The “Unofficial” WHCA Action Guide to the:

WHO—70th

World Health Assembly

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The “Unofficial” World Health Communication Associates (WHCA) Action Guide to the:

WHO – 70th World Health Assembly

22–31 May 2017, Geneva
INTRODUCTION

This “unofficial” WHCA Action Guide is a compilation of information from the WHO website for the 70th World Health Assembly. It is presented for use by World Health Communication Associates (WHCA), World Health Editors Network (WHEN) members and others attending the WHA70 and is not intended for sale. It includes useful information regarding the Assembly, including texts of key discussion papers and resolutions. It aims to serve as a “one-stop” background document to the agenda items for Committee A during WHA70 in Geneva, 22–31 May 2017.

This year the guide is being issued alongside the World Health Minute (WHM), a new public health news aggregation that provides quick access to global public health reporting. The aim of the WHM is to bring early intelligence to communities of practice focused on different agenda items of the WHA and issues related to action areas of the Sustainable Development Goals (SDG). The WHM aggregator aims to be a key information source for public health leaders, managers, practitioners, advocates and investors interested in policy issues, developments in products and patents, political shifts and movements in the world of public health. The website (www.worldhealthminute.com) will be launched in the run-up to the WHA.

A big thank you to WHCA Associates Carinne Allinson and Tuuli Sauren for the compilation and design of this document.

Franklin Apfel
World Health Communication Associates
franklin@whcaonline.org

Sabrina Cecconi
World Health Communication Associates
sabrina@whcaonline.org

Chitra Subramaniam
CSDconsulting
chitras@csdconsulting.net

Mark Chataway
Hyderus Cyf.
mark@hyderus.com

The World Health Editors Network (WHEN) is an international, inter-professional exchange and action platform dedicated to exploring and strengthening communications as a positive determinant of health. Through participation in events, editors get early access to global health news and experts and importantly, key international health agency agenda-setting intelligence. WHEN development is being facilitated by the World Health Professional Alliance and its constituent association members, including the International Council of Nurses (ICN), the International Pharmaceutical Federation (FIP), the FDI World Dental Federation, and the World Medical Association (WMA). WHCA serve as Secretariat to WHEN.

The World Health Communication Associates (www.whcaonline.org) works to improve health by helping public health advocates and organisations acquire the knowledge, savvy and resources to enable their messages to stand out and positively shape health choices, behaviours and perceptions in local, national and global information marketplaces. WHCA focuses exclusively on health and environmental issues and does no product promotion. The Associates are an independent network of active, strategically placed communicators, with practical experience in health and environment
reporting, investigative journalism, policy advocacy, intergovernmental and nongovernmental public and press relations, international conference organisation and cross-border campaigning.

**Hyderus** ([http://www.hyderus.com](http://www.hyderus.com)) is a consultancy, communications and policy organisation specialising in the field of health and public health, providing high-level strategic solutions to governments, corporations and social groups. Operating in over 70 countries around the globe, Hyderus offers a wide portfolio of services which includes: development and politics, public health, treatment decisions, strategic planning and knowledge transfer and capacity-building. Hyderus offers personal service from senior consultants with a background in policy, public relations, stakeholder management as well as market research analysis.

**CSDconsulting** ([www.csdconsulting.net](http://www.csdconsulting.net)) is a communication, research and analysis company with a special focus on public health. It provides strategic political guidance to companies, individuals, civil society groups and international agencies. Policy advocacy is a major area of expertise and it has worked with Fortune 500 companies in India and Europe.
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SECTION I : INTRODUCTION TO WHO AND THE WORLD HEALTH ASSEMBLY
(Adapted from WHO website, www.who.int, accessed April 2017)

The World Health Organization (WHO) is the directing and coordinating authority for health within the United Nations system. It is responsible for providing leadership on global health matters, shaping the health research agenda, setting norms and standards, articulating evidence-based policy options, providing technical support to countries and monitoring and assessing health trends.

WHO experts produce health guidelines and standards, and help countries to address public health issues. WHO also supports and promotes health research. Through WHO, governments can jointly tackle global health problems and improve people’s well-being. WHO’s Constitution came into force on 7 April 1948 – a date now celebrated every year as World Health Day. WHO and its Member States work with many partners, including UN agencies, donors, nongovernmental organisations, WHO collaborating centres and the private sector.

World Health Assembly

The World Health Assembly is the supreme decision-making body for WHO. It generally meets each year in May in Geneva and is attended by delegations from all 194 Member States. Its main function is to determine the policies of the Organization. The Health Assembly appoints the Director-General, supervises the financial policies of the Organization, and reviews and approves the Proposed programme budget. It similarly considers reports of the Executive Board, which it instructs in regard to matters upon which further action, study, investigation or report may be required. All World Health Assembly documentation is available at http://apps.who.int/gb/gov/.

Executive Board

The Executive Board is composed of 34 members technically qualified in the field of health. Members are elected for three-year terms. The main Board meeting, at which the agenda for the forthcoming Health Assembly is agreed upon and resolutions for forwarding to the Health Assembly are adopted, is held in January, with a second shorter meeting in May, immediately after the Health Assembly, for more administrative matters. The main functions of the Board are to give effect to the decisions and policies of the Health Assembly, to advise it and generally to facilitate its work. All Executive Board documentation is available at http://apps.who.int/gb/gov/.

WHO Staff

More than 7000 people from more than 150 countries work for the Organization in over 150 WHO country offices, 6 regional offices, at the Global Service Centre in Malaysia and at the headquarters in Geneva, Switzerland. In line with the mission to provide global leadership in public health, WHO employs health specialists, medical doctors, scientists, epidemiologists and also people with expertise in administration and finance, information systems, economics, health statistics as well as emergency preparedness and response.

Regional Committees

The six WHO Regional Committees meet separately once every year to set policy and approve budgets and programmes of work for their respective regions. Each meeting addresses the specific public health needs of the area represented by the region.
SECTION II : OVERVIEW OF THE 70TH WORLD HEALTH ASSEMBLY AGENDA

Provisional Agenda

PLENARY

1. Opening of the Assembly
   1.1 Appointment of the Committee on Credentials
   1.2 Election of the President
   1.3 Election of the five Vice-Presidents, the Chairmen of the main committees, and establishment of the General Committee
   1.4 Adoption of the agenda and allocation of items to the main committees

2. Reports of the Executive Board on its 139th and 140th sessions

3. Address by Dr Margaret Chan, Director-General

4. Post of Director-General
   4.1 Procedures for the conduct of the election
   4.2 Appointment of the Director-General
   4.3 Contract of the Director-General

5. Admission of new Members and Associate Members [if any]

6. Executive Board: election

7. Awards

8. Reports of the main committees

9. Closure of the Health Assembly

COMMITTEE A

10. Opening of the Committee¹

11. Programme and budget matters
   11.1 Overview of financial situation: Programme budget 2016–2017
   11.2 Proposed programme budget 2018–2019

12. Preparedness, surveillance and response
   12.1 Health emergencies
      • The Independent Oversight and Advisory Committee for the WHO Health Emergencies Programme
      • WHO response in severe, large-scale emergencies
      • Research and development for potentially epidemic diseases
      • Health workforce coordination in emergencies with health consequences
   12.2 Antimicrobial resistance
   12.3 Poliomyelitis
   12.5 Review of the Pandemic Influenza Preparedness Framework

13. Health systems

¹ Including election of Vice-Chairmen and the Rapporteur.
13.1 Human resources for health and implementation of the outcomes of the United Nations’ High-Level Commission on Health Employment and Economic Growth
13.2 Principles on the donation and management of blood, blood components and other medical products of human origin
13.3 Addressing the global shortage of, and access to, medicines and vaccines
13.4 Evaluation and review of the global strategy and plan of action on public health, innovation and intellectual property
13.5 Follow-up of the report of the Consultative Expert Working Group on Research and Development: Financing and Coordination
13.6 Member State mechanism on substandard/spurious/falsey-labelled/falsified/counterfeit medical products
13.7 Promoting the health of refugees and migrants

14. **Communicable diseases**
14.1 Global vaccine action plan
14.2 Global vector control response

15. **Noncommunicable diseases**
15.1 Preparation for the third High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases, to be held in 2018
15.2 Draft global action plan on the public health response to dementia
15.3 Public health dimension of the world drug problem
15.4 Outcome of the Second International Conference on Nutrition
15.5 Report of the Commission on Ending Childhood Obesity: implementation plan
15.6 Cancer prevention and control in the context of an integrated approach
15.7 Strengthening synergies between the World Health Assembly and the Conference of the Parties to the WHO Framework Convention on Tobacco Control
15.8 Action plan for prevention of deafness and hearing loss

16. **Promoting health through the life course**
16.1 Progress in the implementation of the 2030 Agenda for Sustainable Development
16.2 The role of the health sector in the Strategic Approach to International Chemicals Management towards the 2020 goal and beyond
16.3 Global Strategy for Women’s, Children’s and Adolescents’ Health (2016–2030): adolescents’ health

17. **Progress reports**

**Noncommunicable diseases**
A. WHO global disability action plan 2014–2021: better health for all people with disability (resolution WHA67.7 (2014))

**Communicable diseases**
D. Eradication of dracunculiasis (resolution WHA64.16 (2011))
E. Global strategy and targets for tuberculosis prevention, care and control after 2015 (resolution WHA67.1 (2014))
F. Global technical strategy and targets for malaria 2016–2030 (resolution WHA68.2 (2015))

**Promoting health through the life course**

G. Public health impacts of exposure to mercury and mercury compounds: the role of WHO and ministries of public health in the implementation of the Minamata Convention (resolution WHA67.11 (2014))

H. Strategy for integrating gender analysis and actions into the work of WHO (resolution WHA60.25 (2007))

**Health systems**

I. Progress in the rational use of medicines (resolution WHA60.16 (2007))

J. Regulatory system strengthening for medical products (resolution WHA67.20 (2014))

K. Strengthening emergency and essential surgical care and anaesthesia as a component of universal health coverage (resolution WHA68.15 (2015))

**Preparedness, surveillance and response**

L. Smallpox eradication: destruction of variola virus stocks (resolution WHA60.1 (2007))

M. Enhancement of laboratory biosafety (resolution WHA58.29 (2005))

**COMMITTEE B**

18. Opening of the Committee

19. Health conditions in the occupied Palestinian territory, including east Jerusalem, and in the occupied Syrian Golan

20. Financial matters

   20.1 WHO mid-term programmatic and financial report for 2016–2017, including audited financial statements for 2016

   20.2 Status of collection of assessed contributions, including Member States in arrears in the payment of their contributions to an extent that would justify invoking Article 7 of the Constitution

   20.3 Special arrangements for settlement of arrears [if any]

   20.4 Scale of assessments for 2018–2019

   20.5 Assessment of new Members and Associate Members [if any]

   20.6 Amendments to the Financial Regulations and Financial Rules [if any]

21. Audit and oversight matters

   21.1 Report of the External Auditor

   21.2 Report of the Internal Auditor

22. Staffing matters

   22.1 Human resources: annual report

   22.2 Report of the International Civil Service Commission

   22.3 Amendments to the Staff Regulations and Staff Rules

   22.4 Report of the United Nations Joint Staff Pension Board

   22.5 Appointment of representatives to the WHO Staff Pension Committee

23. Management, legal and governance matters

   23.1 Overview of WHO reform implementation

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2 Including election of Vice-Chairmen and the Rapporteur.
23.2 Governance reform: follow-up to decision WHA69(8) (2016)
23.3 Engagement with non-State actors
  • Criteria and principles for secondments from nongovernmental organizations, philanthropic foundations and academic institutions
23.4 Proposed Infrastructure Fund (consolidating the Real Estate Fund and IT Fund)
23.5 Agreements with intergovernmental organizations [if any]
24. Collaboration within the United Nations system and with other intergovernmental organizations
SECTION III : SELECTED AGENDA DISCUSSION TOPICS, DECISIONS AND RESOLUTIONS

12. Preparedness, surveillance and response

12.1 Health emergencies

• The Independent Oversight and Advisory Committee for the WHO Health Emergencies Programme

Document A70/8:

Report of the Independent Oversight and Advisory Committee for the WHO Health Emergencies Programme

The Director-General has the honour to transmit to the Seventieth World Health Assembly the report submitted by the Chair of the Independent Oversight and Advisory Committee (see Annex).

ANNEX

REPORT OF THE INDEPENDENT OVERSIGHT AND ADVISORY COMMITTEE FOR THE WHO HEALTH EMERGENCIES PROGRAMME

I. BACKGROUND

1. The Independent Oversight and Advisory Committee (IOAC) for the WHO Health Emergencies (WHE) Programme provides oversight and monitoring of the Programme and advises the Director-General. The IOAC’s first report was noted by the Executive Board at its 140th session in January 2017. The report was shared with the Secretary-General of the United Nations and with the Inter-Agency Standing Committee.

2. That first report, based on activities during May to December 2016, reviewed the status of implementation of the WHE Programme across the Organization. The report also provided observations on WHO’s response to the Zika virus disease outbreak in Colombia via a field visit and

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5 See document EB140/8 and the summary records of the Executive Board at its 140th session, second meeting, section 3 (document EB140/2017/REC/2).
6 Inter-Agency Standing Committee (https://interagencystandingcommittee.org/+).
7 Headquarters, six regional offices and more than 150 country offices.
on the yellow fever outbreak in the Angola and Democratic Republic of the Congo (DRC) via a desk review.  

3. The findings from the first report suggested that the Zika incident management system was successful and that the declaration of a public health emergency of international concern led to urgent national and global action. Although the country response was led by the Colombian Ministry of Health and Social Protection, there was strong support from PAHO/AMRO through the WHO Representative (WR), who also acted as Incident Manager. This was a successful emergency response, but also emphasized the importance of WHO’s role in responding to complex diseases with lasting sequelae.

4. The IOAC also commended the WHO’s response to the outbreak of yellow fever. Although this was very different from that of the Zika outbreak and involved vaccinating 30 million people, the IOAC observed the use of one integrated incident management system with support from multiple partners in the transition to the new ways of working.

5. Between January and May 2017, the IOAC held its sixth and eighth meetings by teleconference and the seventh meeting in person in Amman. In January, interviews were held with several Member States and six Regional Directors. In March, two field visits were conducted, in Iraq and Nigeria, where the IOAC met with numerous partners and stakeholders. In Amman, IOAC members also interviewed other external partners and WHO staff including the WRs in Iraq, Jordan, Nigeria, Syrian Arab Republic and Yemen.

6. This second report to the governing bodies covers the IOAC’s activities in its first year and provides its observations on progress in the eight thematic areas that were identified in the first report: structure, human resources, emergency business processes, finance, risk assessment, incident management, partnerships, and International Health Regulations (2005). The report focuses in particular on the impact of WHO’s emergency reform in terms of delivery on the ground, functionality of the WHE Programme across the Organization, and barriers to effective operations.

II. OVERALL PROGRESS OF THE WHE PROGRAMME

7. In reaching its assessment, the IOAC adopted a monitoring framework to track progress against the WHE Programme Results Framework indicators. The Director-General’s report to the Sixty-ninth World Health Assembly on the reform of WHO’s work in health emergency management remains the main reference for monitoring implementation. Furthermore, the IOAC carried out interviews, field visits and reviewed various public and internal documents.

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10 Seventh meeting of the Committee (http://www.who.int/about/who_reform/emergency-capacities/oversight-committee/7th-meeting-agenda.pdf, accessed 20 April 2017).
8. The implementation of the WHE Programme has advanced since the IOAC’s first report. Particular progress has been noted in WHO’s response to the health needs of populations in protracted emergencies. The IOAC observes improvement in WHO’s health cluster\(^{16}\) coordination and leadership, which is welcomed by partners on the ground. The IOAC acknowledges encouraging signs in WHO’s field presence and partnership engagement.

9. Evidence from the field visits\(^{17}\) demonstrates that the WHE Programme is improving WHO’s effectiveness in emergencies. However, the IOAC cautions that this progress remains fragile, and WHO’s “no regrets” policy\(^{18}\) has not yet been fully embedded into all areas of crisis response. To date, the success at country level has been driven by the performance of dedicated country office and short-term surge staff in the field, support from WHE Programme staff in headquarters and regional offices, and partner deployments (e.g. the Global Outbreak Alert and Response Network(GOARN)\(^{19}\) and Stand-by partners), while administration and support systems remain a serious constraint.

Structure of the WHE Programme

10. The IOAC acknowledges that the structure of the WHE Programme has been aligned across the three levels of the Organization. However, although some partners are aware of WHO’s emergency reform programme, many country-level staff and some external partners are not. Nevertheless, partners interviewed during field visits have universally noticed positive changes in WHO’s way of working. The IOAC recommends that both internal and external communication about the WHE Programme should be improved.

11. The IOAC recognizes that emergency management structures at country level are being adapted to manage the different types, magnitude and duration of emergencies. The establishment of an incident management system is well suited to new or acute emergencies where the country office (CO) may not be set up for emergency operations. In protracted emergencies where WHO puts in place leadership and emergency management structures, a stand-alone incident management system may not be needed. WHO may instead focus on provision of surge staff from the WHE Programme and partners to deal with the escalation of an emergency such as a disease outbreak within an existing humanitarian emergency.

12. WHO must take a coherent Organization-wide approach to staffing in emergencies to ensure sufficient flexibility. For example, in priority countries of the WHE Programme, including those in protracted crises, an appropriately trained and experienced WR could be designated as Incident Manager. The IOAC notes the importance of establishing a baseline level of emergency operational and management capacity at country level, ideally including a deputy WR. This is particularly necessary for ensuring sufficient management bandwidth in priority countries of the WHE Programme if the WR assumes the Incident Manager position. It is important that in biennial budgetary planning for the COs in priority countries that key senior staff positions are included in the CO’s budget.

13. Clarity on roles, responsibilities, authority, accountability, reporting lines and coordination is of paramount importance. Noting the importance of the Delegation of Authority to Incident Managers

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\(^{17}\) Colombia (8–10 November 2016), Nigeria (28 February–6 March 2017), and Iraq (22–24 March 2017).

\(^{18}\) WHO’s no regrets policy: At the onset of all emergencies, WHO ensures that predictable levels of staff and funds are made available to the WCO, even if it is later realized that less is required, with full support from the Organization and without blame or regret. Emergency Response Framework, second edition, Chapter 4.

and WRs, the IOAC recommends that a standard template for delegation of authority should be developed and adopted across all three levels of the Organization.

**Human resources**

14. As of March 2017, the WHE Programme has established a total of 1438 positions (684 existing staff and 754 vacant positions) compared to 1157 soon after its roll-out. The increase is due to an increase in positions at CO level. However, recruitment has not kept pace with the creation of the new posts and no significant change has been made in the recruitment rate since December 2016: 35% of positions filled in the COs, 50% at regional offices and 70% at headquarters level.

15. While 469 CO level positions remain vacant, there are 386 temporary staff employed for emergency response, with the average length of contract of seven months. Given current funding gaps, the IOAC accepts that short-term contract staff can provide an interim solution to the vacancies, but warns that this will result in high turnover and difficulty recruiting motivated staff with the right profiles and emergency experience. There is also the risk that institutional memory will not be accumulated. Long-term sustainable financing for the WHE Programme needs to be secured to stabilize contractual arrangements for key staff.

16. WHO’s enhanced ability to deliver on the WHE Programme hinges on the quality of its staff. In particular the IOAC recognizes the crucial role that national staff play in emergencies, and acknowledges the need for capacity investment and career support of national staff.

17. Following the IOAC’s recommendation in its first report, the WHO Secretariat conducted a benchmarking exercise of the WHE Programme staffing. This Organization-wide analysis revealed that the proportion of positions in the WHE Programme that are at the senior level (P6 and above) at three levels of WHO is 4.3% against total professional staff, in comparison for the rest of the Organization of 17.5%. The proportion of senior level positions at headquarters only is 7.95% for the WHE Programme and 12.48% for the Organization as a whole. All these figures show that the proportion of senior staff in the WHE Programme is lower than for WHO as a whole (excluding the WHE Programme) at both headquarters and global level. The WHO Secretariat also reported that the proportion of senior staff in the WHE Programme is comparable to that of other humanitarian agencies.

18. The IOAC observes that the Organization shows strong preference for internal WHO candidates in staff recruitment. This limits the recruitment pool, given that candidates with senior-level experience in both health and humanitarian response can be found externally, particularly in the nongovernmental organization sector. While candidates without WHO experience may struggle to navigate the business rules and procedures of the Organization, such staff must be duly considered if WHO is to be effective on the ground. The IOAC recommends that a longer-term recruitment strategy should be developed which can attract, orient and support the best candidates.

19. IOAC field visits underscored the importance of administration and finance as core functions of the WHE Programme. Administrative support staff should be deployed at the beginning of an emergency activation in order to assist the team with its heavy field deployment demands and to navigate the business systems. During a response, a dedicated emergency administrative support officer should also sit in the CO to provide added capacity and facilitate support to the Programme.

20. Staff well-being and protection are essential for both national and international personnel in emergency settings. A clear staff rotation policy consistent with the WHO Geographical Mobility Policy must be implemented in hardship duty stations to prevent staff from burning out, and

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20 The WHO Health Emergencies Programme was launched officially on 1 July 2016.

special considerations and incentives should be given to staff working in emergencies at the most challenging duty stations. The IOAC observes that the United Nations’ rest and recuperation entitlement is not commensurate with the stress and pace of WHO’s emergency field operations. Therefore, WHO is encouraged to develop its own ad hoc incentives and appropriate leave policies specifically for staff working in emergencies in accordance with WHO’s human resources policies. Additionally, psychological support should be provided to staff working in the field, as well as protection against workplace harassment.

**Emergency business processes**

21. Based on the field visits and interviews, the IOAC observes that WHO’s administrative systems are not suited to support emergency operations, particularly for recruitment, procurement, delegations of authority, and grant management. The IOAC recommends setting up a time-limited working group dedicated to addressing major issues for streamlining administrative and operational systems in an emergency response.

22. The IOAC acknowledges that the emergency business rules have been inserted into the WHO e-manual, but feedback from staff and partner organizations indicates that they are not yet fully embedded in the Organization’s culture. For example, although waiver authorities exist, these are rarely used in emergency settings due to lack of awareness, or reluctance to apply them. The IOAC recommends that the WHO Secretariat ensures automatic activation of the Standard Operating Procedures, makes issuance of waivers a standard default practice, and briefs auditors so that their audit expectations are aligned with WHO policy for emergencies. WHO should promote its processes in emergencies to all staff and invest in cultural change across the Organization.

23. According to the analysis in Iraq, the recruitment process takes an average of 87 days from initiation to a staff member arriving at the duty station. This is unworkable for health emergencies as it jeopardizes WHO’s operational readiness. In surge situations, a fast-track recruitment process should be aligned with best practice from other agencies, including recruitment in advance of funding, with final appointments subject to funding availability. The IOAC welcomes the WHE Programme’s practice of building up a roster of pre-screened and fully-validated candidates.

24. Delay in procurement of essential supplies will hamper emergency response and can be caused by lack of clear policies, inadequate delegation of authority or a culture of risk aversion. The IOAC urges the WHO Secretariat to streamline standard operating procedures for emergency procurement: increase the expenditure limits in the delegation of authority, apply standard waivers in accordance with the delegation of authority, systematize pre-qualified suppliers, simplify local contracts and payment processes, and fast track due diligence process as per the provision in the Framework of Engagement with Non-State Actors.

25. The IOAC recommends that WHO should have a more consistent and robust approach to security across its emergency programmes and that this should be funded by an appropriate level of flexible corporate funding. Evidence from field visits indicates that the quality of work of the United Nations Department of Safety and Security (UNDSS) and WHO’s engagement with the UNDSS vary depending on the duty stations. WHO is encouraged to proactively work with the UNDSS on security risk assessment and management and put in place a coherent strategy for security in insecure field settings, both for acute emergencies and outbreaks, and protracted crises. WHO should increase its investment and capacities in field security and other staff protection measures.

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22 WHO e-manual, Section XVII – Health Emergencies.
Finance

26. Findings from the field visits suggest that WHO’s field performance is yielding increased donor confidence, as it demonstrates its ability to both coordinate the health cluster and respond effectively in difficult environments. Recent media coverage on WHO’s response in Iraq reflects this as well.\(^{25}\) However, the WHE Programme still faces financial challenges including lack of multiyear funding arrangements, management of large one-off contributions, competing humanitarian priorities, and ongoing shifts in donor investment.

27. Since the IOAC presented its first report, additional flexible funds have been received for the core budget for the biennium 2016–2017 and the funding gap has been reduced from 56% to 41% over the past three months. This allocation and the projections based on the pledges that the WHE Programme has received, indicate that 86% of the core budget could be funded over the biennium. The appeals budget (for humanitarian acute and protracted emergencies response plans) for 2017 led to receipt in the first quarter of the year of US$ 67 million out of the target US$ 523 million. Since the first report, there has been no change in the shortfall in the Contingency Fund for Emergencies:\(^{26}\) a 67% funding gap for the target of US$ 100 million.

28. Of US$ 284 million raised for the core budget, US$ 82.5 million has been made available at the country level. The IOAC recognizes the progress made in resource mobilization at country level, particularly in Nigeria, South Sudan and Yemen where resource mobilization officers are deployed and resource mobilization strategies are being implemented. The IOAC urges WHO to increase the fundraising authority of COs during emergency response, to enable COs to secure large-scale funding directly rather than through the regional offices. This is critical to maintaining operational agility amidst a fluid response.

29. The IOAC notes that the WHE Programme aims to fill up to 50% of CO vacancies by the end of 2017, depending on funding availability. The WHE Programme does not intend to fund all the CO posts from its flexible funding, but instead COs will need to fund-raise at local level with support from regional offices and headquarters. The IOAC welcomes the plan to recruit greater numbers of national staff with fewer international positions in COs, which would allow the WHE Programme to balance costs and stay within the overall budget.

30. Although the Contingency Fund for Emergencies has shown clear value in addressing immediate needs in emergencies, it has failed to reach the total capitalization of US$ 100 million and replenishment by donors has been weak. As at March 2017, a total of US$ 19.95 million was allocated in support of WHO’s response to 16 health emergencies. Having reviewed report of the WHE Programme on the Contingency Fund,\(^{27}\) the IOAC believes that the Fund has been a useful tool, particularly with respect to ensuring start-up funding in new emergencies. The IOAC believes that the Contingency Fund would be most effective if it was fully functioning as a revolving fund, but recognizes that it is not functioning as one currently, and recommends WHO to come forward with clear plans for its sustainability for the future.

31. The IOAC notes that the core budget projections for the biennium 2016–2017 are looking better; however, they are viewed as fragile, and therefore WHO is also encouraged to consider an appropriate funding strategy to identify additional revenue sources for the core budget of the WHE


Programme, and strengthened budgeting at country level to ensure all project-related costs required for sustainable country operations are included in donor proposals.

Risk assessment
32. The second edition of the Emergency Response Framework\(^{28}\) provides further clarification on risk assessment, the grading system, and application of the incident management system, with roles and responsibilities, performance standards and key performance indicators. The emergency response procedures with their specific timeframes indicate what is expected within 24 hours, 72 hours and up to 60 days.

33. The IOAC welcomes the progress on health emergency information management and risk assessment. With respect to grading decisions, the IOAC emphasizes that these are internal to WHO and should be made solely by WHO’s leadership, based objectively on grading criteria as agreed by the Inter-Agency Standing Committee and described in WHO’s Emergency Response Framework. Based on the experience with the crisis in north-eastern Nigeria, the IOAC also acknowledges the value of confidentially informing the governments concerned of such decisions immediately prior to their announcement, in order to allow the governments to prepare an appropriate response.

34. The IOAC notes that event detection, verification, risk assessment, and grading are complex processes involving many departments and levels of WHO. With specific reference to outbreaks, it is important to recognize that these processes are not necessarily linear, with risk assessment often requiring further field investigation and the implementation of immediate containment/control measures. In these scenarios, the WHE Programme sometimes supports and deploys a field investigation/response before the event is fully assessed and graded. The IOAC encourages the WHE Programme to further clarify roles and responsibilities between departments on leadership of investigation/response operations during the different phases of event management as well as coordination with and engagement of partners in GOARN in outbreak investigation. It is exceptionally important that such processes are carefully and efficiently managed to avoid delays in the response process.

35. The IOAC is pleased to see the development, testing and deployment of a range of core information management systems by the WHE Programme, including the preparatory work for the launch of Epidemic Intelligence from Open Sources in June 2017. The WHE Programme continues to use the existing Event Management System for data related to the verification, assessment and tracking of events but IOAC would advise that this system be assessed in terms of its all-hazards capabilities, utilisation throughout the WHE Programme at all levels and the potential need for this essential system to be updated.

36. The IOAC notes the field application of the Early Warning, Alert and Response System\(^{29}\) and the Health Resource Availability Monitoring System\(^{30}\) in different emergency settings. The further development and testing by the WHO Secretariat and GOARN of GoData, which is a field-deployable system for managing the complex data related to outbreak response, is a positive step. The IOAC thus advises continued investment in the development, deployment and institutionalization of standardized and supported field tools especially at CO level where WHO emergency information management platforms are not standardized.

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**Incident management**

37. Based on country visits in Colombia, Iraq and Nigeria and in-depth briefings on the Democratic Republic of the Congo and the Syrian Arab Republic, the IOAC commends WHO on its improved emergency response activities driven by the strong leaderships of WRs and Incident Managers. The IOAC recognizes that the WHE Programme has strengthened teams by utilizing the skills and knowledge of national staff and surge capacity from regional offices and headquarters. The IOAC recommends building a critical mass of qualified WRs and Incident Managers ready for deployment through rosters, training and linkage to a career development programme.

38. The Executive Director of the WHE Programme and relevant Regional Director should determine whether a WR assumes the Incident Manager position in emergencies. The Incident Manager for acute emergencies and the Emergency Manager for protracted emergencies are typically supervised by the WR, unless alternative arrangements have been agreed by the Executive Director and the Regional Director. Regardless, Incident Managers should continue to have a direct line to the WHE Programme’s leadership in order to ensure appropriate technical and operational oversight.

39. The WHO emergency operations in north-eastern Nigeria are led by an Incident Manager. The incident management system functions are largely self-contained in Maiduguri. The WR’s role is mainly to ensure that the Incident Management Team gets the necessary support from the CO, on the basis of the delegation of authority. This model can be successful, provided that there is a supportive WR and that the CO has sufficient capacity to support the emergency response. The IOAC emphasizes that the Organization should retain overall accountability and that the WR should be held accountable for the performance of the incident management system. Delegation of authority to the Incident Manager must not negate the WR’s accountability.

40. The IOAC considers that the actual level of authority being delegated to the Incident Manager is not adequate for the operational requirements of emergencies. The WHO Secretariat should give greater authority to the Incident Manager to expedite operational and administrative support requirements, particularly in relation to recruitment, procurement and finance. The delegation of authority should be issued concurrent with the activation of an Incident Management Team.

41. The IOAC recommends that Incident Managers should receive pre-deployment orientation on WHO systems, procedures, delegation of authority and its relationship to the CO so as to ensure that Incident Managers and CO staff share a common understanding of roles and responsibilities. The Incident Managers should be engaged on a longer-term contractual arrangement—at least 12 months instead of three-month contracts with extensions.

**Partnerships**

42. External partners recognize and appreciate WHO’s expanded role in emergencies, including on operational coordination at field level. The IOAC observed this improvement directly during the visits in Iraq and Nigeria. In Iraq, WHO was commended for effective coordination, proactive and transparent communication, and provision of technical, financial and operational support with a focus on delivery. In addition, the ability of the Regional Office for the Eastern Mediterranean and headquarters to provide specialist surge capacity (for example, for chemical hazards and trauma pathway management) as well as coordination of support from and deployments through GOARN have been highly appreciated.

43. WHO’s investment in health cluster coordination is paying off. Partners acknowledged WHO’s leadership role in coordinating health cluster partners as well as its critical role as an interface between the government and the humanitarian community. The IOAC reiterates that information management is an essential element of this coordination. Sufficient and consistent support for information management should be provided to the health cluster coordinator.
44. IOAC field visits noted that provision of humanitarian health services is often fragmented across individual agencies based on mandates or funding streams. The structure of care provision should be patient-centred rather than driven by mandate or funding source. Health cluster coordination should be operationally oriented, focusing on assessment of needs and gaps, and corresponding allocation of assets and services by individual partners. Partners interviewed by IOAC expressed willingness to use their collective assets more efficiently and cohesively, but this would require more donor flexibility. WHO’s privileged relationship with host governments should also be used to foster constructive cooperation between governments and partners.

45. The importance of continued focus in building the depth and capacity of partner networks like GOARN and WHO’s Emergency Medical Teams\(^\text{31}\) was stated in the IOAC’s first report. These networks allow WHO to leverage and deploy the specific expertise required to support partners already on the ground, drawing from a global pool of institutions committed to supporting outbreak and emergency response. The IOAC notes that such deployments are much more effective when WHO’s country capacity and coordination role is already in place. Investment in these operational partnerships and networks will ensure that WHO has the best expertise available at short notice for field deployment, and is operating with clear structure, roles and coordination mechanisms.

**International Health Regulations (2005)**

46. The IOAC acknowledges that 37 countries from all six WHO regions have conducted Joint External Evaluations\(^\text{32}\) since the beginning of 2016, with a further 28 scheduled by the end of 2017. The IOAC notes that only three countries have completed their national action plans following the joint external evaluation. The IOAC reaffirms the importance of all four components of the IHR (2005) Monitoring and Evaluation Framework as critical areas of work of the WHE Programme. The IOAC recognizes the importance of the regional offices supporting countries to share best practice and experience in developing the plans, and donor support for the implementation of these costed plans will be essential for building country capacity and health system strengthening.

47. The IOAC acknowledges that the Joint External Evaluation assesses the community, subnational, and national capacities, and includes indicators that reflect community strengthening and engagement. The IOAC wishes to investigate the Joint External Evaluation process through its future field visits programme and interviews. In the meantime, the IOAC also recommends that relevant community-based groups be systematically included in Joint External Evaluation processes to ensure that community-based surveillance and community early response systems are included in all evaluations.

### III. CONCLUDING REMARKS

48. WHO is making efforts at all levels to transform itself into an operational organization in emergencies. Since the launch of the WHE Programme, progress has been noticed in emergency response at country level, with consistently positive feedback on WHO’s expanded role in humanitarian crises. WHO is demonstrating that it can be a reliable and competent partner to governments, organizations in the United Nations system, health cluster partners, implementing nongovernmental organizations and the donor community. However, progress is fragile. WHO’s administrative systems and business processes are not effectively supporting its operations, and the WHE Programme is struggling with a funding shortage. Cultural constraints on the emergency response throughout the Organization remain the main challenge for adopting a “no regrets” policy.

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in practice. The Organization must ensure that the WHE Programme can fulfil its potential. Ensuring this success is ultimately a shared responsibility between Member States, WHO’s partners and the Secretariat.

Precious Matsoso (Chair), Walid Ammar, Geeta Rao Gupta, Felicity Harvey, Jeremy Konyndyk, Hiroki Nakatani, Michael Ryan, Elhadj As Sy

- **WHO response in severe, large-scale emergencies**

Extract from Document A70/9 (Report by the Director-General) (for the full report, see http://apps.who.int/gb/ebwha/pdf_files/WHA70/A70_9-en.pdf):

## ANNEX 1

**LIST OF ACUTE/GRADED EMERGENCIES IN THE REPORTING PERIOD**

(1 JANUARY–1 OCTOBER 2016)

Extract

<table>
<thead>
<tr>
<th>Country, territory or area/ emergency</th>
<th>Type of crisis</th>
<th>Date of initial emergency grading</th>
<th>Date of revision of grading</th>
<th>Current grade</th>
</tr>
</thead>
<tbody>
<tr>
<td>Afghanistan</td>
<td>Earthquake</td>
<td>28/10/2015</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Angola</td>
<td>Yellow fever outbreak</td>
<td>12/02/2016</td>
<td></td>
<td>2</td>
</tr>
<tr>
<td>Bangladesh</td>
<td>Tropical cyclone Roanu</td>
<td>21/05/2016</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Cameroon</td>
<td>Conflict/civil strife</td>
<td>01/04/2015</td>
<td>18/08/2016</td>
<td>2</td>
</tr>
<tr>
<td>Central African Republic</td>
<td>Conflict/civil strife</td>
<td>13/12/2013 (grade 3)</td>
<td>03/06/2015</td>
<td>2</td>
</tr>
<tr>
<td>Democratic People’s Republic of Korea</td>
<td>Floods</td>
<td>12/09/2016</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Democratic Republic of the Congo</td>
<td>Cholera outbreak</td>
<td>23/06/2016</td>
<td></td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Yellow fever outbreak</td>
<td>27/04/2016</td>
<td></td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Complex emergency</td>
<td>20/07/2013</td>
<td></td>
<td>2</td>
</tr>
<tr>
<td>Ecuador</td>
<td>Earthquake</td>
<td>17/04/2016</td>
<td></td>
<td>2</td>
</tr>
<tr>
<td>Ethiopia</td>
<td>Impact of El Niño phenomenon</td>
<td>18/11/2015</td>
<td></td>
<td>2</td>
</tr>
<tr>
<td>Fiji</td>
<td>Tropical cyclone Winston</td>
<td>24/02/2016</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Guinea</td>
<td>Ebola virus disease outbreak</td>
<td>24/03/2014</td>
<td>01/06/2016 (grade end)</td>
<td>ungraded</td>
</tr>
<tr>
<td>Indonesia</td>
<td>Mount Sinabung eruption</td>
<td>22/05/2016</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Iraq</td>
<td>Conflict/civil strife</td>
<td>12/08/2014</td>
<td></td>
<td>3</td>
</tr>
<tr>
<td>Kenya</td>
<td>Severe acute respiratory illness outbreak</td>
<td>20/04/2016</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Liberia</td>
<td>Ebola virus disease outbreak</td>
<td>26/07/2014</td>
<td>09/06/2016 (grade end)</td>
<td>ungraded</td>
</tr>
<tr>
<td>Libya</td>
<td>Conflict/civil strife</td>
<td>28/08/2014 (grade 1)</td>
<td>10/12/2015</td>
<td>2</td>
</tr>
<tr>
<td>Mali</td>
<td>Conflict/civil strife</td>
<td>04/02/2013 (grade 2)</td>
<td>16/10/2015</td>
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<tr>
<td>Myanmar</td>
<td>Floods</td>
<td>12/08/2015</td>
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<td>2</td>
</tr>
<tr>
<td>Niger</td>
<td>Conflict/civil strife</td>
<td>01/04/2015</td>
<td>18/08/2016</td>
<td>2</td>
</tr>
<tr>
<td>Nigeria</td>
<td>Rift Valley fever outbreak</td>
<td>26/09/2016</td>
<td></td>
<td>2</td>
</tr>
<tr>
<td>Nigeria</td>
<td>Complex emergency</td>
<td>01/04/2015 (grade 2)</td>
<td>18/08/2016</td>
<td>3</td>
</tr>
<tr>
<td>Pakistan</td>
<td>Earthquake</td>
<td>28/10/2015</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Displacement</td>
<td>20/06/2014</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Papua New Guinea</td>
<td>Drought related to El</td>
<td>01/09/2015</td>
<td>31/05/2016</td>
<td>1</td>
</tr>
</tbody>
</table>
Niño/food insecurity

<table>
<thead>
<tr>
<th>Country</th>
<th>Onset</th>
<th>Deactivation/downgrading of outbreak</th>
</tr>
</thead>
<tbody>
<tr>
<td>Philippines</td>
<td>24/10/2013</td>
<td></td>
</tr>
<tr>
<td>Typhoon Koppu</td>
<td>25/10/2015</td>
<td></td>
</tr>
<tr>
<td>Sierra Leone</td>
<td>26/07/2014</td>
<td>09/06/2016 (grade end)</td>
</tr>
<tr>
<td>South Sudan</td>
<td>12/02/2014</td>
<td>12/02/2015</td>
</tr>
<tr>
<td>Sri Lanka</td>
<td>15/05/2016</td>
<td></td>
</tr>
<tr>
<td>Syrian Arab Republic</td>
<td>03/01/2013</td>
<td>26/08/2015</td>
</tr>
<tr>
<td>Thailand</td>
<td>19/10/2013</td>
<td></td>
</tr>
<tr>
<td>Ukraine</td>
<td>20/02/2013 (grade 1)</td>
<td>12/02/2015</td>
</tr>
<tr>
<td>United Republic of Tanzania</td>
<td>18/05/2015 (grade 1)</td>
<td>15/12/2015</td>
</tr>
<tr>
<td>West Bank and Gaza Strip</td>
<td>13/07/2014 (grade 2)</td>
<td>10/11/2015</td>
</tr>
<tr>
<td>Yemen</td>
<td>04/04/2015 (grade 2)</td>
<td>01/07/2015</td>
</tr>
<tr>
<td>Zika virus disease outbreak</td>
<td>20/01/2016</td>
<td></td>
</tr>
</tbody>
</table>

ANNEX 2
WHO’S ACTIONS IN GRADE 2 EMERGENCIES
Extracts

Cholera in the African Region
1. During the period under review, 13 countries, areas and territories reported a cumulative total of some 99,000 cases of cholera and 2,000 cholera-related deaths. Three countries accounted for 87% of all cholera cases: the Democratic Republic of the Congo (43%, case-fatality rate 2.5%), United Republic of Tanzania (27%, case-fatality rate 1.5%), and Kenya (17%, case-fatality rate 1.3%). The increase in cholera outbreaks in 2016 is likely due to heavy rains and the effect of El Niño in East and southern Africa, as well as to the humanitarian crises in Burundi, the Central African Republic and South Sudan associated with the displacement of thousands of people.

Table. Cholera in the African Region, June 2015 to June 2016

<table>
<thead>
<tr>
<th>Country</th>
<th>Onset</th>
<th>Deactivation/downgrading of outbreak</th>
</tr>
</thead>
<tbody>
<tr>
<td>Benin</td>
<td>17 February 2016</td>
<td>Ongoing</td>
</tr>
<tr>
<td>Burundi</td>
<td>01 August 2016</td>
<td>Ongoing</td>
</tr>
<tr>
<td>Central African Republic</td>
<td>01 August 2016</td>
<td>Ongoing</td>
</tr>
<tr>
<td>Democratic Republic of the Congo</td>
<td>20 September 2015</td>
<td>Ongoing</td>
</tr>
<tr>
<td>Ethiopia</td>
<td>07 November 2015</td>
<td>Ongoing</td>
</tr>
<tr>
<td>Kenya</td>
<td>01 June 2015</td>
<td>Controlled</td>
</tr>
<tr>
<td>Malawi</td>
<td>18 December 2015</td>
<td>Controlled</td>
</tr>
<tr>
<td>Mozambique</td>
<td>01 August 2015</td>
<td>Controlled</td>
</tr>
<tr>
<td>Nigeria</td>
<td>07 September 2016</td>
<td>Ongoing</td>
</tr>
<tr>
<td>South Sudan</td>
<td>01 June 2015</td>
<td>Ongoing</td>
</tr>
<tr>
<td>Uganda</td>
<td>01 October 2015</td>
<td>Ongoing</td>
</tr>
<tr>
<td>United Republic of Tanzania</td>
<td>21 August 2015</td>
<td>Ongoing</td>
</tr>
<tr>
<td>Zambia</td>
<td>04 February 2015</td>
<td>Ongoing</td>
</tr>
</tbody>
</table>
• Research and development for potentially epidemic diseases

Document A70/10 (Report by the Secretariat):

A blueprint for research and development preparedness and rapid research response

1. In January 2017, the Executive Board, at its 140th session, considered an earlier version of this report.33 Following the Board’s discussions,34 and in order to provide details of new developments, paragraphs 2, 12, 17, 19 and 25 have been updated.

2. In June 2015, in response to resolution EBSS3.R1 (2015) on Ebola,35 the Secretariat started work on the development of a blueprint for research and development preparedness and response (the R&D Blueprint) for potentially epidemic diseases. The overall goal of the R&D Blueprint is to reduce delays between the identification of an outbreak and the deployment of effective medical interventions to save lives and minimize socioeconomic disruption. Areas under the Blueprint include product research and development for diagnostics, vaccines, therapeutics and vector control tools, as well as necessary and relevant research in social sciences and epidemiology.

3. The Blueprint focuses on the following areas of work: identifying priority infectious disease threats as well as gaps and priorities in research and development; improving collaboration between stakeholders; and promoting an enabling environment for the conduct of research and development during outbreaks. In addition, it aims to complement the Secretariat’s efforts to foster research and development related to Type II and Type III diseases, and the specific research and development needs of developing countries in relation to Type I diseases, in line with the global strategy and plan of action on public health, innovation and intellectual property and the recommendations of the Consultative Expert Working Group on Research and Development: Financing and Coordination.36

4. The Blueprint was prepared with global experts from all relevant disciplines and under the guidance of an independent advisory group. The document and a description of its initial activities were noted by the Sixty-ninth World Health Assembly in May 2016.37 The following paragraphs provide an update on progress since then.

R&D ROAD MAPS FOR RESEARCH AND DEVELOPMENT TO ADDRESS POTENTIAL OUTBREAKS OF DISEASE DUE TO PRIORITY PATHOGENS

5. The epidemic of Ebola virus disease in West Africa in 2014–2016 and the current Zika virus outbreak have highlighted the importance of having a clear road map for research and development in place before such an event occurs in order rapidly to activate and coordinate research and development and disburse the necessary funds as soon as the need arises. To that end, the Secretariat has begun to elaborate research and development road maps for the 11 pathogens that were prioritized through an expert consultation (Geneva, 8 and 9 December 2015) as likely to cause public health emergencies in the near future. (The list will be reviewed periodically; see paragraph 33 of Document EB140/9.)
16.) By defining the needed medical products, delineating actions and assigning roles, these road maps will save time and facilitate the activation and coordination of research and development.

6. Following a consultation with experts (Geneva, 10 and 11 December 2015), the Secretariat completed and published an R&D road map for the Middle East respiratory syndrome coronavirus (MERS-CoV). The virus has grown in global importance, causing illness and death across 27 countries, and has attracted significant interest from the research and development community, with efforts to design diagnostic, preventive and therapeutic products for this pathogen and the disease it causes gaining momentum.

7. The road map for MERS-CoV research and product development is based on four strategic goals:

- establishment of a surveillance network of coronavirus laboratories as an early warning system to identify circulating species and strains in animal populations, the causes of new outbreaks of coronavirus disease in human populations, and emerging strains in all populations;

- a better understanding of the pathogenesis MERS-CoV infection, the natural history of the disease it causes, and its veterinary and human epidemiology;

- development, manufacture, testing, licensure and use of improved diagnostics, preventives and therapeutics that enable the interruption of transmission between humans and from dromedary camels to humans;

- establishment by the global donor community of a direct path for manufacturers from preclinical proof-of-concept studies to post-licensing procurement of MERS-CoV products, through initiation of a public health financial model for supporting research and product development on emerging pathogens prioritized in WHO’s Blueprint process.

R&D BLUEPRINT ACTIVITIES ON ZIKA VIRUS

8. Following the declaration on 1 February 2016 that the recent cluster of microcephaly cases and other neurological disorders reported in Brazil, following a similar cluster in French Polynesia in 2014, constituted a Public Health Emergency of International Concern, the Secretariat used the Blueprint framework to trigger rapidly a series of research and development actions. Initial activities included the mapping of existing research and product development for Zika virus infection. On the basis of the findings, the Secretariat convened 130 experts from 27 countries for a consultation (Geneva, 7–9 March 2016) in order to identify gaps in knowledge and agree on a plan for accelerating product development.

9. As a result of the consultation, the Secretariat prioritized research and development activities for diagnostics, vaccines and vector-control measures. In April 2016, WHO and UNICEF jointly published target product profiles for diagnostic tests for Zika virus infection, specifying the desired features for these assays to facilitate development and manufacture.

10. The Emergency Use Assessment and Listing procedure established during the Ebola virus disease outbreak to accelerate quality assessments of new products was opened to candidate in vitro diagnostics for Zika virus infection in early February 2016. To date, more than 20 such diagnostic tests have been submitted for WHO’s assessment and listing, and one has been listed as appropriate

for international procurement. It is expected that more tests will be submitted for assessment to regulatory agencies and WHO in the coming months as many diagnostic companies are developing new products. The Secretariat will continue to use existing regulatory and laboratory capacity to maximum advantage in order to facilitate the Emergency Use Assessment and Listing procedure.

11. In June 2016, the Secretariat convened regulators and vaccine developers for an initial discussion of regulatory considerations of Zika virus vaccines (Geneva, 6 and 7 June 2016). A target product profile for vaccines aimed at protecting against Zika virus infection and associated congenital syndrome vaccines for emergency use as an outbreak response was issued in July 2016.40

12. WHO and the Wellcome Trust jointly organized a meeting (London, 5–7 October 2016) to discuss how best to capitalize on the commonalities of mosquito-borne viral diseases in order to define common research approaches for the development of products to combat these diseases. The latest information on Zika vaccine development was reviewed at a consultation co-organized by WHO and the United States National Institutes of Health (Bethesda, Maryland, United States of America, 10 and 11 January 2017).

PLATFORM TECHNOLOGIES

13. In the absence of market-driven research and development, platforms for sharing technologies have the potential to strengthen research and development efforts, including those in low- and middle-income countries. In October 2015, the Secretariat launched a public consultation on ideas for potential platforms to support development and production of health technologies for the infectious diseases with epidemic potential prioritized by WHO. The main requirement was that these solutions be sufficiently flexible to enable expedited development and manufacture of candidate products for clinical trials (in months rather than years).

14. The initiative was open to international organizations, government agencies, non-profit organizations, for-profit companies and academic institutions. The scope of health products considered included vaccines, therapeutics (medicines and blood products), diagnostics and enabling technologies. The platforms had to apply to three or more pathogens prioritized by WHO.

15. Candidate products emerging from this process should be affordable for use in populations at risk. Proposals that resulted in a strategic geographical distribution of platform production sites were especially welcome. Additionally, a goal of the consultation was the encouragement of the submission of proposals that include significant participation by entities in developing countries.

16. By the closing date of 5 February 2016, 35 proposals had been received. After an initial screening and a technical workshop led by an ad-hoc advisory group of experts, six most-promising proposals were identified: three vaccine platforms, one for diagnostics, one for immunotherapy and one covering all product streams. The six proposals were presented to potential funders and interested Member States during a second technical workshop (Geneva, 21 July 2016).

REVISION OF EPIDEMIC THREATS AND THE LIST OF PATHOGENS PRIORITIZED BY WHO

17. Consultations were held in December 2016 to fine-tune the prioritization methodology. Based on the revised tool, the WHO’s list of pathogens for priority research and development was reviewed and updated on 24 and 25 January 2017. The 2017 list of pathogens contains the infectious agents for the following diseases: Lassa fever and other severe arenaviral haemorrhagic fevers; Crimean-Congo haemorrhagic fever; filoviral diseases (including Ebola virus disease and Marburg

haemorrhagic fever); Middle East respiratory syndrome (MERS); other highly pathogenic coronaviral
diseases (such as severe acute respiratory syndrome (SARS)); Nipah and related henipaviral diseases;
Rift Valley Fever; severe fever with thrombocytopenia syndrome; Zika virus disease; and any new
disease “X” identified by the decision instrument. Experts highlighted that Chikungunya virus disease
continues to warrant further research and development. It is of note that the list of R&D Blueprint
priority diseases only includes pathogens for which there are no medical countermeasures available,
and excludes pandemic influenza.

STAKEHOLDER COORDINATION

18. The Secretariat is leading efforts to better coordinate research and development activities
during epidemics by establishing frameworks for research oversight and management at the
national level and global mechanisms for fruitful collaboration. To that end, it has completed the
mapping of all relevant global stakeholders by their areas or diseases of interest and current
participation in collaborative networks. A database of research preparedness resources has been
created and will be integrated into WHO’s Global Observatory on Health Research and Development.
A guidance document on good participatory practices in a research context as related to prioritized
diseases is being finalized.

19. In addition, a set of principles for a global collaboration framework were discussed at a high-
level meeting being jointly organized by WHO, the Wellcome Trust and Chatham House, the Royal
Institute of International Affairs (London, 10 November 2016). A template for a coordination
framework to streamline global stakeholder collaboration is being drafted and will be discussed
during the first meeting of the Blueprint Global Coordination Mechanism in London on 28 March
2017.

20. Since 2015, the Secretariat has participated as an observer in the Global Research Collaboration
for Infectious Disease Preparedness. This global network brings together organizations that fund
research in order to facilitate an effective research response within 48 hours of a significant
outbreak of a new or re-emerging infectious disease with pandemic potential. This collaboration
allows WHO to inform network members of priority research and development activities during an
outbreak.

21. In September 2016, WHO signed a memorandum of understanding with the Coalition for
Epidemic Preparedness Innovations, a new public–private partnership that aims to finance and
coordinate the proactive and expedited development of new vaccines to prevent and contain
infectious disease epidemics. The memorandum of understanding provides the basis for
collaborative and mutually strengthening efforts within the broad scope of the R&D Blueprint.

SHARING OF DATA AND SAMPLES

22. Sharing of data and samples is crucial for informed research and development efforts and for
ensuring equitable access to potential new products, especially during epidemics. Agreements that
foster such sharing, include scientists from countries at risk and facilitate governance of multiparty
collaborations are effective tools.

23. Following an initial expert consultation on data sharing (Geneva, 1 and 2 September 2015), the
Secretariat has advanced the discussion on this issue through the R&D Blueprint. It is also
developing global norms for sharing data and results, and elaborating mechanisms for collaboration
and data sharing during public health emergencies.
24. The Secretariat has initiated a process to reach consensus on principles for open-access repositories of biological samples (bio-banks), including the development of a virtual resource linking national bio-banks through an information-sharing platform. The principles for a shared system of governance and decision-making are currently being elaborated.

25. A Material Transfer Agreement capacity-building tool has been prepared in order to inform negotiations at country level on sharing biological samples. WHO in collaboration with the Institut Pasteur held a consultation on 16 December 2016 on options to deal with key issues relating to material transfer agreements in the context of a public health emergency. The aim is to finalize such a capacity-building tool during the second quarter of 2017 through consultations with various stakeholders, with subsequent conversion into an electronic web-based application to support partners engaging in negotiations of such agreements.

REGULATORY CAPACITY

26. Building capacity to design and conduct clinical trials for vaccines and therapeutics for emerging disease threats in developing countries is part of the Blueprint’s plans to create enabling environments for research and development during emergencies and to ensure that national actors and scientists in countries at risk can function as equal partners in international efforts. The Secretariat has outlined a clear set of steps to inform exchanges on trial designs for prioritized diseases, and to assess each design in terms of methodological robustness and feasibility. The next step will be the development of generic protocols for the prioritized diseases to ensure consistent approaches among all stakeholders in a given research and development effort.

27. During the outbreak of Ebola virus disease, WHO outlined regulatory pathways for product evaluation in public health emergencies and supported joint clinical trial reviews of candidate products. WHO’s Expert Committee on Biological Standardization, at its recent meeting (Geneva, 17–21 October 2016), considered preliminary guidelines on the quality, safety and efficacy evaluation of Ebola virus disease vaccines. Further efforts to strengthen national, regulatory and ethics bodies to respond to public health emergencies are underway.

ACTION BY THE HEALTH ASSEMBLY

28. The Health Assembly is invited to note the report.

• Health workforce coordination in emergencies with health consequences

Document A70/11 (Report by the Secretariat):

1. This report describes the work that WHO is undertaking at global, regional and country levels to improve coordination of the response to emergencies with health consequences. Strong coordination both of all health actors in emergencies and of collaboration with actors in other sectors is vital to ensuring the predictability, coherence and effectiveness of emergency operations. Central to improved coordination is the concept of the Global Health Emergency Workforce, comprising national responders and international responders from networks and partnerships. These networks and partnerships include the Global Outbreak Alert and Response Network, the Global Health Cluster, emergency medical teams, standby partners and other members of the Inter-Agency Standing Committee.

2. The present report describes the steps that WHO has taken to strengthen internal coordination for emergency response across the three levels of the Organization and external coordination with
partners working on emergencies with health consequences. An earlier version of this report was considered by the Executive Board at its 140th session in January 2017.41

3. Recent history shows that the world is not fully prepared to prevent, detect and respond to large-scale health emergencies. WHO monitors over 160 public health events annually, and between January and October 2016 it responded to emergencies in 47 countries (see the complementary report by the Secretariat on the WHO response in severe, large-scale emergencies).42 The past two decades have witnessed important major outbreaks due to emerging diseases43 as well as “traditional” outbreak-prone diseases.44 Worldwide, an estimated 130 million people are in need of humanitarian assistance, with over 200 million also affected annually by natural and technological disasters. The need for improved coordination among the various actors involved in health emergency preparedness and response has never been more pressing.

COORDINATION ACROSS THREE LEVELS OF WHO

4. Further to the request of the Executive Board during its special session on the Ebola emergency in January 2015,45 and reflecting many of the recommendations from the series of evaluations carried out during and after the Ebola crisis in West Africa, WHO has undertaken substantive reform of the way that it works in emergencies with health consequences. In May 2016, the Health Assembly welcomed the progress made in the development of the new Health Emergencies Programme.46

5. The Programme was established and designed to manage WHO’s work in the prevention of, preparedness for, response to and early recovery from emergencies, regardless of the hazard, including infectious diseases, natural disasters and societal conflicts. Aligned across the three levels of WHO, the Programme now follows a common structure reflecting the major functions of WHO in emergency risk management: infectious hazard management; country preparedness (pursuant to the International Health Regulations (2005)); health emergency information and risk assessment; emergency operations; and management and administration. Over the next 12 to 18 months, all aspects of the Programme will be operationalized, optimizing partnerships and networks to leverage system-wide capacities for emergency work in health. Progress in this effort is already being seen.

6. Standard operating procedures are being developed to ensure coherent approaches to emergency health information, risk assessment, grading and emergency response across the Programme. WHO is strengthening the management of its emergency operations through the adoption and institutionalization of an incident management system – a best practice approach that is increasingly being taken up by public health and emergency agencies worldwide. Under this system, critical emergency management functions are established at country level, with support teams at regional and headquarters levels providing technical and operational backstopping and oversight.

7. Effective application of this new approach to multicountry, multiregional events was demonstrated in the response to the outbreak of Zika virus disease. Following the declaration of the outbreak as a Grade 2 emergency on 22 January 2016, WHO rapidly established an Organization-wide incident management system to support ongoing efforts by the Pan-American Health

41 Document EB140/10; see also the summary records of the Executive Board at its 140th session, second meeting, section 3 and fourth meeting.
42 Document EB140/7.
43 Such as severe acute respiratory syndrome (SARS), infection with avian influenza A(H5N1), influenza A(H1N1) or Middle East respiratory syndrome coronavirus (MERS-CoV), Ebola virus disease and Zika virus disease.
44 Such as yellow fever, cholera, meningitis and measles.
46 See decision WHA69(9) (2016) and documents A69/30 and A69/61.
Organization/WHO Regional Office for the Americas and to coordinate the global response. A consistent structure for that system across the Organization allowed for improved communications, information-sharing and coherence of priorities. Within a week of the grading, US$ 2.6 million was released from the WHO Contingency Fund for Emergencies, facilitating critical early response actions in the Region of the Americas. By mid-February 2016, WHO had published 16 Zika-related interim technical guidance documents. In close collaboration with partners in the Global Outbreak Alert and Response Network, the Inter-Agency Standing Committee and the United Nations Office for the Coordination of Humanitarian Affairs, the incident management planning team led the development of a global strategic response plan and joint operations plan, engaging partners at regional and global levels. Incident management teams were established in other regions to further coordinate response activities. Together with a proactive approach to communications, this has strengthened the operational response, improved the support provided to countries, and advanced WHO’s global leadership role.

8. A biennial results framework for the Programme has been developed to better align and integrate work planning, budgeting and implementation across the three levels of the Organization, as well as to establish clear lines of accountability. It will be used to monitor progress towards specific coordination objectives, with defined and measurable outcomes to be achieved with countries and partners. Furthermore, the Programme’s human resource capacity is being strengthened with additional personnel across offices, and emergency response rosters of staff from within and outside the Programme, to address skills gaps and enhance interoperability.

**COORDINATION AT GLOBAL LEVEL**

**Inter-Agency Standing Committee**

9. The Inter-Agency Standing Committee is the primary mechanism for interagency coordination of humanitarian assistance; it is a forum that involves most of the key United Nations and non-United Nations humanitarian partners. WHO participates actively in the main bodies under the Committee, including: the Principals group, which oversees global priorities and strategies for collective humanitarian action and on which the Director-General represents the Organization; the Emergency Directors Group, which addresses operational priorities and issues at country level; and the Working Group, which oversees the development of interagency policy and guidance.

10. The Inter-Agency Standing Committee already has clear protocols and processes for a collective response to and coordination of large-scale natural disasters or conflicts that require system-wide mobilization (so-called “Level 3 (L3)” emergencies). Similar mechanisms and processes do not currently exist for large-scale outbreaks. In its decision WHA69(9), the Health Assembly encouraged WHO’s “ongoing collaboration with the United Nations Office for the Coordination of Humanitarian Affairs to enhance humanitarian system-wide coordination of the response to large-scale infectious hazards in the future”.

11. To this end, WHO worked closely with the Inter-Agency Standing Committee’s Emergency Directors Group to develop new protocols for leadership and coordination in large-scale events due to infectious hazards, based on existing Committee mechanisms. For these events, the new protocols allow for interagency Level 3 activation, as well as temporary expansion of the Inter-Agency Standing Committee, on an as-needed basis, to include the Global Outbreak Alert and Response Network and major public health institutions involved in the response. This will be known as “IASC+”.

12. The newly defined procedures include a time-bound situation assessment by WHO and the United Nations Office for the Coordination of Humanitarian Affairs; consultation and decision-making with the Emergency Directors Group (and other non-Inter-Agency Standing Committee
stakeholders as appropriate, including the Global Outbreak Alert and Response Network for infectious disease risks and events); recommendations to the Principals of the Standing Committee; and explicit activation and deactivation triggers. The immediate communication of joint strategic response priorities and allocation from the United Nations’ Central Emergency Response Fund to support these priorities will be initiated, as will a review of the coordination and leadership arrangements within 7–10 days.

13. These IASC+ activation procedures were endorsed by the IASC Principals in December 2016.

Global Health Cluster
14. The Inter-Agency Standing Committee’s cluster approach is a vital mechanism for coordinating sectoral action in humanitarian emergencies. The health cluster is currently activated in 24 countries to support national authorities in meeting the health needs of 72.2 million crisis-affected people. The Global Health Cluster comprises 48 partners, including international organizations and United Nations agencies, non-State actors, national authorities, academic and training institutes and donor agencies. There are more than 300 partners at country level.

15. WHO is recruiting 24 health cluster coordinators on longer-term contracts to ensure more predictable, dedicated and skilled leadership at country level. To support countries with coordination of in-country operational partners and to build operational and technical capacity, additional surge roster capacity is being identified through mapping and gap analysis. A new multiyear development plan is being rolled out to build and sustain capacity within the cluster.

16. Strengthened collaboration and coordination are being sought with other clusters (for example, those for nutrition, water and sanitation, food aid and logistics) in order to improve the overall response to emergencies with health consequences. WHO plays an important role in the Inter-Cluster Coordination Group at global level and is working more closely with other clusters in settings such as the humanitarian response to the crisis in northern Nigeria and the cholera outbreak in Yemen. Inter-cluster collaboration is also a key element of the Inter-Agency Standing Committee’s IASC+ protocol.

Global Outbreak Alert and Response Network
17. Enhancing and expanding the Global Outbreak Alert and Response Network, a system of over 200 multidisciplinary technical partners, is a priority for the WHO Health Emergencies Programme. This is being accomplished through strengthening the Network’s oversight, policies and secretariat functions; identifying and engaging new partners and consolidating existing commitments; strengthening its ability to leverage functional experts of the health emergency workforce and provide operational support, specifically for staff health and safety; and implementing joint training with partners to improve field-level coordination.

18. The Network’s 21-member Steering Committee meets every six months to provide strategic direction to the development and operations of the Network, and has agreed on priorities for the development and operations of “GOARN 2.0” in line with the above.

19. Since the beginning of 2016, Network partners have been more involved in alert, risk assessment, preparedness and response activities; they have been holding regular consultations by teleconference in support of early joint assessment of developing outbreaks, and to strengthen coordination and planning of international response and country support. The first European regional meeting of Network partners was held in St Petersburg, Russian Federation, in October 2016.
20. WHO is also exploring how to strengthen Network involvement in and support for national alert and response capacity through the Joint External Evaluation initiative (in the context of the International Health Regulations (2005)), including capability to deploy and receive international experts.

21. The Network’s operational support team is working closely with the Global Health Cluster, emergency medical teams, and others to develop Network-driven international outbreak response training, coordination of partner contributions through a new global faculty, and delivery of new training materials and courses.

Emergency medical teams
22. The WHO emergency medical teams secretariat manages the training, capacity-building, standard-setting and quality assurance processes for this global initiative. The overall goals are to strengthen national capacity to respond to emergencies with health consequences, as part of the global health emergency workforce, and to create mechanisms for that capacity to be effectively leveraged and coordinated by national health emergency operations centres, including through calling on neighbour, regional and global teams to provide temporary surge capacity in times of need, consistent with the principles of the International Health Regulations (2005).

23. A peer-reviewed quality assurance and verification system has been developed allowing emergency medical teams to provide direct patient care in disasters, outbreaks and other emergencies with health consequences. Over 75 organizations have started the process of mentorship, training and quality improvement, with 30 visited in 2015, and seven teams verified as reaching the agreed international standard.47

24. In coordination with the United Nations Office for the Coordination of Humanitarian Affairs, the WHO emergency medical teams secretariat has created a coordination platform for work with other forms of rapid response teams, particularly those engaged in search and rescue. This system, active within minutes of a disaster, uses the agreed virtual on-site operations coordination centre, recording team arrivals and referring them to the affected country’s coordination mechanisms within the ministry of emergency management and ministry of health, with support from the United Nations Office for the Coordination of Humanitarian Affairs and WHO. The system, trialled for the first time in the Nepal earthquake in 2015, was shown to be fit for the purpose of coordinating the 149 teams responding to that disaster, with an estimated 3500 medical responders in the first seven days. That finding was confirmed in Ecuador in 2016.

25. A minimum data set has been agreed for emergency medical teams to report on to the affected Member State when working there. This ensures a standard flow of information that contributes to the early warning system for disease outbreaks, creating sentinel reporting sites that enable the affected health system to respond.

26. The emergency medical teams initiative has become more active in complex and protracted emergencies, with involvement in coordination and operational planning in Iraq, Nigeria and Yemen. In 2017, the WHO emergency medical teams secretariat is continuing to work on defining rapid, field-focused working groups to strengthen other aspects of team deployment, continuing to build the capacity of rapid response clinical and public health teams, and to strengthen coordination systems for national and international or bilateral response operations by bolstering health emergency operating centres in affected Member States.

47 Australia, China, Israel, Japan, the Russian Federation (two teams) and the United Kingdom of Great Britain and Northern Ireland.
Standby partners

27. Launched in 2013, the WHO standby partners initiative is an increasingly central element of WHO’s coordination in response to humanitarian emergencies, and a strong complement to WHO’s other response partnerships. WHO holds global agreements with seven partners and is able rapidly to access and deploy highly skilled personnel of the global health emergency workforce with a broad range of humanitarian and technical profiles to support field emergency work, including information and data management, mapping, water and sanitation, nutrition, public health, logistics, project management and social work.

28. Through the International Humanitarian Partnership, two further partnerships are under negotiation with government agencies to support individual deployments, as well as highly specialized service packages. Further expansion is planned, through the mapping of existing capacity gaps to identify opportunities for new partnerships. A training needs analysis is also planned and will be implemented in priority areas, to ensure greater harmonization across the partnerships.

Operational support and logistics

29. The WHO Health Emergencies Programme provides guidance and technical support to the Global Supply Chain initiative for pandemic preparedness and response. This initiative was launched at the World Economic Forum 2015, under the leadership of WFP, and includes UNICEF, the World Bank and several private-sector supply companies. The goal is to identify public–private supply chain options or preparedness solutions, to estimate needs and monitor global supply resources more accurately, and to develop better mechanisms to access supplies in times of public health emergencies of international concern and pandemics. The (informal) network is developing an information platform with support from the University of Minnesota (United States of America), to provide upstream and downstream supply chain visibility and coordination in operations.

REGIONAL COORDINATION

30. Targeted human resource capacity-building has been undertaken in priority regions, to ensure that the Programme is better able to support vulnerable countries. One country in which this approach has had a significant impact is the Syrian Arab Republic, now entering its sixth year of conflict with no sign of a decrease in intensity or the level of suffering of the population, where WHO has increased its investment in leadership and coordination of the health sector response for the Syrian Arab Republic.

31. In line with the reform of WHO’s work in health emergency management, additional human resources have been deployed at regional and country levels to support the “whole of Syria” humanitarian health response. This has led to increased coordination through joint planning and response by hubs in Jordan, Syrian Arab Republic and Turkey for the delivery of emergency medical assistance, including immunization, to besieged and hard-to-reach areas. Improvements in standardized data collection across the country have also been seen.

COORDINATION AT COUNTRY LEVEL

32. Coordination structures and mechanisms at country level vary according to the capacities of national and local authorities and the scale and type of emergency (for example, outbreak or sudden onset natural disaster). Ensuring strong, inclusive coordination structures involving local and international partners with clear roles and responsibilities at national and subnational levels is vital.

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48 International Civilian Response Corps (CANADEM), the Information Management and Mine Action Program (iMMAP), the Netherlands Enterprise Agency, the NGO Consortium for the Global Health Cluster, the Norwegian Refugee Council, RedR Australia and the United Kingdom Department for International Development.
to optimizing the response. As far as possible, national leadership of health sector coordination is promoted and supported. A growing number of ministries of health are establishing emergency operations centres that can provide a focus for response coordination.

33. In acute public health events, rapid engagement of the appropriate partners of the global health emergency workforce with technical and operational capacities may be sufficient to stop an outbreak. Global Outbreak Alert and Response Network partners are often key to this. When an outbreak amplifies, additional coordination mechanisms may be required to draw on capacities from technical and intersectoral partners, as was the case with the response to the Ebola outbreak in West Africa. For events and outbreaks due to zoonoses, such as the Rift Valley fever outbreak in Niger, coordination with the animal health sector is vital. In this context, joint training events with the World Organisation for Animal Health have already proved to be of great value in the recent outbreak of highly pathogenic avian influenza virus infection in Cameroon and Togo.

34. For conflict-related and sudden onset disasters, a larger array of responders from the global health emergency workforce may be present, including non-State actors, emergency medical teams and technical agencies. In these settings, one overarching coordination mechanism for the health sector is needed, often with related task teams to address specific issues, such as surgical care or reproductive health, in more detail. There may also be a need for a specific coordination cell for emergency medical teams.

35. Depending on the circumstances of the emergency, a health cluster may or may not be formally activated. A health cluster is the main coordination mechanism in 24 of the 47 countries where WHO is currently responding. Regardless of the coordination mechanism in place, established practices of good coordination, clear commitment by partners, accountability to affected populations and transparent communication must be followed, and close linkages and active collaboration with other sectors (such as nutrition or water and sanitation) must be created, supported and utilized.

36. Experience with health clusters is illustrative of some of the issues related to the coordination of large-scale emergencies at country level. Of the 24 active health clusters, 22 are country-focused and two (the Whole of Syria and Pacific Regional health clusters) have a subregional focus. The health ministry co-leads the health cluster in 47% of cases, while a non-State actor partner co-leads in 37%. Eighteen clusters (75%) are operating in settings of a complex emergency or conflict; the others operate primarily in climate-related emergencies.

BUDGET AND RESOURCE MOBILIZATION

37. Financing the work of the new WHO Health Emergencies Programme will require a combination of: core financing for staff and activities at the three levels of the Programme; financing of the US$ 100 million WHO Contingency Fund for Emergencies; and financing for ongoing activities in acute and protracted emergencies.

38. To implement the core activities of the new Programme, WHO must raise US$ 485 million in 2016–2017; a gap of 44% remains. Appeals linked to humanitarian response plans have a funding gap of 66% (the total requirement for funding from appeals is US$ 656 million).

39. The WHO Contingency Fund for Emergencies has raised US$ 31.5 million of its US$ 100 million target capitalization. Allocations to date total US$ 18.16 million in support of WHO activities in response to humanitarian crises, disease outbreaks and the impact of natural disasters.
ACTION BY THE HEALTH ASSEMBLY

40. The Health Assembly is invited to note this report.
12.2 **Antimicrobial resistance**

**Document A70/12 (Report by the Secretariat):**

1. The Executive Board at its 140th session in January 2017 noted an earlier version of this report. This revised version has been updated and takes into account the discussions at that session of the Board.

2. This report provides an update on implementation of resolution WHA68.7 (2015) on the global action plan on antimicrobial resistance and the United Nations General Assembly resolution 71/3, “Political declaration of the high-level meeting of the General Assembly on antimicrobial resistance”, which was the outcome of a high-level meeting on antimicrobial resistance at the United Nations headquarters in New York in September 2016 and adopted in October 2016.

3. The political declaration includes commitments by Heads of State and Government and representatives of States and Governments to develop their multisectoral national action plans in line with the One Health approach; to mobilize funding for, inter alia, the implementation of these plans and for research and development; to ensure that national plans cover the development of surveillance, monitoring and regulatory frameworks on the preservation, use and sale of antimicrobial medicines; and to increase and sustain awareness of and knowledge about antimicrobial resistance among the public and health professionals.

4. The political declaration also includes three major requests to WHO and its partners. First, it advances the Health Assembly’s request by calling for the finalization by WHO, together with FAO and OIE, of a global development and stewardship framework on antimicrobial medicines and resistance. Secondly, it calls on WHO in collaboration with FAO, OIE, regional and multilateral development banks, including the World Bank, other United Nations agencies and intergovernmental organizations, civil society and multisectoral stakeholders to support national action plans and other activities to counter antimicrobial resistance at national, regional and global levels. Thirdly, it requests the Secretary-General to establish, in consultation with WHO, FAO and OIE, an ad hoc interagency coordination group to provide practical advice on approaches to ensure effective action to address antimicrobial resistance. The political declaration also requested the Secretary-General to submit a report to the General Assembly at its seventy-third session. Responses to these requests are discussed below.

5. The Secretary-General announced the establishment of the ad hoc interagency coordination group on 17 March. The group is chaired by the Deputy Secretary-General and WHO’s Director-General. The first meeting is expected to be scheduled soon and an update will be given to the Seventieth World Health Assembly.

6. In resolution WHA68.7 (2015) the Health Assembly urged Member States to adapt the global action plan to their national priorities and specific contexts, and to have national action plans on antimicrobial resistance in place by the Seventieth World Health Assembly. WHO, FAO and OIE have published a manual for developing national action plans with a set of accompanying tools. In addition to high-level meetings to generate political interest and support, workshops have been conducted with the active involvement of FAO and OIE in all WHO regions to share these tools and to support countries in elaborating their national action plans. To date, participants from 87

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49 See document EB140/11 and the summary records of the Executive Board at its 140th session, fourth meeting and seventh meeting, section 2.


countries have attended these workshops, of which more are planned for later in 2017. The Secretariat has also supported antimicrobial resistance situation analyses, the results of which underpin national action plans, and facilitates coordination and planning meetings. It is drawing up a roster of consultants to support this process. To date, 67 Member States have completed their national action plans on antimicrobial resistance, and a further 62 are in the process of doing so. These represent the largest and most populous countries and include all regions, with a wide range of levels of income and development. More than 6500 million people live in a country that has, or will soon have, a national action plan. Many of the remaining countries are either small or fragile or affected by conflict. There are, however, some parts of the African region where provision of more support is being planned to catalyse progress.

7. Almost all national action plans reflect the One Health approach, with a multisectoral coordination group and actions planned across health, agriculture and other sectors. The challenge now is to implement plans, sustain action and ensure that essential priority actions are incorporated into relevant plans and budgets. There are some actions specific to antimicrobial resistance such as surveillance of antibiotic consumption and resistance patterns, awareness raising and antibiotic stewardship programmes for which the prime focus is management of antimicrobial resistance. There is also a wider range of actions related to antimicrobial resistance, such as infection prevention and control, medicines regulation and management, immunization and strengthening of water sanitation and hygiene provisions, that have much wider public health benefits as well as being vital for the prevention and management of antimicrobial resistance. Support for implementation will come through the relevant programmes and departments in the Secretariat, with coordination by the antimicrobial resistance secretariat, through a specific component of the programme budget.

8. In addition to the increased interest in antimicrobial resistance that was generated by the United Nations General Assembly and regional high-level meetings, awareness of antimicrobial resistance is increasing through targeted media outreach and an ongoing, multi-year campaign, Antibiotics: handle with care, aimed at the public, policy-makers, and health and agriculture workers. Led by the Secretariat at headquarters, the campaign is developed and implemented in collaboration with regional offices, FAO, OIE and other partners in the areas of infection prevention and control, water, sanitation and hygiene, maternal and child health, and food safety. Activities during World Antibiotic Awareness Week in 2016 (14–20 November) included the development and dissemination of a comprehensive campaign toolkit for countries, specific messages and materials for different types of health workers, and a series of personal stories from people around the world affected by antibiotic resistance.

Engagement with a broad range of partners, opinion-leading media and the public through social media around the United Nations General Assembly high-level meeting on antimicrobial resistance (New York, 21 September 2016) was highly effective, resulting in unprecedented reporting on the issue and millions sharing WHO’s infographics on antimicrobial resistance through Twitter, Facebook and Instagram.

9. The Global Antimicrobial Surveillance System has been established, with 43 countries either enrolled or in the process of doing so. It will initially focus on bacterial pathogens in humans (see paragraph 14 below), and will also collect information on countries’ progress in strengthening national surveillance systems on antimicrobial resistance. The System will progressively expand to include other types of surveillance related to antimicrobial resistance and links to other global surveillance systems. Guidance has been revised on the integrated surveillance of antimicrobial resistance in the food chain and laboratory capacity-building. The evidence base on the linkages between humans, animals, the food chain and the environment is being strengthened.
10. Following a recommendation from FAO/OIE/WHO tripartite expert meetings in 2002 and 2003, WHO developed a list of Critically Important Antimicrobials for Human Medicine (WHO CIA List) in 2005, which has been subsequently revised. The list ranks antimicrobial agents according to their importance in human medicine, with the objective of helping to prioritize antimicrobial resistance containment strategies related to their non-human use. WHO is currently developing a guideline on the use in food-producing animals of the antimicrobials included in the list, with the objective of preserving their effectiveness and protecting public health.

11. A methodology for monitoring antibiotic consumption at national levels has been developed, with participants from 35 countries having been trained; a further three regional workshops are planned for the end of March 2017. At country level the Secretariat is supporting 40 to 50 Member States. Protocols to measure antibiotic use in a standard way in hospitals are also being developed.

12. Prevention of infections is critical to reducing the need for antibiotics and controlling the spread of resistant microorganisms. In addition to ongoing work on immunization, new recommendations on infection prevention and control were recently published, including global guidelines on the prevention of surgical site infection and guidelines on core components of infection prevention and control programmes. Assessment tools and practical manuals for implementation of core components of infection prevention and control, in particular in low-resource settings, and prevention and control guidelines for reducing infections with carbapenem-resistant Gram-negative bacteria in health care are being developed in close coordination with the planned update during 2017 of WHO’s infection control guidance for tuberculosis (which requires containment measures and laboratories to reduce or prevent airborne transmission).

13. The antibiotic chapter of the WHO Model List of Essential Medicines, which is being updated and will be published in May 2017, will offer guidance on management of major infective syndromes. Guidelines on the management of the five most common paediatric infections have also been revised. Several medications for tuberculosis, which are not yet on the Model List, are being considered for addition to the tuberculosis section of the List. Appropriate use of antibiotics is being supported through ongoing programmes in medicines management in many countries.

14. WHO has also issued a list of priority antibiotic-resistant bacterial pathogens where new medicines are most urgently needed. WHO restates the importance of research and development into interventions for tuberculosis as a major global priority. Work is ongoing to monitor the pipeline for new antibiotics under development, and antimicrobial resistance is now more explicitly considered as a factor in prioritizing new vaccine development. The Global Antibiotic Research and Development Partnership is a new facility for antibiotic development. Its initial focus will be on new products with global application for gonorrhoea and neonatal sepsis; it will also review opportunities for new combinations of medicines and adjustments of current formulations for greater efficacy. WHO is active in providing technical support to the Partnership.

15. WHO, FAO and OIE have developed a monitoring questionnaire to review and summarize each country’s progress; this will provide information for reporting at the global level. Responses to the questionnaire will also be used to guide follow-up actions and identify areas where assistance and support are required. The questionnaire asks countries to assess their progress with multisectoral engagement, development of a national action plan and implementation of key actions to tackle antimicrobial resistance; it includes questions on key components of the global action plan on antimicrobial resistance in human health, animal health, crop production, food safety and the environment. Results will be released on line for the Seventieth World Health Assembly and meetings of the governing bodies of FAO and OIE, and published on the WHO’s website for the Global Health Observatory. Self-reported data will be periodically verified through the Joint External Evaluation of the International Health Regulations process. In parallel, the Secretariat is developing a broader monitoring framework for implementation of the global action plan on antimicrobial resistance. A draft framework has been distributed for consultation across the Organization and with FAO and OIE. The Secretariat will consult more broadly with Member States and other stakeholders to finalize indicators and build consensus on measurements needed at global, regional and national levels.

