

PROVISIONAL SUMMARY RECORD OF THE SIXTH MEETING

**Palais des Nations, Geneva
Saturday, 25 May 2019, scheduled at 09:00**

**Chairman: Dr K. CAMPBELL (Guyana)
later: Mr A. AMEEN (Maldives)**

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COMMITTEE B

SIXTH MEETING

Saturday, 25 May 2019, at 09:10

Chairman: Dr K. CAMPBELL (Guyana)

later: Mr A. AMEEN (Maldives)

1. THIRD REPORT OF COMMITTEE B (document A72/75)

The RAPPORTEUR read out the draft third report of Committee B.

The report was adopted.¹

2. OTHER TECHNICAL MATTERS: Item 12 of the agenda (continued) [transferred from Committee A]

Eleventh revision of the International Classification of Diseases: Item 12.7 of the agenda (documents A72/29 and A72/29 Add.1)

The CHAIRMAN drew attention to document A72/29 and invited the Committee to consider the draft resolution contained in document A72/29 Add.1.

The representative of ROMANIA, speaking on behalf of the European Union and its Member States, said that the candidate countries Turkey, Montenegro, Serbia and Albania, the country of the stabilization and association process and potential candidate Bosnia and Herzegovina, as well as Georgia, aligned themselves with her statement. She welcomed the extensive work undertaken by the Secretariat to revise the International Statistical Classification of Diseases and Related Health Problems (International Classification of Diseases) and adapt it to the current digital environment. A well-balanced strategy for implementation was required, particularly given the increasing complexities and interdependencies with respect to care and the multiple challenges facing governments. She called for the development and sharing of guidelines and best practices to facilitate implementation, including through improved data standardization and promotion of interoperability. The Secretariat should maintain a comprehensive and accessible support platform and assist Member States in the transition process. The transition period should run for at least five years, during which the Secretariat should help Member States report statistics under the tenth and eleventh revisions. Linkages with existing statistical systems and nomenclatures must be retained as the eleventh revision continued to be developed, to enhance interoperability, particularly for morbidity statistics.

The representative of MALAYSIA welcomed the eleventh revision of the International Classification of Diseases, in particular the coding tool and the expansion of clinical content. Although there would be implementation challenges, including management of legacy data and the need to modify

¹ See page [...].

existing infrastructure to accommodate the necessary changes, she hoped that the support provided would be sufficient to enable countries to develop and enact transition plans.

The representative of ESWATINI, speaking on behalf of the Member States of the African Region, welcomed the eleventh revision, especially the supplementary chapter on traditional medicine conditions and the improved recording for maternal health which, together with the other updates, would make it easier to monitor progress towards the Sustainable Development Goals. He supported the formation of a dedicated classifications and statistics advisory committee to advise on implementation. Some Member States had faced challenges during implementation of the tenth revision, particularly regarding data quality, and the Secretariat should therefore provide support to Member States by way of a dedicated capacity-building programme, not simply on request. The eleventh revision should support delivery of primary health care through the development of appropriate tools. He endorsed the draft resolution.

The representative of MEXICO said that the inclusion of new chapters in the eleventh revision would help to improve mortality and morbidity data and monitoring of progress towards the Sustainable Development Goals. Her country had been involved in efforts to improve coding, particularly for maternal mortality, and in the translation of the Spanish-language version. It would continue to support optimum implementation and work with WHO to provide training and guidance to other countries in Latin America on the use of the new classification. She expressed support for the draft resolution and agreed that the eleventh revision should come into effect on 1 January 2022.

The representative of the UNITED STATES OF AMERICA encouraged the Secretariat to continue to provide stakeholders with information on processes for routinely updating the eleventh revision. WHO should develop careful messaging strategies regarding traditional medicine in order to avoid confusion in the absence of clinical evidence supporting recognition of traditional medicine diagnoses and disorders. Further research was required to determine whether gaming disorder was a distinct condition or symptomatic of other classified disorders.

The representative of CHINA said that all countries should tailor the eleventh revision to their own context and noted that the Chinese-language version of the International Classification of Diseases had recently been completed. As the supplementary chapter on traditional medicine conditions failed to meet needs identified in clinical settings in individual countries, China was currently developing code categories for traditional Chinese medicine compatible with the eleventh revision. It called on WHO to promote international exchanges in that connection and to put forward detailed and feasible training schemes to facilitate proper implementation.

The representative of the REPUBLIC OF KOREA said that, while he hoped that the inclusion of gaming disorder would foster a healthy gaming culture, a cautious approach should be taken in defining the criteria for gaming disorders requiring medical interventions. The addition of the supplementary chapter on traditional medicine conditions would facilitate the collection of statistics, which could be used as baseline data to standardize and universalize traditional medicine. In his view, WHO had provided sufficient resources for the eleventh revision and allowed sufficient transition time for implementation.

The representative of the RUSSIAN FEDERATION said that the eleventh revision should come into effect at the beginning of 2022, with the agreed categories and subcategories, and the tabulation lists for morbidity and mortality. Her country, which stood ready to assist in the translation of the Russian-language version, was planning to provide training for medical workers and statisticians during the transition period and incorporate the electronic version into Russian computer systems. Deadlines

for the transition could be met only if sufficient resources were mobilized at the national and international levels. She expressed support for the draft resolution.

The representative of JAPAN said that the new coding would facilitate greater accuracy in reporting and hoped that the improved data quality would have a positive impact on health. The inclusion of gaming disorder was expected to enhance the development of related scientific evidence. The inclusion of a supplementary chapter on traditional medicine conditions would facilitate improved research and clinical practice based on standardized terms and definitions. She urged the Secretariat to provide technical support to Member States for translation and implementation.

The representative of DENMARK welcomed the inclusive process used to revise the International Classification of Diseases to meet requirements associated with the increased use of technology. She commended the inclusion in the eleventh revision of the new chapter on conditions relating to sexual health. The tenth revision had served as an invaluable tool for the collection of global health data for the benefit of all and Denmark had high hopes for the implementation of the eleventh revision.

The representative of AUSTRALIA commended the Secretariat's extensive efforts to develop the eleventh revision and the collaborative approach taken to that end. She welcomed the support provided for the transition and the arrangements enabling Member States to report through earlier versions, and expressed full support for the draft resolution.

The representative of THAILAND asked how data security would be ensured and operational disruption prevented, and whether WHO would establish a single global central server or if a country could establish its own server. She also asked whether a country could decide to design its own system to implement the eleventh revision, how the Secretariat would assist countries with implementation in the transition period, and whether a country would incur any additional costs for using the eleventh revision, in particular with regard to the Systematized Nomenclature of Medicine.

The representative of the NETHERLANDS emphasized that the addition of a supplementary chapter on traditional medicine conditions in no way constituted an acknowledgement of medical interventions for which there was no scientific proof or for interventions using products obtained illegally from endangered plants or animals.

The representative of TOGO welcomed the work around information modelling, mortality, morbidity, quality, safety and traditional medicine conditions undertaken as part of the revision process. Under the tenth revision, several diseases had been grouped for Togo to take account of the national context. The challenge for his country was to implement the eleventh revision, meeting the new requirements in terms of information and communication technology to strengthen the health system.

The representative of GHANA commended the process of consultation leading to the draft resolution and supported the inclusion of five additional chapters in the eleventh revision. He particularly welcomed the chapter on traditional medicine conditions, which should be comprehensive, and appreciated the possibility of reporting on antimicrobial resistance. The Secretariat should provide technical support to help Member States introduce the changes required to implement the eleventh revision.

The representative of PANAMA welcomed the inclusion in the eleventh revision of multiple-cause coding, which was relevant to countries with ageing populations and a growing chronic disease burden, and the other updates introduced. In the future, certain diagnostic categories, such as metabolic syndrome and prehypertension, should be described in greater detail. PAHO was working

with countries in the Region of the Americas to ensure a smooth transition to the eleventh revision. She noted limitations to Internet access in countries of the region and the need to build technical capacity. She expressed support for the draft resolution.

The representative of INDIA welcomed the eleventh revision, which would add to the quality of data available for planning, accountability and research, and supported the inclusion of a chapter on traditional medicine conditions. The revision would facilitate coding, including under electronic health records. He requested the Secretariat to provide technical support to Member States to build capacities to facilitate implementation of the revised classification. An advisory committee of Member States could be established to identify challenges to implementation and promote integration with existing standards and interoperability with electronic health records.

The representative of IRAQ welcomed the efforts to translate the eleventh revision into Arabic and said that the focus should be on ensuring a smooth transition. A gradual introduction might be preferable for countries that had yet to implement the tenth revision. He called on the Secretariat to provide training for Member States to facilitate implementation.

