World Health Organization

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Progress reports

Report by the Director-General

CONTENTS

[1] Moved as document A74/55 under item 26.4.

A. SUSTAINABLE HEALTH FINANCING STRUCTURES AND UNIVERSAL COVERAGE (resolution WHA64.9 (2011))

1. Ten years since resolution WHA64.9 was approved, universal health coverage remains at the top of the health policy agenda globally. Since the 2018 update,[1] WHO has expanded its guidance on health financing policy in support of universal health coverage; almost 9000 individuals across 168 countries have accessed WHO capacity-building training programmes on health financing during this period, with direct technical support delivered to over 100 countries across all regions.

2. Sustained progress towards universal health coverage is largely dependent on public financing, but the picture is nuanced. The aggregate level of service coverage increases with total health spending, indicating that increases in private spending, resulting from income growth, also can have a positive impact, despite the significant equity concerns raised when private spending is the main driver. Public spending certainly remains central to progress on reducing financial hardship and inequity in service use, provided that it is used to support well-designed health financing policies.[2]

3. Good health financing policies, which drive progress towards universal health coverage, are now explicitly identified by WHO in terms of a set of desirable attributes, based on evidence and implementation experience over the past 20 years. These attributes provide the basis for country assessments, which identify strengths and weaknesses and propose priority directions for countries. Such proposals might indicate, for example, that unless resources are allocated to providers in a way that reflects population health needs, progress will be hindered; or that unless public funds are focused on ensuring that the entire population can obtain a set of priority health services, equity and, consequently, progress towards universal health coverage will be compromised.

4. Many health systems still organize coverage in a highly fragmented way with multiple schemes and programmes, each managing its own funds, targeting specific population groups and building parallel systems. This approach hinders progress towards universal health coverage, limiting efforts to tackle inequities in entitlements and access across the population, for example by constraining the ability to direct resources to those most in need or towards priority services. Fragmentation is also inefficient, contributing to a duplication of functions and increasing administrative burden. Some countries are addressing this issue, such as Viet Nam which has recently integrated HIV and tuberculosis services into the benefits package of the national health insurance scheme. Health facilities are now funded from one source and medication is procured by a new, central unit in the Ministry of Health. These changes help to sustain service coverage in the face of declining external assistance, with lower costs and improved system efficiency overall.

5. In addition to ensuring that public funds are focused on priority services, new evidence highlights the importance of robust public financial management systems tailored to health system objectives. Rigid budget formulation processes hinder the ability to allocate and, when necessary, reallocate funds to priority services; improving budget formulation is one measure that can address this issue. Underspending of health budgets is a chronic issue in numerous countries, requiring health and finance authorities to address the underlying bottlenecks; for example, the United Republic of Tanzania recently

[1] See document A71/41 Rev.2, section N.

[2] Primary health care on the road to universal health coverage: 2019 global monitoring report. Geneva: World Health Organization; 2019. (https://www.who.int/healthinfo/universal_health_coverage/report/uhc_report_2019.pdf, accessed 24 February 2021).

introduced a financing mechanism to ensure that front-line primary centres could receive, manage and account for budget funds directly, avoiding disruptions and increasing effectiveness.

6. WHO annual reports on global health expenditures since 2018 show that out-of-pocket spending is persistently high in low- and lower-middle-income countries, accounting for more than 40% of total spending on average. Although external (donor) funding accounts for a mere 0.2% of aggregate global spending on health, it remains critical for many low-income countries, constituting an average of 30% of national health spending. The trend towards reducing the priority given to health in public spending in low-income countries, potentially or partially offsetting increases in development assistance for health, gives cause for concern.

7. The pandemic of coronavirus disease (COVID-19) has created both a health and a fiscal crisis that, without a concerted response, could have a lasting impact on progress towards universal health coverage because of the implications for health financing of changes in income, poverty, public debt and fiscal capacity. While the speed and depth of economic recovery in the coming years remains uncertain, the fiscal deterioration that most countries experienced in 2020 may constrain all public spending, including for health, in the coming years. Governments and the international community must be proactive in addressing this challenging context. Priorities include:

- redressing the underfunding of core public health functions in many countries, with more and better investment in epidemic preparedness and response and in supporting health systems foundations;

- increasing prioritization for health and related social spending in public resource allocation, with attention to the most vulnerable;

- enabling a smooth, multiyear fiscal adjustment rather than austerity measures to mitigate the potential consequences of sharp spending cuts for economic growth, population health and well-being and social stability.

B. PREVENTION OF DEAFNESS AND HEARING LOSS (resolution WHA70.13 (2017))

8. In May 2017, the Seventieth World Health Assembly adopted resolution WHA70.13 on prevention of deafness and hearing loss and requested the Director-General to prepare a world report on ear and hearing care; develop a toolkit and provide technical support for Member States in collecting data and planning national strategies for ear and hearing care; intensify collaboration with the aim of reducing hearing loss caused by recreational exposure to noise; and undertake advocacy through World Hearing Day on 3 March each year.

