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REGIONAL OFFICE FOR Europe

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(For Information Purposes Only)

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- **Implementation of the International Health Regulations (2005)**

Documents A71/7, A71/8, and EB142/2018/REC/1, decision EB142(1)

Annual report on the implementation of the International Health Regulation (2005)
Document A71/7:
This report has been drafted in response to resolution WHA61.2 (2008), which requests the Director-General "to submit every year a single report, including information provided by States Parties and about the Secretariat's activities, to the Health Assembly for its consideration, pursuant to paragraph 1 of Article 54 of the International Health Regulations (2005)".

Event Management
In 2017, WHO recorded 418 public health events, out of which 72% were attributed to infectious diseases. In 33% of the events, the initial information came from national government agencies, including National IHR Focal Points. As there were still substantial delays in IHR notifications and responses to verification requests from WHO, the Secretariat will systematically document IHR compliance in these respects in the future.

During the same period there were 183 Event Information Site (EIS) updates (13% of these for European Region) and 98 disease outbreak news (DON) postings.

In 2017, there were many WHO Emergency Programme actively supported outbreak response operations at all three levels of the Organization. The largest were for the Ebola outbreak in DR Congo, and plague epidemic in Madagascar. The responses involved WHO rapid deployment teams and partners, especially GOARN. In addition to GOARN, WHO worked closely with a number of other partners and networks (EDPLNet, GHC, EMTs, standby partners and UN IASC).

Only one IHR Emergency Committee remains active in 2018, the one for international spread of poliovirus, which meets every three months. Following the latest meeting on 7 February 2018, international spread of poliovirus remains a PHEIC.
The Secretariat piloted a structured approach to monitoring compliance in relation to additional health measures, requesting due justification from the States Parties implementing additional measures. This monitoring will be continued and results included in future reports to the governing bodies.

Strengthening National Core Capacities
Since 2010, 195 of the 196 States Parties have reported at least once to the Secretariat using the annual reporting questionnaire. As of 6 March 2018, 158 (81%) of 196 States Parties had submitted the questionnaire sent in June 2017; 35 (64%) from the European Region.

Progress has been reported since 2010 across the 13 core capacities, particularly in respect of zoonoses, surveillance and laboratory, but the overall average scores suggest further and sustained efforts are urgently needed in the areas of chemical events, capacities at points of entry, human resources and radiation emergencies.

As of 2 February 2018, a total of 67 countries had conducted a voluntary joint external evaluation, of which 39 were conducted in 2017. In the European Region, WHO carried out 10 voluntary joint external evaluations, in Albania, Armenia, Belgium, Finland, Kyrgyzstan, Latvia, Slovenia, Turkmenistan, and Switzerland/Liechtenstein, while Serbia, Lithuania and the Republic of Moldova, have requested to conduct these evaluations in 2018. A voluntary joint external evaluation Team Lead Training was held for international experts in February 2018. The Secretariat has actively supported the development of national action plans for health emergency preparedness, based on the outcome of the different monitoring and voluntary evaluation processes. Two National Action Plans following a voluntary joint external evaluation were undertaken by Finland and Kyrgyzstan and representatives of 10 countries were trained to develop them, in the European Region.

The Secretariat, in particular the regional and country offices, also supported the conduct of simulation exercises and after-action reviews

Procedures under the Regulations

The Secretariat continues to maintain around the clock access to the six Regional IHR Contact Points. A connectivity test conducted in October 2017 revealed less than satisfactory accessibility of the National IHR Focal Points (IHR NFP) for communications with WHO, as required by IHR. 86% of the 196 IHR NFPs accessed the Event Information Site (EIS) at least once in 2017. Four of the six WHO regional offices held meetings with the IHR NFPs during 2017, with the aim of providing training, sharing lessons and experiences and building communities of practice at the regional level. In addition to annual IHR NFP meeting in February 2017, IHR NFPs from selected States Parties in the European Region received training in October 2017 to better understand their functions under the Regulations, discuss commonly encountered challenges and share experiences of their daily work. The WHO Secretariat will maintain the Health Security Learning Platform.

Since 2007, 103 out of a total of 152 non-landlocked countries and four landlocked countries with inland ports have sent WHO the list of ports authorized to issue ship sanitation certificates. Difficulties in this area remain, and to overcome these, the Secretariat provided training to 970 staff in 105 countries in 2017. Training in Management of Public Health Events in Air Transport was also provided in 2017.

The IHR Roster of Experts includes 460 experts, but only 88 have been appointed on the request of States Parties. Less than 1/3 of experts are female. 34% of experts come from European Region, with almost half of these from three countries. Additional efforts are needed to reduce the gender and regional imbalances in this Roster.

Of the 114 countries and 17 territories requesting an Yellow Fever vaccination certificate from incoming travellers, only 42 countries and seven overseas territories confirmed that they accept these certificates as valid for life, as it should be according to IHR Annex 7. In December 2017, the scientific and technical advisory group on geographical yellow fever risk mapping established a small working group, which is now developing an updated map of YF transmission.

Activities by the Secretariat in Support of States Parties to implement the regulations

As requested by the Health Assembly in Decision WHA70(11) (2017), the Secretariat developed a draft five-year global strategic plan to improve public health preparedness and response. This was presented for consideration by the Executive Board at its 142nd session. The Board then adopted decision EB142(1), in which it recommended to the Seventy-first World Health Assembly the adoption of a decision that would, inter alia, endorse the strategic plan

In 2017, WHO and the World Organization for Animal Health (OIE) held a national bridging workshop to support six countries in strengthening collaboration between animal and human health services.

The Health Assembly is requested to note the report.

Public health preparedness and response
Implementation of the International Health Regulation (2005)
Document A71/8

An earlier version of the document was considered by the Executive Board at its 142nd session in January 2018.

This document responds to the Health Assembly's request in decision WHA70(11) (2017) to the Director-General "to develop, in full consultation with Member States, including through the regional committees, a draft five-year global strategic plan to improve public health preparedness and response, based on the guiding principles contained in Annex 2 to document A70/16, to be submitted for consideration and adoption by the Seventy-first World Health Assembly, through the Executive Board at its 142nd session".

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

Through the draft decision included in EB 142 (1), the Executive Board recommends to the World Health Assembly to endorse the five year global strategic plan to improve public health preparedness and response 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.

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 is being prepared with the guidance of the SCRC and in close consultation with Member States and partners and indicates the way forward for WHO/Europe in operationalizing the global strategic plan. It is built on 3 strategic pillars:

- Strategic pillar 1: Build, strengthen and maintain States Parties' core capacities required under the International Health Regulations (2005)
- Strategic pillar 2: Strengthen event management and compliance with the requirements under the International Health Regulations (2005)
- Strategic pillar 3: Measure progress and promote accountability

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.

11.3 Polio transition and post-certification

Document A71/9

Development of the strategic action plan on polio transition was requested through resolution WHA70(9) in May 2017 to be submitted for consideration by the Seventy-first World Health Assembly and was considered by the Executive Board in January 2018.The proposed draft strategic action plan is aligned with the draft thirteenth general programme of work, 2019−2023 and aims to strengthen country capacity around the core goals of that programme of work in order to achieve universal health coverage and enhance global health security.

The drafting of the action plan was informed by the findings of a review of the draft national polio transition plans of 12 of the 16 polio transition priority countries.

Objectives of the Draft Strategic Action Plan for Polio Transition are:

Sustaining a polio-free world after eradication of polio virus . Through the polio Post-Certification Strategy, the Global Polio Eradication Initiative defines 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 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 systems, including surveillance for vaccine-preventable diseases, in order to achieve the goals of WHO's Global Vaccine Action Plan. The phasing-out of polio resources presents serious risks to the immunization systems of 16 priority countries and WHO's capacity to support them. The immunization community wants to avoid this risk by establishing a comprehensive approach, with efforts at the global and regional levels to elaborate a strategic vision for comprehensive vaccine-preventable disease surveillance, aligned with country and regional priorities, with direct linkages to immunization programmes.

Strengthening emergency preparedness, detection and response capacity in countries in order to fully implement the International Health Regulations (2005): As 10 of 16 priority countries are prioritized by the WHO Health Emergencies Programme, 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. These capacities will enable WHO to be fit for purpose, particularly in fragile settings.

Country Level Analysis to Support the Objectives of the Strategic Plan: Data were gathered from each polio priority country and nonpriority countries on the essential polio functions that need to be sustained for the period 2019–2023 according to the requirements of the polio Post-Certification Strategy. These functions are crucial for meeting all the three objectives of the draft strategic action plan. Analysis of the data was based on a standard costing template, which included specific categories from the Global Polio Eradication

Initiative's Financial Resources Requirements that correspond to essential functions required to keep the world polio free, such as surveillance and running costs, core functions and infrastructure needed for outbreak response. The countries used this template to estimate their costs for the time frame aligned with the draft thirteenth general programme of work.

The report further updates the programme budget implications and human resource planning.

