

## **Progress reports**

### **Report by the Director-General**

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## Communicable diseases

### A. GLOBAL HEALTH SECTOR STRATEGIES ON HIV, VIRAL HEPATITIS AND SEXUALLY TRANSMITTED INFECTIONS, FOR THE PERIOD 2016–2021 (resolution WHA69.22 (2016))

1. In May 2016, the Sixty-ninth World Health Assembly, in resolution WHA69.22, adopted the global health sector strategies on, respectively, HIV, viral hepatitis and sexually transmitted infections, for the period 2016–2021. This report describes the progress achieved in implementing the strategies.
2. The regional committees responded proactively, variously endorsing, adapting and promoting the strategies, including through regional action plans.
3. The strategies promote synergies across the diseases and other health areas. A number of advances have been made, including: participation of 60 countries in the Global Antimicrobial Resistance Surveillance System and publication of guidelines and a global action plan on HIV drug resistance; validation of the elimination of mother-to-child transmission of HIV and/or syphilis in 10 countries or areas in 2016 and 2017<sup>1</sup> and endorsement by the Regional Committee for the Western Pacific of a regional framework for the triple elimination of mother-to-child transmission of HIV, hepatitis B and syphilis in Asia and the Pacific 2018–2030;<sup>2</sup> publication of new treatment guidance for HIV infection, hepatitis C, syphilis, *Chlamydia trachomatis* infection, genital herpes and gonorrhoea; publication of advice on the use of a dual HIV/syphilis rapid diagnostic test in antenatal services; and updating of the WHO Model List of Essential Medicines<sup>3</sup> to include new treatments for sexually transmitted infections, the first combination therapy effective against all six genotypes of hepatitis C virus, and antiretroviral drugs for use as pre-exposure prophylaxis to prevent HIV infection.
4. Under the strategies' framework, key partnerships have been strengthened resulting in: the signing of a Memorandum of Understanding between WHO and the Global Fund to Fight AIDS, Tuberculosis and Malaria to improve country impact of the Fund's investments; the signing of a Memorandum of Understanding between WHO and UNODC that makes a commitment to joint action on HIV, viral hepatitis and tuberculosis among people who use drugs; co-signature of a joint United Nations statement on ending discrimination in health care settings; joint advocacy with the World Hepatitis Alliance to drive action to tackle viral hepatitis; and award signing of a grant from Unitaid to WHO to promote research and innovation in HIV and hepatitis C prevention, diagnosis and treatment.
5. **HIV infection.** Treatment scale-up has continued rapidly, with 20.9 million people receiving treatment by mid-2017, compared with 19.5 million in 2016. Progress towards the UNAIDS "90-90-90" target for HIV testing and treatment has been guided by new WHO policies and guidelines, including those on: the use of antiretroviral drugs for treatment and prevention; patient monitoring and case surveillance; HIV-related drug resistance; key populations; HIV self-testing and

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<sup>1</sup> Armenia, for HIV only (2016); Republic of Moldova, for syphilis only (2016); dual elimination in Belarus and Thailand (2016) and Anguilla, Antigua and Barbuda, Bermuda, Cayman Islands, Montserrat and Saint Kitts and Nevis (2017).

<sup>2</sup> See resolution WPR/RC68.R2 (2017).

<sup>3</sup> The selection and use of essential medicines: report of the WHO Expert Committee, 2017 (including the 20th WHO Model List of Essential Medicines and the 6th WHO Model List of Essential Medicines for Children). Geneva: World Health Organization; 2017 (WHO Technical Report Series, No. 1006; <http://www.who.int/medicines/publications/essentialmedicines/trs-1006-2017/en/>, accessed 5 March 2018).

partner notification; managing advanced HIV disease; and sexual and reproductive health and rights of women living with HIV. Monitoring the uptake and implementation of WHO guidance is now routine and has demonstrated country impact: by November 2017, 70% of 139 low- and middle-income countries were following HIV “treat all” guidance, 58% had fully implemented routine viral load testing, 40% had included dolutegravir in first-line antiretroviral therapy combinations and 27% had either implemented or were developing a policy on HIV self-testing.

6. **Viral hepatitis.** In 2017, WHO published the first global hepatitis report, describing the epidemiological situation and response to viral hepatitis. The global health sector strategy on viral hepatitis 2016–2021 has stimulated country action, particularly in the areas of national strategic planning and scale-up of treatment. In 2017, 82 countries reported that viral hepatitis plans were in place, compared with only 17 in 2012, yet only 35% of these countries reported dedicated funding for such plans. The number of persons starting hepatitis C treatment increased from 1.1 million in 2015 to 1.76 million in 2016, with most (86%) receiving direct-acting antiviral medicines, with the increase spurred by decreasing prices of these medicines. The price of a course of sofosbuvir to cure hepatitis C, for example, decreased in some countries from about US\$ 84 000 to less than US\$ 200 between 2014 and 2017. For hepatitis B, the number of persons on lifelong treatment increased from 1.7 million in 2015 to 4.5 million people in 2016, representing an increase in coverage from 8% to 16%. Between 2004 and 2017, the annual cost of treatment with tenofovir for hepatitis B decreased from US\$ 208 to US\$ 28. In 2018, as patents expire, all countries should be able to procure generic tenofovir, further increasing access to hepatitis B treatment. Progress in countries has been facilitated by increased political commitments. The World Hepatitis Summit in November 2017 brought together public health professionals, governments and civil society, resulting in a declaration supporting the elimination of hepatitis as a public health threat.

7. **Sexually transmitted infections.** The global health sector strategy on sexually transmitted infections 2016–2021 identified global targets for 2030 and progress has been made in the generation of global baseline incidence data. Provisional estimates, derived from the Spectrum-STI modelling tool and based on reported data from 129 countries, suggest that in 2016 there were 1.1 million global maternal syphilis cases resulting in more than 660 000 cases of congenital syphilis, with 350 000 of these occurring as adverse birth outcomes. In 2017, five countries developed baseline incidence data for *Neisseria gonorrhoeae* and *Chlamydia trachomatis* infections and a further seven will develop estimates in 2018. Human papillomavirus vaccine for girls was introduced into 71 national immunization programmes by March 2017. The global health sector strategy was promoted and discussed in six regional meetings attended by 105 Member States, the majority of which reported use of the strategy and new treatment guidelines. The development of guidelines on syndromic management of sexually transmitted infections started in 2017, with publication planned in 2018. A survey is planned for 2019 to measure progress towards the achievement of 2020 milestones. Research on new diagnostic tests and vaccines for sexually transmitted infections has advanced, with an independent laboratory-based evaluation of promising point-of-care tests completed and new treatment options for syphilis and gonorrhoea being explored.

8. Despite considerable progress, meeting the 2020 milestones of the three global health sector strategies requires strengthening approaches to reach populations and locations with the highest incidence and poorest prevention and treatment outcomes. The draft thirteenth general programme of work, 2019–2023 provides new opportunities to enhance implementation and impact of the strategies.

## **B. ERADICATION OF DRACUNCULIASIS (resolution WHA64.16 (2011))**

9. In 2017, only two countries, Chad and Ethiopia, reported human cases of dracunculiasis: previously the disease was endemic in 21 countries.<sup>1</sup> The number of human cases fell from an estimated 3.5 million in 1986 to only 30 in 2017: Chad and Ethiopia reported 15 human cases each, from a total of 20 villages. In 2017, for the first time, South Sudan reported zero human cases; Mali reported zero human cases in both 2016 and 2017. The reduction in the risk of dracunculiasis in marginalized communities helps in the attainment of universal health coverage.

10. WHO, its global partners (The Carter Center, UNICEF and the WHO Collaborating Center for Dracunculiasis Eradication at the United States Centers for Disease Control and Prevention), as well as other stakeholders have continued to work hard to ensure that support is provided for dracunculiasis eradication efforts, wherever needed.

11. Following recommendations of the International Commission for the Certification of Dracunculiasis Eradication, WHO has certified a total of 199 countries, territories and areas, including 187 WHO Member States, as free from dracunculiasis transmission, the latest being Kenya, in February 2018. Seven Member States remain to be certified: Chad, Ethiopia and Mali, in which the disease is currently endemic; South Sudan and Sudan, in the pre-certification stage; and Angola and the Democratic Republic of the Congo, which have had no history of the disease since the 1980s.

12. During 2017, the four countries in which the disease was endemic (Chad, Ethiopia, Mali and South Sudan) sustained active community-based surveillance in 6547 villages, compared with 5300 villages in 2016. Nationwide communication campaigns were launched by each of these countries during 2017.

13. In 2017, no human cases or infected animal were found following searches in Angola (in two thirds of the country) and in the Democratic Republic of the Congo (in 18 of the country's 26 provinces).

14. All countries that remain to be certified, except Angola, continue to offer cash rewards for voluntary case reporting. A global reward scheme, similar to that used in the last stage of the smallpox eradication campaign, is being planned by the Secretariat in consultation with Member States. Nearly 40 800 rumours of cases of dracunculiasis were reported globally and investigated during 2017: 19 rumours led to the detection of human cases in Chad and Ethiopia. The majority of post-certification countries in which the disease was previously endemic (11/15) continued to submit quarterly reports to WHO in 2017.