The representative of BAHRAIN supported the draft resolution. The Secretariat must ensure sufficient funding was available to support the introduction of the eleventh revision and assist Member States with the transition. She also highlighted the importance of training and capacity-building.

The representative of BRAZIL said that technical support from the Secretariat would be essential for the implementation of the eleventh revision. His country had developed a timeline for implementation of the new classification, with a field-testing phase planned for 2021.

The representative of ZAMBIA welcomed the inclusion in the eleventh revision of five new chapters, particularly the supplementary chapter on traditional medicine conditions, the possibility of reporting on antimicrobial resistance and an updated classification of HIV. Although the inclusion of several broader categories for reporting health conditions and reasons for encounters with the health system in primary care settings was welcome, the Secretariat could learn from the experiences of Member States in developing and applying community-based methods to fill health information gaps and strengthen information systems. She supported the draft resolution.

The representative of GERMANY expressed support for the draft resolution. The eleventh revision would help to promote digitalization of the health sector, and the changes introduced were necessary to achieve the Sustainable Development Goals. The Secretariat should provide room for discussion before the end of the transition period so that issues associated with implementation could be resolved and the highest levels of international standardization achieved. It should also maintain a comprehensive and accessible support platform, including information material and training tools. As a reliable licence agreement for the eleventh revision had to be in place prior to implementation, she requested a flexible solution ensuring full use within all sectors of the health system, without additional costs for users and providers.

The representative of BELGIUM said that he supported a transition period of five years. The inclusion of a chapter on traditional medicine conditions could not imply an implicit or explicit endorsement of traditional medicine as evidence-based medicine.

The representative of INDONESIA welcomed the inclusion of a supplementary chapter on traditional medicine conditions, which he trusted would be comprehensive. Indonesia would make every

effort to meet the timeline for implementation but might have to request an extension to take account of its geographical challenges.

The representative of the UNITED REPUBLIC OF TANZANIA said that her country had participated in the pilot process for the eleventh revision and had found the reporting of morbidity and mortality data to be straightforward. However, when implementing the eleventh revision, countries should ensure that their software systems were organized by their governments rather than private sector entities to keep costs as low as possible.

The representative of MALDIVES said that her country had made extensive use of the tenth revision for the statistical analysis of morbidity and mortality data, and for insurance purposes. Regarding the eleventh revision, the inclusion of new chapters on sexual health, traditional medicine conditions and developmental anomalies and symptoms was greatly appreciated. It was helpful that the eleventh revision was designed to enable Member States to integrate it into their existing health information systems, although capacity-building materials would be essential to ensure a smooth transition from the tenth revision.

The representative of TURKEY said that she had every confidence that the eleventh revision would meet the needs of health care systems. The new chapters on traditional medicine conditions, diseases of the immune system and sleep-wake disorders were appreciated.

The representative of COLOMBIA said that his country had actively participated in consultations and meetings on the eleventh revision, which had helped to facilitate its transition from the tenth version. He reaffirmed his Government's interest in hosting a new collaborating centre for the WHO Family of International Classifications.

The representative of KENYA commended efforts to ensure that the eleventh revision would meet the needs of diverse users and the demands of information technology, but said that there had to be clear mechanisms for raising issues and concerns during implementation, and technical support for in-country implementation. E-learning materials should be developed to bolster familiarization with the eleventh revision, including modules on post-coordination/cluster coding, chapter and code structure, chapter-specific changes and notes. Offline versions of the eleventh revision should also be made available to assist in the transition process. The Health Assembly should bear in mind resolution WHA43.24 (1990), on the establishment of an updating process within the ten-year revision cycle.

The representative of SRI LANKA said that there should be worldwide uniformity in the classification of traditional medicine conditions. It was also important to have a transition period for the introduction of the eleventh revision and support from the Secretariat in training and capacity-building.

The representative of SUDAN said that the Secretariat should provide support to Member States in capacity-building to prepare for implementation of the eleventh revision, particularly to ensure that appropriate infrastructure was put in place.

The representative of IOGT INTERNATIONAL, speaking at the invitation of the CHAIRMAN, said that her organization strongly supported the timely inclusion of gaming and online gambling disorder in the eleventh revision, as had been recommended by professional organizations working in the field of mental health conditions.

The ASSISTANT DIRECTOR-GENERAL (Data, Analytics and Delivery) said that the historic adoption of the eleventh revision of the International Classification of Diseases was the result of

unprecedented international collaboration. Although the eleventh revision was the first fully electronic version, it would also be available offline and in print to allow all Member States to transition from the tenth revision. The eleventh revision would lead to increased efficiencies and quality while reducing costs, and Member States would continue to have full control of their data. The software required was open source and freely available, and the Secretariat remained committed to assisting Member States during the transition, including through a learning platform and technical support. All technical programmes and all WHO regional networks and country offices would be used to provide the real-time support that Member States needed.

The inclusion of the chapter on traditional medicine conditions should not be understood as an endorsement of any specific therapeutic approaches but rather as a means of filling an existing data gap. Going forward, the Secretariat would focus on responding to Member State needs, maintaining the eleventh revision, keeping up with scientific advances and developments, and translating implementation into new practices to improve public health around the world. She encouraged Member States to become collaborating centres for the WHO Family of International Classifications.

The CHAIRMAN said that she took it that the Committee wished to approve the draft resolution contained in document A72/29 Add.1.

The draft resolution was approved.¹

Emergency and Trauma Care: Item 12.9 of the agenda (document A72/31)

The CHAIRMAN drew attention to a draft resolution proposed by Argentina, Ecuador, Eswatini, Ethiopia, the European Union and its Member States, Israel and the United States of America, which read:

The Seventy-second World Health Assembly,

PP1 Having considered the report on emergency care systems for universal health coverage: ensuring timely care for the acutely ill and injured;²

PP2 Noting the importance of the organization of the health system as a whole, including by distinguishing between elective services and care, non-elective services and care, and emergency services and care in order to address the health needs of populations in a sustainable, effective and appropriate manner;

PP3 Recognizing that many proven health interventions are time-dependent and that emergency care is an integrated platform for delivering accessible, quality time-sensitive health care services for acute illness and injury across the life course;

PP4 Emphasizing that timeliness is an essential component of quality, and that millions of deaths and long-term disabilities from injuries, infections, mental disorders and other mental health conditions, acute exacerbations of noncommunicable diseases, acute complications of pregnancy, and other emergency conditions could be prevented each year if emergency care services exist and patients reach them in time;

PP5 Noting that injury alone accounts for nearly 5 million deaths per year and that road traffic injury is the top killer of all those in the age group of 5–29 years;³

PP6 Noting also that emergency care is an essential part of health service delivery in health systems, and that well-designed emergency services facilitate timely recognition, treatment

¹ Transmitted to the Health Assembly in the Committee's fourth report and adopted as resolution WHA72.15.

² Document A72/31.

³ Global Health Estimates 2016: deaths by cause, age, sex, by country and by region, 2000–2016. Geneva, World Health Organization; 2018.

management, and, when needed, continued treatment of the acutely ill at the appropriate level of the health system;

PP7 Acknowledging Sustainable Development Goal 3 (Ensure healthy lives and promote well-being for all at all ages), and recognizing that well-organized, safe and high-quality emergency care is a key mechanism for achieving a range of associated targets – including those on universal health coverage, road safety, maternal and child health, noncommunicable diseases, mental health, and infectious disease;

PP8 Acknowledging further Sustainable Development Goal 11 (Make cities and human settlements inclusive, safe, resilient and sustainable) and Goal 16 (Promote peaceful and inclusive societies for sustainable development, promote access to justice for all and build effective, accountable and inclusive institutions at all levels), and noting that a strong and well-prepared everyday emergency care system is vital for mitigating the impact of disasters and mass casualty events and for maintaining delivery of health services in fragile situations and conflict-affected areas;³

PP9 Recalling resolutions WHA56.24 (2003) on implementing the recommendations of the *World report on violence and health*, WHA57.10 (2004) on road safety and health (echoed by United Nations General Assembly resolution 72/271 (2018) on improving global road safety), WHA60.22 (2007) on health systems: emergency-care systems, WHA64.10 (2011) on strengthening national health emergency and disaster management capacities and resilience of health systems, WHA66.8 (2013) on the comprehensive global mental health action plan 2013–2020, WHA68.15 (2015) on strengthening emergency and essential surgical care and anaesthesia as a component of universal health coverage, and WHA69.1 (2016) on strengthening essential public health functions in support of the achievement of universal health coverage, in which the Health Assembly prioritized integrated service-delivery models and identified the lack of access to timely emergency care as a cause of extensive and serious public health problems;

PP10 Recalling also the mandate of WHO's Thirteenth General Programme of Work, 2019–2023 to improve integrated service delivery and to serve in particular the most disadvantaged, marginalized and hard-to-reach populations, to ensure that no one is left behind;¹

PP11 Noting that providing non-discriminatory access to all people in need of timely care in well organized, safe and high-quality emergency care services can contribute to the reduction of health inequalities;

PP12 Noting further that in many countries the emergency care system serves as the major health system safety net and the primary point of access to health services, in particular for marginalized populations, which is not an optimal use of health system resources;

PP13 Recognizing that the lack of organized emergency care in many countries leads to wide global discrepancies in outcomes across the range of emergency conditions;

PP14 Noting that many emergency care interventions are both effective and cost effective, and that integrated emergency care delivery can save lives and maximize impact across the health system;

PP15 Concerned that the lack of investment in frontline emergency care is compromising effectiveness, limiting impact and increasing cost in other parts of the health system;

PP16 Acknowledging that frontline health workers, nurses in particular, provide care for the acutely ill and injured, often without the benefit of dedicated training in the management of emergency conditions, and with limited possibilities for consultations;

¹ Thirteenth General Programme of Work, 2019–2023. Geneva: World Health Organization; 2018; as contained in document A71/4 (http://apps.who.int/gb/ebwha/pdf_files/WHA71/A71_4-en.pdf?ua=1or, accessed 19 March 2019) and adopted in resolution WHA71.1 (2018).