The proposed Monitoring and Evaluation Framework for Polio Transition aims at ensuring proper monitoring of planned activities across the three levels of the Organization, over the course of the next five years, and supporting independent evaluation of the process and outcomes using a set of output and outcome indicators.

The uncertainties around the date of global certification of polio eradication will necessitate sustaining essential polio functions for a longer period than currently envisaged.

As the Global Polio Eradication Initiative is being scaled down for non-endemic countries as planned between 2016 and 2019, the quality of surveillance of acute flaccid paralysis might be affected if governments are not able to fully mainstream field surveillance functions and the Secretariat is unable to secure necessary resources.

Funding commitments made by the government of priority countries that have developed national polio transition plans might not be allocated fully or on time. The Secretariat proposes to establish a contingency fund with about 10% of the total domestic funding commitments for the period 2019 to 2023, in order to cover the most urgent needs.

The Way Forward

A road map with activities and milestones (Table 5) is being proposed in order to help to move the polio transition process forward, support implementation of the strategic action plan, track progress, and report to WHO's governing bodies. The four key areas for action are:

1. Critical strategic decisions are to be made, for example with regards to the "merger" of most polio functions and capacities into the immunization programme area and support from the WHO Health Emergencies Programme to incorporate key capacities dealing with outbreak response and containment.
2. Joint planning by the key programme areas in the priority transition countries is needed to help to elaborate the Proposed programme budget 2020–2021.
3. Joint planning at the country level, supported by regional offices and headquarters, must lead to the essential polio functions transitioned into core WHO budget categories for the development of the Proposed programme budget 2020–2021.
4. Supportive services are needed at the country and regional levels to facilitate transition planning, for instance in the areas of planning, resource mobilization, advocacy, communications, and human resources management

In sum, WHO's regional offices for Africa and the Eastern Mediterranean have prepared a business case to support all their Member States on the African continent in fully achieving

their immunization goals. This business case is aligned with the vision of the draft thirteenth general programme of work to strengthen country capacities to achieve the health-related Sustainable Development Goals. In addition, WHO is embarking upon developing an investment case for vaccine-preventable disease surveillance that justifies the need for solid and sensitive surveillance systems as a measure of the impact of interventions against vaccine-preventable diseases.

The Health Assembly is invited to note the report.

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.

11.4 Health, environment and climate change

Documents A71/10 , A71/10 Add 1 and A71/11

Health, environment and climate change

Document A71/10 contains the report by the Director General. The Executive Board, at its 142nd session, adopted an earlier version of this report and a decision EB142(5) in which it requested the Director-General to prepare a report on actions taken on the interlinkages between human health and biodiversity for consideration by the 71st World Health Assembly in order to prepare WHO's contribution to the Convention on Biological Diversity's

fourteenth meeting of the Conference of the Parties held in November 2018. Details of the Secretariat's response to that request are provided in document A71/11.

Known avoidable environmental risk factors cause at least 13 million deaths every year and about one quarter of the global burden of disease. Air pollution alone causes about 6.5 million deaths a year.

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.

Global health and welfare losses from air pollution in 2013 are valued at 7% of gross domestic product (US$5110 billion). Approximately 10% of global gross domestic product is now spent on health care,[1] driven increasingly by the costs of treating noncommunicable diseases. The effects of human actions on the environment are also an ethical and human rights issue.

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.

[1] For further information, see the WHO Global Health Expenditure Database (http://apps.who.int/nha/database, accessed 11 April 2018).

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.

The health sector has specific responsibility to inform policy-makers and the public on the health impacts of climate and environmental change. Continuous need for evidence on the effectiveness of measures to tackle the environmental root causes of disease and on the health impact of sectoral policies is required. Progress in this field would also benefit from research that is more directly connected to policy in health and related sectors.

Influencing core functions of the health sector and other sectors are required for the implementation phase. Additionally, significant initial investments are needed in order to take action on environmental and climate. In order to ensure coherence, it is proposed that tracking the progress of implementation of the thirteenth general programme of work, 2019−2023 should be aligned with monitoring of progress towards the Sustainable Development Goals.

Human health and biodiversity

Document A71/11 reports on actions taken on the interlinkages between human health taking into account the state of knowledge review on biodiversity and human health by WHO and the Secretariat of the Convention on Biological Diversity (CBD), in order to prepare WHO's contribution to the Convention's fourteenth meeting of the Conference of the Parties due to be held in November 2018 as requested by decision EB142(5).

Since 2008, the Conference of the Parties (COP) to the Convention on Biological Diversity has called for strengthening of cooperation with WHO on the nexus between biodiversity and human health., The COP CBD, in 2012, requested the establishment of a joint work programme with WHO, in 2014 and 2016 , adopted decisions on biodiversity and health.

Human health ultimately depends on ecosystems for elements essential to human health and well-being. To address this complexity and the challenges posed by loss of biodiversity and rising global health burdens WHO and the Secretariat of the Convention on Biological Diversity produced the state of knowledge review, drawing on the knowledge and insights of a multidisciplinary group of more than 100 experts. The review included a range of topics including air quality, agro-ecosysems, food security and nutrition, infectious diseases, biomedical discovery, etc. Drivers of change can affect biodiversity and health, both singly and together.

Particularly since the establishment of the joint working programme in 2012, WHO and the CBS Secretariat work closely together. In 2015, WHO and the Secretariat of the CBD signed a Memorandum of Understanding in order to strengthen collaboration and on their respective scientific and technical expertise on the links between health and biodiversity. A Liaison group was established which published a report of its first meeting held in Geneva in 2017.

To support countries in mainstreaming biodiversity and health in national strategies and plans, WHO and CBD held joint capacity building workshops including in the European Region (Helsinki, October 201).

In order to provide support to Member States and as contribution to the collaborative activities under the joint workplan with the CBD Secretariat, the WHO Secretariat plans to continue to support Member States jointly with the Secretariat of the Convention on Biological Diversity and institutional partners, participate in the fourteenth meeting of the Conference of the Parties to the Convention on Biological Diversity , strengthen cross-sectoral cooperation among intergovernmental and international agencies, promote capacity-building, for instance through the development of communication, education and public awareness tools for the general public and for policy-makers in the health sector.

The Secretariat also stands ready to support Member States to consider the activities further to the decisions of the governing bodies of the WHO and the CBD: to facilitate

dialogue amongst agencies responsible for health and those responsible for biodiversity; better integrate health, biodiversity and ecosystem management into holistic approaches such as One Health, consider health-biodiversity linkages when developing national plans, including health plans, environmental health action plans, poverty eradication, to identify opportunities to promote healthy lifestyles, sustainable production and consumption which would benefit both human health and biodiversity; to support interdisciplinary education, strengthen the capacity of relevant national authorities to consider health- biodiversity linkages and for monitoring and for data collection.

The Health Assembly is invited to note on these reports and to provide further guidance.

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.

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

Documents A71/12 and EB142/2018/REC/1, decision EB142(3)

In January 2018, the Executive Board, at its 142nd session, noted an earlier version of this report and adopted decision EB142(3).

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. WHO plays a fundamental role in ensuring access to safe, effective and quality medicines and vaccines around the world, taking a comprehensive health-systems approach that addresses all stages of the pharmaceutical value chain. The Secretariat has undertaken a comprehensive review of the major challenges to ensuring access to medicines and vaccines and analysed progress made to date. On the basis of this review and in accordance with WHO's draft thirteenth general programme of work 2019–2023, the Secretariat has identified actions that could be prioritized for implementation:

Actions with the greatest potential impact with the least complexity and requiring the fewest resources to implement: Examples are: engender and facilitate the development of political will at the national and regional levels to ensure the affordability and availability of safe, effective and quality medical products through effective regulation and policy implementation; support expansion of the Medicines Patent Pool to include all antimicrobial medicines and patented medicines from the WHO Model List of Essential Medicines.

Actions with a potentially high impact but involving greater complexity and requiring additional resources: examples are; develop policies that promote transparency throughout the value chain, including the public disclosure of clinical trial data, research and development costs, production costs, procurement prices and procedures, and supply chain mark-ups.

Actions with a potentially high impact, but that are also highly complex and requiring significant additional resources; examples are; support the development, implementation and monitoring of national medicines policies to reinforce strategies for the appropriate use of medicines; tackling undue influence and corruption in the pharmaceutical system, particularly in procurement and supply chain management; progress in implementing those elements of resolution WHA69.25 pertaining to the global shortage of medicines and vaccines.

During the 69th WHA in May 2016, Member States adopted resolution WHA69.25 , thus acknowledging the increasing incidence of global shortages of medicines and vaccines. In the resolution, the Director-General was requested to assess the nature and the magnitude of the problems of shortages and to develop “a global medicine shortage notification system that would include information to better detect and understand the causes of medicines shortages”.

In July 2017, the Secretariat hosted a technical consultation to review existing systems for reporting medicines shortages, including databases of regulatory authorities, as well as those for substandard and falsified medical products and adverse events. This information will be used in the design of a global reporting system for shortages and stock outs, limited to medicines included on the WHO Model List of Essential Medicines. 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).

