World Health Organization

REGIONAL OFFICE FOR Europe

BRIEFING OF THE REGIONAL OFFICE FOR EUROPE ON TECHNICAL AGENDA ITEMS AT THE World Health Assembly 70th SESSION

(Batch 2)

Version 18 May, 2017

Table of Contents

12. Preparedness, surveillance and response

12.1 Health Emergencies

- **The Independent Oversight and Advisory Committee for the WHO Health Emergencies Programme**

Document A 70/8

The first IOAC report submitted to the Executive Board in January-February was based on activities during May to December 2016. This second report to the governing bodies covers the IOAC's activities in its first year and provides its observations on progress in the eight thematic areas that were identified in the first report: structure, human resources, emergency business processes, finance, risk assessment, incident management, partnerships, and International Health Regulations (2005). The report focuses in particular on the impact of WHO's emergency reform in terms of delivery on the ground, functionality of the WHE Programme across the Organization, and barriers to effective operations.

Overall progress of the program

The implementation of the WHO Health Emergencies Programme has advanced since the IOAC's first report. Particular progress has been noted in WHO's response to the health needs of populations in protracted emergencies. The IOAC observes improvement in WHO's health cluster[1] coordination and leadership, which is welcomed by partners on the ground. The IOAC acknowledges encouraging signs in WHO's field presence and partnership engagement.

Structure of the WHO Health Emergencies *Programme*

The IOAC acknowledges that WHO's work in emergencies has been brought into a common structure across the three levels of the Organization; although some partners are aware of WHO's emergency reform programme, many country-level staff and some external partners are not. Thus the IOAC recommends that both internal and external communication about the WHE Programme should be improved. The IOAC recognizes that emergency management structures at country level are being adapted to manage the different types, magnitude and duration of emergencies. WHO must also take a coherent Organization-wide approach to staffing in emergencies to ensure sufficient flexibility. Clarity on roles, responsibilities, authority, accountability, reporting lines and coordination is of paramount importance. Noting the importance of the Delegation of Authority to Incident Managers and WRs, the IOAC recommends that a standard template for delegation of authority should be developed and adopted across all three levels of the Organization.

*Human resources*As of March 2017, the WHO Health Emergencies Programme has established a total of 1438 positions (684 existing staff and 754 vacant positions) compared to 1157 soon after its roll-out. While 469 County Office level positions remain vacant, there are 386 temporary

[1] Health Cluster (http://www.who.int/health-cluster/en/, accessed 20 April 2017)

staff employed for emergency response, with the average length of contract of seven months.

The IOAC observes that the Organization shows strong preference for internal WHO candidates in staff recruitment and IOAC recommends that a longer-term recruitment strategy should be developed which can attract, orient and support the best candidatesAll international and national positions for the WHE Programme are subject to rotation within the WHO Geographical Mobility Policy[2], but incentives to attract and retain high-calibre staff in hardship duty stations should be considered.

Emergency business processes

WHO's administrative systems are not suited to support emergency operations, particularly for recruitment, procurement, delegations of authority, and grant management. The IOAC acknowledges that the emergency business rules have been inserted into the WHO e-manual[3], but they are not yet fully embedded in the Organization's culture. Delay in procurement of essential supplies will hamper emergency response and can be caused by lack of clear policies, inadequate delegation of authority or a culture of risk aversion.

The IOAC recommends that WHO should have a more consistent and robust approach to security across its emergency programmes and that this should be funded by an appropriate level of flexible corporate funding. WHO is encouraged to proactively work with the UNDSS on security risk assessment and management and should increase its investment and capacities in field security and other staff protection measures.

Finance

Findings from the field visits suggest that WHO's field performance is yielding increased donor confidence, as it demonstrates its ability to both coordinate the health cluster and respond effectively in difficult environments. However, the WHO Health Emergencies Programme still faces financial challenges including lack of multiyear funding arrangements, management of large one-off contributions, competing humanitarian priorities, and ongoing shifts in donor investment.

Since the IOAC presented its first report, additional flexible funds have been received for the core budget for the biennium 2016–2017 and the funding gap has been reduced from 56% to 41% over the past three months. This allocation and the projections based on the pledges indicate that 86% of the core budget could be funded over the biennium. The appeals budget (for humanitarian acute and protracted emergencies response plans) for 2017 led to receipt in the first quarter of the year of US$ 67 million out of the target US$ 523 million. Since the first report, there has been no change in the shortfall in the Contingency Fund for Emergencies: a 67% funding gap for the target of US$ 100 million. Of US$ 284 million raised for the core budget, US$ 82.5 million has been made available at the country level.

[2] Available at: http://www.who.int/employment/WHO-mobility-policy.pdf?ua=1, accessed 20 April 2017
[3] WHO e-manual, Section XVII – Health Emergencies

The IOAC notes that the WHO Health Emergencies Programme aims to fill up to 50% of CO vacancies by the end of 2017, depending on funding availability.

Although the Contingency Fund for Emergencies has shown clear value in addressing immediate needs in emergencies, it has failed to reach the total capitalization of US$ 100 million and replenishment by donors has been weak. As at March 2017, a total of US$ 19.95 million was allocated in support of WHO's response to 16 health emergencies.

The IOAC notes that the core budget projections for the biennium 2016-2017 are looking better, however, they are viewed as fragile, and therefore WHO is also encouraged to consider an appropriate funding strategy to identify additional revenue sources and strengthened budgeting at country level to ensure all project-related costs required for sustainable country operations are included in donor proposals.

Risk assessment

The second edition of the Emergency Response Framework[4] provides further clarification on risk assessment, the grading system, application of the incident management system with roles and responsibilities performance standards and key performance indicators.

The platform for event-based surveillance – Epidemic Intelligence from Open Sources (EIOS) will be launched in June 2017. The Programme continues to use the existing Event Management System for data related to the verification, assessment and tracking of events but IOAC would advise that this system be assessed in terms of its all-hazards capabilities, utilisation and the potential need for this essential system to be updated.

Incident management

The IOAC commends WHO on its improved emergency response activities driven by the strong leaderships of WRs and Incident Managers. The IOAC recognizes that the WHO Health Emergencies Programme has strengthened teams by utilizing the skills and knowledge of national staff and surge capacity from regional offices and headquarters.

The IOAC recommends that Incident Managers should receive pre-deployment orientation so as to ensure that Incident Managers and CO staff share a common understanding of roles and responsibilities. The Incident Managers should be engaged on a longer-term contractual arrangement—at least 12 months instead of three-month contracts with extensions.

Partnerships

External partners recognize and appreciate WHO's expanded role in emergencies, including on operational coordination at field level and acknowledged WHO's leadership role in coordinating health cluster partners as well as its critical role as an interface between the

[4] WHO. Emergency Response Framework. Geneva : World Health Organization ; (http://www.who.int/hac/about/erf/en/, accessed 20 April 2017).

government and the humanitarian community. The IOAC reiterates that information management is an essential element of this coordination.

As it was stated in the IOAC's first report, The Global Health Cluster and the GOARN are the major partnership platforms for humanitarian and public health emergency response, respectively. Specialist initiatives such as emergency medical teams (EMTs) leverage specialized medical/surgical teams in disaster settings and will ensure the best expertise available at short notice for field deployment, operating with clear structure, roles and coordination mechanisms.

International Health Regulations (2005)

The IOAC acknowledges that 37 countries from all six WHO regions have conducted Joint External Evaluations[5] since the beginning of 2016, with a further 28 scheduled by the end of 2017. The IOAC notes that only three countries have completed their national action plans following the joint external evaluation. The IOAC reaffirms the importance of all four components of the IHR (2005) Monitoring and Evaluation Framework as critical areas of work of the WHE Programme.

CONCLUDING REMARKS

WHO is making efforts at all levels to transform itself into an operational organization in emergencies. Since the launch of the WHO Health Emergencies Programme, progress has been noticed in emergency response at country level, with consistently positive feedback on WHO's expanded role in humanitarian crises. WHO is demonstrating that it can be a reliable and competent partner to governments, organizations in the United Nations system, health cluster partners, implementing nongovernmental organizations and the donor community. However, progress is fragile. WHO's administrative systems and business processes are not effectively supporting its operations, and the WHE Programme is struggling with a funding shortage. Cultural constraints on the emergency response throughout the Organization remain the main challenge for adopting a "no regrets" policy in practice. The Organization must ensure that the WHE Programme can fulfil its potential. Ensuring this success is ultimately a shared responsibility between Member States, WHO's partners and the Secretariat.

- **WHO response in severe, large-scale emergencies**

Document A70/9

See Batch 1

- **Research and development for potentially epidemic diseases**

Document A70/10

See Batch 1

[5] Joint External Evaluation mission reports are available at: http://www.who.int/ihr/procedures/implementation/en/ (accessed 20 April 2017).

- **Health workforce coordination in emergencies with health consequences**

Document A70/11

See Batch 1

12.2 Antimicrobial resistance

Documents A70/12, A70/13 and EB 140/2017/REC/1, resolution EB140.R5

See Batch 1

12.3 Poliomyelitis

Documents A70/14

See Batch 1

Polio transition planning

Document A70/14 Add. 1

The Executive Board at its 140th session in January 2017 adopted decision EB140 on poliomyelitis, in which the Director-General was requested to present a report that outlines the programmatic, financial and human-resource-related risks resulting from the transition, as well as an update on planned actions to mitigate those risks while ensuring that essential polio-related functions are maintained.

Polio Transition: Programmatic risks and opportunities ; There are clear inter-relationships and synergies across the Expanded Programme on Immunization and the Global Polio Eradication Initiative.

Risks

Disease surveillance activities – funding for active surveillance activities for acute flaccid paralysis, and also for surveillance activities in respect of other vaccine-preventable diseases. Once the Global Polio Eradication Initiative closes, active disease surveillance may not be conducted optimally, which could lead to delayed detection and response for priority diseases.

Immunization information systems –largely funded by resources for the Global Polio Eradication Initiative, and critical to monitor disease trends regularly, thus allowing disease outbreaks to be detected and responded to in a timely manner.

Laboratory support – polio-funded laboratories will require additional resources to sustain laboratory activities that they conduct also against other vaccine-preventable diseases.

Opportunities

Key technical and operational polio-funded staff, and the extensive polio-funded infrastructure at the country-level, can be re-purposed to help achieve the goals of the global vaccine action plan, and related immunization targets.

Additionally, of the 146 polio laboratories, 122 (84%) are accredited in the measles and rubella network and are at risk of being dismantled when polio resources decline. It is provisionally estimated that it would cost approximately US$ 77 million annually to bolster measles and rubella surveillance at country level. At the present time, a workforce of over 2500 polio-funded individuals is supporting measles and rubella surveillance.

Impact on global health security: capacity to detect and respond to epidemic- and pandemic-prone diseases and other emergencies

Risks

The burden of epidemic-prone diseases can be alleviated and without this field support, it is likely that there will be delays in detecting these threats particularly in the African Region and in mounting an effective response to them.

Polio-funded health workers, and physical assets such as vehicles, and cold chain equipment, have also been used to support logistics required for supervision and surveillance activities for other communicable diseases – recent yellow fever outbreaks; in supporting immunization activities during seasonal outbreaks for meningitis; and in supporting preparedness for the implementation of the Pandemic Influenza Preparedness Framework.

Opportunities

Strengthening the WHO Health Emergencies Programme: WHO is currently responding to an unprecedented number of crises, and increased capacity is needed in a number of country offices, particularly those with on-going emergencies and those in fragile settings.

