innovation commitments of the political declaration, and in response to resolution WHA71.3, the Secretariat will continue the development of a global strategy for TB research and innovation. A road map has been prepared and the Secretariat has initiated consultations, including with members of the WHO Strategic and Technical Advisory Group for Tuberculosis, national TB programme managers, other officials from within and beyond ministries of health, including ministries of science and technology, and other TB research / innovation stakeholders.
(f) As a complement to these initiatives, the 4th WHO End TB Strategy Summit of the national TB programmes of the 30 highest TB-burden countries was held in October 2018 with a focus on national

[35] The 30 countries are: Angola, Bangladesh, Brazil, Cambodia, Central African Republic, China, Congo, Democratic People's Republic of Korea, Democratic Republic of the Congo, Ethiopia, India, Indonesia, Kenya, Lesotho, Liberia, Mozambique, Myanmar, Namibia, Nigeria, Pakistan, Papua New Guinea, Philippines, Russian Federation, Sierra Leone, South Africa, Thailand, Viet Nam, United Republic of Tanzania, Zambia and Zimbabwe

strategic plans and targets to be adapted and strengthened; scaled-up use of rapid diagnostic tests and TB case-finding efforts; application of new WHO guidelines; review of the draft multisectoral accountability framework and related efforts under way in establishing and/or strengthening national accountability mechanisms; and preparation of a global strategy on TB research and innovation.

The Director-General will ensure effective synergy of actions by WHO in follow-up to the high-level meeting: with those in follow-up to resolutions resulting from closely related high-level meetings of the General Assembly, including those pertaining to HIV and AIDS,[36] AMR[37] and NCDs;[38] as well as with the support being provided for preparations for the high-level meeting on UHC in September 2019.

ACTION BY THE HEALTH ASSEMBLY

The Health Assembly is invited to note the report and to provide guidance on advancing the work in support of Member States and the commitments made at the high-level meeting on ending tuberculosis

Implication for the European Region

The 65th Regional Committee has endorsed Tuberculosis action plan for the WHO European Region 2016–2020 and its resolution EUR/65/17 Rev.1. The progress report of implementation of the Action Plan was presented and endorsed at 68th Regional Committee. WHO European Region has the fastest decline in TB incidence and mortality among all WHO Regions with 5% and 10% decrease per year respectively. However, the Region has the highest rate of drug resistant TB with 20% of all patients with multidrug resistant TB in the world being from WHO European Region. WHO European Region is also the Region with increasing number of new HIV infection and TB/HIV coinfection rate. WHO/Europe supports Member States provide people-centered integrated care. WHO/Europe led the development of a **UN common position paper on ending TB, HIV and viral hepatitis in Europe and central Asia** through intersectoral collaboration, which was launched at an official side event of the TB UN High Level Meeting, addressing the three diseases jointly and efficiently, and WHO/Europe is currently operationalizing this document for full-impact and sustainable country-implementation in several Member States.

To overcome the global public health crisis of MDR-TB, in line with AMR efforts, countries are encouraged to regularly update their TB treatment guidelines and national strategic plans, through support of WHO/Europe, the regional mechanisms such as the European Green Light Committee for prevention and care (rGLC Europe) of Drug-resistant (DR) TB and European Laboratory Initiative (ELI), gradually increasing DR-TB detection rates and improving beneficial treatment outcomes, which are not yet satisfactory except for those countries which have embarked on full access to new TB treatment. Most recently updated global DR-TB WHO guidance requires rapid implementation to prevent further DR-TB development, linking with AMR teams and work at EURO.

WHO/Europe provides support to Member States to implement integrated care to address TB/HIV, Non-Communicable Diseases (NCDs), UHC, health systems, i.e. by supporting a joint TB and HIV managers meeting with resulting synergies in May 2019 and linking country level TB/HIV work further; enhancing linkages with NCD work (i.e. on migration, social determinants) expanding further joint and individual TB e-surveillance with ECDC and collaboration on UHC and Health systems strengthening through inter-divisional projects.

[36] United Nations General Assembly resolution 70/266 (2016).
[37] United Nations General Assembly resolution 71/3 (2016).
[38] United Nations General Assembly resolution 73/2 (2018).

Member States are supported in their efforts to scale up research, as guided, promoted and led by the WHO/Europe European Research Initiative on TB, which serves a platform to (a) identify TB research priorities, (b) build national counterparts capacities in TB research provision and (c) facilitates networking between them and big academia and international stakeholders. This aims to eliminate the "knowledge gap" on how to end TB in the WHO European Region.

The Regional Office in order to remove social barriers, stigma and discrimination, is promoting engagement with the communities and civil society organizations, which is supported by the WHO/Europe led the Regional Collaborating Committee on accelerated response to TB, HIV and Viral Hepatitis (RCC-THV).).

WHO/Europe is continuing its efforts to ensure sustainable financing for TB prevention and care and pursuing health and financing reforms where needed to render health services people-centred and efficient. In this aspect, the recommendations of the global/ inter-regional workshop on transitional funding 16-17 October 2018, Tbilisi, Georgia plays a critical role.

Member states are encouraged to implement the Minimum package of Cross Border TB Control and Care for WHO European Region by (i) building their capacities in bringing TB services to those vulnerable and at risks, (ii) engaging in intercountry communication on diagnosis and treatment continuity and (iii) ensure timely management of cross-border outbreaks, and WHO/Europe is providing the necessary support in this aspect.

12. Other technical matters

12.1 "Pandemic Influenza Preparedness Framework for the sharing of influenza viruses and access to vaccines and other benefits

Documents A72/21

The Executive Board, at its 144th session, considered an earlier version of this report that contained a draft decision. During the Board discussions, consensus could not be reached on the text of the draft decision. Certain paragraphs of the text remained pending, and the Board therefore adopted a decision containing a bracketed draft decision. The Board then agreed that the discussion of the outstanding paragraphs would be continued during the intersessional period. A separate report will be submitted to provide details of the outcome of the consultations.

In May 2018, the 71st WHA adopted decision WHA71(11) approving the recommendations contained in the Director-General's report on progress in implementing decision WHA70(10) (2017)[39] and requested that the final text of the analysis, requested under paragraph 8(b) of decision WHA70(10), be submitted to the 72nd WHA in 2019, through the Executive Board at its 144th session. The Director-General submits this report on implementation of the recommendations contained in decision WHA71(11).

[39] See Document A71/24, paragraph 19.

Progress in implementing decision WHA71(11)

Annex, paragraph (a)[40]: implementing the recommendations in the report of the 2016 PIP Framework Review Group[41]

The Secretariat has taken measures to implement all the recommendations in the report of the 2016 PIP Framework Review Group that are within its mandate. A tracking tool is available that provides information on the actions taken to implement these recommendations[42].

Annex, paragraph (c):[43] strengthening critical pandemic preparedness

Implementation of the high-level Partnership Contribution Implementation Plan 2018–2023 began in January 2018, focusing on 6 areas of work: laboratory and surveillance capacity-building; burden-of-disease studies; regulatory capacity-building; risk communication and community engagement; planning for pandemic product deployment; and influenza pandemic preparedness planning. In the biennium 2018–2019, the US$ 31 million budget for Partnership Contribution pandemic preparedness activities is being used to strengthen capacities in 72 countries, as well as to support regional and global preparedness and response capacity-building. Progress reports link financial and technical implementation, and include the progress made against the 31 milestones and 19 indicators established in the implementation plan. The January to June 2018 progress report describes the work carried out and achievements made in strengthening regulatory capacity and carrying out burden-of-disease studies.[44]

Progress in concluding Standard Material Transfer Agreements 2 and in the collection of annual PIP Partnership Contributions is described in the January to June 2018 progress report. Reporting on the PIP Framework is now included on the WHO Programme Budget Portal, where further details can be found.[45]

Engagement with the secretariats of the Convention on Biological Diversity (CBD) and other relevant international organizations involved in implementation of access and benefit-sharing mechanisms has continued and is ongoing. In June 2018, a workshop on facilitating access and benefit sharing for pathogens to support public health was organized by WHO in collaboration with the CBD Secretariat. The objectives were to promote awareness and coordination; to learn from countries' experience in implementing the Nagoya Protocol; and to develop preliminary considerations regarding access and benefit-sharing practices for sharing of pathogens that could support public health surveillance, preparedness and response, as well as the equity objectives of the Nagoya Protocol. The workshop brought together participants from a cross-section of technical areas, as well as from a broad variety of sectors.[46]

Annex, paragraph (d):[47] implementing the recommendations of the External Auditor

The External Auditor performed an audit of PIP Partnership Contributions funds in order to provide: assurances that WHO's Financial Regulations were appropriately applied in the use of funds and that the financial information reported was accurate and reliable; and recommendations to further increase the transparency of reporting on the linkages between expenditure and technical impact. The auditors concluded that revenues, receipts and expenditures incurred were properly accounted for and generally

[40] See decision WHA70(10), paragraph 8(a).
[41] Document WHA70/2017/REC/1, Annex 8.
[42] 2016 PIP Framework Review Group Recommendations – Draft Implementation Tracking Tool, as of 1 October 2018. Geneva: World Health Organization; 2018 (https://www.who.int/influenza/pip/2016RGRecTracking_Oct2018.pdf, accessed 10 December 2018).
[43] See decision WHA70(10), paragraphs 8(c), (d) and (f).
[44] Pandemic Influenza Preparedness Framework. Progress report, 1 January–30 June 2018. Geneva: World Health Organization; 2018:12–13 (http://www.who.int/influenza/pip/pip_progressreport_30jun2018.PDF, accessed 13 November 2018).
[45] Pandemic Influenza Preparedness (PIP) Framework (Category). Geneva: World Health Organization (http://open.who.int/2018-19/our-work/category/20/about/about, accessed 27 November 2018).
[46] For more information, see the meeting report and presentations (http://www.who.int/influenza/ABSworkshop_June2018/en/, accessed 27 November 2018).
[47] See decision WHA70(10), paragraph 8(e).

conformed to WHO's Financial Regulations and Financial Rules. The audit report[48] also contained 5 recommendations that were accepted and have been fully implemented by WHO.

Annex, paragraph (b):[49] carrying out an analysis of issues related to the sharing of seasonal influenza viruses and genetic sequence data

In decision WHA70(10), paragraph 8(b), the 70th WHA requested the Director-General to conduct a thorough and deliberative analysis of the issues raised by the 2016 PIP Framework Review Group's recommendations concerning seasonal influenza and genetic sequence data. The Secretariat collaborated with the PIP Advisory Group and representatives of the WHO Collaborating Centres for Influenza and Essential Regulatory Laboratories that are part of the Global Influenza Surveillance and Response System (GISRS) to develop the analysis in an iterative and consultative manner. The process began with development of an annotated outline, or scoping paper, of the analysis,[50] which was discussed during a consultation in November 2017 to collect the views of Member States, GISRS representatives, PIP Advisory Group members and relevant stakeholders. In April 2018, the Secretariat held an information session with the same stakeholders to provide information about the role and work of the GISRS and to preview the Director-General's draft report on progress to implement decision WHA70(10). Several fact sheets and a timeline of all events relevant to the completion of the analysis were developed and shared before the information session.
Thereafter, in September 2018, the Secretariat published the draft analysis developed using; evidence on seasonal influenza and genetic sequence data collected by the 2016 PIP Framework Review Group; the PIP Advisory Group's work on the handling of genetic sequence data of influenza viruses with pandemic potential under the PIP Framework; and the findings contained in the Secretariat's study on the public health implications of the implementation of the Nagoya Protocol.[51] Considerable input was obtained from the PIP Advisory Group and WHO Collaborating Centres for Influenza part of the GISRS, providing quantitative and qualitative data and evidence on virus and sharing of genetic sequence data and on GISRS's functions in the handling of both seasonal influenza viruses and influenza viruses with pandemic potential. The Secretariat also gathered evidence and views from Member States and stakeholders through 2 in-person consultations (November2017-October2018) and an online one (from October2017 to October2018). The draft analysis contained 3 substantive parts: (1) matters with overarching implications to the analysis; (2) seasonal influenza viruses in the context of the PIP Framework; and (3) genetic sequence data in the context of the PIP Framework. Parts 1 and 3 presented the issues at stake and contained different approaches that could be considered to address them. On 15-16 October 2018, the Secretariat held a consultation to receive views on the draft analysis; to identify potential points of convergence/divergence; and to identify potential next steps; bringing together 115 participants: Member States (37 from all WHO regions), GISRS representatives, PIP Advisory Group members and relevant stakeholders.

High-level outcomes of the consultation – sharing of seasonal influenza viruses

Participants discussed some overarching views, as outlined below.
(a) The PIP Framework is a successful instrument governing access and benefit sharing for pandemic influenza preparedness. The GISRS functions well and laboratories within it share seasonal influenza viruses in a timely manner. It is therefore important to ensure that the outcome of discussions on the scope of the PIP Framework should not negatively affect the work of the GISRS and should not reduce the value of the PIP Framework as an access and benefit-sharing instrument.
(b) Implementation of the Nagoya Protocol presents both opportunities and potential challenges for public health. Difficulties arising from compliance with domestic access and benefit-sharing

[48] Commission on Audit, Republic of the Philippines. Report of the External Auditor on the Implementation of the Pandemic Influenza Preparedness Framework – Partnership Contribution (PIP-PC). Geneva: World Health Organization; 2017 (http://www.who.int/influenza/pip/pip_audit_report.pdf?ua=1, accessed 3 December 2018).
[49] See decision WHA70(10), paragraph 8(b).
[50] Implementation of decision WHA70(10) 8(b). Scoping paper on approaches to seasonal influenza and genetic sequence data under the PIP Framework ("Scoping paper"). Geneva: World Health Organization; 2017 (http://www.who.int/influenza/pip/scopingpaper.pdf, accessed 3 December 2018).
[51] Implementation of the Nagoya Protocol and pathogen sharing: public health implications. Geneva: World Health Organization; (http://www.who.int/un-collaboration/partners/Nagoya_Full_Study_English.pdf?ua=1, accessed 9 December 2018).

requirements have had an impact on the processes of the GISRS. These issues should be addressed urgently.
Participants discussed the 4 approaches to and potential implications of expanding or not the PIP Framework to include seasonal influenza viruses described in the draft analysis.
(a) Participants underscored that discussions within the Nagoya Protocol on the criteria and process for recognizing specialized international access and benefit-sharing instruments were unlikely to be resolved quickly. Until the outcomes of this process are known, it may be difficult to identify or develop the best approach to the sharing of seasonal influenza viruses.
(b) Participants agreed on the importance and benefits of timely sharing of seasonal influenza viruses. However, there was also general agreement that the PIP Framework should not be expanded at this time.

High-level outcomes of the consultation – genetic sequence data

Participants offered different views on whether new technologies using genetic sequence data put at risk the principle of access and benefit-sharing on an equal footing for influenza viruses with pandemic potential, the severity and scope of such a risk. They agreed on the importance of maintaining trust in the PIP Framework and ensuring that its principles remain relevant in the face of technological change.