In the comprehensive report by the Director-General on access to essential medicines and vaccines (annex), the main challenges and progress made regarding access to medicines and vaccine are presented, including:

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.

P*ublic 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.

Needs-based research, development and innovation: Key progress made by the Secretariat on research and development priority-setting includes the establishment of the Global Observatory on Health Research and Development. A mechanism is in the process of being established to highlight critical research priorities, knowledge gaps and identify solutions and innovations in line with the General Programme of Work outcomes and impact framework.

Regulation to ensure quality, safety and efficacy: 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. Moreover, to support Member States in improving the quantity, quality and analysis of accurate data concerning substandard and falsified medical products, the Secretariat established the Global Surveillance and Monitoring System and has provided training for Member States on detection and reporting.

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 policies, reimbursement and affordability: The Secretariat has started collecting evidence for a fair-pricing model that could be adapted by countries according to the national context. The Secretariat has made substantial progress on the vaccine product, price and procurement initiative, which now provides access to procurement prices of vaccines across more than 80% of countries, with the goal of increasing price transparency and informing vaccine introduction and procurement.

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.

Draft Decision (EB142(3)

The Executive Board recommends to the Seventy-first World Health Assembly the adoption of a draft decision to request the Director-General to elaborate a road map report, in consultation with Member States, outlining the programming of WHO’s work on access to medicines and vaccines, including activities, actions and deliverables for the period 2019–2023; and to submit that road map report to the Seventy-second World Health Assembly for its consideration in 2019, through the Executive Board at its 144th session.

The Health Assembly is invited to adopt the draft decision.

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.

In January 2018, WHO Europe co-organized with UNICEF Supply Division in Copenhagen a Medicines Practitioners Procurement’s exchange forum as part of the UN Regional Issue Based Coalition (IBC) on Health. The Forum convened public procurement practitioners from the European and Eastern Mediterranean Region to exchange knowledge, practical experiences and 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.

In addition, in February 2018, the WHO Regional Office for Europe hosted a technical workshop in Copenhagen, Denmark, on strategic procurement of medicines focusing on negotiations. 27 Member States from the Region have now taken part in this training. With topics ranging from budget planning and horizon scanning to practical case studies and sharing of national negotiations practices, Member States reinforced the importance of discussing different approaches and challenges to medicines procurement, to collectively identify options and develop potential solutions. The workshop was organised in

collaboration with the Medical Technology Research Group (MTRG) of London School of Economics Health.

The topic of availability of medicines is also a high priority on the EU agenda and under the Bulgarian presidency of the EU, an informal meeting of Health Ministers "Health as the real winner: Effectiveness, availability and affordability of medicines" discussed the topic in April 2018. WHO/Europe remains active in supporting vaccine price transparency with 35 Member States reporting vaccine product price and procurement data for 2017 and the other 6 Member States sharing procurement data but not the information on price and/or volume.

Securing access to affordable vaccine supply has been identified as a priority by Health Ministers attending the South-eastern Europe Health Ministerial Meeting on Immunization, Podgorica, Montenegro in February 2018. The proposed way forward is applying vaccine market intelligence to inform strategic approaches to enhance vaccine demand visibility and predictability; to address budgeting, procurement and regulatory bottlenecks limiting competition; to strengthen vaccine supply management and to improve communication with suppliers. In addition, establishing a working group to exploring opportunities for joint procurement was among the decisions of the meeting.

Aiming to assist Member States, and in particular – middle income countries, to taking evidence based procurement decisions, the Regional Office provided technical assistance to developing country specific vaccine product price and procurement fact sheets, that generate evidence and analysis of the vaccine market, vaccine supply and shortages, product choices, procurement options and prices paid by individual countries and by country groups.

WHO Europe continues engaging with various platforms to review vaccine supply shortages and potential areas for action: contributions were made to the discussion on recent hepatitis B vaccine shortages in EU countries during the Viral hepatitis board meeting in Portugal in March 2018. The meeting offered the opportunity to share and learn from perspectives of various stakeholders to understanding, preventing and/or mitigating vaccine shortages, including representatives of hepatitis B prevention expert community, Member States, industry, ECDC, EMA and WHO.

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

Documents A71/13 and EB142/2018/REC/1, decision EB142(4)

The Executive Board at its 142nd session noted an earlier version of this report which was submitted in accordance with decision EB140(8) (2017), in which it approved the terms of reference of the overall programme review of the global strategy and plan of action on public health, innovation and intellectual property. In resolution WHA68.18 (2015), the

Sixty-eighth World Health Assembly requested the Director-General 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 to be commissioned by the Secretariat.

The executive summary of the evaluation was presented to the Executive Board at its 140th session[2] and the full report of the evaluation is available on the WHO website.[3]

The 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.

[2] Document EB140/20.
[3] See http://www.who.int/about/evaluation/gspoa_report_final20dec16.pdf (accessed 04 April 2018).
[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 4 April 2018)

Draft Decision (EB142 (4)[5]

The Executive Board recommends to the World Health Assembly to adopt a draft decision to urge Member States to discuss further and to implement the recommendations of the review panel that are addressed to Member States and to further discuss recommendation not emanating from the global strategy and plan of action. The Director General is requested to implement the recommendations of the review panel through an implementation plan and to submit a report on progress made on this decision to the 73st World Health Assembly in 2020, through the Executive Board.

The Health Assembly is invited to adopt the draft decision

Implication for the European Region

In the WHO European Region, all health information and research activities are guided by the Action Plan and Resolution to strengthen the use of evidence, information and research for policy-making in the WHO European Region (resolution EUR/RC66/R12). With the adoption of resolution EUR/RC66/R12, the 66th session of the WHO Regional Committee for Europe called on Member States to consolidate, strengthen and promote the generation and use of multidisciplinary and intersectoral evidence for health policy-making, in alignment with the health-related SDGs and the Health 2020 policy framework. The vision of the Action plan is to contribute to reducing health inequalities and to improve the health status and well-being of individuals and populations within the Region by the rigorous use of evidence for policy. A progress report on the implementation of the Action plan and resolution were submitted to the Standing Committee of the Regional Committee in March 2018 and will be reviewed by the Regional Committee for Europe in September 2018.

At the request of Member States, the WHO European Health Information Initiative (EHII) provides the overarching framework for the implementation of the Action Plan on evidence-informed policy-making. The WHO EHII is a multi-partner network, mandated to enhance population health in the WHO European Region by improving the information and health research that underpins regional policies. The initiative is strategically positioned to influence the WHO European landscape, as it has the express endorsement and commitment by the Region's Member States, and constitutes and important information-sharing mechanism to promote collaboration and coordination in health information and research matters.

With regard to both – the Action plan/resolution on evidence-informed policy-making and the EHII - Member States requested the WHO Director-General at the Regional Committee for Europe in September 2017 to consider establishing these regional initiatives at the global level as they should serve as good practice examples.

[5]Decision EB142 (4) available at: http://apps.who.int/gb/ebwha/pdf_files/EB142/B142(4)-en.pdf (accessed 4 April 2018)

Through the work of two key networks operating under the auspices of the EHII – the Evidence-informed Policy Network (EVIPNet) Europe and the European Health Research Network (EHRN) – the WHO Regional Office for Europe has put in place mechanisms to catalyse and support the establishment of partnerships and collaborations between research and policy communities, including recognised research centres, at intra- and inter-country level, to enhance country capacity in research generation and use.

In line with priority recommendations included in A71/13 WHO/Europe has regularly convened the European Advisory Committee on Health Research (EACHR).

This well-functioning expert committee was established in 2011, and aims to:

- advise the RD on the formulation of policies for the development of health research;
- review the scientific basis of selected regional programmes;
- co-ordinate health research internationally across the Region's Member States, advise on new findings on priority public health issues and evidence-based strategies to address them; and
- facilitate the exchange of information on research agendas in the Region and address evidence gaps in priority areas.

The EACHR, which directly advises the Regional Director, comprises of 24 outstanding public health research experts and is drawn from a range of institutions and disciplines, which meet once a year in person. With its new subgroup on implementation research, new activities have commenced to improve the quality and accessibility of implementation research; create support, and harmonize methodologies; and promote good practices for the use of implementation research for public health practice and policy in the WHO European Region. Other priority activities that the expert review panel suggest in WHA71 document A71/13 shall, if adopted by WHA71, be further deliberated by the EACHR to advise on its adaptation to the WHO European context, in line with Health 2020 and the Action plan/Resolution on evidence-informed policy-making.

11.7 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 A71/14

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), including through strengthening public policies, regulatory frameworks, unlocking the transformative potential of people, aligning private sector incentives with public health goals, fostering domestic and international financing, as well as incentivizing changes in consumption and production patterns. In 2018 and 2019, the Secretariat will conduct a review of international experience in the prevention and control of noncommunicable diseases, including public–private partnerships, and will identify and disseminate lessons learned.

