World Health Organization

SEVENTY-SECOND WORLD HEALTH ASSEMBLY **A72/59**
Provisional agenda item 21.3 **4 April 2019**

Progress reports

Report by the Director-General

CONTENTS

A. GLOBAL TECHNICAL STRATEGY AND TARGETS FOR MALARIA 2016–2030 (resolution WHA68.2 (2015))

1. The *Global technical strategy and targets for malaria 2016–2030* sets ambitious but attainable targets for global efforts to control and eliminate malaria. The 2030 targets are to reduce malaria case incidence and mortality rates globally by at least 90% compared with 2015 baseline levels; eliminate malaria from at least 35 countries; and prevent the re-establishment of malaria in countries that are malaria-free. Strategic milestones for 2020 and 2025 include reduction in malaria case incidence and mortality rates of at least 40% and 75%, respectively, and elimination of malaria in at least 10 and 20 countries that were malaria endemic, respectively.

2. Progress in global malaria control has stalled; according to the *World malaria report 2018*, no significant gains were made in reducing the number of cases worldwide during the period 2015–2017. The estimated number of malaria deaths in 2017 stood at 435 000, similar to 2016. Sub-Saharan Africa continues to bear more than 90% of the global malaria burden; in the 10 African countries most affected, there were 3.5 million more cases in 2017 than in 2016.

3. In view of recent trends, the strategic mortality and morbidity milestones for 2020 are unlikely to be met. The challenge is compounded by insufficient funding for malaria control. In 2017, less than half of the 2020 strategic funding milestone of US$ 6.6 billion had been reached. Urgent action is needed to set the global response to malaria back on track, particularly in countries with the highest malaria burden.

4. At the Seventy-first World Health Assembly in May 2018, the Director-General announced an aggressive new initiative to accelerate progress against malaria. In response, WHO sought jointly with partners and donors to intensify support for countries with the highest burden. In November 2018, WHO and the Roll Back Malaria Partnership to End Malaria launched the "High burden to high impact" initiative, which is based on galvanizing political will to reduce malaria deaths; using strategic information to drive impact; implementing best guidance, policies and strategies; and applying a coordinated national response.

5. The Global technical strategy remains relevant as the overall strategy for malaria, with the "High burden to high impact" initiative accelerating progress in high-burden countries and aligning efforts with strategic targets.

6. **Universal access to malaria prevention, diagnosis and treatment** is the first of the strategy's three pillars. Sleeping under an insecticide-treated net and the use of indoor residual spraying are the two primary vector control methods. In 2017, 50% of the population in sub-Saharan Africa was protected by a treated net, up from 29% in 2010; however, coverage has increased only marginally since 2015. Globally, indoor spraying protection declined from a peak of 5% in 2010 to 3% in 2017, with decreases across all WHO regions. The World Health Assembly adopted resolution WHA70.16 in May 2017, urging Member States to strengthen vector control through increased capacity, improved surveillance, better coordination and integrated action across sectors and diseases. The same message is conveyed in WHO's *Global vector control response 2017–2030.*

7. In addition to nets and residual spraying, antimalarial medicines can prevent malaria. WHO recommends that pregnant women in areas of moderate and high malaria transmission in Africa receive intermittent preventive treatment with sulfadoxine-pyrimethamine; among 33 African countries that reported on coverage levels in 2017, an estimated 22% of eligible women received the recommended doses of the drug, up from 17% in 2015. Furthermore, WHO recommends seasonal malaria chemoprevention for areas of the Sahel subregion; in 2017, 15.7 million children in 12 African countries

were protected through seasonal chemoprevention programmes. However, more than 13 million eligible children were not protected.

8. Prompt diagnosis and treatment are critical to preventing a mild case of malaria from developing into severe disease and death. According to surveys conducted in 30 African countries between 2010 and 2017, the median percentage of children with a fever receiving a malaria diagnostic test in the public health sector was 59% in 2015–2017, up from 33% in 2010–2012. Children are more likely to be given artemisinin-based combination therapies (ACTs) – the most effective antimalarial drugs – if medical care is sought in the public sector. However, only one third (36%) of children with a fever are taken to a public sector medical provider.

9. Therefore, there is an urgent need to make more effective use of currently available tools in order to have a rapid and sustainable impact. The "High burden to high impact" initiative will support countries in scaling up the appropriate combinations of interventions using accessible and affordable front-line services.

10. **Accelerating efforts towards elimination** constitutes the second pillar of the Strategy. According to the *World malaria report 2018*, the 2020 elimination milestone is likely to be reached. In 2018, two countries received official certification of malaria elimination from WHO, having established that the chain of indigenous transmission of malaria has been interrupted for at least the past three consecutive years. Algeria and Argentina are seeking official certification in 2019.

11. **Transforming surveillance into a core intervention** constitutes the third strategic pillar. In 2017, the Secretariat established a dedicated surveillance, monitoring and evaluation unit to guide and support Member States in implementing effective surveillance systems. In 2018, WHO published *Malaria surveillance, monitoring and evaluation: a reference manual*, a valuable resource for malaria-endemic countries and countries that have eliminated the disease but remain susceptible to re-establishment of transmission. Strengthening surveillance capacity and systems in countries is a critical element of the "High burden to high impact" initiative. Data generated from surveillance will help countries to identify their unique context and overcome barriers to scaling up the appropriate combination of interventions for impact.

12. The Secretariat continues to closely monitor three biological threats to malaria control and elimination, namely: mosquito resistance to the insecticides used in core vector control tools; parasite resistance to antimalarials; and *histidine-rich protein 2/3* gene deletions in *P. falciparum* parasites (*pfhrp2/3*).

13. Resistance to at least one insecticide in one malaria vector from one collection site was detected in 68 of 80 malaria-endemic countries that provided data for the period 2010–2017. However, evidence of the public health impact of the reported increase in insecticide resistance is scarce. To prevent erosion of the impact of core vector control tools, WHO has called on all malaria-endemic countries to develop and apply effective insecticide resistance management strategies. In parallel, it highlights the urgent need for new, improved tools in the global response to malaria.

14. Protecting the efficacy of antimalarial drugs is a matter of critical priority for WHO. Studies conducted between 2010 and 2017 show that overall efficacy rates of ACTs exceeded 95% outside the Greater Mekong subregion. Within the subregion, partial resistance to artemisinin and ACT partner drugs has been detected in five countries over the past decade. In response, subregional health ministers adopted the WHO Strategy for Malaria Elimination in the Greater Mekong Subregion 2015–2030, which calls for the elimination of all species of human malaria in the subregion by 2030 and prioritizes actions

targeting areas with multidrug-resistant parasites. By accelerating their efforts to prevent, diagnose and treat malaria among at-risk communities, countries of the subregion reduced cases and deaths by 75% and 93%, respectively, from 2012 to 2017.

15. In some countries, increasing levels of *pfhrp2/3* gene deletions, which enable the parasite to evade detection by some rapid diagnostic tests, threaten the ability of health providers to diagnose and appropriately treat people infected with *P. falciparum* malaria. Although the prevalence of *pfhrp2/3* gene deletions in most high-transmission countries remains low, further monitoring is required.