16. Since the adoption of the global action plan on antimicrobial resistance, the Secretariat has expanded efforts to prevent and control drug resistance in HIV, tuberculosis and malaria. Multidrug-resistant tuberculosis has already reached the level of a public health crisis in many countries, causing an estimated 250 000 deaths in 2015. At present, 83 countries conduct continuous surveillance of tuberculosis drug resistance and an additional 72 countries run periodic surveys. In 2016, WHO issued new guidelines on programmatic management of multidrug-resistant tuberculosis, recommending a shorter treatment regimen for most patients with multidrug-resistant tuberculosis.\(^{57}\) It also approved a rapid test that enables the triage of such patients in order to ensure that they receive the appropriate treatment, and revised the composition of antibiotic combinations for patients who need longer treatment regimens, including children. Recognizing the need for a coordinated global effort to prevent HIV drug resistance and ensure effective first-line antiretroviral treatment, WHO is leading the development of a global action plan on HIV drug resistance (2017–2021). Guidance on global and national responses to increasing HIV drug resistance is being prepared and is due to be disseminated in the second quarter of 2017. The Secretariat is also preparing a global report on HIV drug resistance, based on data for the period 2014–2016.

17. Antimalarial resistance is being monitored globally and resistance management strategies are being implemented. The biggest threat is in the Greater Mekong subregion where multidrug resistance, including resistance to artemisinin-based combination therapy, has emerged. A WHO regional hub was established in Cambodia in 2013 to provide dedicated support to countries and to coordinate partners. Intensive monitoring and management strategies are now part of the subregional malaria elimination effort launched by WHO in May 2015. WHO is also supporting therapeutic efficacy monitoring programmes in sub-Saharan Africa, where the heaviest malaria burden is, and maintains a global antimalarial drug resistance database. Given high treatment coverage rates for neglected tropical diseases in sub-Saharan Africa and South-East Asia, WHO is tracking anthelmintic medicines efficacy and is coordinating the testing of several combinations of medicines for the eventuality that resistance emerges. The UNICEF/UNDP/World Bank/WHO Special Programme for Research and Training in Tropical Diseases, hosted by WHO, is building country capacities to understand the current global situation of antimicrobial resistance and is contributing to the global effort on anthelmintic medicine response and resistance.

18. In resolution WHA68.7 (2015) the Health Assembly also requested the Director-General “to
develop, in consultation with Member States and relevant partners, options for establishing a
global development and stewardship framework to support the development, control, distribution
and appropriate use of new antimicrobial medicines, diagnostic tools, vaccines and other
interventions, while preserving existing antimicrobial medicines, and promoting affordable access to
existing and new antimicrobial medicines and diagnostic tools, taking into account the needs of all
countries, and in line with the global action plan on antimicrobial resistance”. The Sixty-ninth World
Health Assembly noted the progress being made at that time in implementing the resolution. The
Secretariat continues working to meet this and the similar request of the United Nations General
Assembly in its political declaration on antimicrobial resistance (adopted in resolution 71/3) by
consulting Member States as well as FAO and OIE. The Secretariat will make available a draft road
map on how to work towards the finalization of the global development and stewardship
framework, including Member States, FAO, OIE and all other relevant stakeholders, on the WHO
website, in order to inform the discussion at the Seventieth World Health Assembly.

ACTION BY THE HEALTH ASSEMBLY

19. The Health Assembly is invited to note the report.

Document A70/13 (Report by the Secretariat):

Improving the prevention, diagnosis and clinical management of sepsis

1. The Executive Board at its 140th session considered an earlier version of this report, the Board
then adopted resolution EB140.R5.

2. Sepsis arises when the body’s response to infection injures its own tissues and organs. It can lead
to septic shock, multiple organ failure and death, if not recognized early and managed promptly. It is
a major cause of maternal and neonatal morbidity and mortality in low- and middle-income
countries and affects millions of hospitalized patients in high-income countries, where rates of sepsis
are climbing rapidly. The present report summarizes the problem of sepsis as a key issue for global
health, describes the Secretariat’s actions to address it and briefly outlines priority actions for the
future.

3. An international consensus has recently recommended that sepsis should be defined as “life-
threatening organ dysfunction caused by a dysregulated host response to infection” and septic
shock as “a subset of sepsis in which particularly profound circulatory, cellular, and metabolic
abnormalities are associated with a greater risk of mortality than with sepsis alone”. Both
definitions are accompanied by clinical criteria to translate them into practice to support diagnosis
and clinical management during patient care.

4. The occurrence and frequency of sepsis are determined by a complex interplay of many host,
pathogen and health system response factors. Several chronic diseases, such as chronic obstructive
pulmonary disease, cancer, cirrhosis, AIDS and other immunodeficiency disorders, are associated

58 And, where applicable, regional economic integration organizations.
59 See summary record of the Sixty-ninth World Health Assembly, Committee A, sixth meeting and seventh
meeting, section 3 (document WHA69/2016/REC/3).
60 See document EB140/12 and the summary records of the Executive Board at its 140th session, fourth
meeting and seventh meeting, section 2.
61 Singer M et al. The third international consensus definitions for sepsis and septic shock (Sepsis-3). JAMA.
with an increased risk of sepsis. Demographic and social factors, such as diet and lifestyle (for example, use of tobacco and alcohol), poverty, sex and race, also influence the occurrence of sepsis. Access to health care systems, in particular intensive care, as well as the timeliness and quality of care, are also associated with the occurrence of sepsis and its fatality rate.

5. Most types of microorganisms can cause sepsis, including bacteria, fungi, viruses and parasites, such as those that cause malaria. Bacteria such as *Streptococcus pneumoniae*, *Haemophilus influenzae*, *Staphylococcus aureus*, *Escherichia coli*, *Salmonella* spp. and *Neisseria meningitidis* are the most common etiological pathogens. Manifestations of sepsis and septic shock can be the fatal frequent pathway of infections with seasonal influenza viruses, dengue viruses and highly transmissible pathogens of public health concern such as avian and swine influenza viruses, severe acute respiratory syndrome coronavirus, Middle East respiratory syndrome coronavirus and most recently, Ebola and yellow fever viruses.

6. It is impossible to estimate precisely the global epidemiological burden of sepsis. According to crude incidence estimates extrapolated from data gathered in the United States of America, there could be 15–19 million cases of sepsis every year worldwide. Further data report up to 31 and 24 million cases of sepsis and septic shock respectively globally, with clinical conditions resulting in sepsis accounting for about 6 million deaths. In the United States of America, more than 1.1 million patients were hospitalized with sepsis in 2008, corresponding to an incidence of 32.7/10 000 patients, a 70% increase compared with that in 2000. Between 2004 and 2009 the sepsis case fatality rate in the United States of America ranged from 14.7% to 29.9%. The financial burden due to sepsis has been calculated to be more than US$ 24 billion, representing 6.2% of total hospital costs in 2013. Studies in Europe and Canada have estimated the daily costs of hospital care of a septic patient to be between €710 and €1033 in 2000 (equivalent to about US$ 645 and US$ 939, respectively). These estimates were based exclusively on data from high-income countries; the epidemiological burden of sepsis is likely to be much higher in low- and middle-income countries.

7. In the community, sepsis often presents as the clinical deterioration of common and preventable infections such as those of the respiratory, gastrointestinal and urinary tract, or of wounds and skin. Sepsis is frequently under-diagnosed at an early stage when it is still potentially reversible. Early diagnosis and timely and appropriate clinical management of sepsis is crucial to increase the likelihood of survival. Appropriate treatment of sepsis requires not only treatment of the underlying infection, but in parallel requires life-saving medical interventions such as fluid resuscitation or vital organ support. Even in viral epidemics such as Ebola virus disease or avian influenza A(H5N1), substantial improvement of case fatality rates was achieved by providing timely and appropriate patient care (resulting in a reduction of case fatality rates from 80–90% to 40% for Ebola virus disease in 2014–2015 and from 60% to 30% for influenza A(H5N1) in a WHO pooled analysis of data collected between 2004 and 2011).

8. Sepsis may also result from infections acquired in health care settings. These health care-associated infections are mainly caused by bacteria that are often resistant to antibiotics and therefore the clinical condition of the patient can rapidly deteriorate. Hundreds of millions of patients are estimated to be affected annually by health care-associated infections. In Europe, about 80 000 hospitalized patients are estimated to have at least one health care-associated infection on any given day. On average, health care-associated infections affect 7% and 15% of patients in high-income and low- and middle-income countries, respectively. In high-income countries, about 30% of patients in intensive-care units have at least one such infection. In low- and middle-income countries, the frequency of infection acquired in an intensive-care unit is at least two to three times higher than in high-income countries and device-associated infection densities are up to 13 times higher than in the United States of America. Hospital-born babies in low- and middle-income
countries are at a higher risk of being affected by neonatal sepsis, with infection rates three to 20 times higher than in high-income countries.

9. In 2015, infectious diseases accounted for more than 50% of all deaths in neonates and children aged under 5 years, especially in southern Asia and sub-Saharan Africa. Among these, pneumonia (920 000 deaths/year), diarrhoea (526 000 deaths/year), neonatal sepsis (401 000 deaths/year) and malaria (306 000 deaths/year) were the most frequent causes of death. As almost all these fatal cases have signs and symptoms of sepsis or septic shock, more aggressive approaches to improving the management of sepsis with simple tools could have a major impact on child mortality globally. Between 1995 and 2005 in the United States of America, the incidence of severe sepsis in children increased from 0.56 to 0.89 cases per 1000 children, across all age groups. In the United States of America, the overall incidence of neonatal sepsis from 2005 to 2008 was 0.77 cases per 1000 live births, with the highest incidence in African American preterm babies (5.14 per 1000 live births). In southern Asia, sub-Saharan Africa and Latin America, there were an estimated 6.9 million episodes of possible severe bacterial infection in neonates needing treatment in 2012, with overall mortality at about 10%, representing 670 000 deaths. Infections are the third direct leading cause of maternal mortality, causing about 11% (more than 30 000 deaths/year) of maternal deaths; in addition, sepsis is a contributing cause in many other maternal deaths every year. The burden of maternal deaths directly associated with infection is higher in low- and middle-income countries (10.7%), with the greatest burden in southern Asia (13.7%) and sub-Saharan Africa (10.3%), compared with high-income countries (4.7%). In Africa, up to 20% of women who have a caesarean section get a wound infection affecting their health and ability to take care of their baby.

10. Antimicrobial resistance is a major factor determining clinical unresponsiveness to treatment and rapid evolution to sepsis and septic shock. Approximately 214 000 newborn deaths due to sepsis worldwide each year could be attributable to resistant pathogens. Sepsis patients with resistant pathogens have been found to have a higher risk of hospital mortality: in Europe, for example, S. aureus, including meticillin-resistant S. aureus, was found to be the most common causative organism among sepsis patients with positive cultures in intensive-care units. The estimated mortality rate associated with meticillin-resistant S. aureus is about 50% higher than that for patients affected by meticillin-susceptible S. aureus.

INTERNATIONAL CONTEXT – RECENT EFFORTS ON SEPSIS

11. Recognition of sepsis as a major cause of preventable morbidity and mortality globally has grown in recent years, due to efforts of a wide range of public and private actors. One such actor, the Global Sepsis Alliance, a non-profit organization, was launched in 2010 to understand and combat sepsis better. The main initiatives to date include the promotion of World Sepsis Day (on 13 September) and the World Sepsis Congress (the first congress was held in 2016).

12. In order to mitigate sepsis-associated mortality, the Surviving Sepsis Campaign developed guidelines that recommend administration of empirical antimicrobial therapy within one hour of recognition of severe sepsis or septic shock in adult and paediatric patients. Observational studies have demonstrated that adherence to these guidelines improves processes of care and survival in high-income countries. Implementation in low- and middle-income countries, however, is proving very challenging. A survey of 185 African hospitals conducted in 2009 showed that less than 1.5% of the hospitals surveyed implemented the guidelines.

13. A Lancet Infectious Diseases Commission recently discussed the global burden of sepsis, its determinants, clinical management and most importantly a new road map for future research.62

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WHO’S RESPONSE TO SEPSIS

14. WHO’s response to sepsis spans different Secretariat programmes and is part of the Organization’s wider efforts to tackle the causes of global neonatal, paediatric and maternal mortality, to prevent health care-associated infections and epidemic-prone infections caused by highly transmissible pathogens, and to improve the clinical management of communicable diseases, including identification of the most effective treatment regimens to be included in the WHO Model List of Essential Medicines. Preventing and reducing harm from sepsis is relevant to achieving targets 3.1, 3.2, 3.3, 3.8, 3.b and 3.d of Goal 3 (Ensure healthy lives and promote well-being for all at all ages) and Goal 6 (Ensure availability and sustainable management of water and sanitation for all) of the 2030 Agenda for Sustainable Development,63 the United Nations Global Strategy for Women’s, Children’s and Adolescents’ Health, the WHO global action plan on antimicrobial resistance, implementation of the International Health Regulations (2005) and of the WHO framework on integrated, people-centred health services.

15. WHO and other key stakeholders are in the process of launching a global quality of care network for maternal, newborn and children’s health to accelerate reduction of preventable maternal and neonatal deaths, which includes prevention, early detection and prompt management of sepsis, in particular through implementation of essential newborn care packages and care at home. This initiative aims to ensure that every pregnant woman and newborn receives good-quality care throughout pregnancy and childbirth and in the postnatal period too. WHO has also developed the following: guidelines for the early identification of possible severe bacterial infection in newborns and infants; comprehensive packages for the diagnosis and treatment of sepsis at the referral level of care facilities; and guidelines for management of possible serious bacterial infections in newborns and young infants when referral is not possible.

16. WHO has issued recommendations for the prevention and treatment of maternal peripartum infections. Furthermore, WHO has recently developed a new definition for maternal sepsis and, together with Jhpiego and other key partners, launched the global maternal and newborn sepsis initiative. This initiative proposes a new collaborative and innovative approach that combines research, service-delivery programming and advocacy to strengthen the response to maternal and newborn sepsis.

17. Regarding the prevention of sepsis in children and the reduction of its contribution to the global burden of child mortality, the Health Assembly has adopted the following resolutions over the past few years: on working towards the reduction of perinatal and neonatal mortality (WHA64.13 (2011)); global vaccine action plan (WHA65.17 (2012)); and newborn health action plan (WHA67.10 (2014)).

18. Working with several key partners such as FAO, OIE and UNICEF, WHO developed the global action plan on antimicrobial resistance. Resolution WHA68.7 on this plan was adopted by the Sixty-eighth World Health Assembly in 2015. All five principles of the global action plan are relevant to reducing the burden of sepsis worldwide, as they aim to increase awareness of the problem, strengthen surveillance capacity and data dissemination, prevent antimicrobial resistance through infection prevention and control, improve water quality and sanitation, and promote a more appropriate use of antibiotics, as well as research to develop new medicines to overcome the problem of antimicrobial resistance. WHO has developed various recommendations, guidance documents and tools, and launched several new initiatives to accomplish its mandate of combating antimicrobial resistance. All three levels of the Organization are working with Member States to implement the global action plan through national action plans and related activities.

63 See United Nations General Assembly resolution 70/1 (2015).
19. The Secretariat provides support to countries in their efforts to develop or strengthen infection prevention and control programmes to reduce both the endemic and the epidemic burden of health care-associated infections. New evidence-based guidelines outlining the core components for effective infection prevention and control programmes at national and health care facility levels were issued in November 2016 to provide support to capacity-building efforts in countries, including national action plans on antimicrobial resistance. In a global report, WHO and UNICEF recently highlighted major gaps in hygiene, sanitation and access to clean, reliable water in health care facilities and have pointed out priorities for action in a global action plan. WHO provides guidance, in several documents and tools, on standards for water, sanitation and hygiene and management of health care waste; relevant monitoring indicators in health care facilities have also been identified. WHO evidence-based guidelines and implementation strategies to improve hand hygiene practices in health care have been adopted by more than 19 000 health care facilities in 177 countries through WHO’s global campaign, “Save Lives: clean your hands”. Specific recommendations and procedures are also being developed to prevent sepsis associated with invasive procedures such as surgical interventions and use of invasive devices (for example, vascular catheters), as well as infections due to antibiotic-resistant bacteria.

20. To provide relevant guidance on clinical management during outbreak responses, WHO developed the *IMAI district clinician manual: hospital care for adolescents and adults: guidelines for the management of common illnesses with limited-resources* in 2011, which includes guidance on sepsis and severe respiratory infections. During the 2009 A(H1N1) influenza pandemic, previously drafted guidelines were rapidly adapted and disseminated for the management of severely ill patients in low- and middle-income countries. WHO has used the manual to train thousands of front-line health workers during outbreaks in affected, neighbouring and at-risk countries. During the 2013–2016 outbreak of Ebola virus disease in West Africa, WHO incorporated these WHO adult sepsis guidelines into guidance on management of patients (*Clinical management of patients with viral haemorrhagic fever: a pocket guide for front-line health workers. Interim emergency guidance for country adaptation*, first issued in March 2014, updated February 2016). Support for training on sepsis management tailored to settings with limited resources has also been provided through development of a learning programme, the WHO IMAI Quick Check+/Clinician’s role in disease surveillance and response training curriculum (QC+). Complementing existing WHO guidance, this learning programme focuses on triage during emergencies, support for differential diagnosis and early detection of notifiable diseases, infection prevention and control and emergency management of severe conditions such as sepsis.

21. WHO will update the Model List of Essential Medicines in March 2017 and will review the information on antibiotics by reviewing treatment of 20 of the most prevalent and severe syndromes globally. A specific guidance document on neonatal sepsis will be included in the revised list in 2017 to provide support to countries in implementing evidence-based recommendations.

22. WHO and the Drugs for Neglected Diseases Initiative have collaborated in recent years to create the Global Antibiotic Research and Development Partnership, which aims to develop new antibiotic treatments for global health needs and promote sustainable and equitable access to them, including optimal conservation of antimicrobials. This not-for-profit partnership, together with several experts, has set up a project to develop a new first-line treatment for neonatal sepsis, as well as new antibiotics to be used against multidrug-resistant pathogens. The project designs and conducts studies in settings where levels of multidrug-resistance are high to determine the effectiveness and safety of new regimens, comparing them with existing therapies.
FUTURE PRIORITIES

23. The Secretariat has identified the following priorities for WHO and other stakeholders in addressing sepsis.

(a) To work together to improve understanding of the epidemiological and financial burden of sepsis worldwide and its continuous monitoring through availability of reliable data according to standardized definitions.

(b) To eliminate health systems factors that contribute to sepsis occurrence and inappropriate diagnosis and clinical management, and in particular, to prioritize strengthening of infection prevention and control programmes and implementation of infection prevention and control best practices at the point of care, particularly during labour, childbirth and postnatal care, and in intensive-care units and in the community.

(c) To increase access to and use of available vaccines that prevent the most common infections that can lead to sepsis.

(d) To prioritize actions that increase awareness of the clinical manifestations of sepsis among the public and community health care practitioners, to facilitate efforts related to the quality of care aimed at improving early diagnosis and appropriate clinical management.

(e) To support the use of appropriate diagnostic tools, including laboratory quality control, and further research on sensitive and specific new biomarkers and microbiological tests for early identification of sepsis conditions and assessment of their severity.

(f) To ensure that the basics of care – including availability of life-saving supplies required to treat sepsis and reduce its case fatality rate and rates of disability following sepsis – are reliably delivered as part of global efforts to achieve high-quality universal health coverage.

(g) To increase access to management of neonatal and infant sepsis when referral is not possible.

(h) To coordinate, support and undertake high-quality research to identify new medicines and treatments, for prevention and management of infections that most frequently lead to sepsis, in particular those caused by multidrug-resistant pathogens.

ACTION BY THE HEALTH ASSEMBLY

24. The Health Assembly is invited to adopt the resolution recommended by the Executive Board in resolution EB140.R5.

RESOLUTION 12.2:

Executive Board Resolution EB140.R5

Improving the prevention, diagnosis and management of sepsis

The Executive Board, having considered the report on improving the prevention, diagnosis and clinical management of sepsis,64 RECOMMENDS to the Seventieth World Health Assembly, the adoption of the following resolution:

The Seventieth World Health Assembly,

64 Document EB140/12.
Concerned that sepsis continues to cause every year approximately six million deaths worldwide, most of which are preventable;

Recognizing that sepsis as a syndromic response to infection is the final common pathway to death from most infectious diseases worldwide;

Considering that sepsis has a unique and time-critical clinical course which in the early stages is highly amenable to treatment through early diagnosis and timely and appropriate clinical management;

Considering also that infections which may lead to sepsis can often be prevented through appropriate hand hygiene, access to vaccination programmes, access to improved sanitation and water availability and other infection prevention and control best practices; and that forms of septicaemia associated with nosocomial infections are severe, hard to control and have high fatality rates;

Recognizing that while sepsis itself cannot always be predicted its ill effects in terms of mortality and long term morbidity can be mitigated through early diagnosis and appropriate and timely clinical management;

Recognizing the need to improve measures of prevention of infections and control of the consequences of sepsis, due to inadequate infection prevention and control programmes, insufficient health education and recognition of early sepsis, inadequate access to affordable, timely, appropriate treatment and care, insufficient laboratory services as well as the lack of integrated approaches to the prevention and clinical management of sepsis;

Noting that healthcare associated infections represent a common pathway through which sepsis can lead to an increased burden on the healthcare resources;

Considering the need for an integrated approach to addressing sepsis that focuses on prevention, early recognition through clinical and laboratory services and timely access to healthcare including intensive care services, with reliability in the delivery of the basics of care including intravenous fluids and the timely administration of antimicrobials where indicated;

Acknowledging that:

(i) the inappropriate and excessive use of antimicrobials contributes to the threat of antimicrobial resistance;

(ii) the global action plan on antimicrobial resistance adopted by resolution WHA68.7 (2015), as well as resolution WHA67.25 (2014), urged WHO to accelerate efforts to secure access to effective antimicrobials and to use them responsibly and prudently;

(iii) sepsis represents the most vital indication for the responsible use of effective antimicrobials for human health;

(iv) in the absence of appropriate and timely clinical management including effective antimicrobials sepsis would be almost universally fatal;

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65 See document WHA68/2015/REC/1, Annex 3.
(v) ineffective or incomplete antimicrobial therapy for infections including sepsis may be a major contributor to the increasing threat of antimicrobial resistance;

(vi) the incidence of some resistant pathogens may be reduced by the use of appropriate vaccines; and

(vii) immunocompromised patients are most at risk from very serious forms of septicaemia;

Recognizing that many vaccine-preventable diseases are a major contributor to sepsis and reaffirming resolution WHA45.17 (1992) on immunization and vaccine quality which urged Member States, inter alia, to integrate cost-effective and affordable new vaccines into national immunization programmes in countries where it is feasible;

Recognizing the importance of strong functional health systems which include organizational and therapeutic strategies in order to improve patient safety and outcomes from sepsis of bacterial origin;

Recognizing the need to prevent and control sepsis, to increase timely access to correct diagnosis and to provide appropriate treatment programmes;

Recognizing the advocacy efforts of stakeholders, in particular through existing activities held every year on 13 September66 in many countries, to raise awareness regarding sepsis,

1. **URGES Member States:**

   (1) to include prevention, diagnosis and treatment of sepsis in national health system strengthening policies and processes, in the community and in healthcare settings according to international guidelines;

   (2) to reinforce existing or develop new strategies leading to strengthened infection prevention and control programmes including by strengthening hygienic infrastructure, promoting hand hygiene, and other infection prevention and control best practices, clean childbirth practices, infection prevention practices in surgery, improvements in sanitation, nutrition and delivery of clean water, access to vaccination programmes, provision of effective personal protective equipment for health professionals and infection control in healthcare to continue in their efforts to reduce antimicrobial resistance, and promote the appropriate use of antimicrobials in accordance with the global action plan on antimicrobial resistance68 including development and implementation of comprehensive antimicrobial stewardship activities;

   (3) to continue in their efforts to reduce antimicrobial resistance, and promote the appropriate use of antimicrobials in accordance with the global action plan on antimicrobial resistance69 including development and implementation of comprehensive antimicrobial stewardship activities;

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66 See document EB140/12 paragraph 10: civil society organizations promote a World Sepsis Day on 13 September.
67 And, where applicable, regional economic integration organizations.
68 See document WHA68/2015/REC/1, Annex 3.
69 See document WHA68/2015/REC/1, Annex 3.
(4) to develop and implement standard and optimal care and strengthen medical counter measures for diagnosing and managing sepsis in health emergencies, including outbreaks, through appropriate guidelines with a multisectoral approach;

(5) to increase public awareness of the risk of progression to sepsis from infectious diseases, through health education, including on patient safety, in order to ensure prompt initial contact between affected persons and the health care system;

(6) to develop training for all health professionals on infection prevention and patient safety and the importance of recognizing sepsis as a preventable and time-critical condition with urgent therapeutic need and of communicating with patients, relatives and other parties using the term “sepsis” in order to enhance public awareness;

(7) to promote research aimed at innovative means of diagnosing and treating sepsis across the lifespan, including research for new antimicrobial and alternative medicines, rapid diagnostic tests, vaccines and other important technologies, interventions and therapies;

(8) to apply and improve the use of the International Classification of Diseases system to establish the prevalence and profile of sepsis and antimicrobial resistance, and to develop and implement monitoring and evaluation tools in order to focus attention on and monitor progress towards improving outcomes from sepsis, including the development and fostering of specific epidemiologic surveillance systems and to guide evidence-based strategies for policy decisions related to preventive, diagnostic and treatment activities and access to relevant health care for survivors;

(9) to engage further in advocacy efforts to raise awareness of sepsis, in particular through supporting existing activities held every year on 13 September in Member States;

2. REQUESTS the Director-General:

(1) to draw attention to the public health impact of sepsis including by publishing a report on sepsis, describing its global epidemiology and impact on the burden of disease and identifying successful approaches for integrating the timely diagnosis and management of sepsis into existing health systems, by the end of 2018;

(2) to support Member States as appropriate, to define standards and establish the necessary guidelines, infrastructures, laboratory capacity, strategies and tools for reducing the incidence of, mortality from and long-term complications of sepsis;

(3) to collaborate with other organizations in the United Nations system, partners, international organizations and other relevant stakeholders in enhancing access to quality, safe, efficacious and affordable types of treatments of sepsis, and infection prevention and control, including immunization, particularly in developing countries, while taking into account relevant existing initiatives;

(4) to report to the Seventy-third World Health Assembly, through the Executive Board, on the implementation of this resolution.

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70 See document EB140/12 paragraph 10: civil society organizations promote a World Sepsis Day on 13 September.
12.3 Poliomyelitis


1. The Executive Board at its 140th session noted an earlier version of this report. The text has been updated and revised in light of the Board’s deliberations and also now contains an updated version of the report on WHO’s human resources funded by the Global Polio Eradication Initiative, which appeared in document EB140/46, Annex, which was also noted by the Board. The Board adopted decision EB140(4) on poliomyelitis, requesting the Director-General “to present to the Seventieth World Health Assembly a report that outlines the programmatic, financial and human-resource-related risks resulting from the current winding-down and eventual discontinuation of the Global Polio Eradication Initiative, as well as an update on actions taken and planned to mitigate those risks while ensuring that essential polio-related functions are maintained ...”. This requested report is contained in the accompanying document A70/14 Add.1.

2. Strong progress continues to be made since the Health Assembly called for the worldwide eradication of poliomyelitis in 1988. At the time, poliomyelitis was endemic in more than 125 countries around the world and more than 350 000 children a year were paralysed for life by poliovirus. Today, transmission of wild poliovirus is at its lowest levels ever, with endemic transmission occurring in parts of only three countries – (in order of burden of disease) Pakistan, Afghanistan and Nigeria. In 2016, 37 cases of poliomyelitis had been reported worldwide. In 2017, one case of poliomyelitis has been reported, with global certification therefore planned by 2020 (instead of 2019). Only one wild serotype (poliovirus type 1) continues to be detected; wild poliovirus type 2 was officially declared eradicated in 2015 and no case of paralytic poliomyelitis due to wild poliovirus type 3 has been detected anywhere since November 2012. More than 16 million people are walking today who otherwise would have been paralysed. An estimated 1.5 million childhood deaths have been prevented through the systematic administration of vitamin A during polio immunization activities. The world stands on the brink of an historic global public health success.

3. The progress has been made possible by the global network of support and engagement of stakeholders, first and foremost by Member States. More than 20 million volunteers administer polio vaccines and other life-saving medicines to more than 400 million children worldwide every year. To date, the global effort to eradicate polio has saved more than US$ 27 000 million, and the global eradication of poliovirus will result in savings of an additional US$ 20 000–25 000 million, funds which can be applied to the delivery of other life-saving health interventions.

4. The risks and consequences of failure, by contrast, are significant: an epidemic-prone disease, polio will spread again beyond its current borders, and, within 10 years, upwards of 200 000 new cases will again be reported around the world, every year. Progress is, moreover, fragile; this was underscored in August 2016 with the confirmation of four new cases of paralytic poliomyelitis due to wild poliovirus type 1 in Borno State, north-eastern Nigeria, the first reported in the country and the African Region since July 2014. These risks underscore the urgent need for the rapid and sustainable achievement of a polio-free world, recalling resolution WHA68.3 (2015), in which the Health Assembly urged Member States to make available urgently the financial resources required for the

71 See document EB140/13 and the summary records of the Executive Board at its 140th session, tenth meeting, section 1.
73 All data in this report are as at 8 February 2017.
full and continued implementation of the Polio Eradication and Endgame Strategic Plan. To help more effectively to guide and oversee progress towards interrupting poliovirus transmission, the remit of the Independent Monitoring Board is currently being adjusted to focus even more strongly on achieving attainment of this critical objective of the Strategic Plan.

5. The declaration in 2014 of international spread of wild poliovirus as a Public Health Emergency of International Concern and the Temporary Recommendations promulgated under the International Health Regulations (2005) remain in effect. National polio emergency action plans continue to be implemented in all countries affected by circulation of either wild poliovirus or vaccine-derived polioviruses, and all countries currently affected by circulation of either type of virus have declared such events to be national public health emergencies.

6. Between 17 April and 1 May 2016, all 155 countries and territories that were still using trivalent oral polio vaccine successfully switched its use to the bivalent oral polio vaccine through a globally-synchronized replacement. It was the first step in the phased removal of oral polio vaccines, which will culminate with the cessation of use of all oral polio vaccines following global certification of eradication of all wild poliovirus types. Since the declaration of eradication of wild poliovirus type 2 in September 2015, Member States are completing efforts to identify facilities holding type 2 polioviruses (wild, vaccine-derived or Sabin), destroy unneeded materials or appropriately contain needed materials in poliovirus-essential facilities.

7. In 2016, acceleration of transition planning continued (see paragraphs 20–25) in order: to ensure effective advance human resource planning at all levels of the Secretariat to reduce the number of polio-funded staff and associated financial liabilities; to understand the consequences of the loss of polio-funded staff and infrastructure on other WHO programme areas, and WHO country offices; and to help to identify opportunities to mainstream or integrate polio functions into other programmes areas or national health system, where feasible.

8. The partners of the Global Polio Eradication Initiative continue to engage closely with all Member States and the broader international development community in efforts to secure rapidly the additional US$ 1300 million required to achieve a lasting polio-free world.

INTERRUPTION OF POLIOVIRUS TRANSMISSION

9. In 2016, 37 cases of paralytic poliomyelitis due to wild poliovirus had been reported globally, compared to 74 in 2015. All the cases were reported from Pakistan, Afghanistan and Nigeria and were caused by wild poliovirus type 1. Also in 2016, three cases due to circulating vaccine-derived poliovirus of type 1 had been reported from the Lao People’s Democratic Republic (all from January 2016), compared to 32 cases due to circulating vaccine-derived polioviruses from seven countries in 2015. Two separate circulating vaccine-derived polioviruses type 2 have been detected in Borno and Sokoto States, Nigeria (see paragraph 14).

Countries with continued endemic transmission of wild poliovirus: Pakistan, Afghanistan and Nigeria

10. Afghanistan and Pakistan continue to be treated as a single epidemiological block. In 2016, 20 cases of paralytic poliomyelitis had been reported in Pakistan, compared to 54 in 2015. In Afghanistan, 13 cases were reported, compared to 20 in 2015. In 2017, one case has been reported, from Afghanistan. The two countries demonstrated strong progress over the past nine months, and technical advisory groups, reviewing latest epidemiological data in 2016 following the “low season” of poliovirus transmission, concluded that rapid interruption of transmission of wild poliovirus was

74 For most up-to-date budget and financial information, see http://polioeradication.org/financing/ (accessed 6 March 2017).
feasible in both countries. Realization of that goal will, however, depend on reaching all missed children, filling chronic gaps in strategy implementation and being able to vaccinate children in infected areas that have been difficult to access owing to insecurity. The remaining reservoirs of wild poliovirus transmission are the three corridors linking the two countries: eastern Afghanistan/Khyber-Peshawar, Greater Kandahar/Hilmand-Quetta, and Paktika/Patkya/Khost-Khyber Pakhtunkhwa/Federally Administered Tribal Areas. The two country programmes are enhancing their joint focus on improving programme operations (supplementary immunization activities and surveillance) in these three corridors. Programme coordination has significantly improved in 2016 at the national and provincial/regional levels as well as among the bordering districts in the three common corridors of transmission.

11. In Pakistan, the number of reported cases of poliomyelitis continues to decline. The year 2016 saw the lowest-ever annual number of polio cases in the country but environmental surveillance continues to detect poliovirus over a wide geographical range, indicating ongoing transmission. Two of the three core reservoirs of poliovirus (Karachi and Peshawar) have demonstrated encouraging progress in 2016. Of particular note, Karachi has not reported a case of poliomyelitis for almost one year and only three environmental positive samples since March 2016. The situation in the reservoir of the Quetta block is concerning as there is continued local transmission of wild poliovirus together with the emergence of circulating vaccine-derived poliovirus type 2 since June 2016. Moreover, there is an outbreak of poliomyelitis in interior Sindh, with four cases reported during the second half of 2016. A national emergency action plan for the disease is being overseen directly by the office of the Prime Minister. Emergency operations centres at federal and provincial/regional levels ensure almost real time monitoring of activities, implementation of corrective action and increased accountability and ownership at all levels. Most importantly, the national plan focuses on identifying chronically missed children and the reasons why they are missed and on implementing area-specific approaches to overcome these challenges. As a result, innovative community-based strategies are being implemented, operational weaknesses of the programme are increasingly being corrected, and access in previously inaccessible areas is continuously being improved. Increasing vaccination coverage rates are observed in the Peshawar-Khyber corridor and Karachi. Concerted efforts are being applied to improve programme operations and to strengthen supervision and monitoring mechanisms in the Quetta block and interior Sindh. Pakistan has positioned itself to achieve polio eradication, thanks to commitment at all levels across the political parties. Continued leadership and sustained operations throughout the period of the forthcoming national elections will be critical to success.

12. In Afghanistan, polio eradication is at the top of the Government’s health agenda. In 2015 and 2016, the Government scaled up its efforts to accelerate polio eradication nationally amid multiple complex challenges, including increasing conflict and insecurity in many parts of the country. The National Emergency Action Plan continues to serve as the guiding document for its polio eradication activities. Emergency operation centres are operating at the national and regional levels with the aim of intensifying, guiding and coordinating efforts of all partners for implementing the National Emergency Action Plan under one roof. Most areas of Afghanistan are polio-free, but wild poliovirus continues to circulate in localized geographical areas in the Eastern and Southern Regions of the country. In 2016, the country reported a total of 13 cases in just four districts. Two geographical areas are of particular importance: Bermel district in Paktika province and Sheegal district in Kunar province, whence 11 of the 13 polio cases in 2016 have been reported.

13. In Nigeria, four new cases of poliomyelitis due to wild poliovirus type 1 were confirmed in July and August 2016 from Borno State, the first reported from the country since July 2014. Genetic sequencing of the isolated viruses indicate they are most closely linked to a wild poliovirus type 1 last detected in Borno State in 2011. With the lack of access and the inability to conduct high-quality vaccination and surveillance in many areas of the State, this strain has likely circulated undetected in
this inaccessible population since that time. The Government of Nigeria immediately launched an aggressive outbreak response according to revised international outbreak response protocols, with five rounds of large-scale supplementary immunization activities to deliver additional doses of bivalent oral polio vaccine at short intervals. The Government declared the outbreak to be a national public health emergency. At the same time, additional measures are being implemented to increase the sensitivity of subnational surveillance. The response is part of a broader regional outbreak response, coordinated with neighbouring countries, in particular the Lake Chad subregion, including northern Cameroon, parts of Central African Republic, Chad and southern Niger. At the sixty-sixth session of the Regional Committee for Africa (Addis Ababa, 19–23 August 2016), health ministers declared the polio outbreak to be a regional public health emergency for countries in the Lake Chad subregion. Detection of these cases underscores the risk posed by low-level undetected transmission and the urgent need to strengthen subnational surveillance everywhere. The Global Polio Eradication Initiative has reviewed and revised supplementary immunization activity plans to meet the supply requirements of bivalent oral polio vaccine associated with this outbreak response, while ensuring that other high-risk countries are able to maintain high levels of population immunity.

Circulating vaccine-derived poliovirus

14. In late 2015 and early 2016, Member States affected by outbreaks of circulating vaccine-derived polioviruses type 2 intensified their responses to ensure that circulation of these viruses was stopped before the globally-synchronized switch from trivalent oral polio vaccine to bivalent oral polio vaccine in early 2016 (see paragraph 6). In 2016, one case of poliomyelitis due to circulating vaccine-derived poliovirus type 2 was reported in Sokoto State, Nigeria. A separate circulating vaccine-derived poliovirus type 2 was confirmed in Borno State; it was isolated from an environmental sample (collected in March 2016) and stool specimens (collected in August 2016) from a healthy contact of one of the cases of polio due to wild poliovirus type 1 (see paragraph 13), during strengthened surveillance activities in the area. Genetic sequencing of this strain indicates that it has been circulating for almost four years in the area and was last detected in northern Nigeria in November 2014. With the lack of access in many areas and the inability to conduct high-quality vaccination and surveillance in key areas of Borno State, the strain has likely circulated undetected in this inaccessible population. Multicountry response plans, including improvement of surveillance quality at the subnational level across the Lake Chad subregion, continue to be implemented. The Government of Nigeria responded fully and immediately, in line with new protocols established for the detection of vaccine-derived poliovirus type 2 in the period following the switch from use of trivalent oral polio vaccine. The Director-General authorized the release of monovalent oral polio vaccine type 2 from the global stockpile at the request of the Government of Nigeria for use in the response. The Lao People’s Democratic Republic was affected by a circulating vaccine-derived poliovirus outbreak (type 1) and no case has been reported from that country since 11 January 2016. In several countries, however, gaps in the quality of subnational surveillance persist in key areas where previously circulation of vaccine-derived polioviruses had been confirmed, including parts of Guinea.

15. The Global Polio Eradication Initiative is actively monitoring the presence of vaccine-derived poliovirus type 2, from any source. Detection of such strains in the first 6 to 12 months after the switch from trivalent oral polio vaccine to bivalent oral polio vaccine is expected, given that children who had previously received trivalent oral polio vaccine will continue to excrete the type 2 strain originally contained in the trivalent vaccine for a limited period of time. Each detection of type 2 vaccine-derived virus from any source results in the immediate activation at global, regional and country levels of a newly-established incident management system, with the aim of conducting a thorough risk assessment associated with the isolated strain and implementing, if appropriate and necessary, an outbreak response, including the accessing of the global stockpile of monovalent oral polio vaccine type 2. Monovalent oral polio vaccine type 2 was released from the global stockpile for
implementation of response activities in the countries of the Lake Chad subregion (Cameroon, Central African Republic, Chad, Niger and Nigeria), as well as Mozambique and Pakistan. In India and Pakistan, fractional-dose inactivated polio vaccine was used in response to the detections of vaccine-derived poliovirus type 2 in the environment. New evidence indicates that monovalent oral polio vaccine type 2 is more efficacious than previously understood. This new evidence, reviewed by the Strategic Advisory Group of Experts on immunization during recent meetings (Geneva, 18–20 October 201675 and 9–10 February 201776), will underpin revision of global outbreak response protocols, necessitating fewer rounds of supplementary immunization activities.

Public Health Emergency of International Concern – minimizing the risk of international spread of poliovirus

16. Episodes of international spread of poliovirus continued in 2016 with the poliovirus circulating across the shared border of Afghanistan and Pakistan. Minimizing the risk and consequences of new international spread of polioviruses requires: full implementation of the eradication strategies in the remaining infected areas; comprehensive application of the Temporary Recommendations issued by the Director-General under the International Health Regulations (2005); and heightened surveillance and outbreak response preparedness plans by all Member States in order to facilitate a rapid response to new cases of detection of poliovirus. During its teleconference (7 February 2017), the Emergency Committee under the International Health Regulations (2005) regarding the international spread of poliovirus recommended extending the Temporary Recommendations for a further three months.

PHASED REMOVAL OF ORAL POLIO VACCINES

17. The successful switch from trivalent to bivalent oral polio vaccine (see paragraph 6) was a milestone; it was the largest-ever withdrawal of one vaccine and associated introduction of another. By end-September 2016, all Member States had confirmed completion of the switch. This achievement is a tribute to the extraordinary commitment, leadership and engagement of all Member States. Cessation of the use of oral polio vaccine is necessary to eliminate the very rare long-term risks of vaccine-derived polioviruses associated with its use, and is a key strategy of the Polio Endgame Plan, which had been endorsed by the Strategic Advisory Group of Experts on immunization and the Health Assembly.

18. To prepare for the switch to bivalent oral polio vaccine, all countries had committed themselves to introduce at least one dose of inactivated polio vaccine into their routine immunization programmes. The level of commitment to meet this goal has been exceptional. At its meeting in October 2016, the Strategic Advisory Group of Experts on immunization noted both the reduction in supplies of inactivated polio vaccine, due to technical difficulties that manufacturers have encountered in scaling up production, and the expectation that the global vaccine supply will remain fragile through 2018.77 Available supply of this vaccine is being prioritised to routine immunization in areas at highest risk of circulation of vaccine-derived poliovirus type 2 (Tier 1 and 2 countries). Every effort is being made to ensure that remaining low-risk countries receive inactivated polio vaccine supplies in 2018. The Global Polio Eradication Initiative is exploring with Member States and WHO’s regional offices the feasibility of instituting dose-sparing strategies, such as using intradermal

76 The report of the meeting will be made available on the WHO website at http://www.who.int/immunization/policy/sage/en/.
administration of fractional-dose inactivated poliovirus vaccine. The Strategic Advisory Group of Experts on immunization also strongly recommended that countries should start preparing for use of a fractional intradermal dose inactivated poliovirus vaccine in a two-dose schedule, in lieu of a single intramuscular full dose, a recommendation further stressed by the body’s Polio Working Group at its recent meeting (Geneva, 9 and 10 February 2017). Some Member States, notably Bangladesh, India, and Sri Lanka, have already adopted fractional-dose schedules in their immunization programmes in order to ensure that sufficient quantities of inactivated polio vaccine are available for continued vaccination of the full birth cohort.

CONTAINMENT

19. Efforts to contain poliovirus type 2 have progressed in 2016, following the publication of the WHO global action plan to minimize poliovirus facility-associated risk after type-specific eradication of wild polioviruses and sequential cessation of oral polio vaccine use (GAPIII). As at 17 January 2017, 175 countries and territories reported that they no longer had wild or vaccine-derived poliovirus type 2, 18 reported that they did, and 12 were completing reports. So far, 30 countries have designated 75 poliovirus-essential facilities to retain type 2 polioviruses, but some of them still have to nominate the national authority for containment that will be responsible to certify that these facilities meet the containment requirements described in GAPIII. In support of Member States’ efforts to complete Phase I of GAPIII, the Secretariat is developing guidance to help facilities to identify samples that are likely to harbour type 2 polioviruses, recommending their destruction or safe and secure handling. In support of the implementation of Phase II, the Secretariat has raised awareness about containment and strengthened national capacity by training staff of national authorities for containment and poliovirus-essential facilities about GAPIII implementation and certification. WHO has published the Containment Certification Scheme to support the WHO Global Action Plan for Poliovirus Containment, which is aimed at guiding national authorities for containment in their efforts to certify facilities’ compliance with the requirements of GAPIII, in consultation with the Global Commission for the Certification of the Eradication of Poliomyelitis. Furthermore, training is currently offered to auditors expected to participate in containment audits of poliovirus-essential facilities. With this support, concerned Member States are expected to complete Phase I and progress with Phase II of GAPIII, formally engaging concerned facilities in the certification process.

TRANSITION PLANNING

20. Polio transition planning (previously referred to as legacy planning) has intensified in 2016 and in 2017. The transition planning efforts within the Global Polio Eradication Initiative have three goals: (1) to ensure that those functions essential to maintaining a polio-free world after eradication are mainstreamed into continuing public health programmes; (2) to ensure that the lessons learned from polio eradication activities are captured and then shared with other health initiatives and all Member States; and (3) where feasible and appropriate, to plan the transfer of capabilities, assets and processes in order to support other health priorities. In addition to the three programme-specific goals, Organization-wide efforts are underway to assess the significant financial, human resources, programmatic and country-capacity risks associated with the decline in polio funding and eventual closure of the Global Polio Eradication Initiative that eradication of polio creates.

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21. In April 2016, the Global Polio Eradication Initiative published detailed budgets for 2016–2019,\(^{80}\) showing the decreased expenditure from 2017 for each country, region and activity. These budgets provided an impetus to the transition planning process at the country level, which is intended to be driven by countries, in line with their national health goals and priorities. These budgets also help to drive human resource planning, leading to reduction in staffing levels and thereby reduced terminal liabilities for the organization. As noted by the Health Assembly in 2014,\(^{81}\) WHO is liable for significant indemnity costs for the contracts that are terminated because of programme closure, owing to the high number of staff and non-staff contracts financed from polio-specific funds, in particular in the African Region. Details from an independent study conducted in September 2016, and updated information since the study, are provided in the Annex to this document.

22. WHO and other partners in the Global Polio Eradication Initiative are providing technical support to Member States in their polio transition planning efforts. The 16 countries that have the greatest polio-funded infrastructure are in the process of drawing up their transition plans. As a result of the detection of wild poliovirus type 1 in Nigeria, transition planning efforts have been slowed down in Nigeria and other countries of the Lake Chad subregion; however, the momentum should not be lost and planning should continue in the other countries, in close cooperation with other relevant stakeholders, including donors.

23. WHO and other partners in the Global Polio Eradication Initiative have launched a process to develop their agency-specific transition plans. At WHO headquarters, the WHO Global Steering Committee on Transition Planning was established in 2016 with representation from relevant regions and Secretariat departments. An Organization-wide Global Polio Transition Human Resources Working Group has also been established to fully identify and manage the human resource risks and associated liabilities (see Annex); an independent study was commissioned, and conducted in September 2016, to assess country-capacity and WHO’s programmatic risks, and develop appropriate recommendations for the consideration of the Secretariat’s Global Policy Group and WHO’s governing bodies. Further to the Executive Board’s decision EB140(4) (2016), the Secretariat is preparing a report on polio transition planning for submission to the Seventieth World Health Assembly. A meeting of Member States will be held at the end of April 2017 to discuss the first draft of this report.

24. In 2016, a Polio Transition Independent Monitoring Board was established to monitor and guide independently both the country and global aspects of transition planning, reporting on progress and engagement.

25. As part of the transition planning efforts at country, regional and global levels, the Secretariat is also working with its Global Polio Eradication Initiative partners to develop a post-certification strategy that will define and cost the essential functions needed, after certification, to maintain a polio-free world. The development of this strategy will go through extensive consultations with all Member States, including discussions by the regional committees, before it is finalized ahead of the Seventy-first World Health Assembly in 2018.

**FINANCE AND MANAGEMENT OF THE GLOBAL POLIO ERADICATION INITIATIVE**

26. Thanks to the generous continuing support of the international development community, including Member States (especially the countries where poliomyelitis is endemic), multilateral and bilateral organizations, development banks, foundations and Rotary International, the budget for

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\(^{81}\) See document A67/47 and the summary records of the Sixty-seventh World Health Assembly, Committee B, second meeting, section 4 (document WHA67/2014/REC/3).
planned activities for 2016 was fully financed. Efforts are under way to mobilize, by mid-2017, the additional US$ 1300 million\textsuperscript{82} required to fully fund the implementation of the Polio Eradication and Endgame Strategic Plan and to secure a lasting polio-free world and global certification in 2020. In addition to the significant humanitarian benefits associated with polio eradication, the drive is also associated with substantial economic benefits. A polio-free world will reap savings of a total of more than US$ 50 000 million (with US$ 27 000 million already saved), funds that can be used to address other pressing public health and development needs. Critical to achieving a lasting polio-free world is the rapid mobilization of the additional funds needed. The Global Polio Eradication Initiative published an investment case\textsuperscript{83} for polio eradication, clearly summarizing the economic and humanitarian rationale for continued investment in the Initiative.

**ACTION BY THE HEALTH ASSEMBLY**

27. The Health Assembly is invited to note the report, including the information presented in the Annex, and to encourage Member States to ensure full implementation of resolution WHA68.3 (2015).

\textsuperscript{82} The most up-to-date budget and financial information is available at http://polioeradication.org/financing/ (accessed 7 March 2017).


Document A70/15 (Report by the Director-General)

Annual report on the implementation of the IHR (2005)

1. In accordance with paragraph 1 of Article 54 of the International Health Regulations (2005) and resolution WHA61.2 (2008), States Parties and the Director-General report annually to the Health Assembly on the implementation of the Regulations. The current document gives an account of actions taken by the States Parties and the Secretariat within the framework of the Regulations since the last report considered by the Health Assembly in May 2016.  

INTERNATIONAL HEALTH REGULATIONS (2005) COMMITTEES

2. Since June 2016, a number of actions have been taken in relation to emergency and review committees convened under the IHR (2005), a summary of which is provided below.

EMERGENCY COMMITTEES

Poliomyelitis

3. Since the international spread of wild poliovirus was declared a public health emergency of international concern on 5 May 2014, the Emergency Committee regarding the international spread of poliovirus has met on 13 occasions. At its 13th meeting on 24 April 2017, the Committee agreed that the epidemiological situation still constituted a public health emergency of international concern and advised the extension of the revised temporary recommendations. The Committee further urged all countries to avoid complacency, which could easily lead to a resurgence of polio. The Director-General endorsed the Committee’s conclusions and issued temporary recommendations under the Regulations. Travel recommendations were updated.

Zika virus, microcephaly and Guillain–Barré syndrome

4. The Emergency Committee for Zika virus and observed increase in neurological disorders and neonatal malformations met on five occasions in 2016. At its fifth and final meeting on 18 November 2016, the Committee felt that Zika virus and associated consequences remained a significant enduring public health challenge requiring intense action but no longer represented a public health emergency of international concern. The Director-General agreed with the Committee and on 18 November 2016 declared the end of the public health emergency of international concern.

Yellow fever

5. The Emergency Committee concerning yellow fever (in response to outbreaks in Angola and the Democratic Republic of the Congo) met on two occasions in 2016. At its second meeting on 31 August 2016, the Committee examined the use of the fractional dose strategy for yellow fever vaccination in Kinshasa, Democratic Republic of the Congo, which resulted in high population coverage. The impact of the vaccination campaign will be assessed. On the basis of the evidence available at the time of the second meeting, the Director-General accepted the Committee’s assessment that the outbreaks in Angola and the Democratic Republic of the Congo did not constitute a public health emergency of international concern, but advised that, due to the seriousness of the outbreaks, it remains a serious public health event warranting a sustained scale-up of response activities, both nationally and internationally, and a close monitoring of the situation.

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84 Document A69/20.
The Review Committee on the Role of the International Health Regulations (2005) in the Ebola Outbreak and Response

6. In decision WHA69(14) (2016), the Health Assembly requested the Director-General to develop for the consideration of the regional committees in 2016 a draft global implementation plan for the recommendations of the Review Committee. The draft plan was developed and reviewed by all six regional committees in 2016. The results of these regional consultations were taken into account and a revised draft plan was presented to the Executive Board at its 140th session in January 2017.85

7. During the discussions at the 140th session of the Executive Board, the revised draft global implementation plan was discussed in detail by Board Members and Member States. A number of salient issues were raised that require further consultation. Consequently, the Secretariat held on 23 March 2017 an information session for the diplomatic Missions to the United Nations and other International Organizations at Geneva, to receive additional Member State input in relation to key areas of action of the draft global implementation plan.86

PROGRESS ON IMPLEMENTATION OF THE INTERNATIONAL HEALTH REGULATIONS (2005)

Capacity-building

8. States Parties, the Secretariat and other key partners have continued to make progress on the implementation of the Regulations. This progress continues to be achieved through multiple channels and sustained coordination. A summary of the most recent developments is included below.

9. In 2014, the Review Committee on Second Extensions for Establishing National Public Health Capacities and on IHR Implementation recommended to move from exclusive self-evaluation to approaches that combine self-evaluation, peer review and voluntary external evaluation. This approach was also supported by the Review Committee on the Role of the IHR (2005) in the Ebola Outbreak and Response. To that end, a concept note outlining a new approach for monitoring and evaluation of the Regulations was presented to the regional committees in 2015. This proposed new monitoring and evaluation framework was noted by the Sixty-ninth World Health Assembly.87 The Framework has four components: the mandatory annual reporting by States Parties and three complementary elements, all on a voluntary basis, comprising joint external evaluations, after-action reviews and simulation exercises.

10. In 2016, States Parties continued to provide information to the Secretariat. Since 2010, 195 States Parties have reported at least once to WHO using the annual reporting questionnaire. As at 28 February 2017, 120 of 196 States Parties had completed the questionnaire sent in July 2016. Details of the 2016 annual reporting by States Parties and other activities related to the monitoring and evaluation of the implementation of the Regulations are published on the WHO website.88 Globally, progress has been made since 2010 across the 13 core capacities required by the Regulations, particularly in surveillance, response, and zoonoses, but the overall average scores suggest further efforts are urgently needed in the areas of human resources, capacities at points of entry, chemical events and radiation emergencies.

11. An analysis of scores of 27 joint external evaluations conducted in 2016 indicates that surveillance and laboratory systems are relatively well advanced in the countries that volunteered

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85 Document EB140/14.
86 See document A70/16.
87 See document A69/20 and the summary records of the Sixty-ninth World Health Assembly, fifth meeting and seventh meeting, section 1.
for the evaluation. Vaccine coverage, access and delivery are also very well established, with almost all of the 27 countries having demonstrated capacity in these areas. Of these 27 countries, 7% (2/27) had developed or demonstrated capacity in the area of antimicrobial stewardship; 33% (9/27) had developed, demonstrated or sustainable capacity in identifying their priority public health risks; 33% (9/27) had developed, demonstrated or sustainable capacity in terms of the availability of multihazard emergency response plans; 52% (14/27) had developed, demonstrated or sustainable capacity in terms of having procedures for emergency operation centres; and 52% (14/27) had developed, demonstrated or sustainable capacity in activating an emergency operations programme. An initial comparison of the 2016 monitoring questionnaire data and joint external evaluation data from 26 countries (for which both datasets were available) confirms the areas identified above as priorities (human resources, capacities at points of entry, chemical events and radiation emergencies) and the joint external evaluations, in addition, show that the areas of response and preparedness also require attention.

12. In 2016, the Secretariat supported the planning and implementation of 27 simulation exercises in 17 countries, to test various functional capacities in preparedness, detection and response, in support of country health emergency preparedness and implementation of the Regulations. These exercises included discussions stimulated by table-top exercises, drills, functional exercises as well as field exercises. Most simulation exercises were conducted at the national and subnational levels, although some exercises had a regional or global scope. Simulation exercises at the national and subnational level included testing rapid response teams, intersectoral coordination mechanisms and emergency preparedness and response systems for events such as outbreaks of Ebola virus disease, meningitis and cholera and chemical events. They proved to be useful in identifying specific gaps and proposing particular actions to reinforce preparedness and response capacities for public health emergencies.

13. In February 2017, a tool for after-action review was tested in one State Party, which had experienced an unusual outbreak of dengue fever. The method used during the review was evaluated as useful by the majority of the participants.

14. The WHO Health Emergencies Programme provided active support across the three levels of the Organization in relation to implementation of the Regulations. It provides direct assistance to priority countries vulnerable to disease outbreaks such as countries experiencing humanitarian emergencies. Technical and operational support allowed the strengthening of intersectoral and cross-cutting capacities for emergency preparedness, in line with core capacity requirements (such as early warning systems, laboratory quality and biorisk management), the fostering of intersectoral work (such as with the animal sector under the One Health approach), and the transport, travel and tourism sectors for supporting capacities at points of entry.

15. In February 2017, the Secretariat hosted a stakeholders consultation on planning, costing and financing for accelerated IHR implementation and global health security. The consultation allowed participants to share the lessons learned, agree on a process for the development of national action plans and define best practices and models, as well as identifying opportunities for linkages with national health systems strengthening efforts and for multisectoral investment and coordination.

Yellow fever

technical advisory group on geographical yellow fever risk mapping maintains up-to-date yellow fever risk mapping and provides advice to WHO on yellow fever vaccination for travellers.

CHALLENGES TO THE IMPLEMENTATION OF THE IHR (2005)

17. The finalization of the above-mentioned draft global implementation plan for the recommendations of the Review Committee on the Role of the IHR (2005) in the Ebola Outbreak and Response and its full implementation, once adopted, will further accelerate the implementation of the Regulations. Empowering National IHR Focal Points requires the sustained support of governments. Workforce development and intersectoral collaboration remain important challenges despite significant progress made, such as through innovative e-learning and training approaches and, at the human–animal interface, through active collaboration between FAO, OIE and WHO, including under the tripartite agreement. More sustained efforts are required with the transport, travel and tourism sectors as well as with the security sector, public–private partnerships and community involvement. In addition, the rapid development, monitoring and implementation of the national action plans requires sustained support from national authorities and the international communities to ensure adequate and sustained funding of such plans and the regular assessment of the core capacities required under the Regulations.

18. The period of validity of yellow fever vaccination for the life of the person vaccinated was adopted in resolution WHA67.13 (2014) and needs to be implemented by all States Parties, to avoid unnecessary interference with international traffic.

CONCLUSION

19. This year marks the 10th anniversary since the Regulations entered into force for the vast majority of States Parties on 15 June 2007. The Regulations have provided a global framework that has contributed significantly to an increase in information sharing, risk assessment and coordination of response in relation to international public health risks and emergencies. These communications have been carried out through the unique global network of National IHR Focal Points, accessible at all times by WHO IHR Contact Points in all six regional offices. The network has further been used for bilateral communications between countries, such as for international contact tracing. Another hallmark of the Regulations has been the convening by the Director-General of a series of emergency and review committees. Since their entry into force, a total of six emergency committees have been established, four of which have resulted in the declaration of a public health emergency of international concern and the issuance of temporary recommendations by the Director-General.90 The other two emergency committees were instrumental in drawing attention to important public health threats that galvanized the international community to take specific steps to tackle critical emerging health events.91 Three review committees have also been convened by the Director-General, with a view to learning lessons from the influenza A(H1N1) 2009 pandemic92 and outbreaks of Ebola virus disease93 in particular, and more generally to take stock of where the global community stands in relation to the functioning and implementation of the Regulations.94 The recommendations from these review committees have paved the way for a more structured approach to implementing the Regulations. To give but one example, the advent of voluntary joint

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external assessments of core capacities derives from a recommendation of the second and third review committees. Finally, the new WHO Health Emergencies Programme further improves the Secretariat’s operational capacity for the timely detection, risk assessment and response to public health emergencies, the management of specific risks associated with high-threat pathogens, and the Secretariat’s support to country health emergency preparedness.

**ACTION BY THE HEALTH ASSEMBLY**

20. The Health Assembly is invited to note the report.

**Document A70/16 (Report by the Secretariat)**

**Global implementation plan**

1. In May 2016, the Director-General submitted the recommendations of the Review Committee on the Role of the International Health Regulations (2005) in the Ebola Outbreak and Response to the Sixty-ninth World Health Assembly. The Health Assembly adopted decision WHA69(14) in which, inter alia, it requested the Director-General “to develop for the consideration of the Regional Committees in 2016 a draft global implementation plan for the recommendations of the Review Committee that includes immediate planning to improve delivery of the International Health Regulations (2005) by reinforcing existing approaches, and that indicates a way forward for dealing with new proposals that require further Member State technical discussions”. It also requested the Director-General to submit the global implementation plan to the Executive Board for consideration at its 140th session.

2. A draft of a global implementation plan was discussed during the subsequent sessions of all six regional committees. Two regions held formal pre-session meetings (Region of the Americas, and South-East Asia Region). Furthermore, technical briefings were given in the margins of the sessions of most of the regional committees. A document incorporating, to the extent possible, the proposals from all six regional committees, was presented to the Executive Board at its 140th session in January 2017.

3. The Executive Board, at its 140th session, requested that further consideration be given to the input from the six regional committees, and that consultations be held with Member States and the finalized global implementation plan be presented to the Seventieth World Health Assembly. This document is a revised version of document EB140/14, which takes account of the comments made by the Executive Board, further consultations with the regional offices, and comments received from Member States during a mission information session held at WHO headquarters on 23 March 2017.

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95 Document A69/21.
96 See documents AFR/RC66/4, CD55/12, Rev.1, SEA/RC69/10, EUR/RC66/26 and EM/RC63/INF.DOC.4. The draft plan was discussed by the Regional Committee for the Western Pacific during consideration of the agenda item on the Asia Pacific Strategy for Emerging Diseases and Public Health Emergencies (document WPR/RC67/9).
97 Document CD55/12, Rev.1 includes (in Annex B) the report of a regional consultation on the draft document; see also decision CD55(DS) of the Directing Council of PAHO.
98 Document SEA/RC69/10 Add.1 provides the conclusions and responses of an informal regional consultation (New Delhi, 18 and 19 August 2016).
OVERVIEW OF THE GLOBAL IMPLEMENTATION PLAN

4. The Review Committee made 12 major recommendations and 62 supporting recommendations. The global implementation plan proposes modalities and approaches for implementing the recommendations, and identifies six areas of action.

5. An overview of the relationship between the areas of action of the draft global implementation plan, the related objectives and timelines, and the recommendations of the Review Committee is provided in Annex 1. The success of the actions proposed relies on three fundamental and interrelated principles: country ownership, WHO’s leadership and effective global partnerships.

6. The proposed areas of action of this global implementation plan are as follows:

- **Area of action 1: Accelerating States Parties’ implementation of the IHR (2005)** – this area addresses recommendations 2, 3, 8, 9 and 10 of the Review Committee;
- **Area of action 2: Strengthening WHO’s capacity to implement the IHR (2005)** – this area addresses recommendations 4 and 12 of the Review Committee, with the exception of recommendations 12.7 and 12.8;
- **Area of action 3: Improving the monitoring and evaluation of and reporting on core capacities under the IHR (2005)** – this area addresses recommendation 5 of the Review Committee;
- **Area of action 4: Improving event management, including risk assessment and risk communication** – this area addresses recommendation 6 of the Review Committee;
- **Area of action 5: Additional health measures and enhancing compliance with the Temporary Recommendations and advice given by the Director-General under the IHR (2005)** – this area addresses recommendation 7 and sub-recommendations 12.7 and 12.8; and
- **Area of action 6: Rapid sharing of scientific information** – this area addresses recommendation 11.

**AREA OF ACTION 1: ACCELERATING STATES PARTIES’ IMPLEMENTATION OF THE IHR (2005)**

7. In order to enhance States’ capacity to comply with the requirements under the IHR (2005) and, in keeping with the recommendations of the Review Committee, WHO will give great importance to:

(a) drafting a five-year global strategic plan to improve public health preparedness and response, which builds on regional efforts and lessons learned, to be submitted to Member States at the Seventy-first World Health Assembly, in May 2018, followed by the development or adaptation of relevant regional operational plans;

(b) providing support to States Parties for developing national action plans taking into account national context, the strategic directions from the global strategic plan, and the relevant regional operational plans;

(c) linking the building of core capacities required by the IHR (2005) with health systems strengthening;

(d) supporting National IHR Focal Points and strengthening their capacities further, including through building a global network of IHR Focal Points;
(e) prioritizing provision of support to States Parties with high vulnerability and low capacity, based on assessments of national core capacities, and other risk assessments,\textsuperscript{100,101}

(f) mobilizing financial resources to facilitate the implementation of the IHR (2005) at the global, regional and national levels.

The five-year global strategic plan

8. The five-year global strategic plan will be drafted on the basis of the following principles: consultation; country ownership; WHO leadership; broad partnerships; an intersectoral approach; integration with the health system; community involvement; focus on fragile context; regional integration; domestic financing for sustainability; balance between legally binding and voluntary elements; and focus on monitoring, results and accountability. Annex 2 presents these guiding principles, including the proposed consultative process for the development of the five-year global strategic plan.

9. The five-year global strategic plan will present the Organization’s approach to strengthening countries’ ability to implement the core capacities detailed in the IHR (2005) as a legally binding obligation and means to ensure national and global preparedness and response to public health events, including emergencies. It will build on and align with existing global strategies (for instance, WHO’s global action plan on antimicrobial resistance) and regional approaches, networks and mechanisms for health emergency preparedness and response such as the Integrated Disease Surveillance and Response\textsuperscript{102} – a strategy of the Regional Office for Africa, the Asia Pacific Strategy for Emerging Diseases\textsuperscript{103} – a common strategic framework for the regions of South-East Asia and the Western Pacific, Health 2020\textsuperscript{104} – a policy framework and strategy for the European Region, the IHR Regional Assessment Commission established by the Regional Committee for the Eastern Mediterranean,\textsuperscript{105} and other regional approaches. The five-year global strategic plan will be developed in consultation with Member States, regional offices and relevant stakeholders by November 2017, and will be submitted for consideration and prospective endorsement by the Seventy-first World Health Assembly in May 2018, through the Executive Board at its 142\textsuperscript{nd} session.

National action plans

10. WHO will work with countries to support the development or strengthening of national action plans for health emergency preparedness, taking into account the differences between countries when it comes to governance and public health capacity. It will provide guidance and technical support in a continuum of assessment, planning, costing, implementation, monitoring and reviewing. The national action plans will be elaborated on the basis of the results of comprehensive country capacity assessments (including annual reporting under the IHR (2005), joint external evaluations, and others), with emphasis on country ownership, intersectoral coordination, and strategic partnerships. Consideration will also be given to the role and involvement of the private

\textsuperscript{100} The INFORM Index for Risk Management is a tool for understanding the risk of humanitarian crises and disasters. Available at: http://www.inform-index.org/Portals/0/InfoRM/INFORM%20Global%20Results%20Report%202017%20FINAL%20WEB.pdf?ver=2016-11-21-164053-717 (accessed 27 April 2017).

\textsuperscript{101} See also document UPDATE. WHO Health Emergencies Programme: progress and priorities. Financing dialogue. 31 October 2016 for the list of WHO Health Emergencies Programme priority countries. Available at: http://www.who.int/about/finances-accountability/funding/financing-dialogue/whe-update.pdf?ua=1 (accessed 27 April 2017).


\textsuperscript{103} http://www.wpro.who.int/emerging_diseases/documents/docs/ASPED_2010.pdf?ua=1 (accessed 1 May 2017).


sector and community and civil society organizations in the assessment, planning and implementation stages. The planning stage will build on existing country processes (for example, the “One Health” approach, antimicrobial resistance initiatives, pandemic preparedness plans, action plans to implement the 2030 Agenda for Sustainable Development, the Sendai Framework for Disaster Risk Reduction) to ensure a holistic approach and avoid duplication.

11. The Secretariat will work with States Parties to encourage international commitment and the allocation of domestic financial resources for the implementation of the national action plans in order to develop and maintain core capacities for surveillance and response, as agreed in the Addis Ababa Action Agenda of the Third International Conference on Financing for Development. When gaps have been identified and areas for investment prioritized, it is crucial that countries rapidly develop estimates of capital and recurrent expenditures needed to bridge them. The Secretariat will develop costing and budgeting models for the national action plans, in the broader context of national health systems strengthening. It will support efforts at the national level to strengthen institutional mechanisms for coordinating international cooperation, based on the principles of effective development cooperation (country ownership, focus on results, inclusive partnerships, transparency and accountability).

12. The development of the national action plans should be aligned with national health sector’s strategies and plans, and, in their development and implementation, they should emphasize coordination of multiple sectors and partners, such as OIE and FAO under the “One Health” approach. Because the core capacities required under the Regulations cut across several sectors, financial and other sectors should be part of the planning process to ensure cross-sector coordination and appropriate financial allocations.

Health systems strengthening and health security

13. The Secretariat will further strengthen the operational links between its work on health systems strengthening and the WHO Health Emergencies Programme, paying particular attention to ensuring a coordinated programme of work in the development of national action plans and in the implementation of capacity-building activities in the areas of human resources for health, health planning (including monitoring and evaluation), health financing and health system resilience. Such stronger links will have a beneficial impact on health security, through the development of core capacities under the IHR (2005), and on universal health coverage, contributing thus to the attainment of the Sustainable Development Goal 3 (Ensuring healthy lives and promote well-being for all at all ages). Building on the work of the WHO regional offices, a technical consultation will take place in the second half of 2017 to develop a framework for integrating essential public health functions, health systems building blocks and the core capacities required by the IHR (2005), to further support the long-term sustainability of investments in and planning for health security for resilient health systems.

14. Through the coordinated programme of work, the Secretariat will provide support to countries for integrating core capacities detailed in the Regulations into the overall health systems strengthening. The programme of work will include work to support: harmonization of guidance for tools for country planning and assessment, such as the Joint Assessment of National Health Strategies and the Joint External Evaluation of core capacities required under the Regulations; integration of health care delivery systems and essential public health functions; and workforce development as a means to strengthen preparedness and response to public health emergencies.

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107 United Nations General Assembly resolution 69/313.
108 Global Partnership for Effective Development Cooperation – principles. (Available at: http://effective cooperation.org/about/principles/. Accessed 1 May 2017.)
National IHR Focal Points

15. The Secretariat will accelerate action to strengthen the capacity of National IHR Focal Points to implement the IHR (2005), including calling for them to play a more prominent role in the broader national public administration, within and beyond the health sector. In addition, it will accelerate the development or revision of standard operating procedures for, and guidelines on the role of, National IHR Focal Points, and make recommendations on endowing them with adequate resources and the authority to fulfil their obligations. This will be achieved for instance through training programmes and the adoption of appropriate national legislation with respect to the functions of National IHR Focal Points. The Secretariat will maintain a strong network of National IHR Focal Points by holding regular regional meetings to build their capacities and share lessons learned. The content of training courses and their accessibility will be expanded through the Health Security Learning Platform in the context of the Regulations; these will include e-learning and real-time, multi-country exercises.

AREA OF ACTION 2: STRENGTHENING WHO’S CAPACITY TO IMPLEMENT THE IHR (2005)

16. The new WHO Health Emergencies Programme will substantially strengthen the capacity of the Organization to implement the IHR (2005). Under the new Programme, the number of personnel dedicated to work on the Regulations, including work on country health emergency preparedness will continue to be considerably increased at all three levels of the Organization, including especially support of countries with high vulnerability and low capacity. Country health emergency preparedness in the context of both the Regulations and the Sendai Framework for Disaster Risk Reduction 2015–2030 is one of the major elements of the results framework for the new Programme, which includes outputs on the monitoring, evaluation and assessment of core capacities for all-hazards emergency risk management, the development of national plans and critical core capacities for health emergency preparedness.

17. To ensure effectiveness and efficiency the WHO Health Emergency Programme will focus on certain priorities including: increasing core operations capacities; developing standardized services for emergency responses; expanding partnership arrangements; and supporting country preparedness. The Programme is also focused on improving all areas of core services in order to underpin preparedness and response, from sustainable financing and staffing, resource mobilization, communication and advocacy to leadership, planning and performance management.

18. In the context of the new Programme, WHO will enhance its collaboration on health emergencies with other entities and agencies both within and outside the UN system. So as to promote the Regulations and their full implementation, WHO will build on its preliminary work to include in the remit of the UN Secretary-General’s Special Representative for Disaster Risk Reduction a mandate to act as an advocate for the Regulations to ensure that they are well understood and positioned prominently across sectors in both governments and international organizations. The result should be improved global awareness and recognition of the Regulations, which would be a powerful signal from outside the Organization about their importance for national governments and not just health ministries.

111 See also related documents: A70/8 Report of the Independent Oversight Advisory Committee for the WHO Health Emergencies Programme; A70/9 WHO response in severe, large scale emergencies; A70/10 Research and development for potentially epidemic diseases; A70/11 Health workforce coordination in emergencies with health consequences.
19. The Inter-Agency Standing Committee is the primary mechanism for the coordination between agencies of international humanitarian assistance and is convened by the UN Emergency Relief Coordinator of the UN Office for the Coordination of Humanitarian Affairs. The Standing Committee’s Principals concurred on the use of the mechanisms of the Standing Committee and the UN Office for the Coordination of Humanitarian Affairs to coordinate the international response to large-scale infectious disease emergencies, under the strategic and technical leadership of WHO. Standard operating procedures for the work of the Standing Committee for level 3 infectious disease emergencies were developed in December 2016.¹¹³ Progress in this regard will be among the issues reported to the Global Health Crises Task Force that has been established by the UN Secretary-General to monitor and support implementation of the recommendations of the High-level Panel on the Global Response to Health Crises.¹¹⁴

20. The WHO Health Emergencies Programme is also establishing mechanisms to strengthen further WHO’s partnership work in respect of the implementation of the Regulations, particularly in collaboration with the Global Outbreak Alert and Response Network the members of the Global Health Cluster, and a range of expert networks. In June and December 2016, the Steering Committee of the Global Outbreak Alert and Response Network agreed on a number of key strategic orientations to further strengthen the Network’s support to WHO and the global capacity for surveillance, risk assessment, rapid international coordination for investigations and timely response.¹¹⁵


21. Following the adoption by the Health Assembly of resolution WHA61.2 (2008) in which it decided that States Parties shall report to it annually on the implementation of the Regulations, the Secretariat developed a reporting instrument for States Parties to conduct annual self-assessments and annual reporting by States Parties.¹¹⁶ The annual reporting process involved the assessment of the implementation of eight core capacities and the development of capacities at points of entry and for hazards covered by the Regulations, notably biological (zoonotic, food safety and other infectious hazards), chemical, radiological and nuclear, based on Annex 1 of the Regulations.

22. The Review Committee on Second Extensions for Establishing National Public Health Capacities and on IHR Implementation recommended in 2014 to move “from exclusive self-evaluation to approaches that combine self-evaluation, peer review and voluntary external evaluations involving a combination of domestic and independent experts.”¹¹⁷ To that end, a concept note¹¹⁸ outlining a new approach was discussed by the WHO regional committees in 2015, and a revised monitoring and evaluation framework was presented to, and noted by, the Sixty-ninth World Health Assembly.¹¹⁹ The IHR Monitoring and Evaluation Framework has four complementary components:

¹¹⁵ The Global Outbreak Alert and Response Network website: https://extranet.who.int/goarn/.
¹¹⁹ See documents A69/20, Annex, and WHA69/2016/REC/3, summary records of Committee A, fifth meeting and seventh meeting, section 1.
States Parties’ annual reporting required under the IHR (2005), and voluntary joint external evaluation, after-action review and simulation exercises.

23. To ensure coherence and consistency between the various instruments, WHO will review the annual reporting tool, and this revised instrument will be proposed to States Parties for future annual reporting. Lessons learned from other instruments will be reviewed regularly by the WHO Secretariat, together with interested countries and technical partners.

AREA OF ACTION 4: IMPROVING EVENT MANAGEMENT, INCLUDING RISK ASSESSMENT AND RISK COMMUNICATION

24. Central to the WHO Health Emergencies Programme is a new single, unified set of procedures across the three levels of the Organization for conducting rapid risk assessments in response to newly detected public health events. The new procedures will involve a systematic assessment of the hazard, exposure, vulnerability and States Parties’ capacities in order to determine whether an event constitutes a low, medium, high or very high risk of amplification and international spread. The results of these risk assessments will be made available to all States Parties, through the IHR Event Information Site, and, in the case of high and very high risk events, will also be directly and immediately communicated to the UN Secretary-General and the Principals of the Inter-Agency Standing Committee.

25. The WHO Health Emergencies Programme will initiate within 72 hours an on-the-ground assessment when notified of the presence or emergence of a high-threat pathogen (for example, human-to-human transmission of a novel influenza virus), clusters of unexplained deaths in high-vulnerability, low-capacity settings, and other events deemed appropriate at the discretion of the Director-General. When feasible, the Programme will engage partner agencies with relevant expertise to assist in such risk assessments. The outcomes will be communicated to the Director-General within 24 hours of completion of the assessment, together with recommendations of the Programme on risk mitigation, management and response measures as appropriate. The Secretariat will continue to improve reporting of events and risk communication through the established channel of the Event Information System, and the development of new epidemiological intelligence tools.

26. WHO will work with partners to harmonize instruments for risk assessment in the fields of humanitarian assistance and infectious diseases epidemics in order to develop a common approach for risk assessment in health emergencies.

27. In May 2016 the Director-General established the Independent Oversight and Advisory Committee for the WHO Health Emergencies Programme, whose main functions include assessing the performance of the Programme’s key functions in health emergencies; determining the appropriateness and adequacy of the Programme’s financing and resourcing; providing advice to the Director-General; and reporting, through the Director-General and the Executive Board, to the Health Assembly on progress in implementing the programme.

28. The Director-General will establish a Technical Advisory Group of Experts on Infectious Hazards that will help to guide the Organization’s work in evaluating and managing new and evolving public health risks, as well as its broader work in the identification, characterization and mitigation of high threat pathogens. The technical advisory group will have no executive, implementation or supervisory functions and will have a clear role that complements the Independent Oversight and

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120 Document A69/30, paragraph 10.
Advisory Committee and the IHR emergency committees. The draft terms of reference for the Technical Advisory Group are presented in Annex 3.


29. The WHO Secretariat will collect, monitor and report on the health measures implemented by States Parties. In this process, the Secretariat will:

   (a) continue to post on its website the health measures required in response to specific public health risks and the temporary recommendations associated with public health emergencies of international concern;

   (b) systematically collect information on additional health measures taken by States Parties, which may interfere with international traffic, and will post all public health measures on its website, including the source of information;

   (c) request the public health rationale and scientific evidence for additional health measures that significantly interfere with international traffic under Article 43 of the IHR (2005), and enhance structured dialogue with States Parties implementing additional health measures that significantly interfere with international traffic under Article 43 of the IHR (2005), through standard operating procedures;

   (d) post, on the password-protected Event Information System website for National IHR Focal Points, the public health rationale and scientific information provided by States Parties implementing additional health measures that significantly interfere with international traffic, under Article 43 of the Regulations; and

   (e) report to the Health Assembly on additional health measures that significantly interfere with international traffic, implemented by States Parties, as part of the Secretariat’s regular reporting on the application and implementation of the IHR (2005).

30. WHO will maintain regular contact with WTO to develop a mechanism to address trade-related issues during public health emergencies of international concern. Furthermore, the Director-General remains prepared to fulfil mandates related to the settlement of disputes as described in Article 56 of the Regulations.

**AREA OF ACTION 6: RAPID SHARING OF SCIENTIFIC INFORMATION**

31. In 2016, the Director-General established new policies and mechanisms, in the context of public health emergencies, for WHO’s sharing of line-listed data with appropriate entities for the purposes of epidemiological studies and mathematical modelling to facilitate understanding of and the response to emergencies, and for ensuring rapid access to new information and data from public health studies and clinical trials to allow the timely application of such data in a response. In this connection, WHO published a statement on its policy on data sharing in the context of public health emergencies in May 2016. This statement concerns data resulting from surveillance, epidemiological and response activities as well as genetic sequences and the findings of observational studies and clinical trials.

Under this policy, the Secretariat will disclose data related to emergency response in

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122 “Significant interference generally means refusal of entry or departure of international travellers, baggage, cargo, containers, conveyances, goods and the like, or their delay, for more than 24 hours” (Article 43.3 of the International Health Regulations, (2005)).

accordance with the relevant provisions of the IHR (2005). These data will be anonymized to protect privacy and to ensure confidentiality, and the Organization will consult affected countries before disclosing data. The Secretariat further underlines the principle that originating parties in data sharing should always receive appropriate attribution and authorship and be supported in accordance with applicable international principles.

32. The sharing of biological samples will be the subject of additional consultations. More specifically, a consultation on WHO’s Research and Development Blueprint related to the elaboration of an online tool to provide guidance on a material transfer agreement was held in December 2016. A consultation on biobanking is planned for April 2017. Also of relevance to the sharing of biological samples are the accompanying reports on the public health implications of the implementation of the Nagoya Protocol and on the review of the Pandemic Influenza Preparedness Framework.

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(b) systematically collect information on additional health measures taken by States Parties, which may interfere with international traffic, and will post all public health measures on its website, including the source of information;

(c) request the public health rationale and scientific evidence for additional health measures that significantly interfere with international traffic under Article 43 of the IHR (2005); and enhance structured dialogue with States Parties implementing additional health measures that significantly interfere with international traffic under Article 43 of the IHR (2005), through standard operating procedures;

(d) post, on the password-protected Event Information System website for National IHR Focal Points, the public health rationale and scientific information provided by States Parties implementing additional health measures that significantly interfere with international traffic, under Article 43 of the Regulations; and

(e) report to the Health Assembly on additional health measures that significantly interfere with international traffic, implemented by States Parties, as part of the Secretariat’s regular reporting on the application and implementation of the IHR (2005).

124 See document A70/57.
127 Document EB140/15.
129 In accordance with decision EB140(5), the Secretariat has continued collaboration with the Secretariat of the Convention on Biological Diversity and other relevant international entities, in the context of existing international commitments on access to pathogens and fair and equitable sharing of benefits, in the interest of public health, and reports thereon to the Seventieth World Health Assembly.
130 “Significant interference generally means refusal of entry or departure of international travellers, baggage, cargo, containers, conveyances, goods and the like, or their delay, for more than 24 hours” (Article 43.3 of the International Health Regulations, (2005)).
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131 Under this policy, the Secretariat will disclose data related to emergency response in accordance with the relevant provisions of the IHR (2005). These data will be anonymized to protect privacy and to ensure confidentiality, and the Organization will consult affected countries before disclosing data. The Secretariat further underlines the principle that originating parties in data sharing should always receive appropriate attribution and authorship and be supported in accordance with applicable international principles.

