World Health Organization

REGIONAL OFFICE FOR Europe

BRIEFING ON TECHNICAL AGENDA ITEMS EXECUTIVE BOARD 142ND SESSION

WHO REGIONAL OFFICE FOR EUROPE

(For Information Purposes Only)

16 January 2018

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3.3 Public Health Preparedness and response

Document EB142/8

In accordance with decision WHA69(9) (2016)[1], WHO established the Independent Oversight and Advisory Committee (IOAC) for the WHO Health Emergencies (WHE) Programme to guide the development of the new Programme, monitor WHO's work in outbreaks and emergencies and provide oversight. This report is the third IOAC report to the governing bodies and presents a summary of observations of the first 18 months of the WHE programme., since its official launch in July 2016.

IOAC monitors WHE progress under a monitoring framework[2] consisting of eight key thematic areas: structure, human resources (HR), incident management, risk assessment, finance, business processes, partnerships, and International Health Regulations (2005) (IHR). Monitoring modalities used included desk reviews, in-person meetings and interviews, secretariat briefings, group discussions via teleconferences, and field visits to WHE operations in Colombia, Nigeria, Mali, Iraq, and Pakistan.

Progress of the WHE: WHO has successfully launched its Health Emergencies Programme and is establishing a strong coordination and leadership role in health emergencies with the support of partners. Significant progress in WHO's response to emergencies has been welcomed by governments, other entities of the UN system, NGOs and donors on the ground. Significant progress has been observed particularly in structure, incident management, risk assessment, partnerships and IHR.

Performance in outbreak and emergencies at country levels have improved and have been appreciated by UN and other partners at field level. WHO's response to plague in Madagascar merits particular praise. The new Director-General outlining of health emergencies as one of the priorities for the Organization as evidenced by the newly instituted daily briefing on outbreaks and emergencies and the various internal reporting tools to support the WHO senior leadership with decision-making and coordinated response operations.

Launch and use of the Emergency Response Framework (ERF) to grade and manage emergencies. Adaptation of the incident management system to the different contexts of

[1] WHA69/2016/REC/1 (http://apps.who.int/gb/ebwha/pdf_files/WHA69-REC1/A69_2016_REC1- en.pdf, accessed 15 January 2018)

[2] IOAC monitoring framework for WHE (http://www.who.int/about/who_reform/emergency-capacities/oversight-committee/ioac-monitoring-framework.pdf?ua=1, accessed 15 January 2018)

crises and to the culture of the Organization and development of staff suitable for Incident Manager role.

The IOAC is pleased to observe continuing progress in assessing IHR country capacity, monitoring and planning. As at November 2017, 61 countries have completed independent joint external evaluations (JEEs)2 and 24 are planning to carry out the JEEs in the coming months. A total of 12 countries have already finalized their national action plans (NAPs) for health security and 11 countries have such plans under development.

The WHE Programme's progress in developing innovative partnerships, readiness to play leadership role in health under Inter-Agency Standing Committee (IASC) and intensified activities of the partnership networks including the Emergency Medical Team Initiative, the Global Outbreak Alert and Response Network (GOARN) and the Public Health Emergency Operations Centre Network.

Reduction of funding gap for core budget for WHO Program is a marker of increasing public and donors' trust on WHO's work in emergencies.

Challenges and Recommendations in Key Areas:

Information sharing and internal communications: The IOAC acknowledges that the WHE Programme structures are aligned across the three levels of the Organization, as set out in the Programme implementation plan (document A69/30), but observes that many staff are still not fully aware even now of the details of the Programme and relevant changes within the Organization. The IOAC recommends that WHO makes further efforts to embed transparent and proactive communication across the Organization, for both internal and external audiences, especially with regard to the strategic vision, structure, function and deliverables of the WHE Programme

Business processes: The IOAC remains concerned that WHO's business processes are not fit to support emergency response. Observations from the field visits, however, affirmed that WHO systems and procedures are delaying response to emergency operations and require corporate solutions. The IOAC recommends that a series of further measures to reinforce and familiarize staff with the SOPs need to be taken – for example, regular training of operations and administrative staff, focused communication with clear instructions on what to do, and a briefing session for all staff involved in graded emergency response on the emergency SOPs.

Delegation of authority: The IOAC warns that the current system of region-specific delegation of financial authority for managers, which is inconsistent across the regions, obstructs WHO's ability to carry out operations in emergency settings as one organization.

The IOAC recommends that DOA and approval responsibilities should be harmonized and standardized in the WHO-wide resource planning system, Global Management System (GSM).

Human resources planning, recruitment and management: As of October 2017, a total of 1580 positions are being planned for the WHE Programme, of which 751 have been filled. While a comparable number of positions have been filled at each of the three levels of the Organization, this has resulted in a much higher proportional coverage of HQ positions than of regional office (RO) and WCO positions, due to larger staffing needs at the RO and WCO levels. The IOAC reiterates that the balance of HR should be a distribution of 50% in WCOs, 25% across the six ROs and 25% at HQ.
The IOAC is concerned by the insufficiency of professional HR support for talent acquisition and management in the Organization. For alleviating these problems, sufficient dedicated HR staff for the WHE Programme would be required. The IOAC advises WHO to examine the current capacity for HR planning, recruitment and management and propose directions for improvement at the organizational level for the WHE Programme.

Partnerships: WHO is an active partner in the Deliver Accelerated Results Effectively and Sustainably (DARES) initiative2 – a collaboration with the World Bank, UNICEF and WFP – to provide more inclusive, comprehensive, predictable and sustainable support for health system recovery in fragile, conflict-affected and vulnerable countries. IOAC strongly encourages WHO, as it pursues this important initiative, to put in place additional and appropriate risk management and oversight mechanisms to ensure accountability

Finance: While appreciating the increased financial support from Member States and donors, the IOAC noted that a substantial proportion of the funds for the WHE Programme are earmarked, and raised in the last half of the biennium on a one-time basis. The IOAC encourages donors to provide un- or lightly earmarked funding through multiyear partnerships to establish greater resilience in the Programme to enable it to deliver on its goals.

Procurement of goods and services: The IOAC noted with concern that WHO does not have a fully integrated global supply chain management system, and that there is no overall accountability nor harmonized system across the regions in this regard. IOAC recommends that WHO should consider either:

- outsourcing the function to another provider within the UN system, such as UNICEF's Supply Division, to enable the WHE Programme to procure and effectively manage and deliver its emergency stocks; or
- making an investment case for the entire Organization, establishing a central division of supply chain management, with clear objectives and accountabilities across the Organization, upon which the WHE Programme can build if additional capacity for emergencies is required.

Security: The IOAC recommends that WHO should increase its investment and capacities in field security and other staff protection measures. Staff working in emergencies are exposed to a high level of security risk. During the field visits, the IOAC directly observed that the level of security support is inadequate given the number of WHO staff, the distribution of WHO offices and suboffices and the heavy demands of field missions and deployments

Implication for the European Region

Some of the challenges highlighted in the IOAC report are also observed in the European Region, particularly in human resources, financing and business processes, despite no acute emergencies are currently occurring in the region.

As of January 2018, WHO/Europe has carried out 10 Joint External Evaluations (Albania, Armenia, Belgium, Finland, Kyrgyzstan, Latvia, Slovenia, Turkmenistan, Switzerland/Liechtenstein) and 2 National Action Plans following a JEE were undertaken so far (Finland and Kyrgyzstan).

More countries expressed interest to conduct a JEE in 2018 and so far, official requests have been received from Serbia and Lithuania send official JEE request to WHO in 2018. Various simulation exercises are planned; among WHE priority countries (15 in total). Tajikistan and Kyrgyzstan are the first group of countries planned for this type of exercise (flooding scenario) and a scoping mission is planned in February 2018. Other countries in the pipeline include Armenia, Albania, Azerbaijan, Macedonia, and Georgia (infectious disease outbreak scenario)

After Action Reviews are scheduled for Romania. Albania, Slovenia and Bosnia and Herzegovina have also expressed interest to conduct an AAR this year. The Regional Office is working on development of a draft Regional action plan for accelerated implementation of IHR based on the Global Strategic Plan, which will be presented at the regional high level meeting in Germany in February 2018 and to the SCRC in March 2018.

Document EB142/9

The report provides information on WHOs response and coordination in severe, large scale emergencies, as well as research and development in the context of emergencies.

WHO'S RESPONSE AND COORDINATION IN SEVERE, LARGE-SCALE EMERGENCIES.

A system for continuous event-based surveillance of public health events and verification and assessment of detected events is established, with on average, 3000 signals being received per month, of which 300 merit follow-up and 30 are investigated. Standardized risk

assessment processes are used. Standard packages of care for high-priority high-impact pathogens and diseases including cholera, Zika and influenza have been introduced.

New administrative systems have been put in place, including pre-cleared staff rosters for deployments, emergency standard operating procedures, including delegations of authority, fast-track recruitments and procurement. The second edition of WHO's Emergency Response Framework, which includes application of the Incident Management System, is now used to manage all graded events.

During the period under review, WHO responded to 47 graded emergencies. No new declaration of public health emergency of international concern was made in 2017.

Among the acute emergencies, nine were classified Grade 3 emergencies, which is the highest severity level based on WHO's Emergency Response Framework (Syrian Arab Republic, South Sudan, Iraq, Yemen, Nigeria, Ethiopia, Somalia, Democratic Republic of Congo, Bangladesh/Myanmar)

In accordance with the principles of the Emergency Response Framework, WHO activated the Incident Management System to address immediately the health needs of and risks facing the affected population. WHO also led or jointly led health sector coordination, including that of 23 activated health clusters. About US$ 16 million have been disbursed from WHO's Contingency Fund for Emergencies order to ensure rapid expansion of WHO's response in 28 graded emergencies.

Constraints on the health sector response include insecurity and limited access, limited capacities of national health systems and partners, shortages of health personnel, bureaucratic constraints and insufficient funding. During the biennium 2016–2017, WHO has requested US$ 1070 million in appeals funding for outbreak and crisis response of which it has received US$ 848 million (79%).

In the Syrian Arab Republic, WHO has provided sufficient medicines and supplies for 10.5 million treatments (8.4 million from inside the country), and vaccinated 4.5 million children against measles and 2.4 million children against polio.

In response to the large-scale influx of more than 520 000 refugees fleeing violence in Myanmar's Rakhine State to Cox's Bazar in Bangladesh, WHO has mobilized more than 40 national and international staff from all three levels of the organization. Priority health interventions have included preventive campaigns against measles and cholera, the establishment of an early warning alert and response system, strengthening of health sector coordination, and rapid expansion of access to essential health services, including 20 mobile teams supported by WHO.

Other large-scale emergencies for which WHO supported the national response during the reporting period included the yellow fever outbreak in Brazil (Grade 2), Hurricanes Irma and Maria in the Caribbean (Grade 2) and the ongoing humanitarian crisis in Ukraine (Grade 2).

The interrelated issues of safeguarding our health security while promoting our health through universal health coverage are WHO's top priority. Strong health systems are our best defence to prevent disease outbreaks from becoming epidemics and to mitigate the risks caused by the breakdown of health systems in fragile settings, such as those caused by conflict.

RESEARCH AND DEVELOPMENT IN THE CONTEXT OF EMERGENCIES

In June 2015, the Secretariat initiated work on the Research and Development Blueprint for Action to Prevent Epidemics for potentially epidemic diseases. Its goal is to reduce delays between the identification of an outbreak and the deployment of effective medical interventions. Areas covered by the Blueprint include product research and development for diagnostics, vaccines and therapeutics.

WHO's list of diseases for priority research and development was updated at a meeting in January 2017 and will be reviewed at a consultation that will take place on 5 and 6 February 2018.

The Secretariat has developed six vaccine target product profiles (Lassa, Nipah, Zika, MERS, multivalent Ebola and monovalent Ebola Zaire vaccines) and two diagnostic target product profiles (Zika and Ebola) and is working on target product profiles for other key pathogens. Research and development road maps for prioritized diseases are being developed through expert consultations.

An initial workshop on Zika vaccine efficacy trials was organized on1 and 2 June 2017 and generic protocols for Zika vaccine evaluation are being finalized together with criteria for prioritization of vaccine candidates and selection of clinical sites.

The establishment of the Global Coordination Mechanism for Research and Development to Prepare for and Respond to Epidemics was finalized. In November 2017, its terms of reference and core membership were discussed and standard operating procedures for regular communication among members and interaction with existing independent advisory groups of experts informing the global research and development community were outlined. The Secretariat has also developed a visualization tool to facilitate access to information on stakeholders involved in research on various priority pathogens and products. The Coalition for Epidemic Preparedness Innovations has committed itself to working on the diseases prioritized in the R&D Blueprint.

