Governing Body matters:

Key issues arising out of the Seventieth World Health Assembly and the 140th and 141st Sessions of the WHO Executive Board

The attached working paper highlights, from the perspective of the WHO South-East Asia Region, the most important and relevant resolutions endorsed by the Seventieth World Health Assembly (held on 22–31 May 2017) and the 140th and 141st Sessions of the WHO Executive Board (held on 23 January–1 February 2017 and 1–2 June 2017, respectively). These resolutions are deemed to have important implications for the South-East Asia Region and merit follow-up action by both Member States as well as WHO at the regional and country levels.

The background of the selected resolutions, their implications on collaborative activities with Member States, as applicable, along with actions proposed for Member States and WHO have been summarized. All the related resolutions/decisions of the Seventieth World Health Assembly and the Regional One Voice (ROV) on Agenda items presented at the World Health Assembly are provided in the annex to this working paper.

The High-Level Preparatory Meeting held in New Delhi from 10 to 13 July 2017 reviewed the attached working paper and this is now submitted to the Seventieth Session of the WHO Regional Committee for South-East Asia for its consideration.
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Annexure

Resolutions and Decisions of the Seventieth World Health Assembly, the 140th and 141st Sessions of the WHO Executive Board, and the Regional One Voice (ROV) on Agenda items presented at the Seventieth World Health Assembly.
Introduction

1. The Seventieth World Health Assembly and the 140th and 141st Sessions of the WHO Executive Board endorsed a number of resolutions and decisions during the course of their deliberations. These decisions and resolutions relate to health matters as well as Programme Budget and financial matters.

2. The summaries of resolutions and decisions on technical matters that have significant implications for the South-East Asia Region are presented in this paper. Salient information on the implications of these, and actions already taken and to be taken, is also included herein.

3. Also annexed to this paper are copies of all the resolutions and decisions of the Seventieth World Health Assembly (which also cover the subjects of technical resolutions adopted by the 140th and 141st Sessions of the Executive Board) along with the text of the “Regional One Voice” presented in the World Health Assembly by the Delegation of the Member States of the South-East Asia Region on select Agenda items.
1. **Programme Budget 2018–2019 (WHA70.5)**

**Background**

4. As has been the practice in previous years, the Seventieth World Health Assembly passed the Resolution on Programme Budget 2018–2019 to approve the budget for 2018–2019 and also to authorize the Director-General on the implementation of the Programme Budget.

5. The resolution appreciates the work being conducted to identify efficiencies in the area of management and administration.

6. It also identifies the increase in the volume of tasks assigned by the WHO Governing Bodies.

7. It accords approval to the Programme Budget for 2018–2019 as outlined in the Programme Budget document (WHA A70/7).

8. It authorizes the Director-General to make budget transfers among six categories up to an amount not exceeding 5% of the allocated budget to the category from which the transfer is made.

9. It authorizes the Director-General to fund the Programme Budget with a mix of assessed contributions (AC) and voluntary contributions (VC), i.e., the Programme Budget does not differentiate between AC and VC for its funding.

10. Although a 3% increase in assessed contributions would be relatively small in relation to the overall Programme Budget, its adoption is an acknowledgement of the need for an increase in AC – the first increase since the biennium 2006–2007.

11. The resolution also resolves that the budget will be financed by net assessments on Member States adjusted for estimated non-assessed income of the Member State, for a total of US$ 956.9 million, and from voluntary contributions, for a total of US$ 3 464.6 million.

12. Category E – the WHO Health Emergencies Programme – forms part of the Base Budget. No budget has been proposed for the Outbreak Crisis and Response which will be event-driven.

**Main operative paragraph and implications on collaborative activities with Member States**

13. The World Health Assembly vide its resolution WHA70.5 approved the budget for the financial period 2018–2019, under all sources of funds, namely, assessed and voluntary contributions for a total of US$ 4 421.5 million, of which US$ 3 400.3 is for the Base Programme. Major highlights are as appended:
### Categories

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<td>1–Communicable diseases</td>
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<td><strong>4 340.4</strong></td>
<td><strong>4 421.5</strong></td>
<td><strong>81.1</strong></td>
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* Showing the budget increase for the WHO Health Emergencies Programme approved in Decision WHA69(9) (2016).

14. Outbreak and crisis response and scalable operations is subject to the event-driven nature of the activities concerned, and as such, does not have a budget requirement.

15. Major office overall “budget envelope” was maintained at the 2016–2017 level with increases due to the WHO Health Emergencies Programme and the programme on antimicrobial resistance.

16. The distribution of the Programme Budget for the South-East Asia Region sets out a US$ 344.3 million budget space for the Region, with a country office-level budget space of US$ 230.0 million, and a Regional Office-level budget space of US$ 114.3 million. Of the US$ 344.3 million, US$ 288.8 million is base and US$ 55.5 million is for polio.

17. When compared to the Programme Budget 2016–2017, the budget for Category 1, 2 and E get an increase of US$ 4.2, 2.7 and 5.9 million respectively. But the budget for Categories 3, 4 and 6 has been decreased by US$ 5.5, US$ 3.4 and US$ 1.9 million, respectively, and polio by US$ 21.5 million.

18. The budget planning for the Region has been done through a bottom-up consultative process and thus the shifts in budget requirements in the programme areas as well as across Categories clearly denote a shift in focus in terms of technical collaboration as well as an attempt to clearly align the funds with the Regional Flagships and the global technical agenda.

### Actions already taken in the Region

19. All countries in the Region have identified priorities.

20. The Regional Director has identified eight Flagship Priorities and the key deliverables are being strictly monitored.
21. Operational planning has been started ahead of the global schedule and the HR plans are under finalization, and the draft activity plans will undergo a peer review prior to finalization.

22. The increase in budget for antimicrobial resistance will assist in the further progress of the Region’s efforts.

23. SDG roadmaps are being developed.

24. National health monitoring frameworks have been incorporated.

**Actions to be taken in the Region**

25. In terms of Operational Planning:
   i) Distribution of budgets to the Budget Centres by Category/ Programme Area – in line with the discussions during the various phases of the Operational Planning process.
   ii) Finalization of activity workplans through the peer review, all efforts will be made to keep the Top Tasks/ lower tasks measurable – as has been done for the 2016–2017 workplan. This will help in focused technical and financial monitoring during the biennium.

26. In terms of financing of the budget in the Region:
   i) First round of financing of the workplans is expected by mid-November 2017 to facilitate the early implementation of the Programme Budget 2018–2019.
2. Improving the prevention, diagnosis and clinical management of sepsis (WHA70.7)

Background

27. Sepsis causes approximately 6 million deaths worldwide every year, most of which are preventable. In the early stages it is highly amenable to treatment through early diagnosis and timely and appropriate clinical management.

28. The infections which may lead to sepsis can often be prevented through appropriate hand hygiene, access to vaccination programmes, improved sanitation and water quality and availability, and other infection prevention and control best practices.

29. Sepsis also represents the most vital indication for the responsible use of effective antimicrobials for human health. In the absence of appropriate and timely clinical management, including effective antimicrobials, sepsis would be almost universally fatal. Ineffective or incomplete antimicrobial therapy for infections, including sepsis, may be a major contributor to the increasing threat of antimicrobial resistance.

Collaborative activities

30. This resolution urges Member States to include prevention, diagnosis and treatment of sepsis in national health systems strengthening in the community and in health-care settings. It also reinforces existing strategies or develops new ones leading to the strengthening of all aspects of infection prevention and control programmes. Member States have to continue their efforts to reduce antimicrobial resistance and promote the appropriate use of antimicrobials in accordance with the Global Action Plan on Antimicrobial Resistance.

31. Member States also need to develop and implement standard and optimal care and strengthen medical countermeasures for diagnosing and managing sepsis in health emergencies. There is also a need to increase public awareness of the risk of progression to sepsis from infectious diseases, including by extending support for existing activities held every year on 13 September\(^1\) in many countries. Training programmes are also necessary for all health professionals. There is also a need to promote research aimed at innovative means of diagnosing and treating sepsis.

32. In this regard, the WHO Director-General needs to develop specific WHO guidance, including guidelines on sepsis prevention and management, and to draw attention to the public health impact of sepsis. WHO will support, as appropriate, steps to define standards and establish the necessary guidelines, infrastructure, laboratory capacity, strategies and tools for reducing the incidence of, mortality from and long-term complications of sepsis. WHO will 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 for sepsis, and infection prevention and control, including

immunization, particularly in developing countries, while taking into account relevant existing initiatives.

**Actions already taken in the Region**

33. The Regional Office has supported Member States in finalizing their National Action Plans on Antimicrobial Resistance. Two high-level ministerial meetings on antimicrobial resistance involving the Region’s Member States were held in 2016, wherein a roadmap for the creation of national action plans was developed and which allowed Member States the opportunity to troubleshoot in the process of development of their national action plans.

34. As of May 2017, as many as 10 SEA Region Member States have finalized their NAPs; however, of these many have had their NAP solely endorsed by the Ministry of Health.

35. During the Technical Briefing for Member States on subjects to be discussed at the Seventieth World Health Assembly, the 141st Session on the Executive Board and the 26th Meeting of the PBAC, the topic of sepsis was discussed, and Indonesia was assigned to prepare and deliver the Region’s One Voice during Seventieth World Health Assembly.

**Actions to be taken in the Region**

36. The Regional Office will coordinate with WHO headquarters on the WHO guidelines on sepsis prevention and management. The Regional Office will 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. WHO will also collaborate with other organizations in the United Nations System, partners, international organizations and other relevant stakeholders on activities for improving the prevention, diagnosis and clinical management of sepsis.
3. Poliomyelitis: polio transition planning (WHA70(9))

Background

37. Over its three decades of operation, the Global Polio Eradication Initiative (GPEI) has built significant infrastructure to support polio eradication activities in countries across the world. This infrastructure has been increasingly supporting other public health priorities, notably disease surveillance and health systems strengthening and emergency and outbreak response. As the world comes closer to achieving polio eradication, the Global Polio Eradication Initiative will begin to wind down its operations, and will ultimately stop operating in the post-eradication era.

38. There are financial, programmatic and human-resource related risks associated with the winding down and eventual cessation of activities of the GPEI.

Main operative paragraph and implications on collaborative activities with Member States

39. The Seventieth World Health Assembly acknowledged that the ramping down of GPEI has started and highlighted the need to manage the resulting impact on WHO human resources and assets.

40. The Decision WHA70(9) urged the Director-General to make polio transition a key priority for the Organization at all three levels. The overarching principles of transition planning should be to respond to country needs and priorities and ensure participation and support of the national governments in transition planning. The elements of transition planning should include mainstreaming best practices from polio eradication into all relevant health interventions and building capacity and responsibility of national programmes for polio eradication. Innovative ways for mobilizing additional funding for the period 2017–2019 in order to mitigate the possible impact of the winding down of GPEI and for long-term sustainability of key assets that are currently financed by GPEI were emphasized.

41. The Health Assembly requested WHO to develop a strategic action plan on polio transition by end-2017, for the consideration of the Seventy-first World Health Assembly, that includes efforts to mobilize funding for transitioning capacities and assets that are currently financed by GPEI.

Actions already taken in the Region

42. Fully mindful of the risks associated with the winding down of GPEI, the transition planning process has been initiated in all five countries of the region with significant polio assets, namely Bangladesh, India, Indonesia, Myanmar and Nepal.

43. The transition planning has progressed considerably in India. An incremental increase in funding support for the polio network from the domestic budget of the country, over the next few years, is being worked out to maintain essential polio functions, while expanding the scope of operations to other public health priorities.
44. Similar plans are being worked out in Bangladesh, Indonesia, Myanmar and Nepal. Alternative donors are being explored to support funding in these countries.

**Actions to be taken in the Region**

45. Finalization of country-specific plans for the transition of the polio programme’s human resources and other assets in all five countries by applying three principles: (i) identifying the programmatic needs and priorities in consultation with national governments and partners; (ii) outlining the mechanisms to transfer capacities to the government to the extent possible; and (iii) increased engagement in and ownership of the transition process by the national governments resulting in increased funding by the national governments and identification of additional donors to fill future funding gaps.
4. Human resources for health and implementation of the outcomes of the United Nations’ High-level Commission on Health Employment and Economic Growth (WHA70.6)

Background

46. This United Nations High-level Commission was tasked to identify ways to meet the projected global shortfall of 18 million health workers needed to achieve universal health coverage and meet the Sustainable Development Goals, and to create momentum for implementing the new WHO Global Strategy on Human Resources for Health. It provided evidence that the health workforce is a good investment, and on the cost of inaction. It argued that a substantial transformation of the health workforce is needed to meet new health challenges. It had 10 recommendations, with a timeframe up to 2030. The 140th Session of the Executive Board requested the Director-General to (i) finalize, in time for the Seventieth World Health Assembly, the five-year action plan 2017–2021 to support the implementation of the recommendations of the High-level Commission; and (ii) to submit the five-year action plan for consideration by the Seventieth World Health Assembly.

Key issues from the World Health Assembly discussion

47. Member States supported the draft five-year action plan for health employment and inclusive economic growth, setting out how World Health Organization (WHO), International Labour Organization (ILO) and Organisation for Economic Co-operation and Development (OECD) will support Member States. They stressed the importance of basing policy on evidence and the need to collaborate with other key global stakeholders such as the ILO, OECD, World Bank and UNESCO. They reminded the Secretariat of the need to recognize regional and country specificities, and that implementation should be a collaborative effort with countries in the lead.

48. Member States also highlighted problems from loss of trained health workers, in particular nurses. There was a call for the Secretariat to facilitate the protection of health workers in security situations. The need for indicators to measure progress was stressed. The Secretariat pledged to help countries establish or strengthen their National Health Workforce Accounts. The report was noted and the draft resolution approved.

Actions already taken in the Region

49. Member States in the SEA Region are already committed to the Decade of Strengthening Human Resources for Health in the SEA Region 2015–2024. This has a focus on transformative education and rural retention. These priorities fit with the Commission’s recommendations, and the new global human resources for health (HRH) strategy: Health Workforce 2030.

50. The need for more effective HRH governance – coordination, intersectoral action and better HRH data – is increasingly recognized as a precondition for progress in the SEA Region. Six SEA Region countries have begun introducing their national health workforce accounts to improve HRH data.
Actions to be taken in the Region

51. The Commission’s arguments for reforming service delivery, and associated changes needed in HRH development, fit well with the conclusions arrived at during recent discussions in the SEA Region, including the Regional Consultation on Health, the SDGs and role of universal health coverage held in 2016. The Seventieth Session of the Regional Committee for South-East Asia will discuss the following as an item on the Agenda:

   “SDGs and progress towards universal health coverage:
   i. Strengthening PHC and health workforce
   ii. Annual progress monitoring of UHC and SDGs”.

52. The second review of progress on the Decade of Strengthening Human Resources for Health in the SEA Region will take place in 2018, and be presented to the Seventy-first session of the Regional Committee for South-East Asia.
5. Addressing the global shortage of, and access to, medicines and vaccines (Agenda item 13.3 of the Seventieth World Health Assembly)

Background

53. During the 140th Session of the WHO Executive Board, and as the result of the discussions on the report of the UN Secretary-General’s High-level Panel on Access to Medicines, it was agreed to add the term “access to medicines” to the predetermined item on “Shortages of medicines and vaccines”.

54. The report of the High-level Panel on Access to Medicines provides a broad range of recommendations, including on:

- better use of publicly funded research, stronger accountability of governments;
- new incentives and models for research and development of new medicines;
- better use of TRIPS flexibilities and avoidance of TRIPS-plus provisions; and
- a stronger role for the UN General Assembly.

55. The report presented by the Secretariat to the Seventieth World Health Assembly:

- Summarized the Secretariat’s work on access to medicines, and described WHO’s involvement in the UN Secretary-General’s High-level Panel process.

Summary of discussions

56. During the debate a wide range of opinions were expressed. Some Member States were critical of the High-level Panel report; others, including those from South-East Asia, supported its recommendations. Bangladesh, speaking on behalf of the South-East Asia Region, stated that shortage of medicines and vaccines is a global concern, and called for global action given the fact that the issue is critical for the 2030 Agenda for Sustainable Development. Bangladesh also called for greater focus on affordability and pricing and welcomed the new definitions given to “shortages” and “substandard falsified medicines”. The need for public funding of R&D and recognition that high prices hinder access was emphasized.

57. Collaboration between Member States, WHO and international agencies focused on two key areas:

i. Better implementation of policies, and more transparency to address access and shortage challenges, via:

- better implementation of national medicines policies, including improving rational use of medicines,
- more collaboration and information sharing on prices; more collective negotiations,
- pooled procurement for smaller countries, bilateral or regional and mechanisms to avoid overpricing during shortages,
- using market shaping initiatives to improve availability,
- setting up global surveillance mechanism to report on medicines shortages,
- capacity-building for local manufacturing to reduce shortages.

ii. Better models for new medicines development and pricing, through:

- striking the right balance between research costs and pricing of medicines, with consideration of the possibility of delinking these, and
- better use of the flexibilities of TRIPS with improved national legislations.

58. The Committee agreed to include the sub-item in the Agenda for the 142nd session of the Executive Board in January 2018.

Actions already taken in the Region

59. A regional network of national regulatory authorities (SEARN) has been established to support regional collaboration and networking to improve the availability of quality medicines.