16. Based on a deep review of its policy-making and dissemination processes in 2018, the Secretariat is implementing a change initiative to deliver timely, high quality guidance to Member States through processes that are more transparent, consistent, efficient, predictable and innovation-friendly. It is anticipated that this optimization will increase the efficiency and impact of national programmes.

B. ADDRESSING THE BURDEN OF MYCETOMA (resolution WHA69.21 (2016))

17. In May 2016, the Sixty-ninth World Health Assembly adopted resolution WHA69.21 on addressing the burden of mycetoma. This report describes progress achieved in this regard to date.

18. The purpose of the resolution, which highlights key actions required to tackle the disease and addresses a broad range of actors, is to raise awareness of the disease. Wider recognition of the burden of mycetoma is expected to boost the development of control strategies and tools adapted to the poor and remote areas where many cases occur.

19. During 2016 and 2017, burden, policies and practices relating to mycetoma were assessed at country level by means of a questionnaire circulated to the ministries of health of 164 countries in all WHO regions, except the European Region where mycetoma is not endemic. The overall response rate was 32% (52/164). The results indicate that 20 countries (38%) had ever recorded cases of mycetoma, of which only two (4%) included mycetoma in the national surveillance system. Between 2014 and 2016, a total of 2677 new cases of mycetoma were reported by eight countries, with 2330 cases reported by Sudan alone. While 26 countries (50%) reported being able to detect and manage cases, only 11 (21%) reported having a recognized expert or institution working on mycetoma. Only one country had national guidelines for mycetoma diagnosis and treatment available at the time of the survey, although three reported that they were preparing such documents. Diagnostics and drugs for treatment of the disease were available in 20 countries (38%) and those drugs were included on the essential medicines list in 19 of those countries (37%).[1]

20. With regard to technical cooperation and partnership, WHO convened an informal consultation on mycetoma in Geneva on 24 March 2017 in order to identify priority areas of work and make those available to countries affected by the disease and other stakeholders, for action, as relevant. The meeting was attended by representatives from ministries of health, academic institutions, clinical facilities and public-health agencies, and made recommendations on epidemiology, case management, prevention, health system, monitoring and evaluation, and operational research. The meeting was followed by the establishment of the Global Mycetoma Working Group, which held its first meeting on 11 January 2018 by audio/videoconference. The group's secretariat and steering committee include WHO, the United States Centers for Disease Control and Prevention, the Erasmus University Medical Center, the University of Khartoum and the Autonomous University of Guerrero. The group, which gathers some

[1] Results of the 2017 global WHO survey on mycetoma. Weekly epidemiological record, 2018, 93(33): 423–428, available at: https://apps.who.int/iris/bitstream/handle/10665/274016/WER9333.pdf?ua=1 (accessed 20 February 2019).

50 scientists and public health officials to discuss all issues related to mycetoma, regularly holds in person meetings at events attended by its members.

21. In 2016 the Government of Sudan, the country with the highest documented burden at the global level, pledged to allocate domestic funding to tackle the disease. Notably, antifungal treatment was made available free of charge to all patients and mycetoma was included in the national neglected tropical disease plan in order to streamline action and enhance resource mobilization. There is, however, a need for increased global and domestic resources to detect, diagnose and manage mycetoma in countries in which the disease is endemic.

22. In order to build national capacities on mycetoma, the Government of Sudan and WHO convened the First International Training Workshop on Mycetoma (Khartoum, 10–14 February 2019). Drawing on the expertise of the Mycetoma Research Centre in Khartoum (WHO Collaborating Centre on Mycetoma) to address clinical and public health aspects of the disease, the workshop was directed to approximately 50 health staff from a wide range of mycetoma-endemic countries with the aim of sharing experiences and standardizing practices relating to diagnosis, treatment and surveillance.

23. The workshop was followed by the Sixth International Conference on Mycetoma (Khartoum, 15–17 February 2019), with the aim of raising the profile of the disease internationally. The Conference adopted the Khartoum Call for Action on mycetoma, which calls on a wide range of actors to take specific measures, including to assess and address the burden of mycetoma at the global level, ensure its integration within national health services and allow sustained access to diagnostics and medicines.[1]

24. With regard to strategic development, in 2016 mycetoma was included among the diseases eligible for grants under the joint WHO Regional Office for the Eastern Mediterranean and UNICEF/UNDP/World Bank/WHO Special Programme for Research and Training in Tropical Diseases (TDR) Small Grants Scheme for implementation research in infectious diseases of poverty; support was provided to the Mycetoma Research Centre in Khartoum to conduct two operational studies in the field, which sought to develop a protocol to quantify and characterize the burden of mycetoma at the community level and to outline a strategy aimed at decentralizing the provision of health services for the disease. Furthermore, the Centre has developed consensual standard operating procedures for the management of mycetoma, based on extensive consultations among major experts worldwide, as a first step towards the development of WHO-approved guidelines on the subject.

25. In addition, mycetoma was among the diseases addressed at the Regional Course on Capacity-Building in Tropical Disease Implementation Research (Hammamet, Tunisia, 22–24 October 2018), organized by the Institut Pasteur (Tunis) with support from the WHO Regional Office for the Eastern Mediterranean and TDR to foster research interventions that can contribute to the development or refinement of public health policies.

26. Availability of suitable tools for early diagnosis of mycetoma remains a major challenge, as does that of medicines, notably for eumycetoma. The lack of point-of-care diagnostic tools and effective medicines continues to significantly limit the outcomes of case management, which often relies on extensive surgery and amputations. Currently, the Drugs for Neglected Diseases initiative and other partners are investigating the safety and efficacy of fosravuconazole in treating eumycetoma. The

[1] The Sixth International Conference on Mycetoma: the Khartoum Call for Action, available at: https://www.who.int/neglected_diseases/news/The-Khartoum-Call-for-Action.pdf?ua=1 (accessed 20 February 2019).

adoption of this treatment would allow for a shorter therapeutic protocol, boosting compliance with treatment and saving financial resources.

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

27. In 2018, only three countries reported a total of 28 human cases of dracunculiasis, namely, Angola (one case), Chad (17 cases) and South Sudan (10 cases), from a total of 22 villages; when eradication efforts were launched in the 1980s, the disease was endemic in 20 countries. Ethiopia reported zero human cases, as has Mali since 2016. The sustained reduction in dracunculiasis risk in countless marginalized communities yields socioeconomic and educational benefits for families and their children.

28. The global dracunculiasis eradication campaign is based on community- and country-focused interventions. 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 headquarters in Atlanta (GA), United States of America) have continued to work hard with other stakeholders to ensure that support is provided to affected countries for dracunculiasis eradication efforts.

29. The Director-General of WHO addressed the Twelfth meeting of the International Commission for the Certification of Dracunculiasis Eradication (ICCDE) in February 2018. Following the Commission's recommendation, WHO certified Kenya as free from dracunculiasis among a total of 199 other certified countries, territories and areas, including 187 WHO Member States. Seven Member States remain to be certified, namely, Angola Chad, Democratic Republic of the Congo, Ethiopia, Mali, South Sudan and Sudan. The disease remains endemic in Chad, Ethiopia, Mali and South Sudan, while Angola reported its first confirmed case in 2018. Sudan is in the precertification stage, while the Democratic Republic of the Congo has not reported the disease since the 1980s. The Thirteenth meeting of the ICCDE will be held in April 2019 in Addis Ababa.

