Governing Body matters:

Key issues arising out of the Seventy-first World Health Assembly and the 142nd and 143rd Sessions of the WHO Executive Board

The attached Working Paper highlights, from the perspective of the WHO South-East Asia Region, the resolutions endorsed by the Seventy-first World Health Assembly (held on 21–26 May 2018) and the 142nd and 143rd Sessions of the WHO Executive Board (held on 22–27 January 2018 and 28–29 May 2018, respectively) along with other important agenda items. The issues are deemed to have important implications for the Member States of the WHO South-East Asia Region and the resolutions merit follow-up action by both Member States as well as the Organization at the regional and country levels.

The background of the select resolutions/decisions, their implications on WHO’s collaborative activities with Member States, as applicable, along with actions proposed for Member States and WHO have been summarized. All the related resolutions/decisions along with the text of the “Regional One Voice” presented at the Seventy-first World Health Assembly by the Delegation of the Member States of the South-East Asia Region on select Agenda items are provided in the annex to this Working Paper.

The High-Level Preparatory Meeting held in New Delhi from 30 July to 3 August 2018 reviewed the attached Working Paper and made the following recommendations:

Actions by Member States

1. Implement the related provisions of select resolutions endorsed by the Seventy-first World Health Assembly and the 142nd and 143rd sessions of the WHO Executive Board which merit follow-up action.

2. Ensure collaborative actions on important public health issues highlighted in the World Health Assembly and Regional Committee resolutions, such as regional price negotiations and/or pooled procurement for improving accessibility, availability and affordability of essential medical products.
Actions by WHO

(1) Convene knowledge management activities for sharing experiences and best practices on implementation of World Health Assembly and Regional Committee resolutions among Member States.

(2) Take appropriate follow-up action at the regional and country levels to support Member States in the implementation of actionable provisions of World Health Assembly and Regional Committee resolutions.

The Working Paper and recommendations of the HLP Meeting are submitted to the Seventy–first Session of the WHO Regional Committee for South-East Asia for its consideration.
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**Annexure**

Resolutions and Decisions of the Seventy-first World Health Assembly, the 142nd and 143rd Sessions of the WHO Executive Board on select agenda items (listed above), and the Regional One Voice (RoV) intervention on these items made at the Seventy-first World Health Assembly.
Introduction

1. The Seventy–first World Health Assembly in May 2018 and the 142nd and 143rd Sessions of the WHO Executive Board in January and May 2018 respectively 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 along with other important agenda items are presented in this paper. Salient information on the implications of the issues, 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 Seventy–first World Health Assembly (which also cover the subjects of technical resolutions adopted by the 142nd and 143rd Sessions of the Executive Board) along with the text of the “Regional One Voice” presented at the Seventy-first World Health Assembly by the Delegation of the Member States of the South-East Asia Region on select Agenda items.

Background

4. WHO has a proud 70-year history of monumental accomplishments in health development that serve as the foundation for achieving better health and well-being for the people of the world we live in today. Through the Thirteenth General Programme of Work 2019–2023¹, WHO will continue to build on these achievements to address ongoing challenges and respond to new ones while continuously learning and improving on its ways of work with Member States. The way WHO functions and the priorities it sets require constant adaptation and review in a rapidly changing global environment. The Thirteenth General Programme of Work sets out WHO’s strategic direction, including the strategic priorities, goals and outcomes; outlines how the Organization will proceed with their implementation; and provides a framework to measure progress in this effort. This new General Programme of Work has taken into account the strategies and plans of WHO regional offices and has been developed also with inputs from the Regional Directors and WHO Country Representatives.

5. The Thirteenth General Programme of Work was developed in record time (August 2017 to May 2018) and through an iterative consultation process.

Development of the Thirteenth General Programme of Work
Timeline and key consultative steps

Main operative paragraph and implications on the collaborative activities with Member States of the South-East Asia Region

6. The Seventy-first World Health Assembly considered the draft Thirteenth General Programme of Work 2019–2023, and welcomed its ambitious vision as expressed by the aspirational “triple billion” goals.


8. The Seventy-first World Health Assembly urged Member States to support work towards the achievement of the vision of the Thirteenth General Programme of Work 2019–2023; and requested the Director-General to:

   i. use the Thirteenth General Programme of Work as the basis for the strategic direction of planning, monitoring and evaluation of WHO’s work during the period 2019–2023, and to develop programme budgets in consultation with Member States, based on a realistic assessment of income and WHO’s capacity;

   ii. take into consideration the changing state of global health in implementing the Thirteenth General Programme of Work, and to keep Member States informed of progress with implementation through regular updates to the Governing Bodies;

   iii. provide guidance and support to regional and country offices on the implementation of the Thirteenth General Programme of Work, taking into account different contexts; and

   iv. provide a report to the Seventy-fifth World Health Assembly in 2022 to inform about a potential extension of the Thirteenth General Programme of Work to 2025 in order to align it with the wider United Nations planning cycle.

Actions already taken in the Region

9. Following the World Health Assembly approval of the Thirteenth General Programme of Work, a consultation process was launched with Member States in the Region to identify country priorities and relevant General Programme of Work targets at the country level. The country priorities identified in this consultation process are to be used for the development of the Programme Budget 2020–2021.

10. Regular briefings of Member States on the Programme Budget, Evaluation and other related topics that are part of the Regional Committee Agenda have been conducted.

11. Joint meetings with country offices and Member States through regular briefings on the Thirteenth General Programme of Work and Programme Budget have also been held.

Actions to be taken in the Region

12. The following actions need to be taken in the Region in the context of this resolution:

   i. Country priorities and feedback on the Thirteenth General Programme of Work targets will be presented to the Regional Committee as part of the Agenda item on the Programme Budget 2020–2021.

   ii. Country support plans are to be developed to respond to priorities of Member States.

   iii. Updates will be provided to Member States on the Thirteenth General Programme of Work and Programme Budget related matters during the annual meeting of the Subcommittee on Policy Programme Development and Management in August 2018.

Background

13. The 142nd Session of the Executive Board decided to recommend to the Seventy-first World Health Assembly that it adopt the decision to endorse the five-year Global Strategic Plan to improve public health preparedness and response, and to continue reporting annually using the self-assessment annual reporting tool.

14. The Strategic Plan included 10 objectives under three pillars: (i) Building & maintaining State Parties’ Core Capacities; (ii) Strengthening event management and compliance with the requirements under IHR (2005); and (iii) Measuring progress and promoting accountability.

15. Recognizing the report of the Director-General on WHO’s work in health emergencies and the Strategy, as well as the document “Ending Cholera: A Global Roadmap to 2030” launched by the Global Task Force on Cholera Control, the Seventy-first World Health Assembly adopted resolution WHA71.4 for cholera prevention, control and elimination.

16. Bangladesh made the “Regional One Voice” intervention on public health preparedness and response at the World Health Assembly, wherein it expressed appreciation of WHO’s timely support to manage the post-disaster health problems and emphasized the need for sustainable funding to support the implementation of IHR (2005) and the national action plans for health security. Member States of the SEA Region supported the adoption of the decision on the Global Strategic Plan and the proposed resolution on cholera prevention and control.

Main operative paragraph and implications on the collaborative activities with Member States of the South-East Asia Region

17. With its decision WHA71(15), the World Health Assembly envisaged the “Five-year Global Strategic Plan to improve public health preparedness and response, 2018–2023” and decided that the States Parties and the Director-General shall continue to report annually to the Health Assembly on the implementation of the International Health Regulations (2005), using the self-assessment annual reporting tool. The Health Assembly also requested the Director-General to provide the necessary financial and human resources to support the implementation of the five-year Global Strategic Plan and to continue to provide support to Member States to build, maintain and strengthen their Core Capacities under IHR (2005).

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18. Member States, with the support of WHO, will need to continue to maintain momentum over the reporting of IHR (2005) implementation status using the new annual reporting tool, and measure progress through other complementary voluntary instruments under the IHR Monitoring and Evaluation Framework (IHR-MEF) as necessary. WHO will provide technical support to Member States in developing or strengthening national action plans for health emergency preparedness with emphasis on country ownership, intersectoral coordination and strategic partnerships.

19. Resolution WHA71.4 urged Member States to include cholera in national policies and plans, establish national multisectoral cholera and acute diarrhoea prevention and surveillance mechanisms, strengthen surveillance and early reporting of cholera in line with IHR (2005), and strengthen community involvement. It also requested the Director-General to help bolster surveillance and reporting of cholera in line with IHR (2005); to increase capacity to support countries to scale up their long-term cholera prevention, control and elimination ability; and to continue leading the management of the oral cholera vaccine stockpile.

**Actions already taken in the Region**

20. In 2017, all 11 Member States reported using the self-assessment questionnaire. Bangladesh, Bhutan, Indonesia, Maldives, Myanmar, Sri Lanka and Thailand have conducted Joint External Evaluations (JEE) and Indonesia, Myanmar and Sri Lanka are developing national action plans with technical assistance from WHO.

**Actions to be taken in the Region**

21. The Democratic People’s Republic of Korea, Nepal and Timor-Leste have plans for JEE and Bangladesh has plans for initiating the National Action Plan on Health Security (NAPHIS).
3. Polio transition and post-certification (Regional One Voice intervention made at the Seventy-first World Health Assembly); and Eradication of poliomyelitis (resolution WHA71.16 titled ‘Poliomyelitis – containment of polioviruses’)

**Background**

22. The Executive Board, after considering the report on polio transition planning, requested the Director-General, through decision EB142(2) (2018), to submit to the Seventy-first World Health Assembly a detailed Strategic Action Plan on polio transition, aligned with the priorities and strategic approaches of the Thirteenth General Programme of Work 2019–2023.

23. The Strategic Action Plan was submitted to the Seventy-first World Health Assembly in May 2018, through the report by the Director-General on polio transition and post certification contained in document A71/9. The Regional One Voice (RoV) intervention on this Agenda item, appreciating the Strategic Action Plan on polio transition and highlighting key priorities and necessary collaborative actions to achieve the objectives of the transition.

**Main operative paragraph and implications on the collaborative activities with Member States of the South-East Asia Region**

25. The Regional One Voice from the Member States of the WHO South-East Asia Region expressed an overall appreciation of the transition strategy, and especially its three objectives. However, to achieve the key objectives of polio transition, the following priorities/areas of support were identified in the RoV:

   i. Need for global political will and effort as well as the technical endeavour of WHO and partners for sustaining a polio-free world after the eradication of polio.

   ii. Need for a comprehensive approach towards strengthening the immunization systems that is aimed at effective prevention and control of vaccine-preventable diseases, and aligned with country and regional priorities.

   iii. Polio surveillance and laboratory networks would be essential resources that countries can build upon to strengthen IHR Core Capacities to effectively contain or respond to a polio event, including containment of polio viruses in specialized facilities.

   iv. WHO’s technical assistance was also requested by Member States to support countries to:

          (a) strengthen the overall health systems, including vaccine preventable diseases (VPD) surveillance and response plans; and

          (b) coordinate the global withdrawal of bivalent oral polio vaccine and access to inactivated polio vaccine (IPV) as well as the availability of vaccines and funds for any poliovirus outbreak response.

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**Actions already taken in the Region**

26. A very high degree of commitment has been assured from the ministries of health for a seamless transition of polio assets and capacities and implementation of the post-certification strategy.

27. Draft national transition plans have been finalized for five SEA Region Member States – Bangladesh, India, Indonesia, Myanmar and Nepal – and these are now under consideration by the national governments.

28. Allocation of domestic resources has been partially secured in India and Indonesia for ensuring longer-term financial sustainability of the networks.

**Actions to be taken in the Region**

29. The following actions need to be taken in the Region:

   i. Issue a call to priority countries, especially those that have stopped poliovirus transmission, namely Bangladesh, India, Indonesia, Myanmar and Nepal, to finalize their national transition plans.

   ii. Conduct discussions with key stakeholders on transition plan options to focus on:
       (a) a systematic transition of polio assets and capacities; and
       (b) allocation of domestic resources to ensure longer-term financial sustainability of the networks.

   iii. Implementation of the post-certification strategy for polio eradication, and the role of WHO and Member States in it.

   iv. Given the uncertainties around eradication timelines and the Global Polio Eradication Initiative (GPEI) budget beyond 2019, the Strategy will be a “living document”, and therefore regular updates need to be provided to the Governing Bodies including the regional committees, the Executive Board and the World Health Assembly.

   v. Integration of polio essential functions into the WHO Programme Budget 2020–2021, for both immunization and other programme areas, with better articulation of costs and the financial implications.
4. Health, environment and climate change (Regional One Voice intervention made at the Seventy-first World Health Assembly)

Background

30. Under Agenda item 11.4 of the Seventy-first World Health Assembly, the document A71/104 contained an updated report by the Director-General on Health, Environment and Climate Change and the adopted decision EB142(5) (2018), in which it requested the Director-General, inter alia, to: (i) develop a draft action plan for the special initiative to address the health effects of climate change, initially in small island developing states (SIDS), for consideration by the Seventy-second World Health Assembly, and (ii) to develop a draft comprehensive Global Strategy on health, environment and climate change, to be also considered by the Seventy-second World Health Assembly and the 144th Session of the Executive Board.

31. The Agenda item also presented Document A71/10/Add.15 which provided a progress report on the roadmap for an enhanced global response to the adverse health effects of air pollution that were developed pursuant to resolution WHA68.8, and presented Document A71/116 (for further guidance) on actions taken on the interlinkages between human health and biodiversity that will be considered to prepare WHO’s contribution to the fourteenth meeting of the Conference of the Parties of the Convention on Biological Diversity. Work done under the Workers’ Health Global Plan of Action (2008–2017) was also presented as a progress report to the Seventy-first World Health Assembly.

Main operative paragraph and implications on the collaborative activities with Member States of the South-East Asia Region

32. Maldives delivered the Regional One Voice (RoV) Statement at the Seventy-first World Health Assembly on behalf of the South-East Asia Region. In the statement, Member States drew attention to the particular vulnerability of countries in the Region to the adverse impacts of climate change, air pollution and other environmental risks. The statement also drew attention to (i) the significance of the working environment going beyond occupational health; (ii) the work undertaken to lay the foundation for adapting to climate change impacts on health; and (iii) the endorsement of the Male Declaration on Building Health Systems Resilience to Climate Change that was adopted at the Seventieth session of the WHO Regional Committee for South-East Asia.

33. The RoV statement also drew attention to the participation of Maldives and Timor-Leste in the Director-General’s Special Initiative on Climate Change in SIDS. Finally, the RoV statement looked forward to the development of the Global Strategy for health, environment and climate change, and requested the Director-General with other partners to support additional resource mobilization efforts and strategic deployment of resources to execute necessary actions at the country level.

34. Member States welcomed the updated information presented at the Seventy-first World Health Assembly and looked forward to the development of the comprehensive strategy and progress on other initiatives to be presented at the Seventy-second World Health Assembly.
**Actions already taken in the Region**

35. The draft global strategy on health, environment and climate change is under preparation. According to the Decision of the 142nd session of the Executive Board, the draft Global Strategy is to be prepared in consultation with Member States and in coordination with the regional offices and with other relevant United Nations Programmes and Specialized Agencies such as the United Nations Environment Programme. The decision asks the Regional Committees to comment on and provide inputs to the draft Strategy, which is due for completion by October 2018 ahead of the 144th Session of the Executive Board. An early draft of the Strategy has been prepared by the Secretariat at WHO headquarters and was sent to Member States for comments by the Regional Office.

36. Bearing in mind the tight timelines for consideration of the draft Strategy, a WHO South-East Asia Regional Consultation on the Draft Global Strategy on Health, Environment and Climate Change was held on 23–24 August 2018 in New Delhi, India. The objectives of the Consultation were to share experiences, challenges and success stories with work on health, environment and climate change; to prepare report on the draft Strategy for the consideration of the Seventy-first Session of the WHO Regional Committee for South-East Asia; and to discuss and envision operational models for implementation of the Strategy when adopted by the World Health Assembly.

**Actions to be taken in the Region**

37. A summary report of the Regional Consultation has been prepared and is included as an addendum to the Working Paper. It is requested that the summary report is considered by the Seventy-first Session of the WHO Regional Committee for South-East Asia.
5. Addressing the global shortage of, and access to, medicines and vaccines (decision WHA71(8) titled ‘Addressing the global shortage of, and access to, medicines and vaccines’ and Regional One Voice intervention made at the Seventy-first World Health Assembly)

Background

38. During the Seventy-first World Health Assembly in May 2018 a comprehensive report by the Director-General on addressing the global shortage of, and access to, medicines and vaccines was presented to Member States.

39. The report (A71/12) focused on a list of priority options for actions to be considered by Member States, and was extensively discussed during the Health Assembly leading to the decision WHA71(8). Many Member States felt that considering the priority options presented with regard to their likely impact on affordable, reliable access to safe, effective and appropriately used medicines and vaccines, all “possible actions” should be considered carefully and clearly described in a roadmap report that will define WHO’s work for the next five years.

The WHA71(8) decision:

40. The Seventy-first World Health Assembly requested the Director-General to:

   i. elaborate a roadmap report, in consultation with Member States, outlining the programming of WHO’s work on access to medicines and vaccines, including activities, actions and deliverables, for the period 2019−2023; and
   ii. submit this roadmap report to the Seventy-second World Health Assembly in 2019 for its consideration, through the Executive Board at its 144th Session.

Actions already taken in the Region

41. The preparation of the roadmap document was initiated by WHO headquarters in May and WHO’s internal consultations with the inputs of all regional offices, including SEARO, were completed by 30 June 2018. During July and August 2018, the draft roadmap document will be available online for public consultation. A Member States consultation is planned in mid-September 2018 in WHO headquarters in Geneva.

42. The roadmap document will identify specific actions and deliverables in 10 activity areas as shown below, aligned with various global, regional resolutions and strategic documents.

Draft roadmap activity areas

43. The report to the Seventy-first World Health Assembly in May 2018 proposed prioritized actions, i.e. those that provide value for money and lead to achievable and sustainable improvements, with WHO having a comparative advantage to provide leadership for their implementation.

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44. These prioritized actions have been consolidated into 10 action areas of the roadmap, and are as follows:

i. Ensuring that research and development for medicines and vaccines meets public health needs.

ii. Implementation of fair pricing and financing policies for medicines and vaccines.

iii. Application and management of intellectual property to innovation and promotion of public health.

iv. Improving procurement and supply chain management of medicines and vaccines.

v. Appropriate prescribing, dispensing and use of medicines.

vi. Strengthening regulatory systems to ensure quality, safety and efficacy of medicines and vaccines.

vii. Preparedness for emergencies.

viii. Ensuring good governance.

ix. Improving the collection and use of key data on medicines and vaccines.

x. Strengthening pharmaceutical workforce.

**Action to be taken in the Region**

45. The Regional Office in collaboration with WHO headquarters will facilitate wide dissemination of the draft roadmap to key focal points in all SEA Region Member States to ensure that comments and inputs that take into consideration the regional perspective are well represented in the global consultation process that will finalize the roadmap document to be submitted at the 144th Session of the Executive Board by November 2018.
6. Preparation for the third High-Level Meeting of the UN General Assembly on the prevention and control of Noncommunicable diseases, to be held in 2018 (resolution WHA71.2 titled ‘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’ and Regional One Voice intervention made at the Seventy-first World Health Assembly)

Background

46. Noncommunicable diseases – which include cardiovascular diseases, cancer, diabetes and chronic respiratory diseases – account for 40 million deaths each year (70% of all deaths) globally. In the SEA Region, NCDs are the cause of 8.8 million deaths annually (64% of all deaths) with 4.4 million of them being premature deaths (50% of all NCD deaths).

47. Following the Political Declaration of the High-Level Meeting of the UN General Assembly on the Prevention and Control of NCDs promulgated vide UN General Assembly resolution 66/2 on 19 September 2011, the World Health Assembly endorsed the Global Action Plan for the Prevention and Control of Noncommunicable Diseases 2013–2020 in May 2013.


49. The 2014 United Nations General Assembly Outcome Document on NCDs included four strategic time-bound national commitments for the transformation to be implemented in 2015 and 2016.

50. 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. the updated Appendix 3 of the Global Action Plan through the 140th Session of the Executive Board.

51. The Seventieth World Health Assembly endorsed the updated Appendix 3 of the Global Action Plan and noted the approach to regulate the contributions of non-State actors towards achieving the global voluntary targets.

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52. The 140th Executive Board vide EB140.R7 requested the Director-General to submit a report on the preparation for the 2018 High-Level Meeting (HLM) on Noncommunicable Diseases to the Seventy-first World Health Assembly in May 2018, and urged Member States to follow up on their international commitments and support the preparation process for the 2018 High-Level Meeting.

Main operative paragraph and implications on the collaborative activities with Member States of the South-East Asia Region

53. Agenda 11.7 of the Seventy-first World Health Assembly was mainly a procedural resolution (A71/A/CONF./27) that urged Member States to:

i. continue to step up efforts for the prevention and control of noncommunicable diseases in order to attain the Sustainable Development Goal target 3.4 by 2030;

ii. actively engage in the preparations at the national, regional and global levels for the third High-Level Meeting of the UN General Assembly on the Prevention and Control of Noncommunicable Diseases to be held in 2018; and

iii. be represented at the level of Heads of State and Government at the High-Level Meeting of the UN General Assembly on the Prevention and Control of Noncommunicable Diseases, and to call for action therein through a concise, action-oriented outcome document.