PP17 Noting that improving outcomes requires understanding the potential and actual utilization of emergency care, and that existing data do not provide adequate support for effective planning and resource allocation for emergency care;

PP18 Considering that WHO has a range of guidance that allows policy-makers, planners and administrators to develop action plans that are best suited to their national contexts, along with resources for training, as well as standards for essential emergency care services and resources at each level of the health system,¹

OP1 CALLS FOR near-term additional efforts globally to strengthen the provision of emergency care as part of universal health coverage so as to ensure the timely and effective delivery of life-saving health care services to those in need;

OP2 URGES Member States:²

OP2.1 to create policies for sustainable funding, effective governance and universal access to safe, high-quality, needs-based emergency care for all, without regard to sociocultural factors, without requirement for payment prior to care, and within a broader health system that provides quality essential care and services and financial risk protection as part of universal health coverage;

OP2.2 as appropriate, to conduct voluntary assessments using the WHO emergency care system assessments tool to identify gaps and context-relevant action priorities;

OP2.3 to work towards, or promote, at appropriate levels of governance, the inclusion of routine prehospital and hospital emergency unit care into health strategies, and in other relevant planning documents, such as emergency response plans and obstetric and surgical plans;

OP2.4 to develop a governance mechanism, as appropriate to their national context, for the coordination of routine prehospital and hospital-based emergency care services, including linkage with other relevant actors for disaster and outbreak preparedness and response, including the capacity of personnel in other sectors;

OP2.5 to promote more coherent and inclusive approaches to safeguard effective emergency care systems as a pillar of universal health coverage in fragile situations and conflict-affected areas, ensuring the continuum and provision of essential health services, and public health functions, in line with humanitarian principles;

OP2.6 to promote as appropriate, according to the level of health care services, from first level and above, the establishment of a dedicated area or unit for emergency services and care with appropriate equipment and capacity for management and diagnosis;

OP2.7 to promote access to timely prehospital care for all, by using informal or formal systems, as resources allow, including by establishing, where they do not exist, toll-free universal access numbers that meet international standards;

OP2.8 to implement key processes and protocols as identified in WHO guidance on emergency care systems, such as triage and checklists,³ as appropriate;

OP2.9 to provide dedicated training in the management of emergency conditions for all relevant types of health providers, including developing post-graduate training programmes for doctors and nurses, training frontline providers in basic emergency care, and integrating dedicated emergency care training into undergraduate nursing and medical

¹ Emergency care. Geneva: World Health Organization, see <https://www.who.int/emergencycare/en/> (accessed 19 March 2019).

² And, where applicable, regional economic integration organizations.

³ See Emergency and trauma care [website]. Geneva: World Health Organization; 2019 (<https://www.who.int/emergencycare/en/>, accessed 20 May 2019).

curricula, and establishing certification pathways for prehospital providers, as appropriate to their national context;

OP2.10 to increase awareness and capacity in communities to deal with emergency situations, including through campaigns, and through training of standard practices across educational and occupational settings, adapted to their corresponding target populations, so they can identify, mitigate and refer potential emergencies;

OP2.11 to implement mechanisms for standardized data collection to characterize the local acute disease burden and identify high-yield mechanisms for improving the coordination, safety and quality of emergency care;

OP2.12 to support efforts to ensure, based on local risks, that prehospital and hospital emergency units have plans in place to protect providers, patients and infrastructure from violence, to protect providers and patients from discrimination, and to have in place clear protocols for the prevention and management of hazardous exposures;

OP3 REQUESTS the Director-General:

OP3.1 to enhance WHO's capacity at all levels to provide necessary technical guidance and support for the efforts of Member States and other relevant actors to strengthen emergency care systems, including to ensure preparedness in all relevant contexts;

OP3.2 to foster multisectoral networks, partnerships and action plans, and to facilitate collaboration among Member States, to support the effective dissemination and implementation of best practices in emergency care;

OP3.3 to promote equitable and non-discriminatory access to safe, quality emergency care services for all people as part of universal health coverage;

OP3.4 to renew efforts outlined in WHA60.22 to provide support to Member States, upon request, for needs assessments, facility inspection, quality- and safety-improvement programmes, review of legislation, and other aspects of strengthening the provision of emergency care;

OP3.5 to support Member States to expand policy-making, administrative and clinical capacity in the area of emergency care, by the provision of policy options and technical guidance, supported by educational strategies and materials for providers and planners;

OP3.6 to strengthen the evidence base for emergency care by encouraging research on the burden of acute disease and emergency care delivery, and by providing tools, protocols, indicators and other needed standards to support the collection and analysis of data, including on cost-effectiveness;

OP3.7 to facilitate awareness and international and domestic resource mobilization, in line with the Addis Ababa Action Agenda of the Third International Conference on Financing for Development¹ by providing advocacy resources;

OP3.8 to report to the Seventy-fourth World Health Assembly in 2021 on progress in the implementation of this resolution.

¹ United Nations General Assembly resolution 69/313 (2015).

The financial and administrative implications for the Secretariat of the adoption of the draft resolution were:

Resolution: Emergency care systems for universal health coverage: ensuring timely care for the acutely ill and injured
A. Link to the approved Programme budget 2018–2019
<p>1. Output(s) in the approved Programme budget 2018–2019 to which this draft resolution would contribute if adopted:</p> <p>2.3.1. Development and implementation of multisectoral plans and programmes to prevent injuries, with a focus on achieving the targets set under the Decade of Action for Road Safety (2011–2020)</p> <p>2.3.4. Improved pre-hospital and facility-based emergency care systems to address injury</p> <p>4.2.1. Equitable integrated, people-centred service delivery systems in place in countries and public health approaches strengthened</p>
<p>2. Short justification for considering the draft resolution, if there is no link to the results as indicated in the approved Programme budget 2018–2019:</p> <p>Not applicable.</p>
<p>3. Any additional Secretariat deliverables during the biennium 2018–2019, which are not already included in the approved Programme budget 2018–2019:</p> <p>Not applicable.</p>
<p>4. Estimated implementation time frame (in years or months) to achieve the resolution:</p> <p>Five years.</p>
B. Resource implications for the Secretariat for implementation of the resolution
<p>1. Total resource requirements to implement the resolution, in US\$ millions:</p> <p>US\$ 25.69 million.</p>
<p>2.a. Estimated resource requirements already planned for in the approved Programme budget 2018–2019, in US\$ millions:</p> <p>US\$ 0.34 million.</p>
<p>2.b. Estimated resource requirements in addition to those already planned for in the approved Programme budget 2018–2019, in US\$ millions:</p> <p>Zero.</p>
<p>3. Estimated resource requirements in the Proposed programme budget 2020–2021, in US\$ millions:</p> <p>US\$ 12.67 million.</p>
<p>4. Estimated resource requirements in future programme budgets, in US\$ millions:</p> <p>US\$ 12.67 million.</p>

5. Level of available resources to fund the implementation of the resolution in the current biennium, in US\$ millions

– **Resources available to fund the resolution in the current biennium:**

US\$ 0.34 million.

– **Remaining financing gap in the current biennium:**

Zero.

– **Estimated resources, not yet available, if any, which would help to close the financing gap in the current biennium:**

Not applicable.