30. During 2018, Chad, Ethiopia, Mali and South Sudan maintained active community-based surveillance in 6864 villages, compared with 6547 villages in 2017. These countries launched nationwide communication campaigns during 2017 that ran throughout 2018. An external evaluation conducted in Mali in 2018 found no human cases. Sudan maintained precertification surveillance, while Angola and the Democratic Republic of the Congo carried out active case searches.

31. No human cases or infected animals were found in the Democratic Republic of the Congo, following searches in 24 of its 26 provinces.

32. In April 2018, one human case was detected and reported in Angola, following polio and measles immunization activities supported by WHO. The case was subsequently confirmed by the reference laboratory of the WHO Collaborating Centre at the Centers for Disease Control and Prevention headquarters in Atlanta (GA). Follow-up investigations conducted by the Ministry of Health and WHO with The Carter Center concluded that the case was likely to be the result of small, hidden, indigenous transmission foci. The ecological zone concerned may encompass localities in northern Namibia; it remains unknown whether animal infection is involved. Preliminary investigations carried out in Namibia at the border areas concerned did not reveal evidence of transmission of the parasite. WHO is assisting the Namibian Ministry of Health and providing support for a more extensive case search in two northern regions that share a common border with Angola.

33. All countries that remain uncertified continued to offer cash rewards for voluntary case reporting of dracunculiasis in 2018 except for Angola, which is preparing to launch such a scheme. The Secretariat is planning a global cash reward scheme in consultation with Member States and partners. More than 50 000 rumoured dracunculiasis cases were reported globally and investigated during 2018, of which 98% were investigated within 24 hours of notice; three rumours led to the detection of human cases in Chad. The majority of post-certification countries where the disease was previously endemic continued to submit quarterly reports to WHO in 2018.

34. *Dracunculus medinensis* infection in dogs continues to pose a challenge to the global eradication campaign. In 2018, Chad reported 1040 infected dogs and 25 cats; Ethiopia reported 11 infected dogs, five cats and one infected baboon; and Mali reported 18 infected dogs and two infected cats. Operational research findings indicate that transmission can be interrupted through enhanced surveillance, case containment, health education for the community and animal owners and strong and comprehensive vector control interventions. Research continues to define disease transmission patterns and identify interventions to address fish consumption by dogs in Chad. A study of baboons and dogs is under way in Ethiopia to investigate intra- and interspecies disease transmission patterns. Countries in which the disease is currently transmitted took aggressive steps to increase vector control interventions during 2018.

35. Conflict and insecurity continued to hinder eradication programme efforts and accessibility in certain areas of Mali, particularly in the regions of Gao, Kidal, Mopti and Ségou. Population displacement in South Sudan continued to hamper programme implementation and restrict access to areas where the disease is endemic.

36. At the 22nd International Review Meeting of Guinea-Worm Eradication Program Managers (Atlanta (GA), 21–22 March 2018), organized by WHO and The Carter Center, countries reported on the status of their programmes during the preceding year. The 23rd International Review Meeting will be held on 21–22 March 2019 in Atlanta (GA). Certified countries met at the third Biennial Review Meeting for Guinea-Worm Eradication Programmes in Post-Certified Countries (Ouagadougou, 24–25 July 2018), organized by WHO, to review their post-certification surveillance activities.

37. An informal meeting with health ministers of countries affected by dracunculiasis, chaired by the Regional Director for Africa and attended by the Director-General of WHO, was held on the margins of the Seventy-first World Health Assembly in May 2018. The ministers and their representatives expressed their continued commitment to interrupting transmission of the disease at the earliest opportunity.

D. SUSTAINING THE ELIMINATION OF IODINE DEFICIENCY DISORDERS (resolution WHA60.21 (2007))

38. Progress in the elimination of iodine deficiency disorders has been tracked since the early 1990s. Steady improvements continue to be made, with only 19 countries estimated to have insufficient iodine intakes in 2017.[1] This is an improvement from the estimated 25 countries with insufficient iodine intakes in 2015, 32 in 2012, 47 in 2007, 54 in 2003 and 110 in 1993. These data are based primarily on school-age children, and may not reflect the iodine nutrition status among other population groups.

[1] Global Iodine Nutrition Scorecard 2017. Zurich : Iodine Global Network ; 2017. (http://www.ign.org/cm_data/IGN_Global_Scorecard_AllPop_and_PW_May20171.pdf, accessed 5 February 2019).

Pregnant women, infants and younger children are particularly vulnerable to the health consequences of iodine deficiency disorders, which can include impaired fetal brain development and early mental and physical child development. More surveys are including the assessment of iodine status of pregnant women, but data are still limited. In 2017, out of 69 countries reporting data for pregnant women, 39 were considered to have insufficient iodine intakes among pregnant women.[1,2]

39. The number of countries whose populations are at risk of excessive iodine intakes (median urinary iodine concentrations ≥300 μg/L) decreased from 13 in 2015 to 11 in 2017.[1] Continuous monitoring of urinary iodine excretion is needed in order to adjust fortification programmes, as susceptible groups within these countries may be at risk of adverse health consequences such as iodine-induced hyperthyroidism and autoimmune thyroid disease.[3]

Control strategy

40. The preferred strategy for the control of iodine deficiency disorders remains universal salt iodization, which requires that all food-grade salt used in household and food processing be fortified with iodine.[4] A systematic review commissioned by WHO to assess the effects of fortifying foods, beverages, condiments or seasonings other than salt, with iodine alone or in conjunction with other micronutrients, on iodine status and health-related outcomes in all populations confirmed that evidence for the efficacy of alternative food vehicles is very limited.[5] Strategies for salt reduction and salt iodization are compatible, however monitoring of both salt/sodium intake and iodine intake at the country level is needed to ensure that individuals consume sufficient iodine despite reductions in salt intake. Countries should adjust the concentration of iodine added to salt based on their own data regarding dietary salt intake. Nearly 80% (118) of the 148 countries responding to the module on iodine fortification in the Global nutrition policy review 2016–2017[6] had a salt iodization programme, an increase from 71% in the first policy review conducted in 2009–2010. Legislation on salt iodization was mandatory in 81% of these 118 countries. It is further estimated that 86% of households worldwide have

[1] Global Iodine Nutrition Scorecard 2017. Zurich : Iodine Global Network ; 2017. (http://www.ign.org/cm_data/IGN_Global_Scorecard_AllPop_and_PW_May20171.pdf, accessed 5 February 2019).

[2] Micronutrient Database (online platform). Vitamin and Mineral Nutrition Information System Geneva: World Health organization (https://www.who.int/vmnis/database/en/, accessed 6 February 2019).

[3] Urinary iodine concentrations for determining iodine status in populations. Vitamin and Mineral Nutrition Information System. Geneva: World Health Organization; 2013 (http://apps.who.int/iris/bitstream/10665/85972/1/WHO_NMH_NHD_EPG_13.1_eng.pdf?ua=1, accessed 13 March 2019).

[4] Guideline: fortification of food-grade salt with iodine for the prevention and control of iodine deficiency disorders. Geneva: World Health Organization; 2014. (https://apps.who.int/iris/bitstream/handle/10665/136908/9789241507929_eng.pdf;sequence=1, accessed 20 February 2019).