54. Agenda 11.7 also requests the Director-General to report to the Seventy-second World Health Assembly, through the Executive Board, on the outcomes of the High-Level Meeting of the UN General Assembly and its follow-up.

55. The Seventy-first World Health Assembly adopted the resolution on 24 May 2018.

Actions already taken in the Region

56. The following actions have already been taken in the Region:

i. All 11 Member States have developed national multisectoral noncommunicable disease prevention and control policies, strategies and action plans, and nine Member States have endorsed these at their highest Constitutional levels.

ii. All Member States have established a dedicated NCD department or unit within the Ministry of Health with separate budgetary allocations from the government.

iii. All Member States have reported the implementation of at least one fiscal policy intervention related to NCDs; the most common being tobacco and alcohol taxation.

iv. All Member States of the Region reported the inclusion of NCDs in their current national health plans and it is also being reflected in the respective national development agendas.

v. All countries have developed time-bound national targets and indicators.

vi. All Member States have developed essential drugs lists and diagnostics but its implementation is at different stages.

vii. Three Unified Task Force (UNITAF) missions have been completed in the Region in Bhutan, India and Sri Lanka, as well as the follow-up mission to Sri Lanka on 23–28 April 2018.

viii. The most cost-effective interventions for tobacco control are in place in all SEA Region Member States.

ix. Interventions for strengthening the primary health care system response to NCDs have been initiated in all Member States.

x. The implementation of the Dili Declaration of 2015 on Tobacco Control and the Colombo Declaration of 2016 on NCDs has been initiated in all Member States.

xi. The NCD Country Capacity Survey 2017 has been completed, the data validated, and the preliminary regional report published.

xii. All Member States have strengthened their frontline health-care systems to deal with major NCDs with special focus on human resources development. Special government programmes have been initiated in India, Indonesia, Nepal, Sri Lanka and Timor-Leste.

xiii. NCD management policies have been developed with WHO technical support, such as a policy on CVDs, cancer, diabetes and oral health, etc., in all Member States.

xiv. HPV vaccination to combat cervical cancer has been initiated in Bangladesh, Bhutan, Indonesia, Nepal, Sri Lanka and Thailand.

xv. All Member States have initiated the implementation of the set of “best buys” and dietary NCD risk reduction strategies.

**Actions to be taken in the Region**

57. Negotiations on the draft outcome document of the third High-Level Meeting of the UN General Assembly on Prevention and Control of Noncommunicable Diseases titled “Time to deliver: Accelerating our response to address NCDs for the health and well-being of present and future generations”, have already begun in New York. Permanent missions of countries to the United Nations are participating in these discussions. The ministries of health of Member countries need to be in constant dialogue with their foreign ministry counterparts on this and follow up with necessary inputs.

58. The ministries of health of Member countries should engage fully ahead of the participation by their Heads of States for the High-Level Meeting. It is extremely important to ensure the participation of all Heads of State from the Member countries of the South-East Asia Region and delivery of their statements at the main segment of the meeting.

59. The global high-level independent Commission on NCDs launched its report on 1 June 2018 with six robust recommendations. High-level political advocacy at the country level, based on these recommendations, is important and should be jointly conducted by the WHO Regional Office and country offices and ministries of health.

60. The participation of the honourable ministers who would share national experiences during the relevant segments of the High-Level Meeting will make a substantial difference to the outcome.
7. **Preparation for a High-Level meeting of the UN General Assembly on ending tuberculosis** (resolution WHA71.3 titled ‘*Preparation for a high-level meeting of the General Assembly on ending tuberculosis*’ and Regional One Voice intervention made at the Seventy-first World Health Assembly)

**Background**

61. The WHO South-East Asia Region bears close to 45% of the global burden of tuberculosis, which is the leading infectious disease killer responsible for an estimated 700 000 deaths annually in the Region. The TB epidemic, including drug-resistant tuberculosis, poses a serious threat to public health security and is a priority area in the ongoing global response to antimicrobial resistance.

62. The World Health Assembly in May 2017 had concluded that actions on TB at all levels were falling far short of the needs and that high-level global support as well as regional and national commitments on tuberculosis were required.

63. All Member States of the Region vide the Delhi Call for Action in March 2017, the Moscow Declaration in November 2017, and the Delhi Statement of Action in March 2018, have committed to accelerating efforts towards ending TB through multisectoral engagement at the highest level, additional resources commensurate with the requirements for ending TB, patient-centred quality care in all sectors for all forms of TB, and through promoting research and innovation on TB.

**Main operative paragraphs in resolution WHA71.3**

64. According to the resolution, Member States are required to:

   i. support the preparations for the High-Level Meeting of the United Nations General Assembly in 2018 on tuberculosis, including enabling high-level participation; and

   ii. pursue the implementation of all commitments made vide the above-mentioned Statements and Declarations to End TB.

65. The resolution also requests the Director-General of WHO to:

   i. continue to support the UN Secretary-General and the General Assembly in the preparations for the High-Level Meeting;

   ii. continue to provide strategic and technical leadership, assistance, advice and support to Member States; and

   iii. develop the draft multisectoral accountability framework working closely with Member States and partners and present the same at the UN General Assembly.

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Main operative paragraphs in Regional One Voice (RoV) intervention

66. During the Seventy-first World Health Assembly, with relation to the Agenda 11.8, DPR Korea on behalf of the Member States of the WHO South-East Asia Region made a Regional One Voice intervention. The intervention:

i. committed to strengthen TB services and accelerate case detection, and involve civil society in this, while focusing on TB preventive therapy; and

ii. supported the preparations for the High-Level Meeting of the UN General Assembly and ensure participation at the meeting to implement the action-oriented political declaration.

Actions already taken in the Region

67. The Regional Office continues to encourage Member States to participate in the UN General Assembly High-Level Meeting at the highest political level, including that of Head of State or Government.

68. Member States have clearly voiced their commitment towards “Ending TB” at the key meetings held in Delhi in 2017 and 2018.

69. The Regional Office has approached India and Indonesia to co-host a Side-event during the UN General Assembly High-Level Meeting.

Actions to be taken in the Region

70. The following actions need to be taken in the Region:

i. Member States may like to ensure participation from the highest leadership levels at the High-Level Meeting.

ii. Continued coordination between Member States, WHO and partners to facilitate a strong and unified “regional voice” during the High-Level Meeting and leverage support for ending TB taking into account the disease burden and other regional specificities, including those of countries on the verge of ending TB, as well as humanitarian needs.

iii. Member States may send timely inputs to WHO on the Accountability Framework and support its finalization and adoption.

iv. WHO must collaborate with Member States in organizing the Side-event during the High-Level Meeting on TB and encourage participation from key global, regional and country partners at the event.
8. Global snake-bite burden (resolution WHA71.5 titled ‘Addressing the burden of snakebite envenoming’)

Background

71. Snake-bites kill an estimated 81,000–138,000 people annually worldwide and cause physical and psychological disability in as many people as four to five times the mortality figure. Individuals affected by snake-bite are overwhelmingly from among members of impoverished agricultural and herding communities and are usually 10–40 years of age. Several factors including poor prevention, lack of health worker training, delayed diagnosis and lack of accurate treatment of cases of snake-bite, as well as unavailability of tools for prevention, diagnosis and treatment of the disease impede further progress in addressing snake-bite envenoming.

72. Mindful of the magnitude of the problem, the paucity of data, and the disproportionate suffering which could result in catastrophic health expenditure and exacerbation of poverty that in turns hinders the attainment of SDG goals, the WHO Strategic and Technical Advisory Group for Neglected Tropical Diseases categorized snake-bite envenoming as a high-priority neglected disease at its tenth meeting\textsuperscript{11} in Geneva in March 2017.

73. A draft resolution was proposed at the 142nd Executive Board vide Agenda item 4.1 by 26 Member States. Two of these (India and Thailand) were from the South-East Asia Region. The Executive Board recommended the adoption of resolution EB142.R4. The Seventy-first World Health Assembly endorsed the resolution (WHA71.5).

Main operative paragraph and implications on the collaborative activities with Member States of the South-East Asia Region

74. It is important to have an effective national public health strategy for the prevention and control of snake-bite envenoming which should outline cost-effective measures in prevention, diagnosis, early treatment and case management, and include rehabilitation for low-resource settings. It is important to integrate such a strategy into the national health strategy to ensure universal coverage. Some countries of the South-East Asia Region, such as Sri Lanka, have such a strategy in place. Other countries may follow the model.

75. The transfer of knowledge and technology between Member States should be encouraged to improve global availability of antivenoms and for the effective management of cases.

76. Joint training programmes to train relevant health workers on the diagnosis and management of snake-bite envenoming can support the implementation of national snake-bite programmes.

77. Joint efforts in the development (sharing/translation) and dissemination of educational, information and communication material to emphasize the importance of the community in creating awareness about this problem and its simple solutions. Snake-bites are more common in remote and rural areas that are often far from medical facilities. Community involvement, therefore, could be very effective.

78. Relevant stakeholders and donors must be brought together to mobilize resources to support this initiative.

**Actions already taken in the Region**

79. The WHO Regional Office for South-East Asia had developed and published the *Guidelines for the Management of Snake-bites* as part of a special issue of the *South-East Asian Journal of Tropical Medicine and Public Health* in 1999 in an effort to address the major public health problem of snake-bite in the Region. This was followed by the publication of the guidelines as an independent regional document in 2011. With new technical advances in the field, the guidelines were revised again in 2016 with the help of regional and global experts.

80. WHO designated the Queen Saovabha Memorial Institute, Bangkok, Thailand, as a collaborating center on snake venom and toxicology to provide support to Member States in strengthening their capacity for the management of snake-bites.

**Actions to be taken in the Region**

81. It is important to prepare a Region-specific comprehensive, strategic, evidence-based (based on the regional review) roadmap for appropriate reduction and control of the snake-bite cases. It is important to prioritize disease-specific measures (e.g. primary care, improving supportive therapy, strengthening production/evidence-based selection/procurement and quality of antivenoms, and rehabilitation) that will have a rapid and substantial impact on the major current challenges that hinder the prevention, treatment and recovery following snake-bite envenoming.

82. To the greatest extent possible the roadmap should integrate the prevention, control and treatment of snake-bite envenoming within existing health systems and the health system responses to the health of populations.

83. Cooperation and collaboration among Member States, the international community and relevant stakeholders will further bolster national capacities to control, prevent and treat snake-bite envenoming.
9. Physical activity for health (resolution WHA71.6 titled ‘WHO global action plan on physical activity 2018–2030’ and Regional One Voice intervention made at the Seventy-first World Health Assembly)

Background

84. Physical inactivity is a leading risk factor for the cause of premature death from noncommunicable diseases. Insufficient physical activity is estimated to cause 3.2 million global deaths a year\(^\text{12}\). Physical inactivity together with sedentary behaviours increases all causes of mortality, disease-specific mortality, as well as the risk of many NCDs.

85. According to the WHO Global Report on NCDs\(^\text{12}\), 23% of adults and 81% of adolescents aged 11–17 years worldwide do not meet the global recommendations for physical activity, based on the current guidelines. The prevalence of physical inactivity in the adult population of the WHO South-East Asia Region was 15% and that of inadequate physical activity among adolescents was 74%.

86. The Region also has a high gender discrepancy when it comes to levels of physical activity. Apart from adolescents, women, older adults, underprivileged groups and poor people, and those with disabilities and chronic diseases are more likely to be physically inactive.

87. The effective promotion of physical activity needs a comprehensive framework, covering interventions that focus on individuals, targeted population groups, and universally across populations.

88. Traditional methods including yoga have been proven for their effectiveness and relevance to the context.

Main operative paragraph and implications on the collaborative activities with Member States of the South-East Asia Region

89. The Global Action Plan on Physical Activity (GAPPA)\(^\text{13}\) contains four strategic objectives, namely: (i) create an active society; (ii) create active environments; (iii) create active people; and (iv) create active systems. It recommends 20 effective and feasible policy actions to guide national planning, accelerate implementation and address cross-cutting supports/requirements.

90. The GAPPA recommends Member States to adopt the voluntary global target of 15% reduction of prevalence of physical inactivity by 2030. This is an extension from the 10% relative reduction of physical inactivity by 2025 – or the so-called the 10x25 target – as part of the global NCD voluntary target. A 15% reduction target is achievable but requires efforts to accelerate actions and work in coordination with all relevant stakeholders.

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91. The resolution WHA71.6 requests the Secretariat to further develop a monitoring framework by 2018 which will include impact and process indicators to monitor the implementation of this action plan. Besides, the progress report will be in line with the NCD reporting cycles in 2021, 2026 and 2030. The global monitoring framework should take into consideration the utilization of routine data mechanisms and existing databases to avoid reporting burden to Member States.

92. The resolution also requests WHO to develop the first Global Status Report on Physical Activity that will include sedentary behaviour.

**Actions already taken in the Region**

93. The Regional Office has implemented the Regional Committee resolution SEA/RC69/R4 on the similar technical subject of physical activities and sedentary behaviours.

94. All SEA Region Member States have a clear national policy to promote physical activity that is integrated with the existing policy frameworks of NCD prevention and control, healthy lifestyle campaign and health promotion. School health programmes in all countries also include some elements of promotion of physical activity. Few countries, however, have a clear policy on addressing sedentary behaviour at the national level.

95. Most SEA Region Member States have installed surveillance systems, which contain survey elements on physical activity among adult and youth populations. These include the NCD STEP Survey, Global School Health Survey, District Health Survey, and National Health Exam Survey.

96. The Regional Office also supports the involvement of experts and nominated delegations from SEA Region Member States for the development of GAPPA.

97. The Regional Office has demonstrated its capacity to serve as a role model over physical activity, promoting physical activity exercises at its Governing Body and other meetings, and has installed physical activity facilities in its buildings.

98. Good practices in the Region have been shared through WHO channels, including the WHO Bulletin and websites. These include promoting physical activity in public spaces and discussing the roles of the local government in Thailand, the School Health Programme in Sri Lanka, and open-air gymnasiums in Bhutan, and the established electronic repository on physical activity promotional materials in the department website.

99. The Regional Office has established a repository webpage for physical activity promoting materials, including short video clips received from Member States. WHO also conducted the walk-the-talk initiative at the Seventy-first World Health Assembly on 20 May 2018 that was attended by delegations from the Member States of the Region and staff from the Regional Office.

100. The SEA Regional Status Report on Physical Activity and Health is in the process of finalization. This report contains current data on both health behaviours and determinants, as well as physical activity policy and infrastructures in the Region.
**Actions to be taken in the Region**

101. The following actions need to be taken in the Region:

   i. Disseminate the GAPPA and communicate with SEA Region countries for the upcoming new guidelines, including at the Seventy-first Session of the Regional Committee.

   ii. Implement resolution SEA/RC69/R4 together with relevant provisions of resolution WHA71.8 on the same subject.

   iii. Organize the regional launch of GAPPA (and, if possible, the new WHO physical activity guidelines) that has been tentatively planned as a Side-event to the Prince Mahidol Award Conference 2019 (with the theme of NCDs).

   iv. Support Member States in developing/revising their national strategies, policies and plans of action to promote physical activity (based on GAPPA with the new targets for 2030).
10. mHealth (resolution WHA71.7 titled ‘Digital health’ and Regional One Voice intervention made at the Seventy-first World Health Assembly)

**Background**

102. The concept of “digital health” refers to the use of information and communications technology (ICT) for health and health-related fields. The spread of digital health has a significant potential to accelerate the progress of Member States towards achieving universal health coverage (UHC) and the measuring of progress on a number of the Sustainable Development Goals. Governments have found it challenging to assess, scale up and integrate digital solutions due to the multiplicity of pilot projects, lack of data linkages across platforms, and absence of standards. Two prior resolutions on digital health (eHealth) were adopted by the World Health Assembly – WHA58.28 (2005) and WHA66.24 (2013) – promoting the development of national eHealth strategies and adherence to standards. This new resolution mainly focuses on improving digital health implementation with concrete actions and requests over areas for WHO to support.

**Main operative paragraph and implications on the collaborative activities with Member States of the South-East Asia Region**

103. Digital health should become more systematically implemented and scaled up effectively, drawing from established standards-based and inter-operable solutions and lessons learnt. WHO and development partners should continue to provide technical support in the areas of digital health governance, planning, architecture, application of standards and interoperability, programme management, and systems development and implementation.

**Actions already taken in the Region**

104. SEA Region Member States adopted a Regional Strategy for strengthening eHealth in the South-East Asia Region, WHO (2014–2020)\(^{14}\) to address (i) policy and strategy, (ii) tools and methods, (iii) collaboration and partnerships, and (iv) human resource development.

105. WHO established the Asia eHealth Information Network (AeHIN) in 2012 in Bangkok, Thailand. This informal network of health information and digital health professionals includes members from 10 of the 11 Member States of the Region which participate in bi-weekly webinar sessions, training opportunities, and annual conferences to address technical areas in digital health development.

106. Digital health (eHealth) strategies and/or plans have been implemented in eight of the 11 Member States.

**Actions to be taken in the Region**

107. A regional Member States’ technical consultation on digital health is being planned on 10–11 October 2018 in Colombo, Sri Lanka, immediately following the Asia-Pacific Regional

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Conference on Interoperable Digital Health for UHC. The meeting will review the implementation of the Regional Strategy for Strengthening eHealth, discuss the different aspects of the World Health Assembly resolution on digital health, and identify and address the next steps. Member States in the Region have specifically emphasized the need for implementation guidance.

108. The new Global Digital Health Partnership is planning to hold a global forum on digital health in India in 2019.
11. Improving access to assistive technology (resolution WHA71.8 titled ‘Improving access to assistive technology’ and Regional One Voice intervention made at the Seventy-first World Health Assembly)

Background

109. Assistive technology, a subset of health technology, refers to assistive products and related systems and services that are developed for people to maintain or improve functional capabilities, and thereby promote well-being. People with disability, older people, people suffering from noncommunicable diseases, those living with mental health conditions including dementia and autism, and people coping with gradual functional decline benefit from assistive products.

110. WHO estimates that there are currently more than one billion people who would benefit from one or more assistive products. With populations ageing rapidly and widely and the prevalence of noncommunicable diseases rising across the world, this figure may rise to two billion by 2050, with many older people needing two or more products as they age.

111. Today only one in 10 people have access to assistive products, owing to a lack of financing, unavailability, limited awareness, shortage of trained personnel and high costs. For example, 70 million people the world over need a wheelchair but only 5%–15% have access to one. Moreover, 200 million people with low vision do not have access to spectacles or other low-vision devices.

112. Through a series of resolutions – WHA66.4 (2013), WHA67.7 (2014), WHA69.3 (2016), and WHA70.13 (2017), – the World Health Assembly called on Member States, inter alia, to improve access to assistive technology for older people, people with disabilities and people suffering from vision and hearing loss.

Main operative paragraph and implications on the collaborative activities with Member States of the South-East Asia Region

113. Agenda item 12.5 of the Seventy-first World Health Assembly dealt primarily with resolution WHA71.8 which urges Member States to:

   i. develop, implement and strengthen policies and programmes, as appropriate, to improve access to assistive technology and ensure that adequate and trained human resources for the provision and maintenance of assistive products are available at all levels of health and social service delivery;

   ii. develop a national list of priority assistive products that are affordable and cost-effective and meet minimum quality and safety standards;

   iii. promote or invest in research, development, innovation and product design in order to make existing assistive products affordable; and encourage international and/or regional collaboration for the manufacturing, procurement and supply of priority assistive products, ensuring that these remain affordable and available across borders;

   iv. invest in and promote inclusive barrier-free environments so that all people who need assistive technology can make optimum use of it, in order to live independently;
v. promote the inclusion of priority assistive products and inclusive barrier-free environments within emergency preparedness and response programmes;

**Actions already taken in the Region**

114. All Member States have been provided with a model Priority Assistive Products List (APL) from which a national priority assistive products list can be developed according to national needs.

115. Multisectoral meetings on disability and assistive technology and environment building for adoption of the Priority Assistive Products List have been supported in Member States such as Bangladesh, India, Nepal, Sri Lanka and Timor-Leste.

116. A Stakeholders’ Consultative Workshop on “Managing Disabilities: Role of Assistive Technologies (AT)” was organized by the Indian Council of Medical Research (ICMR), with support from the WHO South-East Asia Regional Office, in New Delhi in December 2017.

117. A multistakeholder meeting on “Rehabilitation 2030 in the South-East Asia Region”, and Workshop of the WHO Technical Working Group for the WHO Package of Priority Rehabilitation Interventions, supported by WHO headquarters and M.S. Ramaiah Medical College, Bengaluru, was held in Bengaluru, India, on 16–20 April 2018.

118. A multisectoral meeting – National Workshop on Assistive Technology – was also held in Bhutan in May 2018 with the support of WHO headquarters.

119. WHO Nepal is supporting its Ministry of Health and Population in developing a list of priority assistive products for the country.