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 convened a Global Dialogue on Partnerships for Sustainable Financing of Noncommunicable Disease Prevention and Control from 9 to 11 April 2018 hosted by the Government of Denmark. A list of 10 assignments being completed before the third High-level meeting in 2018 can be viewed in Table 6.

The Secretariat plans to publish its work on the development of a global investment case on the prevention and control of noncommunicable diseases on 20 May 2018, on the occasion of the eve of the Seventy-first World Health Assembly.

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 third 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-second World Health Assembly.

The Health Assembly is invited to note the report.

Document A71/14 Add.1

The document provides a Preliminary evaluation of the Global Coordination Mechanism on NCDs (GCM). A final evaluation will be presented to the WHA in 2021.

GCM is seen as fulfiling its role as a platform for engagement of multisectoral stakeholders and at the same time safeguarding WHO and public health from any undue influence. While noting successes, and the appreciation of Member States, the paper also notes some areas for improvement and makes six recommendations: a medium term strategic plan; an engagement strategy; appropriate processes for coordination, communication and dissemination; enhanced country reach; more effective working groups; enhanced identification and sharing of finance and cooperation information.

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.

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%.

The WHO European Region is leading the way in tackling the challenge of strengthening health systems for better NCD outcomes, as highlighted at the WHO high-level meeting ‘Health systems respond to NCDs’ in Sitges, Spain.

The recommendations for the GCM will add value to the mechanism and improve mechanisms to identify and engage non-State actors, from the health and non-health sectors and the private sector, in a way that safeguards WHO and its Member States from conflicts of interest.

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

Documents A71/15, A71/16, A71/16 Add.1 and EB142/REC/1, resolution EB142.R3

Preparation for a high-level meeting of the General Assembly on ending tuberculosis
The Executive Board at its 142nd session considered and noted an earlier version of this report.

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, jointly with the Government of the Russian Federation, organized the first WHO global ministerial conference on "Ending tuberculosis in the sustainable development era: a

multisectoral response", held in Moscow on 16 and 17 November 2017. The sharing of best practices, discussions on key identified areas for rapid action, and a ministerial declaration emerging from the conference will inform the General Assembly high-level meeting on tuberculosis in 2018.

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.

It is expected that the high-level meeting will be convened in the second half of 2018 in conjunction with the General Assembly and it will result in the adoption of a concise and action-oriented political declaration endorsed by heads of State on ending the tuberculosis epidemic as its outcome. WHO stands ready to provide further support to the Secretary-General and the General Assembly, upon request, in preparation for and follow-up to the high-level meeting.

Preparation for a high-level meeting of the General Assembly on ending tuberculosis
Development process for a draft multisectoral accountability framework to accelerate progress to end tuberculosis

As requested by the Board, document A71/16 lays out the plan of activities undertaken by the Secretariat over the period 1 February to 23 April 2018, date at which the final draft document on a multisectoral accountability framework was submitted for editing, high-level clearance and posting on the governing body pages on the WHO website for the Seventy-first World Health Assembly. The Health Assembly is invited to consider the framework document contained in document A71/16 Add.1.

Draft Resolution (EB142.3)

The Executive Board recommends to the Seventy-first World Health Assembly the consideration of a draft resolution which urges Member States to support preparation for the high-level meeting of the United Nations General Assembly in 2018 on tuberculosis and to pursue the implementation of all the commitments called for in the Moscow Declaration to End TB (2017). The draft resolution also calls upon all international, regional and national partners to pursue the actions called for in the Moscow Declaration to End TB (2017) and to invite those who have not yet endorsed it to add their support. The Director-General is requested to continue to support the United Nations Secretary-General in the preparation of the high-level meeting of the General Assembly on ending tuberculosis in 2018 and to support the implementation of the Moscow Declaration to End TB, to continue to provide

strategic and technical leadership, assistance advice and support to Member States and , to develop a global strategy for tuberculosis research and innovation.

The Health Assembly is invited to adopt the draft resolution.

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.

12. Other technical matters

12.1 Global snakebite burden

Documents A71/17 and EB142/2018/REC/1, resolution EB142.R4

The Executive Board considered at its 140th session and its 142th session a version of this report.

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.

Morbidity, disability and mortality due to snakebite envenoming

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.

Treatment and rehabilitation for snakebite envenoming

Immunotherapy with animal-derived antivenom preparations has been the main treatment for snakebite envenoming for over 120 years. Patients typically require a range of health services. Improving patient outcomes and reaching effective control targets to reduce the incidence of and mortality associated with snakebite envenoming requires: strengthening of

health systems; improved access to essential medicines such as antivenoms; efforts to eliminate substandard antivenoms and other substandard medicines; commitments to strengthen health workers' knowledge of diagnosis and treatment of snakebite envenoming; improved capacity to regulate antivenom products; effective distribution of antivenoms; and monitoring of their use and safety.

WHO's response to snakebite envenoming

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[6]. 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.

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.

Draft Resolution (EB142.R4)

The Executive Board recommends to the Seventy-first World Health Assembly the adoption of a draft resolution which urges Member states to assess the burden of snakebites, strengthen surveillance, prevention, treatment and rehabilitation; improve the availability, accessibility and affordability of antivenoms to populations at risk; to promote knowledge transfer, provide training to relevant health workers, to improve prevention, to promote community awareness of snakebite envenoming and foster collaboration between Member States. The Director-General is requested to accelerate global efforts and provide coordination to the control of snakebite envenoming, continue to offer technical support to institutions working on research into snakebite envenoming, improve the availability,

[6] 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 6 April 2018).

accessibility and affordability of safe and effective antivenoms for all, improve prevention and access to treatment and for reducing and controlling snakebite envenoming, improve cooperation. The Director General is requested to report on progresses in implementing this resolution to the Seventy-third World Health Assembly.

The Health Assembly is invited to adopt the draft resolution.

12.2 Physical activity for Health

Documents A71/18 and EB142/2018/REC/1, resolution EB142.R5

The Executive Board at its 142nd session considered an earlier version of this report and this updated version takes into account the discussions at that session of the Board, including minor changes to policy action 3.1. The draft global action plan has also been updated following input from Member States and these changes are reflected in draft 3 of the global action plan.[7]

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, using a baseline of 2016,[8] in global prevalence of physical inactivity in

[7] See http://www.who.int/ncds/governance/physical_activity_plan/en/ (accessed 2 March 2018).
[8] The relevant data will be made available in the forthcoming document, WHO country comparable estimates on physical inactivity, 2016, which is being prepared for publication in 2018

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 finalize 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 Secretariat will continue to establish and disseminate guidelines and implementation guidance to support regional and country action, in line with the core functions of WHO, and will report on progress towards the target set for 2030.

Draft Resolution (EB142.R5)

The Executive Board recommends to the Seventy-first World Health Assembly the adoption of a draft resolution which endorses the global action plan on physical activity 2018–2030 and adopts the voluntary global target of a 15% relative reduction in the global prevalence of physical inactivity in adolescents[9] and in adults[10] by 2030. The draft resolution urges Member States to implement the global action plan and report on progress regularly. The draft resolution invites relevant partners and stakeholders to implement the global action plan and to contribute to the achievement of its strategic objectives, aligned with domestic plans or strategies. The Director-General is requested to implement the actions for the Secretariat in the global action plan, to finalize a monitoring and evaluation framework by the end of 2018, and to produce, before the end of 2020, the first global status report on physical activity. The Director-General is further requested to incorporate reporting on progress made in implementing the global action plan on physical activity in the reports to

[9] Insufficient physical activity among adolescents (aged 11–17 years) is defined as less than 60 minutes of moderate to vigorous intensity activity daily.

[10] Insufficient physical activity among adults (aged 18+ years) is defined as less than 150 minutes of moderateintensity activity per week.

be submitted to the Health Assembly in 2021 and 2026 and to submit a final report to the Health Assembly in 2030.

The Health Assembly is invited to adopt the draft resolution.

Implication for the European Region

In the European Region, physical inactivity is estimated to attribute to one million deaths (about 10% of the total). More than half the Region's population not active enough to meet health recommendations and there is a trend in the region towards less activity, not more.

The Physical activity strategy for the WHO European Region 2016-25 is the first regional strategy and inspired the global action plan. WHO Europe is 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. 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.

12.3 Global Strategy for Women's, Children's and Adolescent's Health (2016-2030): sexual and reproductive health, interpersonal violence, and early childhood development

Document A71/19

An earlier version of this report was noted by the Executive Board at its 142nd session.

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 The report has been amended to include information on progress made in implementing Health Assembly resolutions WHA57.12 (2004) and WHA69.5 (2016).

More details, including the latest available data on the 60 indicators, are available on the Global Health Observatory data portal[11], in the 2018 report on progress towards the 2030 targets of the Global Strategy for Women's, Children's and Adolescents' Health. It assesses progress to date and suggests evidence-based strategic priorities for achieving the Survive, Thrive and Transform objectives for every woman, child and adolescent.

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: for example, 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. Similarly, work is ongoing to strengthen existing early childhood development indicator 4.2.1, "the proportion of children under 5 years of age who are developmentally on track in health, learning and psychosocial well-being, by sex", in partnership with UNICEF and other stakeholders.