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133 A consultation on biobanking is planned for April 2017. Also of relevance to the sharing of biological samples are the accompanying reports on the public health implications of the implementation of the Nagoya Protocol and on the review of the Pandemic Influenza Preparedness Framework.

33. As part of the Pandemic Influenza Preparedness (PIP) Advisory Group’s ongoing work on the handling of genetic sequence data under the PIP Framework, the PIP Advisory Group’s Technical Working Group on the Sharing of Influenza Genetic Sequence Data submitted to the Advisory Group on 22 June 2016 the final version of a document entitled “Optimal characteristics of an influenza genetic sequence data sharing system under the PIP Framework”. The document is publicly available

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132 See document A70/57.


135 Document EB140/15.


137 In accordance with decision EB140(5), the Secretariat has continued collaboration with the Secretariat of the Convention on Biological Diversity and other relevant international entities, in the context of existing international commitments on access to pathogens and fair and equitable sharing of benefits, in the interest of public health, and reports thereon to the Seventieth World Health Assembly.
on the WHO website\textsuperscript{138} and provides examples of best practices for the sharing of data in relation to other diseases and public health risks and emergencies.

**ACTION BY THE HEALTH ASSEMBLY**

34. The Health Assembly is invited to endorse the Global Implementation Plan. It is further invited to note that the Global Implementation Plan provides areas of action which will constitute a significant proportion of the five-year global strategic plan. As such, the Health Assembly may wish to consider the five-year global strategic plan as an extension of the Global Implementation Plan, building on the guiding principles presented in Annex 2 of this document.

**ANNEX 1**


(Annex 1 is not included here - for the full text, see http://apps.who.int/gb/ebwha/pdf_files/WHA70/A70_16-en.pdf)

**ANNEX 2**

**DRAFT GLOBAL FIVE-YEAR STRATEGIC PLAN TO IMPROVE PUBLIC HEALTH PREPAREDNESS AND RESPONSE 2018–2022: GUIDING PRINCIPLES**

**Background**

Document EB140/14 (draft global implementation plan for the recommendations of the Review Committee on the Role of the IHR (2005) in the Ebola Outbreak and Response) requests the WHO Secretariat to develop a global five-year strategic plan for public health preparedness and response, to be submitted to the Seventy-first World Health Assembly in May 2018, through the Executive Board at its 142\textsuperscript{nd} session in January 2018.

**Scope**

The global five-year strategic plan will comprise guiding principles and strategic orientations for sustained implementation of the IHR (2005), with the aim of strengthening capacities at the global, regional and country levels to prepare, detect, assess and respond to public health emergencies with the potential for international spread.

**Guiding principles**

The global five-year strategic plan will be developed on the basis of 12 interrelated guiding principles:

1. **Consultation**

The development of the plan will follow a consultative process from May to November 2017, which will comprise specific technical consultations, web-based consultations with Member States, regional technical consultations, and at least one information session for focal points from permanent missions to the UN Office at Geneva. The draft plan will be presented to the Executive Board at its 142\textsuperscript{nd} session in January 2018 for submission to the Seventy-first World Health Assembly in May 2018.

2. Country ownership
Building and sustaining capacity for health security and public health emergency preparedness and response is the primary responsibility of national governments. In this process, governments take into account their national health, social, economic, security and political contexts to develop and implement adequate capacities at national and subnational level.

3. WHO leadership and governance
The WHO Health Emergencies Programme will lead the development and implementation of the global five-year strategic plan for public health preparedness and response. The WHO Secretariat will report on progress to the governing bodies, as part of regular reporting on the application and implementation of the IHR (2005).

4. Broad partnerships
Many countries require technical support to assess and enhance their capacities for health security and public health emergencies preparedness. Many global partners support countries in the field of health security and public health emergencies. As decided by the Fifty-eighth World Health Assembly, WHO will cooperate and coordinate its activities, as appropriate, with the following: United Nations, International Labour Organization, Food and Agriculture Organization, International Atomic Energy Agency, International Civil Aviation Organization, International Maritime Organization, International Committee of the Red Cross, International Federation of Red Cross and Red Crescent Societies, International Air Transport Association, International Shipping Federation, and Office International des Epizooties. Cooperation with other relevant non-State actors and industry associations will also be considered.

5. Intersectoral approach
Responding to public health security threats requires a multisectoral, coordinated approach, (for example with agriculture, transport, tourism, and finance sectors). Many countries already have health coordination platforms or mechanisms in place, such as the “One Health” approach. The Global five-year strategic plan will emphasize the importance of planning for public health preparedness across multiple sectors.

6. Integration with the health system
The Ebola virus disease outbreak has put both health security and health system resilience high on the development agenda. Integrating the core capacities required by the IHR (2005) with the essential public health functions will mutually reinforce health security and health systems, leading to resilient health systems.

7. Community involvement
Effective emergency preparedness can only be achieved with the active participation of local governments, civil society organizations, local leaders, and individual citizens. Communities must take ownership of their preparedness and strengthen it for emergencies that range in scale from local or national events to pandemics and disasters.

8. Focus on fragile context: “we are as strong as our weakest link”
While the WHO Health Emergencies Programme is supporting all countries in their preparation for and response to public health risks and emergencies, the initial focus will be on a set of priority countries in fragile situations. The identification of priority countries will take into account an

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assessments of national core capacities and other risk assessments, for example using the INFORM methodology.\textsuperscript{141}

9. Regional integration
Building on the global five-year strategic plan, WHO regional offices will develop regional implementation plans, taking into account existing regional frameworks and mechanisms, such as: Integrated Disease Surveillance and Response – a strategy of the Regional Office for Africa\textsuperscript{142} the Asia Pacific Strategy for Emerging Diseases – a common strategic framework for the regions of South-East Asia and the Western Pacific,\textsuperscript{143} Health 2020 – a policy framework and strategy for the European Region,\textsuperscript{144} the Regional Assessment Commission for the IHR (2005) established by the Regional Committee for the Eastern Mediterranean,\textsuperscript{145} and other regional approaches.

10. Domestic financing
For long-term sustainability, the budgeting and financing of core capacities required by the IHR (2005) should be supported at least in part from domestic resources. WHO will work with countries to encourage the allocation of domestic financial resources to the national action plans for the development and maintenance of the core capacities for surveillance and response. In countries that require substantial external resources the WHO Secretariat will provide support for strengthening the institutional mechanisms for coordinating international cooperation, based on the principles of effective development cooperation (country ownership, focus on results, inclusive partnerships, transparency and accountability).\textsuperscript{146}

11. Linking the global five-year strategic plan with requirements under the IHR (2005)
The five-year global strategic plan will propose strategic directions in relation to the relevant IHR requirements for States Parties and for WHO, as well as voluntary operational and technical aspects that are not a requirement under the IHR (2005).

12. Focus on results, including monitoring and accountability
The Global five-year strategic plan will have its own monitoring framework, including indicators and timelines, which will be developed through the consultative process, and used for annual reporting on progress to the Health Assembly.

ANNEX 3
DRAFT TERMS OF REFERENCE FOR THE TECHNICAL ADVISORY GROUP OF EXPERTS ON INFECTIOUS HAZARDS

Purpose
The purpose of the Technical Advisory Group of Experts on Infectious Hazards is to provide independent analysis and advice to WHO on infectious hazards that may pose a threat to global health security.


\textsuperscript{143} http://www.wpro.who.int/emerging_diseases/documents/docs/ASPED_2010.pdf?ua=1 (accessed 1 May 2017).


\textsuperscript{145} Global Partnership for Effective Development Cooperation – principles. (Available at: http://effective cooperation.org/about/principles/. Accessed 1 May 2017.)
**Functions**

The functions of the Technical Advisory Group are to:

- review information on new and emerging infectious disease events;
- assess the global context, on a regular basis, for changing determinants of infectious hazards;
- conduct horizon scanning of new and emerging infectious hazards;
- review risk assessments of past events;
- review response to past events;
- provide analysis and advice on priority-setting for WHO’s prevention and preparedness activities related to infectious hazards; and
- provide analysis and advice on new partnerships for greater global health security.

**Structure**

The Technical Advisory Group will comprise up to 10 Members, appointed by the WHO Director-General, in accordance with the WHO Regulations for Expert Advisory Panels and Committees.\(^\text{147}\)

The Chairperson shall be appointed by the Director-General.

The Technical Advisory Group shall report to the Executive Director of the WHO Health Emergencies Programme.

The WHO Health Emergencies Programme will provide the Secretariat functions for the Technical Advisory Group, including for organizing meetings and providing the necessary meeting documentation services.

**Procedures**

The Technical Advisory Group will meet quarterly by teleconference.

WHO will keep the Technical Advisory Group informed, through the Group’s Secretariat, about relevant public health events, the ongoing implementation of long-term prevention and control strategies, and any recommendations from other technical advisory groups.

12.5 Review of the Pandemic Influenza Preparedness Framework

**Document A70/17 (Report by the Director-General):**

1. The Director-General has the honour to transmit to the Health Assembly the report of the 2016 Pandemic Influenza Preparedness (PIP) Framework Review Group (see Annex). An earlier version of the Director-General’s report was considered by the Executive Board at its 140th session in January 2017.\(^{148}\) The Board also adopted decision EB140(5) in which, inter alia, it decided to extend until 28 February 2018 the application of decision EB131(2) (2012) on the PIP Framework for the sharing of influenza viruses and access to vaccines and other benefits.\(^{149}\) The Board’s decision was consistent with the Advisory Group’s recommendation to the Director-General,\(^ {150}\) and will allow the Director-General and the Advisory Group to benefit from the discussions of the Seventieth World Health Assembly in developing the next proposal for the proportional division of funds between pandemic preparedness measures and response activities, to be submitted for consideration by the Executive Board at its 142nd session in January 2018.

**ACTION BY THE HEALTH ASSEMBLY**

2. The Health Assembly is invited to note the report.

**Extract from Report of the 2016 PIP Framework Review Group**\(^ {151}\)

**PREFACE**

The risk of another influenza pandemic is ever-present but its timing and impact is unpredictable. Advance planning and preparedness is key to mitigating the adverse outcomes of future influenza pandemics. This includes building capacity to detect and respond to a public health emergency of international concern.

In 2011, WHO and Member States set up the Pandemic Influenza Preparedness (PIP) Framework as a novel international instrument to strengthen the sharing of influenza viruses with human pandemic potential while increasing the preparedness of developing countries, and their access to vaccines and other pandemic related supplies in the event of a pandemic. All players – WHO, Member States, industry, civil society and other stakeholders – came together with a common purpose to better prepare the world to respond to the next pandemic and reduce uncertainty in our collective ability to share viruses and the benefits.

It has been five years since the PIP Framework was signed; while such new and complex initiatives take time to operationalise, it is now timely to review progress as to whether the PIP Framework has both achieved what was intended and continues to remain relevant looking forward.

As the world faces an increasing number of public health threats with international impact (e.g. Middle East respiratory syndrome coronavirus (MERS-CoV), Ebola virus disease and Zika virus), global solidarity is more important than ever to address critical policy, operational and capacity

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\(^{148}\) Document EB140/16; see also the summary records of the Executive Board at its 140th session, tenth meeting, section 3.

\(^{149}\) See also document A70/57 for the report on the Secretariat’s consultations with the secretariat of the Convention on Biological Diversity, as requested in decision EB140(5).


\(^{151}\) The full report is available at http://apps.who.int/gb/ebwha/pdf_files/WHA70/A70_17-en.pdf.
barriers ahead of an emergency. The PIP Framework offers helpful insights for the sharing of other pathogens that require a rapid response and the equitable sharing of benefits. However, it is the view of the PIP Framework Review Group that the PIP Framework will only remain relevant if viruses continue to be shared and the need for clarification around the sharing of genetic sequence data and benefits is rapidly addressed. In addition, linkages to other efforts to strengthen capacity building (e.g. the International Health Regulations (2005)) and to increase influenza vaccine production are improved to maximise the impact of resources leveraged by the PIP Framework. In order to ensure the PIP Framework remains sustainable and maintains the interest of all major players, it is important that its delivery of results is regularly measured and widely communicated.

Dr Christine Kaseba-Sata (Chair), Dr Theresa Tam (acting Chair)
PPIP Review Group
October 2016,
Geneva, Switzerland

ACRONYMS

CVV    Candidate vaccine virus  
FAO    Food and Agriculture Organization of the United Nations  
GAP    Global Action Plan for Influenza Vaccines  
GIP    WHO Global Influenza Programme  
GISAID Global Initiative on Sharing All Influenza Data  
GISRS Global Influenza Surveillance and Response System  
GSD    Genetic sequence data  
HQ    Headquarters  
IVPP    Influenza viruses with human pandemic potential  
IVTM    Influenza Virus Traceability Mechanism  
MOP    Meeting of the Parties  
NIC    National Influenza Centre  
OIE    World Organisation for Animal Health  
PC    Partnership Contribution  
PIP    Pandemic Influenza Preparedness  
PIP BM    PIP biological materials  
SMTA    Standard material transfer agreement  
WHO CC    WHO Collaborating Centre

EXECUTIVE SUMMARY

Global health security has become an international priority over the past decade, with the recognition that infectious diseases know no borders in a world of shifting populations and vastly expanded international travel. While the 2003 severe acute respiratory syndrome (SARS) outbreak provided a wake-up call, the specific global risks posed by influenza were highlighted by the re-emergence of influenza A(H5N1) in 2003 and the influenza A(H1N1)pdm09\textsuperscript{152} pandemic in 2009. Almost a century after the deadly 1918 influenza pandemic swept the world with devastating consequences, the Report of the Review Committee on the Functioning of the International Health Regulations (2005) (IHR (2005)) in relation to the 2009 A(H1N1) outbreak concluded that the world

\textsuperscript{152} Influenza A(H1N1)pdm09 is the virus responsible for the 2009 influenza pandemic that was declared the first Public Health Emergency of International Concern under the International Health Regulations (2005).
remained “ill-prepared” to respond to a severe influenza pandemic and that “tens of millions” of people would be at risk of dying.\textsuperscript{153}

After the influenza A(H5N1) outbreak in 2003, it became clear that an effective response to an influenza pandemic required closer international collaboration. Such collaboration not only needed to cover the sharing of information and of influenza viruses with human pandemic potential (IVPP), but also the distribution of the benefits that flow from such cooperation, including influenza vaccines and other medical products. Negotiations started on the creation of a new system and four years later, in 2011, an international instrument, the Pandemic Influenza Preparedness (PIP) Framework,\textsuperscript{154} was set up by 194 Member States.\textsuperscript{155} From the start, strong engagement with stakeholders – including Member States, industry and civil society – has been crucial to the implementation of the PIP Framework. Successful implementation of the PIP Framework remains as critical as ever given the continual emergence of new influenza viruses and the ever-present potential of a pandemic.

The PIP Framework aims to balance virus sharing with benefit sharing on an equal footing. Advances in vaccine, antiviral and diagnostic technology alone are not enough to protect a world against a pandemic. Whereas access to health services and products remains unequal around the world, the influenza virus is indiscriminate and all countries can be equally at risk. Consequently, it is vital that the influenza products produced through the rapid sharing of viruses are available to the most vulnerable populations in the time of a pandemic.

Viruses are shared through the Global Influenza Surveillance and Response System (GISRS) of 152 laboratories, including 143 National Influenza Centres (NIC) spread across 113 Member States, six WHO Collaborating Centres for Reference and Research on Influenza (WHO CC), four WHO Essential Regulatory Laboratories (WHO ERL), and 13 WHO H5 Reference Laboratories (WHO H5RL).\textsuperscript{156,157} The Standard Material Transfer Agreement 1 (SMTA1), contained in Annex 1 to the PIP Framework, is a binding contract that establishes the conditions under which GISRS laboratories exchange PIP biological materials (PIP BM) among themselves.

The PIP Framework’s benefit sharing aspect occurs in two ways: SMTA2 and Partnership Contribution (PC).\textsuperscript{158} Non-GISRS entities, such as manufacturers or academic institutions, who receive physical virus samples sign an STMA2, a legally binding agreement to provide products such as vaccines, antivirals and diagnostics in the event of a pandemic. Influenza vaccine, pharmaceutical


\textsuperscript{157} Outside GISRS there are also influenza laboratories authorized and designated by a Member State to provide PIP BM to GISRS. These laboratories are either in Member States that do not have a NIC or are additional laboratories carrying out certain roles usually performed by NIC.

and diagnostic manufacturers who use GISRS also pay annual PC funds totalling US$ 28 million, which are used to bolster pandemic Preparedness and Response.

The first review of the PIP Framework

At the start of this Review, the PIP Framework had been implemented for five years. This first review was provided for under section 7.4.2 of the PIP Framework, which states that the PIP Framework and its Annexes should be reviewed by 2016 “with a view to proposing revisions reflecting developments as appropriate, to the World Health Assembly in 2017, through the Executive Board”.

The PIP Framework Advisory Group (the “Advisory Group”) met in a Special Session on 13−14 October 2015 with Member States, industry and other stakeholders, and recommended that an independent group of experts be established to review implementation of the PIP Framework. The Director-General convened the Review Group, consisting of eight experts with wide-ranging expertise, covering all WHO regions and with a good gender balance. As part of its terms of reference, the Review Group was asked to focus on three questions:

1. What are the achievements since the PIP Framework was adopted?
2. Has implementation of the PIP Framework improved global pandemic influenza preparedness, including inter-pandemic surveillance, and capacity to respond?
3. What are the challenges, and possible ways of addressing them?

The Review Group was appointed in December 2015. In addition to analysing the sharing of IVPP through GISRS, the collection of PC and its implementation through five Areas of Work, the signing of SMTA2, and the governance of the PIP Framework, the Review Group also looked at other key contextual and implementation issues including: the handling of genetic sequence data (GSD) under the PIP Framework; linkages with other programmes or instruments (specifically the Global Action Plan for Influenza Vaccines (GAP), the IHR (2005), the implementation of the Nagoya Protocol); interactions with key partners in the PIP Framework, including industry, civil society and other stakeholders; and collateral benefits that may have resulted from implementation of the PIP Framework.

During 2016, the Review Group met several times face to face at WHO Headquarters (HQ) in Geneva and held a number of teleconferences. To inform its deliberations, the Review Group actively sought input from WHO staff, Member States and many key stakeholders, including representatives of GISRS, industry, civil society organizations, and relevant databases. This engagement took place through individual interviews, written submissions, an electronic open consultation process that included questions for response, and two open consultation meetings at WHO HQ. Following several of the Review Group meetings, the Review Group held debriefing and question/answer sessions for

Member States at WHO HQ that were open to all stakeholders and the public via a live webcast on the WHO website.163

The main report begins with an introduction to the PIP Framework and its component parts, followed by a brief description of the Review Group’s Method of Work. The remainder of the report presents the Review Group’s Findings and Recommendations. This Executive Summary summarizes the main Findings and reproduces all the Recommendations.

Findings and recommendations

Overarching analysis

Summary of Findings:
The Review Group found that the PIP Framework is a bold and innovative tool for pandemic influenza preparedness, is being well implemented, and that the principle of the PIP Framework of placing virus sharing and benefit sharing on an equal footing remains relevant today. The implementation of the PIP Framework has led to greater confidence and predictability in the global capacity to respond to an influenza pandemic. The PIP Framework’s success is due in part to the regular, committed engagement by WHO and Member States with key stakeholders including industry, civil society, and others. However, while there are regular reports on the implementation of the PIP Framework, the various elements could be better brought together to give a clearer picture of overall progress.

It is also clear that there are key issues that must urgently be addressed for the PIP Framework to remain relevant, including the issue of how GSD should be handled under the PIP Framework, and whether or not the PIP Framework could be expanded to include seasonal influenza, or indeed be used as a model for the sharing of other pathogens.

Recommendations:
1. WHO should develop a comprehensive evaluation model, including overall success metrics for the PIP Framework for annual reporting. Such reporting should include an infographic that illustrates the status of overall progress in implementing the PIP Framework to allow for greater clarity on progress towards pandemic preparedness and response.
2. WHO should regularly and more effectively communicate the objectives and progress in the implementation of the PIP Framework to Members States, GISRS laboratories, industry, civil society, and other stakeholders. In particular, it should better communicate:
   a. Progress against the comprehensive evaluation model;
   b. PC implementation measures; these should be highlighted in regular Advisory Group reports and post-meeting briefings so that progress is more visible and clearly recognized;
   c. Communication and transparency should be enhanced around issues such as selection of countries to receive PC implementation support for improved understanding of the PIP Framework among Member States;
   d. The significance of stakeholder voluntary contributions, and in-kind Member States’ commitments, including support and maintenance of GISRS through provision of routine running costs of laboratories.

3. The Director-General should undertake a study to determine the implications and desirability of including seasonal influenza viruses in the PIP Framework.

4. The PIP Framework is a foundational model of reciprocity for global public health that could be applied to other pathogens; however, the current scope of the PIP Framework should remain focused on pandemic influenza at this time.

5. Member States should agree the timing of the next review of the PIP Framework, which should be before the end of 2021.

**Virus Sharing**

**Summary of Findings:**
GISRS has expanded in scope and been strengthened since the PIP Framework was adopted in 2011, and provides significant benefits to Member States, including risk assessment, candidate vaccine viruses (CVV), diagnostic kits, reagents, training, capacity building and other expertise. Virus sharing via GISRS generally works well. However, despite a prompt and comprehensive response to the emergence of the H7N9 strain in 2013, there has since been a reduced sharing of IVPP from some countries. At the Advisory’s Group request, the Secretariat is studying the reasons for this reduced sharing.

GISRS collaborates closely with the animal sector to conduct risk assessment and develop CVV; these links between the human and animal sectors are especially important when the sharing of human viruses is delayed, and include relationships with the Food and Agriculture Organization of the United Nations (FAO), the World Organisation for Animal Health (OIE), and the OFFLU (the joint OIE-FAO network of animal influenza experts).

Although the Influenza Virus Traceability Mechanism (IVTM) is vital in tracking the sharing of viruses, and thereby triggering the PIP Framework’s benefit sharing mechanisms, it is not consistently used by all laboratories.

**Recommendations:**

6. The Review Group welcomes the PIP Framework Secretariat’s study of the reasons for the recent decline in the sharing of influenza viruses with human pandemic potential. The Advisory Group should, as a priority, follow-up on the results of this study in order to ensure the timely sharing of all viruses.

7. Given the recent decline in the sharing of influenza viruses with human pandemic potential, WHO should continue to provide technical operational guidance and training for NIC to ensure that they are fully aware of their roles as agreed in the SMTA1, the effective use of the IVTM, and the importance of appropriate sharing of all PIP BM and GSD.

8. WHO should provide clarification to GISRS laboratories on the interpretation of the terms “timely” and “as feasible” with respect to the sharing of PIP biological materials from all cases of A(H5N1) and other IVPP (section 5.1.1 of the PIP Framework).

9. Although GSD do not fully substitute for the physical virus, in cases where it is not possible to ship PIP BM rapidly, GSD should, if available, be shared immediately.

10. The WHO Global Influenza Programme (GIP) should strengthen contacts and linkages with, and processes between, the GISRS system and non-GISRS laboratories and other networks.

11. WHO, GISRS, the FAO, OIE, OFFLU and others should collaboratively establish guidance for GISRS and animal laboratories to strengthen their relationships and enhance surveillance and risk assessment of influenza viruses at the animal-human interface.
Genetic Sequence Data

Summary of Findings:
Due to the complexities of its handling under the PIP Framework, GSD was not included in the definition of PIP BM when the PIP Framework was set up. Thus, while the sharing of viruses is tracked via the IVTM, the sharing of GSD is not, and therefore does not trigger specific benefit sharing under the PIP Framework. However, as technology advances, GSD is becoming increasingly critical in influenza research, and can in some cases substitute for physical samples for pandemic risk assessment and the development of commercial products. Therefore, clarity is urgently required on the handling of GSD under the PIP Framework.

Some good progress has already been made by the Advisory Group in examining possible approaches to handling GSD under the PIP Framework. A key challenge has been the lack of agreement on what should be traced. Options could include tracking access to GSD or tracking the commercial products developed using such data. Transparency in both the sharing and traceability of GSD is crucial in order to identify any resulting benefit that should be shared.

There are a range of players involved in the discussion of how to handle GSD and diverse views about the optimal traceability and monitoring system. It is clear from the Review Group’s interviews and wider discussions that there also remains some confusion among stakeholders as to the potential options for future sharing of GSD.

Recommendations:
12. The Director-General should request Member States to consider amending the definition of PIP BM in section 4.1 of the PIP Framework to include GSD.

13. The Director-General should request Member States to consider clarifying Annex 4, section 9, which currently states that “The WHO GISRS laboratories will submit genetic sequences data to GISAID and Genbank or similar databases in a timely manner consistent with the Standard Material Transfer Agreement”, by amending it to:
   “The WHO GISRS laboratories will submit genetic sequences data to one or more publicly accessible database of their choice in a timely manner consistent with the Standard Material Transfer Agreement”.

14. The Director-General should request Member States to consider updating and correcting the statement in section 5.2.2 of the PIP Framework, which currently states “Recognizing that greater transparency and access concerning influenza virus genetic sequence data is important to public health and there is a movement towards the use of public-domain or public-access databases such as Genbank and GISAID respectively;” by amending it to:
   “Recognizing that greater transparency and access concerning influenza virus genetic sequence data is important to public health and use is made of public-domain or public-access databases such as GenBank and/or GISAID, respectively;”

15. It is critical that the PIP Framework adapts to technological developments, and that the Advisory Group produces with urgency recommendations to clarify the handling of GSD. The Advisory Group should consider asking WHO CC to report on how GSD are actually handled, with a view to providing information about the operational realities in GISRS in relation to the acquisition, sharing and use of such data, to inform the Advisory Group’s recommendations on the optimal handling of GSD under the PIP Framework.

16. The Director-General should enlist the support of Member States to ensure that influenza virus GSD remain publicly accessible in sustainable databases, to enable timely, accurate and accessible sharing of these data for pandemic risk assessment and rapid response.
17. Noting that GSD may be generated from many entities outside of GISRS, and that there are diverse views on the optimal traceability and monitoring mechanism, the Advisory Group should give consideration to broadening and deepening engagement with all stakeholders.

**Benefit Sharing**

**Standard Material Transfer Agreement 2 (SMTA2)**

**Summary of Findings:**

The SMTA2 signed so far have secured access to approximately 350 million doses of pandemic vaccine to be delivered in real time during an influenza pandemic. However, PIP Framework options for SMTA2 commitments from manufacturers of other pandemic products (such as diagnostics, syringes, etc.) are too narrow, and need to include a wider choice of commitments.

Good progress on securing prequalified vaccines and antivirals has been achieved through the PIP Framework Secretariat’s strategic approach of prioritizing agreements with large companies with prequalified vaccines before moving on to negotiations with medium to small companies. In order to facilitate negotiations of SMTA2, the PIP Framework Secretariat has developed tools that outline the technical requirements, such as prequalification, export procedures and regulatory approvals, which must be fulfilled by signatories to SMTA2.

The regularity and high quality of communication between the PIP Framework Secretariat and industry and other stakeholders has helped to facilitate the conclusion of SMTA2. On the few occasions when negotiations have been complicated or have stalled, the PIP Framework Secretariat has successfully implemented the stepwise approach recommended by the Advisory Group to progress towards conclusion of the agreements.

The fulfilment of SMTA2 agreements at the time of a pandemic outbreak will be critical to pandemic response. Member States with in-country influenza vaccine production capacity need to recognize the SMTA2 commitments of the manufacturer(s) to their pandemic influenza response plans.

**Recommendations:**

18. The PIP Framework Secretariat should improve communication of progress and achievements in securing SMTA2 by better highlighting the rationale and prioritization strategy for concluding these agreements, and clarifying the intended use of the antivirals, vaccines and other products secured through these agreements.

19. The PIP Framework Secretariat should develop, for consideration by the Advisory Group, and ultimate decision-making by Member States, an approach to include the provision of financial contributions, specimen collection and processing materials as options for category B SMTA2 commitments in Annex 2.

20. The Director-General should consider requesting that Member States remove section 6.9 in the PIP Framework on pandemic influenza preparedness vaccine stockpiles, since it is no longer relevant.

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21. The Director-General should request Member States with in-country vaccine production capacity to commit to allow manufacturers to release to WHO on a real-time basis, pandemic vaccines and other products secured by WHO under SMTA2.

22. WHO should rapidly finalize and communicate the Interim Pandemic Influenza Risk Management (PIRM) Framework, which will provide clarity on the implementation of the switch from seasonal to pandemic vaccine production.

**Partnership Contribution collection**

**Summary of Findings:**
The involvement of industry in the collaborative development\(^{166}\) of the PC formula has achieved its strong buy-in, and has resulted in early contribution payments being made in 2012, and the collection of 96\(^{167}\)% of the overall funds due for 2013 and 2014. However, not all companies pay their contributions by the expected deadline, which is of concern since the PC mechanism relies on all stakeholders fulfilling their obligations.

Several industry representatives have highlighted as an issue that the fluctuation in the amount of PC they are asked to pay each year poses budgetary challenges, and they would prefer to pay a set amount.\(^{168}\) Consistent with the recommendation of the Advisory Group in April 2016,\(^{169}\) industry has begun a consultative process to review the PC formula, working with all relevant industry sectors (vaccine, diagnostics and pharmaceuticals) and the PIP Framework Secretariat.\(^{170}\)

A survey of GISRS running costs was undertaken for this Review: the estimates from 41 laboratories are that their total annual running costs alone are approximately US$ 39 million. Although this figure is preliminary, and should be studied further, this indicates that total running costs for the whole of the GISRS system are likely to have increased from the 2010 estimate.

**Recommendations:**

23. The Advisory Group should consider updating the 2010 estimate of GISRS running/operating costs, as input to a revision of the PC formula calculation, in collaboration with industry, to facilitate the timely payment of PC, and its sustainability as a financing mechanism for implementation of the PIP Framework.

24. Given the successful use, following a recommendation by the Advisory Group, of a stepwise approach for the agreement of SMTA2, the Advisory Group should consider developing a similar escalation response to underpayment, late payment or default of PC.

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**PC implementation**

**Summary of Findings:**
Since PC funds began to be distributed in 2014, the implementation of the PC mechanism has allowed countries to develop multi-year plans and has fostered sustained and meaningful capacity building in priority countries in each of the five Areas of Work for Preparedness (Laboratory and Surveillance; Burden of Disease; Regulatory Capacity building; Planning for Deployment; and Risk Communication). A Response fund has also been established for use by WHO at the time of a pandemic outbreak.

However, expenditure does not always keep pace with collection, leading to a mistaken perception among some stakeholders that either additional Preparedness funds are not needed or that work plans are failing to be implemented according to planned timeframes.

The PIP Framework Secretariat communicates regularly about the achievements and challenges of PC implementation. Nevertheless, stakeholders regularly raise specific issues with WHO concerning: (1) dissatisfaction that PC funds continue to be collected while the Response funds are left untouched, which seemingly indicates a lack of understanding that the Response Fund is a contingency fund to enable rapid response at the start of a pandemic, and that the value of the Response funds is far below what will be needed at the time of a pandemic outbreak; (2) the basis on which recipient priority countries are selected, even though the criteria and process for selection have been published, though this could indicate the desire of certain countries to be put on this list; and (3) a lack of understanding of how PC funds are building capacity in countries to increase preparedness for pandemic influenza.

**Recommendations:**

25. The Advisory Group should consider for inclusion in the 2018–2022 Partnership Contribution Implementation Plan, the development of process measures to enable better monitoring of progress for key Areas of Work.

26. The Advisory Group should request regular financial reports and audits and ensure that appropriate financial accountability mechanisms are in place; it should also request the PIP Framework Secretariat to illustrate how the PC Response funds will be severely inadequate in a pandemic.

**Governance**

**Summary of Findings:**
The PIP Framework has a well functioning governance structure that oversees how the PIP Framework is operationalized. It has benefited from strong commitment at each of WHO’s three levels: HQ; Regional Offices; and Country Offices. The Advisory Group continues to play a key role in effective governance by providing impartial, committed, and pragmatic oversight and guidance, representing its independent deliberations. However, Advisory Group members usually leave after completing individual terms of three years, meaning that there can be gaps in knowledge continuity.

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172 See Recommendation 2(b) of this report, which states: “WHO should regularly and more effectively communicate the objectives and progress in the implementation of the PIP Framework to Members States, Global Influenza Surveillance and Response System (GISRS) laboratories, industry, civil society, and other stakeholders. In particular, it should better communicate:

b. Partnership Contribution implementation measures; these should be highlighted in regular Advisory Group reports and post-meeting briefings so that progress is more visible and clearly recognized.”
Although the Advisory Group’s Annual Reports\textsuperscript{173} to the Director-General and the Director-General’s Biennial Reports\textsuperscript{174} to the World Health Assembly are comprehensive and well received, the formats and contents differ, leading to inefficient preparation of information.

Some GISRS members, notably WHO CC, feel there should be greater interaction between themselves, the Advisory Group, and the PIP Framework Secretariat, including in the setting up of technical working groups and the subsequent selection of experts. The regular, direct contact that occurs between the Advisory Group and industry/civil society groups might also be helpful if it included GISRS representatives.

An objective of the PIP Framework (section 2) is to strengthen GISRS, and the geographical reach, scope and functioning of GISRS has expanded since 2011. However, the leadership of this network remains largely informal, with the system being coordinated through GIP. The lack of a formalized leadership structure from within GISRS has led to the absence of recognized representation for the entire GISRS network in PIP Framework operations.

Under the 2016 reform of WHO’s work in health emergency management, all WHO’s work in emergencies was brought under a new Health Emergencies Programme, including the Secretariat of the PIP Framework.\textsuperscript{175} WHO’s commitment to the PIP Framework remains unchanged by this internal reorganization. The PIP Framework Secretariat is significantly dependent on close collaboration with many technical units of WHO, especially GIP, which is the technical influenza unit that underpins the implementation of the PIP Framework.

Recommendations:

27. The Director-General should consider options for retaining continuity and knowledge in the Advisory Group, including members being able to serve a second term of flexible duration.

28. The structure of the Advisory Group’s Annual Reports to the Director-General and the Director-General’s Biennial Reports to the World Health Assembly should be harmonized to simplify reporting.

29. The PIP Framework Secretariat and Advisory Group should broaden and deepen engagement with civil society to a greater number of participating organizations.

30. Noting the critical role of the WHO CC in the GISRS network, the Advisory Group should undertake more regular engagement with the WHO CC and other key GISRS laboratories, including when setting up technical working groups.

31. The Director-General should address the issue of the lack of a formalized representation for the GISRS network, and encourage GIP and GISRS to establish such representation as soon as possible.

32. The Director-General should ensure that any internal reorganization of WHO departments under the new Health Emergencies Programmes should ensure that the activities of GISRS and the PIP Framework remain closely aligned and integrated with GIP to ensure stronger scientific and technical leadership in the implementation of the PIP Framework.


\textsuperscript{174} Ibid.

33. The Director-General should continue to make available the necessary human and financial resources to implement the growing activities of the PIP Framework and the Recommendations of this Review.

**Linkages with WHO programmes and other legal instruments**

**GAP**

**Summary of Findings:**
There are important synergies between the PIP Framework and the GAP programme. This includes the encouragement of technology transfers and capacity-building for burden of disease studies, regulatory authorities and risk communications. However, technology transfer agreements are currently not being obtained through SMTA2.

The November 2016 review of GAP will be available to feed into an assessment of which aspects of GAP (burden of disease studies, technical guidance to new vaccine manufacturers, vaccine deployment, or logistics), might be continued as part of the PIP Framework’s implementation of PC.

The quantity of pandemic influenza vaccines secured by the PIP Framework, as well as global vaccine production capacity (including new vaccine capacity available through the GAP programme) currently remain insufficient to meet anticipated global demand at the time of an influenza pandemic.

**Recommendation:**
34. The PIP Framework Advisory Group should consider lessons learned from GAP, which closed in November 2016, to identify any aspects that would support implementation of the PIP Framework.

**IHR (2005)**

**Summary of Findings:**
PIP Framework PC funds may have additional benefits in improving IHR (2005) core capacities, especially in the areas of laboratory and surveillance capacity. However, since PC funds only began to be distributed in 2014, data on the relationship between PC implementation funds and IHR (2005) core capacities are not yet available. An analysis of PC funds’ impact on IHR (2005) core capacities could be undertaken in the next review of the PIP Framework.

**Recommendation:**
35. Activity under the PIP Framework should be undertaken with the provisions of the IHR (2005) in mind, and capacity-building efforts should be aligned, supportive and complementary to those under the IHR (2005). This could be addressed by closer interaction at all three levels of WHO regarding implementation of the IHR (2005) and the PIP Framework to maximise synergies and efficiencies.

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176 The objectives of the GAP programme centre around increasing influenza vaccine manufacturing capacity for developing countries, and include an increase in the manufacture and use of seasonal vaccine, an increase in vaccine production capacity for pandemic vaccine, and relevant research and development. GAP was developed by WHO together with public health and academic experts, vaccine manufacturers and funding agencies from developed and developing countries. The third and final GAP consultation took place in November 2016.

**Nagoya Protocol**

**Summary of Findings:**
The PIP Framework is a multilateral access and benefit sharing instrument that appears to be consistent with the objectives of the Nagoya Protocol on Access to Genetic Resources and the Fair and Equitable Sharing of Benefits Arising from their Utilization to the Convention on Biological Diversity. The intergovernmental negotiation of the PIP Framework established rules for access to IVPP and sharing of benefits; by contrast, the implementation of the Nagoya Protocol may introduce uncertainty in relation to the sharing of influenza viruses, since numerous bilateral transactions could be required to be negotiated, which could delay the access to viruses. As more countries put in place domestic legislation to implement the Nagoya Protocol, the urgency increases to resolve this uncertainty and reduce the risk to global health security.

The public health implications of the implementation of the Nagoya Protocol are not yet widely understood. While the WHO Secretariat is producing a report to clarify these implications, better knowledge, understanding and awareness of the Protocol are required in the public health sector.

The Nagoya Protocol does not expressly identify a mechanism to recognize an instrument under its Article 4(4). The Review Group understands that an authoritative, formal and internationally credible entity such as the Meeting of the Parties (MOP) or World Health Assembly could make a decision that the PIP Framework constitutes a specialized international instrument for pandemic influenza preparedness and response. In this case, the decision should facilitate fulfilment of the PIP Framework’s access and benefit sharing objectives by ensuring that all countries would handle IVPP in the same way. IVPP access and sharing would be covered for Nagoya Protocol purposes by the PIP Framework, and therefore not require bilateral agreements on a case-by-case basis.

**Recommendation:**

36. The PIP Framework should be considered as a specialized international instrument to clarify the implementation of the Nagoya Protocol in relation to pandemic influenza preparedness and response:

- The December 2016 MOP of the Nagoya Protocol provides an opportunity to consider recognizing the PIP Framework as a specialized international instrument for pandemic influenza preparedness and response. In the view of the Review Group, it would serve the aims of the PIP Framework if the MOP took up this opportunity.
- Further, the 2017 World Health Assembly should address the recognition of the PIP Framework as a specialized international instrument under the Nagoya Protocol.

![Figure. Top 10 achievements of the PIP Framework](attachment:top-10-achievements.png)
**Preparedness, surveillance and response**
The World Health Minute is a one-stop public health news intelligence source reporting on what the global press is saying about each of the WHA agenda issues from preparedness to the elections. Here is a sample of articles printed on 17 May for issues related to preparedness, surveillance and response. For more information see www.worldhealthminute.com.

### World Health Minute – Extract example from May 17 2017 issue

- **Malaria has killed 268 people in three months in the Angolan province of Bie**
  In Angola local health authorities said there have been 43,893 cases of malaria and 268 deaths in the province of Bie during the first three months of the year, this is up slightly on last year’s figures (observador.pt: 15/05/17) (noticiasao miminuto.com: 15/05/17) (dn.pt: 15/05/17)

- **No vaccine roll out in DRC yet despite new Ebola infections – but WHO is preparing if needed**
  WHO said it is working with specialists to conduct an epidemiological investigation to better understand the extent of the current outbreak and to establish who is at risk of becoming infected with Ebola. Therefore its experts have not yet decided whether to use newly developed vaccines to try to contain the outbreak in the DRC, but officials are making preparations just in case (businesslive.co.za: 15/05/17) (theaustralian.com.au: 16/05/17)

- **Four die from cholera, dozens of new cases in Sudan’s White Nile state**
  Four people died from cholera Thursday and Friday and dozens of new cases have been recorded in the White Nile state of Sudan, all the while, Sudanese government officials remain silent. The situation is getting out of control as the number of people infected is rapidly increasing in the areas of El Gezira, Aba, Kosti and Rabak, a civil society organization official on the ground told Radio Dabanga (dabangasudan.org: 14/05/17) (africa24.com: 14/05/17)

- **Cholera death toll in Yemen reaches at least 184 – Red Cross**
  Cholera has killed at least 184 people in Yemen in recent weeks, the ICRC said on Monday, a day after authorities declared a state of emergency and called for international aid. After more than two years of war which has destroyed much of the nation's infrastructure only a few medical facilities are still functioning and two-thirds of the population are without access to safe drinking water (reuters.com: 15/05/17) (cnn.com: 15/05/17) (aljazeera.com: 15/05/17) (wsj.com: 15/05/17) (sky.com: 15/05/17) (voa.com: 15/05/17) (france24.com: 15/05/17) (cbc.com: 15/05/17) (reuters.com: 15/05/17) (cnn.com: 14/05/17)

- **Dengue tightens its grip on the city**
  Thruvananthapuram: The dengue-stricken capital has more to worry about as the healers are becoming sick. As of Monday, 50 dengue cases were reported among staff at the General Hospital. This hospital is also dealing with a blood shortage and an ever increasing incidence of dengue cases. One member of the hospital staff has even died from dengue. Times of India reports a lack of availability of preventative vaccines and adequate mosquito control measures in the hospital have added to the crisis (timesofindia.indiatimes.com: 15/05/17)

- **89 chikungunya cases reported so far this year**
  Delhi has already recorded 89 cases of chikungunya so far this year, while there had been no cases of the disease before July last year, according to health data released on Monday. As per this report, there were 89 cases of chikungunya, 36 cases of dengue and 15 cases of malaria as of May 13 (thehindu.com: 16/05/17) (arunchaltimes.in: 16/05/17) (millenniumpost.in: 15/05/17)

- **There is a dengue epidemic in the Piura region and also cases now in Lima - WHO**
  The World Health Organization’s Raul Gonzalez spoke to the media and said there is a dengue epidemic in the Piura region and in the north of the country and added there are cases of dengue in Lima (peru21.pe: 15/05/17) (peru.com: 15/05/17) (gestion.pe: 15/05/17)

- **The yellow fever virus in Brazil has the potential for a number of genetic mutations**
  The current yellow fever virus in Brazil has a built-in number of unprecedented genetic variations, according to researchers at the Oswaldo Cruz Institute. They detected eight possible mutations in the genetic sequence of the virus, seven of them associated with the viral replication mechanism. The Institute says that there is no previous record of such mutations in any world scientific literature (noticias.uol.com.br: 15/05/17) (g1.globo.com: 15/05/17) (folha.uol.com.br: 15/05/17) (globo.globo.com: 15/05/17) (veja.abril.com.br: 15/05/17) (agenciabrasil.ebc.com.br: 15/05/17)

- **Five people have died from influenza H3N2 in Bolivia**
  The Bolivian health authorities confirmed there were 455 cases of H3N2 at a national level and 38 cases of H1N1 and 58 influenza type B. They also confirmed at least five people had died from the current outbreak (hoyentv.com: 15/05/17) (tvn-2.com: 15/05/17) (paginasiete.bo: 14/05/17)
13. Health systems

13.1 Human resources for health and implementation of the outcomes of the UN High-Level Commission on Health Employment and Economic Growth

Document A70/18 (Report by the Secretariat):

1. The Executive Board at its 140th session noted a prior version of this report and adopted decision EB140(3) requesting the Director-General to finalize, in collaboration with ILO, OECD and relevant regional and specialized entities, in consultation with Member States, a draft five-year action plan 2017–2021 and to submit that draft action plan for consideration by the Seventieth World Health Assembly. This updated report provides additional information on the consultative process towards a five-year action plan (paragraph 8) and on resolution 71/159 (Global health and foreign policy: health employment and economic growth) that was adopted by the United Nations General Assembly in December 2016 (paragraph 10). It also contains the draft five-year action plan (2017–2021) “Working for health” (see Annex), which aims to support implementation of the recommendations of the United Nations High-Level Commission on Health Employment and Economic Growth in line with WHO’s global strategy on human resources for health: Workforce 2030 (adopted in May 2016 in resolution WHA69.19).

2. Following the request by the General Assembly in resolution 70/183 (2015) to explore steps to meet the global shortfall of trained health workers, the United Nations Secretary-General launched the High-Level Commission on 2 March 2016. Its task was to make recommendations to stimulate and guide the creation of at least 40 million new jobs in the health and social sectors, and to reduce the projected shortfall of 18 million health workers, primarily in low- and lower-middle-income countries, by 2030. The Commission was designed as a strategic political initiative to create momentum towards the implementation of WHO’s global strategy on human resources for health.

3. The Commission, chaired by the Presidents of France and South Africa with the heads of ILO, OECD and WHO as Vice-Chairs, submitted its report Working for health and growth: investing in the health workforce to the Secretary-General on 20 September 2016. The Commission’s report, through its 10 recommendations and five immediate actions, gives the necessary political and intersectoral momentum to the implementation of WHO’s global strategy on human resources for health, with particular attention to the WHO Global Code of Practice on the International Recruitment of Health Personnel (adopted in 2010 in resolution WHA63.16) and the need to transform health workforce education in support of universal health coverage (resolution WHA66.23 (2013)).

4. This report provides a summary of the Commission’s recommendations and their linkages to existing decisions and resolutions of the Health Assembly, United Nations General Assembly and United Nations Security Council.

THE COMMISSION’S RECOMMENDATIONS AND IMMEDIATE ACTIONS

5. In recognition of the impact of the health workforce on attainment of all the relevant Sustainable Development Goals, commissioners were appointed from the education, employment, health, labour and foreign affairs sectors of governments and international organizations, and from health professional associations, trade unions, academia and civil society. An independent expert group

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178 See document EB140/17, decision EB140(3) and the summary records of the Executive Board at its 140th session, eighth meeting, section 3 and ninth meeting.
179 Available at http://www.who.int/hrh/com-heeg/ (accessed 5 April 2017).
and a joint secretariat of staff members from ILO, OECD and WHO consolidated the available evidence and enabled technical and online consultations with multiple constituencies, including five technical consultations with Member States and other relevant stakeholders, 149 online submissions and 17 background papers.\(^{180}\)

6. The Commission’s report presents evidence from the health and social sector, taking economic and labour perspectives, highlighting its capacity as a crucial source of future jobs, particularly for women and young people.\(^{181}\) The Commission concludes that “to the extent that resources are wisely spent and the right policies and enablers are put in place, investment in education and job creation in the health and social sectors will make a critical positive contribution to inclusive economic growth.”

7. The Commission puts forward six recommendations to transform the global health workforce so as to be able to meet the needs for achieving the Sustainable Development Goals, with focus on the following areas: job creation, gender and women’s rights, education training and skills, health service delivery and organization, technology, and crises and humanitarian settings. An additional four recommendations, in the areas of financial and fiscal space, partnerships and cooperation, international migration, and data, information and accountability, are made to enable this transformation.

8. Stressing the need for urgency, the Commission identifies five immediate actions to be taken between October 2016 and March 2018. These include the development of a five-year action plan, enhanced accountability, accelerated and progressive implementation of national health workforce accounts, the establishment of an interagency data exchange on the health labour market, creation of an international platform on health workers’ mobility to maximize mutual benefits, and the transformation and massive expansion of professional, technical and vocational education and training, skills and jobs. A high-level ministerial meeting was held in Geneva on 14 and 15 December 2016 to propose actions and launch a consultative process that can take these recommendations forward.\(^{182}\) The meeting brought together more than 200 participants, including ministers of education, health, labour and foreign affairs as well as representatives from international organizations, civil society, health worker organizations and unions, the private sector, academia and others to garner commitment and momentum for health and social workforce investment and action. Twenty-six statements of commitment were presented. Two online consultative processes were held with Member States and other relevant stakeholders to provide inputs into the development and finalization of the five-year action plan in October–November 2016 and January–February 2017, respectively. An information session for health and labour attachés in permanent missions in Geneva was also held at WHO with ILO and OECD in February 2017. In the course of both consultative processes, more than 60 submissions were received and used to inform the five-year action plan. Submissions were jointly reviewed by the secretariats of ILO, OECD and WHO, categorized into themes, validated against original submissions, and considered in the revised version.

\(^{180}\) All the information is available through the following link: http://www.who.int/hrh/com-heeg/ (accessed 5 April 2017).


\(^{182}\) The outcome is published on the WHO website at: http://www.who.int/hrh/com-heeg/high-level_meeting/en/ (accessed 5 April 2017).
LINKAGES TO EXISTING DECISIONS OF THE WORLD HEALTH ASSEMBLY, UNITED NATIONS GENERAL ASSEMBLY AND UNITED NATIONS SECURITY COUNCIL

9. The Commission’s recommendations and immediate actions reinforce the pressure to implement WHO’s global strategy on human resources for health and prior resolutions of the Health Assembly related to human resources for health.\textsuperscript{183} They also call for further strengthening of the health workforce implicit within related Health Assembly resolutions on the IHR (2005) and those relating to humanitarian settings and public health emergencies.\textsuperscript{184} The Commission and the draft five-year action plan emphasize the need to ensure the protection and safety of health workers, as called for by United Nations General Assembly resolution 69/132 (2014) and United Nations Security Council resolutions 2175 (2014) and 2286 (2016).

10. The Commission’s report was welcomed by the General Assembly in resolution 71/159 (2016)\textsuperscript{185} in which it recognized “the need for consideration of and action on its recommendations with the aim of contributing to global inclusive economic growth and the creation of decent jobs and achieving universal health coverage, and for the effective implementation of the 2030 Agenda for Sustainable Development and to meet the targets of the Sustainable Development Goals”. The General Assembly encourages Member States to strengthen their institutional mechanisms to coordinate an intersectoral health workforce agenda and urges them to consider the recommendations of the Commission. The General Assembly called upon Member States to make greater investments and promote decent work with adequate remuneration in the health and social sectors, enable safe working environments and conditions, effective retention and equitable and broad distribution of the health workforce, and strengthen capacities to optimize the existing health workforce, to contribute to the achievement of universal health coverage. The General Assembly also requested the Secretary-General in close collaboration with the Directors-General of ILO and WHO, as well as other relevant international organizations, to report to the General Assembly at its seventy-second session on the operationalization of the immediate actions and the five-year action plan.

11. The Commission’s recommendations and immediate actions align closely with WHO’s priorities in support of universal health coverage, with specific links to integrated people-centred health services, meeting workforce requirements for preparedness and response to emergencies, demographic and epidemiological transitions (for example, ageing populations and the increasing importance of noncommunicable diseases), WHO’s gender strategy and related area of work, and International Health Partnership for Universal Health Coverage 2030.\textsuperscript{186}

12. Through its recommendations and immediate actions the Commission aims to deliver gains across the 2030 Agenda for Sustainable Development, including those in particular towards SDG 1 (End poverty in all its forms everywhere), 3 (Ensure healthy lives and promote well-being for all at all ages), 4 (Ensure inclusive and equitable quality education and promote lifelong learning opportunities for all), 5 (Achieve gender equality and empower all women and girls) and 8 (Promote sustained, inclusive and sustainable economic growth, full and productive employment and decent work for all). The development of the draft five-year action plan is a unique example of the type of

\textsuperscript{183} Resolution WHA63.16 (2010) adopting the WHO Global Code of Practice on the International Recruitment of Health Personnel, resolution WHA64.7 (2011) on strengthening nursing and midwifery, and resolution WHA66.23 (2013) on transforming health workforce education in support of universal health coverage.

\textsuperscript{184} For instance, resolution WHA64.10 (2011) on strengthening national health emergency and disaster management capacities and the resilience of health systems; see also decision WHA68(10) (2015) which contains a section on the global health emergency workforce and document A68/27 on global health emergency workforce.

\textsuperscript{185} On global health and foreign policy: health employment and economic growth.

\textsuperscript{186} http://www.internationalhealthpartnership.net/en/ (accessed 20 October 2016).
interagency and intersectoral collaboration required for effective progress towards the goals of the 2030 Agenda.

ACTION BY THE HEALTH ASSEMBLY

13. The Health Assembly is invited to note the report and consider the draft five-year action plan 2017–2021.

ANNEX
WORKING FOR HEALTH
DRAFT FIVE-YEAR ACTION PLAN FOR HEALTH EMPLOYMENT AND INCLUSIVE ECONOMIC GROWTH (2017–2021)

Summary

One vision: Accelerate progress towards universal health coverage and attaining the goals of the 2030 Agenda for Sustainable Development by ensuring equitable access to health workers within strengthened health systems

Two goals: Invest in both the expansion and transformation of the global health and social workforce

Three agencies: International Labour Organization (ILO), Organisation for Economic Cooperation and Development (OECD) and the World Health Organization (WHO)

Four Sustainable Development Goals: Ensure healthy lives and promote well-being for all at all ages (Goal 3); Ensure inclusive and equitable quality education and promote lifelong learning opportunities for all (Goal 4); Achieve gender equality and empower all women and girls (Goal 5); and Promote sustained, inclusive and sustainable economic growth, full and productive employment and decent work for all (Goal 8)

Five workstreams: To facilitate the implementation of intersectoral approaches and country-driven action and catalyse sustainable investments, capacity-building and policy action: (1) advocacy, social dialogue and policy dialogue; (2) data, evidence and accountability; (3) education, skills and jobs; (4) financing and investments; and (5) international labour mobility.

1. Background

1. In its report entitled Working for health and growth: investing in the health workforce, the High-Level Commission on Health Employment and Economic Growth (“the Commission”) proposed 10 recommendations and five immediate actions to transform the health and social workforce for the achievement of the 2030 Agenda for Sustainable Development. Implementation of these will require game-changing interventions and action by Member States, led by ministries of health, education, employment and finance, as well as the international community.

2. Dismantling the long-held belief that investment in the health workforce is a drag on the economy, the Commission found that health workforce investments coupled with the right policy action could unleash enormous socioeconomic gains in quality education, gender equality, decent work, and sustainable economic growth.

work, inclusive economic growth, and health and well-being. This paradigm shift provides new political impetus for Member States to implement WHO’s global strategy on human resources for health: Workforce 2030188 adopted by the Sixty-ninth World Health Assembly in May 2016.189

3. The Commission identifies the health and social sector190 as a major and growing source of employment, and as strategic areas for investment that translate into more decent work opportunities than most other industries and sectors, particularly for women and young people.191 As populations grow and change, the demand for health workers is estimated to almost double by 2030 with the expected creation of around 40 million new health worker jobs, primarily in upper-middle and high-income countries.192 Each health and social worker job is supported on average by at least two additional jobs in other occupations in the broader health economy, offering the potential for job creation in and beyond the health and social sector. Few economic sectors present opportunities for steady growth in decent work, especially in light of large potential job losses in other economic sectors due to rapid technological advances and the changing organization of production and work.193

4. However, the projected growth in jobs takes place alongside the potential shortfall of 18 million health workers if universal health coverage is to be achieved and sustained by 2030, primarily in

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189 Resolution WHA69.19.
190 Note that the draft five-year action plan includes all occupations that contribute towards improved health and well-being in the health and health-related social care sectors, and thus refers to the health and social workforce engaged in health care in all its deliverables.
low- and middle-income countries as envisaged in WHO’s global strategy on human resources for health. Without targeted interventions, the situation in resource-constrained settings could be further exacerbated by increased labour mobility towards countries with the greatest demands, thereby undermining already vulnerable health systems. Investing in the quality of jobs in terms of working conditions, labour protection and rights at work is the key to retaining health workers where they are needed.

5. The Commission called for immediate, bold and game-changing interventions to challenge the status quo and alter the projected trends in the health and social workforce. Achieving a sustainable health and social workforce is an intersectoral pursuit that requires coordinated leadership and action across the sectors of government responsible for finance, labour, education, health, social affairs and foreign affairs, as well as close collaboration with employers’ and health workers’ organizations, professional associations and other key stakeholders. Ten recommendations and five immediate actions (Table 1) are proposed in the pursuit of the Sustainable Development Goals.

Table 1. Recommendations and immediate actions from the High-Level Commission on Health Employment and Economic Growth

<table>
<thead>
<tr>
<th>Recommendations</th>
<th>Immediate actions by March 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Transforming the health workforce</strong></td>
<td>A. Secure commitments, foster intersectoral engagement and develop an action plan</td>
</tr>
<tr>
<td>1. Stimulate investments in creating decent health sector jobs, particularly for women and youth, with the right skills, in the right numbers and in the right places.</td>
<td>B. Galvanize accountability, commitment and advocacy</td>
</tr>
<tr>
<td>2. Maximize women’s economic participation and foster their empowerment through institutionalizing their leadership, addressing gender biases and inequities in education and the health labour market, and tackling gender concerns in health reform processes.</td>
<td>C. Advance health labour market data, analysis and tracking in all countries</td>
</tr>
<tr>
<td>3. Scale up transformative, high-quality education and life-long learning so that all health workers have skills that match the health needs of populations and can work to their full potential.</td>
<td>D. Accelerate investment in transformative education, skills and job creation</td>
</tr>
<tr>
<td>4. Reform service models concentrated on hospital care and focus instead on prevention and on the efficient provision of high-quality, affordable, integrated, community-based, people-centred primary and ambulatory care, paying special attention to underserved areas.</td>
<td>E. Establish an international platform on health worker mobility</td>
</tr>
<tr>
<td>5. Harness the power of cost-effective information and communication technologies to enhance health education, people-centred health services and health information systems.</td>
<td></td>
</tr>
</tbody>
</table>
6. There is no one path to effective implementation of the Commission’s recommendations and immediate actions. To be effective, the implementation of the Commission’s recommendations must be driven by Member States and be aligned and integrated with national and regional priorities and related agendas on health, social protection, employment and economic growth across sectors. Policies and action must be implemented through continuous social dialogue with representatives of employers and health and social workers. Current and future trends and needs must be anticipated and taken into account to ensure equity and inclusivity, such as demographic and epidemiological changes, migration flows, climate change, inequities in access to health services, technological advancements and socioeconomic transitions. Investments must be coupled with a transformative agenda and the right policies to ensure that they result in achieving the right skills for the right jobs, in the right places.

7. ILO, OECD and WHO organized the High-Level Ministerial Meeting on Health Employment and Economic Growth (Geneva, 14 and 15 December 2016) and presented for a first round of consultation a draft plan for how the three agencies can support their Member States in translating the recommendations of the Commission into action. WHO’s Executive Board at its 140th session in January 2017 in turn requested the Director-General in decision EB140(3) to finalize the five-year action plan in time for the Seventieth World Health Assembly in May 2017 – in collaboration with ILO, OECD and relevant regional and specialized entities and in consultation with Member States.

8. Two rounds of open consultation have informed the development of this action plan, with more than 60 contributions both before (25 October–11 November 2016) and after (15 December 2016–17 February 2017) the High-Level Ministerial Meeting on Health Employment and Economic Growth. The draft action plan was also discussed with more than 80 representatives of permanent missions to the United Nations in Geneva through an information session on 9 February 2017. The contributions highlight the breadth of Member States and stakeholders across sectors that are actively working towards adopting and implementing the Commission’s recommendations at national, regional and international levels.

Objectives of the draft five-year action plan

9. The five-year action plan is a joint intersectoral programme of work across ILO, OECD and WHO that is critical to supporting Member States in the effective implementation of the Commission’s recommendations in line with WHO’s global strategy on human resources for health. With the aim of supporting and facilitating country-driven implementation, it sets out how the three agencies will

| Enabling change | 7. Raise adequate funding from domestic and international sources, public and private where appropriate, and consider broad-based health financing reform where needed, to invest in the right skills, decent working conditions and an appropriate number of health workers. |
| | 8. Promote intersectoral collaboration at national, regional and international levels; engage civil society, unions and other health workers’ organizations and the private sector; and align international cooperation to support investments in the health workforce, as part of national health and education strategies and plans. |
| | 9. Advance international recognition of health workers’ qualifications to optimize skills use, increase the benefits from and reduce the negative effects of health worker migration, and safeguard migrants’ rights. |
| | 10. Undertake robust research and analysis of health labour markets, using harmonized metrics and methodologies, to strengthen evidence, accountability and action. |

| Enabling change | 11. Advance international recognition of health workers’ qualifications to optimize skills use, increase the benefits from and reduce the negative effects of health worker migration, and safeguard migrants’ rights. |
| | 12. Undertake robust research and analysis of health labour markets, using harmonized metrics and methodologies, to strengthen evidence, accountability and action. |

| Enabling change | 13. Advance international recognition of health workers’ qualifications to optimize skills use, increase the benefits from and reduce the negative effects of health worker migration, and safeguard migrants’ rights. |
| | 14. Undertake robust research and analysis of health labour markets, using harmonized metrics and methodologies, to strengthen evidence, accountability and action. |
work with Member States and key stakeholders as they translate the Commission’s recommendations into action in line with national, regional and global plans and strategies. As such, the action plan is a good example of the type of collaborative partnerships between international agencies that are needed to support Member States in realizing the 2030 Agenda.

10. The action plan does not prescribe the actions of Member States or key stakeholders required to implement the Commission’s recommendations. Rather, it sets out the deliverables that ILO, OECD and WHO will generate in order to respond to the expected demands and requests of Member States, employers’ and workers’ organizations and other key stakeholders. Where applicable and requested by Member States, the organizations could engage in technical cooperation, convening and coordination, capacity development, research, facilitating investments and financing, and normative guidance.

11. The specific objectives of the five-year action plan are to:

(a) facilitate Member States’ implementation of intersectoral, collaborative and integrated approaches and country-driven action that advance the Commission’s recommendations and immediate actions in line with WHO’s global strategy on human resources for health.

(b) catalyse and stimulate predictable and sustainable investments, institutional capacity-building, and transformative policy action and practice in the health and social workforce, with special consideration to priority countries where universal health coverage and the Commission’s recommendations are least likely to be attained.194

**Approach**

12. The leadership and stewardship role of Member States and other key stakeholders are critical to implementation of the Commission’s recommendations in line with WHO’s global strategy on human resources for health and guided by resolution WHA69.19 (2016) adopting that strategy and the United Nations General Assembly’s resolution 71/159 (2016) on Global health and foreign policy: health employment and economic growth. All stakeholders have a critical role to play and must work together across sectors of education, health, labour, finance and foreign affairs to invest in and transform current health workforce models to be sustainable and fit-for-purpose.

13. Country ownership, all-of-government approaches, social dialogue and outreach to other partners are essential foundations for the implementation of the Commission’s recommendations. With this action plan ILO, OECD and WHO, together with other partners and global initiatives working on relevant goals of the 2030 Agenda (for example, for quality education, youth employment, gender equality, and sustainable business) can support and facilitate country-driven action.

14. By joining forces ILO, OECD and WHO will be better able to work with Member States in the formulation of comprehensive, intersectoral and integrated national health workforce strategies. Using their convening power and drawing on their data and analytical work, the three organizations can facilitate concerted tripartite social dialogue195 and improved health labour market data and evidence, which are critical to the formulation of a new generation of national health workforce strategies and the mobilization of domestic and international resources to implement these (Fig. 1).

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194 Priority countries were defined by the Commission’s report as countries where universal health coverage and the Commission’s recommendations are least likely to be attained. Criteria will be developed by the organizations which could be used by Member States to determine eligibility to access enhanced, targeted support.

195 Social dialogue includes all types of negotiation, consultation or simply exchange of information between, or among, representatives of governments, employers and workers, on issues of common interest relating to economic and social policy.
Investments coupled with the transformation and expansion of education, skills and decent job creation will contribute towards a sustainable health workforce, and in doing so, achieve socioeconomic dividends across Goals 3, 4, 5 and 8.

**Fig. 1. Theory of change**

15. The five-year action plan demonstrates how ILO, OECD and WHO will respond to each recommendation with a number of deliverables at the national, regional and global level that will support Member States in translating these recommendations into action, and also realize related goals of WHO’s global strategy on human resources for health and the global strategic directions for strengthening nursing and midwifery.\(^{196}\) The deliverables will be organized through five workstreams that respond to the available global strategies and recommendations, with priorities set for each year through operational planning processes (Table 2).

**Table 2. Workstreams mapped to global strategies and recommendations**

<table>
<thead>
<tr>
<th>Workstreams</th>
<th>Commission’s recommendations and immediate actions</th>
<th>WHO’s global strategy’s objectives</th>
<th>Strategic directions for strengthening nursing and midwifery thematic areas</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Advocacy, social dialogue and policy dialogue. Galvanizing political support and momentum and building intersectoral commitment at the global, regional and national levels, and strengthening social dialogue and policy dialogue for investments and action.</td>
<td>1–10, A, B</td>
<td>1, 2, 3, 4</td>
<td>2, 4</td>
</tr>
<tr>
<td>2. Data, evidence and accountability. Strengthening data and evidence through implementation of the national health workforce</td>
<td>10, C</td>
<td>3, 4</td>
<td>1, 2</td>
</tr>
</tbody>
</table>

accounts and the Global Health Labour Market Data Exchange; enhancing accountability through monitoring, review and action; and strengthening knowledge management.

3. Education, skills and jobs. Accelerating the implementation of intersectoral national health workforce strategies designed to achieve a sustainable health workforce.

4. Financing and investments. Supporting Member States in catalysing sustainable financing for increased investments in health and social workforces through financing reforms and increased domestic and international resources.

5. International labour mobility. Facilitating policy dialogue, analysis and institutional capacity-building to maximize mutual benefits from international labour mobility.

16. Activities integral to each workstream include: analysis and research, advice on norms and international labour standards, technical cooperation, coordination, knowledge management, institutional capacity-building and catalytic resource mobilization. Operational plans will be produced including programmatic details on the activities towards achieving implementation of deliverables, targets, timeframes, qualitative and quantitative metrics for monitoring and evaluation, the specific roles of each agency, collaboration with stakeholders and resource requirements at national, regional and international levels.

17. There are important interconnections between the workstreams that will be factored into the technical design and operational planning. For example, stimulating investments in creating decent health sector jobs must be connected to efforts to transform and expand education and life-long learning, take into account reforms in service delivery, and be appropriately financed.

1. Key principles

18. The implementation of the five-year action plan will follow the key principles of:

(a) supporting the achievement of the 2030 Agenda for Sustainable Development

(b) being guided by United Nations General Assembly resolutions, World Health Assembly resolutions, normative frameworks and instruments, and International Labour Standards

(c) being country-led and driven, with the agencies working in close consultation with governments, employers and workers’ organizations as well as other key partners at the country, regional and global levels

(d) focusing on making an impact and achieving tangible results at the country level and in key sectors

(e) combining immediate action and longer-term strengthening of laws, policies and institutions

(f) making full use of institutional mandates, strengths and value-added activities across three agencies without duplication; including utilizing existing initiatives, knowledge platforms, networks and lessons learned, particularly those related to education and skills, gender equality, youth employment and decent work, health emergencies amongst others

(g) harnessing and building on credible data and analysis to monitor progress and impact at the national, regional and global levels.
2. Key cross-cutting considerations

19. Key cross-cutting considerations that underpin the five-year action plan and approach include the following:

(a) **Labour market approach.** A labour market approach will be applied in health and social workforce analysis, action and investments, taking full consideration of the dynamics and drivers across sectors (Fig. 2). This approach includes analysis of the education sector, pre-service education systems, available workforce pool (for example, demographics, skills and distribution), life-long learning systems (for example, continuing professional development and continuing education), employment, and workforce investments against current and future population health and social care needs. A suite of appropriate policies, reforms, regulatory frameworks and incentives may be required to address labour market and public failures identified through labour market analysis.

(b) **Coherence and coordinated action across sectors.** Coordinated intersectoral analysis, action and investments across education, health, social, labour, finance, and foreign affairs sectors are critical to effective progress. Policy coherence and alignment across sectors are also essential.

(c) **Decent work.** Health and social workforce investments and interventions must strive towards ensuring decent work for all available and future jobs across the health economy. Attention must be paid to improving working conditions, job security and occupational health and safety as well as the effective recognition and application of labour rights.

(d) **Gender equality.** Gender equality will be mainstreamed as a cross-cutting goal in gender-transformative investments and actions for the health and social workforces. Gender inequalities must be analysed and redressed; an example is women’s provision of unpaid care in the absence of social protection and skilled care workers. Ensure women are appropriately represented in social dialogue mechanisms. Strengthen and use sex-disaggregated data; undertake gender analysis as an integral part of labour market analysis; and develop and strengthen national health workforce strategies, policies and investments that address identified gender biases and inequalities, including gender-sensitive considerations regarding women’s security, working conditions and mobility.

(e) **Youth empowerment.** Opportunities to improve the quality of education, education opportunities, human capital, decent work and career pathways for youth will be maximized. Empower young people and people from vulnerable and disadvantaged communities, including indigenous communities.

(f) **Social dialogue.** Social dialogue between governments, employers and workers as well as other relevant health sector stakeholders will be strengthened as a fundamental process in health and social workforce policy development. Social dialogue facilitates consensus building and contributes positively to health sector reforms and is particularly important in times of structural change.

(g) **Needs-based, fit-for-purpose health and social workforce.** Health and social workforce investments and actions must respond to the current and future needs of populations not only for universal health coverage, but also global health security. Policies should take into account demographic changes, technological changes, inequities in access to health and social services, and socioeconomic transitions. The workforce should be geared towards the social determinants of health, health promotion, disease prevention, primary care and people-centred, integrated, community-based services; including all types of health and social sector workforce. Coherent public action with partnerships with a range of stakeholders is urgently required to develop labour market policies conducive to stimulating demand for a sustainable health workforce, particularly in underserved areas.
(h) **Maximize available opportunities and reinforce linkages with existing initiatives.** Existing opportunities and mechanisms across agencies will be utilized to the greatest extent possible through available projects, collaborations and initiatives, and strengthening international, South–South and triangular cooperation to streamline efforts towards the implementation of the five-year action plan.

(i) **Sustainability.** Reforms and improved use and management of existing financing opportunities will be advocated and supported. Sustainable financing strategies for health workforce investments must be expanded, including general budget, progressive taxation, social health insurance, earmarked funds, and the private sector.

(j) **Public health and protracted emergencies, and humanitarian settings.** Take special consideration of the specificities of the health labour market and challenges in the education and training of health workers, decent work, and the protection and security of health workers in public health, protracted emergencies and humanitarian settings.

Fig. 2. Public policy levers to shape health labour markets

![Diagram showing public policy levers to shape health labour markets]

* Supply of qualified health and social workforce willing to work

** Demand for health and social workforce in the health and health-related social care sectors

**Coordinating implementation of the five-year action plan**

20. ILO, OECD and WHO will oversee and coordinate the implementation of the five-year action plan (Table 3) through regular decision-making meetings at the senior management level; a Steering Committee of the three organizations is being established for that purpose. Working under the direction of the Steering Committee, a joint Technical Secretariat will be responsible for developing annual operational plans, ensuring effective implementation, communications and knowledge management, stakeholder management, consultative processes, monitoring and evaluation, and reporting. Expertise across the three organizations will be organized into the five workstreams to design and implement the technical strategy required to implement the action plan at national, regional and global levels. A high-level Advisory Committee will provide strategic input and political support.

21. Effective implementation of the five-year action plan will require intersectoral and multistakeholder engagement and collaboration. Regular consultative processes with Member
States and key stakeholders will be embedded into the implementation process of the five-year action plan to facilitate input and technical exchange. ILO, OECD and WHO will explore engagement with key stakeholders across sectors at global, regional and national levels as an integral part of conducting their work and drawing on available institutional capacities to derive added value in implementing the action plan in the most effective and efficient way. A website will be established as an online knowledge platform to strengthen intersectoral knowledge management, coordination, analysis, and dissemination of evidence and best practice to inform intersectoral plans, actions and investments.

22. The Global Health Workforce Network,\(^{197}\) coordinated by WHO at the request of Member States, will serve as a mechanism across all workstreams to engage other United Nations agencies, organizations and stakeholders across sectors in the implementation process of the five-year action plan at national, regional and global levels.

23. With the exception of a limited number of deliverables which can be achieved through existing programmes with available institutional resources, additional resources will be required by ILO, OECD and WHO to achieve the deliverables articulated in this action plan.

**Monitoring, evaluation and reporting**

24. As described in the Commission’s report, success will be measurable by the extent to which progress is achieved on the relevant targets and indicators for Sustainable Development Goals 3, 4, 5 and 8. Process metrics including qualitative and quantitative measures will be developed as part of annual operational plans for regular monitoring, evaluation and reporting.

25. The first report on the operationalization of the immediate actions and the five-year action plan will be submitted in September 2017 for consideration by the United Nations General Assembly at its seventy-second session, as requested in its resolution 71/159. Annual progress reports, with formal reporting on performance against the five-year action plan, will be submitted to the Health Assembly, aligned with reporting on the implementation of WHO’s global strategy on human resources for health.

**Table 3. Five-year action plan deliverables\(^{198}\)**

<table>
<thead>
<tr>
<th>Cross-cutting immediate actions (2017–March 2018)</th>
<th>Deliverables</th>
<th>Lead*</th>
<th>Partner</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Commitments and expressions of support by the governing bodies of ILO, OECD, WHO, partner organizations and international decision-making forums secured.</td>
<td>ILO, OECD, WHO</td>
<td>ILO, OECD, WHO</td>
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<td>4. An online knowledge platform established to strengthen intersectoral knowledge management, coordination, analysis, and dissemination of evidence and best practice to inform health and social workforce plans, actions and investments.</td>
<td>ILO, OECD, WHO</td>
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\(^{198}\) Supporting documents from the consultation exercises and frequently asked questions are available on the WHO website at: http://who.int/hrh/com-heet/action-plan-annexes/en/.
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<th>Recommendations</th>
<th>Deliverables</th>
<th>Lead[^a]</th>
<th>Partner</th>
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<td>1. Stimulate investments in creating decent health sector jobs, particularly for women and youth, with the right skills, in the right numbers and in the right places.</td>
<td>1.1 Capacity of governments, employers’ associations and trade unions and other key stakeholders in the health and social sectors strengthened to establish dialogue mechanisms and engage in social dialogue processes.</td>
<td>ILO</td>
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<td>1.2 Development of international, regional and national tripartite dialogue across health, education, finance and labour sectors supported as a step towards strengthening or producing national health workforce strategies.</td>
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<td>1.3 Labour market, gender and fiscal space analysis supported and institutional capacity strengthened for the development of policy options to inform national health workforce strategies, financing reforms and investments.</td>
<td>WHO, ILO, OECD</td>
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<td>1.4 Development and implementation of national health workforce strategies, medium-term fiscal frameworks and investments supported with technical assistance and institutional capacity-building to ensure decent work, gender-transformative approaches, and current and future sustainable health workforce.</td>
<td>WHO, ILO, OECD</td>
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<td>1.5 Alignment of domestic resources and official development assistance with national health workforce strategies and investments facilitated.</td>
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<td>2. Maximize women’s economic participation and foster their empowerment through institutionalizing their leadership, addressing gender biases and inequities in education and the health labour market, and tackling gender concerns in health reform processes.</td>
<td>2.1 Gender-transformative[^b] global policy guidance developed and regional and national initiatives accelerated to analyse and overcome gender biases and inequalities in education and the health labour market across the health and social workforce (for example, increasing opportunities for formal education, transforming unpaid care and informal work into decent jobs, equal pay for work of equal value, decent working conditions and occupational safety and health, promoting employment free from harassment, discrimination and violence, equal representation in management and leadership positions, social protection/child care, and elderly care).</td>
<td>ILO, OECD, WHO</td>
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<td>2.2 Gender-transformative policy development and implementation capacity to overcome gender biases and inequalities in education and the health labour market supported.</td>
<td>ILO, WHO</td>
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<td>3. Scale up transformative, high-quality education and life-long learning so that all health workers have skills that match the health needs of populations and can work to their full potential.</td>
<td>3.1 Transform and expand education and lifelong learning and intersectoral coordination integrated in the development and implementation of health workforce strategies.</td>
<td>WHO</td>
<td>ILO, OECD</td>
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<td>3.2 Massive scale-up of socially accountable and transformative professional, technical and vocational education and training supported with technical cooperation, institutional capacity-building and financing.</td>
<td>WHO</td>
<td>ILO</td>
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<td>3.3 Professional, technical and vocational education, training and lifelong learning systems strengthened for health and social occupations (including community-based health workers) to achieve integrated people-centred care.</td>
<td>WHO</td>
<td>ILO, OECD</td>
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\[^a\] Recommendations are implemented by the lead agency (ILO, WHO, OECD) and may be supported by other entities whenever relevant.

\[^b\] Gender-transformative approaches seek to re-define women’s and men’s gender roles and relations to promote gender equality and achieve positive development outcomes by transforming unequal gender relations in order to promote shared power, control of resources, decision-making, and support for women’s empowerment.
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<th>3.4 Develop skills assessment tools and approaches to evaluate the skills of the health and social workforce, including assessment of skills mix, shortages and mismatches to support greater alignment of skills with jobs and integrated people-centred care.</th>
<th>OECD</th>
<th>ILO, WHO</th>
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<td>4. Reform service models concentrated on hospital care and focus instead on prevention and on the efficient provision of high-quality, affordable, integrated, community-based, people-centred primary and ambulatory care, paying special attention to underserved areas.</td>
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<td>4.1 Governance, regulation, accreditation and quality-improvement mechanisms improved and supported with guidance and institutional capacity-building to ensure safe, ethical, effective and people-centred practice that protects the public’s interests and rights.</td>
<td>WHO, ILO</td>
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<td>4.2 Guidance developed for provision of interprofessional education and organization of multidisciplinary care, including recommendations on skills mix and competencies to achieve integrated people-centred care.</td>
<td>WHO</td>
<td>OECD</td>
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<td>4.3 Evidence and guidance developed on practices to ensure an adequate proportion of the workforce in primary health care appropriately distributed to achieve equitable access in underserved areas and for marginalized groups (for example, recruitment practices, education methods, professional development opportunities, and incentive structures).</td>
<td>ILO, WHO</td>
<td>OECD</td>
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<td>5. Harness the power of cost-effective information and communication technologies to enhance health education, people-centred health services and health information systems.</td>
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<td>5.1 Efficacy and efficiency of information and communication tools with a target product profile that could enhance health worker education, people-centred health services and health information systems mapped, reviewed and disseminated for national adoption.</td>
<td>WHO</td>
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<td>6. Ensure investment in the IHR (2005) core capacities, including skills development of national and international health workers in humanitarian settings and public health emergencies, both acute and protracted. Ensure the protection and security of all health workers and health facilities in all settings.</td>
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<td>6.1 Workforce strategies for full implementation of the International Health Regulations (2005), emergency and disaster risk management and response capacity integrated into national health workforce and emergency strategies and supported.</td>
<td>WHO</td>
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<td>6.2 Evidence and guidance on metrics, methodologies, practices, reporting and information systems that improve the security and protection of health workers in all settings strengthened, including humanitarian and emergency settings.</td>
<td>WHO</td>
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<td>6.3 Capacities of high-risk countries to protect occupational health and safety of health and emergency aid workers strengthened.</td>
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<td>7. Raise adequate funding from domestic and international sources, public and private where appropriate, and consider broad-based health financing reform</td>
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<td>7.1 National health workforce strategies and global, regional and national institutional financing reforms that identify and commit adequate budgetary resources for investments in transformative education, skills and job creation developed and supported.</td>
<td>WHO</td>
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<td>7.2 Sustainable financing for expanding and transforming the health and social workforce expanded, particularly for countries where universal health coverage and the Commission’s recommendations are least likely to be attained.</td>
<td>WHO</td>
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<td>Action</td>
<td>Responsible Organizations</td>
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<td>where needed, to invest in the right skills, decent working conditions and an appropriate number of health workers.</td>
<td>7.3 Mechanisms to track the alignment of official development assistance for education, employment, gender, health and skills development with national health workforce strategies strengthened.</td>
<td>WHO, OECD</td>
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<td>7.4 Tools and methodologies to analyse health and social workforce productivity, performance and wages reviewed and advanced.</td>
<td>WHO, ILO, OECD</td>
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<td>8. Promote intersectoral collaboration at national, regional and international levels; engage civil society, unions and other health workers’ organizations and the private sector; and align international cooperation to support investments in the health workforce, as part of national health and education strategies and plans.</td>
<td>8.1 The Global Health Workforce Network engaged to support coordination, alignment and accountability for WHO’s global strategy on human resources for health and implementation of the Commission’s recommendations with international, regional and national stakeholders.</td>
<td>WHO, ILO, OECD</td>
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<td>8.2 Intersectoral collaboration and coordination for the implementation of national health workforce strategies strengthened and capacity developed among relevant ministries (for instance, health, social, labour, education, finance, and gender), professional associations, labour unions, civil society including women’s civil society organizations, employers, the private sector, local government authorities, education and training providers and other constituencies.</td>
<td>ILO, WHO</td>
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<td>8.3 Global health initiatives ensure that all grants and loans include an assessment of health workforce implications and align contributions with implementation of national health workforce strategies beyond disease-specific in-service training and incentives.</td>
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<td>9. Advance international recognition of health workers’ qualifications to optimize skills use, increase the benefits from and reduce the negative effects of health worker migration, and safeguard migrants’ rights.</td>
<td>9.1 Platform established to maximize benefits from international health worker mobility through: (a) improved monitoring of labour mobility; building on the success of the OECD/WHO EURO/Eurostat collaborative work and with a progressive international scale-up and implementation of the National Health Workforce Accounts; (b) strengthened evidence analysis, knowledge exchange and global public goods on mobility, recognition of qualifications, remittances, resource transfers, good practices and policies.</td>
<td>ILO, OECD, WHO</td>
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<td>9.2 Existing instruments, such as the WHO Global Code of Practice on the International Recruitment of Health Personnel and ILO Conventions on Migrant Workers, strengthened and implementation supported; and policy dialogue facilitated for new innovations and voluntary commitments that maximize mutual benefits informed by lessons from other international instruments.</td>
<td>ILO, OECD, WHO</td>
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<td>9.3 Management of health worker migration improved to ensure mutuality of benefits through institutional capacity-building to governments, employers, workers and other relevant stakeholders in countries of both source and destination.</td>
<td>ILO, WHO, OECD</td>
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<td>10. Undertake robust research and analysis of health labour markets, using harmonized metrics and methodologies, to strengthen evidence, accountability and</td>
<td>10.2 Health workforce monitoring, financing and accountability reports produced.</td>
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<td>10.3 Implementation of national health workforce accounts and disaggregated reporting supported and institutional capacity for implementation strengthened.</td>
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<td>10.4 An interagency global data exchange on the health labour market with harmonized metrics and definitions established and maintained.</td>
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<td>action.</td>
<td>10.5 A health workforce research agenda established, research methodologies advanced, and evidence base expanded for decent work and effective health labour market interventions that optimize the socioeconomic returns on health workforce investments.</td>
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The agency or agencies designated as the lead in the action plan will hold or share responsibility for leading the coordination and implementation of the deliverable. The agency or agencies designated as partners will take a supportive role in contributing specific inputs towards the deliverable.
13.3 Addressing the global shortage of, and access to, medicines and vaccines

Document A70/20 (Report by the Secretariat):

1. The Executive Board at its 140th session noted an earlier version of this report. The title of the report has been updated as agreed by the Board to reflect the importance of access to medicines as a broader public health issue. The report has been revised (particularly paragraphs 2–15) to provide an account of the latest developments relating to implementation of resolution WHA67.22 (2014) on access to essential medicines. It includes information on progress by Member States and the work of the Secretariat to support countries in ensuring access to affordable, high-quality, essential medicines.