Strengthening Integrated Disease Surveillance and Response. Despite the progress made over the years, Integrated Disease Surveillance and Response has not been fully implemented at district and community levels in most countries. The critical gaps in district level implementation include inadequate capacity in managing data, limited capacity of district level epidemic management committees and rapid response teams, and lack of logistic and communication capacities.

Impact on health systems:

Risk

The Global Polio Eradication Initiative has invested heavily in country and international infrastructures and has been able to reach remote, rural, nomadic and migratory populations, and to under-served communities, including the marginalized and urban poor. There could be major benefits for transition countries to strengthen primary care systems on their way to achieving universal health coverage.

The integration of "vertical" programmes like will contribute to provide services across the continuum of care in a more integrated way that creates better health for whole populations. The downsizing of the polio infrastructure will also have an impact on the attainment of the Sustainable Development Goal 3, target 3.8 on achieving universal health coverage, access to health services, and access to essential medicines and vaccines.

Opportunities

Polio funded staff and assets could improving the quality and accessibility of front-line services to achieve universal health coverage by strengthening the primary care infrastructure and quality of basic services.

Data systems to create a culture of information in local health systems. The data systems developed by the Global Polio Eradication Initiative are among the most advanced public health surveillance systems ever created and culture of data use are essential when tracking outbreaks or suspected cases.

Effective management of polio vaccine supply chains and cold chain maintenance: Investment in central supply management and supply chains had overall improvements in access to safe medicines.

Human resource risks and mitigation

An update on staffing as at 20 March 2017 is presented in the Annex . There are a total of 1080 currently filled WHO staff positions funded by the Global Polio Eradication Initiative, and this represents an overall reduction of 3% when compared to January 2017 – African Region (74%), Eastern Mediterranean Region (14%), headquarters (7%) and the South-East Asia Region (4%). The actual salary expenditure for the polio staff was US$ 99.4 million for 2016, only marginally higher than the estimate of US$ 97.3 million reported to the Executive Board in January 2017.

Financial risks and mitigation

The decrease in the polio budgets for 2017–2019 was communicated to the 16 polio transition countries in May 2016. The declining polio budget figures will also have an impact

on other programme areas that have also been benefitting from the use of the polio infrastructure, especially immunization and emergencies.

In the short term (2018– 2019) gaps in programme outcomes are to be expected if polio funding is withdrawn too rapidly, and options for additional and sustainable financing should be explored and included as part of the core budget financing. A more robust and coordinated budget development process must be initiated in early 2018 for Programme budget 2020−2021, where the post-certification polio requirements are to be included.

In order to address the financial liabilities associated with downscaling polio-funded staffing, a Polio Indemnity Fund was established in 2013, and the Fund now stands at US$ 40 million. It is envisaged that by the end of 2019, the Fund will have the US$ 55 million needed to meet the expected separation costs scenario given eradication in 2019.

Organizational risks and mitigation

Polio transition must be reviewed against its broader impact on the Secretariat's capacity to support Member States and on WHO's vision in the medium term.

Partnership and process complexity: Given that the Global Polio Eradication Initiative has been in existence for nearly 30 years, polio transition planning has now become an extremely complex undertaking that poses a reputational risk to WHO if poorly managed.

WHO polio transition strategy: The risks associated with a downsizing of the polio infrastructure should be well planned and executed, and managing these risks should be a corporate priority.

12.4 Implementation of the International Health Regulations (2005)

Documents A70/15

.

- **Annual report on the implementation of the International Health Regulations (2005)**

Document A70/15

The document gives an account of actions taken by the States Parties and the Secretariat within the framework of the Regulations since the last report at the Health Assembly in May 2016[6].

Emergency committees

Poliomyelitis : At its thirteenth meeting in April 2017, the Committee agreed that the epidemiological situation still constituted a public health emergency of international concern (since

[6] Document A69/20

it was declared in May 2014) and advised the extension of the revised temporary recommendations. Travel recommendations were updated.

Zika virus, microcephaly and Guillain-Barre syndrome : At its fifth and final meeting in November 2016, the Committee declared the end of the public health emergency of international concern.

Yellow fever : On the basis of the evidence available at the time of the second meeting (August 2016), the Director-General accepted the Committee's assessment that the outbreaks in Angola and the Democratic Republic of the Congo did not constitute a public health emergency of international concern, but advised that it remains a serious public health event warranting a sustained scale-up of response activities and a close monitoring of the situation.

The Review Committee on the Role of the International Health Regulations (2005) in the Ebola Outbreak and Response: During the discussions at the 140th session of the Executive Board, the revised draft global implementation plan was discussed in detail by Board Members and Member States. Consequently, the Secretariat held on 23 March 2017 an information session for the diplomatic Missions to the United Nations and other International Organizations at Geneva, to receive additional Member State input in relation to key areas of action of the draft global implementation plan[7].

Progress on implementation of the international Health regulations (2005)

Capacity building: As of 28 February 2017, 120 of 196 States Parties had completed the questionnaire and 2016 annual reporting by States Parties and other activities related to the monitoring and evaluation of the implementation of the Regulations are published on the WHO website[8]. Globally, progress has been made since 2010 across the 13 core capacities required by the Regulations, particularly in surveillance, response, and zoonoses, but the overall average scores suggest further efforts are urgently needed in the areas of human resources, capacities at points of entry, chemical events and radiation emergencies. In addition, areas of response and preparedness also require attention.

In February 2017, the Secretariat hosted a stakeholders consultation on planning, costing and financing for accelerated IHR implementation and global health security to agree on a process for the development of national action plans, as well as identifying opportunities for linkages with national health systems strengthening efforts and for multisectoral investment and coordination.

Yellow fever: The period of validity of yellow fever vaccination for the life of the person vaccinated was adopted in resolution WHA67.13 (2014) and entered into force in July 2016, needs to be implemented by all States Parties, to avoid unnecessary interference with international traffic.

[7] See document A70/16

[8] See https://extranet.who.int/spp/sites/default/files/InPage/IHR%20Monitoring%20and%20evaluation%20framework%20report%20for%202016.pdf (accessed 10 May 2017).

Countries' yellow fever vaccination requirements at entry and WHO vaccination recommendations were updated in 2017 on WHO's website[9].

Challenges to the implementation of the International Health Regulations (2005)

Empowering National IHR Focal Points requires the sustained support of governments. Workforce development and intersectoral collaboration remain important challenges. More sustained efforts are required with the transport, travel and tourism sectors as well as with the security sector, public–private partnerships and community involvement. In addition, the rapid development, monitoring and implementation of the national action plans requires sustained support from national authorities and the international communities.

Conclusions

The Regulations have provided a global framework that has contributed significantly to an increase in information sharing, risk assessment and coordination of response in relation to international public health risks and emergencies. These communications have been carried out through global network of National IHR Focal Points, accessible at all times by WHO IHR Contact Points in all six regional offices. Since the regulations entry into force, a total of six emergency committees have been established, four of which have resulted in the declaration of a public health emergency of international concern and the issuance of temporary recommendations by the Director-General[10]. The other two emergency committees were instrumental in drawing attention to important public health threats that galvanized the international community to take specific steps to tackle critical emerging health events[11]. Three review committees have also been convened by the Director-General, with a view to learning lessons from the influenza A(H1N1) 2009 pandemic and outbreaks of Ebola virus disease and more generally to take stock of where the global community stands in relation to the functioning and implementation of the Regulations. The recommendations from these review committees have paved the way for a more structured approach to implementing the Regulations. WHO Health Emergencies Programme further improves the Secretariat's operational capacity for the timely detection, risk assessment and response to public health emergencies, the management of specific risks associated with high-threat pathogens, and the Secretariat's support to country health emergency preparedness.

The Health Assembly is invited to note the report.

- **Global implementation plan**

Document A70/16

[9] See http://www.who.int/ith/en/ (accessed 25 April 2017).
[10] Regarding the influenza A(H1N1) 2009 pandemic, poliomyelitis, Ebola virus disease and Zika virus disease (see http://www.who.int/ihr/ihr_ec/en/, http://www.who.int/ihr/ihr_ec_2014/en/, http://www.who.int/ihr/ihr_ec_ebola/en/ and http://www.who.int/ihr/emergency-committee-zika/en/, accessed 28 April 2017).
[11] On Middle East respiratory syndrome and yellow fever. (see http://www.who.int/ihr/ihr_ec_2013/en/ and http://www.who.int/ihr/emergency-committee-yellow-fever/en/ (accessed 28 April 2017).

This document is a revised version of document EB140/14, which takes account of the comments made by the Executive Board, further consultations and comments received from Member States during a mission information session held at WHO headquarters on 23 March 2017.

Overview of the global implementation plan:

The Review Committee made 12 major recommendations and 62 supporting recommendations. The global implementation plan proposes modalities and approaches for implementing the recommendations, and identifies six areas of action (described in details in Annex 1):

Area of action 1: Accelerating States Parties' implementation of the International Health Regulations (2005) – this area addresses recommendations 2, 3, 8, 9 and 10 of the Review Committee;

Area of action 2: Strengthening WHO's capacity to implement the International Health Regulations (2005) – this area addresses recommendations 4 and 12 of the Review Committee, with the exception of recommendations 12.7 and 12.8;

Area of action 3: Improving the monitoring and evaluation of and reporting on core capacities under the International Health Regulations (2005) – this area addresses recommendation 5 of the Review Committee;

Area of action 4: Improving event management, including risk assessment and risk communication – this area addresses recommendation 6 of the Review Committee;

Area of action 5: Additional health measures and enhancing compliance with the Temporary Recommendations and advice given by the Director-General under the International Health Regulations (2005) – this area addresses recommendation 7 and sub-recommendations 12.7 and 12.8;

Area of action 6: Rapid sharing of scientific information – this area addresses recommendation 11.

Draft global five year strategic plan to improve public health preparedness and response 2018-2020 (in Annex 2) will comprise guiding principles and strategic orientations for sustained implementation of the International Health Regulations (2005), with the aim of strengthening capacities at the global, regional and country levels to prepare, detect, assess and respond to public health emergencies with the potential for international spread. It proposes to develop a global five-year strategic plan for public health preparedness and response, to be submitted to the Seventy-first World Health Assembly in May 2018, through the Executive Board at its 142nd session in January 2018.

The global five-year strategic plan will be developed on the basis of 12 interrelated guiding principles: consultations, country ownership, WHO leadership and governance, broad partnerships, intersectoral approach, integration with the health system, community involvement, focus on fragile context: "we are as strong as our weakest link", regional integration, domestic financing, linking the global five-year strategic plan with requirements under the IHR (2005), focus on results, including monitoring and accountability.

The Health Assembly is invited to note the Global Implementation Plan and that it provides areas of action which will constitute a significant proportion of the five-year global strategic plan. As such, the Health Assembly may wish to consider the five-year global strategic plan as an extension of the Global Implementation Plan, building on the guiding principles presented in Annex 2 of thes document.

Implication for the European Region

Efforts are targeted at increasing the understanding of the nature of the IHR as a whole-of-government obligation and advocating for the principles of the IHR among non-health sectors. Capacity building and evaluation activities will follow a cyclical approach, with tailored capacity building activities at the national level being based on evidence collected through the methods identified by the revised IHR Monitoring and Evaluation Framework. This will therefore contribute to increased effectiveness of the capacity building efforts undertaken by the Regional Office, greater impact and ability to track the progress made by the country in the area of IHR implementation.