9. Accordingly, the Secretariat has undertaken the following key activities.

World report on hearing

10. The *World report on hearing* was launched on 3 March 2021. Developed through a multistakeholder consultative effort with participation of Member States, it is based on the latest high-quality evidence. The report provides data on the prevalence and projections of hearing loss, met and unmet needs for hearing care, the availability of human resources for hearing care and the cost of unaddressed hearing loss. It defines the concept of integrated people-centred ear and hearing care,

proposes a package of evidence-based interventions and measures for their integration into health systems. It provides the cost of implementation and anticipated returns on investment.

Global target and tracer indicators

11. Through consultation, WHO has set a global target of a 20% increase in effective coverage of ear and hearing care interventions by 2030, to be monitored through three tracer indicators relating to newborn hearing screening services within the population; prevalence of chronic ear disease and unaddressed hearing loss in schoolchildren; and hearing technology use among adults with hearing loss. A monitoring framework is being established for reporting these indicators and progress towards the global target.

Toolkit

12. WHO has published a number of tools relating to ear and hearing care, including on situation analysis, planning and monitoring of national strategies and provision of services, surveys, screening and affordable technologies. A free, downloadable software application for hearing testing (hearWHO and hearWHO*pro*) has been developed and is available in Chinese, English, and Spanish. Other tools will be finalized in 2021–2022. Countries in each region have started to use these tools with support from the Secretariat. The hearWHO app has been downloaded by over 250 000 users worldwide.

Technical support

13. The Secretariat has provided technical support to Member States in the development and implementation of national strategies for hearing care, conduct of training programmes and prevalence surveys, and planning of hearing screenings. Since 2019, it has collaborated with Member States in all regions, namely India, Kenya, Nicaragua, Pakistan, Panama, Philippines, Russian Federation and Zambia.

Collaboration

14. WHO established the World Hearing Forum as a global network of stakeholders working in the field of hearing care, with the objective of raising awareness of hearing loss prevention, identification and management. The Forum, which held its first meeting on 4 and 5 December 2019, aims to strengthen global action for hearing care through enhanced advocacy and networking. It will undertake advocacy to promote implementation of resolution WHA70.13 and support WHO's actions in the field of hearing. A WHO Facebook group has been created to boost momentum among stakeholders in this area.

Steps to address hearing loss caused by recreational noise

15. The Secretariat has collaborated closely with the International Telecommunication Union (ITU) to develop and promote the WHO-ITU global standard for safe listening devices and systems, which recommends the inclusion of safe listening features in smartphones and MP3 players that can reduce preventable hearing loss among users. At least two leading smartphone manufacturers have adopted the standard. WHO has also created materials for behaviour change for safe listening. A regulatory framework for safe listening entertainment venues is being developed for launch in 2021.

World Hearing Day

16. In preparation for 3 March every year, WHO develops and promotes evidence-based messages and materials to raise awareness of hearing loss and promote hearing care. In 2020, World Hearing Day was observed under the theme "Hearing for life" and new data on access to hearing aids was released. In 2021, it was observed under the theme "Hearing care for all" and featured the launch of the *World report on hearing* and a WHO Facebook group on hearing care. On both occasions, the Secretariat supported awareness activities in more than 100 countries.

17. The Secretariat will continue to support Member States in their efforts to prevent, identify and address hearing loss through integrating ear and hearing care within their national health systems.

C. PROMOTING THE HEALTH OF REFUGEES AND MIGRANTS (decision WHA72(14) (2019))

18. The Seventy-second World Health Assembly, in decision WHA72(14), requested the Director-General to report back on progress in the implementation of the WHO global action plan on promoting the health of refugees and migrants, 2019–2023. This report highlights progress made to date.

Saving lives through short-term and long-term public health interventions

19. Significant efforts have been made to ensure the inclusion of refugees and migrants in the global response to the COVID-19 pandemic, including by developing and implementing relevant interim guidance[1] and a policy brief on access to services[2] and contributing to the United Nations policy brief;[3] including refugee and migrant health in the COVID-19 Global Humanitarian Response Plan and the UN framework for the immediate socioeconomic response to COVID-19; promoting equitable access to vaccine for refugees and migrants through developing guidance; and supporting the development and implementation of national COVID-19 vaccine deployment and vaccination plans.

20. Support to countries hosting refugees and migrants has been intensified across all regions. This includes humanitarian and long-term health assistance, health assessment, prevention and control of priority diseases, a broad range of health programmes and strengthening of health services along borders and at points of entry to ensure continuity of care and triage for sick refugees and migrants, including suspected COVID-19 cases.