Efforts to strengthen national regulatory and ethics bodies to respond to public health emergencies are under way, including an informal consultation on regulatory preparedness to address public health emergencies for vaccines, diagnostics and therapeutics for priority pathogens.

The Board is invited to note this report.

Implication for the European Region

In the WHO European Region, WHO continued lifesaving operations in the two long standing humanitarian crises, in Ukraine (Protracted Emergency Grade 2, P2) and in Turkey, under the Whole-of Syria operations (Emergency Grade 3, G3). WHO kits were delivered rapidly to Albania post floods in December 2017. Through deployment of staff, WHO/Europe supported the establishment of the Incident Management System in Ethiopia and the response in Iraq.

Whole of Syria operations from Turkey: Entering the seventh year of the crisis, the scale, severity, and complexity of needs across the Syrian Arab Republic remain overwhelming. Some 13.1 million people in Syria require humanitarian assistance. Of these, 5.6 million people are in acute need. More than 700,000 children under five are deprived of vaccines. About 6.1 million are internally displaced and 4.54 million are in besieged and hard to reach areas. The health system in Syria has been severely disrupted by the conflict, leaving less than half fully operational and resulting in thousands of avoidable deaths. Combined with low immunization coverage, the weakening of the health system led to 74 cases of circulating vaccine-derived poliovirus type-2 (cVDPV2) confirmed in Syria during 2017.

The lack of access to besieged and hard-to-reach areas and attacks on health workers and facilities continued to hamper access and service delivery in many parts of the country. In 2017 WHO and its partners continued to lead, coordinate and deliver cross-border lifesaving primary and secondary care from the WHO Field Office in Gaziantep, Turkey to the population in need in the northern parts of the Syrian Arab Republic. WHO supported 3.89 million beneficiaries through cross border operations in 2017.

From January to November 2017, 96 verified incidents of violence against health care infrastructure were reported to WHO. Cluster partners of the Turkey Whole-of-Syria hub are present in nine governorates, 31 districts, 84 sub-districts and 275 communities in northern Syria, providing support to 355 health care facilities, including 76 mobile clinics. Each month, on average over 1.03 million outpatient consultations were provided by WHO/Health Cluster partners and over 10,000 deliveries were assisted by skilled birth attendants, per month. Early warning system has continued reporting from 480 sentinel sites with 97% completeness. The expanded programme of routine immunization was revitalized in seven additional health centres in northern Syria, making a total of 53 operational centres by the end of November 2017.

Supporting provision of health services to Syrian refugees in Turkey: Since 2011, over 3.2 million Syrians found refuge in Turkey, and have been offered temporary protection by the Government of Turkey. Ten percent are cared for in temporary hosting shelters, while the rest have spread in all the 81 provinces in Turkey and living among host communities. The Government and the UN agencies, donors and partners, provide them with shelter, food, equitable access to quality and affordable services. The efforts in the health sector are led

by the Ministry of Health and supported by WHO and several other UN agencies, donors and partners. The humanitarian work is coordinated and implemented under the Regional Refugee and Resilience Plan as part of the Whole of Syria operation. With the Ministry of Health and WHO, vaccination campaigns have reached over 365,000 Syrian children under 5 years of age.

WHO supported the MoH to design and provide a package of essential health services to Syrian refugees in Turkey and improving access to quality and affordable services through the development and provision of adaptations trainings of Syrian doctors, nurses, medical translators, mental health and psycho-social workers. In total more than 1000 Syrian doctors and over 600 nurses have completed the theoretical part of the adaptation training and over 600 doctors and 400 nurses had completed the practical on the job clinical rotations. Over 300 translators were trained in medical terminology. Direct support to the renovation, staffing, provision of equipment and medical supplies to seven Refugee Health Training Centers, located in seven provinces with the highest concentration of Syrian refugees was provided. The estimated number of clinical consultations provided to the Syrian refugees by the strengthened seven health centers mounts to 360,000 every year. The model of service provision successfully implemented in these seven centers was used by the MoH to design and establish 42 extended migrant health centers as part of a larger network of 178 such centers, consisting of 790 migrant health units (staffed by one Syrian doctor and one nurse).

Response in Ukraine: Four years into the crisis in Ukraine, the lives of 4.4 million people have been shuttered. Among them are 1.6 million internally displaced persons (IDPs), half of whom are the elderly. About 3.4 million require humanitarian assistance and protection, and 2.2 million are in need for access to health services and nutrition.

The situation is aggravated by Ukraine's extremely harsh winter, restrictions on humanitarian access and limited livelihood opportunities for those affected by the crisis. WHO reassessed the situation and the emergency continues to be graded Protracted 2 (P2). The risk of communicable disease outbreaks is increasing due to frequent water supply damage and interruption, dysfunctional heating systems and malnutrition. Immunization rates have continued to decrease both nationwide and in the conflict-affected areas. There are escalating cases of multi-drug resistant TB. HIV prevalence among pregnant women in conflict-affected oblasts is significantly higher than the national average. Surveillance remains weak with limited data sharing and early notification, along with documented gaps in laboratory capacity. Non-communicable-disease-related mortality in Ukraine is among the highest in the European Region and chronic diseases are of particular concern in the conflict-affected area of eastern Ukraine.

Healthcare services have been significantly disrupted by the conflict, with over 130 healthcare facilities still require rehabilitation. In the area within 5 km of the 'contact line'

up to 66 percent of healthcare facilities reported damage during the crisis; with 48 percent still in need of rehabilitation.

In 2017 the risk of hazardous chemical release has become more acute, with increased shelling near storage facilities. Systems to provide emergency care for trauma, mass-casualty and chemical exposure are faced by limited resources and gaps in care, and require reorganization and skills updating.

In 2017, health workers were trained in primary and public health quality of care and disease control including immunization; laboratory quality-management systems, mental health services and physical rehabilitation, .

WHO continues to lead the Health and Nutrition cluster since 2014. The Cluster is comprised 36 partners and is based in Kyiv and in the four WHO Field Offices in Donetsk, Luhansk, Kramatorsk and Severodonetsk. In 2017 the Ukrainian Health Cluster requested $22.1 M, and received $9.2M (42%);

Regional level activities: Through the Regional 24/7 event-based surveillance 40,000 signals identified and risk assessment conducted in 93 events, followed by provision of support the Member States. WHO Europe's health emergencies programme team supported the outbreak investigation of travel associated Legionnaires' disease (TALD) among returning European travellers from UAE, with ECDC.

In WHO/Europe, following the country business model, the focus is on 15 Priority Countries in prevention, preparedness and readiness for health emergencies. WHO conducted 10 Joint External Evaluations (JEE), 2 After Action Reviews (AARs) and one Simulation Exercise (SimEx). National Action Plans for Health Security (NAPHS) are being finalized in 3 Member States.

Through the Better Labs for Better Health initiative, public health laboratory systems were improved in 11 countries through development of guidance for licensing and accreditation and implementation of laboratory quality management systems, including through mentoring of 16 national reference labs in 9 countries. In collaboration with EU and US partners, support was provided to UKR to reform its' public health laboratory services. Additional partners were engaged through the 2nd partners meeting, which endorsed the need to improve lab systems as a whole, building on disease-specific initiatives. Work was initiated with countries of the SEEHN to identify gaps in lab networks for emergency response to high threat pathogens other than influenza. Hospital Safety Index assessment completed for 210 hospitals in 14 countries.

Global and Regional aspects of the partnerships with the Global Health Cluster, the Global Outbreak Alert and Response Network, and Emergency Medical Teams networks were strengthened.

Draft five-year global strategic plan to improve public health preparedness and response 2018- 2023

Document EB142/10

The document presents the draft five- year global strategic plan to improve public health preparedness and response, which takes into account comments and suggestions made by Member States during an extensive consultative processes including a web-based consultation, a face-to-face Member States consultation in Geneva and during the six WHO regional committee meetings held in 2017.

The goal of the proposed five year global strategic plan is to strengthen the capacities of both the Secretariat and Member States to ensure implementation of the International Health Regulations (2005), thereby continuously improving public health preparedness and response.

The plan is based on the following guiding principles: consultation; country ownership and leadership; WHO's leadership and governance; broad partnerships; intersectoral approach; integration with the health system; community involvement; focus on countries with greatest risk of emergencies and outbreaks; regional integration; domestic financing; linking the five-year global strategic plan with requirements under the International Health Regulations (2005); and focus on results, including monitoring and accountability (see Appendix 1 for more details)

The proposed strategic plan contains the following objectives under three pillars:

1) Building and maintaining States Parties' core capacities required by the International Health Regulations (2005)
    - Prioritize support to high-vulnerability, low capacity countries
    - Mobilize financial resources to facilitate the implementation of the Regulations
    - Link the building of core capacities under the Regulations with health system strengthening

2) Strengthening event management and compliance with the requirements under the International Health Regulations (2005)
    - Strengthen the Secretariats' capacity for event-based surveillance and response
    - Support and further strengthen the National IHR Focal Points
    - Improve States Parties' compliance with requirements under the Regulations
    - Strengthen the Secretariats' technical capacity by groups of experts

3) Measuring progress and promoting accountability
   - For the Secretariat to maintain and further strengthen the accountability through annual reporting on progress
   - For States Parties to continue annual reporting on IHR (2005) implementation
   - For the Secretariat to provide technical support regarding the use of the voluntary instruments for monitoring and evaluation

Draft Decision

The draft decision included in Annex 2, proposes the EB to recommend to the 71st WHA to endorse the five year global strategic plan to improve public health preparedness and response as outlined in the document and to report annually to the World Health Assembly on the implementation of IHR using the self-assessment reporting tool. The Director General is requested to provide support for the implementation of the five year plan, as necessary, adapted to the regional context ; to submit an annual report to the Health Assembly pursuant to para 1 of article 54 of the IHR ; and to support Member States to build, maintain and strengthen core capacities under the IHR.

The Board is invited to consider the draft strategic plan and the proposed draft decision in Annex 2

Implication for the European Region

Following the 66th session of the WHO Regional Committee for Europe (RC66), the Regional Office developed regional priorities for IHR implementation, which provides the basis for scaling up IHR capacities at the country level, from prevention and preparedness to response, recovery and sustainability, under the guidance of the SCRC subgroup.

Document EUR/RC67/13 on Accelerating implementation of the International Health Regulations (2005) and strengthening laboratory capacities for better health in the WHO European Region, which took account of input from broad consultations with Member States, was presented to RC67 in September 2017. It defines five priority areas for strengthening IHR implementation in the European Region:

- accelerating IHR implementation at the country level, including by strengthening the capacity of national IHR focal points and building health systems to enable IHR capacities;
- improving monitoring, evaluation and reporting on IHR core capacities, not only as part of annual reporting but also through simulation exercises, voluntary external evaluations and after-action reviews;
- improving event management to ensure a strong chain of health security at the local level, including risk assessment and risk communication;

- strengthening laboratory capacities for better detection and verification of public health threats (in line with the WHO Better Labs for Better Health Initiative); and
- strengthening WHO's capacity to implement the IHR.

Document EUR/RC67/13 and the draft five-year global strategic plan, which will be presented to the Seventy-first World Health Assembly in May 2018, will serve as the basis for developing a five-year regional action plan for the WHO European Region to be presented to the Regional Committee in September 2018. The draft Action Plan will be prepared in close consultation with Member States and partners and will indicate the way forward for WHO/Europe in operationalizing the global strategic plan. The primary audience for this Action Plan are States Parties in the WHO European Region as well as a broader constituency from the social and development sectors, civil society, academia and patient groups.

3.4 Polio transmission planning

Document EB142/11

Development of the strategic action plan on polio transition was requested through resolution WHA70(9) in May 2017. The plan, which is a work in process will be finalized by WHA 71 and it supports the three strategic priorities of the 13th GPW to maximize WHO's contribution to achieving the Sustainable Development Goals.