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.

[11] See Global Health Observatory data repository (http://apps.who.int/gho/data/node.gswcah, accessed 22 March 2018).

Adolescent health

The Every Woman Every Child's Independent Accountability Panel, in its 2017 Transformative accountability for adolescents[12] report, urged strategic investments in 10-19 years old, in order to achieve the 2030 Agenda for Sustainable Development.

Following the release of implementation guidance for Global Accelerated Action for the Health of Adolescents (AA-HA!) in May 2017, intercountry meetings to spearhead use of the guidance have been jointly organized by WHO, the other H6 partners and UNESCO in Caribbean, Latin American and African countries.

WHO has worked with other members of the United Nations Inter-Agency Network on Youth Development to develop a United Nations strategy on youth. An open global survey was made available in June 2017 to identify the priority issues for young people and what the United Nations can do to tackle these issues.

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.

Reproductive health

***Maternal health and health care*.** Between 1990 and 2015, global maternal mortality fell by almost 44%. More than 830 women die daily in childbirth or as a result of pregnancy and delivery. In 2016, an estimated 78% of women globally were attended by a skilled health worker during childbirth[13] and only 62% of pregnant women had four or more antenatal care visits. Based on data from 92 low- and middle-income countries, only 59% of women received postpartum care between 2011 and 2016.

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. WHO also works to synthesize and make available evidence on effective family planning delivery models and actions including return to fertility, to inform policies, address barriers and strengthen programmes.

***Safe abortion*.** Approximately 56 million induced abortions per year have been performed worldwide between 2010 and 2014, and 25 million were unsafe, of which the highest rates are in Africa and Latin America where 75% of abortions were unsafe. UN DESA and the Special Programme of Research Development and Research Training have launched the open-access Global Action Policies Database[14]: it includes abortion laws, policies, health

[12] Available at http://iapreport.org/files/IAP%20Annual%20Report%202017-online-final-web_with%20endnotes.pdf (accessed 1 November 2017)
[13] UNICEF. The State of the World's Children 2017 – Children in a Digital World (https://www.unicef.org/sowc2017/, accessed 22 February 2018).
[14] See http://www.srhr.org/abortion-policies and https://esa.un.org/gapp (both accessed 25 October 2017)

standards and guidelines for all WHO and UN Member States, country-specific sexual and reproductive health indicators and the list of human rights treaties ratified by a given country.

***Combating sexually transmitted infections*.** Each year, there are an estimated 357 million new cases of four curable sexually transmitted infections among people aged 15–49 years. The Global health sector strategy on sexually transmitted infections[15] has identified impact targets for 2030 and progress has been made in the generation of global baseline incidence data. Based on country-reported data from 129 countries, in 2016, there were 1.1 million global maternal syphilis cases. In 2017, five countries developed baseline incidence data for N. gonorrheae and chlamydia, and a further seven will develop estimates in 2018. In 2017, the human papillomavirus vaccine for girls was introduced into 71 national immunization programmes and guidelines on the use of the syndromic approach for infection management are developed.

Cervical cancer. In 2012, over 266 000 women died from cervical cancer[16], 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.

Sexual health. WHO has worked with partners on the Global Early Adolescent Study, which aims to generate knowledge of the ways in which gender norms are formed in early adolescence and how they subsequently predispose young people to sexual and other health risks. Phase I of the Study, conducted in 15 countries, has generated valuable information and contributed to the development of a tool kit to assess gender norms in early adolescence.

Violence against women and girls

Millions of women and adolescent girls 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 2016. This momentum needs to be maintained in order to achieve targets 5.2 and 5.3 of SDG 5.

Quality of care

Recognizing the need for action, 10 countries, led by WHO, in collaboration with UNICEF, UNFPA, implementation partners and other stakeholders, have established the Network for Improving Quality of Care for Maternal Newborn and Child Health. These pathfinder

[15] Global health sector strategy on Sexually Transmitted Infections, 2016–2021 http://apps.who.int/iris/bitstream/10665/246296/1/WHO-RHR-16.09-eng.pdf?ua=1 (accessed 21 February 2018).

[16] 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)

countries aim to halve maternal and newborn deaths and stillbirths and improve experience of care in participating health facilities within five years of implementation, by developing and implementing national quality strategies and policies.

Financing investment in women, children and adolescents

Resources from the Global Financing Facility Trust Fund have currently been allocated to 26 countries. As at July 2017, US$ 525 million had been contributed to the Global Financing Facility Trust Fund. 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 (26 current plus 24 other). WHO has been an active partner of the Facility.

Health and Human Rights

WHO and the Office of the High Commissioner for Human Rights have concluded a framework cooperation agreement to implement the recommendations issued in 2017 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.

Environmental Health

Environmental risk factors are important determinants of child health, and account for some 25% of the disease burden among children under the age of 5. Updated information on child health and environment has been included in the Global Health Observatory and training tools and strategies are being developed to empower health professionals to protect children health against environmental risk factors. A total of 37 cities have now joined the Breathe Life Campaign led by WHO and the Climate and Clean Air Coalition, which supports cities with the aim of achieving safe air quality levels by 2030 (currently 92% have air pollution levels above WHO guidelines) and thereby protecting children's respiratory health. The first WHO Air pollution and health conference is currently under preparation, and technical guidance and training tools on air pollution and child health are due to be published in the course of 2018.

Early Childhood Development

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 and UNICEF, supported by the Partnership for Maternal, Newborn and Child Health, and the Action Network for Early Childhood Development, have developed a global

framework for nurturing care, in line with target 4.2 of the SDGs. The framework provides a road map for action and outlines how to support parents and other caregivers in providing nurturing care for young children. It calls for attention to be paid to communities where children are at greatest risk of suboptimal development, in particular those in extreme poverty, or living with violence, conflict or displacement. A two-phased open online consultation process has enabled a wide array of stakeholders to provide inputs.[17] All comments were carefully synthesized, examined and used. 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 World Bank and other leading institutions estimate that financial investments in early childhood development are still minimal in most countries.

Future Developments

Midwifery care is essential to improve maternal and newborn health: it is proposed that the Secretariat report on implementation of the Global Strategy to a future session of the Health Assembly, with a particular focus on how to strengthen midwifery care towards universal health coverage.

The Health Assembly 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 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

[17] Consultations were held on the concept draft (24 January–6 February 2018), followed by consultation on a complete draft (12–26 March 2018).

in the context of Primary Health Care and universal health coverage as the benefits package for children.

Progress on the Regional Child and Adolescent Health strategy will be reported to the Regional Committee at its 68th session.

Through the adoption of the Action Plan for sexual and reproductive health: towards achieving the 2030 Agenda for Sustainable Development in the WHO European region - leaving no one behind the RC66 (EUR/RC66/R7) further committed to a global strategy and a new sexual and reproductive health action for the European Region emphasizing on issue-based, human-rights based approach to Sexual and Reproductive Health.

12.4 mHealth

Document A71/20

A previous version of this report was considered by the Executive Board at its 139th[18] and 142nd[19] sessions. The present document has been amended to take account of Member States' comments, mobile wireless technologies, use of other digital technologies for public health.

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.

Digital technologies have the potential to revolutionize interactions between populations with national health services. Digital health and specifically mHealth have been shown to improve the quality and coverage of care, increase access to health information, services and skills, as well as promote positive changes in health behaviours to prevent the onset of

[18] Document EB139/8; see also document EB139/2016/REC/1, summary records of the third meeting, section 1.
[19] Document EB142/20 and the summary records of the Executive Board at its 142nd session, thirteenth meeting, section 2

acute and chronic diseases[2021]. In order to realize these gains, Member States are seeking to identify standardized approaches for applying digital health in health systems and services.

An increasing proportion of the population is accessing health information and services through mobile telephones, and a vast array of mobile-based solutions – from SMS to complex "smartphone" applications – have been developed to improve health access, knowledge and behaviours across a range of contexts and target groups[22].

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

In the 2030 Agenda for Sustainable Development, it is recognized that there is a need to increase access to information and communication technologies significantly. Such technologies have the potential to play a major role in catalysing and measuring progress towards a number of the Sustainable Development Goals.The spread of digital technologies and global interconnectedness has a significant potential to accelerate Member States' progress towards achieving universal health coverage (UHC), including ensuring access to quality health services.

Increasing the capacity of Member States to implement digital health, and in particular mHealth, could play a major role in realizing potential progresses towards universal health coverage (UHC), particularly:

- by increasing access to quality health services;
- by increasing access to sexual and reproductive health services; reducing maternal, child and neonatal mortality;
- by reducing premature mortality from noncommunicable diseases and noncommunicable disease comorbidities;
- by increasing global health security;
- by increasing the safety and quality of care;
- by increasing patient, family, and community engagement.

[20] Free C, Phillips G, Galli L, Watson L, Felix L, Edwards P, et al. The effectiveness of mobile-health technology-based health behaviour change or disease management interventions for health care consumers: a systematic review. PLoS Med. 2013; 10:e1001362. doi: 10.1371/journal.pmed.1001362.