Providing universal health coverage and refugee- and migrant-sensitive health systems

21. The Secretariat collaborates with the multistakeholder platform UHC2030 to accelerate progress towards universal health coverage that includes refugees and migrants, including through the Mexico City Political Declaration on Universal Health Coverage, and by mobilizing resources, including from

[1] Preparedness, prevention and control of coronavirus disease (COVID-19) for refugees and migrants in non-camp settings: interim guidance. Geneva: World Health Organization; 2020 (https://apps.who.int/iris/handle/10665/331777, accessed 16 February 2021).

[2] United Nations Network on Migration, Enhancing access to services for migrants in the context of COVID-19 Preparedness, prevention, and response and beyond (https://unhabitat.org/sites/default/files/2020/06/final_network_wg_policy_brief_covid-19_and_access_to_services.pdf, accessed 16 February 2021).

[3] United Nations Network Sustainable Development Group, Policy brief: COVID-19 and people on the move. June 2020 (https://unsdg.un.org/resources/policy-brief-covid-19-and-people-move, accessed 16 February 2021).

the European Union. A WHO global school on refugee and migrant health, attended by 185 officials from governments and partners, was organized in October 2020 to build national capacity and knowledge.

22. The Secretariat developed and launched global competency standards providing guidance on training to enable health workers to provide quality health services for refugees and migrants.

Mainstreaming refugee and migrant health into global, regional and country agendas, partnerships and advocacy

23. As a member of the Executive Committee of the United Nations Network on Migration and of the Steering Committee of its Multi-Partner Trust Fund and as co-lead of its Working Group on Access to Services, WHO provides health leadership and strategic direction to the Network, particularly as regards the United Nations system response to the COVID-19 pandemic and the implementation of the Global Compact on Refugees and the Global Compact for Safe, Orderly and Regular Migration. Support has also been provided to regional economic communities and networks to promote refugee and migrant health, including in regional reviews under the latter.

24. A renewed Memorandum of Understanding was signed between WHO and IOM in 2019, followed by a Memorandum of Understanding and Operational Guidance between WHO and UNHCR in 2020. These agreements set out six areas for collaboration. Within WHO, a Technical Expert Network was established to work across the three levels of the Organization, thereby intensifying coordination in jointly addressing the health needs of refugees and migrants at global, regional and country levels.

25. The Secretariat led advocacy efforts in promoting refugee and migrant health and fostering engagement with Member States and partners through successful side events, briefings, and webinars at the United Nations General Assembly and the annual meetings of the United Nations Network on Migration, IOM, the Mayors Mechanism and the Global Forum on Migration and Development, and on World Refugee Day and International Migrants Day.

Health monitoring, information, evidence, communications

26. A network of experts has been established to develop and implement a research agenda through evidence and policy reviews and other normative products, as have mechanisms to develop the first global report on the health status of refugees and migrants. Collaboration on evidence and research has been established with IOM, UNHCR, the United Nations Expert Group on Migration Statistics and the United Nations Expert Group on Refugee and Internally Displaced Persons Statistics, putting health on the agenda of statistics on refugees and migrants.

27. The *ApartTogether survey*,[1] containing information collected from 30 000 refugees and migrants, gives insight into their perceptions of the impact of COVID-19 on their lives.

D. ERADICATION OF DRACUNCULIASIS (resolution WHA64.16 (2011))

28. In 2020, six countries reported a total of 27 human cases of dracunculiasis (Guinea-worm disease), from a total of 18 villages. Angola reported one case, Chad 12 cases in 10 villages, Ethiopia

[1] ApartTogether survey: Preliminary overview of refugees and migrants self-reported impact of COVID-19. Geneva: World Health Organization; 2020 (https://apps.who.int/iris/handle/10665/337931, accessed 16 February 2021).

11 cases in five villages, Mali one case and South Sudan one case; Cameroon reported one case, probably imported from Chad. The total figure for 2020 is 50% less than that reported in 2019. Cameroon, Chad, Ethiopia and Mali also reported animal infections in 2020. When eradication efforts were launched in the 1980s, dracunculiasis was endemic in 20 countries; its eradication will contribute to the attainment of universal health coverage.

29. WHO and its global partners (The Carter Center, UNICEF and the WHO Collaborating Center for Dracunculiasis Eradication at the United States Centers for Disease Control and Prevention) have continued to support community- and country-focused interventions by all affected countries and maintained a steady momentum in eradication efforts, with the effective and sustained collaboration of donors.

30. To date, following the recommendations of the International Commission for the Certification of the Eradication of Dracunculiasis, WHO has certified a total of 199 countries, territories and areas, including 187 WHO Member States. Seven Member States remain to be certified; the disease remains endemic in Chad, Ethiopia, Mali and South Sudan, while Angola reported a third confirmed indigenous human case for the third consecutive year in 2020 and is now classified as endemic for the disease. Sudan is still in the precertification stage, as is the Democratic Republic of the Congo, which has not reported the disease since the 1950s. The fourteenth meeting of the International Commission for the Certification of the Eradication of Dracunculiasis was held virtually in October 2020. In November 2020, some members of the Commission met to further discuss the way forward to develop and implement research and deliberate on certification processes in the context of animal infection with guinea-worm.

