
Progress in the implementation of the 2030 Agenda for Sustainable Development

Report by the Secretariat

1. In May 2016, the Sixty-ninth World Health Assembly adopted resolution WHA69.11 on Health in the 2030 Agenda for Sustainable Development. In January 2017, the Executive Board at its 140th session took note of a report on progress in the implementation of the 2030 Agenda,¹ in which the Secretariat proposed six main lines of action, presented as instruments of change, in order to help Member States achieve the Sustainable Development Goals. Those lines of action were endorsed by Member States at that session.²

2. The present report provides a further update on progress towards the Sustainable Development Goals, taking into account the discussions of the Executive Board at its 140th session. Part I reports on global and regional progress made by Member States towards achieving Goal 3 (ensure healthy lives and promote well-being for all at all ages) and its interlinked targets, as well as other health-related Goals and targets. It is a product of the Secretariat's support to Member States to strengthen reporting on the 2030 Agenda. Part II describes the progress made in implementing resolution WHA69.11.

I. PROGRESS BY MEMBER STATES TOWARDS THE HEALTH-RELATED SUSTAINABLE DEVELOPMENT GOALS AND TARGETS

3. For the purposes of the present report, the Secretariat drew on information provided in *World Health Statistics 2016*,³ which contains the results of a review by WHO of the status of over 30 health and health-related indicators, and the updated information provided in *World Health Statistics 2017*. In addition to the information on indicators, the 2017 publication provides a brief review of the purpose of, and activities undertaken for, each of the six lines of action proposed by the Secretariat. The available data show that, in spite of progress made during the Millennium Development Goal era, major challenges remain in terms of reducing maternal and child mortality, improving nutrition, and achieving further progress in the battle against infectious diseases such as HIV/AIDS, tuberculosis,

¹ Document EB140/32. For the discussion on the report, see the summary records of the Executive Board at its 140th session, fifteenth meeting, section 2.

² The six lines of action are: intersectoral action by multiple stakeholders; health systems strengthening for universal health coverage; respect for equity and human rights; sustainable financing; scientific research and innovation; and monitoring and evaluation.

³ World Health Statistics 2016: monitoring health for the SDGs, sustainable development goals. Geneva: World Health Organization; 2016. Available at http://www.who.int/gho/publications/world_health_statistics/2016/EN_WHS2016_TOC.pdf (accessed 21 April 2017).

malaria, neglected tropical diseases and hepatitis. The situation analysis also provides evidence of the importance of addressing noncommunicable diseases and their risk factors such as tobacco use, mental health problems, road traffic injuries and environmental health issues. Weak health systems remain an obstacle in many countries, resulting in deficiencies in coverage for even the most basic health services and inadequate preparedness for health emergencies. Based on the latest data, the specific situation for eight priority areas, often cutting across multiple Goals and targets, can be summarized as set out below.

Maternal and child health and nutrition

4. The main targets relating to maternal and child health and nutrition are targets 3.1 (by 2030, reduce the global maternal mortality ratio to less than 70 per 100 000 live births), 3.2 (by 2030, end preventable deaths of newborns and children under 5 years of age, with all countries aiming to reduce neonatal mortality to at least as low as 12 per 1000 live births and under-5 mortality to at least as low as 25 per 1000 live births), and 2.2 (by 2030, end all forms of malnutrition, including achieving, by 2025, the internationally agreed targets on stunting and wasting in children under 5 years of age, and address the nutritional needs of adolescent girls, pregnant and lactating women and older persons).

5. In 2015, the maternal mortality ratio stood at 216 per 100 000 live births globally. Achieving target 3.1 will require a global annual rate of reduction of at least 7.3%, more than triple the annual rate of reduction attained between 1990 and 2015. In 2016, millions of births globally were not attended by a trained midwife, doctor or nurse, and only 78% of births were in the presence of a skilled birth attendant.

6. The global under-5 mortality rate in 2015 was 43 per 1000 live births, while the neonatal mortality rate was 19 per 1000 live births. The annual rate of reduction in under-5 mortality was 3.9% between 2000 and 2015. If this momentum can be maintained, it will be possible to meet, at a global level, the target of reducing under-5 mortality to at least as low as 25 per 1000 live births by 2030. Similarly, the annual rate of reduction of 3.1% observed for neonatal mortality between 2000 and 2015 must be maintained in order to achieve the target of reducing the rate to at least as low as 12 per 1000 live births by 2030.