[21] Quinn C, Shardell M, Terrin M, Barr E, Ballew S, Gruber-Baldini A. Cluster-randomized trial of a mobile phone personalized behavioral intervention for blood glucose control. Diabetes Care. 2011; 34:1934–42. doi: 10.2337/dc11-0366

[22] Things are looking app: mobile health apps are becoming more capable and potentially rather useful. The Economist. 10 March 2016 (http://www.economist.com/news/business/21694523-mobile-health-apps-are-becoming-more-capable-and-potentially-rather-useful-things-are-looking, accessed 5 April 2018).

WHO recognizes the value of digital health solutions, evidenced by the resolutions on eHealth adopted by the WHA and regional committees[23]. The WHO Global Observatory for eHealth documented a surge in adoption of eHealth in countries. There are 121 countries (as of 26 March 2018) 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 Health Assembly is invited to note the report.

Implication for the European Region

[23] 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).

The Be He@lthy, Be Mobile initiative (mHealth for NCDs) helps governments create large-scale, sustainable programs which deliver the benefits of mHealth at scale. This initiative (mHealth for NCDs) together with ITU and the European Commission will imminently announce the winner of the process to select a host for the European mHealth Hub. There is much anticipation surrounding the creation of this hub as it is seen by all partners as being the vehicle that will provide support to Member States and drive the strategic direction of mHealth in Europe. The operations of the hub are expected to address several long-term challenges for mHealth and in doing so, accelerate the regional adoption of mHealth.

The future of digital health in health systems in WHO Europe is embodied within the activities of the European Health Information Initiative, which has 38 members (mostly Member States) and which is coordinated by the Division of Information, Evidence, Research and Innovation.

eHealth is critical in the achievement of the Sustainable Development Goals but also their measurement through electronic solutions, including for the Joint Monitoring Framework proposed by Member States for the next Regional Committee.

There has been heightened interest within Member States of the European Region for the development of digital health services in support of NCD interventions, particularly in the area of Mental Health and additional demand for support to other areas is high.

12.5 Improving access to assistive technology

Documents A71/21 and EB142/2018/REC/1, resolution EB142.R6

The Executive Board at its 142nd session considered earlier versions of this report.

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.

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[24].

As at 1 February 2018, a total of 175 Member States had ratified the United Nations Convention on the Rights of Persons with Disabilities since its adoption in 2006. Aims were to create obligations to ensure access to assistive technology at an affordable cost and to foster international cooperation in order to achieve this (Articles 4, 20, 26 and 32).

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[25]. Awareness needs to be raised and sustained about the existence of affordable assistive products and that their use can be a cost-effective intervention to reduce disease and disability burden.

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[26], and the Global strategy and plan of action on ageing and health 2016–2020[27].

Assistive technology plays a key role for the WHO global action plan for the prevention and control of non-communicable diseases 2013–2020[28], and for the implementation of WHO's comprehensive mental health action plan 2013–2020[29]. 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*[30] , 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;

[24] Assistive technology. Fact sheet. Geneva: World Health Organization; 2016 (http://www.who.int/mediacentre/factsheets/assistive-technology/en/, accessed 6 October 2017).
[25] Assistive technology. Fact sheet. Geneva: World Health Organization; 2016 (http://www.who.int/mediacentre/factsheets/assistive-technology/en/, accessed 23 February 2018).
[26] See document WHA67/2014/REC/1, resolution WHA67.7 (2014) and Annex 3.
[27] See document WHA69/2016/REC/1, resolution WHA69.3 (2016) and Annex 1
[28] See document WHA66/2013/REC/1, resolution WHA66.10 (2013) and Annex 4.
[29] See document WHA66/2013/REC/1, resolution WHA66.8 (2013) and Annex 3.
[30] World report on disability. Geneva: World Health Organization; 2011 (http://www.who.int/disabilities/world_report/2011/en/, accessed 2 October 2017).

- Countries should adopt regulatory mechanisms to ensure that assistive products on the market meet the relevant standards and are safe and effective;
- 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.

Draft Resolution (EB142.R6)

The Executive board recommends to the Seventy-first World Health Assembly a draft resolution urging Member States to improve assistive technology, ensure adequate and trained human resources, develop a national list of priority assistive products which are affordable, cost-effective and meeting minimum quality and safety standards, invest in research, development, innovation and product design, collect population-based data on health and long-term care needs, invest in inclusive barrier-free environments.

The Director-General is requested to prepare a global report on effective access to assistive technology in the context of an integrated approach by 2021, to provide the necessary technical and capacity-building support for Member States, to contribute to the development of minimum standards for priority assistive products and services, to report on progress in the implementation of the present resolution to the Seventy-fifth World Health Assembly and thereafter to submit a report to the Health Assembly every four years until 2030.

The Health Assembly is invited to adopt the draft resolution.

Implication for the European Region

WHO Europe supports 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 outlines 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.

A two day workshop for Russian Speaking countries will be held in Belarus on Post market surveillance for In Vitro Diagnostic tests (IVDs) in July 2018.

12.6 Maternal, infant and young child nutrition

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

Document A71/22

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). The Executive Board at its 142nd session considered and noted an earlier version of this report and adopted decision EB142(6), in which inter alia it decided to note the analysis on the extension to 2030 of the 2025 targets on maternal, infant and young child nutrition.[31]

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

[31] See document EB142/22 and the summary record of the Executive Board at its 142nd session, tenth meeting, section 3.

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.

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

In 2016–2017, Member States, partners and the Secretariat continued to accelerate actions to improve infant and young child feeding. To strengthen implementation and monitoring efforts, WHO's Network for Global Monitoring and Support for Implementation of the International Code of Marketing of Breastmilk Substitutes and Subsequent Relevant World Health Assembly resolutions (NetCode) worked on a protocol to provide Member States with practical tools and guidance. In addition, WHO and UNICEF launched an electronic introduction course on the Code in November 2017. Moreover, in response to resolution WHA69.9 (2016), the Secretariat prepared an implementation manual to assist Member States in the effective implementation of the WHO guidance on ending inappropriate promotion of foods for infants and young children.

WHO and UNICEF have also taken steps to ensure that all maternity facilities practice the Ten Steps to Successful Breastfeeding[32].

The Health Assembly is invited to note the report.

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 the goals related 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.

[32] Guideline: protecting, promoting and supporting breastfeeding in facilities providing maternity and newborn services. Geneva: World Health Organization; 2017 (http://www.who.int/nutrition/publications/guidelines/breastfeedingfacilities-maternity-newborn/en/, accessed 22 March 2018)

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 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 particularly in policy development and monitoring and surveillance. The 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 A71/23

The Executive Board at its 142nd session considered and noted this report. 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.[33]

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

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

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 Health Assembly 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.

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

Documents A71/24, A71/24 Add.1 and A71/42

Pandemic Influenza Preparedness Framework for the sharing of influenza viruses and access to vaccines and other benefits
Progress in implementing decision WHA70(10) (2017) on Review of the Pandemic Influenza Preparedness Framework

Document A71/42

In resolution WHA64.5 (2011), the World Health Assembly adopted the Pandemic Influenza Preparedness Framework (the "PIP Framework"), to improve the detection and sharing of influenza viruses with human pandemic potential and to establish more equitable access to the resulting benefits (such as vaccines, antiviral medicines). Each year influenza vaccine, diagnostic and pharmaceutical manufacturers that use the Global Influenza Surveillance and Response System (ie. the WHO–coordinated network of public health laboratories which underpins the PIP Framework) are to make a total cash contribution ("the Partnership Contribution") of US$ 28 million to WHO for pandemic preparedness and response.

The Framework requires the Director-General to inform the World Health Assembly, on a biennial basis, about the status of and progress on the Framework's implementation in five areas:

1. Laboratory and surveillance capacity: Reporting of influenza-related data has steadily increased and has exceeded the targets established by the Partnership Contribution.
2. Global influenza vaccine production capacity: Although the Global Action Plan for Influenza Vaccines, which ended in 2016, facilitated the quadrupling of potential pandemic influenza vaccine production capacity, challenges to maintaining current production capacity persist.
3. Status of agreements entered into with industry, including information on access to vaccines, antivirals and other pandemic material: WHO has concluded 11 Standard Material Transfer Agreements 2 with vaccine and antiviral manufacturers which will provide WHO with access to approximately 400 million doses of pandemic vaccine and 10 million antiviral treatment courses for countries in need during the next pandemic. A total of 65 agreements have been concluded with research and academic institutions and biotechnology companies.
4. Financial report on the use of the partnership contribution: As at 31 December 2017, manufacturers had contributed over US$ 139 million to improve pandemic preparedness capacity. Resources are allocated to pandemic preparedness (70%) and response (30%). The PIP Secretariat uses a portion of funds, not exceeding 10%. The Partnership Contribution Implementation Plan I (2013–2017) guided the use of preparedness funds to strengthen capacities in five areas of work in 73 countries. In

2017, the Partnership Contribution Implementation Plan II (2018–2023) was developed and approved.