31. Despite the coronavirus disease (COVID-19) pandemic, Angola, Chad, Ethiopia, Mali and South Sudan maintained active, community-based surveillance in 6765 villages in 2020, in comparison with 7735 villages in 2019. Sudan maintained precertification surveillance, including case searches, and the Democratic Republic of the Congo continued to conduct active case searches and strengthen national surveillance. No human cases or infected animals were found in either country.

32. Angola reported one human case in March 2020 following Ministry of Health measures, with WHO support, to strengthen surveillance and raise awareness. The case appears to be a limited indigenous transmission focus at the border with Namibia. WHO has sustained its support to the Namibian Ministry of Health and provided support to strengthen cross-border surveillance with Angola.

33. All uncertified countries continued to offer cash rewards for voluntary case reporting of dracunculiasis in 2020. More than 128 000 rumoured human cases and 77 000 rumoured animal infections were provisionally reported globally and investigated during 2020, 99% of which were investigated within 24 hours. Most previously endemic certified countries submitted quarterly reports to WHO in 2020.

34. Cameroon has set up active surveillance in at-risk border areas and raised awareness on cash rewards nationwide, with WHO support. A dracunculiasis infection in a 6-year-old girl and six infected animals were reported in the same localized transmission zone at the border with Chad. Despite the challenging security issues, WHO has provided support to the Central African Republic to improve surveillance in high-risk areas bordering Chad.

35. *Dracunculus medinensis* infection in dogs remains a challenge to the global eradication campaign. In comparison with 2019, the overall number of animal infections was reduced by 20% in 2020, from 1991 to 1600 infections. In 2020, Chad reported infections in 1507 dogs and 63 cats; Ethiopia reported

infections in three dogs, eight cats and four baboons; Mali reported infections in nine dogs and Angola did not report any infected animals. Transmission in animals can be interrupted through proactive tethering (mainly of dogs), enhanced surveillance and case containment, health education for the community and animal owners, and vector control. Countries in which the disease is currently transmitted expanded vector control interventions further during 2020.

36. Conflict and insecurity continued to hinder eradication programme efforts and accessibility in certain areas of Mali. Population displacement in South Sudan continued to hamper programme implementation and restrict access to some areas where the infection is endemic.

37. At the twenty-fourth International Review Meeting of Guinea-Worm Eradication Program Managers, held virtually in March 2020, countries reported on the status of their programmes during the preceding year. The twenty-fifth International Review Meeting was held virtually in March 2021. The fourth Biennial Review Meeting for Guinea-Worm Eradication Programmes in Certified Countries will be held virtually in June 2021, to review post-certification surveillance activities.

38. Due to the COVID-19 pandemic, the annual informal meeting with health ministers of countries affected by dracunculiasis, usually held on the margins of the Health Assembly, was postponed.

E. PROGRESS IN THE RATIONAL USE OF MEDICINES (resolution WHA60.16 (2007))

39. In response to resolution WHA60.16 (2007), Member States, in collaboration with the Secretariat and partners, continue to promote the rational use of medicines, aiming to minimize overuse, underuse and misuse of medicines. The Secretariat develops guidance and provides support for implementation of appropriate policies and strategies to improve the rational use of medicines, including updating national lists of essential medicines, monitoring of the use of medicines and implementation of good practices.

Strategies and commitments

40. The road map for access to medicines, vaccines and other health products 2019–2023[1] identifies appropriate prescribing, dispensing and rational use as a key activity for improving equitable access to medicines, including by ensuring health impacts and the effective use of resources. The road map specifies the need for training of health workers, quality improvement processes and routine monitoring of the use of medicines.

41. Health ministers of the Member States of the WHO South-East Asia Region participating in the Seventy-first session of the WHO Regional Committee for South-East Asia in New Delhi, India in 2018 agreed to the promotion of appropriate use of medical products, especially antimicrobials, as a key action to improving access to effective, safe, quality and affordable medical products.[2]

[1] See document A72/17.

[2] Delhi Declaration on improving access to essential medical products in the region and beyond (SEA/RC71/R2) (https://apps.who.int/iris/bitstream/handle/10665/328050/sea-rc71-r2-eng.pdf?sequence=1&isAllowed=y).

42. The regional strategy to improve access to medicines and vaccines in the Eastern Mediterranean Region, 2020–2030, including lessons from the COVID-19 pandemic, includes rational use of medicines in its framework.[1]

43. The PAHO framework on the essential public health functions in the Americas identifies "[e]nsuring access to and rational use of quality, safe, and effective essential medicines and other health technologies" as an essential function and highlights the importance of rational use of essential medicines and health technologies.[2]

Guidance

44. The WHO Model List of Essential Medicines includes information about dose forms and strengths; specifications as to who should take a medicine; what health conditions a medicine can treat and how it should be taken, as well as details about clinical evidence. More than 150 countries use the list to determine which medicines best meet their national health contexts and priorities for their national essential medicines lists.