High-level conclusions of the consultation and next steps

Participants encouraged the Director-General to identify actionable items that could help to address seasonal influenza viruses and genetic sequence data in the context of the PIP Framework. Following the consultations, the PIP Advisory Group met on 17–19 October 2018 to discuss the implementation of the PIP Framework. It noted that there appeared to be a convergence of views at the consultation that the current scope of the PIP Framework should be maintained at this time. In its report to the Director-General, the Advisory Group provided several specific, short-term recommendations on seasonal influenza and genetic sequence data under the PIP Framework.[52] The Advisory Group further recommended that the Director-General take forward a proposed amendment to the language of footnote 1 of Annex 2 to the PIP Framework (annexed to this report). It aims at addressing a loophole that has arisen in connection with indirect use of PIP biological materials by companies with the result that they do not provide fair and equitable benefit sharing for the use of PIP biological materials. The Director-General accepted all the Advisory Group recommendations, finding them to be reasonable and feasible, and has included them in the draft decision submitted to the Executive Board for its consideration. The final text of the analysis has been prepared,[53] taking into account the feedback received as part of the consultation and relevant decisions from the November 2018 meetings of the fourteenth meeting of the Conference of the Parties to the CBD and the third meeting of the Conference of the Parties serving as the Meeting of the Parties to the Nagoya Protocol.[54]

ACTION BY THE HEALTH ASSEMBLY

The Health Assembly is invited to note the report and consider the draft decision recommended by the Executive Board in decision EB144(6) taking into account, as appropriate, the outcome of the consultations set out in document A72/21 Add.1.

Document A72/21 Add 1. is not available on 5 May 2019

[52] Meeting of the Pandemic Influenza Preparedness Framework Advisory Group. 17–19 October 2018, Geneva, Switzerland. Geneva: World Health Organization; 2018 (http://www.who.int/influenza/pip/AGMR_Oct2018.pdf?ua=1, accessed 3 December 2018).
[53] Approaches to seasonal influenza and genetic sequence data under the PIP Framework. Analysis. Geneva: World Health Organization; 2018 (https://www.who.int/influenza/pip/WHA70108b_Analysis.pdf, accessed 14 December 2018).
[54] United Nations Biodiversity Conference, Sharm El-Sheikh, Egypt, 13–29 November 2018. Montreal: Secretariat of the Convention on Biological Diversity; 2018 (https://www.cbd.int/conferences/2018,accessed 7 December 2018).

Implication for the European Region

The implementation of the PIP Framework Partnership Contribution (PC) in the WHO European Region since 2014 has resulted in the establishment or strengthening of fundamental surveillance and response capacities in the five PIP PC recipient countries (Armenia, Kyrgyzstan, Tajikistan, Turkmenistan and Uzbekistan). The achievements contribute to the implementation and strengthening of the majority of IHR core capacities and thus preparedness and response to outbreaks of other high threat pathogens. A publication in the Public Health Panorama (March 2018) describes the first four years of PIP PC implementation in the WHO European Region[55]. In the coming years, the focus of the work of the Regional Office in the five countries will be on further institutionalizing newly established systems and mechanisms as well as country ownership and long-term sustainability of what has been achieved.

In addition to country specific support, the WHO Europe is strengthening surveillance and response capacities at Regional level with support from the PIP PC, e.g. through:

- Maintaining and strengthening of the Regional influenza network managed jointly with ECDC, and the joint Flu News Europe bulletin.
- Organizing Region-wide influenza surveillance meetings jointly with ECDC (most recent one took place on 6-8 June 2018).
- Strengthening of influenza virus sharing in the Region resulting in 46/53 Member States sharing viruses with WHO CC in time for the February 2018 vaccine composition meeting
- Supporting countries to increase the uptake of seasonal influenza vaccine through e.g. the Flu Awareness Campaign and supporting donations of vaccine to countries by the new Partnership for Influenza Vaccine Introduction (PIVI).

12.2 Member State mechanism on substandard and falsified medical products

Documents A72/22

In accordance with resolution WHA65.19 (2012), the Member State mechanism is required to report to the Health Assembly, through the Executive Board, on progress and any recommendations every two years. Consequently, a comprehensive report is submitted to the Seventy-Second Health Assembly in May 2019 and includes the reports of both the sixth and seventh meetings of the Member State mechanism.

The reports were noted by the Executive Board at its 144th session in January 2019.

The Member State mechanism has decided that its eighth meeting would take place in the week of 21 October 2019.

The Secretariat provided an update on the activities and budget to implement the mechanism's workplan, including on the WHO Global Surveillance and Monitoring System, regulatory systems strengthening and capacity-building activities.

The *Guidance for registers of manufacturers, importers, distributors and medical products authorized by Member States* and its annex, and *Recommendations for health authorities on criteria for risk assessment and prioritization of cases of unregistered/unlicensed, substandard and falsified medical*

[55] http://www.euro.who.int/__data/assets/pdf_file/0010/364879/php-4-1-1202-influenza-eng.pdf?ua=1

products had been shared with Member States before the seventh meeting of the Member State mechanism and will be published on the MedNet platform and the WHO website.

It was agreed that the *Handbook on existing training resources and reference documentation for the prevention, detection and response to SF medical products* and *Guidance for registers of manufacturers, importers, distributors and medical products authorized by Member States*, and the annex of the *Guidance*, should be considered living documents and updated by the WHO secretariat, as needed, and should be made widely available.

The Secretariat provided an update on three strands of work:
1) Detection technologies, including the work of Oxford University and the United States Pharmacopoeial Convention (USP); 2) track and trace models and experiences from Member States; and 3) the lessons learned and best practices emerging from the smartphone application pilot studies in Tanzania and Indonesia.

All reviews of detection technologies published by Oxford University and the USP had been posted on the MedNet platform and the WHO website. It was noted that information exchange around these issues was critical and that sharing the key learnings of such activities to Member States, including the findings of the smartphone application pilot studies, were important.

The Secretariat provided an update on the development of the roadmap on access to medicines and vaccines 2019–2023 decided on by the Health Assembly (Decision WHA71(8) (2018)), which included improved prevention, detection and response to substandard and falsified medical products. The draft roadmap would be submitted to the Seventy-Second World Health Assembly, through the 144th session of the Executive Board. For potential future publications around linkages between access to safe, quality, efficacious, and affordable medical products and SF medical products, it was resolved that key emerging themes for further research would be discussed with the Steering Committee.

Implication for the European Region

The *Guidance for registers of manufacturers, importers, distributors and medical products authorized by Member States* and its annex, and *Recommendations for health authorities on criteria for risk assessment and prioritization of cases of unregistered/unlicensed, substandard and falsified medical products* had been shared with Member States before the seventh meeting of the Member State mechanism and will be published on the MedNet platform and the WHO website. It was agreed that the *Handbook on existing training resources and reference documentation for the prevention, detection and response to SF medical products* and *Guidance for registers of manufacturers, importers, distributors and medical products authorized by Member States*, and the annex of the *Guidance*, should be considered living documents and updated by the WHO secretariat, as needed, and should be made widely available.

The UK, as Chair of the working group, provided an update on *"The IDEAS (insight, data, engagement, action and solutions) framework for substandard and falsified medical products global communications guidance"* and *"Assessing the value of social media for raising awareness of SF medical products* documents as well as the curation and collection of communication campaign materials from Member States will be published on the MedNet platform and the WHO website and it was encouraged that these documents be widely disseminated through other platforms. The WHO Secretariat would monitor the use of the handbook and identify best practices and areas for development and bring these back to the member State mechanism. Whilst it was noted that the UK would no longer be able to Chair this

working group, Member States underscored the value of communications work. Any Member States interested in leading this activity were encouraged to notify the Secretariat.

12.3 Human Resources for Health

WHO Global Code of Practice on the International Recruitment of Health Personnel: third round of national reporting

Documents A72/23

The Executive Board, at its 144th Session, considered an earlier version of this report. The report has been updated to reflect the situation of receipt of national reports from Member States as at March 2019 and revised to include the Secretariat's reflections on the Code's relevance and effectiveness, as requested by the Executive Board.

This report on the third round of national reporting is submitted in line with the requirements of Articles 9.2 and 7.2(c) of the WHO Global Code of Practice on the International Recruitment of Health Personnel (resolution WHA63.16.[56]) and will form the basis for the 2nd review of the Code's relevance and effectiveness in 2019, as called for by the Health Assembly in decision WHA68(11) (2015).

An important context for this report is the adoption of the Global Compact for Safe, Orderly and Regular Migration (GCM) at the Intergovernmental Conference in Marrakech, Morocco, 10 and 11 December 2018. The final text includes important linkages to the Code. The UN Secretary-General's report on International Migration and Development,[57] also highlights the importance of the Code and health workforce-related data to the broader migration agenda.

Within the resources available, the Secretariat has supported the Code's implementation and monitoring, including technical cooperation and provision of support to Member States, and facilitating the 3rd round of national reporting by the designated national authorities.

Designated national authorities and 3rd round of national reporting

As at March 2019, 122 Member States have provided contact information for their designated national authorities with responsibility for exchanging information and Code implementation. During the 3rd round; 29 Member States did so for the first time. Member States and the Secretariat collaborated to simplify the National Reporting Instrument[58] and the Independent Stakeholders Reporting Instrument and outreach was also strengthened to improve engagement with "relevant stakeholders" in the process. Therefore, as at March 2019, 80 Member States had submitted a national report.[59] They represent over two thirds of the world's population, and 26 of the 80 countries were reporting for the first time.

[56] In resolution WHA57.19 (2004), on International migration of health personnel: a challenge for health systems in developing countries, the Health Assembly requested the Director-General to develop a code of practice on the international recruitment of health personnel.
[57] United Nations General Assembly document 73/286.
[58] As urged on Member States by the Health Assembly in resolution WHA69.19 (2016)
[59] The following Member States reported during the current round: Afghanistan, Armenia, Australia, Austria, Bahrain, Bangladesh, Belarus, Belgium, Belize, Bhutan, Brunei Darussalam, Cambodia, Canada, Chad, China, Cyprus, Czechia, El Salvador, Estonia, Finland, Georgia, Germany, Hungary, Iceland, India, Indonesia, Iran (Islamic Republic of), Iraq, Ireland, Italy, Jamaica, Jordan, Lao People's Democratic Republic, Latvia, Libya, Lithuania, Malaysia, Maldives, Malta, Monaco, Montenegro, Morocco, Namibia, Nepal, Netherlands, New Zealand, Nigeria, Norway, Oman, Pakistan, Panama, Papua New Guinea, Philippines, Poland, Portugal, Qatar, Republic of Moldova, Romania, Saint Lucia, Sao Tome and Principe, Saudi Arabia, Singapore, Slovakia, Slovenia, Somalia, Spain, Sri Lanka, Sudan, Sweden, Switzerland, Thailand, Timor-Leste, Trinidad and Tobago, Tunisia, Uganda, United Arab Emirates, United Kingdom of Great Britain and Northern Ireland, United Republic of Tanzania, United States of America, Zimbabwe.

Selected results from submitted national reports (n = 80)

Altogether 74 Member States provided quantitative data, with 67 providing data on the five health professions (dentist, midwife, nurse, pharmacist and physician) representing the largest share of regulated health professions and which are most associated with international migration. A total of 54 Member States provided data on the share of foreign-born and/or trained health workers, with disaggregated data by country of training available for 30 Member States. This figure is a substantial improvement from the 2nd round of reporting in 2016.

The data submitted provides new insights into the international mobility of dentists, midwives and pharmacists. Data on foreign-born and/or foreign-trained health workers provides evidence of a blurring of the distinction between source and destination countries. This suggests that a simplistic binary narrative of source/destination or sending/receiving countries is outdated. Countries that may previously have been identified as source countries are themselves reliant on foreign-trained health workers.[60]

54 Member States identified that they had taken steps to implement the Code. Nearly half the Member States (39) reported the use of bilateral, regional or multilateral arrangements with respect to the international recruitment and migration of health personnel.

More than three quarters of Member States (64) requested technical support from the Secretariat to strengthen implementation of the Code. Requests included strengthening data, policy dialogue and development, and the development of bilateral agreements. Member States also requested the Secretariat to enhance work of relevance to all countries, including: the development, negotiation and implementation of bilateral agreements; the review of both criteria and list of countries with critical health workforce shortages; and the strengthening of the network of designated national authorities to further facilitate information exchange.

Independent stakeholders' reports

As at March 2019, 14 independent stakeholders' reports have been submitted to the Secretariat. This figure is an improvement from the 2nd round which counted only one submission. The 14 submissions received from diverse stakeholders including academia, civil society, national regulatory bodies and international federations. They included country case studies, progress reports and recommendations for implementation of the Code, perspective on bilateral agreements, and requests for technical support.

Targeted support for implementation of the Code at country and global levels

Financial support from the EU and Norwegian Agency for Development Cooperation enabled the Secretariat to provide targeted support for advancing implementation of the Code in 5 countries – India, Ireland, Nigeria, South Africa and Uganda – and at the global level. The work has provided a more dynamic understanding of health worker migration, with substantial intraregional, South–South and North–South movement. It has also informed policy dialogue and development.[61]

In 2016, responding to the increasing volume and complexity of health professional migration, the UN Secretary-General's High-Level Commission on Health Employment and Economic Growth called on ILO, OECD and WHO to establish an international platform on health worker mobility in order to advance dialogue, knowledge and international cooperation in the area, including support to

[60] For example, the following percentages of health workers were reported as having been foreign trained: 83% of medical doctors in Bhutan; 12% of medical doctors in El Salvador; 10% of dentists in the Islamic Republic of Iran; 70% of medical doctors in Jordan; 11% of medical doctors, 9% of pharmacists and 7% of nurses in the public sector in Lao People's Democratic Republic with numbers rising to 40% in the private sector; and 17.5% of medical doctors and 50% of pharmacists in Zimbabwe.

[61] See A dynamic understanding of health worker migration (www.who.int/hrh/HWF17002_Brochure.pdf, accessed 29 October 2018).

strengthening of implementation of the Code. In 2017, the 70th WHA in resolution WHA70.6 adopted the five-year action plan on health employment and inclusive economic growth (2017–2021) with the UNGA also supporting its operationalization in resolution 71/159.

At the first meeting of the International Platform (Dublin, 14 November 2017), on the margins of the 4th Global Forum on Human Resources for Health, Member States, representatives of regional organizations and international organizations shared information on the challenges and opportunities to maximize the benefits from health worker mobility.[62] Thirty Member States attended the following meeting (Geneva, 13 and 14 September 2018). Participants discussed promising policy measures and proposed strategic actions to strengthen the management and governance of health worker mobility; and reiterated the requests included in the 3rd round of reporting.[63]

Second review of the relevance and effectiveness of the Code

As called for by the WHA in decision WHA68(11) (2015) on the Code, the Secretariat is preparing for the further assessment of the Code's relevance and effectiveness. The findings of the second review, scheduled to be undertaken during the period May–October 2019, will be submitted to the 73rd WHA. The Director-General will convene an expert advisory group with the task of preparing and conducting the review; it will consist of 20 members, comprising 12 representatives of Member States (2 nominated from each WHO region) and 8 representatives of organizations with institutional knowledge of the Code's development, negotiation and implementation and individual experts. The group shall elect among its members two co-chairpersons. The Secretariat will provide support for its work.

ACTION BY THE HEALTH ASSEMBLY

The Health Assembly is invited to note this report.

Global Strategy on Human Resources for Health: Workforce 2030

Document A72/24

This report summarizes progress made in the implementation of the WHO Global Strategy on Human Resources for Health: Workforce 2030, adopted by the Health Assembly in resolution WHA69.19 (2016), and is structured according to the four strategic objectives set out therein. The report also provides updates on the implementation of resolutions WHA64.6 (2011) on health workforce strengthening, WHA64.7 (2011) on strengthening nursing and midwifery and WHA70.6 (2017) on human resources for health and implementation of the outcomes of the United Nations' High-Level Commission on Health Employment and Economic Growth.