Activities undertaken in the area of IHR following the Regional Committee in September 2016 included the following:

a. Monitoring and Evaluating IHR functionality

WHO/Europe, in collaboration with regional technical partners, has been conducting assessments of the IHR capacities in Member States based on the revised IHR Monitoring and Evaluation Framework through simulation exercises, after- action reviews and external evaluations aimed at identifying existing capacity gaps and weaknesses and technically address identified issues as a follow-up.

- **National multisectoral exercise on IHR coordination during an emergency response held on 18-19 October, 2016 in Teslić, Bosnia and Herzegovina** on coordination of response and use of IHR mechanisms in relation to a foodborne disease outbreak with elements of infectious disease outbreak, food safety, and the animal human health interface.
- **National multisectoral exercise on IHR coordination during an emergency response held on 19-22 July 2016 in Yerevan, Armenia.**.The scenario involved an initial earthquake with subsequent injects of chemical leak and food safety contamination and infectious disease outbreak and was based upon the country's current arrangements for response during a public health emergency.
- **Joint External Evaluations (JEE):** To date WHO/Europe facilitated six voluntary JEEs in Albania, Armenia, Finland, Kyrgyzstan, Latvia and Turkmenistan. Preparations are ongoing for Belgium, Slovenia and Switzerland/Lichtenstein. JEEs have proven to be an effective tool for bringing various sectors involved in IHR implementation at the country level together and jointly identifying strengths and weaknesses of the existing system guided by international independent experts. Moreover, JEEs helped brining health security and IHR obligations to the attention of the national decision-makers.

b. Strengthening IHR capacities and building country preparedness for cross-border health threats

The Secretariat continued to liaise with international partners in organizing and providing technical trainings and consultations, including at Points of Entry involving ship inspection and aviation

emergency preparedness, and multi-country workshops to exchange best practices and lessons learned.

- **The Fifth European meeting of the Collaborative Arrangement for the Prevention and Management of Public Health Events in Civil Aviation (CAPSCA)**, jointly organized by WHO/Europe and the European and North Atlantic Office of International Civil Aviation Organization (ICAO) held on 12-14 October 2016 in Budapest, Hungary.

- **Bilateral workshop between Azerbaijan and Iran on collaborative management of communicable disease** held on 25-27 September 2016. This meeting has been convened as a step forward to realize better cooperation and collaboration in the management of communicable disease outbreaks between the two countries and discussed improved information sharing about human and animal health surveillance of communicable diseases, coordinated strengthening and implementation of IHR requirements at PoEs and working relationships in cross-border transactions for communicable diseases.

- **Expert consultation to review compliance with the IHR (2005) for airports** in Dushanbe, Tajikistan and Astana, Kazakhstan were conducted in May 2017 2017

c. Technical national, sub-regional and regional platforms for national experts

The Regional Office will continue activities throughout the next two years to provide support to the National IHR Focal Points. Planned activities include trainings to augment NFPs' IHR capacities, such as risk assessment and reporting, as well as promoting the function across sectors during multi-sectoral country missions. A **National IHR Focal Point meeting was held in St. Petersburg, Russia on February 20-21, 2017.** The meeting provided an opportunity to discuss the progress made and the process ahead, to share experiences and to address specific gaps and challenges in complying, implementing and applying the IHR. In particular, it will provide a platform for focused discussions and best- practice exchange and to enhance inter-country and interregional partnerships.

d. Linkages with Sustainable Development Goals and Health 2020

The WHO Health Emergency Programme (WHE), while aiming to save lives during emergencies, is focusing on improving Member States (MS) capacities to manage the full cycle of emergency management, from prevention, to preparedness, response and recovery, thereby contributing to a number of the Sustainable Development Goals and targets of Health 2020. In particular, the Programme is:

a. strengthening capacity of all countries, in particular developing countries, for early warning, risk reduction and management of national and global health risks. Additionally, it is helping to build resilience of the poor and those in vulnerable situations, and reduce their exposure and vulnerability to climate-related extreme events and other economic, social and environmental shocks and disasters (SDG Target 1.5);

b. contributes to a significant reduction of the number of deaths and the number of people affected and substantially decrease the direct economic losses relative to global gross domestic product caused by disasters, including water-related disasters, with a focus on protecting the poor and people in vulnerable situations (SDG Target 11.5);

c. contributes to a substantial increase the number of cities and human settlements adopting and implementing integrated policies and plans towards inclusion, resource efficiency, mitigation and adaptation to climate change resilience to disasters, and develop and implement, in line with the Sendai Framework for Disaster Risk Reduction 2015-2030, holistic disaster risk management at all levels (SDG Target 11.b);

d. Helps to strengthen resilience and adaptive capacity to climate-related hazards and natural disasters in all countries (SDG Target 13.1);

e. For Health 2020, the Programme is focusing strengthening public health capacity, emergency preparedness, surveillance and response, as well as whole-of-government and whole-of-society approaches.

e. Strengthening operational links between health systems and IHR

WHO/Europe has been working on further strengthening operational links between its work at the national level in the area of health systems strengthening and IHR/country emergency preparedness. Components of all six building blocks of a health system will be addressed with particular attention paid to synergies in the development of national action plans and the implementation of capacity building activities in the areas of human resources for health, health financing and health system resilience. It is acknowledged that such approach will benefit both health security – through strengthening IHR capacities and IHR operational functionality on a routine basis - and Universal Health Coverage by minimising the negative impact of health emergencies on health systems.

The Regional Office continues to collaborate with a wide range of **external partners** working in the area of all-hazard preparedness and response. Among such ongoing partnerships are: Several bilateral partnerships for health security have also facilitated capacity development and strengthening across the Region.

To provide guidance to the strategic work of the Regional Office in the area of IHR, a Sub-Group of the SCRC on accelerating the use of the International Health Regulations has been established in order to enable the Standing Committee for the Regional Committee to effectively inform the Regional Committee and contribute to the global discussions on acceleration of the use of the IHR and the process for evaluating and monitoring IHR capacities within the European Region. Members of the Sub-group have been meeting face-to-face and via video/teleconferencing on a regular basis. Under the guidance of the Sub-Group the WHO Regional Office for Europe is working on the development of a draft Regional Action Plan based on the Global Implementation Plan, which will be presented to the Regional Committee in September 2017. The plan aims to operationalize the Global Plan into the European context and identifies priority actions to be implemented in partnership with Member States and all stakeholders based on the current needs and gaps.

12.5 Review of the Pandemic Influenza Preparedness Framework

Document A70/17

See Batch 1

Collaboration with the Secretariat of the Convention on Biological Diversity and other relevant international organizations

Document A70/57

The Executive Board at its 140th session in January 2017 adopted decision EB140(5), inter alia requesting the Director General to continue consultations with the secretariat of the Convention on Biological Diversity and with other relevant international organizations, as appropriate, in the context of existing international commitments, on access to pathogens and fair and equitable sharing of benefits, in the interest of public health, and to report thereon to the Seventieth World Health Assembly.

The document provides an overview of the WHO Secretariat's consultations with the secretariats of the Convention on Biological Diversity and other relevant international organizations, specifically FAO and OIE, and with the newly created Coalition for Epidemic Preparedness Innovations. During this period, WHO Secretariat and the Secretariat of the Convention on Biological Diversity held several interactions.

Based on the foregoing considerations, the two secretariats discussed the following areas for possible future collaboration relating to access to pathogens and the fair and equitable sharing of benefits, in the interest of public health continued sharing of information relevant to the work of both organizations continued engagement with relevant ongoing processes and policy debates within both organizations the development of awareness, raising materials, including fact sheets and policy briefs organizing joint activities, such as workshops on the implementation of the Nagoya Protocol in relation to pathogen sharing and public health emergencies.

Recognizing the complexity of these issues and the need for closer collaboration in order to address them, the two secretariats discussed ways to work together.

It was noted that a memorandum of understanding was concluded between the Secretariat of the Convention on Biological Diversity and WHO in July 2015 to collaborate in activities of mutual interest. Collaborative activities related to access and benefit sharing could be undertaken under the terms of this memorandum of understanding, subject to availability of funds.

The Health Assembly is invited to note the report and provide guidance on possible steps to further advance work in relation to access to human pathogens and equitable sharing of benefits, in the context of emergency situations, the implementation of relevant international instruments and the handling of genetic sequence data.

13. Health systems

13.1 Human resources for health and implementation of the outcomes of the United Nations' High Level Commission on Health Employment and Economic Growth

Document A70/18

The Executive Board at its 140th session noted a prior version of this report and adopted decision EB140(3) requesting the Director-General to finalize, in collaboration with ILO, OECD and relevant regional and specialized entities, in consultation with Member States, a draft five-year action plan 2017–2021 and to submit that draft action plan for consideration by the Seventieth World Health Assembly[12].

In March 2016, the United Nations Secretary-General launched the High-Level Commission on Health Employment and Economic Growth. The Commission was designed as a strategic political initiative to create momentum towards the implementation of WHO's global strategy on human resources for health: workforce 2030 (adopted in May 2016 in resolution WHA69.19).

The Commission, chaired by the Presidents of France and South Africa with the heads of ILO, OECD and WHO as Vice-Chairs, submitted its report Working for health and growth: investing in the health workforce[13] to the United Nations Secretary-General in September, 2016. The report, through its 10 recommendations and five immediate actions, gives the necessary political and intersectoral momentum to the implementation of WHO's global strategy on human resources for health, with particular attention to the WHO Global Code of Practice on the International Recruitment of Health Personnel (adopted in 2010 in resolution WHA63.16) and the need to transform health workforce education in support of universal health coverage (resolution WHA66.23 (2013)).

This report provides a summary of the Commission's recommendations and their linkages to existing decisions and resolutions of the Health Assembly, United Nations General Assembly and United Nations Security Council.

The commission's recommendations and immediate actions

[12] See document EB140/17, decision EB140(3) and the summary records of the Executive Board at its 140th session, eighth meeting, section 3 and ninth meeting.

[13] Available at http://www.who.int/hrh/com-heeg/ (accessed 5 April 2017)

The Commission's report presents evidence from the health and social sector, taking economic and labour perspectives, highlighting its capacity as a crucial source of future jobs, particularly for women and young people[14].

The Commission puts forward six recommendations to transform the global health workforce and meet the needs for achieving the SDGs, with focus in job creation, gender and women's rights, education training and skills, health service delivery and organization, technology, and crises and humanitarian settings. An additional four recommendations, in the areas of financial and fiscal space, partnerships and cooperation, international migration, and data, information and accountability, are made to enable this transformation.

Five immediate actions have to be taken between October 2016 and March 2018: the development of a five-year implementation plan; enhanced accountability, accelerated and progressive implementation of national health workforce accounts, the establishment of an interagency data exchange on the health labour market, creation of an international platform on health workers mobility, and the transformation and massive scale up of professional, technical and vocational education and training. A high-level ministerial meeting was held in Geneva in December 2016 to propose actions and launch a consultative process that can take these recommendations forward. Two online consultative processes were held with Member States and other relevant stakeholders to provide inputs into the development and finalization of the five-year action plan in October–November 2016 and January–February 2017, respectively. An information session for health and labour attachés in permanent missions in Geneva was also held at WHO with ILO and OECD in February 2017.

Linkages to existing decisions of the World Health Assembly, United Nations General Assembly and United Nations Security Council

The Commission's recommendations and immediate actions pressure the implementation of WHO's global strategy on human resources for health and prior resolutions of the World Health Assembly related to human resources for health[15]. They call for further strengthening of the health workforce implicit within related Health Assembly resolutions

[14] High-Level Commission on Health Employment and Economic Growth. Working for health and growth: investing in the health workforce. Geneva: World Health Organization; 2016 (available at: http://apps.who.int/iris/bitstream/10665/250047/1/9789241511308-eng.pdf, accessed 5 April 2017) and the final report of the expert group to the Commission (http://www.who.int/hrh/com-heeg/reports/report-expert-group/en/, accessed 5 April 2017).