120. Resolution WHA71.8 on Assistive Technology has been widely disseminated to Member States, experts, WHO collaborating centres, institutions, NGOs, manufacturers and other stakeholders.

**Actions to be taken in the Region**

121. The following actions need to be taken in the Region:

   i. continue to provide the necessary technical and capacity-building support to Member States in the development of national assistive technology policies and programmes;

   ii. provide technical and capacity-building support to countries, on request, to assess the feasibility of establishing regional or subregional manufacturing, procurement and supply networks for assistive technology;

   iii. contribute to and engage in, as appropriate, the development of minimum standards for priority assistive products and services, in order to promote their safety, quality, cost-effectiveness and appropriateness;

   iv. provide technical and capacity-building support to countries, on request, to support the establishment of national assistive technology centres;

   v. produce a status paper on assistive technology in the region; and

   vi. support and encourage Member States for integration of assistive products into services at the district, subdistrict and primary health care levels.
12. Maternal, infant and young child nutrition (resolution WHA71.9 titled ‘Infant and young child feeding’ and Regional One Voice intervention made at the Seventy-first World Health Assembly)

Background

122. The progress in implementing the Comprehensive Implementation Plan on Maternal, Infant and Young Child Nutrition15 (CIPMIYCN) was outlined, including the following details on infant and young child feeding (IYCF):

i. Measures taken to give effect to the International Code of Marketing of Breast-milk Substitutes (the Code) (resolution WHA34.22, 1981), and subsequent resolutions.

ii. WHO’s new normative guidance and technical tools to improve infant and young child feeding (IYCF). These include the guideline and implementation guidance on the Baby-friendly Hospital Initiative (BFHI); implementation manual on ending the inappropriate promotion of foods for infants and young children; and NetCode toolkit for monitoring and enforcing the Code.

Main operative paragraph and implications on the collaborative activities with Member States of the South-East Asia Region

123. The original draft resolution sponsored by Ecuador was revised and tabled by Russia and Panama, after the United States of America tabled a competing draft due to sensitivities on the inclusion of the WHO guidance on ending inappropriate marketing of food and beverages to infant and young children (resolution WHA69.9) and the WHO toolkits to promote enforcement of the breast-milk code and subsequent World Health Assembly resolutions. The revised document omitted the reference to the draft conflict of interest document and other WHO tools and guidance. Nepal and Thailand were among the 18 original co-sponsors, and the formal drafting group meeting was chaired by Thailand. All Member States of the SEA Region supported the resolution.

124. The resolution on IYCF was tabled and endorsed by the Seventy-first World Health Assembly, and it urged Member States to:

i. increase investment on the protection, promotion and support of breastfeeding;

ii. reinvigorate the BFHI, as well as promote full integration of the revised “Ten Steps to Successful Breastfeeding” in nutrition programmes;

iii. implement and/or strengthen national monitoring and enforcement mechanisms for the effective implementation of national measures to implement the Code and subsequent relevant Health Assembly resolutions and other evidence-based recommendations;

iv. promote timely and adequate complementary feeding in accordance with the guiding principles for complementary feeding;

v. continue taking all necessary measures in the interest of public health to implement recommendations to end the inappropriate promotion of foods for infants and young children; and

vi. take all necessary measures to ensure evidence-based and appropriate infant and young child feeding during emergencies.

**Actions already taken in the Region**

125. All Member States have implemented policies and programmes in line with the Comprehensive implementation plan on maternal, infant and young child nutrition, and these have a particular focus on IYCF.

126. Seven Member States have enacted legal measures with regard to the Code. Thailand was the last country to do so in 2017, with technical support provided by WHO.

127. A regional consultation to protect, promote and support breastfeeding with a focus on BFHI was held in December 2017 in Delhi to update Member States on the new tools and guidance and develop plans to mainstream and scale up BFHI and improve monitoring of the Code using NetCode. Since then, four Member States have initiated scaling up of BFHI and three Member States are planning the implementation of NetCode tools to enforce monitoring of the Code.

**Actions to be taken in the Region**

128. The following actions need to be taken in the Region:

   i. Further advocacy, dissemination and technical support to be provided to Member States to implement WHO tools on IYCF, including scaling up BFHI, Code monitoring through NetCode, and breastfeeding support during emergencies.

   ii. Continue to advocate to countries and provide technical support to implement the WHO guidance on Ending Inappropriate Promotion of Foods for Infants and Young Children.
13. Pandemic Influenza Preparedness Framework for the sharing of influenza viruses and access to vaccines and other benefits (decision WHA71(11) titled ‘Pandemic Influenza Preparedness Framework for the sharing of influenza viruses and access to vaccines and other benefits’ and Regional One Voice intervention made at the Seventy-first World Health Assembly)

Background

129. The Seventieth World Health Assembly decision WHA70(11)\(^{16}\) paragraph 8(b) addressed the issue of virus sharing and genetic sequence sharing, and tasked WHO with reviewing the issues related to the Nagoya Protocol and virus sharing and genetic sequence data (GSD) sharing, as well as the benefits of sharing under the PIP Framework.

Main operative paragraph and implications on the collaborative activities with Member States of the South-East Asia Region

130. Consultations with Member States, the Global Influenza Surveillance and Response System (GISRS), industry and civil society were held in July 2017 and November 2017 on these issues. An additional consultation will be held in October 2018 to continue the dialogue. Some Member States (including from the SEA Region) favour the addition of seasonal influenza (both viruses and GSD) into both the Member State requirements and benefits sharing under the PIP Framework. GISRS partners, including all six of the WHO collaborating centres for influenza, as well as industry, educational institutions, and others, are opposed to including seasonal influenza, because the burdens related to the tracking of shipments and notifications under the PIP Framework would become excessive and may result in facilities ceasing to engage in influenza work. Draft documents from the PIP Secretariat regarding these consultations will be prepared according to the agreed timeframe.

Actions already taken in the Region

131. Member States from the SEA Region have been in consultation as well as been represented among the members of the PIP Framework’s Advisory Group, and are expected to attend the follow-up meeting in October 2018. Issues related to the question include the current status of virus sharing under the current Framework – that is, not all Member States are sharing viruses or GSD in a timely manner as per the agreed upon Framework – and that this is making arguments in favour of an expanded Framework including seasonal influenza harder to justify.

Actions to be taken in the Region

132. Member States from the SEA Region will attend the follow-up meeting in October 2018 in Geneva in conjunction with the PIP Advisory Group.

14. Human resources: annual report (resolution WHA71.13 titled ‘Reform of the Global Internship Programme’ and Regional One Voice intervention made at the Seventy-first World Health Assembly)

Background

133. The Director-General’s report to the Seventy-first World Health Assembly\(^{17}\) highlighted the high priority being accorded to the WHO Global Internship Programme. Towards this end, the existing internship programme is proposed to be revamped to satisfy three specific criteria, namely, (i) fair and equitable access; (ii) offer an experience of high quality; and (iii) create a pool of potential “WHO champions”.

134. In furtherance of this approach, a global system for recruitment of interns was set up in the first half of 2018 with the objective of increasing the knowledge of and interest in WHO internships, both within the Organization and externally. The system allows easy real-time monitoring and reporting on the diversity of interns, thus permitting a targeted outreach, if required.

135. Various measures are being put in place to alleviate the financial burden placed on interns and, in particular, to attract and increase the number of interns from developing countries. This includes the provision of providing health insurance coverage to interns during the period of internship and in-kind support.

136. Other initiatives being considered include the development of a standard terms of reference to guide the hiring managers; a high-quality learning environment; a standard induction package; identification of common training activities beneficial for interns; issuance of internship completion certificates; and the provision for payment of stipends to interns from developing countries.

Main operative paragraph and implications on the collaborative activities with Member States of the South-East Asia Region

137. Acknowledging the efforts being made by WHO to reform its Global Internship Programme, the Seventy-first World Health Assembly, through the adoption of a resolution on the “Reform of the Global Internship Programme” (WHA71.13), has listed four objectives for improvement and called for a report in 2023 on the progress made.

138. Resolution WHA71.13 urges Member States to support WHO in mobilizing the resources necessary for financial sustainability and, where applicable, in-kind assistance for the internship programme, thereby ensuring that talented future health leaders from all Member States can equally access the programme, irrespective of economic circumstance.

**Actions already taken in the Region**

139. The Member States of the SEA Region – through their “Regional One Voice” statement at the Seventy-first World Health Assembly – recognized the value of WHO’s proposed initiatives towards strengthening the internship programme, which they acknowledged to be an important capacity-building platform to create future global health leaders. The statement called for strong leadership from the Director-General in addressing the various structural limitations, including the financial viability issue of the interns, so as to achieve the target of enrolling at least 50% of interns from developing countries by 2022.

140. In 2017, the SEA Region hosted around 2% of the total numbers of interns in WHO, and 68% of these belonged to developing countries.

**Actions to be taken in the Region**

141. The following actions need to be taken in the Region:

i. Provide inputs through the global network of WHO HR managers to initiatives proposed for strengthening the internship programme.

ii. Contribute to strategy and outreach measures to promote WHO internship opportunities for interns from SEA Region countries within our own country offices, in other Regions and at headquarters. SEA Region Member States must look into mechanisms to facilitate internship-related visas for nationals of other Member States.

iii. Use the lessons learnt from regional capacity-building mechanisms, such as, (i) the Junior Public Health Professionals’ (JPP) programme, that was conceived in order to provide valuable learning experiences and leadership skills to young professionals from health and health-related fields in SEA Region countries; and (ii) the Fellowships programme, which is also an important vehicle designed to meet specific training and capacity-building needs of health personnel in the Member States, to further improve internship programme.

Background

142. The Executive Board (EB) approved the WHO Evaluation Policy\(^8\) at its 131st Session in May 2012 (decision EB131(1)). The policy requires the Secretariat to report annually to the Board on progress in the implementation of evaluation activities.

143. After an independent review of the implementation of the evaluation policy and the framework for strengthening evaluation and organizational learning in 2017, it was recommended to revise it along with related documents originally issued in 2012. The draft revised 2018 evaluation policy was informed by inputs from the deliberations of Member States during the 142nd Session of the Executive Board in January 2018 and those of the Independent Expert Oversight Advisory Committee in March 2018.

144. The annual report\(^9\) presented to the 143rd Session of the Executive Board in May 2018: (i) provided information on the progress made in implementing the WHO Evaluation Policy, including the Organization-wide evaluation workplans for 2016–2017 and 2018–2019; and (ii) presented summaries of five recent evaluations for which management responses were available in order to document Organizational learning linked to the findings and recommendations.

145. The Independent Evaluation Office is actively engaged in both corporate evaluations and providing support to decentralized evaluations. Regarding evaluation capacity and resources, the engagement of regional and cluster focal points of the Global Network on Evaluation in corporate and decentralized evaluations has enabled greater coordination of evaluation activities at the three levels of the Organization.

Main operative paragraph and implications on the collaborative activities with Member States of the South-East Asia Region

146. The 143rd Session of the Executive Board in May 2018 noted that eight corporate evaluations/assessments were completed and their outcomes reported in the May 2017 and January 2018 Executive Board sessions.

147. The Executive Board was also updated on the progress of evaluations that were ongoing at the end of 2017, since the last report presented to the Executive Board at its 142nd Session in January 2018.

Actions already taken in the Region

148. Consistent with WHO’s Global Policy and the Region’s commitment and high importance given to evaluation, the WHO South-East Asia Regional Framework for Strengthening Evaluation

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for Learning and Development (SEA/RC70/6-Inf. Doc. 1-Rev.1 20) and SEA Region Evaluation Workplan for 2018–2019 (SEA/RC70/6-Inf. Doc. 2 21) were developed in 2017. The Framework and Workplan were presented to the Seventieth session of the Regional Committee in September 2017. These key documents further expand the culture of evaluation in the Regional Office and country offices.

149. Two evaluations started in 2017 are near completion: (i) Evaluation of Tobacco Control through MPOWER measures in SEA Region Member States, and (ii) Evaluation of collaboration between WHO and WHO collaborating centres in the South-East Asia Region. The first Country Office Evaluation undertaken by the WHO Evaluation Office in Thailand in 2017 provided valuable insights into developing the Global Evaluation Workplan for 2018–2019.

150. Implementation of the SEA Region Evaluation Workplan 2018–2019 is underway with two evaluations being commissioned: (i) 10 years of SEARHEF implementation in the SEA Region; and (ii) Relevance and Impact of National Immunization Technical Advisory Groups in countries.

Actions to be taken in the Region

151. The Following actions need to be taken in the Region:

   i. Full status report on the implementation of the SEA Region Evaluation Workplan 2018–2019 is being prepared to be presented to the Seventy-first Session of the Regional Committee.

   ii. Ongoing monitoring to ensure evaluations are fully independent in accordance with WHO’s Evaluation Policy and Regional Framework.

   iii. Assessment of the implementation of the SEA Region Evaluation Workplan 2018–2019 and documentation of lessons. Based on the findings, review the process with Member States, including criteria, to identify the most relevant evaluation themes for the Region and update the plan accordingly.


Annexures
Thirteenth General Programme of Work, 2019–2023

The Seventy-first World Health Assembly,

Having considered the draft thirteenth general programme of work, 2019–2023, and welcoming its ambitious vision as expressed by the aspirational “triple billion” goals;

Noting that approval of the Thirteenth General Programme of Work, 2019–2023 does not imply approval of the financial estimate contained in document EB142/3 Add.2,

1. APPROVES the Thirteenth General Programme of Work, 2019–2023;

2. URGES Member States to support work towards achievement of the vision of the Thirteenth General Programme of Work, 2019–2023;

3. REQUESTS the Director-General:

   (1) to use the Thirteenth General Programme of Work as the basis for the strategic direction of planning, monitoring and evaluation of WHO’s work during the period 2019–2023, and to develop programme budgets in consultation with Member States, based on a realistic assessment of income and WHO’s capacity;

   (2) to take into consideration the changing state of global health in implementing the Thirteenth General Programme of Work, and to keep Member States informed of progress with implementation through regular updates to the governing bodies;

   (3) to provide guidance and support to regional and country offices on the implementation of the Thirteenth General Programme of Work, taking into account different contexts;

   (4) to provide a report to the Seventy-fifth World Health Assembly to inform potential extension to 2025 of the Thirteenth General Programme of Work in order to align with the wider United Nations planning cycle.

Sixth plenary meeting, 25 May 2018
A71/VR/6

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1 Document A71/4.
Implementation of the International Health Regulations (2005): five-year global strategic plan to improve public health preparedness and response, 2018–2023

The Seventy-first World Health Assembly, having considered the draft five-year global strategic plan to improve public health preparedness and response; recalling decision WHA70(11) (2017), in which the Seventieth World Health Assembly took note of the report contained in document A70/16 on implementation of the International Health Regulations (2005);¹ global implementation plan and requested the Director-General, inter alia, “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”; recalling that Member States may use any voluntary monitoring and evaluation instruments, including those referenced in the five-year global strategic plan; and appreciating the contribution of Member States to the extensive consultative process to develop the draft five-year global strategic plan, including discussions at the sessions of all six regional committees in 2017, the web-based consultation conducted by the Secretariat between 19 September and 13 October 2017, and the consultation of Member States, through the Permanent Missions in Geneva, organized on 8 November 2017,

(1) decided:

(a) to welcome with appreciation the five-year global strategic plan to improve public health preparedness and response, noting that this does not create any legally binding obligations for Member States, and mindful of the legally binding nature of the International Health Regulations (2005) obligations;

(b) that States Parties and the Director-General shall continue to report annually to the Health Assembly on the implementation of the International Health Regulations (2005), using the self-assessment annual reporting tool;

(2) requested the Director-General:

(a) to provide the necessary financial and human resources to support the implementation of the five-year global strategic plan, and, as necessary, its adaptation to regional contexts and existing relevant frameworks;

¹ Document A71/7.
(b) to continue to submit every year a single report to the Health Assembly on progress made in implementation of the International Health Regulations (2005), containing information provided by States Parties and details of the Secretariat’s activities, pursuant to paragraph 1 of Article 54 of the International Health Regulations (2005);

(c) to continue to provide support to Member States to build, maintain and strengthen core capacities under the International Health Regulations (2005).

Seventh plenary meeting, 26 May 2018
A71/VR/7
Cholera prevention and control

The Seventy-first World Health Assembly,

Recalling resolution WHA64.15 (2011) on cholera: mechanism for control and prevention, which led to the revitalization of the Global Task Force on Cholera Control to support Member States to reduce the public health, social and economic consequences of cholera by strengthening WHO’s work in this area, and improving collaboration and coordination among stakeholders;

Recognizing the report by the Director-General on WHO’s work in health emergencies\(^1\) and the Global Task Force on Cholera Control’s recently launched strategy, Ending Cholera: A Global Roadmap to 2030,\(^2\) large-scale outbreaks of cholera continue to cause significant morbidity and mortality among vulnerable populations in both emergency and endemic settings. With an estimated disease burden of 2.9 million cases and 95,000 deaths every year worldwide, the disease still affects at least 47 countries around the globe, with a potential to spread where water, sanitation and hygiene conditions are inadequate;

Acknowledging that the prevention and control of cholera require a coordinated and multisectoral approach that includes access to appropriate health care, early case management, access to safe water, sanitation, education, health literacy and improved hygiene behaviours, with adjunct use of oral cholera vaccines, strengthened surveillance and information sharing, strengthened laboratory capacity and community involvement, including action on the social determinants of health;

Acknowledging also that cholera control is both a matter of emergency response in the case of outbreaks, and a matter of development when the disease is endemic in high-risk contexts, such as in camps for refugees and internally displaced people;

Affirming that progress towards the 2030 Agenda for Sustainable Development including commitment to Goal 3 (Ensure healthy lives and promote well-being for all at all ages); Goal 6 (Ensure availability and sustainable management of water and sanitation for all); and Goal 11 (Make cities and human settlements inclusive, safe, resilient and sustainable), would reduce the prevalence and spread of cholera, along with other diarrhoeal diseases and enteric infections;

Recalling that all States Parties must comply with the International Health Regulations (2005);

Acknowledging that cholera, as a disease of epidemic potential, has to be recognized in itself and reported separately from other diarrhoeal diseases, within national surveillance systems, as not doing so hampers effective control measures,

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\(^{1}\) Document A71/6.

1. URGES Member States:¹

(1) to foster the identification by governments of cholera epidemics and to elevate cholera as a State priority in affected countries through its inclusion in national policies and plans, either as a stand-alone plan or embedded within broader diarrhoeal disease control initiatives, or within national health, health security, water, sanitation and hygiene, development and Sustainable Development Goal implementation plans, where relevant, and national disaster and/or emergency management agencies;

(2) to develop and implement, in affected countries, a multisectoral package of selected effective prevention and control measures, including long-term water, sanitation and hygiene services, access to appropriate health care, access to safe water, sanitation and improved hygiene behaviours, as well as infrastructure development along with associated capacity-building activities for operations, maintenance and repairs and sustainable financing models adapted to the local transmission pattern for long-term control or elimination;

(3) to ensure that national policies and plans regarding the prevention and management of cholera comprise all areas with high-risk of cholera transmission;

(4) to establish national multisectoral cholera and acute diarrhoea prevention and surveillance mechanisms in affected countries to coordinate the implementation of the control or elimination plan, ensuring representation of the different ministries, agencies, partners and communities involved in cholera control efforts;

(5) to strengthen capacity for: preparedness in compliance with the International Health Regulations (2005), early detection and treatment, laboratory confirmation, case management and immediate and effective response to outbreaks in order to reduce the public health, social and economic impact;

(6) to strengthen surveillance and early reporting of cholera in line with the International Health Regulations (2005), and build capacity for data collection and analysis, including information on critical determinants including water and sanitation coverage;

(7) to strengthen community involvement, social mobilization in cholera prevention, early detection, household water treatment and storage, and other related water, sanitation and hygiene response activities;

(8) to support, including through international cooperation, research for better prevention and control, including research for improved vaccines and better rapid diagnostics and treatment; and to support monitoring of antimicrobial resistance;

(9) to refrain from implementing health measures that are more restrictive of international traffic and more invasive or intrusive to persons than reasonably available alternatives that would achieve the appropriate level of health protection, in line with the International Health Regulations (2005);

¹ And, where applicable, regional economic integration organizations.
(10) to establish national targets, when applicable, and make financial and political commitments to cholera control with national Sustainable Development Goal implementation plans;

2. REQUESTS the Director-General:

(1) to strengthen surveillance and reporting of cholera in line with the International Health Regulations (2005) and to further reinforce advocacy, strategic leadership and coordination with partners at all levels via the Global Task Force on Cholera Control secretariat and working groups, including by providing technical support and operational guidance to countries for cholera prevention and control;

(2) to increase capacity to support countries to scale up their ability to implement and monitor multisectoral, integrated interventions for long-term cholera prevention, control and elimination; interventions for preparedness and response to cholera epidemics in accordance with the global initiatives of Ending Cholera: A Global Roadmap to 2030 and aligned with national plans to encourage reporting, monitor progress and disease burden in order to inform country and global strategies; and interventions for control or elimination;

(3) to support countries, upon request, in the assessment of cholera risk factors and capacity for multisectoral engagement within existing technical resources;

(4) to continue leading the management of the oral cholera vaccine stockpile to enable a sufficient global supply, including the support to and monitoring and evaluation of oral cholera vaccine use, and where appropriate vaccine campaigns, in cooperation with relevant organizations and partners, including UNICEF and the GAVI Alliance;

(5) to monitor and support long-term cholera prevention and control and elimination programmes at country and regional levels;

(6) to develop and promote an outcome-oriented research and evaluation agenda for cholera, targeted to address important knowledge gaps, to the improvement of implementation of existing interventions, including for water sanitation and hygiene, and to the development of improved vaccines for better and more durable prevention and outbreak control covering all aspects of cholera control;

(7) to raise the profile of cholera at the highest levels on the global public health agenda, and to strengthen coordination and engagement of multiple sectors, particularly water, sanitation and hygiene, and other non-health sectors such as finance and infrastructure development;

(8) to report to the Seventy-third World Health Assembly, through the Executive Board at its 146th session, on the global cholera situation and evaluate efforts made in cholera prevention and control.