7. Globally in 2016, 155 million children under the age of 5 were stunted (too short for their age), 52 million were wasted (too light for their height) and 41 million were overweight (too heavy for their height). Stunting prevalence was highest in the African Region and in the South-East Asia Region (34% in each Region). Both the highest prevalence of wasting (15.3%) and the highest number of wasted children (27 million) were found in the South-East Asia Region. Between 2000 and 2016, the number of overweight children under 5 years increased globally by 33%. The double burden of malnutrition manifests itself in the South-East Asia Region, where there were more than 9 million overweight children in 2016.

Infectious diseases

8. The main target relating to infectious diseases is target 3.3, which refers to ending by 2030 the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases and combating hepatitis, waterborne diseases and other communicable diseases.

9. Globally, 2.1 million people were estimated to have become newly infected with HIV in 2015, representing a rate of 0.3 new infections per 1000 uninfected people. In the same year, an estimated 1.1 million people died of HIV-related illnesses. At the end of 2015, an estimated 36.7 million people

were living with HIV. The African Region remains the most severely affected Region, with 4.4% of adults aged 15–49 years living with HIV. There is an increasing number of new HIV infections in the European Region.

10. In 2015, the malaria incidence rate was 94 per 1000 persons at risk, representing a global decrease of 41% between 2000 and 2015, and 21% between 2010 and 2015. The decrease was the greatest in the European Region (100%), as the number of indigenous cases was reduced to zero in 2015. There were an estimated 212 million cases of malaria and 429 000 malaria deaths globally in 2015. The burden was heaviest in the African Region, where an estimated 92% of all malaria deaths occurred, and among children under 5 years of age, who accounted for 70% of all deaths.

11. Tuberculosis is a treatable and curable disease, but remains a major global health problem. In 2015, there were an estimated 10.4 million new tuberculosis cases globally. There were 1.4 million deaths from tuberculosis and an additional 0.4 million deaths resulting from tuberculosis among HIV-positive people. In 2015, the case fatality rate varied widely from under 5% in a few countries to more than 20% in most countries in the African Region, indicating large inequities in access to high-quality diagnosis and treatment services. The European Region carries the highest rates of drug-resistant tuberculosis (16% and 48% of new and previously treated cases), and over 20% of the global burden of multidrug-resistant tuberculosis.

12. The total number of global deaths attributable to hepatitis¹ are estimated to have been in the order of 1.3 million in 2015. Global coverage with three doses of hepatitis B vaccine, a priority intervention, reached 84% among infants in 2015.

13. In 2015, 1.59 billion people were reported to require mass or individual treatment and care for neglected tropical diseases, down from 2 billion in 2010. The people who need interventions against such diseases are generally poor and marginalized (see also paragraph 46).

Noncommunicable diseases, tobacco control, mental health and substance abuse

14. The main targets relating to noncommunicable diseases, tobacco control, mental health and substance abuse are targets 3.4 (by 2030, reduce by one third premature mortality from noncommunicable diseases through prevention and treatment and promote mental health and well-being), 3.5 (strengthen the prevention and treatment of substance abuse, including narcotic drug abuse and harmful use of alcohol) and 3.a (strengthen the implementation of the WHO Framework Convention on Tobacco Control in all countries, as appropriate).

15. In 2015, a total of 40 million deaths were due to noncommunicable diseases, accounting for 70% of all deaths worldwide. The majority of these deaths were caused by the four main noncommunicable diseases: 17.7 million (45% of deaths due to noncommunicable diseases) were due to cardiovascular diseases, 8.8 million (22%) were due to cancers, 3.9 million (10%) were due to chronic respiratory diseases, and 1.6 million (4%) were due to diabetes. The risk of dying from these four diseases between the ages of 30 and 70 decreased from 23% in 2000 to 19% in 2015. Adults in the South-East Asia Region had the highest probability (23%) of dying from one of these four diseases, while those in the Region of the Americas had the lowest (15%). Men were at a higher risk than women in all WHO Regions.

¹ Includes deaths from acute hepatitis, liver cancer due to hepatitis, and cirrhosis due to hepatitis.