[15] Resolution WHA63.16 (2010) adopting the WHO Global Code of Practice on the International Recruitment of Health Personnel, resolution WHA64.7 (2011) on strengthening nursing and midwifery, and resolution WHA66.23 (2013) on transforming health workforce education in support of universal health coverage.

on the International Health Regulations (2005) and those relating to humanitarian settings and public health emergencies[16].

Through its recommendations and immediate actions, the Commission stresses the need to ensure the protection and safety of health workers, as called for by United Nations General Assembly[17] and United Nations Security Council[18]. It also aims at delivering gains across the 2030 Agenda for Sustainable Development, in particular towards SDGs 1 (End poverty in all its forms everywhere), 3 (Ensure healthy lives and promote well-being for all at all ages), 4 (Ensure inclusive and equitable quality education and promote lifelong learning opportunities for all), 5 (Achieve gender equality and empower all women and girls) and 8 (Promote sustained, inclusive and sustainable economic growth, full and productive employment and decent work for all).

The Health Assembly is invited to note this report and consider the draft five-year action plan 2017-2021 (in Annex).

Implication for the European Region

European Member States and the Regional Office continue to play a key role at the global level in addressing health workforce challenges. The High-Level Commission on Health Employment and Economic Growth was co-chaired by H.E. Mr. François Hollande, President of France, and included five high-level European policy makers: Dr Vytenis Andriukaitis, Commissioner for Health and Food Safety from the European Commission, Mr. Bent Hoie, Minister of Health and Care Services in Norway, Dr Maris Jesse, Deputy Secretary-General, Ministry of Social Affairs in Estonia, and Mr. Hermann Grohe, Federal Minister of Health in Germany. European Member States, public and private organizations, health professional associations, academia and civil society have provided valuable contributions to the consultative process on the Commission's report, expert papers, and recommendations. To inform European Member States about the report of the Commission the WHO Regional Office held a side event in association with the 66th session of the WHO Regional Committee for Europe.

The report of the Commission, launched during the UN General Assembly in September 2016, highlights the social and economic benefits of investing in the health workforce. ILO, OECD and WHO have developed a five-year action plan that sets out how the three agencies in partnership with their constituents and other multilateral organizations can support their Member States in implementation of the Commission's recommendations. The 71st session

[16] For instance, resolution WHA64.10 (2011) on strengthening national health emergency and disaster management capacities and the resilience of health systems; see also decision WHA68(10) (2015) which contains a section on the global health emergency workforce and document A68/27 on global health emergency workforce.
[17] United Nations General Assembly resolution 69/132 (2014).
[18] United Nations Security Council resolutions 2175 (2014) and 2286 (2016).

of the UN General Assembly adopted the resolution 'Global Health & Foreign Policy: Health Employment & Economic Growth'.

Member States and all relevant stakeholders are invited to review and provide inputs to the finalization of the action plan through a consultative process which was kicked off at the High-Level Ministerial Meeting on Health Employment and Economic Growth (Geneva, 14-15 December, 2016). The European Region was well represented at the Meeting. Following the High-Level Ministerial Meeting, the three agencies (ILO, OECD and WHO) will organize further consultations with Member States through the Permanent Missions in Geneva, discussion with constituents in ILO's and WHO's governance structures, consultation with respective regional offices, a public consultation online, and bilateral meetings and consultations with all relevant international and regional organizations, development partners as well as concerned global initiatives.

The outcomes of the Commission's work and the ongoing consultative process are fully relevant for the WHO European Region. The Commission's recommendations and the Action Plan have a global focus and as such require tuning and clarified focus to be aligned fully with the Region and Member States priorities.

The outcomes of the Commission's work are fully relevant for the WHO European Region however the recommendations and the action plan are presented in the Global context and require tuning and clarification for the WHO European Region and Member States priorities.

The Regional Office is currently working on a Framework for Action towards a sustainable health workforce in the WHO European Region supported by a toolkit drawn from a wide range of relevant sources, (which will be considered at the 67th session of the Regional Committee in September 2017), which will align with, and enable Members States to give informed consideration of the Global Strategy on Human Resources for Health and the five-year Action Plan, which support the High-Level Commission's recommendations.

On 13-17 November 2017 the 4th Global Forum on Human Resources for Health (themed around: Building the health workforce of the future) , hosted by the Irish Department of Health, the Irish Health Service Executive, Trinity College Dublin, WHO, Global Health Workforce Network and Irish Aid will be held in Dublin, Ireland.

The main objectives of the Forum are to: (i) Advance the implementation of the Global Strategy on Human Resources for Health and the Commission's recommendations towards achieving UHC and SDGs; (ii) Promote innovations in policy, practice and research; (iii) Promote the engagement of HRH stakeholder groups in learning and knowledge sharing and in networking and collaborative actions.

13.2 Principles on the donation and management of blood, blood components and other medical products of human origin

Document A70/19

See Batch 1

13.3 Addressing the global shortage of, and access to, medicines and vaccines

Document A70/20

See Batch 1

13.4 Evaluation and review of the global strategy and plan of action on public health, innovation and intellectual property

Document A70/21

See Batch 113.5 Follow-up of the report of the Consultative Expert Working Group on research and Development: Financing and Coordination

Document A70/22

See Batch 1

13.6 Member State mechanism on substandard/spurious/falsely-labelled/falsified/counterfeit medical products

Document A70/23 and EB140/2017/REC/1, decision EB140(6)

See Batch 1

13.7 Promoting the health of refugees and migrants

Document A70/24

In January 2017, the Executive Board at its 140th session noted an earlier version of this report[19] and adopted decision EB140(9)[20] Decision EB140(9) requests, the Director-General to prepare, in full consultation and cooperation with Member States, and in cooperation with IOM, UNHCR and other relevant stakeholders, a draft framework of priorities and guiding principles to promote the health of refugees and migrants, to be considered by the Seventieth World Health Assembly (in Annex).

[19] Document EB140/24.
[20] See the summary records of the Executive Board at its 140th session, seventeenth meeting.

The draft framework will also be used as a basis for the development of a draft global plan of action on the health of refugees and migrants, which is to be submitted to the Seventy-second World Health Assembly in 2019.

The present report summarizes the current global context and the health challenges associated with migrants and refugees, describes the Secretariat's actions at the global and regional levels to address the challenges, and briefly outlines priority actions for the future.

Current context:

At the end of 2015, there were estimated to be over 244 million international migrants (about 3.5% of the world's population), representing an increase of 77 million – or 41% – compared to the year 2000. The world is also witnessing the highest level of forced displacement in decades due to insecurity and conflicts[21].

In the WHO African Region, new and ongoing conflicts have generated further displacement over the past year[22], By the end of 2015, there were 4.2 million refugees and 6.4 million internally displaced persons with largest numbers in Nigeria, South Sudan and the Democratic Republic of the Congo. In the WHO Region of the Americas, the number of people migrating across international borders surged by 36% between 2000 and 2015[23]. In the WHO South-East Asia and Western Pacific Regions, the overall number of refugees has remained stable at 500 000 people since 2001, but the number of internally displaced persons has decreased sharply from 2.5 million to less than 1 million, as some of the forced displacement situations have been resolved.

In the WHO European Region, more than 1.2 million new migrants, asylum seekers and refugees had arrived in Europe by the end of 2015, in addition to the approximately 2.7 million refugees from the Syrian Arab Republic hosted in Turkey. During the period from January to June 2016, there were over 318 000 arrivals by sea, and over 3600 deaths or missing persons reported in the Region. The countries receiving the largest number of arrivals by sea are Greece and Italy.

The WHO Eastern Mediterranean Region is currently the region where the world's biggest emergencies and protracted crises are taking place. Of the total of 65 million refugees, asylum seekers and internally displaced persons worldwide, 34 million come from the

[21] At the end of 2015, there were estimated to be over 21 million refugees and 3 million asylum seekers worldwide, in addition to 763 million internal migrants (about 11% of the world's population), of which over 40 million were internally displaced persons.

[22] Violence in Burundi, the Central African Republic, Nigeria and South Sudan has displaced hundreds of thousands of people internally and across borders, while the deteriorating situation in Yemen has caused significant numbers to seek safety in different countries in the Region. Meanwhile, protracted conflicts in the Democratic Republic of the Congo, Mali and South Sudan have prevented millions from returning home.

[23] To reach 63.7 million in 2015, including 7.1 million internally displaced persons (6.9 million of which are in Colombia alone).

Region. This includes more than 14 million refugees and asylum seekers and more than 20 million internally displaced persons. The Region has seen massive internal displacement in the Syrian Arab Republic with 6.6 million, Iraq with 4.4 million, Sudan with 3.2 million and Yemen with 2.5 million people fleeing their homes by the end of 2015. By the end of 2015, more than half of the 4.9 million refugees from the Syrian Arab Republic were hosted by four countries in the Region, which has a direct or indirect impact on more than 12 million people in the host communities.

Key global and regional framework:

Several resolutions adopted by the WHO governing bodies at the global and regional levels and at international consultations are relevant to the health of refugees and migrants.

The 2030 Agenda for Sustainable Development recognizes migrants, refugees and displaced persons as vulnerable groups and calls for full respect of their human rights. It recognizes the positive contribution of migrants for inclusive growth and sustainable development, for which health is a prerequisite. Pursuing the SDGs and targets will help address multiple economic, social and environmental determinants of the well-being of migrants and refugees.

In September 2016, the UNGA adopted the New York Declaration for Refugees and Migrants, setting out principles and recommendations applying to both migrants and refugees Member States acknowledge a shared responsibility towards refugees and migrants and committed to work towards the adoption in 2018 of the two global compacts. The two annexes of the Declaration pave the way for global compacts on refugees and on migrants in 2018.

Health challenges and opportunities associated with migration and displacement: Despite international protection, migrants and refugees often lack access to health services and financial protection for health. Their health is at risk due to abuse, violence, exploitation, discrimination, barriers to accessing health[24] and social services, and a lack of continuity of care. Large-scale migration may have negative effects on the physical and mental health of mobile populations. Worldwide, access to health services among vulnerable migrant and refugee populations within the recipient countries remains highly variable and is not consistently addressed. Also, the health needs of migrant and refugee populations may differ significantly from those of the populations of the recipient countries.

[24] Barriers to accessing health care may include high costs, language and cultural differences, discrimination, administrative hurdles, the inability to affiliate with local health insurance schemes, and lack of information about health entitlements. In wealthier host countries, health professionals increasingly find themselves treating patients with symptoms that are unfamiliar to them. Delayed or deferred care and a lack of appropriate preventative services are associated with the progression of diseases and the subsequent need for more extensive and costly treatment. Late or denied treatment may be discriminatory, contravene human rights principles and threaten public health.

Action by the secretariat: Since March 2016, WHO has adopted an approach on migration and health based on broader health systems strengthening and the push for universal health coverage. Coordination mechanism on migration and health has been established at global level. WHO contributed to the development of the health component of the New York Declaration. The first side-event on health and migration at the General Assembly ever was organized by Italy, Sri Lanka, WHO, IOM and UNHCR at the UNGA in September 2016.

Under the Grand Bargain commitments, WHO is working on the development of an essential package of health services, a framework for working in protracted emergencies, and leading the discussion on cash-based programming for health activities in emergency situations.