45. The list was updated in June 2019.[3] The Expert Committee considered 65 applications and considered recommendations from the working groups on antibiotics and cancer medicines. The Committee endorsed the recommendations for Access, Watch or Reserve (AWaRe) classification of 177 commonly used antibiotics, to better support antibiotic monitoring and stewardship activities.[4]

46. A digital version of the WHO list was launched that is easily searchable by names of medicines or health issues and allows customized lists to be created and exported.[5]

47. A practical toolkit on how to implement antimicrobial stewardship programmes in health care facilities in low- and middle-income countries was published.[6] The toolkit aims to support implementation of Objective 4 of the Global Action Plan – ''[o]ptimize the use of antimicrobial medicines".

48. New WHO guidelines on the management of chronic pain in children were issued.[7] The guidelines include pharmacological interventions for pain relief in children aged 0–19 years, including the use of

[1] Document EM/RC67/6 (https://applications.emro.who.int/docs/EMRC676-eng.pdf?ua=1, accessed 16 February 2021).

[2] The essential public health functions in the Americas: a renewal for the 21st century. Conceptual framework and description (Washington, D.C.: Pan American Health Organization; 2020) (https://iris.paho.org/bitstream/handle/10665.2/53124/9789275122655_eng.pdf?sequence=1&isAllowed=y, accessed 16 February 2021).

[3] See The selection and use of essential medicines: report of the WHO Expert Committee on Selection and Use of Essential Medicines, 2019 (including the 21st WHO Model List of Essential Medicines and the 7th WHO Model List of Essential Medicines for Children). Geneva: World Health Organization; 2019 (WHO Technical Report Series, No. 1021). (https://www.who.int/publications/i/item/9789241210300, accessed 16 February 2021).

[4] (https://aware.essentialmeds.org/groups, accessed 16 February 2021).

[5] (https://list.essentialmeds.org/, accessed 16 February 2021).

[6] Antimicrobial stewardship programmes in health-care facilities in low- and middle-income countries. A practical toolkit. Geneva: World Health Organization; 2019 (https://apps.who.int/iris/handle/10665/329404, accessed 16 February 2021).

[7] Guidelines on the management of chronic pain in children. Geneva: World Health Organization; 2020 (https://www.who.int/publications/i/item/9789240017870, accessed 16 February 2021).

morphine. The guideline supports Member States and their partners in the development and implementation of national and local policies, regulations, pain management protocols and best practices for pain relief and highlights the importance of opioid stewardship to address concerns about harms arising from misuse of these medicines.

49. The response to the coronavirus pandemic includes accelerated development and regular updating of clinical guidelines outlining the rational use of evidence-based therapeutic interventions for COVID-19 patients. In addition, WHO has launched an extensive public education campaign to discourage the use of irrational and harmful therapies promoted by the global misinformation infodemic, associated with the pandemic.

The way forward

50. More efforts are required to address the rational use of medicines, including in national policies and plans, through regional initiatives and by committing resources as recommended in resolution WHA60.16. In particular, more work is needed to ensure that prescribers have the capacity to implement clinical guidelines and other proven strategies; policy guidance is aligned, from selection of medicines to prescribing practices; health literacy is improved; stewardship programmes are implemented; and countries are supported in developing policies and regulations to ensure access, appropriate prescribing, dispensing and use of medicines, including controlled medicines for the treatment of pain and palliative care, while minimizing the risk of diversion and misuse.

G. SMALLPOX ERADICATION: DESTRUCTION OF VARIOLA VIRUS STOCKS (resolution WHA60.1 (2007))

51. In May 2007, the Sixtieth World Health Assembly adopted resolution WHA60.1 on smallpox eradication: destruction of variola virus stocks.

52. In May 2019, the Seventy-second World Health Assembly discussed the report of the Director-General on this topic.[1] Member States noted the report, emphasized that the benefits of the variola virus research programme overseen by WHO should be accessible to all and suggested that the decision on the date of destruction of live variola virus stocks should be deferred by up to five years to afford time to reflect on the best options for global public health. The Secretariat would continue to facilitate the development of countermeasures and support access to these interventions.

53. This progress report summarizes the proceedings of the twenty-second meeting of the WHO Advisory Committee on Variola Virus Research (Geneva, 4–5 November 2020)[2] on the research carried out at the two authorized repositories of variola virus, in the Russian Federation and in the United States of America.

54. With regard to research on antiviral therapeutics, the Advisory Committee noted that submissions for licensing the antiviral agent tecovirimat, approved in the United States of America for treatment of smallpox in July 2018, were under review in Canada and the European Union. It further noted progress in the development of other antiviral agents and expressed concern at the time that would be required for development of monoclonal antibodies. Work to develop an animal model for smallpox had shown

[1] Document A72/28; see also document WHA72/2019/REC/3, summary records of Committee B, seventh meeting, section 2. See also document A73/32.