This report considers the four key objectives of the Strategy, as follows:

- Objective 1: Evidence-informed policies to optimize the workforce,
- Objective 2: Catalysing investment in health labour markets to meet population needs,
- Objective 3: Building institutional capacity and partnerships; and,
- Objective 4: Data for monitoring and accountability.

[62] See http://www.who.int/hrh/news/2017/high_level-dialogue-int-health-worker-migration-meeting-summary.pdf?ua=1 (accessed 29 October 2018).
[63] See http://www.who.int/hrh/migration/InternationalPlatformHealthWorkerMobilityMeetingNotes.pdf?ua=1 (accessed 29 October 2018).

Objective 1

The document outlines actions to develop normative guidance on, and provide technical cooperation in, key policy areas:

- Professional, technical and vocational education and training,
- Strategic directions for nursing and midwifery,
- Inter-professional competency framework on antimicrobial resistance,
- Joint statement on ending discrimination in health care settings,
- WHO guidelines on health policy and systems support to optimize community health worker programmes,
- Health workforce requirements to achieve the 'triple billion' goals set out in the 13th General Programme of Work 2019-2023.

Objective 2

The report outlines activities to catalyse investment in health labour markets such as the technical cooperation with Member States in a number of areas, including: workload and productivity, projected health worker supply, provision and retention of rural health workers, support with planning capability and capacity (including assessing the financial requirements) and also emergency preparedness.

Evidence is emerging that the recommendations of the United Nations High-level Commission are visible in the policy and investment decisions in countries at all levels of socioeconomic development for example: collaboration between ILO, OECD and WHO on shared data has resulted in a rapid rise in the uptake of National Health Workforce Accounts (NHWA) and health labour market analyses, as stated elsewhere in this report; and the launch of the International Platform on Health Worker Mobility, with the active participation of 30 Member States; including many from the WHO EURO Region, partners and civil society, and in line with the WHO Global Code of Practice.

Objective 3

The report sets the continued activity to build institutional capacity and partnership; paying particular attention to the importance of the work to strengthen governance and leadership in HRH at various levels. This included the effective role of the Fourth Global Forum on Human Resources for Health, held in Dublin, Ireland, in November 2017, which leveraged the political capital built through the *Working for Health* action plan and promoted accountability on the member state commitments to human resources for health.

Objective 4

Finally, the report highlights the ongoing growth in the active take-up, by Member States, of the NHWA has substantially improved the availability of health workforce data points across different occupational groups.

In conclusion, the report notes that a substantial body of work on human resources for health is being taken forward in order to help countries to accelerate progress on primary health care, universal health

coverage and the Sustainable Development Goals. There is growing evidence of progress in Member States where data on human resources for health are informing policy dialogue and enabling effective and often new investments in education and employment, and globally, Member States are reporting reveals a positive trend globally on public sector investment in the health workforce.

ACTION BY THE HEALTH ASSEMBLY

The Health Assembly is invited to note this report.

Implication for the European Region

The Regional Office is committed to supporting Member States in their efforts to achieve sustainable health workforces, in line with the Regional Framework for Action adopted at the 67th Regional Committee in 2017. This includes promoting these WHO guidelines on community health worker programmes, where appropriate in the national context.

The Regional Office for Europe has taken forward activities starting with the Ljubljana Charter on reforming healthcare in Europe and followed by the Tallinn Charter: Health Systems for Health and Wealth, Resolution EUR/RC59/R4 Health workforce policies in the WHO European Region, Health 2020: the European policy for health and well-being, Priorities for health system strengthening in the WHO European Region 2015-2020 and Health Systems for Prosperity and Solidarity: leaving no one behind (2018).

12.4 Promoting the health of refugees and migrants

Document A72/25

The Executive Board, at its 144th session, considered an earlier version of this report.

At its 140th session in January 2017 the Executive Board in decision EB140 on promoting the health of refugees and migrants requested the Director-General, inter alia, to prepare, in full consultation and cooperation with Member States and, where applicable, regional economic integration organizations, and in cooperation with the International Organization for Migration and the United Nations High Commissioner for Refugees and other relevant stakeholders, a draft framework of priorities and guiding principles to promote the health of refugees and migrants. The framework should be a resource for Member States in meeting the health needs of refugees and migrants and contributing to the achievement of the vision of the 2030 Agenda for Sustainable Development.

In May 2017, the World Health Assembly in resolution WHA70.15 noted with appreciation the framework and urged Member States, in accordance with their national context, priorities and legal frameworks, to strengthen international cooperation on the health of refugees and migrants in line with paragraphs 11 and 68 and other relevant paragraphs of the New York Declaration for Refugees and Migrants.[64]

In addition, the Health Assembly requested the Director-General, inter alia, to identify best practices, experiences and lessons learned on the health of refugees and migrants in each region in order to contribute to the development of a draft global action plan on the health of refugees and migrants for consideration by the Seventy-Second World Health Assembly. A version of the draft plan was

[64]United Nations General Assembly resolution 71/1 (2016). New York Declaration for Refugees and Migrants (http://undocs.org/a/res/71/1, accessed 21 November 2018).

considered by the Executive Board at its 144th session[65], and a revised text is submitted in this document.

In line with resolution WHA70.15, the objective of the proposed global action plan is to promote the health of refugees and migrants in collaboration with the International Organization for Migration, the Office of the United Nations High Commissioner for Refugees, other international organizations and relevant stakeholders.

Although their treatment is governed by separate legal frameworks, refugees and migrants are entitled to the same universal human rights and fundamental freedoms as other people. Refugees and migrants also face many common challenges and share similar vulnerabilities[66]. The Secretariat will focus on achieving universal health coverage and the highest attainable standard of health, as mandated in WHO's Constitution, for refugees, migrants and host populations within the context of WHO's Thirteenth General Programme of Work, 2019–2023.

Brief overview of the Global Situation

The number of international migrants[67] has grown as a proportion of the global population. In 2017, international migrants constituted 3.4% of the global population as compared with 2.8% in 2000. During the period 2000–2017, the total number of international migrants rose from 173 million to 258 million, an increase of 49%[68].

The Office of the United Nations High Commissioner for Refugees reports that, globally, the number of forcibly displaced people, 68.5 million, is the highest level of human displacement ever[69]; the figure includes 25.4 million refugees. There are also 10 million stateless people, who lack a nationality and access to basic rights such as education, health care, employment and freedom of movement.

Many refugees and migrants lack access to health care services, including health promotion, mental health services (in particular those for post-traumatic disorders, which affect many refugees and migrants), disease prevention, treatment and care, as well as financial protection.

Nationality should never be a basis for determining access to health care; legal status (often) determines the level of access, as appropriate within national insurance schemes and health systems, without revoking the principle of universal health coverage as set in international agreements. Refugees and migrants may, in some circumstances, fear detection, detention or deportation and may be subject to trafficking or slavery. Unaccompanied children are particularly vulnerable and need specific provisions.

Refugees and migrants may come from areas where communicable diseases are endemic. This does not, however, necessarily imply that they are an infectious risk to host and transit populations. They may rather be at risk of contracting communicable diseases, including foodborne and waterborne diseases, as a result of the perils of travelling and factors in the host country associated with poor living

[65] Contained in document EB144/27. For purposes of clarity, this global action plan on the health of refugees and migrants is voluntary; its acceptance by the Health Assembly would not change the voluntary nature of the plan. The plan is intended solely for the Secretariat and will not have any financial implications for Member States. The Secretariat will provide support to Member States only upon request and in accordance with national legislation and country contexts.

[66] United Nations General Assembly resolution 71/1 (2016). New York Declaration for Refugees and Migrants, paragraph 6 (http://undocs.org/a/res/71/1, accessed 20 March 2019).

[67] United Nations, Department of Economic and Social Affairs, Population Division. International migration report 2017. New York: United Nations; 2017.
(http://www.un.org/en/development/desa/population/migration/publications/migrationreport/docs/MigrationReport2017_Highlights.pdf, accessed 21 March 2019).

[68] United Nations, Department of Economic and Social Affairs, Population Division. Population facts. December 2017

[69] UNHCR. Figures at a glance (http://www.unhcr.org/uk/figures-at-a-glance.html, accessed 21 March 2019).

and working conditions, together with lack of access to essential health care services. Access to vaccination and continuity of care is more difficult for people on the move. Poor access to medicines and poor management of treatment may facilitate the development of antimicrobial resistance. Specific vulnerabilities to HIV infection and tuberculosis require specific integrated health care services for refugees and migrants.

Public health circumstances and obstacles that affect refugees and migrants are specific to both those populations and each phase of the migration and displacement cycle (namely, before and during departure, travel, arrival at destination and possible return). Refugees and migrants with existing chronic conditions and hereditary diseases may experience interruption in their care or episodic care, and they may move without medicines or health records.

Migrant women and displaced women may have limited access to sexual and reproductive health care services[70] and may face specific threats to their corresponding rights[71]. Many migrant and refugee women do not take up antenatal care or face delays in receiving it because of payment barriers at hospitals, lack of referrals to gynaecologists or fears, including that of being brought to the attention of the authorities and a sense of shame.

Roles and Responsibilities of International Organizations and Non-State Actors

Within the United Nations, WHO has a constitutional function to act as the "directing and coordinating authority on international health work"[72]. WHO has primary responsibility for promoting and achieving Health for All and universal health coverage within the context of the 2030 Agenda for Sustainable Development and its associated Goals, while leaving no one behind. Additionally, WHO is the health normative agency within the United Nations system; its Thirteenth General Programme of Work, 2019–2023, determines its strategic work, to which this draft global action plan is aligned.

WHO has collaborated with the International Organization for Migration and the Office of the United Nations High Commissioner for Refugees on several processes to promote the health of refugees and migrants[73]. In support of collaboration between organizations in the United Nations system, WHO is also a member of the recently established United Nations Network on Migration, for which the International Organization for Migration is the coordinator and secretariat, and whose mandate is to ensure effective United Nations system-wide support for implementation, including the capacity-building mechanism, in response to the needs of Member States.

[70] Sustainable Development Goal 3, Target 3.7: by 2030 ensure universal access to sexual and reproductive health care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes; Sustainable Development Goal 5, Target 5.6: ensure universal access to sexual and reproductive health and reproductive rights as agreed in accordance with the Programme of Action of the International Conference on Population and Development and the Beijing Platform for Action and the outcome documents of their review conferences.

[71] In accordance with the Programme of Action of the International Conference on Population and Development and the Beijing Platform for Action and the outcome documents of their review conference.

[72] Constitution of the World Health Organization, Article 2(a). Furthermore, the International Covenant on Economic, Social and Cultural Rights (1966), in Articles 2.2 and 12, recognizes the right of everyone to the enjoyment of the highest attainable standard of physical and mental health without discrimination of any kind as to race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status.

[73] See, for example, the first and second global consultations on the health of migrants in 2010 and 2017, respectively; the outcome of the second (High-level meeting of the Global Consultation on Migrant Health, Colombo, 23 February 2017) was the Colombo Statement which was endorsed by participating countries, and resolution CD55.R13 (2016) of the PAHO Directing Council on health of migrants. Furthermore, on 31 January 2019 the International Organization for Migration and WHO signed a Memorandum of Understanding to provide a framework for cooperation and understanding, and to facilitate collaboration between the two Parties.

Scope

The goal of this proposed global action plan is to assert health as an essential component of refugee assistance and good migration governance. The aim of the plan is to improve global health by addressing the health and well-being of refugees and migrants in an inclusive, comprehensive manner and as part of holistic efforts to respond to the health needs of the overall population in any given setting, including the coordination of international efforts to link health care for refugees and migrants to humanitarian programmes.

The proposed plan reflects the urgent need for the health sector to deal more effectively with the impact of migration and displacement on health, wherever people have settled. It is fully aligned with the principles set forth and specific references made in WHO's Thirteenth General Programme of Work, 2019–2023.

Guiding principles

The guiding principles for implementation of the proposed global action plan are set out in the framework of priorities and guiding principles to promote the health of refugees and migrants and build on existing instruments and resolutions[74], for example, the New York Declaration for Refugees and Migrants and resolution WHA70.15 on Promoting the health of refugees and migrants, in which in particular the Health Assembly recalled the need for international cooperation to support countries hosting refugees, and recognizing the efforts of the countries hosting and receiving large populations of refugees and migrants.

Priorities of the Global Action Plan

Priority 1. Promote the health of refugees and migrants through a mix of short-term and long-term public health interventions.

To promote the physical and mental health of refugees and migrants by strengthening health care services, as appropriate and acceptable to country contexts and financial situations and in line with their national priorities and legal frameworks and competence, ensuring that essential components, such as vaccination of children and adults and the provision of health promotion, disease prevention, timely diagnosis and treatment, rehabilitation and palliative services for acute, chronic and infectious diseases, injuries, mental and behavioural disorders, and sexual and reproductive health care services for women, are addressed.

Priority 2. Promote continuity and quality of essential health care, while developing, reinforcing and implementing occupational health and safety measures.

To improve the quality, acceptability, availability and accessibility of health care services, for instance by overcoming physical, financial, information, linguistic and other cultural barriers, with particular attention to services for chronic conditions and mental health, which are often inadequately addressed or followed up during the migration and displacement process, and by working to prevent occupational and work-related diseases and injuries among refugee and migrant workers and their families by improving the coverage, accessibility and quality of occupational and primary health care services and

[74] For ease of reference the principles are as follows: The right to the enjoyment of the highest attainable standard of physical and mental health; equality and non-discrimination; equitable access to health services; people-centred, refugee-, migrant- and gender-sensitive health systems; non-restrictive health practices based on health conditions; whole-of-government and whole-of-society approaches; participation and social inclusion of refugees and migrants; and partnership and cooperation.

social protection systems, in accordance with Member States' national contexts, priorities and legal frameworks.

Priority 3. Advocate the mainstreaming of refugee and migrant health into global, regional and country agendas and the promotion of: refugee-sensitive and migrant-sensitive health policies and legal and social protection; the health and well-being of refugee and migrant women, children and adolescents; gender equality and empowerment of refugee and migrant women and girls; and partnerships and intersectoral, intercountry and interagency coordination and collaboration mechanisms.

To help to meet the health needs of refugees and migrants by preventing and mitigating the impact of gender-based inequality in health and access to health services throughout the migration and displacement process by advocating refugees' and migrants' right to the highest attainable standard of physical and mental health, in accordance with international human rights obligations and corresponding relevant international and regional instruments, and by working to lower or remove physical, financial, information and discrimination barriers to accessing health care services in synergy with WHO's partners, including non-State actors.

Priority 4. Enhance capacity to tackle the social determinants of health and to accelerate progress towards achieving the Sustainable Development Goals, including universal health coverage.

To ensure that the social determinants of refugees' and migrants' health are addressed through joint, coherent multisectoral actions in all public health policy responses based on all relevant Sustainable Development Goals, especially Goal 3 (Ensure healthy lives and promote well-being for all at all ages) and Goal 10 (Reduce inequality within and among countries), target 10.7 (Facilitate orderly, safe, and responsible migration and mobility of people, including through implementation of planned and well-managed migration policies).

Priority 5. Strengthen health monitoring and health information systems.