15. *Dracunculus medinensis* infection in dogs remains a challenge to the global dracunculiasis eradication campaign. In 2017, Chad reported 817 infected dogs; 11 infected dogs and four infected baboons were reported by Ethiopia, and nine infected dogs by Mali. In Chad, the number of infected dogs fell by 26% and the number of *D. medinensis* worms emerging from infected dogs by 38% during 2017. Results of operational research indicate that transmission can be interrupted through the application of current strategies, including vigorous pursuit of copepod control and the prevention of transmission from human cases and infected dogs.

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<sup>1</sup> Prior to South Sudan's independence in 2011, the disease was endemic in 20 countries.

16. Insecurity and inaccessibility due to conflicts continue to hinder accessibility and eradication programme efforts in certain areas. In Mali, security concerns in the regions of Gao, Kidal, Mopti and Ségou remain a hurdle to programme implementation. Civil unrest, including cattle raids, and massive population displacement in South Sudan continue to hamper programme implementation and restrict access to areas in which the disease is endemic.

17. The Director-General regularly monitors the eradication campaign. An annual meeting of all national dracunculiasis eradication programmes is held in which countries officially report on the status of their programmes during the preceding year.

18. An informal meeting with health ministers of countries affected by dracunculiasis, chaired by the Regional Director for Africa, was held on the margins of the Seventieth World Health Assembly in 2017. The ministers and their representatives expressed their continued commitment to lead in advocating for and supporting their national eradication programmes, and pledged to redouble efforts to interrupt transmission of the disease as soon as possible.

### **C. ELIMINATION OF SCHISTOSOMIASIS (resolution WHA65.21 (2012))**

19. Schistosomiasis remains a significant global public health problem. The main intervention is the periodic administration of the anthelmintic medicine, praziquantel. Increased availability of donated praziquantel allowed some 89.2 million people, particularly school-age children, to be treated in 39 countries in 2016. Although donation of praziquantel from the pharmaceutical industry had increased from 72.3 million tablets in 2014 to 183 million tablets in 2016, these donations still covered only about 30% of the 563 million tablets needed. Some 206.4 million people required preventive chemotherapy for schistosomiasis in 2016; coverage for school-age children was 53.7%.

#### **African Region**

20. Of the 41 Member States in the Region, 31 reported data in 2016, according to which, some 82.1 million people received preventive chemotherapy. In 19 countries, coverage reached 100 % of endemic areas. A total of 57.4 million school-age children were treated, representing 57.2% coverage. The WHO target of 75% coverage for school-age children was met in Burkina Faso, Burundi, Cameroon, Côte d'Ivoire, Guinea, Mali, Malawi, Mozambique, Swaziland, Togo, United Republic of Tanzania and Zimbabwe. The number of people receiving preventive chemotherapy for schistosomiasis increased by nearly 57%, from 52.4 million in 2014 to 82.1 million in 2016.

21. The introduction of preventive chemotherapy through mass treatment campaigns has led to a significant decrease in schistosomiasis prevalence in sub-Saharan Africa from 15.4% in 2010 to 7.7% in 2017. The number of people requiring preventive chemotherapy for schistosomiasis decreased from 258.8 million in 2014 to 206.4 million in 2016.

#### **Region of the Americas**

22. Preventive chemotherapy is required in the Bolivarian Republic of Venezuela and Brazil, with 1.6 million people in need of treatment. In 2016, only Brazil reported having used a test-and-treat strategy, with which it had treated 16 054 people. Suriname has residual transmission in isolated foci, while transmission may have been interrupted in seven other countries or territories: Antigua and Barbuda, Dominican Republic, Guadeloupe, Martinique, Montserrat, Puerto Rico and Saint Lucia.

### **South-East Asia Region**

23. Indonesia is the only Member State in the Region with populations requiring preventive chemotherapy. These populations reside in 28 villages of Central Sulawesi, where prevalence of infection in humans is less than 2%. In 2016, 5319 people were treated. In 2017 a comprehensive national plan of action was launched.

### **European Region**

24. The occurrence of autochthonous cases of schistosomiasis due to *Schistosoma haematobium* in Corsica (France) between 2011 and 2015 highlights the need for vigilance in areas of Southern Europe where the intermediate host snail is present. The situation has been under control since 2015, with no new autochthonous cases reported.

### **Eastern Mediterranean Region**

25. Four Member States in the Region (Egypt, Somalia, Sudan and Yemen) have populations requiring preventive chemotherapy. Preventive chemotherapy was used for the first time in Somalia in 2017. In 2016, Egypt, Sudan and Yemen reported treating 5.6 million people of whom 60% were adults. The number of people treated in the Region decreased from 7.8 million in 2014 to 5.6 million in 2016, mainly due to the impact of years of political instability on treatment rates in Yemen. Of all the cases treated in the Region, 60.3% were in Sudan. In 2017, surveys were conducted in Oman and Iraq to confirm the interruption of schistosomiasis transmission.

### **Western Pacific Region**

26. In 2016, some 3.2 million people required preventive chemotherapy in four Member States in the Region (Cambodia, China, Lao People's Democratic Republic and Philippines), although schistosomiasis cases are restricted to certain communities in those countries. Reports on schistosomiasis treatment were received from Cambodia, Lao People's Democratic Republic and the Philippines in 2016; more than 1.5 million people were treated. Schistosomiasis prevalence in humans has been reduced to very low levels in many endemic areas, meaning that transmission may be interrupted soon. Zoonotic transmission, however, particularly through *S. japonicum*, remains an issue.

27. The Secretariat is using new evidence to draft guidelines on the implementation of schistosomiasis control and elimination, and on the verification of the interruption of the transmission. Furthermore, snail control has been integrated in the Global vector control response 2017–2030. Guidance has been issued on the use of a novel diagnostic test for *S. mansoni*, which is more appropriate for low-transmission areas.

### **Noncommunicable diseases**

#### **D. PUBLIC HEALTH DIMENSION OF THE WORLD DRUG PROBLEM (decision WHA70(18) (2017))**

28. The Seventieth World Health Assembly, in decision WHA70(18), requested that the Director-General continue efforts to improve WHO's coordination and collaboration with the United Nations Office on Drugs and Crime (UNODC) and the International Narcotics Control Board (INCB)

in addressing and countering the world drug problem, and to continue to keep the Commission on Narcotic Drugs (CND) appropriately informed of relevant programmes and progress.

29. In February 2017, a Memorandum of Understanding was concluded between WHO and UNODC setting out seven areas for collaboration. Coordination is thus being intensified in all seven areas, at both the global and country levels. In line with decision WHA70(18), WHO organized a side event at the Sixty-first session of the Commission on Narcotic Drugs.

30. In implementing the WHO/UNODC Joint Programme on Drug Dependence Treatment and Care, the WHO Secretariat has been leading collaborative efforts in field testing the International Standards for the Treatment of Drug Use Disorders. Results and recommendations for updating the Standards were discussed at a joint UNODC/WHO meeting in February 2018. Also in collaboration with UNODC, the Secretariat has developed a clinical tool and training materials to facilitate implementation of the WHO guidelines for identification and management of substance use and substance use disorders in pregnancy. A further joint undertaking to study the community-based management of opioid overdose under the S.O.S. Initiative was launched at the Sixtieth session of the Commission on Narcotic Drugs. Collaborative work with UNODC has also continued with the development of information products on treatment and care for people with drug use disorders in contact with criminal justice system (focusing on alternatives to conviction or punishment), on identification and management of disorders due to use of new psychoactive substances, and on drug epidemiology and statistics. UNODC and INCB also contributed significantly to discussions at the WHO Forum on Alcohol, Drugs and Addictive Behaviours in June 2017.

31. The thirty-ninth meeting of the WHO Expert Committee on Drug Dependence met on 6–10 November 2017, with representatives of UNODC and INCB attending as observers. Both UNODC and INCB support the Expert Committee's prioritization process and provide information on dependence, abuse potential and harm to health for the substances under review. The Committee recommended that six fentanyl analogues, five synthetic cannabinoids and one amphetamine-type stimulant be placed under international control. The fortieth meeting will take place in June 2018 and will be specifically dedicated to reviewing cannabis and cannabis components.

32. The UNODC/WHO annual expert consultation on new psychoactive substances was held in October 2017 in Vienna, with the objective of sharing information on the development of the WHO surveillance system for new psychoactive substances and the UNODC Early Warning Advisory, and to explore synergies between them. The WHO surveillance system will inform Member States about the health risks of these substances, including fatal and non-fatal overdoses, related physical and mental disorders, and impaired driving, thereby enabling timely action to be taken through the establishment of vigilance or regulatory mechanisms.

33. WHO continues to work with UNODC to develop and implement normative guidance on substance use and communicable diseases – in particular HIV, viral hepatitis and tuberculosis – including on: amphetamine-type stimulant use and HIV transmission; differentiated HIV service delivery for people who use drugs; continuity of HIV, tuberculosis and hepatitis care in prisons; prevention of mother-to-child HIV transmission in prisons; and comprehensive prison services. WHO and UNODC also contributed to the development of a document to facilitate the inclusion of specific programmes for prisons in grant proposals submitted to the Global Fund to Fight AIDS, Tuberculosis and Malaria.