[2] The meeting report will be posted on the WHO website on the following page: https://www.who.int/groups/who-advisory-committee-on-variola-virus-research/meeting-documents.

promise. The Advisory Committee recommended that approved countermeasures should be included in the WHO emergency stockpile.

55. The Advisory Committee noted that development of vaccinia-based smallpox vaccines continued, with the primary objective of enhancing vaccine safety. Modified vaccinia Ankara (MVA) vaccine, approved in Canada and the United States of America for prevention of both smallpox and monkeypox, was also approved in Canada in November 2020 for prevention of other orthopoxvirus infections for persons at risk, the first time such a broader indication was approved. Japan continued to study a licensed third-generation vaccinia vaccine (LC16m8) and progress was being made towards licensing a fourth-generation vaccine (VacΔ6) in the Russian Federation. In reviewing incidents reported to WHO involving vaccinia virus, the Advisory Committee re-emphasized the importance of making vaccine and treatments available for laboratory personnel, and of continuing work to expand licensing of all countermeasures and enhance access for prevention and control of monkeypox.

56. The Advisory Committee recommended that development of diagnostics should continue in order to make them more widely available and enhance access in field settings, and emphasized the importance of building national laboratory capacity for the rapid confirmation of monkeypox and smallpox. It also strongly encouraged the development of diagnostic technology without recourse to live variola virus.

57. With regard to paleogenomic research on human remains, the Advisory Committee provided guidance for situations where variola virus DNA might be an incidental finding or the proposed subject of investigation, recommending that researchers undertake a risk assessment using a WHO framework. The current WHO Recommendations concerning the distribution, handling and synthesis of variola virus DNA would be updated.

58. In addition to the work of the Advisory Committee, WHO biosafety inspections at the authorized variola virus repositories in 2019 found that international biosafety and biosecurity standards were met.[1] Plans for regular inspections are in place. However given the constraints imposed by the pandemic of coronavirus (COVID-19), the next round of inspections have been scheduled to take place in the period late 2021–early 2022. The biennial inspections of the two authorized repositories will continue to apply in the future in accordance with resolution WHA60.1.

59. On 8 May 1980, the Thirty-third World Health Assembly in resolution WHA33.3 declared the global eradication of smallpox. On 8 May 2020, WHO celebrated the fortieth anniversary of this momentous achievement with remarks by the Director-General, a videoconference with special guests, the release of a short film and the unveiling of a commemorative stamp, activities to help remind all of what can be achieved when Member States work together in solidarity.

H. WATER, SANITATION AND HYGIENE IN HEALTH CARE FACILITIES (resolution WHA72.7 (2019))

60. In 2019, the Seventy-second World Health Assembly adopted resolution WHA72.7 on water, sanitation and hygiene (WASH) in health care facilities, which draws on the existing WHO and UNICEF global vision, targets and guidance. In 2020, WHO and UNICEF published a detailed global progress

[1] See documents WHO/WHE/CPI/2019.25 and WHO/WHE/CPI/2019.26.

report on this topic.[1] The main points covered in the report and progress achieved in implementing the resolution are summarized below.

Progress against global targets

61. The global target is that at least 80% of health care facilities will have basic WASH services by 2025 and 100% by 2030. According to updated data from the WHO/UNICEF Joint Monitoring Programme, major gaps exist globally: one in four facilities have no basic water services, one in 10 have no sanitation services and one in three do not have adequate facilities to clean hands at the point of care. Furthermore, one in three do not segregate waste safely.

62. In least developed countries, half of health care facilities lack basic water services and 60% have no sanitation services, while seven out of 10 lack basic health care waste management services. The economic consequences of coronavirus disease (COVID-19) restriction measures threaten to widen this gap.

63. At the global level, a number of health programmes have integrated WASH in health care facilities into global standards, strategies and training packages. Similarly, WHO and its partners have provided recommendations on the minimum requirements for effective infection prevention and control programmes at the national and health care facility levels. However, implementation is limited and the resources allocated are scant.

Progress in implementing resolution WHA72.7 (2019)

64. Data from 47 countries indicate that, in response to resolution WHA72.7 (2019), more than 70% have conducted related situation analyses, 86% have updated and are implementing standards and 60% are working to incrementally improve infrastructure and operation and maintenance of WASH services. Progress is occurring even in fragile and conflict-affected countries, and in all regions, propelled by strong national leadership and coordination, the use of data to direct resources and action, and empowering health workers and communities to develop solutions together.

65. However, critical gaps remain. Only one in three countries have developed costed road maps for action and just over 10% have integrated WASH indicators into regular national health system monitoring.