To ensure that information and disaggregated data at global, regional and country levels are generated and that adequate, standardized, comparable records on the health of refugees and migrants are available to support policy-makers and decision-makers to develop more evidence-based policies, plans and interventions.

Priority 6. Support measures to improve evidence-based health communication and to counter misperceptions about migrant and refugee health.

To provide accurate information and dispel fears and misperceptions among refugee, migrant and host populations about the health impacts of migration and displacement on refugee and migrant populations and on the health of local communities and health systems.

ACTION BY THE HEALTH ASSEMBLY

The Health Assembly is invited to note the Global Action Plan, 2019-2023. Promoting the health of refugees and migrants.

Implication for the European Region

The WHO European Region has led the way in addressing the challenges of refugee and migrant health.

In 2012 the Public Health Aspects of Migration in Europe (PHAME) project was established, designed to develop a systematic and evidence-based response to the public health needs of migrants, and to strengthen the health sector's preparedness and the public health capacity to better address emergency-related migration. Since then PHAME has provided continuous support to Ministries of Health through health-system assessments, the collection and dissemination of evidence, and the provision of on-site technical assistance, good practices, standard operating procedures, and policy advice. As part of the PHAME project a PHAME Quarterly Newsletter is produced, providing news, know-how and best practices, and encouraging a cross-national political dialogue on migration. This initiative is a partnership between the WHO European Regional Office and the University of Pécs, Hungary.

Nine WHO Health Evidence Network (HEN) synthesis reports have been developed gathering evidence in the region concerning refugee and migrant health. These HEN synthesis reports have served as WHOs core, authoritative evidence to inform the research agenda in the Region and to identify priority areas of action contributing to the development and implementation of the Regional strategy and action plan for refugee and migrant health in 2016.

A Knowledge Hub on Health and Migration was established through a joint effort between the WHO European Regional Office, the Ministry of Health of Italy, the Regional Health Council of Sicily and the European Commission. The Technical Guidance series, developed over two years, was designed as a tool for policy makers addressing a specific aspect of the health of refugees and migrants.
Five publications are currently available, each with a special focus; children's health, health promotion, healthy ageing, maternal and new-born health and mental health.

Two successful Summer Schools on Refugee and Migrant Health have been conducted with the support of the Italian Ministry of Health and the Sicily Regional Health Authority, and in collaboration with IOM, The European Commission, the European Public Health Association and the National Institute of Health, Migration and Poverty, Italy.

In December 2018 the WHO Regional office for Europe, published the Report on the health of refugees and migrants in the WHO European Region. The report was a collaborative effort on the implementation of the regional strategy and action plan and creates a knowledge base to support evidence-informed policymaking to meet the health needs of both migrant and host populations. 40 of the 53 regional Member States submitted responses which were presented to the WHO Regional Committee in September 2018.

12.5 Patient safety

Global action on patient safety

Documents A72/26, resolution EB144.R12

The global landscape of health care is changing, and health systems operate in increasingly complex environments. While new treatments, technologies and care models can have therapeutic potential, they can also pose novel threats to safe care. Patient safety is now being recognized as a large growing global public health challenge. Global efforts to reduce the burden of patient harm have not achieved substantial change over the past 15 years despite pioneering work in some health care settings. Safety measures – even those implemented in high-income settings – have had limited or varying impact, and most have not been adapted for successful application in low- and middle-income countries.

All Member States are striving to achieve UHC and the SDGs. However, the benefits of increased access to health care have been undermined by service structures, cultures and/or behaviours that inadvertently harm patients. Global action on patient safety will enable UHC to be delivered while reassuring communities that they can trust their health care systems to keep them safe. Policy-makers will want to assure that, in planning and resourcing their vision of UHC, they are not presiding over flawed and wasteful models of care.

Global burden of patient harm in health care

It is estimated that 64 million disability-adjusted life years are lost every year because of unsafe care worldwide. Thus, patient harm due to adverse events is one of the top 10 causes of death and disability in the world. Available evidence suggests that annually 134 million adverse events due to unsafe care occur in hospitals in low- and middle-income countries, contributing to 2.6 million deaths. Approximately two thirds of the global burden of adverse events resulting from unsafe care occurs in low- and middle-income countries. Estimates indicate that in high-income countries, about 1 in 10 patients is harmed while receiving hospital care.

Many medical practices and risks associated with health care are emerging as major challenges for patient safety and contribute significantly to the burden of harm due to unsafe care. For example:
• **Medication errors** are a leading cause of injury and avoidable harm: globally, the cost associated with it has been estimated at US$ 42 billion annually;
• **Health care-associated infections** prevalence in mixed patient populations of high-income countries is about 7.6% and about 10% in low- and middle-income countries. Resistant infections currently claim at least 50 000 lives each year across Europe and USA;
• **Unsafe surgical care** procedures cause complications in up to 25% of patients; almost 7 million surgical patients annually suffer significant complications, 1 million of whom die during or immediately after surgery;
• **Unsafe injections practices** can transmit infections posing direct danger to patients and workers; they account for estimated 9.2million disability-adjusted life years lost per year worldwide;
• **Diagnostic errors** occur in about 5% of adults in ambulatory care settings, more than half of which have the potential to cause severe harm; most people will suffer a diagnostic error in their lifetime;

• **Unsafe transfusion practices** expose patients to the risk of adverse transfusion reactions and transmission of infections; data on adverse transfusion reactions from a group of 21 countries show an average incidence of 8.7 serious reactions per 100 000 distributed blood components;
• **Radiation errors** involve overexposure to radiation and cases of wrong-patient and wrong-site identification; a review of 30 years of published data on safety in radiotherapy estimates the overall incidence of errors is 1500 per 1 million treatment courses;
• **Sepsis** is frequently not diagnosed early enough to save a patient's life; as these infections are often resistant to antibiotics, they can rapidly lead to deteriorating clinical conditions, affecting an estimated 31 million people worldwide and causing over 5 million deaths per year;
• **Venous thromboembolism** is one of the most common and preventable adverse events, contributing to one third of the complications attributed to hospitalization; annually, there are estimated to be 3.9 million cases in high-income countries and 6 million cases in low- and middle-income countries;
• **Unsafe care in mental health settings**, concerns avoidable harm principally linked to seclusion and restraint, self-harming behaviour and suicide, absconding and reduced capacity for self-advocacy.

Failures in primary care contribute to the burden of unsafe care globally. Half the global burden of patient harm originates in primary and ambulatory care, with 4 out of 10 patients facing safety lapses. It is estimated that up to 80% of harm in primary care settings can be avoided.

Poor-quality care imposes costs of US$ 1.4 trillion to 1.6 trillion each year in lost productivity in low- and middle-income countries. At the political level, the cost includes loss of trust in health systems, governments and social institutions. Overall, the sound systematic implementation of patient engagement strategies and health literacy programmes could reduce harm by up to 15%, which would constitute a very good return on investment.

Health care delivery systems are complex by design and prone to errors in which human factors are a core element. Punitive cultures of blaming individuals prevent reporting of safety-related incidents and impede learning. Certain patient groups are more vulnerable to safety incidents, including the elderly, children, migrant populations, patients with chronic conditions and those in palliative care.

WHO action to date

The global need for quality of care and patient safety was first put to the WHA in 2002. Resolution WHA55.18, entitled "Quality of care: patient safety WHO's work on patient safety began with the launch of the World Alliance for Patient Safety in 2004. One of the concrete ways in which WHO has facilitated improvements in the safety of health care within Member States is through **Global Patient Safety Challenge (GPSC)**. Three such challenges have been launched to date: i) Clean care is safer care in 2005, ii) Safe surgery saves lives in 2008 and iii) Medication without harm in 2017.

Since 2016, the Governments of Germany and the UK in collaboration with WHO, have co-led annual **Global Ministerial Summits on Patient Safety,** seeking political commitment and leadership to prioritize patient safety at the global level. The fourth such summit took place on 2-3 March 2019 in Jeddah, Kingdom of Saudia Arabia.

WHO has been collaborating with key international partners and working in cooperation with several countries to advance improvements in patient safety. The Organization has created the **Global Patient Safety Network** to connect stakeholders; currently more than 125 countries and key international are members. The Organization has been supporting the WHO-established **Patients for Patient Safety network** for the last 12 years to foster the engagement of patients and families.

Technical guidance and resources. WHO published the Multi-Professional Patient Safety Curriculum Guide to assist in patient safety education in universities, schools and professional institutions in the

fields of dentistry, medicine, midwifery, nursing and pharmacy. The WHO Technical Series on Safer Primary explores the magnitude and nature of harm and provides possible solutions for improving safety in primary care. WHO published the Safe Childbirth Checklist and the Surgical Safety Checklist to reduce risks related to childbirth and associated with surgery and has developed the Minimal Information Model for Patient Safety (and user guide) to facilitate the collection, analysis and learning derived from adverse events. WHO published Patient Safety Solutions as standardized tools and the High 5s standard operating procedures for safe clinical practices. To strengthen the underlying science, WHO promoted research and established global priorities,[75] generated estimates for the global burden of unsafe care and set up a research funding scheme.

New impetus for global action to improve patient safety

Modern health care organizations serve as a good example of "complex adaptive systems".[76] As the levels of complexity and unpredictability continue to rise, more intangible determinants of patient safety are being given increasing prominence and recognition, as is the need for a more integrated, system-based view of safety. First, there is a "knowledge gap" in understanding the extent of the problem and the contributory and causal factors. There is hardly any systematic data or research on the burden and causality of harm in low- and middle-income countries. Second, there is a "policy gap" reflecting an inadequate policy environment. Most health systems have not formulated policies or have fragmented ones. Third, there is a "design gap" involving the inadequate application of science to design policies, strategies, plans and implementation tools for patient safety in the local context and in resource-limited settings. Fourth, teams of trainers in management science and practice need to be developed at the organizational and delivery-of-care levels to close the "delivery gap". Fifth, health systems should also establish monitoring and incentive systems to help close the "know – do gap" and reduce the difference between what health care providers know and what they actually do. Finally, the "communication gap" can only be closed when isolated best practices, innovations and coping mechanisms are collated, generalized and disseminated globally.

Primary care is the first point of contact between the population and health care. It is the setting in which overall public trust in health care systems is formed and sustained. Unsafe, poor-quality care is one of the critical reasons why patients often bypass primary care. Hence, addressing **patient safety at primary care level** is critical to ensuring trust and to having a functioning, high-performing health system.

Evidence and knowledge generated from research are not always incorporated into policies and practices on patient safety. This disconnect needs to be tackled. **Translational research** in different contexts and settings will address specific needs, respond to country-specific situations, while special attention to the needs of vulnerable population groups will ensure prioritization of interventions.

Patients, families and communities are the co-producers of health, and have a central role in ensuring people-centred care. Engaging them is a key to the provision of safe care.

Effective leadership and availability of a competent and compassionate workforce is a prerequisite for the provision of safe care. Patient safety concepts and principles should become an indispensable part of clinical training, education and continuous professional development for all categories of health care professionals.

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[75] As set out in the publication, Global priorities for patient safety research. Geneva: World Health Organization; 2009 (http://apps.who.int/iris/bitstream/handle/10665/44205/9789241598620_eng.pdf?sequence=1, accessed 7 November 2018).

[76] Forrester JW. Counterintuitive behaviour of social systems. Cambridge, United States: Alumni Association of the Massachusetts Institute of Technology;1971 (https://ocw.mit.edu/courses/sloan-school-of-management/15-988-system-dynamics-self-study-fall-1998-spring-1999/readings/behavior.pdf, accessed 23 October 2018).

Availability of information on the extent, types and causes of errors, adverse events and near misses is central to the development and implementation of patient safety policies, strategies and plans. Hence, establishment of reporting and learning systems on adverse events should be given a special priority.

Application of digital technologies is indispensable for implementing patient safety interventions, monitoring and measuring their impact. In an era in which health care delivery systems become increasingly complex, it can help supporting/enhancing critical elements of patient safety.

Mainstreaming the multidimensional concept of **patient safety culture** into health care systems is a prerequisite for providing people-centred, safe care. While safety culture is multifaceted, certain factors are critical, such as leadership, organizational learning, human factors, teamwork and communication, and patient and family engagement. One important aspect of this effort is to appreciate the interconnection between people, systems and cultures, and how focusing on **system improvement and learning** is the best way to improve patient safety.

The grave burden of unsafe care can only be challenged by global coordinated efforts that are grounded in principles of accountability and cooperation. There is a need to establish a **global coordination mechanism** that has a mandate for enabling countries to implement minimum standards, share information based on analysis of major incidents and subsequent learning and disseminate best practices, among other functions.

Role of stakeholders

National governments are in a position to identify patient safety as a policy priority within broader UHC policies and plans, and to provide political support and resources for the assimilation of patient safety essentials in health systems as well as in frontline care. Coordination and fostering inter- and intra-sectoral collaborative action for patient safety is also an important role for health ministries and governments. Other governmental agencies, academic and research institutions, bodies responsible for health care professionals' education, civil society organizations, industry and other key stakeholders working at national and international levels will be important players in the transformation required.

WHO will continue cooperating with countries and partners to enable the global action on patient safety through investing and mobilizing resources, sharing knowledge, coordinating efforts and fostering intersectoral action, providing technical expertise and establishing systems and practices for patient safety to ensure sustainable progress towards UHC.

ACTION BY THE HEALTH ASSEMBLY

The Health Assembly is invited to adopt the draft resolution

DRAFT RESOLUTION EB144.R12

The Executive Board recommends the Health Assembly to adopt a resolution which endorsed the World Patient Safety Day on 17 September, and urges Member States to recognize patient safety as a health priority and assess the magnitude of the problem to take preventive action and develop national policies and strategies; to work in collaboration with other Member States and relevant actors to promote patient safety and share best practices; integrate patient safety strategies in all clinical programmes and promote a safety culture in basic training to health professional and develop blame free patient safety incident reporting systems; build sustaining human resource capacity, promote research and consider use of traditional and complementary medicines to provide safe health care; engage patients families and communities in delivery of safe health care and consider participation in annual Global Ministerial Summits on Patient Safety. The resolution invites to international organisations and relevant

stakeholders to collaborate with Member States and requests the Director General to emphasis patient safety as key to Universal Health Coverage; develop norms and standard, policies and tools for patient safety; provide technical guidance to support Member States to build national capacity including on use of digital technologies and systems for active participation of communities and families, strengthen global patient safety networks to share best practices; develop a system for global sharing of patient safety incidents; design and launch the Global Patient Safety Challenges; work jointly with Member States to promote the World Patient Safety Day. The Director General is also requested to formulate a global patient safety action plan in consultation with Member States for submission to the 74th Health Assembly through the Executive Board and to report on progress of this resolution the 74th, 76th and 78th World Health Assembly.

Implication for the European Region

Patient safety is a very important to countries in the European Region, many of which were instrumental in pushing for the inclusion of this item on the agenda of EB144. WHO/Europe is committed to enhancing the quality of health care and patient safety and will intensify its work with WHO collaborating centres, international professional associations, patient organizations and international experts, who are active in the area of patient safety and national governments, to support the development and dissemination of technical resources and implementation of patient safety interventions at country level.

WHO/Europe will work closely with national governments to support the critical role that they play in making patient safety a policy priority within broader universal health coverage policies and plans. It will also support national efforts to ensure that patient safety initiatives become the foundation for the strengthening of health systems, starting with the primary health care level. It will also continue cooperating with countries and partners to enable the global and regional action on patient safety through investing and mobilizing resources, sharing knowledge, coordinating efforts and fostering intersectoral action, providing technical expertise and establishing systems and practices for patient safety to ensure sustainable progress towards universal health coverage.