WHO continues working with other partners (i.e. ILO, OECD, UNHCR, IOM, etc.) on several aspects related to migration, including health workers' mobility, vulnerability to HIV and TB, sexual and reproductive health, strengthening of health system capacity, surveillance, preparedness and response, synthesis of evidence for informed-policies.

The first WHO Strategy and action plan for refugee and migrant health in the WHO European Region was adopted in September 2016. In the same month, a resolution on the health of migrants supported by a policy document was adopted in the Americas. Sri Lanka hosted the Second WHO-IOM Global Consultation on the Health of Migrants in February 2017.

Regarding sexual and reproductive health services for women and girls, the Secretariat is working to implement the Global Strategy for Women's, Children's and Adolescents' Health, and priority is being given to the provision of a minimum initial service package for reproductive health by national health systems and partners in emergencies. A Director-General's report entitled "Women on the Move" is expected to be launched in May 2017. The report will examine how the inequities and the experiences faced by women and girls on the move affect their health.

Development of a draft framework: The development of a draft framework of priorities and guiding principles was based on the policy documents outlined in paragraph 11–13. The Secretariat held consultations with key WHO technical departments and regional offices as well as other relevant stakeholders including IOM and UNHCR in February 2017 to develop the first draft. A second draft of the framework was shared in March 2017 with Member States and a wide range of partners, including other international organizations and stakeholders, through a web-based consultation lasting 14 days. In April 2017, a final draft framework was prepared, which is to be submitted to the Seventieth World Health Assembly.

Draft framework of priorities and guiding principles to promote the health of refugees and migrants: The framework describes a number of overarching guiding principles and priorities to promote the health of refugees and migrants, building on existing instruments and resolutions including a strategy and action plan for refugee and migrant health in the WHO European Region and resolution CD55.R13 (2016) on the health of migrants adopted by Member States at the sessions of the WHO Regional Committee for the Americas/Directing Council in September 2016.

Guiding principles are the following: 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- and 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; partnership and cooperation.

The main priorities are:

1. Advocate mainstreaming refugee and migrant health in the global, regional and country agendas and contingency planning.

2. Promote refugee- and migrant-sensitive health policies, legal and social protection and programme interventions

3. Enhance capacity to address the social determinants of health

4. Strengthen health monitoring and health information systems

5. Accelerate progress towards achieving the Sustainable Development Goals including universal health

6. Reduce mortality and morbidity among refugees and migrants through short- and longterm public health interventions

7. Protect and improve the health and well-being of women, children and adolescents living in refugee and migrant settings.

8. Promote continuity and quality of care

9. Develop, reinforce and implement occupational health safety measures

10. Promote gender equality and empower refugee and migrant women and girls

11. Support measures to improve communication and counter xenophobia

12. Strengthen partnerships, intersectoral, intercountry and interagency coordination and collaboration mechanisms

The Health Assembly is invited to note this report and to consider the draft framework of priorities and guiding principles to promote the health of refugees and migrants contained in the Annex to the report..

Implication for the European Region

First Strategy and action plan for refugee and migrant health in the WHO European Region was adopted with an accompanying resolution by the WHO Regional Committee for Europe in September 2016. The strategy and action plan were developed on the basis of the outcome document "S*tepping up action on refugee and migrant healt",* agreed at the High-level Meeting on Refugee and Migrant Health in November 2015, where 50 countries from the European, Eastern Mediterranean and African Regions participated. The development of these strategy, action plan and resolution has been guided by the subgroup on migration and health of the Standing Committee of the Regional Committee (SCRC) for Europe. It outlies the following 9 priority areas in relation to migration and health:

1. Establishing a framework for collaborative action.
2. Advocating for the right to health of refugees, asylum seekers and migrants.
3. Addressing the social determinants of health.
4. Achieving public health preparedness and ensuring an effective response.
5. Strengthening health systems and their resilience.
6. Preventing communicable diseases.
7. Preventing and reducing the risks posed by noncommunicable diseases.
8. Ensuring ethical and effective health screening and assessment.
9. Improving health information and communication.

The documents are informed by the extensive work that the WHO Regional Office for Europe has conducted since 2012 through the project Public Health Aspects of Migration in Europe (PHAME) financed by the Ministry of Health of Italy:

- Joint assessment missions have been conducted in many European countries to assess the health system capacity for large-scale migration, followed by country-tailored technical assistance, such as the development of contingency plans.
- The evidence available on migration and health across the 53 European countries is being synthesized for policy makers in order to promote evidence-informed migration health policies.
- Technical and policy briefs and guidance notes on several urgent issues such as immunization or mental health have been developed by WHO jointly with other partners such as UNHCR and IOM and made publicly available.

- In November 2016, the WHO Regional Office for Europe has launched the first Knowledge Hub on Health and Migration, financed by the regional health authorities of Sicily in Italy, in order to bring science and practice together by strengthen the collection and analysis of evidence on migration and health, developing training opportunities in this area, and organizing policy dialogues and high-level events to promote intercountry collaboration.
- A side-event technical briefing was organized at the Paris Conference on intersectoral action in December 2016 focused on the implications of for the health, social and education sectors with regards to unaccompanied minors, an issue of growing importance in the European Region and beyond.
- Migration and health is also included among the key issues being discussed under the European Regional Issue-based Coalition on Health for sustainable development.

The global strategy on refugee and migrant health may embrace the progress made at regional level across the globe while promoting inter-regional collaboration in line with the recommendations made at the High-level meeting in Rome. Given the recent demographic changes in the European Region and worldwide and the progress made with regards to the understanding of the public health aspects of migration and in relation to the areas of equity, gender, right and the determinants of health, it may be convenient to revise and update accordingly the resolution WHA 61.17 on the health of migrants.

14. Communicable diseases

14.1 Global vaccine action plan

Document A70/25

See Batch 1

14.2 Global vector control response

Document A70/26

See Batch 1

15. Noncommunicable diseases

15.1 Preparation for the third High-level Meeting of the general Assembly on the Prevention and Control of Non-communicable Diseases, to be held in 2018

Document A70/27 and EB140/2017/REC/1, resolution EB140.R7

The report describes the current situation regarding preparations for the Third High-level Meeting of the General Assembly on the Prevention and Control of Noncommunicable Diseases (NCDs). In January 2017, the Executive Board, at its 140th session, noted an earlier version of this report and adopted resolution EB140.R7, which is recommended to the Health Assembly for adoption. Since then, the report has been updated to take account of mortality estimates for 2015 and other recent developments. Annex 1 has been brought into line with the outcomes of WHO-CHOICE modelling.

Noncommunicable diseases: Current situation

Over 80% of these premature deaths, which occurred in people between the ages of 30 and 69, were the result of the four main noncommunicable diseases: cardiovascular disease, cancer, diabetes and chronic respiratory disease. Globally, premature mortality from these four main noncommunicable diseases declined by 15% between 2000 and 2012. This rate of decline is insufficient to meet target 3.4 of the Sustainable Development Goals (by 2030, reduce by one third premature mortality from noncommunicable diseases through prevention and treatment and promote mental health and well-being).

The situation analysis within the reports highlights the poor progress made by Member States in meeting the four time-bound commitments set out in the 2014 Outcome document of the UN high-level meeting. Although some gains have been achieved by countries, it appears that the pace of progress in 2015 and 2016 has been insufficient. Main obstacles include: lack of political expertise; unmet demands for technical assistance; a change in patterns of health financing; insufficient legal capacity to increase domestic taxes; and interference from industry.

Draft updated Appendix 3 of WHO's global action plan for the prevention and control of NCDs 2013–2020

Appendix 3 of the Global NCD action plan is a menu of policy options and cost-effective interventions to assist Member States in implementing actions, as appropriate to national context, to achieve the nine voluntary global targets for the prevention and control of NCDs. These are organised in accordance with the six objectives of the Global NCD action plan. In the updated version, there are more (16 compared with 14 in the original version) interventions that are considered to be the most cost-effective and feasible for implementation.

Proposed workplan 2018–2019 for the global coordination mechanism on the prevention and control of NCDs, in line with the mechanism's terms of reference

The workplan sets out the activities of the global coordination mechanism (GCM), including time-bound Working Groups, on the prevention and control of NCDs for the period 2018-19. It will be fully integrated into programme area 2.1. of the proposed programme budget 2018-2019 .

It is organized around five objectives in line with the five functions of the GCM according to its terms of reference: 1) Advocacy; 2) Knowledge dissemination; 3) Forum provision; 4) Multi-sectoral action; 5) Information on finance and cooperation mechanisms. Objectives 3 and 4 involve establishment of at least one working group (Action 3.1.) and strategic roundtables (Action 4.1.)

Evaluations:

Later in 2017*,* the Secretariat will convene a representative group of stakeholders, including Member States and international partners, to conduct a mid-point evaluation of progress on the implementation of the global action plan. The results will be reported to the Seventy-first Health Assembly, through the Executive Board. In accordance with the modalities of the preliminary evaluation of the global coordination mechanism on the prevention and control of noncommunicable diseases, the Health Assembly will conduct a preliminary evaluation of the global coordination mechanism between May 2017 and January 2018, in order to assess its results and its added value. The results will be reported to the Seventy-first Health Assembly, through the Executive Board.

Preperatory process leading to the third High-level meeting of the General Assembly on the prevention and control of non-communicable diseases to be held in 2018:

In September 2017 the Director-General will submit to the United Nations General Assembly a report on the progress achieved in the implementation of the Outcome document and of the 2011 Political Declaration of the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases, in preparation for a comprehensive review by the General Assembly.

Draft resolution

The Health Assembly is invited to consider a draft resolution which endorses the updated Appendix 3; notes the workplan for the global coordination mechanism. It urges Member States to continue to implement specific relevant resolutions (WHA66.10; WHA69.6; UN General Assembly resolutions 66/2, 68/300, 69/313 and 70/1; UN Economic and Social Council resolutions 2013/12 2014/10, 2015/8 and 2016/5).

The draft resolution also requests that the Director-General submits a report on the preparation of the third High-level Meeting of the General Assembly on the prevention and

control of NCD, to be held in 2018 and to the 71st WHA in 2018, through the Executive Board.

The Health Assembly is invited to note the report and to adopt the draft resolution recommended by the Executive Board.

Implication for the European Region

Resolutions in the WHO European Region that relate to this topic specifically are: EUR/RC66/R4 Towards a roadmap to implement the 2030 agenda for Sustainable Development in the WHO European Region; EUR/RC66/R5 Strengthening people-centred health systems in the WHO European Region; EUR/RC66/R11 Action Plan for the prevention and control of NCDs in the WHO European Region; EUR/RC65/R3 Physical Activity Strategy for the WHO European region 2016-2020; EUR/RC65/R4 Roadmap of actions to strengthen the implementation of the WHO FCTC in the WHO European Region 2015-2025; Ashgabat Declaration on the Prevention and Control of NCDs in the context of Health2020; EUR/RC64/R7 European Food and Nutrition Action Plan 2015-2020; EUR/RC63/R4 Vienna Declaration on nutrition and NCDs in the context of Health2020; EUR/RC61/R4 European action plan to reduce the harmful use of alcohol 2012-2020; EUR/RC62/9 Health 2020: a European policy framework supporting action across government and society for health and well-being.

It is critical that European Member States maintain the high levels of reporting (>90%), as achieved in the 2013 and 2015 CCS rounds to allow for accurate reporting. In this regard, it is worth noting that the European region is one of the WHO regions where monitoring and information of NCDs has been at the forefront and is more developed.

