

Implementation of the 2030 Agenda for Sustainable Development

Report by the Director-General

1. In May 2016, the Sixty-ninth World Health Assembly adopted resolution WHA69.11 on health in the 2030 Agenda for Sustainable Development. A first report on progress made in implementing the resolution was submitted to the Seventieth World Health Assembly, in 2017.¹ The Executive Board at its 144th session considered and noted an earlier version of this report.²

2. This report provides a further update on progress towards the Sustainable Development Goals. Part I summarizes global and regional progress made by Member States towards achieving Goal 3 (Ensure healthy lives and promote well-being for all at all ages), as well as other health-related Sustainable Development Goals and targets; it is a product of the Secretariat's support for Member States in strengthening their reporting on the 2030 Agenda.

3. Part II describes the progress made in implementing resolution WHA69.11. It includes the progress made in the strengthening of emergency and essential surgical care and anaesthesia as a component of universal health coverage, as requested in resolution WHA68.15 (2015) and decision WHA70(22) (2017).

I. PROGRESS TOWARDS HEALTH-RELATED SUSTAINABLE DEVELOPMENT GOALS AND TARGETS

4. The status of more than 30 health and health-related indicators are reported in World health statistics 2018³ and summarized below. The data show that while remarkable progress has been made in some areas towards the health-related Sustainable Development Goals, especially in reducing under-five mortality, increasing the coverage of HIV treatment and reducing cases of and deaths from tuberculosis, it has stalled in other areas, such as malaria, drug-resistant tuberculosis, alcohol use, road traffic deaths and overweight in children, and the gains that have been made could easily be lost. In many countries, weak health systems remain an obstacle to progress and lead to gaps in the coverage of even the most basic health services, as well as poor preparedness for health emergencies. The global and regional status of implementation to meet the Goals in seven thematic areas are summarized below.

¹ Document A70/35.

² See document EB144/11 Rev.1 and the summary records of the Executive Board at its 144th session, fifth meeting, section 2 and sixth meeting.

³ World health statistics 2018: monitoring health for the SDGs, sustainable development goals. Geneva: World Health Organization; 2018.

Reproductive, maternal and child health and nutrition

5. The main targets of the Sustainable Development Goals relating to reproductive, maternal and child health are targets 3.7, 3.1, 3.2, and 2.2.

6. The most recent estimates suggest that 76% of women of reproductive age had their family planning needs met with a modern contraceptive method. There are an estimated 12.8 million births annually among adolescent girls aged 15–19 years, representing 44 births per 1000 adolescent girls. Regional figures are lowest in the Western Pacific Region (14 births per 1000 adolescent girls) and highest in the African Region (99 births per 1000 adolescent girls). Early childbearing can negatively impact the health of newborn children as well as that of young mothers.

7. In 2015, an estimated 303 000 women worldwide died during pregnancy and childbirth. Almost all of these deaths (99%) occurred in low- and middle-income countries and almost two thirds (64%) in the African Region. Reducing maternal mortality depends crucially upon ensuring that women have access to high-quality care before, during and after childbirth. The data indicate that more than 90% of births in most high and upper-middle income countries benefited from the presence of a trained midwife, doctor or nurse, while less than half of all births in several low- and lower-middle-income countries were assisted by such skilled personnel.

8. The world has made remarkable progress in reducing child mortality since 1990, with the global under-five mortality rate dropping from 93 per 1000 live births to 39 per 1000 live births in 2017. Nevertheless, 5.4 million children died in 2017 before reaching their fifth birthday. If current mortality rates continue, 56 million children under the age of five years are projected to die between 2018 and 2030. The risk of dying is greatest in the first month of life, with 2.5 million newborns dying within one month of being born in 2017. Prematurity, intrapartum-related events such as birth asphyxia and birth trauma, and neonatal sepsis accounted for almost three quarters of neonatal deaths. Among children aged 1–59 months, acute respiratory infections, diarrhoea and malaria were the leading causes of death in 2017. Congenital anomalies are an important cause of death among newborns and children under the age of five, especially in countries with low neonatal and under-five mortality rates.

9. Globally in 2018, 149 million children under the age of five (21.9%) were stunted (short for their age), with three quarters of such children living in the South-East Asia Region or African Region. High levels of stunting negatively impact the development of countries due to its association with childhood morbidity and mortality, learning capacity and noncommunicable diseases later in life. In 2018, 49 million children under the age of five (7.3%) were wasted (too light for their height), while 40 million (5.9%) were overweight (too heavy for their height). Wasting and overweight may sometimes coexist in the same populations – the so-called “double burden of malnutrition” – as observed in the Eastern Mediterranean Region.

10. Another related Sustainable Development Goal target is 5.2 on eliminating all forms of violence against all women and girls. Data for these indicators are currently derived from either stand-alone or demographic and health, population-based surveys. WHO and partners UNICEF, UN Women, UNFPA and UNODC are working to improve measurement and data collection and reporting to enhance comparability across studies.

Infectious diseases

11. The main Sustainable Development Goal target relating to infectious diseases is target 3.3.

12. Globally, HIV incidence declined from 0.40 per 1000 uninfected population in 2005 to 0.25 per 1000 uninfected population in 2017. The African Region remained the most heavily impacted, with an incidence rate of 1.22 per 1000 uninfected population, twentyfold the rate in the Eastern Mediterranean and Western Pacific regions. An estimated 940 000 people died of HIV-related illnesses in 2017, 110 000 of whom were children. A record 21.7 million people were receiving treatment by the end of 2017, a net increase of 2.3 million people since the end of 2016. However, 41% of people living with HIV were still not receiving treatment.

13. After unprecedented global gains in malaria control, progress has slowed. No significant gains were made in reducing the number of malaria cases worldwide in the period 2015 to 2017. The African Region continues to carry the heaviest burden of disease. Worryingly, there were an estimated 3.5 million more malaria cases in the 10 highest burden African countries in 2017 compared with the previous year.