Water, sanitation and hygiene in health care facilities

Documents A72/27, resolution EB144.R5

The provision of water, sanitation and hygiene (WASH), as well as health care waste and environmental cleaning infrastructure and services should be available and accessible in all health care facilities, where people are at their most vulnerable[77]. Yet, the WHO and UNICEF 2019 SDG baseline report concluded that one in four health care facilities lack basic water services, and one in five have no sanitation service – impacting 2.0 and 1.5 billion people, respectively. Many more people are thought to be served by health care facilities lacking hand hygiene materials, and waste segregation. WASH services are more likely to be available in hospitals and in urban areas than in non-hospitals and rural health care facilities. Compared to hospitals, non-hospitals are twice as likely to have no water or sanitation services. Similar

[77] The United Nations General Assembly recognized the right to safe and clean drinking water and sanitation as a human right that is essential for the full enjoyment of life and all human rights (resolution 64/292).

disparities exist across the urban/rural divide with urban areas having better WASH services[78]. Access to WASH services in birthing settings and primary health care facilities are even lower than in other service areas or types of facilities, highlighting important inequities.

In March 2018 the Secretary-General of the United Nations issued a Global Call to Action to elevate the importance of and prioritize action on WASH in all health care facilities, including primary, secondary and tertiary facilities in both the public and private sectors. The call recognises the important role WASH plays in preventing infections, saving lives, and improving quality of care. The call to action asked for committed leadership and greater accountability for providing WASH services in all health care facilities.

Limited access to WASH in health care facilities impedes the ability to maintain hygienic environments and prevent health care acquired infections. An estimated 15% of patients develop one or more infections during a hospital stay[79]. Lack of WASH in health care facilities also contributes to the unnecessary use of antibiotics and the spread of antimicrobial resistance.

More than 1 million deaths each year are associated with unclean births, while infections account for 26% of neonatal deaths and 11% of maternal mortality[80]. While inadequate WASH enables infections, evidence suggests that poor WASH in health care facilities also leads to increased prophylactic use of antibiotics before birth, which may be an important contributor to antimicrobial resistance. Antimicrobial resistance is a major factor determining clinical unresponsiveness to treatment and rapid evolution to sepsis and septic shock.

Challenges

Many countries have incomplete WASH in health care facility standards, while if they do exist there is limited financing or action to drive implementation. While approximately 80% of 78 countries who participated in the WHO-led Global Analysis and Assessment of Sanitation and Water survey have a policy for WASH or infection prevention and control, less than 25% reported that these policies are fully funded and being implemented[81].

Staff in health care facilities are usually overburdened and often have neither the incentives nor the training to improve and manage WASH services. Facility administrators, health care providers and patients alike often consider that problems of inadequate WASH are intractable.

While health management information systems require facility administrators to report on key inputs for delivering safe, quality and effective care, few national health management information systems collect meaningful information on WASH in health care facilities. Without reliable data on the quality of WASH services, disaggregated by facility type and location, it is difficult to develop and cost plans for improvements.

Environmental health is often disconnected from other key health programmes, resulting in a lack of inclusion of WASH in health care facilities standards and a lack of development of costed WASH elements in other areas of health services, such as quality of care, maternal and child health, and outbreak preparedness and response.

Many national health budgets are organized and prioritized around diseases and fixed costs, such as workforce, rather than on delivering core health systems functions. This contributes to a lack of funds

[78] WASH in health care facilities. Global baseline report 2019. Geneva: World Health Organization and UNICEF; 2019 (https://www.who.int/water_sanitation_health/publications/wash-in-health-care-facilities-global-report/en/, accessed 25 April 2019).
[79] Allegranzi B, et al., 2011. Burden of endemic health-care-associated infection in developing countries: systematic review and meta-analysis. Lancet, 377: 228-241.
[80] Say, L., et al., Global causes of maternal death: a WHO systematic analysis. Lancet Glob Health, 2014. 2(6): p. e323-33.
[81] UN-Water Global Analysis and Assessment of Sanitation and Drinking-Water (GLAAS) 2017 report. Geneva: World Health Organization; 2017 (http://www.who.int/water_sanitation_health/publications/glaas-report-2017/en/, accessed 2 November 2018).

for infrastructure and repair and for the human resources needed to operate, maintain and perform regular functions such as cleaning. And while many countries have decentralized budgeting responsibilities, there are often few local or sufficient revenue schemes to generate funds for WASH in health care facilities, especially in rural areas. This is compounded by the fact that many primary health care services are provided free of charge and thus do not generate revenue to cover recurrent costs or handling of wastes.

Furthermore, most low-income countries and many middle-income countries lack fully functioning, safely managed municipal water and sanitation services. Ensuring safe WASH services in health care facilities may require large capital investments that are beyond the financial means of health budgets.

WHO activities

Globally and regionally, WHO closely partners with UNICEF to advance the agenda on WASH in health care facilities. Both organizations have been jointly coordinating a number of activities to accelerate advocacy, monitoring, national standards and joint WASH and health implementation. Global harmonized indicators have been developed[82], leading to significantly more precise and comparable country data, which makes this issue amenable to target setting and measurement.

In 2019, WHO and UNICEF have released a document, which summarizes the global response to the UN Secretary-General's Call to Action and provides guidance on practical steps that Member States can take at the national and sub-national level to improve WASH in health care facilities to achieve universal access to quality care[83]. These steps guide support WHO support to Member States and focus on conducting a situation analysis and assessment; setting targets and defining a national roadmap; establishing national standards and accountability mechanisms; improving and maintaining infrastructure; monitoring progress and reviewing data; developing the health workforce; engaging communities; and conducting operational research and share learning.

The WHO and UNICEF Water and Sanitation for Health Facility Improvement Tool (WASH FIT) contains practical step-by-step directions and tools for assessing and improving services and utilizes a quality improvement approach to prioritize and address WASH risks[84].

Implementation efforts have consistently highlighted the importance of leadership. Through a coordinated headquarters, regional and country approach, WHO is providing technical and financial support to many countries to establish and strengthen intersectoral leadership and coordination, undertake comprehensive country assessments and support uptake of the WASH FIT approach.

Strong cross-departmental collaborations have allowed for WASH in health care facilities standards to be embedded in WHO global initiatives in the areas of infection prevention and control, national strategies and policies, newborn and child health, and antimicrobial resistance and emergencies.

Regional offices are involved in a number of important regional efforts. The Regional Office for Europe have led efforts to conduct national surveys and to organize forums to discuss results and priority actions. In the European Region, multilateral instruments, such as the Protocol on Water and Health to the 1992 Convention on the Protection and Use of Transboundary Watercourses and International Lakes

[82] Core questions and indicators for monitoring WASH in health care facilities in the Sustainable Development Goals. Geneva: World Health Organization and UNICEF; 2018 (https://www.who.int/water_sanitation_health/publications/core-questions-and-indicators-for-monitoring-wash/en/, accessed 25 April 2019).

[83] WASH in health care facilities. Practical steps to achieve universal access to quality care. Geneva: World Health Organization and UNICEF; 2019 (https://www.who.int/water_sanitation_health/publications/wash-in-health-care-facilities/en/, accessed 25 April 2019).

[84] Water and sanitation health facility improvement tool. Geneva: World Health Organization and UNICEF; 2018 (https://www.who.int/water_sanitation_health/publications/water-and-sanitation-for-health-facility-improvement-tool/en/, accessed 2 November 2018).

and the Ostrava Declaration of the 6th Ministerial Conference on Environment and Health, put due emphasis on WASH in health care facilities.

The Regional Offices for the Eastern Mediterranean and the Western Pacific have both developed regional strategies, which are embedded in universal health care efforts and take into consideration emergencies and climate resilience. In the Regional Offices for Africa and South-East Asia, efforts to establish WASH in health care facilities are being integrated into relevant training, monitoring and implementation packages.

Way forward

WHO and UNICEF, in collaboration with over 30 partners and all regions, have developed a global work plan and architecture on WASH in health care facilities to respond to the Secretary General's call to action[85], promoting a vision in which every health care facility has functional WASH services and practices that enable essential, quality health services for everyone, everywhere. Global targets and metrics for progress have been proposed[86] and will be verified through monitoring of Sustainable Development Goals 3 (health) and 6 (safe water and sanitation). Improvements should focus on inequities across geographic (rural and urban) areas and among primary, secondary and tertiary facilities. In addition, countries are encouraged to set national targets and develop costed plans to incrementally meet such targets.

he WHO/UNICEF Joint Monitoring Programme for Water Supply, Sanitation and Hygiene will regularly report on progress, with the first global baseline report launched earlier in 2019 in time to inform World Health Assembly discussions[87]. An advisory group has been established to provide strategic direction and review to WHO, UNICEF and the partners committed to the global workplan on WASH in health care facilities. A UN-Water expert group is dedicated to this issue and will offer technical and implementation support. Actions will focus on five thematic areas: good practice in leadership and governance; improving monitoring and accountability; providing technical assistance and training; empowering civil society, the community and the workforce; and acting on evidence.

ACTION BY THE HEALTH ASSEMBLY

The Health Assembly is invited to note this report, to adopt the proposed resolution and to focus its discussions on providing guidance on:

- future action by the Organization in respect of water, sanitation and hygiene in health care facilities;
- the process of mainstreaming WASH in health care facilities into health programming and monitoring, to ensure that it is sufficiently addressed by health ministries.

DRAFT RESOLUTION

The Executive Board at its 144th session recommended to the Health Assembly the adoption of a resolution which urges Member States to assess availability and quality of safe water, sanitation and hygiene (WASH) in health care facilities and infection prevention and control (IPC) status, develop and implement a road map and establish minimum standards for WASH and IPC in all health care settings:

[85] Meeting the challenge: responding to the UN Secretary General's Call on WASH in health care facilities. Meeting report. Geneva: World Health Organization and UNICEF; 2018 (https://www.who.int/water_sanitation_health/facilities/en/, accessed 2 November 2018).
[86] WASH in health care facilities. Practical steps to achieve universal access to quality care. Geneva: World Health Organization and UNICEF; 2019 (https://www.who.int/water_sanitation_health/publications/wash-in-health-care-facilities/en/, accessed 25 April 2019).
[87] WASH in health care facilities. Global baseline report 2019. Geneva: World Health Organization and UNICEF; 2019 (https://www.who.int/water_sanitation_health/publications/wash-in-health-care-facilities-global-report/en/, accessed 25 April 2019).

integrate WASH in health programming and provide procedures and funding to operate WASH and IPC in health facilities; set targets within health policies and integrate indicators for WASH and IPC into national monitoring and into accreditation systems; raise awareness on WASH especially in settings used by mothers and children; establish multisectorial collaboration to support the delivery of WASH and IPC across the health system. The resolution further invites international, regional and local partners to support government efforts to empower communities and raise profile of WASH and IPC to strengthen health systems. The Director General is requested to provide global leadership and technical guidance, raise the profile of WASH and IPC and report on the status of WASH in health care facilities as part of SDG 6; catalyse domestic and external resources to support WASH and IPC in health care facilities; report on progress of the resolution to the Health Assembly in 2021 and 2023 through the Executive Board.

Implication for the European Region

Improving access to safely managed WASH services in health care facilities is an unfinished business in several parts of the WHO European Region, especially in rural areas, and thus remains a priority until all health care facilities provide such services. A regional stocktaking workshop on WASH in health care facilities was organized (Bonn, 27-28 September 2017) to raise health sector leadership and to call for national policy action to address WASH in health care facilities[88].

The 2017 Ostrava Declaration on Environment and Health calls upon Member States of the WHO European Region, *inter alia*, to ensure access to safe drinking-water, sanitation and hygiene for all. It specifically stipulates the actions towards ensuring and sustaining the provision of adequate WASH services in health care facilities through systematic situation assessments and by setting national targets and action plans.

The WHO/UNECE Protocol on Water and Health is the key regional policy instrument on water, sanitation and health to operationalize the achievement of the Ostrava Declaration and the aspirations of SDGs into the national context. The improvement of WASH services in institutional settings, including in health care facilities, is a priority area under the Protocol, which will be confirmed at the 5th session of the Meeting of the Parties to the Protocol (Belgrade, November 2019.

The WHO Regional Office for Europe will continue to support several Member States (including Hungary, Kazakhstan, Serbia, Tajikistan) in undertaking baseline assessments and policy analyses on WASH in health care facilities and taking up the WASH FIT approach.

The DG report A72/27 and draft resolution EB144.R5fully align with the EURO regional priorities and actions, as defined by the 2017 Ostrava Declaration Environment and Health and the priorities set under the WHO/UNECE Protocol on Water and Health, as referred to in paragraph 20 of the DG's report. It thus clearly strengthens and reinforces regional, national and sub-national implementation in the WHO European Region.

[88] Improving water, sanitation and hygiene in health care facilities. Copenhagen: WHO Regional Office for Europe (http://www.euro.who.int/en/health-topics/environment-and-health/water-and-sanitation/publications/2019/improving-water,-sanitation-and-hygiene-in-health-care-facilities-2019, accessed 25 April 2019)

12.6 Smallpox eradication: destruction of variola virus stocks

Document A72/28

This report provides an overview of the work undertaken by the Secretariat in preparation for the Seventy-Second World Health Assembly. It summarizes the proceedings and conclusions of the twentieth meeting of WHO's Advisory Committee on Variola Virus Research (Geneva, 26 and 27 September 2018)1 and provides an update on the status of the biennial biosafety inspections of the two authorized repositories of variola virus stocks: the WHO Collaborating Centre for Orthopoxvirus Diagnosis and Repository for Variola Virus Strains and DNA, State Research Centre for Virology and Biotechnology (VECTOR), Koltsovo, Novosibirsk Region, Russian Federation; and the WHO Collaborating Centre for Smallpox and Other Poxvirus Infections, Centers for Disease Control and Prevention (CDC), Atlanta, Georgia, United States of America.

Every two years, WHO biosafety inspection teams visits the variola virus repositories and inspect the containment facilities in the Russian Federation and the United States of America. In this round, the inspection team visited VECTOR in January-February 2019 and is scheduled to visit CDC between 20 and 24 May 2019.

Successive biosafety inspections of the two repository facilities have found that the repositories meet international levels of biosafety and biosecurity, concluded that variola virus stocks remain in secure safekeeping, and made recommendations for ongoing improvement in biosafety in line with evolving knowledge and best practices.

The Advisory Committee also received reports on the status of the WHO Smallpox Vaccine Emergency Stockpile.

In 2018, 10 ongoing project proposals were assessed by the Advisory Committee and approved by the WHO Secretariat. Most notably, having met all regulatory requirements, the antiviral agent tecovirimat was approved for treatment of smallpox by the United States Food and Drug Administration in July 2018.