16. Worldwide alcohol consumption in 2016 was estimated to be 6.4 litres of pure alcohol per person aged 15 or older, with considerable global variation between WHO Regions. Available data indicate that treatment coverage for alcohol and drug use disorders is inadequate, although further work is needed to improve the measurement of such coverage.

17. In 2015, over 1.1 billion people smoked tobacco. Far more males than females currently smoke tobacco. The WHO Framework Convention on Tobacco Control has been ratified by 180 States Parties, representing 90% of the global population. More than 80% of States Parties have either adopted new or strengthened their existing tobacco control laws and regulations. Further action is needed to ratify the Protocol to Eliminate Illicit Trade in Tobacco Products.

18. Nearly 800 000 suicide deaths occurred worldwide in 2015, representing the second leading cause of injury death after road traffic injuries. Nearly twice as many men die by suicide than women. Suicide mortality rates are highest in the European Region (14.1 per 100 000) and lowest in the Eastern Mediterranean Region (3.8 per 100 000).

Injuries and violence

19. The main targets relating to injuries and violence are targets 3.6 (by 2020, halve the number of global deaths and injuries from road traffic accidents), 5.2 (eliminate all forms of violence against all women and girls in the public and private spheres, including trafficking and sexual and other types of exploitation), 13.1 (strengthen resilience and adaptive capacity to climate-related hazards and natural disasters in all countries), 16.1 (significantly reduce all forms of violence and related death rates everywhere) and 16.2 (end abuse, exploitation, trafficking and all forms of violence against and torture of children).

20. Around 1.25 million people died from road traffic injuries in 2013, with up to 50 million people sustaining non-fatal injuries as a result of road traffic collisions or crashes. Road traffic injuries are the main cause of death among people aged between 15 and 29 years and disproportionately affect vulnerable road users, in other words pedestrians, cyclists and motorcyclists. The vast majority (90%) of these deaths occurred in low- and middle-income countries, which account for 82% of the world's population, but only 54% of the world's registered vehicles. Between 2000 and 2013, the number of road traffic deaths globally increased by approximately 13%.

21. During the period 2011–2015, the global annual average death rate due to natural disasters was 0.3 deaths per 100 000 population. The Western Pacific Region had the highest rate, at 0.5 deaths per 100 000 population. During the same period, there was a marked decline in homicide rates of 19% globally. In 2015, there were an estimated 468 000 murders. Four fifths of the victims were men. The Region of the Americas had the highest rate of homicides (18.6 per 100 000 population).

22. In 2015, an estimated 156 000 people were killed in wars and conflicts, corresponding to around 0.3% of all global deaths. This estimate does not include deaths due to the indirect effects of war and conflict on the spread of diseases, poor nutrition and collapse of health services.

23. Latest estimates indicate that globally nearly a quarter of adults (23%) suffered physical abuse as a child, and about one third (35%) of women have experienced either physical or sexual intimate partner violence or non-partner sexual violence at some point in their lifetime.

Sexual and reproductive health services

24. The main target relating to sexual and reproductive health services is target 3.7 (by 2030, ensure universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes).

25. Globally, in 2016, 77% of women of reproductive age who were married or in a union had their need for family planning with a modern method met. However, while nine out of 10 women in the Western Pacific Region had their family planning needs satisfied, the same could be said for only half of women in the African Region. The global adolescent birth rate in 2015 was 44.1 per 1000 women aged 15–19 years. The rate in low-income countries (97.3 per 1000 women aged 15–19 years) was five times higher than that in high-income countries (19.1 per 1000 women aged 15–19 years).

Universal health coverage and health systems

26. The main targets relating to universal health coverage and health systems are targets 3.8 on achieving universal health coverage, 3.b on supporting research and development, 3.c on increasing health financing and the health workforce, and 17.19 on building on existing initiatives to develop measurements of progress on sustainable development.

27. Consultations with Member States on estimates for universal health coverage indicators 3.8.1 (coverage of essential health services) and 3.8.2 (proportion of the population with large household expenditure on health as a share of total household expenditure of income) began in February 2017. Once completed, this process will provide the first comparable set of monitoring figures for an index of essential health service coverage and the proportion of the population with large household expenditures on health as a share of total household expenditure or income, as a measure of lack of financial protection coverage in health. On average, countries have data since 2010 for around 70% of tracer interventions for indicator 3.8.1, and 50% of countries have at least one data record for indicator 3.8.2 since 2005.