Table. Breakdown of estimated resource requirements (in US\$ millions)^a

Biennium	Costs	Region						Headquarters	Total
		Africa	The Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific		
2018–2019 resources already planned	Staff	–	–	–	–	–	–	0.25	0.25
	Activities	–	–	–	–	–	–	0.09	0.09
	Total	–	–	–	–	–	–	0.34	0.34
2018–2019 additional resources	Staff	–	–	–	–	–	–	–	–
	Activities	–	–	–	–	–	–	–	–
	Total	–	–	–	–	–	–	–	–
2020–2021 resources to be planned	Staff	2.86	1.50	0.85	1.19	1.14	1.25	1.39	10.17
	Activities	0.36	0.36	0.36	0.36	0.36	0.36	0.36	2.50
	Total	3.21	1.86	1.21	1.55	1.50	1.61	1.74	12.67
Future bienniums resources to be planned	Staff	2.86	1.50	0.85	1.19	1.14	1.25	1.39	10.17
	Activities	0.36	0.36	0.36	0.36	0.36	0.36	0.36	2.50
	Total	3.21	1.86	1.21	1.55	1.50	1.61	1.74	12.67

^a The row and column totals may not always add up, due to rounding.

The representative of ETHIOPIA, speaking on behalf of the Member States of the African Region, said that prehospital and emergency care could significantly reduce morbidity and mortality rates in low- and middle-income countries. However, Member States of the African Region that had conducted a WHO emergency care system assessment had reported critical gaps limiting progress towards attainment of Sustainable Development Goal 3 (Ensure healthy lives and promote well-being for all at all ages). Addressing those gaps, along with legislative and policy gaps, was essential to achieve quality emergency care and ensure that no one was left behind. Developing an integrated platform for emergency care delivery could save lives and maximize the impact of investments across the health system. He therefore called on the Health Assembly to adopt the draft resolution.

The representative of PANAMA said that addressing the lack of emergency care in many low- and middle-income countries was a public health priority. Further efforts should be made to offer first aid training to the public and provide 24-hour emergency care, including specialized care, coordinated jointly by prehospital and hospital services. Moreover, in order to reduce the impact of public health problems, financial resources should be optimized, focusing on ensuring quality care and universal access to emergency care. Services should be monitored using established processes and protocols, and effective data collection mechanisms should be supported.

The representative of the DOMINICAN REPUBLIC said that the report's recommendations provided a road map for ensuring access to emergency care, step-by-step solutions to the common problems experienced by different countries (such as funding, staff training and implementation), and measures to improve the coverage of emergency services nationwide, so as to provide timely and free health care to the most vulnerable.

The representative of MALAYSIA said that her Government agreed that organized emergency care was key to achieving many of the targets of the Sustainable Development Goals. She outlined some of the measures it had taken to strengthen the emergency care system in Malaysia, adding that it would like to join the WHO International Registry for Trauma and Emergency Care.

The representative of MOZAMBIQUE said that, as Chair of the Committee on Victim Assistance under the Convention on the Prohibition of the Use, Stockpiling, Production and Transfer of Anti-Personnel Mines and Their Destruction, he was pleased to see WHO highlight emergency and trauma care, which was critical to the provision of victim assistance in mine-affected areas. He looked forward to the strengthening of synergies between the work of his Committee and WHO in support of States affected by anti-personnel mines, and would welcome an updated study on potential measures to reduce the mortality rate of people who suffered traumatic injuries.

The representative of THAILAND said that the WHO Emergency Care System Framework should include not only in-hospital emergency care and prehospital care, but also a referral system and preparedness in mass casualty incident and disaster situations. In South-East Asia, emergency care systems, including disaster preparedness and response, should be dispersed throughout each country to mitigate the impact of natural disasters. The involvement of private sector and non-governmental organizations in prehospital care could help extend the coverage of emergency medical services. Emergency services should be advertised to ensure that people knew how to access them quickly.

The representative of TOGO said that lack of timely access to emergency care was a serious public health problem. The lack of prehospital emergency care was a weak link in his country's health system, and he outlined some of the steps taken to improve the situation.

The representative of the UNITED STATES OF AMERICA said that, in the global effort to improve public health, recognizing that timely care was an essential component of an integrated health service delivery model would increase access to quality health care, save lives, and help achieve health-related global goals and targets.

The representative of ALGERIA said that emergency medical care required close coordination between health care facilities and other stakeholders in order to manage response times, as well as specialized training for health care professionals. He called on the Secretariat and WHO partners to help Member States train the human resources and obtain the equipment needed to provide emergency and trauma care.

The representative of BAHRAIN said that his country was making every effort to respect international standards on emergency and trauma care services, which were widely available. Various policies and strategies had been developed to mobilize the necessary resources.

The representative of INDIA said that many lives could be saved with timely intervention, which was critically linked to the availability of sufficient infrastructure and trained staff. Standard protocols and key performance indicators were essential for quality emergency and trauma care services. It was also crucial to train the public to administer basic first aid to accident or emergency victims.

The representative of ZAMBIA affirmed her Government's commitment to conducting a periodic WHO emergency care system assessment and to reviewing essential processes and clinical protocols as identified in the WHO Emergency Care Systems Framework. She requested the Secretariat to support the strengthening of standardized data collection mechanisms and to provide training and standards for essential emergency care services in the quest for quality improvement.

The representative of CHINA said that he supported the draft resolution but would welcome the inclusion of the following actions: to facilitate effective connections between prehospital and emergency care by creating an integrated prehospital and in-hospital fast-track system to improve the efficiency of treatment and care; to deploy more ambulances, particularly in rural areas; to encourage countries with the requisite capacity to deploy more automated external defibrillators in public places; and to provide more training programmes for the public in basic emergency awareness and skills.

The representative of CANADA said that her Government would be interested in learning from any new knowledge arising from recent initiatives launched by the WHO to support emergency care services. It supported the draft resolution.

The representative of the ISLAMIC REPUBLIC OF IRAN said that establishing a well-organized emergency care regulatory body to provide and oversee timely and quality care was important to achieving many of the targets of the Sustainable Development Goals. Emergency care should not be considered as a costly intervention but an essential step in avoiding costly interventions throughout the whole health system. Emergency preparedness and response in primary health care and health system resilience should be priorities in all at-risk countries. She requested WHO and other organizations in the United Nations system to take steps to ensure that all countries had access to essential drugs and medical equipment, including those subject to unilateral coercive measures. Her country was willing to help develop the regional road map for disasters and to serve as an educational hub for disasters and emergencies in the Eastern Mediterranean Region.

The representative of SOUTH SUDAN said that his country would appreciate support from the Secretariat and WHO partners to assist Member States in establishing and strengthening the systems and capacities required for an effective emergency care system.

The representative of AFGHANISTAN said that his country's high incidence of road-traffic injuries made the availability of emergency and trauma care essential. He requested the Secretariat to provide technical support to his Government in implementing the measures required under the draft resolution.

The representative of the UNITED REPUBLIC OF TANZANIA said that the recent launch of the WHO International Registry for Trauma and Emergency Care would provide countries with standard guidance on facilitating collaborative efforts to ensure that their priority programme needs were met. It was positive that the Secretariat had identified the challenges affecting low- and middle-income countries, including the lack of dedicated funding streams to sustain established targets. She supported the draft resolution.

The representative of MALDIVES said that the priority for countries worldwide must be to establish efficient emergency and trauma care services so as to reduce deaths and disabilities and have a positive impact on peoples' lives. Stakeholder engagement and public-private partnerships were vital to guaranteeing sustainability and establishing viable funding mechanisms for emergency care. She supported the draft resolution.

The representative of KIRIBATI said that the main challenge in providing timely emergency and trauma care in her country was the geographical dispersal of its islands. The Secretariat was helping the Government revise its emergency preparedness plan.

The representative of NAMIBIA, emphasizing that emergency and trauma care formed an essential part of universal health coverage, outlined the measures taken by her Government to address the country's lack of emergency units and trained health professionals and thereby reduce avoidable deaths and disabilities, particularly as road-traffic crashes caused a significant proportion of trauma-related deaths and injuries in Namibia.

The representative of GHANA, expressing support for the draft resolution, said that, in recognition of the importance of emergency care, his Government had added timeliness as an important component of universal health coverage, emphasizing that timely access to services should be guaranteed for all people in the country regardless of their ability to pay.

The representative of THE WORLD MEDICAL ASSOCIATION, INC., speaking at the invitation of the CHAIRMAN, said that it was vital to adopt a systematic approach to emergency care and to strengthen health sector leadership, incorporating a leading role for emergency care physicians. He urged Member States to guarantee the personal safety of physicians, other responders and patients. A well-trained workforce was needed to meet patient needs. To that end, emergency care training should be included in training curricula for future doctors.

The representative of the GLOBAL HEALTH COUNCIL, INC., speaking at the invitation of the CHAIRMAN, urged Member States to adopt and fund the draft resolution and the Secretariat to work with Member States to train care providers and strengthen emergency care programmes, evaluate disease patterns and emergency implementation strategies, and prioritize access to emergency care regardless of ability to pay.