1. Tecovirimat is the first therapeutic compound approved for use against smallpox.
2. The Advisory Committee noted continuing progress in the development of other antiviral agents, including brincidofovir and NIOCH-14, which are in advanced stages of pre-clinical and clinical trials, and monoclonal antibodies that neutralize variola virus more efficiently than vaccinia immune globulin.
3. The Advisory Committee noted the results of a successful non-inferiority trial for a third-generation vaccine with a better tolerability profile than existing vaccines, and progress towards the development of a more immunogenic and less reactogenic fourth-generation vaccine with an improved safety profile.
4. It also noted advances in development of diagnostics: at VECTOR, a new multiplex real- time polymerase chain reaction technique for species-specific identification of human pathogenic orthopoxviruses and a new reagent kit;
5. At CDC, diagnostic assays specific for orthopoxviruses including variola virus in a multiplex format for automated diagnostic platforms using pre-packaged reagents, a protein-based assay based on monoclonal antibodies for variola virus detection in remote areas, and a variola-virus encoded protein microarray for use in evaluation of antibody responses.

The benefits of variola virus research, including potential applications for prevention and control of monkeypox outbreaks, which are currently seeing a resurgence in Central and West Africa were acknowledged.

The majority view of the Advisory Committee assessed that there is no need to retain live variola virus for development of safer smallpox vaccines beyond those studies already approved. With regard to diagnostic assays essential for public health, members of the Advisory Committee were divided on the question of whether use of live variola virus remained necessary.

The majority view that live variola virus was still needed for the further development of antiviral agents against smallpox. It was particularly noted that it would be prudent and important to encourage the development and licensure of a second antiviral agent with a different mechanism of action from that of tecovirimat, the compound approved in 2018.

In November 2018, WHO published the document Identifying and responding to serious adverse events following immunization following use of smallpox vaccine during a public health emergency. It provides guidance on rapidly establishing vaccine safety monitoring in countries using smallpox vaccine during a smallpox event or outbreak in order to assist the national emergency operations or crisis management committee, national immunization programmes, health care workers, immunization staff and other stakeholders who are part of the response.

ACTION BY THE HEALTH ASSEMBLY

The Health Assembly is invited to note the report.

12.7 Eleventh revision of the International Classification of Diseases

Document A72/29 and A72/29 add 1.

An earlier version of the report was considered by the Executive Board at its 144th session. Document A72.29 add 1. contains a draft resolution.

The International Statistical Classification of Disease and Related Health Problems (ICD) is the global standard classification for mortality and morbidity statistics. Such data, broken down by age, sex and cause of death, are the foundation of public health.

The Health Assembly adopted the tenth revision (ICD-10) in resolution WHA43.24 in 1990. That revision came into effect on 1 January 1993, and currently some 120 Member States report cause-of-death data on its basis to WHO.

Preparation of the revision of ICD10

WHO formally launched the process of revising ICD-10 in 2007. The programme of work has been guided by regular meetings of representatives of the WHO collaborating centres, nongovernmental organizations and some other non-State actors, as well as the ICD-11 Revision Steering Group. Extensive preparation was devoted to a review of the suitability of the structure of ICD, which was by definition a statistical classification of diseases and other health problems, to serve a wide variety of needs for mortality statistics, morbidity statistics, reimbursement, measuring quality of care, patients' safety, monitoring primary care and clinical recording. In addition to the consultations and reports

discussed below, and consultations at regional level, the Secretariat field tested the proposed ICD-11 in 31 Member States across all regions.

At the ICD-11 Revision Conference (Tokyo, 12–14 October 2016), hundreds of experts and representatives of institutions from around the world provided WHO with positive feedback on the content and structure of ICD-11. Comments emphasized that many Member States still do not have adequate systems to support reporting of cause of death and morbidity.

Between January and October 2017, the Secretariat sought comments from Member States onICD-11's new content, structure, features, implementation needs, and data priorities in relation to the2016 version of the eleventh revision. Feedback, including shared responses, was received from Member States in all WHO regions, as were inputs from field testing and dedicated scientific reviews. The version for preparation of implementation released in June 2018 reflected this feedback.

In April 2018, WHO convened statistical experts in a meeting in Geneva to review the chapter structure and categories of the draft ICD-11 for its suitability in legacy use of ICD for mortality and morbidity statistics. The meeting agreed a short set of recommendations regarding nomenclature and some individual categories, which the Secretariat acted upon. The current set of mortality coding rules has been adapted for use with ICD-11.

As of November 2018, projects to prepare for implementation based on the version for preparation of implementation are starting in various Member States, with support from the Secretariat.

Oversight by the Joint Task Force of consolidation and finalization of the revision process

The Joint Task Force, comprising statistical and scientific experts from the former Topic Advisory Groups, served as the steering group and provided strategic and technical advice to WHO for the finalization of the eleventh revision. At its 10th session in October 2018, the Joint Task Force confirmed that the tabular structure, chapter structure and codes were stable, the coding mechanism and coding format were in place, the coding tool was functional, the reference guide and rule base were mature, and the governance mechanisms for maintenance and updating were in place and described. The Joint Task Force, in its final report to the Secretariat on 26 October 2018, recommended that the Secretariat should submit ICD-11 to the Seventy-Second World Health Assembly in May 2019, through the Executive Board in January 2019, for consideration for adoption. The Secretariat should provide adequate resources for maintenance and implementation of ICD-11. Work should continue to be undertaken that goes beyond the core task of revising ICD for morbidity and mortality statistics, and which is necessary if the potential utility and value of ICD-11 are to be tapped, as was the case for ICD-10.

The new structure of ICD-11 and the changes compared with ICD-10, the proposed mechanism for updating ICD, the amendments to mortality and morbidity coding rules, the mechanism for computer-assisted coding and the proposed design of the updating process were presented at the meeting. Participants, including representatives of 55 Member States, suggested that ICD-11 was ready for use and should be submitted to the Health Assembly for consideration of adoption.

General characteristics and content

ICD-11 is designed to meet the needs of diverse users and the demands of information technology. One important innovation is the use of electronic tools and platforms for support of coding, translation and testing, and its presentation for use in electronic environments. Compared with ICD-10, ICD-11 has five new chapters, on: Diseases of blood or blood-forming organs, Diseases of the immune system, Sleep-wake disorders, Conditions related to sexual health, and a supplementary chapter Traditional

medicine conditions. Highlights of updates include the possibility to report antimicrobial resistance, an updated classification of HIV, improved coding of diabetes and of allergies, and the ability to describe patient safety events.

Among additional new features of the eleventh revision are: the inclusion of the concepts of pre-coordination and post-coordination (using multiple codes to describe a condition), which allow health conditions to be described to any level of detail by applying either one pre-coordinated code or more than one code by post-coordination of two or more codes; the inclusion of the concept of multiple parenting, in order to indicate that an entity may be correctly classified in different places; descriptions for all entities throughout ICD-11, not just mental, behavioural or neurodevelopmental disorders (as was the case in ICD-10); two supplementary sections: Section V – Supplementary section for functioning assessment, and Supplementary Section X – Extension Codes; the inclusion of morphology information in the hierarchy in the chapter on Neoplasms; restructuring and renaming of the chapter in ICD-10 on Congenital malformations, deformations and chromosomal abnormalities as Developmental anomalies; reallocation of all genetic syndromes without structural developmental anomalies to appropriate chapters of ICD-11, according to the affected body system(s); relocation of codes that serve to add detail and codes identified as "asterisk" codes in ICD-10 to Chapter 21 (Symptoms, signs or clinical findings, not elsewhere classified), Section X (Extension codes), or in chapters 1 to 24, as appropriate; the section containing the Extension Codes groups anatomy, agent, histopathology, International Non-proprietary Names, devices, and other aspects that may be used to add detail to a code; addition of a Content Model that includes a range of descriptive components for each ICD entity; linkages to other classifications and terminologies or their inclusion where possible, and alignment of items used in other members of WHO's Family of International Classifications wherever possible.

Implementation

ICD-11 will be published both electronically and in print. In the electronic version, information will be interlinked and visible in the relevant context. In the print version, the information will be divided into three volumes, as before: the tabular list, the reference guide, and the index. All three are needed to use ICD-11 correctly. Member States intending to produce national language versions of the eleventh revision should notify the Secretariat of their intentions. All translations should be done on, or integrated in, the ICD-11 translation platform, access to which will be provided by the Secretariat.

The release will be accompanied by an implementation package containing training materials, implementation guidance, transition tables, translation tools, information about governance and maintenance, and different formats of ICD-11 for incorporation into existing health-reporting systems.

A global ICD-11 training and Implementation workshop took place in February 2019 in Tunis to discuss ICD-11 implementation preparation and formulation of a regional and global implementation plan.

Future revision and update of ICD 11

The Health Assembly in resolution WHA43.24 (1990) endorsed an updating process within the 10-year revision cycle for ICD-10. During the extended period of use of the tenth revision, difficulties have been experienced owing to the lack of incorporation of updates by all Member States and the need for some major updates.

For ICD-11, broader outreach to Member State participation in the discussions and the formation of a dedicated Medical Scientific Advisory Committee are expected to overcome the issues experienced with ICD-10 and facilitate the future dissemination of updates for ICD-11 to users. With respect to statistical impact and based on the experiences with different levels and speeds of uptake of updates,

any changes proposed during the lifetime of ICD-11 will be considered very carefully in relation to their impact on analyses and trends. Optional subcategories, index entries and improvements to user guidance will be updated more frequently than the four-character categories.

ACTION BY THE HEALTH ASSEMBLY

The Health Assembly in invited to note the report

DRAFT RESOLUTION

Document A72/29 Add.1 contains a draft resolution which was developed through informal consultations during the intersessional period, in line with the course of action agreed by the Executive Board at its 144th session

The draft resolution proposed for adoption by the Health Assembly adopts the eleventh revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-11), to come into effect on 1 January 2022, subject to transitional arrangements, with the following constituents: (1) the detailed list of four-character categories and optional five- and six-character subcategories1 with the short tabulation lists for mortality and morbidity; (2) the definitions, standards and reporting requirements related to maternal, fetal, perinatal, neonatal and infant mortality; (3) the rules and instructions for underlying cause coding for mortality and main condition coding for morbidity. The

Resolution requests the Director-General to allocate sufficient resources within the Organization for the regular updating and maintenance of ICD-11 and its eventual revision; to publish the ICD-11 in the six official languages of the Organization and put in place the digital tools and support mechanisms; to provide support upon request to Member States in implementing ICD-11; to provide transitional arrangements from 1 January 2022 for at least five years, and as long as necessary to enable Member States to compile and report statistics using previous revisions of the International Classification of Diseases. It also requests the Director General to implement a regular updating process for ICD-11and to report on progress in implementing this resolution, through the Executive Board, to the Seventy-Sixth World Health Assembly in 2023, the Eightieth World Health Assembly in 2027, and the Eighty-fifth World Health Assembly in 2032, and to include in the 2032 report an assessment of the need for revision of ICD

Implication for the European Region

In the European Region 51 countries report to the WHO Global Mortality Database in ICD-10.
Two Member States still submit data to WHO coded in ICD-9

The European Region is integrating health information at an accelerating rate. ICD is one of the key classifications that allow systematic use and analysis of key health information. Currently, all modernisation efforts in European Member States focus on better use of ICD-10.

In the WHO European Region, there are several WCCs that support WHO in the work on the international family of classifications and assist with provision of support to Member States

12.8 Global Strategy for Women's, Children's and Adolescents' Health (2016–2030)

Document A72/30

This report provides an update on the implementation of resolution WHA69.2 (2016) on reporting on the implementation of the Global Strategy for Women, Children and Adolescent Health (2016-2030) and progress made towards universal coverage of maternal, newborn, child and adolescents` health interventions. The Global Strategy offers a road map for attaining its 3 objectives: survive, thrive and transform – to end preventable mortality, to promote health and well-being, and to expand enabling environments with evidence-based action areas for the health sector, other sectors and community action. Its guiding principles include equity, universality, human rights, development effectiveness and sustainability.

Reducing inequities between the countries and subnational inequities as well, ensuring universal health coverage and progressively realizing the rights to health and to health care of every woman, child and adolescent everywhere remain challenge in most settings.

While important gains have been made during the last two decades in reducing maternal and neonatal mortality, globally, an estimated 303 000 maternal deaths occurred in 2015 and 2.5 million neonatal deaths in 2017[89]. Estimates for 2015 suggest 2.6 million stillbirths. The major complications that account for most cases of maternal and new-born deaths are preventable or treatable.

Worldwide in 2017, 151 million children under 5 suffered from stunting, 51 million from wasting, and 38 million were overweight. Coverage of key interventions for children under 5 varies. Interventions vital for keeping children healthy and treating common illnesses have lower coverage rates, globally. Exclusive breastfeeding among infants aged 0–5 months is 38% median, and 64% of children with acute respiratory infection taken to a health facility.

Access to family planning services and to wide-range contraceptive commodities, quality antenatal care services and emergency obstetrical and neonatal care, and skilled birth attendance during pregnancy and post-partum period are critical for preventing maternal and new-born deaths. However, huge inequities in coverage and quality of care in general- and of women`s, children`s and adolescent`s health in particular – continue. Stronger effort is needed to improve quality of health services and to build resilient health systems as universal health coverage cannot be achieved without substantial improvements in the quality of care. The WHO's normative activity in 2018 in different areas of women, children and adolescent health (e.g. WHO recommendations on intrapartum care for a positive childbirth experience, on uterotonics for prevention of postpartum haemorrhage, recommendation on non-clinical interventions to reduce unnecessary caesarean sections) drive the change and advance improvements in quality of care in countries. Global survey and consultations on priority

[89] UNICEF, WHO, World Bank, UN-DESA Population Division. Levels and trends in Child Mortality Report 2018: estimates developed by the UN Inter-agency Group for Child Mortality Estimation. New York: United Nations Children's Fund; 2018.

actions to strengthen midwifery, supported by WHO, contributed to a special report development on strengthening quality of midwifery education being produced.

WHO and UNICEF have initiated the Child Health Redesign initiative with the aim of updating strategic directions for global child health, aligned with the Sustainable Development Goals. The Nurturing Care Framework (2018), a road map for actions to enable children to survive, thrive and reach their full potential, has been taken up by numerous countries and partners. An initiative on early child development was embraced, showing commitment to the early years for strengthening human capital.

WHO's global nutrition policy review for 2016-2017 showed that 89% of 160 countries had some type of school health and nutrition programme, but most specific programme components have weakened since the review for 2009–2010. WHO and UNESCO have launched an initiative on making every school a health-promoting school, which aims to develop and promote global standards in this area.

Cervical cancer is the fourth most common cancer among women globally, with 570,000 new cases and 311,000 deaths in 2018, nearly 90% of these deaths were in low- and middle-income countries.[90] Prevention of cervical cancer by HPV vaccination and proven strategies across the care continuum from vaccination to screening and treatment of pre-cancerous lesions, early detection and treatment offer the potential to eliminate cervical cancer as a public health problem. A global call for action towards the elimination of cervical cancer at the World Health Assembly in May 2018 and the elimination of cervical cancer made as a priority under the Thirteenth WHO General Programme of Work will contribute to the realization of the 2030 Sustainable Development Goals and the Global Strategy for Women's Children's and Adolescents' Health (2016-2030).

In terms of leaving no one behind, critical new evidence points to the importance of paying urgent attention to emergencies. Specific vulnerabilities of migrant and refugee women, children, and adolescents threaten their health and wellbeing. WHO is working to address these issues through a number of relevant initiatives, networks and research. A recent report by the WHO Health Evidence Network suggests improved access to services by the removal of legal restrictions and provision of full health coverage for all pregnant women and for children regardless of immigration status.[91] The adaptation of WHO existing guidelines on sexual and reproductive health to humanitarian and emergency settings is underway to ensure meeting the needs of populations in challenging settings.