ACCESS TO MEDICINES

2. In 2014, the Health Assembly in resolution WHA67.22 requested the Director-General inter alia: to urge Member States to recognize the importance of effective national medicines policies, and their implementation under good governance; to facilitate collaboration among Member States on how to implement medicines policies most effectively; to support Member States in the selection of essential medicines and in ensuring a supply of affordable and effective essential medicines; to support Member States in monitoring essential medicines shortages; to urge Member States to expedite progress towards the achievement of the Millennium Development Goals; and to provide, on request, in collaboration with other international organizations, technical support on issues relating to intellectual property and access. In 2016, the Sixty-ninth World Health Assembly noted a progress report on implementation of that resolution.

3. The continuing importance of ensuring access to essential medicines has been recognized in target 3.8 of the Sustainable Development Goals, which aims to achieve universal health coverage, including access to safe, effective, quality and affordable essential medicines for all. Access to medicines has also been recognized as a crucial element of the solutions to numerous important public health problems and features in several Health Assembly resolutions, such as resolution WHA60.16 (2007) on progress in the rational use of medicines, resolution WHA69.20 (2016) on promoting innovation and access to quality, safe, efficacious and affordable medicines for children, resolution WHA67.23 (2014) on health intervention and technology assessment in support of universal health coverage, and resolution WHA69.25 on addressing the global shortage of medicines and vaccines.

Access to medicines is central to strategies and action plans for programmes implemented across the Secretariat, such as those on antimicrobial resistance, noncommunicable diseases, maternal and child health, HIV, tuberculosis and malaria. Access to medicines under international control has been identified as a priority by the United Nations General Assembly which adopted in resolution S-30/1 (2016) the outcome document of its special session on tackling the world drug problem. Member States and the Director-General have been requested to improve access to controlled medicines through several Health Assembly resolutions, such as those on palliative care and the management of pain, emergency surgery and anaesthesia, and mental health disorders such as epilepsy.

200 See document EB140/19 and the summary records of the Executive Board at its 140th session, ninth meeting.
201 See the summary records of the Executive Board at its 140th session, eighteenth meeting, section 2.
202 See document A69/43, G and the summary records of the Sixty-ninth World Health Assembly, Committee B, seventh meeting, section 3 (document WHA69/2016/REC/3).
4. In 2016, the United Nations Secretary-General convened the High-Level Panel on Access to Medicines “to review and assess proposals and recommend solutions for remedying the policy incoherence between the justifiable rights of inventors, international human rights law, trade rules and public health in the context of health technologies”. WHO participated in discussions through its membership in the Expert Advisory Group, and made a substantive submission to the Panel.\textsuperscript{205} The report of the High-Level Panel\textsuperscript{206} echoes conclusions of previous reports prepared under the auspices of WHO, which drew attention to disparities in research and development and lack of access to essential medicines (in particular the reports of the Commission on Intellectual Property Rights, Innovation and Public Health\textsuperscript{207} and the Consultative Expert Working Group on Research and Development\textsuperscript{208}). It also picks up elements of WHO’s global strategy and plan of action on public health, innovation and intellectual property. A major theme of the High-Level Panel’s report is the call for more policy coherence – in line with the global strategy and plan of action, which requested WHO to work more closely with other relevant international agencies, namely UNCTAD, WIPO and WTO.

5. Access to quality, safe and effective medicines requires a comprehensive health systems approach that addresses all of the stages throughout the medicines value chain from needs based research, development and innovation; manufacturing processes and systems that ensure quality products as well as managing the problem of substandard and falsified medicines; public health-oriented intellectual property and trade policies; selection, pricing and reimbursement policies; integrity and efficiency of procurement and supply; and appropriate prescribing and use. Throughout this chain there is a need to oversee the quality, safety and efficacy of medicines. Pharmaceutical systems need to meet the needs of specific populations such as children and people requiring palliative care and need to be responsive in the face of emerging threats. In addition, routine and transparent monitoring of quality, access and use is essential to support decision-making and accountability as well as allowing adaptation of national policies to respond to evolving community needs. Progress has been made by the Secretariat in several of these areas, as described below.

\textbf{(a) Needs-based research, development and innovation.} The Global Observatory on Health R&D went live in January 2017 and provides information on research and development for products for neglected diseases.\textsuperscript{209} The Global Antibiotic Research and Development Partnership, a joint activity of WHO and the Drugs for Neglected Diseases initiative, has been established for developing and delivering new or improved antibiotic treatments, while endeavouring to ensure sustainable access. WHO has published a priority pathogens list to highlight neglected areas of research and development. Moreover, under the strategy and plan of the R&D Blueprint, WHO is maintaining a list of priority emerging infectious diseases that have epidemic potential. This list is updated annually. In the future, it is expected that

\textsuperscript{206} Available at: https://static1.squarespace.com/static/562094dee4b0d00c1a3ef761/t/57d9c6ebf5e231b2f02c3d4/1473890031320/UNSG+HLP+Report+FINAL+12+Sept+2016.pdf (accessed 21 March 2017).
\textsuperscript{209} Available at http://www.who.int/research-observatory/en/ (accessed 22 March 2017).
WHO’s new Expert Committee on Health Research and Development\textsuperscript{210} will provide oversight to the above prioritization exercises.

(b) **National regulatory capacity and local production.** In line with resolution WHA61.21 (2008) on the global strategy and plan of action on public health, innovation and intellectual property, preparatory work was carried out to look at the interplay of health and industrial policies and to explore the trends and context of mechanisms that ensure quality-assured local production. A regulatory benchmarking tool has been developed and used in several countries, it serves as an important method for identifying gaps in regulatory capacity that need to be filled in order to ensure quality-assured medicines. To support access to products in emergency situations, new regulatory pathways are now being evaluated.

(c) **Quality, safety and efficacy.** To ensure access to quality-assured pharmaceuticals, WHO not only sets norms and standards by developing appropriate guidelines and reference standards, but also supports Member States and their national regulatory authorities on issues related to safety and quality of medicines. The Secretariat continues to provide support to countries in building national regulatory capacity for regulation and pharmacovigilance of health products through harmonization and networking initiatives, regional or country-specific training programmes and information sharing. These activities have been endorsed and supported by Member States through numerous Health Assembly resolutions including WHA67.20 (2014) on regulatory system strengthening for medical products. Prequalification of medicines, vaccines, diagnostics and vector control products by WHO is an important component of these activities and mandate.

(d) **Substandard and falsified medicines.** The Member State Mechanism on Substandard/Spurious/Falsely-labelled/Falsified/Counterfeit Medical Products has requested research to examine the links more closely between accessibility and affordability and their impact on the emergence of substandard and falsified medical products.\textsuperscript{211} That research has recently commenced with a view to reporting back to the Mechanism at the end of 2017. Examination of reports received by the WHO Global Surveillance and Monitoring System for substandard and falsified medical products clearly indicates that shortages and stock outs of medicines and vaccines contribute to the appearance of substandard and falsified medical products in the supply chains.

(e) **Public health-oriented intellectual property and trade policies.** WHO, WIPO and WTO have intensified their collaboration in order to foster a better understanding of the linkage between public health and intellectual property policies and to enhance a mutually supportive implementation of those policies. Based on the three organizations’ joint study on promoting access to medical technologies and innovation\textsuperscript{212} the aim of collaboration is that: each agency can fulfil its own mandate more effectively; respective initiatives support each other; efforts are not duplicated; and resources are used efficiently. Collaboration covers various areas, including training activities, joint symposia and joint publications.\textsuperscript{213} WHO has also intensified its collaboration with UNCTAD on local production and continues to work closely with United Nations programmes and international agencies, including UNAIDS, UNDP and UNITAID. In December 2016 WHO called for an “all-agency meeting” with UNAIDS, UNCTAD, UNDP,

\textsuperscript{210} See document EB140/22 and the summary records of the Executive Board at its 140\textsuperscript{th} session, eleventh meeting.


UNITAID, WTO, WIPO and the High Commissioner for Human Rights to discuss the different activities and plan for the future, including how to best follow up on the High-Level Panel’s report. The Secretariat provided guidance and advice to Member States on the interrelationship of public health, intellectual property and trade policies, including how to make use of the flexibilities contained in the Agreement on Trade-Related Aspects of Intellectual Property Rights as recognized by the Doha Declaration on the TRIPS Agreement and Public Health in line with the mandate of WHO conferred by the global strategy and plan of action on public health, innovation and intellectual property. Detailed reports on these activities over the past 16 years can be found on the WHO website.\(^\text{214}\) WHO has also engaged in various training activities and published updated patent information on the new treatments for hepatitis C and those for cancer and diabetes.\(^\text{215}\)

(f) **Selection of medicines.** Additional medicines for cancer and new medicines for hepatitis C and tuberculosis were included in the 19\(^\text{th}\) WHO Model List of Essential Medicines and the 5\(^\text{th}\) WHO Model List of Essential Medicines for Children. Antibiotics for infectious diseases, sexually transmitted infections and paediatric indications were reviewed by the Expert Committee on the Selection and Use of Essential Medicines at its 21\(^\text{st}\) meeting (Geneva, 27–31 March 2017), which also evaluated medicines for noncommunicable diseases including cancer, palliative care and diabetes. WHO is preparing treatment guidelines for the management of pain in cancer patients. In 2015, some 140 countries had established national lists of essential medicines.

(g) **Pricing, reimbursement and affordability.** The WHO guideline on country pharmaceutical pricing policies was issued in 2015 to support Member States in managing pharmaceutical prices.\(^\text{216}\) In 2016, WHO published the first global report on access to treatment for hepatitis C,\(^\text{217}\) which provides detailed information on the patent and regulatory status of the new hepatitis C treatments and pricing information for all new treatments, and describes ways to access these treatments at affordable prices. Expert consultations took place in November 2015 on health technology assessment and in November 2016 for the review of the 10 key policy areas to ensure access to affordable medicines. The consultations prepared the way for the Fair Pricing Forum due to be held in Amsterdam (the Netherlands, 11 May 2017), which will explore options to ensure a sustainable supply of affordable, quality medicines, including assessment of the production costs of essential medicines.

(h) **Efficient procurement and supply-chain management.** Support has been provided to Member States for the establishment of policies and good practices, as well as capacity-building for improving governance, efficiency and quality of procurement and supply-chain management, both in ordinary and emergency situations. The work includes normative guidance and support to countries to improve coordination and quality of donations and the development of pre-packaged medical kits (for example, the Interagency Emergency Health Kit and the piloting and expanding use of noncommunicable diseases kits).

(i) **Appropriate prescribing and rational use.** Guidelines on the use of antimalarials, contraceptives, medicines for the treatment of maternal infections and other medicines have

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\(^\text{214}\) Overview on technical cooperation programmes relating to the implementation of the TRIPS agreement. available at: http://www.who.int/phi/wto_communications/en/ (accessed 7 March 2017).


been published.\textsuperscript{218} The Secretariat is leading work on surveillance of the consumption and use of antimicrobial medicines. An expert consultation (Geneva, 29 March–1 April 2016) contributed to the development of a WHO methodology for surveillance of antimicrobial consumption.\textsuperscript{219} Training and survey implementation began in 2016. The Secretariat developed a protocol for WHO’s hospital point prevalence survey on antimicrobial use on the basis of that issued by the European Centre for Disease Prevention and Control. Implementation of surveys of use of antimicrobials in hospitals is planned for later in 2017.

(j) \textbf{Access to controlled medicines}. WHO has played a leading role in the promotion of balanced public policies, including a published guidance document.\textsuperscript{220} It has also responded to the challenges in forecasting and quantification of controlled medicines by issuing a joint WHO/International Narcotics Control Board guide on estimating requirements for substances under international control.\textsuperscript{221} WHO works in close collaboration with the United Nations Office on Drugs and Crime and the International Narcotics Control Board to promote access to controlled medicines, providing training and support to countries. WHO is part of the Joint Global Programme (in cooperation with the United Nations Office on Drugs and Crime and Union for International Cancer Control) on access to controlled medicines for medical purposes, in particular for the management of pain.\textsuperscript{222} The Secretariat provides support to countries for identifying potential regulatory or procurement barriers that limit access to controlled substances and for identifying potential interventions to improve access.

(k) \textbf{Transparency}. WHO’s Global Price Reporting Mechanism provides pricing and procurement data for HIV, tuberculosis and malaria treatments and has recently been expanded to include the new hepatitis C treatments.\textsuperscript{223} The Secretariat has set up a comprehensive web platform that provides data on vaccine product, price and procurement with the goal of increasing price transparency and informing decisions on vaccine introduction and implementation.\textsuperscript{224} Within the framework of a new initiative on fair pricing, WHO is assessing the production costs of essential medicines. The results of such analysis will allow procurement agencies to evaluate better their performance and will contribute to the overall objective of transparency.

(l) \textbf{Monitoring}. WHO has developed a data collection tool for gathering information on the prices and availability of medicines using a smartphone application. In early 2016, pilot tests in 19 low- and middle-income countries proved the application to be a simple and cost-effective way to collect national data on access to medicines. The use of the tool is now being extended to more countries and being used for programme-specific purposes such as gathering price and availability data on medicines for noncommunicable diseases.

6. Despite the diverse initiatives towards improving access to medicines described above, more effort is required to improve access to quality medicines, including measures in national policies and plans, through regional activities and by committing resources, as recommended in resolution WHA60.16 (2007) on progress in the rational use of medicines.

\textsuperscript{219} Available at: http://www.who.int/medicines/areas/rational_use/WHO_AMCsurveillance_1.0.pdf?ua=1 (accessed 14 March 2017).
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7. In resolution WHA69.25 (2016) on addressing the global shortage of medicines and vaccines, the Health Assembly requested the Director-General “to develop technical definitions, as needed, for medicines and vaccines shortages and stock outs, taking due account of access and affordability in consultation with Member State experts in keeping with WHO-established processes, and to submit a report on the definitions to the Seventieth World Health Assembly, through the Executive Board”.

8. WHO commissioned a systematic review of the available definitions used in the management of shortages and stock outs of medicines and vaccines. The preliminary results revealed, among other things, that functional definitions vary broadly depending on the context in which they are used, underscoring the need to harmonize and develop well-understood definitions. The review also showed that terms are used interchangeably to refer to different aspects of shortages.

9. Together, the preliminary results of the systematic review and consultations with Member States and experts in supply-chain and programme management for medicines and vaccines allow the following conclusions to be drawn.

(a) On the supply side, existing definitions and indicators are found mainly in reporting mechanisms established by national medicines regulatory authorities – which therefore vary from country to country – and which require timely advance notice of potential shortages by market authorization holders. The advance notification mechanisms use these definitions as part of a system to detect shortages at the manufacturing level and to plan approaches to mitigating the potential negative impact of a shortage or stock out on the public health system, such as the rapid deployment of other supply sources or the temporary use of other clinically appropriate medicines. These systems and the related definitions were developed with a view to providing public health solutions at the national level.

(b) On the demand side, existing definitions are used mainly in reference to problems related to procurement, planning and supply-chain management. These definitions most frequently describe and define various types of disruptions at various levels in medicines and vaccines supply systems, ranging from the absence of a physical inventory to failures to meet the needs of individual patients. In the case of a stock out, the demand-side definitions are generally also linked to the duration of the stock out; however, the time-bound aspects of the demand-side definitions are measured only in terms of hours and days and not in terms of consequences to the patient of delayed treatment.

(c) The existing definitions used in relation to both the supply and the demand sides include references to reporting mechanisms and to the availability of data related to shortages and stock outs. In the case of supply-side shortages and stock outs, summary information on specific products is generally made available to the public by the responsible agencies, usually a national medicines regulatory authority. In the case of demand-side shortages, data come from multiple sources and are not systematically validated or provided to a central entity. Also on the demand side, information is limited regarding the management of data from the various reporting mechanisms, and there is an absence of systems to manage the quality, reliability and appropriate use of these data across multiple potential data sources. Immunization programmes frequently have separate monitoring and reporting mechanisms.

10. Based on the preliminary results of the systematic review and the consultations, the Secretariat has developed a draft technical definition of shortages and stock outs of medicines and vaccines. In

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addition, it is designing a framework for the purpose of articulating more detailed considerations, such as variables for implementation and indicators for measurement. The overarching draft technical definition is divided into supply-side and demand-side definitions, in accordance with the outcome of the systematic review and informal expert consultations.

11. The draft definition, which refers to shortages on the supply side and shortages and stock outs on the demand side, reads as follows:

- On the supply side: a “shortage” occurs when the supply of medicines, health products or vaccines identified as essential by the health system is considered to be insufficient to meet public health and patient needs. This definition refers only to products that have already been approved and marketed, in order to avoid conflicts with research and development agendas.

- On the demand side: a “shortage” will occur when demand exceeds supply at any point in the supply chain and may ultimately create a “stock out” at the point of appropriate service delivery to the patient if the cause of the shortage cannot be resolved in a timely manner relative to the clinical needs of the patient.

12. All definitions must have a clear purpose, and guidance on the appropriate context is needed in order for them to be useful and to avoid unintended consequences. Examples of unintended consequences include instances of reporting of shortages at the wholesale level contributing to hoarding and price increases. In addition, the reporting of shortages at lower levels of the supply chain is considered to be a sensitive area, as health care workers could face reprisals for shortages or stock outs and may therefore avoid reporting them. A report of a facility stock out is a useful indicator of the overall status of a facility or system, but is not diagnostic in nature, underscoring the need for guidance on the use of such reports. National medicines regulatory authorities that monitor shortages and stock outs among their market authorization holders have specific requirements and use reported data to react with multiple mitigation responses; however, the capacity to implement a reporting and response system depends on resources. Furthermore, the impact of shortages in one region of the world may be limited to that particular region, or may have global consequences, depending on the manufacturing base of the medicine or vaccine. Final definitions will be accompanied by guidance on how to use the definitions in various contexts, including on how best to use the definitions in appropriate strategies in order to mitigate or avoid a shortage or stock out.

13. The Secretariat will conduct a broader Member State consultation in 2017 in order to expand the involvement of stakeholders, including those from countries with small markets and in remote locations, in the development of these definitions and the understanding of the causes of shortages and the relation with issues of access and affordability. Appropriate guidance will be developed and strategic efforts will be continued to develop a notification system for medicines and vaccines at risk of shortage.

14. Pursuant to the other provisions of resolution WHA69.25, the Secretariat has embarked on collaborative work on health data management, notably as part of the Health Data Collaborative, to promote the availability of reliable data on shortages and stock outs and data for improved planning and management. In addition, WHO’s programme on the prequalification of medicines and vaccines aims to include medicines at risk of shortage and stock outs in order to provide efficient regulatory pathways and contribute to improved market stability. In this regard, the programme’s fee structures have been revised to ensure its sustainability. WHO is also supporting collaboration at high levels across supply-chain programmes and will serve as the secretariat for the Interagency Supply Chain Group in 2017.
ACTION BY THE HEALTH ASSEMBLY

15. The Health Assembly is invited to note the report.
13.4 Evaluation and review of the global strategy and plan of action on public health, innovation and intellectual property

Document A70/21:

1. In line with resolution WHA68.18 (2015), the Executive Board at its 140th session considered and noted the report of the comprehensive evaluation of the implementation of the global strategy and plan of action on public health, innovation and intellectual property. The Board also adopted decision EB140(8).

2. Further to the provisions of resolution WHA68.18, the Secretariat is submitting the executive summary of the final comprehensive evaluation report to the Seventieth World Health Assembly (see Annex).

ACTION BY THE HEALTH ASSEMBLY

3. The Health Assembly is invited to note the report.

ANNEX


EXECUTIVE SUMMARY

delivered to the World Health Organization by Capra International Inc.

In 2008, following a two-year negotiation process, the Sixty-first World Health Assembly debated the output of an inter-governmental working group and subsequently the global strategy and plan of action on public health, innovation and intellectual property (GSPOA) was adopted in resolution WHA61.21.

The aim of the strategy is to promote new thinking on innovation and access to medicines and to secure an enhanced and sustainable basis for needs-driven essential health research and development relevant to diseases that disproportionately affect developing countries. The strategy comprises eight elements, 25 sub-elements and 108 specific actions.

In the following year (2009) resolution WHA62.16 finalized the list of stakeholder categories responsible for the implementation of each element and sub-element, established progress indicators for each element and proposed time frames in which the actions specified in the GSPOA should be accomplished.

At the Sixty-eighth World Health Assembly, Member States decided to extend the time frames of the plan of action from 2015 until 2022 and to undertake a comprehensive evaluation of the implementation of GSPOA in 2015/2016. The design of the evaluation, as well as the data analysis...

226 See document EB140/20, Annex 1 and the summary records of the Executive Board at its 140th session, eleventh meeting, twelfth meeting, section 2 and seventeenth meeting, section 1.

227 The full report of the comprehensive evaluation is available on the website of the WHO Evaluation Office, see http://www.who.int/about/finances-accountability/evaluation/reports/en/ (accessed 10 February 2017).

benefited from the valuable input of the members of the ad hoc Evaluation Management Group, composed of six independent external subject matter experts and two evaluation experts from the United Nations Evaluation Group (UNEG), and the WHO Evaluation Office.

The overall purpose of the comprehensive evaluation is to assess the status of implementation of the eight elements of the global strategy: (a) prioritizing research and development needs, (b) promoting research and development, (c) building and improving innovative capacity, (d) transfer of technology, (e) application and management of intellectual property to contribute to innovation and promote public health, (f) improving delivery and access, (g) promoting sustainable financing mechanisms, and (h) establishing monitoring and reporting systems.

The goals of this evaluation include: assessing the implementation of GSPOA; informing the overall programme review planned for 2017; identifying achievements, gaps and remaining challenges; and providing a forward-looking view of improvements and their implementation with an assessment of the possible and existing constraints involved.

The scope of the evaluation covers the eight elements, 25 sub-elements and the 108 specific actions defined in the action plan over the period of 2008–2015.

The evaluation methodology followed the UNEG norms and standards for evaluations and ethical guidelines. The approach to the evaluation employed mixed methods, using both secondary and primary quantitative and qualitative data. To facilitate data collection throughout the 194 WHO Member States, WHO invited all Member States to nominate one Focal Point each to facilitate data collection on behalf of relevant governmental entities, or to coordinate data collection among these. 101 Member States (52%) responded by providing a Focal Point; of these 101 Member States, 68 contributed to this evaluation. Data were collected in the six United Nations official languages (Arabic, Chinese, English, French, Russian and Spanish). The evaluation addressed the criteria of relevance, effectiveness and sustainability, as well as, in a limited way, some indications of early impact. The data sources comprised documents, key informant interviews, focus groups, three survey tools (comprehensive online invitational survey to Member States and key stakeholder groups in GSPOA; short invitational survey to solicit participation from those who had not replied to the long invitational survey; and a web-based public survey) and 15 country case studies. The country case studies were stratified by the six WHO Regions and four World Bank country income groups (high, upper-middle, lower-middle and low) and selected by sampling from among those countries that had appointed Focal Points.

In aligning the terminology of GSPOA with the four income groups of the World Bank, whenever GSPOA refers to developing countries, these countries are referred to in this evaluation as lower-middle-income and low-income countries, especially when evaluation findings are being reported and recommendations made.

GSPOA identifies stakeholders in the following groups:

- Governments (Member States);
- WHO Secretariat;
- Other international intergovernmental organizations, both global and regional; and
- Other relevant stakeholders, including international and national research institutions; academia; national and regional regulatory agencies; relevant health-related industries, including both public and private; public–private partnerships; public–private and product development partnerships; nongovernmental organizations, concerned communities; development partners; charitable foundations; publishers; research and development groups; and regional bodies and organizations.
The opinions of all stakeholder groups were represented to varying degrees in the data collected and analysed.

In the course of data collection it became evident that many activities related to the eight elements were being undertaken without reference to GSPOA and had already started prior to 2008, which indicates that there was not necessarily a causal relationship in terms of attribution between many observed actions and GSPOA.

**Emergence of a theory of change**

GSPOA, being a Member States-negotiated instrument, does not spell out a Theory of Change. Since no Theory of Change currently exists, the Evaluators developed one during the course of the evaluation based on the *Force Field Analysis* model. Change is not an event, but rather a process and there are many different factors (forces) for and against making any change. Force Field Analysis enhances awareness of these factors. If the factors for change outweigh the factors against change, the change to the desired state will be successful.

The **positive factors** for change include: stakeholders’ awareness of and support for the programme; the priority given to the health sector; prioritization and promotion of R&D needs by stakeholders; strong willingness to build and improve innovative capacity; willingness to improve delivery and access; and support for Member States by WHO and its partners.

The **negative risk forces** impeding change include: weak awareness of GSPOA; weak building and improvement of innovative capacity, particularly in low-income countries; weak sustainable financing mechanisms; lack of coordination among partners; weak monitoring and reporting systems; and weak local ownership and leadership, particularly in low-income countries.

**The evaluation resulted in the following key overall findings:**

- **Awareness and engagement of stakeholders.** The evaluation sample is restricted to countries that at least named a Focal Point and responded. The observed findings may therefore be better than the reality, as a result of excluding countries that have not even named a Focal Point, and may not have made as much progress or are not aware of GSPOA. It was also noted that many local stakeholders in the countries visited were not aware of or engaged in the implementation of GSPOA.

- **Variance across income groups.** For several, if not all, elements the finding is quite similar: stakeholders may be aware of GSPOA, but progress in implementation varies and it seems to be smaller in lower-middle-income and low-income countries with less resources. The way in which each element was implemented therefore depended on the priorities and capacity of each country.

- **Attribution.** Findings show countries doing related activities, but not considered a result of GSPOA. This also has to be taken into account in the interpretation of this report. GSPOA does not occur in a vacuum and the challenge here is to see what effects can be attributed to GSPOA. It may not be possible to separate the effect as a result of GSPOA from the internal dynamics of the countries in some cases.

**Note:** This evaluation report presents a comprehensive list of recommendations which are aimed at addressing areas identified for future work. While it may not be possible for all recommendations to be taken further, the ultimate intention was to provide the forthcoming overall programme review with a comprehensive list of areas for future work and forward-looking recommendations for discussion and provision of guidance.
Element 1: Prioritizing research and development needs

GSPOA suggests that health R&D policies of developed countries need to reflect adequately the health needs of developing countries. Mapping global R&D for identifying gaps in R&D is needed and R&D in traditional medicine needs to be encouraged.

Key findings. Mapping of health R&D for identifying gaps was conducted by stakeholders and gaps were identified. There is evidence that some countries prioritize R&D needs at national level; however, the level of effort differs across and within different regions and income groups. There is some evidence of collaborative partnerships in R&D in traditional medicine between countries.

Key observations from country case studies. High-income and upper-middle-income countries prioritize R&D from both the national and global perspectives. They reviewed their health policies, including the research components, during the implementation of GSPOA, but not necessarily as a consequence of GSPOA. Upper-middle-income countries have relatively well defined national R&D policies and/or strategies. Most health R&D work is being done in the private sector. At the lower-middle-income level, national R&D policies exist in some countries; however, even in countries where they exist, the overall national coordination between different agencies is less than optimal. In low-income countries, national health policies exist – however, without precisely addressing health research needs. The main gap in the implementation is the low level of awareness of GSPOA in all country income groups.

Key achievements. The WHO engagement with Member States led to progress towards a global framework for R&D and to the coordination of R&D for diseases that disproportionately affect lower-middle-income and low-income countries.

Key gaps and challenges identified. Investments in health research, in particular in traditional medicine, are insufficient and not appropriately directed towards tackling priority health problems. Current market mechanisms and publicly-funded research result in far too little investment in R&D for diseases that mainly affect lower-middle-income and low-income countries. There are challenges of explicitly linking the R&D needs, gaps and activities to an evidence-based and transparent R&D prioritization process and in orchestrating health R&D at the global level.

Recommendations

Recommendations for consideration by Member States

1. Member States to ensure that their health R&D at national and sub-national level is prioritized, including for traditional medicine, through multistakeholder consultation, using national focal points or units for effective intersectoral coordination.

Recommendations for consideration by the WHO Secretariat

2. The Secretariat to support Member States to monitor progress in R&D prioritization.

3. The Secretariat, in collaboration with partners across all sectors, to promote coordination of health R&D at national, regional and global levels, with a view to closing critical gaps in research agendas in support of global health research priorities.

4. The Secretariat to promote publicly accessible repositories for health research in order to improve access to knowledge.

5. The Secretariat to further support Member States in carrying out national assessments and analyse and compare data gained at national and regional level and identify further steps for improved assessment.
6. The Secretariat and WHO partners to conduct periodical re-evaluations of the coordination of health research.

Element 2: Promoting research and development
GSPOA recognizes the need for political, economic and social institutions in each country to participate in the development of health research policy.

Key findings. GSPOA promoted health R&D, and improved access to knowledge and technology via databases and libraries, as well as by capacity building; however, the extent and the effectiveness vary among regions. Political and economic institutions participated in the development of health research policies; however, the involvement of social institutions was weak and varied across income groups.

Key observations from country case studies. High-income countries promote R&D in all three types of disease. These countries also promote health research in lower-middle-income and low-income countries with the involvement of governmental bodies from both sides and, in certain cases nongovernmental organizations. In upper-middle-income countries, several institutions are dedicated to R&D in health, including some that conduct research in traditional medicine. In lower-middle-income countries, national research or science and technology policies are in place; however, the national coordination between the different agencies is less than optimal. Innovation is primarily demonstrated by the private sector in market-driven conditions and largely outside the scope of GSPOA. Health research capacity is very low in low-income countries. In terms of gaps, the overall national coordination between the different agencies is limited in upper-middle-income, lower-middle-income and low-income countries.

Key achievements. GSPOA has promoted health R&D in all income groups and improved access to knowledge and technology. Databases on clinical trials, patents, intellectual property (IP) and health knowledge were created or became available.

Key gaps and challenges identified. Lack of funding for health research impedes complying with many aspects of GSPOA in almost every region, predominantly in lower-middle-income and low-income countries. Funds are often provided for research activities which do not address the health needs of these countries. There is a clear need for a communications strategy to overcome the current lack of communication tools for increasing access to knowledge in many lower-middle-income and low-income countries. Measures to promote and coordinate research into all types of disease need to be substantially enhanced. Greater investment in Member States into development and implementation of national health research programmes and establishing strategic research networks is also needed.

Recommendations
Recommendations for consideration by Member States
1. Member States to promote upstream research in lower-middle-income and low-income countries with strengthened international cooperation and joint work between the public and private sector in areas that address their health needs, as well as at the international level and between high-income and lower-middle-income countries.

2. Member States to enhance national capacity for analysing and managing clinical trial data.

3. Member States to promote broader multisectoral participation in the development of health research policy.
Recommendations for consideration by the WHO Secretariat
4. The Secretariat to strengthen its work with partners for creating and renewing strategic research networks to support governments to develop their national health programmes, including the necessary communication tools.

Recommendations for consideration by all stakeholders
5. All stakeholders to improve access to scientific and technological knowledge, including wider availability of libraries and databases.

6. All stakeholders to strengthen the efforts towards improving cooperation, participation and coordination of health and biomedical R&D with and between lower-middle-income and low-income countries.

Element 3: Building and improving innovative capacity
GSPOA acknowledges the need for framing, developing and supporting policies which promote health innovation capacity improvement in developing countries. The key areas for capacity development are science and technology, regulation, clinical trials, IP, production of pharmaceuticals and evidence-based traditional medicine.

Key findings. The investments made in building and improving health innovation capacity were disproportionally allocated and implemented across regions and country income groups.

Key observations from country case studies. Several high-income countries promote R&D capacity in lower-middle-income and low-income countries at national agencies, research institutes and universities. Public–private partnerships participate in applied research in collaboration with local partners of lower-middle-income and low-income countries. Public–private partnerships build and improve innovative capacity. Nongovernmental organizations support the development and use of traditional medicine. While much innovative capacity has been built or improved, this is not necessarily a consequence of GSPOA. In one upper-middle-income country it was noted that coordination of innovative capacity building throughout the different departments of the Ministry of Health was limited. In lower-middle-income countries, respondents indicated that policies to build and improve innovative capacity existed, but their implementation remained fragmented. Furthermore, investment in health R&D is not coordinated at an optimal level. In low-income countries there are limited research activities due to restricted access to research funding. In terms of gaps, the health innovation system is often rudimentary and fragmented in most low-income, lower-middle-income and some upper-middle-income countries.

Key achievements. Several networks and partnerships were built for promoting investments in R&D capacity in lower-middle-income and low-income countries, such as a regional platform on access and innovation for health technologies to look into research funding needs and gaps.

Key gaps and challenges identified. Policies to promote the development of health innovation capacity exist; however, their implementation remained fragmented in many countries. The public sector provides most funding and infrastructure for research. R&D is generally still not a major priority for lower-middle-income and low-income countries, which face daunting issues stemming from a lack of skilled researchers and financial resources, together with competing, seemingly more urgent, priorities. Although research is conducted in academic institutions, owing to the lack of capacity to conduct translational research, and the limited local manufacturing capacity, it often has little applicability to local health problems. Despite the achievements noted in the implementation of this Element, the remaining challenges are considerable and multiple. They include the lack of baseline data and effective policies in several lower-middle-income and low-income countries, as
well as the often limited capacity of regulatory agencies, research institutions and production facilities.

Capacity improvement should be pursued in parallel in different fields, including policy development, education and training, research and regulatory institutions.

**Recommendations**

**Recommendations for consideration by Member States**

1. Member States, with the support of WHO and other international organizations, to strengthen their efforts for tapping the still largely unrealized potential contained in traditional medicinal knowledge, notably by boosting local R&D and manufacturing capacity, enhancing educational and training efforts to safeguard the locally available knowledge base on traditional herbal medicine and traditional medical treatment methods; and to negotiate partnerships with high-income and upper-middle-income countries for mutual advantage.

2. Member States to align their R&D objectives with the public health needs of their populations.

**Recommendations for consideration by the WHO Secretariat**

3. The Secretariat to explore options to support the development of health products in accordance with the demonstrated R&D needs of lower-middle-income and low-income countries, focusing on Type II and Type III diseases and the specific needs of these countries in relation to Type I diseases.

4. The Secretariat and WHO partners to increase their support to lower-middle-income and low-income countries in the area of better safeguarding and exploiting the existing traditional medicinal knowledge in terms of development of new products and treatments.

5. The Secretariat, in collaboration with Member States, to promote, organize and support more actions in teaching and training, including building R&D capacity, with a focus on Type II and Type III diseases and the specific needs of lower-middle-income and low-income countries in relation to Type I diseases.

**Recommendations for consideration by all stakeholders**

6. All stakeholders to actively contribute to the development of possible new incentive schemes for health-related innovation, in line with the recommendations of the Consultative Expert Working Group on Research and Development: Financing and Coordination regarding sustainable funding and the coordination of health-related R&D.

7. All stakeholders to improve innovative capacity in lower-middle-income and low-income countries by providing more funding and infrastructure for research, including translational research.

**Element 4: Transfer of technology**

GSPOA supports development cooperation, partnerships and networks for building and improving transfer of technology related to health innovation. The aim of Element 4 is the promotion of technological innovation and transfer of technology to the mutual advantage of producers and users of health technologies.

**Key findings.** Several national, regional and global coordination initiatives have been set up for increasing and facilitating transfer of health-related technologies. However, there are significant variations across regions and income groups. There is evidence of several North–South
collaborations that involve international organizations, international nongovernmental organizations, philanthropic organizations, academia and the private sector. Furthermore, there is evidence of some South–South cooperation initiatives that mainly involve harmonization of strategies, regulations and commercially-based activities. The promotion of health technology transfer to enable production of health products is mainly taking place between countries that have an established production capacity. Low-income countries are still encumbered with weak regulatory and institutional frameworks that impede the absorption of technologies, although there is evidence that a number of these countries have developed strategies to overcome this obstacle. United Nations agencies, such as UNCTAD, WHO and WIPO, have played a pivotal role in promoting the transfer of health-related technologies between the owners of the technologies and lower-middle-income and low-income countries. The most frequent types of activity include technical assistance, facilitating dialogue, increasing availability of information, and more directly setting up concrete initiatives to support technology transfer.

**Key observations from country case studies.** In a high-income country a respondent pointed out that technology transfer is voluntary and that the private sector leads, and there is some scepticism regarding production in lower-middle-income and low-income countries. In particular, it was pointed out that substandard/spurious/falsely labelled/falsified/counterfeit (SSFFC) medical products pose significant risks to consumer health and safety. In other high-income countries there is evidence of the transfer of knowledge and technologies by the public and private sectors, as well as by nongovernmental organizations. While there is evidence of much activity, it is not necessarily a consequence of GSPOA. In upper-middle-income countries, transfer of technology is taking place – however, often without assessing its value to the local health systems. Most lower-middle-income and low-income countries lack health innovation structures that can receive and make good use of transferred technologies. In terms of gaps, despite the achievements in health-related technology transfer to lower-middle-income and low-income countries, at global level the number of collaboration initiatives seems to be limited. Most pharmaceutical manufacturers in low-income and lower-middle-income countries lack the capacity to use transferred technology effectively.

**Key achievements.** National initiatives in high-income countries include incentive programmes to encourage large, established private sector organizations to undertake technology transfer initiatives, as well as guidance on modalities of technology transfer to the low-income countries. Global initiatives are driven by international organizations, e.g. WHO, WTO, and development banks. These organizations facilitate collaboration by promoting technical cooperation between large private sector organizations and the global initiatives; and by providing capacity development through direct technical assistance to countries.

**Key gaps and challenges identified.** The gaps identified in technology transfer in many cases are correlated with the income group into which a given country falls. Several low-income countries lack technology transfer strategies, initiatives for investments and capacity to become the users of new pharmaceutical and health technologies. These countries are encumbered with weak regulatory and institutional frameworks that impede the absorption of technologies. Speeding up capacity development in the regulatory sector is one of the challenges facing several lower-middle-income and low-income countries. On the other hand, there is evidence that a number of these countries have developed and implemented strategies to overcome those challenges with the help of North–South and South–South cooperation.

**Recommendations**

Recommendations for consideration by Member States

1. Member States to work with other stakeholders to improve the enabling environment for technology transfer for the production of health products.
Recommendations for consideration by the WHO Secretariat

2. The Secretariat and other stakeholders to undertake or encourage further work in needs assessment of lower-middle-income and low-income countries with a view to continuing to provide support for technology transfer.

3. The Secretariat to encourage relevant studies and analyses to better understand local needs with a view to improving local capacity for providing essential medicines and health technologies for those in need and creating a business-friendly environment for these efforts.

Recommendations for consideration by all stakeholders

4. All stakeholders to undertake or encourage further capacity building in lower-middle-income and low-income countries regarding technology transfer and related action plans.

Element 5: Application and management of intellectual property to contribute to innovation and promote public health

GSPOA acknowledges the need for strengthening innovation capacity and the capacity to manage and apply IP in developing countries. This includes the use of flexibilities provided in the Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS) to take measures to protect public health.

Key findings. Many GSPOA stakeholders are engaged in the implementation of this Element. International organizations with a mandate in this field provide support for the implementation of the TRIPS Agreement in a way that facilitates access to affordable medicines.

Key observations from country case studies. Traditional IP models appear to support predominantly large companies, and it is difficult to promote alternative (non-commercial) IP models. Efforts are evident in some countries to balance IP rights and make research findings and new health products accessible to low-income countries. In one upper-middle-income country, there are efforts to develop an IP database. Many lower-middle-income countries are involved in clinical trial and ethical review processes. There is limited capacity in most low-income countries and lower-middle-income countries to address the issue of SSFFC medical products. There is limited capacity in some low-income countries to apply the TRIPS flexibilities effectively. In terms of gaps, IP barriers continue to be a challenge in most income groups, especially in lower-middle-income and low-income countries. They limit access to, and affordability of, medicines for poor people in most countries, including those countries that are excluded from licensing agreements sometimes available to poorer countries.

Key achievements. Countries are engaged in initiatives to strengthen capacity to manage and apply IP rights to contribute to innovation and promote public health. Upon request, WHO, WIPO, WTO, UNCTAD, UNDP and other international organizations provide support to those countries that intend to use the flexibilities provided in the TRIPS Agreement for the application and management of IP in a manner that promotes access to health products. This involves guidance on developing public health-sensitive patent legislation and incorporating TRIPS flexibilities within domestic legislation. Some pharmaceutical companies support the spirit of these flexibilities by not enforcing patents in lower-middle-income and low-income countries. Flexibilities for protection of public health in the TRIPS Agreement have been integrated into national legislation by some countries. There are Member States which implemented the WTO 30 August 2003 decision on the implementation of paragraph 6 of the Doha Declaration on compulsory licensing, primarily to export medicines.

Key gaps and challenges identified. It is still difficult to obtain clear and up-to-date information about the patent status of most health products and the available information is usually scattered in many places. Resources and know-how required for the implementation of TRIPS flexibilities are still
scarce in most countries, coupled with reluctance to use these or other legitimate mechanisms to advance access to medicines. The lack of baseline data on the actual status of the implementation of IP rights conducted in lower-middle-income and low-income countries makes it difficult to judge the current situation. The resistance of some stakeholder groups with regard to the use of TRIPS flexibilities could complicate efforts to provide access to new medicines and health technologies for treating certain, mostly chronic, diseases and health conditions in lower-middle-income and low-income countries.

**Recommendations**

Recommendations for consideration by Member States, the WHO Secretariat, other international organizations and nongovernmental organizations

1. To strengthen awareness of the flexibilities provided in the TRIPS Agreement, IP rights and the need for equitable and affordable access to essential health products in lower-middle-income and low-income countries.

2. To strengthen capacity and create incentives related to IP management, taking into account the public health perspective in lower-middle-income and low-income countries.

3. To continue efforts to better integrate existing and new initiatives and schemes in this area in the implementation of GSPOA.

4. To focus more attention on creating the required baseline data, indicators and evidence base needed to properly evaluate the outcome of GSPOA initiatives under this element.

5. To support ongoing non-profit drug development models, by exploring and promoting possible incentive schemes to overcome IP barriers and promote public health.

**Element 6: Improving delivery and access**

Access to medicines is directly related to income and, despite progress made during the last decade, this access is still a major problem for most lower-middle-income and low-income countries.

**Key findings.** GSPOA has addressed the availability of health products in lower-middle-income and low-income countries, and Member States have improved delivery and access. However, the extent of improvements varies highly and depends on the disease and the specific features of the health care system, in particular the available supply chains. Most low-income countries import essential, quality medicines and have little room to negotiate pricing. From the outset of the implementation of GSPOA, initiatives have emerged to increase access to essential medicines. Nevertheless, inexistent, or limited, coordination among stakeholders constitutes the main challenge for these initiatives. Member States and the WHO Secretariat are joining efforts to establish and strengthen mechanisms to improve the ethical review of health products and medical devices and ensure their quality, safety and efficacy.

**Key observations from country case studies.** One high-income country provided evidence of its support for lower-middle-income and low-income countries in prioritizing health care in national agendas. That country also contributed to the strengthening of national health systems in some lower-middle-income and low-income countries by advocating for improving access and by providing training. One high-income country is very active in improving access to affordable health products, but not as a consequence of GSPOA. In one upper-middle-income country, the Government aims to increase accessibility to essential medicines and treatment and has introduced a central procurement system. In most lower-middle-income and low-income countries there is a lack of effective communication between government officials and other stakeholders regarding issues related to access and affordability. In terms of gaps, access to health products depends on the
bargaining capacity of countries, which is weak in the case of most low-income and lower-middle-income countries. In upper-middle-income countries, there is a move away from traditional medicine due to the easier availability of modern medicine.

**Key achievements.** During the implementation of GSPOA, some initiatives have emerged to increase access to essential medicines. Examples include increasing access to HIV treatment over the past 15 years and, more recently, accelerating access to the treatment for Hepatitis C viral infections. Among other achievements, these initiatives have developed tools to help lower-middle-income and low-income countries to conduct self-assessment, develop strategies, build or improve capacity and engage in partnerships to improve access to essential medicines.

**Key gaps and challenges identified.** The availability and accessibility of health products is still limited in many lower-middle-income and low-income countries. This is usually the outcome of systemic failures within, and the lack of financing for, health systems in these countries which require a strongly-coordinated whole-of-government multi- and inter-sectoral response to address the underlying causes. In order to strengthen the health systems and improve delivery and access to health products, the lack of resources in lower-middle-income and low-income countries should be addressed. The weak infrastructure in lower-middle-income and low-income countries represents a barrier to the improvement of the delivery chain of health products as well as to the accessibility of health care services.

**Recommendations**

**Recommendations for consideration by Member States**

1. Member States, in collaboration with other stakeholders, to join efforts for increasing funding to improve delivery of, and access to, health products.

2. Member States to strengthen their national regulatory agencies to facilitate rapid access to health products for their citizens.

3. Member States, in collaboration with other stakeholders, to explore regional partnerships to share expertise between countries and strengthen policies and regulations for health products.

**Recommendations for consideration by the WHO Secretariat**

4. The Secretariat to continue and strengthen its efforts under the Prequalification of Medicines Programme.

5. The Secretariat, in collaboration with WHO partners, to expand its efforts at conducting and coordinating joint reviews of clinical trials of medicines and vaccines.

6. The Secretariat, in collaboration with WHO partners and relevant stakeholders, to further strengthen national drug regulatory capacity, improve ethical review of clinical trials, and help to develop capacity to address barriers to access to affordable health products and medical devices.

**Element 7: Promoting sustainable financing mechanisms**

GSPOA aims to make health products available in developing countries through new and innovative mechanisms.

**Key findings.** Financing mechanisms for R&D of neglected and tropical diseases as well as diseases affecting all income group countries, including emerging, highly infectious diseases, were addressed during the implementation of this Element. During the implementation of GSPOA, new financing
innovations and initiatives have emerged, including those of public–private partnerships and product development partnerships, many of them addressing Type III diseases, in partnership with international nongovernmental organizations, high-income countries and pharmaceutical companies.

**Key observations from country case studies.** *High-income* countries supported *lower-middle-income* and *low-income* countries through public–private partnerships and product development partnerships. One such country reported that it was active in pursuing sustainable financing mechanisms, but not as a consequence of GSPOA. Respondents in an *upper-middle-income* country felt that financing should come from the private and public sectors and support the entire process from R&D to market launch. Public–private partnerships are seen as an important incentive to involve the private sector and develop a balance between competition and affordability. The financing of health-related infrastructure is a major challenge in most *low-income* and *lower-middle-income* countries. In terms of gaps, one *upper-middle-income* country stated that the funding in health services, health technology, health financing and health governance research is not adequate and needs to be increased. It is evident that *low-income* and *lower-middle-income* countries have very limited access to sustainable financing mechanisms.

**Key achievements.** There are promising grant schemes in *lower-middle-income* and *low-income* countries for stimulating innovation through broad participation of small and medium-sized enterprises in support of relevant R&D. These schemes contribute to the promotion of high-risk pre-proof-of-concept research and end-stage development by small and medium-sized enterprises. Available procurement funds under purchase or procurement agreements stimulate increased R&D and provide large-scale access to new products. Successful product development partnerships brought together the public, private and philanthropic sectors to fund and manage the discovery, development and delivery of new health products. A further achievement is the recommendations of the Consultative Expert Working Group on Research and Development: Financing and Coordination that have been endorsed by the World Health Assembly.

**Key gaps and challenges identified.** Most health sector financing in *low-income* countries has been aid-dependent, but major multilateral partners are now conditioning their support with a view to phased withdrawal. In order to reach long-term sustainability there is a need to pool resources to ensure that *lower-middle-income* and *low-income* countries are enabled to carry out the necessary research and regulatory work to secure their own requirements in terms of health products. Such steps are still in the early stages in many of these countries, including domestic investment in research institutions, capacity development in regulatory systems, education and training. Facilitating the use of financing through public–private partnerships and product development partnerships may require stronger global or regional efforts in identifying possible partners, the countries where the business environment is favourable and where the capacity is available or where it can be developed within a relatively short period of time.

**Recommendations**

Recommendations for consideration by Member States

1. Member States, in the context of Sustainable Development Goal 3.8 on universal health coverage, to secure adequate funding and facilitate R&D efforts for development of health products and medical devices.

2. Member States to increase funding and encourage public–private partnerships and product development partnerships to ensure availability and affordability of health products and medical devices in *lower-middle-income* and *low-income* countries.
3. Member States and other stakeholders to lend their political support to new, innovative schemes for identifying new sources of funding for health R&D and operationalize their use, such as those recommended by the Consultative Expert Working Group on Research and Development: Financing and Coordination.

Recommendations for the consideration by WHO Secretariat
4. The Secretariat to work with other stakeholders to implement the recommendations of the Consultative Expert Working Group on Research and Development: Financing and Coordination.

Element 8: Establishing monitoring and reporting systems
GSPOA supports the establishment of systems to monitor performance and progress towards the objectives contained in the strategy and the plan of action.

Key findings. While several countries listed many health-related initiatives of relevance to their countries, which they monitor regularly and on which they report to their national governments, donors or WHO, these were not comprehensive national strategies set up specifically to implement GSPOA or WHO initiatives in this context. The majority of national stakeholders and survey respondents were not aware of whether their country monitored and reported on investments in health R&D.

Key observations from country case studies. Many stakeholders in all income groups stated that they were asked to report on their activities without knowing that this was a GSPOA requirement. Others cited a lack of incentives to use the WHO monitoring system. Weaknesses in Element 8 are also partly a reflection of the limited resource base in many countries. In terms of gaps, in all income groups, WHO Member States experienced difficulty in complying with the strategy’s provision to establish monitoring and reporting systems for gathering evidence about their implementation processes and results of GSPOA. There is a lack of regular reporting on progress towards implementation of GSPOA, in most cases in all income groups. There is some evidence among low-income, upper-middle-income and high-income countries that gaps and needs in health products have been monitored and assessed. However, there is little evidence that this monitoring was implemented due to GSPOA.

Key achievements. WHO submitted biennial progress reports on GSPOA implementation to the Health Assembly in 2010, 2012 and 2014.229 Furthermore, several countries monitor and report on their health-related initiatives without necessarily referring to the goals of GSPOA.

Key gaps and challenges identified. While there were multiple examples of national strategies to tackle health issues in a given country, these were not comprehensive national strategies set up specifically to implement GSPOA. There was little awareness of GSPOA in a few countries as it was not well disseminated, promoted and financed. The limited resources, weak capacity and competence base of many countries in this area, together with insufficient WHO capacity for support and guidance, further contributed to the observed weaknesses in achieving the monitoring and reporting goals of GSPOA. Some countries undertake knowledge gap analyses created by advances in the development of health products and medical devices, but there is no evidence that these are directly related to GSPOA and are reported to WHO. While there appeared to have been various country-specific monitoring efforts, no specific evidence was provided regarding the monitoring by countries of the impact of IP rights on the development of, and access to, health products during GSPOA implementation. There is also little evidence of countries of any income level actively monitoring and reporting the impact of incentive mechanisms on the innovation of, and

229 Documents A63/6, A65/26 and A67/40.
access to, health products and medical devices. The same is true regarding the impact of investment in R&D to address the health needs of lower-middle-income and low-income countries.

**Recommendations**

Recommendations for consideration by Member States
1. Member States and WHO to plan for a final evaluation of GSPOA implementation in 2023.
2. Member States to strengthen their monitoring and evaluation systems to monitor progress and evaluate the performance of the implementation of GSPOA in their countries.

Recommendations for consideration by the WHO Secretariat
3. The Secretariat to complete the development of a web-based platform for monitoring and information-sharing regarding Member States’ progress and experience in implementing GSPOA.
4. The Secretariat to revise the National Assessment Tool appropriately so as to capture better the existing capacity of Member States to effectively discharge their obligations and responsibilities regarding GSPOA monitoring and reporting.

**Overall programme review in 2017**
An overall programme review is envisaged to be initiated in 2017 and is to be informed by this evaluation.

Recommendations for the overall programme review
1. The overall programme review should address areas identified for future work in this report and consider and provide guidance on the recommendations.
2. Member States, through the overall programme review, to further review resources expended and financing available for the implementation of GSPOA in order to identify best practices and constraints.
13.6 Member State mechanism on substandard/spurious/falsely-labelled/falsified/counterfeit medical products

Document A70/23 (Report by the Director-General):

1. The Director-General has the honour to transmit to the Seventieth World Health Assembly the report of the fifth meeting of the Member State mechanism on substandard/spurious/falsely-labelled/ falsified/counterfeit medical products (see Annex), which met in Geneva from 23 to 25 November 2016.\(^\text{230}\)

2. The Executive Board at its 140\(^{\text{th}}\) session considered an earlier version of the Director-General’s report and adopted decision EB140(6).\(^\text{231}\)

**ACTION BY THE HEALTH ASSEMBLY**

3. The Health Assembly is invited to adopt the following draft decision in light of the recommendation made by the Executive Board in decision EB140(6):

   The Seventieth World Health Assembly, having considered the report of the fifth meeting of the Member State mechanism on substandard/spurious/falsely-labelled/falsified/counterfeit medical products and resolution WHA65.19 (2012),\(^\text{232}\) decided:

   (1) to endorse the definitions as set out in Appendix 3 to the Annex to document A70/23;

   (2) to request the Director-General to replace the term “substandard/spurious/falsely-labelled/falsified/counterfeit medical products” with “substandard and falsified medical products” as the term to be used in the name of the Member State mechanism and in all future documentation on the subject of medical products of this type.

**ANNEX**

**FIFTH MEETING OF THE MEMBER STATE MECHANISM ON SUBSTANDARD/SPURIOUS/FALSELY-LABELLED/ FALSIFIED/COUNTERFEIT MEDICAL PRODUCTS**

**AGENDA ITEM 9**

**REPORT OF THE FIFTH MEETING OF THE MEMBER STATE MECHANISM ON SUBSTANDARD/SPURIOUS/FALSELY-LABELLED/FALSIFIED/COUNTERFEIT MEDICAL PRODUCTS**

1. The fifth meeting of the Member State mechanism on substandard/spurious/falsely-labelled/falsified/counterfeit (SSFFC) medical products was held in Geneva on 23–25 November 2016 and was chaired by Dr Rassoul Dinarvand of the Islamic Republic of Iran with the following Vice-Chairpersons: Dr Amadou Moctar Dieye (Senegal); Mrs. Yetunde Oluremi Oni (Nigeria); Ms Lou Valdez (United States of America); Mr Maximiliano Derecho on behalf of Ambassador Marcelo Cima (Argentina); Dr Mariam Saeed (Pakistan); Ambassador Carole Lanteri (Monaco); Mr Alastair Jeffrey (United Kingdom of Great Britain and Northern Ireland); Dr V G Somani (India); Ms Tika Wihanasari

\(^{230}\) The goal, objectives, and terms of reference for this meeting were approved at the Sixty-fifth World Health Assembly in resolution WHA65.19 (2012), set out in the Annex to the resolution.

\(^{231}\) See document EB140/23 and the summary records of the Executive Board at its 140\(^{\text{th}}\) session, eleventh meeting.

\(^{232}\) See document WHA65/2012/REC/1, and in particular the footnote in the first paragraph of the Annex to the resolution.
Tahar on behalf of Mr Acep Somantri (Indonesia); Ms. Siew Wei Chua on behalf of Ms Annie Tan (Singapore) and Ms Shi Le on behalf of Mr Qin Xiaoling (China). The session was attended by 47 Member States and one regional economic integration organization.

2. The Secretariat provided an update on activities to implement the workplan, including on the WHO Global Surveillance and Monitoring System, the smartphone application pilot study, regulatory strengthening and capacity-building activities, and the circulation of a survey from the International Coalition of Medicines Regulatory Authorities. Member States were encouraged to comment on the WHO Draft Guidance on Testing of “Suspect” Spurious/Falsely-Labelled/Falsified/Counterfeit Medicines by 10 January 2017.

Activity A
3. An informal working group on Activity A was convened by Brazil on 21 November 2016. The working group meeting revised and agreed by consensus a document entitled “Guidance on developing a national plan for preventing, detecting responding to actions, activities and behaviours that result in SSFFC medical products,” which was agreed by consensus by the fifth Meeting of the Member State mechanism and is attached at Appendix 1. It was agreed that this document would be made available on the MedNet platform and WHO website.

4. With reference to other elements of the mandate of Activity A, Member States agreed on a proposed schedule and timeline of activities presented for 2017 on the development and distribution of a survey to identify existing expertise and training materials concerning the prevention, detection and response to SSFFC medical products, as well as on the need for training for countries or regions, and on the redrafting of the document entitled “Recommendations for Health Authorities on criteria for risk classification and assessment prioritization of cases of SSFFC medical products”.

Activity B
5. The Secretariat provided an update on its activities towards formalizing and expanding the network of focal points, including that all Heads of National Medicines Regulatory Authorities would be contacted to reconfirm or nominate their National Focal Points.

Activity C
6. An informal working group on Activity C was convened by Argentina on 21 November 2016. The working group meeting revised and agreed by consensus a document entitled “Available authentication technologies for the prevention and detection of SSFFC medical products,” which was agreed by consensus by the fifth Meeting of the Member State mechanism and is attached (Appendix 2). It was agreed that this document would be made available on the MedNet platform and WHO website.

7. With reference to remaining elements of the working group mandate, namely, the assessment of field detection technologies, the Member State mechanism decided to suspend the working group activities for a year in order to consider ongoing work of other entities related to field detection technologies, and that the Secretariat should ask those entities to make update reports of the progress of their work during the next year, and especially in the plenary of the next meeting of the Member State mechanism, in order to decide if any additional work is needed.

Activity D
8. The Secretariat provided an update on the WHO’s work aimed at deepening the understanding of the link between access to quality, safe, efficacious and affordable medical products and the

emergence of SSFFC medical products. The Member State mechanism emphasized the importance of this issue and supported the idea that Secretariat start the work on the proposed study as contained in document A/MSM/5/2 and requested an update on Phase 1 of the work at the next Steering Committee meeting.

Activity E
9. An informal working group on Activity E (risk communication) was convened by the United Kingdom of Great Britain and Northern Ireland on 22 November 2016. The meeting provided comments on a workplan for 2017–2018. Member States were encouraged to join and contribute to the Communications Working Group.

Activity F
10. The Secretariat provided an update on the study on the public health and socioeconomic impact of SSFFC medical products, as outlined in document A/MSM/4/6. It was agreed that the Member States would receive a minimum of four weeks to provide comments on the third draft, which will highlight the changes made from the second draft. The third draft is scheduled to be released in January 2017. It was agreed that the study could be updated in the future, including as a result of agreement by Member States on definitions, following the work undertaken by the technical working group on Activity H.

Activity G
11. The Secretariat provided an estimation of the annual costs of the prioritized activities for the years 2016 and 2017. In response to concerns expressed on the budget shortfall, Member States emphasized the importance of mobilizing resources to ensure the sustainability of the Member State mechanism. Member States requested WHO Secretariat to allocate and mobilize resources to ensure sustainability of the Member State mechanism, including by considering the possible incorporation of the Member State mechanism in the draft Programme budget 2018–2019.

Activity H
12. An informal working group on Activity H was convened by Argentina on 22 November 2016. The meeting revised and agreed by consensus recommendations on draft working definitions, as contained in the report of the informal technical group annex to document A/MSM/5/7. The Member State mechanism amended and agreed by consensus the document on the working definitions, which is attached, as Appendix 3. It was agreed that this document would be made available on the MedNet platform and on the WHO website.

13. The Member State mechanism agreed by consensus to recommend that the WHO governing bodies endorse the definitions as set out in Appendix 3. The Member State mechanism further agreed by consensus to recommend the WHO to replace the use of “substandard/spurious/ falsely-labelled/falsified/counterfeit medical products” with “substandard and falsified medical products” as the term to be used in the name of the mechanism and in all future documentation on the subject of medical products of this type.

Activity outcomes
14. The Member State mechanism requested the Secretariat to publish the outcomes and documents of the Member State mechanism on the WHO website and MedNet as standalone documents.

WHO’s participation in the Global Steering Committee for Quality Assurance of Health Products
15. The Secretariat provided an update on WHO’s participation in the Global Steering Committee for Quality Assurance of Health Products, as outlined in document A/MSM/5/3. Member States
requested the Secretariat to assess this engagement under WHO’s Framework of Engagement with Non-State Actors and requested that a report on the work and documentation of the Global Steering Committee be provided as appropriate to the Steering Committee of the Member State mechanism. Pending this assessment, it was agreed that the WHO would continue observing, on a provisional basis, the meetings of the Global Steering Committee. The Member State mechanism agreed by consensus to invite a representative of the Global Fund to brief the Steering Committee on the Global Steering Committee.

**Update on WHO’s activities for regulatory systems strengthening, and on the application of WHO’s global benchmarking tool**

16. The Secretariat provided an update on WHO’s work on regulatory systems strengthening for medical products. It was agreed that the Secretariat would provide the SSFFC-related indicators currently used in the global benchmarking tool to the sixth meeting of the mechanism. It was also agreed by consensus to request WHO to publish a guidance manual for the use of the global benchmarking tool and also to keep all channels of support for regulatory systems strengthening open, other than assessment through the global benchmarking tool.

**Review of the Member State mechanism on substandard/spurious/falsely-labelled/falsified/counterfeit medical products**

17. The WHO Evaluation Office provided an update on the review of the Member State mechanism and presented the terms of reference for the review as contained in document A/MSM/5/4 and the survey questionnaire as contained in document A/MSM/5/4 Add.1. The survey questionnaire was agreed as updated, based on comments received during the discussion. The Member State mechanism agreed by consensus on the document A/MSM/5/4 Add.1 and recommended that the survey proceed.

**Date of the next meeting**

18. The Member State mechanism decided that its sixth meeting would be held in October or November 2017 and that the exact dates would be further discussed by the Steering Committee.

19. Member States noted that, as agreed by the Steering Committee at its meeting in September 2016, the proposed agenda item on transit would be discussed by the Steering Committee at its next meeting.

20. Member States noted that the new composition of the Steering Committee beginning from the closure of the fifth meeting of the mechanism would be as follows:

- African Region: Togo and the United Republic of Tanzania
- Region of the Americas: Brazil and the United States of America
- Eastern Mediterranean Region: Islamic Republic of Iran and Morocco
- European Region: Spain and the United Kingdom of Great Britain and Northern Ireland
- South-East Asia Region: India and Indonesia
- Western Pacific Region: China and Malaysia

21. As recommended by the Health Assembly in decision WHA66(10)\textsuperscript{234} and agreed by the mechanism, the Chair of the Member States mechanism rotates among the six regions in English alphabetical order. In this regard, the next Chair will come from the European Region.

\textsuperscript{234} Paragraph 8 of the report of the second meeting of the Member States mechanism as contained in document A67/29, Annex.
Appendix 1

GUIDANCE ON DEVELOPING A NATIONAL PLAN FOR PREVENTING, DETECTING AND RESPONDING TO ACTIONS, ACTIVITIES AND BEHAVIOURS THAT RESULT IN SSFFC MEDICAL PRODUCTS

INTRODUCTION

1. Actions, activities and behaviours that result in SSFFC medical products are a local and global health problem related to the integrity of the manufacturing and supply chain that must be prevented, detected and effectively responded to, while maintaining a public health perspective.

2. The problem is potentially more severe in countries with weak or nonexistent health regulatory systems and health surveillance infrastructures. These characteristics increase the risk that medical products that are not in compliance with national and regional health regulations will be manufactured and/or distributed – a scenario that puts patients at risk.

3. High prices, inadequate access to affordable medicines, and drugs in shortage are incentives for actions, activities and behaviours that result in SSFFC medical products. These problems must be tackled from the public health perspective.

4. Attention should also be given to the supply of SSFFC medical products through the Internet, given its specificities, the challenges involved in its prevention, detection and effective response, as well as the major dimension this problem has reached globally.

5. Given the nature of the problem and measures related to the prevention, detection and response in respect of actions, activities, and behaviours that result in SSFFC medical products, this guidance must be read from a public health perspective and in accordance with the Member State mechanism’s mandate.

Scope

6. This guidance focuses on the measures and actions to be adopted by national or regional regulatory authorities when developing a national or regional plan, driven by public health concerns, for preventing, detecting and responding to actions, activities and behaviours that result in SSFFC medical products.

7. Collaborative measures and actions with other national, regional and international stakeholders are also described in this guidance.

8. This document presents three goals and the respective desired outcomes to be achieved by a national or regional plan for preventing, detecting and responding to actions, activities and behaviours that result in SSFFC medical products, as well as a road map with examples of actions that might be considered by national and regional regulatory authorities. The road map and the example of actions presented should support the achievement of the three goals, and are by no means exhaustive.

Guiding principles

9. Actions, activities and behaviours that result in SSFFC medical products can involve branded and generic products aimed at the domestic market or the global supply chain.

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235 See Annex 1 of document A/MSM/2/6: actions, activities and behaviours that result in substandard/spurious/falsely-labelled/falsified/counterfeit medical products.
10. Given the fact that actions, activities and behaviours that result in SSFFC medical products are a public health problem, the definitions adopted by the national or regional plan should be based on a common understanding at international level, where feasible, and take into account public health concerns and practices.

11. Measures adopted by the national or regional plan should take into consideration national policies that support access to medical products, including generic medicines.

12. There is not a one-size-fits-all solution to effectively combat actions, activities and behaviours that result in SSFFC medical products. A multilayer approach that considers prevention, detection, and response strategies is required and should be based on coordination of efforts, exchange of information, and training to strengthen the national or regional health regulatory authority and system.

13. Furthermore, the national or regional plan benefits from a multidisciplinary approach, with the involvement of different stakeholders. Countries or regions with limited resources that are considering developing a plan can benefit from the identification of key action areas in order to ensure that resources can be directed to those activities that will have the most impact first.

14. A national or regional plan would lead to the development of legislative instruments, and legislation enforcement would contribute to the desired outcomes. National or regional legislations on SSFFC medical products should include effective and appropriate enforcement tools and penalties, as well as adequate resources.

GOAL 1: BETTER PREVENTION OF ACTIONS, ACTIVITIES AND BEHAVIOURS THAT RESULT IN MARKET ENTRY OF SSFFC PRODUCTS

Desired outcomes:
1.1. Reduced actions, activities and behaviours that result in SSFFC medical products
1.2. Improved manufacturing and supply chain integrity
1.3. Improved communication, education, and awareness
1.4. Increased collaboration and cooperation among all stakeholders
1.5. Increased industry responsibility
1.6. Strengthened oversight by regulators.

GOAL 2: BETTER DETECTION OF SSFFC MEDICAL PRODUCTS AND BETTER DETECTION OF ACTIONS, ACTIVITIES AND BEHAVIOURS THAT RESULT IN SSFFC MEDICAL PRODUCTS

Desired outcomes:
2.1. Improved surveillance
2.2. More effective investigation of suspect incidents
2.3. More efficient confirmation that products are SSFFC
2.4. Improved vigilance systems
2.5. More appropriate technology (with consideration given to the technological and financial realities of the national or regional regulatory authority)
2.6. Strengthened capacity and capabilities of laboratories
2.7. Better exchange of information and experiences with all stakeholders.
GOAL 3: MORE EFFECTIVE RESPONSE TO SSFFC MEDICAL PRODUCTS AND MORE EFFECTIVE RESPONSE TO ACTIONS, ACTIVITIES AND BEHAVIOURS THAT RESULT IN SSFFC MEDICAL PRODUCTS

Desired outcomes:

3.1. More effective notification of confirmed actions, activities and behaviours that result in SSFFC medical products
3.2. More effective communication and awareness about detected SSFFC medical products
3.3. More efficient and effective removal of SSFFC products from the market
3.4. Improved response to SSFFC products and actions, activities and behaviours that result in SSFFC medical products
3.5. Improved enforcement
3.6. More effective investigation of confirmed actions, activities and behaviours that result in SSFFC medical products
3.7. Enhanced legal/regulatory tools and measures; and
3.8. Increased collaboration and cooperation among all stakeholders.

ROAD MAP AND EXAMPLES OF ACTIONS

1. Establish or review legislation and regulations aiming at preventing, detecting and responding to actions, activities and behaviours that result in SSFFC medical products

1.1 Develop a compendium of regulatory guidelines related to the issue of actions, activities and behaviours that result in SSFFC medical products
1.2 Assess the existing legislation and identify gaps that allow the entry of SSFFC medical products into the market
1.3 Develop, update and strengthen the legal framework – for example, regulations on marketing authorization, good manufacturing practice, good distribution practice, good pharmacy practice, good pharmacovigilance practice, good importation practice compliance, and good clinical practice – aimed at preventing the actions, activities and behaviours that result in market entry of SSFFC medical products (to be developed and implemented according to good regulatory practices)
1.4 Ensure that only authorized and licensed supply chain stakeholders are involved in medical product transactions.

2. Strengthen capacity of national and regional regulatory authorities

2.1 Increase autonomy and empowerment of national and regional regulatory authorities
2.2 Strengthen capacity on inspections in order to check compliance with the legislation, to identify risks and suspect cases, to implement enforcement actions when non-compliance is detected
2.3 Strengthen capacity for inspections at borders
2.4 Strengthen the capacity for intelligence gathering and investigations on actions, activities and behaviours that result in SSFFC medical products
2.5 Improve good practices of coordination at all levels of governmental authorities, especially in countries where the health surveillance and the health regulatory systems are decentralized
2.6 Include education, increasing awareness and training modules on regulatory affairs in the curricula of regulators (promotion of practices/regulations/guidelines)
2.7 Develop a code of conduct/ethics for regulators
2.8 Engage in regional and global initiatives aimed at developing the strength and capacity of national and regional regulatory authorities
2.9 Create specialized functions, capacities, and capabilities within the national or regional regulatory authority to organize and implement the national or regional plan.

3. Collaborate and/or cooperate appropriately with relevant stakeholders
3.1 Establish sustained, regular and public health-driven partnerships among governmental stakeholders
3.2 Empower the National and Regional Regulatory Authority in the process of coordination and collaboration with other governmental stakeholders
3.3 Establish/maintain channels for communication of the national or regional regulatory authority with all stakeholders, including industry associations, without conflict of interest and from a public health perspective
3.4 Provide databases that can be consulted online by all national (or regional) authorities involved (e.g. authorized manufacturers, wholesalers, registered products, banned or recalled products, etc.)
3.5 Develop and implement investigational/intelligence capacities that go beyond the health regulatory authority (in collaboration with the police, for example)
3.6 Provide multidisciplinary training for the health regulatory staff in the relevant areas of action from a public health perspective
3.7 Adopt strategies for the efficient exchange of information between the governmental bodies involved in the prevention of actions, activities and behaviours that result in market entry of SSFFC medical products, including the provision for a single point of contact system
3.8 When considered necessary by national or regional regulatory authorities, conduct joint national operations and investigations with customs and police, as well as with other relevant stakeholders, from a public health perspective.

4. Strengthen capacity of other governmental bodies, observing the public health perspective
4.1 Adjust, if necessary, the existing legal framework adopted by these governmental bodies to public health-driven demands related to the prevention of actions, activities and behaviours that result in market entry of SSFFC medical products
4.2 Include education, increasing awareness and training modules on regulatory affairs in the curricula of the staff in relevant governmental bodies (promotion of practices/regulations/guidelines).

5. Sensitize stakeholders on the risks of actions, activities and behaviours that result in SSFFC medical products
5.1 Develop and implement communication strategy
5.2 Develop advocacy documents
5.3 Educate and increase awareness (promotion of practices/regulations/guidelines) specifically to:
   • Health professionals in general
   • Regulated sector
• Public in general (development of public campaigns).

6. Prevent, monitor and control actions, activities and behaviours that result in the supply of SSFFC medical products through the internet

6.1 Develop a tailored strategy to address the issue of the Internet as a facilitator for the sale and supply of SSFFC medical products

6.2 Develop and implement a communication strategy targeting the supply of SSFFC medical products through the Internet

6.3 Educate and increase awareness to the public in general (development of public campaigns)

6.4 Understand Internet governance and the role of the Internet Corporation for Assigned Names and Numbers. In particular, develop relationships and establish agreements with the domain name registry and registrars, and with hosting service providers and Internet service providers in order to remove and disrupt websites

6.5 Develop relationships and establish agreements with financial merchant service providers in order to remove payment facilities and thereby disrupt the online sale of SSFFC medical products

6.6 Develop relationships and establish agreements with social media providers where SSFFC medical products may be advertised

6.7 Develop relationships and establish agreements with online market places where SSFFC medical products may be sold

6.8 Consider developing a regulatory framework for registering legitimate online sales websites and allocating a logo or other authentication so that consumers can purchase medicines safely.

7. Collaborate to ensure the availability of safe, quality, efficacious and affordable medical products

7.1 Develop and implement national policies for access to generic medical products

7.2 Support authorized local production

7.3 Promote adoption of guidelines to qualify suppliers of medical products and to manage the risks in the supply chain

7.4 Share or exchange experiences, best practices, and information related to identifying measures that address access to quality, safe, efficacious and affordable medical products, including (but not limited to) the supply and use of generic medical products.

8. Strengthen pharmacovigilance system

8.1 Assess the existing national pharmacovigilance system

8.2 Map existing successful national experiences

8.3 Develop/strengthen capacity for pharmacovigilance reporting, including IT systems

8.4 Encourage the reporting of trends to identify patterns in adverse reactions and lack of therapeutic effect

8.5 Establish a complementary system to collect and analyse complaints directly from patients
8.6 Adopt good practices of coordination at all levels of governmental authorities, especially in countries where the health surveillance and the health regulatory system are decentralized.

8.7 Improve collaboration and information sharing by national health regulatory authorities on a global scale.

9. Strengthen post-marketing surveillance programmes

9.1 Assess the existing national post-marketing surveillance system
9.2 Map existing successful national experiences
9.3 Develop/strengthen capacity for post-marketing surveillance
9.4 Establish a complementary system to collect and analyse complaints directly from patients
9.5 Adopt good practices of coordination at all levels of governmental authorities, especially in countries where the health surveillance and the health regulatory system are decentralized.
9.6 Implement a structured and systematic risk-based post-market surveillance programme, in order to ensure efficient use of limited available resources
9.7 Establish or improve risk-based programmes for sampling of medical products for testing by laboratories
9.8 Intensify risk-based inspections of premises and customs controls
9.9 Establish a reliable and cost-effective traceability system for medical products, based on a risk approach.\(^\text{236}\)
9.10 Implement the use of reliable and cost-effective detection technologies
9.11 Improve collaboration and information sharing by national health regulatory authorities on a global scale.

10. Strengthen laboratory capacity and capabilities for quality control of medical products and detection of SSFFC medical products

10.1 Assess the capacity and capabilities of quality control laboratories for the detection and confirmation of suspect cases
10.2 Establish or improve the capacity and infrastructure of quality control laboratories
10.3 Establish inter-country platforms for collaboration and information sharing among quality control laboratories.

11. Encourage timely and accurate dissemination of information and improve information sharing on incidents nationally, regionally and globally

11.1 Provide adequate communication of risk
11.2 Develop and conduct training programmes on incident management and risk communication
11.3 Strengthen the coordination at all levels of governmental authorities, especially in countries where the health surveillance and the health regulatory system are decentralized and/or weak
11.4 Take part in international initiatives aimed at sharing information and rapid alerts

\(^{236}\) See document EB138/40 Appendix 2, Existing technologies and “track and trace” models in use and to be developed by Member States and the document for the current meeting under Activity C.
11.5 Train focal points, establish and implement procedures to report SSFFC medical products to monitoring and alert systems, including the WHO global surveillance and monitoring system

11.6 Develop infrastructure, activities, capacity-building and operational mechanisms for sharing of information

11.7 Regularly update and publish a compendium of authorized pharmaceutical establishments and medical products.

12. Ensure the timely intervention of national and regional regulatory authorities to react quickly and proportionately, in order to safeguard public health, to incidents involving actions, activities and behaviours that result in SSFFC medical products

12.1 Implement procedures for suspension of marketing authorization, quarantine, recall/return of suspect medical products, safety alerts and destruction of SSFFC medical products

12.2 Adopt procedures for regulatory authority rapid response when a suspect SSFFC medical product is identified

12.3 Adopt procedures for regulatory authority rapid response when an action, activity or behaviour that results in SSFFC medical products is identified

12.4 Adopt good practices of coordination at all levels of governmental authorities, especially in countries where the health surveillance and the health regulatory systems are decentralized.

13. Ensure adequate enforcement and collaboration from the public health perspective

13.1 Sensitize and implement joint training initiatives involving the following: customs, police, legislature, judiciary and prosecutors

13.2 Actively investigate, prosecute and sanction in accordance with national legislation the actions, activities and behaviours that result in SSFFC medical products

13.3 Monitor measures and results of the actions taken by the police, customs, and regulatory authorities for preventing, detecting and responding to actions, activities and behaviours that result in SSFFC medical products.

Appendix 2

AVAILABLE AUTHENTICATION TECHNOLOGIES FOR THE PREVENTION AND DETECTION OF SSFFC MEDICAL PRODUCTS

[This Appendix is not included here. The full document can be downloaded from the WHO WHA70 web page, at http://apps.who.int/gb/ebwha/pdf_files/WHA70/A70_23-en.pdf.]

Appendix 3

WHO MEMBER STATE MECHANISM ON SSFFC MEDICAL PRODUCTS WORKING DEFINITIONS

INTRODUCTION

1. At the fourth meeting of the Member State mechanism on SSFFC medical products held on 19 and 20 November 2015, the decision was taken237 to establish a working group on refining the

working definitions of SSFFC medical products,\textsuperscript{239} based on those currently used by the WHO global surveillance and monitoring system. This decision followed comments received from Member States with reference to the working definitions document circulated on the MedNet platform in 2015, which have been consolidated in the present paper.

**Scope**

2. This working group seeks to achieve a simplified common global understanding and provide clarity of what is meant by the term “SSFFC medical product” to Member States and all other stakeholders; and to recommend a definition of what constitutes a SSFFC medical product to the fifth meeting of the Member State mechanism.

3. In this sense, in the terms of reference set out in resolution WHA65.19 (2012)\textsuperscript{240} it was stated in the relevant footnote that “The Member State mechanism shall use the term “substandard/spurious/ falsely-labelled/falsified/counterfeit medical products” until a definition has been endorsed by the governing bodies of WHO. Previous discussions between Member States show that there would be a consensus among them to accept the use of the term “falsified” for the purposes of the work carried out within the Member State mechanism. Should consensus among Member States be achieved, the term “SSFFC” could, therefore, be replaced by that agreed by them.

4. It is not intended to propose, or affect in any way, national and/or regional legislation either in existence or that may be drafted in the future by Member States and/or regional organizations relating to SSFFC medical products. No matter which terms are adopted by each Member State, it is important to have a clear understanding about the terms and their correlation with the working definitions adopted by the Member State mechanism.

**Methodology**

5. The classification of reports of SSFFC medical products to WHO permits a more thorough and accurate comparison and analysis of reports, separating substandard medical products from those that are deliberately/fraudulently making a misrepresentation (spurious, falsely-labelled, falsified or counterfeit) and those that are unregistered/unlicensed in the country of marketing (see Figure).

**Figure. Classification of medical products to be used by the WHO global surveillance and monitoring system and the Member State mechanism**

\textsuperscript{238} See document A/MSM/4/10.

\textsuperscript{239} A medical product is defined as a medicine, vaccine or in vitro diagnostic (paragraph 3 document A/SSFFC/WG/5) and it may also include medical devices at an appropriate time in the future.

\textsuperscript{240} See document WHA65/2012/REC/1.
6. The classification table shown in the figure above sets out three separate and mutually exclusive classifications of medical products reported to the WHO global surveillance and monitoring system.

7. For the purpose of this document and the classifications below, Authorized medical products means medical products in compliance with national and regional regulations and legislation. NRRAs can, according to national or regional regulations and legislation, permit the marketing or distribution of medical products with or without registration/licence.

(a) Substandard medical products

Also called “out of specification”, these are authorized medical products that fail to meet either their quality standards or their specifications, or both.\(^\text{241}\)

(b) Unregistered/unlicensed medical products

Medical products that have not undergone evaluation and/or approval by the NRRA for the market in which they are marketed/distributed or used, subject to permitted conditions under national or regional regulation and legislation.