Some recent less than satisfactory results from the NCD progress report 2015 have prompted countries to raise concerns and complains about the quality of the reporting, including its validity and completeness and limited representativeness of the European Region when presenting global results. In the upcoming 2017 Country Capacity Survey, different levels of the WHO European Regional Office will be providing information to countries to assist in completing their replies to the questionnaire and further communicating with them for answering questions along the data collection and validation processes. A better and more credible report is expected as a result.

The WHO European Region developed the Health 2020 policy and its monitoring framework, including elements that are contributing as catalysers to enhancing both the NCD action plan and policy implementation and the monitoring of its progress.

Member States from the WHO European Region participated in the consultation on the draft Appendix 3. A draft of Appendix 3 was considered when preparing the *Action Plan for the prevention and control of NCDs in the WHO European Region* and the two are consistent.

15.2 Draft global action plan on the public health response to dementia

Document A70/28 and EB140/2017/REC/1, decision EB140

See Batch 1

15.3 Public health dimension of the world drug problem

Document A70/29

See Batch 1

15.4 Outcome of the Second International Conference on Nutrition

Document A70/30

Biennial report: In November 2014, FAO and WHO jointly hosted the Second International Conference on Nutrition, which adopted the Rome Declaration on Nutrition and its companion Framework for Action. In 2015, the Sixty eighth World Health Assembly adopted resolution WHA68.19, in which it endorsed the outcome documents of that Conference and requested the Director-General, in collaboration with the Director-General of the FAO and other United Nations agencies, funds and programmes and other relevant regional and international organizations, to prepare a biennial report to the Health Assembly on the status of implementation of commitments of the Rome Declaration on Nutrition.

The biennial report, which has been compiled by FAO and WHO for submission to both the Health Assembly and Conference of FAO, outlines progress made in the follow-up actions of the Second International Conference on Nutrition over the course of the period 2015−2016.

Implementation of commitments by the second international conference on nutrition in international level: The United Nations General Assembly adopted resolution 70/259, in which it endorsed the Rome Declaration on Nutrition and the Framework for Action, and included in the 2030 Agenda for Sustainable Development a goal that specifically aims to end hunger, achieve food security and improved nutrition, and promote sustainable agriculture (Goal 2). n resolution 70/259, it also decided to proclaim 2016-2025 the United

Nations Decade of Action on Nutrition, and called upon FAO and WHO to lead the implementation of the Decade of Action.

The work programme of the Decade of Action embraces six cross-cutting and connected action areas derived from the recommendations in the Framework for Action:

- sustainable, resilient food systems for healthy diets;
- aligned health systems providing universal coverage of essential nutrition actions;
- social protection and nutrition education;
- trade and investment for improved nutrition;
- safe and supportive environments for nutrition at all ages;
- strengthened nutrition governance and accountability.

In October 2016 the Committee on World Food Security at its forty-third session endorsed a framework to step up its contribution to the global fight against malnutrition and serve as an intergovernmental and multistakeholder global forum on nutrition.

Implementation of commitments by the second international conference on nutrition at country level[25] is performed through the following actions: preventing all forms of malnutrition, increasing investments, raising the profile of nutrition in national policies, strengthening human and institutional capacities.

Contribution by organizations in the United Nations system: the Secretariat, FAO, UNICEF, WFP and IFAD have supported countries with technical assistance and development of national plans and policies as well as strategic plans and new nutritious strategies.

Conclusion: International commitments of ICN2 have been implemented. Achievement of global nutrition targets is still off track, but some progress has been made in the implementation of the national commitments. Almost all countries have policies related to nutrition, often covering all forms of malnutrition, although nutrition is not always an objective in sectoral policies or national development plans. Intersectoral coordination mechanisms have been established, often including multiple stakeholders. In general, implementation needs to be expanded, investments have to be increased and greater policy coherence must be created. The Decade of Action on Nutrition provides an opportunity for taking these actions and accelerating progress.

The Health Assembly is invited to note the report.

Implication for the European Region

[25] National data are based on self-reporting by countries for WHO's second Global Nutrition Policy Review (2016–2017); the Status Report 2016 on national implementation of the International Code of Marketing of Breast-milk Substitutes; WHO's Global database on the implementation of nutrition action; and WHO's Noncommunicable Diseases Country Capacity Survey in 2015.

The Decade of Action on Nutrition underlines the continuing importance for European countries to tackle childhood obesity and unhealthy diets. It reinforces existing European frameworks on food/nutrition and physical activity.

The Decade of Action recognises that the nutrition landscape has changed in recent decades, and the rise of overweight, obesity and diet-related noncommunicable diseases (NCDs) is now better profiled. This increases the relevance for European Member States.

It is also consistent with the global NCD and nutrition targets, which European countries are working towards, and will increase the focus on malnutrition and health and well-being goals in the SDGs:

- Importantly, European Member States are not on track to meet the global target of a zero increase in obesity/diabetes by 2025.
- Rates of breastfeeding and early life nutrition can be significantly improved in the European Region, which has some of the lowest rates worldwide

Many Member States have been taking action in many areas like product reformulation; school food policies; food labelling, however, comprehensive approach has been missing. Countries need to review their strategies and policies to (1) close any gaps and (2) ensure that existing measures are fit for purpose.

To support Member States, WHO will continue to support by developing evidence-informed guidance, based on robust science; support the adoption of guidance and implementation of effective actions; monitor and evaluate policy and programme implementation; track improvements to nutrition outcomes.

15.5 Report of the Commission on Ending Childhood Obesity: implementation plan

Document A70/31

See Batch 1

15.6 Cancer prevention and control in the context of an integrated approach

Document A70/32See Batch 1

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

Document A70/33

The report provides an overview of the main outcome and decisions adopted by COP7 (Delhi, November 2016) with a view to sharing the information with the Health Assembly.

The Health Assembly is invited to note this report.

COP7 adopted 31 decisions, which can be found on the Convention Secretariat website[26]: 10 on treaty instruments and technical matters, four on reporting implementation assistance and international cooperation, 11 on budgetary and institutional matters, five on proceedings of the COP, and the Delhi Declaration.

Reporting, implementation assistance, international cooperation (four decisions)

COP7 reviewed the global progress in implementation of the WHO FCTC[27] based on the 133 reports received in the 2016 reporting cycle (74% of the 180 that were due to report). Among all Parties, the average adult (aged 15 years and over) smoking prevalence estimated3 for the year 2014 was 20.5% (34.6% of males; 6.2% of females). This amounts to a small drop since 2012, when the respective prevalence was 21.1% (35.6% of males; 6.6% of females). An increasing number of Parties reported progress in developing or amending tobacco control legislation. Upward trends of strengthening time-bound requirements4 continue to be identified, as Parties advance towards: plain packaging or large pictorial warnings; banning the display of tobacco products at points of sale; and extending smoke-free environmental legislation to cover outdoor areas in addition to those indoors. More progress is also detectable in implementing measures under Articles 6 (price and tax measures), 15 (illicit trade in tobacco products), 17 (economically viable alternative livelihood) and 19 (liability). The lack of human and financial resources remains the most frequently mentioned deficiency, while the tobacco industry continues to be the most important barrier in implementation of the Convention.

Delhi declaration

COP7 adopted the Delhi Declaration (decision FCTC/COP7(29)), which calls on Parties to increase their efforts to prevent interference by the tobacco industry at all levels. The declaration calls on Parties to actively pursue the achievement of Target 3a of Sustainable Development Goal 3 and requests the Convention Secretariat to take the lead in coordinating support to Parties to this effect in collaboration with WHO and other intergovernmental organizations, and to make all efforts to promote additional related targets. It also calls on Parties to engage in international cooperation to ensure effective

[26] See http://who.int/fctc/cop/cop7/Documentation-Decisions/en/

[27] See document FCTC/COP/7/4 for details: http://www.who.int/fctc/cop/cop7/FCTC_COP_7_4_EN.pdf?ua=1

implementation of the WHO FCTC, and to promote new and innovative forms of cooperation, including South–South and Triangular cooperation.

COP8 will be held from 1 to 6 October 2018 and the first session of the Meeting of the Parties to the Protocol to Eliminate Illicit Trade in Tobacco Products, from 8 to 10 October 2018 at WHO headquarters, should the Protocol enter into force in time.

15.8 Prevention of deafness and hearing loss

Document A70/34 and EB139/2016/REC/1, resolution EB139.R1

The Health Assembly is invited to note the report and to adopt the draft resolution recommended by the Executive Board in resolution EB139.R1.

Globally, 360 million people (about 5% of the world's population) live with disabling hearing loss, of whom 32 million are children. Nearly 180 million people aged 65 years or older (that is, more than 30% of the population in this age group) have hearing loss that interferes with understanding normal conversational speech. Nearly 90% of those with hearing loss live in low- and middle-income countries. High-quality, national and local epidemiological data on hearing loss are generally lacking and this scarcity contributes to low awareness of the problem. More than 1000 million young persons between the ages of 12 and 35 years are estimated to have an increased risk of developing hearing loss because of the unsafe use of personal audio devices and exposure to damaging levels of sound in noisy entertainment venues.

Overall, unaddressed hearing loss poses a considerable economic burden on countries, estimated that the annual cost of unaddressed hearing loss is US$ 750 billion, which include the cost of health care provision, loss of earnings, the need for education, provision of care and intangible costs due to loss in quality of life. But timely interventions to address hearing loss can be cost-effective and contribute to the economic independence of affected individuals.

The importance of prevention and intervention

It is estimated that 60% of hearing loss in children are preventable. In childhood, more than 30% of hearing loss is caused by diseases such as measles, mumps, rubella, meningitis and cytomegalovirus infection; these can be prevented through immunization and hygienic practices. Another 17% of childhood hearing loss results from complications at birth, including prematurity, low birth weight, birth asphyxia and neonatal jaundice. Improved maternal and child health practices would help to prevent these complications and their consequences for hearing.

Exposure to recreational noise poses a serious threat to hearing in adolescents and young adults such as unsafe use of personal audio systems and exposure at recreational locations and there is a need to raise awareness for safe-listening practices. At present, it is estimated that hearing aid production meets only 10% of the global need, and in developing countries only about 3% of those who need hearing devices have access to one[28].

WHO's response

Secretariat has developed technical materials to support the planning and implementation of hearing care strategies by Member States. In order to raise awareness of the different aspects of hearing loss, WHO has created global advocacy campaigns for World Hearing Day (3 March), and Make Listening Safe initiative in 2015.

Actions needed at country level

- Raising awareness and building political commitment;
- Integrating strategies for ear and hearing care in the health care system;
- Improving data on ear diseases and hearing loss, to inform policy decision-making;
- Develop human resources for ear and hearing care;
- Implementing screening programmes;
- Provide access to hearing devices;
- Draft, adopt and implement regulations for control of ototoxic medicines ;
- Raise awareness of noise-induced hearing loss and draft, adopt and implement legislation for its prevention;
- Improve access to communication;

Actions needed at secretariat level

The secretariat should continue to provide technical support in the development and implementation of strategies for ear and hearing care to MS; continue and intensify collaboration with stakeholders in the field of ear and hearing loss, plan to develop technical support tools.

It is proposed that the Director-General commission a world report on ear and hearing care, which will be based on the best available scientific evidence of need, human resource availability, current practices and recommendations for future actions.