34. Coordination and collaboration with UNODC and INCB will be strengthened to support Member States' implementation of the operational recommendations from the 2016 United Nations General Assembly Special Session on Drugs. Successful collaboration, particularly at the country



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level, requires increased efforts to mobilize resources and strengthen WHO's capacity to address the world drug problem.

**E. GLOBAL BURDEN OF EPILEPSY AND THE NEED FOR COORDINATED ACTION AT THE COUNTRY LEVEL TO ADDRESS ITS HEALTH, SOCIAL AND PUBLIC KNOWLEDGE IMPLICATIONS (resolution WHA68.20 (2015))**

35. In May 2015, the Sixty-eighth World Health Assembly adopted resolution WHA68.20 on the global burden of epilepsy and the need for coordinated action at the country level to address its health, social and public knowledge implications. The present report provides the requested update on progress made with regard to the implementation of the resolution.

36. Evidence-based guidelines and a comprehensive implementation package have been developed and disseminated through an online sharing platform to strengthen countries' capacities to develop and scale up services for persons with epilepsy. The Secretariat has contributed to international advocacy and raising awareness by developing a WHO information kit on epilepsy,<sup>1</sup> which includes videos and an infographic.

37. The WHO departments for Mental Health and Substance Abuse and for Neglected Tropical Diseases have undertaken to develop guidelines on the diagnosis and treatment of *Taenia solium* *Neurocysticercosis* to prevent epilepsy. These will be finalized in 2018.

38. In the African Region, where the treatment gap for epilepsy is particularly large, the Secretariat facilitated a multicountry regional workshop in Ghana (September 2015) where policy-makers, experts, people living with epilepsy, non-State actors and other key stakeholders from 17 Member States were represented. In the Region of the Americas, a Regional epilepsy workshop was held in Honduras (August 2015) to discuss successful experiences, progress, and lessons learned. In addition, the mid-term review of the Strategy and Plan of Action on Epilepsy adopted in 2011 was presented at the Twenty-ninth Pan American Sanitary Conference in September 2017.

39. The management of epilepsy has been integrated into primary health care as part of mental health Gap Action Programme (mhGAP) implementation across all WHO regions. In the Western Pacific Region, this strategy was initiated in rural China, and 14 other countries and areas (Cook Islands, Fiji, Kiribati, the Federated States of Micronesia, Nauru, Niue, Palau, the Philippines, Samoa, Solomon Islands, Tokelau, Tonga, Tuvalu and Vanuatu). In the Eastern Mediterranean Region, epilepsy management in primary health care has been initiated in Egypt, Pakistan, and Tunisia, and strengthened in Afghanistan, Jordan, Kuwait, Lebanon, Oman, Qatar and in the occupied Palestinian territory. Similarly, epilepsy management is also integrated into mhGAP implementation in countries in the European and South-East Asia regions.

40. The Secretariat has provided intensive and comprehensive technical support to four Member States implementing innovative models of epilepsy care: Ghana, Mozambique, Myanmar and Viet Nam. In the context of universal health coverage, epilepsy management is being integrated into primary health care using a community-based approach. As a result, some 14 000 people living with epilepsy have been identified and have gained access to quality care. Service coverage has increased from 17% to 51% in the four countries' implementing areas.

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<sup>1</sup> [http://www.who.int/mental\\_health/neurology/epilepsy/information\\_kit\\_epilepsy/en/](http://www.who.int/mental_health/neurology/epilepsy/information_kit_epilepsy/en/) (accessed 13 February 2018).

41. Several initiatives have been undertaken to foster engagement with civil society and international non-State actors to support the implementation of resolution WHA68.20. International Epilepsy Day, a joint initiative by the International Bureau for Epilepsy and the International League Against Epilepsy, promotes awareness of epilepsy. The day is marked in more than 120 countries each year on the second Monday in February. In 2017, China marked the day by adopting the theme: “Caring for school students with epilepsy”. A workshop was facilitated (September 2015) gathering 35 chapters of the International Bureau for Epilepsy, to promote the role of civil society in implementing resolution WHA68.20. Furthermore, the Secretariat, in collaboration with the above organizations, is preparing a global report on epilepsy to provide information and guidance on approaches for improving policies, plans and programmes to increase access to epilepsy care in the community.

## **F. COMPREHENSIVE MENTAL HEALTH ACTION PLAN 2013–2020 (resolution WHA66.8 (2013))**

42. Through resolution WHA66.8 the Sixty-sixth World Health Assembly adopted the comprehensive mental health action plan 2013–2020 in May 2013. This report summarizes progress in implementing the action plan thus far.

43. The action plan includes six global targets and associated indicators to measure implementation. Baseline data were collected from Member States in 2014, using the indicators agreed in the Mental Health Atlas 2014 and again in 2017 to monitor progress. By January 2018, 177 Member States submitted responses to the Mental Health Atlas questionnaire.

44. Since 2013, 104 Member States have updated their national mental health policy or plan in line with international human rights instruments, and 94 have updated their legislation in line with international human rights instruments. Availability of resources and services for mental health varies considerably, remaining extremely limited in lower-income countries. The median number of mental health workers globally, which has remained unchanged since 2013, is 9 per 100 000. Approximately 40% of Member States reported ongoing collaboration between mental health and social services. Approximately 70% reported that care and treatment of persons with major mental disorders (psychosis, bipolar disorder, depression) was included in their national health insurance or reimbursement schemes, and more than 45% confirmed that these disorders were explicitly listed. Preliminary analysis shows that 40% of Member States regularly prepare a specific report on mental health activities. Less than 50% of countries have functioning prevention and promotion programmes. Finally, regarding service coverage, response rates were much lower than for other aspects of the questionnaire and quality of data was variable. This reflects current limitations in information systems in countries.

45. Several initiatives have been undertaken to improve this situation. Regional mental health strategies and frameworks for action have been developed: in September 2013, the Regional Committee for Europe adopted the European Mental Health Action Plan 2013–2020;<sup>1</sup> in October 2014, the 66th session of the Regional Committee of WHO for the Americas adopted the Plan of Action on Mental Health 2015–2020;<sup>2</sup> in October 2014, the Regional Committee for the Western Pacific approved the Regional Agenda for Implementing the Mental Health Action Plan 2013–2020 in

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<sup>1</sup> See resolution EUR/RC63/R10.

<sup>2</sup> See resolution CD53.R7.

the Western Pacific;<sup>1</sup> and in October 2015, the Regional Committee for the Eastern Mediterranean adopted *Scaling up mental health care: a framework for action*.<sup>2</sup> The Strategy for mental health for the African Region is currently being reviewed.

46. WHO MiNDbank provides access to international resources and national policies, strategies, laws and service standards related to mental health, substance abuse, disability and human rights from 192 countries.

47. Responding to lack of implementation of evidence-based psychological interventions, WHO released two psychosocial guides that may be delivered by lay providers: a group psychological treatment guide for depression, and a transdiagnostic scalable psychological intervention for adults impaired by distress in communities exposed to adversity. WHO has also issued guidance on setting up surveillance systems for suicide attempts and self-harm and has updated its guidance for media professionals.

48. The Secretariat provides technical support across all regions on mental health, substance use disorders, neurological conditions, suicide prevention and on system strengthening related to policy, planning, law reform and service development, (including during and after conflict and natural disasters). Significant focus has also been placed on human rights capacity building and promoting a recovery approach in mental health. The intervention guide for WHO's mental health Gap Action Programme (mhGAP) and its implementation tools (mobile application and training package) has been updated. It is available in 20 languages and currently being used in more than 100 countries. The WHO QualityRights initiative is rapidly gaining momentum, with guidance and training tools being implemented in more than 40 countries. The Secretariat led advocacy efforts for mental health, including the very successful World Health Day in 2017 on depression, with the theme "Depression: let's talk", and the organization of the annual mhGAP forum in Geneva, as well as participation in global, regional and national events.

## **G. COMPREHENSIVE AND COORDINATED EFFORTS FOR THE MANAGEMENT OF AUTISM SPECTRUM DISORDERS (resolution WHA67.8 (2014))**

49. In May 2014, the Sixty-seventh World Health Assembly adopted resolution WHA67.8 on comprehensive and coordinated efforts for the management of autism spectrum disorders. The present report provides the requested update on progress. The resolution requested the Director-General, *inter alia*, to implement Health Assembly resolution WHA66.8 (2013) on the comprehensive mental health action plan 2013–2020, as well as resolution WHA66.9 (2013) on disability, to scale up care for individuals with autism spectrum disorders and other developmental disorders, as applicable, and as an integrated component of the scale-up of care for all mental health needs.

50. In line with the resolution, the Secretariat is working towards the implementation of resolutions WHA66.8 and WHA66.9 and the Global Strategy for Women's, Children's and Adolescents' Health (2016–2030) to ensure a coordinated approach to managing autism spectrum disorders and other neurodevelopmental disabilities.

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<sup>1</sup> See resolution WPR/RC65.R3.

<sup>2</sup> See resolution EM/RC62/R.5.