Actions to be taken in the Region

60. A regional consultation in August 2017 on access to medicines will discuss strategies for greater regional collaboration to strengthen public procurement to improve access to essential medicines in the South-East Asia Region. Conclusions will be reported to the Seventieth Session of the Regional Committee.
6. Strengthening immunization to achieve the goals of the Global Vaccine Action Plan (WHA70.14)

Background

61. In 2012, the Sixty-fifth World Health Assembly endorsed the Global Vaccine Action Plan (GVAP) for the period 2012–2020. In 2013, the Sixty-sixth World Health Assembly agreed on the process for reviewing and reporting progress on vaccines under the oversight of the Strategic Advisory Group of Experts on immunization (SAGE). In 2016 Assessment Report, SAGE expressed concern over the progress made towards the goals to eradicate polio, eliminate measles and rubella, eliminate maternal and neonatal tetanus, and increase equitable access to vaccines, despite improvements in coverage in individual countries and a strong global rate of new vaccine introduction.

Main operative paragraph and implications on collaborative activities with Member States

62. The Seventieth World Health Assembly endorsed a resolution on strengthening immunization to achieve the goals of the GVAP. The resolution urges Member States to demonstrate stronger leadership with and governance of their national immunization programmes including increasing their effectiveness and efficiency, allocating adequate resources, strengthening national advisory bodies, efficiently managing vaccination programme funds, and promoting awareness about the benefits of immunization.

63. The resolution urges the WHO Director-General to support countries to achieve vaccination goals including advocating in forums for accelerating the progress toward achieving the GVAP goals, ensure monitoring of implementation of vaccine action plans, and support Member States in strengthening National Immunization Technical Advisory Groups (NITAG).

Actions already taken in the Region

64. The Regional Vaccine Action Plan (RVAP) was developed aligned to GVAP and has been endorsed by the Regional Immunization Technical Advisory Group.

65. Considerable progress has been made in the region vis-à-vis six GVAP Goals:

- The SEA Region’s polio-free status has been maintained for more than six years.
- Maternal and neonatal tetanus elimination has been achieved in 2016 in the SEA Region.
- Measles elimination and rubella/CRS control is a Regional Flagship Programme. Bhutan and Maldives have eliminated measles in 2017. Substantial reduction in measles mortality has been achieved in the Region. Rubella vaccine has been introduced in 10 countries.
- DTP3 coverage in the SEA Region has improved from 82% in 2010 to 88% in 2016. Seven countries have achieved more than 90% national coverage for DTP3. In five countries, all districts have achieved more than 80% coverage.
- At least two new vaccines have been introduced in all countries since 2010.
Actions to be taken in the Region

66. All countries need to develop national annual activity plans aligned to the RVAP. NITAGs to monitor the implementation and advise on strategies to achieve goals.

67. Member States with less than 90% DTP3 national coverage and/or less than 80% coverage in all districts (India, Indonesia, Myanmar, Nepal and Timor-Leste) need to strengthen routine immunization by focusing implementation of planned initiatives and utilizing available national and donor resources.

68. Member States need to recognize the importance of predictable financing for measles elimination and use all funding opportunities presented by domestic sources, polio transition and GAVI support.

69. Member States need to recognize routine immunization (RI) as the fundamental strategy to achieve measles elimination. When RI has not reached desired coverage, supplementary immunization activities should be conducted to enhance population immunity. India and Indonesia should ensure that the planned national wide-age range catch-up Measles and Rubella Containing Vaccine (MRCV) campaigns are conducted under high-quality standards.
7. **Global vector control response: an integrated approach for the control of vector-borne diseases (WHA70.16)**

**Background**

70. Global vector control response was discussed at the 140th session of the Executive Board in January 2017. Member States welcomed the draft global vector control response and there was overwhelming support with 22 countries making interventions on the Agenda item. Countries mentioned the rising incidence and threat of vector-borne diseases, challenges in controlling them, the shortage of entomologists as well as the risk of climate change on vector-borne diseases. It was mentioned that the draft global vector control response was both timely and appropriate, and its goals and targets were realistic. While welcoming the draft global vector control response, the representative of Thailand cautioned that it may fail unless global warming and climate change were addressed effectively. The representative of Thailand also stressed that WHO and its partners should support translation of vector control response measures into programme implementation, and monitoring and evaluation at the country level, and emphasized the need to strengthen human resources for vector control and to sustain the performance of entomologists and vector control operations teams including regional networks that enhanced mutual support between Member States. The representative of Fiji requested the Secretariat to prepare a draft resolution on the global vector control response, in consultation with Member States, before the Seventieth World Health Assembly. This was supported by the representative of the People’s Republic of China. The Executive Board noted the report and requested the Secretariat to prepare a draft resolution, in consultation with Member States, for consideration at the Seventieth World Health Assembly.

71. Committee A of the World Health Assembly discussed the global vector control response on 30 May 2017. Interventions were made by 39 Member States, and were overwhelmingly supportive. Maldives made an intervention on behalf of all countries of the WHO South-East Asia Region, with further interventions by Indonesia, Sri Lanka and Thailand. The Assembly welcomed the strategic approach and adopted resolution WHA70.16 on Global vector control response: an integrated approach for the control of vector-borne diseases.

72. The strategic document will soon be finalized and published. To support implementation of the global vector control response, a Framework for a national vector control needs assessment is under finalization, and will be released shortly.

**Main operative paragraph and implications on collaborative activities with Member States**

73. Developing or adapting existing national vector control strategies and operational plans to align them with the strategic approach for integrated global vector control and response.

74. Building and sustaining adequate human-resource (especially public health entomology), infrastructural and institutional capacity and capability at all levels of government and across all relevant sectors, based on a vector control needs assessment.

75. Strengthening the capacities and capabilities of the Secretariat at the global, regional and country levels and ensure that all relevant parts of the Organization across all three levels are
actively engaged to lead a coordinated global effort that includes collaboration with other bodies of the United Nations System and other intergovernmental agencies for better implementation of vector control.

76. Developing, in consultation with Member States and through Regional Committees, regional action plans aligned with WHO’s technical guidance on vector control, including the priority activities as described in the report.

77. These actions require a much closer collaboration and joint activities between WHO (all three levels) and Member States to undertake needs assessment, develop action plans, strengthen capacity and systems, etc.

**Actions already taken in the Region**

78. Work on the vector control needs assessment has begun in each of the 11 Member States.

79. An item on “vector control” has been included in the Agenda of the Seventieth Session of the Regional Committee to be held in September 2017.

**Actions to be taken in the Region**

80. Regional and national action plans need to be developed in line with the global vector control response.

81. A regional plan to build or strengthen entomological capacity in the region has to be developed.

82. Additional resources to strengthen regional capacity and implement the plans of action need to be mobilized.
8. Preparation for the third High-level Meeting of the General Assembly on the Prevention and Control of Noncommunicable Diseases, to be held in 2018 (WHA70.11)

Background

83. Noncommunicable diseases which include cardiovascular disease, cancer, diabetes and chronic respiratory disease are the leading causes of deaths globally and regionally with estimated annual deaths of 38 million and 8.5 million, respectively.

84. Following the 2011 UN High-level Political Declaration, the World Health Assembly endorsed the Global Action Plan 2013–2020 in May 2013.

85. The South-East Asia Regional Action Plan for the NCDs was adopted on 13 September 2013 during Sixty-sixth session of the Regional Committee.

86. The 2014 UN General Assembly High-level Meeting on Noncommunicable Diseases adopted a resolution (UN 66/300) declaring four strategic time-bound national commitments.

87. The Sixty-ninth World Health Assembly in 2016 through resolution WHA69.6 requested the Director-General to submit:
   i. the report on the approach to register and publish contributions of non-State actors; and
   ii. updated appendix 3 of the Global Action Plan through the 140th Session of the Executive Board.

Main operative paragraph and implications on collaborative activities with Member States

88. The Agenda 15.1 of the Seventieth World Health Assembly was mainly a procedural agenda with four distinct major components:
   i. The World Health Assembly endorsed the updated appendix 3 of the Global Action Plan for Prevention and Control of NCDs 2013–2020 (in its 1st operative paragraph) of the resolution WHA 70.11.
   ii. Member States noted the approach to register the contribution of NSAs towards the achievements of global voluntary targets.
   iii. The workplan for 2018–2019 of the Global Coordinating Mechanism of NCDs (GCM/NCDs) was supported by Member States.
   iv. The World Health Assembly supported the preparation of the comprehensive report by the Secretariat/World Health Organization to Third High-level Meeting of the UN General Assembly in 2018.
Actions already taken in the Region

89. All SEA Region Member States have set up national NCD targets and nine of the 11 Member States have developed and endorsed multisectoral action plans.

90. WHO recommended best buys for tobacco and alcohol control are being adopted by all Member States to a varying degree.

91. The WHO recommended best buys for a healthy diet are implemented across countries but at a slower pace. Concerted efforts are being taken to accelerate their implementation.

92. All SEA Region countries have made efforts to strengthen their primary health systems to address NCDs and this was further strengthened with the “Colombo Declaration” issued by the Sixty-ninth session of the Regional Committee in 2016.

93. The Regional Office has already planned a Regional Flagship Forum to accelerate the implementation of best buys in 2017.

Actions to be taken in the Region

94. Increase awareness among Member States on newly endorsed Appendix 3 of the Global Action Plan for Prevention and Control of NCDs 2013–2020 at the Seventieth World Health Assembly, which contains the cost-effective and affordable interventions to address NCDs’, in view of speedy implementation of such interventions.

95. Ensure support for the “fast-track” countries (Bhutan, Nepal and Sri Lanka) to prepare the business cases for the third High-level Meeting of the UN General Assembly.

96. Promote the visibility of SEA Region Member states in GCM/NCD structures and bring GCM/NCD activities to the Region.

97. Support the national efforts in the implementation of multisectoral NCD action plans in Member countries more comprehensively.
9. **Outcome of the Second International Conference on Nutrition**  
(Agenda item 15.4 of the Seventieth World Health Assembly)

**Background**

98. The report on the outcome of the Second International Conference on Nutrition (ICN2) documented the progress of ICN2 commitments. All international and some national commitments have been implemented, though achievement of global nutrition targets is yet off track. The Decade of Action (DoA) on Nutrition 2016–2025 provides an opportunity for accelerating progress to achieve the nutrition targets of Sustainable Development Goal 2.

99. A joint statement made on behalf of all Member States of the South-East Asia Region centered on the directions provided by the Strategic Action Plan to reduce the double burden of malnutrition in the SEA Region 2016–2025 (the Action Plan), and emphasized further challenges to achieving nutrition security, including food safety issues. The World Health Assembly noted the report.

**Main operative paragraph and implications on collaborative activities with Member States**

100. The Action Plan incorporates the recommendations of ICN 2, is aligned with action areas of the DoA and SDG targets, and guides all Regional Office activities to provide policy advice to Member States on all forms of malnutrition.

**Actions already taken in the Region**

101. Almost all Member States have been provided policy guidance to develop multisectoral nutrition policies covering undernutrition, overweight and obesity and other diet-related risk factors for NCDs. The Regional Office has provided technical assistance to Member States to develop and update their nutrition action plans and strategies and to develop and implement legislation and guidance to improve nutrition status. Capacity to generate nutrition data, monitor programmes and create policy coherence between nutrition and other sectors has been enhanced. Policy advice has been given to address micronutrient malnutrition, a significant public health issue in most Member States. Technical assistance has also been provided for implementing regulatory policies to improve food environments to promote healthy diets.

**Actions to be taken in the Region**

102. Member States will be supported in implementing multisectoral action plans since the current implementation levels are unsatisfactory. Member States will also be supported in prioritizing specific nutrition action for scaling up as part of the DoA implementation plan. The Regional Office will facilitate Member States to address conflicts of interest issues in nutrition, especially in implementing action for healthy and safe diets. Implementing food safety actions such as mandatory labelling of foods, and addressing the informal food sector issues, will be supported.
10. Report of the Commission on Ending Childhood Obesity: implementation plan (WHA70(19))

Background

103. The implementation plan to guide further action on the Ending Childhood Obesity (ECHO) recommendations was welcomed by the World Health Assembly. The decision urged Member States to develop national responses to end infant, child and adolescent obesity and called for an integrated system of monitoring progress of the implementation plan within existing nutrition and NCD reporting frameworks. A joint statement by all Member States of the South-East Asia Region fully supported the implementation plan.

Main operative paragraph and implications on collaborative activities with Member States

104. The Region has adopted the Strategic Action Plan to Reduce the Double Burden of Malnutrition in the SEA Region 2016–2025 (Strategic Action Plan) which has incorporated key elements of ECHO recommendations and guidance on implementation. Most Member States have endorsed nutrition policies that address undernutrition, overweight and obesity and other diet-related NCD risks. Member States are being supported to implement childhood obesity policy actions via three forms of interventions; reducing the obesogenic environment, settings-based interventions and individual interventions across the life cycle.

Actions already taken in the Region

105. The Regional Office has held successful advocacy and capacity-building initiatives to ensure that Member States address childhood obesity. Region-specific tools and frameworks were developed and are in use. Support is being provided to Member States to generate evidence on unhealthy diets that are contextual to the Region. Technical expertise is being provided to improve the obesogenic environment in many Member States through fiscal policies to promote healthy diets, implementing marketing recommendations on foods and non-alcoholic beverages to children, food labelling and initiating food reformulation discussions. Technical support is ongoing to scale up healthy diet interventions in institutional settings such as schools.

Actions to be taken in the Region

106. Disseminate the ECHO implementation plan and provide support to Member States to prioritize obesity interventions as per country context. Design a framework to guide Member States to add on actions for overweight and obesity into existing programmes and packages that address the entire spectrum of nutrition across the life cycle. Provide further support to Member States to reduce the obesogenic environment, improve settings-based nutrition and build capacity to address conflicts of interest.
11. Cancer prevention and control in the context of an integrated approach (WHA70.12)

Background

107. Cancer is a growing public health concern globally. In 2012, there were 14.1 million new cases and 8.2 million cancer-related deaths worldwide, of which 4.3 million were premature deaths in low- and middle-income countries. In the WHO South-East Asia Region cancer kills over 1.1 million people each year.

108. The Seventieth Session of the World Health Assembly discussed the draft resolution on “cancer prevention and control in the context of an integrated approach”. India presented the Regional One Voice, addressing issues including smokeless tobacco and chewing of arecanut, and proposed further amendment to the progress report timeframe. The draft resolution was approved.

Main operative paragraph and implications on collaborative activities with Member States

109. The resolution contains five broad recommendations for Member States and three actions for the Secretariat. These recommendations provide strategic action areas on which Member States can advance national responses to cancer control within an integrated response. Key opportunities, implications and collaborative activities related to the resolution include:

i. Member States developing national cancer control plans which will enable countries to implement comprehensive cancer control with operational plans linked to specific budgets, deliverables and clear outcomes that are currently inadequate in the majority of Member States.

ii. Enhancing synergistic linkages of cancer control with ongoing efforts in tobacco and alcohol prevention, promotion of healthy diet and physical activity programmes.

iii. Strengthening capacity of the overall health systems components and expand cancer screening and early detection at the primary health care level.

iv. Strengthening civil and vital registration systems in addition to other routine information systems for evidence-based policy decisions.

v. Enhanced roles for WHO to impart technical support to Member countries in planning and implementation of cancer control programmes.

Actions already taken in the Region


111. Implementation of WHO’s package of essential noncommunicable diseases (PEN) interventions or PEN equivalent programmes in Member States.

112. Dili Declaration of the Sixty-eighth session of the Regional Committee in 2015 and implementation of the WHO MPOWER package.
113. NCD risk factor surveys including population-based tobacco surveys and population-based cancer registry programmes.

**Actions to be taken in the Region**

114. Initiate dialogue within Member States to develop cancer control plans and advocate for resources within the national and international sources.

115. WHO to map expertise in cancer control and management within the Region.

116. Continue to support population-based cancer registration and integration of screening for cervical, oral and breast cancers at the primary health care level.

117. Assist Member States in implementing cost-effective measures for tobacco control with particular focus on raising tobacco taxes for effective rise in the price of tobacco products.

118. Support for strengthening smoke-free policies, enforcing ban on tobacco advertising, promotion and sponsorship (TAPS), health warnings and media campaigns and tobacco cessation services.

119. Strengthening measures to reduce the supply of tobacco by providing technical support in implementing policies to prevent youth from taking up tobacco use, prohibit illicit trade and provide alternate livelihoods to tobacco growers and workers.
12. Prevention of deafness and hearing loss (WHA70.13)

Background

120. The prevalence of hearing loss is rising globally. Currently, an estimated 360 million people (5.3% of the world’s population) live with disabling hearing loss, and they include 32 million children. Nearly 90% of them live in low- and middle-income countries of the world.

121. The prevalence of hearing loss is likely to rise in coming years. This is due to: i) ongoing demographic shift leading to a greater number of older adults, one third of whom are expected to have hearing loss; ii) the increasing practice of listening to loud music over long periods and exposure to damaging levels of noise in entertainment venues. It is estimated that over 1 billion young persons (12–35 years of age) are at risk of hearing loss due to unsafe listening.

122. Unaddressed hearing loss has a profound impact, especially on communication. Deaf children fail to develop language skills unless timely interventions are provided. Adults with hearing loss commonly face problems in education and employment, and suffer from cognitive decline and lack of social inclusion.

123. Recent estimates suggest that unaddressed hearing loss poses an annual cost of US$ 750 billion globally. Cost-effective and suitable interventions to prevent, identify and address hearing loss are available.