5. Experience arising from the use of the definition of PIP biological materials: The Director-General is conducting an analysis of the implications of pursuing – or not pursuing – possible approaches to including seasonal influenza viruses and genetic sequence data under the PIP Framework

The Health Assembly is requested to note the report

Pandemic Influenza Preparedness Framework for the sharing of influenza viruses and access to vaccines and other benefits .Report on implementation .Executive Summary

Document A71/24

In May 2017, the Seventieth World Health Assembly adopted decision WHA70(10) on Review of the Pandemic Influenza Preparedness Framework. In accordance with the request in paragraph 8(g) thereof, the Director-General submits this report on progress in implementing the decision and on recommendations for further action.

The report by the Director-General on progress to implement decision WHA70(10) outlines that:

- The Secretariat has reviewed and developed specific actions to implement each recommendation from the report of the 2016 PIP Framework Review Group and several have been completed.
- The Director-General developed a process in 2017 which includes collaboration with the Global Influenza Surveillance and Response System Collaborating Centres and the PIP Advisory Group, in order to conduct a thorough analysis of issues raised by the PIP Framework Review Group in relation to genetic sequence data and seasonal influenza.
- To continue supporting the strengthening of regulatory capacities and the carrying out of burden-of-disease studies, the high-level partnership contribution implementation plan (2018–2023) will focus on six areas including strengthening of regulatory capacities and undertaking burden-of-disease studies.
- To continue encouraging manufacturers and other relevant stakeholders to engage in PIP Framework efforts, WHO has now concluded Standard Material Transfer Agreements 2 with all multinational influenza vaccine manufacturers and six of the seven companies with a prequalified influenza vaccine. The Secretariat has continued to encourage the full and timely payment of PIP Partnership Contributions.
- The Secretariat has collaborated closely with the secretariats of the Convention on Biological Diversity, the Food and Agriculture Organization and the World Organisation for Animal Health to advance work relating to access to pathogens and

the fair and equitable sharing of benefits in the interest of public health.[34] The four secretariats are planning to hold a joint workshop in June 2018 in order to discuss and develop tools that could facilitate access to pathogens and sharing of benefits during public health emergencies.

The Director-General's report includes recommendations for further action :

- to aim to implement measures to complete all actions within its mandate before the Seventy-second World Health Assembly,
- to complete the analysis in order to submit a comprehensive draft to the Seventy-second World Health Assembly,
- to continue to strengthen critical pandemic preparedness (eg. through implementation of the high-level Partnership Contribution Implementation Plan 2018–2023, regular engagement with the secretariats of the Convention on Biological Diversity),
- to take measures to implement the recommendations of the External Auditor and report thereon to the Seventy-second World Health Assembly through the Executive Board at its 144th session.

The Health Assembly is invited to note the report and approve the recommendations through the adoption of a draft decision.

Proposed draft decision

The Health Assembly is invited to approve the recommendations included in document A71/42.

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.Ssurveillance 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 substantially 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

[34] For a report on collaboration in the first part of 2017, see document A70/57

addition to existing areas of work35, 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.

12.8 Rheumatic fever and rheumatic heart disease

Document A71/25 and EB141/2017/REC/1, resolution EB141.R1

In May 2017, the Executive Board, at its 141st session, noted an earlier version of this report and adopted resolution EB141.R1 on rheumatic fever and rheumatic heart disease.

Rheumatic heart disease is a preventable yet serious public health problem in low- and middle income countries and in marginalized communities in high-income countries, including indigenous populations. Some 30 million people are currently thought to be affected by rheumatic heart disease globally,[36] and in 2015 rheumatic heart disease was estimated to have been responsible for 305 000 deaths and 11.5 million disability-adjusted life years lost. Rheumatic heart disease persists in countries in all WHO regions.

Rheumatic heart disease disproportionately affects girls and women. Socioeconomic and environmental factors increase the likelihood to contract these diseases.

The prevention, control and elimination or eradication of rheumatic heart disease is increasingly being recognized as an important developmental issue by Member States. Secondary prevention of rheumatic fever and rheumatic heart disease is among the policy options for Member States in WHO's Global Action Plan for the Prevention and Control of Noncommunicable Diseases 2013–2020.

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

[36] Global Burden of Disease Collaborative Network. Global Burden of Disease Study 2016 (GBD 2016) Results.
Seattle, United States: Institute for Health Metrics and Evaluation (IHME), 2017, available at http://ghdx.healthdata.org/gbdresults-tool
(accessed 26 April 2018)

There are three levels of prevention for rheumatic heart disease: reducing the risk factors for rheumatic fever (primordial prevention); primary prevention of rheumatic fever and rheumatic heart disease; and secondary prevention (prophylaxis) of rheumatic fever and rheumatic heart disease.

Potential future research areas may include: better understanding of disease epidemiology and case detection; further elucidation of the pathogenic mechanisms of disease, aiming to identify new pathways amenable to therapeutic intervention and to inform vaccine development and application; development of a safe and effective group A streptococcal vaccine; and development of a long-acting formulation of penicillin that might improve adherence to secondary prophylactic regimens.

The main barriers to prevention, control and elimination of rheumatic heart disease are: the neglect of rheumatic fever and rheumatic heart disease in national health policies and budgets in countries in which rheumatic heart disease is endemic; the paucity of data to enable targeting of prevention efforts; poor primary and secondary prevention and access to primary health care; inadequate numbers and training of health workers at all levels; limited understanding of rheumatic fever and/or rheumatic heart disease in affected communities; and inaction on the social determinants of the disease and inequities in health. Ensuring a consistent supply of quality-assured benzathine benzylpenicillin for secondary prophylaxis is a significant challenge in some settings.

The last WHO global programme for the prevention and control of rheumatic heart disease covered the period 1984 to 2000.

Recommended actions for Member States include the following.

a- Develop and implement national programmes in countries where rheumatic fever and rheumatic heart disease remain significant health problems;
b- Improve appropriate identification and antibiotic treatment of group A streptococcal pharyngitis in high-risk groups;
c- Improve identification and secondary prophylaxis of rheumatic heart disease;
d- Ensure the consistent supply of injectable benzathine benzylpenicillin in primary care Facilities;
e- to promote appropriate use of antibiotics, educate professionals and the public about the need for prompt and complete antibiotic treatment for group A streptococcal pharyngitis in settings where rheumatic fever remains a problem;
f- Improve access to specialist diagnosis and surgical treatment, as needed;
g- Take measures to address the known determinants of rheumatic fever and rheumatic heart disease, including poor housing, overcrowding and delayed access to primary health care;
h- Foster increased international collaboration and resource mobilization to pursue the goal of prevention, control and elimination of rheumatic heart disease through bilateral, regional and multilateral channels.

Actions for the Secretariat include the following

a- Launch a coordinated global response to pursue the goal of prevention, control and elimination of rheumatic heart disease;
b- Update technical documents and guidelines on identification and clinical management of group A streptococcal pharyngitis, rheumatic fever and rheumatic heart disease;
c- Provide technical support to Member States on developing and implementing national programmes for the prevention and control of rheumatic heart disease in endemic areas;
d- Work with pharmaceutical manufacturers and governments to ensure continuous supply of quality-assured benzathine benzylpenicillin and improve the consistency of availability at community and primary care levels in affected countries;
e- Convene stakeholders in order to advance a prioritized research agenda.

Proposed Draft resolution

The proposed draft resolution urges Member States to estimate their burden of rheumatic heart disease, and, in the case of countries where the disease is endemic; improve access to primary health care, to cost-effective essential laboratory technologies and medicines; and to strengthen national and international cooperation to address rheumatic heart disease. Relevant stakeholders are invited to put people living with rheumatic heart disease at the centre of the prevention and control agenda; raise the profile of rheumatic heart disease and other noncommunicable diseases of children and adolescents on the global agenda; and facilitate timely, affordable and reliable access to existing and cost-effective new medicines and technologies for prevention and control of rheumatic heart disease.

The Director General is requested to reinvigorate engagement, lead and coordinate global efforts on prevention and control of rheumatic heart disease; support Member States and foster international partnerships for resource mobilization; to assess and report on the magnitude and nature of the problem of rheumatic heart disease according to agreed measures; and report on implementation of this resolution to the Seventy-fourth World Health Assembly

The Health Assembly is invited to note the report and consider the draft resolution

Implementation for the European Region

The WHO European Action Plan for the Prevention and Control of Noncommunicable Diseases 2016-2025 refers to ‘Vaccination and relevant communicable disease control’ within its list of Priority interventions (individual-level), and specifically mentions streptococcal disease and rheumatic valvular disease as part of the rationale for this. There is not currently a vaccine for group A streptococci however the report advocates for this,

especially given that reduction in use of antibiotics would be useful for decreasing anti-microbial resistance.