WHO actions

66. In response to multiple requests for guidance and trainings in the context of the COVID-19 pandemic, WHO updated existing WASH in health care facility training modules, with emphasis on COVID-19 and climate. In 2020, WHO held a series of water and sanitation for health facility improvement tool (WASH-FIT) training webinars, in addition to a global webinar series on infection prevention and control in the context of COVID-19 in collaboration with the United States Centers for Disease Control and Prevention. It also produced a brief overview and a simplified version of WASH-FIT for rapid deployment in COVID-19 affected areas. WHO/UNICEF interim guidance on WASH and COVID-19 focused on health care facilities was developed and widely disseminated. Consequently, new WASH and health partners engaged in WASH-FIT training and follow-up support and at least 10 countries adapted and implemented the tool, with strong focus on infection prevention

[1] Global progress report on water, sanitation and hygiene in health care facilities: fundamentals first. Geneva: World Health Organization; 2020 (https://apps.who.int/iris/handle/10665/337604, accessed 17 February 2021).

and control and climate resilience. In 2019, WHO launched 10 comprehensive training modules on infection prevention and control, complemented by additional training resources and modules in 2020 to support the COVID-19 pandemic response.

67. WHO continues to provide financial and technical support to countries to develop national WASH in health care facility road maps, update standards and address specific areas of concern. In 2019, WHO conducted a global survey on infection prevention and control and hand hygiene to support country monitoring of national programmes. Since 2019, it has issued key guidance to support national efforts to develop or strengthen such programmes and expertise across the health system, integrating WASH, quality of care and patient safety programmes, including key recommendations on the minimum requirements for infection prevention and control programmes[1] and the core competencies for infection prevention and control professionals.[2] To support country monitoring of infection prevention and control (IPC) programmes in 2019 WHO conducted the Global Survey on IPC and hand hygiene at the health care facility level, with participation of 4673 facilities in 126 countries, including 38 that conducted the survey nation-wide.

68. WHO and UNICEF organized a global webinar and two think-tank meetings to discuss the findings and implications of the *Global progress report*. The issue of WASH was given high visibility in an opinion article published jointly by the Director-General of WHO and the Executive Director of UNICEF. In 2020, WHO and UNICEF launched the "Hand Hygiene for All Initiative", aimed at ensuring implementation of WHO global recommendations on hand hygiene in the context of the COVID-19 pandemic and as a mainstay of wider infection prevention control and WASH efforts. WHO continues to celebrate its global campaign on hand hygiene in health care, "SAVE LIVES: Clean Your Hands", on 5 May every year with media events, supported by a wide range of communications and technical tools.

69. The estimated annual cost of providing universal basic WASH in health care facilities in the 47 least developed countries from 2021 to 2030 is modest (US$ 0.30 per capita). Increasing investments in this area and in energy services is a core prescription for a healthy, green recovery from the COVID-19 pandemic. Improving WASH in health care facilities is also critical for COVID-19 response and recovery.

70. All WHO regions took actions to implement the resolution and support countries conducting baseline assessments, strengthening standards, conducting training and integrating with health programmes. In the African Region, 21 countries are implementing joint WASH and national infection prevention and control programmes. In the Region of the Americas, a regional leaders summit in October 2020 elevated WASH in health care facilities to the highest political levels and supported a number of countries in joint training on WASH and infection prevention control. In the South-East Asia Region, the "Fit for Service" dashboard provides real-time information on WASH services and other quality of care indicators, and a new advocacy toolkit helps countries influence policies and investments. In the European Region, the Protocol on Water and Health to the 1992 Convention on the Protection and Use of Transboundary Watercourses and International Lakes supports national target setting and monitoring for WASH in health care facilities. Five countries were supported in conducting in-depth policy and situational analyses that led to the integration of WASH aspects in the relevant policies, standards and regulations and the formulation of advanced WASH service levels in health care facilities.

[1] Minimum requirements for infection prevention and control programmes. Geneva: World Health Organization; 2019 (https://apps.who.int/iris/handle/10665/330080, accessed 30 March 2021).

[2] Core competencies for infection prevention and control professionals. Geneva: World Health Organization; 2020. (https://apps.who.int/iris/handle/10665/335821, accessed 30 March 2021).

In the Eastern Mediterranean Region, efforts are focused on reviewing and strengthening WASH in health care facilities in the context of emergencies, including to support infection prevention control interventions. In the Western Pacific Region, WASH in health care facilities was named a top priority and a series of national situational analyses were conducted.

Next steps

71. WHO will continue to work with UNICEF and partners to intensify efforts to implement the four key recommendations contained in the *Global progress report*. In addition, a global taskforce on WASH in health care facilities is being established with senior influencers to advance advocacy and policy, country support and investments.

I. PLAN OF ACTION ON CLIMATE CHANGE AND HEALTH IN SMALL ISLAND DEVELOPING STATES (decision WHA72(10) (2019))

Background

72. The Seventy-second World Health Assembly noted a WHO plan of action on climate change and health in small island developing States.[1] This is the first progress report on the plan.