Main operative paragraph and implications on collaborative activities with the Member States

124. Based on the above considerations, the resolution urges Member States to: integrate strategies for ear and hearing care within the framework of their health-care systems; collect epidemiological data; establish training programmes for human resource development; ensure vaccination coverage; implement screening programmes for early identification of ear diseases and hearing loss in infants, young children, older adults and other “at-risk” groups; improve access to affordable, high-quality hearing technologies (e.g. hearing aids and cochlear implants); improve access to communication; and work towards the attainment of SDG goals 3 and 4, with special reference to people with hearing loss.

125. The resolution also requests the Director-General to undertake a series of tasks for raising awareness and providing technical support to Member States.

Actions already taken in the Region

126. The Regional Office initiated work in this area in 2002 and since then it has:

i. launched and updated a report on status of ear and hearing care in the SEA Region (in 2004 and 2007);
ii. launched the “Sound Hearing 2030” initiative in collaboration with regional partners in 2005;
iii. organized a regional meeting in 2012; and
iv. in 2013, seven Member States in the Region have reported the availability of national plans for hearing care.

**Actions to be taken in the Region**

127. Update the report on status of ear and hearing care in the Region.

128. Provide support for national strategy development, implementation and monitoring in one or two Member States in each biennium.

129. Promote knowledge and experience sharing, including an experts’ network in the Region.

130. Observe and promote World Hearing Day on 3 March of every year.
13. Progress in the implementation of the 2030 Agenda for Sustainable Development (WHA70(22))

Background

131. The Secretariat’s report reflected on progress by Member States, and progress in implementing resolution WHA69.11, since May 2016. Progress by Member States was based on information in World Health Statistics 2016. Progress in implementing resolution WHA69.11 covered the support for the development of national health plans as part of 2030 Agenda; regional office activities; finalization of SDG indicators; supporting Member States’ statistical capacity; supporting thematic reviews of progress on the SDGs for the High-level Political Forum in July 2017; the International Health Partnership for UHC 2030; supporting national efforts to “leave no one behind”; promoting multisectoral approaches to the 2030 Agenda, including the International Health Regulations (2005); strengthening R&D of new technologies and tools; supporting health systems research and facilitating South-South cooperation.

Key issues arising from the World Health Assembly discussions

132. Many issues were raised at the Seventieth World Health Assembly. There was appreciation for placing the coordination of SDGs within the Director-General’s Office, and the establishment of the regional coordinating networks. There was a suggestion that a global action plan should be developed, as signals of support had been received from the G7 and G20. Given the ambitious nature of the SDGs, partnerships were noted as being key to success. Collaboration is needed on generating/improving quality of data. Nepal commented that the SDGs provided countries an opportunity to go beyond health and asked for a standardized monitoring tool. Finally, despite some disagreement about an associated resolution on surgical care, this was accepted and a decision on this taken.

Actions already taken in the Region

133. National SDG consultations have been held. Most Member States have created national SDG coordination bodies. Many have begun discussions on SDG monitoring.

134. A regional consultation on the SDGs and the role of UHC was held in 2016. At the Sixty-ninth Regional Committee, Ministers discussed lessons from the MDGs, and steps being taken on SDG implementation. The SEARO publication “Health in the Sustainable Development Goals: where are we now? What next?”, provided a baseline analysis of all SDG3 targets for the 11 countries in the Region.

135. In early 2017 there was a Regional technical consultation on monitoring the health-related SDGs. Priority areas for follow-up include: better quality mortality statistics; improved equity analysis; more interoperable data platforms and better use of data for accountability.

136. In March 2017 the Asia Pacific Forum on Sustainable Development held roundtables on the SDGs to be discussed at the High-level Political Forum in New York in July. WHO co-organized the roundtable on SDG3 with UNFPA. The conclusion was to continue building on the successes of the MDGs but also that more integrated, multisectoral approaches based on
UHC are needed to overcome systemic barriers, along with legislative changes where needed, a focus on frontline services, and equity monitoring.

**Actions to be taken in the Region**

137. The Regional Office will publish an update of progress on SDG3 indicators annually.

138. The Regional Office will continue to support countries in setting national SDG3 targets, and strengthening national information systems for tracking progress.

139. A South-East Asia Regional Forum to Accelerate NCDs Prevention and Control in the Context of the SDGs will be held in October 2017.

Background


141. A revised document incorporating to the extent possible the proposals from all six regional committees was presented by headquarters to the Seventieth World Health Assembly in May 2017 through the Executive Board at its 140th Session in January 2017.

142. The finalized global implementation plan included six areas of action for taking forward the recommendations of the Review Committee and 12 guiding principles for the five-year global strategic plan to improve public health preparedness and response.

143. The Seventieth World Health Assembly through Decision A70/11 (see Annexure), requested the Director-General “to develop, in full consultation with Member States, including through the regional committees, a draft five-year global strategic plan to improve public health preparedness and response”. This is for consideration and adoption by the Seventy-first World Health Assembly, through the Executive Board at its 142nd Session.

144. In this regard, a document “Development of a draft five-year global strategic plan to improve public health preparedness and response” (see below) has been prepared for consultation with Member States at the sessions of the regional committees in 2017, in order to develop a draft five-year global strategic plan to improve public health preparedness and response.

Main operative paragraph and implications on collaborative activities with Member States

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

146. This document includes issues raised by Member States on implementation of the International Health Regulations (2005) during the Seventieth World Health Assembly; the mandates and technical work carried out by the Secretariat on monitoring and evaluation of the Core Capacities required by the Regulations; and a proposed way forward for the consultative process for the development of the draft five-year global strategic plan. The Annex to this document contains the guiding principles and pillars proposed by the Secretariat for the five-year global strategic plan.

147. The majority of Member States appreciated the Secretariat’s leadership in implementing the new and voluntary components of the IHR Monitoring and Evaluation Framework, including the joint external evaluation. This was considered by some Member States as a powerful tool for effectively acquiring the Core Capacities required by the International Health Regulations (2005). A few Member States expressed substantial reservations and concerns with regard to the
joint external evaluation and the IHR Monitoring and Evaluation Framework. Other Member States considered that the introduction of external evaluations and other new mechanisms not provided by the Regulations may require amendments to the Regulations. Another concern was in relation to whether the external evaluation should not become a precondition for receiving financial and technical assistance.

148. Member States were unanimous in acknowledging the critical importance of strong resilient health systems for the implementation of the International Health Regulations, and the need to integrate the Core Capacities required by the Regulations with essential public health functions, within the framework of universal health coverage.

149. Additional comments were related to developing the national action plans for public health preparedness and response, supporting the National IHR Focal Points, developing tools for an international early warning system, and risk assessment.

150. The finalization and full implementation of the draft global implementation plan will further accelerate the implementations of the Regulations. The approved Global Implementation Plan for IHR will be a guiding tool for further national action plans and relevant regional action plans.

**Action already taken in the Region**

151. The SEA Region held a formal High-Level Meeting (HLM) in July 2016 where the IHR global implementation plan was discussed. The HLM recommended the conduct of consultations with all Member States to further discuss in detail the IHR global implementation plan. This consultation took place in August 2016 with the participation of the Director of Country Preparedness and IHR from WHO headquarters.

152. The outcome of this consultation was presented and discussed at the 2016 Regional Committee session in September in Colombo.

153. Five countries in the Region have completed the Joint External Evaluation (JEE) and two are scheduled to conduct theirs before the end of this year.

154. Three countries have initiated the steps to develop their National Action Plans for Health Security (NAPHS) based on the outcomes of the completed JEEs.

**Action to be taken in the Region**

155. The draft five-year global strategic plan to improve public health preparedness and response that was developed shall be discussed at the Seventieth Session of the Regional Committee in September in Maldives under Item 10.1: Key issues arising out of the Seventieth World Health Assembly and 140th and 141st Sessions of the WHO Executive Board.
Development of a draft five-year global strategic plan to improve public health preparedness and response

Consultation with Member States

SUMMARY

1. This document has been prepared for consultation with Member States at the sessions of the regional committees in 2017, in order to develop a draft five-year global strategic plan to improve public health preparedness and response, as requested in decision WHA70(11) (2017). It includes: issues raised by Member States on implementation of the International Health Regulations (2005) during the Seventieth World Health Assembly; the mandates and technical work carried out by the Secretariat on monitoring and evaluation of the core capacities required by the Regulations; and a proposed way forward for the consultative process for the development of the draft five-year global strategic plan. The Annex to this document contains the guiding principles and pillars proposed by the Secretariat for the five-year global strategic plan.

BACKGROUND

2. In response to decision WHA69(14) (2016), the Secretariat developed a draft global implementation plan for the recommendations of the Review Committee on the Role of the International Health Regulations (2005) in the Ebola Outbreak and Response. The final version of the global implementation plan was submitted to the Seventieth World Health Assembly in May 2017, through the Executive Board at its 140th session in January 2017. The finalized global implementation plan incorporated proposals from extensive consultations with all six regional committees, and included six areas of action for taking forward the recommendations of the Review Committee, and 12 guiding principles for the five-year global strategic plan to improve public health preparedness and response.

3. The Seventieth World Health Assembly took note of the report containing the global implementation plan and through decision WHA70(11) requested the Director-General, “to develop, in full consultation with Member States, including through the regional committees, a draft five-year global strategic plan to improve public health preparedness and response, based on the guiding principles contained in Annex 2 to document A70/16, to be submitted for consideration and adoption by the Seventy-first World Health Assembly, through the Executive Board at its 142nd session”.

1 Document A70/16.
ISSUES RAISED BY MEMBER STATES ON IMPLEMENTATION OF THE INTERNATIONAL HEALTH REGULATIONS (2005) DURING THE SEVENTIETH WORLD HEALTH ASSEMBLY

IHR Monitoring and Evaluation Framework

4. The main issue for which divergent views were raised by Member States during the Seventieth World Health Assembly was the proposed IHR Monitoring and Evaluation framework.¹

5. The majority of Member States appreciated the Secretariat’s leadership in implementing the new and voluntary components of the IHR Monitoring and Evaluation Framework, including the joint external evaluation. This was considered by some Member States as a powerful tool for effectively acquiring the core capacities required by the International Health Regulations (2005). These Member States also appreciated the fact that the process of external evaluation is implemented as a package, whereby the evaluation is planned together with the development of national action plans for public health preparedness and response. Some Member States considered that the technical guidance developed by the Secretariat for monitoring and reporting on implementation of the Regulations should be evidence-based, neutral and never subject to political influence. Some Member States stressed the need to take into account regional resources to achieve the core capacities required by the Regulations, particularly in the context of small countries, such as small island States.

6. A few Member States expressed substantial reservations and concerns with regard to the joint external evaluation and the IHR Monitoring and Evaluation Framework. They requested that new instruments for monitoring, evaluation and reporting should be submitted to and adopted by the WHO governing bodies. Other Member States considered that the introduction of external evaluations and other new mechanisms not provided by the Regulations may require amendments to the Regulations. Another concern was in relation to national sovereignty: it was considered that the external evaluation should not become a precondition for receiving financial and technical assistance.

Integrating core capacities required by the International Health Regulations (2005) and resilient health systems

7. There was an overwhelming realisation by Member States following the Ebola virus disease outbreak in West Africa in 2014 and 2015 that strong and resilient health systems are an underlying factor for well functioning core capacities required by the Regulations. Member States were unanimous in acknowledging the critical importance of strong resilient health systems for the implementation of the Regulations, and the need to integrate the core capacities required by the Regulations with essential public health functions, within the framework of universal health coverage. They requested the Secretariat to develop specific guidance on how countries, in particular those that face resource constraints, could be supported in building their core capacities required by the Regulations. A forum on universal health coverage in December 2017 – co-organized by the World Bank, WHO, UNICEF, UHC2030, the Government of Japan and the Japan International Cooperation Agency² – is expected to provide a framework and a road map for building resilient health systems.

¹ See the provisional summary records of the Seventieth World Health Assembly, Committee A, first, second, fourth and seventh meetings.
through the framing of core capacities required by the International Health Regulations (2005) as essential public health functions of health systems.

**Other issues**

8. Additional comments were related to developing the national action plans for public health preparedness and response, supporting the National IHR Focal Points, developing tools for an international early warning system, and risk assessment.

9. The issues of research and development in emergency situations, data and sample sharing, and overall administration and functioning of the WHO Health Emergencies Programme were also raised by many Member States, but they are not included in this document, as these will be addressed in separate reports on the WHO Health Emergencies Programme to the Seventy-first World Health Assembly in 2018.

**MONITORING AND EVALUATION OF CORE CAPACITIES REQUIRED BY THE INTERNATIONAL HEALTH REGULATIONS (2005): MANDATES AND TECHNICAL WORK OF THE SECRETARIAT TO DATE**

10. The International Health Regulations (2005) are legally binding on 196 States Parties, including all 194 WHO Member States. They were adopted by the Health Assembly in May 2005 and entered into force on 15 June 2007. Following the entry into force, States Parties had five years to “develop, strengthen and maintain … the capacity to respond promptly and effectively to public health risks and public health emergencies of international concern”, including the core capacity requirements for designated airports, ports and ground crossings, as described in Annex 1 to the Regulations. For States Parties that were not able to meet these minimum requirements in the first five years, the Regulations provided for two two-year extensions (2012–2014 and 2014–2016) to allow States Parties time to comply.

11. Article 54.1 of the Regulations requires that “States Parties and the Director-General shall report to the Health Assembly on the implementation of these Regulations as decided by the Health Assembly”, which also comprises monitoring the status of core capacities. In 2008, the Health Assembly, through resolution WHA61.2, decided that “States Parties and the Director-General shall report to the Health Assembly on the implementation of the Regulations annually”. That resolution also requested the Director-General “to submit every year a single report, including information provided by States Parties and about the Secretariat’s activities, to the Health Assembly for its consideration” In 2008 and 2009, a questionnaire was sent by the Secretariat to States Parties, focused mainly on self-reported processes related to the establishment and functioning of the National IHR Focal Points.

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1 See resolution WHA58.3 (2005).
3 See documents A62/6 and A63/5.
12. In 2010, the Secretariat developed and shared with States Parties a core capacity monitoring framework, with a questionnaire for States Parties to complete on a voluntary basis on the status of implementation of the Regulations. This framework included a checklist and 20 indicators on the status of eight core capacities and capacities at points of entry and four specific hazards covered by the Regulations, notably biological (zoonotic diseases, food safety events and other infectious hazards), chemical, radiological and nuclear events. The self-assessment tool, completed and submitted by States Parties to the Secretariat on an annual basis (from 2010 to 2017), constituted the basis for compiling the report on the implementation of the Regulations by the Secretariat to the Health Assembly. States Parties’ specific scores related to the status of each core capacity were included in the Secretariat’s annual implementation report to the Health Assembly from 2013 to 2015. From 2015, these scores were made available online through the Global Health Observatory.

13. In 2015, the Review Committee on Second Extensions for Establishing National Public Health Capacities and on IHR Implementation recommended that the Secretariat should develop options 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”. Resolution WHA68.5 (2015) urged Member States to support the implementation of the recommendations of the Review Committee and requested the Director-General to present an update to the Sixty-ninth World Health Assembly on progress made in taking forward the recommendations of the Review Committee. The Secretariat then developed a concept note outlining a new approach for monitoring and evaluation of the core capacities required by the Regulations. The concept note was discussed by the regional committees in 2015, and a revised monitoring and evaluation framework was submitted to, and noted by, the Sixty-ninth World Health Assembly in 2016.

14. The revised IHR Monitoring and Evaluation Framework submitted to the Health Assembly in 2016 comprises four complementary components: the mandatory annual self-reporting by States parties in accordance with resolution WHA61.2 (2008) on implementation of the Regulations, and three voluntary components: joint external evaluation, after-action review and/or simulation exercise(s). As part of its function and mandate under the Regulations, the Secretariat is developing technical tools for each of the three voluntary components. The IHR Monitoring and Evaluation Framework is an important part of pillar 3 of the draft five-year global strategic plan to improve public health preparedness and response (see the Annex to this document).

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2 Documents A64/9, A65/17, A66/16 and A66/16 Add.1, A67/35 and A67/35 Add.1 and A68/22.


4 See WHA68/2015/REC/1, Annex 2.


7 Resolution WHA58.3 (2005), Article 44.2 and Annex 1.
PROPOSED WAY FORWARD FOR THE CONSULTATIVE PROCESS FOR THE DEVELOPMENT OF THE DRAFT FIVE-YEAR GLOBAL STRATEGIC PLAN

15. The current document highlights the area of monitoring and evaluation of implementation of the Regulations as the main issue to be brought for further consultation in preparing for the development of the draft five-year global strategic plan.

16. In addition to consulting Member States at the sessions of the regional committees between August and October 2017, the Secretariat is also planning a web-based consultation on the document between mid-August and mid-October 2017.

17. The input received from Member States at the sessions of the regional committees will be used by the Secretariat to further refine the draft plan. The Secretariat will also organize a face-to-face consultation of Member States through the Geneva-based mission focal points. The consultation is planned to take place in Geneva in November 2017. The updated version of the draft five-year global strategic plan will be submitted to the Executive Board at its 142nd session in 2018.

ACTION BY THE REGIONAL COMMITTEES

18. The regional committees are invited to review the guiding principles and pillars of the five-year global strategic plan, and to provide their views on the IHR Monitoring and Evaluation Framework.
ANNEX

FIVE-YEAR GLOBAL STRATEGIC PLAN TO IMPROVE PUBLIC HEALTH PREPAREDNESS AND RESPONSE: GUIDING PRINCIPLES AND PILLARS

This Annex recalls the guiding principles contained in document A70/16 and proposes three pillars for public health preparedness and response. The goal of the plan is to strengthen capacities at the global, regional and country levels to prepare for, detect, assess and respond to public health risks and emergencies with the potential for international spread. The guiding principles are outlined in the table.