The representative of the INTERNATIONAL FEDERATION OF SURGICAL COLLEGES, speaking at the invitation of the CHAIRMAN, said that Member States needed to ensure that emergency preparedness measures guaranteed the capability to deliver essential surgical, obstetric, trauma and anaesthesia services as an integral part of prepared, coordinated and resilient health systems. Given that surgery was an indispensable part of health care, universal health coverage could never be achieved without access to safe, timely and affordable surgical care.

The ASSISTANT DIRECTOR-GENERAL (Universal Health Coverage, Communicable and Noncommunicable diseases) said that global disparities in access to emergency care created disparities in outcomes. That situation was unacceptable, given that simple, low-cost interventions were available, particularly in primary care settings. More lives could be saved by implementing key processes that enhanced the quality of care delivery. Emergency care was currently underfunded and insufficiently emphasized in health strategies. Ensuring timely delivery of such care would help achieve universal health coverage, improve maternal and child health, and ease the impact of disasters and violence. Many Member States had identified priority actions relating to their national emergency care systems. In response, WHO had launched a global emergency and trauma care initiative and developed tools and technical guidance to help Member States strengthen their care systems, including support for training front-line health workers, standardized documentation and data collection, and measures to guarantee sustainable funding and effective governance, in order to ensure access to emergency care for all. No one should die from lack of access to emergency care, which was an essential aspect of universal health coverage. The Secretariat would continue to work with partners to support countries and populations in need.

The CHAIRMAN took it that the Committee wished to approve the draft resolution.

The draft resolution was approved.¹

Global Strategy for Women's, Children's and Adolescents' Health (2016–2030): Item 12.8 of the agenda (document A72/30)

The representative of BOTSWANA, speaking on behalf of the Member States of the African Region, said that, despite a significant decrease in maternal mortality, women continued to die from preventable conditions such as cervical cancer, because of poor access to contraception, and from gender-based violence, genital mutilation and sexually transmitted infections. Member States must continue to improve the health of women, children and adolescents, in line with the Global Strategy for Women's, Children's and Adolescents' Health (2016–2030). The Secretariat should continue to provide support to ensure access to contraception, guarantee the competencies of service providers in family planning and control of sexually transmitted infections, and promote the expansion of cervical cancer prevention and treatment coverage. The Secretariat should also support the African Region in strengthening human papillomavirus (HPV) vaccination coverage and prenatal and neonatal health services. The African Region strongly advocated for enhanced multisectoral action to address the social and other determinants of health, especially with regard to women, children, adolescents and marginalized groups. It welcomed efforts by the Secretariat to standardize monitoring tools and harmonize methodologies to ensure the consistent monitoring of progress on the implementation of the Global Strategy.

The representative of the UNITED STATES OF AMERICA, speaking on behalf of Brazil, Egypt, Ghana, Haiti, Indonesia, Iraq, Nigeria and Saudi Arabia, said that health in women, children and adolescents led to health in communities and families, the family being the foundational institution of society. She welcomed the prioritization of equal access to tools that were predictive of health and well-being throughout the life course, and of measures to expand access to health care. Member States were urged to expand health services and opportunities for women, children and adolescents, especially those in situations of risk and/or vulnerability. Efforts should focus on topics that united rather than divided Member States. In that regard, she did not support references to ambiguous terms such as the "right to sexual and reproductive health" in the context of WHO's work because they did not take into account the key role of the family. She strongly supported the highest attainable health outcomes for women, children and adolescents, including, but not exclusively related to, reproductive concerns. In that context, a more holistic approach would be beneficial. Stressing the importance of international solidarity in building consensus, she said that efforts should focus on concrete issues and challenges.

The representative of HONDURAS said that her Government supported the implementation of the Global Strategy. She outlined the steps taken and progress made in her country to improve women's, children's and adolescents' health, including legislative measures on health service provision and initiatives to address the social and other determinants of health relating to women, children, adolescents and marginalized groups. She welcomed the platforms and tools provided by WHO/PAHO to facilitate access to data.

The representative of FRANCE, speaking on behalf of Australia, Belgium, Canada, Estonia, Finland, Guyana, Iceland, Latvia, Luxembourg, Mexico, Mozambique, the Netherlands, New Zealand, Norway, Portugal, Spain, Sweden, Tunisia, the United Kingdom of Great Britain and Northern Ireland and Uruguay, said that women, children and adolescents were being left behind in terms of access to

¹ Transmitted to the Health Assembly in the Committee's fourth report and adopted as resolution WHA72.16.

quality health services and were particularly vulnerable to abuse and violence. Inequality, including with respect to access to safe abortion services, was a major potential setback to ending preventable maternal and child mortality and undermined adolescent health. It was essential to ensure universal access to high quality, affordable health services, and to information and education relating to sexual and reproductive health, including comprehensive sexuality education. Political leadership was needed to meet the needs and protect the dignity and rights of women, children and adolescents and to eliminate all social, gender-based, structural and cultural barriers. The Secretariat, Member States and partners must take bold action to improve the health and human rights of women, children and adolescents.

The representative of LEBANON said that his Government was working to incorporate measures and targets relating to women's, children's and adolescents' health into its national health strategy, adopting a life course approach. He drew attention to the importance of community engagement and of incorporating emergency response into national plans. More time should be given to States in crisis, including those hosting migrants, owing to the additional burden on their health systems.

The representative of ALGERIA pointed out that maternal, neonatal, child and adolescent mortality was high in countries where access to cost-effective interventions was unequal or inadequate. It would be difficult to achieve the Sustainable Development Goals, notably universal health coverage, without the necessary human and financial resources. It was therefore important to implement country-specific mechanisms to expand coverage and improve the quality of care, in line with the political commitment to strengthen the Global Strategy.

The representative of SWEDEN said that sexual and reproductive health and rights, including provision of comprehensive sexuality education and access to contraceptives and to safe, legal abortion services, were key to reducing maternal mortality and protecting the right of all to the highest attainable standard of health. He strongly supported strengthening access to maternal care provided by well-trained staff, and stressed that universal health coverage should include an integrated package of interventions on sexual and reproductive health and rights that safeguarded women's and girls' rights to their own bodies and lives. Creating equitable conditions for all and leaving no one behind were essential to achieving the Sustainable Development Goals. Strengthening sexual and reproductive health and rights, reducing sexual and gender-based violence and improving early childhood development were all important aspects of that approach.

The representative of SAUDI ARABIA, outlining measures taken by his Government at the national level, stressed the importance of cooperation and encouraged Member States to establish a legislative framework to improve systems for women's, children's and adolescents' health and the requisite specific performance indicators.

The representative of BAHRAIN said that primary health care and universal health coverage should have key roles in national health strategies, in line with the Global Strategy and the Sustainable Development Goals. His Government supported implementation of the Global Strategy as an effective way to improve health care for women, children and adolescents.

The representative of CANADA said that the Sustainable Development Goals would not be achieved and poverty ended by 2030 if sufficient attention was not paid to the health, rights and well-being of women, children and adolescents. She welcomed WHO efforts to improve quality of care, strengthen monitoring and enhance accountability, including through global data standardization, and to encourage increased investment in adolescent health, including measures to improve the collection of disaggregated data and to develop normative tools. Cooperation with a wide range of stakeholders, including women's and youth-led organizations and civil society, was vital to foster coordination and collaboration and to enable women's and girls' voices to be heard within and outside the health and

nutrition sectors. Her Government strongly supported a multisectoral and integrated approach to meeting health needs throughout the life cycle. She appreciated the greater emphasis on sexual and reproductive health and rights and addressing social and other determinants of health.

The representative of TOGO said that, in order to address challenges in women's, children's and adolescents' health at the national level, in particular high maternal, neonatal and infant mortality rates, his Government's actions had been aligned with the Sustainable Development Goals and the recommendations of the Global Strategy.

The representative of THAILAND outlined some of the measures taken by her Government to improve the health of women, children and adolescents, including in the areas of nutrition and vaccination. It had introduced universal vaccination against HPV for all fifth-grade female students, but had struggled to obtain a sufficient vaccine supply to complete the 2019 vaccination programme. She urged the Organization to take action to facilitate the production of HPV vaccine, so as to ensure adequate global supplies.

The representative of DENMARK said that giving young people a voice in sexual and reproductive health and rights was a priority for her Government. The focus should be on prevention rather than treatment, and comprehensive sexuality education was an effective measure that should be implemented globally.

The representative of NIGER described the steps taken by his Government to improve women's, children's and adolescents' health. Challenges remained, including in obstetric care, the use of contraception and meeting the needs of people living in humanitarian emergency situations. He urged the Secretariat to provide more financial support for Member States facing major challenges.