Seventh plenary meeting, 26 May 2018
A71/VR/7
Regional One Voice (RoV) intervention made by the
Member States of the WHO South-East Asia Region

WHA71 Agenda 11.2: Public health preparedness and response

Lead country: Bangladesh Supporting country: Nepal

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 “Public health preparedness and response”.

2. All countries of the South-East Asia Region are prone to various types of emergencies such as:
   a. natural hazards (e.g. earthquake, cyclones, floods);
   b. disease outbreaks (e.g. Cholera, Ebola, MERS-CoV, Avian Influenza); or
   c. complex emergencies.
   The health consequences of these emergencies are often devastating, including deaths, illnesses, disabilities, psycho-social distress.

3. In SEA Region, seven Member States (BAN, BHU, INO, MAV, MMR, SRL, THA) have completed Joint External Evaluation in 2016-2017 and 3 Member States are likely to conduct JEE in 2018. Four Member States are in process for developing their National Action Plan based on the JEE they conducted to strengthen systems to handle these emergencies.

4. Chair, of note is the Grade 3 emergency caused by the largest and fastest influx of the Rohingya population in Bangladesh since 25 August 2017.

5. Chairperson, indeed the IOAC visited Bangladesh and SEARO to look at the response in Cox’s Bazar. Let me share that in response to the humanitarian crisis, Bangladesh, Ministry of Health and Family Welfare has managed with all of its resources to address this event.
The IOAC was impressed by the progress in WHE implementation at SEARO and WHO’s response. We also would like to thank the secretariat for the WHO response for: vaccination campaigns (Cholera, Measles, Diphtheria Polio etc.); technical support, and uninterrupted provision of medicines, equipment and medical camp kits (MCKs). We are also thankful to the over 100 partners on the ground who continue to assist in this emergency.

6. Chair, we appreciate the WHO’s timely support to manage the post-disaster health problems. We would like to underscore that several countries in the SEA Region have the potential to contribute to minimize these public health risks. Still, we have challenges of:
   • insufficient funding;
   • limited access and capacities of national health systems and partners;
   • shortages of health personnel; and
   • procurement delays.
We urge the global community to work together to be better prepared and respond promptly to these emergencies.

7. Finally, we would like to emphasize on the need for sustainable funding to support implementation of IHR and National Action Plans for Health Security. With this, the importance of good governance, transparency and accountability to minimize the gaps in public health preparedness and response needs to be underscored.

8. With these context, we, on behalf of the SEA Region Member States, would like to support:
   a. the EB142 recommendation to the WHA71 for the adoption of the decision to endorse the five-year global strategic plan and to report annually using self-assessment annual reporting tool. This will further accelerate the implementation of the IHR and build stronger/resilient health systems; and
   b. The proposed Cholera prevention and control resolution (A71/A/CONF./3) which supports “Ending Cholera: A Global Roadmap to 2030” aligned with national plans and SDGs.

Thank you, Chairman.
Poliomyelitis – containment of polioviruses

The Seventy-first World Health Assembly,

Having considered the report on eradication of poliomyelitis;¹

Recalling resolution WHA65.5 (2012) on poliomyelitis: intensification of the global eradication initiative and WHA68.3 (2015) on poliomyelitis, and in which the Health Assembly urged all Member States inter alia to implement appropriate containment of all polioviruses starting with the serotype 2;

Noting the eradication of wild poliovirus type 2 globally, declared by the Global Commission for the Certification of the eradication of poliomyelitis in September 2015;

Acknowledging the continued progress in eradicating poliovirus types 1 and 3;

Recognizing the successful globally synchronized switch in April 2016 from the use of trivalent to bivalent oral polio vaccine, active only against poliovirus types 1 and 3;

Noting the development of the Polio Eradication and Endgame Strategic Plan 2013–2018, including objective 3 – containment and certification, considered by the Sixty-sixth World Health Assembly;²

Commending the work of WHO and the Global Commission for the Certification of the eradication of poliomyelitis in promoting the containment of all polioviruses, starting with type 2, the first serotype being eradicated;

Noting with alarm delays in implementation and certification of poliovirus containment for type 2 polioviruses planned for 2016, as well as the accidental release of wild poliovirus type 2 from a vaccine-production facility in 2017;

Underscoring the urgent need to accelerate globally activities to implement and certify containment of polioviruses;

Underlining that successful containment of all polioviruses will ensure the long-term sustainability of the eradication of poliomyelitis,

¹ Document A71/26.
² Document WHA66/2013/REC/3, summary records of the ninth meeting of Committee A, section 1.
1. **URGES all Member States:**

   (1) to fully implement all strategic approaches outlined in the Polio Eradication and Endgame Strategic Plan 2013–2018;

   (2) to intensify efforts to accelerate the progress of poliovirus containment certification as outlined in national requirements as well as in the WHO Global Action Plan to minimize poliovirus facility-associated risk after type-specific eradication of wild polioviruses and sequential cessation of oral polio vaccine use (GAPIII);

   (3) to complete inventories for type 2 polioviruses, destroy unneeded type 2 materials and to begin inventories and destruction of unneeded type 1 and 3 materials in accordance with the latest available published WHO guidance;

   (4) to ensure that any confirmed event associated with a breach in poliovirus containment is immediately reported to the National IHR Focal Point;

2. **URGES all Member States retaining polioviruses:**

   (1) to reduce to a minimum the number of facilities designated for the retention of polioviruses, prioritizing facilities performing critical national or international functions;

   (2) to appoint, as soon as possible and no later than the end of 2018, a competent National Authority for Containment that will process containment certification applications submitted by the facilities designated to store and/or handle poliovirus post-eradication and communicate its contact details to WHO by 31 March 2019;

   (3) to make available to the National Authority for Containment all necessary resources, including technical, personnel and financial, required for the full and successful certification of implementation of appropriate poliovirus containment measures;

   (4) to request facilities designated to retain poliovirus type 2 to formally engage in the Containment Certification Scheme by submitting to their National Authorities for Containment their applications for participation, which is the first step of the global certification process, as soon as possible and no later than 31 December 2019;

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1 And, where applicable, regional economic integration organizations.


(5) to initiate steps for the containment for wild type 1 and 3 materials so that, by the time of global certification of eradication, all facilities retaining poliovirus meet containment requirements;

(6) to prepare a national response framework for use in the event of a breach of poliovirus containment and risk of community exposure and to conduct a polio-outbreak simulation exercise that covers the risk of poliovirus release from a facility;

3. REQUESTS the Director-General:

   (1) to provide technical support to Member States in their efforts to implement poliovirus containment safeguards and certify that facilities retaining poliovirus meet the requirements outlined in the WHO Global Action Plan to minimize poliovirus facility-associated risk after type-specific eradication of wild polioviruses and sequential cessation of oral polio vaccine use (GAPIII);

   (2) to facilitate the harmonization of certification mechanisms for the long-term sustainability of the implementation of poliovirus containment in the post-eradication era;

   (3) to update all WHO’s recommendations and guidance on poliovirus containment, as and when needed;

   (4) to report regularly to the Executive Board and the Health Assembly on progress and on the status of global poliovirus containment, aligned with other polio reporting requirements.

Seventh plenary meeting, 26 May 2018
A71/NR/7
Regional One Voice (RoV) intervention made by the
Member States of the WHO South-East Asia Region

WHA71 Agenda 11.3:  Polio transition and post-certification

Lead country:  Myanmar  Supporting country:  Nepal

THANK YOU MR.CHAIRMAN!

1. MYANMAR takes the floor on behalf of the eleven Member States in WHO SEA Region who appreciate the strategic action plan on polio transition, aligned with the priorities and strategic approaches of the draft thirteenth general programme of work 2019–2023, contained in document A71/9.

2. Clear identification of the capacities and assets, especially at country level, that are required to sustain progress in other programmatic areas and to maintain a polio-free world after eradication will be crucial in implementation of the post-certification strategy for polio, and to ensure that national health sector plans reflect the need to sustain the polio-essential functions necessary for a polio-free world.

3. Sustaining a polio-free world after eradication of polio virus will also need global political will and effort and technical endeavour of WHO and partners.

4. Polio surveillance and laboratory networks would be essential resources that countries can build upon to strengthen IHR core capacities in order to effectively contain or respond to a polio event, including containment of live polio virus in specialized laboratories.

5. We also need a comprehensive approach of immunization system strengthening aimed at effective prevention and control of vaccine-preventable disease, aligned with country and regional priorities.

6. In this, we request WHO to provide technical assistance to assist countries to strengthen overall health systems, including VPD surveillance and response plans, coordinating the global withdrawal of bivalent oral polio vaccine and access to safe and effective vaccines, especially Inactivated Polio Vaccine (IPV) and Type 2 containing OPV.
7. **We request WHO to support priority countries to develop logical and systematic transition plan from oral polio vaccine to inactivated polio vaccine (IPV), taking seriously IPV stock out incidents after the global switch from tOPV to bOPV in 2016.** In addition, as for the type 2 outbreak response plan, **WHO should also formulate response plans for any polio case with quick mobilization of vaccines and funds globally.**

8. We look forward to the integration of polio essential functions into the WHO Programme Budget 2020–2021, for both immunization and other programme areas.

9. The programmatic risks and challenges associated with the polio ramp down are substantial and, to deal with them, seamless transition of polio assets and capacities continues to be a priority for the Region, with a very high commitment of Ministries of Health.

10. **Draft National Transition Plans are under consideration in all 5 SEA Region countries, by the national governments, namely Bangladesh, India, Indonesia, Myanmar and Nepal.** Discussion on the Transition plan options with key stakeholders are focused on systematic transition of polio assets and capacities, with due emphasis on allocation of domestic resources for ensuring longer-term financial sustainability of the networks.

11. All the South-East Asia Region countries are committed to maintaining "Polio free region status", and here we would like to commend, in particular, the Government of India, for putting significant domestic resources into the programme. India is also setting an example by constructively engaging in polio transition to sustain the GPEI funded assets and capacities, reflected through its funding support for the polio laboratory network as well as to migrate from polio to public health. Likewise, Government of Indonesia has initiated actions to self-fund a large proportion of the surveillance, laboratory and immunization costs, previously funded by GPEI.

12. With these words, we support the efforts being made in finalizing national transition plans by governments in all countries especially those which have stopped poliovirus transmission and look forward to the implementation of the post-certification strategy for polio eradication.”

Thank you very much.
Regional One Voice (RoV) intervention made by the Member States of the WHO South-East Asia Region

WHA71 Agenda 11.4: Health, environment and climate change

Lead country: Maldives  Supporting country: Bangladesh

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 sharing the comprehensive updates.

2. Member States in South-East Asia Region are particularly vulnerable to the adverse impacts of climate change, air pollution and other environmental risks. SEA Region Member States also recognize the significance of working environments, which go beyond the technical area of occupational health, and are unfortunately neglected in the environmental health framework. Chair, air pollution both household and ambient, is our key concern. The Region accounts for a disproportional share of the global burden of diseases attributable to air pollution. The rapid acceleration of urbanization in the Region calls for robust implementation of effective preventive actions and the health sector needs to be fully engaged in these actions. All sectors should be made aware of the mitigation measures and that health sector should build its resilience to climate change.

3. SEA Region Member States, with support of WHO and partners, have already laid the foundation for adapting to climate change impacts on health. We have endorsed the Male’ Declaration on building health systems resilience to climate change during the 70th Regional Committee in 2017.

4. One aspect of our concern is that negative effects of climate change and other environmental risks are inequitably distributed across population groups. It disproportionately affects children, young population, elderly, women and other vulnerable groups, including informal workers. We therefore, strongly urge that targeted support needs to be provided for the most vulnerable nations and populations.
5. The political commitment and investment need to reach a scale sufficient to address these challenges globally. The absence of adequate commitment and measures to cut carbon emissions contributing to climate change, Member States have already suffered great loss of life and damage to crucial health infrastructure resulting from extreme weather events. In addition, addressing the upstream drivers of hazards to health are required for regular monitoring and review of progress towards the Goals and targets of the 2030 Agenda for Sustainable Development.

6. Moreover, Chair, a holistic and integrative strategy is anticipated making full use of existing conventions and international agreements while leveraging additional support. Mainstreaming health and biodiversity linkages into national strategies and programs provides novel opportunities for nature-based solutions for strengthening system resilience. We call for the effort to foster further scientific research on the links between biodiversity and health.

7. We appreciate the efforts of WHO, UNEP, WMO and the Secretariat of the UNFCCC in launching a global initiative on Health, Environment and Climate Change and look forward to considering the proposed global strategy on health, environment and climate change.

8. Chair, SEA Region Member States urge DG to expedite the process to apply WHO for the Green Climate Fund, and also collaborate with other accredited agencies during this period.

9. We, eleven Member States from SEA Region, appreciate initiatives and progresses in this technical area. Our two Small Island Developing States have participated in the development of the SIDs initiative and look forward to see its launching. We are grateful for the development of the Global Strategy on Health, Environment, and Climate change. We stand ready to discuss this Strategy in our Regional Committee this September in New Delhi. Lastly, Chair, we request the Director–General with other partners to support additional resource mobilization efforts and strategic deployment of resources to support actions at country-level.

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

The Seventy-first World Health Assembly, having considered the report on addressing the global shortage of, and access to, medicines and vaccines,1 decided to request the Director-General:

(1) to elaborate a road map report, in consultation with Member States, outlining the programming of WHO’s work on access to medicines and vaccines, including activities, actions and deliverables for the period 2019–2023;

(2) to submit this road map report to the Seventy-second World Health Assembly for its consideration in 2019, through the Executive Board at its 144th session.

Sixth plenary meeting, 25 May 2018
A71/VR/6

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1 Document A71/12.
Regional One Voice (RoV) intervention made by the
Member States of the WHO South-East Asia Region

WHA71 Agenda 11.5: Addressing the global shortage of, and access to, medicines and vaccines

Lead country: Bangladesh Supporting country: India

Chairperson, Excellencies, Distinguished delegates,

1. The Bangladesh Delegation on behalf of 11 WHO Member States of the South-East Asia Region are fully aware that shortage of medicines and vaccines is a major global concern, calling for urgent action, and would like to thank the Secretariat for preparing the report on “Addressing the global shortage of, and access to, medicines and vaccines”.

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

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

4. 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.

5. 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.

6. The SEA Region Member States who have the expertise as well as experience on production of quality medicines and vaccines at affordable cost, have the capacity to fill the global gap of shortage of medicines and vaccines.
7. 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. Also, efforts to safeguard access to medicines for diseases which have been eradicated in countries; for instance Malaria in Sri Lanka and Maldives; are important.

8. When global shortages of essential medicines occur, the option of supporting qualified manufacturers in the SEA 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.

9. We would like to emphasize the importance of good governance, transparency and accountability being maintained throughout the supply chain for medical products and reiterate that, 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.

10. To meet the increasing cost of innovation, there is a need to boost public funding of research and development. We also note 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.

11. Finally, the WHO must ensure complementarity between the roadmap of WHO’s work on medicines and vaccines for the 2019-2023 period, on which the Health Assembly is invited to approve a decision, and the implementation of the principles of the GSPOA, in view of the criticality of de-linking the cost of R&D and pricing of the end products. Regular programme review of the GSPOA and proposed roadmap implementation will help us overcome hindrances in access to new products and supply and demand side shortages.

12. With the view to improve access to affordable, quality medicines, SEA Region Member States endorse the decision contained in document EB142(3).

Thank you, Chairman.
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 Seventy-first World Health Assembly,

Having considered the reports on the Preparation for the third High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases, to be held in 2018;¹

Having recognized that the Political Declaration of the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases² has catalysed action and retains great potential for engendering progress towards Sustainable Development Goal target 3.4 (by 2030, reduce by one third premature mortality from noncommunicable diseases through prevention and treatment and promote mental health and well-being);³

Noting with concern that, according to WHO, each year, 15 million people between the ages of 30 and 69 years die from a noncommunicable disease and that the current levels of decline in the risk of dying prematurely from noncommunicable diseases are insufficient to attain Sustainable Development Goal target 3.4 by 2030;

Welcoming the convening of the WHO Global Conference on Non-communicable Diseases,⁴ which was organized by Uruguay and WHO, co-chaired by Finland, the Russian Federation and Uruguay, from 18 to 20 October 2017 in Montevideo;

Welcoming also the convening of the WHO Global Dialogue on Partnerships for Sustainable Financing of Noncommunicable Disease (NCD) Prevention and Control hosted by the Government of Denmark and WHO, from 9 to 11 April 2018 in Copenhagen, recognizing the need to prioritize tackling noncommunicable diseases as an essential pillar of sustainable development and an integral part of countries’ efforts towards universal health coverage;

Recalling the Shanghai Declaration on promoting health in the 2030 Agenda for Sustainable Development, adopted at the 9th Global Conference on Health Promotion, held in China from 21 to 24 November 2016;

¹ Documents A71/14 and A71/14 Add.1.
² United Nations General Assembly resolution 66/2.
³ United Nations General Assembly resolution 70/1.
Taking note that the Director-General has established a WHO Independent High-level Commission on Noncommunicable Diseases\(^1\) and a WHO Civil Society Working Group on the third High-level Meeting of the General Assembly on NCDs;\(^2\)

Recalling United Nations General Assembly resolution 72/274 (2018) on the scope, modalities, format and organization of the third high-level meeting of the General Assembly on the prevention and control of non-communicable diseases,

1. WELCOMES the outcome document of the WHO Global Conference on the Prevention and Control of Non-communicable Diseases entitled “Montevideo roadmap (2018-2030) on the prevention and control of Noncommnicable Diseases as a sustainable development priority”,\(^3,4\) as a contribution to the preparatory process leading to the third High-level Meeting;

2. URGES Member States:\(^5\)
   
   (1) to continue to step up efforts on the prevention and control of noncommunicable diseases in order to attain Sustainable Development Goal target 3.4 by 2030;

   (2) to actively engage in the preparations at national, regional and global 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;

   (3) to be represented at the level of Heads of State and Government at the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases and to call for action through a concise, action-oriented outcome document;

3. REQUESTS the Director-General:
   
   (1) to continue to support Member States, in coordination with United Nations specialized agencies, funds and programmes as well as other stakeholders, in their efforts to reduce by one third premature mortality from noncommunicable diseases through prevention and control and promote mental health and well-being, including by applying evidence-based multisectoral and multistakeholder approaches;

   (2) to report to the Seventy-second World Health Assembly, through the Executive Board, on the outcomes of the third High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases and its follow-up.

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\(^3\) See Annex.


\(^5\) And, where applicable, regional economic integration organizations.
ANNEX

WHO GLOBAL CONFERENCE ON NCDS
PURSUING POLICY COHERENCE TO ACHIEVE SDG TARGET 3.4 ON NCDS
(MONTEVIDEO, URUGUAY, 18–20 OCTOBER 2017)

MONTEVIDEO ROADMAP 2018–2030 ON NCDS AS A SUSTAINABLE
DEVELOPMENT PRIORITY

1. We, Heads of State and Government, Ministers and representatives of State and Government participating in this Conference, have come together to restate our commitment to take bold action and accelerate progress to, by 2030, reduce by one third the premature mortality from non-communicable diseases (NCDs) in line with the 2030 Agenda for Sustainable Development. We continue to be inspired by the action catalysed by the 2011 Political Declaration of the UN General Assembly on NCDs, and the WHO Global Action Plan for the Prevention and Control of NCDs 2013–2020. We reaffirm our commitment to their implementation, according to national context.

2. We acknowledge that premature mortality from NCDs continues to constitute one of the major challenges for development in the 21st century, driven by economic, environmental and social determinants of health. Despite the remarkable progress achieved in some countries or regions, this has been highly uneven and insufficient to reach the global target on NCDs. Each year, 15 million people between the ages of 30 and 69 years die from an NCD; over 80% of these premature deaths occur in developing countries, disproportionately affecting the poorest and those furthest behind. Implementing coherent policies and ensuring that cost-effective, affordable and evidenced-based NCD interventions are available to all countries, according to national context and priorities, can reduce inequities and premature deaths from NCDs.