Elements of the Strategic Action Plan

National transition plans: There are 16 priority Member States that receive over 90% of the Global Polio Eradication Initiative (GPEI) resources and have been identified as priorities for transition planning, all of them are in the African, Eastern-Mediterranean and South East Asian regions. In order to mitigate the negative impact of the planned decrease of GPEI resources, a process has been set in motion to develop national transition plans in these countries[3]. The GPEI, through its Transition Management Group, has been supporting the planning process with guidelines, technical assistance, communications and advocacy support, and tracking progress through a series of milestones

The draft post-certification strategy: As the world moves towards certification of the eradication of wild poliovirus, the Global Polio Eradication Initiative has started a process to define the technical standards and guidance for the essential functions required to sustain a polio-free world. The strategy has strong focus on mitigation of the current and future risks

[3] Country transition planning (http://polioeradication.org/polio-today/preparing-for-a-polio-free-world/transitionplanning/country-transition-planning)

to maintaining a polio-free world and identified three main goals: 1) Containing polioviruses; 2) Protecting populations; and 3) Detecting and responding to a polio event.

Strengthening immunization: The phasing-out of polio resources presents serious risks to the immunization systems of 16 priority countries and WHO's capacity to support them. In order to mitigate this risk, WHO is developing a business case to mobilize political commitment and financial resources to continue supporting Member States in fully achieving their immunization goals.

Strengthening emergency preparedness and response: As eleven of 16 priority countries are prioritized by WHE for health emergencies, there is a need to adjust WHE country business model, including the need to further strengthen core laboratory, health systems, staff safety and security capacities, and take over the functions related to EPI, disease surveillance and operational support.

Strengthening country core capacities for full implementation of the International Health Regulations (2005): As the polio programme has significant experience in community-based surveillance, particularly at local or district level, the future initiatives in the context of the International Health Regulations (2005) should learn from or use polio capacities all levels. The core capacity needs for implementation of the IHR must be integrated in national health and government planning cycles through, for example, the Country Cooperation Strategy and national polio transition plans

Implication for the European Region

None of the 16 priority Member States are in the WHO European Region.

The draft post-certification strategy: As majority of polio vaccine manufactures are located in the European Region, with 14 countries having identified at least 30 poliovirus essential facilities (PEFs), the regional office puts emphasis on containment activities and developing preparedness to a polio event. Polio outbreak simulation exercises (POSE) for Member States that are retaining polioviruses in PEFs will be conducted in the October 2018in collaboration with ECDC to help identify risks and put in place mitigation activities. National POSE in countries rolled out from 2016 and will continue in 2018-19.

Strengthening immunization: The European Vaccine Action Plan 2015–2020 (EVAP) is complementing, regionally interpreting and adapting the GVAP in harmony with Health 2020 and other key regional health strategies and polices. The EVAP goal on sustaining polio-free status, including maintaining high immunization coverage with polio vaccines, is steadily n track.

Strengthening emergency preparedness and response: Strong collaboration between regional Vaccine-preventable diseases and immunization (VPI) program and WHE continues for Ukraine with synergy and complementarity of activities.

3.5 Health, environment and climate change

Document EB142/12

Known avoidable environmental risk factors cause at least 13 million deaths every year and about one quarter of the global burden of disease.

Member States face a combination of long-standing unresolved and new environmental and health challenges. These range from lack of universal access to clean household energy, safe water and sanitation, to the consequences of unsustainable development, such as air, water and soil pollution and exposure to hazardous chemicals, and more complex, chronic and combined exposure in working and residential settings, and to ageing infrastructure, stagnating environmental health progress, and increasing inequalities, in all countries. Longevity, migration, urbanization and the ageing of the population put further pressures on the physical environments.

These challenges result in a triple burden of environmental risks, including the direct impacts of emergencies, persistent and in some cases expanding infectious disease risks, and noncommunicable diseases. For the latter, environmental risk factors are now of a comparable magnitude to other well-established risks (tobacco consumption, diet, alcohol consumption and physical inactivity).

Human influences on the global environment contribute significantly to climate change, which is considered potentially the greatest threat to global health in the 21st century. Many Member States already suffer significant loss of life and damage to crucial health infrastructure from extreme weather events. These developments threaten to undermine gains in health and development, and may exacerbate migration and increase social and political tensions within and between countries.

Responsibility for and tools to tackle many environmental determinants of health most often lie outside the direct control of individuals or the health sector alone. Therefore, a wider societal, intersectoral and population-based public health approach is needed. WHO promotes a Health-in-All-Policies approach, including coverage of health in environmental and labour regulations and safeguards, assessment of the health impact of development projects, and tackling several environmental health issues in a single setting, community or system.

Effective response to environmental determinants of health lies in system approaches rather than only interventions with direct and local effects on single environmental causes of death and disease.

The persistent burden of environmental disease and the evolving range of risks clearly call for a strengthening of primary prevention. However, health sector engagement and investment have not increased proportionately to meet the need. According to OECD, Member States typically allocate about 3% of health expenditure to prevention, in contrast to the 97% allocated to curative medicine.

In confronting challenges of this scale, incremental changes to deal with individual environmental risks are not sufficient, and the environmental contribution to the global burden of disease has remained almost static for a decade. Instead, the health sector must show leadership and work with other sectors to assume its obligations in shaping a healthy and sustainable future.

The 2030 Sustainable Development Agenda and its goals provide an integrated framework for addressing upstream determinants of health, including the environment and climate. Effective public health action requires the direct engagement of the health sector and of WHO in addressing multiple SDGs beyond SDG 3 through health sector's engagement in broad, inclusive and expanded primary prevention.

The Secretariat is committed to using WHO's mandate and core functions to support this effort, as a priority for the forthcoming draft thirteenth general programme of work (2019–2023). The resolutions and decisions of the World Health Assembly and WHO Regional Committees, and the commitments of the regional health and environment Ministerial processes, provide guidance for dealing with many environmental risks to health. However, the most recent Health Assembly resolution and the global strategy providing an overarching and unifying direction for WHO's work on health, environment and climate change, dates from 1993.

Draft decision

The EB is invited to take note of the Director General's Report and to request the Director General to develop (in consultation with Member States and other relevant stakeholders and in coordination with the Regional Offices) a draft action plan for the flagship initiative to address health effects of climate change in small developing States and vulnerable settings. The Decision also requests to develop (in consultation with Member States and other relevant stakeholders and in coordination with the Regional Offices) a draft comprehensive global strategy on health, environment and climate change, to be considered be the 72nd WHA in May 2019, through the EB at its 144th session in January 2019 and to ensure that in accordance with WHA 65(9) (2012) the Regional Committees are asked to comment and provide input on the global strategy on health, environment and climate change.

The Board is invited to note this report and consider the adoption of the draft decision.

Implication for the European Region

In the European Region, environmental risk factors are estimated to cause at least 1.4 million deaths per year, with approximately half of these being attributable to ambient and household air pollution. But also approximately one in 4 ischaemic heart diseases and strokes and one in 5 cancers are estimated to be attributable to environmental exposures. The work in this area in the WHO European Region is delivered under the umbrella of the European Environment and Health Process (EHP) – established in 1989 by the Regional Office, the Region's Member States, UNECE and other partners –which focuses on recognizing the multiple interconnections between risk factors and environmental determinants, translating science into evidence and supporting the development of policies in the Region and in Member States.

A recent milestone in the Process was the Sixth Ministerial Conference on Environment and Health, held in Ostrava, Czechia, 13-15 June 2017. The Conference took stock of the changed geopolitical, socioeconomic and demographic conditions in the European Region, defined the environment and health priorities for 21st-century in Europe. It also leveraged EHP as a platform for coordinated implementation of the 2030 Agenda and Health 2020 by focusing on the protection of vulnerable groups, improved governance, intersectoral work and rights-based approaches in addressing key health determinants in seven interconnected thematic priorities identified by Member States as defining the European environment and health agenda of the future.

The main political commitments taken through the Ostrava Declaration, endorsed by the 67th WHO Regional Committee for Europe in September 2017 and noted by the 23rd UNECE Committee on Environmental Policy in November 2017 evolve around five main areas:

- The Declaration defines the European Environment and Health Process as a mechanism for the attainment of environment and health-related goals and targets of the 2030 Agenda, through the implementation of Health 2020 and of the relevant WHO resolutions and decisions;
- It reaffirms the commitment to address the persistent gaps and needs in environment and health in the European Region, focusing on indoor and outdoor air quality, access to safe drinking water, sanitation and hygiene, chemical safety, waste management and contaminated sites, climate change, supporting European cities and regions to become healthier, more inclusive, safe resilient and sustainable, and building the environmental sustainability of health systems;
- It fully recognizes the paramount role of cities and regions in addressing environment and health challenges, and commits to promoting coherence across all policy levels, from international to local, and to developing inclusive platforms to facilitate dialogue at the international, national and subnational levels of policy-making, and engaging institutional and social actors and stakeholders, and

- It commits to enhance national implementation through the development of national portfolios of actions on environment and health by the end of 2018, which will take into account national priorities, means and capacities.
- In terms of governance, Member States decided to make the European Environment and Health Task Force as the single coordinating body for the work under the European Environment and Health Process, Process, and to strengthen the links to the governing bodies of the WHO and of the United Nations Economic Commission for Europe.

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

Document EB142/13

Access to medicines has been recognized as a crucial element of the solutions to numerous important public health problems in several World Health Assembly resolutions.

During the 69th WHA in May 2016, Member States acknowledged the increasing incidence of global shortages of medicines and vaccines. The Secretariat was asked to assess the nature and the magnitude of the problems of shortages (insufficient manufacturing capacity; problems with active pharmaceutical ingredients (API), financial constraints, problems with forecasting, challenges with procurement and supply chain management).

National regulatory capacity and local production: A regulatory benchmarking tool has been developed and used in several countries; it serves as an important method for identifying gaps in regulatory capacity that need to be filled in order to ensure quality-assured medicines.

Public health-oriented intellectual property and trade policies. WHO, WIPO and WTO have intensified their collaboration in order to foster a better understanding of the linkage between public health and intellectual property policies and to enhance a mutually supportive implementation of those policies.

Selection of medicines. Additional medicines for cancer and new medicines for hepatitis C and tuberculosis were included in the 19th WHO Model List of Essential Medicines and the 5th WHO Model List of Essential Medicines for Children.

Pricing, reimbursement and affordability. The WHO guideline on country pharmaceutical pricing policies was issued in 2015 to support Member States in managing pharmaceutical prices.

The Secretariat has developed a new draft technical definition of shortages and stock outs of medicines and vaccines :

- On the supply side: a “shortage” occurs when the supply of medicines, health products or vaccines identified as essential by the health system is considered to be insufficient to meet public health and patient needs. This definition refers only to products that have already been approved and marketed, in order to avoid conflicts with research and development agendas.

- On the demand side: a “shortage” will occur when demand exceeds supply at any point in the supply chain and may ultimately create a “stock out” at the point of appropriate service delivery to the patient if the cause of the shortage cannot be resolved in a timely manner relative to the clinical needs of the patient.

In addition, WHO’s programme on the prequalification of medicines and vaccines aims to include medicines at risk of shortage and stock outs in order to provide efficient regulatory pathways and contribute to improved market stability.

The Board is invited to note this report, including the comprehensive report on access to essential medicines and vaccines (Annex), and also note the update on the progress in implementing those elements of resolution WHA69.25 pertaining to the global shortage of medicines and vaccines

Implication for the European Region

WHO Europe works with Member States on effective national medicines policies, and their implementation under good governance: to support Member States in the selection of essential medicines, ensuring a supply of affordable and effective quality essential medicines, pricing policies. Several missions and workshops have been organized in 2017 to strengthen Member States capacity in all those areas, in collaboration with other UN agencies.

From 22 to 24th January 2018, WHO Europe will co-organize with UNICEF Supply Division in Copenhagen a Medicines Practitioners Procurement’ s exchange forum as part of the UNRCM Issue Based Coalition (IBC) on Health activities. The Forum will convene public procurement practitioners from the European and Eastern Mediterranean Region to exchange knowledge, practical experiences & challenges, best practices in procurement of HIV- and hepatitis- related medicines as well as NCD medicines and medical devices. The target audience are public procurement practitioners in Member States where The Global Fund will cease their support and the Member States need to switch to domestic funding and procurement of relevant supplies.

3.7 Global strategy and plan of action on public health, innovation and intellectual property

Document EB142/14 and EB142/14 Add 1.

This report is submitted in accordance with the Executive Board decision EB140(8)). In resolution WHA68.18, the Director General was requested to establish a panel of 18 experts to conduct an overall programme review of the global strategy and plan of action as a complement to the comprehensive evaluation done by the Secretariat. Aim of the report[4] is to provide recommendations in order to move the global strategy and plan of action on public health, innovation and intellectual property forward, including details of what elements or actions should be added, enhanced or concluded in the next stage of implementation until 2022.