28. The global percentage of children that had received their third dose of diphtheria, pertussis and tetanus (DPT3) vaccine, as a proxy for full immunization among children, was 86% in 2015. Data from 2007–2014 show that, for selected essential medicines, median availability was only 60% and 56% in the public sector of low-income and lower-middle-income countries respectively. Access to medicines for chronic conditions and noncommunicable diseases is even worse than that for acute conditions. Despite improvements in recent decades, innovation for new products remains focused away from the health needs of those living in developing countries. The current landscape of health research and development is insufficiently aligned with global health demands and needs. As little as 1% of all funding for health research and development is allocated to diseases that predominantly affect developing countries.¹

29. Health workers are distributed unevenly across the globe. Regions with the highest burden of disease have the lowest proportion of health workforce to deliver much needed health services. Available data from 2005–2015 show that around 40% of countries have less than one physician per 1000 population and almost half of all countries have less than three nursing and midwifery personnel

¹ Röttingen J-A, Regmi S, Eidt M et al. Mapping of available health research and development data: what's there, what's missing, and what role is there for a global observatory. *Lancet*. 2013; 382:1286–1307.

per 1000 population. Even in countries with higher national health workforce densities, the workforce is inequitably distributed; rural and hard-to-reach areas tend to be understaffed as compared to capital cities and other areas.

30. It is estimated that only half of the 194 Member States register at least 80% of deaths with information on causes of death.

31. The report of the High-level Commission on Health Employment and Economic Growth, entitled “Working for health and growth: investing in the health workforce” was launched in 2016 during the United Nations General Assembly.¹ In the report, the Commission makes 10 recommendations and proposes five immediate actions to guide and support the creation of 40 million new health worker jobs, while addressing the shortfall of 18 million health workers needed to achieve universal health coverage by 2030. Considering the full breadth of the 2030 Agenda for Sustainable Development, the Commission identifies social and economic gains that could be made from investments in the health workforce beyond decent work and economic growth (Goal 8), including poverty elimination (Goal 1), good health and well-being (Goal 3), quality education (Goal 4), and gender equality (Goal 5). The report and the proposed five-year implementation plan (2017–2021) illustrate the value of intersectoral policy action and interagency efforts across the 2030 Agenda.

Environmental risks

32. The Sustainable Development Goals include several targets relating to environmental sustainability and human health. These include targets under Goals 3 (ensure healthy lives and promote well-being for all at all ages), 6 (ensure access to water and sanitation for all), 7 (ensure access to affordable, reliable, sustainable and modern energy for all), 9 (build resilient infrastructure, promote sustainable industrialization and foster innovation), 11 (make cities inclusive, safe, resilient and sustainable), 12 (ensure sustainable consumption and production patterns) and 13 (take urgent action to combat climate change and its impacts).

33. Around 3 billion people still cook and heat their homes using solid fuels (wood, crop wastes, charcoal, coal and dung) in open fires and on leaky stoves. Such inefficient cooking fuels and technologies produce high levels of household air pollution with a range of health-damaging pollutants. Globally in 2012, household air pollution caused 4.3 million deaths. Women and children are at a particularly high risk of disease caused by exposure to household air pollution and account for 60% of all premature deaths attributed to such pollution.

34. In 2014, 92% of the world population was living in places where the WHO air quality guidelines levels were not met. Ambient (outdoor) air pollution in both cities and rural areas was estimated to cause 3 million premature deaths worldwide in 2012. Some 87% of those premature deaths occurred in low- and middle-income countries. Jointly, indoor and outdoor air pollution caused an estimated 6.5 million deaths, or 11.6% of all global deaths, in 2012.

35. Worldwide in 2012, an estimated 871 000 deaths were caused by contamination of drinking-water, water bodies and soil, by inadequate hand-washing facilities, and by practices resulting from inappropriate or inadequate services. Almost half (45%) of these deaths occurred in the African Region. In 2015, 6.6 billion people used an improved drinking-water source, but the coverage of safely managed drinking-water services is low, with preliminary estimates at 68% in urban areas and

¹ Available at <http://apps.who.int/iris/bitstream/10665/250047/1/9789241511308-eng.pdf> (accessed 21 April 2017).

only 20% in rural areas. About one third of the world's population (32%) did not have access to improved sanitation facilities in 2015, including the 946 million people practising open defaecation.