3. We recognize the importance of SDG 3 and ensuring that people not just survive, but live long and healthy lives, as well as the importance of preventing NCDs as specified in SDG target 3.4 on NCDs in achieving this overall goal. We also recognize that there are obstacles that countries must overcome to achieving SDG target 3.4. Addressing the complexity of the main risk factors, namely: tobacco use, physical inactivity, harmful use of alcohol and unhealthy diets, as well as air pollution, and the determinants of NCDs, including health literacy, requires multisectoral responses which are challenging to develop and implement, particularly when robust monitoring of NCD risk factors is absent at country level. Consequently, successful action requires enhanced political leadership to advance strategic, outcome-oriented action across sectors and policy coherence for the prevention and control of NCDs, in line with whole-of-government and health-in-all-policies approaches.

4. One obstacle at country level is the lack of capacity to effectively address public health goals when they are in conflict with private sector interests, in order to effectively leverage the roles and contributions of the diverse range of stakeholders in combatting NCDs. Policies to prevent and control

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1 Mainly four types of noncommunicable diseases (NCDs): cardiovascular diseases, cancers, chronic respiratory diseases and diabetes.

2 By 2030, reduce by one third premature mortality from noncommunicable diseases through prevention and treatment and promote mental health and well-being.
NCDs, including effective regulatory and fiscal measures, may be negatively influenced by private sector and other non-State actors’ interests, and may be subject to legal disputes or other means to delay, curtail or prevent their effective use to reach public health goals. Health systems need to improve NCD prevention, diagnosis and management and to strengthen effective health promotion over the life course, as part of efforts to achieve universal health coverage and reduce health inequities, including in the context of population ageing. Reducing NCDs should be a higher priority across the relevant UN Agencies, NGOs, philanthropic foundations and academic institutions. The increasing disease burden from NCDs should be taken fully into account in international cooperation and development policies with a view to address the unmet demand for technical cooperation to strengthen national capacities.

5. Unless coherent political action to address these obstacles is accelerated, engaging across sectors and across stakeholders, the current rate of decline in premature mortality from NCDs is insufficient to meet SDG 3.4 by 2030. In order to address the premature mortality and excess morbidity caused by NCDs, we commit to pursue these actions:

**Reinvigorate political action**

6. We will continue to address the complexity and challenging nature of developing and implementing coherent multisectoral policies across government through a health-in-all-policies approach in order to achieve improved outcomes from the perspectives of health, health equity and health system functioning.

7. We will prioritize the most cost-effective, affordable, equitable and evidence-based interventions that will bring the highest public health return on investment, in accordance with national context and priorities. We will emphasize health as a political priority, with measures that address the impact of the major NCD risk factors, including regulation, standard setting and fiscal policies and other measures that are consistent with countries’ domestic legal frameworks and international obligations.

8. We will act across relevant government sectors to create health-conducive environments and identify opportunities to establish concrete cross-sectoral commitments in order to promote co-benefits and to reduce negative impacts on health, including through health impact assessments. We will encourage NCDs implementation research to enhance the operationalization of national strategies and integrate them, where possible, within wider health sector strategic planning. We will work collaboratively to share and improve the implementation of best practices towards implementing innovative approaches to ensure improved surveillance and monitoring systems to support these actions.

**Enable health systems to respond more effectively to NCDs**

9. We will strengthen, as necessary, essential population level, people-centred public health functions and institutions for effective prevention and control of NCDs, including palliative care, and to promote mental health and wellbeing.

10. We will continue investing in health workers as an essential part of strengthening health systems and social protection. We will work to ensure a highly skilled, well-trained and well-resourced health workforce to lead and implement actions to promote health and prevent and control NCDs.
11. We commit to improve implementation of cost-effective measures of health promotion, including health literacy, and disease prevention throughout the lifecycle, early detection, health surveillance, and reduction of risk factors, including exposure to environmental risk factors, and sustained efforts to address people at risk, as well as the treatment and care for people with NCDs.

12. Recognizing that mental disorders and other mental health conditions contribute to the global NCD burden and that people with mental disorders and other mental health conditions have an increased risk of other NCDs and higher rates of morbidity and mortality, we commit to implementing measures to improve mental health and well-being, address their social determinants and other health needs and human rights of people with mental disorders and other mental health conditions and prevent suicides as part of a comprehensive response to NCDs.

13. We will work towards enhancing synergies in preventing and controlling communicable diseases and NCDs at the national, regional, and global levels, where appropriate, recognizing the opportunity to achieve gains through integrated approaches.

14. We will work to ensure the availability of resources and strengthen the capacity to respond more effectively and equitably to NCDs as part of Universal Health Coverage, including through strengthened community-level prevention and health services delivery and access to essential NCD medicines and technologies for all. In our health systems, we will strive to secure access to quality basic and specialised health services, including with financial risk protection in order to avoid social and economic hardship.

15. Recalling previous commitments, we will better measure and respond to the critical differences in specific risk factors and determinants affecting morbidity and mortality from NCDs for children, adolescents, women and men across the life course, and pursue and promote gender-based approaches for the prevention and control of NCDs to address these critical differences. We invite WHO to provide guidance on how to accelerate the implementation of national efforts to address the critical differences in the risks of morbidity and mortality from NCDs for men and women, boys and girls.

Increase significantly the financing of national NCD responses and international cooperation

16. We acknowledge that national NCDs responses – supported through domestic, bilateral and multilateral channels – require adequate, predictable and sustained financing, commensurate with the global health and socioeconomic burden they impose. We will start by prioritizing domestic budgetary allocations for addressing NCDs, where possible.

17. Where needed, we will work on national investments cases for the prevention and control of NCDs, their risk factors and determinants, to create the fiscal space for action. We will consider applying policy options that, in addition to having a positive effect on reducing the occurrence of NCDs throughout the life course, also have the capacity to generate complementary revenues to finance national NCD responses, as appropriate. These options may include, consistent with national policies and international obligations, taxation, including of tobacco as well as other products. We will continue to explore other complementary financing options, including voluntary innovative financing mechanisms, as appropriate.

18. We call upon UN agencies and other global health actors to scale up support to governments in developing and implementing the national responses for the prevention and control of NCDs, including palliative care aligned with national priorities. We look to WHO to continue to exercise its global leadership and coordination role and to explore how existing mechanisms could best be
leveraged to identify and share information on existing and potential sources of finance and development cooperation mechanisms for the prevention and control of NCDs at the local, national, regional and global levels to support action to reach SDG 3.4 on NCDs and better integrate NCDs into development funding mechanisms.

19. NCDs can perpetuate poverty. For the poor and near poor, chronic illness and disability can be an economic catastrophe. Hard fought economic gains can be quickly wiped out, especially when diagnosis, treatment, and palliative care services are not available or accessible. Women face a double NCD burden, often assuming gender-based roles as unpaid caregivers for the sick. We will take action on the impacts of NCDs on poverty and development using gender-based approaches. We strongly encourage including the prevention and control of NCDs in Official Development Assistance to complement domestic resources and catalyse additional resources for action, including research.

Increase efforts to engage sectors beyond health

20. We acknowledge that working constructively with public sectors beyond health is essential in reducing NCD risk factors and achieving health gains to reduce premature deaths from NCDs. In addition, we recognize the interconnectedness between the prevention and control of NCDs and the achievement of the SDGs beyond target 3.4, including targets related to poverty, substance abuse, nutrition, hazardous environmental exposure, sustainable cities and others. Coordinated upstream action across sectors, including agriculture, environment, industry, trade and finance, education and urban planning, as well as research, will help to create a healthy and enabling environment that promotes effective, coherent policies and supports healthy behaviours and lifestyles. The health sector has a role to play in advocating for these actions, presenting evidence-based information, supporting health impact assessments and providing policy reviews and analyses on how decisions impact health, including implementation research with a view to increase and scale up implementation of best practices. We therefore commit to strong leadership and to fostering collaboration among sectors to implement policies to achieve shared goals.

21. We will enhance policy and legal expertise to develop NCDs responses in order to achieve the SDGs. We call upon the UN Inter-Agency Task Force on the Prevention and Control of NCDs and its Members, within their mandates, to scale up and broaden intersectoral work integrating expertise relevant to public health-related legal issues into NCD country support, including by providing evidence, technical advice, and case studies relevant to legal challenges. We encourage the UN Inter-Agency Task Force on the Prevention and Control of NCDs to explore the relationship between NCDs and the law to improve support to Member States in this area and to raise the priority it gives to this work.

22. We recognize that access to education that promotes health literacy at all levels of society and contexts is a key determinant of health. In particular, the school environment will be enabled to provide evidence-based education, including information and skills. We will improve awareness-raising on health and well-being throughout society, including the prevention and control of NCDs supported through public awareness campaigns and health-conducive environments that make the healthy choice the easier choice and facilitate behavioural changes. Besides the general responsibility of relevant sectors to promote health, it is in particular the task of the health sector to develop and provide appropriate information to increase health literacy.

23. We will scale up efforts to use information and communication technologies, including e-health and m-health, and other non-traditional and innovative solutions, to accelerate action towards achieving SDG target 3.4 by 2030.
24. We are concerned that the increased production and consumption of energy-dense, nutrient poor foods has contributed to diets that are high in saturated fats, sugars and salts. We will work towards advancing the implementation of global strategies and recommendations that aim at strengthening national food and nutrition policies, and their monitoring. This would include, inter alia, developing guidelines and recommendations that support and encourage healthy diets throughout the life course of our citizens, increasing the availability and affordability of healthy, safe nutritious food, including fruits and vegetables, while enabling healthier food choices as part of a balanced diet, and ensuring access to clean and safe drinking water. We call on WHO and FAO and other relevant international organizations to fully leverage the UN Decade of Action on Nutrition to promote health-conducive food production and supply systems reduce diet-related NCDs and contribute to ensure healthy diets for all.

25. We call on WHO to fast-track its review of national and regional experience of intersectoral policies to achieve SDG 3, and particularly target 3.4 on NCDs, to update its guidance on multisectoral and multi-stakeholder action for the prevention and control of NCDs and disseminate knowledge and best practices through WHO GCM/NCD’s communities of practice in a manner supportive of action at country level.

Reinforce the role of non-State actors

26. We acknowledge the need to engage with non-State actors in view of their significant role for the advancement and promotion of the highest attainable standard of health and to encourage non-State actors to use their own activities to protect and promote public health, in line with national context and priorities.

27. We will increase opportunities for meaningful participation of, where and as appropriate, nongovernmental organizations, private sector entities, philanthropic foundations and academic institutions, in building coalitions and alliances across the spheres of sustainable development in the prevention and control of NCDs, recognizing that they can complement the efforts of governments at varying levels and support the achievement of SDG target 3.4, in particular in developing countries.

28. We call on the private sector, ranging from micro-enterprises to cooperatives to multinationals, to contribute to addressing NCDs as a development priority, in the context of the achievement of the SDGs, in particular SDG 17.2

Seek measures to address the negative impact of products and environmental factors harmful for health and strengthen the contribution and accountability of the private sector and other non-State actors

29. One notable challenge for the prevention and control of NCDs is that public health objectives and private sector interests can conflict. We commit to enhancing the national capacity to engage constructively with the private sector for NCDs prevention and control in a way that maximizes public health benefits.

30. We acknowledge that we need to continue to develop coordinated and coherent policies, strengthen evidence-based policy and regulatory frameworks, and align private sector incentives with

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1 WHO Global Coordination Mechanism on the Prevention and Control of NCDs (WHO GCM/NCD).
2 Strengthen the means of implementation and revitalize the global partnership for sustainable development.
public health goals, to make health conducive choices available and affordable in healthy environments, and in particular, to empower and provide people with the necessary resources and knowledge, including health literacy, in order to enable healthy choices and active lifestyles.

31. We further encourage the private sector to produce and promote more food and beverage products consistent with a healthy diet including by reformulating products, especially those products with the largest impacts on health, to provide healthier options that are affordable and accessible for all and that follow appropriate nutrition facts and labelling standards, including information on sugars, salt and fats and, where relevant, trans-fat content. We also encourage the private sector to reduce the exposure of and impact on children of marketing of foods and non-alcoholic beverages, consistent with WHO recommendations and guidance, and in accordance with national legislation, policies, and relevant international obligations.

32. We acknowledge the importance of improving environmental determinants and reducing risk factors in the prevention and control of NCDs and the inter linkage of SDG targets 3.4 and 3.9. These interlinkages illustrate that the prevention and control NCDs can also contribute positively to the SDG goal 13 on climate change. We will promote actions that are mutually reinforcing and support achievement of these goals and targets.

33. We will continue to work with all stakeholders, including industry, food business operators, health and consumer NGOs, and academia, towards the achievement of the nine voluntary NCD targets for 2025. This may include, as appropriate, promoting the recording and making publicly available of the verifiable commitments of non-State actors, as well as their reporting on the implementation of those commitments. We call on WHO to continue the development of expertise, tools, guidance and approaches that can be used to register and publish contributions of non-State actors in the achievement of these targets, and to assist Member States in effectively engaging non-State actors and leveraging their strengths in the implementation of national NCD responses.

34. We call upon States parties, to accelerate the full implementation of the WHO Framework Convention on Tobacco Control, as one of the cornerstones of the global response to NCDs and encourage countries that have not yet done so to consider becoming a Party to the Convention. Recognizing the fundamental and irreconcilable conflict of interest between the tobacco industry and public health, we will continue to implement tobacco control measures without any tobacco industry interference.

35. We encourage the WHO GCM/NCD to explore the impact of economic, market and commercial factors on the prevention and control of NCDs to better improve the understanding of their implications for health outcomes and opportunities to advance action in the global NCD agenda.

**Continue relying on WHO’s leadership and key role in the global response to NCDs**

36. We reaffirm WHO as the directing and coordinating authority on international health work and all its functions in this regard, including its normative work and convening role. WHO’s support is essential in the development of national NCD and mental health responses as an integral part of the implementation of the 2030 Agenda for Sustainable Development. WHO’s advice to Member States on how to address the determinants and risk factors remains indispensable for the global action on NCDs and mental health.

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1 By 2030, substantially reduce the number of deaths and illnesses from hazardous chemicals and air, water and soil pollution and contamination.
37. We also reaffirm WHO’s leadership and coordination role in promoting and monitoring global action against NCDs in relation to the work of other UN agencies, development banks, and other regional and international organizations in addressing NCDs in a coordinated manner.

38. We call on WHO to strengthen its capacity to provide technical and policy advice and enhance multistakeholder engagement and dialogue, through platforms such as the WHO GCM/NCD and the UN Inter-Agency Task Force on NCDs.

39. We further call on WHO to consider prioritizing the implementation of strategic actions, including cost-effective and evidence-based policies and interventions, in preparation of the third United Nations High-level Meeting on NCDs in 2018.

**Act in unity**

40. We acknowledge that the inclusion of NCDs in the 2030 Agenda for Sustainable Development provides the best opportunity to place health and in particular NCDs at the core of the pursuit of shared progress and sustainable development. Ultimately, the aspiration of the 2030 Agenda is to create a just and prosperous world where all people can exercise their rights and live long and healthy lives.

41. Acting in unity to address NCDs demands a renewed and strengthened commitment to show that we can be effective in shaping a world free of the avoidable burden of NCDs. In so doing, we will continue to listen to and involve the peoples of the world – those exposed to NCD risk factors, and those with health care needs for NCDs and mental health. We will continue to build a future that ensures present and future generations enjoy the highest attainable standard of health and well-being.

Seventh plenary meeting, 26 May 2018

A71/VR/7

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Regional One Voice (RoV) intervention made by the
Member States of the WHO South-East Asia Region

WHA71 Agenda 11.7: Preparation for the third High-level Meeting of the General Assembly on the Prevention and Control of Noncommunicable Diseases, to be held in 2018

Lead country: Timor-Leste Supporting country: Sri Lanka

Thank you, Chairperson.

Timor Leste delivers this intervention on behalf of 11 Member States of the South-East Asia Region.

We appreciate the continuous supports from the Secretariat. Many initiatives and technical tools have been made available since the first high-level meeting in 2011. The political declaration has set the way forward for us, including NCD global and regional action plans, global and regional targets, and progress indicators. We appreciate the recent efforts in updating the list of cost-effective interventions in the Appendix 3, the Montevideo NCD-road map 2018-2030, the establishment of the independent High-Level Commission on NCDs, the launch of the Bloomberg Fiscal Policy Commission, the WHO Dialogue on partnerships and financing NCDs, and many more.

All Member States in South-East Asia Region have prioritized NCD prevention and control as a public health significance. We reaffirm that utmost efforts within their capacity have been made by the respective Member countries to fulfill the four-time bound commitments as per the 2014 UN outcome document or the second High Level meeting.

We commend the Regional Director in declaring NCDs Best Buys implementation as the regional flagship.

On behalf of the Member countries, Timor Leste is pleased to mention notable progresses in our region. Apart from the progress made in general terms in the area of Governance, risk factor reduction, and NCD management, many Member States have implemented, Novel, innovative interventions over last few years.

All 11 Member States have developed national multisectoral NCD action plans, with time bound national targets and indicators; and all have established a dedicated NCD unit within the Ministries of Health with earmarked budgetary allocations.
All 11 Member States have implemented at least one fiscal policy intervention related to NCDs, in particular Tobacco and Alcohol Taxation, and that cost-effective tobacco control interventions are in place in all countries.

All 11 Member States have strengthened the frontline health care to deal with major NCDs with special focus on human resources development and deployment, national essential drug list and basic technologies.

With these progresses, Chair, however there are still many gaps and challenges to overcome in order to meet all the global and regional targets and SDG targets 3.4. Chair, we need to sustain, synergize and augment political commitments and to promote correct political choices, strengthen health system including access to medicines and diagnostic technologies particularly at primary health care level, further building up national capacities including legislation and enforcement, to coordinate with other sectors, to mobilize more resources, and finally to address commercial factors such as industry interference and trade of health-harming products. WHO certainly can help us addressing these gaps.

In addition, Chair, SEA Region is facing a sharp increase in sugar consumption in the region, particular in the forms of ultra-processed foods and beverages, and among our children and young population. High sugar consumption is an urgent concern for us to promote healthy diet and prevention of NCDs.

Most of all, chair, we have to shift our gear from discussion and planning to action mode.

Finally, we SEA Region countries stand ready to proactively participate and hope that the discussions at the 3rd High-level meeting will bring more robust and practical solutions to these challenges so that the aims for NCD Prevention and Control could be met.