Table. Guiding principles for the five-year global strategic plan to improve public health preparedness and response

<table>
<thead>
<tr>
<th>Guiding principle</th>
<th>Details</th>
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<tbody>
<tr>
<td>1. Consultation</td>
<td>Consultative process from May to November 2017 through the regional committees and a web-based consultation. One formal consultation of Member States, through the Geneva-based mission focal points, is planned to be held in Geneva, in November 2017.</td>
</tr>
<tr>
<td>2. Country ownership</td>
<td>Building and sustaining core capacities as required by the International Health Regulations (2015) as essential public health functions of their health systems, at the national and subnational levels, is the primary responsibility of national governments, taking into account their national health, social, economic, security and political contexts.</td>
</tr>
<tr>
<td>3. WHO leadership and governance</td>
<td>The WHO Health Emergencies Programme will lead the development and implementation of the five-year global strategic plan. The WHO Secretariat will report on progress to the meetings of the governing bodies, as part of the regular reporting on the application and implementation of the International Health Regulations (2005).</td>
</tr>
<tr>
<td>4. Broad partnerships</td>
<td>Many countries require technical support to assess, build and maintain their core capacities as required by the Regulations as essential public health functions of their health systems. Many global partners support countries in the field of health systems strengthening and public health preparedness and response. As decided by the Fifty-eighth World Health Assembly, WHO will cooperate and coordinate its activities, as appropriate, with the following: the United Nations, ILO, FAO, IAEA, ICAO, IMO, International Committee of the Red Cross, International Federation of Red Cross and Red Crescent Societies, IATA, International Shipping Federation and OIE. Cooperation with other relevant non-State actors and industry associations will also be considered, within the Framework of Engagement with Non-State Actors.</td>
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1 Based on document A70/16, Annex 2.
### Annex

<table>
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<tr>
<th>Guiding principle</th>
<th>Details</th>
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<tr>
<td><strong>5. Intersectoral approach</strong></td>
<td>Responding to public health risks, events and emergencies 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 five-year global strategic plan will provide strategic orientation for planning for public health preparedness and response across multiple sectors.</td>
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<td><strong>6. Integration with the health system</strong></td>
<td>The Ebola virus disease outbreak in West Africa in 2014 and 2015 put both health security and health systems resilience high on the development agenda. Framing the core capacities detailed in Annex 1 to the Regulations as essential public health functions will mutually reinforce health security and health systems, leading to resilient health systems.</td>
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<td><strong>7. Community involvement</strong></td>
<td>Effective public health 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.</td>
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<tr>
<td><strong>8. Focus on fragile contexts</strong></td>
<td>While the WHO Health Emergencies Programme is supporting all countries in their preparedness and response efforts in relation to public health risks, events 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 assessment of national core capacities and other risk assessments, for example using the INFORM methodology.¹</td>
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<tr>
<td><strong>9. Regional integration</strong></td>
<td>Building on the five-year global strategic plan, the regional offices will develop regional operational plans, taking into account existing regional frameworks and mechanisms, such as: the regional strategy for health security and emergencies 2016–2020 – a strategy of the Regional Office for Africa;² the Asia Pacific Strategy for Emerging Diseases and Public Health Emergencies (APSED III) – a common strategic framework for the regions of South-East Asia and the Western Pacific;³ Health 2020 – a policy framework and strategy for the European Region;⁴ the Regional Assessment Commission for the International Health Regulations (2005) established by the Regional Committee for the Eastern Mediterranean,⁵ and other regional approaches.</td>
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10. Domestic financing

For long-term sustainability, the budgeting and financing of core capacities required by the Regulations as essential public health functions should be supported to the extent possible from domestic resources. The Secretariat will work with countries to encourage the allocation of domestic financial resources to build and sustain essential public health functions within the context of existing national planning and financing mechanisms. In countries that require substantial external resources, the 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).\(^1\)

11. Linking the five-year global strategic plan with requirements under the International Health Regulations (2005)

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

12. Focus on results, including monitoring and accountability

The five-year global 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.

Pillars

1. Building and maintaining State Parties core capacities required by the International Health Regulations (2005)

(a) In view of lessons learned from the Ebola virus disease outbreak in West Africa in 2014 and 2015 and other recent public health events, States Parties should focus on building and maintaining resilient health systems, and on framing core capacities as essential public health functions of their health systems. While complying with requirements to ensure mutual accountability at international level with respect to the application and implementation of the IHR, countries need to establish domestic monitoring and evaluation mechanisms as part of their health systems, which would also facilitate the monitoring of the status of core capacities, as essential public health functions.

(b) The implications and potential gains, in terms of continuity of certain country capacities that will be triggered by the transition of the Global Polio Eradication initiative towards a post-certification strategy, will have to be considered. The Seventieth Health Assembly requested the Director-General, inter alia, “to develop a strategic action plan on polio transition by the end of 2017, to be submitted for consideration by the Seventy-first World Health Assembly, through the Executive Board at its 142nd session, that: (i) clearly identifies the capacities and assets, especially at country and, where appropriate, community levels, that are required to: sustain progress in other programmatic areas, such as: disease surveillance; immunization and health systems strengthening; early warning, emergency

\(^1\) Global Partnership for Effective Development Co-operation – principles. Available at: http://effectivecooperation.org/about/principles/ (accessed 17 July 2017).
and outbreak response, including the strengthening and maintenance of core capacities of core capacities under the International Health Regulations (2005).\(^1\)

(c) State Parties have had slightly more than 10 years to put in place core capacities to prevent, detect, assess, report and respond to public health risks, events and emergencies with potential to spread internationally, in accordance with the requirements of the Regulations. States Parties should continue to build and maintain these core capacities as essential public health functions of their health systems, for the effective application of the implementation of the Regulations, including those capacities related to points of entry.

(d) For those States Parties where the existing national planning, financing, and monitoring and evaluation mechanisms of their health systems are suboptimal, the Secretariat will develop guidance to facilitate the building and maintenance of core capacities, as essential public health functions, as part of the continuum of the assessment and planning process, and in alignment with the national health strategy. Similarly, the Secretariat will develop guidance to facilitate the national approach to intersectoral planning and financing. The Secretariat will develop guidance and provide technical support to countries to develop these plans. The development of the national action plans should be aligned with the 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.

2. Event management and compliance

(a) The Secretariat and States Parties should continue to fulfil their obligations under the Regulations in relation to detection, assessment, notification and reporting of and response to public health risks and events with the potential for international spread. The role of the National IHR Focal Points will have to be strengthened, including through the provision of technical guidance, standard operating procedures, training, information sharing and lessons-learned activities.

(b) The Secretariat will strengthen its functions for event-based surveillance through the newly developed Epidemic Intelligence from Open Sources platform for early detection and risk assessment of public health events.

(c) The Secretariat will strengthen its role in administering the expert advisory groups established to support the application and implementation of and compliance with the Regulations, that is, the roster of experts for the emergency and review committees, the scientific and technical advisory group on geographical yellow fever risk mapping, and the ad hoc advisory group on aircraft disinsection for controlling the international spread of vector-borne diseases. It will also pursue the establishment of the Technical Advisory Group of Experts on Infectious Hazards, based on the draft terms of reference in Annex 3 to document A70/16.

(d) A critical element for the optimal functioning of the global alert and response system is compliance by States Parties with the requirements of the Regulations in relation to health measures taken in response to public health risks and events, including during public health emergencies of

\(^1\) See decision WHA70(9).
international concern. The Secretariat, in compliance with Article 43 of the Regulations, will share with States Parties information related to additional health measures implemented by States Parties. It will systematically collect information on additional measures, and, for measures that significantly interfere with international traffic under Article 43, it will share with other States Parties the public health rationale and the scientific evidence provided by the States Parties implementing those measures.

3. Measuring progress and accountability

(a) An important element for global health preparedness and response is the continuous monitoring of progress, both in establishing and maintaining by States Parties of the core capacities detailed in Annex 1 to the Regulations, and in the ability of the global system to respond to public health events with the potential for international spread.

(b) Article 54.1 of the Regulations requires that “States Parties and the Director-General shall report to the Health Assembly on the implementation of these Regulations as decided by the Health Assembly”. This also comprises monitoring the status of core capacities detailed in Annex 1 to the Regulations. The annual frequency of reporting to the Health Assembly was determined by the Sixty-first World Health Assembly in 2008. Since 2010, the Secretariat has proposed a self-assessment tool, exclusively focusing on core capacities, for States Parties to fulfil their annual reporting obligation to the Health Assembly. In compliance with Article 54 of the Regulations on reporting and review, and with resolution WHA68.5 (2015) on the recommendations of the Review Committee on Second Extensions for Establishing National Public Health Capacities and on IHR Implementation, and as a result of the consultations during the regional committees in 2017, the five-year global strategic plan will propose a revised IHR Monitoring and Evaluation Framework for reporting to the Health Assembly on the status of the application and implementation of the Regulations.

(c) In the interim, the Secretariat will continue to propose the self-assessment annual reporting tool, introduced in 2010, while at the same time responding to requests from Member States that would like to implement additional monitoring and evaluation instruments as part of the IHR Monitoring and Evaluation Framework. As mentioned in document A70/16, which was noted by the Seventieth World Health Assembly in 2017, in order to ensure coherence and consistency between the various instruments, the Secretariat will review the annual self-reporting tool, and this revised instrument will be proposed to States Parties for future annual reporting.

(d) The five-year global strategic plan will include indicators and timelines for measuring progress at the global and regional levels. Most regions already have specific strategies and frameworks that will be taken into account in developing the monitoring approach for the five-year global strategic plan.

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1 See resolution WHA61.2 (2008).
Annexures
Programme budget 2018–2019

The Seventieth World Health Assembly,

Having considered the Proposed programme budget 2018–2019;¹

Having noted the report of the Programme, Budget and Administration Committee of the Executive Board to the Seventieth World Health Assembly;²

Welcoming the work being conducted to identify efficiencies in the area of management and administration;

Considering the continuing increase in the volume of tasks assigned by WHO’s governing bodies to the Director-General, including the recent creation of the WHO Health Emergencies Programme;

Conscious of the necessity to prioritize and, in a context of limited resources, to concentrate such resources on those programmes that have the greatest impact on public health, or where WHO has a significant comparative advantage, as agreed by the Member States;

Stressing that proposed increases above the level of the approved Programme budget 2018–2019 should be requested only when necessary for the purpose of the Organization’s mandated activities and after all possible steps have been taken to finance such increases through savings, efficiencies and prioritization,

1. APPROVES the programme of work, as outlined in the Proposed programme budget 2018–2019;

2. APPROVES the budget for the financial period 2018–2019, under all sources of funds, namely, assessed and voluntary contributions of US$ 4421.5 million;

3. ALLOCATES the budget for the financial period 2018–2019 to the following categories and other areas:

   (1) Communicable diseases US$ 805.4 million;

   (2) Noncommunicable diseases US$ 351.4 million;

¹ Document A70/7.
² Document A70/59.
(3) Promoting health through the life course US$ 384.3 million;

(4) Health systems US$ 589.5 million;

(E) WHO Health Emergencies Programme US$ 554.2 million;

(6) Enabling functions/corporate services US$ 715.5 million;

Other areas:

- Polio (US$ 902.8 million), Tropical disease research (US$ 50.0 million), and Research in human reproduction (US$ 68.4 million) totalling US$ 1021.2 million; and

- Outbreak and crisis response and scalable operations, which is subject to the event-driven nature of the activities concerned and, as such, does not have a budget requirement;

4. RESOLVES that the budget will be financed as follows:

- by net assessments on Member States adjusted for estimated Member State non-assessed income, for a total of US$ 956.9 million;

- from voluntary contributions, for a total of US$ 3464.6 million;

5. FURTHER RESOLVES that the gross amount of the assessed contribution for each Member State shall be reduced by the sum standing to their credit in the Tax Equalization Fund; that reduction shall be adjusted in the case of those Members that require staff members to pay income taxes on their WHO emoluments, taxes which the Organization reimburses to said staff members; the amount of such tax reimbursements is estimated at US$ 31.8 million, resulting in a total assessment on Members of US$ 988.7 million;

6. DECIDES that the Working Capital Fund shall be maintained at its existing level of US$ 31 million;

7. AUTHORIZES the Director-General to use the assessed contributions together with the voluntary contributions, subject to the availability of resources, to finance the budget as allocated in paragraph 3, up to the amounts approved;

8. FURTHER AUTHORIZES the Director-General, where necessary, to make budget transfers among the six categories, up to an amount not exceeding 5% of the amount allocated to the category from which the transfer is made. Any such transfers will be reported in the statutory reports to the respective governing bodies;

9. FURTHER AUTHORIZES the Director-General, where necessary, to incur expenditures in the Outbreak and crisis response and scalable operations subject to availability of resources;

10. FURTHER AUTHORIZES the Director-General, where necessary, to incur expenditures in the Polio, Tropical disease research, and Research in human reproduction components of the budget beyond the amount allocated for those components, as a result of additional governance and resource
mobilization mechanisms, as well as their budget cycle, which inform the annual/biennial budgets for these special programmes, subject to availability of resources;

11. REQUESTS the Director-General:

(1) to submit regular reports on the financing and implementation of the budget as presented in document A70/7 and on the outcome of the financing dialogue, the strategic allocation of flexible resources and the results of the coordinated resource mobilization strategy, through the Executive Board and its Programme, Budget and Administration Committee, to the World Health Assembly;

(2) to submit regular reports on the availability of resources and expenditures under the components of Outbreak and crisis response and scalable operations, Polio and on the special programmes of the Tropical disease research, and Research on human reproduction components of the budget;

(3) to provide additional information on the prioritization process and a plan, including details of the activities that should be discontinued, in preparation for the Thirteenth General Programme of Work, through the Executive Board and its Programme Budget and Administration Committee, to the Seventy-first World Health Assembly;

(4) to control costs and seek efficiencies, and to submit regular reports with detailed information on savings and efficiencies as well as an estimation of savings achieved.

Eighth plenary meeting, 26 May 2017
A70/VR/8
Improving the prevention, diagnosis and clinical management of sepsis

The Seventieth World Health Assembly,

Having considered the report on improving the prevention, diagnosis and clinical management of sepsis;¹

Concerned that sepsis continues to cause approximately six million deaths worldwide every year, 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 follows 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, improved sanitation and water quality and 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 also the need to improve measures for the prevention of infections and control of the consequences of sepsis, due to inadequate infection prevention and control programmes, insufficient health education and recognition in respect of early sepsis, inadequate access to affordable, timely and appropriate treatment and care, and insufficient laboratory services, as well as the lack of integrated approaches to the prevention and clinical management of sepsis;

Noting that health care-associated infections represent a common pathway through which sepsis can place an increased burden on health care resources;

¹ Document A70/13.
Considering the need for an integrated approach to tackling sepsis that focuses on prevention, early recognition through clinical and laboratory services, and timely access to health care, 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 in resolution WHA68.7 (2015),¹ 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; (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 major contributors 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 this is feasible;

Recognizing also 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;

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

Also recognizing the advocacy efforts of stakeholders, in particular through existing activities held every year on 13 September² in many countries, to raise awareness regarding sepsis,

1. **URGES** Member States:**³

   (1) to include prevention, diagnosis and treatment of sepsis in national health systems strengthening in the community and in health care settings, according to WHO guidelines;

   (2) to reinforce existing strategies or develop new ones 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 health care settings;

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¹ See document WHA68/2015/REC/1, Annex 3.

² See document A70/13, paragraph 11: civil society organizations promote a World Sepsis Day on 13 September.

³ And, where applicable, regional economic integration organizations.
(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 resistance, including the development and implementation of comprehensive antimicrobial stewardship activities;

(4) to develop and implement standard and optimal care and strengthen medical countermeasures 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 on 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

2. REQUESTS the Director-General:

(1) to develop WHO guidance including guidelines, as appropriate, on sepsis prevention and management;

(2) 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;

(3) 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;

1 See document WHA68/2015/REC/1, Annex 3.

2 See document A70/13, paragraph 11: civil society organizations promote a World Sepsis Day on 13 September.
(4) 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 for sepsis, and infection prevention and control, including immunization, particularly in developing countries, while taking into account relevant existing initiatives;

(5) to report to the Seventy-third World Health Assembly on the implementation of this resolution.

Ninth plenary meeting, 29 May 2017
A70/VR/9
South-East Asia Regional One Voice

Agenda Item 12.2: Antimicrobial resistance

Lead country: Indonesia
Support country: Bhutan

Thank you, Chair.

1) Indonesia speaks on behalf of the 11 member states of the South-East Asia Region. We appreciate WHO Secretariat for the reports on this agenda including the Resolution by the EB.

2) We reaffirm our commitments and responsibility to the Political Declaration on AMR made by Heads of state at the UN General Assembly in 2016 which calls for a multi-sectoral collaborative, global response to the threat of antimicrobial resistance (AMR); We also support G20 Health Ministers Declaration in Berlin last week on “Together Today for a Healthy Tomorrow”, which further emphasize the significant role of the National Action Plan on AMR which cover all the five strategic objectives of the Global Action Plan on AMR and the use of One Health Approach through the well functioning of Tri-partite (WHO-FAO-OIE) partners at country level.

3) Multi-drug resistance Tuberculosis, artemisinine monotherapy resistance malaria, very prevalent in member states in South East Asia, are high in AMR priorities.