36. An estimated 108 000 deaths were caused by unintentional poisonings in 2015, down from 133 000 in 2000. The African Region had the highest mortality rate from unintentional poisonings in 2015 (2.8 per 100 000 population), almost twice the global rate (1.5 per 100 000 population).

Health risks and disease outbreaks

37. Target 3.d is to strengthen the capacity of all countries, in particular developing countries, for early warning, risk reduction and management of national and global health risks. In that connection, the International Health Regulations (2005) monitoring process involved assessing, through a self-assessment questionnaire sent to States Parties, the implementation status of 13 core capacities, such as legislation, coordination and preparedness. In 2016, 129 (66% of all States Parties) responded to the questionnaire. The average score across all capacities and across all reporting States Parties in 2016 was 76%.

II. PROGRESS MADE IN IMPLEMENTING RESOLUTION WHA69.11

38. **Supporting comprehensive and integrated national plans for health as part of implementation of the 2030 Agenda.** National health policies, strategies and plans help to define and implement priorities for health and development. According to WHO's 2017 report on WHO presence in countries, territories and areas, 60 WHO country offices have already engaged with governments, either directly or via United Nations country teams, in order to align national health policies, strategies and plans with the Sustainable Development Goals. A further 65 country offices were beginning to engage with national authorities and United Nations country teams. The remaining 23 country offices are expected to begin a dialogue with national authorities in the course of 2017. WHO has partnered with the European Union and the Grand Duchy of Luxembourg to develop national health policies, strategies and plans in more than 30 countries. These include Tunisia (population consultations); Chad, the Democratic Republic of the Congo and Timor-Leste (setting priorities for the health sector and for achieving healthy lives); and Guinea, Kyrgyzstan, the Lao People's Democratic Republic, Liberia, Moldova, Mozambique, Sudan, Sierra Leone, Ukraine and Viet Nam (monitoring the implementation of national health policies, strategies and plans). Over the past seven years, many European countries have aligned their national health policies with Health 2020: the European policy for health and well-being, which is aligned with the 2030 Agenda. WHO has developed a guide to developing national health policies, strategies and plans, entitled "Strategizing national health in the 21st century: a handbook".¹

39. **Developing regional plans to implement the 2030 Agenda.** WHO's regional offices have begun numerous activities to promote health in the context of the Sustainable Development Goals. Some examples, discussed by regional committees and in WHO publications, are provided below. The Regional Office for Africa has focused recently on health systems strengthening and universal health coverage.² The Regional Office for the Americas is reinforcing the Health in All Policies approach, and in May 2016 launched an Equity Commission as a first and practical step to implement the 2030

¹ Available at <http://www.who.int/healthsystems/publications/nhpsp-handbook/en/> (accessed 21 April 2017).

² See WHO Regional Office for Africa. Health systems strengthening for attainment of universal health coverage: an action framework (2016).

Agenda. In 2016, the Regional Office for South-East Asia published a baseline analysis of the status of the health-related Sustainable Development Goals in all 11 Member States of the Region and in early 2017 it held a regional consultation on monitoring the health-related Goals, at which agreement was reached on four priorities: improved cause of death registration (through civil registration and vital statistics); improved equity monitoring; improved interoperability, especially of staff and working methods rather than technologies; and improved transparency and use of data. The Regional Office for Europe has carried out reviews of how national health policies address the Sustainable Development Goals and how health is placed in existing national development strategies. In addition to 31 country profiles, the Regional Office has drafted a road map for implementation of the 2030 Agenda (which is under review), is mapping financial protection across all countries, chairs the Issue-based Coalition on Health¹ of the United Nations regional coordination mechanism, and is steering the European Environment and Health Process towards the implementation of the 2030 Agenda.² The Regional Office for the Eastern Mediterranean has highlighted the importance of emergency care and of having a defined package of essential health services in working towards universal health coverage. Recognizing that each Member State will set its own priorities among the 169 agreed targets (including the health-related targets), the Regional action agenda on achieving the Sustainable Development Goals in the Western Pacific³ provides guidance, for example, on putting health equity in national planning, on working across sectors, on participation by affected communities, and on the role of the health sector in driving the 2030 Agenda. One task ahead for the Secretariat is to make wider use of these many initiatives by collaborating across Regions and countries, and by sharing information worldwide.