The representative of NAMIBIA said that it was critical to accelerate the implementation of programmes and initiatives tailored to the health needs of adolescents. He expressed appreciation that neonatal health had been closely linked to maternal health, and said that focusing on life-saving interventions would go a long way to reducing maternal and neonatal mortality rates.

The representative of the DOMINICAN REPUBLIC said that intersectoral action and transparency across all levels of the Organization should be strengthened to address the social determinants of women's, children's and adolescents' health. Efforts to improve data systems and harmonize indicators were vital for analysis and decision-making. She supported, and was involved in, the development of applications and digital initiatives on sexual and reproductive health.

The representative of BRAZIL, welcoming the Global Strategy, outlined some of the measures taken by her Government to guarantee sexual and reproductive health rights, including access to modern, safe and effective contraceptive methods, the promotion of breastfeeding and an HPV vaccination programme to prevent cervical cancer.

The representative of BURKINA FASO expressed support for the Global Strategy and encouraged collaboration to develop technical support for its implementation. Improving reproductive and child health was a priority for her Government, which was using a number of WHO tools in its programmes in the field.

The representative of GHANA, observing that the unacceptably high maternal, neonatal and child mortality rates in Ghana remained a concern, outlined the initiatives taken by the Government to address the problem and other issues related to women's, children's and adolescents' health.

The representative of INDONESIA, providing an overview of steps taken by her Government to implement the Global Strategy, said that strengthening primary health care and referral health facilities was key to ensuring quality health services for all.

The representative of SRI LANKA welcomed the report's timely focus on identifying the gaps that were hindering the achievement of universal health coverage. Adolescent health services were a particular challenge for her country, and it would be useful for Member States to share best practices in that area.

The representative of INDIA said that, although he welcomed the development of a draft global strategy to accelerate cervical cancer elimination, it was equally important for the global community to work on market shaping to ensure that adequate supplies of the HPV vaccine were available at a reasonable price. Given the global shortage of the vaccine, governments would find it difficult to commit or adhere to cervical cancer elimination targets. Moreover, countries should have the flexibility to set their own targets based on their local, epidemiological and financial situations.

The representative of SOUTH AFRICA said that, despite Member State efforts to ensure access to health services, many challenges remained, including the exorbitant cost of vaccines and medicines, which perpetuated inequalities between high-, low- and middle-income countries. She asked for greater commitment from all stakeholders to make products affordable, including the pharmaceutical industry and GAVI, the Vaccine Alliance. Women should be able to seek care without fear of stigma or discrimination. It was also essential to consider the mental health needs of women.

The representative of MEXICO said that it was important to strengthen efforts to prevent maternal and neonatal deaths by ensuring access to antenatal care and trained health professionals. More progress needed to be made in addressing stunting and obesity, and coverage of key interventions, such as immunization, should be expanded. In terms of adolescent health, it was important to address the issues of road safety, suicide and interpersonal violence among young people, along with mental health disorders, teenage pregnancy, substance use and HIV prevention and care. It was essential to adapt WHO guidelines on sexual and reproductive health to humanitarian and emergency settings.

The representative of MALAYSIA described the action taken by her Government to improve women's, children's and adolescents' health, including primary HPV screening to accelerate cervical cancer elimination.

The representative of TUNISIA, describing some of the measures taken by his Government to improve the health of women, children and adolescents, requested the Secretariat to provide support, in particular for implementation of Tunisia's multisectoral strategy for children's development and the creation of a data system to track children's health.

The representative of the UNITED REPUBLIC OF TANZANIA said that her Government had put in place frameworks and action plans to strengthen women's, children's and adolescents' health services, in particular to address the country's slow progress in lowering the high maternal, neonatal and infant mortality rates, low contraceptive use and high adolescent pregnancy rate.

The representative of PANAMA said that her Government was committed to implementing the Global Strategy and described the measures it had taken to make progress in those areas, including a sexual and reproductive health programme for adolescents funded by a tobacco tax.

The representative of TIMOR-LESTE described the action taken to improve women's, children's and adolescents' health in her country, such as building maternity clinics closer to communities. Universal health coverage was key to addressing health as a fundamental human right.

The representative of ZAMBIA requested the Secretariat's support for providing quality health care throughout Zambia. The socio-cultural factors that influenced delivery of services in some countries should not be viewed as obstacles, but rather as ways to leverage locally acceptable methods, leading to improved health outcomes. The Secretariat should develop global targets in adolescent health so that progress could be charted. Lack of access to HIV and syphilis test kits remained a problem, and she appealed for an investigation of the issue.

The representative of the NETHERLANDS encouraged the Secretariat to use the monitoring framework adopted in 2018 at the International Conference on Population and Development to fill data gaps in the European Region. Although she was pleased to see the new sexual and reproductive health and rights guidelines for adolescents, the issue of sexual health needed to be included more consistently in future reports, particularly in sections on adolescents. Future reports should also reflect on the contribution of unsafe abortion to maternal mortality and morbidity. An indicator should be developed on the causes of maternal deaths, and the contextual indicator on different legal circumstances tracked. Everyone agreed that access to antenatal care, treatment of sexually transmitted infections, vaccinations, family planning and safe deliveries were key, yet it seemed that a political discussion of the right to safe abortion was jeopardizing what had been achieved. She trusted that WHO, as a technical organization, would continue to let evidence prevail. Universal access to sexual and reproductive health care and reproductive rights were Sustainable Development Goals and not a matter of belief: evidence showed that it was essential for attainment of the Goals.

The representative of CHINA said that, although progress had been made in women's, children's and adolescents' health, major discrepancies still existed between countries and regions. He encouraged WHO to continue to work with global partners and increase funding for high disease burden countries. He asked how WHO would achieve better health for women and children under the "triple billion" goals. He hoped that recently launched expert and advisory groups for women's, children's and adolescents' health would lead to timely norms and standards being developed.

The representative of COLOMBIA said that the global and regional picture provided of the status of key women's health issues, violence against children and adolescents, and other challenges faced in early childhood, childhood and adolescence would inform public policy development. The systematic approach to experiences in different regions could serve as a basis for generating local data. However, the recommendations should be broader and more in-depth, particularly with respect to the health status of migrant pregnant women and minors, pregnant women and minors in post-conflict settings, and evidence-based interventions to promote protective environments and mental health and help prevent consumption of psychoactive substances by women, children and adolescents.

The representative of SLOVAKIA appreciated the call for a child- and family-centred multisectoral approach to programming. She asked for the global platform mentioned in the report to include evidence on country measures and standardized approaches to support natural methods of fertility control, diagnostics and treatment. With respect to the adaptation of WHO's existing guidelines on sexual and reproductive health to humanitarian and emergency settings, she emphasized the role of ethical approaches in the standardization of health care solutions when addressing stigmatization, vulnerability and trauma.

The representative of the UNITED KINGDOM OF GREAT BRITAIN AND NORTHERN IRELAND appreciated that the report reflected the centrality of women's, children's and adolescents'

health and rights to the attainment of universal health coverage. As midwifery skills enabled one professional to cover a spectrum of health issues, there was a critical need to scale up access to quality pre-service training. She therefore welcomed the planned WHO special report on strengthening quality interprofessional midwifery education by 2030. A comprehensive package of sexual and reproductive health and rights was critical to achieving the Sustainable Development Goals.

The representative of SOUTH SUDAN said that efforts to reduce maternal mortality should be intensified in the African Region. His country's adoption of the Boma Health Initiative, which was aligned with the Sustainable Development Goals and addressed socio-cultural barriers to the health of women, would help reduce the burden of morbidity and mortality and enhance the achievement of universal health coverage. He asked the Secretariat and partners for support in implementing the Initiative.

The representative of NICARAGUA expressed his Government's support for the Global Strategy and outlined the progress it had made in reducing maternal, neonatal and infant mortality, deaths from cervical cancer and chronic undernutrition in children under 5 years of age, and in eliminating some vaccine-preventable diseases. It was committed to continued progress on universal health coverage as part of the right to health for all people.

The representative of the BAHAMAS requested the Secretariat to provide support, in concert with her country's Caribbean partners, to strengthen the standardization, collection and analysis of data at the country level and to develop digital health applications for family planning and reproductive, maternal, newborn, child and adolescent health. As achieving the goals set for 2030 required sustained but flexible approaches, she requested technical support for the development and testing of interventions and the preparation of investment cases to strengthen grant applications.

The representative of MOROCCO outlined the steps taken by his Government to implement the Global Strategy, including developing a national strategy to end preventable deaths of mothers and newborns and a national child health policy. He welcomed the upcoming coordination meeting of the H6 Partnership as an opportunity to mobilize and optimize the use of resources for better convergence and accelerated achievement of goals.