Thank you, Chairperson.
Preparation for a high-level meeting of the General Assembly on ending tuberculosis

The Seventy-first World Health Assembly,

Having considered the reports on the preparation for a high-level meeting of the General Assembly on ending tuberculosis;¹

Noting with concern that tuberculosis remains the leading infectious disease killer in the world today, responsible for an estimated 1.3 million deaths and an additional 374 000 deaths among people living with HIV/AIDS in 2016, and that the epidemic, including drug-resistant tuberculosis, poses a serious threat to health security and is a priority in the response to antimicrobial resistance;

Reaffirming resolution WHA67.1 (2014) adopting the global strategy and targets for tuberculosis prevention, care and control after 2015, subsequently known as the End TB Strategy; and resolution WHA68.7 (2015) adopting the global action plan on antimicrobial resistance; as well as recalling the General Assembly resolution 71/3 (2016) “Political Declaration of the High-Level Meeting of the General Assembly on Antimicrobial Resistance”;

Recalling the General Assembly resolution 70/1 (2015), which adopted the 2030 Agenda for Sustainable Development and defined the Sustainable Development Goals, as well as the associated target of ending the tuberculosis epidemic by 2030;

Recalling further the report submitted to the Seventieth World Health Assembly in May 2017 on the implementation of the End TB Strategy, which concluded that global, regional and country-level actions as well as investments were falling far short of those needed and that high-level global support and regional and national commitments were required; and noting that progress is slow on all three targets of the Strategy (reducing TB incidence, reducing TB mortality, and eliminating catastrophic costs among TB patients and their households);²

Recognizing that to achieve the tuberculosis targets and milestones of the Sustainable Development Goals and of WHO’s End TB Strategy, care and prevention-related actions should be reinforced, paying particular attention to vulnerable groups, taking into account national contexts and circumstances, in the context of each country’s path towards achieving universal health coverage and taking into account social, economic and environmental determinants and consequences of tuberculosis;

¹ Documents A71/15, A71/16 and A71/16 Add.1.
² Document A70/38, section E.
Welcoming the decision contained in the General Assembly resolution 71/159 (2016), to hold a high-level meeting on the fight against tuberculosis in 2018;

Welcoming also the first WHO global ministerial conference on “Ending TB in the Sustainable Development Era: A Multisectoral Response”, organized jointly with the Government of the Russian Federation and held in Moscow on 16 and 17 November 2017, and the resulting Moscow Declaration to End TB, with commitments and calls to action regarding, notably: advancing the response to tuberculosis within the Sustainable Development Agenda; ensuring sufficient and sustainable financing; pursuing science, research and innovation; developing a multisectoral accountability framework; and, acting immediately to prepare for the high-level meeting of the United Nations General Assembly in 2018 on the fight against tuberculosis;

Noting the commitment made in the Moscow Declaration to End TB to support the development of the multisectoral accountability framework, and recalling in this regard resolution EB142.R3 (2018);

Welcoming the Secretariat’s report on a draft multisectoral accountability framework to accelerate progress to end tuberculosis,

1. URGES Member States:
   (1) to support preparation for the high-level meeting of the United Nations General Assembly in 2018 on the fight against tuberculosis, including enabling high-level participation; and
   (2) to pursue the implementation of all the commitments called for in the Moscow Declaration to End TB, which will contribute to reaching the targets of the End TB Strategy and the Sustainable Development Goals target to end the tuberculosis epidemic;

2. CALLS UPON all international, regional and national partners, as appropriate, to pursue the actions called for in the Moscow Declaration to End TB and invite those who have not yet endorsed it to add their support;

3. REQUESTS the Director-General:
   (1) to continue to support the United Nations Secretary-General and the General Assembly, upon request, in the preparation of the high-level meeting of the General Assembly in 2018 on the fight against tuberculosis;
   (2) to support, together with all relevant stakeholders, the implementation of the Moscow Declaration to End TB as a direct contribution to the success of the United Nations General Assembly high-level meeting in 2018 on the fight against tuberculosis, and to advance tuberculosis prevention and care and the specific actions requested of WHO in the Moscow Declaration, including: actions to strengthen health systems towards achieving universal health coverage, including for tuberculosis prevention and care; to urgently support high multidrug-resistant tuberculosis (MDR-TB) burden countries in their national emergency

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2 Documents A71/16 and A71/16 Add.1.
3 And, where applicable, regional economic integration organizations.
response and to address MDR-TB as a major threat to public health security by supporting implementation of the global action plan on antimicrobial resistance, including tuberculosis-specific actions in all countries;

(3) to continue to provide strategic and technical leadership, assistance, advice and support to Member States, as well as working with international institutions and all other relevant stakeholders, towards sufficient and sustainable financing;

(4) to develop a global strategy for tuberculosis research and innovation, taking into consideration both ongoing and new efforts, and to make further progress in enhancing cooperation and coordination in respect of tuberculosis research and development, considering where possible drawing on relevant existing research networks and global initiatives;

(5) to continue to develop, in consultation with Member States, the draft multisectoral accountability framework, working in close collaboration with all relevant international, regional and national partners as recommended in the Moscow Declaration to End TB (2017), and to provide technical support to Member States and partners, as appropriate, including for national adaptation and use of the draft multisectoral accountability framework to accelerate progress to end tuberculosis, taking into account national context, laws, regulations and circumstances, in order to enable the monitoring, reporting, review and actions needed to accelerate progress to end tuberculosis, both globally and nationally, leaving no one behind, through an independent, constructive and positive approach, especially in the highest burden countries, and the independent review of progress achieved by those countries;

(6) to present the draft multisectoral accountability framework to accelerate progress to end tuberculosis at the high-level meeting of the United Nations General Assembly in 2018 on the fight against tuberculosis;

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

Seventh plenary meeting, 26 May 2018
A71/VR/7
Regional One Voice (RoV) intervention made by the Member States of the WHO South-East Asia Region

WHA71 Agenda 11.8: Preparation for a high-level meeting of the General Assembly on ending tuberculosis

Lead country: DPR Korea Supporting country: Myanmar

Thank you Chair,

We would like to Support the preparation for High-level meeting of the General Assembly on ending Tuberculosis on behalf of the eleven Member States in the SEA Region. I appreciated WHO Secretariat for their effort to End-TB and for all the milestones made in those years after End-TB Strategy was endorsed in 2014.

Along our strong commitment to End TB shown in Delhi and Moscow last year, we could achieve very steadily progress in TB care and control in our Member States in last 12 months.

- Our active participations in both high level meetings in Delhi and Moscow facilitated Advocacy Communication and Social Mobilization activities on TB in Member States. Some of the Member States in this region has shown the some political leadership as a good examples and involving in the path finding process to end TB.

- We committed to strengthen the services and accelerate the case detection and involving civil society in this and will focus on the preventive therapy. All the activities implementation formulated with the regional leadership will have annual funding gap and need to have the global attention on this for achieving the end-TB targets. It needs the global, regional and country level commitment as well as investment.

- New technologies and inventions began to play essential roles to narrow the case detection gaps, however, the coverage of new tools has to be linked with the treatment facilities. We would like to call more international attention to develop regional, international, mechanism to support X-DR and pre-XDR TB management and it should be part of the response to antimicrobial resistance.

- We recognize that multi stakeholders, multi-sectoral efforts are crucial in achieving the ambitious End-TB targets.

- We would like to urge the Members States to support the preparation for the HLM of UNGA and to make sure the high level participation and to ensure the action oriented political declaration has been implemented.
The SEA Region could show very concrete progress, however, we still have enormous challenges, and progress found new challenges, too. We, SEA Region Member States, stand ready to proactively participate and hope that the discussions at the High-level meeting will bring more robust and practical solutions to these challenges so that ending TB targets could be achieved.

We commit to take part in the high-level meeting in UNGA by high-level delegation to achieve End TB in line with UHC and SDGs.
Addressing the burden of snakebite envenoming

The Seventy-first World Health Assembly,

Having considered the report on global snakebite burden;¹

Deeply concerned that snakebite envenoming² kills an estimated 81 000–138 000 men, women and children a year worldwide and causes physical and psychological disability in four or five times that figure;

Noting that the individuals affected by snakebite are overwhelmingly members of impoverished agricultural and herding communities, the great proportion of whom are 10–40 years of age;

Concerned that several factors, including poor prevention, health worker training, diagnosis and treatment of cases of snakebite envenoming and inadequacy of available tools for prevention, diagnosis and treatment of the disease, impede further progress in addressing snakebite envenoming;

Recognizing that snakebite envenoming causes disproportionate suffering, but has to date been largely overlooked by the global health community even though it can induce catastrophic health expenditure and exacerbate poverty;

Recognizing further that snakebite envenoming has been categorized by WHO as a high priority neglected tropical disease,³ following the recommendation of WHO’s Strategic and Technical Advisory Group for Neglected Tropical Diseases at its 10th meeting (Geneva, 29 and 30 March 2017),⁴ in response to the urgent need to implement effective control strategies, tools and interventions;

Recognizing also the lack of statistics and accurate information and the need to further improve data on the epidemiology of snakebite envenoming for a better understanding of the disease and its control;

Aware that early diagnosis and treatment are essential for reducing the morbidity, disability and mortality that snakebite envenoming can cause;

¹ Document A71/17.
² Snakebite envenoming is the disease resulting from the pathological and pathophysiological alterations induced by the deleterious action of venom injected in the body as a consequence of snakebite.
Noting with satisfaction the progress made by some Member States with regard to research into snakebite envenoming and improved case management;

Acknowledging the urgent need to improve access to safe, effective and affordable treatments in all regions of the world where snakebite envenoming is endemic;

Recognizing the work of WHO towards developing guidelines for the diagnosis and management of snakebite envenoming and for the production, control and regulation of antivenoms and the need to make these available to all regions of the world;

Mindful that achievement of the Sustainable Development Goals of the 2030 Agenda for Sustainable Development, particularly those concerning poverty, hunger, health and education, may be hampered by the negative impact of neglected diseases of the poor, including snakebite envenoming,

1. URGES Member States:

   (1) to assess the burden of snakebite and, where necessary, establish and/or strengthen surveillance, prevention, treatment and rehabilitation programmes;

   (2) to improve the availability, accessibility and affordability of antivenoms to populations at risk, and develop mechanisms to ensure that additional costs related to treatment and rehabilitation after snakebite envenoming are affordable for all;

   (3) to promote the transfer of knowledge and technology between Member States in order to improve the global availability of antivenoms and the effective management of cases;

   (4) to integrate, where possible and appropriate, efforts to control snakebite envenoming with other relevant disease-control activities;

   (5) to improve access to specific treatment and rehabilitation services for the individuals affected by snakebite envenoming, by mobilizing national resources;

   (6) to provide training to relevant health workers on the diagnosis and management of snakebite envenoming, with particular emphasis in regions of high incidence;

   (7) to intensify and support research on snakebite envenoming, particularly in order to develop new tools to diagnose, treat, prevent and measure the burden of the disease;

   (8) to promote community awareness of snakebite envenoming, through culturally contextualized public campaigns, in support of early treatment and prevention, and intensify community participation in awareness and prevention efforts;

   (9) to foster cooperation and collaboration among Member States, the international community and relevant stakeholders in order to strengthen national capacities to control, prevent and treat snakebite envenoming;

1 And, where applicable, regional economic integration organizations.
2. REQUESTS the Director-General:

(1) to accelerate global efforts and provide coordination to the control of snakebite envenoming, ensuring the quality and safety of antivenoms and other treatments and prioritization of high impact interventions;

(2) to continue to offer technical support to institutions working on research into snakebite envenoming, including WHO collaborating centres, in support of improved, evidence-based disease control efforts;

(3) to foster international efforts aimed at improving the availability, accessibility and affordability of safe and effective antivenoms for all;

(4) to provide support to Member States for strengthening their capacities for improving awareness, prevention and access to treatment and for reducing and controlling snakebite envenoming;

(5) to foster technical cooperation among Member States as a means of strengthening surveillance, treatment and rehabilitation services;

(6) to cooperate, as appropriate and in accordance with their respective mandates, with international agencies, nongovernmental organizations, foundations and research institutions, directly to provide support to Member States in which snakebite envenoming is prevalent, upon request, in order to strengthen snakebite management activities;

(7) to report on progress in implementing this resolution to the Seventy-third World Health Assembly.

Seventh plenary meeting, 26 May 2018
A71/VR/7
The Seventy-first World Health Assembly,

Having considered the report on physical activity for health;

Concerned by the rapidly growing burden of noncommunicable diseases, mental health disorders and other mental health conditions globally, and its negative impact on health, well-being, quality of life, and socioeconomic development;

Acknowledging that increasing physical activity and reducing sedentary behaviour can prevent at least 3.2 million noncommunicable disease-related mortalities globally per year, reduce related disability and morbidity and the financial burden on health systems, and increase the number of healthy life years;


Acknowledging the Secretariat’s work in providing Member States with tools, including WHO’s global Noncommunicable Diseases Progress Monitor, and guidelines to promote physical activity, and further acknowledging that supplementary tools and guidelines may need to be

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1 Document A71/18.


4 General Assembly resolution 68/300 (2014).

5 General Assembly resolution 70/1 (2015).

developed to support Member States to scale up their actions in increasing physical activity and reducing sedentary behaviour;

Recognizing the efforts made by Member States and all relevant stakeholders in recent years to promote physical activity and reduce sedentary behaviour as part of broader efforts to prevent and control noncommunicable diseases and improve mental health;

Recognizing also the need to further scale up actions and enable environments to facilitate physical activity and reduce sedentary behaviour throughout the life course, bearing in mind different national contexts, priorities and policy opportunities,

1. **ENDORSES** the global action plan on physical activity 2018–2030;

2. **ADOPTS** the voluntary global target of a 15% relative reduction, using a baseline of 2016, in the global prevalence of physical inactivity in adolescents\(^1\) and in adults\(^2\) by 2030, as an extension of the existing voluntary global target of a 10% relative reduction in prevalence of insufficient physical activity by 2025;\(^3\)

3. **URGES** Member States\(^4\) to implement the global action plan on physical activity 2018–2030, according to national contexts and priorities, and to monitor and report on progress regularly in order to improve programme performance;

4. **INVITES** relevant national, regional and international partners along with other relevant stakeholders, including the private sector, to implement the global action plan on physical activity 2018–2030 and contribute to the achievement of its strategic objectives, aligned with domestic plans or strategies;

5. **REQUESTS** the Director-General:

   (1) to implement the actions for the Secretariat in the global action plan on physical activity 2018–2030, including providing necessary support to Member States for implementation of the plan, in collaboration with other relevant partners;

   (2) to finalize, in consultation with Member States and other relevant stakeholders, a monitoring and evaluation framework on the implementation of the global action plan on physical activity 2018–2030, including a recommended set of process and impact indicators, by the end of 2018, taking into account the existing monitoring framework and indicators at the global and regional levels, and to publish it on the WHO website;

   (3) to produce, before the end of 2020, the first global status report on physical activity, building on the latest available evidence and international experience, including on sedentary behaviour;

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\(^1\) Insufficient physical activity among adolescents (aged 11–17 years) is defined as less than 60 minutes of moderate to vigorous intensity activity daily.

\(^2\) Insufficient physical activity among adults (aged 18+ years) is defined as less than 150 minutes of moderate-intensity activity per week.

\(^3\) See resolution WHA66.10.

\(^4\) And, where applicable, regional economic integration organizations.
(4) to incorporate reporting on progress made in implementing the global action plan on physical activity 2018–2030 in the reports to be submitted to the Health Assembly in 2021 and 2026 in accordance with the agreed reporting sequence set out in resolution WHA66.10 (2013); and to submit a final report on the global action plan on physical activity 2018–2030 to the Health Assembly in 2030;

(5) to update the global recommendations on physical activity for health 2010.

Seventh plenary meeting, 26 May 2018
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Regional One Voice (RoV) intervention made by the Member States of the WHO South-East Asia Region

**WHA71 Agenda 12.2: Physical activity for health**

Lead country: Thailand                      Supporting country: India

Thank you, Chair

Thailand speaks on behalf of the 11 Member States of the South-East Asia Region.

First, we would like to sincerely appreciate Dr. Tedros and his team for the success of the “WHA Walk the Talk: The Health for all challenge” with more than 3,500 participants from around the world involved in this event on Sunday 20 May in Geneva, especially with his commitment to make it an annual event. South-East Asia wish this becomes a daily activity for everyone. We also commend the chair of the Executive Board to lead the physical activity breaks during the Executive Board Meeting. These activities are example of ‘Actions without Planning’. We are sure that regular physical activities will become a global norm and culture of WHO, the leading role model for ‘health’.

Second, we fully commit to the global action plan on physical activity or GAPPA and the draft resolution. We are convinced that soon our target would become ‘Physical Activities for all’ rather than just to reduce certain percentage of insufficiency.

We strongly support the development of the global monitoring framework. We expect the secretariat to develop technical tools alongside the global monitoring framework that can support member states in formulating and implementing their national and sub-national plans.

Chair,

In 2016, South-East Asia Region Member States adopted the regional resolution SEA/RC69/R4 to promote physical activity including the alternative and traditional methods, such as yoga. We are drafting the first status report of physical activity, which will be the first regional efforts in monitoring the progress in a more sustainable way.

With this context, Chair,

South-East Asia Region suggests to adopt the resolution EB142.R5.

Lastly, we would like to reiterate that ‘Actions without planning is better than planning without action’.

Thank you, chair.
Digital health

The Seventy-first World Health Assembly,

Having considered the report on mHealth;¹

Recalling resolutions WHA58.28 (2005) on eHealth and WHA66.24 (2013) on eHealth standardization and interoperability;

Recognizing the potential of digital technologies to advance the Sustainable Development Goals, and in particular to support health systems in all countries in health promotion and disease prevention, and by improving the accessibility, quality and affordability of health services;

Recognizing also that while technology and innovations can enhance health service capabilities, human interaction remains a key element to patients’ well-being;

Underscoring the need to ensure that digital health solutions complement and enhance existing health service delivery models, strengthen integrated, people-centred health services and contribute to improved population health, and health equity, including gender equality, and addressing the lack of evidence on the impact of digital health in these respects;

Acknowledging that the transfer of technology and knowledge on mutually agreed terms, as well as technical cooperation, aligned with Sustainable Development Goal 17 (Strengthen the means of implementation and revitalize the global partnership for sustainable development), are important in promoting digital health;

Highlighting recent progress in the development and implementation of digital health strategies, policies, legislation and programmes by Member States,² WHO and partner organizations;

Acknowledging previous experience³ of countries and organizations, the interconnectedness of digital technologies, the collection, management and evaluation of health data, the robustness of the enabling environment, in line with established good practices, while considering the sustainability of innovations, and their feasibility, scale-up and inclusivity.

¹ Document A71/20.
² And, where applicable, regional economic integration organizations.
³ Programmes specified in comments from Missions included the Global Observatory for eHealth, WHO-ITU initiative on mHealth for noncommunicable diseases, the Innovation Working Group, Every Woman Every Child initiative and the WHO-ITU National eHealth Strategy Toolkit. Principles for Digital Development (WHO endorsed).
1. **URGES Member States:**

   (1) to assess their use of digital technologies for health, including in health information systems at the national and subnational levels, in order to identify areas of improvement, and to prioritize, as appropriate, the development, evaluation, implementation, scale-up and greater utilization of digital technologies, as a means of promoting equitable, affordable and universal access to health for all, including the special needs of groups that are vulnerable in the context of digital health;

   (2) to consider, as appropriate, how digital technologies could be integrated into existing health systems infrastructures and regulation, to reinforce national and global health priorities by optimizing existing platforms and services, for the promotion of people-centered health and disease prevention and in order to reduce the burden on health systems;

   (3) to optimize, in health systems development and reforms, the use of resources by developing health services alongside the application and use of digital technologies;

   (4) to identify priority areas where normative guidance and technical assistance and advice on digital health would be beneficial, including, but not limited to, gaps in research, evidence-based standards, support to implementation and scale-up, financing and business models, content, evaluation, cost-effectiveness and sustainability, data security, ethical and legal issues, re-use and adaptation of existing digital health and other relevant tools;

   (5) to work towards and support interoperability of digital technologies for health by, inter alia, promoting the use of international and open standards as an affordable, effective and easily adaptable solution;

   (6) to disseminate, as appropriate, best practices and successful examples of digital health architecture, programmes, and services, in particular effective policy design and practical implementation, with the international community, including through WHO, bilateral, regional, cross-regional and global networks, digital platforms and hubs;

   (7) to strengthen public health resilience and promote opportunities, as appropriate, through the use of digital technologies, including to improve access to, and monitoring, sharing and use of, quality data, direct citizen, health worker and government engagement, and to build capacity for rapid response to disease incidents and public health emergencies, leveraging the potential of digital information and communication technology to enable multidirectional communications, feedback loops and data-driven “adaptive management”;

   (8) to build, especially through digital means, capacity for human resources for digital health, as appropriate, across both health and technology sectors, and to communicate areas of specific need to WHO in order to receive appropriate technical assistance;

   (9) to improve the digital skills of all citizens, including through working with civil society to build public trust and support for digital health solutions, and to promote the application of digital health technology in the provision of, and access to, everyday health services;

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1 And, where applicable, regional economic integration organizations.
(10) to develop, as appropriate, legislation and/or data protection policies around issues such as data access, sharing, consent, security, privacy, interoperability and inclusivity consistent with international human rights obligations and to communicate these on a voluntary basis to WHO;

(11) to develop, as appropriate, and in coordination with existing and emerging regional hubs and support mechanisms, effective partnerships with stakeholders from across all sectors in the use of digital health;

2. REQUESTS the Director-General:

(1) to develop, within existing resources, and in close consultation with Member States\(^1\) and with inputs from relevant stakeholders as appropriate, a global strategy on digital health, identifying priority areas including where WHO should focus its efforts;

(2) to elevate the strategic capacity of WHO in digital technologies and to mainstream these in WHO’s work, operations and relevant programmes, including when working with Member States;

(3) to provide technical assistance and normative guidance to Member States, on request, for scaling up the implementation of digital health – including through the development and implementation of Member States’ digital health strategies, and in line with the Thirteenth General Programme of Work, 2019–2023, with the appropriate structure, resources, assets and capabilities, within existing resources;

(4) to ensure that WHO builds on its strengths, by developing guidance for digital health, including, but not limited to, health data protection and usage, on the basis of its existing guidelines and successful examples from global, regional and national programmes, including through the identification and promotion of best practices, such as evidence-based digital health interventions and standards;

(5) to develop a repository on regulations, evidence related to improvements and unintended effects regarding health promotion, disease prevention and access to, and quality and cost–effectiveness of, health services, and best practices relating to digital health technologies, provided by, inter alia, Member States on a voluntary basis;

(6) to monitor developments and trends of digital technologies in health systems, public health and data science, and analyse their implications for the achievement of the health-related Sustainable Development Goals;

(7) to promote WHO’s collaboration with other organizations of the United Nations system and other relevant stakeholders to strengthen digital health implementation, by leveraging their capabilities;

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\(^1\) And, as applicable, regional economic integration organizations.
(8) to submit a report to the Seventy-third World Health Assembly in 2020 on the progress made in implementing this resolution.

Seventh plenary meeting, 26 May 2018
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Regional One Voice (RoV) intervention made by the Member States of the WHO South-East Asia Region

WHA71 Agenda 12.4: mHealth

Lead country: India Supporting country: Thailand

Thank you, Chairperson.

1. India delivers this statement on behalf of 11 WHO Member States of the South-East Asia Region. We appreciate hard work of the Secretariat in preparing the report on “Use of appropriate digital technologies for public health”.

2. Our Region believes that, while suitably addressing concerns related to confidentiality, integrity, ownership, usage and access, Digital Health could provide required answers for positive disruption in the area of health.

3. The Digital Health paradigm provides an opportunity for all of us to scale up the access to health care to areas where connectivity is available however health coverage is lagging. The defining feature of digital health has gone from a mere technology to comprehensive use of information for multiple purposes through various applications.