These medical products may or may not have obtained the relevant authorization from the national/regional regulatory authority of its geographical origin.

(c) Falsified medical products

Medical products that deliberately/fraudulently misrepresent their identity, composition or source.

Any consideration related to intellectual property rights does not fall within this definition.

Such deliberate/fraudulent misrepresentation refers to any substitution, adulteration, reproduction of an authorized medical product or the manufacture of a medical product that is not an authorized product.

“Identity” shall refer to the name, labelling or packaging or to documents that support the authenticity of an authorized medical product.

“Composition” shall refer to any ingredient or component of the medical product in accordance with applicable specifications authorized/recognized by NRRA.

“Source” shall refer to the identification, including name and address, of the marketing authorization holder, manufacturer, importer, exporter, distributor or retailer, as applicable.

Medical products should not be considered as falsified solely on the grounds that they are unauthorized for marketing in any given country.

Intellectual property rights

8. The terms of reference of the Member State mechanism on SSFFC medical products expressly exclude the protection of intellectual property rights from the mandate of the mechanism and, therefore, the same criteria shall be used in the definitions to be used in its deliberations and work.

\(^\text{241}\) When the authorized manufacturer deliberately fails to meet these quality standards or specifications due to misrepresentation of identity, composition, or source, then the medical product should be considered “falsified”.
The term “counterfeit” is now usually defined and associated with the protection of intellectual property rights. For reference purposes, the definitions of “trademark counterfeit goods”\(^\text{242}\) and pirated copyright goods\(^\text{243}\) are included as defined under the Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS).

9. In the context of medical products, the term “falsified” appears to adequately include all the various types of deliberate misrepresentation of a medical product in such a way which enables the specific exclusion of intellectual property rights.

**Conclusion and recommendation**

10. This document is not intended to be an exhaustive examination of legal texts and definitions, but; rather, it is meant to start the process of simplifying the current terminology in use by the WHO global surveillance and monitoring system and the Member State mechanism from a public health perspective.

11. Based on the deliberation of the working group it is recommended that the Member State mechanism replace the use of “substandard/spurious/falsely-labelled/falsified/counterfeit medical products” with “substandard and falsified medical products”, as the term to be used in its name and in all future documentation on the subject of medical products of this type.

**Document A70/23 Add1:**

**Review of the Member State mechanism on SSFFC medical products**

1. Further to resolution WHA65.19 (2012) and decision WHA68(12) (2015), a review of the Member State mechanism on SSFFC medical products was conducted, covering the period 2012–2016. At the fourth meeting of the Member State mechanism in November 2015, there was agreement that the review process should be led by the WHO Evaluation Office.\(^\text{244}\)

2. In line with the terms of reference of the Member State mechanism,\(^\text{245}\) the Secretariat is submitting the executive summary of the final review report to the Seventieth World Health Assembly (see Annex).\(^\text{246}\)

**ACTION BY THE HEALTH ASSEMBLY**

3. The Health Assembly is invited to note the report.

The Annex containing the Executive Summary can be downloaded from http://apps.who.int/gb/ebwha/pdf_files/WHA70/A70_23Add1-en.pdf.

\(^{242}\) “Trademark counterfeit goods: goods, including packaging, bearing without authorization a trademark that is identical to the trademark validly registered in respect of such goods, or which cannot be distinguished in its essential aspects from such a trademark, and which thereby infringes the rights of the owner of the trademark in question under the law of the country of importation.”

\(^{243}\) “Pirated copyright goods: any goods that are copies made without the consent of the right holder or person duly authorized by the right holder in the country of production, and which are made directly or indirectly from an article where the making of that copy would have constituted an infringement of a copyright or a related right under the law of the country of importation.”

\(^{244}\) See document A69/41, Annex.

\(^{245}\) See resolution WHA65.19, Annex (document WHA65/2012/REC/1).

\(^{246}\) The full report of the review is available on the website of the WHO Evaluation Office, see http://www.who.int/about/finances-accountability/evaluation/SSFFC_FinalReport_28Apr17.pdf?ua=1 (accessed 28 April 2017).
13.7 Promoting the health of refugees and migrants

Document A70/24 (Report by the Secretariat):

Draft framework of priorities and guiding principles to promote the health of refugees and migrants

1. In January 2017, the Executive Board at its 140th session noted an earlier version of this report and adopted decision EB140(9). The version of the report that follows has been updated, new text has been included and a draft framework of priorities and guiding principles to promote the health of refugees and migrants has been added as an Annex.

2. Decision EB140(9) requests, inter alia, the Director-General to prepare, in full consultation and cooperation with Member States, and in cooperation with IOM, UNHCR and other relevant stakeholders, a draft framework of priorities and guiding principles to promote the health of refugees and migrants, to be considered by the Seventieth World Health Assembly.

3. The present report summarizes the current global context and the health challenges associated with refugees and migrants, describes the Secretariat’s actions at the global and regional levels to address the challenges, and briefly outlines priority actions for the future in relation to resolution WHA61.17 (2008), in which the Health Assembly requested the Director-General, inter alia, to promote: migrants’ health on the international health agenda; the inclusion of migrants’ health in the development of regional and national health strategies; dialogue and cooperation on migrants’ health among all Member States involved in the migratory process; and interagency, interregional and international cooperation on migrants’ health.

4. The draft framework of priorities and guiding principles to promote the health of refugees and migrants should inform discussions among Member States and partners engaged in the development of the global compact on refugees and the global compact for safe, orderly and regular migration to ensure that the health aspects of refugees and migrants are adequately addressed. This framework will also be used as a basis for the development of a draft global plan of action on the health of refugees and migrants, which is to be submitted to the Seventy-second World Health Assembly in 2019. Furthermore, Member States can consider this framework when addressing the health needs of refugees and migrants, in alignment with the Sustainable Development Goals and other global and regional policy frameworks as appropriate to their contexts, priorities and partners.

CURRENT CONTEXT

5. More people are on the move now than ever before. The overwhelming majority of migrants leave their countries of origin voluntarily, in search of better economic, social and educational opportunities and a better environment. At the end of 2015, there were estimated to be over 244 million international migrants (about 3.5% of the world’s population), representing an increase of 77 million – or 41% – compared with the year 2000. Of these, 48% were women. However, the world is also witnessing the highest level of forced displacement in decades due to insecurity and conflicts. At the end of 2015, there were estimated to be over 21 million refugees and 3 million asylum seekers worldwide, in addition to 763 million internal migrants (about 11% of the world’s population), of whom over 40 million were internally displaced persons.250

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248 See the summary records of the Executive Board at its 140th session, seventeenth meeting.
249 And, where applicable, regional economic integration organizations.
6. In the WHO African Region, new and ongoing conflicts have generated further displacement in the Region over the past year. Violence in Burundi, the Central African Republic, Nigeria and South Sudan has displaced hundreds of thousands of people internally and across borders, while the deteriorating situation in Yemen has caused significant numbers to seek safety in different countries in the Region. Meanwhile, protracted conflicts in the Democratic Republic of the Congo, Mali and South Sudan have prevented millions from returning home. By the end of 2015, there were 4.2 million refugees and 6.4 million internally displaced persons in the Region. Their largest numbers were concentrated in Nigeria, South Sudan and the Democratic Republic of the Congo.252

7. In the WHO Region of the Americas, the number of people migrating across international borders surged by 36% between 2000 and 2015, to reach 63.7 million in 2015, including 7.1 million internally displaced persons (6.9 million of whom were in Colombia alone). The Region has also been experiencing an increase in irregular migrants, specifically unaccompanied children, many of whom are fleeing violence, with unforeseen consequences to their mental health.

8. In the WHO European Region, more than 1.2 million new migrants, asylum seekers and refugees had arrived in Europe by the end of 2015. This is in addition to the approximately 2.7 million refugees from the Syrian Arab Republic who are hosted in Turkey. During the period from January to June 2016, there were over 318,000 arrivals by sea, and over 3,600 deaths or missing persons reported in the Region. The countries receiving the largest number of arrivals by sea are Greece and Italy.

9. The WHO Eastern Mediterranean Region is currently the region where the world’s biggest emergencies and protracted crises are taking place. Of the total of 65 million refugees, asylum seekers and internally displaced persons worldwide, 34 million come from the Region. This includes more than 14 million refugees and asylum seekers and more than 20 million internally displaced persons. The Region has seen massive internal displacement in the Syrian Arab Republic with 6.6 million, Iraq with 4.4 million, Sudan with 3.2 million and Yemen with 2.5 million people fleeing their homes by the end of 2015. By the end of 2015, more than half of the 4.9 million refugees from the Syrian Arab Republic were hosted by four countries in the Region, which has a direct or indirect impact on more than 12 million people in the host communities.

10. In the WHO South-East Asia and Western Pacific Regions, the overall number of refugees has remained stable at 500,000 people since 2001, but the number of internally displaced persons has decreased sharply from 2.5 million to less than 1 million, as some of the forced displacement situations have been resolved.

**KEY GLOBAL AND REGIONAL FRAMEWORKS**

11. Several resolutions adopted by the WHO governing bodies at the global and regional levels and at international consultations are relevant to the health of refugees and migrants. These include: resolution WHA61.17 on the health of migrants, adopted in 2008, which was followed up by the first and second Global Consultation on Migrant Health, organized by WHO, IOM and the Government of Spain in 2010 and the Government of Sri Lanka in 2017; resolution WHA69.11 (2016) on health in the 2030 Agenda for Sustainable Development; resolution WHA62.14 (2009) on reducing health inequities through action on the social determinants of health; and resolutions adopted by the WHO Regional Committee for the Americas (CD55.R.13 (2016)) on the health of migrants, and the WHO Regional Committee for Europe (EUR/RC66/R6 (2016)) on a strategy and action plan for refugee and migrant health in the WHO European Region.

252 Listed in descending order of number of refugees and internally displaced persons.
12. In the 2030 Agenda for Sustainable Development, the needs of refugees, internally displaced persons and migrants are explicitly recognized. The Agenda recognizes the positive contribution of refugees and migrants for inclusive growth and sustainable development, for which good health is a prerequisite. Member States have made a commitment to work towards its full implementation, have pledged that no one will be left behind and wish to see the Sustainable Development Goals and their targets met for all nations and peoples and for all segments of society. Pursuing the health-related Goals and their relevant targets, will help Member States and partners to address multiple economic, social and environmental determinants of the well-being of refugees and migrants.

13. On 19 September 2016, the United Nations General Assembly adopted the New York Declaration for Refugees and Migrants, setting out commitments to enhance the protection of both refugees and migrants. Its two annexes pave the way for the development of the global compact on refugees and the global compact for safe, orderly and regular migration in 2018.

HEALTH CHALLENGES AND OPPORTUNITIES ASSOCIATED WITH MIGRATION AND DISPLACEMENT

14. Migratory movements can benefit individuals as well as whole societies, through both remittances sent to a person’s country of origin (with potentially positive impacts on health, education and business investments for economic growth) and labour market, human and social capital contributions. For example, as highlighted in the report of the High-Level Commission on Health Employment and Economic Growth,253 the health sector is a leading source of employment and skilled migrant workforce. The international migration of health workers is increasing. Over the past decade, the number of migrant doctors and nurses working in OECD countries increased by 60%. Future projections in economic demand and the supply of health workers indicate a continuing acceleration in the international migration of health workers. Patterns of health worker mobility are also growing increasingly complex.254

15. Refugee and migrant movements may result from and can lead to human insecurity and health-related human rights restrictions. Economic deprivation, disparities, employment, food insecurity, disasters, climate change, environmental hazards, violence, conflict, political and religious persecution, and ethnic- and gender-based discrimination can all lead to large flows of refugees and migrants. It is important to note that the distinction between a refugee,255 asylum seeker256 and migrant257 is not always an easy one to establish immediately. The distinction between transit and

255 A person who, owing to well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of his nationality and is unable or, owing to such fear, is unwilling to avail himself of the protection of that country; or who, not having a nationality and being outside the country of his former habitual residence as a result of such events, is unable or, owing to such fear, is unwilling to return to it. Source: United Nations General Assembly. Convention relating to the Status of Refugees. A/CONF.2/108/Rev.1; http://www.refworld.org/docid/3be01b964.html, accessed 3 May 2017).
256 An individual who is seeking international protection. In countries with individualized procedures, an asylum-seeker is someone whose claim has not yet been finally decided on by the country in which he or she has submitted it. Not every asylum-seeker will ultimately be recognized as a refugee, but every refugee is initially an asylum-seeker. Source: UNHCR. Master glossary of terms. Rev.1 (http://www.refworld.org/docid/42ce7d444.html, accessed 3 May 2017).
257 At the international level, there is no universally accepted definition of the term “migrant”. Migrants may remain in the home country or host country (“settlers”), move on to another country (“transit migrants”), or move back and forth between countries (“circular migrants” such as seasonal workers). Source Strategy and
destination countries is also complex, as refugees and migrants may have been turned away from their initial destinations and may have returned to places that they had already travelled through. They often face different types and levels of vulnerability before, during and after migration and displacement, depending on their age, gender, ethnicity, income, education, access to employment opportunities and care responsibilities.

16. Despite the fact that the right of everyone to enjoy the highest attainable standard of physical and mental health is established in the WHO Constitution of 1948, and despite the existence of ratified international human rights conventions to protect the rights of refugees and migrants, including their right to health, refugees and migrants often lack access to health services and financial protection for health. Worldwide, access to health services among vulnerable refugee and migrant populations within the host countries remains highly variable and is not consistently addressed. The health needs of refugee and migrant populations may differ significantly from those of the populations of the host countries. Barriers to accessing health care may include high costs, language and cultural differences, discrimination, administrative hurdles, the inability to affiliate with local health insurance schemes, and lack of information about health entitlements.

17. Many refugees and migrants often have to deal with poverty, poor living conditions and marginality. They often work in sectors and occupations with high levels of occupational health risks and substandard working conditions, which can increase the risk of occupational accidents. Few workplaces employing refugees and migrants provide basic occupational health services, and few refugees and migrants benefit from national social security compensation or rehabilitation schemes for occupational-related illness or injury. Female migrant care workers, despite increasingly contributing to buttressing host country health systems and filling gaps in care work, face multiple layers of disadvantage, discrimination and exclusion from services that are themselves based on intersecting forces of inequality. More comprehensive policy and legal frameworks (including visas and work permits) that cover all cadres of health and care workers, from formal health system settings to informal home-based settings, are needed, taking into account the changing dynamics of transnational care chains.

18. Victims of conflict and human trafficking – especially women, children including unaccompanied minors, and people with disabilities – are particularly vulnerable to health problems. These individuals are at higher risk of developing communicable and noncommunicable diseases, including mental health problems. Migration and displacement can also pose specific health threats, including sexual violence, especially against women and girls. This is particularly significant, since women and girls who are refugees or migrants often face diverse sexual and reproductive health challenges and are most vulnerable to preventable mortality and morbidity arising from lack of sexual and reproductive health services.

19. Mass population movement, lack of clean drinking water, and inadequate shelter and poor sanitation conditions increase the risk of refugees and migrants acquiring communicable diseases. Access to the full vaccination schedule, through follow-up vaccinations, is difficult to ensure while people are on the move. Those most at risk of developing vaccine-preventable diseases are young children who have not yet been vaccinated because the vaccination programmes in their home countries have been interrupted by civil unrest and war. Furthermore, many refugees and migrants choose not to be vaccinated due to misconceptions about vaccines, complacency, poor awareness of the benefits of vaccination, or religious or philosophical beliefs. Others do not have access to

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vaccination services because they do not have health insurance or are not registered with the health system.\textsuperscript{258}

20. Being a refugee or a migrant does not, by itself, make individuals significantly more vulnerable to developing mental disorders, but refugees and migrants can be exposed to various stress factors that influence their mental well-being.\textsuperscript{259} Refugees and migrants often face war, persecution and extreme hardship in their countries of origin. Many experience displacement and hardship in transit countries and embark on dangerous travels. Lack of information, uncertainty about immigration status, potential hostility, changing policies, and undignified and protracted detention all add additional stress. Furthermore, forced migration often requires multiple adaptations in short periods of time, making them more vulnerable to abuse and neglect. Pre-existing social and mental health problems can be exacerbated. Importantly, the way people are received by host countries and how protection and assistance are provided may induce or aggravate problems, for example by undermining human dignity. An acute sense of urgency among people on the move may prompt them to take extreme medical and psychosocial risks and their fast-paced mobility through several countries leaves only very little time for service provision.\textsuperscript{260}

21. Some transit and destination countries perform health assessments of refugees and migrants. Other countries have provisions imposing certain health conditions that may prevent refugees and migrants from entering the country or result in them being subject to deportation. This issue poses a challenge in defining public health preventive and treatment measures that adhere to basic human rights. The challenge is even more complicated when dealing with refugees and undocumented/irregular migrants, since there are no mechanisms to detect health conditions before migration and displacement.

22. At the global and national levels, health policies and strategies to manage the health consequences of migration and displacement have not kept up with the speed and diversity of modern migration and displacement. Numerous national, international and civil society organizations are finding ways to improve aspects of refugee and migrant health, including by providing access to health services and addressing health equality and the social determinants of health. But the approaches are often fragmented and costly, sometimes operating in parallel to national health systems, and may depend on external funding, which can lack sustainability.\textsuperscript{261} Few country health information systems disaggregate data in a way that permits analysis of the main health issues either found among refugees and migrants or resulting directly from migration and displacement. Lack of disaggregated data hampers the efforts to fully understand the extent of their health challenges and develop evidence-informed health policies.


23. Since March 2016, WHO has shifted its approach on migration and health from a solely humanitarian-based approach to one based on broader health systems strengthening and the push for universal health coverage. A well-functioning mechanism for coordinating WHO’s efforts on migration and health at the global level has been established across the Organization. In May 2016, during the Sixty-ninth World Health Assembly, a technical briefing on health and migration was organized and the recommendations and priority actions discussed during the briefing have been used to guide WHO’s work on health and migration. WHO was fully engaged in the discussions on the content of the New York Declaration for Refugees and Migrants, to ensure that health commitments were included in the Declaration. In September 2016, a United Nations General Assembly side event on health in the context of migration and forced displacement was successfully co-organized by the Governments of Italy and Sri Lanka, WHO, IOM and UNHCR. This was the first time that the health of refugees and migrants had been discussed at the General Assembly. In addition, as a member of the Working Group on Migration, Human Rights and Gender within the Global Migration Group, WHO provided technical support towards the development of the draft principles and guidelines, supported by practical guidance, on the human rights protection of migrants in vulnerable situations within large and/or mixed migratory movements. This initiative places emphasis on the human rights protection gaps, including right to health, experienced by migrants in vulnerable situations who do not have access to refugee protection.

24. Unfortunately, health is not included in the six thematic sessions of the modalities for the development of the global compact for safe, orderly and regular migration, despite health being cross-cutting and a prerequisite to sustainable development. To ensure that health is adequately addressed, WHO is actively providing input on health issues into the six issue briefs for the six thematic sessions of this global compact. These issue briefs are being developed by the Office of the Special Representative of the UN Secretary General on International Migration for the Office of the President of the General Assembly. They will be used to inform Member States for the intergovernmental negotiations. WHO co-leads on health with the Office of the High Commissioner for Human Rights to develop the Global Migration Group’s inputs into issue brief 1 on human rights, social inclusion, cohesion and all forms of discrimination, including racism, xenophobia and intolerance. WHO is working and liaising closely with IOM and UNHCR and international organizations such as ILO and UNICEF on these issue briefs. In addition, WHO is working closely with UNHCR and the pilot countries on a comprehensive refugee response framework.

25. At the World Humanitarian Summit, convened in Istanbul in May 2016 by the United Nations Secretary-General, donors and aid organizations endorsed “The Grand Bargain: shared commitment to better serve people in need”, a document that identifies 10 areas, such as providing cash-based assistance and increasing support to local and national responders, where donors and aid organizations propose to change existing practices to render humanitarian assistance more effective and efficient. WHO actively participated in the discussions on, and continues to work towards the implementation of, the Grand Bargain commitments, many of which were included in its strategic plans and programme of work before the World Humanitarian Summit. Its current work includes the development of an essential package of health services and a framework for working in protracted emergencies. In addition, WHO is leading a discussion on cash-based programming for health activities in emergency situations. All these activities are applicable to situations affecting refugees and migrants.

26. The international migration of health workers is increasing. Over the last decade, there has been a 60% increase in the number of migrant doctors and nurses working in OECD countries.\(^{263}\) This figure rises to 84% for doctors and nurses originating from countries facing severe health workforce shortages. WHO has been working with key partners, including ILO and OECD, to support the development of an international platform on health worker mobility, with the aim of strengthening existing instruments, such as the WHO Global Code of Practice on the International Recruitment of Health Personnel, and ensuring mutuality of benefits. The report of the High-level Commission on Health Employment and Economic Growth was submitted to the UN Secretary-General in the sidelines of the Seventy-first session of the UN General Assembly.\(^{264}\) The report recognizes both the challenges and the opportunities presented by the international migration of health workers. In it, the Commission calls for the development of an international platform on health worker migration, which should be in line with the discussion on and development of the global compact for safe, orderly and regular migration in 2018.

27. WHO is working with partners to address the increased vulnerability to HIV of refugees, asylum seekers and migrants. For example, steps are being taken to mitigate risk factors such as increased rates of male and female sex work among refugees and migrants, sexual violence, incarceration, an absence of social protection, increased susceptibility to sexually transmitted infections, and a lack of access to HIV prevention, testing, care and treatment services. WHO is working to expand the cross-border sharing of information to ensure HIV service continuity among this population, as well as to define and implement HIV interventions for refugees, migrants and mobile populations, tailored to the local context, capacity and resources. WHO is also working to ensure that services are relevant, acceptable and accessible and provided in an environment that protects the human rights of people living with HIV.

28. The WHO’s End TB Strategy seeks to end the tuberculosis epidemic, with milestones for 2030 of achieving a 90% reduction in the number of deaths due to tuberculosis and an 80% reduction in the tuberculosis incidence rate compared with 2015, and eliminating the catastrophic cost burden for those affected. When adopting the strategy in 2014,\(^{265}\) the Sixty-seventh World Health Assembly placed particular emphasis on the need for cross-border collaboration to address the needs of vulnerable communities, including migrant populations, and the threats posed by multidrug resistance. Since then, the Secretariat has taken action to meet the specific health needs of refugees and migrants with tuberculosis by providing specific guidance, promoting research, establishing regional frameworks and partnerships and providing technical assistance, in particular to address the urgent needs arising from the current migration crisis. It is also helping to generate and review evidence on effective screening, diagnosis and continuity of care among migrant populations in high and low tuberculosis burden settings. In addition to working with Member States, the Secretariat is working with partners, such as IOM, UNHCR and the Global Fund to Fight AIDS, Tuberculosis and Malaria.

29. There are an estimated 26 million women and girls of reproductive age living in emergency situations, all of whom need sexual and reproductive health services. Maternal mortality ratios are estimated to be above 300 per 100 000 live births in three quarters of States designated as fragile. To address these sexual and reproductive health needs, the Secretariat is working to implement the Global Strategy for Women’s, Children’s and Adolescents’ Health, and priority is being given to the provision of a minimum initial service package for reproductive health by national health systems and partners in emergencies. The strategy recognizes that sustainable service delivery depends on programmes that transition from the emergency response to long-term health systems.

\(^{265}\) Resolution WHA67.1 (2014).
strengthening and that there is a critical need to ensure the safety of health workers and their facilities in conflict settings. For some women, migration can be a disempowering experience, especially when they are employed in unregulated sectors of the economy. A Director-General’s report entitled Women on the Move is expected to be launched in May 2017. The report will examine how the inequities and the experiences faced by women and girls on the move affect their health.

30. In the WHO African Region, in order to address the health needs of refugees, migrants, asylum seekers and internally displaced persons, WHO has provided support to strengthen local health systems and to enhance surveillance, preparedness for and response to disease. Health services and assistance have been provided for over 1.5 million refugees both inside and outside camps across the Region. Promoting access to national health care structures and adopting a community approach have been key components for achieving sustainability. WHO and health partners have supported countries in their efforts to include refugees and internally displaced persons in national programmes, including vaccination campaigns, and have responded to outbreaks of meningitis in South Sudanese refugee populations in Ethiopia, and to cholera outbreaks in camps for internally displaced persons in Malawi, where more than 160 000 affected persons were vaccinated. In Ghana, by the end of 2015, 87% of refugees had access to the national health insurance scheme. In Ethiopia, vaccines against measles and polio for children under 15 years of age were delivered, with over 19 600 refugee children being vaccinated against measles and over 21 000 against polio. Working across sectors, WHO and partners put in place preventive and control measures relating to the quality of water and sanitation facilities in camps, promoted community mobilization on hygiene and health risk education, and provided support for case management and surveillance.

31. In the WHO Region of the Americas, at the sessions of the WHO Regional Committee for the Americas/Directing Council, in September 2016, Member States adopted a resolution on the health of migrants, supporting a policy document on the issue and recognizing that the regional Strategy for universal access to health and universal health coverage constituted a framework for the health system’s actions to protect the health and well-being of all migrants. In other words, the Strategy establishes the framework whereby the Region’s countries can design and implement collaborative strategies to address the health needs of migrant populations with a firm commitment to the right to health. Such a commitment entails providing access to high-quality comprehensive health services for migrants in their territories of origin and destination, during transit, and upon return to their country of origin. In addition, it recognizes the contributions of previous strategies or mandates from the Region that deal with this issue, and is aligned with other related strategies and commitments, including the Sustainable Development Goals.

32. In the WHO South-East Asia Region, several countries are both receiving and sending refugees and migrants. In Bangladesh, WHO has supported the Government and partners in developing a national strategic action plan on health and migration for 2015–2018, with the aim of enhancing the policy and legal framework for migrants, establishing a monitoring and information system and promoting multisectoral partnerships. In Sri Lanka, a national migration health policy has been developed since 2013 to promote health of outbound, inbound and internal migrants. Sri Lanka is also playing a major role in coordinating the different sectors. For example, in collaboration with WHO and IOM, it will host the second Global Consultation on Migrant Health, in February 2017. The 69th session of the Regional Committee for South-East Asia, held in September 2016, included an agenda item on health and migration. The Committee proposed that rapid situation analyses should be conducted by each country in the Region on the health of migrants, and made available prior to the Global Consultation. In Thailand, migrant health is a priority in the country cooperation strategy. Support has been given to the Ministry of Public Health to update the Second Border Health Development Master Plan 2012–2016 and for the development and implementation of a national

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266 Resolution CD55.R13 (2016).
plan for migrant health 2016–2021. Under this plan, undocumented migrants and their dependents are covered under a compulsory migrant health insurance scheme similar to the scheme for Thai people. In addition, WHO is supporting ASEAN in the implementation of the “Healthy borders” programme in the Greater Mekong subregion.

33. In the WHO European Region, the Strategy and action plan for refugee and migrant health in the WHO European Region was adopted in September 2016, along with an accompanying resolution, at the 66th session of the Regional Committee for Europe. Technical assistance has been provided to health ministries to improve the response to the public health challenges of migration. This assistance includes joint assessment missions, the development and updating of national and subnational preparedness and contingency plans and the development of training modules on health and migration. Medical supplies have been provided to countries in response to the health needs of refugees, migrants and asylum seekers. Technical guidance related to health and migration has been developed, such as the WHO–UNHCR–UNICEF joint technical guidance on general principles of vaccination of refugees, migrants and asylum seekers in the WHO European Region. Guidance on mental health for refugees and migrants is also being developed with multiple international partners. The Secretariat has begun a major exercise to analyse the available evidence on migration and health across the 53 countries of the Region, and is compiling it into synthesis reports for policy-makers in order to promote evidence-informed migration health policy-making. Several Health Evidence Network reports have been published, including on maternal health, mental health and the health care access implications of the different definitions of the term “migrant”. In addition, the Regional Office for Europe is currently working with the European Commission on the finalization of a joint project on migration and health knowledge management, with two main objectives: to develop and disseminate technical guidance notes on key issues related to noncommunicable diseases and migration; and to organize webinars using new and existing training materials on migration and health, to improve the education of health and non-health professionals on this specific topic. The project will be part of a larger initiative, the European Knowledge Hub on Migration and Health, which was launched in November 2016.

34. In the WHO Eastern Mediterranean Region, in all host countries affected by the conflict in the Syrian Arab Republic, WHO is leading health assessments and is generating and disseminating health information to ensure the provision of health care based on real-time evidence. WHO is also providing technical support and training to health ministries and partners and is working with partners to monitor water quality, support vector control and conduct immunization campaigns. WHO is also coordinating with regional partners, including IOM and UNHCR, to integrate migrant-related health challenges into the operational framework of public health interventions, which are now being given higher consideration in the national emergency preparedness plans in some countries of the Region. In addition, WHO is providing health care, including support for referral services and for patients with disabilities. WHO is also strengthening the interventions of communicable disease and early warning alert and response systems, immunization campaigns against polio and measles, maternal and child health strategies, and interventions to combat noncommunicable diseases among the refugee population and host populations. Given that the rates for mental disorders, especially depression and anxiety, are high in the Region because of the ongoing situation of insecurity, the Regional Office for the Eastern Mediterranean is providing mental health and psychosocial support services in the countries of the Region, including for migrants. The Regional Office is also coordinating closely with its counterparts in the European and African Regions to address the health challenges of refugees and migrants in the Region and with a view to developing a joint action plan to address the health challenges of refugees and migrants.

35. In the WHO Western Pacific Region, a review of access to health services by migrant populations in the Greater Mekong subregion is being finalized. The annual meeting of WHO Representatives from the subregion provides a forum for intercountry and regional collaboration for addressing
important migration issues, including health risks, social determinants and access to essential services of migrant populations in the cross-border areas. In addition, a second Biregional Meeting on Healthy Borders in the Greater Mekong Subregion is under consideration, to be convened with partners in 2017.

DEVELOPMENT OF A DRAFT FRAMEWORK

36. The development of a draft framework of priorities and guiding principles was based on the policy documents outlined in paragraph 11–13. In addition, the Secretariat held consultations with key WHO technical departments and regional offices as well as other relevant stakeholders including IOM and UNHCR in February 2017 to develop the first draft. A consultation with a health and migration core group of Member States was held on 27 February 2017. A second draft of the framework was shared on 7 March 2017 with Member States and a wide range of partners, including other international organizations and stakeholders, through a web-based consultation lasting 14 days. An informal consultation with Member States, United Nations agencies and other relevant stakeholders was convened on 4 April 2017 to facilitate discussions on the framework. On 10 April 2017, a final draft framework was prepared, which is to be submitted to the Seventieth World Health Assembly.

ACTION BY THE HEALTH ASSEMBLY

37. The Health Assembly is invited to note this report and to consider the draft framework of priorities and guiding principles to promote the health of refugees and migrants contained in the Annex to the report.

ANNEX

DRAFT FRAMEWORK OF PRIORITIES AND GUIDING PRINCIPLES TO PROMOTE THE HEALTH OF REFUGEES AND MIGRANTS

A. INTRODUCTION AND PURPOSE

To achieve the aim of the 2030 Agenda for Sustainable Development – to leave no one behind – and the health-related commitments outlined in the New York Declaration for Refugees and Migrants, it is imperative that the health needs of refugees and migrants are adequately addressed in the global compact on refugees and the global compact for safe, orderly and regular migration, to be endorsed in 2018.

This framework was requested in January 2017 by the Executive Board at its 140th session, to be considered during the Seventieth World Health Assembly. The purpose of this framework is threefold:

(a) to inform discussions among Member States and partners engaged in the development of the global compact on refugees and the global compact for safe, orderly and regular migration to ensure that the health aspects of refugees and migrants are adequately addressed;

(b) to serve as a foundation for the development of a draft global plan of action on the health of refugees and migrants, which is planned to be submitted to the Seventy-second World Health Assembly in 2019;

(c) to provide a resource for consideration by Member States in addressing the health needs of refugees and migrants, in alignment with the Sustainable Development Goals and other

267 Adopted by the United Nations General Assembly in resolution 71/1 (2016).
global and regional policy frameworks as appropriate to each country’s context and priorities.

B. SCOPE
This framework describes a number of overarching guiding principles and priorities to promote the health of refugees and migrants, building on existing instruments and resolutions including a strategy and action plan for refugee and migrant health in the WHO European Region and resolution CD55.R13 (2016) on the health of migrants adopted by Member States at the sessions of the WHO Regional Committee for the Americas/Directing Council in September 2016. The framework recognizes the urgent need for the health sector to address more effectively the impact of migration and displacement on health. The framework seeks to contribute to improving global public health by addressing the health of refugees and migrants in an inclusive, comprehensive manner and as part of holistic efforts to respond to the health needs of the overall population in any given setting. It is designed to promote the right to health, in accordance with international human rights obligations, including refugee law and relevant international and regional instruments. It also aims to support actions to minimize vulnerability to ill-health and to address the social determinants of health by promoting refugees’ and migrants’ ability to access promotive, preventive, curative and palliative health services. This framework acknowledges that laws, regulations and policies governing access to health services and financial protection for health by refugees and migrants vary across countries and are determined by national laws, policies and priorities.

C. GUIDING PRINCIPLES
1. The right to the enjoyment of the highest attainable standard of physical and mental health. Refugees and migrants have the fundamental right, as do all human beings, to the enjoyment of the highest attainable standard of health, without distinction of race, religion, political belief, economic or social condition. Furthermore, States parties to the 1951 Convention relating to the Status of Refugees shall accord to refugees lawfully staying in their territory the same treatment as accorded to their host country nationals, with respect to public relief and social security, which may include access to health services.

2. Equality and non-discrimination. The right to the enjoyment of the highest attainable standard of health should be exercised through non-discriminatory, comprehensive laws, and policies and practices including social protection.

3. Equitable access to health services. Equitable access to health promotion, disease prevention and care should be provided for migrants, subject to national laws and practice, without discrimination on the basis of gender, age, religion, nationality or race; and in accordance with the international law for refugees. The health of refugees and migrants should not be considered

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270 1951 Convention relating to the Status of Refugees.
272 As declared in the preamble to the Constitution of the World Health Organization. Also, the International Covenant on Economic, Social and Cultural Rights, Article 2.2 and Article12, recognizes the right of everyone to the enjoyment of the highest attainable standard of physical and mental health without discrimination of any kind as to race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status.
275 1951 Convention relating to the Status of Refugees.
separately from the health of the overall population. Where appropriate, it should be considered to include refugees and migrants into existing national health systems, plans and policies, with the aim of reducing health inequities and to achieve the Sustainable Development Goals.

4. **People-centred, refugee- and migrant-and gender -sensitive health systems.** Health systems should be refugee- and migrant-, and gender-sensitive, and people-centred, with the aim of delivering culturally, linguistically and gender- and age-responsive services. While the legal status of refugees and migrants is different, their health needs may be similar to or vary greatly from those of the host population. They may have been exposed to distress, torture and sexual and gender-based violence associated with conflict or their movements and may have had limited access to preventive and curative services before arrival in the host country. All of these factors may result in additional health care needs that require specific health responses.

5. **Non-restrictive health practices based on health conditions.** The health conditions experienced by refugees and migrants should not be used as an excuse for imposing arbitrary restrictions on the freedom of movement, stigmatization, deportation and other forms of discriminatory practices. Safeguards should be in place for health screening to ensure non-stigmatization, privacy and dignity, and the screening procedure should be carried out based on informed consent and to the benefit of both the individual and the public. It should also be linked to accessing risk assessment, treatment, care and support.

6. **Whole-of-government and whole-of-society approaches.** Addressing the complexity of migration and displacement should be based on values of solidarity, humanity and sustainable development. The health sector has a key role to play in ensuring that the health aspects of migration and displacement are considered in the context of broader government policy and in engaging and coordinating with other sectors, including civil society, the private sector, refugees’ and migrants’ associations and the affected populations themselves, to find joint solutions that benefit the health of refugees and migrants.

7. **Participation and social inclusion of refugees and migrants.** Health policies, strategies and plans and interventions across the migration and displacement cycle and in countries of origin, transit, and destination should be participatory, so that refugees and migrants are involved and engaged in relevant decision-making processes.

8. **Partnership and cooperation.** Managing large movements of refugees and migrants in a humane, sensitive, compassionate and people-centred manner is a shared responsibility. Greater partnership and international cooperation among countries, the United Nations system including WHO, IOM and UNHCR, and other stakeholders, is essential to assist countries in addressing the health needs of refugees and migrants; and to ensure harmonized and coordinated responses. WHO, in collaboration with other relevant international organizations, has a lead role to coordinate and promote refugees’ and migrants’ health on the international agenda.

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277 The international legal framework applicable to refugees includes the 1951 Convention relating to the Status of Refugees and its 1967 Protocol, and relevant resolutions and conclusions of international bodies relating to the rights of refugees in respect of health, including the conclusions adopted by the Executive Committee of UNHCR.

278 At the international level, there is no universally accepted definition of the term “migrant”. Migrants may remain in their home country or host country (“settlers”), move on to another country (“transit migrants”), or move back and forth between countries (“circular migrants” such as seasonal workers).

279 New York Declaration for Refugees and Migrants, paragraph 11.
D. PRIORITIES
To promote the health of refugees and migrants, the following priorities could be considered:

1. **Advocate mainstreaming refugee and migrant health in the global, regional and country agendas and contingency planning.** Special attention should be given to promote and monitor the health of refugees and migrants, as part of efforts to achieve the Sustainable Development Goals.

   Efforts should also be made to ensure that the health aspects of refugees and migrants are included in the global compact on refugees and the global compact for safe, orderly and regular migration.

2. **Promote refugee- and migrant-sensitive health policies, legal and social protection and programme interventions** that incorporate a public health approach and that can provide equitable, affordable and acceptable access to essential health promotion, disease prevention, and high-quality health services, including palliative care for refugees and migrants. This may require modifying or improving regulatory and legal frameworks to address the specific health needs of these populations, consistent with applicable national and international laws.

3. **Enhance capacity to address the social determinants of health** to ensure effective health responses and health protection in countries of origin, transit and destination. This includes improving basic services such as water, sanitation, housing and education. Priority should be given to implement a Health in All Policies approach to promote health equality for refugees and migrants. This will require joint and integrated action and coherent public policy responses involving multisector collaboration such as the health, social, welfare and finance sectors, together with the education, interior and development sectors.

4. **Strengthen health monitoring and health information systems** in order to: assess and analyse trends in refugees’ and migrants’ health, disaggregate health information by relevant categories, as appropriate; conduct research; and identify, collate and facilitate the exchange of experiences and lessons learned among Member States, and generate a repository of information on relevant experiences in the affected countries.

5. **Accelerate progress towards achieving the Sustainable Development Goals including universal health coverage** by promoting equitable access to quality essential health services, financial risk protection, and access to safe, effective, quality and affordable essential medicines and vaccines for all (target 3.8), including refugees and migrants. This may require strengthening and building the capacities and resilience of health systems. As a part of these efforts, priority should also be given to developing sustainable financial mechanisms to enhance social protection for refugees and migrants, and to strengthen the implementation of the WHO Global Code of Practice on the International Recruitment of Health Personnel.

6. **Reduce mortality and morbidity among refugees and migrants through short- and long-term public health interventions** aimed at saving lives and promoting the physical and mental health of refugees and migrants. Rapid and effective emergency and humanitarian responses is essential to saving lives and relieving suffering, but longer-term planning for more systematic development-oriented approaches to ensure the continuity and sustainability of the response should begin early. Priority should be given to efforts to enhance local capacity to address public health issues such as communicable and noncommunicable diseases, with an emphasis on disease prevention, for example through vaccination. Vaccines should be provided for refugees and migrants in an equitable

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281 The Code was adopted by the Sixty-third World Health Assembly through resolution WHA63.16 (2010).
manner, with a systematic, sustainable, non-stigmatizing approach. As vaccination is a health intervention that requires a continuum of follow-up until the full schedule is completed, there must be cooperation among the countries of origin, of transit and of destination.

7. **Protect and improve the health and well-being of women, children and adolescents living in refugee and migrant settings.** Priority should be given to the provision of essential health services such as: a minimum initial service package for reproductive health, sexual and reproductive health information and services; maternal health care including emergency obstetric services, pre- and postnatal care; prevention, treatment, care and support for sexually transmitted infections including HIV, and specialized care for survivors of sexual violence, as well as supporting for child health activities.

8. **Promote continuity and quality of care** delivered by public and private institutions and providers, non-State actors and other service providers for refugees and migrants, in particular for persons with disabilities, people living with HIV/AIDS, tuberculosis, malaria, mental health and other chronic health conditions as well as those with physical trauma and injury. It is important to ensure that adequate information on continuity of care is provided and is adhered to, especially during mobility, and particularly for the management of chronic health needs. Access to adequate mental health care, including at reception and through referrals to appropriate secondary services, should be provided. Priority should be given to ensure that children have access to specific care and psychological support, which takes into account the fact that they experience and deal with stress differently than adults do.

9. **Develop, reinforce and implement occupational health safety measures** in work places where refugees and migrant workers are employed, in order to prevent work injuries and fatal accidents. Provide information and training to educate refugee and migrant workers about occupational health and safety risks in hazardous occupations. Refugee and migrant workers should have equal access to treatment of work-related injuries and disability, rehabilitation and death compensation according to national contexts.

10. **Promote gender equality and empower refugee and migrant women and girls** including through recognizing gender differences, roles, needs and related power structures among all relevant stakeholders and mainstreaming gender into humanitarian responses, and longer-term policy development and interventions. Also consider implementing the recommendations of the High-Level Commission on Health Employment and Economic Growth (2016), which call for tackling gender concerns in the health reform process and the health labour market.

11. **Support measures to improve communication and counter xenophobia** by making efforts to dispel fears and misperceptions among refugee, migrant and host populations on the health impacts of migration and displacement; and share accurate information on the impact of refugees and migrants on the health of local communities and health systems, as well as to acknowledge the contribution of refugees and migrants to society. Provide appropriate, accurate, timely and user-friendly information on the health services available in countries of origin, transit and destination to refugees and migrants.

12. **Strengthen partnerships, intersectoral, intercountry and interagency coordination and collaboration mechanisms** to achieve synergies and efficiency, including within the UN system, with IOM and UNHCR in particular, and with other stakeholders working towards improving the health of refugees and migrants; strengthen the humanitarian–development nexus to enhance better coordination between humanitarian and development health actors; and foster the exchange of best practices and lessons learned on the health of refugees and migrants among relevant actors. Also strengthen resource mobilization for flexible and multiyear funding to enable countries and
communities to respond to both the immediate and the medium/longer-term health needs of refugees and migrants; identify gaps and innovative financing to ensure a more effective use of resources.
Health systems
The World Health Minute is a one-stop public health news intelligence source reporting on what the global press is saying about each of the WHA agenda issues from preparedness to the elections. Here is a sample of articles printed on 17 May for issues related to health systems. For more information see www.worldhealthminute.com.

World Health Minute – Extract example from May 17 2017 issue

• Over one million health workers paid less than Rs 1,000 a month in India
Nearly a million workers, forming the frontline of India’s faltering public health system, are inadequately trained and underpaid, according to an IndiaSpend analysis of health ministry data, imperilling the country’s progress in healthcare efforts. Accredited Social Health Activists considered to be voluntary workers are paid an honorarium by the government and most make about Rs 1,000 a month, less than the cost of a bottle of single malt whisky. They are required to undergo a 23 day training spread across 12 months, but a third of them in north Bihar were not trained at induction and the rest received seven days training or read the manual, according to the study (business-standard.com: 16/05/17)

• Illegal blood banks spreading disease
Illegal blood banks are thriving under the nose of the health department in Pakistan, and spreading diseases like hepatitis, HIV and thalassemia. According to the health department, there are at least 1,600 blood banks across the Punjab province and they need to be regulated. Express Tribune reported that the Punjab Blood Transfusion Authority has never conducted any raids on these illegal banks which sell blood on without a screening process (tribune.com: 15/05/17)

• Kenya: Report lays bare Kenya’s frail health sector
The Kenya Health Workforce Report lays bare Kenya’s ill-preparedness in tackling non-communicable diseases in terms of human resource capacity. For instance, cancer killed 15,714 people in 2015 yet there are only 9 experts in radiology/oncology and 128 in radiology. For all the cases of diabetes there is only one diabetologist. There are only 71 psychiatrists in Kenya, yet the latest mental health report from WHO showed that 4.4% of all Kenyans have a mental health problem of some sort (allafrica.com: 14/05/17) (dailynation.co.ke: 14/05/17)

• Ceaseless Middle East wars are forcing a change in approach to medical care
The ICRC warned that drawn-out crisis which are plaguing the Middle East could lead to the total collapse of health systems. One example is the disruption to vaccinations. As the children will not be vaccinated, diseases previously thought to be eradicated will simply re-emerge. Resistance to antibiotics because of drug usage in excess of prescribed limits has accelerated. Infections have spread as war has destroyed sanitation and clean water systems and triggered chaotic population movements (reuters.com: 15/05/17)

• Kenya’s first gay health clinic provides care without the judgement
NBC News speaks to the director of Ishtar, the first health care clinic in Kenya run by gay men that serves a population primarily of gay men. With discrimination still high in the country the clinic is a place where treatment comes without judgement as the staff are drawn from the community too. At present they are still unable to provide antiretroviral therapy to those who are HIV-positive but they refer members to either an NGO with whom they have an agreement or to a government run facility. Many refuse to go as they are not treated well (nbcnews.com: 15/05/17)

• Health sector prepares for anti-abortion policy’s impact on HIV/Aids fight
Health officials and experts said they will monitor how the Trump administration’s expansion of an anti-abortion policy affects a longstanding initiative to beat back the global HIV/AIDS epidemic. How the new policy will affect the U.S. war on HIV overseas will depend in part on which foreign NGOs sign the new clause to receive PEPFAR funding, a senior State department official said. The detailed data PEPFAR regularly collects on the use of its funding would be watched closely for signs that its reach is either being expanded or is being restricted (wsj.com: 16/05/17)

• WHO members are urged to delink R&D from cancer medicine prices
A number of civil society organizations and health specialists have sent a letter to delegates at the annual World Health Assembly and member states urging them to delink the R&D costs from the prices of cancer medicines. The letter reads ‘none of the 56 novel cancer medicines approved by the U.S. FDA from 2010 to 2016 are included in the WHO Model List of Essential Medicines’ (figo.org: 16/05/17)
14. Communicable diseases

14.1 Global vaccine action plan

Document A70/25 (Report by the Secretariat):

1. In May 2012, the Sixty-fifth World Health Assembly adopted resolution WHA65.17, in which it endorsed the global vaccine action plan\(^{282}\) and requested the Director-General, inter alia, to monitor progress and report annually, through the Executive Board, to the Health Assembly, until the seventy-first World Health Assembly, on progress towards achievement of global immunization targets, as a substantive agenda item, using the proposed accountability framework to guide discussions and future actions.

2. In May 2013, the Sixty-sixth World Health Assembly considered and noted the report by the Secretariat,\(^{283}\) including the proposed framework for monitoring and evaluation and accountability, as well as the process for reviewing and reporting progress under the independent oversight of the Strategic Advisory Group of Experts on immunization.

3. In accordance with the monitoring, evaluation and accountability process,\(^{284}\) the Strategic Advisory Group of Experts on immunization reviewed progress against each of the indicators for the goals and strategic objectives of the global vaccine action plan, based on data from 2015,\(^{285}\) and prepared the 2016 Assessment Report of the Global Vaccine Action Plan.\(^{286}\) A summary of the Assessment Report is included in the Annex.

4. At its 140\(^{th}\) session in January 2017, the Executive Board considered an earlier version of this report, together with a draft resolution.\(^{287}\) The Board agreed to postpone the adoption of the draft resolution in order to allow for further consultations among Member States during the intersessional period before the Seventieth World Health Assembly in order to reach consensus.

**ACTION BY THE HEALTH ASSEMBLY**

5. The Health Assembly is invited to take note of the report and to consider the recommendations for actions to be taken by the various stakeholders of the global vaccine action plan, in particular by Member States.

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\(^{283}\) Document A66/19; see also document WHA66/2013/REC/3, summary record of the tenth meeting of Committee A, section 2.

\(^{284}\) See document A66/19, paragraphs 16 and 17.


\(^{287}\) Document EB140/25; see also the summary records of the Executive Board at its 140\(^{th}\) session, twelfth meeting, section 1.
ANNEX
A SUMMARY OF THE 2016 ASSESSMENT REPORT OF THE GLOBAL VACCINE ACTION PLAN BY
THE STRATEGIC ADVISORY GROUP OF EXPERTS ON IMMUNIZATION

1. At the midpoint of the Global Vaccine Action Plan, or GVAP (2012–2020), the Strategic Advisory
Group of Experts on Immunization (SAGE) remains gravely concerned that progress toward the goals
to eradicate polio, eliminate measles and rubella, eliminate maternal and neonatal tetanus, and
increase equitable access to life saving vaccines is too slow.

2. Despite improvements in individual countries and a strong global rate of new vaccine
introduction, global average immunization coverage has increased by only 1% since 2010.

3. In 2015, 68 countries fell short of the target to achieve at least 90% national coverage with the
third dose of diphtheria-tetanus-pertussis vaccine. Not only that, 26 countries reported no change in
coverage levels and 25 countries reported a net decrease in coverage since 2010.

4. The 16 countries that have made measurable progress since 2010 are to be commended for
reaching more people, especially vulnerable and marginalized members of society with
immunization. Some of the countries with the highest numbers of unvaccinated people have made
the most progress, including the Democratic Republic of the Congo, Ethiopia and India, and even
though coverage targets have not been achieved in these countries, they are moving forward in the
right direction.

5. The 111 countries that entered the decade with high immunization coverage and sustained it
through 2015 are already setting their sights on more aggressive goals, additional vaccines, and
more equitable coverage. Immunization programmes in these countries can lead the way by
increasing access to other public health interventions and providing a platform for the delivery of
preventive health services throughout the life course. Vaccine research and development is
progressing rapidly, and an expanding pipeline of new vaccines underscores the need to build health
systems that can reliably reach new target age groups.

6. The members of the SAGE are steadfast and passionate believers in the power of immunization
to give individuals and their families a better start in life and to protect people from a growing array
of debilitating illnesses. Immunization is one of the world’s most effective and cost-effective tools
against the threat of emerging diseases and has a powerful impact on social and economic
development. Recognizing the role that immunization plays in ensuring good health and the role
that good health plays in achieving sustainable development, the SAGE has supported the inclusion
of immunization indicators to measure progress toward the Sustainable Development Goals.

7. The next four years present unprecedented opportunities for countries to leverage the attention
and support that immunization receives and apply it for the benefit of people everywhere. Strident
efforts on the part of all countries and immunization stakeholders are required to catch up and
achieve GVAP goals by 2020.

8. The SAGE recommends that Member States demonstrate stronger leadership and governance of
national immunization systems through the following actions:

   (a) Ministers at all levels should be strong immunization advocates within their countries and
   regions. These high-level officials should be able to convey the high return on investment,

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the urgency and value of investing more in and sustaining immunization programmes as an integral part of government-supported Universal Health Coverage packages.

(b) Governments are encouraged to enact laws that guarantee access to immunization, establish National Immunization Technical Advisory Groups (NITAGs) or equivalent groups, ensure that sufficient budgets are allocated to immunization each year and create mechanisms to monitor and efficiently manage funds at all levels (including those from the private sector).

(c) National leaders must take courageous decisions to upgrade systems, protocols and policies that are necessary to achieve and sustain high immunization coverage. Such upgrades might require redesigning supply chains, information systems and procurement policies, and reassessing roles and responsibilities in case the government decides to implement the decentralization of the health system.

(d) National immunization programme managers should report each year to their NITAGs or equivalent groups on progress made, lessons learned and remaining challenges toward implementing National Immunization Plans and show how these plans are aligned to Regional and GVAP goals.

9. The SAGE recommends that Member States prioritize immunization system strengthening through the following actions:

(a) Countries should expand immunization services beyond infants and children to the whole life course, and determine the most effective and efficient means of reaching other age groups within integrated health service provision. New platforms are urgently needed to reach people during the second-year-of-life, childhood, adolescence, pregnancy, and into later adulthood.

(b) The 34 countries with DTP3 national coverage levels below 80% should accelerate the implementation of proven interventions to strengthen immunization systems as part of integrated health services. Countries, with advice from the NITAGs or equivalent, should identify and implement priority interventions, including human resource development, increase of domestic funding for immunization and improved quality and use of data.

10. The SAGE recommends that Member States secure necessary investments to sustain immunization during polio and Gavi transitions through the following actions:

(a) All countries should mitigate any risk to sustaining effective immunization programmes when polio funding decreases. Countries with large numbers of staff and resources issued from the Global Polio Eradication Initiative are requested to describe, in their polio transition plan, how they propose to maintain and fund critical immunization, laboratory and surveillance activities that are currently supported with polio funding and staff.

(b) In all countries transitioning from Gavi support, national and global immunization partners must advocate strongly and persistently for increased domestic financing to sustain immunization gains over time.

(c) Immunization donors must also look beyond their investments in Gavi to ensure that Gavi-transitioning and self-supporting countries as well as countries facing large decreases in polio funding have the necessary capacity, tools and resources to sustain immunization over the long term.

11. The SAGE recommends that Member States improve surveillance capacity and data quality and use through the following actions:
(a) All countries should strengthen and sustain their surveillance capacity by investing in disease
detection and notification systems, routine analysis and data reporting systems, stronger
laboratory capacity; establishing a clear process for investigating and confirming cases of
vaccine preventable diseases; and responding to and preventing outbreaks.

(b) Decision makers at all levels of the immunization programme are requested to use up-to-
date data (i.e., disease surveillance, coverage, and programme delivery data) to guide
programmatic and strategic decisions that reduce disease and protect at-risk populations.

12. The SAGE recommends that Immunization Partners enhance accountability mechanisms to
monitor implementation of Global and Regional Vaccine Action Plans through the following actions:

(a) The leaders of GVAP secretariat agencies and global immunization partners should advocate
forcefully and consistently in national and international fora for the urgency and value of
accelerating the pace of global progress toward achieving the GVAP goals by 2020.

(b) WHO Regional Directors should make sure the progress towards the Global and Regional
Vaccine Actions Plans is reviewed annually at Regional Committee meetings as requested in
resolution WHA65.17. Reports prepared at the country level to review and discuss the
progress made should be the basis of the discussion.

(c) Civil society organizations should describe how their work maps against different national
immunization plans in their 2017 GVAP report, so that the geographic and programmatic
scope of their work is more visible. Where possible, CSOs should also measure and share the
impact of their work.

13. The SAGE recommends that Immunization Partners achieve elimination targets for maternal and
neonatal tetanus, measles, rubella and congenital rubella syndrome. The Maternal and Neonatal
Tetanus and Measles and Rubella Initiatives are each requested to develop an investment case that
specifies the additional funding required to achieve and sustain elimination targets in routine
immunization programmes and use the investment case to solicit necessary support from donors
and national governments by the end of July 2017.

14. The SAGE recommends that Immunization Partners resolve barriers to timely supply of
affordable vaccines in humanitarian crisis situations. International agencies, donors, vaccine
manufacturers and national governments must work together to alleviate the financial burden
placed on countries to buy and deliver vaccines for displaced populations at high risk of vaccine-
preventable diseases and ensure a timely supply of affordable vaccines in humanitarian crisis
situations.

15. The SAGE recommends that vaccine research and development partners support vaccine R&D
capacity in low- and middle-income countries:

(a) R&D partners must continue supporting the expansion of regulatory capacity and clinical
trial capacity by building upon models like the African Vaccine Regulatory Forum and the
Developing Country Vaccine Regulators’ Network, accelerating regulatory pathways for
vaccines in emergency settings, and insisting on compliance with the existing WHO position
to register clinical trials and report results in a timely manner.

(b) WHO and the Product Development for Vaccines Advisory Committee (PDVAC) should
continue developing global consensus-based strategic goals and prioritizing R&D for vaccines
and delivery technologies that address unmet needs in low- and middle-income countries.
(c) Researchers should support the development of high-quality, standardized animal models, standardized assays and human challenge models to streamline product development and provide better-quality information for product advancement decisions.

16. The SAGE recommends that vaccine research and development partners accelerate the development and introduction of new vaccines and technologies:

(a) Researchers and investigators, worldwide, should accelerate the development of priority new vaccines and technologies from R&D to full-scale use.

(b) Implementation research must occur at the earliest possible stage of the clinical development process to reduce the delay between market authorization, financing and implementation of vaccines activities.
14.2 Global vector control response

Document A70/26 (Report by the Secretariat):

1. At its 140th session, the Executive Board noted an earlier version of this report289 and requested the Secretariat, in consultation with Member States, to prepare a draft resolution for consideration by the Seventieth World Health Assembly. Such a text will be submitted separately following the conclusion of the consultations with Member States.

2. This updated version of the report reflects comments made in the discussion at the Board’s 140th session and input from a broad online consultation held in late 2016. In particular, the revisions concern extending the response to cover schistosomiasis (paragraph 3), including morbidity targets (paragraph 14) and providing more details on the role of the Secretariat (paragraphs 25 and 26). New text has been added on cost estimates for implementation (paragraph 23).

3. Vector-borne diseases pose a major threat to the health of societies around the world. They are caused by parasites, viruses and bacteria transmitted to human beings by mosquitoes, sandflies, triatomine bugs, blackflies, ticks, tsetse flies, mites, snails and lice. Major global vector-borne diseases of humans include malaria, dengue, lymphatic filariasis, Chagas disease, onchocerciasis, leishmaniasis, chikungunya, Zika virus disease, yellow fever, Japanese encephalitis and schistosomiasis. Other vector-borne diseases are of local importance in specific areas or populations.

4. The major vector-borne diseases together account for around 17% of the estimated global burden of communicable diseases and claim more than 700,000 lives every year. The burden is highest in tropical and subtropical areas. More than 80% of the global population live in areas at risk from at least one major vector-borne disease, with more than half at risk from two or more. The risk of infection is particularly high in towns and cities where vectors proliferate because of favourable habitats and contact with human beings is high. Morbidity and mortality rates are often disproportionately high in poorer populations. People who survive these diseases can be left permanently disabled or disfigured. Vector-borne diseases exact an immense toll on economies and restrict both rural and urban development.

5. Impressive gains have been made against malaria, onchocerciasis, lymphatic filariasis and Chagas disease, but the burden of many other vector-borne diseases has increased in recent years. Social, demographic and environmental factors have altered pathogen transmission patterns, resulting in intensification, geographical spread, re-emergence, or extension of transmission seasons. In particular, unplanned urbanization, lack of reliable piped water supply and inadequate solid waste or excreta management can render large populations in towns and cities at risk of viral diseases spread by mosquitoes.

6. Most vector-borne diseases can be prevented by vector control, if it is implemented well. Proven interventions targeting vectors offer some of the highest cost-effectiveness ratios in public health. Major reductions in the incidence of malaria, onchocerciasis and Chagas disease have been largely due to strong political and financial commitment and substantial investments in vector control. Of the 663 million cases of malaria estimated to have been averted in sub-Saharan Africa between 2001 and 2015, more than half have been attributed to the wide-scale deployment and use of long-lasting insecticidal nets and indoor residual spraying. For other vector-borne diseases, vector control has not yet been used to its full potential or had maximal impact because interventions are inadequately delivered; this situation arises not only because of meagre investments, but also due to the collapse of...
and dire lack of public health entomology capacity, poor coordination within and between sectors, weak or non-existent monitoring systems and limited sustainable and proven tools for certain vectors and situations.

7. Since 2014, major outbreaks of dengue, malaria, chikungunya, yellow fever and Zika virus have afflicted populations, claimed lives and overwhelmed health systems in many countries. In 2016, Zika virus infections and their associated complications directly affected individuals and families, and caused social and economic disruption.

8. The global fight against vector-borne diseases is beset by multiple interconnected difficulties. Numerous countries affected by or at risk of more than one vector-borne disease do not capitalize on available resources and capacity as well as experience learned from other diseases. Disease-specific programmes may compete for resources. Increased availability of suitable vector habitats has resulted from urbanization and changes in land use, water management, farming practices and climate – their consequences are often unpredictable, uncontrollable and complex. Insecticide resistance and shifts in vector behaviour that reduce the efficacy of interventions threaten to undermine prevention approaches. Political and financial commitments have been lacking, with limited investments in vector control beyond scale-up of deployment of insecticide-treated nets and indoor residual spraying against malaria vectors.

9. Owing to the strong influence of social, demographic and environmental factors on transmission of vector-borne diseases, it is essential that vector control delivery and monitoring systems are flexible in order to support locally tailored approaches. Re-alignment of national programmes to optimize implementation of interventions against multiple vectors and diseases would ensure that available resources are applied with maximum impact. Health systems must be prepared to detect, and respond quickly and effectively to, changes. This capability requires not only the availability of effective control tools but also well trained staff who can build sustainable systems for evidence-based delivery of vector control interventions.

10. The recent upsurge in vector-borne diseases has generated renewed attention to and reiterates the need for a comprehensive approach to vector control. Achievement of Sustainable Development Goal 3 (Ensure healthy lives and promote well-being for all at all ages) relies on effective vector control, and work towards other targets under the 2030 Agenda for Sustainable Development, such as those in Goal 6 (Ensure availability and sustainable management of water and sanitation for all), Goal 11 (Make cities and human settlements inclusive, safe, resilient and sustainable) and Goal 13 (Take urgent action to combat climate change and its impacts) will further contribute to that end. Additional opportunities for better vector control will also become available through the development of novel tools, technologies and approaches. Advantage can be taken of recent advances that enable an evidence-based approach, such as real-time data-capture systems or social media as well as predictive informatics tools, in order to strengthen planning, implementation and evaluation of vector control.

11. The Secretariat began in June 2016 a fast-track global consultative process on a global vector control response with Member States and stakeholders, including organizations of the United Nations system, scientific and research groups, non-State actors and implementation partners. The process for developing the response was launched by three departments in the Secretariat with support from a steering committee consisting of representatives of Member States, leading vector control experts and other scientists as well as other stakeholders, and from regional offices, WHO’s Malaria Policy Advisory Committee and the Strategic and Technical Advisory Group for Neglected Tropical Diseases.
12. The steering committee has convened twice (Geneva, 3 and 4 August and 4 and 5 October 2016) and reviewed preliminary drafts of a global vector control response for the period 2017–2030 (in alignment with the 2030 Agenda for Sustainable Development). Further comments on the draft text from Member States and members of the global health community were elicited through a broad online consultation in November 2016, with updates to the text made accordingly. Vector control was discussed by some WHO regional committees in 2016 in the context of dengue and malaria, and the draft response has been or will be presented at a series of scientific and technical meetings held or to be held between June 2016 and April 2017.

THE DRAFT GLOBAL VECTOR CONTROL RESPONSE 2017–2030 IN BRIEF

13. The draft global vector control response aims to support the implementation of a comprehensive approach to vector control that will enable the setting and achievement of disease-specific national and global goals and contribute to attainment of the Sustainable Development Goals. It also aims to support countries in mounting coherent and coordinated efforts to counter the increasing burden and threat of vector-borne diseases.

14. The document provides strategic guidance to countries and development partners for urgent strengthening of vector control as a fundamental approach to preventing disease and responding to outbreaks. This objective calls for significant enhancement of vector control programming, supported by increased numbers of technical staff, stronger monitoring and surveillance systems, and improved infrastructure. The vision of this response is a world free of human suffering from vector-borne diseases, with the goal of reducing the burden and threat of vector-borne diseases through effective locally adapted and sustainable vector control. The response sets an ambitious target of at least 75% reduction in mortality and 60% reduction in morbidity due to vector-borne diseases globally by 2030 relative to 2016, with epidemics prevented in all countries in line with Sustainable Development Goal 3. Interim milestones have been set, with reductions in mortality of at least 30% by 2020 and at least 50% by 2025, and reductions in morbidity of at least 25% and 40% over the same time periods.

15. The response comprises two core elements: (1) enhanced human, infrastructural and health systems capacity and capability for vector control and vector surveillance within all locally relevant sectors, and (2) increased basic and applied research to underpin optimized vector control, and innovation for development of new tools, technologies and approaches.

16. **Enhance vector control capacity and capability.** Formulating an inventory of the human, infrastructural, institutional and financial resources available and making an appraisal of existing organizational structures for vector control are essential first steps. Career structures in vector control within national and subnational programmes must be evaluated. Opportunities to attract resources from beyond the health sector should be explored, including staffing arrangements that involve collaboration and time-sharing. Where the number of human resources is inadequate, efforts should be made to recruit and train staff from across sectors in the field of vector management and control and more broadly in public health, epidemiology and programme management.

17. **Increase basic and applied research, and innovation.** Vector control must be evidence-based to ensure local appropriateness and generate impact data required to justify continued investment in implementation. Basic research is urgently needed to understand better those aspects of vectors that influence interactions with human beings and pathogen transmission, such as biology,

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290 Meeting reports are available on request.
behaviour and environment. The results of such research should inform the development of innovative approaches and interventions. Applied research is also needed to assess effectiveness and optimize delivery of interventions. A research agenda that prioritizes strategic areas for attention should be defined by the national vector-borne disease control programme, in collaboration with relevant partners. This agenda should serve to guide research and academic institutions in aligning their work, help to avoid gaps or overlap, and assist in identifying additional external resources to support priority work.

18. Action is required in four key areas (pillars) to attain effective locally adapted and sustainable vector control. These four areas are aligned with the key elements of an integrated vector management approach.

19. Pillar 1. Strengthen inter- and intra-sectoral action and collaboration. For maximum impact and efficiency, collaboration with non-health sectors must be enhanced, along with improved coordination of activities within the health sector such as water, sanitation and hygiene initiatives. National vector control programmes should become an integral part of national development strategies on poverty reduction and resilience to climate change, as well as regional development cooperation strategies. Engagement with ministries of agriculture, education, environment, finance, housing, tourism, transport and water is especially important. Municipality and local administrative structures can contribute to improving vector control services, enhance community engagement and mobilization, and create towns and cities more resilient to climate change. Collaboration will require strong political commitment and resources from central government with respective ministerial strategic plans to reflect adequately contributions to vector control. An interministerial taskforce should be established and funded appropriately to conduct the necessary coordination activities. The initial task should be to coordinate an assessment of national vector control capacity and needs, if that has not recently been done. An appraisal of the partnership landscape will help to identify all the existing and potential resources available to support vector control. Strategies need to be adapted to country-specific social determinants.

20. Pillar 2. Engage and mobilize communities. Given the major role of communities in the prevention, control and elimination of vector-borne diseases, the success and sustainability of vector control interventions require coordination between many stakeholders but especially depend on harnessing local knowledge and skills. Communities need to be mobilized to take responsibility for and implement vector control and surveillance actions through appropriate participatory community-based approaches. Strategies for engaging communities should be built upon research, behavioural situation analyses, monitoring and evaluation of engagement, and long-term sustainability.

21. Pillar 3. Enhance vector surveillance and monitoring and evaluation of interventions. As the capacity of vectors to transmit pathogens and their susceptibility to vector control measures can vary by species, location and time, depending on local environmental factors, vector control must be implemented on the basis of up-to-date local data. Vector surveillance should be routinely conducted at representative sites in areas where vector-borne diseases are endemic as well as those with conditions favourable for transmission. Linkage with epidemiological and health intervention coverage or usage data is essential. This information should be used to inform sound decision-making for policy, planning and implementation of vector control and assist in early responses to the build-up of vector populations before outbreaks occur.

22. Pillar 4. Scale up and integrate tools and approaches. A key action to maximize the public health impact of vector control is the deployment and expansion of tools and approaches appropriate to the epidemiological and entomological context. Each vector control intervention that is selected for use in a particular setting should be applied to a high standard of quality and at
optimal coverage. One tool can have multiple effects against several vectors and diseases. In some settings, an approach using multiple vector control interventions can have greater impact in reducing transmission or disease burden than use of one intervention alone. Core interventions may need to be supplemented with additional tools in order to meet specific challenges such as insecticide resistance. Integrated strategies should also be applied to reduce vector habitats by altering the domestic environment, for instance by improving water supply so as to prevent household-level storage, or to prevent access of vectors to human dwellings by installing screening on house entry points.

23. Three determining factors are needed to implement the response: (1) country leadership; (2) advocacy, resource mobilization and partner coordination; and (3) regulatory, policy and normative support. Achievement of the targets and milestones set out in this draft response will need significant investment from both international and domestic sources to strengthen vector control capacity and capability, research and innovation, cross-sectoral coordination, community involvement, and surveillance and monitoring systems. It is estimated that full implementation of the priority activities defined for the interim period 2017–2022 will require an annual investment of US$ 330 million. This equates to an average of US$ 0.05 per person per year at risk from at least one vector-borne disease, with variation by burden and risk as well as other local factors such as income level. This represents a maximum value as it is assumed that over time adequate and well-trained local workforces will expand to undertake surveillance and coordination functions. The figures exclude both the cost of vector control commodities and their deployment, and research and innovation implementation costs. Required resource costs were estimated using WHO’s tools for cost–effectiveness and strategic planning and cost assumptions. These costs for workforce, coordination and surveillance represent a relatively modest investment in relation to implementation of core interventions, such as insecticide-treated nets (US$ 1.27 per person protected per year), indoor residual spraying (US$ 4.24 per person protected per year), and community-based activities for dengue prevention (estimated to exceed US$ 1.00 per person protected per year). Accurate estimates of resource requirements and costs are expected to be made through comprehensive vector control needs assessments at country and subnational levels.

ROLE OF THE SECRETARIAT

24. In line with WHO’s core functions, the Secretariat will continue to set and disseminate normative guidelines, policy advice and implementation guidance to support regional and country actions. It will provide, on request, support to Member States in implementing the draft global vector control response and provide guidance in reviewing and updating national vector control strategies.

25. The Secretariat will ensure that its policy-setting process responds to changing vector control needs and that its global technical guidance is regularly updated by incorporating information about innovative tools, technologies and approaches that are proven to be safe, effective and of public health value with due consideration of ethical issues and impact on the natural environment. Expert groups will be convened as necessary to address key issues related to policy development.

26. The Secretariat will strengthen its own capacities and capabilities at the global, regional and country levels so that it is better positioned to lead a coordinated global effort. It will continue to coordinate activities across related programmes and initiatives of the Organization, including the WHO Health Emergencies Programme, International Health Regulations, and R&D blueprint for action to prevent epidemics. It will also provide support to initiatives on advocacy, resource mobilization and partner coordination.

27. The Secretariat will promote the generation of research and knowledge that is required to accelerate progress towards a world free of human suffering from vector-borne diseases. It will monitor implementation of the response and regularly evaluate progress towards the interim milestones and the targets for 2030.

**ACTION BY THE HEALTH ASSEMBLY**

28. The Health Assembly is invited to note the report and adopt the draft resolution contained in the accompanying document A70/26 Add.1.
Communicable diseases
The World Health Minute is a one-stop public health news intelligence source reporting on what the global press is saying about each of the WHA agenda issues from preparedness to the elections. Here is a sample of articles printed on 17 May for issues related to communicable diseases. For more information see www.worldhealthminute.com.

World Health Minute – extract from 17 May 2017 issue

• Many U.S. day care centres may lack plans for a pandemic flu outbreak - study
Fewer than one in 10 U.S. day care centre directors have taken concrete steps to prepare for a pandemic flu outbreak, a recent study suggests. Pandemic influenza is different from seasonal influenza. It is a novel virus which transmits from person to person and to which most of the world’s population has no immunity (reuters.com: 15/05/17)

• Many South African toddlers are falling through the South Africa vaccination net
One in 10 of Mpumalanga’s children under the age of two has not had any of the shots required under a government childhood immunization programme, according to the DHMS 2016 survey. The findings signal potential deadly weaknesses in the childhood immunization programme, as inadequate coverage of the population increases the likelihood of disease outbreaks. Both Gauteng and Western Cape have seen measles outbreaks this year (businesslive.co.za: 15/05/17)

• Commitment at all levels is essential for the prevention of dengue – Indian minister
Union Minister of Health and Family Welfare, JP Nadda, said commitment at all levels is essential for prevention and control of dengue, adding that by working together dengue can be prevented. For this purpose cleanliness is the most important thing. National Dengue Day is an occasion to spread awareness about its prevention and control. We must not create an environment for the dengue to breed in (businessstandard.com: 16/05/17) (outlookindia.com: 16/05/17)

• Officials: Measles outbreak caused by anti-vaccination campaigns
There has been a recent measles outbreak in Minnesota and now the authorities know the reason behind it. A group of Somali-Americans, mostly children, have been diagnosed with the disease. The Minnesota Department of Health released a report that said the vast majority, 55 out of 58 cases, were unvaccinated (aol.com: 16/05/17)

• Liberia: UNAIDS, Chinese television giant sign agreement for HIV awareness across Africa
Star Times, a Chinese digital television provider, and UNAIDS, have signed an agreement to increase awareness of HIV through its broadcast networks and to reduce the stigma and discrimination against those living with HIV throughout the African continent (allafrica.com: 15/05/17) (frontpageafricaonline: 15/05/17)

• Alert – there have been 140 cases of tuberculosis in 2017 to date
In Colombia, Cartagena health authorities told the press that the backdrop of TB cases is still a significant concern to them as the number of cases has stayed high over the last three years. In 2016, there were 263 TB patients of which 33 died but only seven directly from TB itself. 2015 saw 277 cases with 34 deaths, 20 directly linked to TB. In 2014, there were 292 cases and 28 deaths with 18 directly caused by TB (eluniversal.com: 15/05/17)

• Swine flu attack in Maharashtra – second victim dies in Mumbai, patient toll reaches 196
Swine flu H1N1 claimed its second victim in Mumbai, while as many as 196 people have succumbed to the infection across the state so far in 2017, an official said. Civic health authorities said six cases of swine flu infection were reported this month in the city, while as many as 19 swine flu patients are currently on ventilators across the state (firstpost.com: 16/05/17)
15. Noncommunicable diseases

15.1 Preparation for the third High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases, to be held in 2018

Document A70/27 (Report by the Director-General):

1. This report is submitted in response to Health Assembly resolution WHA69.6 (2016) and provides an update on the preparation for the third High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases, to be held in 2018, including the responses to specific assignments given to the Secretariat.

2. In January 2017, the Executive Board, at its 140th session, noted an earlier version of this report and adopted resolution EB140.R7, which it recommended to the Health Assembly for adoption. Since then, the report has been updated to take account of mortality estimates for 2015 and other recent developments. Annex 1 has been brought into line with the outcomes of WHO-CHOICE modelling.

NONCOMMUNICABLE DISEASES: CURRENT SITUATION

3. WHO estimates that in 2015, 15 million people between the ages of 30 and 69 died from noncommunicable diseases, as shown below:

<table>
<thead>
<tr>
<th>Category</th>
<th>Men</th>
<th>Women</th>
<th>Total</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low-income countries</td>
<td>0.4 million</td>
<td>0.4 million</td>
<td>0.9 million</td>
<td>6%</td>
</tr>
<tr>
<td>Lower middle-income countries</td>
<td>3.6 million</td>
<td>2.6 million</td>
<td>6.1 million</td>
<td>41%</td>
</tr>
<tr>
<td>Upper middle-income countries</td>
<td>3.5 million</td>
<td>2.4 million</td>
<td>5.8 million</td>
<td>39%</td>
</tr>
<tr>
<td>High-income countries</td>
<td>1.4 million</td>
<td>0.8 million</td>
<td>2.2 million</td>
<td>15%</td>
</tr>
<tr>
<td>Total</td>
<td>8.9 million</td>
<td>6.2 million</td>
<td>15.0 million</td>
<td>100%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Region</th>
<th>Men</th>
<th>Women</th>
<th>Total</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>African Region</td>
<td>0.7 million</td>
<td>0.6 million</td>
<td>1.3 million</td>
<td>9%</td>
</tr>
<tr>
<td>Region of the Americas</td>
<td>1.1 million</td>
<td>0.8 million</td>
<td>1.9 million</td>
<td>13%</td>
</tr>
<tr>
<td>Eastern Mediterranean Region</td>
<td>0.6 million</td>
<td>0.5 million</td>
<td>1.0 million</td>
<td>7%</td>
</tr>
<tr>
<td>European Region</td>
<td>1.5 million</td>
<td>0.8 million</td>
<td>2.4 million</td>
<td>16%</td>
</tr>
<tr>
<td>South-East Asian Region</td>
<td>2.6 million</td>
<td>1.8 million</td>
<td>4.4 million</td>
<td>29%</td>
</tr>
<tr>
<td>Western Pacific Region</td>
<td>2.4 million</td>
<td>1.6 million</td>
<td>4.0 million</td>
<td>27%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>8.9 million</strong></td>
<td><strong>6.2 million</strong></td>
<td><strong>15.0 million</strong></td>
<td><strong>100%</strong></td>
</tr>
</tbody>
</table>

4. Over 80% of these premature deaths, which occurred in people between the ages of 30 and 69, were the result of the four main noncommunicable diseases: cardiovascular disease, cancer, diabetes and chronic respiratory disease.

5. Globally, premature mortality from these four main noncommunicable diseases declined by 15% between 2000 and 2012. This rate of decline is insufficient to meet target 3.4 of the Sustainable Development Goals (by 2030, reduce by one third premature mortality from noncommunicable diseases through prevention and treatment and promote mental health and well-being).

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293 See document EB140/27 and the summary records of the Executive Board at its 140th session, fifteenth meeting, section 1.
6. In 2015, 138 Member States had shown very poor or no progress towards implementing the four time-bound national commitments for 2015 and 2016 set out in the Outcome document of the high-level meeting of the General Assembly on the comprehensive review and assessment of the progress achieved in the prevention and control of non-communicable diseases. The attainment of those commitments by Member States is currently being assessed using the indicators set out in WHO’s technical note dated 1 May 2015. It appears that the pace of progress in 2015 and 2016 has been insufficient.

7. Although the number of countries which have an operational national noncommunicable disease policy with a budget for implementation increased from 32% in 2010 to 50% in 2013, many countries, in particular developing countries, continue to struggle to move from commitment to action. The main obstacles include: a lack of policy expertise to integrate measures to address noncommunicable diseases into national responses to the Sustainable Development Goals; unmet demands for technical assistance to be provided through bilateral and multilateral channels to strengthen national capacity, which would enable countries to develop their national multisectoral noncommunicable disease responses; a change in patterns of health financing (where more of the burden is placed on domestic budgets); insufficient analytical, legal and tax administrative capacity to increase domestic taxes on health-harming products in order to ensure the self-financing of national responses; and industry interference that blocks the implementation of certain measures.

8. In order to help Member States overcome these obstacles, the Secretariat has continued to scale up its technical assistance through the existing actions set out in programme area 2.1 (noncommunicable diseases) of the Programme budget 2016–2017. Outputs since May 2016 have included:

- the launch of the new Data for Health programme to support Member States in conducting household surveys on risk factors for noncommunicable diseases (June 2016);
- updated systematic reviews on the effect of saturated fatty acid and trans-fatty intake on blood lipids (June 2016);
- the launch of the report of the 2015 global survey on assessing national capacity for the prevention and control of noncommunicable diseases (July 2016);
- the launch of a global communications campaign on noncommunicable diseases (July 2016).

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297 The assessment is based on the outcomes of the WHO’s global noncommunicable disease country capacity survey, which is being conducted during the first half of 2017. See the question and answer document available at http://www.who.int/nmh/events/2015/technical-note-qa-en.pdf?ua=1 (accessed 2 May 2017).
• the release of a technical package for cardiovascular disease management in primary health care (September 2016);\textsuperscript{304}

• the adoption of the Shanghai Declaration on promoting health in the 2030 Agenda for Sustainable Development\textsuperscript{305} at the Ninth Global Conference on Health Promotion (Shanghai, 21–24 November 2016), which sets out bold political choices for health that governments may wish to include in their ambitious national responses to the 2030 Agenda;

• the launch of the second phase of the ITU/WHO joint global programme, “Be He@althy, be mobile” (November 2016);\textsuperscript{306}

• the launch of the WHO Global Noncommunicable Disease Document Repository (December 2016);\textsuperscript{307}

• the launch of three global joint programmes with other agencies of the United Nations system (September 2016);\textsuperscript{308}

• the launch of a report on fiscal policies for diet and the prevention of noncommunicable diseases (October 2016);\textsuperscript{309}

• the launch of practice communities on noncommunicable disease governance, health care, prevention and surveillance, to facilitate the exchange of lessons learned between Member States (January 2017);\textsuperscript{310}

• the Global Dialogue meeting on the role of non-State actors in supporting countries in their national efforts to attain Sustainable Development Goal target 3.4 on noncommunicable diseases (November 2016);\textsuperscript{311}

• the publication of the National Cancer Institute Tobacco Control Monograph report, The Economics of Tobacco and Tobacco Control;\textsuperscript{312} and

• an annual progress report by the Secretary-General to the United Nations Economic and Social Council on the WHO-led United Nations Inter-Agency Task Force on the Prevention and Control of Noncommunicable Diseases from June 2016 to March 2017.\textsuperscript{313}

9. In addition, the Secretariat has been finalizing its work on a number of specific global assignments, as set out below, for consideration by Member States.


\textsuperscript{306} http://www.itu.int/en/ITU-D/ICT-Applications/eHEALTH/Be_healthy/Pages/Be_Healthy.aspx (accessed 2 May 2017)


\textsuperscript{313} The progress report will be published by ECOSOC for consideration by Member States during the Coordination and Management Meeting from 7 to 9 June 2017 in New York (see https://www.un.org/ecosoc/en/about-the-cmm).
SPECIFIC GLOBAL ASSIGNMENTS

Draft updated Appendix 3 to the global action plan for the prevention and control of noncommunicable diseases 2013–2020

10. In paragraph 3(10) of resolution WHA66.10 (2013), the Director-General was requested to propose an update of Appendix 3 to the global action plan for the prevention and control of noncommunicable diseases 2013–2020, in the light of new scientific evidence. Accordingly, an initial expert group meeting was held to advise the Secretariat on an appropriate methodology and a review of evidence was conducted in 2015.  