4) By August 2017, all eleven member states in South East Asia Region will launch the National Action Plan on AMR and start active implementations.

5) We request WHO to collaborate with FAO and OIE in one health approach to strengthen country capacities to sustain the effective implementation of national action plan on AMR. We urge Member States to strengthen laboratory capacitie as a foundation for AMR surveillance. We recommend GLASS to accelerate inclusion of AMR in animal and agriculture and monitoring of antimicrobial consumption.

6) We appreciate the ongoing work by the IACG on AMR appointed by the UN Secretary General. We do expect IACG report to contain recommendations, inter alia, on (a) synergies and seamless coordination among the tri-partite partners at global, regional and country level; and (b) strategies to improve country implementation and monitoring capacities.
7) As regards to the draft resolution EB140.R5 South East Asia region has several comments:

8) On implementing the EB resolution on Sepsis; we are conscious that we must not lose sight of AMR as its scope is much wider than Sepsis. Though Sepsis has certain links with AMR, such as prevention and control of Infection with hand hygienes behaviour in clinical setting, contributes to sepsis prevention; but comprehensive implementation of GAP-AMR will fully contribute to Sepsis.

9) We recognize sepsis as one of the major causes of preventable morbidity and mortality globally and its significant increase of cases fatality resulting high financial burden in many countries notably in the developing countries. Sepsis can be caused by normal pathogen for the immuno-compromised hosts or by AMR pathogens. Therefore, it is important to emphasize the implementation of the all five pillars as indicted in the GAP-AMR.

Chair,

10) SEAR Member states would like to amend the draft resolution as follows:

First, on Operative Paragraph 1 point (1) to replace international guidelines with WHO guidelines. Therefore the OP 1 will read as follows:

“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 WHO guidelines.”

Second, on Operative Paragraph 2 point (1) to insert at the beginning of the sentence, it reads as followed:

“To develop sepsis prevention and management guidelines and draw attention to the public health impact of sepsis including by publishing a report on sepsis, (and so on) 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.”

11) Finally, we support the draft resolution EB140.R5 on improving the prevention, diagnosis and management of sepsis.

Thank you, Chair.
Poliomyelitis: polio transition planning

The Seventieth World Health Assembly, having considered the updated report on polio transition planning,¹ decided:

(1) to acknowledge that the active role taken by the Office of the Director-General in directing and leading this process is of key importance;

(2) to emphasize the critical and urgent need to maintain and pursue eradication efforts in polio-endemic countries and to sustain surveillance in countries through polio eradication certification, and the importance of ensuring that the Global Polio Eradication Initiative is fit for purpose, with adequate levels of qualified staff;

(3) to acknowledge that the ramp-down of the Global Polio Eradication Initiative has started and highlight the need for WHO to strategically manage the resulting impact on WHO human resources and other assets;

(4) to note the ongoing process of developing a post-certification strategy that will define the essential polio functions needed to sustain eradication and maintain a polio-free world;

(5) to highlight the need for WHO to work with all relevant stakeholders on options for ensuring effective accountability and oversight after eradication in the post-certification strategy;

(6) to note with great concern the reliance on the Global Polio Eradication Initiative’s funding of WHO at global, regional and country levels, involving many WHO programme activities, and the financial, organizational and programmatic risks that this reliance entails for WHO, including risks for the sustainability of WHO’s capacity to ensure effective delivery in key programmatic areas and to maintain essential continuing functions;

(7) to note also the proposed list of actions to be implemented by the end of 2017, as referred to in document A70/14 Add.1, in particular in relation to the development of a comprehensive WHO strategic action plan on polio transition;

(8) to urge the Director-General:
    
    (a) to make polio transition a key priority for the Organization at its three levels;
    
    (b) to ensure that the development of the WHO strategic action plan on polio transition is guided by an overarching principle of responding to country needs and priorities;

¹ Document A70/14 Add.1.
including by participating in and supporting Global Polio Eradication Initiative country transition planning;

(c) to mainstream best practices from polio eradication into all relevant health interventions and build capacity and responsibility for polio eradication ongoing functions and assets in national programmes, while maintaining WHO’s capacity to provide norms and standards for post-eradication planning and oversight;

(d) to explore innovative ways for mobilizing additional funding for the period 2017−2019 in order to mitigate the possible impact on the ramp-down of the Global Polio Eradication Initiative and on the longer-term sustainability of key assets that are currently financed by the Global Polio Eradication Initiative, and to update Member States on this work, through a dedicated session at the forthcoming financing dialogue;

(9) to request the Director-General:

(a) to develop a strategic action plan on polio transition by the end of 2017, to be submitted for consideration by the Seventy-first World Health Assembly, through the Executive Board at its 142nd session, that:

(i) clearly identifies the capacities and assets, especially at country and, where appropriate, community levels, that are required to:

– sustain progress in other programmatic areas, such as: disease surveillance; immunization and health systems strengthening; early warning, emergency and outbreak response, including the strengthening and maintenance of core capacities under the International Health Regulations (2005);

– maintain a polio-free world after eradication;

(ii) provides a detailed costing of these capacities and assets;

(b) to present to the Seventy-first World Health Assembly a report on the efforts to mobilize funding for transitioning capacities and assets that are currently financed by the Global Polio Eradication Initiative into the programme budget, to enable the Seventy-first World Health Assembly to provide guidance for the development of the programme budget for the biennium 2020–2021 and the Thirteenth General Programme of Work on a realistic basis;

(c) to report regularly on the planning and implementation of the transition process to the Health Assembly, through the Regional Committees and the Executive Board.

(Ninth plenary meeting, 29 May 2017)
Madam Chair, Sri Lanka presents this one voice statement on behalf of the 11 countries in the South-East Asia Region. Our region was declared polio free in March 2014. Since then we have been committed to implementing the polio end game plan.

All countries in our region ensured routine immunization emphasizing marginalized and hard-to-reach populations. All our countries introduced the recommended single dose IPV in 2015 ahead of the successful globally synchronized “polio Switch.” But our member countries are currently affected by global IPV supply deficit that has led India and Sri Lanka to change over to the fractional dose-IPV schedule. Bangladesh and Nepal would soon follow. To overcome the effect of the global shortage for IPV, our other member countries too are likely to introduce fractional dose which pose further challenge for the want of trained health workforce.

The Region wishes to request IPV supply assurance under the Healthy Markets Framework for continuous supply, on an affordable price to all countries including GAVI transitioned countries.

The South-East Asia Region is fully cognizant of the organizational and programmatic risks thus involved with the ramp-down of funding from the Global Polio Eradication Initiative during 2017 – 2019, followed by the eventual cessation of polio funding.

Madam Chair, the ramp down of funding for poliomyelitis will have impact on the control of other communicable diseases as much as it would have on VPD surveillance and further expansion of new vaccines. The five countries, namely Bangladesh, India, Indonesia, Myanmar and Nepal, who have accrued significant assets funded by the Global Polio Eradication Initiative, have started transition planning seriously, thus demonstrating their strong leadership and will to take forward the transition in a strong and coordinated manner. Our Region was also the first to switch fully to bOPV and to introduce IPV in our routine programme, therefore we have commenced our plans for comprehensive polio transition well in advance. India is well on track with a draft polio transition plan already worked out, and other four countries are working to put together similar plans for polio transitioning.
While we are confident that we will succeed in the eventual transition from GPEI funded support to domestic sources to ensure that polio free status is maintained while the lessons and assets of polio are integrated to serve other public health needs, we are concerned that the ramp-down may impact on the measles elimination and rubella control, VPD and other diseases surveillance activities, ensuring quality laboratory networks, strengthening routine immunization, introduction of new vaccines, elimination of NTDs such Kala Azar and lymphatic filariasis.

Chair, the member countries request from the Director General and the global partners to continue to the extent feasible, assistance, technically and financially, in the event of polio importation and / or in situation of emergence of circulatory VDPV even after 2020. Polio transition countries may also face hard times with polio in emergencies for which assistance is required.

We urge the Director General to consider additional support to our region and this should be considered in program budgeting for the Region.
The Seventieth World Health Assembly,

Having considered the report on human resources for health and implementation of the outcomes of the United Nations’ High-Level Commission on Health Employment and Economic Growth;

Reaffirming resolution WHA69.19 (2016) on global strategy on human resources for health: workforce 2030, in which the Health Assembly adopted WHO’s Global Strategy on Human Resources for Health: Workforce 2030, including its strong call to engage across public and private sectors and stakeholders including government, education and training institutions, employers and health workers’ organizations in order to coordinate an intersectoral health and social workforce agenda towards achieving a fit-for-purpose workforce for the 2030 Agenda;

Recalling resolution WHA63.16 (2010) on the WHO Global Code of Practice on the International Recruitment of Health Personnel, which adopted the Global Code, and the Global Code’s recognition that an adequate and accessible health workforce is fundamental to an integrated and effective health system, and to the provision of health services, bearing in mind the necessity of mitigating the negative effects of health personnel migration on the health systems of developing countries;

Recalling also previous Health Assembly resolutions aimed at strengthening the health workforce;\(^1\)

Further recalling the United Nations General Assembly resolutions in 2015 (resolution 70/183) and 2016 (resolution 71/159) that, respectively, requested the establishment of the United Nations’ High-Level Commission on Health Employment and Economic Growth (hereinafter “the Commission”) and welcomed the Commission’s report;

\(^1\) Document A70/18.

\(^2\) Resolutions WHA64.6 (2011) on health workforce strengthening, WHA64.7 (2011) on strengthening nursing and midwifery, WHA65.20 (2012) on WHO’s response, and role as the health cluster lead, in meeting the growing demands of health in humanitarian emergencies, WHA66.23 (2013) on transforming health workforce education in support of universal health coverage, WHA67.19 (2014) on strengthening of palliative care as a component of comprehensive care throughout the life course, WHA67.24 (2014) on follow-up of the Recife Political Declaration on Human Resources for Health: renewed commitments towards universal health coverage, and WHA68.15 (2015) on strengthening emergency and essential surgical care and anaesthesia as a component of universal health coverage.
Underlining that investing in the health and social workforce has multiplier effects that enhance inclusive economic growth, both locally and globally, and that it contributes to the ambition of the 2030 Agenda for Sustainable Development and to progress towards achieving the Sustainable Development Goals, including Goal 1 (End poverty in all its forms everywhere), Goal 3 (Ensure healthy lives and promote well-being for all at all ages), Goal 4 (Ensure inclusive and equitable quality education and promote lifelong learning opportunities for all), Goal 5 (Achieve gender equality and empower all women and girls), Goal 8 (promote sustained, inclusive and sustainable economic growth, full and productive employment and decent work for all), and Goal 10 (Reduce inequality within and among countries) and exploiting the interlinkages between the Goals and their targets;

Acknowledging that twenty-first century health challenges related to demographic, socioeconomic, environmental, epidemiological and technological changes will require a health and social workforce that is fit for purpose for the provision of integrated people-centred health and social services across the continuum of care;

Recalling decision EB140(3) which, inter alia, welcomed the report of the High-Level Commission on Health Employment and Economic Growth, and its task of lending the necessary political, intersectoral and multistakeholder momentum, through the elaboration of 10 recommendations and the identification of five immediate actions, in order to guide and stimulate the creation of health and social sector jobs as a means to advance inclusive economic growth and social cohesion;

Underscoring that skilled and motivated health and social sector workers are integral to building strong and resilient health systems, and underlining the importance of adequate workforce investments to meet needs in respect of universal health coverage and to develop core capacities under the International Health Regulations (2005), including the capacity of the domestic health workforce to ensure preparedness for and response to public health threats;

Recognizing the need to substantially expand and transform health financing and the recruitment, development, education and training, distribution and retention of the health and social workforce;

Recognizing also the need to substantially increase the protection and security of health and social workers and health facilities in all settings, including in acute and protracted public health emergencies and humanitarian settings,

1. ADOPTS the five-year action plan for health employment and inclusive economic growth (2017–2021) as a mechanism for coordinating and advancing the intersectoral implementation of the Commission’s recommendations and immediate actions in support of WHO’s Global Strategy on Human Resources for Health: Workforce 2030;

2. URGES all Member States to act forthwith on the Commission’s recommendations and immediate actions, with the support of WHO, ILO and OECD,\(^1\) as appropriate and consistent with national contexts, priorities and specificities;

3. INVITES international, regional, national and local partners and stakeholders responsible for health, social and gender matters, and for foreign affairs, education, finance and labour, to engage in and support, the implementation of the Commission’s recommendations and the five-year action plan for health employment and inclusive economic growth (2017–2021) as a whole;

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\(^1\) And, where applicable, regional economic integration organizations.
4. REQUESTS the Director-General:

(1) to collaborate with Member States, upon request, with agencies in other relevant sectors, and with partners, in implementing the Commission’s recommendations and immediate actions as elaborated in the five-year action plan for health employment and inclusive economic growth (2017–2021), including to:

(a) strengthen the progressive development and implementation of national health workforce accounts;

(b) strengthen the relevance, effectiveness and implementation of the WHO Global Code of Practice on the International Recruitment of Health Personnel, including by continuously fostering bilateral and multilateral dialogue and cooperation to promote mutuality of benefits deriving from the international mobility of health workers;

(c) catalyse the scale-up and transformation of professional, technical and vocational education and training, including inter-professional education, particularly in community- and health systems-based settings, and stimulate investments in creating decent health and social jobs with the right skills, in the right numbers and in the right places, particularly in countries facing the greatest challenges in attaining universal health coverage and in implementing the Global Strategy on Human Resources for Health: Workforce 2030;

(2) to coordinate and work with ILO, OECD and other relevant sectors, agencies and partners to develop their joint capacity to support Member States, upon request, in this agenda, including with respect to:

(a) the establishment of an inter-agency data exchange and online knowledge platform on the health and social workforce, respecting personal confidentiality and relevant data protection laws, that progressively brings together data and information from multiple agencies, sectors and sources to advance health and social labour market data, analysis, accountability, monitoring and tracking, as an open-access, electronic, and real-time web-based resource, building on the progressive implementation and reporting of national health workforce accounts; and

(b) the establishment of an international platform on health worker mobility for transparent intersectoral policy dialogue, exchange and collective action in order to achieve a sustainable health and social workforce, maximize mutual benefits, promote ethical recruitment and mitigate adverse effects arising from such mobility;

(3) to utilize the Global Health Workforce Network as a mechanism to engage stakeholders in the implementation of the five-year action plan for health employment and inclusive economic growth (2017–2021);

(4) to explore intersectoral and innovative financing mechanisms necessary for advancing implementation of the five-year action plan for health employment and inclusive economic growth (2017–2021);
(5) to accelerate progress in health workforce monitoring with the application of national health workforce accounts, and to ensure the appropriate number, competency and equitable distribution of health workers;

(6) to submit a regular report to the Health Assembly on progress made in implementing the five-year action plan for health employment and inclusive economic growth (2017–2021), aligned with reporting on the Global Strategy on Human Resources for Health: Workforce 2030.

Ninth plenary meeting, 29 May 2017
A70/VR/9
South-East Asia Regional One Voice

Agenda Item 13.3: Addressing the global shortage of, and access to, medicines and vaccines

Lead country: Bangladesh
Support country: India

Chairperson,
Excellencies,
Distinguished delegates,

1. The Bangladesh Delegation on behalf of 11 WHO Member States of the South East Asia Region would like to thank the Secretariat for preparing the report on “Addressing the global shortage of, and access to, medicines and vaccines”.

2. We, the 11 Member Countries of WHO SEAR are fully aware that shortage of medicines and vaccines is a major global concern and calls for urgent action.

3. Access to safe effective quality and affordable essential medicines and vaccines for all as enshrined in SDG 3.8 is critical for realizing 2030 Sustainable Development Agenda. The focus has to be on enhancing affordability and access to Medicines for attaining public health goals.

4. Although there are limited data to quantify the full extent and burden of stock outs, it is reported that there have been instances of shortages like that of antibiotics, chemotherapeutics, anesthetics, Inactivated Polio Vaccine (IPV) and cholera vaccines.

5. We support the definitions drafted by the secretariat on shortages at the supply and demand side and also substandard and falsified medical products and welcome further consultation to refine and create consensus on these definitions.

6. We would like to underscore that several countries in the SEA Region have the potential to contribute to minimize global risks of medicines and vaccines shortages, if information on shortage of specific medicines is collated at global level in a timely manner.

7. The SEAR countries who have the expertise as well as experience on production of quality medicines and vaccines at low cost, have the capacity to fill the gap of shortage of medicines and vaccines in the region.
8. On the other hand, member states in the region with no or limited production facilities will need to be given special consideration and support to improve access to quality medicines and vaccines through either bilateral, multilateral agreements or systematic regional facilitation by WHO.

9. There is a need to undertake public funding of research and development. The cost of innovation is increasing. It is important that the entire cost of R&D is not loaded on to the price of the end product which hinders access to new products and creates supply and demand side shortages. Such a practice raises the cost to the ultimate consumer and also throws up opportunities for substandard products entering the market.

10. When global shortages of essential medicines occur, the option of supporting qualified manufacturers in the SEAR region to manufacture these products could be an effective solution. Strengthening the regulatory capacity of manufacturing countries in the region through support from WHO and countries in other regions could help ensure quality of such products.

11. In this context, it is also noted that the report of the United Nations Secretary-General High Level Panel on Access to Medicines provides a comprehensive strategy and makes out a compelling case for better coordination amongst the UN and other international bodies and removing the incoherencies between trade and IP related issues and the right to health. The recommendations are worth pursuing and we request that the recommendations be taken to a logical conclusion.