Draft resolution

[28] World Health Organization, World Bank. World report on disability. Geneva: World Health Organization; 2011. http://www.who.int/disabilities/world_report/2011/en/ (accessed 25 April 2017)

The Health Assembly is invited to adopt the draft resolution urging Member States to ensure political commitment, intersectoral collaboration, particularly between health and education to attain SDG3 and 4, regulations for control of noise and to integrate strategies for ear and hearing care under the universal health coverage umbrella. It calls for high quality data and access to hearing technologies, as well as screening programmes for early detection. The Resolution requests the Director General to prepare a global report, a toolkit and to provide technical assistance to Member States. It also calls for intensified collaboration with all stakeholders, and advocates for the World Hearing Day on 3 March.

Implementation for the European region

Prevalence of disabling hearing loss varies - within high income countries, such as in western Europe, it is about 4.4%. For central, eastern Europe and central Asia, prevalence is around double that level and according to a study,29estimated prevalence of hearing loss in 2012 is 9% (all ages) and 11% for persons over 65 years in central/eastern Europe and central Asia.

Emerging challenges for Europe are; increasing exposure to noise in occupational and recreational settings and changing demographic profile with increase in older-age population.

Hearing loss can be addressed through a public health approach, encompassing prevention and treatment, population-level and individual-level interventions. The wide range of causes and potential interventions for prevention and mitigation of hearing loss mean that the actions are likely to be shared amongst multiple programmes and beyond the health sector.

16. Promoting health through the life course

16.1 Progress in implementation of the 2010 Agenda for Sustainable Development

Document A70/35

In May 2016, the Sixty-ninth World Health Assembly adopted resolution WHA69.11 on Health in the 2030 Agenda for Sustainable Development. In January 2017, the Executive Board at its 140th session took note of a report on progress in the implementation of the 2030 Agenda, in which the Secretariat proposed six main lines of action, in order to help Member States achieve the Sustainable Development Goals.

The report provides a further update on progress towards the Sustainable Development Goals, taking into account the discussions of the Executive Board at its 140th session. Part I

[29] http://www.who.int/pbd/deafness/WHO_GE_HL.pdf?ua=1

reports on global and regional progress made by Member States towards achieving Goal 3 (ensure healthy lives and promote well-being for all at all ages) and its interlinked targets, as well as other health-related Goals and targets. Part II describes the progress made in implementing resolution WHA69.11.

Progress by member states towards the health-related sustainable development goals and targets

The Secretariat drew on information provided in World Health Statistics 2016[30], which contains the results of a review by WHO of the status of over 30 health and health–related indicators, and the updated information provided in World Health Statistics 2017. In addition to the information on indicators, the 2017 publication provides a brief review of the purpose of, and activities undertaken for, each of the six lines of action proposed by the Secretariat.

The available data show that, in spite of progress made during the Millennium Development Goal era, major challenges remain in terms of reducing maternal and child mortality, improving nutrition, and achieving further progress in the battle against infectious diseases such as HIV/AIDS, tuberculosis, malaria, neglected tropical diseases and hepatitis. The situation analysis also provides evidence of the importance of addressing noncommunicable diseases and their risk factors such as tobacco use, mental health problems, road traffic injuries and environmental health issues. Weak health systems remain an obstacle in many countries, resulting in deficiencies in coverage for even the most basic health services and inadequate preparedness for health emergencies. Based on the latest data, the specific situation for eight priority areas is summarized in the report.

Progress made in implementing resolution WHA69.11

The progress was made throughout the following actions:

- Supporting comprehensive and integrated national plans for health as part of implementation of the 2030 Agenda;
- Developing regional plans to implement the 2030 Agenda;
- Developing and finalizing the health-related Sustainable Development Goal indicators;
- Supporting Member States in strengthening national statistical capacity;

[30] World Health Statistics 2016: monitoring health for the SDGs, sustainable development goals. Geneva: World Health Organization; 2016. Available at http://www.who.int/gho/publications/world_health_statistics/2016/EN_WHS2016_TOC.pdf (accessed 21 April 2017).

- Supporting thematic reviews by Member States of progress on the Sustainable Development Goals;
- WHO's role in providing health information as a public good;
- Supporting the International Health Partnership for UHC 2030;
- Supporting national efforts to "leave no one behind";
- Promoting a multisectoral approach to the 2030 Agenda;
- Promoting multisectoral collaboration with reference to the International Health Regulations (2005);
- Supporting Member States in strengthening research and development of new technologies and tools;
- Supporting Member States in undertaking health systems research;
- Facilitating North–South, South–South and triangular regional and international cooperation on and access to health-related science, technology and innovation;
- Maximizing the impact of WHO contributions to the 2030 Agenda, considering the programme budget and general programme of work.

The Health Assembly is invited to note the report.

Implication for the European Region

The 66th session of the WHO Regional Committee for Europe (RC66) endorsed in resolution EUR/RC66/R4 the development of a regional roadmap to support Member States in the implementation of the SDGs, building on Health2020. The roadmap builds on decisions made by Member States in relation to the SDG implementation at the WHA, and acknowledge the regional and national diversity and specificities. This report is a useful first step in highlighting some cross cutting supporting action, which could be relevant to all Regions.

Since RC66, the Secretariat supported Member States in localizing the SDGs and in developing national development strategies. The SDGs were the focus of discussion of meetings of the WHO Regions for Health Network, the Small Countries Initiative and the Nordic and Baltic States. Case studies highlighted numerous opportunities for the "co-creation" of health and well-being. Many of the case studies presented focused on health equity in development. Other studies provided evidence of the need for further health financing and for greater investment in prevention.

In November 2016, United Nations agencies set up the Issue-based Coalition on Health. The purpose of the Coalition is to act as a pan-European enabling mechanism to facilitate and to promote implementation in the Region of SDG 3 and the health-related targets of the other Goals by coordinating the activities of the relevant United Nations funds, programmes and specialized agencies and other intergovernmental organizations and partners. The Issue-based Coalition is in particular targeted at lower middle- and middle-income countries in the Region, which still face significant challenges in fully implementing the Health Assembly and Regional Committee resolutions, Health 2020 and, consequently, sustainable development.

In December, Member States met in Paris, France, to launch a new partnership to promote intersectoral and interagency action for health and well-being in the WHO European Region. Member States acknowledged the urgent fact that good health and well-being for all children, from infants to adolescents, and their families and communities is essential to reduce inequities and to achieve sustainable development: this means exploring transformative pathways and adopting responsive policies, as well as a mix of interventions. The Paris Declaration calls for universal social protection floors for better health and well-being for all children and adolescents, schools and preschools promoting health and well-being for all children and adolescents, and good governance for the health and well-being of all children and adolescents.

16.2 The role of the health sector in the Strategic Approach to International Chemicals Management towards the 2020 goal and beyond

Document A70/36

The Executive Board at its 140th session considered and noted an earlier version of this report and the associated draft road map to enhance health sector engagement in the Strategic Approach to International Chemicals Management towards the 2020 goal and beyond[31].

Resolution WHA69.4 adopted at the 69th World Health Assembly in May 2016 requested the DG to develop, in consultation with Member States, United Nations agencies and other relevant stakeholders, a road map for the health sector at the national, regional and international levels towards achieving the 2020 goal and the targets of the 2030 Agenda for Sustainable Development and present it to the WHA.

The Secretariat prepared a draft road map, including comments provided during an electronic consultation in September 2016 which is available on the WHO website[32]. The

[31] See document EB140/33 and the summary records of the Executive Board at its 140th session, fifteenth meeting, section 2

[32] Available on the WHO website : http://www.who.int/ipcs/saicm/roadmap/en/ (accessed 8 may 2017)

current document provides subsequently revised draft road map (in Annex) after comments submitted by February, 2017 .

Introduction to the draft road map

The Secretariat took into account the overall orientation of the Strategic Approach to International Chemicals Management[33], the intersessional process to prepare recommendations regarding the Strategic Approach, the sound management of chemicals and waste beyond 2020. The draft roadmap identifies concrete actions where the health sector has either a lead or important supporting role to play. The action are organised in four action areas: risk reduction; knowledge and evidence; institutional capacity; and leadership and coordination, closely aligned with the Strategic Approach's Overarching Policy Strategy

The actions are described in more details in Annex:.

- In the area of risk reduction, focus is on risk management, including health protection strategies, the regulation of chemicals, public education and the sharing of information and best practices, intended to result in improved health and reducing the health risks posed by exposure to chemicals throughout their life cycle.
- The area of knowledge and evidence includes actions on filling gaps in knowledge and methodology for risk assessment, increasing biomonitoring and disease surveillance, estimating the burden of disease attributable to chemicals, and measuring progress. Those actions will enhance engagement of the health sector in cooperate efforts.
- With regard to institutional capacity, the focus is on strengthening national institutional capacities to address health threats posed by chemicals including chemical incidents and emergencies by developing national policy and regulatory frameworks, building core capacity for the International Health Regulations (2005), and training and education. This will increase capacity and resilience of health systems to address chemical safety.
- The area of leadership and coordination includes actions to promote the inclusion of health considerations in all chemicals policies, the engagement of the health sector in chemicals management activities at national, regional and international level and with other sectors. Those are aimed at increasing awareness and engagement of the health sector.

For each action, the main actor, or lead, has been identified, while it is recognized that success depends on cooperation with various stakeholders and sections.

The timeline of the roadmap is towards the 2020 goal and beyond.

[33] See resolution ICCM IV/4, The Strategic Approach and sound management of chemicals and waste beyond 2020, in document SAICM/ICCM.4/15, Annex I, available at http://www.saicm.org/Portals/12/documents/meetings/ICCM4/doc/K1606013_e.doc (accessed 18 April 2017).

Main findings of the consultation[34]

In the electronic consultation, Member States, bodies of the UN system and others were invited to comment on the content and general structure of the roadmap. 60 responses were received (40 Member States and 3 UN agencies, 17 from others). Survey respondents were very supportive and welcoming of the draft road map. It was noted however that actual achievement of the actions would depend on capacity, resources and political commitment.

A range of suggestions were proposed to, ensure active participation of the health sector in the intersessional process to prepare recommendations for the Strategic Approach, especially for ensuring health sector representation in the delegations to the meeting, raising health sector concerns at all levels, networking, and holding meetings in conjunction with international meetings at which the health sector is already represented. Member States also suggested that information could be shared through networks, online platforms and reporting processes and through Secretariat reports to various international forums, including the Health Assembly and the International Conference on Chemicals Management.

Development since the 140th session of the executive board

In response to the written comment submitted by one MS following the 140th session of the Executive Board, the Secretariat made two changes to the knowledge and evidence action area:

- “based on objective evidence” was added to the overview of the actions included in this action area;

- the action for WHO to provide guidance on how to prioritize chemicals for assessment and management was changed to be an action for Member States to identify priority chemicals for national assessment and management from a health perspective, to reflect the ultimate output of this activity.

The first meeting of the intersessional process to prepare recommendations regarding the Strategic Approach and sound management of chemicals and waste beyond 2020, held in February 2017, in Brasilia. The draft road map was described during the meeting as useful for assessing and identifying national priorities and was suggested as a model for other sectors to consider.

Report on health impacts of waste

[34] Member States, bodies of the United Nations system and others were invited to answer a survey on the content and general structure of the draft road map. The Secretariat received 60 responses (40 from Member States; three from bodies of the United Nations system; and 17 from others) and took them into account when revising the draft.

The Secretariat has undertaken an initial review of available data on solid waste production and related health risks globally, mainly concerning disposal of domestic and clinical sourced solid waste. The initial findings indicate that the review will need to be broadened to take into account the health risks resulting from solid waste being discharged into water bodies and contributing to atmospheric pollution. The Secretariat is in the process of identifying the additional resources needed to broaden the data collection for the report.