[5] Santos JAR, Land M-A, Christoforou A, Trieu K, McKenzie BL, Downs S, Billot L, Neal B, Webster J, Li M. Iodine fortification of foods and condiments, other than salt, for preventing iodine deficiency disorders. Cochrane Database of Systematic Reviews 2019, Issue 2. Art. No.: CD010734. DOI: 10.1002/14651858.CD010734.pub2. (https://www.cochranelibrary.com/cdsr/doi/10.1002/14651858.CD010734.pub2/full?, accessed 20 February 2019).

[6] Global nutrition policy review 2016–2017: country progress in creating enabling policy environments for promoting healthy diets and nutrition. Geneva: World Health Organization; 2018. (https://apps.who.int/iris/bitstream/handle/10665/275990/9789241514873-eng.pdf?ua=1, accessed 20 February 2019).

access to iodized table salt (2011–2016),[1] an increase from 75% in the previous reporting period 2009–2013.

41. Iodine supplementation is an additional option for the control of iodine deficiency disorders, particularly for vulnerable groups such as pregnant women and young children living in high-risk communities who are unlikely to have access to iodized salt. It can also serve as a temporary strategy when salt iodization is not successfully implemented. An updated systematic review on the effects of iodine supplementation for women during the preconception, pregnancy and postpartum periods was published in 2017.[2] However, data were considered insufficient for any meaningful conclusions on the benefits and harms of routine iodine supplementation in women before, during or after pregnancy. In the Global nutrition policy review 2016–2017, 15% (21 of 140 countries) of countries implementing a vitamin and mineral supplementation programme targeted at pregnant women provided iodine, and 8% (9 of 107 countries) implementing vitamin and mineral supplementation schemes targeted at children provided iodine.

42. Continuous monitoring and evaluation of programmes to control iodine deficiency disorders is needed to ensure that interventions are effective, safe and equitable.

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

43. 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; to develop a toolkit and provide technical support for Member States in collecting data and planning national strategies for ear and hearing care; to intensify collaboration with the aim of reducing hearing loss caused by recreational exposure to noise; and to undertake advocacy through World Hearing Day on 3 March each year.

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

45. **World report on hearing.** The World report on hearing is under development and expected to be launched on 3 March 2020. The Secretariat is working with experts to review literature, develop background papers, analyse available data and identify priority interventions. Consultations are being organized with Member States in different regions to collect feedback on the draft content and prepare for its dissemination.

46. **Toolkit for ear and hearing care.** WHO has published a number of tools including *Ear and hearing care situation analysis tool*, *Ear and hearing care: planning and monitoring of national strategies* and *Preferred profile for hearing-aid technology suitable for low- and middle-income countries*. Other tools, including indicators for ear and hearing care and an ear and hearing survey handbook and training resources for primary health care workers, are under development and will be

[1] The state of the world's children 2017: children in a digital world. New York: United Nations Children's Fund; 2017 (https://www.unicef.org/publications/files/SOWC_2017_ENG_WEB.pdf, accessed 5 February 2019).

[2] Harding KB, Peña-Rosas JP, Webster AC, Yap CM, Payne BA, Ota E, De-Regil LM. Iodine supplementation for women during the preconception, pregnancy and postpartum period. Cochrane Database of Systematic Reviews 2017, Issue 3. Art. No.: CD011761. doi: 10.1002/14651858.CD011761.pub2. (https://www.cochranelibrary.com/cdsr/doi/10.1002/14651858.CD011761.pub2/full#CD011761-abs-0004, accessed 20 February 2019)

finalized in 2019–2020. At least two countries in each region have started to use these tools with support from the Secretariat.

47. **Technical support to countries.** 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. In the past two years, the Secretariat has collaborated with Member States in all regions, namely China, India, Kenya, Nigeria, Pakistan, Panama, Philippines and Tajikistan.

48. **Collaboration with stakeholders.** WHO established the World Hearing Forum as a global network of stakeholders working in the field of hearing care. The Forum's objective is to raise awareness on hearing loss prevention, identification and management. The first Membership Assembly of the Forum will be held on 4–5 December 2019.

49. **Steps to address hearing loss caused by recreational noise.** WHO has launched the Make Listening Safe initiative with the aim of reducing the growing burden of preventable hearing loss caused by listening to loud sounds. In collaboration with the International Telecommunication Union (ITU), the Secretariat is developing a global standard for safe listening devices to reduce hearing loss among users of personal audio devices, such as smartphones and MP3 players. Future plans include the development of a regulatory framework to promote safe listening in entertainment venues.

50. **World Hearing Day.** In preparation for 3 March every year, WHO develops and promotes evidence-based messages and materials to raise awareness on hearing loss and promote hearing care. In 2018, World Hearing Day was observed under the theme "Hear the future" and new data on hearing loss prevalence and projections for future growth were launched. In 2019, the Day was observed under the theme "Check your hearing" and a WHO software application for hearing testing, "HearWHO App", was launched for free download and use. On both occasions, the Secretariat supported awareness activities in more than 60 countries.

51. 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.

F. STRATEGY FOR INTEGRATING GENDER ANALYSIS AND ACTIONS INTO THE WORK OF WHO (resolution WHA60.25 (2007))

52. This progress report focuses on advances over the 2017–2018 period in the implementation of resolution WHA60.25, which has become the cornerstone for scaling up WHO action towards, and achieving, the health- and equality-related targets of the Sustainable Development Goals.

Country progress

53. In 2017, 71 countries (compared to 63 in 2015) implemented at least two WHO-supported activities to integrate equity, gender and human rights in their health policies and programmes.

Support provided to Member States, in particular promoting the use of sex-disaggregated data and gender analysis

54. The Secretariat has responded to requests for technical support from Member States in implementing the resolution, including technical backup and capacity-building for data disaggregation and health inequality monitoring. For example, WHO provided training on health equity monitoring in five countries of the South-East Asia Region, and published a manual on national health inequality monitoring.[1]

55. In 2018, WHO's Health Equity Monitor database included disaggregated data entailing more than 30 reproductive, maternal, newborn and child health indicators from 111 countries, up from 102 countries in 2016. The Health Equity Assessment Toolkit Plus was released in 2017, allowing users to undertake health equity assessments using their own data.

56. WHO increasingly uses data that are disaggregated by sex and other equity stratifiers and incorporates a gender analysis into its information materials. In the Western Pacific Region, the analysis and use of disaggregated data is part of the regional monitoring framework for universal health coverage and the Sustainable Development Goals. The Regional Office for South-East Asia publishes annual reports to monitor and track progress towards health goals, highlighting areas of inequities.

Building capacity in Member States and the Secretariat

57. Countries were provided with technical guidance and support to strengthen their capacity to mainstream gender in public health.

- To inform action to improve men's health and well-being while promoting gender equality, countries of the European Region adopted the first-ever regional strategy for the health and well-being of men.

- WHO piloted a handbook for conducting an adolescent health services barriers assessment with a focus on disadvantaged adolescents in Nigeria and the United Republic of Tanzania and published a Facilitator's manual for the Innov8 approach for reviewing national health programmes to leave no one behind.[2]

- The Regional Office for the Western Pacific developed the first regional report on advancing health through attention to equity, gender and human rights, which was discussed by the Sixty-eighth Regional Committee in 2017.