12. Finally, we would like to emphasize the importance of good governance, transparency and accountability being maintained throughout the supply chain for medical products. With technical support from WHO, South East Asian countries are willing to contribute to fill the gaps of regional and global shortages of medicines and vaccines.

Thank you, Chairman.
Addressing the global shortage of, and access to, medicines and vaccines

Report by the Secretariat

1. The Executive Board at its 140th session noted an earlier version of this report.\(^1\) 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.\(^2\) 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.\(^3\)

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.

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\(^1\) See document EB140/19 and the summary records of the Executive Board at its 140th session, ninth meeting.

\(^2\) See the summary records of the Executive Board at its 140th session, eighteenth meeting, section 2.

\(^3\) 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).
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.

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 forremedying 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. The report of the High-Level Panel 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 and the Consultative Expert Working Group on Research and Development). 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.

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(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.\(^1\) 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 WHO’s new Expert Committee on Health Research and Development\(^2\) 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/Sporious/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.\(^3\) 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.

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\(^2\) See document EB140/22 and the summary records of the Executive Board at its 140th session, eleventh meeting.

(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 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. 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, 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. 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.

(f) **Selection of medicines.** Additional medicines for cancer and new medicines for hepatitis C and tuberculosis were included in the 19th WHO Model List of Essential Medicines and the 5th WHO Model List of Essential Medicines for Children. Antibiotics for infectious diseases, sexually transmitted infections and pediatric indications were reviewed by the Expert Committee on the Selection and Use of Essential Medicines at its 21st 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. In 2016, WHO published the first global report on access to treatment

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3 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).


for hepatitis C,\textsuperscript{1} 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 been published.\textsuperscript{2} 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{3} 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) **Access to controlled medicines.** WHO has played a leading role in the promotion of balanced public policies, including a published guidance document.\textsuperscript{4} 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{5} 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,

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\textsuperscript{3} Available at: http://www.who.int/medicines/areas/rational_use/WHO_AMCsurveillance_1.0.pdf?ua=1 (accessed 14 March 2017).


\textsuperscript{5} Available at: http://www.who.int/medicines/areas/quality_safety/guide_estimating_requirements/en/ (accessed 3 March 2017)
in particular for the management of pain.\textsuperscript{1} 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) **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{2} 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{3} 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) **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.

**SHORTAGES**

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.\(^1\) 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 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.

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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.
Strengthening immunization to achieve the goals of the global vaccine action plan

The Seventieth World Health Assembly,

Having considered the report on the global vaccine action plan;¹

Recalling resolutions WHA65.17 (2012) and WHA68.6 (2015) on the global vaccine action plan; and resolution WHA67.23 (2015) on health intervention and technology assessment;

Welcoming the declaration by the International Expert Committee for Documenting and Verifying Measles, Rubella and Congenital Rubella Syndrome Elimination, that the Member States in the Region of the Americas have achieved the interruption of endemic transmission of both rubella and measles viruses,² in 2015 and 2016, respectively;

Welcoming the validation of the elimination of maternal and neonatal tetanus in all districts in all 11 Member States of the South-East Asia Region;

Having considered the 2016 assessment report from the Strategic Advisory Group of Experts on immunization on the implementation of the global vaccine action plan and progress towards its stated strategic objectives and goals;³

Noting that although many countries have achieved the 2015 goals of the global vaccine action plan, and that others are making substantial progress, indicating that while the goals and targets are ambitious, they are achievable, the 2016 assessment report from the Strategic Advisory Group of Experts on immunization concluded that progress is not on track and that only one of the six mid-decade targets of the action plan was met;

Noting the progress made on the introduction of new vaccines and the impact that these vaccines have at the individual level and, when high vaccination rates are achieved, at the population level, in reducing morbidity and/or mortality from vaccine-preventable diseases, such as pneumonia, diarrhoea and cervical cancer;

¹ Document A70/25.
² See document CD55/INF/10, Rev.1.
Concerned that at the mid-point of the Decade of Vaccines (2011−2020), progress toward the goals of the global vaccine action plan to eradicate polio, eliminate measles and rubella, eliminate maternal and neonatal tetanus, and increase equitable access to affordable, life-saving vaccines is too slow; and recognizing that middle-income countries, in particular, have faced specific challenges with the introduction of new vaccines;

Noting that although Member States in all six WHO regions have measles elimination goals, and that three regions have rubella elimination goals, additional efforts should be invested to reach measles and rubella elimination;

Recognizing the important contribution of vaccines and immunization to: improving the health of populations; achieving the ambitious Sustainable Development Goals; ensuring outbreak preparedness and response, including in respect of outbreaks involving emerging pathogens; and tackling antimicrobial resistance;

Recognizing that strong health systems and integrated routine immunization programmes that are well coordinated across other relevant sectors contribute to achieving immunization goals and targets, and universal health coverage;

Recognizing the significant progress achieved towards polio eradication and the significant contribution of the polio-related assets, human resources and infrastructure, which should be transitioned effectively, to the strengthening of national immunization and health systems;

Recognizing the need for enhanced international cooperation aimed at, in a sustainable manner, strengthening the capacities of developing countries to achieve the goals of the global vaccine action plan,

1. URGES Member States: 1

1) to demonstrate stronger leadership and governance of national immunization programmes by:

(a) increasing the effectiveness and efficiency of national immunization programmes, as an integrated part of strong and sustainable health care systems;

(b) allocating adequate financial and human resources to immunization programmes according to national priorities;

(c) strengthening national processes and advisory bodies for independent, evidence-based, transparent advice, including on vaccine safety and effectiveness, such as health intervention and technology assessments and/or National Immunization Technical Advisory Groups working in collaboration with national regulatory authorities;

(d) strengthening mechanisms to monitor and efficiently manage vaccination programme funds at all levels;

1 And, where applicable, regional economic integration organizations.
(e) making up-to-date and accurate information on the effectiveness and safety of vaccines publicly available;

(f) strengthening systems to monitor and deal with adverse events following immunization;

(g) promoting awareness-raising campaigns on immunization, underlining public health benefits and vaccine safety and effectiveness;

(h) strengthening the immunization systems, procedures and policies that are necessary to achieve and sustain high immunization coverage;

(i) reviewing periodically, through the National Immunization Technical Advisory Groups or equivalent independent groups, the progress made, including immunization coverage, lessons learned and possible solutions for dealing with remaining challenges;

(j) continuing to report on progress to the regional committees, as urged in resolution WHA65.17;

(2) to ensure use of up-to-date data including, where possible, sex-disaggregated data on immunization coverage to guide strategic and programmatic decisions that protect at-risk populations and reduce disease burden;

(3) to strengthen and sustain surveillance capacity by investing in disease detection and notification systems, routine analysis and data reporting systems;

(4) to expand immunization services beyond infancy to cover the whole life course, as appropriate, guided by evidence, including on the burden of disease, cost effectiveness, budget impact assessment and system capacities, and using the most appropriate and effective means of reaching the other age groups and high-risk populations with immunization and integrated health services;

(5) to strengthen international and national actions to ensure the application of the International Health Regulations (2005), which aim to prevent, protect against, control and provide a public health response to the international spread of diseases;

(6) to mobilize domestic financing, as appropriate, in order to sustain the immunization gains achieved through the support from the Global Polio Eradication Initiative and the GAVI Alliance;

(7) to continue to strengthen international cooperation to achieve the goals of the global vaccine action plan, including by enhancing sustainable, national and regional manufacturing capacity for affordable vaccines and technologies through collaboration and exchange, as appropriate;
2. REQUESTS the Director-General:

(1) to continue supporting countries to achieve regional and global vaccination goals;

(2) to advocate in national and international forums in support of the urgency and value of accelerating the pace of progress toward achieving the goals of the global vaccine action plan by 2020, including, addressing the nine recommendations made by the Strategic Advisory Group of Experts on immunization in their 2016 mid-term review of the global vaccine action plan;

(3) to ensure that accountability mechanisms for monitoring global and regional vaccine action plans are fully implemented;

(4) to support Member States in strengthening National Immunization Technical Advisory Group or equivalent mechanisms cooperating with regulatory authorities to inform national decisions based on national context and evidence to achieve national immunization goals;

(5) to collaborate with all key partners, including civil society organizations, in order to assess how their work complements national routine immunization systems and the implementation of costed national immunization plans and targets;

(6) to continue working with all partners to support research, development and production of vaccines against new and re-emerging pathogens;

(7) to continue to strengthen the WHO prequalification programme and provide technical assistance to support developing countries in capacity building for research and development, technology transfer, and other upstream to downstream vaccine development and manufacturing strategies that foster proper competition for a healthy vaccine market;

(8) to continue working with all parties to support use of joint procurements and other mechanisms to increase efficiency, cost-effectiveness and sustainability of vaccine supply;

(9) to continue working with all parties to support research and development, especially in developing countries, for supply chain innovations and vaccine-administration technologies, to increase the efficiency of vaccine delivery, as appropriate;

(10) to cooperate with, as appropriate, international agencies, in accordance with their respective mandates, donors, vaccine manufacturers and national governments\(^1\) in order to overcome barriers to timely and adequate access to affordable vaccines of assured quality for all, and to implement effective preventive measures for the protection of health workers including in public health emergencies of international concern and in the specific context of humanitarian crises;

(11) to report to the Seventy-third World Health Assembly through the Executive Board, on the epidemiological aspects and feasibility of, and potential resource requirements for, measles and rubella eradication, taking into account the assessment of the Strategic Advisory Group of Experts on immunization;

\(^1\) And, where applicable, regional economic integration organizations.
(12) to continue to monitor progress annually and to report to the Health Assembly, through the Executive Board, as a substantive agenda item in 2020 and 2022 on the achievements made against the 2020 global vaccine action plan goals and targets.

Tenth plenary meeting, 31 May 2017
A70/VR/10
**South-East Asia Regional One Voice**

**Agenda Item 14.1: Global Vaccine Action Plan**

Lead country: **Myanmar**

Support country: **Thailand**

1. On behalf of the 11 countries of the South East Asia Region – representing 25% of the world’s population; 33% of the world’s disease burden; and 25% of the world’s poor, I would like to say that the countries of the Region are striving to achieve the regional health security by means of preventing, detecting and responding to the vaccine preventable diseases.

2. We appreciate the efforts of the secretariat and the independent oversight of the Strategic Advisory Group of Experts on immunization or SAGE who review the progress of Global Vaccine Action Plan or GVAP every year of the progress the world is making towards the GVAP goals.

3. The secretariat report on the Global Vaccine Action Plan (GVAP) is very comprehensive and highlights that countries have well-functioning NITAGs to provide technical advice on immunization matters at the country level, and the strong country leadership and accountability indicated by the fact that all countries put immunization as a priority.

   The summary of the 2016 GVAP report by SAGE notes 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 not sufficient. 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.

4. Immunization is one of the world’s most effective and cost-effective public health interventions. 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.

5. The next four years present 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 the GVAP 2020 goals. To that end Member States are encouraged to demonstrate stronger leadership and governance of national immunization systems and by investing more in and sustainable immunization programmes as an integral part of Universal Health Coverage packages, and to make every effort achieve and sustain high immunization coverage.
6. Further, SEAR will request global immunization partners that they continue to strongly and persistently support financing to sustain immunization gains over time. 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.

7. Given the differences in disease profile, health infrastructure and economic status, SAGE recommends governments to develop their own capacity to assess vaccine priority to ensure impact, value for money, sustainability of their health investment. Improving only surveillance capacity is not enough to support the governments to make the right choice on vaccine investment.

8. Countries should take note of the SAGE noting that despite the best of efforts, there are still many unvaccinated and under-vaccinated children, including in areas of conflict and crisis where WHO’s guidance to countries and partners on implementation of immunization programmes and strategies would be useful.

9. Finally, it is important to describe where this programme lies in the larger global agendas related to immunization - the IHR and Global Health Security Agenda are drivers for better preparedness in public health emergencies.

10. We, the Member States of the SEA region, feel these should be clarified at the outset, although GVAP is all governments’ responsibility–we want a stronger WHO to assist us in achieving these goals.

11. SEAR has demonstrated its continued commitments on EPI by having eliminated Maternal and Neonatal Tetanus and continues its commitment to eliminate measles and rubella by 2020 as one of the regional flagships as decided in the Regional Committee Resolution SEA/RC66/R5 of September 2013. Therefore all eleven SEAR Member States welcome and support adoption of the resolution contained in A70/A/CONF./1.
Global vector control response: an integrated approach for the control of vector-borne diseases

The Seventieth World Health Assembly,

Having considered the report on global vector control response;¹

Appreciating the work of the Secretariat in developing, through broad consultation with Member States and members of the global health community, a comprehensive global vector control response 2017–2030,² which served as the basis for the report;¹

Acutely aware of the burden and threat of vector-borne diseases to individuals, families and societies throughout the world, and the influence of social, demographic and environmental factors, including climate change and other climate- and weather-related factors, and increasing vector resistance to insecticides and the spread of mosquitoes and other vectors to unaffected areas;

Recognizing the need for cooperation to prevent, detect, report on and respond to outbreaks of vector-borne diseases so as to avoid a public health emergency of international concern under the International Health Regulations (2005);

Noting the recent gains that have been made against malaria, onchocerciasis, lymphatic filariasis, Chagas disease and others, as well as previous failures and existing challenges, and that lessons learned could be used for other vector-borne diseases;

Recognizing the need for an integrated, comprehensive approach to vector control that will enable the setting and achievement of disease-specific national and global goals, and that will contribute to the attainment of the Sustainable Development Goals, to addressing the social determinants of health and to tackling health inequities;

Deeply concerned by the current limited capacity and capability for vector control globally, and in particular the acute shortage in public health and development programmes of personnel with skills in public health entomology,

1. WELCOMES the strategic approach for integrated global vector control and response, as articulated in the report and its Annex;

¹ Document A70/26 Rev.1.

2. URGES Member States:

(1) to develop or adapt, as appropriate, existing national vector control strategies and operational plans to align them to the strategic approach for integrated global vector control and response, as summarized in the report, and consistent with the International Health Regulations (2005);

(2) to build and sustain, as appropriate, adequate human-resource (especially public health entomology), infrastructural and institutional capacity and capability at all levels of government and across all relevant sectors, based on a vector control needs assessment;

(3) to promote basic research on vectors and their transmission of pathogens, and applied research on vector control tools, including biological tools, technologies and approaches to evaluate their impact on disease, socioeconomic development, human populations and the environment; and to assess how to integrate them with vaccines, medicines and other interventions;

(4) to promote collaboration in line with the “One Health” approach and the integrated vector and communicable disease approach, as appropriate, across all levels and sectors of government, including municipality and local administrative structures, and with the engagement and mobilization of communities through organized stakeholder groups;

(5) to strengthen national and subnational capacity, as appropriate, for vector surveillance, forecasting and intervention monitoring, including for vector pesticide resistance, and the impact of pesticides on environmental and human health, and to integrate them with public health surveillance systems;

(6) to strengthen and engage in cross-border and regional collaboration by means that include networks in line with the International Health Regulations (2005) in order to build adequate capacity for prevention, surveillance, control and response for vector-borne diseases;

(7) to collaborate, as appropriate, with international, regional, national and local institutions and non-State actors from relevant sectors to support and contribute to the implementation of WHO’s strategic approach for integrated global vector control and response;

3. REQUESTS the Director-General:

(1) to continue to develop and disseminate normative guidance, policy advice and implementation guidance that provides support to Member States to reduce the burden and threat of vector-borne diseases, including to strengthen human-resource capacity and capability for effective locally adapted sustainable and ethically sensitive vector control;

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1 And, where applicable, regional economic integration organizations.

2 Document A70/26 Rev.1.
(2) to continue to promote research on vector-borne disease systems and development of innovative products, methods, tools, technologies and approaches, and to support the generation of evidence-based knowledge on their safety, efficacy and impact on disease, socioeconomic development, human populations and the natural environment;

(3) to review and provide technical guidance on the ethical aspects and issues associated with the implementation of new vector control approaches in order to develop mitigating strategies and solutions;

(4) to undertake a review of the ethical aspects and related issues associated with vector control implementation that will include social determinants of health, in order to develop mitigating strategies and solutions to tackle health inequities;

(5) to disseminate widely, and update as appropriate, technical guidance on integrated vector control for all relevant vector-borne diseases, especially as new evidence-based knowledge becomes available for improved and novel products, tools, technologies and approaches;

(6) to strengthen the capacities and capabilities of the Secretariat at the global, regional and country levels and ensure that all relevant parts of the Organization across all three levels are actively engaged to lead a coordinated global effort that includes collaboration with other bodies of the United Nations system and other intergovernmental agencies for better implementation of vector control;

(7) to develop, in consultation with Member States and through regional committees, as appropriate, regional action plans aligned with WHO’s technical guidance on vector control, including the priority activities as described in the report;¹

(8) to provide support to countries to develop and/or update national vector control and vector-borne disease control strategies aligned to the strategic approach for integrated global vector control and response and, as appropriate, to other ongoing communicable disease control strategies and emergency responses to outbreaks;

(9) to monitor the implementation of the strategic approach for integrated global vector control and response, and report back on its impact and the progress made towards the milestones and targets at the Seventy-fifth, Eightieth and Eighty-fifth World Health Assemblies.

Tenth plenary meeting, 31 May 2017
A70/VR/10

¹ Document A70/26 Rev.1.
Agenda Item 14.2 - Global vector control responses

Lead country: Maldives

Support country: Sri Lanka

Thank you Mr. Chair

1. On behalf of eleven Member states of SEA Region, Maldives would like to deliberate on this important agenda item. We appreciate the secretariat for making this comprehensive draft of global vector control response.