The Health Assembly is invited to note this report and consider the draft decision.

Draft Decision

The draft decision requests the WHA to approve the roadmap and requests the Director General to report to the 72th WHA on the progress. The report to the 74th session is requested to also include an update on the roadmap.

Implication for the European Region

The health sector priorities in chemical safety in the WHO European Region were identified during the meeting "Strategic Approach to International Chemicals Management: implementation and priorities in the health sector" organized in Bonn, in June 2015. The identified priorities are:

- *Policy development and strengthening legislation* in a number of areas, including identifying the role of the health sector, promotion of interagency coordination, facilitation of safer alternatives to hazardous chemicals, integrating chemicals and health in broader development agendas;

- *Monitoring, surveillance, risk assessment, and evidence collection* including biomonitoring, collection of information on chemical in products and chemicals health effects;

- *Capacity-building* for strengthening of institutional and human resources necessary for dealing chemical emergencies, monitoring and surveillance, health effects assessment, and green procurement and use of chemicals by the health sector;

- *Scientific research* including development of tools for assessment of risk of real-life exposure and indicators of early health effects of chemicals.

Priorities in chemical safety area, including involvement of all relevant sectors, are currently discussed in the context of the upcoming 6th Ministerial Conference on Environment and Health (Ostrava, Czech Republic, June 2017 including development and implementation of policies and strategies to protect vulnerable population groups; creation of mechanisms and means to raise awareness of health impacts of chemicals, and strengthening partnerships

between state and non-state stakeholders; fulfilment of the role of the health sector in sound chemicals management; and, advanced implementation of the relevant MEAs to promote sound management of chemicals in WHO European Region.

16.3 Global Strategy for Women's, Children's and Adolescents' Health (2016-2030)

Document A70/37

In January 2017 The Executive Board at its 140th session noted an earlier version of this report. As an implementation platform for the SDGs, the UN Secretary-General launched the Global Strategy for Women's, Children's and Adolescents' Health (2016–2030)[35] with the objectives to end preventable mortality, to promote health and well-being, and to expand enabling environments (survive, thrive and transform). A road map for attaining these objectives with evidence-based action areas is provided. Its guiding principles include equity, universality, human rights, development effectiveness and sustainability.

In May 2016, the Health Assembly adopted resolution WHA69.2 on Committing to implementation of the Global Strategy for Women's, Children's and Adolescents' Health, and invited Member States to implement in accordance with their national plans and strengthen accountability and follow-up. It requested the Director-General to provide adequate technical support, continue to collaborate, to advocate and leverage multistakeholder assistance for implementation of national plans, and report regularly on progress.

This report provides an update on the current status of women's, children's and adolescents' health and is aligned with the report on the Progress in the implementation of the 2030 Agenda for Sustainable Development (document A70/35). For reporting to the Seventieth World Health Assembly, the theme is adolescents' health.

Status of women's, children's and adolescents' health – monitoring progress and promoting accountability: WHO undertook a consultative process to elaborate an indicator and monitoring framework for the Global Strategy. The overall framework has 60 indicators whose 16 are key indicators which were selected as a minimum subset to provide a snapshot of progress towards the survive, thrive and transform objectives of the Global Strategy[36].

[35] The Global Strategy for Women's, Children's and Adolescents' Health (2016–2030): survive, thrive and transform. (http://globalstrategy.everywomaneverychild.org/, accessed 9 May 2017).

[36] See par. 5, 6,7, 8 of the Report for detailed results and numbers.

An assessment of the Global Strategy monitoring priorities in 2016 indicates that high-quality data are routinely collected at country level only for a few indicators[37]. This stresses the need to invest in civil registration and vital statistics and country health information systems, to prioritize indicators and sharpen the focus, to harmonize monitoring efforts and galvanize the required political support[38].,

In resolutions WHA69.2 (2016) on Committing to the implementation of the Global Strategy and WHA69.11 (2016) on Health in the 2030 Agenda for Sustainable Development, Member States emphasized the importance of improving data and strengthening information systems. The Secretariat, with the Health Data Collaborative and other partners, will provide technical support and help to mobilize resources as appropriate. The Secretariat established an expert group, Maternal and Newborn Information for tracking Outcomes and Results (MONITOR) to harmonize maternal and newborn measurement efforts and provide guidance for improving data collection national capacities, based on evidence. The Partnership for Maternal, Newborn and Child Health will coordinate the multistakeholder Unified Accountability Framework and host the Every Woman, Every Child's Independent Accountability Panel[39].

By March 2017, 60 governments had made commitments to implement the Global Strategy. There are more than 110 multistakeholder commitments to support country-led implementation as well has many mechanisms to support country-led investment, implantation and monitoring.

WHO and the partners in the H6 Partnership provide technical support to countries preparing new strategies and/or Global Financing Facility investment cases for reproductive, maternal, newborn, child and adolescent health and provided capacity building to health ministries particularly in the African Region.

In February 2017 WHO together with the UNICEF, UNFPA and partners from all stakeholder groups launched the Network for Improving Quality of Care for Maternal, Newborn and Child Health to introduce evidence-based interventions to improve quality of care for maternal and newborn health supported by a learning system

High-level working group on health and human rights of women, children and adolescent health : In recent years, the health and human rights of women, children and adolescents have come under unprecedented attack in several countries owing to restrictive legal and policy considerations, conflict, violence and disaster, especially in the context of their sexual

---

37 Country data, universal accountability: Monitoring priorities for the Global Strategy for Women's, Children's and Adolescents' Health (2016–2030), available at: http://www.who.int/life-course/partners/global-strategy/gs-monitoringreadiness-report/en/ (accessed 5 April 2017)

38 See Document A70/35 on Progress in implementation of the 2030 Agenda for Sustainable Development.

39 The Panel's report for 2016 called for action in three main areas – leadership, resources and institutional strengthening, particularly around human resources for health.

and reproductive health. The High-Level Working Group on the Health and Human Rights of Women, Children and Adolescents met (Geneva, 7 and 8 February 2017) to address challenges in implementation of health and human rights for these populations, and to underscore the urgency of promoting and protecting health and human rights in order to achieve the relevant targets set out in the Sustainable Development Goals and the Global Strategy for Women's, Children's and Adolescents' Health. To address these issues and create a new model for the promotion and protection of health and human rights, the Working Group identified a set of key recommendations (in Annex).

Special theme: Adolescent health – the new frontier in global public health: There are sound reasons for an increased attention to adolescents and many member states are expanding their investment in adolescent health. The global mortality rate is neither negligible nor declining as rapidly as in under 5 year olds. Furthermore, the frequency of health related behaviours that begin or are consolidated during adolescence, such as unprotected sex (compounded by a lack of access to contraception), tobacco use, poor diets, alcohol use, physical inactivity and drug use has declined very little or increased.

The Secretariat, in collaboration with WHO's other partners in the H6 Partnership and UNESCO and an External Advisory Group, is preparing guidance on implementing global accelerated action for the health of adolescents (AA-HA!)[40]. It aims to support countries on planning, implementing and responding to the health needs of adolescents in line with the Global Strategy.. It has drawn on inputs received during extensive consultations with Member States, bodies in the United Nations system, adolescents and young people, civil society and other partners. The final version will be made available by the time of the Seventieth World Health Assembly. WHO's efforts to advance adolescent health are also embedded in other United Nations-wide and other partners' initiatives.

Future developments: It is proposed that the Secretariat's report on implementation of the Global Strategy to a future session of the Health Assembly feature early childhood development.

The Health Assembly is requested to note the report.

Implication for the European Region

Implementation of the Global Strategy at the regional level is supported by the following regional strategies endorsed by the Regional Committee: the European Strategy for Child and Adolescent Health and Development (2014), the European Strategy for Women's Health and Well-being (2016), the Action plan for sexual and reproductive health: Towards

[40] See http://www.who.int/maternal_child_adolescent/topics/adolescence/framework-accelerated-action/en/ (accessed 16 May 2017)

achieving the 2030 Agenda for Sustainable Development in Europe – leaving no one behind (2016).

For monitoring of the European Strategy for Child and Adolescent Health (2014) and making children and adolescents live more visible, country profiles for the 53 Member States for child and adolescent health (CAH) have been developed, and are available on the WHO data gateway. A baseline survey on policies and practices in countries for CAH has been compiled. Adolescent health policies are documented through the survey. WHO/Europe has developed a guidance process for countries for developing a CAH strategy or action plan, making the tools available.

Health Behaviour in School-aged Children (HBSC) is the main tool for evidence based policy making in adolescent health and a flagship collaboration for WHO, which provides valuable data for policy-making in adolescent health and development.

Schools have become a major focus for addressing the integration of health promotion and disease prevention based on WHO standards and competencies. A WHO Europe high-level conference on promoting intersectoral and interagency action for health and well-being in the WHO European Region took place in December 2016 in Paris, and approved a joint Declaration on “Partnerships for the health and well-being of our young and future generations”, focusing on strengthening intersectoral cooperation between the health, education and social sectors in the WHO European Region, for better, more equal health and social outcomes for children and adolescents and their families. It emphasised that every school should be a health promoting school.

The European Strategy for Women’s Health and Well-being adopted by member States in 2016 aims at reducing inequalities among women on the region and at addressing the impact of gender and socioeconomic determined inequalities in women and presents recommendations within four interconnected areas of action: i) strengthening governance of women’s health and well-being; ii) eliminating discriminatory norms and practices that affect the health of women and girls; iii) tackling the impact of gender and other social, economic and environmental determinants and iv) improving health system responses to women’s health. The European report on Women’s Health and Well-being was launched in September 2016 to accompany the Strategy and it provides the evidence that guided the selection of priorities in the Strategy.

The European Strategy takes a life-course approach acknowledging the importance of youth and adolescence for health outcomes and well-being also in later life. For example, it recommends countries to develop and implement multisectoral policies that value girls and eliminate harmful practices; to ensure that health promotion initiatives project a positive and strong self-image for all girls; to address the impact of gender in exposure and vulnerability towards noncommunicable disease and mental health problems; to

strengthen the capacity of the health services providers to provide gender and age-responsive services and to be better equipped to care women and girls experiencing intimate partner violence; and to strengthen comprehensive sexuality education aimed at transforming gender norms. Several of these recommendations were developed further in the European Action plan for sexual and reproductive health , also adopted by Member States in September 2016.

The European Strategy highlights the impact on adolescent girls of gender stereotypes. Challenging the negative impact on health of gender stereotypes on adolescent boys will also be addressed into the future Strategy on men's health and well-being being developed for 2018.

The process of development of an "Action plan for sexual and reproductive health: Towards achieving the 2030 Agenda for Sustainable Development in Europe – leaving no one behind - includes key actions on promoting sexual and reproductive health and related human rights of all people including adolescents. These actions are based on the available evidence and life-course approach principles from pregnancy to postpartum period, from sexuality education to youth friendly services and access to quality health care. Several countries have started development of their national policies based on the adopted European Regional Action plan.

Currently, the WHO Regional Office for Europe is expanding its support to countries in implementing the Strategy on women's health and well-being through various activities and partnerships. Moreover, the WHO Regional Office for Europe is developing a gender sensitive framework for monitoring the implementation of the strategy based on already existing indicators, including the SDGs, the Global Strategy on Women's, Children's and Adolescents' health and Health 2020. This work is conducted in partnership with other UN agencies operating in the European Region, through the R-UNDG issue-based coalition on gender.

= = =