- The Regional Office for Africa established an internal working group on mainstreaming equity, gender and human rights.

- The Regional Office for South-East Asia developed fact sheets addressing equity differentials with regard to reproductive, maternal, newborn, child and adolescent health for all 11 countries in order to support the development of national strategies. It also organized a high-level meeting on revisiting the strategies for intervention among key populations for HIV, focusing on

[1] National health inequity monitoring: a step-by-step manual (https://www.who.int/gho/health_equity/manual/en/).

[2] http://www.who.int/life-course/partners/innov8/innov8-facilitators-manual/en/.

interventions among populations such as female sex workers, men who have sex with men and injecting drug users.

58. All regions strengthened the capabilities of staff to integrate equity, gender and human rights into WHO programmes in country and regional offices. In the Sierra Leone country office, for example, 30 staff members were trained in mainstreaming gender and ensuring equity and rights in the delivery of health services. In the Eastern Mediterranean Region, training was conducted for staff on health responses to gender-based violence in emergencies.

59. In 2017 WHO produced a country support package for equity, gender and human rights to benefit health information systems, national health policies and strategies and national health programmes.[1]

Mainstreaming gender into WHO's management and programme areas and establishing accountability

60. Two evaluations were conducted to assess integration of equity, gender and human rights in WHO programmes. Results of the evaluations provided the relevant baseline and targets for the Programme budget 2018–2019.

61. The Secretariat is developing actionable, measurable and mandatory criteria to ensure health policies and programmes based on equity, gender and human rights across all three levels of the Organization. The criteria have been included in the Proposed programme budget 2020–2021 through Output 4.2.6 ("Leave no one behind" approach focused on equity, gender and human rights progressively incorporated and monitored).

62. The Thirteenth General Programme of Work includes integrating equity, gender and human rights as a strategic shift in the Organization. A Senior Adviser on Gender and Youth to the Director General was appointed.

63. In 2017, WHO and other United Nations entities issued a Joint United Nations statement on ending discrimination in health care settings, addressing discrimination based on sex, sexual orientation and gender identity.[2]

64. WHO's Performance Management and Development policy was updated in September 2018 to include gender and diversity criteria for granting performance awards, so that exceptional contributions to WHO's gender and diversity goals are recognized.

65. The Secretariat is responsible and accountable for meeting the requirements of the accountability framework of the updated United Nations System-Wide Action Plan on Gender Equality and Women's Empowerment (UN-SWAP 2.0), including reaching targets on gender equality through WHO's gender equality in staffing policy.

66. As of July 2018, equal representation of men and women among General Service staff has been reached: 46.17% male/53.93% female. Women accounted for 44.7% of staff members in the professional and higher categories holding long-term appointments, representing an increase of 1% since July 2017 (43.7%). The number of women at the P4 grade and above also increased by 1.4% over the

[1] https://www.who.int/gender-equity-rights/knowledge/country-support-package-lnb-to-uhc.pdf?ua=1.

[2] http://www.who.int/mediacentre/news/statements/2017/discrimination-in-health-care/en/.

same period. As at July 2018, women accounted for 35% of the staff at the D1 and D2 grades, an increase of 5% since July 2017. At the ungraded level, the percentage of women was 56.5%. As at July 2018, 33% of the heads of country offices were women.

67. In 2017, the methodology for undertaking a review of equity, gender and human rights in the work of the Office of Internal Oversight Services was revised in consultation with the Secretariat.

G. THE ROLE OF THE HEALTH SECTOR IN THE STRATEGIC APPROACH TO INTERNATIONAL CHEMICALS MANAGEMENT TOWARDS THE 2020 GOAL AND BEYOND (decision WHA70(23) (2017))

68. In May 2017, the Seventieth World Health Assembly in decision WHA70(23) decided to approve the road map to enhance health sector engagement in the Strategic Approach to International Chemicals Management towards the 2020 goal and beyond. During the Health Assembly's deliberations, the Secretariat was also requested to provide regular updates on the global progress made towards the implementation of the Minamata Convention, welcomed by the Health Assembly in resolution WHA67.11 (2014), as part of the reporting on the Strategic Approach.[1] In reporting on implementation of decision WHA70(23), the present report also responds to that request.

69. As called for in the road map, the WHO Global Chemicals and Health Network was established to facilitate implementation of the road map. Its inaugural meeting, held in Geneva, Switzerland on 6–8 November 2018, led to the identification of common challenges, successes and opportunities for collaboration in implementation of the road map; greater awareness of the health impacts of chemicals and the importance of health ministry participation in chemicals management at the national, regional and global levels; and sharing of views on the role of the health sector in international chemicals discussions. A recommendation was made to hold a second meeting in 2020 in order to finalize plans beyond that date.

70. Since May 2017, the Secretariat has developed tools to support implementation of the road map, including a brochure and workbook.[2] The workbook was developed in consultation with members of the Network, including through a workshop held in Geneva, Switzerland on 25–26 October 2017, in order to ensure that it was user-friendly and helpful for establishing national priorities.

71. The Secretariat's technical work to implement road map activities includes the publication of updated estimates of the burden of disease attributable to chemicals. In 2016, an estimated 1.6 million lives were lost due to exposures to selected chemicals.[3] However, data are only available for a small number of chemical exposures and people are exposed to many more chemicals in their daily lives.

[1] See document WHA70/2017/REC/3, summary records of the fourteenth meeting, section 2.

[2] Chemicals road map: workbook. Geneva: World Health Organization; 2018. Both brochure and workbook are available in six languages (https://www.who.int/ipcs/saicm/roadmap/en/, accessed 24 January 2019).

[3] Public health impact of chemicals: knowns and unknowns – Data addendum for 2016. Geneva: World Health Organization; 2018 (https://apps.who.int/iris/bitstream/handle/10665/279001/WHO-CED-PHE-EPE-18.09-eng.pdf?ua=1, accessed 8 February 2019).

Unintentional poisonings (Sustainable Development Goal indicator 3.9.3) cause over 100 000 deaths annually,[1] yet only 46% of countries had a poisons centre in 2017.[2]

72. Addressing lead exposure would prevent significant deaths and disabilities; however, only 71 countries have confirmed that they have legally-binding controls on lead paint.[3] The Secretariat is working with UNEP through a project funded by Global Environment Facility to support the establishment of controls in a further 40 countries. Furthermore, WHO released a report to inform policy-makers about the need to control the recycling of used lead-acid batteries, which can cause significant human exposure to lead.[4]

73. Additional materials were developed to support the implementation of resolution WHA67.11 (2014) on public health impacts of exposure to mercury and mercury compounds: a booklet was released on health sector involvement in the Minamata Convention on Mercury, summarizing the outcomes of WHO regional workshops for health ministries,[5] while a WHO-commissioned review of mercury biomarkers in human populations[6] established a global benchmark for human exposure to mercury and identified vulnerable populations and geographical regions lacking data. A number of developing countries were supported to collect their own biomonitoring data. Guidance on strategic planning for implementation of the health-related articles of the Convention is in development.