14. Globally, the tuberculosis incidence rate declined by 1.5% per year since 2000, reaching 133 per 100 000 population in 2017. The severity of national epidemics varied widely: there were under 10 new cases per 100 000 population in most high-income countries in 2017, 150–300 new cases per 100 000 population in most of the 30 countries with a high burden of tuberculosis and above 500 new cases per 100 000 population in a few countries. In 2017, an estimated 10 million people fell ill with tuberculosis, 87% of them in the 30 high-burden countries in all six WHO regions, while an estimated 1.3 million HIV-negative people and an estimated 300 000 HIV-positive people died of the disease. Between 2000 and 2017, tuberculosis treatment averted an estimated 45 million deaths among HIV-negative people and, supported by antiretroviral treatment, averted 9 million deaths among HIV-positive people. Drug-resistant tuberculosis is a continuing threat. In 2017, there were 560 000 new cases of the disease that were resistant to rifampicin (the most effective first-line drug), of which 460 000 were multidrug-resistant.

15. In 2015, an estimated 325 million people worldwide were living with hepatitis B virus (HBV) or hepatitis C virus (HCV) infection. Most of the burden of disease due to HBV infection results from infections acquired before the age of five. The widespread use of hepatitis B vaccine in infants has considerably reduced the incidence of new chronic HBV infections, as reflected by the decline in hepatitis B prevalence among children under five years of age, from 4.7% in the pre-vaccine era to 0.8% in 2017. Unsafe health care procedures and injection-drug use are the major routes of HCV transmission. To reduce this risk, well-targeted interventions to prevent infections need to be expanded. Screening, diagnosis and treatment also need to be expanded to enable people with infections to be cured. The WHO's *Global hepatitis report, 2017* provides baseline data and analysis for the drive towards elimination.

16. Neglected tropical diseases are a group of diseases characterized by their proliferation in tropical environments where multiple infections in a single individual are common and by their association with poverty. A reported 1.6 billion people required mass or individual treatment and care for neglected tropical diseases in 2017, down from 2 billion people in 2010. Progress has been driven in large part by the fact that at least one neglected tropical disease has been eliminated in 34 countries, as certified by WHO. In 2017, more than 1 billion people were treated during mass administration campaigns for at least one of five neglected tropical diseases amenable to preventive chemotherapy (lymphatic filariasis, onchocerciasis, soil-transmitted helminthiasis, trachoma and schistosomiasis).

Noncommunicable diseases, tobacco control, substance abuse and mental health

17. The main Sustainable Development Goal targets relating to noncommunicable diseases, tobacco control, substance abuse and mental health are targets 3.4, 3.5 and 3.a.

18. In 2016, an estimated 41 million deaths occurred due to noncommunicable diseases, accounting for 71% of the overall total of 57 million deaths worldwide. The majority of such deaths were caused by the four main noncommunicable diseases: cardiovascular disease (17.9 million deaths or 44% of all deaths from noncommunicable diseases); cancer (9.0 million deaths or 22%); chronic respiratory disease (3.8 million deaths or 9%); and diabetes (1.6 million deaths or 4%). Globally, the risk of dying from any one of the four main noncommunicable diseases between ages 30 and 70 decreased from 22% in 2000 to 18% in 2016.

19. The worldwide level of alcohol consumption in 2016 was 6.4 litres of pure alcohol per person aged 15 years or older, a level that remained stable since 2010. In 2016, some 2.3 billion adults (43% of the adult population) were current drinkers, while some 2.4 billion others (45% of the adult population) had never consumed alcohol. Consumption in the South-East Asia Region increased by almost 30% since 2010, while that of the European Region decreased by 12% but remained the highest in the world. 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.

20. Tobacco use is a major risk factor for cardiovascular diseases, cancers and chronic respiratory diseases, and has negative social, environmental and economic consequences. In 2016, globally more than 1.1 billion people aged 15 years or older smoked tobacco (34% of all males and 6% of all females in this age group). To date, the WHO Framework Convention on Tobacco Control has been ratified by 181 Parties, representing more than 90% of the global population. While the status of implementation has consistently improved since the Convention's entry into force in 2005, progress towards implementation of the various articles remains uneven, with implementation rates ranging from 13% to 88%. Time-bound measures under the Convention, such as Articles 8 (Protection from exposure to tobacco smoke) and 11 (Packaging and labelling of tobacco products) continue to be the most implemented. Articles 17 (Provision of support for economically viable alternative activities), 18 (Protection of the environment and the health of persons) and 19 (Liability) and seem to be the least successfully implemented, with little or no progress in comparison to 2016. The Protocol to Eliminate Illicit Trade in Tobacco Products, which entered into force on 25 September 2018, presents a comprehensive set of tools to fight illicit trade, such as the establishment of a tracking and tracing system and measures to promote international cooperation, including sanctions and law enforcement.

21. The Sustainable Development Goal indicator 3.4.2, relating to mental health, focuses on suicide mortality rates. Almost 800 000 deaths by suicide occurred in 2016. Men are 75% more likely than women to die as a result of suicide. Suicides deaths occur in adolescents and adults of all ages. Suicide mortality rates were highest in the European Region (15.4 per 100 000 population) and lowest in the Eastern Mediterranean Region (3.9 per 100 000 population).

Injuries and violence

22. The main Sustainable Development Goal targets relating to injuries and violence are targets 3.6, 5.2, 13.1, 16.1 and 16.2.

23. Road traffic crashes killed 1.35 million people worldwide in 2016 and injured up to 50 million more. The death rate due to road traffic injuries was 3.3 times higher in low-income countries

(27.5 deaths per 100 000 population) than in high-income countries (8.3 deaths per 100 000 population), despite lower rates of vehicle ownership in low-income countries.

24. About one third (35%) of women have experienced either physical and/or sexual intimate partner violence or non-partner sexual violence at some point in their life.

25. It is estimated that over the period 2012–2016, on average there were 11 000 deaths globally each year due to natural disasters, equating to 0.15 deaths per 100 000 population. Low- and lower-middle-income countries typically have higher mortality rates and struggle to meet financial, logistical and humanitarian needs for recovery from disasters.

26. An estimated 477 000 murders occurred globally in 2016, with four fifths of all homicide victims being male. Men in the Region of the Americas suffered the highest rate of homicide deaths, at 31.8 per 100 000 population, down from 33.5 per 100 000 population in 2000.