51. The Secretariat has issued updated evidence-based guidance and capacity-building tools on early detection and management of developmental delays and disorders, including autism spectrum disorders, as a component of the mental health Gap Action Programme (mhGAP) Intervention Guide version 2.0,<sup>1</sup> along with a mobile application to provide advice and guidance to non-specialist care providers at the primary health care level.<sup>2</sup> These tools are being used in countries to strengthen capacity for scaling up care.

52. The WHO caregiver skills training package has been made available for families of children with developmental delays and disorders, through close cooperation with civil society partners like Autism Speaks and others. This package promotes evidence-based management of autism and other developmental disorders by providing skills training for caregivers. Workshops for health care providers who work with children have been organized in Argentina (with participants from six Member States in the WHO Region of Americas, August 2016), Nigeria (attended by child health and mental health specialists from nine African countries May 2016), Bhutan (attended by 41 experts from the South-East Asia Region) and in Xiamen (with participants from 14 low-, middle- and high-income countries from different regions, December 2017). Technical support on policy development and programming for autism and other neurodevelopmental disabilities has also been provided to Member States.

53. The Secretariat has contributed to generating and disseminating evidence on scalable approaches to managing autism and other developmental disorders, by providing technical advice and support to more than 30 Member States across all regions, for adapting and field testing the WHO mhGAP Intervention Guide and caregiver skills training, working closely with Member States, other United Nations agencies, academic institutions and civil society organizations, including parents' associations.

54. In support of efforts to meet the Sustainable Development Goals and the objectives of the Global Strategy for Women's, Children's and Adolescents' Health (survive, thrive and transform), WHO is working with UNICEF, supported by the Partnership for Maternal, Newborn and Child Health, and the Action Network for Early Childhood Development, to develop a global framework for nurturing care as a roadmap for action. This framework will outline how parents and other caregivers can be supported to provide nurturing care for young children, including addressing the special needs of caregivers and children with developmental difficulties and disabilities.

55. The Secretariat has contributed to international advocacy and raising awareness by participating in and organizing events on United Nations World Autism Awareness Day and World Mental Health Day, among others, in collaboration with advocate and self-advocate organizations.

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<sup>1</sup> [http://www.who.int/mental\\_health/mhgap/mhGAP\\_intervention\\_guide\\_02/en/](http://www.who.int/mental_health/mhgap/mhGAP_intervention_guide_02/en/) (accessed 13 February 2018).

<sup>2</sup> [http://www.who.int/mental\\_health/mhgap/e\\_mhgap/en/](http://www.who.int/mental_health/mhgap/e_mhgap/en/) (accessed 13 February 2018).

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## Promoting health through the life course

### H. GLOBAL STRATEGY AND ACTION PLAN ON AGEING AND HEALTH 2016–2020: TOWARDS A WORLD IN WHICH EVERYONE CAN LIVE A LONG AND HEALTHY LIFE (resolution WHA69.3 (2016))

56. The Sixty-ninth World Health Assembly in resolution WHA69.3 adopted the Global strategy and action plan on ageing and health. It provides the political mandate to:

- (a) achieve immediate country impact by building commitment, strengthening country capacity and taking action where evidence is available; and
- (b) establish the global evidence and partnerships needed to set up a decade of concerted global action, the Decade of Healthy Ageing, from 2020 to 2030.

57. The following key activities have been undertaken by the Secretariat. Further information, including additional quantifiable indicators, is provided on the WHO website.<sup>1</sup>

58. **Building commitment and capacity.** A total of 109 national focal points on ageing and health have been identified and 85 countries currently have a national policy on ageing and health. Meetings of Member States have been held to review regional strategies for the African and South-East Asia regions and the Regional framework for action on ageing and health in the Western Pacific. To foster understanding and commitment to long-term care in Sub-Saharan Africa, a regional policy dialogue involving representatives of 28 countries was convened in partnership with the International Association of Gerontology and Geriatrics. The WHO Global Network for Age-friendly Cities and Communities has grown substantially to cover over 157 million people in more than 500 municipalities and other administrative levels across 37 countries.

59. **Supporting country action.** Guidelines for primary care practitioners on integrated care for older people have been developed, together with an associated mobile health programme (mAgeing) to provide easy access to recommendations and encourage their uptake. A global consultation has also been held to identify the actions needed to support countries in the delivery of integrated care for older people as part of universal health coverage. To support those who are closest to older adults, the Secretariat has developed an online training programme designed to support caregivers of people living with dementia. The Regional Office for Europe has issued guidance for policy-makers and planners on the development of age-friendly environments. Members of the Global Network of Age-friendly Cities and Communities have also contributed to setting up a database of specific examples of how cities and communities are making their environments better places in which to grow old.

60. **Towards a Decade of Healthy Ageing.** The Secretariat convened a global expert consultation to guide the development of metrics to monitor healthy ageing and serve as a baseline for the Decade. A public consultation has been conducted to identify priority areas for research, and the Campbell-Cochrane Global Ageing review group will help identify and respond to evidence gaps in the area of ageing. A global Clinical Consortium on Healthy Ageing has been established, bringing together key geriatricians and researchers to provide guidance on clinical care, and South-East Asian

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<sup>1</sup> <http://www.who.int/ageing/en/> (accessed 12 February 2018).

Member States have initiated research into health systems' response to population ageing. WHO has also strengthened alignment and collaboration with other United Nations agencies and partners, including the International Federation on Ageing and HelpAge International. A global campaign to combat ageism is also underway, including activities to raise awareness through various high-level events, establish a multi-stakeholder governance structure, and create an international research group to ensure the campaign is evidence based. As requested through the resolution, the Secretariat is working with key partners to develop a final proposal for the Decade of Healthy Ageing, to be considered by the Seventy-second World Health Assembly.

61. **Key challenges.** Comprehensive action will require strengthened capacity at the country level. The Secretariat is working with the Government of Malta to develop an online learning programme that will be accessible globally.

## **Health systems**

### **I. PROMOTING THE HEALTH OF REFUGEES AND MIGRANTS (resolution WHA70.15 (2017))**

62. In January 2017, the Executive Board at its 140th session requested several actions of the Director-General in decision EB140(9). In May 2017, the Seventieth World Health Assembly adopted resolution WHA70.15. This report describes the progress in implementing both.

63. **Working with Member States and partners to ensure that health aspects of refugees and migrants are adequately addressed in the development of the global compact on refugees and the global compact for safe, orderly and regular migration.** In response to the request in decision EB140(9), the Secretariat provided input on health aspects for all issue briefs of the six thematic sessions on facilitating safe, orderly and regular migration, held between April 2017 and November 2017, including co-leading on health aspects in the issue brief for the first thematic session.<sup>1</sup> The Secretariat led an interagency group in the development of the "Proposed health component in the global compact for safe, orderly and regular migration", which was submitted for input into the United Nations Secretary-General's report "Making migration work for all". The Secretariat organized four side events during the thematic sessions and during the high-level meetings of the 72nd session of the United Nations General Assembly in September 2017. Periodic information-sharing sessions and bilateral meetings with Member States and partners were held in Geneva and New York throughout 2017. The Secretariat worked closely with UNHCR and provided input on health for the zero draft of the global compact on refugees, as well as providing technical support to countries that host refugees.

64. **Using the framework of priorities and guiding principles to promote the health of refugees and migrants in order to increase advocacy at all levels.** In response to the request in resolution WHA70.15, the Secretariat presented the framework: at side events, jointly organized with Member States and partners, at high-level meetings on migration in Geneva and New York; during the Tenth Summit Meeting of the Global Forum on Migration and Development in Germany; and at other global, regional and country meetings and workshops throughout 2017. Support was provided to Member States and partners in adapting the framework to the regional context, resulting in regional and subregional position papers in the Region of the Americas, South-East Asia Region and Eastern

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<sup>1</sup> On human rights of all migrants, social inclusion, cohesion and all forms of discrimination, including racism, xenophobia and intolerance.

Mediterranean Region. The Secretariat also worked with Member States and partners to ensure that the issue of refugee and migrant health, and mention of resolution WHA70.15, was included in Human Rights Council resolution 35/23 (2017),<sup>1</sup> and that health was included in the Mayoral Declaration on Migrants and Refugees: Meeting Needs, Protecting Rights and Fostering Empowerment,<sup>2</sup> the first time it has been included in a Mayoral Declaration.

**65. Developing, reinforcing and maintaining the necessary capacities to provide health leadership and providing support to Member States and partners in promoting the health of refugees and migrants, in close collaboration with relevant stakeholders, and avoiding duplication.** In response to the request in resolution WHA70.15, the Secretariat has outlined four strategic directions of its work to improve the health of refugees and migrants: providing support to Member States in developing policies that promote refugees' and migrants' right to health and ensure that their health needs are met by the national health system; ensuring that the delivery of health services is culturally and linguistically appropriate; strengthening health monitoring and data collection, to allow realistic priority-setting; and enhancing collaboration between countries and sectors.