Monitoring and accountability is critical to track the progress towards implementation of essential policies on sexual, reproductive, maternal, new-born, child and adolescent health in

[90] 90 IARC/WHO. Global Cancer Observatory's GLOBOCAN 2018 figures, drawn from available population-based cancer registry; Cervical Cancer Fact Sheet: available at: http://globocan.iarc.fr/Pages/fact_sheets_cancer.aspx.

[91] 9 Bradby H, Humphris R, Newall D, Phillimore J. (2015) Public health aspects of migrant health: a review of the evidence on health status for refugees and asylum seekers in the European Region. Health Evidence Network synthesis report 44. Copenhagen: WHO Regional Office for Europe

countries. WHO global platform to track these policies has been developed and data collection from countries initiated.

ACTION BY THE HEALTH ASSEMBLY

The Health Assembly is invited to note this report.

Implication for the European Region

The WHO Regional Office for Europe's 2016 Action plan for sexual and reproductive health, adopted by the Regional Committee for Europe Resolution EUR/RC66/R7 at the 66th session in September 2016, provides a rights-based and comprehensive framework to maintain and improve sexual and reproductive health.

Despite important progress made towards improving key sexual and reproductive health indicators in the Region, there are challenges ahead at country level. The evidence to date suggests that universal access to sexual and reproductive health is an unfinished agenda for the Region and a challenge to the attainment of the Sustainable Development Goals.

WHO Regional Office for Europe provides support to Member States to improve and maintain sexual and reproductive health in line with its Action plan for sexual and reproductive health by providing technical assistance for conducting a situation analysis of present needs; assisting countries in evaluating implementation of the national sexual and reproductive strategies and developing the new strategies and action plans; assisting with the development of monitoring and accountability frameworks. In this aspect, inter-country regional meeting in Sweden, in August 2018, attended by 25 Member States played a critical role and resulted in increased expressions of interest and requests from Member States in evaluation of their existing strategies and development of new ones, which is evidence of their commitment towards SRH.

WHO/Europe is working to provide Member States with support in accelerating Universal Health Coverage (UHC) through strengthening primary health care and overall health system to deliver comprehensive, people-centred sexual, reproductive, maternal, child and adolescents health services and achieving greater health equity. This is provided by assessing policies on universal coverage for sexual, reproductive, maternal, child and adolescents' health in the country, the extent to which they are available to the people for whom they are intended and at what cost and identifying potential health system barriers to the provision of these health services. A standardized methodology for country assessment was developed, together with assessment reports and case studies, specific recommendations tailored to country needs, integrated technical assistance and policy dialogue approach for each country. These resources will aid understanding of the situation in individual countries and support Member States to translate policies into action for the progressive realization of universal access to sexual, reproductive, maternal, child and adolescents' health services.

WHO/Europe is supporting sixteen Member States to implement quality of care instruments and tools, guidance on evidence-based standards of care across continuum of maternal and new-born health care, and other sexual and reproductive health areas, maternal nutrition and weight gain during pregnancy, as well as new-born, infant and young child nutrition identified as top priorities.

There is a strong response from WHO/Europe and the readiness for action among the Member States on migration and refugee issues. The policy guidance on migrant maternal and new-born health launched to increase knowledge of Member States on priority actions, and available tools and to provide them with practical suggestions and recommendations based on experience and scientific evidence. Implementation of the policy guidance and practical action points in countries will require multi-stakeholder collaboration and coordination. A multi-level policy dialogue on migrant and refugee women health needs on both the national and the EU levels is a priority.

Promoting Early Childhood development (ECD) is an integral part of the Regional Child and Adolescent Health Strategy, 2016-2020. The Baseline Survey on the implementation of the strategy indicated that all countries have some interventions to promote Early Childhood development in place. However, only 39% had systems that offer a combination of medical approaches and psychosocial interventions. Following the first technical meeting on Early Childhood development in October 2018, the WHO Regional Office for Europe embarked on developing a regional Early Childhood development framework based on adapting the global Nurturing Care Framework for the European Region's context and addressing more prominently the monitoring of child development, early detection and response to developmental concerns.

Based on the recommendations of the Child health redesign Regional technical consultation in October 2018 a revision of the clinical guidelines of primary care for children and adolescents has been commissioned. They will support provision of quality care by primary health providers working with children and adolescents.

In December 2016, a high-level conference in Paris strengthened intersectoral cooperation between the health, education and social sectors for better, more equal health and social outcomes for children and adolescents. The school setting was acknowledged as essential for developing a healthy generation and the conference declaration called for making every school in the Region a health promoting school.

Making schools health promoting settings is the aim of the WHO-associated Schools for Health in Europe (SHE) network. Twelve Eastern European and Central Asian countries developed national road maps with a focus on non-communicable disease prevention in and through schools. Azerbaijan, Moldova, Kazakhstan, Ukraine and Uzbekistan piloted school health approaches and were specifically supported. Based on successful model of health promoting schools in 2019 Kazakhstan initiated its scaling up in all the regions.

Furthermore, through multisectoral action at regional and country level, WHO Europe is supporting promotion of comprehensive sexuality education (CSE) policies and intersectoral policy dialogues, working with partners on country capacity buildings in CSE. This is an area of work where WHO Europe can share comprehensive sexuality education competency frameworks, policies, educational tools as well as successful implementation approaches from countries.

There is strong collaboration, coordination and partnership with WHO Collaborating Centers in Europe, Eastern Europe and Central Asia Regional Office of the United Nations Population Fund and Regional office of the United Nations Children's Fund in implementing activities in countries in support of the Action Plan and progress towards universal access to sexual and reproductive health and development of new European child and adolescent health strategy post 2020.

12.9 Emergency and trauma care

Document A72/31

The 144th session of Executive Board in January 2019 requested that emergency care and trauma be included on the provisional agenda of the Seventy-Second World Health Assembly, and this report has been prepared in response.

Access to Emergency Care

Emergency Care is an integrated platform aimed at delivering seamless, continuous and people-cantered care across the different health services in a time sensitive manner for acute health conditions across the life course. Emergency Care System is an essential element of Universal Health Coverage. Especially when there are barriers to accessing health care, people may seek care only when they are acutely ill or injured. Effective emergency care systems are designed to respond rapidly to people's acute needs even before a diagnosis is known, and they ensure continuity of care and safe transition from the primary to the secondary level of the health system.

The effectiveness of many proven health interventions declines with delays to care, and timeliness is a critical dimension of quality. Maintaining an unbroken chain of care from the community to the hospital saves lives. Implementing community-based education and first-aid training, certification for prehospital providers and 24-hour availability of emergency unit services at first-level hospitals save lives and maximize the effectiveness of later interventions. Well organized emergency care is therefore a key mechanism for achieving a range of Sustainable Development Goal targets, including those on universal health coverage, road safety, maternal and child health, noncommunicable diseases, infectious diseases, disasters and violence. The World Bank Disease Control Priorities project estimates that more than half the deaths and around 40% of the total burden of disease in low- and middle-income countries result from conditions that could be treated with prehospital and emergency care.2 The lack of organized emergency care in many low- and middle income countries leads to wide discrepancies in outcomes across the range of emergency conditions.

Strengthening emergency care systems

A common misconception is that emergency care services are too costly for health systems in low- and middle-income countries, but many high-impact improvements in emergency care can be made at very low cost. Implementing simple systematic processes can improve the quality of emergency care and save lives, even without input of other resources. Many recent studies have ranked components of emergency care as among the most cost-effective public health interventions. Strengthening of prehospital care through training of community-based providers and use of staffed community ambulances has been estimated to cost less than US$ 100 per disability-adjusted life year averted or per life saved and has been shown to reduce mortality by 25–50% in some low- and middle-income country contexts.

Most emergency care around the world is not provided by specialists. Effective expansion of emergency care systems requires educational and planning initiatives to cover the full range of providers who deliver emergency care. Because prehospital services must be delivered where and when they are needed, and emergency units must remain accessible to all who need them, ensuring the safety of emergency care providers is a challenge. Prehospital and hospital emergency units should have both dedicated plans in place to protect providers, patients and infrastructure from violence, and clear protocols for the prevention and management of hazardous exposures.

Improving outcomes requires understanding the potential and actual utilization of emergency care, and that this usage be taken account of in planning and allocating resources. Existing data often fail to characterize undifferentiated presentations and their level of acuity.

Emergency care systems promote equity by providing non-discriminatory access to all people in need of timely care, without regard to ability to pay or other socio-cultural factors. In many countries, the emergency care system serves as the major health system safety net and is the primary point of access to the health system for marginalized populations with limited access to services

The report recommends that all Member States take steps towards strengthening their emergency care systems and lists a number of activities for achieving this such as developing policies, emergency care assessments, data collection for improving care, emergency care training. WHO has defined a framework of essential emergency care functions and an associated assessment tool that allows policy-makers to draft action plans that are best suited to their national contexts. Furthermore, WHO identified shared challenges for many low- and middle-income countries and offers a range of tools to help address these such as assessment tool, standards, training resources.

ACTION BY THE HEALTH ASSEMBLY

The Health Assembly is invited to note this report and provide further guidance.

Implication for the European Region

The WHO Emergency Programme (WHE) in the European Region is focusing on linking the Emergency care system (ECS) with public health services, primary, secondary and specialized care, ensuring the above-mentioned principles and including hazard-specific services and care for all hazards. The WHE in the European Region, including its teams in the Priority Countries, have been working closely with the noncommunicable diseases teams to upgrade the existing Emergency Care System Assessment tool, ECSA, to ECSA+. The new tool is linked to the IHR (2005) Core Capacities

monitoring and evaluation and tackling the all hazards approach. The assessment using the ECSA+ will be used first in the Priority Countries of the WHO European Region. Romania and Israel have been the Centres of Excellence for ECS in Region. Training, simulation exercises have been hosted in support of Priority Countries.

Support to Member States within WHO European Region, mostly to Low Middle Income Countries, is provided in an interdivisional manner and with support of WHO Collaborating Centres and professional associations.

In the European region, the Emergency Medical Team (EMT) clinical standards are integrated into the standard setting of emergency care at public health services, primary, secondary and specialized care and aims at the highest standards of professionalism across all functions and specializations, including for ECS. Focusing on the health workers, learning and on-the-job trainings are based on the best available evidence and technical expertise. To strengthen communities' resilience, WHO Regional Office is working with community workers, such as social workers, anthropologists and psychologists.

Many Member States in the European Region have ECS, but access is limited or costly, sometimes preventing the provision of time-sensitive care to those who really need the urgent care. WHO Regional Office is supporting Member States to strengthen the continuum of care.

12.10 The public health implications of implementation of the Nagoya Protocol

Document A72/32

The Executive Board at its 144th session, agreed to include an item on the public health implications of implementation of the Nagoya Protocol. This report provides considerations of this matter and builds upon the report by the Secretariat noted at the 140th session of the Executive Board which concluded that the Nagoya Protocol has public health implications, which include opportunities to advance both public health and principles of fair and equitable sharing of benefits. In addition, the report inter alia outlined the importance of timely pathogen sharing to global public health and examined how the sharing of benefits arising from their use has been, and will increasingly be, important both for public health reasons and in light of the entry into force and implementation of the Nagoya Protocol.

Timely sharing of pathogens and benefits enables identification of the pathogen, a sound risk assessment, initiation of evidence-based interventions and the subsequent development and deployment of countermeasures such as diagnostics, vaccines and therapeutics. The Nagoya Protocol to the Convention on Biological Diversity [92]is a treaty that supports these objectives and that offers opportunities to further them. The aim of the Protocol is the implementation of the Convention's third objective of the fair and equitable sharing of benefits arising from the use of genetic resources. The Protocol includes, inter alia, a recognition of the importance of genetic resources to public health; it requires its Parties, in their implementation, to pay due regard to cases of present or imminent public health emergencies; and it makes reference to the International Health Regulations (2005). National implementation of the Nagoya Protocol involves multiple government sectors. In this context, engagement of the health sector is crucial to ensuring that public health considerations are duly taken into account.

Governments can make arrangements for access and benefit sharing to facilitate the sharing of pathogens and corresponding benefits, by means that include multilateral arrangements. The principles

[92] Nagoya Protocol on Access to Genetic Resources and the Fair and Equitable Sharing of Benefits Arising from their Utilization to the Convention on Biological Diversity: text and annex. Montreal, Quebec, Canada: Secretariat of the Convention on Biological Diversity; 2011 (https://www.cbd.int/abs/doc/protocol/nagoya-protocol-en.pdf, accessed 13 March 2019)

of global public health, including those enshrined in the Constitution of the World Health Organization, and the critical importance of timely access and fair and equitable benefit sharing can serve as a reference for future steps in developing collaborative arrangements to promote: both access and benefits; surveillance of pathogens; effective international response to outbreaks; and appropriate collective use of benefits and their distribution based on global public health needs.

The importance of ensuring timely access to human pathogens for public health preparedness and response purposes is clear and is reiterated in the Nagoya Protocol's preamble. Importantly, the Protocol includes provisions with potential application for collaborative approaches to accessing pathogens and sharing benefits arising from their use, furthering core principles of fairness, equity and the protection of global public health.

Member States should take proactive steps to ensure that health ministries are represented and engaged in discussions and planning. In support, WHO is ready to explore, in close dialogue and collaboration with all relevant partners, possible options, including codes of conduct, guidelines and best practices, and global multilateral mechanisms, for pathogen access and benefit sharing. Such work would be done in harmony with the Nagoya Protocol and its principles. It would focus on: (1) preserving and promoting the ability to respond to future outbreaks of disease in the best interest of global public health by ensuring timely sharing of pathogens according to appropriate biosafety and biosecurity standards; (2) increasing the fairness and equity of benefit sharing in order to further support public health surveillance, preparedness and response; (3) advancing implementation of the International Health Regulations (2005), especially the strengthening of core capacities in countries, particularly those in need.

ACTION BY THE HEALTH ASSEMBLY

The Health Assembly is invited to note this report and to provide further guidance.

21. Matters for information

21.1 Strengthening synergies between the World Health Assembly and the Conference of the Parties to the WHO Framework Convention on Tobacco Control

Document A72/57

This document is a report by the Head of the Convention Secretariat on behalf of the 8th session of the Conference of the Parties to the WHO Framework Convention on Tobacco Control.

The 8th session of the Conference of the Parties to the WHO Framework Convention on Tobacco Control (CoP) took place on the 1–6 October 2018. This Report provides an overview of the main decisions adopted by the Conference of the Parties and of the main outcomes of the first session of Meeting of the Parties to the Protocol to Eliminate Illicit Trade in Tobacco Products.

The CoP was attended by delegations from 148 Parties to the Convention and representatives from WHO, other organizations in the United Nations, intergovernmental organizations and civil society. The CoP adopted 24 decisions of which four related to the proceedings of the Conference of the Parties, six to treaty instruments and technical matters, two to the reporting of implementation assistance and

international cooperation, and 12 to budgetary and institutional matters. One of the most significant outcomes of the CoP was the adoption of the Global Strategy to Accelerate Tobacco Control: Advancing Sustainable Development through Implementation of the WHO FCTC 2019–2025. The Global Strategy aims to strengthen implementation of the Framework Convention and provides a road map to guide the work of the Parties, the Convention Secretariat and other stakeholders. It aims also for stronger alignment between, and cooperation with, WHO, entities in the United Nations system and other relevant international agencies and initiatives.