27. It is estimated that in 2016, 180 000 people were killed in wars and conflicts, not including deaths due to the indirect effects of war and conflict such as the spread of diseases, poor nutrition and collapse of health services. The average death rate due to conflicts during the previous five years (2012–2016), at 2.5 deaths per 100 000 population, was more than double the average rate in the preceding five-year period (2007–2011). The Eastern Mediterranean Region had the highest conflict death rate in 2012–2016, at 24.1 deaths per 100 000 population.

Emergency and essential surgical care and anaesthesia

28. The main Sustainable Development Goal targets relating to emergency and essential surgical care and anaesthesia are targets 3.8, 3.1, 3.2, 3.3, 3.4, 3.6, 3.7, 3.b and 3.c.

29. Access to safe, timely, and affordable emergency and essential surgical care and anaesthesia is a critical component of universal health coverage. Globally, 5 billion people lack this access; 1.7 billion are children under the age of 15 years.

30. Each day, 830 women die from complications of childbirth. The majority of these deaths could be prevented and are most commonly caused by obstructed labour and post-partum haemorrhage. The primary treatment of such complications is surgical care.

31. A total of 6.3 million children under the age of 15 years died in 2017. Some 5.4 million of them were under the age of 5 years and 2.5 million of those children died within the first month of life. This translates into 15 000 under-five deaths per day. Many of these deaths among children under 15 years of age are caused by congenital malformations, violence and injury, and childhood neoplasms: the majority of these are most appropriately treated with surgical care.

32. Each year, 15 million people die from a noncommunicable disease between the ages of 30 and 69 years; about 85% of these deaths occur in low- and middle-income countries and are a result of cardiovascular diseases (heart disease and stroke), cancers and diabetes. Surgical care is a major component in tackling each of these diseases and is essential in order to reduce these premature deaths.

33. Some 1.35 million people die each year as a result of road traffic crashes; 93% of which occur in low- and middle-income countries and are the leading cause of death for children and young adults aged 5–29 years. Surgical care is an integral part of emergency resuscitation, life-saving interventions and follow-up care necessary to reduce the enormous burden resulting from road traffic crashes.

Universal health coverage and health systems

34. The main Sustainable Development Goal targets relating to universal health coverage and health systems are targets 3.8, 3.b, 3.c, 17.19 and 1.a.

35. Globally, the average national percentage of total government expenditure devoted to health was 10.6% in 2016, ranging from 7% in the African Region and South-East Asia Region to over 15% in the Region of the Americas. This measure indicates the level of government spending on health from domestic sources within the total expenditure for public-sector operations in a country and could constitute part of Sustainable Development Goal indicator 1.a.2.

36. The service coverage index for universal health coverage is a single indicator computed from tracer indicators of the coverage of essential services in the areas of reproductive, maternal, newborn and child health, infectious disease control, noncommunicable diseases and service capacity and access. As measured by this index, the levels of service coverage varied widely across countries in 2015, from 22 to 86 (out of a maximum index score of 100). At least half of the world's population do not have full coverage of essential health services. Among those who were able to access needed services, many suffered undue financial hardship. In 2010, an estimated 808 million people or 11.7% of the world's population spent at least 10% of their household budget (total household expenditure or income) paying out of their own pocket for health services, for 179 million of whom such payments exceeded a quarter of their household budget. An estimated 97 million people or 1.4% of the world's population were impoverished by out-of-pocket health care spending in 2010 (at the 2011 poverty line of US\$ 1.90 a day (purchasing power parity)).

37. According to the latest available data for the period 2013–2018, 71 countries reported having less than 10 medical doctors per 10 000 population, with 105 countries reporting having fewer than 40 nursing and midwifery personnel per 10 000 population. In many countries, nurses and midwives constitute more than half of the national health workforce. The safety and security of health workers are matters of major concern in protracted crises and acute emergencies. Eighty-six per cent of killings of and injuries to health workers reported globally in 2015 involved the Eastern Mediterranean Region.

38. Essential medicines cover a wide range of diseases and conditions, including pain management and palliative care. Data from health facility surveys conducted nationally in 29 countries during the period 2007–2017 indicate that 64% of public-sector facilities surveyed in low-income countries and 58% of public-sector facilities surveyed in lower-middle income countries stocked medicines for pain management and palliative care. Less than 10% of the public-sector health facilities surveyed in low-income countries stocked opioid analgesics such as morphine, buprenorphine, codeine, methadone and tramadol – essential medications for treating the pain associated with many advanced progressive conditions.

39. During 2017, about 85% of infants worldwide (116.2 million infants) received three doses of diphtheria-tetanus-pertussis (DTP3) vaccine, protecting them against infectious diseases that can cause serious illness and disability or be fatal. By 2017, 123 countries had reached at least 90% coverage of DTP3 vaccine. However, an estimated 19.9 million children under the age of one did not receive DTP3 vaccine in 2017. By the end of 2017, 85% of children had received one dose of measles vaccine by their second birthday and 167 countries had included a second dose as part of routine immunization, with 67% of children receiving two doses of measles vaccine according to national immunization schedules. Global coverage levels of more recently recommended vaccines such as rotavirus vaccine and pneumococcal-conjugated vaccine were still under 50%. Human papillomavirus vaccine was

introduced in 80 countries by the end of 2017, not counting four countries where it was only partially introduced.

40. Each year, billions of dollars are spent on research and development into new or improved health products and processes, ranging from medicines to vaccines to diagnostics. But the way these funds are distributed and spent is often poorly aligned with global public health needs. Countries with comparable levels of income and health needs receive different levels of official development assistance for medical research and for basic health sectors. In 2015, low-income countries received only 0.3% of direct grants for health research.

41. It is estimated that only about half of the 194 Member States register at least 80% of the deaths of their population aged 15 years and older, with associated information on cause of death. In addition, data-quality problems further limit the use of such information.

Environmental risks

42. The Sustainable Development Goals include several targets relating to environmental sustainability and human health, including targets under Goals 3, 6, 7, 9, 11, 12 and 13.