66. The topic of refugee and migrant health was included in the draft thirteenth general programme of work, 2019–2023, its first inclusion in the Organization's general programme of work. This should help to ensure that the public health aspects of refugees and migrant are addressed in a coherent manner across all levels of the Organization. In close collaboration with IOM and UNHCR, substantial progress was made in 2017 in providing health leadership and technical and operational support to Member States and partners. This included support for: public health interventions; implementation of the strategy and action plan for refugee and migrant health in the WHO European Region<sup>3</sup> and of resolution CD55.R13 (2016) on the health of migrants;<sup>4</sup> implementation of national plans on migration in the South-East Asia Region; refugees and migrants in vulnerable situations in the context of universal health coverage in countries of the Region of the Americas, South-East Asia Region and Western Pacific Region; and development of a regional position paper and action plan on promoting the health of refugees and migrants in the Eastern Mediterranean Region.

**67. Identifying best practices, experiences and lessons learned on the health of refugees and migrants in each region, in order to contribute to the development of a draft global action plan.** In response to the request in resolution WHA70.15, the Secretariat issued a global call for information, including case studies, on current policies and practices, and lessons learned in promoting refugee and migrant health. Between August 2017 and January 2018, 199 submissions were received, covering 85 countries, from 52 Member States and partners. Each region conducted a situation analysis: their reports, including best practices and a collection of practices, will be published on the WHO website. The draft global action plan will be developed and issued for consultation in the second half of 2018.

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<sup>1</sup> On the right of everyone to the enjoyment of the highest attainable standard of physical and mental health in the implementation of the 2030 Agenda for Sustainable Development.

<sup>2</sup> Endorsed at the 4th Mayoral Forum on Human Mobility, Migration and Development, held in Germany in 2017.

<sup>3</sup> See resolution EUR/RC66/R6 (2016).

<sup>4</sup> Adopted by the 55th Directing Council of PAHO at the 68th session of the Regional Committee for the Americas.

## **J. STRENGTHENING INTEGRATED, PEOPLE-CENTRED HEALTH SERVICES (resolution WHA69.24 (2016))**

68. In May 2016 the Sixty-ninth World Health Assembly, in resolution WHA69.24, adopted the framework on integrated, people-centred health services and requested the Director-General: to provide technical support and guidance to Member States for the implementation, national adaptation and operationalization of the framework; to ensure that all relevant parts of the Organization, at all three levels, are aligned, actively engaged and coordinated in promoting and implementing the framework; and to perform research and development on indicators to trace global progress on integrated people-centred health services. This report provides details of the activities undertaken by the Secretariat in response to this resolution.

69. **Capacity-building and provision of support to Member States.** The framework on integrated, people-centred health services has been adapted to national health policies and strategic plans in 12 countries. Additionally, in the African Region improvements to hospital management and the organization of health records have been made in three countries. In South Africa, for instance, implementation of people-centred care principles in one district has yielded a 19% increase in the proportion of patients receiving care in less than two hours following presentation at a health care facility. The Regional Office for the Americas has supported health reforms in five countries in the Region, as well as the integration of health services in 10 countries. National training of trainers courses for building capacities of general practitioners and hospital managers have been implemented in 10 countries in the Eastern Mediterranean Region. In the Western Pacific Region, six country offices have collaborated with Member States on a range of service delivery reforms. A further three countries of the Region have developed strategies to integrate traditional medicine into their national health system.

70. **Development of technical documents, instruments and tools.** The Secretariat, in collaboration with experts and international organizations, has developed position papers on the role of hospitals within the framework, and on high-performing primary health care (linked to the 40th anniversary of the Alma-Ata Declaration). Policy and practice briefs have been drafted to provide evidence-informed recommendations on implementing the framework in a variety of contexts. The topics of these briefs include: reaching the underserved and marginalized populations; integrating vertical programmes into health systems; health innovation; and continuity and coordination of care. Additionally, the Secretariat has prepared a document entitled *Critical pathways towards integrated people-centred health services* that will be accompanied by an assessment and planning toolkit to support subnational health authorities in health planning.

71. **Knowledge exchange.** A web-based knowledge platform, “IntegratedCare4People”, has been launched by WHO to support the exchange of knowledge on the framework across regions, countries and stakeholder groups. As at May 2018, 70 case studies and 400 resource documents have been added to the platform. In addition, three communities of practice have been established. In 2017 the platform attracted over 4000 new visitors.

72. **Building the evidence base and monitoring progress.** A total of 14 indicators for monitoring global progress on integrated, people-centred health services, as well as 19 indicators for measuring national and subnational improvement, have been identified through an expert review, using the Delphi technique. Where possible, these indicators have been drawn from global reference lists, including the WHO global reference list of 100 core health indicators (plus health-related Sustainable Development Goals). Additional indicators that require further research and development have also been identified.



73. **Partnership development.** The Secretariat continues to work closely with all existing partners, including WHO collaborating centres (on integrated health services and primary health care), international organizations such as the International Foundation for Integrated Care, development agencies and academic institutions, while also seeking opportunities to engage with new actors. The launch of the WHO Global Service Delivery Network has been crucial in raising the profile of the framework to ensure that it remains visible, and a high priority on the international health agenda.

74. **Mainstreaming.** The capability of staff members of the Organization to bring the framework into the mainstream of their work has also been strengthened through technical meetings, and through the provision of advice and support to those working in other technical programme areas, including ageing and life course, and gender, equity and human rights.

### **The way forward**

75. Despite significant progress made by the Secretariat in response to resolution WHA69.24, a considerable amount of work remains to be done. The 40th anniversary of the Alma-Ata Declaration this year will be an important milestone to reaffirm the role of integrated, people-centred health services and primary health care as the foundation of WHO's efforts to achieve universal health coverage. The Secretariat will continue to provide technical support and guidance to Member States in their efforts to adapt the framework to their national strategies and plans, and will provide support to them in monitoring and evaluating health service delivery reforms.

## **K. PROMOTING INNOVATION AND ACCESS TO QUALITY, SAFE, EFFICACIOUS AND AFFORDABLE MEDICINES FOR CHILDREN (resolution WHA69.20 (2016))**

76. In response to resolution WHA69.20 (2016), Member States, in collaboration with the Secretariat and partners, are working to promote innovation and access to quality, safe, efficacious and affordable medicines for children through the following: formulation and implementation of policies and plans that aim to improve children's health and improve access to children's medicines; establishment of processes for the evidence-based selection of children's medicines for the national essential medicines list and for reimbursement and procurement decisions; collection and analysis of data on pricing and use of children's medicines; and strengthening of the national regulatory system to promote quality, ethical clinical trials of medicines for children.

77. The following key activities have been undertaken by the Secretariat in line with the resolution.

78. The Secretariat, in collaboration with partners, convened the third meeting on Paediatric Antiretroviral Drug Optimization in December 2016, to take stock of progress made and to further the discussion on optimal treatment.<sup>1</sup> The meeting facilitated coordination across the continuum of antiretroviral drug development. Lessons learned in prioritization of antiretroviral drug development that could apply to medicines for other diseases, such as viral hepatitis and tuberculosis, were discussed with the goal of identifying synergies and promoting alignment in drug and formulation development of anti-infective agents for children.

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<sup>1</sup> See Paediatric Antiretroviral Drug Optimization (PADO) Meeting 3. Geneva: World Health Organization (<http://www.who.int/hiv/pub/meetingreports/paediatric-arv-optimization-pado3/en/>, accessed 13 February 2018).

79. Work is under way to re-establish the Paediatric medicines Regulators Network and a meeting will be held in June 2018 with regulators and other stakeholders to define the terms of reference for the network. It is envisaged that the network will provide a forum for discussion, facilitate collaboration and build capacity on regulatory issues concerning paediatric medicines. An online platform has been established by the Secretariat for sharing regulatory guidelines, standard treatment guidelines and other important information relevant to paediatric medicines.

80. Since 2016, 14 child-friendly products for the treatment of HIV infection, tuberculosis, malaria and diarrhoeal diseases have been prequalified by WHO, providing vital information on quality assurance of these products for agencies and organizations involved in bulk purchasing of medicines.

81. In 2017, six paediatric specialists were included in the WHO Expert Committee on the Selection and Use of Essential Medicines. The Expert Committee analysed systematic reviews on diarrhoeal diseases, cholera, community-acquired pneumonia, sepsis and severe malnutrition, as a common approach to gathering evidence for updates to the 6th WHO Model List of Essential Medicines for Children and WHO standard treatment guidelines for paediatric indications of these conditions. Reviews of optimal dosing for paediatric antibiotic treatments are under way, for discussion at the next meeting of the Expert Committee in 2019.

82. Technical assistance has been provided to six countries<sup>1</sup> through the Maternal, Newborn and Child Health Muskoka Initiative for improving access to safe, effective and quality medicines. Support was provided for strengthening procurement and supply chain management, developing policies for generic medicines, monitoring access, revision of national essential medicines lists and standard treatment guidelines, assessment of the pharmaceutical workforce and strengthening communities of practice.

83. Technical support was provided to China through the China–WHO Biennial Collaborative Project 2016–2017 on Drug Safety and Accessibility in Children. The project covers the development of strategies for promoting: the development of a national essential medicines list for children; the regulation of off-label use of medicines for children; the production of priority essential medicines for children; and improved pricing and supply mechanisms.

84. The project Speeding Treatments to End Paediatric Tuberculosis, implemented by the Global Alliance for TB Drug Development and the Secretariat, facilitated early availability of new paediatric formulations at an affordable price, through the Stop TB Partnership Global Drug Facility. Extensive planning and engagement with target countries facilitated rapid uptake of these new fixed-dose combinations.