2. Two countries in the South-East Asia Region, Maldives and Sri Lanka have recently been certified by WHO as malaria-free. This demonstrates very strong political and financial commitments and substantial investments in health system capacities which led to eradication and are now sustaining efforts in vector control.

3. Although the implementation of many regional and global health initiatives has helped to lower the incidence and death rates from some vector-borne diseases, factors such as globalization of trade and travel in addition to environmental challenges are impacting their transmission.

4. Therefore, we strongly support the draft global vector control response especially the pillar 2: engage and mobilize communities; which this pillar will make the implemented intervention more sustainable. However we would like to propose three amendments to the draft resolution:

   i. First, we would like to amend the OP2 (2) to build and sustain, as appropriate, adequate human-resource including public health entomology. We propose to change "including" to be "especially" to emphasize the importance of shortage of public health entomologists.

   it would read;

   (2) to build and sustain, as appropriate, human-resource especially public health entomology.
ii. Second in OP2(3) insert the phrase as would be read as follow;

(3) to promote basic research on vectors and their transmission of pathogens, and applied research on vector control tools (including biological tools) technologies and approaches to evaluate their impact on disease to encourage using of non-chemical tools.

iii. Third, in OP2(5) insert the phrase as would be read as follow;

(5) to strengthen national and subnational capacity, as appropriate, for vector surveillance and intervention monitoring, including for vector pesticide resistance and impact of pesticides on environmental and human health, and to integrate with public health surveillance systems.

This will keep member states maintain focus on impact of insecticides to the environment and health.

5. In conclusion, we support the draft resolution contained in the accompanying document A70/26, and all eleven Member States are committed to implement WHO strategies to reduce mortality, morbidity and economic impact of vector borne diseases in South-East Asia Region.

Thank you Chair.
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

The Seventieth World Health Assembly,

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;¹


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:²

   (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 outcome document of the high-level meeting of the General Assembly on the comprehensive review and

¹ Document A70/27.
² 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 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.

Tenth plenary meeting, 31 May 2017
A70/VR/10
South-East Asia Regional One Voice

Agenda Item 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

Lead country: Sri Lanka

Support country: Nepal

1. Sri Lanka makes this intervention on behalf of 11 member states of South East Asia Region.

2. We support the endorsement of the updated Appendix 3 as proposed in the draft resolution.

   Chair,

3. Alcohol kills, it is not possible to set an acceptable limit for non-harmful use of alcohol.

4. Worldwide consumption in 2010 was equal to 6.2 Liters of pure alcohol consumed per person aged 15 years or older. Alcohol consumption is a top disease burden in several SEAR countries, such as Thailand, India and Sri Lanka. A quarter of this consumption (24.8%) was unrecorded, i.e., homemade alcohol, illegally produced or sold outside normal government controls.

5. The healthcare cost, the social cost, the economic cost of alcohol are massive. In 2004 alone, 350,000 people died in SEAR of alcohol-related causes, with economic losses amounting into billions of US dollars.

6. According to Institute of Alcohol Studies, there is evidence for an association between prior alcohol advertising and marketing exposure and subsequent alcohol drinking behaviour in young people.

7. Low socioeconomic groups often experience a higher disease and economic burden from alcohol consumption. Many poor people in SEAR spend their meagre income on binge drinking, so much so that almost nothing for household expenditure to meet the necessities of life such as food and shelter.

8. “Intervention fatigue” occurs in many developing countries, as the private alcohol manufacturing, marketing and sales companies have strong political connection and persuasive economic power.
9. The spending by alcohol industry in marketing and advertisement is more than the entire health budget in certain low and middle income countries, while exploiting health of the people.

10. In the context of the preparation for the UN HLM on the prevention and control of NCDs in 2018, 11 member states of South East Asia believe harmful use of alcohol is a major issue in need of urgent attention. The last Expert Committee on this topic met in 2006 and the situation has changed markedly since then especially with regard to cross-border marketing including in the social media. Therefore, SEARO member states request the DG to initiate and resource an Expert Committee to report on the alcohol control situation and progress prior to the UNHLM, 2018.

Thank you Chair.
Agenda Item 15.4 – Outcome of the Second International Conference on Nutrition

Lead country: Bhutan

Support country: India

Mr. Chairman,

Bhutan makes this statement on behalf of the 11 Member States of the South East Asia Region.

We thank the Secretariat for the comprehensive WHO-FAO joint report on the progress in implementation of ICN2 commitments at international and country levels. We are pleased to note the progress on this important public health issue.

The South East Asia Region endorsed the Strategic Action Plan to reduce the double burden of malnutrition in 2016. The Action Plan addresses the recommendations of the ICN 2 and is aligned with the action areas of the UN Decade of Action on Nutrition 2016-2025 and SDG 2.

While food security is a challenge, the Region recognizes food safety as a major public health issue. Contamination of the environment and food chain by pesticides and chemicals used in agriculture is a significant concern in countries in the Region. Therefore, this calls for intensified multi-sectoral actions to safeguard health of the people.

All Member States are making efforts to improve nutrition quality of the food supply and improve dietary environments: these include measures to attain universal salt iodization; population wide food fortification where relevant; food product reformulation and legal measures such as the Code of marketing for breast milk substitutes aligning with the Codex Alimentarius Commission recommendations; restrictions on marketing of food and non-alcoholic beverages to children; strengthening fiscal and regulatory capacities against unhealthy foods and interpretative labeling of food products.
The South East Asia Region has mainstreamed policies, programmes and initiatives to ensure healthy diets throughout life course. These include initiatives of starting from early stages of childhood, before and during pregnancy with focus on the first 1000 days, promoting exclusive breast feeding during the first six months, healthy eating by families and at schools.

Mr. Chairman,

Malnutrition in all forms threatens human health and development. The WHO SEAR carries a high burden of child under-nutrition due to socioeconomic disadvantages and other biological and social determinants.

The picture is now changing with a parallel rise in both child and adult overweight and obesity. Today most countries face double burden of malnutrition characterized by persistent under-nutrition and coexisting overweight and obesity across the life course. The emergence of obesity and lifestyle related non communicable diseases such as cardiovascular disease, diabetes mellitus and cancer is threatening the already stretched and under-resourced health systems.

While less than half of all under-5 children live in lower and lower-middle income countries, 2/3rd of all stunted children and 3/4th of all wasted children live in our Region. The trend of over-weight children have doubled in the last 5 years in the Region.

The close link between nutrition and diet-related NCD programming could be further aligned in order to ensure dual benefits;

Nutrition action calls for a concerted multi-sectoral approach. However, this poses a significant challenge to us.

Engagement of non-State actors on nutrition needs to be harnessed and intensified.

High level of political support and sustained resources are required to implement national policies and programmes outlined in the UN Decade of Action on Nutrition, to achieve SDG 2 and achieve the global nutrition targets.

Thank you.
Outcome of the Second International Conference on Nutrition

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 United Nations 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 United Nations 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 United Nations 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 United Nations 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.

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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\(^1\) 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 United Nations 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;

\(^1\) [http://www.who.int/nutrition/decade-of-action/workprogramme-2016to2025/en/](http://www.who.int/nutrition/decade-of-action/workprogramme-2016to2025/en/)
(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.1

IMPLEMENTATION OF COMMITMENTS BY THE SECOND INTERNATIONAL CONFERENCE ON NUTRITION AT COUNTRY LEVEL2

10. Preventing all forms of malnutrition.3 In 2014–2016, globally 793 million people were estimated to be undernourished – a drop of 216 million since 1990–1992.4 In 2016 globally child stunting, wasting and overweight rates were 22.9% (155 million), 7.7% (52 million) and 6.0% (41 million) of all children aged under 5 years. The rate of exclusive breastfeeding among infants less than 6 months reached 43% and the prevalence of anaemia in women of reproductive age was 29%.5 In 49 countries the rate of stunting had fallen since 20126 and in 36 the rate of exclusive breastfeeding had increased.7 Conversely, the prevalence of overweight is increasing and that of anaemia is not decreasing.6 The prevalence of obesity in adults more than doubled between 1975 and 2014; in 2014 11% of men and 15% of women were obese.8

11. Increasing investments.9 The World Bank estimates that the current yearly global spending on nutrition-specific interventions against stunting, severe acute malnutrition and anaemia in women and

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3 Commitment (a) of the Rome Declaration on Nutrition.
5 Data for 2011.
9 Commitment (b) of the Rome Declaration on Nutrition.
to promote exclusive breastfeeding is US$ 2900 million from government sources and US$ 1000 million from donors.\(^1\) To attain the Health Assembly’s targets an additional US$ 7000 million per year should be spent over the next 10 years.\(^2\) Donor funding for nutrition is primarily focused on undernutrition; less than 2% goes to noncommunicable diseases (US$ 611 million in 2014).\(^3\)

12. *Raising the profile of nutrition in national policies.*\(^3\) 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 United Nations 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.\(^4\)

13. *Strengthening human and institutional capacities.*\(^5\) 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:\(^6\)

1. *Sustainable, resilient food systems for healthy diets*\(^2\)

- 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.

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\(^3\) Commitment (d) of the Rome Declaration on Nutrition.


\(^5\) Commitment (e) of the Rome Declaration on Nutrition.


\(^7\) Recommendations from Framework for Action: 9–10, 11 12, 14, 50, and 53–54, 55, 56, 57. See also commitment (c) of the Rome Declaration on Nutrition.
• 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.

1 Recommendations from Framework for Action: 25, 26, 27, 28, 34, 35, 36, 37, and 44–45, 46, 47, 48, and 49.


3 See also commitment (h) of the Rome Declaration on Nutrition.

4 Recommendations from Framework for Action: 4, 8, 17 and 18.
(5) Safe and supportive environments for nutrition at all ages¹

- 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.²

- 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 accountability³

- 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 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.⁴

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¹ 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.


³ Recommendations from Framework for Action: 1, 2, 3 and 5–6, and 7, 58, 59, 60.

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.¹ UNICEF has a specific outcome for nutrition in its Strategic Plan 2014–2017 and has developed a new nutrition strategy.²

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)³ 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.


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.

Report of the Commission on Ending Childhood Obesity: implementation plan

The Seventieth World Health Assembly, recalling, inter alia, the WHO Comprehensive Implementation Plan on Maternal, Infant and Young Child Nutrition, resolution WHA69.9 (2016) on ending inappropriate promotion of foods for infants and young children, 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, which includes the WHO global action plan for the prevention and control of noncommunicable diseases 2013–2020, and the accountability and monitoring framework of the FAO/WHO Second International Conference on Nutrition (Rome, 19–21 November 2014); and having considered the report of the Commission on Ending Childhood Obesity: implementation plan,¹ decided:

(1) to welcome the implementation plan² to guide further action on the recommendations included in the report of the Commission on Ending Childhood Obesity;

(2) to urge Member States to develop national responses, strategies and plans to end infant, child and adolescent obesity,³ taking into account the implementation plan;²

(3) to request the Director-General to report to the Health Assembly periodically on progress made towards ending childhood obesity, including on the implementation plan,² as part of existing reporting in respect of nutrition and noncommunicable diseases.

(Tenth plenary meeting, 31 May 2017)

¹ Document A70/31.
³ As defined in footnote 4 on page 3 of document A70/31.
Agenda Item 15.5 - Report of the Commission on Ending Childhood Obesity: Implementation plan

Lead country: Thailand (read by Voramon Agrasuta)

Support country: Myanmar

Thank you Chair,

1. Thailand is speaking on behalf of South East Asia Region.

   We thank Madam DG for her visionary initiation and likewise looking forward to the continued commitment by the new DG.

2. To tackle nutrition transition in our region, the South-East Asia Regional Committee 69 had adopted “the strategic action plan to reduce the double burden of malnutrition”

Chair,

We need redouble efforts to achieve effective inter-sectoral implementation.

We would like to highlight a few key priorities.

3. First, Ample evidences show strong linkage between SSB consumption and increased risk for NCDs and its major risk factors in particular in low income population. Evidences also show that increased SSB taxes is effective in reducing consumption as demonstrated from Mexico, US and France. Increased excise tax on SSB generates revenue for health program and health gains.

4. Second, beyond ECHO, we wish to see concrete progress on the implementation of the resolution WHA69.9 on Ending inappropriate promotion of foods for infants and young children; and the BMS code both of which have synergistic contributions to ECHO.

5. Third, monitoring and evaluation (M&E) are critical tools contributes to effective implementation. SEAR recommends integrating M&E of ECHO into the national NCDs framework.
Chair,

6. Finally, the SEAR countries fully support the implementation plan and the draft decision in conference paper 10. In view of harmonization and fragmentation, we would like to propose a friendly amendment as followed.

To replace the decision 3 with the new para and it reads;

"To request the DG to harmonize the timeline of regular reporting of the implementation plan to the health assembly until 2025 in alignment with the global action plan for the prevention and control of NCDs 2013-2020, SDG monitoring framework, the comprehensive implementation plan on maternal, infant and young child nutrition, WHO global nutrition targets for 2025, the resolution WHA 69.9, WHA 66.10 and; accountability and monitoring framework of ICN2".

Thank you chair.
Cancer prevention and control in the context of an integrated approach

The Seventieth World Health Assembly,

Having considered the report on cancer prevention and control in the context of an integrated approach;¹

Acknowledging that, in 2012, cancer was the second leading cause of death in the world with 8.2 million cancer-related deaths, the majority of which occurred in low- and middle-income countries;

Recognizing that cancer is a leading cause of morbidity globally and a growing public health concern, with the annual number of new cancer cases projected to increase from 14.1 million in 2012 to 21.6 million by 2030;

Aware that certain population groups experience inequalities in risk factor exposure and in access to screening, early diagnosis and timely and appropriate treatment, and that they also experience poorer outcomes for cancer; and recognizing that different cancer control strategies are required for specific groups of cancer patients, such as children and adolescents;

Noting that risk reduction has the potential to prevent around half of all cancers;

Aware that early diagnosis and prompt and appropriate treatment, including pain relief and palliative care, can reduce mortality and improve the outcomes and quality of life of cancer patients;

Recognizing with appreciation the introduction of new pharmaceutical products based on investment in innovation for cancer treatment in recent years, and noting with great concern the increasing cost to health systems and patients;

Emphasizing the importance of addressing barriers in access to safe, quality, effective and affordable medicines, medical products and appropriate technology for cancer prevention, detection, screening diagnosis and treatment, including surgery, by strengthening national health systems and international cooperation, including human resources, with the ultimate aim of enhancing access for patients, including through increasing the capacity of the health systems to provide such access;

Recalling resolution WHA58.22 (2005) on cancer prevention and control;

¹ Document A70/32.
1. URGES Member States,\(^1\) taking into account their context and institutional and legal frameworks, as well as national priorities:

(1) to continue to implement the road map of national commitments for the prevention and control of cancer and other noncommunicable diseases included in United Nations General Assembly resolutions 66/2 (2011) on the Political Declaration of the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases and 68/300 (2014) on 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;

(2) to also implement the four time-bound national commitments for 2015 and 2016 set out in the Outcome document, in preparation for a third High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases, to be held in 2018, taking into account the technical note published by WHO on 1 May 2015, which sets out the progress indicators that the Director-General will use to report to the United Nations General Assembly in 2017 on the progress achieved in the implementation of national commitments, including those related to addressing cancer, taking into account cancer-specific risk factors;

(3) to integrate and scale up national cancer prevention and control as part of national responses to noncommunicable diseases, in line with the 2030 Agenda for Sustainable Development;

(4) to develop, as appropriate, and implement national cancer control plans that are inclusive of all age groups; that have adequate resources, monitoring and accountability; and that seek synergies and cost-efficiencies with other health interventions;

(5) to collect high-quality population-based incidence and mortality data on cancer, for all age groups by cancer type, including measurements of inequalities, through population-based cancer registries, household surveys and other health information systems in order to guide policies and plans;

(6) to accelerate the implementation by States Parties of the WHO Framework Convention on Tobacco Control; and, for those Member States that have not yet done so, to consider acceding to the Convention at the earliest opportunity, given that the substantial reduction of tobacco use is an important contribution to the prevention and control of cancer; and to act to prevent the tobacco industry’s interference in public health policy for the success of reducing the risk factors of noncommunicable diseases;

(7) to promote the primary prevention of cancers;

(8) to promote increased access to cost-effective vaccinations to prevent infections associated with cancers, as part of national immunization schedules, based on country epidemiological profiles and health systems’ capacities, and in line with the immunization targets of the global vaccine action plan;

\(^1\) And, where applicable, regional economic integration organizations.
(9) to develop, implement and monitor programmes, based on national epidemiological profiles, for the early diagnosis of common cancers, and for screening of cancers, according to assessed feasibility and cost-effectiveness of screening, and with adequate capacity to avoid delays in diagnosis and treatment;

(10) to develop and implement evidence-based protocols for cancer management, in children and adults, including palliative care;

(11) to collaborate by strengthening, where appropriate, regional and subregional partnerships and networks in order to create centres of excellence for the management of certain cancers;

(12) to promote recommendations that support clinical decision-making and referral based on the effective, safe and cost-effective use of cancer diagnostic and therapeutic services, such as cancer surgery, radiation and chemotherapy; and to facilitate cross-sectoral cooperation between health professionals, as well as the training of personnel at all levels of health systems;

(13) to mobilize sustainable domestic human and financial resources and consider voluntary and innovative financing approaches to support cancer control in order to promote equitable and affordable access to cancer care;