4. In view of innovations and advancements of the digital technologies, we have to ensure that these developments happen in an equitable manner, and reduce the existing inequalities in Health; Also, digital health should minimize the current digital divide in terms of literacy, income and urbanization levels. We do believe that data gathered from digital health can be good source of information for health policy and systems researchers.

5. We recognize that, while technology and innovations can enhance health service capabilities responding to country contexts and needs, human interaction remains a key element to patients’ wellbeing.

6. The resolution on Digital Health in A71/A/Conference paper number 1 will pave the way for WHO so that it can work towards mainstreaming Digital Health in its various ongoing programmes as well as developing the Global Strategy on Digital Health in order to leverage digital health technologies in achieving Universal Health Coverage. This landmark resolution would lay down the foundation for creating a formal mechanism within WHO for taking this futuristic agenda forward.
7. We are of the view that WHO needs to assume a leading role in order to work on contemporary issues related to digital health to achieve equitable Universal Health Coverage by 2030 and beyond.

8. In conclusion, SEA Region Member States support the adoption of the resolution on digital health.

Thank you, Chairperson.
Improving access to assistive technology

The Seventy-first World Health Assembly,

Having considered the report on improving access to assistive technology;¹

Considering that one billion people need assistive technology and that, as the global population ages and the prevalence of noncommunicable diseases increases, this figure will rise to more than two billion by 2050;²

Noting that assistive technology enables and promotes the inclusion, participation and engagement of persons with disabilities, ageing populations and people with co-morbidities in the family, community and all areas of society, including the political, economic and social spheres;

Recalling that 90% of those who need assistive technology do not have access to it, and that this has a significant adverse impact on the education, livelihood, health and well-being of individuals, and on families, communities and societies;¹

Recalling also the 2030 Agenda for Sustainable Development and its ultimate aim of “leaving no one behind”;

Recognizing that the inclusion of assistive technology, in line with countries’ national priority and context, into health systems is essential for realizing progress towards the targets in the Sustainable Development Goals relating to universal health coverage, inclusive and equitable quality education, inclusive and sustainable economic growth, full and productive employment and decent work for all, reducing inequality within and among countries by empowering and promoting the social, economic and political inclusion of all, making cities and human settlements inclusive, safe and sustainable, and providing universal access to safe, inclusive and accessible green and public spaces, particularly for persons with disabilities;

Recalling the United Nations Convention on the Rights of Persons with Disabilities, under which 175 Member States have committed, inter alia, to ensuring access to quality assistive technology at an affordable cost (Article 20) and to foster international cooperation (Articles 4, 20, 26 and 32) in support of national efforts for the realization of the purpose and objectives of the Convention;

¹ Document A71/21.
Emphasizing the need for a comprehensive, sustainable and multisectoral approach to improving access to assistive technology that fulfils the safety and quality standards established by national and international regulations, at the national and subnational levels;

Recalling resolutions WHA69.3 (2016), WHA67.7 (2014), and WHA66.4 (2013) and WHA70.13 (2017) in which, respectively, the Health Assembly calls on Member States, inter alia, to improve access to assistive technology for older people, people with disabilities and people with vision and hearing loss;

Noting the request made to the Executive Board by the WHO Regional Committee for the Eastern Mediterranean, in resolution EM/RC63/R.3 (2016) on improving access to assistive technology, to include assistive technology as an agenda item for the Health Assembly,

1. **URGES Members States:**

   (1) to develop, implement and strengthen policies and programmes, as appropriate, to improve access to assistive technology within universal health and/or social services coverage;

   (2) to ensure that adequate and trained human resources for the provision and maintenance of assistive products are available at all levels of health and social service delivery;

   (3) to ensure that assistive technology users and their carers have access to the most appropriate assistive products and use them safely and effectively;

   (4) where appropriate, based on national needs and context, to develop a national list of priority assistive products that are affordable and cost-effective and meet minimum quality and safety standards, drawing on WHO’s priority assistive products list;

   (5) to promote or invest in research, development, innovation and product design in order to make existing assistive products affordable; and to develop a new generation of products including high-end or advanced assistive technology, taking advantage of universal design and new evidence-based technologies, in partnership with academia, civil society organizations, in particular with persons with disabilities and older persons and their representative organizations, and the private sector, as appropriate;

   (6) to encourage international and/or regional collaboration for the manufacturing, procurement and supply of priority assistive products, ensuring that these remain affordable and available across borders;

   (7) to collect population-based data on health and long-term care needs, including those that may be met by assistive technology in order to develop evidence-based strategies, policies and comprehensive programmes;

   (8) to invest in and promote inclusive barrier-free environments so that all people who need assistive technology can make optimum use of it, in order to live independently and safely and participate fully in all aspects of life;

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1 And, where applicable, regional economic integration organizations.
(9) to promote the inclusion of priority assistive products and inclusive barrier-free environments within emergency preparedness and response programmes;

2. REQUESTS the Director-General:

(1) by 2021, to prepare a global report on effective access to assistive technology in the context of an integrated approach, based on the best available scientific evidence and international experience, with the participation of all relevant units within the Secretariat and in collaboration with all relevant stakeholders, giving consideration to the possibility of establishing an Expert Advisory Group, within existing resources, for this purpose;

(2) to provide the necessary technical and capacity-building support for Member States, aligned with national priorities, in the development of national assistive technology policies and programmes, including procurement and financing, regulation, training for health and social services, appropriate service delivery, and inclusive barrier-free environments;

(3) to provide technical and capacity-building support to countries, on request, to assess the feasibility of establishing regional or subregional manufacturing, procurement and supply networks for assistive technology and cooperation platforms;

(4) to contribute to and engage in, as appropriate, the development of minimum standards for priority assistive products and services, in order to promote their safety, quality, cost-effectiveness and appropriateness;

(5) to report on progress in the implementation of the present resolution to the Seventy-fifth World Health Assembly and thereafter to submit a report to the Health Assembly every four years until 2030.

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A71/VR/7
Regional One Voice (RoV) intervention made by the Member States of the WHO South-East Asia Region

WHA71 Agenda 12.5: Improving access to assistive technology

Lead country: Bhutan
Supporting country: Sri Lanka

Thank You Madam Chair!

1. Bhutan presents this statement on behalf of the 11 Member States of the South-East Asia Region.

2. We note with appreciation and thank the Secretariat for the comprehensive report by the Director-General. At the same time, we commend the organization for its progressive role in taking forward the Convention on the Rights of Persons with Disabilities (CRPD), which has recognized access to assistive technology as a matter of human right.

3. Of the more than one billion people living with some form of disability, an estimated 80 per cent live in developing countries\(^1\). The South-East Asia Region has the second highest prevalence of moderate disability and third highest prevalence of severe disability from amongst the WHO regions\(^2\).

4. We are deeply concerned of the increasing rates of disability due to ageing population and the rising trend of noncommunicable diseases. Consequently, more than 2 billion individuals can benefit from improved access to assistive products by the year 2050\(^3\) of which 65% of the global increase in disability for older persons will occur in Asia, which will be the highest in the world\(^4\).

5. People suffering from disability face deficiencies in accessing quality and timely healthcare services, including rehabilitation services and most importantly, education. People living with disabilities are the most vulnerable in terms of social mobility. They are, therefore, deprived of the opportunity to derive the benefits of education and employment and hence remain economically vulnerable and poor.

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\(^2\) The South-East Asia Region has the second highest prevalence rate of moderate disability (16%) and the third highest prevalence rate of severe disability (12.9%) http://www.searo.who.int/entity/disabilities_injury_rehabilitation/topics/disability_factsheet.pdf

\(^3\) http://apps.who.int/gb/ebwha/pdf_files/WHA71/A71_21-en.pdf

6. These would culminate in a situation seriously challenging the World Health Organization’s strategies in realizing the ambitious triple billion goal set forth in the GPW-13 and Agenda 2030 goals.

7. We remain positive that the WHO’s flagship “Global Cooperation on Assistive Technology (GATE)” programme – in collaboration with UN Agencies and other partners will provide exemplary guidance and leadership in strengthening global partnership to address this as a common agenda and improve access to quality and affordable assistive products globally.

8. In the true spirit of “Leaving No One Behind” and recalling the articles 20, 25 and 32 of the CRPD, we call on Member States to be a signatory to the convention and take steps towards ratification of the United Nations CRPD and enhance international cooperation to improve access to assistive technology.

9. Bhutan, on behalf of the 11 South-East Asia Region Member States, welcomes the draft resolution and has the pleasure to support the adoption of the draft resolution EB142.R6.

I Thank You Madam Chair.

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5 Goal 3: Ensure healthy lives and promote well-being for all at all ages


The Seventy-first World Health Assembly,

Having considered the reports on maternal, infant and young child nutrition;\(^1\)


Reaffirming the commitment made in the 2030 Agenda for Sustainable Development, including to end all forms of malnutrition by 2030;

Recalling the commitment to implement relevant international targets and action plans, including WHO’s global maternal, infant and young child nutrition targets for 2025 and WHO’s global action plan for the prevention and control of noncommunicable diseases 2013–2020 and the Rome Declaration on Nutrition resulting from the Second International Conference on Nutrition;

Reaffirming also that breastfeeding is critical for child survival, nutrition and development, and maternal health;

Affirming that the protection, promotion and support of breastfeeding contributes substantially to the achievement of the Sustainable Development Goals on nutrition and health, and is a core element of quality health care;

Recognizing that appropriate, evidence-based and timely support of infant and young child feeding in emergencies saves lives, protects child nutrition, health and development, and benefits mothers and families;

Expressing concern that nearly two in every three infants under 6 months of age are not exclusively breastfed; that fewer than one in five infants are breastfed for 12 months in high-income countries; and that only two in every three children between 6 months and 2 years of age receive any breast milk in low- and middle-income countries;

Acknowledging that achievement of the WHO global target to increase to at least 50% the proportion of infants under 6 months of age who are exclusively breastfed by 2025 requires

\(^1\) Documents A71/22 and A71/23.
sustainable and adequate technical and financial resources, and supportive and protective policy and regulatory interventions as well as political will, and that this needs to be part of broader efforts to strengthen health systems;

Welcoming the inclusion of support for exclusive breastfeeding in the Thirteenth General Programme of Work, 2019–2023;

Welcoming also the annual celebration of World Breastfeeding Week as an opportunity to communicate the importance of breastfeeding and advocate for the protection, promotion and support of breastfeeding;¹

Also recognizing the ongoing implementation by WHO of the Framework of Engagement with Non-State Actors, including in nutrition programmes,

1. **URGES** Member States²³⁴ in accordance with national context and international obligations:

   (1) to increase investment in development, implementation and monitoring and evaluation of laws, policies and programmes aimed at protection, promotion, including education and support of breastfeeding, including through multisectoral approaches and awareness raising;

   (2) to reinvigorate the Baby-friendly Hospital Initiative, including by promoting full integration of the revised Ten steps to successful breastfeeding, in efforts and programmes aimed at improving quality of care for maternal, newborn and child health;

   (3) to implement and/or strengthen national mechanisms for effective implementation of measures aimed at giving effect to the International Code of Marketing of Breast-milk Substitutes, as well as other WHO evidence-based recommendations;

   (4) to promote timely and adequate complementary feeding in accordance with the guiding principles for complementary feeding of the breastfed child,⁵ as well as guiding principles for the feeding of the non-breastfed child 6–24 months of age;⁶

   (5) to continue taking all necessary measures in the interest of public health to implement recommendations to end inappropriate promotion of foods for infants and young children;

   (6) to take all necessary measures to ensure evidence-based and appropriate infant and young child feeding during emergencies, including through preparedness plans, capacity-building of personnel working in emergency situations, and coordination of intersectoral operations;


² And where applicable, regional economic integration organizations.

³ Taking into account the context of federated states.

⁴ Member States could take additional action to end inappropriate promotion of food for infants and young children.


(7) to celebrate World Breastfeeding Week\(^1\) as a valuable means to promote breastfeeding;

2. REQUESTS the Director-General:

(1) to provide, upon request, technical support to Member States in mobilizing resources, including financial resources, and monitoring and implementation of WHO recommendations to support infant and young child feeding, including in emergencies, and to review national experiences from this implementation and continue to update and generate evidence-based recommendations;

(2) to provide, upon request, technical support to Member States to establish, review and implement national laws, policies and programmes to support infant and young child feeding;

(3) to continue developing tools for training, monitoring and advocacy on the revised Ten steps to successful breastfeeding and the Baby-friendly Hospital Initiative, to provide support to Member States with implementation;

(4) to support Member States in establishing nutrition targets and intermediate milestones for maternal, infant and young child nutrition indicators, consistent with the time frame for implementation of the Framework for Action, the conference outcome document of the Food and Agriculture Organization’s and World Health Organization’s Second International Conference on Nutrition and the United Nations Decade of Action on Nutrition (2016–2025) and the timeframe of the Sustainable Development Goals (2015–2030);

(5) to continue providing adequate technical support to Member States, upon request, in assessing national policies and programmes, and other measures, including quality data collection and analyses;

(6) to develop tools for training, monitoring, advocacy and preparedness for the implementation of the operational guidance on infant and young child feeding in emergencies and support Member States to review experiences in its adaptation, implementation and monitoring;

(7) to report to the Seventy-third World Health Assembly in 2020 on the progress made in implementing this resolution and in alignment with the reporting requested in resolution WHA69.9.

Seventh plenary meeting, 26 May 2018
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Regional One Voice (RoV) intervention made by the Member States of the WHO South-East Asia Region

WHA71 Agenda 12.6: Maternal, infant and young child nutrition

Lead country: Sri Lanka
Supporting country: Maldives

Thank you Chair.

1. Sri Lanka speaks on behalf of the 11 Member States of the South-East Asia Region. We appreciate the summary on progress provided by the Secretariat in implementing the Comprehensive Implementation Plan on MIYCN.

2. The region has prioritized addressing maternal and child malnutrition. As a long term strategy to mitigate the emerging epidemic of noncommunicable diseases, optimum breast feeding and complementary feeding are vital cornerstones. Our region recognize that protection, promotion, and support of breastfeeding and appropriate complementary feeding will contribute substantially to the achievement of SDGs on nutrition and health.

3. For SEA Region countries, breastfeeding is critical for child survival, nutrition and development. Political commitment is strong in our region and has lead to 7 of the 11 Member States enacting relevant legislation for breast feeding and appropriate complementary feeding, showcasing our understanding that law enforcement is important. All Member States fully support the strengthening of the implementation of International code on marketing of breast milk substitutes to protect mothers and children from unethical marketing of breast milk substitutes.

4. All SEA Region Member States recognize that adverse marketing to promote inappropriate foods for infants and young children can hinder the implementation of the comprehensive MIYCN plan. We support the tools to address conflict of intersest in nutrition programmes and we request for further support from WHO to overcome the existing challenges of inappropriate promotion in line with WHA69.8.

5. The SEA Region fully support the implementation of the Comprehensive Action Plan on MIYCN and all our Member States support the new draft resolution in A71/A/conference paper 4 on Infant and young child feeding, which we have worked hard to reach consensus.

Thank you, Chair.
Pandemic Influenza Preparedness Framework for the sharing of influenza viruses and access to vaccines and other benefits

The Seventy-first World Health Assembly, having considered the report by the Director-General on progress to implement decision WHA70(10) (2017), approved the recommendations contained therein at paragraph 19, and reproduced in the Annex to this decision, and requested that the final text of the analysis, requested under paragraph 8(b) of decision WHA70(10), be submitted to the Seventy-second World Health Assembly, through the Executive Board at its 144th session.

1 Document A71/24.
ANNEX

Recommendations on further action

(a) **Paragraph 8(a)**

Subject to completion of the analysis as specified in paragraph 8(b) below, the Secretariat aims to implement measures to complete all actions within its mandate before the Seventy-second World Health Assembly.

(b) **Paragraph 8(b)**

The Secretariat intends to complete the analysis in order to submit a comprehensive draft to the Seventy-second World Health Assembly through the Executive Board at its 144th session. The draft will reflect broad input from Member States and relevant stakeholders, notably the PIP Advisory Group and representatives of the Global Influenza Surveillance and Response System. Pursuant to the decisions of the Seventy-first World Health Assembly and any further work so entailed, a final text of the analysis will be submitted to the Seventy-second World Health Assembly through the Executive Board at its 144th session.

(c) **Paragraphs 8(c), (d) and (f)**

The Secretariat will continue to strengthen critical pandemic preparedness through, inter alia:

(i) implementation of the high-level Partnership Contribution Implementation Plan 2018–2023, which will support strengthening of laboratory, surveillance and regulatory capacities as well as burden-of-disease studies;

(ii) conclusion of more Standard Material Transfer Agreements 2;

(iii) regular engagement with the secretariats of the Convention on Biological Diversity and other relevant international organizations that are involved in implementation of access and benefit-sharing mechanisms;

(iv) reporting on the foregoing by the Director-General to Seventy-second World Health Assembly through the Executive Board at its 144th session.

(d) **Paragraph 8(e)**

The Secretariat will take measures to implement the recommendations of the External Auditor and report thereon to the Seventy-second World Health Assembly through the Executive Board at its 144th session.

Seventh plenary meeting, 26 May 2018
A71/VR/7
Seventy-first World Health Assembly (WHA71)
Geneva, 21–26 May 2018

Regional One Voice (RoV) intervention made by the
Member States of the WHO South-East Asia Region

WHA71 Agenda 12.7: Pandemic Influenza Preparedness Framework for the sharing of influenza viruses and access to vaccines and other benefits

Lead country: Indonesia Supporting country: DPR Korea

1. On behalf of the 11 WHO Member States of the South-East Asia Region, Indonesia appreciates the Secretariat’s Report of the Special Session of the Pandemic Influenza Preparedness Framework Advisory Group. The SEA Region countries support the full implementation of the PIP Framework and encourage all WHO Member States and partners to do so.

2. We would also like to reiterate that it is essential to support collaboration in pandemic preparedness strengthening through the WHO Global Influenza Surveillance and Response System (GISRS).

3. We also support the recommendation made by the PIP Advisory Group, to extend the scope of the PIP Framework budget for all activities that could strengthen Member States’ capacities in pandemic influenza preparedness, including supporting efforts for knowledge and technology transfer for vaccine development.

4. With regard to the extension of PIP Framework to include Genetic Sequence Data (GSD), we acknowledge and appreciate the effort made by the PIP Advisory Group on this issue. As we are all aware, the sharing of influenza virus is declining, while individual GSD sharing is on the rise.

5. As the technology advances, it is highly likely that in the future GSD will play a greater role in influenza research, as in some cases they are used as substitute for biological materials. Therefore, failure to properly regulate the GSD sharing under the PIP Framework will have implications for biosecurity, biosafety, and intellectual property rights.

6. In line with the Technical Working Group recommendation on GSD, we are of the view that the Genetic Sequence Data needs to be recognized as a form of biological material under the PIP Framework to facilitate tracking sequencing data, hold the involved parties accountable, as well as to facilitate research, while limiting the misuse of the GSD and its products.

Thank you, Chair.
Reform of the global internship programme

The Seventy-first World Health Assembly,

Having considered the human resources annual reports of 2015, 2016 and 2017;¹

Recognizing, consistent with the implementation of the 2030 Agenda for Sustainable Development and progress toward the attainment of universal health coverage, the need for effective public health leadership, resilient health systems and strong health workforce capacity;

Guided by the Thirteenth General Programme of Work, outlining the WHO’s strategic vision for the period 2019–2023, which commits to, inter alia, promoting greater access to, and equity in, the internship programme;

Affirming the internship programme’s goal to build future leaders in public health through professional training and capacity-building opportunities across headquarters, regional and country offices, and the valuable contributions interns make to the Organization;²

Recalling Member States’ concerns over the persistent imbalance in geographical participation on the internship programme, due in large part to the absence of financial support for talented future health leaders and insufficient attention paid so far to geographical diversity and gender equity among interns;

Underscoring the commitment of all Member States towards improvements in the WHO reform process across the three levels of the Organization, including balanced geographical participation and gender equity;

Recognizing WHO’s efforts and changes to improve the transparency and accessibility of the internship programme and its ambition to implement comprehensive reform,

1. DECIDES that continued improvements to the internship programme be achieved through:

   (1) the development of a sustainable and equitable internship programme based on an internship strategy and semi-structured training curriculum for interns to maximize their training experience and reinforce the learning objectives of the programme, which are, inter alia, to build

¹ Documents A69/52, A70/45 and A71/35.