43. Access to clean fuels and technologies for cooking has marginally improved and in 2017 reached 61% globally – an increase of 11 percentage points since 2000. However, coverage levels vary greatly between countries and population growth continues to outpace the transition to clean fuels and technologies, leaving more than 3 billion people still cooking with polluting fuel and stove combinations. While over 90% of the population in the Region of the Americas (92%) and the European Region (97%) used clean fuels and technologies for cooking, less than one fifth (17%) of the population in the African Region did. The resulting household air pollution is estimated to have caused 3.8 million deaths from noncommunicable diseases (including heart disease, stroke and cancer) and acute lower respiratory infections in 2016.

44. In 2016, 91% of the world's population did not breathe clean air, while more than half of the global urban population were exposed to outdoor air pollution levels at least 2.5 times above the safety standard set by WHO. In some countries in the Eastern Mediterranean and African regions, as a result of additional natural sources of atmospheric pollution such as natural dust, ambient air pollutants may rise to more than eight times the WHO-recommended safe levels. It is estimated that in 2016, outdoor air pollution in both cities and rural areas caused 4.2 million deaths worldwide, while indoor pollution caused a further 2.8 million deaths – a total of 7 million, or one in eight, deaths globally. Housing conditions, in addition to fuels used for heating and cooking, are matters of substantial importance for public health. The *WHO Housing and health guidelines* highlight that “improved housing conditions can save lives, reduce disease, increase quality of life, reduce poverty, help mitigate climate change and contribute to the achievement of a number of Sustainable Development Goals, including those addressing health (Goal 3) and sustainable cities (Goal 11). Housing is therefore a major entry point for intersectoral public health programmes and primary prevention”.¹

45. Unsafe drinking water, unsafe sanitation and lack of hygiene also remain important causes of death, with an estimated 870 000 associated deaths occurring in 2016. The African Region suffered a disproportionate burden from such deaths, with a mortality rate four times the global rate. Available data from fewer than 100 countries indicate that safely managed drinking water services – that is, located on premises, available when needed and free from contamination – were enjoyed by only 71% of the global

¹ WHO Housing and health guidelines. Geneva: World Health Organization; 2018, p. vii.

population (5.2 billion people) in 2015, whereas safely managed sanitation services – with excreta safely disposed of in situ or treated off-site – were available to only 39% of the global population (2.9 billion people). Untreated household wastewater contaminates drinking water sources, posing risks to public health and the environment. Preliminary estimates from 79 countries (excluding much of Africa and Asia) show that, in 22 countries, less than 50% of all household wastewater flows are safely treated. Ensuring water and sanitation for all requires financial resources and technical capacity to support and sustain investments in infrastructure. While total official development assistance committed and disbursed across all sectors steadily increased between 2011 and 2016, the share of such commitments to water-related activities declined. A 2017 survey found that more than 80% of countries reported insufficient financing to meet national water, sanitation and hygiene targets.

46. Unintentional poisonings were responsible for more than 100 000 deaths in 2016. Although the number of deaths from unintentional poisonings has steadily declined since 2000, mortality rates continue to be relatively high in low-income countries. Unintentional poisoning can be caused by household chemicals, pesticides, kerosene, carbon monoxide and medicines or can be the result of environmental contamination or occupational chemical exposure.

Health risks and disease outbreaks

47. The main Sustainable Development Goal target relating to health risks and disease outbreaks is target 3.d. Under the International Health Regulations (2005), all States Parties are required to have or to develop minimum core public health capacities to implement the Regulations effectively. In 2017, 167 States Parties (85%) responded to the monitoring questionnaire, up from 129 States Parties (66%) in 2016. All 196 States Parties have responded to the monitoring questionnaire at least once since 2010. The average core capacity score of all reporting countries in 2017 was 71%.

II. PROGRESS IN IMPLEMENTING RESOLUTION WHA69.11

Promoting a multisectoral and coordinated approach to implementation of the 2030 Agenda

48. WHO's Thirteenth General Programme of Work, 2019–2023 recognizes that multisectoral approaches are needed to respond to the social, environmental and economic determinants of health. WHO supports whole-of-government, whole-of-society and Health in All Policies approaches that deal comprehensively with all health determinants.

49. WHO has been involved in several intersectoral initiatives to address Sustainable Development Goal 3. The Global Strategy for Women's, Children's and Adolescents' Health (2016–2030) covers 11 Sustainable Development Goals, including all targets under Goal 3 and targets under 10 other Goals (1–7, 9, 10, 16 and 17). The 2017 report of the Commission on Ending Childhood Obesity¹ highlights fiscal and legislative actions to be taken. The Nurturing Care for Early Childhood Development Framework,² developed with UNICEF, the World Bank, the Partnership for Maternal, Newborn and Child Health and the Early Childhood Development Action Network, sets strategic directions to inspire action in multiple sectors from pregnancy up to age three. The Third Global Conference on Climate and Health in 2018 saw the formal launch of the WHO special initiative on climate change and health in small island developing States, developed in collaboration with the secretariat of the United Nations

¹ Document WHO/NMH/PND/ECHO/17.1.

² WHO, UNICEF, World Bank Group. Nurturing care for early childhood development: a framework for helping children survive and thrive to transform health and human potential. Geneva: World Health Organization; 2018.

Framework Convention on Climate Change and the Government of Fiji at a meeting of the Conference of the Parties to the Convention. In line with resolution WHA70.15 (2017), WHO made an online global call for evidence on practices of dealing with migration and health, receiving responses from 52 Member States and international partners. In a landmark United Nations General Assembly political declaration, entitled “United to end tuberculosis: an urgent global response to a global epidemic”, approved on 26 September 2018, Heads of State pledged to provide leadership and increase annual funding to US\$ 13 billion in order to treat all 40 million people in need of care by 2022. At the Third United Nations High-level Meeting on Noncommunicable Diseases convened by the United Nations General Assembly on 27 September 2018, Heads of State committed to fiscal, information and legislative measures recommended by WHO, including restricting alcohol advertising, nutrition labelling and marketing, banning smoking, taxing sugary drinks, public education, vaccinations, treating hypertension and diabetes, promoting regular physical activity, reducing air pollution and improving mental health and well-being.