## **L. SUSTAINABLE HEALTH FINANCING STRUCTURES AND UNIVERSAL COVERAGE (resolution WHA64.9 (2011))**

85. A growing number of countries have made more explicit political commitment to universal health coverage in their national policies. Since the 2015 update,<sup>2</sup> WHO has supported over 100 countries from all regions with technical assistance, policy dialogue and capacity building related to health financing. This has included facilitation of cross-country exchange of experience, synthesis

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<sup>1</sup> Benin, Côte d'Ivoire, Guinea, Mali, Niger and Senegal.

<sup>2</sup> See document A68/36, section L.

of key lessons learned, health financing training programmes, diagnostic analysis of the main technical challenges and priorities for country reforms, and high-level dialogue to address key political factors in implementation.

86. The evidence shows that problems emerge when both out-of-pocket payments and voluntary health insurance account for a large share of total health spending; conversely, greater public spending on health enhances financial protection. In support of universal health coverage, countries at all levels of income have taken steps to sustain public funding. One approach is to increase the priority given to health in public resource allocation, as in the Islamic Republic of Iran. Another has been to change the flow and purpose of general budget revenues, for example in India, where national and many state budgets fund health insurance coverage for the poor. Many countries have also diversified sources of public funding, for example, by combining general tax revenues with the direct contribution of the insured population in countries that make use of social health insurance. This has proved to be a useful strategy in both lower- and higher income countries. In Estonia, the Government recently decided to increase tax transfers to the Estonian Health Insurance Fund and thereby diversify its funding base beyond almost sole reliance on employer–employee contributions.

87. Further support for universal health coverage has come through the recognition that reducing fragmentation in the pooling of prepaid funds creates the best opportunity for directing resources towards the greatest need. Merging general revenues with social insurance contributions in a common pool is an approach that many countries use. This also enhances efficiency by consolidating the management of these funds. The consequences of fragmentation can also be mitigated by unifying benefit entitlements and provider payment methods. Implementation is made possible through a unified national information platform serving multiple schemes or regions.

88. Progress cannot be made towards universal health coverage unless funds are used well. The main health financing instrument to ensure appropriate use is “strategic purchasing” of health services, which involves linking the payments of providers to data on their performance and the health needs of the population they serve. As recognition of the power of this instrument has grown since the Secretariat’s previous report, so too have efforts to strengthen and analyse such mechanisms. Experience suggests that more strategic purchasing in health systems calls for a focus on three broad areas: (1) mechanisms for selecting and modifying the services to be purchased, including health technology and budget impact assessments; (2) provider payment methods to incentivize efficiency and equity gains, and support effective delivery of promised services; and (3) strengthened capacities, management systems, and governance of the agency or unit responsible for implementing strategic purchasing, including the analysis of data generated by the payment system and its application in future policy and payment decisions.

89. The momentum given to universal health coverage by the 2030 Agenda for Sustainable Development has reinforced the need for high-quality progress monitoring. A universal health coverage monitoring report was issued in late 2017.<sup>1</sup>

90. The system for classifying health expenditures has been revised in collaboration with OECD and Eurostat. As a result, more disaggregated and policy-relevant health expenditure tracking can be performed using the online WHO Global Health Expenditure Database. This allows for continued

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<sup>1</sup> Tracking universal health coverage: 2017 global monitoring report. World Health Organization and International Bank for Reconstruction and Development/The World Bank: 2017 ([www.who.int/healthinfo/universal\\_health\\_coverage/report/2017/en/](http://www.who.int/healthinfo/universal_health_coverage/report/2017/en/), accessed 6 February 2018).

monitoring of high-priority concerns and also provides new insights that are critical to sustainable financing, such as the extent to which domestic health spending is funded from external aid.

91. Many challenges remain, and, in future, it will be essential to build on what has worked while increasing the focus on issues that merit more attention.

92. Experience has shown that for reforms to go beyond small pilot initiatives, close engagement with national finance and budgetary authorities is essential.

93. For sustainable progress towards universal health coverage to be maintained, a truly comprehensive approach is needed. Effective design and implementation requires coherence with other changes, such as those in service delivery and governance. All too often, insufficient attention is paid to population-based services and public health programmes.

94. There is a continuing need to improve data quality and analysis. Countries should seize the opportunity to make more effective use of strategic purchasing databases in order to create a virtuous cycle of data quality, use and analysis.

95. Renewed political commitment remains essential if countries around the world are to make equitable progress towards universal health coverage.

#### **M. AVAILABILITY, SAFETY AND QUALITY OF BLOOD PRODUCTS (resolution WHA63.12 (2010))**

96. **Strengthening national blood supply systems.** The WHO Secretariat has provided country support for national blood policies and supply systems in 12 countries<sup>1</sup> and has supported the strengthening of national blood transfusion services in countries affected by Ebola virus disease. During the recent outbreak of Zika virus disease, WHO provided emergency guidance.

97. In the Eastern Mediterranean Region, the regional strategic framework for blood safety and availability (2016–2025) was endorsed by the Sixty-third session of the Regional Committee for the Eastern Mediterranean.<sup>2</sup> Assessments and a regional consultation have been conducted to strengthen emergency preparedness and response capacity in 11 countries and territories in respect of blood transfusion.<sup>3</sup> The Regional Office for South-East Asia organized a regional workshop for national blood programme managers to review the existing capacities of blood transfusion services in order to identify challenges and develop action plans.

98. World Blood Donor Day is celebrated in a growing number of countries and to provide a focus for campaigns on voluntary non-remunerated blood donation. The Secretariat has supported many Member States in conducting national World Blood Donor Day campaigns, and in developing or improving blood donor management.

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<sup>1</sup> Bangladesh, Bhutan, Cambodia, Congo, Côte d'Ivoire, Ethiopia, Gabon, Maldives, Myanmar, Nepal, Pakistan and South Sudan.

<sup>2</sup> See resolution EM/RC63/R.5.

<sup>3</sup> Afghanistan, Iran (Islamic Republic of), Jordan, Lebanon, Libya, Pakistan, Somalia, Sudan, Syrian Arab Republic, Yemen and in the occupied Palestinian territory.

99. **Quality systems and haemovigilance.** In 2016, WHO published guidance on establishing national haemovigilance systems and on implementing external quality assessment programmes for screening donated blood for transfusion-transmissible infections. In December 2016, the WHO Regional Office for the Eastern Mediterranean organized a regional consultation on haemovigilance with the aim of launching the WHO guidance documents in the Region. The Secretariat has supported Algeria, Bhutan and Pakistan in developing and implementing haemovigilance systems. Information on blood safety and availability was collected, analysed and disseminated through WHO's global database on blood safety. A report was published based on the data reported to the Secretariat by Member States.

100. **National blood regulatory systems.** The Organization has provided support for the assessment of regulatory systems in three countries, and for building the capacity of authorities and transfusion services in 18 countries in the African Region.<sup>1</sup> WHO has reviewed existing blood legislations in the countries in WHO Region for the Eastern Mediterranean and developed a template legislation that can be adapted by countries to foster adherence to good manufacturing principles and harmonization across countries in the Region.

101. **Expert Committee on Biological Standardization.** The Committee established the guidelines on management of blood and blood components as essential medicines and on the estimation of residual risk in blood components for transmissible viruses, and international reference preparations for blood products and in vitro diagnostics, including those needed for detection of pathogens in disease outbreaks. The WHO guidelines for the production, control and regulation of snake antivenom immunoglobulins were revised.

102. **Safe and rational use of blood and blood products.** The Secretariat has provided technical support to countries in developing systems and capacities for the appropriate use of blood. WHO has begun updating the WHO handbook on the clinical use of blood in collaboration with the International Society of Blood Transfusion.

103. **Challenges and next steps.** Progress has been made, but major challenges remain for many low- and middle-income countries in providing a sufficient and safe supply of blood and blood products. In future, the Secretariat will continue to support countries to build effective and sustainable blood supply systems and achieve the vision of universal access to safe blood and blood products for all countries.

## **N. HUMAN ORGAN AND TISSUE TRANSPLANTATION (resolution WHA63.22 (2010))**

104. In resolution WHA63.22 (2010), the World Health Assembly endorsed the WHO Guiding Principles on Human Cell, Tissue and Organ Transplantation, which have since influenced the creation and modification of laws, legislation and regulations in some 60 countries, and have served as a model for improving or building donation and transplantation programmes globally. The Guiding Principles are helping Member States to combat commercial transplantation more effectively and simplify donation after brain- and cardio-circulatory death, as well increasing protection for living donors.

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<sup>1</sup> Benin, Burkina Faso, Burundi, Cameroon, Congo, Côte d'Ivoire, Democratic Republic of the Congo, Ethiopia, Ghana, Guinea, Kenya, Mauritius, United Republic of Tanzania, Togo, Senegal, South Africa, Zambia and Zimbabwe.

105. During the 136th session of the Executive Board in January 2015, the Secretariat was requested to convene consultations with Member States and international partners to develop global consensus on guiding ethical principles for the donation and management of all medical products of human origin beyond the scope of human cell, tissue and organ transplantation. Several other types of these products have human clinical applications and significant commonalities inherent to their human origin. The safety issues for donors and recipients are therefore very similar, including the need to ensure quality, traceability, vigilance, surveillance and equitable access to these products in the context of universal health coverage.