² The WHO e-Manual defines an intern is an individual who is at least 20 years old, enrolled in a university or equivalent institution leading to a formal qualification (graduate or postgraduate). Applicants who have already graduated may also qualify for consideration provided that they apply for an internship within six months after completion of their formal qualification. Interns do not have the status of WHO staff members and cannot represent the Organization in any official capacity.
a diverse pool of future leaders in public health and provide experience in the technical and administrative programmes of WHO;

(2) the strengthening of a transparent, merit-based intern recruitment process that promotes the widest possible geographical participation and gender equity, through objective review of all intern applicants who meet the criteria;

(3) the setting of a target that by 2022, at least 50% of accepted interns on the programme originate from least developed countries and middle-income countries with the objective of achieving balanced participation among WHO regions and gender equity;

(4) the provision by the Secretariat of financial assistance, as soon as possible and no later than 2020, and where applicable, in-kind assistance, including through collaboration with host countries, for all accepted interns without sufficient existing support, at a level set for the duty station, to cover reasonably incurred travel and living expenses for the duration of the internship;

2. URGES Member States, development partners and donors to support WHO in mobilizing the resources necessary for financial sustainability and where applicable in-kind assistance for the internship programme, thereby ensuring that talented future health leaders from all Member States can equally access the programme, irrespective of economic circumstance;

3. INVITES international, regional, national and local stakeholders, to engage in and support the implementation of the actions set out in this resolution;

4. REQUESTS the Director-General:

(1) to take the necessary measures and, in keeping with the aims of broader human resources policy, to operationalize the objectives of this resolution, across all three levels of the Organization, drawing from the best practices of other United Nations agencies and in line with United Nations rules, regulations and relevant resolutions;

(2) to include as part of the human resources annual report, statistics on applicants’ and accepted interns’ demographic data, including gender and country of origin, as well as information on progress towards the implementation of this resolution;

(3) to submit a report to the Executive Board at its 144th session in January 2019, detailing by which mechanism financial and in-kind support to accepted interns will be provided commensurate with their needs;

(4) to submit a stand-alone report to the Seventy-sixth World Health Assembly through the Executive Board in 2023, outlining the progress made in achieving the targets set out in this resolution and the future steps planned.

Seventh plenary meeting, 26 May 2018
A71/VR/7
Regional One Voice (RoV) intervention made by the Member States of the WHO South-East Asia Region

WHA71 Agenda 17.1: Human resources: annual report (Reform of the global internship programme)

Lead country: Thailand Supporting country: Bangladesh

Thank you, Chair.

Thailand speaks on behalf of Member States of the South-East Asia (SEA) Region.

We appreciate the Director-General’s efforts in giving priority to the WHO internship programme. We note good progress in developing global systems for recruitment and exploring possibilities to reduce the financial burden placed on interns.

The SEA Region strongly supports the principles of geographical diversity, equal opportunity, gender equity, merit-based recruitment and programme effectiveness. The internship programme is an important capacity-building platform to create the future global health leaders. The programme should rectify the current severe under-representation of interns from developing countries. The intern statistic between 2015 and 2017 reflects the large scale difference and gross inequality against developing countries. The top five countries of interns are all from developed countries which accounts around 45% of total 2,587 interns. On the other hand, more than 50% of Member States do not have any intern representation.

In order to achieve the target of at least 50% of interns from developing countries and ensure geographical diversity by 2022, WHO needs to address several structural limitations, including financial affordability awareness, and living cost in duty stations which requires strong leadership of the Director-General, effective programme management, and partial financial subsidy from development partners, and host institutions.

Finally, South-East Asia Region urges WHO to effectively implement the reform of the global internship programme set out in the conference paper A71/B/CONF./1. We are looking forward to see the innovative financial mechanism report in the 144th Session of the Executive Board to ensure proportionate geographical diversity and financial sustainability of the Internship Programme.

Thank you, Chair.

The Executive Board, having considered the draft formal evaluation policy presented by the Secretariat, approved the evaluation policy as amended.\(^1\)

\(^1\) Document EB143/6.

\(^2\) See Annex.
ANNEX

EVALUATION POLICY (2018)

BACKGROUND

1. As part of the WHO reform process, the Executive Board at its 131st session in May 2012 approved the first WHO evaluation policy.¹ This was followed by the publication of the WHO evaluation practice handbook in 2013.²

2. On 1 August 2014, the evaluation function was moved from the Office of Internal Oversight Services to become a separate unit to support independent evaluation within the Office of the Director-General. As a key first step, a framework for strengthening evaluation and organizational learning in WHO³ was developed and submitted to the Executive Board at its 136th session in 2015.⁴ Together with the evaluation policy (2012), this framework has been instrumental in guiding evaluative work in the Organization during the past few years. In 2017, the Office of the Director-General launched an independent review of the evaluation function at WHO, which documented findings and provided critical recommendations, one of which was the need to revise the 2012 evaluation policy.⁵

3. As part of the organizational shifts envisaged in its Thirteenth General Programme of Work, 2019–2023,⁶ WHO will “measure impact to be accountable and manage for results”. It further states that the “focus on impact will require a meaningful account of WHO’s contribution on each goal and by each level of the Organization”. The evaluation policy (2018) supports this organizational shift.

4. The external environment in which WHO operates has also considerably evolved in recent years. The adoption of the Sustainable Development Goals in 2015, as well as the transformation in the humanitarian sector following the 2016 World Humanitarian Summit, provides new directions for the conduct of evaluation. Thus, in a 2014 resolution, the United Nations General Assembly⁷ reiterated the importance of national evaluation capacities, as did the quadrennial comprehensive policy review of operational activities for development of the United Nations system in 2016,⁸ which also underscored the strengthening of joint and system-wide evaluations to support more effectively the

¹ Document EB131/3; see also decision EB131(1) (2012).
⁴ Document EB136/38, noted by the Executive Board at its 136th session (see document EB136/2015/REC/2, summary records of the fourteenth meeting, section 4).
⁵ See the full evaluation report: http://www.who.int/about/evaluation/who_evaluation_function_review.pdf?ua=1 (accessed 10 April 2018).
implementation of the Sustainable Development Goals. Also in 2016, the United Nations Evaluation Group revised its norms and standards.¹

5. Furthermore, the evaluation policy (2018) takes into account the recommendations of the independent review of the evaluation function as well as all relevant internal and external changes and is informed by international best practices in order to frame the Secretariat’s evaluation function.

PURPOSE

6. The purpose of this policy is to define the overall framework for evaluation at WHO, to foster the culture and use of evaluation across the Organization, and to facilitate conformity of evaluation at WHO with best practices and with the norms and standards for evaluation of the United Nations Evaluation Group.

7. The accountability framework of WHO includes several types of assessments. WHO considers that all are crucial to programme development and institutional learning. This policy addresses only the assessments qualifying as “Evaluation” and excludes other forms of assessments conducted in WHO, such as monitoring, performance assessment, surveys, and audit.

POLICY STATEMENT

8. Evaluation is an essential function at WHO, carried out at all levels of the Organization. It ensures accountability and oversight for performance and results, and reinforces organizational learning in order to inform policy for decision-makers and support individual learning.

EVALUATION DEFINITION

9. An evaluation is an assessment, conducted as systematically and impartially as possible, of an activity, project, programme, strategy, policy, topic, theme, sector, operational area or institutional performance. It analyses the level of achievement of both expected and unexpected results by examining the results chain, processes, contextual factors and causality using appropriate criteria such as relevance, effectiveness, efficiency, impact and sustainability. An evaluation should provide credible, useful evidence-based information that enables the timely incorporation of its findings, recommendations and lessons into the decision-making processes of organizations and stakeholders.²

10. In WHO there are two categories of evaluation.

   (a) Corporate evaluations are managed, commissioned or conducted by the Evaluation Office, and include programme evaluations, thematic evaluations and office-specific evaluations.

   (b) Decentralized evaluations are managed, commissioned or conducted outside the central Evaluation Office, that is, they are initiated by headquarters clusters, regional offices or country


offices and mainly comprise programmatic and thematic evaluations. In this instance, the central Evaluation Office would provide quality assurance and technical backstopping.

PRINCIPLES AND NORMS

11. This policy provides a framework to ensure the systematic application of the key United Nations Evaluation Group evaluation principles to the evaluation function in WHO. These key principles set out below are interrelated and underpin the approach to evaluation in WHO and are applicable to both corporate and decentralized evaluations.

Impartiality

12. The key elements of impartiality are objectivity, professional integrity and absence of bias. The requirement for impartiality exists at all stages of the evaluation process, including planning an evaluation, formulating the mandate and scope, selecting the evaluation team, providing access to stakeholders, conducting the evaluation and formulating findings and recommendations.

13. Evaluators need to be impartial, implying that evaluation team members must not have been (or expect to be in the near future) directly responsible for the policy setting, design or management of the evaluation subject.

Independence

14. Independence of evaluation is necessary for credibility, influences the ways in which an evaluation is used and allows evaluators to be impartial and free from undue pressure throughout the evaluation process. The independence of the evaluation function comprises two key aspects – behavioural independence and organizational independence.

(a) **Behavioural independence** entails the ability to evaluate without undue influence by any party. Evaluators must have the full freedom to conduct their evaluative work impartially, without the risk of negative effects on their career development, and must be able to freely express their assessment. The independence of the evaluation function underpins the free access to information that evaluators should have on the evaluation subject.

(b) **Organizational independence** requires that the central evaluation function is positioned independently from management functions, carries the responsibility of setting the evaluation agenda and is provided with adequate resources to conduct its work. Organizational independence also necessitates that evaluation managers have full discretion to directly submit evaluation reports to the appropriate level of decision-making and that they should report directly to an organization’s governing body and/or the executive head. Independence is vested in the Evaluation Head to directly commission, produce, publish and disseminate duly quality-assured evaluation reports in the public domain without undue influence by any party.¹

15. Evaluators shall not be directly responsible for the policy, design, or overall management of the subject under review. WHO staff performing evaluations shall abide by the ethical principles and conduct of staff.\(^1\) External contractors shall abide by the WHO requirements for external contractual agreements. Evaluators must maintain the highest standards of professional and personal integrity during the entire evaluation process. They are expected to ensure that evaluations address gender and equity; and be sensitive to contextual factors, such as the beliefs, manners and customs of the social and cultural environments evaluated.

16. The whistle-blower policy and other relevant policies will protect staff participating in evaluations from retaliation or repercussions.

**Utility**

17. In commissioning and conducting an evaluation, there should be a clear intention to use the resulting analysis, conclusions or recommendations to inform decisions and actions. The utility of evaluation is manifest through its use in making relevant and timely contributions to organizational learning, informed decision-making processes and accountability for results. Evaluations could also be used to contribute beyond the organization by generating knowledge and empowering stakeholders.\(^2\)

18. Utility relates to the impact of the evaluation on decision-making and requires that evaluation findings be relevant and useful, presented in a clear and concise way, and monitored for implementation. The utility of an evaluation depends on its timeliness, relevance to the needs of the programme and stakeholders, the credibility of the process and products, and the accessibility of reports.

19. Utility will be ensured through: the systematic prioritizing of the evaluation agenda based on established criteria and consultation with relevant stakeholders; the systematic follow-up of recommendations; public access to the evaluation products; and alignment with the results-based management framework.

**Quality**

20. Quality relates to the appropriate and accurate use of evaluation criteria, impartial presentation and analysis of evidence, and coherence between findings, conclusions and recommendations.

21. Quality will be ensured through (i) the continuous adherence to WHO evaluation methodology as elaborated in the WHO evaluation practice handbook, the applicable guidelines and the norms and standards for evaluation of the United Nations Evaluation Group; (b) an independent quality assurance mechanism for all decentralized evaluations; and (c) independent quality assessment of corporate and decentralized final evaluation reports. It will cover both the evaluation process and products.

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Transparency

22. Transparency is an essential element of evaluation that establishes trust and builds confidence, enhances stakeholder ownership and increases public accountability. Evaluation products should be publicly accessible.¹

23. To achieve transparency, stakeholders should be aware of the reason for the evaluation, the selection criteria, and the purposes for which the findings will be used. Transparency of process is also important, as is the accessibility of evaluation materials and products.

24. Transparency will be ensured through the approaches described below. The commissioner of the evaluation will ensure a continuous consultation process with relevant stakeholders at all stages of the evaluation process. The evaluation report shall contain details of evaluation methodologies, approaches, sources of information and costs incurred. In accordance with the WHO disclosure policy, evaluation plans, reports, management responses and follow-up reports will be made public on the WHO Evaluation Office website.

Credibility

25. Evaluations must be credible. Credibility is grounded on independence, impartiality and a rigorous methodology. Key elements of credibility include transparent evaluation processes, inclusive approaches involving relevant stakeholders and robust quality assurance systems. Evaluation results (or findings) and recommendations are derived from – or informed by – the conscientious, explicit and judicious use of the best available, objective, reliable and valid data and by accurate quantitative and qualitative analysis of evidence. Credibility requires that evaluations are ethically conducted and managed by evaluators that exhibit professional and cultural competencies.²

Ethics

26. Evaluation must be conducted with the highest standards of integrity and respect for the beliefs, manners and customs of the social and cultural environment; for human rights and gender equality; and for the “do no harm” principle for humanitarian assistance. Evaluators must respect the rights of institutions and individuals to provide information in confidence, must ensure that sensitive data is protected and that it cannot be traced to its source and must validate statements made in the report with those who provided the relevant information. Evaluators should obtain informed consent for the use of private information from those who provide it. When evidence of wrongdoing is uncovered, it must be reported discreetly to a competent body (such as the relevant office of audit or investigation).³

Human rights and gender equality

27. The universally recognized values and principles of human rights and gender equality need to be integrated into all stages of an evaluation. It is the responsibility of evaluators and evaluation


managers to ensure that these values are respected, addressed and promoted, underpinning the commitment to the principle of “no-one left behind”.

**TYPES OF EVALUATIONS**

28. The WHO Secretariat commissions the following main types of evaluations.

   (a) **Thematic evaluations** focus on selected topics, such as a new way of working, a cross-cutting theme or core function, or they address an emerging issue of corporate institutional interest. Thematic evaluations provide insight into relevance, effectiveness, sustainability and broader applicability. They require an in-depth analysis of a topic and cut across organizational structures. The scope of these evaluations may range from the entire Organization to a single WHO office.

   (b) **Programmatic evaluations** focus on a specific programme. This type of evaluation provides an in-depth understanding of how and why results and outcomes have been achieved over several years and examines their relevance, effectiveness, sustainability, and efficiency. Programmatic evaluations address achievements in relation to WHO’s results chain, and require a systematic analysis of the programme under review. The scope of programmatic evaluations may range from a country to interregional or global levels.

   (c) **Office-specific evaluations** focus on the work of the Organization in a country, region or at headquarters in respect of WHO’s objectives and commitments.

29. The Executive Board may, at its discretion, also commission an evaluation of any aspects of WHO.

**EXTERNAL AND JOINT EVALUATIONS**

30. Evaluations may be commissioned by the governing bodies to be conducted by external evaluators independent from the Secretariat. Other stakeholders, such as Member States, donors or partners, may also commission external evaluations of the work of WHO for the purpose of assessing performance and accountability or prior to placing reliance on the work of the Organization.

31. The Secretariat will fully cooperate in external evaluations through a process of disclosure of appropriate information and facilitation of their performance. The results of external evaluations, when made available, will be disclosed on the WHO Evaluation Office website.

**PLANNING AND PRIORITIZATION OF EVALUATIONS**

32. WHO will develop a biennial, Organization-wide evaluation workplan as part of the Organization’s planning and budgeting cycle.

33. The workplan shall be established in consultation with senior management at headquarters and regions and with Heads of WHO Offices in countries, areas and territories, based on established criteria. The biennial workplan will be updated annually on the basis of the annual report to the

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Programme, Budget and Administration Committee and the Executive Board. The workplans shall be submitted to the Executive Board for approval through the Programme, Budget and Administration Committee.

34. The following categories shall be considered in the development of criteria\(^1\) for the selection of topics for evaluation:

(a) Organizational requirement relevant to: global, international or regional commitments; specific agreements with stakeholders, partners or donors; requests from governing bodies;

(b) Organizational significance relating to: general programme of work priorities and core functions; level of investment; inherent risks; performance issues or concerns in relation to achievements of expected results;

(c) Organizational utility relating to: a cross-cutting issue, theme, programme or policy question; potential for staff or institutional learning (innovation); degree of comparative advantage of WHO.

EVALUATION METHODOLOGY

35. The evaluation methodology and process for both corporate and decentralized evaluations will be informed by the 2016 United Nations Evaluation Group norms and standards and is detailed in the WHO evaluation practice handbook (which will be revised following the approval of this policy).

36. The Evaluation Office is also responsible for establishing a framework that provides guidance, quality assurance, technical assistance and professionalization support to the decentralized evaluation function.

RESOURCING OF THE EVALUATION FUNCTION

37. The Director-General shall ensure that there are adequate resources, within the range recommended by the United Nations Joint Inspection Unit (JIU/REP/2014/6),\(^2\) to implement the biennial Organization-wide evaluation workplan which includes not only the evaluations to be conducted but all activities required to ensure the strengthening of the evaluation culture and the professionalization of evaluation conduct across the Organization.

38. Deputy Directors-General, Regional Directors, Assistant Directors-General, Directors and Heads of WHO country offices must ensure that resources are adequate to implement their respective components of the Organization-wide evaluation workplan. An appropriate evaluation budget must be an integral part of the operational workplan of a programme, and shall be discussed as necessary with stakeholders during the planning phase of each project/programme/initiative.

39. In determining the amount required to finance the evaluation function in WHO, factors to be considered include: the Organization’s mandate and size; the types of evaluations to be considered; and the role of the evaluation function in institutionalization and support to strengthening decentralized evaluation, national capacities for evaluation and evaluation partnerships. With respect

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\(^1\) Refer to the WHO evaluation practice handbook for further guidance on detailed selection criteria.

\(^2\) Cf. paragraph 39.
to financial benchmarking, the United Nations Joint Inspection Unit (JIU/REP/2014/6) concluded that organizations should consider a range of funding that is between 0.5% and 3.0% of organizational expenditure.¹

ACCOUNTABILITY AND OVERSIGHT

40. The accountability framework defines from whom, and to whom, authority flows and for what purpose. It further defines the accountability of those with authority and their responsibility in exercising that authority. This section defines the roles and responsibilities for the main actors in the evaluation process as well as the monitoring mechanism used to implement the evaluation policy.

Roles and responsibilities

41. The Executive Board of WHO² shall:

(a) determine the evaluation policy and subsequent amendments, as needed;

(b) provide oversight of the evaluation function within the Organization;

(c) encourage the performance of evaluations as an input to planning and decision-making;

(d) provide input to the biennial Organization-wide evaluation workplan on the items of specific interest to Member States;

(e) approve the biennial Organization-wide evaluation workplan, including its budget; consider and take note of the annual report of the implementation of the biennial Organization-wide evaluation workplan;

(f) periodically revise the evaluation policy, as necessary.

42. The Evaluation Office is the custodian of the evaluation function and reports directly to the Director-General, and annually in a report for consideration by the Executive Board, on matters relating to evaluation at WHO. The Office is responsible for the following functions related to evaluation:

(a) leading the development of a biennial Organization-wide evaluation workplan;

(b) informing senior management on evaluation-related issues of Organization-wide importance;

(c) facilitating the input of evaluation findings and lessons learned for programme planning;

(d) coordinating the implementation of the framework for evaluation across the three levels of the Organization;


² WHO Executive Board and its subsidiary organ the Programme, Budget and Administration Committee.
(e) maintaining a system to track management responses to evaluations;

(f) maintaining an online inventory of evaluations performed across WHO;

(g) maintaining a roster of experts with evaluation experience;

(h) providing guidance material and advice for the preparation, conduct and follow-up of evaluations;

(i) reviewing evaluation reports for compliance with the requirements of the policy;

(j) strengthening capacities in evaluation among WHO staff (for example, making available standardized methodologies or training on evaluation);

(k) submitting an annual report on evaluation activities to the Executive Board;

(l) supporting the periodic review and updates to the policy as needed.

43. The Director-General shall appoint a technically qualified head of the Evaluation Office after consultation with the Executive Board. The Director-General shall likewise consult the Executive Board before any termination of the incumbent of that office. The head of the Evaluation Office serves for a fixed term of four years with a possibility of reappointment only once for a further term of four years, and is barred from re-entry into the Organization after the expiry of his/her term.

44. Additionally, the Director-General, Regional Directors, senior management and programme directors across the Organization also play a critical role in promoting a culture of evaluation. These roles and responsibilities are detailed in the evaluation practice handbook.

**USE OF EVALUATION FINDINGS**

**Utilization and follow-up of recommendations**

45. Recommendations contained in evaluation reports reflect the value added by the evaluation process. Each evaluation shall have an identified owner, such as the responsible officer of a cluster, programme, office or project. It is the responsibility of the owner to utilize the findings of the evaluation and develop an action plan for implementing the recommendations.

46. The evaluation owner shall ensure that an appropriate management response is issued in a timely manner to the appropriate Deputy Director-General/Assistant Director-General at headquarters, or to the Regional Director in the regions and countries.

47. The Director-General will establish a mechanism to ensure the effective follow-up of the implementation of evaluation recommendations in a systematic manner, coordinating efforts with the evaluation owners. Annual status reports on progress in the implementation of the recommendations will be submitted to the Executive Board through the Programme, Budget and Administration Committee.
Disclosure and dissemination of evaluation reports

48. WHO shall make evaluation reports available in accordance with the Organization’s disclosure policy.

49. Lessons learned from evaluations shall be distilled, reported and disseminated as appropriate.

COMMUNICATION

50. Once approved, the 2018 policy will be rolled out alongside the revised WHO evaluation practice handbook through a communication plan in order to strengthen the evaluation culture across the three levels of the Organization and develop a common understanding of WHO evaluation policy standards, expectations and potential use.

Fourth meeting, 29 May 2018
EB143/SR/4