74. Guidance on chemical releases triggered by natural hazard events, including earthquakes, floods and cyclones, was published. [7] Such disasters are increasing in intensity, frequency and impact, in part due to climate change. The activities of the Chemical Risk Assessment Network, which comprises more than 90 institutions, included a range of normative work and capacity-building.

75. The Secretariat has supported Member States in respect of their contributions to the Strategic Approach and its intersessional process to prepare recommendations beyond 2020. It has done so by providing health ministries with support to attend meetings so that health sector views are shared, and by convening health sector side meetings and panel discussions.

76. Significant work remains to be done, including devising better methods to estimate the impacts of chemicals on health, as called for in the road map and in paragraph 2(4) of resolution WHA69.4

[1] Mortality from unintentional poisoning. In: Global Health Observatory (http://apps.who.int/gho/data/node.sdg.3-9-viz-3?lang=en, accessed 8 February 2019).

[2] World directory of poison centres (as of September 2017). In: Global Health Observatory (https://www.who.int/gho/phe/chemical_safety/poisons_centres/en/.

[3] WHO member states with legally-binding controls on lead paint, as of 30 September 2018. In: Global Health Observatory (https://www.who.int/gho/phe/chemical_safety/lead_paint_regulations/en/, accessed 8 February 2019).

[4] Recycling used lead-acid batteries: health considerations. Geneva: World Health Organization; 2017 (https://www.who.int/ipcs/publications/ulab/en/, accessed 8 February 2019). Available in six languages.

[5] Health sector involvement in the Minamata Convention on Mercury. Geneva: World Health Organization; 2018 (https://www.who.int/ipcs/assessment/public_health/publication/en/, accessed 8 February 2019). Available in six languages.

[6] Basu N, Horvat M, Evers DC, Zastenskaya I, Weihe P, Tempowski J. A state-of-the-science review of mercury biomarkers in human populations worldwide between 2000 and 2018. In: Environ Health Perspect. 2018 Oct;126(10):106001. doi: 10.1289/EHP3904 (https://ehp.niehs.nih.gov/doi/full/10.1289/EHP3904, accessed 8 February 2019).

[7] Chemical releases caused by natural hazard events and disasters – information for public health authorities. Geneva: World Health Organization; 2018 (https://www.who.int/ipcs/publications/natech/en/, accessed 8 February 2019). Language versions in development.

(2016), in order to inform priority-setting at the national, regional and international levels. The Secretariat will report further on progress at the Seventy-fourth World Health Assembly.

H. REGULATORY SYSTEM STRENGTHENING FOR MEDICAL PRODUCTS (resolution WHA67.20 (2014))

77. This report describes the activities undertaken by the Secretariat in response to resolution WHA67.20 (2014) since the last report to the World Health Assembly in May 2017.

78. **Regulatory systems strengthening.** Work on a unified global benchmarking tool for assessing medicine and vaccine regulatory programmes has been completed following an extensive consultation process. The tool will be used to identify regulatory authorities that can be publicly designated as WHO-listed authorities. Listing these authorities is a transparent way to increase recognition for performing to internationally accepted standards, thereby promoting reliance, broadening the pool of authorities contributing to the supply of quality assured medical products, and increasing the efficiency of the prequalification process.

79. WHO has also continued to implement innovative and effective approaches to regulatory system strengthening jointly with partner organizations, establishing centres of excellence and developing tools for prioritization, monitoring and evaluation.

80. **Norms and standards.** WHO expert committees have approved guidance on:

- quality, safety and efficacy of Ebola vaccines;
- biotherapeutics, including an update of the 2009 similar biotherapeutic products guideline;
- testing and subsequent classification of "suspect" falsified medicines;
- good manufacturing practice; and
- waiving in vivo bioequivalence requirements for medicines included in the WHO Model List of Essential Medicines (Biowaiver list).

81. WHO has also developed:

- guidance on good reliance practices;
- draft guidance on quality management systems for national regulatory authorities;
- a draft programme to advance universal access to quality and safe blood and blood components;
- proposals for modernizing the WHO certification scheme for pharmaceutical products; and
- an interagency statement on local production of quality assured health commodities.

82. Use of WHO norms and standards is being promoted through implementation workshops, benchmarking missions and partnering with other international standard-setting organizations.

83. **Engagement and coordination at all levels of the Organization.** Regulatory system strengthening is recognized as integral to improving access to safe, and effective medical products of assured quality, and is supported at all levels of the Organization under outcome 1.3 of the Programme budget 2020–2021.

84. **Prequalification programme.** A new financing arrangement has been introduced to ensure the financial sustainability and quality of WHO's prequalification programme. The national registration of prequalified medicines is being accelerated through a collaborative registration procedure. A procedure is also in place for vaccines, and work is under way on diagnostics. 2016 marked the end of the WHO Pesticide Evaluation Scheme, as prequalification was expanded to vector control products.

85. **Regulatory networks.** WHO has expanded technical support to:

- the African Medicines Regulatory Harmonization Initiative;
- form a regional coalition to maximize the impact of development partners working together through the New Partnership for Africa's Development;
- the formation of pan-African technical working groups, providing a solid basis for the establishment of a future African medicine agency;
- the African Vaccine Regulatory Forum, which continues to be instrumental in promoting product development and addressing public health emergencies;
- the ASEAN joint assessment group for conducting evaluations of priority medicines; and
- the global network of vaccine control laboratories to expand its membership and further its work to promote best practices and efficiency in lot release of WHO-prequalified vaccines.

86. **International Conference of Drug Regulatory Authorities.** Recommendations from the 18th International Conference of Drug Regulatory Authorities have contributed to the regulatory policy agenda, underscoring the importance of smart safety surveillance over the product lifecycle, investment in regulatory system strengthening and reliance for increasing the availability of essential medical products of assured quality.

87. **Coordination with the Member State mechanism on substandard and falsified medical products.** The Secretariat continues to work closely with the Member State mechanism, which has agreed by consensus working definitions in this area of work; has commissioned a study on the public health and socioeconomic impact of substandard and falsified medical products; has developed training and educational materials; and has set criteria for incident risk assessment.

88. Specific indicators relating to substandard and falsified medical products have been incorporated into the global benchmarking tool and regulatory focal points in 170 Member States have been trained in prevention, detection and response techniques.

89. Well-functioning regulatory systems are the key to access to safe and effective medical products of assured quality. Ensuring that all countries have such a system will require continued, long-term efforts.

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

90. In response to resolution WHA60.16 (2007), Member States, in collaboration with the Secretariat and partners, are working to promote the rational use of medicines, aiming to minimize the overuse, underuse and misuse of medicines through the following: planning and implementation of interventions, such as evidence-based selection; policy guidance and promotion of best practices; capacity-building; and collection and analysis of data on the use of medicines.

Norms and standards for selection and rational use

91. The 20th WHO Model List of Essential Medicines includes an additional 30 medicines for adults and 25 for children, including two oral leukaemia treatments, a pill for hepatitis C that combines two medicines for higher cure rates, a new drug for HIV as well as medicines that can be taken to prevent HIV infection in people at high risk, new paediatric formulations of medicines for tuberculosis, two pain relievers for people with cancer and new contraceptives for family planning. It also specifies new uses for nine already-listed products.