During the review process, the panel of experts conducted surveys, interviews and several information sessions with Member States and relevant stakeholders, as well as meetings to assess the continued relevance of the aims and objectives of the programme, and to review its achievements.

The reviewing panel identified the following challenges faced by the programme: a lack of new health products in areas of need and of sustainable financing, the unaffordability of many new medicines, a lack of essential health products and inappropriate use, ineffective delivery and supply chain infrastructure and the absence of robust regulatory frameworks and trained personnel, mainly but not exclusively in developing countries.

The priority actions between 2018 -2022 recommended by the review panel are set out in the annex to the report , including indicative timeframes and include specific action to prioritize research and development (R&D) needs, promote R&D, build and improve research capacity, promote technology transfer, manage intellectual property to contribute to innovation and public health, improve delivery and access, promote sustainable financing mechanisms and establish a monitoring and accountability mechanism.

The Secretariat estimates that the budget for full implementation of the review's panel recommended actions will be US$ 31.5 million over the period 2018-2022; in particular, the estimated budget for implementation of the high-priority actions would be US$16.3 million. This indicative budget, not covered within existing resources, would allow the Secretariat to ensure implementation and monitoring of the global strategy and plan of action and provide technical guidance and support to Member States in the implementation of the review panel's recommendations for the period 2018-2022. Accurate estimates of the resource implications for Member States are not possible at this time.

[4] The full report of the comprehensive evaluation of the implementation of the global strategy and plan of action on public health, innovation and intellectual property is available at: http://www.who.int/about/evaluation/gspoa_report_final20dec16.pdf (accessed 18 October 2017)

Draft Decision

The Board decides to recommend to the WHA to request the Director General to take forward the recommendations of the review panel following the drawing up of a detailed implementation plan and to submit a report on progress made on this decision to the 73st WHA in 2020.

The Board is invited to note the report and adopt the draft decision in EB142/14 Add1

Implication for the European Region

The global strategy and plan of action on public health, innovation and intellectual property addresses topics of utmost importance for the WHO European Region. WHO/Europe has already taken several actions in line with the pillars of the global plan of action , especially in relation to;

Pillar 5: manage intellectual property to contribute to innovation and promote public health

WHO/ Europe, with support from HQ, has developed a significant stream of work in this area in recent years. High-level policy dialogues and technical trainings on medicines IPRs were held both in Ukraine and Moldova in 2017. National laws (medicine laws, patent laws) were also reviewed by experts to ensure that the full flexibilities defined in the TRIPS agreement were reflected in national legislations. Such activities will be carried out in 2018 in other countries of the Region.

Pillar 6: improve delivery and access

WHO/ Europe supports regional collaboration and cooperation on this topic and has set-up an information network of competent authorities on pricing and reimbursement for the CIS countries. WHO/Europe, in collaboration with the Austrian Public Health Institute, delivers annually a training on pharmaceutical pricing and reimbursement policies.

WHO/Europe is currently finalizing a comprehensive report on comparison and analysis of medicines reimbursement policies in the region. Quality of medicines is a critical issue for countries in the region. The Secretariat has been supporting countries in increasing the capacity and standards of their National Regulatory Authorities. In parallel, the UN pre-qualification programme managed by WHO is strongly being promoted, particularly in line with HIV/AIDS and TB medicines production, as this pathology represent a dramatic burden for a lot of the countries in the region.

On the question of strategic procurement of medicines and how to support value for money decisions, a consultation was held in September 2016, gathered some 40 countries and was the opportunity to discuss good practices and exchange information. A report ‘Challenges and opportunities in improving access to medicines through efficient public procurement in

the WHO European Region' was published in relation to the consultation. Collaboration further developed in 2017 and trainings on strategic procurement and price negotiations for national competent authorities were held.

In 2017 , the WHO European Regional Committee adopted a decision on Strengthening Member State collaboration on improving access to medicines in the WHO European Region.

3.8 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 EB142/15

Pursuant to the request in resolution WHA70.11 (2017), this report is submitted for consideration at the Seventy-first World Health Assembly.

The global epidemic of premature deaths from noncommunicable diseases is driven by; 1) poverty, 2) the impact of globalization of marketing and trade of products deleterious to health, 3) rapid urbanization, and 4) population ageing – leading to an increasing number of people between the ages of 30 and 70 years, particularly in countries with the highest probability of dying from one of the four main noncommunicable diseases. 15 million people died prematurely from noncommunicable diseases in 2015. The burden continues to rise disproportionally in low and low-middle income countries.

In 2015, the risk of premature death between the ages of 30 and 70 years from any of the four main noncommunicable diseases ranged from 8% to 36% (both sexes). Efforts to reach target 3.4 of the Sustainable Development Goals require that existing political commitments made at the United Nations General Assembly in 2011 and 2014 be implemented on a dramatically larger scale. At the current rate, 2030 targets will not be met.

Implementation of the recommended interventions in resolution WHA70.11 for prevention of, and investing in better management of, noncommunicable diseases is crucial to preventing one third to one half of premature deaths from such diseases. As the WHO's Noncommunicable Diseases Progress Monitor 2017 shows (Table 3), overall progress to implement the four national time-bound commitments has been uneven and insufficient.

Current investments in the implementation of prevention and control interventions lack the scale needed to accelerate progress towards the SDG3.4 target – for obstacles faced (Table 5).

To help Member States overcome these obstacles, support will be provided by WHO to attain specific targets by 2023 as defined in the 13th General Programme of Work). Member States are invited to hold open, inclusive, and transparent discussions on filling the shortfall in the mobilization of international support towards official development assistance. Member States are also encouraged to consider the use of taxes received from sales of tobacco products, alcoholic and sugar-sweetened beverages to support lower income countries in prevention of noncommunicable diseases.

The preparatory process leading to the third High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases is well underway. The co-chairs of the WHO Global Coordination Mechanism on the Prevention and Control of Noncommunicable Diseases provided a statement clarifying the role of non-State actors towards the achievement of SDG3.4 targets.

WHO convened a meeting on The NCD Challenge: Current status and priorities for sustained action on the road to 2030 in June 2017, and the WHO Regional Office for Europe organized the European Meeting of National NCD Directors and Programme Managers (June 2017) which both resulted in a report of recommendations for the preparatory process. The WHO Independent High-level Commission on Noncommunicable Diseases was established by the Secretary General in October 2017 to make recommendations which may serve as an input into the preparatory process. The Commission intends to submit its first report with recommendations which may serve as an input to the development of a zero-draft outcome document, developed under the auspices of the President of the United Nations General Assembly in June 2018.

At the WHO Global Conference on Noncommunicable Diseases (October 2017), Member States committed themselves to the Montevideo Roadmap 2018-2030 on Noncommunicable Diseases as a Sustainable Development Priority. The main outcomes of the conference include: raised awareness about the preparatory process leading to the third High-level meeting in 2018; and agreed set of commitments in the Montevideo Roadmap 2018-2030; contours of the WHO Independent High-level Commission on Noncommunicable Diseases established; knowledge exchanged regarding implementation of best buys in each country; and new solutions launched to help countries build their national responses to reach target SDG3.4.

Pursuant to paragraph 38 of the United Nations General Assembly resolution 68/300 (2014), WHO submitted on 13 December 2017 to the General Assembly a report on the progress achieved in the implementation of resolutions 68/300 and 66/2 (2012). In January 2018, the President of the United Nations General Assembly will appoint two co-facilitators at the level of Permanent Representatives in New York who will preside over the informal consultations of a modalities resolution and outcome document. To further support this process, WHO plans to convene a dialogue in April 2018 on how to finance national

noncommunicable disease responses. A list of 10 assignments being completed before the third High-level meeting in 2018 can be viewed in Table 6.

The Director-General submits the following reports:

- In response to paragraph 3(9) of resolution WHA66.10 (2013), Annex 1 contains the report on progress made in implementing the global plan for the prevention and control of noncommunicable diseases 2013-2013 made between May 2016 and November 2017.
- In response to the second request in paragraph 3(9) of resolution WHA66.10, Annex 2 contained the report on progress made implementing the workplan of the WHO Global Coordination Mechanism on Prevention and Control of Noncommunicable Diseases covering 2016-2017.
- In response to subparagraph 2(10) of resolution WHA70.12 (2017) on cancer prevention and control in the context of integrated approach, the report is contained in Annex 3.
- In response to paragraph 11 of the Economic and Social Council's resolution 2017/8, the preliminary report on progress made by the United Nations Inter-Agency Task Force on the Prevention and Control of Noncommunicable Diseases covers 2017, with 2017-2018 being submitted during the second quarter of 2018 (see Annex 4).

In accordance with the modalities of the preliminary evaluation of the WHO Global Coordination Mechanism on the Prevention and Control of Noncommunicable Diseases, a preliminary evaluation was conducted of the Coordination Mechanism to assess its results and value. The results are being reported separately to the Seventy-first World Health Assembly, through the Executive Board.

In accordance with paragraph 60 of the global action plan for the prevention and control of noncommunicable diseases 2013-2020, and in conformity with the evaluation workplan for 2018-2019, the Secretariat will convene a representative group of stakeholders that will work during the first quarter of 2018 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 World Health Assembly.

The Board is invited to note the report.

Document EB142/15 Add.1

Further to resolution WHA66.10 (2013), the Director General developed draft terms of reference for a global coordination mechanism on the prevention and control of noncommunicable diseases. A preliminary evaluation of the mechanism by the Health Assembly took place in 2017. The current document provides the executive summary of the

preliminary evaluation which aims to assess how the results and outcomes have been achieved between 2014 and 2017.

The Board is invited to note the report

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 should be noted that the WHO European Region is likely to achieve SDG target 3.4 to reduce premature mortality from NCDs by one third by 2030, earlier than 2030, and will most probably exceed it significantly. It appears to be the only Region which will do so and could even set an example for the rest of the world in achieving a greater reduction. This was the main topic of discussion at the WHO European meeting of NCD Directors that took place in Moscow, Russian Federation in June 2017, and it was presented by the Regional Director at the WHO Global Conference on NCDs in Montevideo, Uruguay in October 2017.

Nevertheless, within the WHO European Region tobacco use and alcohol consumption are declining too slowly, and prevalence of overweight and obesity is rising rapidly, so the global NCD targets in those areas are unlikely to be achieved. Robust assessment of other selected targets – such as salt reduction, physical activity and access to essential medicines and technologies – is currently not possible owing to limited comparable data.

Within the WHO European Region implementation of progress monitoring indicators has improved significantly over the last two years. Between 2015 and 2017 the proportion of full implementation of indicators in countries increased on average from 34% to 42%; Bulgaria, Turkey and the United Kingdom have the highest share of fully implemented indicators in 2017. The proportion of at least partial implementation of indicators increased from 69% to 76%.

3.9 Preparation for a high-level meeting of the General Assembly on ending tuberculosis

Document EB142/16

With the adoption of the 2030 Agenda for Sustainable Development by the United Nations in 2015, target 3.3 of SDG3 includes a commitment to end the tuberculosis epidemic by 2030. The Sixty-seventh World Health Assembly adopted the global strategy and targets for tuberculosis prevention, care and control after 2015 (the End TB Strategy). With the ambitious commitment to end the global tuberculosis epidemic, the End TB Strategy rests on three pillars: integrated, patient-centred care and prevention; bold policies and supportive systems; and intensified research and innovation. The Stop TB Partnership's Global Plan to End TB 2016-2020 estimates the resources required for 2016-2020. A progress report submitted to the Seventieth World Health Assembly (2017) on the implementation of the End TB Strategy cautioned that current actions and investments fall short of those needed to end the tuberculosis epidemic.

Tuberculosis (TB) is the leading cause of death worldwide from a single infectious agent with 1.3 million deaths estimated to have occurred in 2016. An estimated 10.4 million people globally fell ill with TB in 2016. Drug resistant TB is a worldwide threat. In May 2014, the 67th World Health Assembly adopted the global strategy and targets for TB prevention, care and control after 2015, subsequently known as the End TB Strategy. Globally, the TB mortality and incidence rates are decreasing annually at about 3% and 2%, respectively which are too slow to reach the 2020 milestones and ending TB by 2030. In December 2016, the UNGA adopted resolution 71/159, in which it decided to hold a high level meeting in 2018 on TB. The General Assembly resolution has led to increasing recognition of the need to enhance commitments, efforts and investments to prevent and control TB, with series of events addressing TB, including the G20 leaders meeting, Summit of BRICS group of countries and later in November 2017 with a global Ministerial conference on TB under SDG area, which was held in Moscow, Russian Federation.