73. A special initiative on climate change and health in small island developing States was launched at the twenty-third session of the Conference of the Parties to the United Nations Framework Convention on Climate Change in November 2017 and included as a platform in the WHO Thirteenth General Programme of Work, 2019–2023. Regional action plans inform and deliver on the global plan.

74. The plan envisions that all health systems in small island developing States will be resilient to climate variability and change by 2030 and sets out four strategic lines of action, namely: Empowerment: Supporting health leadership in small island developing States to engage nationally and internationally; Evidence: Building the business case for investment; Implementation: Preparedness for climate risks, adaptation, and health-promoting mitigation policies; Resources: Facilitating access to climate and health finance.

Progress under the four strategic lines of action

75. Progress is summarized below using the eight indicators specified in the plan,[2,3] based on data from the 2018 WHO global survey on health and climate change.

[1] See document WHA72/2019/REC/1, Annex 3.

[2] For the purposes of the action plan and the work programme of the Secretariat, the following WHO Member States are included: African Region: Cabo Verde, Comoros, Guinea-Bissau, Mauritius, Sao Tome and Principe, Seychelles; Region of the Americas: Antigua and Barbuda, Bahamas, Barbados, Belize, Cuba, Dominica, Dominican Republic, Grenada, Guyana, Haiti, Jamaica, Saint Kitts and Nevis, Saint Lucia, Saint Vincent and the Grenadines, Suriname, Trinidad and Tobago; South-East Asia Region: Maldives, Timor-Leste; Eastern Mediterranean Region: Bahrain; Western Pacific Region: Cook Islands, Fiji, Kiribati, Marshall Islands, Micronesia (Federated States of), Nauru, Niue, Palau, Papua New Guinea, Samoa, Singapore, Solomon Islands, Tonga, Tuvalu, Vanuatu.

[3] The descriptions of these indicators have been refined to reflect discussions with the respective regions on good indicators of performance.

Indicator 1.1 – A small island developing States coordination mechanism has been established by the Secretariat.

Indicator 1.2 – Six small island developing States submitted National Adaptation Plans to the central platform of the United Nations Framework Convention on Climate Change; all six have included health as a priority in their plans. Thirty-four out of 40 small island developing States included health as a priority in their Nationally Determined Contribution (first cycle – 2015). These are considered baseline values.

Indicator 2.1 – Twenty small island developing States have completed WHO United Nations Framework Convention on Climate Change health and climate change country profiles, an increase from the 2018 baseline value of six small island developing States.

Indicator 2.2 – Data on the number of collaborating centres actively engaged in supporting the plan of action will be provided in future progress reports.

Indicator 3.1 – Twenty-three small island developing States have initiated actions for climate resilient, environmentally sustainable health care facilities.

Indicator 3.2 – Seven of the 22 small island developing States for which data are available have national health and climate change plans/strategies. Of the seven small island developing States with plans/strategies in place, most reported moderate to high levels of implementation. These are considered baseline values.

Indicator 4.1 – Thirteen out of the 22 small island developing States for which data are available are currently receiving international climate funds for climate change and health. These are considered baseline values.

Indicator 4.2 – US$ 42 million has been received or committed for climate change and health across 24 small island developing States since 2017. Approximately 80% of these funds have been committed or approved in 2020–2021.[1]

Conclusions and upcoming actions

76. The COVID-19 pandemic has caused profound economic and health system distress for small island developing States. Moreover, climate-related disasters have continued to occur, and poor and vulnerable populations have been especially affected by these myriad crises. Despite this, the results noted above show generally good progress in small island developing States across all domains, although there is marked unevenness between countries in terms of technical and/or financial capacity and levels of support from WHO. Intensified collaboration with the Green Climate Fund can help alleviate this.

77. The Secretariat has expanded the plan to further address related health priorities of small island developing States, including noncommunicable diseases, nutrition, integrated primary health care and

[1] The Secretariat has mobilized US$ 42 million for climate change and health across 24 small island developing States since the Seventy-second World Health Assembly, with support from the Global Environmental Facility, the European Union, and the Governments of the Republic of Korea and Norway. WHO has been approved as a “readiness partner” for the Green Climate Fund, and WHO/PAHO has supported successful applications for the Fund’s readiness projects covering Belize, Guyana, Haiti, Jamaica, Saint Kitts and Nevis, Saint Lucia and Trinidad and Tobago. Other country proposals are in process.

achievement of universal health coverage. The Director-General is working to establish a small island developing States Leaders Group in 2021 in order to elevate dialogue on health and accelerate progress towards targets. WHO has scheduled a small island developing States Summit for Health in June 2021. Outcomes will inform key political agendas, including the Food Systems Summit, the United Nations General Assembly, the twenty-sixth session of the Conference of the Parties to the United Nations Framework Convention on Climate Change, the Nutrition for Growth Summit and a small island developing States ministerial meeting on noncommunicable diseases.

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