50. WHO regional offices have developed plans to support countries in taking multisectoral action. For example, in the European Region, the road map to implement the 2030 Agenda for Sustainable Development, building on Health 2020, the European policy framework for health and well-being, was adopted,¹ highlighting five strategic priorities (governance, health determinants, healthy places, leaving no one behind and universal health care) and four enabling measures. Using the roadmap, 20 European Member States have been supported in their implementation of the 2030 Agenda. Through one of the enabling measures, namely, multipartner cooperation, the WHO Regional Office for Europe calls on the Issue-based Coalition on Health and Well-being, a partnership of multiple United Nations agencies and other intergovernmental organizations and stakeholders, led by the Regional Office for Europe, to jointly implement the health-related targets. One of the first achievements was recorded when 14 regional United Nations agencies joined forces to end HIV infection, tuberculosis and viral hepatitis through coordinated approaches. In 2018, the Regional Committee for Europe decided to adopt a set of indicators for the joint monitoring framework for the Sustainable Development Goals, Health 2020 and the Global Action Plan for the Prevention and Control of Noncommunicable Diseases 2013–2020.² In the same year, members of the WHO European Healthy Cities Network adopted the Belfast Charter for Healthy Cities, which defines new bold health roles for city mayors and local government. In 2012, the Regional Office for the Eastern Mediterranean established the Regional Healthy City Network, which currently recognizes 67 healthy cities from 14 Member States. The Healthy Cities programme in the Eastern Mediterranean Region guides local authorities at the city level to address determinants of health and well-being, using a set of criteria and indicators developed by the Regional Office. In the Western Pacific Region, the Asia-Pacific Parliamentary Forum on Global Health is working to improve public health legislation. WHO in the African Region and the African Union Commission have reaffirmed their commitment to strengthen collaboration and to implement a joint workplan for 2019–2020 and engagement protocols between WHO and the Africa Centres for Disease Control and Prevention. With regard to environmental sustainability, several regions are increasingly active through multisectoral forums such as the African Inter-Ministerial Conference on Health and Environment; the Asia-Pacific Regional Forum on Health and Environment; the European Environment and Health Process; the Council of Arab Ministers of Health and the Council of Arab Ministers Responsible for the Environment; and the ongoing work of PAHO to improve environmental health and strengthen health promotion through networks of cities.

51. WHO has also engaged with other partners on health-related issues beyond Sustainable Development Goal 3. It has strengthened ties with FAO and other partners around an ambitious work

¹ Resolution EUR/RC67/R3 (2017).

² Adopted by the Regional Committee in decision EUR/RC68(1).

programme¹ aimed at ending hunger (Sustainable Development Goal 2) and has also identified specific, measurable, achievable, relevant and time-bound (SMART) commitments for Member States.² In the area of education (Goal 4), WHO, ILO and OECD launched Working for Health, a five-year action plan for health, employment and inclusive economic growth (2017–2021),³ and established the Working for Health Multi-Partner Trust Fund, which will support partners to invest in the health, environmental health and social service workforces. In 2018, WHO published its first global *Guidelines on sanitation and health*,⁴ which will help countries to invest in safe, culturally and gender-appropriate sanitation (Goal 6). WHO and ILO jointly established the Global Occupational Safety and Health Coalition to promote health and well-being in the working environment (Goal 8). WHO and ILO are developing their first joint methodology and estimates of the work-related burden of disease and injury. WHO continues to be involved in several interagency networks and committees on gender equity and human rights (Goals 5, 10 and 16). Addressing the combined Sustainable Development Goals for energy, sustainable cities and communities and climate action (Goals 7, 11 and 13), the first WHO Global Conference on Air Pollution and Health was held in Geneva from 31 October to 1 November 2018 to address the 7 million premature deaths related to air pollution. Commitments to address air pollution will be taken forward by the new global coalition on Health, Environment and Climate Change, founded in 2018 by WHO, UNEP and WMO; it will also accelerate the action plan for health and climate and align air pollution and climate mitigation efforts. With regard to responsible consumption and production (Goal 12) as well as clean water (Goal 6), the Seventieth World Health Assembly approved the road map to enhance health sector engagement in the Strategic Approach to International Chemicals Management towards the 2020 goal and beyond. As called for, WHO has established a Global Chemicals and Health Network to facilitate implementation.

52. As part of WHO's contribution to the achievement of the 2030 Agenda for Sustainable Development and to the promotion of a coordinated multisectoral approach to implement the Sustainable Development Goals (in accordance with resolution WHA69.11), the Secretariat is working with 11 global health and development organizations (Gavi, the Vaccine Alliance; the Global Financing Facility; the Global Fund; UNAIDS; UNDP; UNFPA; UNICEF; Unitaid; UN Women; the World Bank Group and WFP) to develop a global action plan for healthy lives and well-being for all that is designed to support countries to achieve the targets of the health-related Sustainable Development Goals. The development of the plan, which is based on a request addressed to the Director-General by the Heads of State of Germany, Ghana and Norway, has received the support of the United Nations Secretary-General and the leaders of the G20 nations.

53. The outcome of the first phase of this work, which outlines the joint vision and landmark commitment of the 12 organizations concerned was presented at both the World Health Summit in Berlin and the Global Conference on Primary Health Care in Astana in October 2018.

¹ Focused on food systems; essential nutrition actions; social protection; trade and investment; supportive environments; and strengthened governance.

² For a review of SMART commitments of countries to the implementation framework of the Rome Declaration on Nutrition, see FAO, IFAD, UNICEF, WFP and WHO. The state of food security and nutrition in the world 2018. Rome: Food and Agriculture Organization of the United Nations; 2018 (<https://data.unicef.org/resources/sofi-2018/>, accessed 20 February 2019); and FAO and WHO. Strengthening nutrition action: a resource guide for countries based on the policy recommendations of the Second International Conference on Nutrition (ICN2). Rome: Food and Agriculture Organization of the United Nations; 2018 (<http://www.who.int/nutrition/publications/strengthening-nutrition-action/en/>, accessed 20 February 2019).

³ Five-year action plan for health employment and inclusive economic growth (2017–2021). Geneva: World Health Organization; 2018 (<http://www.who.int/hrh/com-heeg/action-plan-annexes/en/>, accessed 19 February 2019).

⁴ Guidelines on sanitation and health. Geneva: World Health Organization; 2018.