The representative of SAINT LUCIA called on the Health Assembly to focus on achievement of target 3.8 of the Sustainable Development Goals as its core mandate. She urged Member States to focus on the areas of universal health coverage that enjoyed broad consensus and affected all countries, and to avoid topics that divided rather than united. Terms such as "comprehensive sexuality education" and "sexual and reproductive health and rights" should be avoided in any document originating in WHO because they undermined the role of the family and promoted practices like abortion in circumstances that did not enjoy international consensus. The quest for universal health coverage would benefit from a more holistic approach that addressed health outcomes not exclusively related to reproductive concerns.

The representative of TURKEY supported the statement made by the United States of America on behalf of a group of countries and strongly encouraged WHO to avoid any ambiguity in the terminology pertaining to sexual and reproductive health.

The representative of BANGLADESH, expressing support for the Global Strategy and the crucial role of universal health coverage in women's, children's and adolescent's health, noted the strides made by his country in reducing maternal and child mortality through programmes and national policies and

strategies addressing maternal, newborn and adolescent health. He fully agreed with the report on the importance of standardizing monitoring tools and harmonizing methodologies.

The representative of COSTA RICA provided details of the various measures, strategies, regulations and legislation his Government had put in place to offer comprehensive care to women, children and adolescents regardless of their ethnicity or insurance and immigration status, taking into account social determinants as well as biological conditions.

The representative of ESWATINI called on Member States to work together to address the gaps identified in the report. He was concerned about the continued poor access to some medicines and vaccines that had proven effective, such as the HPV vaccine, and stressed the need to act quickly to improve access, especially in developing countries.

The representative of AFGHANISTAN called for more collaborative efforts at national and global level to implement universal health coverage. Adequate technical and financial support were also required. He supported the recommendations, particularly with respect to poor and conflict-affected countries, but emphasized that they should be tailored to the country context.

The observer of the HOLY SEE noted the key role of access to high-quality antenatal care in preventing maternal and newborn deaths. With respect to the high number of children who died before their fifth birthday, WHO should help States take action on the social determinants of health, strengthen the capacity of families to nurture children and facilitate access to universal health coverage for all family members. He found it difficult to understand why, with regard to humanitarian contexts, the report focused exclusively on the vague concept of “sexual and reproductive health”.

The observer of PALESTINE requested the Secretariat to support Palestine’s efforts to implement its national strategy to reduce maternal, child and adolescent mortality, notably by helping to reinforce regional and international resources available to improve maternal, child and adolescent health conditions, especially during conflicts and crises such as the one being experienced in Palestine, particularly in east Jerusalem. He urged WHO to work with the Palestinian Ministry of Health, UNRWA and UNICEF to improve the health of women, children and adolescents.

The representative of the INTERNATIONAL FEDERATION OF MEDICAL STUDENTS’ ASSOCIATIONS, speaking at the invitation of the CHAIRMAN, called on Member States to take women’s, children’s and adolescents’ health needs into consideration, ensure equitable distribution of health care services, minimize out-of-pocket expenditure for and promote knowledge of sexual and reproductive health and rights, and use digital technologies to enable the health workforce to provide holistic and evidence-based family planning and sexual and reproductive health services.

The representative of THE WORLD MEDICAL ASSOCIATION, INC., speaking at the invitation of the CHAIRMAN, called on WHO and its Member States to involve physicians, who played a key role in educating patients, in the prevention of female genital mutilation. She urged Member States to provide adequate funding and programmes for training physicians on HPV and associated diseases, HPV vaccination and routine cervical cancer screening. She encouraged Member States to provide accessible information on maternal and child health.

The representative of the INTERNATIONAL COUNCIL OF NURSES, speaking at the invitation of the CHAIRMAN, said that women and girls experienced human rights violations in connection with access to sexual and reproductive health services, female genital mutilation and gender-based violence. Noting the work of health care professionals in raising people’s awareness of their rights, empowering

them to demand that they be upheld, and improving access to health care services, she urged Member States to invest in and support the health workforce, which was made up largely of women.

The representative of the INTERNATIONAL PHARMACEUTICAL STUDENTS' FEDERATION, speaking at the invitation of the CHAIRMAN, said that, given women's, children's and adolescents' continued lack of access to essential primary health care services, policies and practices should be reviewed to develop and expand community-centred health care services and optimize health outcomes. As pharmacists were easily accessible health care professionals and able to offer medication counselling and family planning services, they should be integrated into services at the community and individual levels.

The representative of IOGT INTERNATIONAL, speaking at the invitation of the CHAIRMAN, expressed concern that the absence of alcohol-related topics indicated that there was little or no action on related health and development issues, such as the health and development threats to children in families with alcohol problems, gender-based violence fuelled by alcohol, fetal alcohol spectrum disorders, and the alcohol-stoked causes of adolescent deaths. She urged WHO and its Member States to institute stronger cross-sectoral mechanisms to identify and address alcohol as a risk factor.

The representative of the GLOBAL HEALTH COUNCIL, INC., speaking at the invitation of the CHAIRMAN, called for noncommunicable disease services, such as access to the HPV vaccine and cervical cancer screening, to be integrated into existing programmes for young girls, adolescents and women. Supporting the urgent appeal of the Independent Accountability Panel for Every Woman, Every Child, Every Adolescent, she urged Member States to push for increased investment in adolescent health in order to achieve universal health coverage and the Sustainable Development Goals.

The representative of MEDICUS MUNDI INTERNATIONAL – NETWORK HEALTH FOR ALL, speaking at the invitation of the CHAIRMAN, expressed concern that some governments were pushing regressive and conservative steps in policies for women, children and adolescents. She was concerned about the removal of all references to sexual and reproductive health in a recent United Nations Security Council resolution on ending sexual violence in conflict. She urged Member States to promote evidence-based policies on sexual and reproductive health and rights.

The EXECUTIVE DIRECTOR (Universal Health Coverage/Life Course) said that, as the momentum for universal health coverage and primary health care continued to grow, it was clear that women and children must remain at the core of the agenda. WHO's universal health coverage index relied heavily on available data on reproductive, maternal, newborn, child and adolescent health indicators, and its tracking of equity relied solely on those indicators. Over the Millennium Development Goals period, collective progress in reducing both maternal and child mortality had been impressive. However, it was also clear that, in order to make progress, attention should centre on certain areas, which included the unfinished agenda on maternal and newborn mortality, with a focus on high-burden countries, as four countries accounted for 80% of global newborn mortality; reduction of the more than 2.5 million stillbirths occurring globally every year; the twin epidemics of stunting and obesity; the unmet need for family planning; the unmet needs for adolescent health, which included but were not limited to suicide prevention, prevention of violence and road-traffic crashes/injuries; and the prevention of violence against women generally, including the scourge of female genital mutilation.

National aggregate data no longer sufficed; subnational disparities needed to be addressed. There were major unmet needs in countries affected by conflict. Ten countries had an immunization rate lower than 50% nationally and those same countries accounted for more than half of maternal, under-five and newborn mortality. There was therefore a clear call for WHO to focus on those countries with new programmatic models. In addition, all parties should increasingly focus on the reduction and ultimate elimination of cervical cancer. WHO would be presenting an elimination strategy at the Seventy-third

World Health Assembly and had begun scaling up the relevant efforts, incorporating its activities to that end into its work on universal health coverage and primary health care. Vaccine security for HPV and other vaccines during the life course were also issues. WHO pledged to continue to work with Gavi, the Vaccine Alliance, UNICEF and other partners to look at how the market could be shaped to be fairer for low- and middle-income countries. It had also begun to look at affordable diagnostics and screening technologies.

Addressing specific issues that had been raised, the Executive Director said that WHO was working on a global action plan for the measurement of adolescent health, and an advisory group had been set up to harmonize the relevant indicators. It had agreed an accelerated action plan for adolescent health with the H6 Partnership. In terms of humanitarian emergencies, an audited assessment was being conducted of all available guidance to ensure its applicability. Gaps in the research were being reviewed so that they could be filled with appropriate guidance. Quality in women's and children's health was very much a part of WHO's focus on quality in universal health coverage and primary health care. WHO was addressing quality issues in relation to women's and children's health, including standards for midwifery and nursing, and patient safety. With respect to syphilis, WHO needed to scale up its work in partnership with colleagues working on HIV to eliminate mother-to-child transmission of syphilis and HIV. Only 11 countries had validated that elimination strategy. Finally, WHO would continue to prioritize evidence-based analysis, norms and standards, technical support and action for women's, children's and adolescents' health as a central pillar of universal health coverage, as part of the United Nations Secretary-General's Every Woman Every Child strategy, and under the Sustainable Development Goals framework, language, goals, targets and indicators.

The Committee noted the report.

Mr Ameen took the Chair.

3. MATTERS FOR INFORMATION: Item 21 of the agenda (continued)

Progress reports: Item 21.3 of the agenda (document A72/59)

The CHAIRMAN invited the Committee to consider the progress reports submitted under item 21.3 of the agenda by thematic group.