11. In paragraph 5(1) of resolution WHA69.6, the Director-General was requested to submit a draft updated Appendix 3, through the Executive Board, to the Seventieth World Health Assembly, in 2017, in accordance with the timeline contained in Annex 2 to document A69/10.

12. In response to these resolutions, in May 2016 the Secretariat announced to the permanent missions in Geneva the process that the Secretariat is following to update Appendix 3. The process has included: a second expert group meeting (27 and 28 June 2016); a web-based consultation on a WHO discussion paper dated 25 July 2016 on the draft updated Appendix 3 (25 July–1 September 2016); an informal consultation of Member States (24 August 2016); and an informal hearing with non-State actors (25 August 2016). The process and its outcomes to date are described on WHO’s website.  

13. Taking into account the feedback received during the process to date, the Secretariat has prepared a draft updated Appendix 3 for consideration by Member States, which is set out in Annex 1 to the present document. In revising the Annex since its presentation to the Executive Board in document EB140/27, the menu of policy options to reduce tobacco use has been updated to take into account up-to-date scientific knowledge, available evidence and a review of international experience.

14. The Secretariat convened an information session on 24 April 2017 to provide Member States with: additional information to explain the underlying analysis related to interventions included in Appendix 3; and additional technical briefings on the evidence underpinning the inventions presented in Appendix 3.2

Draft approach that can be used to register and publish contributions of non-State actors to the achievement of the nine voluntary targets for noncommunicable diseases

15. In paragraph 37 of the 2014 Outcome document of the high-level meeting of the General Assembly on the comprehensive review and assessment of the progress achieved in the prevention and control of non-communicable diseases, the General Assembly called upon WHO, in consultation with Member States, in the context of the comprehensive global coordination mechanism for the prevention and control of noncommunicable diseases, while ensuring appropriate protection from vested interests, to develop, before the end of 2015, an approach that can be used to register and publish contributions of non-State actors to the achievement of the nine voluntary targets for noncommunicable diseases.

317 Paragraph 37 of United Nations General Assembly resolution 68/300 refers to “the private sector, philanthropic entities and civil society”. However, for the purpose of discussions at the World Health Assembly, it is assumed that all non-State actors identified in paragraph 8 of WHO’s Framework of Engagement with Non-State Actors are included in the scope of this approach (i.e. nongovernmental organizations, private sector entities, philanthropic foundations and academic institutions).
publish contributions of the private sector, philanthropic entities and civil society to the achievement of the nine voluntary targets for noncommunicable diseases.

16. In response to this resolution, the Secretariat submitted a report to the Sixty-ninth World Health Assembly on the development of such an approach, outlining a conceptual framework that the Secretariat proposed to explore in 2016. The report also proposed an initial set of overarching principles and a preliminary analysis of potential risks. Member States adopted resolution WHA69.6, endorsing the process to further develop the approach in 2016 and requesting the Director-General to submit a report setting out the approach, through the Executive Board, to the Seventieth World Health Assembly, in 2017, in accordance with the timeline contained in Annex 4 to document A69/10.

17. In response to resolution WHA69.6, in September 2016 the Secretariat announced to the permanent missions in Geneva the process that the Secretariat is following to finalize its work on the development of the approach. The process is described on WHO’s website and has included a web-based consultation on a WHO discussion paper dated 26 September 2016 setting out a draft approach (26 September–14 October 2016). The feedback received through the web-based consultation has been given due consideration by the Secretariat and is reflected in the revised draft approach as set out in Annex 2 to the present document, which remains a work in progress.

**Proposed workplan for the global coordination mechanism on the prevention and control of noncommunicable diseases covering the period 2018–2019**

18. In paragraph 15 of the terms of reference for the global coordination mechanism on the prevention and control of noncommunicable diseases, the Director-General is requested to submit draft workplans for the global coordination mechanism to the Health Assembly, through the Executive Board, setting out the activities of the global coordination mechanism.

19. In response to this request, the Secretariat has prepared a proposed workplan for the global coordination mechanism, covering the period 2018–2019, for consideration by Member States, which is set out in Annex 3 to the present document.

**EVALUATIONS**

20. In accordance with paragraph 60 of the global action plan for the prevention and control of noncommunicable diseases 2013–2020 and in conformity with the evaluation workplan for 2016–2017, the Secretariat will convene a representative group of stakeholders, including Member States and international partners, that will work from the beginning of the second quarter of 2017 to the end of third quarter of 2017, in order to conduct a mid-point evaluation of progress on the implementation of the global action plan. The results will be reported to the Seventy-first Health Assembly, through the Executive Board.

21. In accordance with the modalities of the preliminary evaluation of the global coordination mechanism on the prevention and control of noncommunicable diseases, paragraph 19 of the terms of reference for the global coordination mechanism, and the evaluation workplan for 2016–2017, the Health Assembly will conduct a preliminary evaluation of the global coordination mechanism between May 2017 and January 2018, in order to assess its results and its added value. The results will be reported to the Seventy-first Health Assembly, through the Executive Board.
PREPARATORY PROCESS LEADING TO THE THIRD HIGH-LEVEL MEETING OF THE GENERAL ASSEMBLY ON THE PREVENTION AND CONTROL OF NON-COMMUNICABLE DISEASES, TO BE HELD IN 2018

22. In response to paragraph 38 of the 2014 Outcome document of the high-level meeting of the General Assembly on the comprehensive review and assessment of the progress achieved in the prevention and control of non-communicable diseases, in September 2017 the Director-General will submit to the United Nations General Assembly a report on the progress achieved in the implementation of the Outcome document and of the 2011 Political Declaration of the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases, in preparation for a comprehensive review by the General Assembly, in 2018, of the progress achieved in the prevention and control of noncommunicable diseases. The contours of the report are described in Annex 7 to document A69/10.

23. As in the preparation for the first High-level Meeting of the General Assembly, in 2011, the Secretariat will hold global and regional multisectoral informal consultations of Member States between October 2017 and May 2018, as appropriate, which will serve to provide inputs to the preparation for the third High-level Meeting, as well as to the meeting itself. The results of these informal consultations will be reported to the Seventy-first Health Assembly, through the Executive Board.

24. The President of Uruguay will host the WHO Global Conference on Noncommunicable Diseases: enhancing policy coherence between different spheres of policy-making that have a bearing on attaining SDG target 3.4 on NCDs by 2030, which will take place from 18 to 20 October 2017 in Montevideo. The mandate for the conference derives from action 1.3 of the workplan of the WHO Global Coordination Mechanism on the prevention and control of noncommunicable diseases covering the period 2016–2017, and the preparatory process for the third High-level Meeting of the United Nations General Assembly on Non-communicable Diseases, which will be held in 2018. The Global Conference is expected to result in a concise outcome document, to be endorsed by the conference participants, setting out a roadmap that Member States may consider implementing to attain SDG target 3.4.

ACTION BY THE HEALTH ASSEMBLY

25. The Health Assembly is invited to note the report and to adopt the draft resolution recommended by the Executive Board in resolution EB140.R7.

ANNEX 1
DRAFT UPDATED APPENDIX 3 TO THE GLOBAL ACTION PLAN FOR THE PREVENTION AND CONTROL OF NONCOMMUNICABLE DISEASES 2013–2020

What is Appendix 3?
1. Appendix 3 is a part of the global action plan for the prevention and control of noncommunicable diseases 2013–2020. It consists of a menu of policy options and cost-effective interventions to assist Member States in implementing, as appropriate for national context (without prejudice to the sovereign rights of nations to determine taxation among other policies), actions to achieve the nine voluntary global targets for the prevention and control of noncommunicable diseases. They are

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325 More information will be posted at http://www.who.int/montevideo2017.
326 See Annex 3 of document A68/11.
presented under the six objectives of the global action plan. The list of interventions is not exhaustive but is intended to provide information and guidance on the effectiveness and cost-effectiveness of population-based and individual interventions based on current evidence, and to serve as the basis for future work to develop and expand the evidence base. Countries are implementing the global action plan, as appropriate for the national context, and Appendix 3 has been used in the development and prioritization of national action plans.

Why update Appendix 3?
2. Appendix 3 has been updated at the request of Member States, to take into consideration the emergence of new evidence of cost-effectiveness and the issuance of new WHO recommendations since the adoption of the global action plan in 2013, and also to refine the existing formulation of some interventions based on lessons learned from the use of the first version. The global action plan ends in 2020, and any future updates will be considered as part of the development of any subsequent global strategies for noncommunicable diseases.

What has changed?
3. The menu of options listed for objectives 1 (raising the priority accorded to noncommunicable diseases), 2 (strengthening leadership and governance), 5 (research) and 6 (monitoring and evaluation) are process-related recommendations and have not changed. Within objectives 3 (risk factors) and 4 (health systems), in the updated Appendix 3, there are now a total of 86 interventions and overarching/enabling actions, representing an expansion from the original list of 62. This increase is due to the greater availability of scientific evidence and to the need to disaggregate some previous interventions (such as “reduce salt intake”) into more clearly defined and implementable actions.

4. As in the original Appendix 3, a select number of interventions, considered to be the most cost-effective and feasible for implementation, are identified in bold text. In the updated Appendix 3, 16 interventions are listed in bold,327 as compared to 14 in the original version, and the method for identifying such interventions has been modified.328 Other interventions, for which cost-effectiveness analysis by the WHO’s Choosing interventions that are cost-effective (WHO-CHOICE) project could be completed, are listed in descending order of cost-effectiveness.329 Interventions that are mentioned in WHO’s guidelines and technical documents where WHO-CHOICE analysis has not been able to be conducted are also listed. Care needs to be taken when interpreting these lists; for example, the absence of WHO-CHOICE analysis does not necessarily mean that an intervention is not cost-effective, affordable or feasible — rather, there were methodological or capacity reasons for which the WHO-CHOICE analysis could not be completed. The economic analyses in the technical annex,330 upon which this list is based, give an assessment of cost–effectiveness ratio, health impact and the economic cost of implementation. These economic results present a set of parameters for consideration by Member States, but it must be emphasized that such global analyses should be accompanied by analyses in the local context. Other WHO tools, such as the OneHealth Tool,331 are available to help individual countries cost specific interventions in their national context.

327 With an average cost-effectiveness ratio of s1$ 100/disability-adjusted life-year averted in low and lower-middle income countries. The international dollar (I$) is a hypothetical unit of currency that has the same purchasing power parity that the United States dollar had in the United States at a given point in time.

328 The listing of interventions in bold text in this updated Appendix 3 is based on economic analyses only. Critical non-financial considerations that may affect the feasibility of certain interventions in some settings are set out in a new column in the updated Appendix 3.

329 Based on cost–effectiveness ratio in low and middle income settings.


The importance of non-financial considerations

5. Cost–effectiveness analysis is a useful tool but it has limitations and should not be used as the sole basis for decision-making. When selecting interventions for the prevention and control of noncommunicable diseases, consideration should be given to effectiveness, cost–effectiveness, affordability, implementation capacity, feasibility, according to national circumstances, and impact on health equity of interventions, and to the need to implement a combination of population-wide policy interventions and individual interventions.

6. Critical non-financial considerations that may affect the feasibility of certain interventions in some settings are set out in a new column in the updated Appendix 3. Many of the interventions for the prevention and control of noncommunicable diseases involve multisectoral benefits and costs that need to be taken into account, and examples of the multisectoral aspects of these interventions are outlined in Appendix 5 to the global action plan. It was not possible to provide an equity rating for each intervention, given the importance of context, but, in general, population-based interventions, including fiscal policies and environmental changes, show the most potential to reduce inequalities in the prevention and control of noncommunicable diseases. Individual interventions, especially those involving education and awareness campaigns, are most likely to widen inequalities and should be accompanied by measures to assess and address other barriers to behaviour change. For any intervention, the impact on health inequalities needs to be considered and evaluated, in order to ensure that policies are effective across all population groups.

Technical annex

7. Based on feedback from experts and Member States, this updated Appendix 3 is accompanied by a technical annex. The annex provides more detailed information about the methodology used to identify and analyse interventions, and presents the results of the economic analysis separately for low and lower-middle income, and upper-middle and high income countries. The Secretariat will explore options to provide an interactive web-tool, to enable users to compare and rank the information according to their own needs. The detailed description of the WHO-CHOICE methods for these analyses, including the assumptions, strength of evidence and the individual studies used to inform the development of models for each intervention, will be published separately as peer-reviewed scientific papers, which will be publicly available through open access.


333 For example, accompanying tobacco price increases with smoking cessation support for the poor, and ensuring food product reformulation involves the entire product range and not just the more expensive options.

334 The draft technical annex is available in the WHO discussion paper dated 25 July 2016 on the draft updated Appendix 3, which is available at http://who.int/ncds/governance/appendix3-update/en/ (accessed 10 October 2016). It will be updated after the 140th session of the Executive Board, before the Seventieth World Health Assembly.
<table>
<thead>
<tr>
<th>Menu of policy options</th>
<th>Critical non-financial considerations</th>
<th>WHO tools</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>OBJECTIVE 1</strong></td>
<td></td>
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</tbody>
</table>
| Overarching/enabling actions | • Raise public and political awareness, understanding and practice about prevention and control of NCDs  
• Integrate NCDs into the social and development agenda and poverty alleviation strategies  
• Strengthen international cooperation for resource mobilization, capacity-building, health workforce training and exchange of information on lessons learned and best practices  
• Engage and mobilize civil society and the private sector as appropriate and strengthen international cooperation to support implementation of the action plan at global, regional and national levels  
• Implement other policy options in objective 1 | – WHO global status report on NCDs  
2014  
– WHO fact sheets  
– Noncommunicable diseases country profiles (2014)  
– IARC GLOBOCAN 2008 |
| **OBJECTIVE 2**        |                                       |            |
| Overarching/enabling actions | • Prioritize and increase, as needed, budgetary allocations for prevention and control of NCDs, without prejudice to the sovereign right of nations to determine taxation and other policies  
• Assess national capacity for prevention and control of NCDs  
• Develop and implement a national multisectoral policy and plan for the prevention and control of NCDs through multistakeholder engagement  
• Implement other policy options in objective 2 to strengthen national capacity including human and institutional capacity, leadership, governance, multisectoral action and partnerships for prevention and control of noncommunicable diseases | – United Nations Secretary-General’s Note A/67/373  
– NCD country capacity survey tool  
– Online NCD MAP Tool for developing, implementing and monitoring national multisectoral action plans |
<p>| <strong>OBJECTIVE 3</strong>        |                                       |            |
| TOBACCO USE            |                                       |            |
| For the Parties to the WHO Framework Convention on Tobacco Control (WHO FCTC): | • Strengthen the effective implementation of the WHO FCTC and its protocols | – The WHO FCTC, its guidelines and its Protocol to Eliminate Illicit Trade in Tobacco Products |</p>
<table>
<thead>
<tr>
<th>Overarching/enabling actions</th>
<th>WHO-CHOICE analysis available</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Establish and operationalize national mechanisms for coordination of the WHO FCTC implementation as part of national strategy with specific mandate, responsibilities and resources</td>
<td>– MPOWER capacity-building modules to reduce demand for tobacco, in line with the WHO FCTC (2011–2014) MPOWER policy measures (2009)</td>
</tr>
<tr>
<td>• Consider implementing the measures set out in the WHO FCTC and its protocols, as the foundational instrument in global tobacco control</td>
<td>– Assessing the national capacity to implement effective tobacco control policies (2011)</td>
</tr>
<tr>
<td>• Increase excise taxes and prices on tobacco products</td>
<td>– Technical resource for country implementation of the WHO Framework Convention on Tobacco Control Article 5.3 (2012)</td>
</tr>
<tr>
<td>• Implement plain/standardized packaging and/or large graphic health warnings on all tobacco packages</td>
<td>– WHO tobacco tax simulation model (TaXSiM) (2014)</td>
</tr>
<tr>
<td>• Enact and enforce comprehensive bans on tobacco advertising, promotion and sponsorship</td>
<td>– WHO technical manual on tobacco tax administration (2010)</td>
</tr>
<tr>
<td>• Implement effective mass media campaigns that educate the public about the harms of smoking/tobacco use and second-hand smoke</td>
<td>– Plain packaging of tobacco products: evidence, design and implementation (2016)</td>
</tr>
<tr>
<td>• Provide cost-covered, effective and population-wide support (including brief advice, national toll-free quit line services) for tobacco cessation to all those who want to quit</td>
<td>– Banning tobacco advertising, promotion and sponsorship – What you need to know (2013)</td>
</tr>
<tr>
<td></td>
<td>– Making your city smoke-free: brochure (2011) and workshop package (2013)</td>
</tr>
<tr>
<td>HARMFUL USE OF ALCOHOL</td>
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<tr>
<td>------------------------</td>
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<tr>
<td>Implement measures to minimize illicit trade in tobacco products</td>
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<tr>
<td>Ban cross-border advertising, including using modern means of communication</td>
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</tr>
<tr>
<td>Provide cessation for tobacco cessation to all those who want to quit</td>
<td></td>
</tr>
<tr>
<td>Implement the WHO global strategy to reduce harmful use of alcohol through multisectoral actions in the recommended target areas</td>
<td></td>
</tr>
<tr>
<td>Strengthen leadership and increase commitment and capacity to address the harmful use of alcohol</td>
<td></td>
</tr>
<tr>
<td>Increase awareness and strengthen the knowledge base on the magnitude and nature of problems caused by harmful use of alcohol by awareness programmes, operational research, improved monitoring and surveillance systems</td>
<td></td>
</tr>
<tr>
<td>Increase excise taxes on alcoholic beverages</td>
<td></td>
</tr>
<tr>
<td>Enact and enforce bans or comprehensive restrictions on exposure to alcohol advertising (across multiple types of media)</td>
<td></td>
</tr>
<tr>
<td>Enact and enforce restrictions on the physical availability of retailed alcohol (via reduced hours of sale)</td>
<td></td>
</tr>
<tr>
<td>Requires an effective system for tax administration and should be combined with efforts to prevent tax avoidance and tax evasion</td>
<td></td>
</tr>
<tr>
<td>Requires capacity for implementing and enforcing regulations and legislation</td>
<td></td>
</tr>
</tbody>
</table>

- Strengthening health systems for treating tobacco dependence in primary care (2013)
- Training for tobacco quit line counsellors: telephone counselling (2014)
- Developing and improving national toll-free tobacco quit line services (2011)
- Confronting the tobacco epidemic in a new era of trade and investment liberalization (2012)
- Global strategy to reduce the harmful use of alcohol (2010) (WHA63.13)
- WHO global status report on alcohol and health (2014)
- WHO fact sheets and policy briefs on harmful use of alcohol
- WHO implementation toolkit for the global strategy to reduce the harmful use of alcohol (2017)
### WHO-CHOICE analysis available

- Enact and enforce drink-driving laws and blood alcohol concentration limits via sobriety checkpoints
- Provide brief psychosocial intervention for persons with hazardous and harmful alcohol use
- Formal controls on sale need to be complemented by actions addressing illicit or informally produced alcohol
  - Requires allocation of sufficient human resources and equipment
  - Requires trained providers at all levels of health care
- Manuals for the alcohol, smoking and substance involvement screening test (ASSIST) and the ASSIST-linked brief interventions (2011)

### WHO-CHOICE analysis not available

- Carry out regular reviews of prices in relation to level of inflation and income
- Establish minimum prices for alcohol where applicable
- Enact and enforce an appropriate minimum age for purchase or consumption of alcoholic beverages and reduce density of retail outlets
- Restrict or ban promotions of alcoholic beverages in connection with sponsorships and activities targeting young people
- Provide prevention, treatment and care for alcohol use disorders and comorbid conditions in health and social services
- Provide consumer information about, and label, alcoholic beverages to indicate, the harm related to alcohol
- WHO implementation toolkit for the global strategy to reduce the harmful use of alcohol (2017)
- mhGAP intervention guide 2.0 (2016)

### UNHEALTHY DIET

#### Overarching/enabling actions

- Implement the global strategy on diet, physical activity and health
- Implement the WHO recommendations on the marketing of foods and non-alcoholic beverages to children
- Global strategy on diet, physical activity and health (2004)
- WHO Set of recommendations on the marketing of foods and non-alcoholic beverages to children (2010)
- Framework for implementing the set of recommendations on the marketing of foods and non-alcoholic beverages to children (2012)
| WHO-CHOICE analysis available | • Reduce salt intake through the reformulation of food products to contain less salt and the setting of target levels for the amount of salt in foods and meals | – Requires multisectoral actions with relevant ministries and support by civil society | – WHO nutrient profile model(s) for regulating marketing food and non-alcoholic beverages to children |
| • Reduce salt intake through the establishment of a supportive environment in public institutions such as hospitals, schools, workplaces and nursing homes, to enable lower sodium options to be provided | | – Report of the Commission on Ending Childhood Obesity (2016)WHO e-Library of Evidence for Nutrition Actions (eLENA) |
| • Reduce salt intake through a behaviour change communication and mass media campaign | | – Fact sheet on healthy diet |
| • Reduce salt intake through the implementation of front-of-pack labelling | | – Interventions on diet and physical activity: what works: summary report (2009) |
| • Eliminate industrial trans-fats through the development of legislation to ban their use in the food chain | | – Guideline: sodium intake for adults and children (2012) |
| • Reduce sugar consumption through effective taxation on sugar-sweetened beverages | | – Guideline: potassium intake for adults and children (2012) |
| | – Regulatory capacity along with multisectoral action is needed | – SHAKE the salt habit: technical package for salt reduction (2016) |
| | | – Fiscal policies for diet and the prevention of noncommunicable diseases (2016) |
| | | | – Evidence for the ten steps to successful breastfeeding (1998) |
| | | | – Marketing of breast-milk substitutes: national implementation of the international code: status report (2016) |
| | • Promote and support exclusive breastfeeding for the first 6 months of life, including promotion of breastfeeding | | |
### WHO-CHOICE analysis not available

- Implement subsidies to increase the intake of fruits and vegetables
- Replace trans-fats and saturated fats with unsaturated fats through reformulation, labelling, fiscal policies or agricultural policies
- Limiting portion and package size to reduce energy intake and the risk of overweight/obesity
- Implement nutrition education and counselling in different settings (for example, in preschools, schools, workplaces and hospitals) to increase the intake of fruits and vegetables
- Implement nutrition labelling to reduce total energy intake (kcal), sugars, sodium and fats

### PHYSICAL INACTIVITY

<table>
<thead>
<tr>
<th>Overarching/enabling actions</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>• Implement the global strategy on diet, physical activity and health</td>
<td></td>
</tr>
</tbody>
</table>

- Five keys to a healthy diet (2016)
- Fruit and vegetables for health (2004)
- Population-based approaches to childhood obesity prevention (2012)
- Essential nutrition actions: improving maternal, newborn, infant and young child health and nutrition (2013)
- Planning guide for national implementation of the Global Strategy for Infant and Young Child Feeding (2007)
- School policy framework: implementation of the WHO global strategy on diet, physical activity and health (2008)
- Prioritizing areas for action in the field of population-based prevention of childhood obesity (2012)

- Global recommendations on physical activity for health (2010)
- WHO global strategy on diet, physical activity and health: a framework to monitor and evaluate implementation (2008)
- Physical activity technical package (Draft)
<table>
<thead>
<tr>
<th>WHO-CHOICE analysis available</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>• Provide physical activity counselling and referral as part of routine primary health care services through the use of a brief intervention</td>
<td>Requires sufficient, trained capacity in primary care</td>
</tr>
<tr>
<td>• Implement public awareness and motivational communications for physical activity, including mass media campaigns for physical activity behavioural change</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>WHO-CHOICE analysis not available</th>
<th></th>
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</thead>
<tbody>
<tr>
<td>• Ensure that macro-level urban design incorporates the core elements of residential density, connected street networks that include sidewalks, easy access to a diversity of destinations and access to public transport</td>
<td>Requires involvement and capacity of other sectors apart from health</td>
</tr>
<tr>
<td>• Implement whole-of-school programme that includes quality physical education, availability of adequate facilities and programs to support physical activity for all children</td>
<td></td>
</tr>
<tr>
<td>• Provide convenient and safe access to quality public open space and adequate infrastructure to support walking and cycling</td>
<td></td>
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<tr>
<td>• Implement multi-component workplace physical activity programmes</td>
<td></td>
</tr>
<tr>
<td>• Promotion of physical activity through organized sport groups and clubs, programmes and events</td>
<td></td>
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</table>

<table>
<thead>
<tr>
<th>OBJECTIVE 4</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>• Integrate very cost-effective noncommunicable disease interventions into the basic primary health care package with referral systems to all levels of care to advance the universal health coverage agenda</td>
<td></td>
</tr>
<tr>
<td>• Explore viable health financing mechanisms and innovative economic tools supported by evidence</td>
<td></td>
</tr>
<tr>
<td>• Scale up early detection and coverage, prioritizing very cost-effective high-impact interventions including cost-effective interventions to address behavioural risk factors</td>
<td>Implementation tools: WHO package of essential noncommunicable (PEN) disease interventions for primary health care in low-resource settings (2013)</td>
</tr>
<tr>
<td>• Train the health workforce and strengthen the capacity of health systems, particularly at the primary care level, to address the prevention and control of noncommunicable diseases</td>
<td>WHO model list of essential medicines</td>
</tr>
<tr>
<td></td>
<td>Scaling-up the capacity of nursing and midwifery services to contribute to the Millennium Development Goals</td>
</tr>
<tr>
<td></td>
<td>Scaling up action against noncommunicable diseases: How much will it cost? (2011)</td>
</tr>
<tr>
<td></td>
<td>Health systems financing: the path to universal coverage (2010)</td>
</tr>
</tbody>
</table>
- Improve the availability of the affordable basic technologies and essential medicines, including generics, required to treat major noncommunicable diseases, in both public and private facilities
- Implement other cost-effective interventions and policy options in objective 4 to strengthen and orient health systems to address noncommunicable diseases and risk factors through people-centred health care and universal health coverage
- Develop and implement a palliative care policy, including access to opioids and analgesics for pain relief, together with training for health workers
- Expand the use of digital technologies to increase health service access and efficacy for NCD prevention, and to reduce the costs in health care delivery

<table>
<thead>
<tr>
<th>CARDIOVASCULAR DISEASE AND DIABETES</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Drug therapy</strong> (including glycaemic control for diabetes mellitus and control of hypertension using a total risk approach) and counselling to individuals who have had a heart attack or stroke and to persons with high risk (≥ 30%) of a fatal and non-fatal cardiovascular event in the next 10 years</td>
</tr>
<tr>
<td><strong>Drug therapy</strong> (including glycaemic control for diabetes mellitus and control of hypertension using a total risk approach) and counselling to individuals who have had a heart attack or stroke and to persons with moderate to high risk (≥ 20%) of a fatal and non-fatal cardiovascular event in the next 10 years</td>
</tr>
<tr>
<td>Treatment of new cases of acute myocardial infarction with either: acetylsalicylic acid, or acetylsalicylic acid and clopidogrel, or thrombolysis, or primary percutaneous coronary interventions (PCI)</td>
</tr>
<tr>
<td>Treatment of acute ischemic stroke with intravenous thrombolytic therapy</td>
</tr>
</tbody>
</table>

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335 Total risk is defined as the probability of an individual experiencing a cardiovascular disease event (for example, myocardial infarction or stroke) over a given period of time, for example 10 years.
336 Costing assumes hospital care in all scenarios.
- Primary prevention of rheumatic fever and rheumatic heart diseases by increasing appropriate treatment of streptococcal pharyngitis at the primary care level
- Secondary prevention of rheumatic fever and rheumatic heart disease by developing a register of patients who receive regular prophylactic penicillin

- Treatment of congestive cardiac failure with angiotensin-converting-enzyme inhibitor, beta-blocker and diuretic
- Cardiac rehabilitation post myocardial infarction
- Anticoagulation for medium-and high-risk non-valvular atrial fibrillation and for mitral stenosis with atrial fibrillation
- Low-dose acetylsalicylic acid for ischemic stroke
- Care of acute stroke and rehabilitation in stroke units

- Preventive foot care for people with diabetes (including educational programmes, access to appropriate footwear, multidisciplinary clinics)
- Diabetic retinopathy screening for all diabetes patients and laser photocoagulation for prevention of blindness
- Effective glycaemic control for people with diabetes, along with standard home glucose monitoring for people treated with insulin to reduce diabetes complications

- Lifestyle interventions for preventing type 2 diabetes
- Influenza vaccination for patients with diabetes
- Preconception care among women of reproductive age who have diabetes including patient education and intensive glucose management
- Screening of people with diabetes for proteinuria and treatment with angiotensin-converting-enzyme inhibitor for the prevention and delay of renal disease

- Vaccination against human papillomavirus (2 doses) of 9–13 year old girls
### Prevention of cervical cancer by screening women aged 30–49, either through:

- Visual inspection with acetic acid linked with timely treatment of pre-cancerous lesions
- Pap smear (cervical cytology) every 3–5 years linked with timely treatment of pre-cancerous lesions
- Human papillomavirus test every 5 years linked with timely treatment of pre-cancerous lesions
- Treatment of cervical cancer stages I and II with either surgery or radiotherapy +/- chemotherapy
- Treatment of breast cancer stages I and II with surgery +/- systemic therapy
- Screening with mammography (once every 2 years for women aged 50–69 years) linked with timely diagnosis and treatment of breast cancer
- Treatment of colorectal cancer stages I and II with surgery +/- chemotherapy and radiotherapy
- Basic palliative care for cancer: home-based and hospital care with multidisciplinary team and access to opiates and essential supportive medicines

### Practices to improve coverage of the hepatitis B birth dose vaccine

- National cancer control programmes core capacity self-assessment tool (2011)
- Guidelines for primary healthcare in low-resource settings (2012)
- Cancer control: knowledge into action, six modules (2008)
- WHO position paper on mammography screening (2014)
- Monitoring national cervical cancer prevention and control programmes (2013)
- Use of cryotherapy for cervical intraepithelial neoplasia (2011)
- Global atlas of palliative care at the end of life (2014)
- Planning and implementing palliative care services: a guide for programme managers (2016)
- Practices to improve coverage of the hepatitis B birth dose vaccine (2013)
## CHRONIC RESPIRATORY DISEASE

| WHO-CHOICE analysis available | • Symptom relief for patients with asthma with inhaled salbutamol  
• Symptom relief for patients with chronic obstructive pulmonary disease with inhaled salbutamol  
• Treatment of asthma using low dose inhaled beclometasone and short acting beta agonist | – Guidelines for primary health care in low-resource settings (2012)  
– Selected pollutants: WHO guideline for indoor air quality (2010)  
– WHO air quality guidelines for particular matter, ozone, nitrogen, dioxide and sulphur dioxide (2005) |
| --- | --- | --- |
| WHO-CHOICE analysis not available | • Access to improved stoves and cleaner fuels to reduce indoor air pollution  
• Cost-effective interventions to prevent occupational lung diseases, for example, from exposure to silica, asbestos  
• Influenza vaccination for patients with chronic obstructive pulmonary disease | – WHO guidelines for indoor air quality: Household fuel combustion (2014)  
– Outline for the development of national programmes for elimination of asbestos-related diseases (2014) |

## OBJECTIVE 5

| Overarching/enabling actions | • Develop and implement a prioritized national research agenda for noncommunicable diseases  
• Prioritize budgetary allocation for research on noncommunicable disease prevention and control  
• Strengthen human resources and institutional capacity for research  
• Strengthen research capacity through cooperation with foreign and domestic research institutes  
• Implement other policy options in objective 5 to promote and support national capacity for high-quality research, development and innovation | – Prioritized research agenda for the prevention and control of noncommunicable diseases 2011  
– Global strategy and plan of action on public health, innovation and intellectual property (WHA61.21) |

## OBJECTIVE 6

| • Develop national targets and indicators based on global monitoring framework and linked with a multisectoral policy and plans  
• Strengthen human resources and institutional capacity for surveillance and monitoring and evaluation | – Noncommunicable diseases progress monitor 2015  
– Global monitoring framework  
– Verbal autopsy instrument  
– STEPwise approach to surveillance |
Overarching/enabling actions

- Establish and/or strengthen a comprehensive noncommunicable disease surveillance system, including reliable registration of deaths by cause, cancer registration, periodic data collection on risk factors and monitoring national response
- Integrate noncommunicable disease surveillance and monitoring into national health information systems

| Global Tobacco Surveillance System |
| Global Information System on Alcohol and Health |
| Global database on the Implementation of Nutrition Action (GINA) |
| Global school-based student health survey, ICD-10 training tool |
| IARC GLOBOCAN 2008 |

- Implement other policy options in objective 6 to monitor trends and determinants of noncommunicable diseases and evaluate progress in their prevention and control

- Service Availability and Readiness (SARA) assessment tool

Cost-effectiveness alone does not imply the feasibility of an intervention in all settings. This column highlights some of the critical non-financial aspects that should be taken into account when considering the suitability of interventions for specific contexts.

An up-to-date list of WHO tools and resources for each objective can be found at: http://www.who.int/nmh/ncd-tools/en/ (accessed 10 October 2016).

Interventions in bold font are those with an average cost-effectiveness ratio of ≤$100/DALY averted in low and lower-middle income countries.

ANNEX 2
DRAFT APPROACH THAT CAN BE USED TO REGISTER AND PUBLISH CONTRIBUTIONS OF NON-STATE ACTORS TO THE ACHIEVEMENT OF THE NINE VOLUNTARY TARGETS FOR NONCOMMUNICABLE DISEASES

PROCESS

1. In paragraph 37 of the 2014 Outcome document of the high-level meeting of the General Assembly on the comprehensive review and assessment of the progress achieved in the prevention and control of non-communicable diseases, the General Assembly called upon WHO, in consultation with Member States, “in the context of the comprehensive global coordination mechanism for the prevention and control of non-communicable diseases, while ensuring appropriate protection from vested interests, to develop before the end of 2015, an approach that can be used to register and publish contributions of the private sector, philanthropic entities and civil society to the achievement of the nine voluntary targets for non-communicable diseases”.

2. In response to this resolution, the Secretariat submitted a report to the Sixty-ninth World Health Assembly on the development of such an approach, outlining a conceptual framework that the Secretariat proposed to explore in 2016. The report also proposed an initial set of overarching principles and a preliminary analysis of potential risks.

3. Member States adopted resolution WHA69.6 (2016), endorsing the process to further develop the approach in 2016 and requesting the Director-General to submit a report setting out the approach, through the Executive Board, to the Seventieth World Health Assembly, in 2017, in accordance with the timeline contained in Annex 4 to document A69/10.

4. In response to resolution WHA69.6, the Secretariat prepared a WHO discussion paper (version dated 26 September 2016)\textsuperscript{339} setting out a draft approach, including a set of proposed output indicators, which was submitted for comments from Member States and non-State actors, through a web-based consultation, from 26 September 2016 to 14 October 2016. The Secretariat received comments from four Member States and two non-State actors. The feedback received has been given due consideration in developing the draft approach set out in the present document, which remains a work in progress.

**CONTEXT**

5. In paragraph 37 of the 2011 Political Declaration of the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable diseases,\textsuperscript{340} the General Assembly acknowledged “the contribution of and important role played by all relevant stakeholders, including individuals, families and communities, intergovernmental organizations and religious institutions, civil society, academia, the media, voluntary associations and, where and as appropriate, the private sector and industry, in support of national efforts for noncommunicable disease prevention and control”, and recognized “the need to further support the strengthening of coordination among these stakeholders in order to improve the effectiveness of these efforts”.

6. In addition, in paragraph 44 of the Political Declaration, the General Assembly called upon the private sector, with a view to strengthening its contribution to noncommunicable disease prevention and control, to: (a) take measures to implement the WHO’s set of recommendations to reduce the impact of the marketing of unhealthy foods and non-alcoholic beverages to children; (b) consider producing and promoting more food products consistent with a healthy diet; (c) promote and create an enabling environment for healthy behaviours among workers; (d) work towards reducing the use of salt in the food industry; and (e) contribute to efforts to improve access to and affordability of medicines and technologies in the prevention and control of noncommunicable diseases.

7. In paragraph 26 of the 2014 Outcome document of the high-level meeting of the General Assembly on the comprehensive review and assessment of the progress achieved in the prevention and control of non-communicable diseases,\textsuperscript{341} the General Assembly acknowledged that limited progress has been made in implementing paragraph 44 of the Political Declaration, and “although an increased number of private sector entities have started to produce and promote food products consistent with a healthy diet, such products are not always broadly affordable and available in all communities within countries”.

8. Although a global accountability framework on the prevention and control of noncommunicable diseases has been established for Member States,\textsuperscript{342} no agreed set of predefined indicators exists to encourage non-State actors to register and publish their own contributions to the achievement of the nine voluntary targets for noncommunicable diseases in the most objective and independently verifiable manner.

**SCOPE AND PURPOSE OF THE DRAFT APPROACH**

9. In Annex 4 to document A69/10, the Secretariat highlighted some considerations to be taken into account when developing the approach, including alignment, impact and participation criteria and methodological options. Accordingly, the approach will consist of (a) a self-reporting tool for non-State actors and (b) a platform to publish the use of the tool by non-State actors.


\textsuperscript{340} Adopted by the United Nations General Assembly in resolution 66/2 (2011).

\textsuperscript{341} Adopted by the United Nations General Assembly in resolution 68/300 (2014).

\textsuperscript{342} Summarized in Annex 8 to document A69/10.
10. In 2013, Member States adopted the global action plan for the prevention and control of noncommunicable diseases 2013–2020, which provides a comprehensive set of policy options for Member States and proposed actions for international partners and the private sector. The implementation of the global action plan would accelerate progress towards the achievement of the nine voluntary global targets by 2025 and provide the impetus for the attainment of noncommunicable disease-related targets of the Sustainable Development Goals.

11. The Secretariat considers that the actions for international partners as reflected in the global action plan are the cornerstone for developing an approach that ensures coordination among non-State actors and alignment with WHO’s technical support to Member States. Although the global action plan is time-bound, its objectives remain relevant for addressing noncommunicable diseases and reaching the noncommunicable disease-related targets of the Sustainable Development Goals.

12. The six objectives of the global action plan are mutually reinforcing and it is likely that a non-State actor’s activities may cover more than one objective. However, non-State actors are encouraged to register only those contributions related to activities within their core area of business, as defined in their strategy documents, that have the highest impact in reducing the burden of noncommunicable diseases.

13. The Secretariat does not have the capacity to quality assure all activities by non-State actors. The purpose of the draft approach is therefore to allow the Secretariat to give further guidance on the contributions that non-State actors can make to help accelerate the achievement of the nine targets, including a set of proposed output indicators for the different categories of non-State actors, and to enable aggregate reporting on the level of these activities by non-State actors to the Health Assembly.

PARTICIPATION
14. Given the multiplicity of actors currently working to advance the fight against noncommunicable diseases, and the wide range of activities engaged in, the participation of non-State actors in the implementation of the approach will serve a meaningful purpose only if the participation criteria are selective.

15. In paragraph 38 of the 2011 Political Declaration, the General Assembly recognized the fundamental conflict of interest between the tobacco industry and public health. This irreconcilable conflict is recognized in the guidelines for implementation of Article 5.3 of the WHO Framework Convention on Tobacco Control, which stress the inherent contradiction between the tobacco industry and social responsibility. Accordingly, the tobacco industry is excluded from participation. The arms industry is also excluded.


Proposed Platform to publish the use of the approach
17. The global coordination mechanism on the prevention and control of noncommunicable diseases will promote the use of the approach by non-State actors. When endorsed by the Health Assembly, however, the approach will be a self-reporting method. It is proposed that the process of publishing the use of the self-reporting tool would entail detailed guidelines from the Secretariat on ways in which non-State actors can contribute to the achievement of the nine voluntary global targets.

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343 Adopted by the Sixty-ninth World Health Assembly in resolution WHA69.10 (2016).
344 Endorsed by the Sixty-sixth World Health Assembly in resolution WHA66.10 (2013).
targets, including the development of quality criteria and quantifiable output indicators against which the achievement of the six agreed objectives of the global action plan can be measured. The process would also entail self-publishing by non-State actors of their contributions on their own websites, using the guidelines developed by the Secretariat.

18. To develop the approach – consisting of a self-reporting tool for non-State actors and a platform to publish the use of the self-reporting tool by non-State actors – further, the Secretariat is seeking guidance from Member States on the level of ambition that is required from the Secretariat in order to:
   – develop a concrete self-reporting tool for non-State actors, including related indicators; and
   – develop an open Internet platform which non-State actors could access in order to upload their own reports for broad comparison and assessment.

**ANNEX 3**

**PROPOSED WORKPLAN FOR THE GLOBAL COORDINATION MECHANISM ON THE PREVENTION AND CONTROL OF NONCOMMUNICABLE DISEASES COVERING THE PERIOD 2018–2019**

1. This workplan sets out the activities of the global coordination mechanism on the prevention and control of noncommunicable diseases, including those of time-bound Working Groups, covering the period 2018–2019. The workplan takes into account the terms of reference for the global coordination mechanism, the workplans covering the periods 2014–2015 and 2016–2017, the global action plan for the prevention and control of noncommunicable diseases 2013–2020, the Political Declaration of the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases, the Outcome document of the high-level meeting of the General Assembly on the comprehensive review and assessment of the progress achieved in the prevention and control of non-communicable diseases, and the 2030 Agenda for Sustainable Development.

2. This workplan takes into consideration the 2030 Agenda for Sustainable Development and the need to enhance multisectoral and multistakeholder advocacy, engagement and action that supports whole-of-government approaches across sectors beyond health and whole-of-society approaches engaging all sectors of society, in order to achieve the noncommunicable disease-related targets of the Sustainable Development Goals.

3. During the implementation of this workplan, account will be taken of: the evaluations mentioned in paragraphs 16 and 17 of document EB140/27; the Outcome document to be adopted at the third High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases, to be held in 2018; and outcomes adopted at other relevant high-level meetings, forums and events convened by the United Nations General Assembly as part of the systematic follow-up and review of the implementation of the 2030 Agenda for Sustainable Development at the global level.

4. As with the previous two workplans, this workplan is organized around five objectives, in line with the five functions of the global coordination mechanism stated in its terms of reference. It will

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346 Document A67/14 Add.3 Rev.1.
348 Endorsed by the Sixty-sixth World Health Assembly in resolution WHA66.10 (2013).
351 Adopted by the United Nations General Assembly in resolution 70/299 (2016).
be implemented between January 2018 and December 2019 in line with the time frame of the Proposed programme budget 2018–2019 and the budgetary provisions related to the activities of the global coordination mechanism included in that programme budget. This workplan will be fully integrated into programme area 2.1 (noncommunicable diseases) of the Proposed programme budget 2018–2019, which will be operationalized through Programme Area Network 2.1, in accordance with established operating procedures.

5. As with the workplan covering the period 2016–2017, and in line with the scope and purpose of the global coordination mechanism, the draft third workplan covering the period 2018–2019 aims to facilitate and enhance the coordination of activities, multistakeholder engagement and action across sectors at the local, national, regional and global levels, in order to contribute to the implementation of the global action plan for the prevention and control of noncommunicable diseases 2013–2020, while avoiding duplication of efforts, using resources in an efficient and results-oriented way, and safeguarding WHO and public health from any undue influence by any form of real, perceived or potential conflicts of interest.\textsuperscript{352}

\textbf{OBJECTIVES AND ACTIONS}

\textbf{Objective 1. Advocate for and raise awareness of the urgency of implementing the global action plan for the prevention and control of noncommunicable diseases 2013–2020, and mainstream the prevention and control of noncommunicable diseases in the international development agenda.}

\textbf{Action 1.1:} Continue the implementation and development of the global communications campaign launched in 2016, with a focus on achieving the noncommunicable disease-related targets of the Sustainable Development Goals and realizing the commitments to prevent and control noncommunicable diseases, as agreed by Member States.\textsuperscript{353}

\textbf{Action 1.2:} Raise awareness of the need to accelerate action to strengthen national responses to noncommunicable diseases by facilitating and enhancing the coordination of activities, multistakeholder engagement and actions across sectors by participants in the global coordination mechanism at high-level political forums.

\textbf{Action 1.3:} Conduct at least one dialogue to facilitate and enhance the coordination of activities, multistakeholder engagement and action across sectors at the local, national, regional and global levels, to support Member States in realizing their commitments to address noncommunicable diseases.

\textbf{Objective 2. Disseminate knowledge and share information based on scientific evidence and/or best practices regarding implementation of the global action plan for the prevention and control of noncommunicable diseases 2013–2020.}

\textbf{Action 2.1:} Continue to facilitate the exchange of information on noncommunicable disease-related research and its translation, identify barriers to research generation and translation, and facilitate innovation in order to enhance the knowledge base for ongoing national, regional and global action.

\textbf{Action 2.2:} Curate a resource library through the portal\textsuperscript{354} of the global coordination mechanism by the end of 2018, which will include relevant and appropriate materials that promote multisectoral and multistakeholder action on noncommunicable diseases.

\textsuperscript{352} Document A67/14 Add.1, Annex, Appendix 1, paragraph 1.

\textsuperscript{353} See United Nations General Assembly resolutions 66/2 (2011) and 68/300 (2014).

Action 2.3: Support knowledge dissemination and information sharing, including through communities of practice and webinars to support the implementation of the global action plan for the prevention and control of noncommunicable diseases 2013–2020 at the national, regional and global levels.

Action 2.4: Develop and disseminate an annual activity report describing progress made in the implementation of the workplan.

Objective 3. Provide a forum to identify barriers and share innovative solutions and actions for the implementation of the global action plan for the prevention and control of noncommunicable diseases 2013–2020 and to promote sustained actions across sectors.

Action 3.1: Establish at least one working group to recommend ways and means of encouraging Member States and non-State actors to realize the commitments made to prevent and control noncommunicable diseases through multisectoral and multistakeholder approaches.

Action 3.2: Conduct at least one meeting of participants in the global coordination mechanism to facilitate and enhance the coordination of activities, multistakeholder engagement and action across sectors at the local, national, regional and global levels.

Objective 4. Advance multisectoral action by identifying and promoting sustained actions across sectors that can contribute to and support the implementation of the global action plan for the prevention and control of noncommunicable diseases 2013–2020.

Action 4.1: Establish strategic roundtables aimed at supporting governments in strengthening their whole-of-government approaches across sectors beyond health and whole-of-society approaches engaging all sectors of society, in collaboration with relevant WHO technical units, the United Nations Inter-Agency Task Force on the Prevention and Control of Non-communicable Diseases, and other stakeholders, as appropriate.

Action 4.2: Work with relevant WHO technical units and the United Nations Inter-Agency Task Force in efforts to meet the requests by Member States to implement the recommendations of the WHO working groups of the global coordination mechanism.

Action 4.3: Continue to contribute to an integrated initiative, in collaboration with relevant WHO technical units and offices, the United Nations Inter-Agency Task Force and other stakeholders, that ensures an appropriate, coordinated and comprehensive response to provide support to Member States that are committed to making fast-track progress towards achieving the nine voluntary global targets for noncommunicable diseases by 2025, and the noncommunicable disease-related targets of the Sustainable Development Goals by 2030.

Objective 5. Identify and share information on existing and potential sources of finance and cooperation mechanisms at the local, national, regional and global levels for implementation of the global action plan for the prevention and control of noncommunicable diseases 2013–2020.

Action 5.1: Continue to promote the implementation of the approach that WHO will have developed to register and publish contributions of non-State actors to the achievement of the nine voluntary targets for noncommunicable diseases.
Action 5.2: Map and publish the commitments made by participants in the global coordination mechanism to implement the global action plan for the prevention and control of noncommunicable diseases 2013–2020.355

Action 5.3: Establish an ongoing dialogue to explore the feasibility of establishing voluntary innovative financing mechanisms and partnerships356 to develop and implement national noncommunicable disease responses through multisectoral and multistakeholder approaches.

RESOLUTION 15.1:

Executive Board Resolution EB140.R7

The Executive Board, Having considered the report on preparation for the third High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable diseases, to be held in 2018,357 RECOMMENDS to the Seventieth World Health Assembly the consideration of the following draft resolution:

The Seventieth World Health Assembly,


1. [ENDORSES] the updated Appendix 3 to the global action plan for the prevention and control of noncommunicable diseases 2013–2020;

2. NOTES the workplan for the global coordination mechanism on the prevention and control of noncommunicable diseases covering the period 2018–2019;

3. URGES Member States.358

(1) to continue to implement resolutions WHA66.10 (2013) on the Political Declaration of the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases and WHA69.6 (2016) on responses to specific assignments in preparation for the third High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable diseases; United Nations General Assembly resolutions 66/2 (2011) on the Political Declaration of the High-level Meeting, 68/300 (2014) on the

355 See document A67/14 Add.1, Annex, Appendix 1, paragraph 22.
356 In accordance with Sustainable Development Goal 17 (Strengthen the means of implementation and revitalize the global partnership for sustainable development).
357 Document EB140/27.
358 And, where applicable, regional economic integration organizations.

(2) to support the preparation at the national, regional and international levels for the third High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases, to be held in 2018;

4. REQUESTS the Director-General to submit a report on the preparation for the third High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases, to be held in 2018, to the Seventy-first World Health Assembly, in 2018, through the Executive Board.
15.2 Draft global action plan on the public health response to dementia

Document A70/28 (Report by the Director-General):

1. In June 2016, the Executive Board in decision EB139(1) requested the Director-General to develop with the full participation of Member States and in cooperation with other relevant stakeholders a draft global action plan on the public health response to dementia, with clear goals and targets, for consideration by the Seventieth World Health Assembly, through the Executive Board at its 140th session. The Annex to this report duly includes a draft action plan, covering the period 2017–2025.

2. In January 2017, the Executive Board, at its 140th session, noted this report and adopted decision EB140(7).

CONSULTATIVE PROCESS

3. In June 2016, the Secretariat initiated the following consultative process in order to facilitate its preparation of a draft action plan:
   • in July and August 2016, internal consultations conducted with regional offices and relevant WHO departments at headquarters supported the development of a zero draft of a global action plan on the public health response to dementia;
   • from 5 September 2016 until 15 October 2016, a web-based consultation was held to seek comments from Member States and views of non-State actors on a WHO discussion paper (version dated 5 September 2016) containing the zero draft of the global action plan; in parallel, the zero draft was also disseminated and presented to Member States and other relevant stakeholders in various meetings, as opportunities arose;
   • on 10 October 2016 an informal consultation of Member States and other relevant stakeholders was held at WHO headquarters.

4. Written and oral feedback from the consultative process on the zero draft was received from 79 Member States and 34 other relevant stakeholders. Overall the zero draft was thought by all stakeholders to be comprehensive, useful and fulfilling a definite need. Some specific suggestions were received on the vision, goal, action areas, indicators and targets and these were considered during the revision of the draft and acted on, as appropriate.

CONTEXT, FRAMING AND SYNERGIES

5. The draft global action plan on the public health response to dementia has close conceptual and strategic links to, and builds upon, other global action plans and strategies adopted or endorsed by the World Health Assembly including: WHO’s Comprehensive mental health action plan 2013–2020, the Global action plan for the prevention and control of noncommunicable diseases 2013–2020, the WHO global disability action plan 2014–2021, the Global strategy and plan of action on ageing and health 2016–2020 and the Global Strategy on Human Resources for Health.

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also draws on regional action plans, including WHO/PAHO’s Strategy and Plan of Action on Dementias in Older Persons 2015–2019.\textsuperscript{364}

6. The draft action plan builds upon a report, jointly published by WHO and Alzheimer’s Disease International in 2012, on dementia as a public health priority\textsuperscript{365} and the outcome of the First Ministerial Conference on the Global Action against Dementia (Geneva, 16 and 17 March 2015).\textsuperscript{366} It is also aligned with the objectives of WHO’s Global Dementia Observatory, a monitoring and knowledge exchange platform that is being established, inter alia to strengthen health systems and policies related to the treatment and care of dementia.

7. In keeping with the pledge made by Heads of State and Government at the United Nations General Assembly in September 2015 that no one will be left behind in the 2030 Agenda for Sustainable Development,\textsuperscript{367} the draft action plan also responds to the global Sustainable Development Goals and the General Assembly’s determination to ensure that all human beings can fulfil their potential in dignity and equality. The Shanghai Declaration on Promoting Health in the 2030 Agenda for Sustainable Development\textsuperscript{368} also provides opportunities for synergy. In addition, in the Convention on the Rights of Persons with Disabilities, States Parties undertake to develop, implement and monitor policies, strategies, legislative and other measures to promote and protect the rights of people with disabilities. The draft plan includes actions in line with the Convention on the Rights of Persons with Disabilities as applicable to people with dementia.

**GENERAL STRUCTURE OF THE DRAFT ACTION PLAN**

8. The draft action plan is global in its scope and was developed through consultation with WHO’s Member States, organizations of the United Nations system, and non-State actors including nongovernmental organizations, private sector entities, philanthropic foundations and academic institutions as well as people with dementia, their carers and families. In line with the 2030 Agenda for Sustainable Development, it takes a comprehensive and multisectoral approach, including coordinated services of the health and social sectors, with an emphasis on promotion of well-being and overall health, prevention, treatment, rehabilitation and care of people with dementia.

9. The draft plan sets out clear actions for Member States, the Secretariat and partners at the international, regional and national levels, and proposes key indicators and global targets that can be used to evaluate overall levels of implementation, progress and impact.

10. The draft global action plan is designed to provide guidance for the development and implementation of policies on dementia in alignment with the principles of universal health coverage and existing action plans on national mental health, ageing, noncommunicable disease and disability. It aims to address, for all resource settings, the response of health, social and other sectors, as well as promotion and prevention strategies.


\textsuperscript{367} United Nations General Assembly resolution 70/1.

\textsuperscript{368} Adopted by the participants of the 9\textsuperscript{th} Global Conference on Health Promotion (Shanghai, China, 21–24 November 2016); see http://www.who.int/healthpromotion/conferences/9gchp/shanghai-declaration/en/ (accessed 8 March 2017).
ACTION BY THE HEALTH ASSEMBLY

11. The Health Assembly is invited to adopt the draft decision recommended by the Executive Board in decision EB140(7).

ANNEX

DRAFT GLOBAL ACTION PLAN ON THE PUBLIC HEALTH RESPONSE TO DEMENTIA 2017–2025

OVERVIEW OF THE GLOBAL SITUATION

1. Dementia is an umbrella term for several diseases that are mostly progressive, affecting memory, other cognitive abilities and behaviour that interfere significantly with a person’s ability to maintain the activities of daily living. Alzheimer disease is the most common form of dementia and may contribute to 60–70% of cases. Other major forms include vascular dementia, dementia with Lewy bodies, and a group of diseases that contribute to frontotemporal dementia. The boundaries between different forms of dementia are indistinct and mixed forms often coexist.

2. In 2015, dementia affected 47 million people worldwide (or roughly 5% of the world’s elderly population), a figure that is predicted to increase to 75 million in 2030 and 132 million by 2050. Recent reviews estimate that globally nearly 9.9 million people develop dementia each year; this figure translates into one new case every three seconds. Nearly 60% of people with dementia currently live in low- and middle-income countries and most new cases (71%) are expected to occur in those countries.

3. Crucially, although age is the strongest known risk factor for the onset of dementia, it is not an inevitable consequence of ageing. Further, dementia does not exclusively affect older people, with young onset dementia (defined as the onset of symptoms before the age of 65 years) accounting for up to 9% of cases. Some research has shown a relationship between the development of cognitive impairment and lifestyle-related risk factors that are shared with other noncommunicable diseases. These risk factors include physical inactivity, obesity, unbalanced diets, tobacco use and harmful use of alcohol as well as diabetes mellitus and mid-life hypertension. Other potentially modifiable risk factors more specific to dementia include mid-life depression, low educational attainment, social isolation and cognitive inactivity. Additionally, non-modifiable genetic risk factors exist that increase a person’s risk of developing dementia. There is also evidence suggesting that overall more women develop dementia than men.

4. Dementia is a major cause of disability and dependency among older people worldwide, having a significant impact not only on individuals but also on their carers, families, communities and societies. Dementia accounts for 11.9% of the years lived with disability due to a noncommunicable

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In light of the improved life expectancy globally, this figure is expected to increase further.

5. Dementia leads to increased costs for governments, communities, families and individuals, and to loss in productivity for economies.
   - In 2015, dementia costs\(^{374}\) were estimated at US$ 818 billion, equivalent to 1.1% of global gross domestic product, ranging from 0.2% for low- and middle-income countries to 1.4% for high-income countries. By 2030, it is estimated that the cost of caring for people with dementia worldwide will have risen to US$ 2 trillion, a total that could undermine social and economic development globally and overwhelm health and social services, including long-term care systems specifically.\(^{375}\)
   - People with dementia and their families face significant financial impact from the cost of health and social care and from reduction or loss of income. In high-income countries, the costs related to dementia are shared between informal care (45%) and social care (40%). In contrast, in low- and middle-income countries social care costs (15%) pale in comparison to informal care costs. The expected disproportionate increase in dementia in low- and middle-income countries will contribute further to increasing inequalities between countries and populations.

6. Currently, the gap is wide between the need for prevention, treatment and care for dementia and the actual provision of these services. Dementia is underdiagnosed worldwide, and, if a diagnosis is made, it is typically at a relatively late stage in the disease process. Long-term care pathways (from diagnosis until the end of life) for people with dementia are frequently fragmented if not entirely lacking. Lack of awareness and understanding of dementia are often to blame, resulting in stigmatization and barriers to diagnosis and care. People with dementia are frequently denied their human rights in both the community and care homes. In addition, people with dementia are not always involved in decision-making processes and their wishes and preferences for care are often not respected.

7. WHO and the World Bank estimate a need by 2030 for 40 million new health and social care jobs globally and about 18 million additional health workers, primarily in low-resource settings, in order to attain high and effective coverage with the broad range of necessary health services. In addressing dementia, expanding the health and social care workforce with appropriate skill mixes as well as available interventions and services will be essential to prevent, diagnose, treat and care for people with dementia.

**VISION, GOALS AND CROSS-CUTTING PRINCIPLES**

**Vision**

8. The vision of the draft action plan is a world in which dementia is prevented and people with dementia and their carers live well and receive the care and support they need to fulfil their potential with dignity, respect, autonomy and equality.

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\(^{374}\) Direct medical and social care costs and costs of informal care.

Goal
9. The goal of the draft global action plan on the public health response to dementia is to improve the lives of people with dementia, their carers and families, while decreasing the impact of dementia on them as well as on communities and countries.

Cross-cutting principles
10. The draft action plan is grounded in the following seven cross-cutting principles.

(a) Human rights of people with dementia. Policies, plans, legislation, programmes, interventions and actions should be sensitive to the needs, expectations and human rights of people with dementia, consistent with the Convention on the Rights of Persons with Disabilities and other international and regional human rights instruments.

(b) Empowerment and engagement of people with dementia and their carers. People with dementia, their carers and organizations that represent them should be empowered and involved in advocacy, policy, planning, legislation, service provision, monitoring and research of dementia.

(c) Evidence-based practice for dementia risk reduction and care. Based on scientific evidence and/or best practice, it is important to develop strategies and interventions for dementia risk reduction and care that are person-centred, cost-effective, sustainable and affordable, and take public health principles and cultural aspects into account.

(d) Multisectoral collaboration on the public health response to dementia. A comprehensive and coordinated response to dementia requires collaboration among all stakeholders to improve prevention, risk reduction, diagnosis, treatment and care. To achieve such collaboration requires engagement at the government level of all relevant public sectors, such as health (including alignment of existing noncommunicable disease, mental health and ageing efforts), social services, education, employment, justice, and housing, as well as partnerships with relevant civil society and private sector entities.

(e) Universal health and social care coverage for dementia. Designing and implementing health programmes for universal health coverage must include financial risk protection and ensuring equitable access to a broad range of promotive, preventive, diagnostic and care services (including palliative, rehabilitative and social support) for all people with dementia and their carers.

(f) Equity. All efforts to implement public health responses to dementia must support gender equity and take a gender-sensitive perspective, keeping in mind all vulnerabilities specific to each national context, consistent with the 2030 Agenda for Sustainable Development, which recognizes that people who are vulnerable, including people with disabilities, older people and migrants, must be empowered.

(g) Appropriate attention to dementia prevention, cure and care. Steps to realize this focus include using existing knowledge and experience to improve prevention, risk reduction, care and support for people with dementia and their carers and generation of new knowledge towards finding disease-modifying treatments or a cure, effective risk reduction interventions and innovative models of care.

PROPOSED ACTIONS AND TARGETS FOR MEMBER STATES, THE SECRETARIAT AND INTERNATIONAL, REGIONAL AND NATIONAL PARTNERS
11. Effective implementation of the draft global action plan on the public health response to dementia will require actions by Member States, the Secretariat and international, regional, national and subnational partners. Depending on national context, these partners include but are not limited to:
development agencies, including international multilateral agencies (for example, OECD, United Nations development agencies and the World Bank), regional agencies (for example, regional development banks), subregional intergovernmental agencies and bilateral development aid agencies;

academic institutions and research agencies, including the network of WHO collaborating centres for mental health, ageing, disability, human rights and social determinants of health, and other related networks;

civil society, including people with dementia, their carers and families and associations that represent them, and other relevant organizations;

the private sector, health insurance, and the media.

12. The roles of these four groups often overlap and can include multiple actions cutting across the areas of governance, health and social care services, promotion of understanding and prevention in dementia, and information, evidence and research. Country-based assessments of the needs and capacities of different partners will be essential to clarify the roles and actions of stakeholder groups.

13. Targets included in this draft global action plan are defined for achievement globally. Each Member State can be guided by these global targets when setting its own national targets, taking into account national circumstances. Each Member State will also decide how these global targets should be adapted for national planning, processes (including data collection systems), policies and strategies.

14. The draft action plan recognizes that each Member State faces specific challenges in implementing these action areas and therefore suggests a range of proposed actions that each Member State will need to adapt to the national context.

Action areas

15. The draft plan comprises seven action areas, which form the underlying structural framework:

1. Dementia as a public health priority
2. Dementia awareness and friendliness
3. Dementia risk reduction
4. Dementia diagnosis, treatment, care and support
5. Support for dementia carers
6. Information systems for dementia
7. Dementia research and innovation

Action area 1: Dementia as a public health priority

16. Given the range of the population affected directly or indirectly by dementia and the complexity of this condition, dementia requires a whole-of-government, broad, multistakeholder, public health approach. Such an approach will lead to a comprehensive response from the health and social care system (both public and private) and other government sectors, and will engage people with dementia and their carers and other relevant stakeholders and partners.

17. Rationale. The development and coordination of policies, legislation, plans, frameworks and integrated programmes of care through a comprehensive, multisectoral approach will support the recognition, and address the complex needs, of people with dementia within the context of each country. This approach is in line with the principle of universal health coverage and the standards outlined in the Convention on the Rights of Persons with Disabilities.
18. **Global target 1:** 75% of countries will have developed or updated national policies, strategies, plans or frameworks for dementia, either stand-alone or integrated into other policies/plans, by 2025.\(^{376}\)

**PROPOSED ACTIONS FOR MEMBER STATES**

19. Develop, strengthen and implement national and/or subnational strategies, policies, plans or frameworks that address dementia, whether as separate instruments or integrated into other planned actions for noncommunicable diseases, mental health, ageing, and disability (or equivalent). These undertakings should give consideration to equity, dignity and the human rights of people with dementia and support the needs of carers, in consultation with people with dementia and other relevant stakeholders.

20. Promote mechanisms to monitor the protection of the human rights, wishes and preferences of people with dementia and the implementation of relevant legislation, in line with the objectives of the Convention on the Rights of Persons with Disabilities and other international and regional human rights instruments. These mechanisms include safeguards for concepts such as legal capacity, self-determination, supported decision-making, and power of attorney, and for protection against exploitation and abuse in institutions as well as in the community.

21. Set up a focal point, unit or functional division responsible for dementia or a coordination mechanism within the entity responsible for noncommunicable diseases, mental health or ageing within the health ministry (or equivalent body), in order to ensure sustainable funding, clear lines of responsibility for strategic planning, implementation, mechanisms for multisectoral collaboration, service evaluation, monitoring and reporting on dementia.

22. Allocate sustainable financial resources that are commensurate with the identified service need and human and other resources required to implement national dementia plans and actions, and set up mechanisms for tracking expenditures on dementia in health, social and other relevant sectors such as education and employment.

**PROPOSED ACTIONS FOR THE SECRETARIAT**

23. Offer technical support, tools and guidance to Member States, and strengthen national capacity in:

- leadership within health ministries and other relevant sectors for the development, strengthening and implementation of evidence-based national and/or subnational strategies or plans and associated multisectoral resource planning, budgeting and tracking of expenditure on dementia;
- evaluating and implementing evidence-based options that suit Member States’ needs and capacities and assessing the health impact of public policies on dementia by supporting national and international partners and establishing or strengthening national reference centres, WHO collaborating centres and knowledge-sharing networks;
- coordinating programmes on dementia with those on related noncommunicable diseases, ageing, mental health and health systems, and with service delivery and processes to ensure maximum synergy and optimal use of existing and new resources.

24. Compile and share knowledge and best practices on existing policy documents dealing with dementia, including codes of practice and mechanisms to monitor the protection of human rights

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\(^{376}\) The global target indicators and means of verification are provided in the Appendix to this Annex.
and implementation of legislation, consistent with the Convention on the Rights of Persons with Disabilities and other international and regional human rights instruments.

25. Promote and support collaboration and partnerships with countries at international, regional and national levels for multisectoral action in the response to dementia and aligning these with the principle of universal health coverage. Collaboration and partnerships should include all relevant sectors: health, justice and social services sectors, civil society, people with dementia, carers and family members, and organizations in the United Nations system, United Nations interagency groups and intergovernmental organizations.

PROPOSED ACTIONS FOR INTERNATIONAL, REGIONAL AND NATIONAL PARTNERS

26. Create and strengthen associations and organizations of people with dementia, their families and carers, and foster their collaboration with existing disability (or other) organizations as partners in the prevention and treatment of dementia.

27. Motivate and actively engage in dialogue between associations representing people with dementia, their carers and families, health workers and government authorities in reforming health and social laws, policies, strategies, plans and programmes relevant to dementia while paying explicit attention to the human rights of people with dementia and their carers as well as their empowerment, engagement and inclusion.

28. Support the development and application of national dementia policies, legislation, strategies and plans, and the creation of a formal role and authority for people with dementia and their carers to influence the process of designing, planning and implementing policies, laws and services related to dementia.

Action area 2: Dementia awareness and friendliness

29. There is common misbelief that dementia is a natural and inevitable part of ageing rather than a disease process, resulting in barriers to diagnosis and care. The lack of understanding also causes fear of developing dementia and leads to stigmatization and discrimination. Furthermore, people with dementia are frequently denied their human rights in both the community and care homes.

30. Dementia-awareness programmes should foster an accurate understanding of dementia and its various subtypes as clinical diseases, reduce stigmatization and discrimination associated with dementia, educate people about the human rights of people with dementia and the Convention on the Rights of Persons with Disabilities, enhance the general population’s ability to recognize early symptoms and signs of dementia, and increase the public’s knowledge of risk factors associated with dementia, thereby promoting healthy lifestyles and risk reduction behaviour in all.

31. A dementia-friendly society possesses an inclusive and accessible community environment that optimizes opportunities for health, participation and security for all people, in order to ensure quality of life and dignity for people with dementia, their carers and families. Shared key aspects of dementia-friendly initiatives include safeguarding the human rights of people with dementia, tackling the stigmatization associated with dementia, promoting a greater involvement of people with dementia in society, and supporting families and carers of people with dementia. The concept of dementia-friendliness is tightly linked to societies also being age-friendly. Both age- and dementia-friendly initiatives should take into account the fact that a significant number of older people are living alone and are sometimes very isolated.

32. Dementia-awareness campaigns and dementia-friendly programmes that are tailored to the cultural contexts and particular needs of a community can promote enhanced health and social
outcomes that reflect the wishes and preferences of people with dementia, as well as improve the quality of life for people with dementia, their carers and the broader community.

33. **Rationale.** Increasing public awareness, acceptance and understanding of dementia and making the societal environment dementia-friendly will enable people with dementia to participate in the community and maximize their autonomy through improved social participation.

34. **Global target 2.1:** 100% of countries will have at least one functioning public awareness campaign on dementia to foster a dementia-inclusive society by 2025.

35. **Global target 2.2:** 50% of countries will have at least one dementia-friendly initiative to foster a dementia-inclusive society by 2025.

**PROPOSED ACTIONS FOR MEMBER STATES**

36. In collaboration with people with dementia, their carers and the organizations that represent them, the media and other relevant stakeholders, organize national and local public health and awareness campaigns that are community- and culture-specific. This cooperative action will improve the accuracy of the general public’s knowledge about dementia, reduce stigmatization, dispel myths, promote early diagnosis, and emphasize the need for gender- and culturally-appropriate responses, recognition of human rights and respect for the autonomy of people with dementia.

37. Support changing all aspects of the social and built environment, including the provision of amenities, goods and services, in order to make it more inclusive and age- and dementia-friendly, promoting respect and acceptance in a manner that meets the needs of people with dementia and their carers and enables participation, safety and inclusion.

38. Develop programmes, adapted to the relevant context, to encourage dementia-friendly attitudes in the community and the public and private sectors that are informed by the experiences of people with dementia and their carers. Target different community and stakeholder groups, including but not limited to: school students and teachers, police, ambulance, fire brigades, transport, financial and other public service providers, education and faith-based organizations, and volunteers.

**PROPOSED ACTIONS FOR THE SECRETARIAT**

39. Offer technical support to Member States and strengthen global, regional and national capacity:

- to engage and include people with dementia, their carers and organizations that represent them in decision-making within WHO’s own processes and on issues that concern them;
- for the selection, formulation, implementation and dissemination of best practices for awareness-raising and reduction of stigmatization and discrimination towards people with dementia.

40. Building upon the WHO Global Network of Age-friendly Cities and Communities and its dedicated website,³⁷⁷ integrate and link dementia-friendly initiatives by documenting and evaluating existing dementia-friendly initiatives in order to identify evidence of what works in different contexts and disseminate this information.

41. Promote awareness and understanding of dementia, the human rights of people with dementia and the role of families and/or other carers as well as maintain and strengthen partnerships with organizations representing people with dementia and their carers.

42. Develop guidance for Member States on how to implement, monitor and evaluate dementia-friendly initiatives.

PROPOSED ACTIONS FOR INTERNATIONAL, REGIONAL AND NATIONAL PARTNERS

43. Encourage all stakeholders to:
   - raise awareness of the magnitude of the social and economic impact of dementia;
   - include people with dementia, their carers and families in all aspects of developing and strengthening services that support the autonomy of people with dementia;
   - protect and promote human rights of people with dementia and support their carers and their families;
   - redress the inequities in vulnerable populations.

44. Ensure that people with dementia are included in activities of the wider community and foster cultural, social and civic participation by enhancing their autonomy.

45. Share in the development and implementation of all relevant programmes to raise awareness about dementia and make communities more dementia-friendly and inclusive.

Action area 3: Dementia risk reduction

46. Growing evidence suggests an interrelationship between dementia on one side and noncommunicable disease and lifestyle-related risk factors on the other. These risk factors include physical inactivity, obesity, unbalanced diets, tobacco use, harmful use of alcohol, diabetes mellitus and mid-life hypertension. In addition, other potentially modifiable risk factors are more specific to dementia and include social isolation, low educational attainment, cognitive inactivity and mid-life depression. Reducing the level of exposure of individuals and populations to these potentially modifiable risk factors, beginning in childhood and extending throughout life, can strengthen the capacity of individuals and populations to make healthier choices and follow lifestyle patterns that foster good health.

47. There is growing consensus that the following measures are protective and can reduce the risk of cognitive decline and dementia: increasing physical activity, preventing and reducing obesity, promotion of balanced and healthy diets, cessation of tobacco use and the harmful use of alcohol, social engagement, promotion of cognitive stimulating activities and learning as well as prevention and management of diabetes, hypertension, especially in mid-life, and depression.

48. **Rationale.** By improving the capacity of health and social care professionals to provide evidence-based, multisectoral, gender and culturally-appropriate interventions to the general population, educate about and proactively manage modifiable risk factors for dementia that are shared with other noncommunicable diseases, the risk of developing dementia can be reduced or its progression delayed.

49. **Global target 3:** The relevant global targets defined in the Global action plan for prevention and control of noncommunicable diseases 2013–2020 and any future revisions are achieved for risk reduction and reported.

PROPOSED ACTIONS FOR MEMBER STATES

50. Link dementia with other programmes, policies and campaigns on noncommunicable disease risk reduction and health promotion across relevant sectors by promoting physical activity, healthy and balanced diets. Specific actions include weight management for obese individuals, cessation of
tobacco use and the harmful use of alcohol, formal education and mentally-stimulating activities as well as lifelong social engagement in line with the principle of balancing prevention and care.

51. Develop, deliver and promote evidence-based, age-, gender-, disability- and culturally-sensitive interventions and training to health professionals, especially within the primary health care system, to improve knowledge and practices of such staff, and proactively manage modifiable dementia risk factors when conducting counselling about risk reduction. Routinely update these interventions as new scientific evidence becomes available.

PROPOSED ACTIONS FOR THE SECRETARIAT
52. Linking to the actions specified in the global action plan for the prevention and control of noncommunicable diseases 2013–2020, offer technical support and strengthen global, regional and national capacities and capabilities to:

- raise awareness of the links between dementia and other noncommunicable diseases;
- integrate the reduction and control of modifiable dementia risk factors into national health-planning processes and development agendas;
- support the formulation and implementation of evidence-based, multisectoral interventions for reducing the risk of dementia.

53. Strengthen the evidence base and share and disseminate evidence to support policy interventions for reducing potentially modifiable risk factors for dementia by providing a database of available evidence on the prevalence of those risk factors and the consequences of reducing them.

PROPOSED ACTIONS FOR INTERNATIONAL, REGIONAL AND NATIONAL PARTNERS
54. Encourage all stakeholders to engage in activities to:

- promote and mainstream population health strategies that are age-inclusive, gender-sensitive and equity-based at national, regional and international levels in order to support a socially active lifestyle that is physically and mentally healthy for all, including people with dementia, their carers and families;
- take particular actions that have been shown to reduce the risk of dementia, particularly during mid-life;
- support national efforts for prevention and control of noncommunicable diseases in general and dementia in particular, for example, through exchange of information on evidence-based best practices and dissemination of research findings.

Action area 4: Dementia diagnosis, treatment, care and support

55. Dementia is associated with complex needs and high levels of dependency and morbidity in its later stages, requiring a range of health and social care, including long-term-care services. People with dementia are also less likely to be diagnosed for comorbid health conditions, which, when left untreated, can cause faster decline, and to receive the care and support they need to manage them. The services that they require include case-finding, diagnosis, treatment (including pharmacological and psychosocial), rehabilitation, palliative/end-of-life care and other support such as home help, transport, food and the provision of a structured day with meaningful activities.

56. People with dementia should be empowered to live in the community and to receive care aligned with their wishes and preferences. To ensure that people with dementia can maintain a level of functional ability consistent with their basic rights, fundamental freedoms and human dignity, they need integrated, person-centred, accessible, affordable health and social care, including long-term care. Long-term care covers all activities, whether these are provided by health, social or palliative care services or result from a dementia-friendly environment. Palliative care is a core
component of the continuum of care for people living with dementia from the point of diagnosis through to the end of life and into the bereavement stages for families and carers. It provides physical, psychosocial and spiritual support for people with dementia and their carers including support with advance care planning.

57. The draft action plan proposes some principles for organizing and developing health and social care, including long-term care systems for dementia. Providing sustainable care across the continuum from diagnosis to the end of life requires: timely diagnosis; the integration of dementia treatment and care into primary care; coordinated continuity of health and social care including long-term care between different providers and system levels, multidisciplinary collaboration and active cooperation between paid and unpaid carers. Planning responses to and recovery from humanitarian emergencies must ensure that individual support for people with dementia and community psychosocial support are widely available.

58. Adequately trained and qualified workforces are required to provide these interventions. The continuity of care between different care providers, multiple sectors and system levels and active collaboration between paid and unpaid carers are crucial, from the first symptoms of dementia until the end of life. Integrated, evidence-based, person-centred care is required in all settings where people with dementia live, ranging from their homes, the community, assisted-living facilities and nursing homes to hospitals and hospices. The skills and capacity of the workforce and services are often challenged by the complex needs of people with dementia.

59. **Rationale.** The needs and preferences of people with dementia can be met and their autonomy from diagnosis to the end of life respected through integrated, culturally-appropriate, person-centred, community-based health, psychosocial, long-term care and support and, where appropriate, the inputs of families and carers.

60. **Global target 4:** In at least 50% of countries, as a minimum, 50% of the estimated number of people with dementia are diagnosed\(^{378}\) by 2025.

**PROPOSED ACTIONS FOR MEMBER STATES**

61. Develop a pathway of efficient, coordinated care for people with dementia that is embedded in the health and social care system (including long-term care), to provide integrated, person-centred care as and when it is required. The pathway should provide quality care and management that integrates multiple services, including primary health care, home care, long-term care, specialist medical care, rehabilitation and palliative services, household help, food and transport services, other social welfare services and meaningful activities, into a seamless bundle that enhances the capacity and functional ability of people with dementia.

62. Build the knowledge and skills of general and specialized staff in the health workforce to deliver evidence-based, culturally-appropriate and human rights-oriented health and social care, including long-term care services for people with dementia. (Mechanisms may include teaching the core competences of dementia diagnosis, treatment and care in undergraduate and graduate medical and paramedical training, and continuing training programmes for all health and social care professionals, in collaboration with key stakeholders such as regulatory bodies.) Earmark budgets and resources for in-service training for these professionals, or include such budgets and resources in specific programmes.

63. Improve the quality of care towards the end of life by: recognizing advanced dementia as a condition requiring palliative care; promoting awareness about advanced care planning for all people living with dementia to document their wishes for the end of their life; using validated

\(^{378}\) All people who are diagnosed should receive appropriate post-diagnostic health and social care.
end-of-life pathways and ensuring that people with dementia have their values and preferences respected and are cared for in their place of choice; and providing training for health care professionals and palliative care specialists.

64. Systematically shift the locus of care away from hospitals towards community-based care settings and multidisciplinary, community-based networks that integrate social and health systems and provide quality care and evidence-based interventions.

65. Enhance access to a range of person-centred, gender-sensitive, culturally-appropriate and responsive services including liaison with local nongovernmental organizations and other stakeholders in order to provide information that empowers people with dementia to make informed choices and decisions about their care. Respect their rights and preferences and foster active collaboration between the person with dementia, their families and carers and service providers from the first symptoms through to the end of life.

PROPOSED ACTIONS FOR THE SECRETARIAT

66. Offer technical support to Member States for documenting and sharing best practices of evidence-based service delivery and care coordination, and provide support to Member States in developing dementia care pathways in line with the principle of universal health coverage.

67. Develop and implement guidelines, tools and training materials, such as model training curricula covering core competencies relating to dementia for health and social care workers in the field. Provide support to Member States in the formulation of human resource strategies for dementia, including the identification of gaps, specific needs and training requirements for health and social care workers as well as graduate and undergraduate education about integrated provision of long-term care that is person-centred from diagnosis to the end of life.

68. Provide guidance on strengthening the implementation of the dementia component of the WHO Mental Health Gap Action Programme379 to enhance capabilities of existing human resources and train more staff, and the ability to provide quality care and evidence-based interventions through primary health care.

PROPOSED ACTIONS FOR INTERNATIONAL, REGIONAL AND NATIONAL PARTNERS

69. Support people with dementia and their families and carers, for example, by developing evidence-based, user-friendly information and training tools concerning dementia and available services to allow timely diagnosis and enhance the continued provision of long-term care, or by setting up national helplines and websites with information and advice at local levels.

70. Support the training of health and social care personnel to provide evidence-based treatment and care for people with dementia, by developing training relevant to needs, supporting teaching institutions in revising the contents of curricula so as to place greater emphasis on dementia, and ensuring that people with dementia are engaged, as appropriate, in the development and provision of education and training.

71. Promote community-based rehabilitation as an effective strategy to enable and support people with dementia in preserving their autonomy and rights and ensuring that the person with dementia remains at the centre of all discussions on diagnosis, treatment and care.

72. Carers can be defined by their relationship to the person with dementia and their care input. Many dementia carers are relatives or extended family members, but close friends, neighbours and paid lay persons or volunteers can also take on responsibilities for caring. Carers are involved in providing “hands-on” care and support for people with dementia or play a significant role in organizing the care delivered by others. Carers often know the person with dementia well, and therefore are likely to have knowledge of and information about the person with dementia that is crucial for developing effective personalized needs-based treatment and care plans. Carers should therefore be considered essential partners in the planning and provision of care in all settings according to the wishes and needs of the person with dementia.

73. It should be noted that being a carer for someone with dementia may affect the carer’s physical and mental health and well-being and social relationships. Health systems must consider both the substantial need of people with dementia for help from others and its significant impact on carers and families, including economic impact. Carers should have access to support and services tailored to their needs in order effectively to respond to and manage the physical, mental and social demands of their caring role.

74. Rationale. The creation and implementation of means to deliver multisectoral care, support and services for carers will help to meet the needs of carers, and prevent a decline in their physical and mental health and social well-being.

75. Global target 5: 75% of countries provide support and training programmes for carers and families of people with dementia by 2025.

PROPOSED ACTIONS FOR MEMBER STATES
76. Provide accessible and evidence-based information, training programmes, respite services and other resources tailored to the needs of carers to improve knowledge and caregiving skills, such as coping with challenging behaviour, to enable people with dementia to live in the community and to prevent stress and health problems for their carers.

77. Provide training programmes for health care and social care staff for the identification and reduction of stress and burn-out of carers.

78. Develop or strengthen protection of carers, such as social and disability benefits, policies and legislation against discrimination, for example in employment, and support them beyond their caregiving role in all settings.

79. Involve carers in the planning of care, with attention being given to the wishes and preferences of people with dementia and their families.