106. The Secretariat has responded to the growing interest in all issues related to medical products of human origin, developing a special initiative in the Health Systems and Innovation Cluster to foster consistency of ethical practices in order to strengthen the overall safety, quality and availability of such products.

107. Since different types of medical products of human origin can require different operational systems and regulatory oversight adapted to their specificities, 10 new guiding principles, aligned with resolution WHA63.22, were proposed at the Seventieth World Health Assembly. The Secretariat is working on the creation of a task force that will assist Member States in developing their donation programmes in line with those guiding principles. The task force's main objectives are to analyse barriers to implementation of the Guiding Principles at the global and national levels, identify high-risk areas and guide intervention, provide evidence-based support and capacity-building at the regional and country levels, at WHO's request, and establish a global governance mechanism for efficient coordination of efforts to combat organ trafficking and transplant tourism, including to improve transplantation registries.

108. Data on activities and practices are collected by the Global Observatory on Donation and Transplantation,<sup>1</sup> a collaborative project between WHO and the Spanish National Transplant Organization. The practice of organ transplantation is increasing worldwide, and is currently carried out in over 110 countries, a global increase of more than 12% over the past four years, with a significant increase around 50% in Latin American countries. Despite this growth, these figures still fall far short of meeting actual needs.

109. The Notify Library,<sup>2</sup> developed jointly by WHO and the Italian National Transplant Centre, has updated the Notify Booklet, which targets clinicians and health authorities, to provide a better didactic overview of vigilance and surveillance related to medical products of human origin.

110. In April 2017, the Argentinian National Coordination Centre for Donation and Transplantation was designated as a WHO collaborating centre. The Centre will assist the Pan American Health Organization in reinforcing policies, enhancing training, and developing donation and transplantation programmes in the Region of the Americas.

111. The Secretariat has also increased collaboration with other United Nations entities on implementing United Nations General Assembly resolution 71/322 (2017), to prevent and combat trafficking in persons for the purpose of organ removal and trafficking in human organs, which is in line with WHO Guiding Principles 5, 6 and 7.

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<sup>1</sup> <http://www.transplant-observatory.org/> (accessed 12 February 2018).

<sup>2</sup> <http://www.notifylibrary.org/> (accessed 14 February 2018).

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**O. WHO STRATEGY ON RESEARCH FOR HEALTH (resolution WHA63.21 (2010))**

112. In January 2016, a demonstration version of the Global Observatory on Health R&D was published online. User feedback was taken into consideration and the Observatory was launched on 19 January 2017.<sup>1</sup> Its data sources, which cover a range of data and analysis relevant to health research and development, include: funding flows for product-related health research and development for neglected diseases; health products that are under development; research publications; clinical trials; health researchers capacity; and other relevant global indicators for comparisons, such as gross domestic expenditure on health research and development, and official development assistance by donor and recipient country for medical research and basic health sectors. The Observatory has continued to grow since its launch, totalling 19 data sources by the end of 2017.

113. Responding to resolution WHA67.25 (2014) on tracking research and development resources for antimicrobial resistance, and the Secretariat report on options for strengthening information-sharing on diagnostic, preventive and therapeutic products, submitted to the Executive Board at its 138th session in document EB138/28, the secretariat of the Global Observatory on Health R&D is working closely with the WHO secretariats for antimicrobial resistance and for the research and development blueprint for action to prevent epidemics to track and analyse research and development relevant to antimicrobial resistance and epidemics through data in the Observatory.

114. In relation to the “Organization Goal” of the WHO strategy on research for health, WHO’s Guidelines Review Committee and its secretariat provide WHO with stringent quality assurance processes for its guidelines, as well as its support and quality improvement activities, and for the development of new methods and approaches. During the biennium 2016–2017, the Committee approved 49 sets of technical normative guidelines for Member States. In addition, the secretariat provided over 500 consultations and organized 26 seminars and workshops for Secretariat staff at headquarters and in the regional offices in order to facilitate the development of trustworthy and impactful guidelines.

115. The Secretariat has expanded its collaboration and partnerships with various key stakeholders in health research and development to ensure effective communication of WHO’s positions and priorities, and a more harmonized approach to data sharing. Examples of partnerships and collaboration include: the G7 Health R&D working group and G20 discussions; Heads of International Research Organizations through its membership of the Steering Group of the World RePORT platform, which collates, on an annual basis, data on health research grants from key funders; and the Coalition for Epidemic Preparedness and Innovations, which funds new vaccine research and development targeting emerging infectious diseases prioritized by the WHO research and development blueprint.

116. On 18 May 2017, in response to the Secretariat’s concerted efforts to increase public disclosure of the results of clinical trials, some of the world’s largest funders of medical research and international non-State actors agreed new standards, according to which all clinical trials that they fund or support must be registered and the results disclosed publicly.<sup>2</sup> Currently, 30–50% of clinical trials go unreported, sometimes because the results are negative or inconclusive. These unreported results leave an incomplete and potentially misleading picture of the risks and benefits of vaccines,

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<sup>1</sup> See Global Observatory on Health R&D (<http://www.who.int/research-observatory/en/>, accessed 9 March 2018).

<sup>2</sup> See International Clinical Trials Registry Platform (ICTRP) (<http://www.who.int/ictrp/results/jointstatement/en/>, accessed 9 March 2018).

drugs and medical devices, and can lead to the use of suboptimal or even harmful products. By the end of 2017, 21 key funders had signed a joint statement affirming their commitment to the new standards.

117. Secretariat activities in the field of global health ethics have contributed to three goals of the strategy.

- **Organization goal.** The relevant Secretariat staff supported: (i) the development of both the code of conduct for responsible research, and policy on misconduct in research; (ii) improved staff competencies in research ethics by developing e-training courses on ethics for conducting research during disaster; (iii) strengthened ethical standards through ongoing work of the WHO Ethics Review Committee.
- **Capacity goal.** Training tools and guidance were developed in relation to ethics of operational research.
- **Standards goal.** Three major sets of WHO guidelines were developed: *WHO guidelines on ethical issues in public health surveillance*; *Guidance for managing ethical issues in infectious disease outbreaks*; and *Ethics in epidemics, emergencies and disasters: research, surveillance and patient Care: training manual*.<sup>1</sup>

118. Regional offices have continued to be active in implementing the WHO strategy on research for health, and advisory committees on health research have remained active in five of the six regional offices. The Evidence Informed Policy Network is active at the country and regional levels in the African, European and Eastern Mediterranean regions, and in the Region of the Americas.

## **P. WORKERS' HEALTH: GLOBAL PLAN OF ACTION (resolution WHA60.26 (2007))**

119. In 2013, the Sixty-sixth World Health Assembly noted the progress made during the period 2008–2012 on the implementation of the global plan of action on workers' health 2008–2017.<sup>2</sup>

120. This report describes the progress made by the Secretariat on the five objectives of the global plan of action on workers' health 2008–2017 since 2013.

### **Objective 1: to devise and implement policy instruments on workers' health**

121. Technical support was provided to 13 countries in developing national profiles and action plans for workers' health and for strengthening relevant capacities of health ministries.

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<sup>1</sup> WHO guidelines on ethical issues in public health surveillance. Geneva: World Health Organization; 2017; Guidance for managing ethical issues in infectious disease outbreaks. Geneva: World Health Organization; 2016 and Ethics in epidemics, emergencies and disasters: research, surveillance and patient care: training manual. Geneva: World Health Organization; 2015.

<sup>2</sup> See documents A66/27, section J, and WHA66/2013/REC/3, summary records of Committee B, seventh meeting, section I.



122. A global framework for national programmes for occupational health and safety of health workers was elaborated jointly with ILO, and support was provided to 12 countries for developing such programmes. This work also contributes to the ILO, OECD and WHO action plan for health employment and inclusive economic growth (2017–2021).

### **Objective 2: to protect and promote health at the workplace**

123. The Secretariat developed guidelines for protecting workers from potential risks of manufactured nanomaterials and compiled minimum requirements for workplace health protection. Practical tools and capacity-building materials for work improvement in health care facilities were published jointly with ILO, and implementation support was provided to eight countries.

124. Recommendations were issued on working with the private sector to stimulate healthy behaviours among workers and for the prevention and control of noncommunicable diseases at the workplace. An information sheet on mental health in the workplace was published on the 2017 World Mental Health Day. Occupational risks for tuberculosis, particularly among miners and health care workers, were tackled in the WHO Global Ministerial Conference Ending TB in the Sustainable Development Era: A Multisectoral Response (Moscow, 16–17 November 2017).

125. Recommendations on the protection of occupational safety and health were issued and updated jointly with ILO in 2014 during the outbreak of Ebola virus disease in West Africa, and interim guidance was developed on occupational safety and health in emergency vector control of *Aedes* mosquitoes. A WHO/ILO manual on occupational safety and health in outbreaks and public health emergencies was published, covering different types of risks and emergencies. The Secretariat organized training for national focal points for occupational health and emergency preparedness from 17 African countries (held in Johannesburg, South Africa, in 2016) and capacity-building for work improvement in health care facilities in eight countries (in 2016 and 2017).