(14) to promote cancer research to improve the evidence base for cancer prevention and control, including research on health outcomes, quality of life and cost-effectiveness;

(15) to provide pain relief and palliative care in line with resolution WHA67.19 (2014) on the strengthening of palliative care as a component of comprehensive care throughout the life course;

(16) to anticipate and promote cancer survivor follow-up, late effect management and tertiary prevention, with the active involvement of survivors and their relatives;

(17) to promote early detection of patients’ needs and access to rehabilitation, including in relation to work, psychosocial and palliative care services;

(18) to promote and facilitate psychosocial counselling and aftercare for cancer patients and their families, taking into account the increasingly chronic nature of cancer;

(19) to continue fostering partnerships between government and civil society, building on the contribution of health-related nongovernmental organizations and patient organizations, to support, as appropriate, the provision of services for the prevention and control, treatment and care of cancer, including palliative care;

(20) to work towards the attainment of Sustainable Development Goal 3, target 3.4, reiterating the commitment to reduce, by 2030, premature mortality from cancer and other noncommunicable diseases by one third;

(21) to promote the availability and affordability of quality, safe and effective medicines (in particular, but not limited to, those on the WHO Model List of Essential Medicines), vaccines and diagnostics for cancer;
(22) to promote access to comprehensive and cost-effective prevention, treatment and care for the integrated management of cancers including, inter alia, increased access to affordable, safe, effective and quality medicines and diagnostics and other technologies;

2. REQUESTS the Director-General:

   (1) to develop or adapt stepwise and resource-stratified guidance and toolkits in order to establish and implement comprehensive cancer prevention and control programmes, including for the management of cancers in children and adolescents, leveraging the work of other organizations;

   (2) to collect, synthesize and disseminate evidence on the most cost-effective interventions for all age groups, and support Member States\(^1\) in the implementation of these interventions; and to make an investment case for cancer prevention and control;

   (3) to strengthen the capacity of the Secretariat both to support the implementation of cost-effective interventions and country-adapted models of care and to work with international partners, including IAEA, to harmonize the technical assistance provided to countries for cancer prevention and control;

   (4) to work with Member States\(^1\) and collaborate with nongovernmental organizations, private sector entities, philanthropic foundations and academic institutions as defined in the Framework of Engagement with Non-State Actors in order to develop partnerships to scale up cancer prevention and control, and to improve the quality of life of cancer patients, in line with Sustainable Development Goals 3 (Ensure healthy lives and promote well-being for all at all ages) and 17 (Strengthen the means of implementation and revitalize the global partnership for sustainable development);

   (5) to strengthen the collaboration with nongovernmental organizations, private sector entities, academic institutions and philanthropic foundations, as defined in WHO’s Framework for Engagement with Non-State Actors, with a view to fostering the development of effective and affordable new cancer medicines;

   (6) to provide technical assistance, upon request, to regional and subregional partnerships and networks, including, where appropriate, support for the establishment of centres of excellence to strengthen cancer management;

   (7) to develop, before the end of 2019, the first periodic public health- and policy-oriented world report on cancer, in the context of an integrated approach, based on the latest available evidence and international experience, and covering the elements of this resolution, with the participation of all relevant parts of WHO, including IARC, and in collaboration with all other relevant stakeholders, including cancer survivors;

   (8) to enhance the coordination between IARC and other parts of WHO on assessments of hazards and risks, and on the communication of those assessments;

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\(^1\) And, where applicable, regional economic integration organizations.
(9) to prepare a comprehensive technical report to the Executive Board at its 144th session that examines pricing approaches, including transparency, and their impact on availability and affordability of medicines for the prevention and treatment of cancer, including any evidence of the benefits or unintended negative consequences, as well as incentives for investment in research and development on cancer and innovation of these measures, as well as the relationship between inputs throughout the value chain and price setting, financing gaps for research and development on cancer, and options that might enhance the affordability and accessibility of these medicines;

(10) to synchronize the periodic report on progress made in implementing this resolution with, and integrate it into, the monitoring and report timeline of the prevention and control of noncommunicable diseases, set out in resolution WHA66.10.

Tenth plenary meeting, 31 May 2017
A70/VR/10
Agenda Item 15.5 - Report of the Commission on Ending Childhood Obesity: Implementation plan

Lead country: Thailand (read by Voramon Agrasuta)

Support country: Myanmar

Thank you Chair,

1. Thailand is speaking on behalf of South East Asia Region.

   We thank Madam DG for her visionary initiation and likewise looking forward to the continued commitment by the new DG.

2. To tackle nutrition transition in our region, the South-East Asia Regional Committee 69 had adopted “the strategic action plan to reduce the double burden of malnutrition”

Chair,

We need redouble efforts to achieve effective inter-sectoral implementation.

We would like to highlight a few key priorities.

3. First, Ample evidences show strong linkage between SSB consumption and increased risk for NCDs and its major risk factors in particular in low income population. Evidences also show that increased SSB taxes is effective in reducing consumption as demonstrated from Mexico, US and France. Increased excise tax on SSB generates revenue for health program and health gains.

4. Second, beyond ECHO, we wish to see concrete progress on the implementation of the resolution WHA69.9 on Ending inappropriate promotion of foods for infants and young children; and the BMS code both of which have synergistic contributions to ECHO.

5. Third, monitoring and evaluation (M&E) are critical tools contributes to effective implementation. SEAR recommends integrating M&E of ECHO into the national NCDs framework.
Chair,

6. Finally, the SEAR countries fully support the implementation plan and the draft decision in conference paper 10. In view of harmonization and fragmentation, we would like to propose a friendly amendment as followed.

To replace the decision 3 with the new para and it reads;

"To request the DG to harmonize the timeline of regular reporting of the implementation plan to the health assembly until 2025 in alignment with the global action plan for the prevention and control of NCDs 2013-2020, SDG monitoring framework, the comprehensive implementation plan on maternal, infant and young child nutrition, WHO global nutrition targets for 2025, the resolution WHA 69.9, WHA 66.10 and; accountability and monitoring framework of ICN2".

Thank you chair.
Prevention of deafness and hearing loss

The Seventieth World Health Assembly,

Having considered the report on prevention of deafness and hearing loss;¹

Recognizing that 360 million people across the world live with disabling hearing loss, a total that includes 32 million children and nearly 180 million older adults;

Acknowledging that nearly 90% of the people with hearing loss live in low- and middle-income countries, which often lack resources and strategies to address hearing loss;

Concerned by the persistent high prevalence of chronic ear diseases, such as chronic suppurative otitis media, which lead to hearing loss and may cause life-threatening complications;

Acknowledging the significance of work-related, noise-induced hearing loss, in addition to issues related to recreational and environmental noise-induced hearing loss;

Aware that unaddressed hearing loss is linked with cognitive decline and contributes to the burden of depression and dementia, especially in older adults;

Noting the significant impact of ear diseases and hearing loss on the development, ability to communicate, education, livelihood, social well-being and economic independence of individuals, as well as on communities and countries;

Aware that most of the causes of hearing loss are avoidable with preventive strategies; that the interventions available are both successful and cost-effective; but that, despite this, most people with ear diseases and hearing loss do not have access to suitable services;

Recalling resolution WHA48.9 (1995) on prevention of hearing impairment, and resolution WHA58.23 (2005) on disability, including prevention, management and rehabilitation;

Recalling also the World report on disability 2011, which recommends investment in improved access to health services, rehabilitation and assistive technologies and the WHO global disability action plan 2014–2021, ² based on that report’s recommendations;

Mindful of the Sustainable Development Goals in the 2030 Agenda for Sustainable Development, specifically Goal 3 (Ensure healthy lives and promote well-being for all at all ages) with

¹ Document A70/34.
² See document WHA67/2014/REC/1, Annex 3.
its target 3.8 on achieving universal health coverage, which implicitly recognizes the need for persons with disabilities to have access to quality health care services, and recognizing that the targets of Goal 4 (Ensure inclusive and equitable quality education and promote lifelong learning opportunities for all) explicitly mention persons with disabilities, and that unaddressed hearing loss greatly hinders their education and academic outcomes;

Appreciating the efforts made by Member States and international partners in recent years to prevent hearing loss, but mindful of the need for further action,

1. **URGES** Member States, taking into account their national circumstances:

   (1) to integrate strategies for ear and hearing care within the framework of their primary health care systems, under the umbrella of universal health coverage, by such means as raising awareness at all levels and building political commitment and intersectoral collaboration;

   (2) to collect high-quality population-based data on ear diseases and hearing loss in order to develop evidence-based strategies and policies;

   (3) to establish suitable training programmes for the development of human resources in the field of ear and hearing care;

   (4) to ensure the highest possible vaccination coverage against rubella, measles, mumps and meningitis, in line with the immunization targets of the global vaccine action plan 2011–2020, and in accordance with national priorities;

   (5) to develop, implement and monitor screening programmes for early identification of ear diseases, such as chronic suppurative otitis media and hearing loss in high-risk populations, including infants, young children, older adults and people exposed to noise in occupational and recreational settings;

   (6) to improve access to affordable, cost-effective, high-quality, assistive hearing technologies and products, including hearing aids, cochlear implants and other assistive devices, as part of universal health coverage, taking into account the delivery capacity of health care systems in an equitable and sustainable manner;

   (7) to develop and implement regulations for the control of noise in occupational settings, at entertainment venues and through personal audio systems, as well as for the control of ototoxic medicines;

   (8) to improve access to a variety of ways of communicating through promoting alternative methods of communication, such as sign language and captioning;

   (9) to work towards the attainment of Sustainable Development Goal 3 (Ensure healthy lives and promote well-being for all at all ages) and Goal 4 (Ensure inclusive and equitable quality education and promote lifelong learning opportunities for all) in the 2030 Agenda for Sustainable Development, with special reference to people with hearing loss;
2. REQUESTS the Director-General:

   (1) to prepare a world report on ear and hearing care, based on the best-available scientific evidence;

   (2) to develop a toolkit as well as provide the necessary technical support for Member States in collecting data, planning national strategies for ear and hearing care, specifying how prevention of hearing loss can be integrated into other health care programmes, raising awareness, screening for hearing loss and ear diseases, and organizing training in and provision of assistive technologies;

   (3) to intensify collaboration with all stakeholders with the aim of reducing hearing loss due to recreational exposure to noise through the development and promotion of safe-listening standards, screening protocols, software applications to promote safe-listening and information products;

   (4) to undertake advocacy through World Hearing Day on 3 March each year, with a different theme every year;

   (5) to report on progress in the implementation of the present resolution to the World Health Assembly.¹

Tenth plenary meeting, 31 May 2017

A70/VR/10

¹ The Executive Board agreed that the long-term reporting requirements of the present resolution should be included in the forward-looking planning schedule of expected agenda items, established by decision WHA69(8) (2016). See document EB139/2016/REC/1, summary record of the Executive Board at its 139th session, second meeting.
**South-East Asia Regional One Voice**

**Agenda Item 15.8 – Prevention of deafness and hearing loss**

Lead country: **DPR Korea**

Support country: **Nepal**

Chair,

(DPR Korea) makes this intervention on behalf of eleven countries of the South-East Asia Region.

1. Chair, over a 100 million people live with hearing loss in countries of the South East Asia Region. Untreated hearing loss has a profound impact on the affected individuals, their families and communities. Adults with unaddressed hearing loss have higher unemployment rates, as compared to the rest of the population. Deafness and Hearing loss have a significant impact on economy.

2. The increased risk of developing hearing loss is due to, among others, ear infections, the unsafe use of personal audio devices and exposure to damaging levels of sound in noisy entertainment venues. Furthermore, excessive noise, including occupational noise such as that from machinery and explosions are posing major risks for our Region.

3. We recognize that in response to the WHA resolution 48.9, adopted in 1995, WHO developed technical guidelines, training manuals for health workers, primary level functionaries and doctors. In 2015, WHO also launched the Make Listening Safe initiative to address the growing issue of hearing due to unsafe listening practices.

4. Overall lack of data and human resources; the increasing number of older adults; the growing use of personal audio systems; and the lack of access to services, including assistive technologies, are the main challenges in the countries of South-East Asia Region.

5. WHO SEARO, in 2005, in collaboration with other organizations, set up the Sound Hearing 2030 programme with the aim of establishing sustainable systems for ear and hearing care. A Regional Consultation on hearing loss was held in 2012, which highlighted the need to raise awareness about this growing issue at the levels of policymakers, community and professionals and for government-led action to address it.
6. Chair, efforts on prevention, early diagnosis and management of hearing loss need to be integrated with the Health Care System of the Member States of the region, including newborn screening and raising public awareness on the preventable causes of hearing loss.

7. Chair, we call upon WHO and other partners to provide support to Member States for conducting epidemiological surveys, effective management of human resources, including audiologist professionals, establishing training programmes as well as development and implementation of national hearing care strategies and their integration within the framework of their primary health care systems.

8. While we welcome the draft resolution on this agenda item, we would like to highlight the need to promote research and development and implementation of new, better and cost-effective technologies to prevent and manage hearing loss.

Thank you for your attention.
Progress in the implementation of the 2030 Agenda for Sustainable Development

The Seventieth World Health Assembly, having considered the report on progress in the implementation of the 2030 Agenda for Sustainable Development,\(^1\) decided to request the Director-General to continue to report every two years, as requested in resolution WHA69.11 (2016), on health in the 2030 Agenda for Sustainable Development, including on the strengthening of emergency and essential surgical care and anaesthesia as a component of universal health coverage, as requested in resolution WHA68.15 (2015).

(Tenth plenary meeting, 31 May 2017)

\(^1\) Document A70/35.
**South-East Asia Regional One Voice**

**Agenda Item 16.1: Progress in the implementation of the 2030 Agenda for Sustainable Development**

Lead country: **Maldives**

Support country: **Nepal**

Thank you Mr. Chair

1. On behalf of eleven Member states of SEA Region, Maldives would like to deliberate on this important agenda item. We reiterate our commitment to the Sustainable Development Goals.

2. Member states of South-East Asia Region recognize the central and transformative role of health in sustainable development, centred on SDG3 but linked to other goals through six universal instruments of change to achieve the 17 SDGs.

3. There has been significant action to enhance understanding of the SDGs, and to begin implementation. In SEAR, national consultations have been held. Most Member States have created national SDG coordination bodies and come up with national targets and indicators. Many have begun discussions on SDG monitoring, which can benefit from the significant efforts already underway to improve national information systems. SDGs should be recognized for its “unprecedented scope and significance”.

4. We recognize the achievements of the Millennium Development Goals in galvanizing collective action at global level for better health outcomes. In spite of progress made during the MDG era, major challenges remain in terms of reducing maternal and child mortality, improving nutrition, and achieving further progress against infectious diseases such as HIV/AIDS, tuberculosis, malaria. As well as against the fight against hepatitis, Ebola and other communicable diseases and epidemics, including addressing growing antimicrobial resistance and the problem of neglected tropical diseases affecting developing countries and prevention and treatment of noncommunicable diseases and their risk factors such as tobacco/alcohol use, mental health problems, road traffic injuries and environmental health issues.

5. We support the emphasis on the importance to foster alignment and coordination of global health interventions in the area of health systems strengthening, including at the primary health care level, and we recognize the important role WHO has to play in this regard. Functional health systems aligned with country objectives and actions towards health systems strengthening is critical to the achievement of health specific and interlinked targets as well as other health-related goals and targets.
6 It is essential that cooperative action at the national, regional and global levels across and within all government/private sectors is undertaken to tackle social, environmental and economic determinants of health to reduce health inequities, achievement of universal health coverage and access to quality health care ensuring that no one is left behind. We further emphasize the need for strategic planning, implementation on the basis of existing mechanisms wherever possible.

7 In the context of national accountability processes, quality, inclusive, transparent information consistent with national policies, plans and priorities, are required for regular monitoring and review of progress towards the Goals and targets of the 2030 Agenda for Sustainable Development, as this would form the basis for global and regional progress assessment.

8 We urge member states to prioritize investments in health and strengthen the mobilization and effective use of domestic and international resources for health in accordance with the broad multisectoral impact taking into account different national realities, capacities and levels of development and respecting national policy space and priorities to promote a multisectoral approach and the active engagement of WHO. Goals of the 2030 Agenda for Sustainable Development are integrated and indivisible, including through alignment and improved collaboration across WHO programmes.

In view of the validity of WHA69.11 and the reporting requirements contained therein (OP.2 (10 to 14), which would inform us on global and regional progress towards achieving the health Goal as a whole and interlinked targets, member states of SEAR may not be able to support the draft decision as contained in conference paper A70/A/CONF./2.

Thank you Chair.
Implementation of the International Health Regulations (2005)

The Seventieth World Health Assembly, having considered the report on implementation of the International Health Regulations (2005): global implementation plan,\(^1\) mindful of the legally binding nature of the International Health Regulations (2005), recalling country ownership and WHO’s leadership in the implementation of the International Health Regulations (2005), and aware of the urgency of their implementation, decided:

(1) to take note of the report contained in document A70/16; and

(2) to request the Director-General:

(a) to develop, in full consultation with Member States, including through the regional committees, a draft five-year global strategic plan to improve public health preparedness and response, based on the guiding principles contained in Annex 2 of document A70/16, to be submitted for consideration and adoption by the Seventy-first World Health Assembly, through the Executive Board at its 142nd session;

(b) to continue to pursue and strengthen efforts to support Member States in the full implementation of the International Health Regulations (2005), including through building their core public health capacities.

(Ninth plenary meeting, 29 May 2017)

\(^1\) Document A70/16.