54. The first phase in the development of the plan united organizations by a common aim and established a joint action framework, based on a commitment to align, accelerate and account in order to build on existing coordination efforts and collaboration in countries and to further leverage the capacities of the larger multilateral system in support of countries. The first phase builds a foundation for expanded partner engagement, with a view to aligning policies, approaches and methodologies to enhance efficiency and effectiveness; accelerating progress in cross-cutting areas that have potential to significantly impact achievement across the targets of the health-related Sustainable Development Goals; and accounting for maximized investments and delivering value-for-money and sustainable results for people.

55. The next phase of the development of this work is focused on defining concrete, collective actions of the 12 organizations to support countries in accelerating progress toward the health-related targets of the Sustainable Development Goals through consultation and engagement among stakeholders at country, regional and global levels. The plan is aimed at generating additional commitment to health among relevant global actors. The plan will build on institutional strategies, such as WHO's Thirteenth General Programme of Work, and will strive to align with other processes and initiatives, such as the Secretary-General's reform efforts. It is envisaged that the plan will be ready to be launched in September 2019 during the United Nations General Assembly.

Engaging in United Nations system-wide strategic planning, implementation and reporting

56. WHO is an active member of the United Nations Development Group and of the Inter-Agency Standing Committee. The Development Group unites the United Nations system entities that contribute to the attainment of the 2030 Agenda for Sustainable Development at the country level. WHO has also participated in consultations of task teams, including those for country-focused data and reporting, leave no one behind and on integrated policy support. WHO also contributes to the reporting of the progress towards 27 Sustainable Development Goal targets, as sole custodian for 19 indicators, co-custodian for 15 indicators and partner agency for an additional 13 indicators. As custodian, co-custodian or partner for 20% of the global indicator framework, to strengthen country monitoring and reporting capacity, WHO, through the United Nations Statistical Commission and other regional bodies such as the African Union Commission, is also engaged with national statistical offices, who are coordinating monitoring progress made towards the Sustainable Development Goals at the country level.

57. As set forth in the Thirteenth General Programme of Work, WHO is committed to supporting the United Nations Secretary-General's proposal to work as "one UN" to improve the efficiency and effectiveness of operational activities at the country level to support countries towards achievement of the Sustainable Development Goals. WHO engages as part of United Nations country teams within the resident coordinator system and aims to strengthen the health capacity of countries, while recognizing its constitutional mandate to act as the directing and coordinating authority on international health work. WHO also recognizes the option, in 2023, subject to satisfactory progress, of extending the Thirteenth General Programme of Work to 2025, thereby aligning WHO's strategic planning cycle with that of the wider United Nations family.

58. WHO actively contributed to a range of progress reports on implementation of the Sustainable Development Goals and joint agency reporting.

Developing a long-term plan for maximizing the impact of the contributions of WHO

59. The Thirteenth General Programme of Work, 2019–2023 sets out WHO’s strategic direction, outlines how the Organization will proceed with its implementation and provides a framework to measure progress. It will guide the development of implementation plans, the programme budget, results frameworks and operational plans. It has taken account of the strategic plans of WHO regional offices and has been developed in collaboration with the Regional Directors.

60. A major shift will be to create a seamless organization, in which people’s primary affiliation is to WHO rather than their own particular programme. All three levels of the Organization will work closely together, with a clear focus on country impact, results and accountability. There will be greater alignment between WHO’s vision and strategy and its daily activities.

Working with the Inter-Agency and Expert Group on Sustainable Development Goal Indicators

61. WHO has advised the Inter-Agency and Expert Group on Sustainable Development Goal Indicators. Recent contributions covered the refinement of indicators 3.b.1 and 3.8.1 and the reclassification of indicator 3.b.3. A comprehensive review of Sustainable Development Goal indicators is expected in 2020, based on the criteria set out by the group at its ninth meeting in March 2019.¹

Supporting comprehensive and integrated national plans for health

62. All regional offices have developed strategies to advance universal health coverage. In the Region of the Americas, 26 countries are preparing comprehensive national health policies, strategies and plans within the context of the regional strategy. Among Caribbean countries, comprehensive reform processes are under way. Furthermore, 13 countries have implemented a monitoring framework for universal health. The Regional Office for the Western Pacific has promoted an action framework on the Sustainable Development Goals that mobilizes parliamentarians and WHO collaborating centres. The Regional Office for Africa has also developed an action framework and provided technical support to 23 countries to develop comprehensive national health strategic plans. The Regional Office for the Eastern Mediterranean pursues the Framework for action for advancing universal health coverage in the Eastern Mediterranean Region; in September 2018, health ministers and heads of delegations in the Region signed the UHC2030 Global Compact for progress towards universal health coverage and adopted the Salalah Declaration, in order to ensure that at least 100 million more people benefit from universal health coverage in the Region by 2023.

63. WHO country offices have been supporting governments and partners in the implementation of Sustainable Development Goals, including by providing advice, facilitation, coordination on setting national targets and indicators (130 country offices), providing advocacy for mainstreaming the Goals in national plans (139), providing technical support to mainstream the Goals into national plans (133), providing support on measuring and reporting (104), promoting the establishment of alliances and a multisectoral approach (110), providing support on resource mobilization (76) and providing capacity-building for a multisectoral approach (110).

¹ See the workplan and timeline for the 2020 comprehensive review (<https://unstats.un.org/sdgs/files/meetings/iaeg-sdgs-meeting-09/11.%20Comprehensive%20Review.pdf>, accessed 2 May 2019).

Supporting Member States in strengthening research and development of new technologies and tools

64. The 2018 review of the WHO research and development Blueprint for action to prevent epidemics identified an urgent need for accelerated research and development on nine diseases. Applying the Blueprint to Zika virus has allowed the development of a vaccine to progress at an unprecedented speed. For Middle East respiratory syndrome coronavirus, WHO has developed a global research and development road map and vaccine target product profiles.

65. WHO has collaborated on numerous product development partnerships. For example, with the Drugs for Neglected Diseases initiative, it has established the Global Antibiotic Research and Development Partnership to develop new antibiotics on a not-for-profit basis. Clinical trials have started to develop a new first-in-class treatment for drug-resistant gonorrhoea and to develop new treatments for neonatal sepsis.¹

66. WHO is engaged in various activities to promote research availability and transparency, such as the International Clinical Trials Registry Platform, the publication of a formal position on the timing of reporting and a statement on public disclosure of clinical trial results. In order to foster an enabling environment for research on vaccines, medicines and diagnostics for outbreak response, a number of tools have been developed, including material transfer agreements for sample-sharing and an agreement with stakeholders for rapid sharing of data. WHO also provides support for the Coalition for Epidemic Preparedness Innovations.