92. The List provides advice on which antibiotics to use for the most common or severe infections and which to reserve for the most serious patients. Furthermore, it categorizes antibiotics into three groups: ACCESS, WATCH, RESERVE (AWARE), with a view to optimizing antibiotic use and reducing antibiotic resistance without restricting access. The categorization serves to guide stewardship measures such as the development or updating of national essential medicine lists and standard treatment guidelines, monitoring of antibiotic consumption, setting targets to improve antibiotic use and access to antibiotics at local, national and global levels. The uptake of AWARE categories to monitor antibiotics use has been swift and highly successful and has contributed to defining an ACCESS index for all countries.

Responsible use of antimicrobials

Surveillance of antibiotic use

93. The Secretariat is leading work on surveillance of the consumption and use of antimicrobial medicines. A WHO methodology for surveillance of antimicrobial consumption has been developed and implemented in several low- and middle-income countries. The first global report on surveillance of antibiotic consumption was published in November 2018 with data from 65 Member States and areas, presented by AWARE categories, among others.[1] The global monitoring of antimicrobial consumption will be included in the Global Antimicrobial Resistance Surveillance System information technology platform in 2019 to provide access to data on both antimicrobial consumption and antimicrobial resistance. Furthermore, WHO hospital guidance on the surveillance of antibiotic consumption is under development to support the routine monitoring of antibiotic consumption at facility level.

[1] WHO report on surveillance of antibiotic consumption: 2016–2018 early implementation. Geneva: World Health Organization; 2018 (https://www.who.int/medicines/areas/rational_use/who-amr-amc-report-20181109.pdf?ua=1, accessed 29 January 2019).

94. A protocol for the WHO point prevalence survey on antibiotic use in hospitals was published online in January 2019.[1] Survey implementation is planned in several countries, starting with the African Region. An information technology platform for data entry and reporting is under development to support the survey. Data obtained by means of the WHO protocol will be comparable to that of other point prevalence survey protocols. The surveys can make use of the AWARE categories and inform antimicrobial stewardship programs in hospitals.

Antimicrobial stewardship

95. WHO has developed advocacy materials on antimicrobial stewardship to optimize use of antimicrobials, including key messages on antibiotic use for policy-makers, prescribers and the public,[2] a video[3] and posters about the importance of efficient antibiotics and their use. Furthermore, WHO is providing technical support to countries on establishing and strengthening antimicrobial stewardship programmes in hospitals through an integrated approach linked to the implementation of AWARE categories and surveillance of consumption and use of antimicrobials, with a view to strengthening health systems. A draft toolkit is currently being finalized to support the implementation of antimicrobial stewardship programmes in hospitals in low- and middle-income countries. The toolkit will include guidance on structures, such as leadership; how to plan, perform and assess the implementation of interventions to promote appropriate antibiotic use; and education and training, including a compilation of e-learning resources for antimicrobial surveillance.

96. The WHO Model List will be updated in 2019 and a new iteration of AWARE categorization of antibiotics will be undertaken, including an evaluation and categorization of all newly registered antibiotics. New recommendations on optimal antibiotic dosing regimens and duration will be published with the updated List.

97. WHO will also develop an AWARE manual for policy-makers for wider adoption at country level.

Progress in regions and countries

98. In 2018, more than three quarters of countries in the African Region expressed support for promoting the rational dispensing, prescribing and use of medicines and other health technologies with a view to increasing universal health coverage.[4]

---

[1] WHO methodology for point prevalence survey on antibiotic use in hospitals. Geneva: World Health Organization; 2018 (https://apps.who.int/iris/bitstream/handle/10665/280063/WHO-EMP-IAU-2018.01-eng.pdf?ua=1, accessed 26 February 2019).

[2] Key messages on antibiotics use. Geneva: World Health Organization; 2018 (https://www.who.int/medicines/access/antimicrobial_resistance/Key_messages-Stewardship.pdf?ua=1, accessed 29 January 2019).

[3] Amala's story: how to prevent antimicrobial resistance [video]. Geneva: World Health Organization; 2018 (https://www.youtube.com/watch?v=Y9WEERSh5G0, accessed 29 January 2019).

[4] Programme Budget 2020–2021: Regional Committee Consultation Document. Brazzaville: WHO Regional Office for Africa; 2018 (AFR/RC68/13), para. 35 and Annex 4, p. 24 (https://apps.who.int/iris/bitstream/handle/10665/275832/AFR-RC68-13-eng.pdf?sequence=1&isAllowed=y, accessed 26 February 2019).

99. The Health Technologies and Pharmaceuticals Programme in the European Region contributed to strengthening countries' pharmaceutical sector systems by addressing various topics relevant to the selection and responsible use of medicines and providing technical advice in that regard in its 2017 annual report.[1] The Regional Office for Europe collaborates with WHO headquarters to provide direct support to countries by organizing capacity training for health professionals and relevant stakeholders to improve prescribing. In addition, it helps identify successful strategies to improve the use of medicines through medicine and therapeutic committees, formularies and clinical guidelines, feedback on medicine use data and policies on medicine promotion. In February 2019, countries in the South-East Asia Region gathered to discuss national and regional initiatives to optimize the use of antimicrobials with a focus on antimicrobial stewardship, to be implemented in an integrated approach linked to AWARE categories and surveillance of the consumption and use of antimicrobials, with a view to strengthening health systems. Further technical support will be provided to countries and regions.

The way forward

100. In addition to the initiatives described above, further efforts are needed to address the rational use of medicines including through stronger and more focused guideline implementation activities, by means of national policies and plans integrating WHO standards and norms with regional initiatives and by investing sufficiently in human and financial resources as recommended in resolution WHA60.16.

J. TRADITIONAL MEDICINE (resolution WHA67.18 (2014))

101. In May 2014, the Sixty-seventh World Health Assembly adopted resolution WHA67.18 on traditional medicine. This report describes progress achieved in this regard from 2012, prior to the launch of the WHO traditional medicine strategy: 2014–2023, to 2018.[2]

102. The number of countries with a legal and regulatory framework for traditional and complementary medicine increased from 79 in 2012 to 109 in 2018 and is gradually increasing. A number of countries have enacted or expanded existing legislation and policies relating to this sphere or are in the process of doing so. Infrastructure for the governance of traditional and complementary medicine at country level has also been significantly improved.

103. Between 2012 and 2018, the growth of national policies and regulation for traditional and complementary medicine providers outstripped that of regulation for herbal medicines, indicating that Member States paid greater attention to the establishment of comprehensive policy and regulatory systems relating to traditional and complementary health services. As at 2018, 124 countries (64% of WHO Member States) reported having laws or regulations on herbal medicines and 78 countries reported having regulations on traditional and complementary medicine providers; furthermore,

[1] Health technologies and pharmaceuticals programme. Annual report 2017. Copenhagen: WHO Regional Office for Europe; 2017 (http://www.euro.who.int/en/health-topics/Health-systems/health-technologies-and-medicines/publications/2017/health-technologies-and-pharmaceuticals-programme.-annual-report-2017, accessed 7 February 2019).