40. Developing and finalizing the health-related Sustainable Development Goal indicators. The Secretariat advises the Inter-Agency and Expert Group on Sustainable Development Goal Indicators (comprising representatives of 28 national statistical offices). Recent contributions include finalizing indicators for the health-related Sustainable Development Goals. In March 2017, modifications to some indicators were adopted by the United Nations Statistical Commission in response to some concerns from Member States. The revisions included a better definition of financial risk protection as part of universal health coverage. A more extensive review of indicators is expected in 2020. WHO has also published regional guidance on the use of standard indicators.⁴

41. Supporting Member States in strengthening national statistical capacity. The Secretariat has reviewed data availability and quality for disaggregated statistics on the health and health related indicators⁵ and for the indicators in the Global Strategy for Women's, Children's and Adolescents'

¹ See http://www.euro.who.int/__data/assets/pdf_file/0010/324784/1st-mtg-report-issue-based-Coalition-Health-nov-2016.pdf (accessed 25 April 2017).

² See www.euro.who.int/en/health-topics/environment-and-health/pages/european-environment-and-health-process-ehp (accessed 21 April 2017).

³ WHO Regional Office for the Western Pacific. Regional action agenda on achieving the Sustainable Development Goals in the Western Pacific (2017).

⁴ For example, see: WHO Regional Office for Europe. Core health indicators in the WHO European Region 2016. Special focus: 2030 Agenda for Sustainable Development (2016).

⁵ World Health Statistics 2016: monitoring health for the SDGs, sustainable development goals. Geneva: World Health Organization; 2016. Available at http://www.who.int/gho/publications/world_health_statistics/2016/EN_WHS2016_TOC.pdf (accessed 21 April 2017).

Health (2016–2030).¹ WHO is also leading the Health Data Collaborative, including 38 global and regional partners, to strengthen country health information systems.

42. Supporting thematic reviews by Member States of progress on the Sustainable Development Goals. The Secretariat has supported and coordinated preparations for the voluntary national reviews to be presented by 40 Member States at the High-level Political Forum on Sustainable Development in July 2017. The reviews are an opportunity for Member States to show how, drawing on the latest evidence, better health (Goal 3) can be achieved in the context of poverty reduction (Goal 1), elimination of hunger (Goal 2), gender equality (Goal 5), industry and innovation (Goal 9), conserving life below water (Goal 14), and building partnerships (Goal 17).

43. WHO's role in providing health information as a public good. In 2016, WHO published "Best practices for sharing information through data platforms: establishing the principles"² and a policy statement setting out principles and practice for the sharing of data and results during public health emergencies, based on the International Health Regulations (2005).³ WHO and others also released guidelines for accurate and transparent health estimates reporting,⁴ which encourage WHO, other United Nations organizations and independent researchers to share datasets and methods that are used to calculate estimates of disease burden and trends. In 2017, WHO will publish a policy on open access principles and practice applicable to all data held by the Organization. In 2016, WHO published an open access policy applicable to all WHO publications, with a focus on reducing the supply of print publications in favour of publishing digitally and on demand.

44. Supporting the International Health Partnership for UHC 2030. To achieve target 3.8 on universal health coverage, the International Health Partnership and related initiatives (IHP+) evolved in 2016 to become the International Health Partnership for UHC 2030, an alliance to strengthen health systems, whose partners include national governments, WHO and other United Nations organizations, other international agencies and civil society organizations. Further information on specific initiatives to achieve universal health coverage can be found in progress reports to the Seventieth World Health Assembly.⁵

45. Supporting national efforts to "leave no one behind". In respect of gender equality and equality in general, Secretariat support to Member States has contributed to Goals 3 (ensure healthy lives and promote well-being for all at all ages), 5 (achieve gender equality and empower all women and girls) and 10 (reduce inequality within and among countries), and to target 17.18 on data disaggregation. In terms of monitoring, WHO's data portal to track progress towards universal health coverage, featuring data from 194 Member States and launched in December 2016, includes information on equity.⁶ Data for 102 countries were available through WHO's Health Equity Monitor as of February 2017. The Secretariat supports Member States in: using normative guidance and resources for health inequality monitoring; monitoring catastrophic and impoverishing health expenditures; monitoring intersectoral action relevant to reducing health inequities and gender gaps in

¹ See www.who.int/life-course/partners/global-strategy/gc-monitoring-readiness-report.pdf (accessed 21 April 2017).