Communicable diseases

- A. Global technical strategy and targets for malaria 2016–2030 (resolution WHA68.2 (2015))**
- B. Addressing the burden of mycetoma (resolution WHA69.21 (2016))**
- C. Eradication of dracunculiasis (resolution WHA64.16 (2011))**

The representative of GUINEA, speaking on behalf of the Member States of the African Region on progress report C, said that educational and socioeconomic progress required lasting reductions in the risk of contracting dracunculiasis, particularly in disadvantaged communities, and that the community- and country-focused interventions of the global eradication campaign should therefore be maintained. Conflicts, security concerns and population movements continued to hamper programme implementation and limit access to regions where the disease was endemic. Despite those difficulties, it remained of the utmost importance to maintain eradication efforts.

The representative of the UNITED STATES OF AMERICA, referring to progress report A, saluted the proactive work done by WHO with Unitaaid and the Global Fund to Fight AIDS, Tuberculosis and Malaria to deploy new insecticide-treated nets quickly through the innovative New Nets Project. WHO should clarify the requirements for Prequalification Vector Control listing for new nets impregnated with pyrethroids plus another compound or compounds other than pyrethroids, it being critical to address insecticide resistance in the field as quickly as possible while weighing the importance of additional epidemiological data generation against the immediate need for new tools. He urged the global malaria community to work together across sectors to design and deploy innovative financing approaches that would increase private investments and domestic resource commitments.

The representative of SAUDI ARABIA emphasized the importance of strengthening the response to malaria cases and of moving towards eradication, inter alia through vaccines and stronger health systems. Greater investment was desperately needed at all levels, including in terms of prevention and surveillance. His Government hoped to work alongside other countries to provide medicines and improve data collection.

The representative of CHINA noted that there had been no notable decrease in the number of malaria cases between 2015 and 2017; in fact, in the African countries most affected it had even increased. His Government, which was closely monitoring the resistance of *P. falciparum* to artemisinin, was ready to work alongside other Member States to promote South-South cooperation on implementation of the global technical strategy for malaria 2016–2030. He recommended closer communication between WHO and Member States on the risks of imported transmission.

The representative of INDIA said that, in line with the global technical strategy, his country had launched a national framework for malaria elimination in 2016. As noted in the *World Malaria Report 2018*, India had been the only high-burden country to report a decline in malaria cases in 2017, a development attributed to renewed political commitment, strengthened technical leadership focused on prioritizing the right mix of vector control measures, and increased levels of domestic funding. India's approach could serve as an example, and WHO should therefore promote cross-learning between India and other high-burden countries.

The representative of MALAYSIA said that, Malaysia being one of the countries identified through the E-2020 initiative as having the potential to eliminate malaria by 2020, his Government was stepping up implementation of its national strategic plan and developing a strategic plan to prevent malaria re-establishment. His country had reported zero indigenous human malaria cases for the first time in 2018 and remained well positioned to achieve its elimination goal.

The representative of TOGO, referring to progress report C and recalling that his country had been certified as free of dracunculiasis transmission since December 2011, said that a 2017 study in districts that had previously reported cases of guinea-worm disease had found no cases of infection in dogs. Post-certification surveillance would continue until dracunculiasis had been eradicated worldwide.

The representative of TIMOR-LESTE, referring to progress report A, said that the number of confirmed malaria cases in her country had fallen significantly in recent years. Following a recommendation from the Malaria Elimination Oversight Committee at its meeting in February 2019, Timor-Leste was moving towards achieving certification of malaria elimination by 2021. She thanked WHO and other relevant international partners for their indispensable contributions to her country's national malaria programmes.

The representative of HONDURAS said that her country had made progress towards universal access to malaria prevention, diagnosis and treatment, a key step in ensuring that mild cases of malaria did not result in severe illness or death. Successful strategies included insecticide-treated mosquito nets, indoor residual spraying and proper use of antimalarial medicines. Her Government, alongside others in the region, would be implementing a new initiative that would improve results and thereby guarantee elimination by 2020.

The representative of SUDAN, referring to progress report B, said that his Government had been actively working to reduce the burden of mycetoma in the country's hardest hit provinces, opening treatment centres and running clinical trials to assess new medicines to treat the disease. It had also helped to organize a recent international conference on treating mycetoma with WHO. It remained committed to continue fighting the disease.

The representative of INDONESIA said that her country was continuing to work towards being declared malaria-free, with annual parasite incident rates having significantly decreased thanks to strong collaboration with relevant stakeholders. Her Government stood ready to further intensify comprehensive malaria elimination efforts, and supported extending malaria elimination activities and the applicable budget in order to achieve the 2030 malaria elimination target.

The representative of the UNITED REPUBLIC OF TANZANIA, referring to the socioeconomic burden that mycetoma placed on rural and underserved communities in her country, said that addressing the disease would improve the economy and reduce absenteeism owing to sickness. She commended the efforts of Member States in which mycetoma was endemic to conduct research and manage the disease accordingly, and expressed support for research and capacity-building for better diagnosis, treatment and prevention.

The ASSISTANT DIRECTOR-GENERAL (Communicable Diseases) said that the Secretariat would continue to work with Member States and partners to formulate new targets for malaria elimination in the coming years. It appreciated the strong commitments and support from Member States that were already on track to eliminate malaria by 2020 and was committed to ensuring timely certification. Regarding dracunculiasis, he said that the Secretariat fully understood the difficulties of last-mile eradication, when animal infections posed a problem. He commended the Government of Sudan for its mycetoma coverage centres and clinical trials for new medicines to treat the disease, and pledged the Secretariat's support to help Member States bring mycetoma under control.

Noncommunicable diseases

- D. Sustaining the elimination of iodine deficiency disorders (resolution WHA60.21 (2007))**
- E. Prevention of deafness and hearing loss (resolution WHA70.13 (2017))**

The representative of THAILAND, referring to progress report D, commended the progress made on sustaining the elimination of iodine deficiency disorders. While she agreed with the use of salt iodization for that purpose, monitoring would be required to limit excessive salt consumption. Regarding progress report E, it was essential to raise awareness about deafness and hearing loss among high-risk groups. Early detection in newborns remained a challenge, as did access to hearing aids and cochlear implants, especially in resource-poor settings. Efforts to promote access to such tools therefore had to be supplemented with work to develop innovative communication strategies and a supportive environment for people living with hearing loss.

The representative of the UNITED STATES OF AMERICA expressed support for WHO's efforts to raise awareness about hearing loss and noise exposure in occupational and recreational settings. The Organization should continue engaging on the subject, focusing on the early identification and management of deafness and hearing loss. In that regard, the importance attached by the Secretariat to partnerships with stakeholders, including organizations of people with hearing loss and family support groups, was commendable, and the technical work undertaken to implement resolution WHA70.13 (2017) encouraging.

The representative of SOUTH AFRICA, referring to progress report E, noted with appreciation the activities undertaken by the Secretariat to provide support to Member States, adding that her country had developed a public-sector programme to manage ototoxicity in cases of drug-resistant tuberculosis that it was considering expanding to cancer patients.

The representative of SLOVAKIA noted with appreciation that tool kits for ear and hearing care were being developed for release in 2019 and 2020. She welcomed WHO's leadership in establishing the World Hearing Forum and its activities to prevent deafness and hearing loss.

The representative of the RUSSIAN FEDERATION said that, thanks to WHO's work, governments were disseminating more information to their citizens about treatment and rehabilitative action for hearing loss and deafness. She was pleased with the progress made on developing new materials, reiterated her country's readiness to continue to engage in international, regional and national efforts to combat hearing loss and urged the Secretariat to pursue its work on the topic.

The representative of ZAMBIA outlined the steps taken by her Government to prevent deafness and hearing loss and called on the Secretariat to continue providing technical, financial and material support in that regard.

The representative of INDONESIA said that it was essential to include the prevention of deafness and hearing loss in priority programmes at the national and international levels, given the adverse effect that such impairments could have on quality of life. She described the range of measures taken by her Government in response to resolution WHA70.13 (2017).

The representative of INDIA, referring to progress report D, said that her Government was committed to sustaining the elimination of iodine deficiency disorders in the country and outlined the successful measures it had taken to that end.

The representative of MALAYSIA said that, as iodine deficiency disorders still existed among some segments of the population in Malaysia, her Government intended to begin implementing universal salt iodization in September 2020.

The representative of PANAMA, referring to progress report E, described the steps taken by her Government, at both the national and international levels, to prevent deafness and hearing loss, particularly in terms of awareness-raising and hearing tests.

(For the continuation of the discussion, see the summary record of the seventh meeting, section 3.)

The meeting rose at 13:55.

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