67. WHO provides technical support to countries to enhance clinical trial oversight, especially in low- and middle-income countries, including by facilitating the acceleration of clinical trial and market approvals through work with national regulatory authorities and regulatory and other networks, such as the African Vaccine Regulatory Forum. Other regional activities include the establishment by the Regional Office for the Western Pacific of a health research portal, national health research/clinical trial registries and an Ethics Review Committee to provide an ethical review of research involving human participants.

68. Under the umbrella of the global strategy and plan of action on public health, innovation and intellectual property,² WHO set up 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.

Supporting Member States to develop more effective approaches to ensuring and delivering universal access to health services

69. Along with other departments, the Alliance for Health Policy and Systems Research, a partnership hosted by WHO, is working to strengthen the capacity of policy-makers to better engage with research to improve health systems. It has established an innovative embedded research approach, which provides support to policy-makers to address context-specific factors and challenges through research; more than 100 projects around the world that utilize this approach have been supported. WHO is also leading a new portfolio of work to strengthen institutional capacity for health policy and systems research in

¹ See Global Antibiotic Research and Development Partnership website (<https://www.gardp.org/>, accessed 19 February 2019).

² See document A70/21.

six low- and middle-income countries and has supported more than 20 policy-makers from low- and middle-income countries to attend the Fifth Global Symposium on Health Systems Research in Liverpool, United Kingdom of Great Britain and Northern Ireland. An innovative model is being tested to embed rapid review production directly within health decision-making institutions in lower and middle-income countries. Together with PAHO and UNICEF/UNDP/World Bank/WHO Special Programme for Research and Training in Tropical Diseases (TDR), WHO expanded this model's reach in the Region of the Americas in 2018 by supporting 13 further projects in 11 countries that are targeted at achieving the health-related Sustainable Development Goals. The Regional Office for the Eastern Mediterranean (EMRO) identifies and prioritizes health research gaps every two years, on the basis of which it calls for proposals for WHO-funded research grants in the Region (such as the Research in Priority Areas of Public Health Grant or the Joint EMRO/TDR Small Grants Scheme for implementation research in infectious diseases of poverty). WHO is working directly with Ethiopia, India and Nepal to identify health systems research priorities as they work to achieve universal health care.

Supporting Member States to strengthen emergency and essential surgical care and anaesthesia as a component of universal health coverage

70. The Secretariat, together with other key stakeholders, has been involved in a variety of projects.

(a) The development of national surgical, obstetric and anaesthesia care plans: the demand from Member States has been so great that regional workshops leading to the development of these plans have been carried out in the African and Eastern Mediterranean regions. Progress has been made in developing such plans in more than 20% of low- and middle-income countries (with a combined population of 1 billion individuals) in all regions except the European Region. A manual on developing these plans will be published soon.

(b) The development of norms and standards: the Secretariat is finalizing global guidelines for the prevention of Ebola or Marburg virus transmission during surgery and invasive procedures and has completed *Surgical approaches to the urogenital manifestations of lymphatic filariasis* the WHO-World Federation of Societies of Anaesthesiologists *International standards for a safe practice of anaesthesia*.

(c) Workforce development: the Secretariat continues to work with Member States and various surgical colleges and development partners to provide platforms for sharing evidence of best practices, and develop minimum standards and core curricula in order to ensure that there are fully trained and mid-level providers (through task-sharing) in the surgical, obstetric and anaesthesia health workforce.

71. Although progress has been made in certain areas, it is clear that further improvement is needed, at the country, regional and international levels, if full implementation of resolution WHA68.15 is to be achieved. The specific challenges are:

(a) resource development – currently, efforts are continuing: to ensure there are adequate resources to develop and implement national surgical, obstetric and anaesthesia care plans; to strengthen workforce development; and to develop greater capacity in surgical care service delivery platforms;

(b) system strengthening – specific areas that need to be additionally strengthened are children's surgery, surgical care for noncommunicable diseases and injuries, including traumatic brain injury;

- (c) workforce development – threats to the expansion of an adequate health workforce through training programmes in surgery, anaesthesia and obstetrics continue, due to a diminished teaching workforce and constrained resources, and are likely to be protracted.

Facilitating enhanced North–South, South–South and triangular regional and international cooperation

72. Globally, half of the WHO offices in the six regions reported supporting a total of 241 South–South and/or triangular cooperation initiatives, of which 68% cover communicable diseases, 47% cover health systems and universal health care, 38% cover health emergencies and international health regulation initiatives, 31% cover noncommunicable diseases, 30% cover promoting health through the life-course and 16% cover other issues. In addition, 76% of initiatives include technical support, 74% include training and capacity-building, 47% establish information-sharing platforms and networks, 32% provide financial and equipment support and 18% provide other services.

73. Country offices in the Region of the Americas provided most reporting to support South–South and/or triangular cooperation initiatives (78%), followed by the South-East Asia Region (64%), the Western Pacific Region (60%), the African Region (55%), the Eastern Mediterranean Region (28%) and the European Region (20%). The African Region supported 80 initiatives, the Region of the Americas supported 55 initiatives, the Western Pacific Region supported 38 initiatives, the South-East Asia Region supported 35 initiatives, the European Region supported 17 initiatives and the Eastern Mediterranean Region supported 16 initiatives.

74. The major focus of the initiatives varied by region. In the Region of the Americas, most initiatives were related to health systems, universal health care and communicable diseases. In the African Region, most were related to communicable diseases and health emergencies/international health regulations. In the Western Pacific, South-East Asia and Eastern Mediterranean regions, most initiatives were related to communicable diseases, while in the European Region most were related to noncommunicable diseases.

75. In the African Region and the Region of the Americas, the focus was on technical support and training and capacity-building, while in the Western Pacific and Eastern Mediterranean regions, the focus was on training and capacity-building. In the South-East Asia Region, the focus was on technical support; in the European Region, the focus was on technical support, training and capacity-building, in addition to establishing information-sharing platforms and networks.