² www.who.int/bulletin/volumes/94/4/16-172882/en/ (accessed 21 April 2017).

³ Weekly epidemiological record No 18, 2016, 91, 237–248.

⁴ Stevens G, Alkema L, Black R et al. Guidelines for accurate and transparent health estimates reporting: the GATHER statement. *Lancet*. 2016; 388, e19-e23. doi: 10.1016/S0140-6736(16)30388-9.

⁵ See document A70/38, sections A, C, F and K.

⁶ See <http://apps.who.int/gho/cabinet/uhc.jsp> (accessed 21 April 2017).

health; using AccessMod, a tool for modelling physical accessibility to health care and geographic coverage;¹ and conducting benefit incidence analysis on the extent to which different social and economic groups benefit from services. WHO also launched in 2016 a technical handbook entitled “The Innov8 approach for reviewing national health programmes to leave no one behind”.² In addition, the 9th Global Conference on Health Promotion, jointly organized by WHO and the National Health and Family Planning Commission of the People’s Republic of China, which took place in Shanghai, China, in November 2016 on the 30th anniversary of the Ottawa Charter for Health Promotion, reinforced the role of health promotion in improving health equity. Further information on gender and equity can be found in separate documents.³

46. Promoting a multisectoral approach to the 2030 Agenda. Some of the many initiatives on cooperative action at the national, regional and global levels supported by WHO are described below. The Global Strategy for Women’s, Children’s and Adolescents’ Health (2016–2030) covers 11 Sustainable Development Goals – all of the targets in Goal 3, and specific targets across 10 others (Goals 1–7, 9, 10, 16 and 17).⁴ In recognition of the importance of energy in delivering safe, high quality health services, the United Nations Secretary-General created the Energy for Women’s and Children’s Health initiative and WHO, together with the United Nations Foundation and the United Nations Entity for Gender Equality and the Empowerment of Women (UN-Women), was asked to lead this effort as part of the Sustainable Energy for All movement, linked to Goal 7. The High-level Commission on Health Employment and Economic Growth contributes to Goal 8 (promote inclusive and sustainable economic growth, employment and decent work for all) by promoting the creation of jobs in health and social sectors and improved working conditions in the health sector, paying specific attention to the needs of low- and lower-middle income countries. In the control of neglected tropical diseases, pharmaceutical companies, the national governments of 74 countries and other partners supplied preventive chemotherapy to at least 979 million people in 2015 – perhaps the world’s largest ever public health intervention. To strengthen neglected tropical disease control in Africa, the Regional Office for Africa – together with a coalition of multinational organizations – has launched the Expanded Special Project for Elimination of Neglected Tropical Diseases, including onchocerciasis, lymphatic filariasis, schistosomiasis, soil-transmitted helminths and trachoma. In April 2016, the United Nations General Assembly proclaimed a United Nations Decade of Action on Nutrition, 2016–2025, calling on FAO and WHO to lead its implementation in collaboration with several other United Nations programmes and coordination mechanisms. At the request of Member States, the Regional Office for Europe convened the Ad Hoc Regional Platform for Working Together for Better Health and Well-being for All.⁵

47. Promoting multisectoral collaboration with reference to the International Health Regulations (2005). WHO’s programme on One Health, established in January 2017, works to protect health at the human–animal–ecosystem interface. The programme makes information and expertise from all relevant sectors and disciplines consistently available during implementation of the IHR Monitoring and Evaluation Framework and Joint External Evaluation Tool and national health

¹ See www.who.int/ehealth/resources/accessmod/en/ (accessed 21 April 2017).

² See www.who.int/life-course/partners/innov8/innov8-technical-handbook/en/ (accessed 21 April 2017).

³ See documents A70/24 and A70/38, section H.

⁴ See also document A70/37.