In response to the General Assembly's request to propose options and modalities for the conduct of the high-level meeting, including potential deliverables, WHO has submitted a draft report for consideration by the Secretary-General, including feedbacks from diverse stakeholders.

WHO and key partners may be invited to organize partners' consultation and to consider initiatives in support of the preparatory process of the high-level meeting. WHO will support and participate in any interactive civil society hearings that may be organized by the President of the General Assembly. Should the President of the General Assembly decide to convene interactive exchange or multi-stakeholder panels, WHO will actively participate.

The Executive Board is invited to note the report.

Implication for the European Region

WHO European region has the fastest decline of TB mortality and incidence among all WHO Regions (8.3% and 5% annual decrease respectively since 2010). Yet in 2016, 290,000 people fell ill with TB and 26,000 lost their lives due to this disease in our Region. Drug resistant tuberculosis is a major challenge with resistance among new TB cases increasing from 11% in 2011 to 18% in 2015. More than 80% of TB cases and 90% of multidrug resistant (MDR) TB cases are in Eastern Europe and Central Asia. Despite universal access to MDR-TB treatment and modest increase of treatment outcomes, still about half of MDR-TB patients are not cured. Only in a handful number of high TB priority countries and thanks to sustained efforts, MDR-TB rate and/or MDR-TB absolute numbers are decreasing.

WHO European Region is the only WHO Region with increase of new HIV infections. Consequently TB/HIV co-infection has also increased from 5.5% in 2011 to 12% in 2016. Health system strengthening approach, along with introduction and rational use of new medicines for more effective treatment are essential. WHO Regional Office for Europe is hosting several platforms including Green Light/MDR-TB Committee to support improving clinical management, European TB Lab Initiative to improve early and accurate diagnosis, European Research Initiative on TB to improve operations and innovation and Regional Collaborating Committee to engage all partners including civil society organizations. The Regional Office works intensively with the countries to help them adapt and implement multisectoral Action Plans in line with Tuberculosis Action Plan for WHO European Region 2016-2020. Emphasis is on early detection and improving treatment success rate. Diagnostic tools and laboratory networks are improving: molecular diagnostic techniques are more widely being used, allowing for more effective treatment and better treatment outcomes.

Health system challenges in terms of governance and stewardship, procurement and supply, human resources, people-centered care and aligned financing mechanisms for effective TB prevention and care remain major concerns in many settings particularly in eastern Europe and Central Asia. Under the first ever regional TB Global Fund project focusing on 11 countries of eastern Europe and Central Asia to improve health system response to TB, the Region has developed a “blueprint” on people-centered care, catalyzing reforms for integrated care. Together with partners, WHO/Europe is helping countries implement this blueprint with aligned financing mechanisms.

TB is more common among vulnerable groups.. WHO Regional Office has been working extensively with the national programmes and key partners on a minimum package of cross border TB control and care. However, due to lack of funding to provide actual diagnosis and treatment by reliable service providers, the package has not been fully operationalized. As a result, these vulnerable groups continue to suffer greatly and often acquire resistant forms of tuberculosis. Through a UN based Issue-Based Coalition on Health mechanism, WHO Regional Office is preparing a common position paper to end not only TB, but also HIV and

viral hepatitis by acting across different sectors, tackling social, economic and environmental determinants of the three diseases. The Member States need to ensure adequate resources are available and they are used efficiently. Increasing domestic resources are very important as some countries are still dependent on the Global Fund and not ready for transitioning.

4. Other technical matters

4.1 Global snakebite burden

Document EB142/17

This item was submitted to the 140th session of the Board, but deferred for consideration at the Board's session in January 2018.

Snakebite envenoming is a potentially life-threatening disease and snakebite envenoming affects multiple organ systems and can cause, among other things: haemorrhage and prolonged disruption of haemostasis, neuromuscular paralysis, tissue necrosis, myolysis (muscle degeneration), cardiotoxicity, acute kidney injury, thrombosis, and hypovolaemic shock.

The recently released Global Burden of Disease 2016 study estimated there was a total of 79,000 deaths caused by venomous animals in 2016, with an uncertainty range of 56,800 to 89,400. An estimated 400,000 people a year face permanent disabilities following snakebite envenoming.

Snakebite envenoming affects people in predominantly poor, rural communities in tropical and subtropical countries throughout the world. Immunotherapy with animal-derived antivenom preparations has been the main treatment for snakebite envenoming for over 120 years but currently many regions experience poor availability and accessibility of appropriately manufactured and quality-assured products

In March 2017, a subcommittee of the WHO Strategic Technical Advisory Group for Neglected Tropical Diseases at its 10th meeting recommended that snakebite envenoming should be included in the WHO neglected tropical disease portfolio as a Category A neglected tropical disease[5]. The Director-General endorsed this recommendation in May 2017 and WHO included snakebite envenoming in the list of tropical diseases in June 2017.

WHO has included snakebite envenoming as part of the Organization's wider efforts to overcome the global impact of neglected tropical diseases and recognises the need to improve the quality, safety and regulation of snake antivenom immunoglobulin preparations that are used in the treatment of snakebite envenoming. The WHO Technical guidance was revised and updated in 2017 and the creation of an online tool to assist with appropriate antivenom selection based on the distribution of venomous snakes. The Secretariat has established a working group on snakebite envenoming to assist in the development of a strategic plan for the disease.

[5] Report of the tenth meeting of the WHO Strategic and Technical Advisory Group for Neglected Tropical Diseases, 29–30 March 2017, WHO Geneva. Geneva: World Health Organization; 2017 (http://www.who.int/neglected_diseases/NTD_STAG_report_2017.pdf?ua=1, accessed 15 November 2017).

Early diagnosis, treatment and rehabilitation using available tools is the most appropriate approach for lessening the disease burden imposed by snakebite envenoming. Increasing community-based efforts to promote prevention, first aid and improved health-seeking behaviours, coupled with health systems strengthening, will further reduce the incidence of snakebite envenoming and increase access to effective treatment.

The Board is invited to note the report and provide further guidance on the Organization's response to the global snakebite burden.

4.2 Physical activity for Health

Document EB142/18

The Executive Board at its 140th session asked the Secretariat to present a draft action plan and report for consideration by the Board at the 142nd session.

Physical inactivity is a leading risk factor for premature death from noncommunicable diseases. Worldwide, 23% of adults (this varies by country up to 80%) and 81% of adolescents do not meet the global recommendations for physical activity. Significant inequities exist, with girls, women, older adults, vulnerable groups and poor people, people with disabilities and chronic diseases and those residing rurally all having less access to appropriate places for physical activity. The popularity of walking and cycling are declining in many countries, and sport is underutilized. Sport can contribute in humanitarian programmes for health and social needs.

Investment in policy action on physical activity such as walking can contribute to achieving the Sustainable Development Goals. However, there is no one-policy solution. Effective national action to reverse current trends requires a strategic combination of policy responses. The draft global action plan on physical activity 2018-2030 acknowledges the limits to progress and accordingly proposes solutions to strengthen leadership, governance, multisectoral partnerships, workforce capabilities, information systems and advocacy.

The priorities of the draft global action plans are to increase overall levels of physical activity and reduce disparities in participation through inclusive solutions. This plan's goal is a 15% relative reduction in global prevalence of physical inactivity in adults and adolescents by 2030. The plan's vision for "more active people in a healthier world" will be achieved by ensuring all people have access to safe and enabling environments to be physically active, as a means of improving individuals and community health and contributing to social, cultural and economic development of all nations.

The draft global action plan contains four strategic objectives:

1. Create an active society – social norms and attitudes
2. Create active environments – spaces and places
3. Create active people – programmes and opportunities
4. Create active systems – governance and policy enablers

Progress towards the 2030 target will be monitored using two existing indicators adopted in resolution WHA66.10 (2013) and including the comprehensive global monitoring framework for the prevention and control of noncommunicable diseases. Member States are encouraged to strengthen reporting of disaggregated data and to reflect the dual priorities of this action plan. The Secretariat will finalise a recommended set of process and impact indicators by December 2018 and will publish an associated technical note. Reports on the implementation of the action plan will be submitted to the Health Assembly in line with paragraph 3(9) of resolution WHA66.10 (2013). The final report will be submitted to the Health Assembly in 2030 as part of the reporting on the Sustainable Development Goals.

The Board is invited to note the report and provide guidance on the further development of the draft global action plan on physical activity.

Implication for the European Region

WHO Europe is highly supportive of the global physical activity action plan and encourages Member States to take ownership as it incorporates the major elements of the European Physical Activity Strategy and is inspired by it to a large extent. WHO Europe is working with the European Commission and EU Member States to develop a system to evaluate policy implementation in the area of physical activity for health. WHO is also supporting a project to develop a standardised physical activity and sports monitoring system for the WHO European Region.

WHO Europe has been supporting a network of EU health-enhancing physical activity (HEPA) focal points. EU physical activity country profiles have been developed and are being updated in 2018. Other countries outside the EU have been collecting similar data with the support of the GDO in Moscow. Similar publications are envisaged.

Joint work with the European Commission and three European Commissioners from agriculture, education, sports and health led to the adoption of a joint statement on healthy lifestyles including physical activity.

Surveillance: the childhood obesity surveillance initiative (COSI) is collecting data and providing information for policy makers on the connection between overweight and physical activity in 40 countries in the region. The STEPS survey provides unique information for several countries on risk factors for NCDs including physical activity, in particular in the Eastern part of the region.

Support is being provided to countries and cities on urban planning to support physical activity – recent publication developed jointly with different stakeholders highlighted good practices and inspirational examples across Europe.

Capacity building for prescription of physical activity as part of primary health care and other levels of the health system based on guidance from a publication on integrating diet, physical and weight management services into primary care (2016). Education sector support aimed to increase the amount and improve the quality of physical education in schools and comparing policies between countries.

4.3 Global Strategy for Women's, Children's and Adolescent's Health (2016-2030): early childhood development

Document EB142/19

In accordance with resolution WHA69.2, the report presents new data and initiatives concerning women's, children's and adolescents' health, also giving special consideration to early childhood development. In 2018, a report on Global Strategy for Women's, Children's and Adolescents' Health, including 60 indicators, analysis of progress and strategic priorities will be made available on the Global Health Observatory website[6] and submitted to the Health Assembly.

Universal health coverage is technically and financially possible, and the returns are highest when investments are made across the life course, targeting the vulnerable population groups, such as women, children, adolescents and older peoples, especially in humanitarian crises and fragile situations.

Work is being done to strengthen existing indicators: a broad Member States and stakeholder consultation is ongoing for developing a joint statement on an update on definition of "skilled health personnel" relating to indicator 3.1.2 (the proportion births attended by skilled health personnel) under SDG 3, that will also inform the revision of the International Standard Classification of Occupations by ILO.

Women's health

WHO support for Family Planning 2020 goals. WHO is committed, to expand contraceptive access, choice and method mix; to assess the safety and efficacy of new and existing methods; and to scale up the availability of high-quality contraceptive commodities.

Safe abortion. Approximately 56 million induced abortions per year have been performed worldwide between 2010 and 2014, and 25 million were unsafe. UN DESA and the Special Programme of Research Development and Research Training have launched the open-

[6] See Global Health Observatory data repository (http://apps.who.int/gho/data/node.gswcah, accessed 13 November 2017).

access Global Action Policies Database[7]: it includes abortion laws, policies, health standards and guidelines for all WHO and UN Member States.

Cervical cancer. In 2012, over 266 000 women died from cervical cancer[8], a disease that can be eliminated. The political will to prevent the disease is stronger than ever, and cost-effective tools already exist. WHO, with IAEA, IARC, UNAIDS, UNFPA, UNICEF and UN Women, has established the 5-year UN Joint Global Programme on Cervical Cancer Prevention and Control. Six priority countries – one from each WHO region – have been selected for amplified action.

Violence against women. Millions of women globally experience violence with grave consequences to their health. The WHO global plan of action to strengthen the role of the health system within a national multi-sectoral response to address interpersonal violence has been already endorsed by resolution WHA69.5 in 2014. This momentum needs to be maintained in order to achieve targets 5.2 and 5.3 of SDG 5.

Child health

Together with UNICEF, WHO has launched an initiative to redesign child health guidelines in order to revise the child health policies and programmes that will define universal health coverage during the first 18 years of life. This initiative focuses on both “survive” and “thrive” interventions up to the age of 18 through context-specific approaches. In May 2017, new global and regional estimates of adolescent (10-19 years) mortality and disability-adjusted life years lost were released; in October 2017, child mortality figures for under-5s and those aged 5-14 years were released.