The WHO European Action Plan for Sexual and Reproductive Health within its list of key actions also refers to providing quality pre-conception information and services, including timely diagnoses of NCDs and taking all measures to secure quality health care to go safely through pregnancy and childbirth. It also prioritizes establishing confidential enquiries into all cases of maternal death at the national level and analysis of severe maternal morbidity cases ("near-miss" events) at the national and health-facility levels to better understand the causes and factors for maternal mortality and morbidity and develop relevant policies and actions. These will also help us to better understand true burden of RhHD in the Region and develop guidance on better ways to provide care during antenatal period, childbirth and post-partum to reduce the maternal mortality and morbidity from RhHD. WHO/Europe is supporting 12 countries in the Region to implement confidential enquires and near miss case reviews.

12.9 Eradication of poliomyelitis

Document A71/26 and A71/26 Add.1

This report provides an update on the status of the Polio Eradication and Endgame Strategic Plan 2013–2018. It summarizes programmatic, epidemiological and financial challenges to achieving a lasting polio-free world. At its 142nd session, the Executive Board noted an earlier version of this report. A report on the strategic action plan on polio transition, highlighting the post-certification strategy which defines the essential functions that Member States will need to maintain to sustain a polio-free world[37] is submitted separately to the current Health Assembly, in line with decisions WHA70(9) (2017) and EB142(2) (2018).

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. As at 31 January 2018, three cases of paralytic poliomyelitis due to wild poliovirus type 1 had been reported in 2018 in Afghanistan.

Circulating vaccine-derived poliovirus transmission

[37] Polio Post-Certification Strategy (http://polioeradication.org/polio-today/preparing-for-a-polio-free-world/transition-planning/polio-post-certification-strategy/ accessed 15 March 2018).

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 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. To prepare for the switch to bivalent oral polio vaccine, all countries had committed themselves to introduce at least one dose of inactivated poliovirus vaccine into their routine immunization programmes.

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).38 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.39 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.

As at January 2018, 174 countries and territories reported that they no longer hold wild or vaccine-derived poliovirus type 2, 28 reported that they intend to retain type 2 polioviruses in 91 poliovirus-essential facilities, and two were completing their reports. Despite increasing interest and efforts demonstrated by all stakeholders, accelerating implementation of polioviruses

[38] 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).

[39] 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).

containment requires intense commitment from all Member States so that the certification of poliovirus eradication can be achieved and sustained. Recognizing that poliovirus transmission levels are currently at the lowest point in history and the feasibility of eradication in the short-term is a realistic expectation, an urgent intensification of containment activities by all parties is necessary.

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.

Proposed Draft resolution A71/26 Add.1

The proposed draft resolution urges all Member States to fully implement all strategic approaches outlined in the Polio Eradication and Endgame Strategic Plan 2013–2018; intensify efforts to accelerate the progress of poliovirus containment certification; complete inventories for type 2 polioviruses; and ensure that any confirmed event associated with a breach in poliovirus containment is immediately reported to the National IHR Focal Point. It further urges all Member States retaining polioviruses to reduce to an absolute minimum the number of facilities designated for the retention of polioviruses; appoint a competent National Authority for Containment no later than by the end of 2018; and provide the National Authority all necessary resources; to request facilities designated to retain poliovirus type 2 to submit containment certification applications no later than 30 June 2019; and to initiate steps for the containment for type 1 and 3 materials; to prepare a national response protocol for use in the event of a breach of poliovirus containment and risk of community.

The Director General is requested to provide technical support to Member States; to facilitate the harmonization of certification mechanisms for the long-term sustainability; to update all WHO's recommendations and guidance on poliovirus containment, and report regularly to the Executive Board and the Health Assembly on progress and status of global poliovirus containment.

The Health Assembly is invited to note the report and consider the draft resolution set out in document A71/26 Add.1.

Implication for the European Region

The WHO/Europe was certified polio-free in 2002 after the last case of indigenous WPV was detected in 1998. In June 2017, the Regional Certification Commission (RCC) reaffirmed that

the European Region continued to be polio-free. The next meeting of RCC will be held 30-31 May in Copenhagen, Denmark.

Due to the large number of global-level polio/enterovirus laboratories and Europe-based polio vaccine manufacturers, the number of polio essential facilities (PEFs) in the Region is expected to be high, which will require a considerable amount of work to fully implement all of the polio containment requirements.

Poliovirus detection and interruption of transmission. Existing sensitive surveillance system in the Region allowed for prompt detection of vaccine derived and Sabin-like type 2 polioviruses in humans and environment in several Member States during 2016-2018 (Azerbaijan, Belarus, the Netherlands, the Russian Federation, Ukraine), and thanks to maintained adequate capacity and resources these events were adequately responded to and contained.

Phased removal of oral polio vaccines. As of 2018, eighteen countries in the Region have oral polio vaccine in the immunization schedules. Setting ground for preparation for coordinated global withdrawal of bivalent OPV will be initiated soon. Access of Member States to available and affordable stand-alone and combination polio vaccines supply will remain as a key factor to ensuring protection from any poliovirus emergence

Introduction of IPV in five countries of the Region – Kyrgyzstan, Moldova, Tajikistan, Turkmenistan and Uzbekistan – was postponed to 2018 due to inability of GPEI to ensure implementation of contractual obligations by manufacturers and by consequent insufficient supply of IPV. Turkmenistan has already introduced IPV from 1 January 2018, and Moldova has introduced from 2 April 2018. Kyrgyzstan, Tajikistan and Uzbekistan will introduce one dose of IPV into their routine immunization schedule between 23 April and 1 June 2018. Preparations are underway for catch up campaigns cohorts missed during 2016-2017 in early 2019 when sufficient supply of IPV will be available. Selected countries with full-IPV primary schedule will gradually withdraw booster bOPV doses during this biennium.

Containment of polioviruses remains the major challenge for the Region in implementation of the End-game plan. Due to the large number of global-level/enterovirus laboratories and Europe-based polio vaccine manufacturers, the European Region has the largest global burden and will require substantial technical and financial support to fully implement all of the polio containment requirements. In 2017-18, the Region made substantial progress in implementing the containment certification scheme – GAPIII, and fulfilling the national requirement for establishing polio essential facilities (PEFs) – joint efforts between WHO, EC and ECDC.

Two polio outbreak simulation exercise (POSE) for Member States that are retaining polioviruses in polio essential facilities (PEFs) will be conducted in October 2018 to help identify risks and put in place mitigation activities – support from ECDC is being provided for EU Member States.

Financing of Global Polio Eradication Initiative. European Member States are among the major donors of GPEI: Germany recently pledged €21.9 million for global polio eradication.

20. Matters for Information

20.1 Global vaccine action plan

Document A71/39

In January 2018, the Executive Board at its 142nd session noted an earlier version of this report.

Following resolutions WHA65.17 and WHA70.14, the Strategic Advisory Group of Experts on immunization (SAGE), based on its review of data from 2016[40], prepared the 2017 assessment report of the global vaccine action plan[41]. 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 Health Assembly is invited to take note of the report.

Annex 1; Executive Summary of the 2017 Assessment Report of the Global Vaccine Action Plan and Recommendations by the Strategic Advisory Group of Experts on Immunization.

In 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.

[40] 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).

[41] 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)

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 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 tetanus 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.

Annex 2; A Summary of WHO's Activities in Response to the Requests in Resolution WHA70.14 (2017)

The draft thirteenth general programme of work 2019–2023[42] envisages the Secretariat intensifying its support to Member States that host the most vulnerable populations. The Secretariat continues to provide technical support to regional and national immunization technical advisory groups.

At the global level, the monitoring and accountability framework provides the mechanism for monitoring progress in the implementation of the global vaccine action plan. At the national leve, the WHO/UNICEF Joint Reporting Form serves as the unified instrument for collecting the coverage, financial and programme data that are needed for monitoring progress. Each WHO region has developed independent monitoring and accountability mechanisms, the results of these are included in each regional director's report to the respective regional committee.

WHO has updated its list of priority pathogens likely to cause major epidemics. For example, for the Middle East respiratory syndrome coronavirus, WHO has issued a road map for research and development and vaccine target product profiles; one candidate vaccine is currently undergoing clinical evaluation.

WHO's prequalification of medicines offers manufacturers a well-established and robust means of accessing markets for products that meet internationally accepted quality norms and standards. For cold-chain equipment and vaccine-delivery devices, the Secretariat carried out an external review of the standards development, prequalification and laboratory accreditation processes in 2017 in order to identify potential areas of improvement in the regulatory process for these devices and equipment. Plans are being put in place for a robust post-market monitoring system for immunization equipment. Progress has been made on the thermostability of vaccines, such that additional vaccines

[42] Document EBSS/4/2.

are showing promise for licensure for use and administration outside the standard cold-chain.

WHO has been working with relevant stakeholders (including governments, UNICEF, non-State actors, industry and the GAVI Alliance) to develop policies and programmes to enhance availability and affordability of supply, to collect data to inform policy-making and countries' procurement choices and to provide some limited support to countries to strengthen their forecasting and financial planning, procurement and information use for improving timely access to affordable vaccines.

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.

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