⁵ See <http://www.euro.who.int/en/media-centre/events/events/2016/12/paris-high-level-conference/documentation/working-papers/explanatory-note-proposal-for-the-establishment-of-an-ad-hoc-regional-platform-for-working-together-for-better-health-and-well-being-for-all> (accessed 21 April 2017).

planning processes. WHO, OIE and FAO are currently working together to prepare practical, national-level standard tools, guidance and joint One Health training to support countries in the implementation of multisectoral collaborative approaches. One example of the One Health approach is the intersectoral management of antimicrobial resistant pathogens, which is discussed in a separate document.¹

48. Supporting Member States in strengthening research and development of new technologies and tools. Under the umbrella of the global strategy and plan of action on public health, innovation and intellectual property,² WHO supports research and development into diseases that primarily afflict the poor, currently with two new initiatives in particular. First, in accordance with resolution WHA69.23 (2016) and the report of the Consultative Expert Working Group on Research and Development: Financing and Coordination,³ WHO has launched the Global Observatory on Health Research and Development, a centralized and open-data platform that will monitor and analyse what health research and development is being conducted globally, where it is being conducted, by whom and how. Second, the UNICEF/UNDP/World Bank/WHO Special Programme for Research and Training in Tropical Diseases has proposed models for pooled financing that would support research and development to control neglected diseases. These models are under discussion with Member States. Further information on WHO support for research and development of, and access to, vaccines, medicines and other technologies is provided in separate documents.⁴

49. Supporting Member States in undertaking health systems research. The majority of health research is focused on biomedical and clinical interventions, while health systems research remains underfunded globally. The Alliance for Health Policy and Systems Research, an international partnership hosted by WHO, has developed an innovative model of embedded research led by decision-makers that addresses context-specific factors relevant to health system priorities. The Alliance is now supporting, in collaboration with PAHO and the Regional Office for the Eastern Mediterranean, 33 embedded implementation research projects in 18 different countries. Furthermore, the Alliance launched, in 2016, an initiative to identify health policy and systems research priorities to support progress towards the Sustainable Development Goals, giving special attention to low- and middle-income countries.

50. Facilitating North–South, South–South and triangular regional and international cooperation on and access to health-related science, technology and innovation. To stimulate international cooperation on access to health science, technology and innovation, the United Nations Development Group has established a South–South and triangular (South–North–South) cooperation task team, including WHO, which will foster cooperation across United Nations system operations. The task team issued a report in 2016 on good practices in South–South and triangular cooperation for sustainable development.⁵ WHO, WIPO and WTO are also strengthening their cooperation and practical coordination on issues around public health, intellectual property and trade.⁶ The European

¹ See document A70/12.

² See document A70/21.

³ See document A65/24, Annex.

⁴ See documents A70/10, A70/20 and A70/38, section I.

⁵ See ssc.undp.org/content/ssc/library/publications/books/good_practices_in_south_south_and_triangular_cooperation_for_sustainable_development.html (accessed 21 April 2017).

⁶ See www.wipo.int/policy/en/global_health/trilateral_cooperation.html (accessed 21 April 2017).

Region is cultivating partnerships to share information and experiences through the Healthy Cities programme, the small countries initiative,¹ and the South-eastern Europe Health Network.

51. **Maximizing the impact of WHO contributions to the 2030 Agenda, considering the programme budget and general programme of work.** The Proposed programme budget 2018–2019 takes advantage of new opportunities offered by the 2030 Agenda for Sustainable Development to propose ways of working that enhance collaboration across WHO's categories of work. It is clear that the control of communicable diseases (category 1) and noncommunicable diseases (category 2) depends on promoting health through the life course (category 3, responding for example to questions concerning gender, equity, ageing, and social and environmental determinants) and on strengthening health systems (category 4, for example by aligning national health policies and plans with the Sustainable Development Goals). Enhancing collaboration in this way would allow WHO's mode of operation to better reflect the needs and opportunities of the 2030 Agenda by working at the interface between two or more categories, promoting projects that have the potential to accelerate health gains in ways that cannot easily be achieved by working in separate categories. To empower WHO country offices, these projects would be explicitly aligned with the priorities defined in country cooperation strategies. In the course of 2017, these ideas will be carried through to initial drafts of the thirteenth general programme of work, which will begin in 2020. To aid WHO-wide coordination of this work, the Director-General established in January 2017 a Sustainable Development Goals network, linking headquarters, regional and country offices and the United Nations system through the Department of Country Cooperation and Collaboration with the United Nations System.

ACTION BY THE HEALTH ASSEMBLY

52. The Health Assembly is invited to note this report.

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¹ See www.euro.who.int/__data/assets/pdf_file/0017/325322/ISA-Experiences-small-countries-WHO-ER.pdf (accessed 21 April 2017).