Adolescent health

The Every Woman Every Child’s Independent Accountability Panel, in its 2017 Transformative accountability for adolescents[9] report, urged strategic investments in 10-19 years old, in order to achieve the 2030 Agenda for Sustainable Development.

WHO has worked with partners on the Global Early Adolescent Study and is now working with other members of the UN Inter-Agency Network on Youth Development to develop a UN strategy on youth. The Compact for Young People in Humanitarian Action, adopted at the World Humanitarian Summit in 2016, will further strengthen the role of young people and empower them as agents of change.

Financing investment in women, children and adolescents

[7] See http://www.srhr.org/abortion-policies and https://esa.un.org/gapp (both accessed 25 October 2017)
[8] See GLOBOCAN 2012: Estimated Cancer Incidence, Mortality and Prevalence Worldwide in 2012 (http://globocan.iarc.fr/Pages/fact_sheets_cancer.aspx, accessed 13 November 2017)
[9] Available at http://iapreport.org/files/IAP%20Annual%20Report%202017-online-final-web_with%20endnotes.pdf (accessed 1 November 2017)

As at July 2017, US$ 525 million had been contributed to the Global Financing Facility Trust Fund and allocated to 16 countries. The first replenishment was launched in September 2017, mobilising an additional US$ 2 billion to expand the Facility process period 2018–2023 to the 50 countries facing the most significant needs (16 current plus 34 other). WHO has been an active partner of the Facility.

WHO and the Office of the High Commissioner for Human Rights are working on a framework cooperation agreement to implement the recommendations of the High-Level Working Group on the Health and Human Rights of Women, Children and Adolescents, to build institutional capacity and expertise, and to ensure ongoing monitoring of progress.

Early childhood development is essential for the transformation sought under the 2030 Agenda. The concept covers childhood from conception to 8 years of age. Parents and other primary caregivers are the main providers of nurturing care, therefore, policies and services must be designed to give them the knowledge, time and material resources needed for appropriate child care.

WHO is working with UNICEF, the Partnership for Maternal, Newborn and Child Health, and the Action Network for Early Childhood Development to draft a global framework for nurturing care, to facilitate action and results. Consultations in all regions started in July 2017, while an online consultation is being completed. WHO is also developing guidelines for nurturing care in early childhood and leading a global effort to develop a measurement framework and additional indicators to assess child development in children under the age of 3. The Care for child development[10] approach is being scaled-up in at least 25 countries for strengthening caregiving and early learning,

Midwifery care is essential to improve maternal and newborn health: it is proposed that the Secretariat's report on implementation of the Global Strategy to a future session of the Executive Board examine how to extend midwifery care to all women and newborns.

The Board is invited to note the report.

Implication for the European Region

Promoting Early Childhood Development (ECD) is a component of the Regional Child and Adolescent Health Strategy adopted by 64st WHO European Regional Committee (EUR/RC64/R6). The Baseline Survey on the implementation of the strategy undertaken by WHO Europe indicated that all countries have some interventions to promote ECD in place.

A Technical Briefing on ECD, at the 67th WHO European Regional Committee in Budapest, showcased the Hungarian experience with Early Childhood Interventions (ECI). It concluded that the importance of ECD and ECI was undisputed. It was important that countries review the situation, to address gaps and remove overlap, waste and perverse incentives. The

[10] WHO/UNICEF. Care for Child Development. Geneva: World Health Organization; 2012.

system needed to be transparent for parents to navigate and centred about their and the child's needs. Screening or monitoring needed to be linked to services. ECD and ECI were intersectoral by their nature, and structures and resources needed to be identified. Investments were needed, but yielded large returns.

In the context of the implementation of the Child and Adolescent Health strategy, WHO Europe is supporting countries in the promotion of ECD and ECI, developing referral pathways and mapping health systems support for addressing developmental support needs. ECD and ECI also features in Child Health Redesign, an update of the current child health guidelines (Integrated Management of Childhood Illness) currently being developed in the context of Primary Health Care and universal health coverage as the benefits package for children.

4.4 mHealth

Document EB142/20

Originally noted at the 139th session of the Executive Board, and deferred to the 140th session, the report (now updated to include digital technology) was further deferred by Officers of the Board to the 141st session.

mHealth, the use of mobile wireless technology for public health, is an integral part of eHealth, which refers to the cost effective and secure use of information and communication technology to support health and health-related fields. The umbrella term 'digital health' often encompasses eHealth alongside developing areas such as use of advanced computing sciences, e.g. big data.

Use of digital, particularly mobile, technologies are of particular use for health service delivery due to the easy, broad reach alongside widespread acceptance. The International Telecommunication Union (ITU) indicates that, in 2015, there were more than 7 billion mobile phone subscriptions worldwide, with 70% of those in low-/middle- income countries. This makes mobile technology more accessible worldwide than safe water, electricity or bank accounts, however it can be harnessed to improve the quality and coverage of care and access to health information.

Governments find assessing, scaling up and integrating digital health solutions challenging due to: multiplicity of pilot projects; lack of interconnectedness between projects or integration with existing eHealth strategies; absence of standards and tools for assessing digital health solutions resulting in a lack of guidance; and lack of multi-sectoral approach within government and within donor agencies.

Priority areas for future consideration

Increasing the capacity of Member States to implement digital, especially mobile, technologies has significant potential for progressing towards universal health coverage (UHC.

WHO recognizes the value of digital health solutions, evidenced by the resolutions on eHealth adopted by the WHA and regional committees[11]. The WHO Global Observatory for eHealth documented a surge in adoption of eHealth in countries. There are 121 countries (as of 27 November 2017) that have national eHealth strategies representing a shift to systematic, integrated approaches for cost-effective investment and alignment of partners. The Secretariat will work with ITU through multiple avenues, including raising awareness, to use digital health as a tool to promote service delivery. Significant technical engagement towards the implementation of programmes include:

- Joint initiative with ITU "Be He@lthy Be Mobile";
- development of guidelines for digital health interventions;
- building digital solutions for Tuberculosis patients.

New priorities for WHO in digital health/mHealth include:

- Update the existing strategic approach to align better WHO's collective activities and future direction in the use of digital health to support UHC;
- support cross-sectoral collaboration between different UN Agencies and other bodies for identification and scale-up of digital/mHealth solutions;
- update the Global Health Observatory for eHealth mechanism for data collection and reporting;
- build a repository of knowledge to help Member States to implement digital health technologies;
- support and strengthen evidence-based guidance on mHealth for person-centred health services and UHC;
- provide guidance and assessment frameworks on mHealth to aid good governance and investment decisions in Member States;
- work with Member States and partners to build platforms for sharing experiences on mHealth implementation; and,
- support building capacity and empowerment of health workers and their beneficiary populations to use information and communication technology to catalyse and monitor the progress on specific SDGs using mHealth.

The Executive Board is invited to note the report.

[11] Relevant resolutions of the World Health Assembly (WHA) include WHA58.28 (2005) and WHA66.24 (2013); various resolutions of the regional committees include EM/RC53/R.10 (2006), AFR/RC56/R8 (2006), AFR/RC60/R3 (2010), CD51.R5 (2011) and AFR/RC63/R5 (2013).

Implication for the European Region

The report highlights the increasing importance of digital technologies in contributing to the achievement of major public health objectives as well as the enhanced monitoring efforts and harmonization and integration of health information systems in the Region. Digital technologies will be a key element in the implementation of the Regional Action plan to strengthen the use of evidence for policy making, adopted at 67th WHO European Regional Committee.

Member States of the WHO European Region have, in particular, shown great progress in developing and implementing national eHealth strategies. Member States should integrate technology and health information coordination, instead of fragmenting it further by unclear definition of digital health and relation to health information systems and public health. Overall, eHealth strategies should not exist separate form health information strategies and this point is not mentioned in the recommendation.

The European Health Information Initiative, EHII, is the umbrella under which all WHO regional health information activities are coordinated. Digital health is an important catalyst for the mission of the EHII which seeks to harmonize and integrate health information in the region.

Finally, closer engagement with key partners for developing and overcoming barriers to the implementation of digital health in Europe, including the European Commission, World Bank and OECD as well as non-governmental organizations, non-profit organizations and the private sector (respecting the FENSA agreement) will be crucial to ensure delivery of consistent and coordinated action on digital health to Member States of the WHO European Region.

4.5 Improving access to assistive technology

Document 142/21

An earlier version of this report[12] has already been noted by the Executive Board in 2016; this version takes into account input from Member States from the 2017 Executive Board session.

Assistive technology, a sublet of health technology, refers to assistive products and related systems and services developed for people to maintain or improve functioning and thereby promote well-being. It can reduce the need for formal health and support services, long-term care and the burden on carers.

[12] Document EB139/4; see also document EB139/2016/REC/1, summary records of the Executive Board at its 139th session, second meeting

Assistive products include any external product whose primary purpose is to maintain or improve an individual's functioning and independence and thereby promote his or her well-being.

WHO estimates that over 1 billion people would benefit from one or more assistive products, and this number is likely to rise above 2 billion by 2050. Those who most need assistive technology include people with disability, older people, people with non-communicable diseases, people with mental health conditions including dementia and autism, and people with gradual functional decline. Today only 1 in 10 people in need have access to assistive products, owing to high costs and a lack of financing, availability, awareness and trained personnel[13].

In accordance with the request put forward by stakeholders on occasion of the 68th session of the UN General Assembly on disability and development in September 2013, and following a consultative meeting in July 2014, the Secretariat established the Global Cooperation on Assistive Technology in partnership with international organizations, donor agencies, professional organizations, academic institutions and user groups. This Global Cooperation has one goal: to improve access to high-quality, affordable, assistive products globally. It will support the WHO global disability action plan 2014–2021[14], and the Global strategy and plan of action on ageing and health 2016–2020[15].

Assistive technology plays a key role for the WHO global action plan for the prevention and control of non-communicable diseases 2013–2020[16], and for the implementation of WHO's comprehensive mental health action plan 2013–2020[17]. Increasing access to assistive technology will also support the Secretariat's activities in tackling other major contributors to the global burden of disease.

According to the *World report on disability*[18] , many people have little or no access to basic assistive products, even in some high-income countries; and where available, an astonishingly high proportion of assistive products are abandoned by users (estimates run as high as 75%). The challenges are outlined below.

- Urgent need for research and development to be driven by the needs of the diverse users and contexts around the globe, and for more focus on the workforce and service provision;
- Countries should adopt regulatory mechanisms to ensure that assistive products on the market meet the relevant standards and are safe and effective;

[13] Assistive technology. Fact sheet. Geneva: World Health Organization; 2016 (http://www.who.int/mediacentre/factsheets/assistive-technology/en/, accessed 6 October 2017).
[14] See document WHA67/2014/REC/1, resolution WHA67.7 (2014) and Annex 3.
[15] See document WHA69/2016/REC/1, resolution WHA69.3 (2016) and Annex 1
[16] See document WHA66/2013/REC/1, resolution WHA66.10 (2013) and Annex 4.
[17] See document WHA66/2013/REC/1, resolution WHA66.8 (2013) and Annex 3.
[18] World report on disability. Geneva: World Health Organization; 2011 (http://www.who.int/disabilities/world_report/2011/en/, accessed 2 October 2017).

- Assistive products need to be manufactured with parts that can be repaired, maintained and replaced locally;
- Affordable access to assistive technology needs governmental commitment to adequate and sustained financing;
- Long-term planning and sustainable systems need to be in place at national level to ensure a reliable supply of assistive products and their replacement parts;
- Need for standards that provide guidance on the essential elements of a quality assistive products service;
- Robust coordination mechanisms are needed to ensure that assistive products are procured and provided appropriately during health emergencies.

The Secretariat's experience has shaped the focus of the Global Cooperation on Assistive Technology initiative on four interlinked components within the framework of universal health coverage (policy, products, personnel and provision); the Secretariat is working on developing tools and providing technical support to the Member States.

Initiatives to strengthen rehabilitation services are under way by the Secretariat, including tools for rehabilitation situation assessment, policy dialogues, strategic planning, and monitoring and evaluation. Deliverables to support the development of rehabilitation workforce and service delivery models are also under development.

The Board is invited to note the report and provide further guidance on the future direction and focus of the Secretariat's activities towards improving access to assistive technology.

Implication for the European Region

WHO Europe supported Member States in the region to increase access to quality and affordable pharmaceuticals and health technologies, however specific advice on assistive technology has not been provided. Assistive technologies are often classified as medical devices in terms of regulation. A subregional workshop to strengthen medical device regulation in 5 CIS countries in the region was organized by WHO/Europe in Yerevan, Armenia.