PROPOSED ACTIONS FOR THE SECRETARIAT
80. Build evidence on and articulate the importance of carers in the lives of people with dementia, while raising awareness about the disproportionate effect on women, and offer technical support to Member States by monitoring trends in availability of carer-support services. Provide support to Member States in developing evidence-based information, training programmes and respite services for carers, using a multisectoral approach, and foster outcome measurement.

81. Facilitate access to affordable, evidence-based resources for carers to improve knowledge and skills, reduce emotional stress and improve coping, self-efficacy and health by making use of
information and communication technologies such as internet and mobile phone technologies (for instance, WHO iSupport\(^{380}\)), for education, skills training and social support.

**PROPOSED ACTIONS FOR INTERNATIONAL, REGIONAL AND NATIONAL PARTNERS**

82. Increase awareness of the involvement, and its consequences, of carers and families in the lives of people with dementia, protecting them from discrimination, supporting their ability to continue their caregiving in a gender-sensitive manner, and empowering carers with opportunities to develop self-advocacy skills to be able to meet specific challenges in accessing health and social care, including long-term care services.

83. Assist in carrying out appropriate training programmes: for carers and families to enhance knowledge and caregiving skills across the progression of dementia; and on a person-centred approach to promote respect and well-being.

**Action area 6: Information systems for dementia**

84. Systematic, routine population-level monitoring of a core set of dementia indicators provides the data needed to guide evidence-based actions to improve services and to measure progress towards implementing national dementia policies. By building and/or strengthening information systems for dementia the functional trajectories of people with dementia, their carers and families can be improved. However, this will require significant changes, while respecting existing regulatory frameworks, to the routine collection, recording, linkage and disaggregation for sharing of health and administrative data of each encounter of a person with dementia with the health and social care system.

85. **Rationale.** Systematic monitoring and evaluation of the usage of health and social care systems can provide the best available evidence for policy development and service delivery, and can improve prevention and the accessibility and coordination of care for people with dementia across the continuum from risk reduction to the end of life.

86. **Global target 6:** 50% of countries routinely collect a core set of dementia indicators through their national health and social information systems every two years by 2025.

**PROPOSED ACTIONS FOR MEMBER STATES**

87. Develop, implement and improve, as needed, national surveillance and monitoring systems, including registers that are integrated into existing health information systems, in order to improve availability of high-quality, multisectoral data on dementia. Enable access to health and social care data and map available services and resources at national and regional levels in order to improve service delivery and coverage across the care continuum from prevention through risk reduction to the end of life.

88. Update or create supportive policy or legislation pertaining to the measurement, collection and sharing of data on health and social care for dementia and integrate this information routinely into national health information systems so as to facilitate routine reporting on dementia.

89. Collect and use the necessary data on epidemiology, care and resources relating to dementia in the country in order to implement relevant policies and plans.

**PROPOSED ACTIONS FOR THE SECRETARIAT**

90. Offer technical support to Members States as they:

- develop and/or reform national data collection systems, including health information systems, in order to strengthen multisectoral dementia data collection;
- build national capacity and resources for systematic collection, analysis and use of dementia-specific data through development of targets and indicators that account for national circumstances, yet are aligned as closely as possible with indicators and targets of the global monitoring framework.

91. Develop a core set of indicators in line with this action plan and provide guidance, training and technical assistance on capturing information and facilitating the use of these data to monitor outcomes. WHO’s Global Dementia Observatory provides the mechanism to monitor systematically and facilitate the use of data from these core indicators, offering a platform for the exchange of data and knowledge in order to support evidence-based service planning, sharing of best practices and strengthening of both policies on dementia and health and social care systems.

92. Offer technical support to Member States in generating and providing information for monitoring of global, regional and national targets as required, through the Global Dementia Observatory.

PROPOSED ACTIONS FOR INTERNATIONAL, REGIONAL AND NATIONAL PARTNERS

93. Provide support to Member States and the Secretariat in developing tools and strengthening capacity for surveillance and information systems that: capture data on core indicators on dementia; monitor usage of health and social care and support services for people with dementia, carers and families; and enable an assessment of trends over time.

94. Advocate the involvement of people with dementia and their families and carers in the creation, collection, analysis and use of data on dementia.

**Action area 7: Dementia research and innovation**

95. If the incidence of dementia is to be reduced and the lives of people with dementia are to be improved, research and innovation are crucial as is their translation into daily practice. It is important not only that funding and appropriate infrastructures for dementia research and innovation are available but also that mechanisms are in place that assist appropriate recruitment of people with dementia, their families and carers into research studies. Research and development costs are higher for dementia than other therapeutic areas, because of lower success rates, longer development times, and low recruitment rates into trials; this disproportion discourages investment in this area. Research is needed to find a cure for dementia, but research is equally needed into prevention, risk reduction, diagnosis, treatment and care, including the disciplines of social science, public health and implementation research.

96. Collaboration among and between Member States and relevant stakeholders, with a particular focus on strengthening North–South, South–South and triangular cooperation, to implement a global dementia research agenda will increase the likelihood of effective progress globally towards better prevention, diagnosis, treatment and care for people with dementia.

97. There is a growing interest in, and call for, the use of innovative health technologies in prevention, risk reduction, early diagnosis, treatment, care and support relating to dementia. These innovations aim to improve knowledge, skills and coping mechanisms in order to facilitate and support the daily lives of people with dementia and their carers while meeting in particular identified needs in an evidence-based and age-, gender- and culturally-sensitive manner.
98. **Rationale.** The successful implementation of research into dementia aligned with identified research priorities and social and technological innovations can increase the likelihood of effective progress towards better prevention, diagnosis, treatment and care for people with dementia.

99. **Global target 7:** *The output of global research on dementia doubles between 2017 and 2025.*

**PROPOSED ACTIONS FOR MEMBER STATES**

100. Develop, implement and monitor the realization of a national research agenda on prevention, diagnosis, treatment and care of people with dementia in collaboration with academic and research institutions; this work could be stand-alone or integrated into related research programmes that focus on filling gaps in evidence to support policy or practice. Strengthen research capacity for academic collaborations on national priorities for research into dementia by engaging relevant stakeholders, including people with dementia. Relevant steps may include: improving research infrastructure for dementia and related fields, enhancing competence of researchers to conduct high-quality research and establishing centres of excellence for research into dementia.

101. Increase investment in dementia research and innovative health technologies and improve research governance as an integral component of the national response to dementia. In particular, allocate budgets to promote projects that: support collaborative national and international research; promote sharing of and open access to research data; generate knowledge on how to translate what is already known about dementia into action; and support the retention of the research workforce.

102. Foster the development of technological innovations that, in terms of design and evaluation, respond to the physical, psychological and social needs of people with dementia, their carers or people at risk of developing dementia; these innovations include but are not limited to diagnosis, disease monitoring and assessment, assistive technologies, pharmaceuticals and new models of care or forecasting/modelling techniques.

103. Following the national ethical requirements for research, promote equitable opportunities and access for people with dementia and their carers to be part of clinical and social research that concerns them.

**PROPOSED ACTIONS FOR THE SECRETARIAT**

104. Draw up a global research agenda and work together with Member States to strengthen and build capacity in the area of dementia research by incorporating it in national and subnational policies and plans relating to dementia. Advocate increased investment in dementia research, capacities, methods and collaboration in the fields of biomedical and social sciences research, inter alia, through a network of WHO collaborating centres, countries from all WHO regions, and civil society organizations.

105. Engage relevant stakeholders, including people with dementia and their organizations, in the development and promotion of a global dementia research programme; facilitate global networks for research collaboration; and carry out multisectoral research related to the burden of disease, dementia risk reduction, treatment, care, policy and service evaluation. Promote international cooperation and intercountry exchange of research expertise, policy and practice through the systematic mapping of national investments in research and outputs of that research.

106. Support the inclusion of technological innovation in national and subnational policies and plans on dementia and offer technical support to Member States in developing and strengthening the provision of assistive and innovative technologies to maximize the functional ability of people with dementia, particularly in resource-poor settings.
PROPOSED ACTIONS FOR INTERNATIONAL, REGIONAL AND NATIONAL PARTNERS

107. Support Member States and the Secretariat, where appropriate, by collaborating in setting priorities for dementia research, promoting increased governmental investment, mobilizing and increasing financial support, and disseminating research findings in user-friendly language to policymakers, the public, people with dementia, their carers and families.

108. Advocate the engagement of people with dementia and their carers in applied research, clinical trials and the evaluation of new technologies that take account of the different physiology, needs and preferences of people with dementia and their carers.

109. Assist in the implementation and evaluation of innovative technologies, community-based service delivery structures and new dementia care concepts. Promote the use of information and communications technology to improve programme implementation, health outcomes, health promotion, monitoring and reporting and surveillance systems, and to disseminate, as appropriate, information on affordable, cost-effective, sustainable and high-quality interventions, best practices and lessons learned in the field of dementia.

110. Strengthen national capacity for research, development and innovation, for all aspects of dementia prevention, risk reduction, treatment and care in a sustainable and cost-effective manner, including the strengthening of institutional capacity and the creation of research fellowships and scholarships.

Appendix

INDICATORS FOR MEASURING PROGRESS TOWARDS THE DEFINED TARGETS OF THE DRAFT GLOBAL ACTION PLAN ON THE PUBLIC HEALTH RESPONSE TO DEMENTIA AND MEANS OF VERIFICATION

(The Appendix is not included here in full - see http://apps.who.int/gb/ebwha/pdf_files/WHA70/A70_28-en.pdf)

LINKS TO OTHER GLOBAL ACTION PLANS, STRATEGIES AND PROGRAMMES


381 All websites accessed 8 March 2017.


LIST OF OTHER DOCUMENTS THAT ARE LINKED TO THE GLOBAL ACTION PLAN ON THE PUBLIC HEALTH RESPONSE TO DEMENTIA


DECISION 15.2:

Executive Board Decision EB140(7): Draft global action plan on the public health response to dementia

The Executive Board, having considered the draft global action plan on the public health response to dementia 2017–2025, decided to recommend to the Seventieth World Health Assembly the adoption of the following decision:

The Seventieth World Health Assembly, having considered the draft global action plan on the public health response to dementia 2017–2025,

382 All websites accessed 8 March 2017.
(1) endorsed the global action plan on the public health response to dementia 2017–2025;

(2) urged Member States to develop, as soon as practicable, ambitious national responses to the overall implementation of the global action plan on the public health response to dementia 2017–2025;

(3) requested the Director-General to submit a report on progress made in implementing this decision to the Health Assembly in 2020, 2023 and 2026.

384 And, where applicable, regional economic integration organizations.
15.3 Public health dimension of the world drug problem

**Document A70/29 (Report by the Secretariat):**

1. The Executive Board at its 140th session in January 2017 considered and noted an earlier version of this document. The Secretariat had previously reported on the subject to the Sixty-ninth World Health Assembly. The present report has been updated to take account of the latest activities.

2. In resolution S-30/1, the General Assembly adopted the outcome document of its special session on the world drug problem (New York, United States of America, 19–21 April 2016). Heads of State and Government, ministers and representatives of Member States reiterated their commitment to promote the health, welfare and well-being of all individuals, families, communities and society as a whole. They reaffirmed the need to strengthen cooperation among the United Nations entities, within their respective mandates, in their efforts to address the world drug problem and support Member States in the implementation of international drug control treaties and to promote the protection of and respect for human rights and the dignity of all individuals in the context of drug programmes, strategies and policies. Furthermore, they made operational recommendations, in some of which WHO is explicitly mentioned.

3. In December 2016, the General Assembly adopted resolution 71/211, which supported strengthened international cooperation to address and counter the world drug problem and which, inter alia, encouraged all relevant United Nations bodies and specialized agencies to commence implementing recommendations made in the outcome document mentioned above within their existing mandates.

4. Drug use, drug use disorders and related health conditions are major public health concerns. According to WHO’s latest estimates for 2015, psychoactive drug use is responsible for more than 450,000 deaths per year. The drug-attributable disease burden accounts for about 1.5% of the global burden of disease, and injecting drug use accounts for an estimated 30% of new HIV infections outside sub-Saharan Africa and contributes significantly to the epidemics of hepatitis B and hepatitis C in all regions.

5. Public health problems caused by psychoactive substance use have reached alarming proportions and globally constitute a significant, but to a large extent preventable, health and social burden. Rapid globalization, technological and communication developments, and growing availability and diversity of synthetic compounds with psychoactive and dependence-producing properties all require adequate and proportionate policy and programmatic responses to the drug problem. The public health strategies and the health sector have an important and growing role in mitigating drug-related harm at all levels. At the same time, health systems face significant challenges such as emerging epidemics of use of new psychoactive substances and the need to find the right balance between availability of medicines controlled by international drug treaties and prevention of their diversion, misuse and abuse. Funding, governance and organization of prevention, treatment and harm reduction services for drug use disorders continue to be challenges in different jurisdictions. These challenges exist in well developed health systems and are even more prominent in less-resourced countries with insufficiently developed or no infrastructure for carrying out situation assessment and implementation of appropriate health sector policy and programmatic responses. Strengthening country capacity to respond to drug-related public health challenges and providing the required technical support is an important task for WHO in implementing the recommendations.

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385 Document EB 140/29; see also summary records of the Executive Board at its 140th session, fourteenth meeting.
386 Document A69/12; see also document WHA69/2016/REC/3, summary records of Committee A, thirteenth meeting, section 5.
of the General Assembly’s special session on the world drug problem. If public health measures are not adequately prioritized and urgent action is not taken, drug-related mortality, morbidity, disability and impact on well-being will continue to pose a significant global public health problem.

6. Target 3.5 of Sustainable Development Goal 3 sets out a commitment by governments to strengthen the prevention and treatment of substance abuse. Several other targets are also of particular relevance to drug policy-related health issues, especially target 3.3, referring to ending the AIDS epidemic and combating viral hepatitis; target 3.4, on preventing and treating noncommunicable diseases and promoting mental health; target 3.8, on achieving universal health coverage; and target 3.b, with its reference to providing access to affordable essential medicines.387

WHO’S ROLE IN THE FOLLOW-UP TO THE SPECIAL SESSION OF THE UNITED NATIONS GENERAL ASSEMBLY ON THE WORLD DRUG PROBLEM

7. As the directing and coordinating authority for health within the United Nations system, WHO has an important role to play in promoting a public health approach to counter the world drug problem, strengthening the role of health systems in reducing the disease burden due to psychoactive drug use and improving the well-being of populations at all levels. While recognizing UNODC as the leading entity in the United Nations system for countering the world drug problem, WHO will intensify its efforts to ensure the coherence of public health-oriented drug-related policies in areas such as: noncommunicable diseases and mental health; access to and rational use of essential medicines; alcohol and tobacco control; violence, injuries and road safety; prevention and control of HIV, viral hepatitis, tuberculosis and other communicable diseases; sexual and reproductive health; and health systems strengthening and emergency responses. It will provide special support to health ministries and other public health entities at country level for strengthening public health responses to drug problems.

8. Effective action on the public health elements of a comprehensive and balanced drug policy requires intensified international cooperation – among Member States, United Nations entities and other relevant partners, including civil society; strengthened multisectoral cooperation; and greater capacity of the Secretariat to provide support to Member States, within WHO’s mandate and in line with its core functions. Effective technical support to countries in their efforts to implement the health-related operational recommendations adopted at the special session and to achieve drug-related targets in Sustainable Development Goal 3 will require a new level of coordinated effort by United Nations entities and other relevant organizations. Cooperation needs to be strengthened between WHO, UNODC, the International Narcotics Control Board and other competent United Nations bodies, within their respective mandates and with acknowledgement of the primacy of the Commission on Narcotic Drugs as the policy-making body of the United Nations with overall responsibility for drug control matters.

9. In February 2017, WHO and UNODC signed a memorandum of understanding to strengthen and expand existing cooperation on the public health dimension of the world drug problem, with special emphasis on the implementation of the health-related operational recommendations included in the outcome document of the General Assembly’s special session on the world drug problem. The memorandum of understanding builds on the ongoing collaboration between WHO and UNODC and is focused on seven main areas of current and planned collaborative activities: (a) prevention of drug use; (b) prevention and treatment of drug use disorders; (c) access to medicines under international control; (d) new psychoactive substances; (e) prevention, diagnosis, treatment, care and support for HIV, viral hepatitis and tuberculosis among people who use drugs and among people who are in prisons; (f) prevention of violence and violence-related deaths; and (g) monitoring drug use and its

387 United Nations General Assembly resolution 70/1, Transforming our world: the 2030 Agenda for Sustainable Development.
health and social consequences. By signing this memorandum of understanding, WHO and UNODC, within their respective roles and mandates, agreed to strengthen their working relationship and to establish the arrangements necessary to implement and achieve matters of common interest by, inter alia, developing joint initiatives and projects, capacity-building programmes and the collection, analysis and dissemination of information and lessons learned on good policies and practices.

**Demand reduction and related measures**

10. In order to support the implementation of public health-oriented drug policies and programmes in health systems, WHO will intensify its normative function in the areas of prevention, early intervention, treatment, care, harm reduction, recovery, rehabilitation and social reintegration, with a focus on drug use disorders and associated comorbidities. It will promote regular updates of evidence on the effectiveness and cost–effectiveness of strategies and interventions for prevention and treatment, improve the systematic collection of information through WHO’s already-existing data systems and surveys at global and regional levels, and collect and disseminate good practices in support of the formulation and implementation of prevention and treatment strategies, taking into account the specific needs of children, young people and women, and working with UNODC and other relevant United Nations entities. Accordingly, WHO will develop, promote, implement and evaluate guidelines, norms, information products and standards, and, on request, provide technical support with a view to improving the quality and coverage of prevention, treatment, care and harm reduction interventions in health systems and services within the overall context of achieving universal health coverage. Within the overall framework of the global strategy on human resources for health, the Secretariat will provide support to Member States in ensuring the universal availability, accessibility, acceptability, coverage and quality of the health workforce for the effective prevention and management of drug use, drug use disorders and associated health conditions at all levels of health systems.

11. The collaborative programme of WHO with UNODC on drug dependence treatment and care, which has already provided support to more than 20 countries to develop services, will be strengthened and expanded to other health-related areas. Recent examples of collaboration with UNODC on demand reduction include the development of standards for treatment of drug use disorders, promotion of the international standards on drug use prevention and of cooperation within the framework of UNODC’s “Listen First” initiative, collecting information on good practices of public health-oriented interaction between health and law enforcement sectors, development of drug dependence treatment services for people living in rural areas, and identification and management of disorders due to use of new psychoactive substances. WHO and UNODC will continue to organize joint information sessions for Member States, technical expert meetings and scientific consultations, will collaborate on the preparation of joint information products and technical tools, and will provide support to Member States in development of their drug treatment systems.

12. Special efforts will be invested in promoting and implementing the international standards on the treatment of drug use disorders, developed jointly by UNODC and WHO, once they have been tested and finalized, together with other relevant international standards on preventing drug use and on reducing the harms associated with drug use. Emphasis will be placed on the provision of guidance, assistance and training in their appropriate use, including, on request, certification and accreditation to health professionals, competent authorities and institutions. Particular attention will be given to strengthening the capacity of health and social services and institutions to interact and, as appropriate, cooperate with the justice, education and law enforcement sectors with a view to achieving public health objectives based on an understanding that drug use disorders are health conditions and drug dependence is a disease. In this regard, close collaboration between WHO, with its primary constituencies at country level in the health and public health sectors, and UNODC, with

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its primary constituencies at country level in drug control and law enforcement sectors, is of paramount importance.

13. Within the framework of the global health sector strategies on HIV and viral hepatitis,\(^{389}\) and of the End TB Strategy,\(^{390}\) WHO will continue to promote and support the implementation of harm reduction interventions outlined in the WHO, UNODC and UNAIDS technical guide\(^{391}\) with the aim of reaching the 2020 and 2030 fast-track targets in line with the Sustainable Development Goals. WHO will further collaborate with UNODC on the development, implementation and monitoring of evidence-based policies and interventions for prevention, testing, treatment and care of HIV, viral hepatitis and tuberculosis in the community and in prisons.

**Access to controlled medicines**

14. Ensuring access to controlled substances for medical and scientific purposes as part of a balanced national drug policy is an essential element of several Health Assembly resolutions, such as those on effective cancer control, strengthening palliative care, emergency and essential surgical care and anaesthesia, and epilepsy.\(^{392}\) WHO will intensify and expand its activities for developing and disseminating normative guidance and will continue to provide technical support to countries to improve adequate access to controlled substances for medical and scientific purposes, in collaboration with the International Narcotics Control Board, UNODC and other competent United Nations entities, and other partners such as members of civil society. As part of its core function, WHO regularly updates the WHO Model Lists of Essential Medicines, including those medicines that are under control of international drug treaties. The Secretariat is reviewing medicines for pain and mental and behavioural disorders which will be considered for addition to the Model Lists by WHO’s Expert Committee of Selection and Use of Essential Medicines at its 21st meeting in March 2017. In addition, the Secretariat is drafting guidelines for the management of cancer pain.

15. WHO takes a collaborative approach to access to controlled medicines and works closely with UNODC and the International Narcotics Control Board to provide training and support to countries to maximize access to controlled medicines. WHO is actively contributing to the latter’s Learning Project, which provides training for national authorities on important controlled medicines issues. The first regional and national seminars took place in April 2016 in Kenya and in July 2016 in Thailand. Enhanced collaboration with the International Narcotics Control Board will be instrumental in estimating the needs for these medicines and benchmarks for their consumption.

16. WHO is also part of the Joint Global Programme (in collaboration with UNODC and the Union for International Cancer Control) on access to controlled drugs for medical purposes, in particular for the management of pain. The Joint Global Programme, which is currently being implemented in the Democratic Republic of the Congo, Ghana and Timor-Leste, aims to support countries in identifying barriers to access, through the assessment of policies and legislation and the monitoring of availability and prices of controlled medicines including medicines for pain. The Joint Global Programme aims also to support countries address these barriers, and implement sound policies, regulations and practices for improving availability of affordable controlled medicines.

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\(^{389}\) Resolution WHA69.22 (2016) on global health sector strategies on HIV, viral hepatitis and sexually transmitted infections, for the period 2016–2021.


Cross-cutting issues
17. Actions to reduce drug use through enforcement of the prohibition of the non-medical use of internationally controlled substances and related law enforcement strategies have largely dominated the implementation of national drug control strategies to date. There is thus a need to ensure the implementation, in a multisectoral and coordinated manner, of a comprehensive package of drug control measures that cover the entire public health continuum – from primary prevention and risk reduction to management of drug use disorders, rehabilitation, care and harm reduction – and that are grounded in the fundamental public health precepts of equity, social justice and human rights, place emphasis on countries and populations in greatest need, and give due consideration to the economic, social and environmental determinants of health, science and evidence-based interventions, and people-centred approaches.

18. In its work on drug-related issues, WHO will take into account the specific health needs of children, young people and women, including pregnant women, and prioritize development, implementation and evaluation of normative guidance and technical tools to improve equitable coverage and effectiveness of appropriate prevention, treatment, care and harm reduction interventions, as well as ensuring access to controlled medicines for medical use. Recently, WHO collaborated with UNODC and UNESCO on the development of an educational sector response to the use of psychoactive substances with a focus on that sector’s role in prevention of substance use among children and adolescents.

19. The Single Convention on Narcotic Drugs, 1961, as amended by the 1972 Protocol, and the Convention on Psychotropic Substances, 1971, entrust WHO with the responsibility of reviewing and assessing substances to determine whether they should be controlled under the conventions. Fulfilling this mandate involves ensuring the provision of robust data to the WHO Expert Committee on Drug Dependence for the review of the most prevalent, persistent and harmful psychoactive substances. The Expert Committee will then be providing timely, evidence-based advice to facilitate informed decision-making by the Commission on Narcotic Drugs on the international scheduling of psychoactive substances. The Expert Committee will continue to meet annually. Support from Member States, UNODC, the International Narcotics Control Board, and the European Monitoring Centre for Drugs and Drug Addiction is sought for collecting robust evidence on dependence, abuse and harm to health, for substances to be reviewed by the Expert Committee. The WHO Secretariat is creating a mechanism for surveillance of substances with the potential for abuse, dependence and harm to health, including new psychoactive substances and for which there is not enough data to justify a review by the Expert Committee.

20. Further work will be undertaken, in collaboration with UNODC and other international organizations, on monitoring drug use and drug-related mortality and morbidity in populations at all levels, and will include technical support and guidance provided to Member States in order to improve their national monitoring systems. Special attention will be paid to monitoring both (1) treatment coverage for drug and other substance use disorders, using information based on available health system indicators and estimates of the prevalence of drug use disorders in populations derived from available information systems that are integrated into or linked with the WHO Global Health Observatory, and (2) coverage of health services for people who use drugs along the HIV prevention, testing and treatment cascade. New projects will develop appropriate sets of indicators and strengthen the research capacity of Member States to generate, collate, analyse and report scientific data in order to inform policy and programme development aimed at reducing...
the drug-related public health and social burden. Special efforts are required particularly with regard to new psychoactive substances, in particular collection of data on the prevalence of their use, persistence and harm to health. This work stream will review, assess and summarize evidence of the impact of drug use and drug use disorders on population health by producing technical reports, WHO estimates of the drug-attributable disease burden, and reviews of evidence of the effectiveness of policy options and interventions.

21. In the area of epidemiology, WHO and UNODC jointly organized a consultation (Geneva, August 2016) to discuss opportunities and ways for better coordination and harmonization of international efforts to improve epidemiological data on extent of drug use, prevalence of drug use disorders in populations and their impact on public health and well-being. An interagency technical working group on drug epidemiology has been established with the aim of improving coordination and cooperation between intergovernmental organizations in this area, including regional intergovernmental entities and institutions such as the African Union and the European Monitoring Centre for Drugs and Drug Addiction and producing joint estimates related to drug use and its consequences. A result of such interagency collaboration is the generation of the global estimates issued in UNODC’s annual world drug reports of the number of people who inject drugs and the prevalence rates of their infection with HIV and hepatitis viruses.

**ACTION BY THE HEALTH ASSEMBLY**

22. The Health Assembly is invited to note the report and to provide further guidance on the implementation of the operational recommendations related to health of the special session on the world drug problem.
15.4 Outcome of the Second International Conference on Nutrition

Document A70/30:

Biennial report

1. In November 2014, FAO and WHO jointly hosted the Second International Conference on Nutrition, which adopted the Rome Declaration on Nutrition and its companion Framework for Action. In 2015, the Sixty-eighth World Health Assembly adopted resolution WHA68.19, in which it endorsed the outcome documents of that Conference and requested the Director-General, in collaboration with the Director-General of the FAO and other UN agencies, funds and programmes and other relevant regional and international organizations, to prepare a biennial report to the Health Assembly on the status of implementation of commitments of the Rome Declaration on Nutrition. The Conference of FAO at its thirty-ninth session also endorsed the outcome documents and urged FAO Members to implement the commitments set out in the Rome Declaration and the recommendations in the Framework for Action.

2. This biennial report has been compiled by FAO and WHO for submission to both the Health Assembly and Conference of FAO (at its 40th session). It outlines progress made in the follow-up actions of the Second International Conference on Nutrition over the course of the period 2015–2016, including key developments at international and country levels.

IMPLEMENTATION OF COMMITMENTS BY THE SECOND INTERNATIONAL CONFERENCE ON NUTRITION AT INTERNATIONAL LEVEL

3. The UN General Assembly adopted resolution 70/259, in which it endorsed the Rome Declaration on Nutrition and the Framework for Action, and included in the 2030 Agenda for Sustainable Development a goal that specifically aims to end hunger, achieve food security and improved nutrition, and promote sustainable agriculture (Goal 2). In resolution 70/259, it also decided to proclaim 2016–2025 the UN Decade of Action on Nutrition, and called upon FAO and WHO to lead the implementation of the Decade of Action, in collaboration with WFP, IFAD and UNICEF and to develop a work programme along with its means of implementation, using coordination mechanisms such as the UN Standing Committee on Nutrition and multistakeholder platforms such as the Committee on World Food Security, in line with its mandate, in consultation with other international and regional organizations and platforms. It also invited the Secretary-General to inform the General Assembly about implementation of the Decade on the basis of the biennial reports jointly compiled by FAO and WHO.

4. In resolution WHA69.8 (2016) the Health Assembly welcomed resolution 70/259 and requested the Director-General to work with the Director-General of FAO “to support Member States, upon request, in developing, strengthening and implementing their policies, programmes and plans to address the multiple challenges of malnutrition, and convene periodic meetings of inclusive nature to share best practices, including consideration of commitments that are specific, measurable, achievable, relevant and time-bound (SMART) within the framework of the Decade of Action on Nutrition (2016–2025)”.

5. The work programme for the Decade of Action on Nutrition\textsuperscript{397} has been developed through an inclusive, continuous and collaborative process, including face-to-face discussions with Member States and two open online consultations organized by the UN Standing Committee on Nutrition.

6. The aim of the Decade of Action is to provide a clearly-defined time-bound operational framework that works within existing structures and available resources to implement the commitments made at the Second International Conference on Nutrition and in the 2030 Agenda for Sustainable Development. The Decade of Action’s added value is to establish a defined period to set, track and achieve agreed outcomes, produce impact and put in place an accessible and transparent mechanism for tracking progress and ensuring mutual accountability for the commitments made. It will build on existing efforts, promote alignment among actors and actions, accelerate implementation of commitments, and foster new commitments in line with the transformative ambitions of the Sustainable Development Goals, the outcome documents of the Second International Conference on Nutrition, and the targets adopted by the Health Assembly in resolution WHA65.6. Its actions will be inclusive and the Decade of Action will provide an enabling framework such that policies and programmes respect, protect and fulfil human rights obligations and gender considerations.

7. The work programme of the Decade of Action embraces six cross-cutting and connected action areas derived from the recommendations in the Framework for Action:

(a) sustainable, resilient food systems for healthy diets;
(b) aligned health systems providing universal coverage of essential nutrition actions;
(c) social protection and nutrition education;
(d) trade and investment for improved nutrition;
(e) safe and supportive environments for nutrition at all ages;
(f) strengthened nutrition governance and accountability.

8. The means of implementing the Decade include:

(a) Member States’ submission to FAO and WHO of specific, measurable, achievable, relevant and time-bound commitments for actions, in the context of national nutrition and nutrition-related policies and in dialogue with a wide range of stakeholders, that are tracked through an open access database;
(b) the convening of action networks, namely informal coalitions of countries aimed at advocating the establishment of policies and enactment of legislation, allowing the exchange of practices, highlighting successes and providing mutual support to accelerate implementation;
(c) the convening of public meetings for planning, sharing knowledge, recognizing success, voicing challenges and promoting collaboration;
(d) the mobilization of financial resources to support implementation of national policies and programmes.

9. In October 2016 the Committee on World Food Security at its forty-third session endorsed a framework to step up its contribution to the global fight against malnutrition and serve as an intergovernmental and multistakeholder global forum on nutrition.\textsuperscript{398}

\textsuperscript{397} http://www.who.int/nutrition/decade-of-action/workprogramme-2016to2025/en/
IMPLEMENTATION OF COMMITMENTS BY THE SECOND INTERNATIONAL CONFERENCE ON
NUTRITION AT COUNTRY LEVEL

10. Preventing all forms of malnutrition. In 2014–2016, globally 793 million people were estimated to be undernourished – a drop of 216 million since 1990–1992. In 2016 globally child stunting, wasting and overexcessive breastfeeding among infants less than 6 months reached 43% and the prevalence of anemia in women of reproductive age was 29%. In 49 countries the rate of stunting had fallen since 2012 and in 36 the rate of exclusive breastfeeding had increased. Conversely, the prevalence of overweight is increasing and that of anemia is not decreasing. The prevalence of obesity in adults more than doubled between 1975 and 2014; in 2014 11% of men and 15% of women were obese.

11. Increasing investments. The World Bank estimates that the current yearly global spending on nutrition-specific interventions against stunting, severe acute malnutrition and anemia in women and to promote exclusive breastfeeding is US$ 2900 million from government sources and US$ 1000 million from donors. To attain the Health Assembly’s targets an additional US$ 7000 million per year should be spent over the next 10 years. Donor funding for nutrition is primarily focused on undernutrition; less than 2% goes to noncommunicable diseases (US$ 611 million in 2014).

12. Raising the profile of nutrition in national policies. Currently, 183 countries have national policies on nutrition, 105 countries have health sector plans with nutrition components and 48 have integrated nutrition objectives in their national development plans. Among 60 UN development assistance frameworks analysed, 50% include the global nutrition targets adopted by the Health Assembly. More than 70 countries worldwide have made efforts in 2014 and 2015 to mainstream food security and nutrition in sectoral policies and investment programmes.

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400 Commitment (a) of the Rome Declaration on Nutrition.
402 Data for 2011.
407 Commitment (b) of the Rome Declaration on Nutrition.
410 Commitment (d) of the Rome Declaration on Nutrition.
13. **Strengthening human and institutional capacities.** In WHO’s second Global Nutrition Policy Review (2016–2017) 73 countries indicated that they have trained nutrition professionals, and 63 provide training for health workers on maternal and child nutrition. Capacity-building has been carried out on food safety, the Codex Alimentarius and antimicrobial resistance.

14. For reporting on progress in implementing the recommendations in the Framework for Action, they have been grouped in six action areas:

(1) **Sustainable, resilient food systems for healthy diets**

- Adoption of improved practices related to agroforestry and agroecology, climate change adaptation, peri-urban and school gardening has been documented in more than 90 countries.

- Efforts to improve the nutrition quality of the food supply are underway with 67 countries fortifying wheat, 102 fortifying salt with iodine and 42 fortifying oils with vitamin A. Fifty countries are implementing product reformulation (mandatory or voluntary) and at least 10 have established measures to reduce the content of *trans*-fatty acids in food products.

- Twenty-seven countries have been supported to reduce food loss and waste through awareness-raising campaigns, capacity-building and evidence-based policies. In increasing numbers countries are considering sustainability in their food-based dietary guidelines.

- Fifty-one countries have policies to reduce marketing of food and non-alcoholic beverages to children; about 30 countries have reported using fiscal policies to drive food choices. Eleven countries have improved various aspects of their national food control systems.

- Prevention and mitigation of food insecurity risk have been implemented in 57 countries and 28 countries have applied socioeconomic measures that reduce vulnerability and strengthen resilience of communities at risk of threats and crisis.

(2) **Aligned health systems providing universal coverage of essential nutrition actions**

- The main interventions delivered are supplementation with iron or iron and folic acid to women of reproductive age (111 countries), supplementation with vitamin A (71 countries), iron (37 countries), zinc (33 countries), and multiple micronutrient powders (47 countries) to children under 5 years of age. In 63 countries deworming programmes are being conducted. Nutrition is integrated into programmes on HIV/AIDS in 71 countries and on tuberculosis in 57 countries.

(3) **Social protection and nutrition education**

- Forty-two countries deal with nutrition through social protection, and 38 implement conditional cash transfers.
• On nutrition education, 108 countries provide counselling on healthy diets and 90 run media campaigns. Eighty-nine countries reported that they have school health and nutrition programmes, 61 including nutrition education. In 116 countries food-based dietary guidelines have been developed and many countries are implementing nutrition labelling, but only 25 indicated they have front-of-pack labelling. Food safety is integrated with nutrition programmes through WHO’s Five Keys to Safer Food.

(4) **Trade and investment for improved nutrition**

• FAO supported countries and regional economic communities in the formulation and implementation of 18 international trade agreements. WHO promoted the use of international food safety standards through the SPS Committee. Some countries have imposed restrictions and tariffs on imports on foods high in fats, sugars and salt, sometimes facing challenges to comply with international trade agreements.

(5) **Safe and supportive environments for nutrition at all ages**

• In 114 countries exclusive breastfeeding is recommended for six months, and 85 countries recommend women to continue breastfeeding until their children are 2 years or older. However, only 11% of births occur in facilities designated as “baby-friendly”; 135 countries have enacted legal measures covering some of the provisions of the International Code of Marketing of Breast-milk Substitutes, but only 39 incorporate all or most provisions. Of 167 countries, 77 currently provide cash benefits for maternity leave of at least two thirds of prior earnings for 14 weeks.

• Forty-six countries have included in their policies or plans actions to create healthy food environments in the workplace, 32 in hospitals, and 97 in schools, but only 40 countries have clear standards for foods and beverages available in schools. Adolescent underweight and anaemia was addressed only in 23 countries.

(6) **Strengthened nutrition governance and accountability**

• One or more intersectoral coordination mechanisms exist in 146 countries. Such mechanisms are chaired by the health ministries in 115 countries and the agriculture ministry in 27, and by the Prime Minister’s or President’s office in 36. Most of these mechanisms are intersectoral and involve multiple stakeholders; 51 countries reported that the private sector is included, a fact that emphasizes the need to have robust safeguards against conflicts of interest.

**CONTRIBUTIONS BY ORGANIZATIONS IN THE UNITED NATIONS SYSTEM**

15. The Secretariat has developed evidence-informed guidance on healthy diet and effective nutrition interventions and provided technical assistance to 70 countries (22 in the African Region, 10 in the Region of the Americas, six in the South-East Asia Region, 11 in the European Region, 13 in the Eastern Mediterranean Region and eight in the Western Pacific Region), with a focus on dissemination and adaptation of guidelines, nutrition surveillance, capacity-building, and

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417 See also commitment (h) of the Rome Declaration on Nutrition.
418 Recommendations from Framework for Action: 4, 8, 17 and 18.
419 Recommendations from Framework for Action: 13, 15, 16, 29, 30, 31, 32, 33, 38, 39, 40, 41, 42, 43, 51 and 52. See also commitment (g) of the Rome Declaration on Nutrition.
421 Recommendations from Framework for Action: 1, 2, 3 and 5–6, and 7, 58, 59, 60.
development of strategies, action plans and national legislation. Altogether 154 countries are members of the International Food Safety Authorities Network. WHO developed a 2016–2025 nutrition strategy.

16. FAO has provided technical support to 94 countries (40 in Africa, 20 Asia and the Pacific, five in Europe and Central Asia), 20 in Latin America and the Caribbean, and nine in the Near East and North Africa) with focus on the integration of food-based approaches into multisectoral nutrition strategies and of nutrition in agriculture policies and investment plans, school food and nutrition, nutrition information systems and nutrition education. 422

17. UNICEF has supported 127 countries with a high burden of malnutrition, provided vitamin A supplements to nearly 270 million children and supported management of severe acute malnutrition in both development and humanitarian contexts, reaching nearly two million children. 423 UNICEF has a specific outcome for nutrition in its Strategic Plan 2014–2017 and has developed a new nutrition strategy. 424

18. WFP reaches more than 70 million vulnerable and food-insecure people each year, supporting the development and delivery of national plans and policies to end malnutrition in all its forms. The WFP Strategic Plan (2017–2021) 425 includes a strategic objective in nutrition and a new nutrition strategy has been endorsed.

19. IFAD’s investments are aimed at strengthening local food production through smallholder and family farmers, with a focus on women. One third of projects approved for the period 2016–2018 are nutrition-sensitive, aimed particularly at dietary diversification.

20. To enhance coherence in the UN system, the UN Standing Committee on Nutrition in 2016 issued a new Strategic Plan 2016–2020.

CONCLUSION

21. International commitments of ICN2 have been implemented. Achievement of global nutrition targets is still off track, but some progress has been made in the implementation of the national commitments. Almost all countries have policies related to nutrition, often covering all forms of malnutrition, although nutrition is not always an objective in sectoral policies or national development plans. Intersectoral coordination mechanisms have been established, often including multiple stakeholders. In general, implementation needs to be expanded, investments have to be increased and greater policy coherence must be created. The Decade of Action on Nutrition provides an opportunity for taking these actions and accelerating progress.

ACTION BY THE HEALTH ASSEMBLY

22. The Health Assembly is invited to note the report.

15.5  Report of the Commission on Ending Childhood Obesity: implementation plan

Documento A70/31 (Documento de la Secretaría):

1. La prevalencia de obesidad infantil y en los niños pequeños está aumentando en todos los países, con los aumentos más rápidos ocurriendo en los países de bajo- y medio-ingreso. El número de niños sobrepeso o obesos globalmente aumentó de 31 millón en 1990 a 42 millón en 2015. En el área africana, por ejemplo, en el mismo período, el número de niños sobrepeso o obesos menores de 5 años de edad aumentó de 4 millón a 10 millón. La obesidad infantil está asociada con varias complicaciones de salud, la prematura aparición de enfermedades tales como la diabetes y enfermedades del corazón, la obesidad continuada hasta la edad adulta y el riesgo aumentado de enfermedades no transmisibles.

2. Con el objetivo de proporcionar una respuesta integral al problema de la obesidad infantil, el Director General estableció en 2014 un alto nivel de Comisión en la lucha contra la obesidad infantil, compuesta por 15 individuos exitosos y prestigiosos de diferentes ámbitos relevantes. La Comisión fue encargada de preparar un informe especificando las enfoques y combinaciones de intervenciones que serían más efectivas para abordar la obesidad infantil y adolescente en diferentes contextos de los países alrededor del mundo. Revisó la evidencia científica, consultó más de 100 Estados Miembros y consideró casi 180 comentarios en línea antes de presentar su informe al Director General en enero de 2016.

3. En la decisión WHA69(12) (2016), la Sesión 69 de la Asamblea de la Salud Mundial decidió pedir al Director General, en consulta con los Estados Miembros y relevantes stakeholders, un plan de implementación guiando una acción adicional sobre las recomendaciones presentadas en el Informe de la Comisión en la Lucha contra la Obesidad Infantil, para su consideración en la Sesión 140 de la Asamblea de la Salud Mundial.

4. Un borrador del plan de implementación fue disponible para consulta en línea en septiembre/octubre de 2016 y comentarios fueron recibidos de 106 entidades, incluyendo 16 Estados Miembros. La Secretaría utilizó la feedback proporcionado a través de esta consulta pública para preparar el anexado borrador de plan de implementación para guiar una acción futura sobre las recomendaciones de la Comisión en la Lucha contra la Obesidad Infantil.

5. En enero de 2017 el Consejo Ejecutivo, en su Sesión 140, consideró una versión anterior de este documento y se expresó amplia apoyo por el borrador del plan de implementación.

**Acción por la Asamblea de la Salud**

6. La Asamblea de la Salud es invitada a considerar y aprobar el borrador del plan de implementación.

428 Y, donde sea aplicable, organizaciones de integración económica regional.
430 Document EB140/30.
431 Ver los resúmenes de los debates del Consejo Ejecutivo en su Sesión 140, décimo cuarto encuentro.
ANNEX

DRAFT IMPLEMENTATION PLAN TO GUIDE FURTHER ACTION ON THE RECOMMENDATIONS INCLUDED IN THE REPORT OF THE COMMISSION ON ENDING CHILDHOOD OBESITY

1. The Sustainable Development Goals,\(^{432}\) adopted by the United Nations General Assembly in 2015, identify prevention and control of noncommunicable diseases as one of the health challenges in the 2030 Agenda for Sustainable Development. Among the risk factors for noncommunicable disease, overweight and obesity are particularly concerning and have the potential to negate many of the health benefits that have contributed to increased life expectancy. The global action plan for the prevention and control of noncommunicable diseases 2013–2020\(^{433}\) calls for a halt in the rise in obesity among adolescents, and the comprehensive implementation plan on maternal, infant and young child nutrition\(^{434}\) sets a target of no increase in childhood overweight by 2025. Yet the prevalence of obesity in infants, children and adolescents\(^{435}\) is rising around the world and many children who are not yet obese are overweight and on the pathway to obesity. Renewed action is therefore urgently needed if these targets are to be met.

2. Almost three quarters of the 42 million children under 5 years of age who are overweight and obese live in Asia and Africa.\(^{436}\) In countries where prevalence of overweight and obesity is plateauing, there are growing economic and health inequities, and rates of obesity continue to increase among people with low socioeconomic status and minority ethnic groups. Obesity can affect a child’s immediate health, educational attainment and quality of life. Children with obesity are very likely to remain so as adults and are at risk of developing serious noncommunicable diseases. Despite the rising global prevalence of overweight and obesity, awareness of the magnitude and consequences of childhood obesity is still lacking in many settings, particularly in countries where undernutrition is common and prevention of childhood obesity may not be seen as a public health priority. As countries undergo rapid socioeconomic and/or nutrition transition, they face a double burden, in which inadequate nutrition and excessive weight gain may coexist, in the same household and even in the same individuals. Children who have been undernourished, either in utero or in early childhood, are at particular risk of becoming overweight and obese if then faced with an obesogenic environment, that is, one that promotes high energy intake and sedentary behaviour. An individual’s biological and behavioural responses to such an environment can be strongly influenced by developmental or life course factors from before conception and across generations, as well as by peer pressure and social norms.

3. Recognizing that progress in tackling obesity in infants, children and adolescents has been slow and inconsistent, the Director-General established the Commission on Ending Childhood Obesity in 2014 to review, build upon and address gaps in existing mandates and strategies in order to prevent


\(^{433}\) Endorsed by the Health Assembly in resolution WHA66.10 (2013) on Follow-up to the Political Declaration of the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases; see document WHA66/2013/REC/1, Annex 4 for the text of the action plan.

\(^{434}\) Endorsed by the Health Assembly in resolution WHA65.6 (2012) on Comprehensive implementation plan on maternal, infant and young child nutrition; see document WHA65/2012/REC/1, Annex 2 for the text of the implementation plan.

\(^{435}\) The Convention on the Rights of the Child defines children as those below the age of 18 years. WHO defines adolescents as those between 10 and 19 years of age. In global surveys, overweight and obesity in persons aged 18 years and over is reported as adult data. Therefore, in this context, childhood obesity refers to all children under 19 years of age, including adolescents, with body mass index-for-age more than 3 standard deviations above the WHO growth median for children less than 5 years of age, and more than 2 standard deviations above the WHO growth reference median for children aged 5–19 years.

infants, children and adolescents from developing obesity. The aim is to reduce the risk of morbidity and mortality due to noncommunicable diseases, lessen the negative psychosocial effects of obesity in both childhood and adulthood, and reduce the risk of the next generation developing obesity.

4. Having reviewed the scientific evidence, consulted with more than 100 Member States and considered nearly 180 online comments, the Commission finalized its report, which contained a comprehensive, integrated package of recommendations to address childhood obesity. The report presents the rationale for these recommendations and provides the background for this draft implementation plan. The Commission called for governments to take leadership and for all stakeholders to recognize their moral responsibility in acting on behalf of the child to reduce the risk of obesity by recognizing the importance of remedying obesogenic environments, taking a life course approach and improving or addressing the treatment of children who are already obese.

5. In 2016, the Sixty-ninth World Health Assembly adopted decision WHA69(12) in which it requested the Director-General to develop, in consultation with Member States, an implementation plan guiding further action on the recommendations included in the report of the Commission.

6. The resulting draft plan comprises two sections. The first sets out the aim, scope and guiding principles of the implementation plan. The second defines the actions needed to end childhood obesity in the specific areas of (I) leadership; (II) the set of six recommendations of the Commission; (III) monitoring and accountability; (IV) key elements for successful implementation; and (V) roles and responsibilities of stakeholders.

DRAFT IMPLEMENTATION PLAN

Aim and scope

7. This draft implementation plan builds on the recommendations and accompanying rationales in the report of the Commission on Ending Childhood Obesity and aims to guide Member States and other partners on the actions needed to implement these recommendations. It recognizes that Member States face different challenges with respect to all forms of malnutrition. The draft plan acknowledges variations in constitutional frameworks among Member States, differences in the sharing of responsibility between levels of government, and variance in the public health policies already in place in different countries. Actions to end childhood obesity should be integrated into existing policies and programmes across diverse domains at all levels. The goal to end childhood obesity aligns with the objectives of the 2030 Agenda for Sustainable Development, such as the targets of the Sustainable Development Goals that call for an end to malnutrition in all its forms (target 2.2), a reduction in premature mortality from noncommunicable diseases (target 3.4), ensuring universal health coverage (target 3.8), as well as contributing to quality education (Goal 4) and reduced inequalities within and among countries (Goal 10). If Member States take prompt and comprehensive action to prevent and treat childhood obesity, then other health initiatives, including those to improve maternal, child and adolescent health, nutrition and physical activity, will be further strengthened, thus contributing to broader targets for health and well-being. This synergy provides an additional focus for concentrating efforts for long-term impact. Figure 1 depicts how ending childhood obesity can draw together and add value to different strategies such as the United


439 And, where applicable, regional economic integration organizations.
Nations Secretary-General’s Global Strategy for Women’s, Children’s and Adolescents’ Health, the Political Declaration of the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases, and the United Nations Decade of Action on Nutrition (2016–2025), and so contribute to improving the health and well-being of this and the next generation of children.

**Figure 1. Ending childhood obesity contributes to several other strategies**

Guiding principles
8. In its report the Commission on Ending Childhood Obesity identified the following guiding principles, which underpin this draft implementation plan.

(a) **The child’s right to health.** Government and society have a moral and legal responsibility to act on behalf of, and in the best interest of, the child to reduce the risk of obesity by protecting children’s rights to health and food. A comprehensive response for tackling childhood obesity is consistent with the universal acceptance of the rights of the child to a healthy life as well as the obligations assumed by State Parties to the Convention on the Rights of the Child.440

(b) **Government commitment and leadership.** Governments need to accept primary responsibility for taking action and implementing effective policies on behalf of the children they are ethically bound to protect. A failure to act will have major health, well-being, social and economic consequences.

(c) **A whole-of-government approach.** Prevention and treatment of obesity require a whole-of-government approach in which policies across all sectors systematically consider health outcomes. Avoiding harmful health impacts can help all sectors to achieve their goals. Current approaches are clearly insufficient and additional coordinated intervention is needed if the targets to halt the rise in obesity in children, adolescents and adults are to be

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achieved.\textsuperscript{441} For example, the education sector plays a crucial role in providing education about nutrition and health, increasing the opportunities for physical activity and promoting healthy school environments. Agriculture and trade policies and the globalization of the food system affect food affordability, availability and quality at national and local levels. Urban planning and design, and transport planning, all have direct consequences on opportunities for physical activity and access to healthy foods. Intersectoral governmental structures, such as a high-level inter-ministerial task force for child and adolescent health that includes childhood obesity as one of its tasks, can identify mutual interests and facilitate coordination, collaboration and exchange of information through coordinating mechanisms.

(d) **A whole-of-society approach.** The complexity of obesity calls for a comprehensive approach that involves, in addition to all levels of government, other actors, such as parents, carers, civil society, academic institutions, philanthropic foundations and the private sector. Moving from policy to action to prevent and reverse childhood obesity demands a concerted effort and active engagement of all sectors of society at the local, national, regional and global levels, with appropriate attention to conflicts of interest. Joint ownership and shared responsibility are essential for effective interventions to have reach and impact.

(e) **Equity.** Governments should ensure equitable coverage of interventions, particularly for excluded, marginalized or otherwise vulnerable population groups, who are at high risk both of malnutrition in all its forms and of developing obesity. Obesity and its associated morbidities erode potential improvements in social and health capital, and increase inequity and inequality. The social determinants of health mean that these population groups often have poor access to healthy foods, safe places for physical activity and preventive health services and support. Attention needs to be given to ensuring that interventions are developed in ways that are acceptable and culturally sensitive.

(f) **Aligning with the global development agenda.** The Sustainable Development Goals call for an end to malnutrition in all its forms (target 2.2) and a reduction in premature mortality from noncommunicable diseases (target 3.4). Reducing childhood obesity will also contribute to universal health coverage (target 3.8), quality education (Goal 4) and reduced inequalities (Goal 10). Integrating ending childhood obesity into national development and financing frameworks for the Sustainable Development Goals will ensure a response from all sectors.

(g) **Integration into a life course approach.** The Commission has highlighted the need to reduce the risk of childhood obesity by action even before conception. Integrating interventions to prevent and treat childhood obesity into existing WHO and other initiatives, using a life course approach, will offer additional benefits for longer-term health.\textsuperscript{442} These initiatives include the United Nations Secretary-General’s Global Strategy for Women’s, Children’s and Adolescents’ Health, the Political Declaration of the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases, the Rome Declaration on Nutrition adopted at the Second International Conference on Nutrition (Rome, 19–21 November 2014) and the United Nations Decade of Action on Nutrition (2016–2025). Several other strategies and implementation plans of WHO and other bodies in the United Nations system related to optimizing maternal, infant, young child and adolescent nutrition and health exist that are highly relevant to key elements of a comprehensive approach to prevention of obesity. Relevant principles and

\textsuperscript{441} Resolution WHA66.10 (2013) on Follow-up to the Political Declaration of the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases, and resolution WHA65.6 (2012) on Comprehensive implementation plan on maternal, infant and young child nutrition.

recommendations can be found in related documents providing guidance throughout the life-course. Initiatives to address childhood obesity should be integrated within these existing areas of work and build upon them to help children to realize their fundamental right to health and, improve their well-being, while reducing the burden on the health system.

(h) **Accountability.** Political and financial commitment is imperative in combating childhood obesity. A robust mechanism and framework are needed to monitor policy development, implementation and outcomes, thus facilitating the accountability of governments and non-State actors for the commitments they make.

(i) **Universal health coverage.** Sustainable Development Goal target 3.8 calls for the achievement of universal health coverage through integrated health services that enable people to receive a continuum of health promotion, disease prevention, diagnosis, treatment and management, over the course of a lifetime. As such, access to and coverage of interventions for the prevention of overweight and obesity and the treatment of children already obese and those who are overweight and on the pathway to obesity, should be considered important elements of universal health coverage.

**ACTIONS NEEDED TO END CHILDHOOD OBESITY**

9. The Commission proposed six sets of recommendations to tackle the obesogenic environment and interventions at critical time points in the life course for the prevention of obesity and the treatment of children who are already obese.

10. Effective implementation of the recommendations will require political commitment and leadership as well as capacities to deliver the required interventions and effective monitoring of accountabilities of different stakeholders. The framework is illustrated in Figure 2.

**Figure 2. Action framework for ending childhood obesity**

11. In advance of a global strategy, WHO’s regional offices developed several strategies and action plans that address some aspects of the recommendations below. These instruments can be

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443 As also expressed in United Nations General Assembly resolution 69/132 on Global health and foreign policy.
integrated and further strengthened, where necessary, by alignment with the recommendations of the Commission on Ending Childhood Obesity.

12. A multisectoral approach will be essential for sustained progress. The following sections provide guidance on the necessary actions that Member States must consider, and the supportive actions by other stakeholders, in order to achieve the aims of this implementation plan. In recognition of the policies already in place in some Member States, and the differing prevalence rates of malnutrition in all its forms, Member States are encouraged to prioritize actions in a step-wise approach according to local context, drivers of obesity and opportunities to intervene.

I. PROVIDE LEADERSHIP FOR COMPREHENSIVE, INTEGRATED, MULTISECTORAL ACTION

Rationale

13. Governments bear the ultimate responsibility for ensuring their citizens have a healthy start in life. Preventing childhood obesity requires the coordinated contributions of all governmental sectors and institutions contributing to policy development and implementation. National strategic leadership includes establishing the governance structures across a variety of sectors that are necessary to manage the development and implementation of laws, policies and programmes. Resources need to be dedicated to policy implementation and workforce capacity strengthening. National leadership is also necessary to manage engagement with non-State actors, such as nongovernmental organizations, the private sector and academic institutions, in order to successfully implement, monitor and evaluate the impact of programmes, activities and investments.

14. Table 1 proposes actions to be taken by Member States to implement the recommendation of the Commission on the roles and responsibilities of Member States. Some countries may already have implemented some of these policies and can build upon and strengthen these.

Table 1. Recommended roles and responsibilities and proposed actions for Member States

<table>
<thead>
<tr>
<th>Recommended roles and responsibilities outlined by the Commission</th>
<th>Steps to be taken by Member States</th>
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</thead>
<tbody>
<tr>
<td>(a) Take ownership, provide leadership and engage political commitment to tackle childhood obesity over the long term.</td>
<td>Ensure regular contact with parliamentarians to consolidate high-level commitment to prevention of childhood obesity. Conduct regular high-level policy dialogues on childhood obesity. Mobilize sustainable resources to tackle childhood obesity. Prepare a budget and legislation or regulatory instrument to implement key interventions to reduce childhood obesity.</td>
</tr>
<tr>
<td>(b) Coordinate contributions of all government sectors and institutions responsible for policies, including, but not limited to: education; food and agriculture; commerce and industry; development; finance and revenue; sport and recreation; communication; environmental and urban planning; transport and social affairs; and trade.</td>
<td>Establish or expand an existing multisectoral group, comprising relevant government agencies, to coordinate policy development, implementation of interventions, monitoring and evaluation across the whole of government, including accountability systems.</td>
</tr>
</tbody>
</table>

(c) Ensure data collection on body mass index-for-age of children – including for ages not currently monitored – and set national targets for childhood obesity. Set national or local, time-bound targets for reductions in childhood obesity and monitoring mechanisms that include body mass index-for-age in addition to other appropriate measures, disaggregated by age, sex and socioeconomic status.

(d) Develop guidelines, recommendations or policy measures that appropriately engage relevant sectors – including the private sector, where applicable – to implement actions, aimed at reducing childhood obesity. Establish mechanisms to coordinate the engagement of non-State actors and hold them to account in the implementation of interventions. Establish clear mechanisms/policies for the management of conflicts of interest.

II. RECOMMENDATIONS OF THE COMMISSION

Rationale
15. No single intervention can halt the advance of the epidemic of obesity. To challenge childhood obesity successfully requires countering the obesogenic environment and addressing vital elements in the life course through coordinated, multisectoral action that is held to account.

16. Member States already have some relevant programmes in place that provide guidance on diet and physical activity at population level, in settings such as schools and child care, and throughout the life course. The recommendations of the Commission highlight the urgent need to add additional elements for prevention and treatment of obesity that will contribute to the achievement of a range of targets for maternal, infant, young child and adolescent health.

17. The prevalence of childhood obesity, the risk factors that contribute to this issue, and the political and economic situations differ between Member States. The actions recommended below are designed to allow countries to assess which package of integrated interventions may best be implemented in their particular settings. Section IV details how to prioritize actions and develop a step-wise approach to implementation in order to support governments in realizing these actions. Some tools and resources are available at both global and regional levels to support Member States in developing policies and interventions and implementing, monitoring and evaluating them. A page on the WHO website will be created to list tools and resources currently available and others as they are developed.445

18. The tables below outline examples of actions that Member States may consider taking in order to implement the six recommendations of the Commission. Interventions to tackle childhood obesity can be integrated into and build upon existing national plans, policies and programmes.

1. Actions to implement comprehensive programmes that promote the intake of healthy foods and reduce the intake of unhealthy foods and sugar-sweetened beverages by children and adolescents (Table 2)

Rationale
19. An obesogenic environment is one that promotes high-energy intake and physical inactivity, including sedentary behaviour. This includes foods and opportunities for physical activity that are available, affordable, accessible and marketed, and social norms in relation to food and physical activity. Children and families need to be empowered to make healthier choices about diet and physical activity. Knowledge underlying choices of healthy food and physical activity will be undermined if there are conflicting messages, both through marketing in the media and in settings where children gather. Voluntary measures or self-regulation commonly have limited value unless

445 This will appear on the WHO webpage at: http://www.who.int/end-childhood-obesity/en/.
there is active government involvement in establishing the standards and the time frame for achievement, and in determining sanctions for non-compliance. Voluntary approaches and self-regulation can also impede progress if they are used to defer effective regulation. Enabling the choice of a healthy lifestyle needs healthy foods and opportunities for physical activity to be readily available and affordable to all members of society; it also requires that less advantaged children, who are at particular risk of obesity, are fully engaged in the intervention.

Table 2. Recommendation 1 of the Commission and steps to be taken by Member States

<table>
<thead>
<tr>
<th>Recommendations of the Commission</th>
<th>Steps to be taken by Member States</th>
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</table>
| 1.1 Ensure that appropriate and context-specific nutrition information and guidelines for both adults and children are developed and disseminated in a simple, understandable and accessible manner to all groups in society. | Inform the population about childhood overweight and obesity and consequences for health and well-being.  
Update, as necessary, guidance on the prevention of childhood obesity through the consumption of a healthy diet throughout the life course.  
Ensure that food-based dietary guidance is disseminated in an accessible manner for children, carers, school staff and health professionals.
Develop and implement evidence-based, public education campaigns about what constitutes a healthy diet and the need for it and for physical activity, which are appropriately funded and sustained over time. |
| 1.2 Implement an effective tax on sugar-sweetened beverages. | Analyse the administration and impact of a tax on sugar-sweetened beverages.  
Levy an effective tax on sugar-sweetened beverages according to WHO’s guidance. |
| 1.3 Implement the set of recommendations on the marketing of foods and non-alcoholic beverages to children to reduce the exposure of children and adolescents to, and the power of, the marketing of unhealthy foods. | Assess the impact of legislation, regulation and guidelines to tackle the marketing of unhealthy foods and non-alcoholic beverages to children, where required.  
Adopt, and implement effective measures, such as legislation or regulation, to restrict the marketing of foods and non-alcoholic beverages to children and thereby reduce the exposure of children and adolescents to such marketing.  
Establish mechanisms to effectively enforce implementation of legislation or regulation on the marketing of foods and non-alcoholic beverages to children. |
| 1.4 Develop nutrient profiles to identify unhealthy foods and beverages. | Establish a national nutrient-profiling model to regulate marketing, taxation, labelling and provision in public institutions, based on WHO’s regional or global nutrient-profile models. |
| 1.5 Establish cooperation between Member States to reduce the impact of cross-border marketing of unhealthy foods and beverages. | Engage in intercountry discussions on policies and proposals for regulating cross-border marketing of unhealthy foods and non-alcoholic beverages to children through WHO regional committees and other relevant regional mechanisms. |

446 Endorsed by the Health Assembly in resolution WHA63.14 (2010) on Marketing of food and non-alcoholic beverages to children; see also document WHA61/2008/REC/1, Annex 3.

1.6 Implement a standardized global nutrient-labelling system.

At the international level, work through the Codex Alimentarius Commission to develop a standardized system of food labelling, to support health literacy education efforts through mandatory labelling for all pre-packaged foods and beverages.

At the domestic level, adopt mandatory laws and regulations for nutrition labelling.

1.7 Implement interpretive front-of-pack labelling, supported by public education of both adults and children for nutrition literacy.

Consider undertaking pre-market/consumer testing of interpretive front-of-pack labelling, based on a nutrient-profile model.

Adopt, or develop as necessary, a mandatory interpretive front-of-pack labelling system based on the best available evidence to identify the healthfulness of foods and beverages.

1.8 Require settings such as schools, child-care settings, children’s sports facilities and events to create healthy food environments.

Set standards for the foods that can be provided or sold in child-care settings, schools, children’s sports facilities and at events (see also recommendations 4.9 and 5.1) based on a national nutrient-profile model.

Apply such food laws, regulations and standards in catering services for existing school, child-care and other relevant settings.

1.9 Increase access to healthy foods in disadvantaged communities.

Involve actors and resources outside the health system to improve access, availability and affordability of nutritious foods at a sustained scale in disadvantaged communities (for instance, through incentives to retailers and zoning policies).

Establish regulations and standards for social support programmes based on national and international dietary guidelines.

Incentivize local production of fruit and vegetables, such as urban agriculture.

2. Actions to implement comprehensive programmes that promote physical activity and reduce sedentary behaviours in children and adolescents (Table 3)

Rationale

20. Physical activity declines from the age of school entry and low physical activity is rapidly becoming a social norm. Yet, physical activity is known to reduce the risk of diabetes, cardiovascular disease and cancers and to improve children’s ability to learn, their mental health and well-being. Moreover, childhood experience can influence lifelong physical activity behaviours.

Table 3. Recommendation 2 of the Commission and steps to be taken by Member States

<table>
<thead>
<tr>
<th>Recommendations of the Commission</th>
<th>Steps to be taken by Member States</th>
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</table>
| 2.1 Provide guidance to children and adolescents, their parents, carers, teachers and health professionals on healthy body size, physical activity, sleep behaviours and appropriate use of screen-based entertainment. | Develop and implement evidence-based, targeted and appropriately funded, public education campaigns on the importance of physical activity.  
Update existing materials, as necessary, to include guidance on physical activity throughout the life course.  
Disseminate guidance on physical activity to children, carers, school staff and health professionals in an accessible manner.  
Use peer education and whole-of-school initiatives to influence the physical activity behaviours of children and social norms. |
| 2.2 Ensure that adequate facilities are available on school premises and in public spaces for physical activity during recreational time for all children (including those with disabilities), with the provision of gender-friendly spaces where appropriate. | Provide, in collaboration with other sectors (such as urban planning and transportation) and stakeholders, safe facilities, resources and opportunities for all children to be physically active during recreational time. |
3. Actions to integrate and strengthen guidance for noncommunicable disease prevention with current guidance for preconception and antenatal care, to reduce the risk of childhood obesity (Table 4)

Rationale
21. The risk of obesity can be passed from one generation to the next and maternal health can influence fetal development and the risk of a child becoming obese. The care that women receive before, during and after pregnancy has profound implications for the later health and development of their children. Current guidance for preconception and antenatal care focuses on the prevention of maternal and fetal undernutrition. Given changing exposures to obesogenic environments, guidelines are needed that address malnutrition in all its forms (including excessive energy intake) and the risk of subsequent development of obesity in the offspring. Interventions to tackle childhood obesity risk factors also prevent other adverse pregnancy outcomes and so contribute to improving maternal and newborn health.

Table 4. Recommendation 3 of the Commission and steps to be taken by Member States

<table>
<thead>
<tr>
<th>Recommendations of the Commission</th>
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<tbody>
<tr>
<td>3.1 Diagnose and manage hyperglycaemia and gestational hypertension.</td>
<td>Ensure that screening for hypertension and hyperglycaemia are included in antenatal care.</td>
</tr>
<tr>
<td>3.2 Monitor and manage appropriate gestational weight gain.</td>
<td>Ensure that measurement of weight and gestational weight gain are included in antenatal care.</td>
</tr>
<tr>
<td>3.3 Include an additional focus on appropriate nutrition in guidance and advice for both prospective mothers and fathers before conception and during pregnancy.</td>
<td>Ensure that diet and nutrition counselling is included in antenatal care.</td>
</tr>
<tr>
<td>3.4 Develop clear guidance and support for the promotion of good nutrition, healthy diets and physical activity, and for avoiding the use of and exposure to tobacco, alcohol, drugs and other toxins.</td>
<td>Include information on the association between prospective parents’ diet, physical activity and health behaviours and the risk of childhood obesity in the curriculum of health care providers. Disseminate guidance and provide support for healthy diet and physical activity to prospective parents whom preconception or antenatal care may not reach.</td>
</tr>
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4. Actions to provide guidance on, and support for, healthy diet, sleep and physical activity in early childhood to ensure children grow appropriately and develop healthy habits (Table 5)

Rationale
22. The first years of life are critical in establishing good nutrition and physical activity behaviours that reduce the risk of developing obesity. Exclusive breastfeeding for the first six months of life, followed by the introduction of appropriate complementary foods, is core to optimizing infant development, growth and nutrition and may also be beneficial for postnatal weight management in women. Current global guidance for infant and young child feeding primarily targets undernutrition. It is also important to consider the risks created by unhealthy diets in infancy and childhood.

Table 5. Recommendation 4 of the Commission and steps to be taken by Member States

<table>
<thead>
<tr>
<th>Recommendations of the Commission</th>
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<tbody>
<tr>
<td>4.1 Enforce regulatory measures such as the International Code of Marketing of Breast-milk Substitutes and subsequent World Health Assembly resolutions.</td>
<td>Ensure that legislation and regulations on the marketing of breast-milk substitutes adhere to all the provisions in the International Code of Marketing of Breast-milk Substitutes and subsequent related Health Assembly resolutions.</td>
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| 4.2 Ensure all maternity facilities fully practice the Ten Steps to Successful Breastfeeding. | Establish regulations for all maternity facilities to practice the Ten Steps to Successful Breastfeeding. Build or enhance assessment systems to regularly verify maternity facilities’ adherence. |
| 4.3 Promote the benefits of breastfeeding for both mother and child through broad-based education to parents and the community at large. | Include information on the benefits of breastfeeding for promoting appropriate infant growth, health and reducing the risk of childhood obesity in guidance for parents and public communications. |
| 4.4 Support mothers to breastfeed, through regulatory measures such as maternity leave, facilities and time for breastfeeding in the work place. | Ratify ILO Convention 183 and enact legislation mandating all the provisions of ILO Recommendation 191 on maternity leave and provision of time and facilities in the work place for breastfeeding. |
| 4.5 Develop regulations on the marketing of complementary foods and beverages, in line with WHO recommendations, to limit the consumption of foods and beverages high in fat, sugar and salt by infants and young children. | Assess the impact of legislation, regulations and guidelines to address the marketing of complementary foods for infants and young children, where required. Adopt and implement effective measures, such as legislation or regulation, to restrict the inappropriate marketing of complementary foods for infants and young children. Establish mechanisms to enforce effectively and monitor implementation of legislation or regulation on the marketing of complementary foods for infants and young children. |
| 4.6 Provide clear guidance and support to carers to avoid specific categories of foods (e.g. sugar-sweetened milks and fruit juices or energy-dense, nutrient-poor foods) for the prevention of excess weight gain. | Include the following in guidance on infant and young child feeding: (1) the introduction of appropriate complementary foods, avoiding the use of added sugar or sweeteners; (2) responsive feeding to encourage infants and young children to eat a wide variety of healthy foods; (3) which foods and beverages high in sugar, fat and salt should not be given to infants and young children; (4) appropriate portion sizes for children of different ages. Train community health workers or peer support groups to support appropriate complementary feeding. |
| 4.7 Provide clear guidance and support to caregivers to encourage the consumption of a wide variety of healthy foods. | |
| 4.8 Provide guidance to caregivers on appropriate nutrition, diet and portion size for this age group. | |
| 4.9 Ensure only healthy foods, beverages and snacks are served in formal child-care settings or institutions. | Set mandatory nutrition standards for foods and beverages provided (including meals) or sold (including vending machines and school shops) in public and private child-care settings or institutions. Implement such food laws, regulations and standards into catering services for existing child-care and other relevant settings. |
| 4.10 Ensure food education and understanding are incorporated into the curriculum in formal child-care settings or institutions. | Develop nutrition, food and health education curricula jointly between education and health sectors. Train teachers in curriculum delivery. Integrate nutrition and health education components, including practical skills, developed in collaboration with the education sector, into the core curriculum. |
| 4.11 Ensure physical activity is incorporated into the daily routine and curriculum in formal child-care settings or institutions. | Set standards for physical activity in child-care settings. Provide guidance to carers on the provision of safe and developmentally-appropriate physical activity, active play and active recreation for all children. |
| 4.12 Provide guidance on appropriate sleep time, sedentary or screen-time, and physical activity or active play for the 2–5 years of age group. | Develop guidance on physical activity for children under 5 years of age, including age-appropriate activities and ideas to support and encourage participation in physical activity at home and in the community all year round. |
4.13 Engage whole-of-community support for carers and child-care settings to promote healthy lifestyles for young children.

Develop guidelines on appropriate sleep time and use of screen-based entertainment by children and adolescents (see recommendation 2.1) and ideas to avoid sedentary activities, including avoiding excessive screen-time, and to model regular physical activities for families.

Conduct public awareness campaigns and disseminate information to increase awareness of the consequences of childhood obesity.

Promote the benefits of physical activity for both carers and children through broad-based education to carers and the community at large.

Promote communication and community participation to raise awareness and create an enabling environment and social demand for policy action to improve diet and physical activity in children.

Identify community champions/leaders/civil society organizations to work with, and ensure community representation.

5. Actions to implement comprehensive programmes that promote healthy school environments, health and nutrition literacy and physical activity among school-age children and adolescents (Table 6)

Rationale
23. Children and adolescents are highly susceptible to the marketing of unhealthy foods and beverages and the need to protect children from such marketing has been recognized.\(^{449}\) Peer pressure and perceptions of ideal body image also influence children’s attitudes to diet and physical activity. Adolescents in particular are exposed to influences and market forces different from those bearing on younger children and families. It is unfortunate that a significant number of school-age children are not in formal education, as the compulsory school years provide an easy entry point to engage this age group and embed healthy eating and physical activity habits for lifetime prevention of obesity. To be successful, programmes to improve the nutrition and physical activity of children and adolescents need to engage various stakeholders and ensure that conflicts of interest, such as those that can arise when the food and beverage industry is involved in such programmes, do not undermine progress. The active engagement of the education sector and integration of activities into health-promoting school initiatives, will help to ensure the success of such programmes and improve school attainment. Older children and adolescents, as well as their community, need to be engaged in the development and implementation of interventions to reduce childhood obesity.\(^{450}\)

Table 6. Recommendation 5 of the Commission and steps to be taken by Member States

<table>
<thead>
<tr>
<th>Recommendations of the Commission</th>
<th>Steps to be taken by Member States</th>
</tr>
</thead>
<tbody>
<tr>
<td>5.1 Establish standards for meals provided in schools, or foods and beverages sold in schools that meet healthy nutrition guidelines.</td>
<td>Set mandatory nutrition standards for foods and beverages provided (including meals) or sold (including vending machines and school shops) in the public and private school environment.</td>
</tr>
<tr>
<td>5.2 Eliminate the provision or sale of unhealthy foods, such as sugar-sweetened</td>
<td>Implement such food laws, regulations and standards into catering services for existing school and other relevant</td>
</tr>
</tbody>
</table>

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\(^{449}\) United Nations Committee on the Rights of the Child, General comment No. 15 (2013) on the right of the child to the enjoyment of the highest attainable standard of health (art. 24), 17 April 2013, document CRC/C/GC/15.

beverages and energy-dense, nutrient-poor foods, in the school environment.

5.3 Ensure access to potable water in schools and sports facilities. Ensure all school and sports facilities provide free access to safe drinking water.

5.4 Require inclusion of nutrition and health education within the core curriculum of schools. Develop nutrition, food and health education curricula jointly between education and health sectors. Train teachers in curriculum delivery. Integrate nutrition and health education components, including practical skills, developed in collaboration with education sector, into the core curriculum.

5.5 Improve the nutrition literacy and skills of parents and carers. Work with schools and communities to deliver skills through community classes/groups.

5.6 Make food preparation classes available to children, their parents and carers. Set standards for quality physical education in the school curriculum.

5.7 Include quality physical education in the school curriculum and provide adequate and appropriate staffing and facilities to support this.

6. Actions to provide family-based, multicomponent services on lifestyle weight management for children and young people who are obese (Table 7)

Rationale
24. When children are already overweight or obese, weight management to reduce body mass index-for-age and to reduce or prevent obesity-related morbidities will improve current and future health outcomes. Primary health-care services are important for the early detection and management of obesity and its associated complications. Regular growth monitoring at the primary health care facility or at school provides an opportunity to identify children at risk of becoming obese. The mental health needs of children who are overweight or obese, including issues of stigmatization and bullying, need to be given special attention.

Table 7. Recommendation 6 of the Commission and steps to be taken by Member States

<table>
<thead>
<tr>
<th>Recommendations of the Commission</th>
<th>Steps to be taken by Member States</th>
</tr>
</thead>
<tbody>
<tr>
<td>6.1 Develop and support appropriate weight management services for children and adolescents who are overweight or obese that are family-based, multicomponent (including nutrition, physical activity and psychosocial support) and delivered by multiprofessional teams with appropriate training and resources, as part of universal health coverage.</td>
<td>Implement a context-appropriate multicomponent weight management protocol that covers diet, physical activity and psychosocial support services tailored to children and families. Align services with existing clinical guidelines and clearly configure the roles of primary health care providers for effective multidisciplinary work. Educate and train concerned primary health care providers in identification and management of childhood obesity and associated stigmatization. Include childhood weight management services as part of universal health coverage.</td>
</tr>
</tbody>
</table>

III. MONITORING AND ACCOUNTABILITY FOR EFFECTIVE PROGRESS (TABLE 8)

25. Monitoring can serve to sustain awareness of the problem of childhood obesity and is necessary to track progress in the development, implementation and effectiveness of interventions. Governments are understandably wary of increasing the burden of reporting on their commitments. Several monitoring mechanisms currently exist that countries could draw upon and integrate into a

26. Member States do not want unnecessarily to increase the reporting burden. Thus, a second phase of work is required to identify all relevant existing indicators and reporting mechanisms that can be harnessed for monitoring implementation and to develop technical advice and tools for monitoring and accountability that take this into consideration. The Secretariat will develop a framework for evaluating progress on the implementation plan, which will define baselines, indicators and responsible sectors. It should also provide specific examples of the roles of different sectors/ministries in supporting a whole-of-government response to prevention and treatment of childhood obesity.

Table 8. Recommendations of the Commission on monitoring and accountability and steps to be taken by Member States

<table>
<thead>
<tr>
<th>Recommendations of the Commission</th>
<th>Steps to be taken by Member States</th>
</tr>
</thead>
<tbody>
<tr>
<td>Establish monitoring systems to provide evidence of the impact and effectiveness of interventions in reducing the prevalence of childhood obesity and use data for policy and implementation improvement.</td>
<td>Ensure weight and height of children are regularly measured in all primary care settings with adequate quality control. Establish monitoring systems to provide evidence of the impact and effectiveness of interventions in achieving their policy goals and use data for policy and implementation improvement.</td>
</tr>
<tr>
<td>Develop an accountability mechanism that encourages participation of nongovernmental organizations and academic institutions in accountability activities.</td>
<td>Establish coordinating mechanisms for the involvement of non-State actors in monitoring and accountability activities aligned with the accountability mechanisms for the Sustainable Development Goals, the Global Strategy on Women’s, Children’s and Adolescents’ Health, the United Nations Decade of Action on Nutrition (2016–2025), Global Monitoring Framework on the Prevention and Control of Noncommunicable Diseases and the associated set of progress indicators.</td>
</tr>
</tbody>
</table>

27. The logic model presented in Figure 3 provides guidance to Member States in identifying short- and medium-term outcomes in order to define specific indicators to measure determinants in a standardized manner.

28. Strong commitments must be accompanied by strong implementation systems and well-defined accountability mechanisms for effective progress in preventing childhood obesity. A whole-of-society approach offers the best opportunity for tackling childhood obesity. Both governments and other actors, notably, civil society, can hold each other and private-sector entities to account in order to ensure that they adopt policies and comply with standards.

**Interventions**

1. **Promote the intake of healthy foods**
   - Improved understanding of nutrition information
   - An effective tax on sugar-sweetened beverages
   - Reduced exposure of children to marketing of foods and non-alcoholic beverages
   - Increased access to healthy food choices, particularly in disadvantaged communities

2. **Promote physical activity**
   - Improved knowledge and understanding of benefits of physical activity by teachers, carers and children
   - All children have access to facilities and opportunities for physical activity during recreation time and can use them

3. **Provide preconception and pregnancy care**
   - Improved diagnosis and management of hyperglycaemia and gestational hypertension
   - Prospective parents better informed on healthy diet, physical activity and avoidance of exposure to tobacco, alcohol, drugs and toxins before and during pregnancy

**Outputs**

1. Improved understanding of nutrition information
2. An effective tax on sugar-sweetened beverages
3. Reduced exposure of children to marketing of foods and non-alcoholic beverages
4. Increased access to healthy food choices, particularly in disadvantaged communities

**Outcomes**

1. Increased consumption of healthier diets
2. Reduced consumption of sugar-sweetened beverages and unhealthy diets
3. Increased physical activity in children and adolescents
4. Reduced sedentary time and screen-time and adequate sleep in children and adolescents
5. Reduced exposure of fetus to risk factors for childhood obesity
6. Reduced proportion of low-birth-weight and large-for-gestational-age infants

**Impact**

- Lower incidence and prevalence of childhood obesity
- Lower prevalence of health conditions associated with childhood obesity
- Reduced prevalence of obesity in young children
- Reduced incidence of obesity in school-aged children and adolescents
- Better health outcomes and well-being for children who are overweight and obese

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Figure 3. Logic model for childhood obesity prevention interventions
4. **Provide guidance and support for early childhood diet and physical activity**

- Reduced exposure to the marketing of breast-milk substitutes
- Increased awareness of the benefits of exclusive breastfeeding
- More opportunities for women to continue breastfeeding

5. **Promote health, nutrition and physical activity in child care and school settings**

- Increased availability and access to healthy diets and safe drinking water in schools
- Reduced availability of foods high in sugar, salt and fats in schools
- School-aged children and adolescents and their carers better informed about healthy diet and physical activity
- Physical activity is featured daily in child care and school settings

6. **Provide weight management**

- Increased access of children who are overweight or obese to appropriate family-based, multicomponent weight management services

<table>
<thead>
<tr>
<th>Improved infant and young child feeding practices</th>
</tr>
</thead>
<tbody>
<tr>
<td>Increased consumption of healthy diets and reduced consumption of foods high in sugar, salt and fats by children and adolescents</td>
</tr>
<tr>
<td>Increased consumption of water consumed in schools and sports facilities as an alternative to sugar-sweetened beverages</td>
</tr>
<tr>
<td>School-aged children and adolescents more physically active</td>
</tr>
<tr>
<td>Increased use by children who are overweight or obese of appropriate family-based, multicomponent weight management services</td>
</tr>
<tr>
<td>Reduced incidence of obesity in school-aged children and adolescents</td>
</tr>
<tr>
<td>Better health outcomes for children who are overweight and obese</td>
</tr>
</tbody>
</table>
29. Governments bear primary responsibility for setting the policy and regulatory framework for the prevention of childhood obesity at the country level. A whole-of-government approach requires that a clear chain of responsibility and accountability is established and that relevant institutions, tasked with developing or implementing interventions, are held accountable for the performance of those tasks. This can be facilitated through the development of a policy and action planning matrix. The matrix (see Figure 4) could serve as a tool for ensuring a whole-of-government accountability, through a clear delineation of the actions, the actors, the tasks, outputs or outcomes that an actor is accountable for, monitoring of the actions, and processes for holding parties to account. Government entities also have a broad range of tools and processes for holding external actors to account, including legal processes, regulatory arrangements, economic incentives, and market-based and media-based approaches.