[2] This report is based on the second WHO global survey on traditional medicine, conducted in 2010–2012, and the subsequent update survey, conducted in 2016–2018. It includes data from Member States, nongovernmental organizations in official relations with WHO, WHO collaborating centres for traditional medicine and WHO regional offices, in addition to information recorded by the WHO's Traditional, Complementary and Integrative medicine unit.

45 countries reported that traditional and complementary medicine were covered by health insurance. Most countries reported that partial coverage was available for traditional and complementary medicine.

104. The number of WHO Member States with a national programme for traditional and complementary medicine increased from 58 in 2012 to 79 in 2018. Countries continue to make efforts to integrate traditional and complementary medicine at all levels of health service delivery, including through minimum packages of primary services, wellness clinics, pain clinics and the use of locally manufactured herbal medicines. The 2018 Declaration of Astana on Primary Health Care[1] acknowledges the need to include traditional medical knowledge and technologies in the delivery of primary health care.

105. The Secretariat has been working continuously since 2014 on the development of technical documents,[2] international terminologies[3] and tools[4] to guide Member States and stakeholders on minimum reference standards for the delivery of safe, quality and effective traditional, complementary and integrative medicine services. During the period 2016–2018, a survey was conducted to update the second WHO global survey on traditional medicine, conducted in 2010–2012, in order to analyse global trends and obtain an overview of the current situation. The findings of both surveys will be reflected in the forthcoming WHO global report on traditional and complementary medicine.[5]

106. Interregional and regional networks and arrangements on traditional, complementary and integrative medicine regulation and quality assurance promoted by WHO include the International Regulatory Cooperation for Herbal Medicines network[6] and the working group on quality assurance and improvement of acupuncture service, among others.[7] Eight WHO interregional training workshops, each attended by nominees from some 20 Member States, have been conducted in coordination with the Government of Macao Special Administrative Region, China in order to build national capacity in areas related to traditional and complementary medicine.

---

[1] Available at https://www.who.int/docs/default-source/primary-health/declaration/gcphc-declaration.pdf (accessed 4 February 2019).

[2] Including the following: WHO Guidelines for selecting marker substances of herbal origin for quality control of herbal medicines. In: WHO Expert Committee on Specifications for Pharmaceutical Preparations: fifty-first report. Geneva: World Health Organization; 2017: Annex 1 (WHO Technical Report Series, No. 1003; https://www.who.int/medicines/areas/quality_safety/quality_assurance/expert_committee/WHO_TRS_1003_full-version.pdf?ua=1, accessed 5 February 2019); WHO Guidelines on good herbal processing practices for herbal medicines. In WHO Expert Committee on Specifications for Pharmaceutical Preparations: fifty-second report. Geneva: World Health Organization; 2018: Annex 1 (WHO Technical Report Series, No. 1010; https://apps.who.int/iris/bitstream/handle/10665/272452/9789241210195-eng.pdf?ua=1, accessed 5 February 2019); and Guidelines on good manufacturing practices for the manufacture of herbal medicines. Geneva: World Health Organization; 2018: Annex 2 (WHO Technical Report Series, No. 1010; https://apps.who.int/iris/bitstream/handle/10665/272452/9789241210195-eng.pdf?ua=1, accessed 5 February 2019).

[3] Terminologies relating to Ayurveda, Siddha medicine, traditional Chinese medicine and Unani medicine are at different stages of development.

[4] Tools such as benchmarks for training in anthroposophic medicine, Tibetan medicine and yoga and for practice in acupuncture, Ayurveda, cupping, Panchakarma, Tuina and Unani medicine are at different stages of development.

[5] Forthcoming in 2019.

[6] This became a WHO network in September 2017, with WHO headquarters functioning as its secretariat.

[7] Including a regional framework for regulation of traditional medicine practitioners, practices and products (African Region); the Virtual Health Library on Traditional, Complementary and Integrative Medicine (Americas Region); and the South-East Asia regulatory network.

107. One highly significant achievement is the inclusion of a chapter on traditional medicine in the Eleventh Revision of the International Statistical Classification of Diseases and Related Health Problems. Furthermore, two traditional and complementary medicine indicators have been listed as additional indicators in the 2018 edition of WHO's Global Reference List of 100 Core Health Indicators (plus health-related SDGs). Other WHO initiatives include a tool package, in addition to region-specific indicators and frameworks, tested in selected Member States,[1] to monitor and guide the appropriate integration of traditional and complementary medicine in the universal health coverage process in the context of the Sustainable Development Goals.[2,3]

108. WHO, Member States and non-State actors are collaborating to develop national, regional and global knowledge platforms providing evidence-based information on traditional and complementary medicine. Such platforms include ObservaPICS,[4] the Brazilian Academic Consortium for Integrative Health,[5] the Acupuncture-Moxibustion Clinical Trial Registry[6] and the Global Health Observatory.[7]

109. It is imperative to harness the full potential of traditional and complementary medicine in order to achieve the "triple billion" targets of the Thirteenth General Programme of Work, 2019–2023, universal health coverage and the Sustainable Development Goals. Member States have requested general technical guidance from WHO, including on research into and the evaluation of traditional and complementary medicine; information-sharing on regulatory issues; workshops on national capacity-building; and the provision of research databases. WHO will continue to promote the safe and effective use of traditional, complementary and integrative medicine through the regulation, research and integration of traditional and complementary medicine products, practices and practitioners into existing health systems, as appropriate, in order to contribute to the achievement of the Thirteenth General Programme of Work, 2019–2023, universal health coverage and the Sustainable Development Goals. WHO will also continue to monitor progress at country level by collecting reliable information.

[1] The Regional Office for South-East Asia developed and tested standard core and reference indicators in selected Member States.

[2] In 2017, the Regional Committee for Africa adopted the Regional Framework for health systems development towards universal health coverage in the context of the Sustainable Development Goals (document AFR/RC67/10) at its Sixty-seventh session (https://www.afro.who.int/sites/default/files/2018-01/AFR-RC67-10%20Framework%20for%20health%20systems%20development-Rev%2023.09.17.pdf, accessed 11 February 2019).

[3] The Sustainable Development Goals and Universal Health Coverage Regional Monitoring Framework, endorsed by the Regional Committee for the Western Pacific in 2016, includes selected indicators relevant to traditional and complementary medicine (see http://iris.wpro.who.int/bitstream/handle/10665.1/13961/9789290618379-eng.pdf, accessed 11 February 2019).

[4] National Observatory of Traditional, Complementary and Integrative Medicine Health Practices and Knowledge in Brazil (http://observapics.com.br/, website under construction).

[5] Launched with support from the Brazilian Ministry of Health through the Latin American and Caribbean Center on Health Sciences (BIREME), the project aspires to form the basis of a regional network of collaboration for research on traditional and complementary medicine.

[6] A secondary platform under the Chinese Clinical Trial Registry, the WHO International Clinical Trials Registry Platform is a collaborative initiative between the World Federation of Acupuncture and Moxibustion Societies, the China Academy of Chinese Medical Sciences and China Association of Acupuncture-Moxibustion. It was officially approved by WHO in March 2018.

[7] WHO is collaborating with the China Academy of Chinese Medical Sciences and relevant institutions to build evidence and sustain resources for and disseminate knowledge of traditional medicine. The platform currently being developed is to be included in the Global Health Observatory data repository.

= = =