The 67th Regional Committee approved a Decision on "Towards improving access to medicines in the WHO European Region: a proposal for member state co-operation". The background report outlined the key issues and priority areas of work for improving access to medicines in the WHO European Region. The purpose of this document was to propose strategic areas in which increased Member State collaboration could be undertaken with the support of the Regional Office. While focus was on medicines the collaboration can be expanded to cover assistive technologies though adding expertise in this area, as need be.

4.6 Maternal, infant and young child nutrition

- **Comprehensive plan on maternal, infant and young child nutrition: biennial report**

Document EB142/22

This report describes the progress made in carrying out the comprehensive implementation plan on maternal, infant and young child nutrition endorsed by the Health Assembly in resolution WHA65.6 (2012), as well as information on the status of national measures to give effect to the International Code of Marketing of Breast-milk Substitutes, adopted in resolution WHA34.22 (1981) (subsequently updated) and progress made in drawing up technical guidance on ending the inappropriate promotion of food for infants and young children, in resolution WHA69.9 (2016).

Global target 1 (stunting). Between 2000 and 2016, the number of children stunted worldwide fell from 198 million to 155 million, with 58% of children concerned living in Asia and 38% in Africa. Out of 44 countries, 17 are on track and 19 are showing progress of meeting the 2016 global target.

Global target 2 (anaemia). Recent estimates see a rise in global prevalence of anaemia from 30% (2012) to 33% (2016) amongst women of reproductive age.

Global target 3 (low birth weight). WHO and UNICEF are updating estimates to account for a high proportion of unrecorded live births. According to latest estimates, between 2005-2010, 15% of neonates weighed less than 2500g.

Global target 4 (overweight). Globally in 2016, an estimated 41 million children under 5 years old (6%) were overweight, an increase of 10 million from 2000.

Global target 5 (breastfeeding). Globally, in 2011-2016, an estimated 40% of infants under 6 months of age were exclusively breastfed.

Global target 6 (wasting). Globally, an estimated 52 million children under 5 years old qualified as wasted in 2016, of which 17 million were severely wasted – 69% of these lived in Asia.

Countries have expressed the ambition of ending all forms of malnutrition by 2030, including achieving internationally agreed targets on stunting and wasting in children under the age of 5 years. WHO and UNICEF analysis on the impacts of extending action to 2030 states that if the agreed annual reduction rate for stunting of 4% were maintained for a further five years, this would lead to a 50% reduction in the number of stunted children by 2030. Furthermore, a 50% reduction of women of reproductive age with anaemia could be

expected by 2030; for low birth weight, a 30% reduction could be expected by 2030; for overweight, global prevalence could be reduced by <3%, thus reversing the rising trend by 2030; 70% of infants could be exclusively breastfed by 2030; and for wasting, the global prevalence could be reduced by <3% by 2030.

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

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

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

Action 4: to provide sufficient human and financial resources for the implementation of nutritional interventions.

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

Draft decision

The Executive Board is invited to note the analysis on the extension of the 2025 targets on maternal, infant and young child nutrition to 2030; to approve the four remaining indicators of the Global Monitoring Framework on maternal, infant and young child nutrition, as set out in this report;
and to invite Member States to consider the full list of indicators in their national nutrition monitoring frameworks and report in accordance with decision WHA68(14)(2015).

The Board is invited to note the report and to consider the draft decision.

Implication for the European Region

Addressing malnutrition in all its forms is a leading priority for Member States. With regards to progress in achieving the global targets for nutrition, the WHO European region has made excellent progress towards goals relating to stunting and wasting, with consistent downward trends in countries where these issues remain a concern.

With regards to childhood overweight and obesity, the situation is more complex. We see limited evidence of countries achieving the “zero increase” target; rather we see worrying trends towards an increase in overweight among under 5s and school-aged children (6-9 years of age).

Anaemia prevalence remains persistently high in some countries, notably among women of reproductive age. While countries have established effective strategies to address micronutrient deficiencies among young children and pregnant women, non-pregnant women of reproductive age normally are not well covered.
In the area of nutrition, the European report has been launched recently detailing implementation of nutrition policies. It was launched for informal consultation with Member State in the Budapest in December:http://www.euro.who.int/en/health-topics/disease-prevention/nutrition/publications/2017/better-food-and-nutrition-in-europe-progress-report-

The European Food and Nutrition Action Plan 2015-2020 addresses many of the issues and topics under this agenda item and European Member States are leading the way at the global level in many of the areas particulalrly in policy development and monitoring and surveillance.

The EB document has implications for the European Members States at the national level , particularly for those where progress is slow (notably around breastfeeding).

- **Safeguarding against possible conflicts of interest in nutrition programmes**

Document EB142/23

Resolution WHA65.6 endorsed the comprehensive implementation plan on maternal, infant and young child nutrition and requested the Director-General to develop risk assessment, disclosure and management tools to safeguard against possible conflicts of interest in policy development and implementation of nutrition programmes consistent with WHO's overall policy and practice. In relation to WHA67(9) (2014), the Director-General convened informal consultations with Member States on risk assessment and management tools for conflicts of interest in nutrition for consideration at the Sixty-ninth World Health Assembly.

The draft approach proposes a methodology for Member States to consider their engagement with individuals and non-State actors for preventing and managing conflicts of interest in the area of nutrition, including at country level. A public consultation between the UN, Member States and non-state actors was held in September 2017, and resulting comments were considered in the current version of the approach. Additionally, WHO has considered different procedures and practices, and reviewed the scientific literature, for preventing and managing conflicts of interest. The proposed approach has been developed in consideration of WHO's overall policies and practices, including, inter alia, the WHO Framework of Engagement with non-State Actors.[19]

[19] See document WHA69/2016/REC/1, Annex 5.

A Member State's engagement with non-State actors or individuals may be successful if it: conforms with the Member State's agenda and demonstrates a clear benefit to public health and nutrition; respects the Member State's decision-making authority and leadership over the engagement in all settings; does not compromise the Member State's integrity, independence and reputation; is aligned and coherent with other policies and objectives of the Member State; conforms with internationally recognized human rights standards that the Member State is a State Party to; and is conducted on the basis of evidence, transparency, independent monitoring and accountability.

The tool is a step-by-step decision-making process that will support Member States in the process related to conflict of interest in the areas of nutrition. The process consists of six steps, each followed by an assessment by the national authority of whether the engagement should continue or stop.

Step 1: Rational for engagement: clarify the public health nutrition goal.

Step 2: Profiling and performing due diligence and risk assessment: have a clear understanding of the risk's profile of the external actor and the engagement.

Step 3: Balancing risks and benefits: analyse the risks and benefits of the proposed engagement based on impacts.

Step 4: Risk management: manage the risks based on mitigation measures and develop a formal engagement agreement.

Step 5: Monitoring and evaluation and accountability: ensure that the engagement has achieved the public health nutrition goals and decide to continue or disengage.

Step 6: Transparency and communication: communicate the engagement activities and outcomes to relevant audiences.

The Secretariat will pilot the approach at country level in the six WHO regions to test its applicability and practical value.

The Board is invited to note the report.

Implication for the European Region

The European Food and Nutrition Action Plan 2015-2020 addresses the issues of commercial determinants of diet-related NCDs and provides guidance to member states on the need to properly deal with issues of conflict of interest.

The discussion paper includes a useful proposal of a general typologies for classifying institutional and individual conflicts of interest and principles for avoiding and managing conflicts of interest, which is relevant to the European Region.

5. Other managerial, administrative and governance matters

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

Document EB142/24

The Pandemic Influenza Preparedness (PIP) Framework Partnership Contribution (PC) is an annual cash contribution received by WHO from influenza vaccines, diagnostic and pharmaceutical manufacturers using the WHO Global Influenza Surveillance and Response System (GISRS). The annual PIP PC amounts to $28 million which is half of the estimated running costs of the GISRS. The EB in decision EB131 (2012) decided that in the period 2012-2016, 70% of the PC should be used for pandemic preparedness activities in Member States (MS), coordinated by WHO, and 30% should be reserved for the response to the next pandemic, recognizing the need for and usefulness of flexibility in allocating resources. The application of this decision was extended at the EB140 in 2017 until 28 February 2018. The Director-General (DG) was also requested to make a new proposal for future proportional division of PC to be considered by the EB at its 142nd session based on recommendation by the PIP Advisory Group (AG).

Following the request in decision EB 140(5) (2017), the Director- General, after consulting the Pandemic Influenza Preparedness Framework Advisory Group, puts forward the following proposal.

- During the next five years (1 March 2018 to the end of 2022) the current proportional division of contributions between pandemic preparedness (70%) and response activities (30%) should continue.
- In order to ensure that the proportional division does not hinder necessary response measures during pandemic influenza emergencies, the Director-General should continue to be able to modify temporarily the allocation of Partnership Contribution resources as required to respond to said emergencies. The Director-General should report on any such modification to Member States.
- The proportional division should be reviewed again in 2022.

Draft Decision

he board is invited to consider the Director-General's proposal and adopt the draft decision.

Implication for the European Region

The decision to maintain the proportional division of PIP PC is welcome as this allows a continuation of ongoing work in PIP recipient countries in the WHO European Region (Armenia, Kyrgyzstan, Tajikistan, Turkmenistan and Uzbekistan) as well as in support of regional level activities. Fundamental surveillance and response capacities have been established by the PIP recipient countries in the first four years of PIP PC implementation in

the WHO European Region and the achievements contributed to the implementation of IHR core capacities and thus preparedness and response to outbreaks of other high threat pathogens, such as Ebola. In 2018, the PIP PC High Level Implementation plan II , covering the period 2018-2023, will be launched. WHO/Europe will maintain the same PIP PC recipient countries in 2018-2023 to allow further institutionalizing of newly established systems and mechanisms and to focus on country ownership and long-term sustainability of what has been achieved. In addition to existing areas of work20, the new High Level Implementation plan II includes pandemic preparedness plan development and testing as a specific output.

In addition to the country specific work, PIP PC is also used to enhance influenza surveillance and response at the regional level by:

- Maintaining and strengthening the Regional influenza network managed jointly with ECDC (TESSy), and the joint Flu News Europe bulletin.
- Organizing Region-wide influenza surveillance meetings jointly with ECDC.
- Strengthening of influenza virus sharing in the Region resulting in 47/53 MS sharing viruses with WHO CC in the past year and thereby contributing to global influenza vaccine production and global influenza surveillance.
- Supporting countries to increase the uptake of seasonal influenza vaccine through e.g. the fifth Flu Awareness Campaign, Tailoring Immunization Programmes for seasonal influenza (TIP FLU) and supporting donations of vaccine to countries.

[20] Laboratory and Surveillance, Burden of Disease, Regulatory Capacity building, Risk Communication and Community engagement and Planning for Deployment.

6. Matters for Information

6.2 Global vaccine action plan

Document EB142/35

Following resolutions WHA65.17 and WHA70.14, the Strategic Advisory Group of Experts on immunization (SAGE), based on its review of data from 2016[21], prepared the 2017 assessment report of the global vaccine action plan[22]. A summary of the report and the recommendations for action are contained in Annex 1. The actions taken by WHO and other partner agencies are summarized in Annex 2.

The Board is invited to take note of the report and to consider the recommendations of the Strategic Advisory Group of Experts on immunization for actions to be taken.

Annex 1; SAGE report and recommendations

In October 2017, the Strategic Advisory Group of Experts on Immunization (SAGE) reviewed the progress made by countries and partners. The report outlines the findings and recommendations of that review, at the GVAP mid-point .

The report re-affirms immunization as one of the world's most effective and cost-effective tools against the threat of emerging diseases and has a powerful impact on social and economic development.

The report notes that while some progress has been made towards the GVAP goals in 2016:

- Fewest number of wild poliovirus reported
- Three more countries achieving maternal and neonatal tetanus elimination
- Nine countries introducing new vaccines
- A slight increase in Diphtheria-Tetanus-Pertussis (DTP3) vaccination coverage
- Progress remains too slow to achieve most goals to be reached by 2020.

SAGE highlight some the key issues that may stall further progress and heighten global inequalities in vaccine access, such as: economic uncertainty, conflict and natural disasters, migration and displacement, disease outbreaks, inadequate political commitment, vaccine hesitancy, supply shortages, and the simultaneous phasing out of funding for polio and from the GAVI Alliance.