### **Objective 3: to improve the performance of and access to occupational health services**

126. Regional consultations and conferences on scaling up workers' health coverage with essential interventions and basic occupational health services were held in Semnan, Islamic Republic of Iran (2014), Bangkok, Thailand (2016) and Saint Petersburg, Russian Federation (2017) to develop indicators and road maps, disseminate good practices and promote intercountry collaboration.

127. A set of essential interventions for workers' health was included in the United Nations OneHealth costing tool to allow countries to plan and cost their delivery at the primary care level and to develop scenarios for scale-up. A toolkit for building capacities of primary care providers to deliver these essential interventions is being elaborated.

128. Migrant workers' access to occupational health services was further promoted under the framework of priorities and guiding principles to promote the health of refugees and migrants.

129. The Secretariat also assessed the effectiveness of different schemes for financial health coverage of workers in the informal economy.

#### **Objective 4: to provide and communicate evidence for action and practice**

130. The Secretariat worked with ILO to develop diagnostic and exposure criteria for occupational diseases. WHO and ILO also started developing a joint methodology for estimating work-related burden of disease.

131. A global workers' health database of existing international indicators measuring workers' health status and its determinants was compiled with data by country, and a visualization tool is being developed to allow countries to monitor workers' health and develop national profiles.

#### **Objective 5: to incorporate workers' health into other policies**

132. The Secretariat published an overview of occupational health aspects related to green technologies and climate change. It contributed to the implementation of the United Nations toolkit for mainstreaming employment and decent work and to the Minamata Convention on Mercury.

#### **Implementation**

133. Specific initiatives to implement the global plan of action at the regional level included: Plan of Action on Workers' Health 2015–2025 in the Region of the Americas, Regional Framework for Action on Occupational Health 2011–2015 in the Western Pacific Region, and the South East European Network on Workers' Health. Priority actions on workers' health were also included in the Regional Strategy for the Management of Environmental Determinants of Human Health in the African Region 2017–2021, the Arab Strategy on Health and Environment 2017–2030, and the outcomes of the fifth and sixth ministerial conferences of the European Environment and Health Process (held in Parma, Italy, 10–12 March 2010 and Ostrava, Czechia, 13–15 June 2017, respectively).

134. The global network of 45 WHO collaborating centres for occupational health supported the Secretariat in the prevention of occupational noncommunicable diseases, safety of health care workers, capacity-building for early detection of occupational diseases, assessing workers' health metrics, and workers' health in the informal economy.

135. The Secretariat organized events to promote workers' health at three global congresses organized by ILO and the International Commission on Occupational Health.

136. Continuous financial support for the Secretariat's normative work on the implementation of the global plan of action on workers' health was received from the governments of the United States of America and the United Kingdom of Great Britain and Northern Ireland.

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## Health emergencies programme

### **Q. SMALLPOX ERADICATION: DESTRUCTION OF VARIOLA VIRUS STOCKS (resolution WHA60.1 (2007))**

137. At the Sixty-ninth World Health Assembly in May 2016, Member States discussed the issue of the timing of the destruction of existing variola virus stocks. Given the advent of synthetic biology technologies, which makes it possible to create variola virus using publicly available information and common laboratory procedures, the Health Assembly urged the WHO Advisory Committee on Variola Virus Research to review the current research needs using live variola virus. It agreed to include on the provisional agenda of the Seventy-second World Health Assembly in 2019 a substantive item on the destruction of variola virus stocks in order to allow time for any additional research, with annual progress reports submitted to the Health Assembly in the interim on the status of the research.<sup>1</sup>

138. This progress report provides an overview of the work undertaken by the Secretariat since the Seventieth World Health Assembly in May 2017. It summarizes the proceedings and conclusions of the nineteenth meeting of the WHO Advisory Committee on Variola Virus Research (Geneva, 1 and 2 November 2017) and provides an update on the status of the biennial biosafety inspections of the two authorized repositories of variola virus stocks (the WHO Collaborating Centre for Orthopoxvirus Diagnosis and Repository for Variola Virus Strains and DNA, State Research Centre for Virology and Biotechnology (VECTOR), Koltsovo, Novosibirsk Region, Russian Federation, and the WHO Collaborating Centre for Smallpox and Other Poxvirus Infections, Centers for Disease Control and Prevention (CDC), Atlanta, Georgia, United States of America).

139. At its nineteenth meeting, the Advisory Committee received reports from the Secretariat on its work during the previous year and from the two collaborating centres on the virus collections in the repositories. The Advisory Committee reviewed the work of each collaborating centre on the authorized programme of research with live variola virus. In 2017, six ongoing research proposals were received by WHO and evaluated by the Advisory Committee's Scientific Subcommittee; five (all from CDC) were deemed to be "essential research for public health benefit that requires use of live variola virus" and therefore were recommended by the Scientific Subcommittee for approval by WHO. The Advisory Committee also received updates on the regulatory and licensure status of diagnostic tests, antivirals and smallpox vaccines.

140. The Advisory Committee carefully considered the progress made in ongoing research and future research needs requiring live variola virus. It noted the advances in the area of diagnostics (a licensed real-time polymerase chain reaction (PCR) assay and a protein-based one in development) and the forthcoming submissions of licensure applications to the United States Food and Drug Administration for: one antiviral (imminent) and for another (in the pipeline), as well as for a third-generation vaccine (later in 2018). The Advisory Committee was informed of and acknowledged the benefits of variola virus research, especially for the control of other orthopoxviruses, particularly monkeypox, which is currently endemic in Central and West Africa. Overall, the Advisory Committee emphasized the need for preparedness at the country and global levels, in particular the availability and accessibility of diagnostics and other related tools.

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<sup>1</sup> See document WHA69/2016/REC/3, summary records of Committee A, sixth meeting.

141. The current round of the WHO's biennial biosafety inspections of the repository sites was completed at VECTOR (10–15 October 2016) and at CDC (8–12 May 2017), with the same international team of biosafety experts for both inspections, led by WHO. The protocol used for the inspections follows the European Committee for Standardization's Laboratory Biorisk Management Standard CWA 15793, which covers 16 elements of laboratory biorisk management. Reports of both inspections are in the final stages of approval and will be made available on the WHO website. The next round of inspections is being planned and will take place in 2018 and 2019.

### **Corporate services/enabling functions**

#### **R. MULTILINGUALISM: IMPLEMENTATION OF ACTION PLAN (resolution WHA61.12 (2008))**

142. The multilingualism: plan of action was adopted by the Sixty-first World Health Assembly in May 2008.<sup>1</sup> The present report summarizes progress in implementing the action plan requested in resolution WHA61.12.

143. Efforts to increase multilingual content on the WHO website have continued. The multilingual team of web editors, working with the Secretariat's translation service, has reduced the gap in availability of technical content between English and the other five official languages of the Organization. The team has also made all corporate web content available in the six official languages. During the biennium 2016–2017, 1371 webpages were added in Arabic, 1918 in Chinese, 9739 in English, 2181 in French, 1747 in Russian and 1828 in Spanish. Some 150 million readers visited WHO multilingual website during that period.

144. As at February 2018, WHO's Institutional Repository for Information Sharing (IRIS) included more than 205 000 records in the official languages, comprising WHO information products and governing bodies documentation (including Health Assembly and Executive Board documentation from 1948 onwards). The Repository is currently tracking an average of 2.9 million downloads per month.

145. In 2017, the Russian Federation provided funds to support a second project for increasing the quality and quantity of WHO's technical and scientific information products available in the Russian language, and for improving their dissemination to Russian-speaking audiences: 19 publications will be translated and published in Russian at headquarters and in the Regional Office for Europe, and 20 existing print publications in Russian will be digitized and stored in IRIS. Two special issues of the *Bulletin of the World Health Organization* in Russian and four issues of the journal *Public Health Panorama* will be published. A *data and evidence* section in Russian will be created on the website of the Regional Office for Europe. A Russian language glossary of public health terminology will also be created. Citation analyses of WHO materials in Russian will be produced.

146. Work to ensure that WHO's information products are available in official and non-official languages has continued. During the biennium 2016–2017, WHO Press authorized external partners and regional offices to undertake 410 translations of 273 headquarters' products into 58 languages (five official and 53 non-official).

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<sup>1</sup> Document WHA61/2008/REC/1.

147. WHO continues to offer a distance-learning language programme for the official languages of the Organization, as well as for German and Portuguese.

148. During the biennium 2016–2017, WHO continued to publish the following serials with multilingual content: *Bulletin of the World Health Organization* (English full text; abstracts in Arabic, Chinese, French, Russian and Spanish); *Eastern Mediterranean Health Journal* (Arabic, English or French full text; abstracts in Arabic, English and French); *African Health Monitor* (English, French or Portuguese full text; abstracts in English, French and Portuguese); *Public Health Panorama* (English and Russian); *Weekly Epidemiological Record* (English and French); *Pan American Journal of Public Health* (English, Portuguese and Spanish); *Western Pacific Surveillance and Response* (Chinese and English); *WHO Drug Information* (English, with International Nonproprietary Names in English, French, Latin and Spanish).

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