Figure 4. Policy and action planning matrix for monitoring and accountability

<table>
<thead>
<tr>
<th>Actions (recommendations of the Commission)</th>
<th>Identify specific actions/sets of actions to be addressed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Actors</td>
<td>Who will formulate the policy or action for implementation?</td>
</tr>
<tr>
<td></td>
<td>Who will implement the policy/action? [separate question]</td>
</tr>
<tr>
<td></td>
<td>Are there other relevant actors, and, if so, who are they?</td>
</tr>
<tr>
<td>Allocation of responsibility for tasks and outcomes</td>
<td>What will each of the relevant actors be held accountable for? For example: formulating a policy/programme; implementing a policy/programme; complying with the policy; achieving measurable progress towards the ultimate (or an appropriate intermediate) policy objective; collecting and analysing data disaggregated by key determinants such as sex, age, socioeconomic level and education</td>
</tr>
<tr>
<td>Monitoring</td>
<td>Who will monitor the tasks or actions which the actors are being held accountable for?</td>
</tr>
<tr>
<td>Holding to account (accountability relationships)</td>
<td>Who will hold the actors (that is, those who formulate the policy and actions for implementation) to account?</td>
</tr>
<tr>
<td></td>
<td>Who will hold the actors that implement the actions to account?</td>
</tr>
<tr>
<td></td>
<td>Who will hold other relevant actors to account?</td>
</tr>
<tr>
<td>Monitoring indicators (process, outputs and outcomes)</td>
<td>What indicators provide measures of the actions for which actors are being held accountable?</td>
</tr>
<tr>
<td>Tools and processes for holding to account</td>
<td>How will the actors be held to account for their performance?</td>
</tr>
</tbody>
</table>

30. Civil society can play a critical role in bringing social, moral and political pressure on governments to fulfil their commitments. Ending childhood obesity should form part of civil society’s agenda for advocacy and accountability. Improving coordination of civil society organizations and strengthening their capacity to monitor effectively and ensure accountability for commitments made is vitally important. Governments may consider providing opportunities for formal participation by civil society in the policy-making, implementation and evaluation process, as well as ensuring mutual accountability and transparency.

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31. The private sector can play a role in tackling childhood obesity, with appropriate consideration of their core business, but additional accountability strategies are often necessary. Risks of conflicts of interest need to be identified, assessed and managed in a transparent and appropriate manner when engaging with non-State actors. Codes of conduct and independently audited assessments of compliance with government oversight are therefore important.

IV. KEY ELEMENTS FOR SUCCESSFUL IMPLEMENTATION

32. In implementing actions for ending childhood obesity, consideration should be given to certain elements, as highlighted by the Commission in its report.

Prioritization
33. Regions, countries and national subregions may have differing childhood obesity prevalence and socioeconomic distribution, as well as different economic and health service capacity. They may also have a mix of nutrition conditions that have to be simultaneously addressed, including overweight, undernutrition and micronutrient deficiencies. An analysis that takes into account prevalence data by key determinants of health, such as gender, age, socioeconomic level and ethnicity, combined with a prioritization exercise, can help governments to choose combinations and the order of implementation of interventions that will effectively redress childhood obesity. Interventions that have the capacity to generate revenue, such as taxation of sugar-sweetened beverages, may assist governments in meeting the cost of implementation. Various prioritization tools exist that can guide this process.\(^\text{455}\) Synergistic interventions and combinations that enable the healthy choice to become the easier choice, interventions that have the benefit of stimulating population-wide discussion, and education on childhood obesity all can prove effective in raising public awareness and building support for legislation and regulation. Ensuring the involvement of relevant stakeholders in the prioritization exercise and policy development, with attention to potential conflicts of interest, is also important. All countries are invited to take action to prevent and control childhood overweight, even at very low prevalence levels, as the epidemic is quickly evolving.

Awareness, communication and education
34. Values and norms influence the perception of healthy or desirable body weight, especially for children. Communication to improve knowledge, correct misperceptions and ensure that communities support and participate in policies and interventions that encourage behaviour change is vital. Peer education and whole-of-community initiatives can engage children, adolescents, families and individuals in designing together new approaches to preventing and tackling obesity, empowering them to act but more importantly creating a demand and support for services and interventions. Capacity-building programmes to teach health care providers and community health workers additional skills in communications and education are also critical for effective programme implementation.

35. Evidence-based mass-media campaigns based on integrated marketing principles, and implemented at appropriate scale and with suitable frequency, should be conducted in order to justify and gain support for a wider programme of action. Such approaches have been shown to be important for changing perceptions, attitudes and intentions, and for promoting community discussions about obesity, physical activity and healthy diets. Such campaigns and programmes can also be targeted, for example, at parents and carers.

Mobilization of resources
36. Governments and stakeholders need resources to implement actions and to find innovative approaches for domestic and international financing. Taxation of sugar-sweetened beverages could generate revenue for programmes against childhood obesity, although due regard must be given to avoiding or managing conflicts of interest.

37. To ensure long-term impact, sustainable domestic and international resources are needed for implementing the recommendations of the Commission.

Capacity-building
38. Strengthening institutional capacity and providing appropriate training to health care workers, child-care and school staff are also essential for the successful implementation of the recommendations of the Commission. In addition, both capacity and capability are also needed to support the design, implementation, evaluation and enforcement of population-based policies, such as taxation of sugar-sweetened beverages and restriction of the marketing of foods and non-alcoholic beverages to children.

39. Networks can provide support for countries committed to implementing specific activities as well as building capacity through platforms for sharing experience and exchanging policies between Member States.

V. ROLES AND RESPONSIBILITIES OF STAKEHOLDERS

40. Successful implementation of further action on the recommendations of the Commission requires the committed input, focus and support of numerous agencies besides Member States (see section II). The Commission identified the following stakeholder groups with specific roles and responsibilities.

WHO Secretariat
41. Momentum must be maintained. The Secretariat will lead and convene high-level dialogue within the United Nations system and with and between Member States. Its aim will be to fulfil the commitments made in the 2030 Agenda for Sustainable Development, the Political Declaration of the High-level Meeting of United Nations General Assembly on the Prevention and Control of Non-communicable Diseases, the Rome Declaration on Nutrition and other relevant global and regional policy frameworks through the actions detailed by the Commission on Ending Childhood Obesity in its report.

42. Using its normative function, both globally and through its network of regional and country offices, WHO can provide technical assistance by developing or building on guidelines, tools and standards in order to put the recommendations of the Commission and other relevant WHO mandates into effect at country level. The Secretariat can disseminate guidance for implementation, monitoring and accountability, and monitor and report on progress to end childhood obesity.

Actions
(a) Collaborate with other bodies in the United Nations system whose mandates encompass nutrition and childhood obesity, in particular FAO, UNDP, UN Habitat, UNICEF and WFP.

(b) Institutionalize a cross-cutting and life course approach to ending childhood obesity across all relevant technical areas in WHO headquarters, regional and country offices.

(c) Develop, in consultation with Member States, guidelines for engaging constructively with the private sector for the prevention of childhood obesity.

(d) Strengthen capacity to provide technical support for action to end childhood obesity at global, regional and national levels, by for example:
(i) building legal and regulatory capacity, by means including workshops and courses in collaboration with other government sectors;

(ii) developing guidelines on obesity risk prevention during antenatal care, on physical activity for pregnant women and young children, and on appropriate sleep time and screen use by children and adolescents;

(iii) providing technical support and tools to Member States, as requested, through the establishment of multisectoral committees or task forces, for instance, in order to support the implementation of the recommendations of the Commission;

(iv) offering a platform to enable cooperation between Member States with similar priorities for implementation of the recommendations.

(e) Support international agencies, national governments and relevant stakeholders in turning existing commitments into relevant actions to end childhood obesity at global, regional and national levels.

(f) Promote collaborative research on ending childhood obesity with a focus on the life course approach.

(g) Encourage innovative means of financing implementation of strategies for prevention of childhood obesity, with due attention to conflicts of interest.

(h) Report on global progress in ending childhood obesity.

International organizations
43. Cooperation between international organizations including entities in the United Nations system can promote global and regional partnerships and networks for advocacy, resource mobilization, capacity-building and collaborative research. The United Nations Inter-agency Task Force on the Prevention and Control of Non-communicable Diseases can support Member States in tackling childhood obesity.

Actions
(a) Cooperate to build capacity and support respective Member States in tackling childhood obesity.

(b) Incorporate prevention of childhood obesity into country-level programmes in the United Nations Development Assistance Framework.

(c) Provide support for the development and dissemination of guidance on healthy diet and physical activity.

(d) Collaborate with organizations in the United Nations system dealing with nutrition to review current practices on the delivery of food and nutrition programmes and ensure that the programmes contribute to the prevention of childhood obesity.

(e) Partner with governments to implement interventions to end childhood obesity, through for example the United Nations Inter-agency Task Force on the Prevention and Control of Non-communicable Diseases, the United Nations Network for Scaling Up Nutrition and the WHO-UNDP Global Joint Programme to activate National Responses to Noncommunicable Diseases, which can support implementation of the recommendations of the Commission.

Nongovernmental organizations
44. Although governments build policy frameworks, in some countries the tasks of developing nutrition information and education campaigns, implementing programmes, and monitoring and holding actors to account for commitments made may be shared between government and civil
society. Social movements can engage members of the community and provide a platform for advocacy and action.

**Actions**

(a) Raise the profile of prevention of childhood obesity through advocacy and dissemination of information.

(b) Motivate consumers to demand that governments support healthy lifestyles and that the food and non-alcoholic beverage industry provide healthy products and do not market unhealthy foods and beverages to children.

(c) Call on governments to create the legal and regulatory frameworks needed to implement recommendations to end childhood obesity.

(d) Contribute to the development and implementation of a mechanism for monitoring and accountability.

**The private sector**

45. The private sector is not a homogeneous entity and includes the agricultural food production sector, the food and beverage industry, retailers, catering companies, sporting-goods manufacturers, advertising and recreation businesses, and the media, among others. It is, therefore, important to consider the level of governmental engagement with entities in the private sector whose activities could have a positive or negative impact on childhood obesity. Governments need to engage constructively with the private sector to encourage implementation of government-determined and government-led policies and interventions.

46. Some private sector initiatives exist that have the potential to reduce childhood obesity. These need to be encouraged where they are supported by an evidence base and do not have coincident negative impacts, such as delaying more effective regulation. As many companies operate globally, international collaboration between their different arms is vital. However, attention must also be given to local and regional entities and artisans. Although some cooperative relationships with industry have led to some encouraging outcomes related to diet and physical activity, others have been seen to shift responsibility from the food and beverage industry to the consumer and to be intended to improve the company’s image in the community. Initiatives by the food manufacturing industry to reduce the content of fat, sugar and salt and portion sizes of processed foods, and to increase the production of innovative, healthy and nutritious choices, could accelerate health gains worldwide if implemented widely. Multinational companies should apply consistent approaches to labelling and marketing across their entire global portfolios so as to ensure that actions are global and do not differ between countries. In doing so, multinational companies should apply the highest standards to which their products are subjected. However, engagement between governments and the private sector needs to be health-goal oriented, transparent and accountable and to pay particular attention to managing potential conflicts of interest.

**Actions**

(a) Support the production of, and facilitate access to, foods and non-alcoholic beverages that contribute to a healthy diet.

(b) Facilitate access to, and participation in, physical activity.

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Philanthropic foundations
47. Philanthropic foundations are uniquely placed to make significant contributions to global public health and can also engage in monitoring and accountability activities.

Actions
(a) Recognize childhood obesity as endangering child health and educational attainment with long-term consequences and thus address this important issue.
(b) Mobilize funds to support research, capacity-building, service delivery, and monitoring and accountability.

Academic institutions and health professional associations
48. Academic institutions can contribute to prevention and control of childhood obesity through studies on biological, behavioural and environmental risk factors and determinants, and the effectiveness of interventions on each of these. Associations of health professionals have an important role in raising public awareness of the immediate and long-term consequences of childhood obesity to health and well-being and advocate implementation of effective interventions. They can also provide support for health professional training and contribute to monitoring and accountability.

Actions
(a) Raise the profile of prevention and treatment of childhood obesity through the dissemination of relevant information and its incorporation into appropriate curricula at all levels (pre- and post-graduate).
(b) Fill gaps in knowledge through research that is free from commercial interests in order to provide evidence to support policy implementation.
(c) Support and evaluate monitoring and accountability activities.

CONCLUSIONS
49. Childhood obesity undermines the physical, social and psychological well-being of children and is a known risk factor for adult obesity and noncommunicable diseases. There is an urgent need to act now to improve the health of this and the next generation of children. Overweight and obesity cannot be solved through individual action alone. Comprehensive responses are needed to create healthy environments that can support individuals in making healthy choices grounded on knowledge and skills related to health and nutrition. These responses require government commitment and leadership, long-term investment and engagement of the whole of society to protect the rights of children to good health and well-being. Progress can be made if all actors remain committed to working together towards a collective goal of ending childhood obesity.
15.6 Cancer prevention and control in the context of an integrated approach

Document A70/32 (Report by the Secretariat):

1. In January 2017, the Executive Board, at its 140th session, considered an earlier version of this report that contained a draft resolution. During the discussions, an informal drafting group was set up so that consensus could be reached on the text of the draft resolution. Despite progress made by the drafting group, consensus was not achieved before closure of the Board’s session and certain paragraphs of the draft resolution remained pending. The Board then agreed that the discussion of those outstanding paragraphs would be continued during the intersessional period.

BURDEN AND TRENDS

2. Cancer is a growing public health concern. In 2012, there were 14.1 million new cases and 8.2 million cancer-related deaths worldwide. The number of new cases is projected to increase to 21.6 million annually by 2030. The greatest impact is in low- and middle-income countries, many of which are ill-equipped to cope with the escalating burden of disease, and where 65% of cancer deaths occur.

3. In 2012, there were 4.3 million premature deaths from cancer worldwide, 75% of which were in low- and middle-income countries. In order to achieve Sustainable Development Goal 3 (Ensure healthy lives and promote well-being for all at all ages) and its target 3.4 to reduce, by 2030, premature mortality from noncommunicable diseases, including cancer, by one third, an urgent scale-up of actions is needed. This scale-up should include actions that apply also to other targets, such as target 3.a to strengthen the implementation of the WHO Framework Convention on Tobacco Control by all Parties to the Convention, as appropriate.

4. Progress in cancer control has been uneven. In spite of known effective interventions, the burden of cervical cancer, for example, remains greatest in low- and middle-income countries, where progress has been the slowest. While there have been moderate improvements in age-standardized cancer mortality rates in high-income countries, reaching a 25% reduction in some settings, overall declines in mortality from cancer have not been achieved globally.

5. Outcomes for childhood acute lymphoblastic leukaemia, a highly treatable cancer, reflect global inequities: five-year survival is less than 20% in some low- and middle-income countries, as compared to 90% in some high-income countries. In many countries, women, children, indigenous groups, ethnic minorities and socioeconomically disadvantaged groups are often inequitably exposed to risk factors and have limited access to diagnosis and care services, which may result in poorer outcomes for these vulnerable groups.

6. The economic impact of cancer is significant and is increasing. In 2010, the total annual economic cost of cancer was estimated at approximately US$ 1.16 trillion, threatening health budgets and economies at all income levels as well as causing financial catastrophe for individuals and families.

7. Effective cancer control planning requires accurate data, including reliable cancer registries and monitoring and evaluation programmes for quality assurance. While most countries (84%) have reported having a cancer registry, only one in five low- and middle-income countries have the necessary data to drive policy.

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458 See the summary records of the Executive Board at its 140th session, fourteenth meeting, fifteenth meeting, section 1 and eighteenth meeting, section 3.
DEVELOPING AND IMPLEMENTING NATIONAL CANCER CONTROL PLANS

8. In the 2015 country capacity survey for noncommunicable diseases, 459 87% of the 177 responding Member States reported having a policy, strategy or action plan for all or some cancers but only 68% reported that such a policy, strategy or action plan was operational. Implementing a national cancer control plan requires adequate resources, monitoring and accountability together with an effective health system, founded on the principles of universal health coverage and strong primary health care.

9. Orienting funding through domestic, bilateral and multilateral channels towards evidence-based, cost-effective interventions to reduce risk factors, including tobacco use, unhealthy diet, physical inactivity and harmful use of alcohol, can reduce unnecessary expenditure on high-cost interventions, medicines and technologies. As recognized in the Addis Ababa Action Agenda, 460 resources for financing national cancer responses increasingly need to come from domestic budgets. According to some estimates, only 5% of global resources for cancer prevention and control are spent in low- and middle-income countries, despite the majority of preventable deaths occurring in these countries. Innovative financing is needed, including through increased taxes on tobacco and alcohol.

PREVENTION, EARLY DIAGNOSIS, SCREENING AND TREATMENT

10. Based on current knowledge, between one third and one half of all cancers are potentially preventable; this proportion will rise as further understanding of cancer risk factors and the development of associated preventive interventions is gained. Cancer is caused by a wide range of risk factors, including the four shared noncommunicable disease risk factors (tobacco use; unhealthy diet; physical inactivity; and harmful use of alcohol), obesity, infections, indoor and outdoor air pollution, radiation, environmental chemicals and occupational exposures. Tobacco use directly contributes to 22% of global cancer deaths. Cancer-causing infections are responsible for over 20% of cancer deaths in low- and middle-income countries. Vaccines are currently available for two of the most common oncogenic infectious agents, human papilloma virus and hepatitis B virus, and are very cost-effective strategies for cancer prevention.

11. Identifying cancer at the earliest possible stage means that treatment is less costly and cure is more likely. Late diagnosis of cancer is common in low- and middle-income countries, where many individuals present with advanced or metastatic cancer. Access to diagnostic, including pathology, and treatment services is limited in many low- and middle-income countries.

12. Cancer screening has had a limited impact in many low- and middle-income countries due to low participation, inadequate quality assurance measures and insufficient health infrastructure to deliver organized services. In 2015, only 20% of the countries that reported in the country capacity survey for noncommunicable diseases as having a screening programme achieved greater than 70% participation for cervical or breast cancer screening.

13. Of the estimated 20 million people who need palliative care each year, 6.6 million (33%) are cancer patients. Over half of cancer patients at all stages experience pain, even more so when undergoing treatment and when in advanced phases of disease, yet 83% of the global population live in countries with low or non-existent access to adequate pain management. In resolution WHA67.19 (2014) on the strengthening of palliative care as a component of comprehensive care throughout the life course, the Sixty-seventh World Health Assembly urged Member States to integrate palliative care services in the continuum of care, with emphasis on primary care, community and home-based care, and universal coverage schemes.

WHO’S RESPONSE

14. The Secretariat is supporting the fulfilment of the commitments made by Heads of State and Government in the Political Declaration of the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases, and the achievement of the Sustainable Development Goal targets pertaining to comprehensive cancer control. It is also supporting Member States in their efforts to develop, strengthen, implement and monitor national cancer control plans, and to prioritize cost-effective interventions in noncommunicable disease prevention and control.

15. The Secretariat has developed technical materials to support the planning and implementation of cancer prevention strategies by Member States. These include publications and activities to support the implementation of the WHO Framework Convention on Tobacco Control (2005) and provide guidance on interventions to promote healthy diet and physical activity (2014), reduce the harmful use of alcohol (2010) and implement vaccination programmes (2014). In addition, strategies have been developed on promoting cancer early diagnosis and screening (2007 and 2017), developing a comprehensive approach to cervical cancer control (2014), identifying priority medical devices (2016), strengthening palliative care services (2016) and analysing selected cost-effective cancer control interventions (2016). The 2015 update of the WHO Model List of Essential Medicines provides guidance on cancer medicines and treatment indications for 33 cancers and supports countries in negotiating lower medicine prices. Cancer control capacity is periodically assessed through the WHO global noncommunicable disease country capacity survey.

16. IARC, the specialized cancer research agency of WHO, has provided a global reference for cancer information through the Global Cancer Observatory, which is a web-based platform that uses data from several of IARC’s key projects, including the GLOBOCAN project and the Cancer Incidence in Five Continents series of monographs. IARC leads the Global Initiative for Cancer Registry Development, which provides expertise, training and support to national authorities and cancer registries in low- and middle-income countries to address the lack of quality data. The IARC Monographs on the Evaluation of Carcinogenic Risks to Humans programme is the most comprehensive international approach to the evaluation and identification of carcinogenic agents. IARC conducts extensive research to evaluate screening methodologies with particular emphasis on technologies appropriate to low- and middle-income countries.

17. A global joint programme has been developed by the WHO-led United Nations Inter-agency Task Force on the Prevention and Control of Non-communicable Diseases, with seven organizations of the United Nations system (IAEA, IARC, UNAIDS, UNFPA, UNICEF, the United Nations Entity for Gender Equality and the Empowerment of Women, and WHO) providing support to governments to prevent and control cervical cancer. In addition, IAEA, IARC and WHO have been working together to provide support to countries in respect of comprehensive cancer control.

18. All WHO regional offices, and many country offices, have provided direct support to Member States in respect of cancer prevention and control by organizing regional workshops and training courses, convening meetings and passing resolutions. Some of the regional activities are described below.

(a) The Regional Office for Africa has been providing support for cancer prevention and control policies, strategies and plans in 19 Member States and has developed five normative documents on cancer prevention and control.

(b) The Regional Office for the Americas has developed five information products on cervical cancer to inform and provide direct in-country support for 11 Member States.

(c) The Regional Office for South-East Asia, in the light of the resolution on cancer prevention and control adopted by the Regional Committee for South-East Asia at its Sixty-eighth session (2015), has been promoting activities to strengthen the early diagnosis, referral and management of cancers, focusing on primary care and on enhancing information systems and registries.

(d) The Regional Office for Europe has produced training materials for health professionals and in 2014 published a progress report for policy-makers on the prevention and control of noncommunicable diseases in the Region.

(e) The Regional Office for the Eastern Mediterranean has developed a regional framework (2016) and a regional strategy for cancer prevention and control (2009–2013).

(f) The Regional Office for the Western Pacific has supported workshops on leadership and capacity building for cancer control and, in partnership with a WHO collaborating centre in the Republic of Korea, has developed an e-learning course on the subject, based on WHO publications.

RECOMMENDED ACTIONS FOR MEMBER STATES AT THE COUNTRY LEVEL

19. **As part of the national commitments to develop policies and plans for the prevention and control of noncommunicable diseases, develop and implement a national cancer control plan with a focus on equity and access.** Countries should develop and implement national cancer control plans with adequate resources and accountability to provide high-quality, resource-appropriate cancer prevention and control services for all and the targets of the 2030 Agenda for Sustainable Development.

20. **Reduce risk factors for cancer through policies and programmes.** In accordance with existing global strategies to reduce the shared risk factors for noncommunicable diseases and multisectoral implementation of the WHO Framework Convention on Tobacco Control, cost-effective policies must be implemented to reduce the cancer burden, such as policies to: impose higher taxes on tobacco and alcohol; eliminate exposure to tobacco smoke or tobacco marketing tactics; restrict the marketing of foods and non-alcoholic beverages to children; ensure a quality public open space and adequate infrastructure for physical activity; reduce air pollution; and promote access to human papillomavirus vaccination. Research on the causes of human cancer and carcinogenesis is needed. Preventing the tobacco industry’s interference in public health policy is a cross-cutting intervention critical for the success of reducing the risk factors of noncommunicable diseases.

21. **Improve access to timely diagnosis and treatment.** Pursuant to commitments made at the United Nations General Assembly in 2011, 2014 and 2015, Member States should increase efforts to strengthen health systems at the national and local levels to ensure early diagnosis and accessible, affordable and high-quality care for all cancer patients. The implementation of comprehensive packages for noncommunicable disease prevention and control, such as WHO’s Package of essential noncommunicable disease interventions for primary health care in low-resource settings, can improve service delivery by promoting early diagnosis.

22. **Optimize the use of existing human resources and anticipate future requirements for cancer prevention and control.** Countries should ensure that their workforce has the appropriate competencies and skills for comprehensive cancer control through education and training.

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programmes and appropriate recruitment, deployment and retention strategies, including career-development opportunities.

23. **Improve data to inform policy decision-making.** Effective policies must be founded on accurate data. In that respect, there is a need for renewed commitment to: the development and maintenance of population-based cancer registries; the surveillance of risk factors and of the measures implemented to control them; strengthened civil registration and vital statistics systems; routine health information systems that assess both technical and experiential quality; facility assessments to determine readiness and the quality of the services provided; and a rigorous monitoring and evaluation framework at the national and subnational levels.

**ACTIONS FOR THE SECRETARIAT**

24. The Secretariat will develop technical tools for and provide support to Member States in the planning, implementation, monitoring and evaluation of cancer prevention and control strategies, in the context of integrated national responses to noncommunicable diseases. This will include help with the costing of national cancer control plans, the implementation of cost-effective interventions including “best buys” in the context of the global action plan for the prevention and control of noncommunicable diseases 2013–2020, strengthening the workforce, promoting access to essential medicines and technology and integrating cancer prevention and control into national health systems. The Secretariat will also help to implement national cancer control plans and will provide in-country technical assistance as needed.

25. The Secretariat will also support efforts to strengthen the policy environment including the efforts by Member States to scale-up tobacco control, reduce the harmful use of alcohol, address environmental and occupational carcinogens, promote healthy diet and physical activity and increase human papillomavirus and hepatitis B vaccination coverage.

26. In addition, the Secretariat will support data collection and analysis, including through cancer registries, and the development of a monitoring and evaluation framework to assist with cancer prevention and control planning and quality assurance.

**ACTION BY THE HEALTH ASSEMBLY**

27. The Health Assembly is invited to note this report.
15.7 Strengthening synergies between the World Health Assembly and the Conference of the Parties to the WHO Framework Convention on Tobacco Control

Document A70/33:

1. The Director-General has the honour to transmit to the Seventieth World Health Assembly the report submitted by the President of the Conference of the Parties to the WHO Framework Convention on Tobacco Control (see Annex).

ACTION BY THE HEALTH ASSEMBLY

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

ANNEX
REPORT BY THE PRESIDENT OF THE CONFERENCE OF THE PARTIES

(The Annex is not included here - see http://apps.who.int/gb/ebwha/pdf_files/WHA70/A70_33-en.pdf for the full document)
Noncommunicable diseases

The World Health Minute is a one-stop public health news intelligence source reporting on what the global press is saying about each of the WHA agenda issues from preparedness to the elections. Here is a sample of articles printed on 17 May for issues related to noncommunicable diseases. For more information see www.worldhealthminute.com.

World Health Minute – extract from May 17 217 issue

- Segregated neighbourhoods may influence blood pressure
  African-Americans who move from segregated neighbourhoods to more racially diverse communities might experience improvements in their blood pressure, a U.S. study suggests. The authors say the findings are interesting as they point to the important role that social policy can have on health (reuters.com: 15/05/17)

- Billionaire Bloomberg to fund $5m public health projects in 40 cities worldwide
  The Guardian reports on Michael Bloomberg’s Partnership for Healthy Cities. Bloomberg was appointed as the World Health Organization’s ambassador for NCDs last year. And now he is taking his philosophy and his cash to about 40 cities so far offering technical support for cities which choose to focus on one of 10 healthy lifestyle issues including, curbing sugary drinks consumption, air pollution, promoting exercise and bans on smoking (theguardian.com: 16/05/17)

- People above 30 are to be screened in 100 districts for NCDs
  All Indian citizens over 30 years of age are to be screened in 100 districts of the country under the first phase of a programme of universal screening and control for five non-communicable diseases. Gradually, it will cover the entire country and everyone will be screened under the programme to reduce the disease burden in the nation, the Indian health minister told the press (economic times.indiatimes.com: 16/05/17) (news18.com: 16/05/17) (news.webindia123.com: 16/05/17)

- Vietnam has burden of non-communicable diseases
  Vietnam’s Deputy Health Minister said that of every ten deaths, seven are caused by cardiovascular disease, diabetes, cancer and pulmonary diseases. Non-communicable diseases cause 73% of all deaths and 40% of these people are dying before the age of 70. The financial burden of these diseases will cost the country $47bn over the next 20 years. Vietnam also bears a further cost of $1bn in tobacco-related diseases. Vietnam is committing to intensifying prevention but also propagating more information about the risks and investing in earlier detection (vietnamnet.vn: 15/05/17)

- Tobacco consumption epidemic reaches alarming levels
  The epidemic of tobacco consumption has reached alarming levels in Indonesia, where more than one-third of the country population are smokers. The fast rising number of cases of non-communicable diseases caused by tobacco consumption now pose a serious threat to the sustainability of the National Health Security Programme in Indonesia, the health minister said. Some 20% of teenagers between the ages of 13 and 15 smoke and unhealthy lifestyles of smoking, alcoholic drinks and sugary drinks are creating a slow burning health crisis in the country (antaranews.com: 15/05/17)

- Walking linked to improved brain function
  A moderate intensity walking regimen may reduce symptoms of mild cognitive impairment that are linked to poor blood vessel health in the brain, a study suggests. Participants with vascular dementia who walked three hours per week for six months had improved reaction times and other signs of improved brain function (reuters.com: 16/05/17)

- Workers are going deaf and some are dying, working in this city’s factories
  Star2.com reports on the Indian textile hub of Surat on how many migrants from places like Odisha come to the city to work on the power looms in such appalling conditions that it often damages their hearing and ruins their health. Textiles workers are exposed to around 102-104 decibels of sound, according to a study by India’s National Institute of Occupational Health, much more than the legally permissible 90 decibels, putting them at severe risk of hearing damage (star2.com: 16/05/17)

- NHS could save £67m a year if smoking rates are cut
  Cancer Research UK said the NHS would save some £67m a year if the UK can cut by half the number of people who smoke. The UK is projected to have a smoking rate of 10% by 2035, with a marked difference between the most deprived groups (15% of whom are expected to smoke) and the wealthiest (whose rate is expected to be just 2.5%). Cutting the rate to 5% nationally by 2035 would save millions in direct NHS and social care costs but also £548m in additional revenue (pharmatimes.com: 16/05/17)
16. Promoting health through the life course

16.1 Progress in the implementation of the 2030 Agenda for Sustainable Development

Document A70/35 (Report by the Secretariat):

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

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

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

3. For the purposes of the present report, the Secretariat drew on information provided in *World Health Statistics 2016*, which contains the results of a review by WHO of the status of over 30 health and health-related indicators, and the updated information provided in *World Health Statistics 2017*. In addition to the information on indicators, the 2017 publication provides a brief review of the purpose of, and activities undertaken for, each of the six lines of action proposed by the Secretariat. The available data show that, in spite of progress made during the Millennium Development Goal era, major challenges remain in terms of reducing maternal and child mortality, improving nutrition, and achieving further progress in the battle against infectious diseases such as HIV/AIDS, tuberculosis, malaria, neglected tropical diseases and hepatitis. The situation analysis also provides evidence of the importance of addressing noncommunicable diseases and their risk factors such as tobacco use, mental health problems, road traffic injuries and environmental health issues. Weak health systems remain an obstacle in many countries, resulting in deficiencies in coverage for even the most basic health services and inadequate preparedness for health emergencies. Based on the latest data, the specific situation for eight priority areas, often cutting across multiple Goals and targets, can be summarized as set out below.

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

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

Maternal and child health and nutrition

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

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

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

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

Infectious diseases

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

9. Globally, 2.1 million people were estimated to have become newly infected with HIV in 2015, representing a rate of 0.3 new infections per 1000 uninfected people. In the same year, an estimated 1.1 million people died of HIV-related illnesses. At the end of 2015, an estimated 36.7 million people were living with HIV. The African Region remains the most severely affected Region, with 4.4% of adults aged 15–49 years living with HIV. There is an increasing number of new HIV infections in the European Region.

10. In 2015, the malaria incidence rate was 94 per 1000 persons at risk, representing a a global decrease of 41% between 2000 and 2015, and 21% between 2010 and 2015. The decrease was the greatest in the European Region (100%), as the number of indigenous cases was reduced to zero in 2015. There were an estimated 212 million cases of malaria and 429 000 malaria deaths globally in 2015. The burden was heaviest in the African Region, where an estimated 92% of all malaria deaths occurred, and among children under 5 years of age, who accounted for 70% of all deaths.
11. Tuberculosis is a treatable and curable disease, but remains a major global health problem. In 2015, there were an estimated 10.4 million new tuberculosis cases globally. There were 1.4 million deaths from tuberculosis and an additional 0.4 million deaths resulting from tuberculosis among HIV-positive people. In 2015, the case fatality rate varied widely from under 5% in a few countries to more than 20% in most countries in the African Region, indicating large inequities in access to high-quality diagnosis and treatment services. The European Region carries the highest rates of drug-resistant tuberculosis (16% and 48% of new and previously treated cases), and over 20% of the global burden of multidrug-resistant tuberculosis.

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

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

Noncommunicable diseases, tobacco control, mental health and substance abuse

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

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

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

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

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

468 Includes deaths from acute hepatitis, liver cancer due to hepatitis, and cirrhosis due to hepatitis.
Injuries and violence

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

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

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

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

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

Sexual and reproductive health services

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

25. Globally, in 2016, 77% of women of reproductive age who were married or in a union had their need for family planning with a modern method met. However, while 9 out of 10 women in the Western Pacific Region had their family planning needs satisfied, the same could be said for only half of women in the African Region. The global adolescent birth rate in 2015 was 44.1 per 1000 women aged 15–19 years. The rate in low-income countries (97.3 per 1000 women aged 15–19 years) was five times higher than that in high-income countries (19.1 per 1000 women aged 15–19 years).

Universal health coverage and health systems

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

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

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

29. Health workers are distributed unevenly across the globe. Regions with the highest burden of disease have the lowest proportion of health workforce to deliver much needed health services. Available data from 2005–2015 show that around 40% of countries have less than one physician per 1000 population and almost half of all countries have less than three nursing and midwifery personnel per 1000 population. Even in countries with higher national health workforce densities, the workforce is inequitably distributed; rural and hard-to-reach areas tend to be understaffed as compared to capital cities and other areas.

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

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

Environmental risks
32. The Sustainable Development Goals include several targets relating to environmental sustainability and human health. These include targets under Goals 3 (ensure healthy lives and promote well-being for all at all ages), 6 (ensure access to water and sanitation for all), 7 (ensure access to affordable, reliable, sustainable and modern energy for all), 9 (build resilient infrastructure, promote sustainable industrialization and foster innovation), 11 (make cities inclusive, safe, resilient

and sustainable), 12 (ensure sustainable consumption and production patterns) and 13 (take urgent action to combat climate change and its impacts).

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

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

35. Worldwide in 2012, an estimated 871 000 deaths were caused by contamination of drinking-water, water bodies and soil, by inadequate hand-washing facilities, and by practices resulting from inappropriate or inadequate services. Almost half (45%) of these deaths occurred in the African Region. In 2015, 6.6 billion people used an improved drinking-water source, but the coverage of safely managed drinking-water services is low, with preliminary estimates at 68% in urban areas and only 20% in rural areas. About one third of the world's population (32%) did not have access to improved sanitation facilities in 2015, including the 946 million people practising open defecation.

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

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

II. PROGRESS MADE IN IMPLEMENTING RESOLUTION WHA69.11

38. Supporting comprehensive and integrated national plans for health as part of implementation of the 2030 Agenda. National health policies, strategies and plans help to define and implement priorities for health and development. According to WHO's 2017 report on WHO presence in countries, territories and areas, 60 WHO country offices have already engaged with governments, either directly or via United Nations country teams, in order to align national health policies, strategies and plans with the Sustainable Development Goals. A further 65 country offices were beginning to engage with national authorities and United Nations country teams. The remaining 23 country offices are expected to begin a dialogue with national authorities in the course of 2017. WHO has partnered with the European Union and the Grand Duchy of Luxembourg to develop national health policies, strategies and plans in more than 30 countries. These include Tunisia (population consultations); Chad, the Democratic Republic of the Congo and Timor-Leste (setting priorities for the health sector and for achieving healthy lives); and Guinea, Kyrgyzstan, the Lao People’s Democratic Republic, Liberia, Moldova, Mozambique, Sudan, Sierra Leone, Ukraine and Viet Nam (monitoring the implementation
of national health policies, strategies and plans). Over the past seven years, many European countries have aligned their national health policies with Health 2020: the European policy for health and well-being, which is aligned with the 2030 Agenda. WHO has developed a guide to developing national health policies, strategies and plans, entitled *Strategizing national health in the 21st century: a handbook.* 471

39. **Developing regional plans to implement the 2030 Agenda.** WHO’s regional offices have begun numerous activities to promote health in the context of the Sustainable Development Goals. Some examples, discussed by regional committees and in WHO publications, are provided below. The Regional Office for Africa has focused recently on health systems strengthening and universal health coverage.472 The Regional Office for the Americas is reinforcing the Health in All Policies approach, and in May 2016 launched an Equity Commission as a first and practical step to implement the 2030 Agenda. In 2016, the Regional Office for South-East Asia published a baseline analysis of the status of the health-related Sustainable Development Goals in all 11 Member States of the Region and in early 2017 it held a regional consultation on monitoring the health-related Goals, at which agreement was reached on four priorities: improved cause of death registration (through civil registration and vital statistics); improved equity monitoring; improved interoperability, especially of staff and working methods rather than technologies; and improved transparency and use of data. The Regional Office for Europe has carried out reviews of how national health policies address the Sustainable Development Goals and how health is placed in existing national development strategies. In addition to 31 country profiles, the Regional Office has drafted a road map for implementation of the 2030 Agenda (which is under review), is mapping financial protection across all countries, chairs the Issue-based Coalition on Health473 of the United Nations regional coordination mechanism, and is steering the European Environment and Health Process towards the implementation of the 2030 Agenda.474 The Regional Office for the Eastern Mediterranean has highlighted the importance of emergency care and of having a defined package of essential health services in working towards universal health coverage. Recognizing that each Member State will set its own priorities among the 169 agreed targets (including the health-related targets), the Regional action agenda on achieving the Sustainable Development Goals in the Western Pacific475 provides guidance, for example, on putting health equity in national planning, on working across sectors, on participation by affected communities, and on the role of the health sector in driving the 2030 Agenda. One task ahead for the Secretariat is to make wider use of these many initiatives by collaborating across Regions and countries, and by sharing information worldwide.

40. **Developing and finalizing the health-related Sustainable Development Goal indicators.** The Secretariat advises the Inter-Agency and Expert Group on Sustainable Development Goal Indicators (comprising representatives of 28 national statistical offices). Recent contributions include finalizing indicators for the health-related Sustainable Development Goals. In March 2017, modifications to some indicators were adopted by the United Nations Statistical Commission in response to some concerns from Member States. The revisions included a better definition of financial risk protection as

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475 WHO Regional Office for the Western Pacific. Regional action agenda on achieving the Sustainable Development Goals in the Western Pacific (2017).
part of universal health coverage. A more extensive review of indicators is expected in 2020. WHO has also published regional guidance on the use of standard indicators. 476

41. **Supporting Member States in strengthening national statistical capacity.** The Secretariat has reviewed data availability and quality for disaggregated statistics on the health and health related indicators 477 and for the indicators in the Global Strategy for Women’s, Children’s and Adolescents’ Health (2016–2030). 478 WHO is also leading the Health Data Collaborative, including 38 global and regional partners, to strengthen country health information systems.

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

43. **WHO’s role in providing health information as a public good.** In 2016, WHO published *Best practices for sharing information through data platforms: establishing the principles* 479 and a policy statement setting out principles and practice for the sharing of data and results during public health emergencies, based on the International Health Regulations (2005). 480 WHO and others also released guidelines for accurate and transparent health estimates reporting, 481 which encourage WHO, other United Nations organizations and independent researchers to share datasets and methods that are used to calculate estimates of disease burden and trends. In 2017, WHO will publish a policy on open access principles and practice applicable to all data held by the Organization. In 2016, WHO published an open access policy applicable to all WHO publications, with a focus on reducing the supply of print publications in favour of publishing digitally and on demand.

44. **Supporting the International Health Partnership for UHC 2030.** To achieve target 3.8 on universal health coverage, the International Health Partnership and related initiatives (IHP+) evolved in 2016 to become the International Health Partnership for UHC 2030, an alliance to strengthen health systems, whose partners include national governments, WHO and other United Nations organizations, other international agencies and civil society organizations. Further information on specific initiatives to achieve universal health coverage can be found in progress reports to the Seventieth World Health Assembly. 482

45. **Supporting national efforts to “leave no one behind”.** In respect of gender equality and equality in general, Secretariat support to Member States has contributed to Goals 3 (ensure healthy lives and promote well-being for all at all ages), 5 (achieve gender equality and empower all women and girls) and 10 (reduce inequality within and among countries), and to target 17.18 on data disaggregation. In terms of monitoring, WHO’s data portal to track progress towards universal health coverage, featuring

476 For example, see: WHO Regional Office for Europe. Core health indicators in the WHO European Region 2016. Special focus: 2030 Agenda for Sustainable Development (2016).
482 See document A70/38, sections A, C, F and K.
data from 194 Member States and launched in December 2016, includes information on equity.\textsuperscript{483} Data for 102 countries were available through WHO’s Health Equity Monitor as of February 2017. The Secretariat supports Member States in: using normative guidance and resources for health inequality monitoring; monitoring catastrophic and impoverishing health expenditures; monitoring intersectoral action relevant to reducing health inequities and gender gaps in health; using AccessMod, a tool for modelling physical accessibility to health care and geographic coverage;\textsuperscript{484} and conducting benefit incidence analysis on the extent to which different social and economic groups benefit from services. WHO also launched in 2016 a technical handbook entitled *The Innov8 approach for reviewing national health programmes to leave no one behind.*\textsuperscript{485} In addition, the 9th Global Conference on Health Promotion, jointly organized by WHO and the National Health and Family Planning Commission of the People’s Republic of China, which took place in Shanghai, China, in November 2016 on the 30\textsuperscript{th} anniversary of the Ottawa Charter for Health Promotion, reinforced the role of health promotion in improving health equity. Further information on gender and equity can be found in separate documents.\textsuperscript{486}

46. **Promoting a multisectoral approach to the 2030 Agenda.** Some of the many initiatives on cooperative action at the national, regional and global levels supported by WHO are described below. The Global Strategy for Women’s, Children’s and Adolescents’ Health (2016–2030) covers 11 Sustainable Development Goals – all of the targets in Goal 3, and specific targets across 10 others (Goals 1–7, 9, 10, 16 and 17).\textsuperscript{487} In recognition of the importance of energy in delivering safe, high quality health services, the United Nations Secretary-General created the Energy for Women’s and Children’s Health initiative and WHO, together with the United Nations Foundation and the United Nations Entity for Gender Equality and the Empowerment of Women (UN-Women), was asked to lead this effort as part of the Sustainable Energy for All movement, linked to Goal 7. The High-level Commission on Health Employment and Economic Growth contributes to Goal 8 (promote inclusive and sustainable economic growth, employment and decent work for all) by promoting the creation of jobs in health and social sectors and improved working conditions in the health sector, paying specific attention to the needs of low- and lower-middle income countries. In the control of neglected tropical diseases, pharmaceutical companies, the national governments of 74 countries and other partners supplied preventive chemotherapy to at least 979 million people in 2015 – perhaps the world’s largest ever public health intervention. To strengthen neglected tropical disease control in Africa, the Regional Office for Africa – together with a coalition of multinational organizations – has launched the Expanded Special Project for Elimination of Neglected Tropical Diseases, including onchocerciasis, lymphatic filariasis, schistosomiasis, soil-transmitted helminths and trachoma. In April 2016, the United Nations General Assembly proclaimed a United Nations Decade of Action on Nutrition, 2016–2025, calling on FAO and WHO to lead its implementation in collaboration with several other United Nations programmes and coordination mechanisms. At the request of Member States, the Regional Office for Europe convened the Ad Hoc Regional Platform for Working Together for Better Health and Well-being for All.\textsuperscript{488}

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

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\textsuperscript{483} See http://apps.who.int/gho/cabinet/uhc.jsp (accessed 21 April 2017).
\textsuperscript{484} See www.who.int/hehealth/resources/accessmod/en/ (accessed 21 April 2017).
\textsuperscript{486} See documents A70/24 and A70/38, section H.
\textsuperscript{487} See also document A70/37.
\end{footnotesize}
and Evaluation Framework and Joint External Evaluation Tool and national health planning processes. WHO, OIE and FAO are currently working together to prepare practical, national-level standard tools, guidance and joint One Health training to support countries in the implementation of multisectoral collaborative approaches. One example of the One Health approach is the intersectoral management of antimicrobial resistant pathogens, which is discussed in a separate document.  

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

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

50. Facilitating North–South, South–South and triangular regional and international cooperation on and access to health-related science, technology and innovation. To stimulate international cooperation on access to health science, technology and innovation, the United Nations Development Group has established a South–South and triangular (South–North–South) cooperation task team, including WHO, which will foster cooperation across United Nations system operations. The task team issued a report in 2016 on good practices in South–South and triangular cooperation for sustainable development. WHO, WIPO and WTO are also strengthening their cooperation and practical coordination on issues around public health, intellectual property and trade. The European Region is cultivating partnerships to share information and experiences through the Healthy Cities programme, the small countries initiative, and the South-eastern Europe Health Network.

489 See document A70/12.  
490 See document A70/21.  
492 See documents A70/10, A70/20 and A70/38, section I.  
51. **Maximizing the impact of WHO contributions to the 2030 Agenda, considering the programme budget and general programme of work.** The Proposed programme budget 2018–2019 takes advantage of new opportunities offered by the 2030 Agenda for Sustainable Development to propose ways of working that enhance collaboration across WHO’s categories of work. It is clear that the control of communicable diseases (category 1) and noncommunicable diseases (category 2) depends on promoting health through the life course (category 3, responding for example to questions concerning gender, equity, ageing, and social and environmental determinants) and on strengthening health systems (category 4, for example by aligning national health policies and plans with the Sustainable Development Goals). Enhancing collaboration in this way would allow WHO’s mode of operation to better reflect the needs and opportunities of the 2030 Agenda by working at the interface between two or more categories, promoting projects that have the potential to accelerate health gains in ways that cannot easily be achieved by working in separate categories. To empower WHO country offices, these projects would be explicitly aligned with the priorities defined in country cooperation strategies. In the course of 2017, these ideas will be carried through to initial drafts of the thirteenth general programme of work, which will begin in 2020. To aid WHO-wide coordination of this work, the Director-General established in January 2017 a Sustainable Development Goals network, linking headquarters, regional and country offices and the United Nations system through the Department of Country Cooperation and Collaboration with the United Nations System.

**ACTION BY THE HEALTH ASSEMBLY**

52. The Health Assembly is invited to note this report.
16.3 Global strategy for Women’s, Children’s and Adolescents’ Health (2016–2030): adolescents’ health

Document A70/37 (Report by the Secretariat):

1. In January 2017, the Executive Board at its 140th session noted an earlier version of this report. This updated version takes into account the discussions at that Board session, with revisions in particular to paragraphs 5–10, the section on the High-level Working Group on Health and Human Rights of Women, Children and Adolescents (paragraphs 13–15) and paragraphs 20–24.

2. The United Nations Secretary-General launched the Global Strategy for Women’s, Children’s and Adolescents’ Health (2016–2030) in September 2015 as a front-runner implementation platform for the Sustainable Development Goals. The shift from the health-related Millennium Development Goals to Sustainable Development Goals is reflected in the Global Strategy’s three objectives: survive, thrive and transform – to end preventable mortality, to promote health and well-being, and to expand enabling environments. The Global Strategy provides a road map for attaining these ambitious objectives with evidence-based action areas for the health sector, other sectors and community action. Its guiding principles include equity, universality, human rights, development effectiveness and sustainability.

3. In May 2016, the Health Assembly adopted resolution WHA69.2 on Committing to implementation of the Global Strategy for Women’s, Children’s and Adolescents’ Health, and invited Member States to commit, in accordance with their national plans and priorities, to implementing the Global Strategy and strengthen accountability and follow-up. It requested the Director-General to provide adequate technical support, continue to collaborate in order to advocate and leverage multistakeholder assistance for aligned and effective implementation of national plans, and report regularly on progress.

4. Pursuant to resolution WHA69.2 this report provides an update on the current status of women’s, children’s and adolescents’ health. It also includes updates in relation to resolution WHA61.16 (2008) on Female genital mutilation, resolution WHA58.31 (2005) on Working towards universal coverage of maternal, newborn and child health interventions, resolution WHA67.10 (2014) on the newborn health action plan, resolutions WHA67.15 (2014) and WHA69.5 (2016) on strengthening the health systems response to address interpersonal violence, in particular against women and girls and against children. It is aligned with the Secretariat’s report on the progress in the implementation of the 2030 Agenda for Sustainable Development (document A70/35). In its regular reporting on progress towards women’s, children’s and adolescents’ health the Secretariat will choose a particular theme each year, focusing on priorities identified by Member States and topics for which there is new evidence to support country-led plans. For reporting to the Seventieth World Health Assembly, the theme is adolescents’ health.

STATUS OF WOMEN’S, CHILDREN’S AND ADOLESCENTS’ HEALTH – MONITORING PROGRESS AND PROMOTING ACCOUNTABILITY

5. In 2016, WHO, working with partner agencies, conducted technical reviews and undertook a consultative process to elaborate an indicator and monitoring framework for the Global Strategy.498

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496 See document EB140/34 and the summary records of the Executive Board at its 140th session, fifteenth meeting and sixteenth meeting, section 1.
The overall framework has 60 indicators and aims to minimize the burden on countries of reporting to the global level by aligning them with 34 Sustainable Development Goal indicators. The additional 26 indicators are drawn from established global initiatives for reproductive, maternal, newborn, child and adolescent health. Together these 60 indicators provide sufficient depth and breadth for tracking progress on implementing the Global Strategy. Sixteen key indicators were selected as a minimum subset to provide a snapshot of progress towards the three objectives – survive, thrive and transform – of the Global Strategy. This section provides an update on those 16 key indicators. Reporting across the full set of 60 indicators, for all countries, is available from the newly-developed global strategy online portal at the Global Health Observatory. 499 These data will inform the Secretariat’s reports to the Health Assembly and support Member States in reviewing progress. In addition, a multistakeholder Global Strategy Progress Report on monitoring the implementation of the Global Strategy will be issued; its production will be coordinated by the Partnership for Maternal, Newborn and Child Health under the auspices of Every Woman Every Child in collaboration with WHO, the H6 Partnership, Countdown to 2030: Maternal, Newborn and Child Survival, the Health Data Collaborative and other partners.

6. An assessment of the latest available data in 2016 on the 16 key indicators for implementing the Global Strategy shows that, for the “survive” objective, in 2015: the estimated maternal mortality ratio globally was 216 per 100,000 live births; the under-5 mortality rate was 43 per 1000 live births; the neonatal mortality rate was 19 per 1000 live births; and the still-birth rate was 18.4 per 1000 total births. To date, 49 countries, territories or areas with the highest burden of newborn mortality have finalized their newborn plans or strengthened the relevant components within their health strategies. 500 Additionally, 14 countries are currently undertaking actions to strengthen newborn health in their national health strategies. 501 The joint WHO/UNFPA report Maternal Death Surveillance and Response summarizes progress in implementation: 86% of respondents to a questionnaire have adopted a policy on maternal deaths notification, yet only 46% of countries, territories and areas have a functional mechanism to systematically report, review, and respond to maternal deaths. 502 The establishment of a minimum perinatal data set in every country, territory and area is most important, in order to understand and deal with newborn health-related conditions and emerging health problems such as Zika virus disease. Although the adolescent mortality rate is a key indicator in the Global Strategy, there are currently few empirical data on that parameter for the many countries without robust civil registration and vital statistics or nationally-representative sample registration systems. The total number of adolescent deaths is estimated to have been 1.2 million in 2015.

7. With regard to the objective “thrive”, globally in 2015 an estimated 156 million young children (23% of all young children) were affected by stunting and the birth rate was 44.1 per 1000 women in

499 Available at: is http://apps.who.int/gho/data/node.gswcah; see also http://www.who.int/gho/en/ (accessed 17 March 2017).
501 Azerbaijan, Central African Republic, Chad, Guinea-Bissau, Iran (Islamic Republic of), Lesotho, Mozambique, Pakistan, Republic of Moldova, Sierra Leone, South Sudan, Syrian Arab Republic, Zambia, and Zimbabwe.
adolescent girls aged 15–19 years. With regard to coverage of essential health services, in 2016, 77% of women had their family planning needs met with modern contraceptive methods, 58% of pregnant women in the developing regions had at least four antenatal care visits, 39% of mothers exclusively breastfed for the recommended six months in low- and middle-income countries, and coverage with three doses of diphtheria-tetanus-pertussis vaccine was 86%. In 2016, 78% of women delivered with a skilled birth attendant. Care seeking for children under 5 years of age with suspected pneumonia was 58% in the period 2007–2014, and 49% of children under 5 years of age with diarrhoea received oral rehydration therapy in the same period. The average country out-of-pocket health expenditure as a share of total health spending in 2014 was 30%, ranging from 40% in low-income countries to 21% in high-income countries. In 2014, 57% of the global population were reliant primarily on clean fuels for cooking, and the remaining 43% were primarily using polluting fuels: biomass, kerosene and coal, which contribute significantly to poor health. Latest data show that, in 2016, 114 countries had laws and regulations that guarantee women aged 15–49 years access to sexual and reproductive health care, information and education.

8. On the objective “transform”, the proportion of children under 5 years of age whose births have been registered with a civil authority was 74% worldwide in 2014, but only 45% in least developed countries. It is estimated that 30% of ever-partnered women and girls aged 15 years and older have been subjected to physical and/or sexual violence by a current or former intimate partner in their lifetime; the proportion is 29% among 15–19 year olds. It is further estimated that around 120 million girls under the age of 20 years have been subjected to forced sexual intercourse or other forced sexual acts at some point in their lives. Tackling violence against women and girls has been identified as an important priority by Member States for improving the health of women, children and adolescents. In May 2016, the Health Assembly in resolution WHA69.5 endorsed the WHO global plan of action to strengthen the role of the health system within a multisectoral response to address interpersonal violence, in particular against women and girls and against children. In increasing numbers, Member States are strengthening their health systems’ response to violence against women by using the WHO clinical and policy guidelines for responding to intimate partner violence and sexual violence504 to develop or update national protocols and train health care workers in first-line support and clinical response, including mental health care for survivors. Currently about 100 countries have population-based data on prevalence of intimate partner violence. Similarly, recognizing that 200 million women and girls globally have undergone female genital mutilation,505 the Sustainable Development Goals include target 5.3: eliminate all harmful practices, such as child, early and forced marriage and female genital mutilation. This requires that Member States implement policies and programmes to address this issue, and that progress towards its achievement is monitored. The relevant indicator in the monitoring framework for tracking progress in this target (the proportion of women and girls aged 15–49 years who have undergone female genital mutilation/cutting, by age) is also included among the indicators for measuring progress in implementation of the Global Strategy for Women’s, Children’s and Adolescents’ Health (2016–2030).506 Overall, the practice of female genital mutilation has been declining over the past three decades. Availability of survey data from 30 Member States in Africa, Asia and the Middle East has resulted in improved global prevalence figures. Since 2014, two

503 The figures are the unweighted averages for 192 countries, territories and areas, with source data from WHO’s Global Health Expenditure Database (http://apps.who.int/nha/database, accessed 28 March 2017).
505 This figure for 2016 has increased since 2013 owing to population growth and the inclusion of data from an additional country. The reporting of absolute numbers of women and girls affected gives the impression of an increase in the practice, but the prevalence rates in many countries are reportedly decreasing.
additional countries (Indonesia and Iraq) have carried out surveys, and eight countries have carried out repeat surveys on female genital mutilation. Rapid declines in the practice among girls aged 15–19 have occurred across countries, with varying rates of prevalence of female genital mutilation, including Burkina Faso, Egypt, Kenya, Liberia and Togo.\(^\text{507}\) Since 2014, Gambia and Nigeria have adopted legislation, and in total 24 of the 30 high-prevalence countries now have legislation against female genital mutilation in place. Member States continue to carry out various activities to change the social norm towards abandonment at the community and national levels, including community declarations of abandonment, alternative rites of passage, youth-focused awareness raising, mass media and social media campaigns, and engagement of community and religious leaders. In response to evidence of increasing trends of medicalization of female genital mutilation in eight countries for which data are available, WHO actively works with partners in efforts to prevent health care providers from carrying out female genital mutilation. Activities include promoting and enforcing health policies to prevent such medicalization, implementing programmes to empower health care providers by building skills and knowledge, conducting research to understand the motivations of health care providers to perform female genital mutilation, and developing and testing health sector-based interventions towards the abandonment of medicalized female genital mutilation. In May 2016, the Secretariat in collaboration with the UNFPA–UNICEF Joint Programme on Female Genital Mutilation/Cutting issued the first evidence-based guidelines on the management of health complications from female genital mutilation.\(^\text{508}\) In the context of expanding enabling environments, the percentage of the global population using improved sanitation facilities was about 68% in 2015.

9. An assessment of the Global Strategy monitoring priorities in 2016 indicates that high-quality data are routinely collected at country level only for a few indicators.\(^\text{509}\) As noted in document A70/35 on progress in the implementation of the 2030 Agenda for Sustainable Development, this gap highlights the urgent need to invest in civil registration and vital statistics and country health information systems, to prioritize indicators and sharpen the focus, to harmonize country, regional and global monitoring efforts, and to galvanize the required political support in order to meaningfully track progress and drive action and accountability at all levels.

10. In resolutions WHA69.2 (2016) on Committing to the implementation of the Global Strategy and WHA69.11 (2016) on Health in the 2030 Agenda for Sustainable Development, Member States emphasized the importance of improving data and strengthening information systems. The Secretariat, with the Health Data Collaborative and other partners, will provide technical support and help to mobilize resources as appropriate. The Secretariat established an expert group, Maternal and Newborn Information for tracking Outcomes and Results (MONITOR) to harmonize maternal and newborn measurement efforts and provide guidance for improving data collection national capacities, based on evidence. The Partnership for Maternal, Newborn & Child Health will coordinate the multistakeholder Unified Accountability Framework and host the Every Woman, Every Child’s Independent Accountability Panel. The Panel’s report for 2016\(^\text{510}\) called for action in three main areas: leadership, resources, and institutional strengthening, particularly around human resources for health.


11. By March 2017, 60 governments at the Head of State or ministerial level had made commitments to implement the Global Strategy, through the Every Woman, Every Child movement, and there are more than 110 multistakeholder commitments to support country-led implementation.

12. There are established multistakeholder mechanisms to support country-led investment, implementation and monitoring. WHO and the other partners in the H6 Partnership provide technical support to countries preparing new strategies and/or Global Financing Facility investment cases for reproductive, maternal, newborn, child and adolescent health and provided capacity-building to health ministries particularly in the African Region. In order to support improvement in care, WHO published standards for improving the quality of maternal and newborn care in health facilities\(^{511}\) and developed a framework for improving the quality of maternal and newborn care.\(^{512}\) In February 2017 WHO together with the UNICEF, UNFPA and partners from all stakeholder groups launched the Network for Improving Quality of Care for Maternal, Newborn and Child Health to introduce evidence-based interventions to improve quality of care for maternal and newborn health supported by a learning system.\(^{513}\)

**HIGH-LEVEL WORKING GROUP ON HEALTH AND HUMAN RIGHTS OF WOMEN, CHILDREN AND ADOLESCENT HEALTH**

13. Health and the human rights of women, children and adolescents form the cornerstone of the global development agenda. Over the past 20 years, governments have taken steps towards implementing the commitments made in relation to these health and human rights. Although progress has been made, women, children and adolescents worldwide continue to face challenges in accessing essential, good-quality health services. They often face violence and discrimination, are unable to participate fully in society, and encounter other barriers to realizing their health and human rights, especially sexual and reproductive health and rights.\(^{514}\) As a result, they continue to experience tragically high rates of mortality and morbidity: in 2015 it was estimated that more than 300 000 maternal deaths, 2.6 million stillbirths, 5.9 million deaths in children under the age of 5 – including 2.7 million newborn deaths – and 1.2 million adolescent deaths occurred.\(^{515}\) About 250 million children younger than 5 years in low- and middle-income countries are at risk of suboptimal development and fail to reach their full potential due to poverty and.stunting alone.

14. This preventable mortality and morbidity has its roots, to a very great extent, in failure of governments to protect the human rights of their citizens. A powerful instance of this failure are the

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\(^{513}\) See http://www.who.int/maternal_child_adolescent/topics/quality-of-care/network/en/ and http://www.qualityofcarenetwork.org/about/network-activities (accessed 4 April 2017); countries that have initially joined are Bangladesh, Côte d’Ivoire, Ethiopia, Ghana, India, Malawi, Nigeria, Uganda, and United Republic of Tanzania.


15. In recent years, the health and human rights of women, children and adolescents have come under unprecedented attack in several countries owing to restrictive legal and policy considerations, conflict, violence and disaster, especially in the context of their sexual and reproductive health. The High-Level Working Group on the Health and Human Rights of Women, Children and Adolescents met (Geneva, 7 and 8 February 2017) to address challenges in implementation of health and human rights for these populations, and to underscore the urgency of promoting and protecting health and human rights in order to achieve the relevant targets set out in the Sustainable Development Goals and the Global Strategy for Women’s, Children’s and Adolescents’ Health. The Working Group emphasizes that we stand at a crossroads; how we address these inequalities and injustices will determine the extent to which peoples’ lives are improved everywhere but specifically the ability of societies to harness the dividends of the demographic transition and create a new paradigm of health, dignity and well-being for the next generation of women, children and adolescents. The Working Group cautioned that a failure to promote and protect the health and human rights of women, children and adolescents will translate into the inability to achieve the goals set in the 2030 Agenda for Sustainable Development. To address these issues and create a new model for the promotion and protection of health and human rights, the Working Group identified a set of key recommendations (Annex). The Working Group issued an urgent call to all actors to reaffirm their commitment to universal values of health, dignity and human rights for all and to champion the cause of women’s, children’s and adolescent’s health and rights through action, advocacy and activism. It called on the health and human rights communities to work together to support accelerated action for the health and human rights of women, children and adolescents.

SPECIAL THEME: ADOLESCENT HEALTH – THE NEW FRONTIER IN GLOBAL PUBLIC HEALTH

Global adolescent health is coming of age

16. In his call for action related to the Global Strategy for Women’s, Children’s and Adolescents’ Health, the United Nations Secretary-General said: “The updated Global Strategy includes adolescents because they are central to everything we want to achieve, and to the overall success of the 2030 Agenda.” This statement reflects the widespread realization that adolescents’ health merits greater attention.

17. There are sound public health reasons for this increased attention to adolescents. First, although it is true that the global mortality rate is not as high for adolescents as it is for infants and young children, it is neither negligible nor declining as rapidly as in under-5 year olds. Between 2000 and 2012, the global under-5 mortality rate declined by 38%, whereas the adolescent mortality rate declined by only 12%. In the same period, the rate of disability-adjusted life years lost per 100 000 adolescents decreased by only 8%, less than half the 17% decline for all age groups combined, and the rate for unipolar depression, the top cause of disability-adjusted life years lost in adolescents in 2012, increased by 1% over this period. Furthermore, the frequency of health-related behaviours that begin or are consolidated during adolescence, such as unprotected sex (compounded by a lack of access to contraception), tobacco use, eating poor diets, alcohol use, physical inactivity and drug use, which have their impact later in life, has declined very little or has even increased.

18. Furthermore, there have never been more compelling economic reasons to invest in adolescent health. Broadening opportunities to develop skills and use them productively will ensure that adolescents become a valuable resource and not an economic burden or threat to social harmony. Sound investment in adolescent health in low-income countries will provide the “demographic dividend” to energize their economies and lift their standards of living.

19. The Global Strategy highlights the health and social challenges that adolescents face and lists evidence-informed health and social interventions needed to address them at different levels and by different sectors for these interventions to be effectively and equitably delivered. Finally, it provides high-level advice on what is needed at national and international levels to translate these ideas into action.

Many Member States are expanding their investment in adolescent health

20. The Sustainable Development Goals and the Global Strategy for Women’s, Children’s and Adolescents’ Health, with its linked Global Financing Facility, provide a strong platform for accelerated action on adolescent health. Member States are already starting to use these opportunities and are including adolescent health in their plans and programmes. For example, by February 2017, Cameroon, Liberia and Uganda had already included adolescent health within their investment cases for the Global Financing Facility, and several other countries were working to do so.

21. Increasingly, countries have stepped up their commitments to adolescent health. A tangible example is the introduction or expansion of national multisectoral programmes to end child marriage. The African Union and the South Asian Association for Regional Cooperation have launched high-profile initiatives to end child marriage in their member countries, 14 of which have developed comprehensive national strategies to reduce the health and social consequences of this practice. Another example is that a growing number of low- and middle-income countries such as Argentina, India and South Africa have updated and considerably increased the human and financial resources allocated to their national adolescent health programmes. By March 2017, 60 countries had made formal commitments to the Global Strategy, of which 35 included specific commitments related to adolescent health.

Secretariat’s contributions to providing support to Member States

22. In response to a request from Member States at the Sixty-eighth World Health Assembly in May 2015, the Secretariat, in collaboration with WHO’s other partners in the H6 Partnership, UNESCO and an External Advisory Group, is finalizing guidance on implementing global accelerated action for the health of adolescents (AA-HAI). The guidance document aims to support countries on how to plan, implement and monitor a response to the health needs of adolescents in national plans with the objectives of survive, thrive and transform, in line with the Global Strategy. It has drawn on inputs received during extensive consultations with Member States, bodies in the United Nations system, adolescents and young people, civil society and other partners. The final version will be made available by the time of the Seventieth World Health Assembly. Several Member States have expressed interest in using this document as the basis for developing or updating national adolescent health strategies and programmes, and the Secretariat has been working with early adopter countries to support their application of the guidance.

23. WHO’s efforts to advance adolescent health are also embedded in other United Nations-wide and other partners’ initiatives. To enhance the coherence and coordination of United Nations bodies’ activities on youth, the first United Nations System-wide Action Plan on Youth was developed, with

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517 See the summary records of the Sixty-eighth World Health Assembly, Committee A, tenth meeting and eleventh meeting, section 3 (document WHA68/2015/REC/3).
health as one of five key areas of focus. In 2016 a survey was carried out across the United Nations system to take stock of recent and ongoing initiatives, including joint activities, on youth. Data collected through the survey are being used in the preparation of a comprehensive global report on the United Nations’ work on youth. This report will contribute to strengthening United Nations-supported programming and will bolster inter-agency collaboration in the area of youth.

24. WHO is collaborating on related initiatives with UNICEF (for example, the Adolescent Country Tracker), UNFPA and the United Nations Secretary-General’s Envoy on Youth (for example, the development of the Sustainable Development Goals Global Youth Index and technical guidance for prioritizing adolescent health\(^\text{519}\)), and the Committee on the Rights of the Child.\(^\text{520}\) It will support the Young Voices Count initiative, in which adolescents and young people themselves will monitor and help to shape progress towards their health and the attainment of the Sustainable Development Goals. To support adolescents and youth in becoming effective advocates for their health and well-being, the Adolescent and Youth Constituency of the Partnership for Maternal, Newborn and Child Health is developing a practical advocacy and accountability toolkit for young people on how to advance adolescent health and well-being at country level.

FUTURE DEVELOPMENTS

25. The importance of early childhood development as a foundation for life-long health, educational attainment, economic productivity, social cohesion and peace is increasingly documented and understood. The Global Strategy provides a unique opportunity to catalyse investment in that area. The health sector has a special responsibility to play as it has the capacity to reach carers and families during the earliest years of a child’s life, deliver essential interventions and serve as a platform for multisectoral collaborations that promote and support early childhood development. To explore the full remit of what can and needs to be done, it is proposed that the Secretariat’s report on implementation of the Global Strategy to a future session of the Health Assembly feature early childhood development.

ACTION BY THE HEALTH ASSEMBLY

26. The Health Assembly is invited to note the report.

ANNEX

RECOMMENDATIONS OF THE HIGH-LEVEL WORKING GROUP ON HEALTH AND HUMAN RIGHTS

(The Annex is not included here - see http://apps.who.int/gb/ebwha/pdf_files/WHA70/A70_37-en.pdf for the full document)


Promoting health through the life course
The World Health Minute is a one-stop public health news intelligence source reporting on what the global press is saying about each of the WHA agenda issues. Here is a sample of articles printed on 17 May for issues related to promoting health through the life course. For more information see www.worldhealthminute.com.

**World Health Minute – extract from May 17 2017 issue**

- **Borealis and Borouge help provide safe water for over 50,000 thanks to PE pipes**
  Borealis, Borouge, the OPEC Fund for International Development and DFID have funded a Nairobi project that has brought safe and affordable drinking water to more than 50,000 of Kenya's poorest residents. The Nairobi City Water and Sewerage Company found it hard to invest in services here due to the haphazard nature of the settlements and perception residents would not pay. So residents without piped water bought water from private street vendors at much higher prices. The partners extended the existing network into the settlements using high-quality pipes, allowing pre-paid water dispensers to be installed which now provide water for as low as a 10th of the price it would be from a street vendor [britishplastics.co.uk: 15/05/17]

- **Tobacco sale is banned near health centres in Rajasthan**
  Rajasthan banned the sale of tobacco products, such as cigarettes and gutka, within 100 yards of all health centres on Monday. Issuing the order, the health department asked all health facilities, including private ones, to put up signage saying ‘Tobacco Free Health Care Facility,’ thus the state became the first to comply with a 2003 law on tobacco restrictions that has not been properly implemented [hindustantimes.com: 15/05/17]

- **New analysis reveals deadly scale of diesel emissions**
  Illegal and unregulated diesel emissions are causing tens of thousands of unnecessary deaths worldwide, a new analysis says. The meta-analysis examined data from 30 studies and found excess nitrogen oxide was linked to 107,626 premature deaths around the world in 2015. Researchers warned the number of people dying due to diesel emissions could grow to 180,000 in 2040 if governments don't act [dw.com: 15/05/17] (theguardian.com: 15/05/17) [phys.org: 15/05/17]

- **Child sex crimes remain taboo as cases surge in conservative India**
  Sexual violence against children remains a taboo subject in India, despite reports of children being raped, molested and trafficked for sex surging by almost 70% in the latest data, activists and government officials said. There were 14,913 reported sex crimes committed against children in 2015, against 8,904 the previous year. In India’s socially conservative society it remains ignored within families and communities, where victims are afraid to come forward for fear of being blamed for the abuse [trust.org: 15/05/17]

- **Shocking stats show one in five South African women experience domestic violence**
  A new Stats SA study indicates that one in five women report experiencing violence at the hands of a partner. Some 21% of women over 18 reported domestic violence. Eight percent of women reported experiencing violence in the previous 12 month period. A further six percent reported experiencing sexual violence by a partner, with the poorest women being most at risk [timeslive.co.za: 15/05/17] (dailymaverick.co.za: 15/05/17)

- **Pregnancy problems are a leading global killer of females aged 15 to 19**
  The World Health Organization said that more than 1.2m girls and boys die annually, mostly from preventable causes. Pregnancy complications are the leading cause of death globally among females aged 15-19, with self-harm in second place, a global study has found. The main causes are mental health issues, poor nutrition, reproductive health problems and violence. Failure to address the health of 10-19 year olds undermines the improvements achieved in maternal and child health worldwide [guardian 16/05/17]

- **How a Tsunami in Japan endangered children in Cambodia**
  Cambodia has long struggled with iodine deficiency in its soil and crops. In 1999, with help from donors Cambodia began iodizing table salt. From 2000-2011 iodized salt use rose to 70% from 13% of households, according to a 2015 study. In 2010 UNICEF and donors turned responsibility for iodination over to the government and salt producers. Enforcement grew lax and spraying machines went unrepaired. Then after the 2011 tsunami in Japan, the global price of iodine tripled as the catastrophe damaged wells and slashed supply. UNICEF is now urging the government to enforce its own laws. In 1997 almost a fifth of all Cambodians had goiters, which can cause other preventable diseases [nytimes.com: 15/05/17]
17. **Progress reports**

**Noncommunicable diseases**

A. WHO global disability action plan 2014–2021: better health for all people with disability (resolution WHA67.7 (2014))


**Communicable diseases**

D. Eradication of dracunculiasis (resolution WHA64.16 (2011))

E. Global strategy and targets for tuberculosis prevention, care and control after 2015 (resolution WHA67.1 (2014))

F. Global technical strategy and targets for malaria 2016–2030 (resolution WHA68.2 (2015))

**Promoting health through the life course**

G. Public health impacts of exposure to mercury and mercury compounds: the role of WHO and ministries of public health in the implementation of the Minamata Convention (resolution WHA67.11 (2014))

H. Strategy for integrating gender analysis and actions into the work of WHO (resolution WHA60.25 (2007))

**Health systems**

I. Progress in the rational use of medicines (resolution WHA60.16 (2007))

J. Regulatory system strengthening for medical products (resolution WHA67.20 (2014))

K. Strengthening emergency and essential surgical care and anaesthesia as a component of universal health coverage (resolution WHA68.15 (2015))

**Preparedness, surveillance and response**

L. Smallpox eradication: destruction of variola virus stocks (resolution WHA60.1 (2007))

M. Enhancement of laboratory biosafety (resolution WHA58.29 (2005))

4. **Post of Director-General**

The World Health Minute is a one-stop public health news intelligence source reporting on what the global press is saying about each of the WHA agenda issues. Here is a sample of articles printed on 17 May for issues related to the election for the new Director-General. For more information see www.worldhealthminute.com.

**World Health Minute – extract from May 17 2017 issue**

- **WHO’s the boss? Inside the race to elect a new head of the World Health Organization**
  UN Dispatch reports on the race to become the next Director General of WHO; it reviews the three main candidates' backgrounds and the challenges any new leader will face on taking office ([undispatch.com: 15/05/17](https://undispatch.com))

- **An end to pandemics is within reach, but we must redouble our efforts now**
  Daniel Schar, senior regional infectious diseases advisor for USAID’s regional mission in Bangkok, writes a personal opinion article for Stat News in which he makes a strong case for the newly elected Director General of WHO making ‘ending the era of pandemic diseases’ one of their top priorities ([statnews.com: 15/05/17](https://statnews.com))

- **The World Health Assembly in times of Ebola and the election of a new DG**
  The News Minute discusses the forthcoming World Health Assembly, the outbreak of Ebola coming just as they are about to meet and the election for the new Director General to lead WHO. It discusses how the world approached the Ebola crisis last time around and the lessons learnt and Dr David Nabarro’s involvement in helping to find a solution to the Ebola crisis ([thenewsminute.com: 16/05/17](https://thenewsminute.com))

- **Q&A: Former MSF president on the WHO leadership**
  International Business Times talks to Dr David Nabarro about the last Ebola crisis, canvassing his view on what occurred last time and how lessons learnt then can be put to good use now. He also discusses the threat of antimicrobial resistance, the risk to health systems posed by the startling rise in non-communicable diseases across the world and the balance of donor funding and the outcomes it buys inside WHO ([ibtimes.co.uk: 16/05/17](https://ibtimes.co.uk))

- **I am confident because of my transparency stance**
  The Gulf Times talks to Dr Sania Nishtar about her campaign to become the new head of the World Health Organization ([gulf-times.com: 15/05/17](https://gulf-times.com))

- **Bureaucratic, weak and ineffective: How can we reform the World Health Organization**
  Lawrence Gostin, O’Neill Chair in Global Health Law and Director, WHO Collaborating Center on National and Global Health Law, talks to International Business Times about the World Health Organization, describing it as bureaucratic, weak and ineffective. Gostin lines up the challenges that a new Director-General of WHO is facing and is optimistically suggesting this is a good opportunity to bring about the reform the organization needs ([ibtimes.co.uk: 16/05/17](https://ibtimes.co.uk))

- **Ethiopia – Who is for WHO?**
  Dr Tedros Adhanom’s candidacy to become Director-General of WHO is challenged by Ethiopian opponents of the ruling regime. The author makes a case arguing that Tedros is unsuited to such an important role and makes allegations about his past ([nazret.com: 14/05/17](https://nazret.com))

- **As WHO Director-General election nears, Ethiopia’s candidate is accused of cholera cover-ups**
  The recent story in the New York Times which questioned Tedros Adhanom’s record as health minister in Ethiopia accusing him of covering up cholera is provoking sharp reactions. **Journalist Barry Malone**, now an online editor for Al Jazeera, says he was working for Reuters at the time in 2009 and obtained Minutes of an NGO/UN meeting at which a cholera outbreak was acknowledged. Malone goes on to say UN officials pressured him not to run this story at the time. Malone added ‘at the time UN officials regularly complained in private that a lack of acknowledgement from the government was stopping them getting more aid in’ ([globalvoices.org: 16/05/17](https://globalvoices.org))
## ANNEX 1. STRUCTURE OF WHO

### Six Regional Offices:

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<thead>
<tr>
<th>Regional Office for South-East Asia (SEARO):</th>
<th>Bangladesh</th>
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| Western Pacific Region                     |                       |       |       |

**African Region** | **South-East Asia Region** | **Eastern Mediterranean Region** | **European Region** | **Region of the Americas** | **Western Pacific Region**
| Regional Office for the Western Pacific (WPRO):  
| P O Box 2932  
| 1000 Manila  
| Philippines  
| Tel: +63 2 528 8001  
| Fax: +63 2 521 1036 or 526 0279  
| Email: wpropio@who.int | American Samoa  
| American Samoa  
| Australia  
| Brunei Darussalam  
| Cambodia  
| China  
| Cook Islands  
| Fiji  
| French Polynesia  
| Guam  
| Hong Kong SAR  
| Japan  
| Kiribati  
| Lao People's Democratic Republic | Macao  
| Macao SAR  
| Malaysia  
| Marshall Islands  
| Micronesia (Federated States of)  
| Mongolia  
| Nauru  
| New Caledonia  
| New Zealand  
| Niue  
| Northern Mariana Islands (Commonwealth of the) | Palau  
| Palau  
| Papua New Guinea  
| Philippines  
| Pitcairn Islands  
| Republic of Korea  
| Samoa  
| Singapore  
| Solomon Islands  
| Tokelau  
| Tonga  
| Tuvalu  
| Vanuatu  
| Viet Nam  
| Wallis and Futuna |
| Regional Office for Europe (EURO):  
| UN City  
| Marmorvej 51  
| DK-2100 Copenhagen 0  
| Denmark  
| Tel: +45 45 33 7000  
| Fax: +45 45 33 7001 | Albania  
| Andorra  
| Armenia  
| Austria  
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| Switzerland  
| Tajikistan  
| The former Yugoslav Republic of Macedonia  
| Turkey  
| Turkmenistan  
| Ukraine  
| United Kingdom of Great Britain and Ireland  
| Uzbekistan |
| Regional Office for the Eastern Mediterranean (EMRO):  
| Monazamet El Seha El Alamia Street  
| Extension of Abdul Razzak Al Sanhouri Street  
| P O Box 7608, Nasr City, Cairo 11371, Egypt  
| Tel: +202 2276 50 00  
| Fax: +202 23492092/23492075 | Afghanistan  
| Bahrain  
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ANNEX 2: INFORMATION OFFICERS

Communications contacts in WHO Headquarters (Geneva)

Gregory Hartl
Telephone: +41 22 791 4458
Mobile: +41 79 203 6715
E-mail: hartlg@who.int

Fadéla Chaib
Telephone: +41 22 791 3228
Mobile: +41 79 475 5556
E-mail: chaibf@who.int

Christian Lindmeier
Telephone: +41 22 791 1948
Mobile: +41 79 500 6552
E-mail: lindmeierch@who.int

Tarik Jasarevic
Telephone: +41 22 791 5099
Mobile: +41 79 367 6214
E-mail: jasarevict@who.int

Officer on duty
Mobile: +41 79 501 1346

Please use listed contact information. If an officer cannot be reached and the matter is urgent, contact:
Telephone: +41 22 791 2222
E-mail: mediainquiries@who.int

For TV and radio interviews

Chris Black
Telephone: +41 22 791 1460
E-mail: blackc@who.int

Communications officers in the WHO regions

WHO Regional Office for South-East Asia
New Delhi, India
Shamila Sharma
Communication Officer
Telephone: (91-11) 23370804, extension: 26575
Mobile: (91) 9818287256
Email: sharmasha@who.int

WHO Regional Office for the Western Pacific
Manila, Philippines
Eloi Yao
Public Information Officer
Telephone: + 63 2 528 9992
Email: yaoe@wpro.who.int

WHO Regional Office for Africa
Brazzaville, Republic of Congo
Collins Boakye-Agyemang
Telephone: +47 24 13 94 20
Email: boakyc@afro.who.int
WHO Regional Office for the Eastern Mediterranean
Cairo, Egypt

Rana Sidani
Senior Communication Officer
Media & Communication Unit
Telephone: +20 2 22 76 55 52
Mobile: +20 10 99 75 65 06
E-mail: sidanir@who.int

Mona Yassin
Telephone: +20 2 22 76 50 20
Mobile: +20 10 06 01 92 84
Email: yassinm@who.int

WHO Regional Office for Europe
Copenhagen, Denmark

Liuba Negru
Media Relations Officer
Telephone: +45 45 33 67 89
Mobile: +45 20 45 92 74
E-mail: lne@euro.who.int

Cristiana Salvi
Communications Officer
Health emergencies & communicable diseases
Telephone: +45 45 33 68 37
Email: cs@euro.who.int

Tina Kiaer
Communications Officer
Noncommunicable diseases and life-course
Tel.: +45 45 33 67 40
Email: tki@euro.who.int

WHO Regional Office for the Americas
Washington D.C., USA

Leticia Linn
Telephone: +1 20 29 74 34 40
Mobile: +1 20 27 01 40 05
Email: mediateam@paho.org

Sebastian Oliel
Telephone: +1 202 974 3459
Mobile: +1 202 316 5679
Email: mediateam@paho.org

Daniel Epstein
Telephone: +1 202 974 3579
Email: mediateam@paho.org

To sign up for news and press releases, send an email to PRS@euro.who.int