Alongside specific leadership recommendations and in light of the risks highlighted, SAGE (the report) calls for: broadening the dialogue to align immunization with emerging global

[21] Global Vaccine Action Plan Monitoring, Evaluation & Accountability: Secretariat Annual Report 2017 http://www.who.int/immunization/global_vaccine_action_plan/previous_secretariat_reports_immunization_scorecards/en/ (accessed 16 October 2017).

[22] Strategic Advisory Group of Experts on immunization. 2017 Assessment Report of the Global Vaccine Action Plan. Geneva: World Health Organization; 2017 (http://www.who.int/immunization/web_2017_sage_gvap_assessment_report_en.pdf?ua=1, (accessed 31 October 2017)

health and development agendas, maintaining sensitive and high quality surveillance, focusing on outlier countries who are least likely to achieve the goals, achieving maternal and neonatal tetatus elimination by 2020, identifying good practice and gaps in knowledge in reaching mobile and displaced population with vaccination services, addressing demand and acceptance for vaccination, engaging civil society, working with countries on vaccine access and supply and attending to middle-income country challenges.

Implication for the European Region

The European Vaccine Action Plan 2015–2020 (EVAP) endorsed by the Regional Committee complements, and adapts the Global Vaccine Action Plan. EVAP sets the Region on a course that is fully aligned with the newly established Sustainable Development Goals 3 and 10.

Regional progress towards EVAP goals is steady (5/6 are on-track): Member States have made steady progress in measles and rubella elimination, with 42 Member States having interrupted endemic transmission of one or both diseases by the end of 2016, compared to 32 in 2014. The number of Member States with endemic measles has dropped from 18 in 2014 to 9 in 2016.

The Region remains polio-free and has made tremendous progress in implementing the WHO Global Action Plan to minimize poliovirus facility-associated risk (GAPIII).

Additionally, Member States are taking advantage of the significant health gains offered by new and under-utilized vaccines. By 2017, 40 Member States had introduced pneumococcal vaccine, 32 implemented human papillomavirus (HPV) vaccination, and 18 started universal immunization with rotavirus vaccine, helping to tackle diseases that threaten life at all ages, from pneumonia in infancy to cancer in adulthood. A hepatitis b control goal is now set and a verification process has been initiated – following the endorsement of the Action Plan on Viral Hepatitis in September 2016. More countries than ever have established National Immunization Technical Advisory Groups (NITAGS) (N.45) and have achieved financial sustainability in procuring vaccines (N.47).

Progress towards the regional vaccination coverage target is, however, off-track. Coverage with the third dose of diphtheria-tetanus-pertussis vaccine (DTP3) at national and sub-national levels showed no improvement in 2016 compared with 2014 and 2015, with regional coverage declining by 1 percentage point over the two-year period. The number of Member States with >95% national DTP3 coverage decreased from 36 in 2014 and 2015 to 31 in 2016, while the milestone for 2018 is 42 and the target for 2020 is 48.

The declining trend in coverage of all antigens in the South-east European Region through 2015-2017, is particularly concerning and emphasizes the uneven progress towards EVAP goals. The middle-income countries, many of whom self-procure vaccines and rely solely on their domestic financial resources, continue to face significant challenges in expanding their

immunization programmes through introduction of new vaccines and sustaining performance of their programmes.

Additionally, 2017 was marked as a year of discourse and debate on individual versus community responsibility, where some Member States introduced vaccine mandates, laws and fines (incl. Italy, Germany and France) to interrupt the transmission of measles and prevent future outbreaks, and/or respond to the threat posed by vaccine opponents and vaccine hesitant caregivers and providers.

In 2017, support from the WHO Regional Office for Europe (Regional Office) to national immunization programmes included political advocacy and dialogue on vaccine policy, provision of normative guidance, support to multi-year planning and transitional plans (in GAVI eligible Member States) price transparency projects, vaccine safety management and communications technical assistance and capacity building, resource mobilization tool development, dissemination and training to secure domestic financing of immunization programmes and capacity building on specific elements of vaccine demand, such as awareness raising and measurement of vaccine hesitancy.

Furthermore, recognizing the need at country level to prepare for and mitigate potential crises in confidence, the Regional Office developed a comprehensive vaccination and trust library and training package and introduced tools to counteract vaccine opponents. The Regional Office also continues to support Member States in strengthening capacity on vaccine procurement, vaccine cold chain and immunization logistics, injection safety and waste management, causality assessment methodology, cold chain upgrades and evaluations, laboratory accreditation and training on contraindications as part of the holistic improvement of immunization service delivery.

European Immunization Week in April 2017 was used a platform to maximize ongoing advocacy efforts in all Member States to maintain sustainability of their immunization programmes and to move towards financial self-sufficiency where donor support is utilized to achieve programme targets.

Three key developments in 2018 that warrant Member State attention:

- The Region will develop of a more cohesive strategy that addresses the challenges that MICs are facing. A South-eastern European ‘Statement of Intent’ is to provide the foundation for development of a MICs Road Map to address shared threats with joint solutions. On February 20, 2018, in Montenegro, the South-eastern European Health Network Member States will meet to kick-start Road Map development. Member States may wish to express support for this initiative to develop a strategy and action plan for MICs in our Region in 2018 - in consultation with Member States - with a potential for replication and adaptation by other Regions.
- The European Vaccine Action Plan (2015-2020) mid-term evaluation will take place and progress is due to be reported at the Regional Committee in September 2018, in Rome

(Agenda Item: Realizing the full potential of the European Vaccine Action Plan.). Member States may wish to convey their support and engagement in the mid-term evaluation – that will take place March–May 2018).

- Despite progress on measles and rubella elimination, the Region needs to remain committed and vigilant. Political commitment, resource allocation and continued advocacy for this goal is needed as we near its achievement. In 2018, it is paramount that Member States continue to convey their support for the goal, express their willingness to collaborate to equitably extend the benefits of vaccination and close immunity gaps.

6.4 Eradication of poliomyelitis

Document EB142/37

This report provides an update on the status of the Polio Eradication and Endgame Strategic Plan. A separate report on the ongoing process to develop a strategic action plan on polio transition and a post-certification strategy has been prepared[23], for consideration at by the Seventy-first World Health Assembly, as per decision WHA70(9) (2017).

Wild poliovirus transmission

In 2017, there was strong global progress towards achieving the objectives of the Polio Eradication and Endgame Strategic Plan (2013-2018). Wild poliovirus (WPV) transmission is at its lowest level ever. As of 3 January 2018, there were 21 cases of WPV reported globally compared to 35 cases reported for the same period in 2015. All cases were in endemic countries – Afghanistan (13 cases) and Pakistan (8 cases), and were poliovirus type 1.

Circulating vaccine-derived poliovirus transmission

In 2017, two countries were newly affected by circulating vaccine-derived poliovirus (type 2) transmission: the Syrian Arab Republic and the Democratic Republic of Congo, with 40 cases and nine cases reported, respectively. Internationally agreed outbreak response protocols were used to respond these outbreaks. These outbreaks underscore the continued risk posed by immunity gaps anywhere in the world.

Public health emergency of international concern

The declaration in 2014 of the international spread of wild poliovirus as a public health emergency of international concern and the temporary recommendations promulgated under the International Health Regulations (2005) remain in effect.

Phased removal of oral polio vaccines

In April 2016, the global switch from trivalent oral polio vaccine (tOPV) to bivalent oral polio vaccine (bOPV) was successfully completed and involved 155 countries and territories. It is

[23] Document EB142/11

expected to lead to significant public health benefits as 40% of all vaccine-associated paralytic poliomyelitis cases and 90% of circulating vaccine –derived poliovirus outbreaks over the past 10 years were associated with the type 2 components of the trivalent oral polio vaccine.

Containment of Poliovirus

Efforts to contain poliovirus type 2 were implemented progressively in 2016 -2017, guided by the WHO global action plan to minimize poliovirus facility-associated risk after wild poliovirus eradication and sequential cessation of oral polio use (GAPIII).24 The Global Commission for the Certification of the eradication of poliomyelitis has accepted responsibility for global containment oversight in support of the WHO Global Action Plan for Poliovirus Containment.25 As of 18 September 2017, 174 countries and territories reported that they no longer hold wild or vaccine-derived poliovirus type 2. Twenty-nine countries reported that they intend to retain type 2 polioviruses in 96 poliovirus-essential facilities. Eighteen countries have made significant progress with establishment of national containment authorities and preparing to certify their poliovirus-essential facilities as described in GAPIII.

Financing the global polio eradication initiative

Through the continued support of Member States, the international development community, development banks, foundations, and Rotary International, the budget for planned activities in 2017 was fully financed. After the Rotary International Convention in June 2017, there were a total of US$1.2 billion in pledges towards the US$1.5 billion budget, which was validated by the Polio Oversight Boards.

The Executive Board is invited to note the report.

Implication for the European Region

Wild poliovirus and circulating vaccine-derived poliovirus transmission: There were no wild or circulating vaccine-derived polioviruses detected in the Region in 2016-17. The Regional Certification Commission for Polio Eradication (RCCPE) assesses the polio-free status on an annual basis. Member States are requested to provide an updated National Polio Outbreak Preparedness Plan as part of their Annual Status Report (ASR). Eighty percent (80%) of European Member States have provided updated National Polio Outbreak Preparedness Plans, but only seven Member States have actively tested their plans with a polio outbreak simulation exercise (POSE). All Member States are requested to update and test their preparedness plans as soon as possible.

[24] WHO global action plan to minimize poliovirus facility-associated risk after type-specific eradication of wild polioviruses and sequential cessation of oral polio vaccine use (GAPIII). Geneva: WHO Health Organization, 2015 (http://polioeradication.org/wp-content/uploads/2016/09/GAPIII_2014.pdf, accessed 17 October 2017).
[25] Containment certification scheme to support the WHO global action plan for poliovirus containment. Geneva: WHO; 2017 (http://polioeradication.org/wp-content/uploads/2017/03/CCS_19022017-EN.pdf, accessed 17 October 2017).

Public health emergency of international concern:
In November 2017, the International Health Regulation (IHR) Emergency Committee regarding the international spread of poliovirus26 met for the fifteenth time. There are currently no WHO European Member States on the list of infected or vulnerable countries. The Emergency Committee met every three months. All Member States are requested to ensure that surveillance, reporting and outbreak response systems are in place to response to polioviruses in a timely manner.

Phased removal of oral polio vaccines: By the end of April 2016, all 20 Member States in the Region using OPV successfully switched from tOPV to bOPV.27 Seven Member States successfully introduced IPV into their routine schedules.28 Introduction in five countries29 was delayed due to IPV supply constraints. These countries will complete introduction by April 2018 with plans to cover the sizable cohorts of children without protection against polio type 2 since the withdrawal of tOPV. Member States should have procurement mechanisms in place to ensure that there is an adequate quantities of polio vaccines to maintain high population immunity.

Containment of polioviruses: In 2017, the Region has made substantial progress in implementing GAPIII. The process was enhanced by collaborating with the European Commission (EC) and the European Centre for Disease Prevention and Control (ECDC). Due to the large number of polio/enterovirus laboratories and polio vaccine manufacturers, there are a large number of polio essential facilities (PEFs) in the Region, and will require a considerable amount of work to fully implement all of the polio containment requirements. Member States wanting to retain polioviruses and establish PEFs should be fully aware of all of the GAPIII requirements.

Financing the Global Polio Eradication Initiative (GPEI): The WHO European Region was certified polio-free in 2002 after the last case of indigenous WPV was detected in 1998. The Region has transitioned its polio-specific assets to support routine immunization and other vaccine preventable diseases. The Region receives minimal financial support from global partners for polio eradication activities. Current funding for the European Region is directed at maintaining polio surveillance, supporting poliovirus containment, conducting certification activities in anticipation of global eradication and certification.

[26] http://www.who.int/ihr/ihr_ec_2014/en/
[27] Eight countries are procuring bOPV through UNICEF tenders (Albania, Armenia, Azerbaijan, Georgia, Kyrgyzstan, Tajikistan, Turkmenistan and Uzbekistan), 11 are self-procuring (Belarus, Bosnia and Herzegovina, Israel, Kazakhstan, Montenegro, Republic of Moldova, Poland, the former Yugoslav Republic of Macedonia, Serbia, Turkey and Ukraine), and one is self-producing (Russian Federation)

[28] Albania, Armenia, and Azerbaijan introduced standalone IPV, Georgia, Kazakhstan, Serbia and the Former Yugoslav Republic of Macedonia introduced IPV-containing combination vaccines
[29] Kyrgyzstan, Republic of Moldova, Tajikistan, Turkmenistan and Uzbekistan