The CoP recognized the major breakthrough heralded by the entry into force of the Protocol to Eliminate Illicit Trade in Tobacco Products on 25 September 2018. The first session of the Meeting of the Parties to the Protocol drew participants from 44 State Parties to the Protocol and 56 State Non-Parties, along with representatives from civil society and intergovernmental organizations, incl. WHO. As at 28 February 2019, 50 Parties have joined the Protocol. In this regard, WHO's Member States that are Parties to the Framework Convention are encouraged to become Parties to the Protocol.

ACTION BY THE HEALTH ASSEMBLY

The Health Assembly is invited to note the report.

Implication for the European Region

As of end of April 2019, out of 53 countries in the WHO European Region, 50 countries and the European Union are Parties to the WHO Framework Convention on Tobacco Control. This is a clear expression of strong political commitment to tackle the tobacco epidemic in countries and in the European Region. 17 countries from the WHO European Region and the European Union have joined the Protocol to Eliminate Illicit Trade in Tobacco Products.

The tobacco industry is strong and continues to threaten public health gains in tobacco control.
Trends show that tobacco use is fast becoming a major equity issue, while continuing to be the largest preventable public health risk the world faces. Tobacco control is key to achieving SDG 3.4 and 3a and WHO's goals in pillar 3 of the 'triple billion'. The demands for WHO's assistance in tobacco control matters are high in the Region and globally (110 countries have asked WHO for support in the coming biennium. Based on the analysis by the WHO, large majority of countries would not reach the global voluntary target in tobacco use, 30% of relative decrease in tobacco use, by 2025.

Tobacco control team in the European Office is country-focused and works as one team across all levels of WHO as well as the Convention Secretariat in assisting Member States to implement the Convention. There is a need to ensure the continuous prioritizing of the most cost-effective solutions available to meet the challenge of tobacco epidemic. Identifying synergies and using policies that achieve multiple government goals, whilst at the same time protecting entire populations, especially the vulnerable, is core of the transformation and part of the organization's future strategy for accelerated country level impact, and to protect the world from the very real danger that tobacco continues to represent to all.

21.2 Outcome of the Second International Conference on Nutrition

Document A72/58

This document is the second biennial report by the Director-General focusing on progress made in the implementation of the Rome Declaration on Nutrition. It has been prepared jointly by FAO and WHO and mainly highlights main achievements at the international and country levels. The Rome Declaration on Nutrition was adopted in November 2014, at the Second International Conference on Nutrition organized by FAO and WHO. In its resolution WHA68.19 (2015), the Sixty-Eighth World Health Assembly endorsed the outcome documents from the International Conference.

Implementation of Rome Declaration

The Global database on the Implementation of Nutrition Action (GINA) gathers policies with nutrition goals in 189 countries including on stunting (111 countries), on anaemia (87), on low birth weight (100), on child overweight (139), on exclusive breastfeeding (127) and on wasting (127). A nutrition coordination mechanism with intersectoral involvement across government sectors and nongovernmental partners exists in 147 countries, while a high-level mechanism (in the Office of the President or Prime Minister) in 38 countries.

Nearly all countries have implemented counselling on breastfeeding (159) and complementary feeding (144) and growth monitoring and promotion. Some progress has been made in the implementation of actions to promote healthy diets (151 have counselling programmes), the prevention of obesity and diet-related NCDs, nutrition counselling on primary health care and media campaigns on healthy diets and nutrition (148). Vitamin and mineral supplementation programmes generally target pregnant women and children. Food distribution programmes and the treatment of moderate acute malnutrition and severe acute malnutrition were most common in the WHO African and South-East Asia regions.

The WHO Country Capacity Survey, the Second Global Nutrition Policy Review and ongoing monitoring through GINA have tracked the status of implementation of recommendations from the Second ICN and the Ending Childhood Obesity implementation plan: 59 countries have established a tax on sugar-sweetened beverages; 46 have mandatory regulations on marketing to children; 55 have established front-of-pack labelling (8 with mandatory regulations); 28 have regulations on the inappropriate marketing of complementary food; 87 have school food standards; 28 have banned food and drink vending machines in schools and 27 are taking action to ban the use of industrially produced *trans*-fats. A database to formally register countries' SMART commitments has been developed[93].An additional 12 Member States have made commitments in increasing domestic financing of nutrition action and eliminating industrially produced *trans*-fats, among others.

Norway is leading a global action network on sustainable food from the oceans and inland waters for food security and nutrition[94]. Australia and France are leading a global one on efforts around nutrition labelling. A regional action network for ending childhood obesity has been established in the Pacific by seven Pacific island countries. Seven countries from the Region of the Americas established a regional action network for healthy food environments, led by Chile. A regional action network for healthy schools in South-East Asia, brought together ministries of health and education in addition to

[93] https://extranet.who.int/nutrition/gina/en/commitments/summary.
[94] https://nettsteder.regjeringen.no/foodfromtheocean/.

nongovernmental partners from four countries, to identify priority areas for diet and physical activity in schools.

A number of commitments were made at international conferences in 2017-2018 including in the Montevideo Roadmap 2018–2030 on NCDs as a Sustainable Development Priority,[95] and the third High-level Meeting of the UNGA on the Prevention and Control of NCDs (New York, September 2018). During the Global Nutrition Summit, held on the margins of the G7 Health Ministers' Summit (Milan, November 2017), US$ 3.4 billion was pledged to tackle the global malnutrition crisis, including US$ 640 million in new funding. The Mar Del Plata Health Declaration,[96] adopted by the G20 Meeting of Health Ministers (Argentina, October 2018), focused on AMR, childhood overweight and obesity, the strengthening of health systems and the responsiveness of health systems to disasters, catastrophes and pandemics, which are all areas of the Framework for Action from the Second ICN.

Contributions by Organizations in the UN System

WHO has developed normative products to support the implementation of the Second ICN, including evidence-informed guidelines on physical activity and sedentary and sleep behaviour for children under five years of age; assessing and managing children at primary health care facilities to prevent overweight and obesity; fortification of rice with vitamins and minerals;[97] effective actions for improving adolescent nutrition;[98] iodine thyroid blocking guidelines for use in planning and responding to radiological and nuclear emergencies;[99] protecting, promoting and supporting breastfeeding in facilities providing maternity and newborn services;[100] guiding principles on nutrition labelling of foods; implementation manuals on ending the inappropriate promotion of foods for infants and young children;[101] the Baby-friendly Hospital Initiative;[102] and tracking progress in meeting targets for 2025.[103]

FAO and WHO have jointly developed tools to support the implementation of the DAN, including a guide for countries to translate the policies and actions of the voluntary Framework for Action into country-specific commitments and a policy brief on driving commitment for nutrition within the Decade.[104]

WHO has launched REPLACE, a global initiative to eliminate trans-fats from the food supply by 2023, and to date commitments for action have been made by 24 countries.[105]

WHO has supported the implementation of the Global Nutrition Monitoring Framework in 36 countries. In the European Region, more than 40 countries are involved in the Childhood Obesity Surveillance Initiative. Jointly with UNICEF and the World Bank, WHO published malnutrition estimates;[106] and jointly with the NCD Risk Factor collaboration, WHO published the first global estimates for obesity in children aged 5–19.[107] Several reports have been published with partner organizations, including *The*

[95] http://www.who.int/conferences/global-ncd-conference/montevideo-report.pdf?ua=1.
[96] https://g20.org/sites/default/files/health_ministers_declaration.pdf.
[97] http://www.who.int/nutrition/publications/guidelines/rice-fortification/en/.
[98] http://www.who.int/nutrition/publications/guidelines/effective-actions-improving-adolescent/en/.
[99] http://www.who.int/nutrition/publications/guidelines/iodine-thyroid-blocking/en/.
[100] http://www.who.int/nutrition/publications/guidelines/breastfeeding-facilities-maternity-newborn/en/.
[101] http://www.who.int/nutrition/publications/infantfeeding/manual-ending-inappropriate-promotion-food/en/.
[102] http://www.who.int/nutrition/publications/infantfeeding/bfhi-implementation/en/.
[103] http://www.who.int/nutrition/publications/operational-guidance-GNMF-indicators/en/.
[104] http://apps.who.int/iris/bitstream/handle/10665/274375/WHO-NMH-NHD-17.11-eng.pdf?ua=1.
[105] http://www.who.int/nutrition/topics/replace-transfat/.
[106]http://www.who.int/nutgrowthdb/2018-jme-brochure.pdf?ua=1&ua=1. https://www.thelancet.com/pdfs/journals/lancet/PIIS0140-6736(17)32129-3.pdf.
[107] https://www.thelancet.com/pdfs/journals/lancet/PIIS0140-6736(17)32129-3.pdf.

State of Food Security and Nutrition in the World,[108] *The Global Nutrition Report 2017*[109] and "*Taking action on childhood obesity*".[110]

In June 2018, WHO and Chatham House held a dialogue with private-sector representatives of the food and non-alcoholic beverage industries at Chatham House in London. WHO submitted specific expectations on the reduction of salt, free sugars and unsaturated fats and on the elimination of industrial *trans*-fats from foods, which has led to new public commitments on the part of the industry.

Regarding food safety and AMR in the food chain, FAO and WHO have developed and field-tested a food control assessment tool in 5 countries in 2017–2018 with a view to official release in 2018. Following the relaunch of the FAO/WHO Project and Trust Fund for Enhanced Participation in Codex (Codex Trust Fund) in 2016, FAO and WHO are supporting 14 countries through multi-year country projects. The membership of the FAO/WHO International Food Safety Authorities Network (INFOSAN) has grown from 440 members in 186 Member States in 2015 to more than 500 in 188 Member States in 2018. In 2017, the FAO/WHO Codex Alimentarius Commission approved new work for the Ad Hoc Intergovernmental Task Force on AMR, which is to complete its work by 2021. Finally, FAO, WHO and the African Union are organizing the First International Conference on Food Safety in Addis Ababa in February 2019, ahead of the FAO/WHO/WTO International Forum on Food Safety and Trade, to be held in Geneva in April 2019, to raise awareness of the importance of food safety and further the commitments made at the Second ICN.

FAO has prioritized the prevention of overweight and obesity through the promotion of healthy diets, providing support to countries to transform their food systems and include nutrition objectives in their food and agricultural policies. The FAO Committee on Agriculture also approved the establishment of an International Year of Fruits and Vegetables and an International Day of Awareness of Food Loss and Waste.

UNICEF entered its new strategic plan period (2018–2021) with a vision to consolidate and expand the programmatic gains of addressing child malnutrition in all its forms – stunting, wasting, micronutrient deficiencies and overweight around the world. UNICEF intends to meet three annual targets by 2021: 1/ reach at least 250 million children under five years of age with services to prevent stunting and other forms of malnutrition – 2/ reach at least 100 million adolescent girls and boys with services to prevent anaemia and other forms of malnutrition – 3/ reach at least 6 million children with services to treat severe wasting and other forms of severe acute malnutrition in development and humanitarian contexts.

WFP continues to maintain its twin-track approach of responding to the immediate food and nutrition needs of people affected by conflict and emergencies, while supporting countries in achieving their national SDG targets, in particular 2.2. In 2017, WFP directly assisted 91.4 million people in 83 countries, 55 of which implemented nutrition-specific programming that reached 16.3 million people. Its nutrition programming is guided by the WFP Nutrition Policy (2017–2021) and by its implementation and costing plan.

International Fund for Agricultural Development (IFAD) investments target the most vulnerable farming households in rural areas and adopt a people-centred approach with the goal of shaping food systems for healthy diets and optimizing the contribution of agriculture and rural development interventions to nutrition, while ensuring that investments in nutrition-sensitive agriculture are also

[108] http://www.who.int/nutrition/publications/foodsecurity/state-food-security-nutrition-2017-fullreport-en.pdf?ua=1.
[109] http://globalnutritionreport.org/wp-content/uploads/2017/11/Report_2017-2.pdf ; 2018 edition forthcoming in November 2018.
[110] http://apps.who.int/iris/bitstream/handle/10665/274792/WHO-NMH-PND-ECHO-18.1-eng.pdf?ua=1.

environmentally sustainable. IFAD is ensuring that projects approved in 2016−2018 are nutrition-sensitive, thus addressing all forms of malnutrition by improving dietary quality.

Way forward

While international advances indicate that the Second ICN has led to a broad international debate on the double burden of malnutrition and the role of food systems in healthy diets, national progress has been uneven. Action networks will be a driver for scaling up commitments and achieving concrete results.

The status of implementation of commitments of the Rome Declaration will be reviewed at the mid-term of the DAN and in the course of preparation of the third biennial report, the review will be aligned with the convening of the 2020 Nutrition for Growth meeting.

ACTION BY THE HEALTH ASSEMBLY

The Health Assembly is invited to note the report.

Implication for the European Region

In most Member States of the WHO European Region, the prevalence of stunting, wasting and anaemia has been declining rapidly since the 1990s, however issues do persist in some countries and among some vulnerable groups. At the same time maternal, infant and young child nutrition are not optimal and the WHO European Region has the worst rate of exclusive breastfeeding of all WHO. As such the relevance of the work around nutrition for NCD and SDG agenda in line with the Rome Declaration is of crucial importance.

Poor diet is one of the leading the leading cause of total mortality and morbidity across the WHO European Region. This refers specifically to excessive intakes of energy, saturated and trans-unsaturated (trans) fatty acids, sodium and free sugars and low intakes of fruits, vegetables and polyunsaturated fatty acids. Such dietary practices contribute to metabolic risk factors, including high blood pressure, high body mass index, high fasting plasma glucose and high total cholesterol, which, in turn, increase risk for diet-related NCDs, including type 2 diabetes mellitus, cardiovascular diseases and some types of cancer.

Addressing malnutrition (in all its forms) is therefore essential to sustainable development, requiring coherent and innovative actions covering the entire food system and across other sectors to ensure access to a diversified, balanced and healthy diet for all.

Important progress has been achieved by European member states so far inspired by the European Food and Nutrition Action Plan 2015-2020 and in line with the Rome Declaration. The Food and Nutrition Action Plan 2015-2020 has placed the European region at the forefront of global discussions around policy development, evaluation and surveillance. The number of countries with direct support from WHO on nutrition has increased significantly since 2015 (more than 30 in 2018) and the nutrition programme has been one of the most active programmes in supporting countries and implementing project funding.

The challenges ahead and the unfinished business at country level in particular that require WHO further support. Some of the priorities that would benefit being revisited and strengthened as a result of this report would be:

- Providing tailored regional guidance on complementary feeding and the challenge of commercial foods for infants;
- Advancing interpretive front of pack labelling - finding systems that work best for consumers and countries;
- Incorporating concerns of sustainable food systems to ensure that good nutrition is also good for the environment;
- Revitalising the role of the education sector in providing healthy foods and developing competences, skills and food literacy;
- Ensuring good maternal nutrition by transforming maternal health services and supporting countries to advise and train health professionals;
- Addressing important gender dimensions to nutrition, diets and obesity, including *missing* men;
- Learning from countries different childhood obesity management systems - providing guidance on what works;
- Improving health systems response to nutrition related diseases in particular obesity and diabetes with a focus on PHC and inspired by Astana Declaration PHC2018
- Getting to grips with digital marketing of foods to children and providing countries with tools to reduce the harmful impact of commercial promotions for "unhealthy" foods
- Maintaining and expanding existing monitoring and surveillance systems for nutrition and diet related NCD notably CVD, diabetes and obesity.

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