76. WHO country offices have been supporting numerous South–South and/or triangular cooperation initiatives and activities of several technical areas in different ways. South–South and triangular cooperation has been mainstreamed to the policies and programmes of the Organization and has become a means of implementation to achieve the health-related Sustainable Development Goals. However, there is still a need to further strengthen South–South and triangular cooperation by addressing the major challenges faced by country offices in promoting this kind of cooperation.

Supporting thematic reviews of progress on the Sustainable Development Goals

77. The High-level Political Forum on Sustainable Development convened by the United Nations Economic and Social Council in 2016, on the theme “Ensuring that no one is left behind”, was the first since the adoption of the 2030 Agenda and the Sustainable Development Goals. In 2016, WHO launched a technical handbook, the *Innov8 approach for reviewing national health programmes to leave no one behind*, which has been translated into Spanish and French. It involves an eight-step pathway to review who is left behind, why and what can be done to respond within the health sector and beyond. WHO also

piloted methods for conducting assessments of barriers to health services and to integrate a “leave no one behind” approach in national health policies, strategies and plans and related subnational planning. The role of health promotion in improving health equity was reinforced at the Ninth Global Conference on Health Promotion, organized by WHO and the National Health and Family Planning Commission of China in November, 2016. In July 2017, WHO issued three information products in this area, namely: (a) the Health Equity Assessment Toolkit Plus, a software application allowing Member States to assess within-country inequalities in health using their own data; (b) *National health inequality monitoring: a step-by-step manual*, designed to help countries embed health inequality monitoring in their health information systems and create the statistical codes needed to analyse household survey data in order to reveal where inequalities lie; and (c) AccessMod, a tool for modelling physical accessibility to health care and geographical coverage. In December 2017, the joint report of WHO and Indonesia was published to provide a comprehensive assessment of health inequalities in that country. Data for 111 countries has been made available through WHO’s Health Equity Monitor as of February 2018.

Reporting to Member States on global and regional progress

78. WHO has reported on global and regional progress towards achieving the health-related Sustainable Development Goal targets through the 2016, 2017 and 2018 editions of *World health statistics*; the 2019 edition will be published in the first half of 2019. WHO and the World Bank published *Tracking universal health coverage: 2017 global monitoring report*, which summarized the status of health service coverage and financial protection under Sustainable Development Goal indicators 3.8.1 and 3.8.2. The WHO Global Health Observatory provides ready access to data on each health-related Goal, with different levels of geographical and temporal breakdown.

Supporting Member States in strengthening national statistical capacity

79. WHO has worked with partners in the Health Data Collaborative to develop a technical package of health information standards and tools to strengthen country health information systems, including a harmonized data-quality review toolkit, an updated global reference list of 100 core health indicators, guidelines for analysing health facility data, a master facility list resource package, a civil registration and vital statistics e-Learning course, community health information system guidelines, a digital health atlas and a handbook on national health workforce accounts.

80. Health Data Collaborative pathfinder countries (Cameroon, Kenya, Malawi and the United Republic of Tanzania) have adopted the Collaborative’s approach in rallying partners behind national monitoring and evaluation plans in order to reduce the number of health indicators, decrease duplication in health facility data collection and curb the proliferation of disjointed digital data systems. The number of countries interested in adopting the Collaborative’s approach is increasing. WHO regional offices support a variety of activities to improve vital statistics, including cause of death, as well as routine health information systems. The Regional Office for the Eastern Mediterranean has been implementing a regional strategy for the improvement of civil registration and vital statistics systems 2014–2019, in addition to a regional core indicators programme since 2015. Furthermore, it has conducted comprehensive health information system assessments in response to country requests.

81. By strengthening health information systems, the Health Data Collaborative is undertaking a critical role in improving country systems for planning and monitoring of the health-related Sustainable Development Goals, including universal health coverage.

Supporting Member States in strengthening reporting on the 2030 Agenda

82. In collaboration with Health Data Collaborative partners, WHO has developed the SCORE¹ technical package, which helps countries to strengthen country data systems and their capacity to track progress towards the health-related Sustainable Development Goals and other national and subnational health priorities and targets. In addition, SCORE provides a framework for development partners to better align funding and technical support for countries.

83. SCORE reviews the status of country health data systems in monitoring health priorities and identifies the most effective strategies to strengthen them. The five strategies are: (a) survey populations and health risks to know what makes people sick and their risks; (b) count births, deaths and causes of death to know who is born and what people die from; (c) optimize health service data to ensure equitable, quality services for all; (d) review progress and performance to make informed decisions; and (e) enable data use for policy and action to accelerate improvement.

84. The package encourages national policy-makers, development partners, civil society and the private sector to invest in a select number of interventions and tools that synergistically have the greatest impact on the quality, availability, analysis, use and accessibility of national data. A structured survey tool supports the baseline assessment and monitoring of implementation of SCORE interventions at country level. A web-based global repository will provide easy access to SCORE tools and resources.

Taking the 2030 Agenda into consideration in the development of the programme budget and general programme of work

85. WHO has based the Thirteenth General Programme of Work on the Sustainable Development Goals. Its three strategic priorities – universal health coverage, health security and improved health and well-being – encapsulate each of the health-related targets encompassed by Goal 3 and are accompanied by an impact framework to enable WHO to measure progress and remain focused on outcomes rather than outputs. While Goal 3 is devoted to good health and well-being, WHO's work indirectly influences, and is influenced by, other Sustainable Development Goals.

86. The programme budget is the primary instrument for the translation of the Thirteenth General Programme of Work into concrete plans for implementation. The first programme budget that fully articulates the implementation of the General Programme of Work will be the Programme budget 2020–2021. The development of the Programme budget 2020–2021 will be guided by the following principles, outlined in the Thirteenth General Programme of Work: (a) it will be based on the Sustainable Development Goals; (b) WHO will measure its impact, especially on the implementation of those Goals relating to improvements in people's health; and (c) WHO will prioritize its work to drive impact in every country.

ACTION BY THE HEALTH ASSEMBLY

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

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¹ SCORE: survey, count, optimize, review, enable.