Governing Body matters:
Key issues arising out of the Seventy-second
World Health Assembly and the
144th and 145th 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-second World Health Assembly, held in Geneva on 20–28 May 2019, and the 144th and 145th sessions of the WHO Executive Board, held on 24 January–1 February 2019 and 29–30 May 2019, 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 related resolutions merit follow-up action by both Member States as well as the Organization at the regional and country levels.

The background of the selected 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-second World Health Assembly by the delegation of the Member States of the South-East Asia Region on select Agenda items are provided as an Annex to this Working Paper.

The High-Level Preparatory Meeting held in New Delhi on 1–4 July 2019 reviewed the attached Working Paper and noted the provisions of the select resolutions which merit follow-up actions at the regional and country levels. Highlighting the serious public health issue of snakebite envenoming as a neglected tropical disease, especially in the WHO South-East Asia Region, and with the objective of ensuring access to safe, effective and affordable treatment outlined in the Global Strategy to prevent and control snakebite and envenoming, it was proposed to include an Agenda item in the Provisional Agenda for the Seventy-second Session of the WHO Regional Committee for South-East Asia on the issue to facilitate development of a “Regional Snakebite Prevention and Control Plan of Action” in line with the WHO Global Strategy.
The HLP Meeting, following a review of the document and keeping in view the above proposal, made the following recommendations:

**Actions by Member States**

1. Implement the related provisions of the select resolutions endorsed by the Seventy-second World Health Assembly and the 144th and 145th sessions of the WHO Executive Board which merit follow-up actions.

2. Submit a formal proposal to the Regional Office for addition of an Agenda item on “Regional Snakebite Prevention and Control Plan of Action” in the Provisional Agenda of the Seventy-second Session of the Regional Committee.

**Actions by WHO**

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

2. Note and act upon the formal proposal for addition of an Agenda item on “Regional Snakebite Prevention and Control Plan of Action” from Member States in the Provisional Agenda of the Seventy-second Session of the Regional Committee as per rules of procedure.

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

Resolutions and Decisions of the Seventy-second World Health Assembly (which also cover the subjects of technical resolutions adopted by the 144th and 145th sessions of the Executive Board), related resolutions and decisions of the previous Health Assemblies and sessions of the Executive Board, and the Regional One Voice (RoV) intervention on these items made at the Seventy-second World Health Assembly.
Introduction

1. The Seventy-second World Health Assembly in May 2019 and the 144th and 145th sessions of the WHO Executive Board in January and May 2019 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 Working Paper. Salient information on the implications of the issues, and actions already taken and to be taken, are also included herein.

3. Also annexed to this paper are copies of all the resolutions and decisions of the Seventy-second World Health Assembly (which also cover the subjects of technical resolutions adopted by the 144th and 145th sessions of the Executive Board), related resolutions and decisions of the previous Health Assemblies and sessions of the Executive Board and the text of the “Regional One Voice” presented at the Seventy-second World Health Assembly by the delegation of the Member States of the South-East Asia Region on select Agenda items.
1. **Polio: Eradication and transition** *(Regional One Voice intervention made at the Seventy-second World Health Assembly)*

**Background**

1. The Global Polio Eradication Initiative (GPEI) Polio Endgame Strategy 2019–2023, that sets out the roadmap to achieving global certification by 2023, was presented to and noted by the Seventy-second World Health Assembly in May 2019.

2. The progress report on polio transition, providing an update on the implementation of the strategic action plan on polio transition, was noted by the World Health Assembly.

3. Member States of the WHO South-East Asia Region made the Regional One Voice (RoV) intervention on this Agenda item, noting the Global Polio Eradication Initiative (GPEI) Endgame Strategy 2019–2023 and the report on the Strategic Action Plan on Polio Transition, and highlighted key priorities and necessary collaborative actions to achieve the objectives of transition.

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

4. The Regional One Voice from Member States of the WHO South-East Asia Region expressed commitment to fully implement the GPEI Polio Endgame Strategy 2019–2023 and identified the following priorities/areas of support:

   a) need for Member States in which poliovirus was still present to implement the action plan fully to achieve polio eradication;

   b) utilization of polio assets for other health activities such as strengthening routine immunization, introduction of new vaccines, surveillance for other vaccine preventable diseases and capacity for implementation of IHR;

   c) advocacy with donors and partners to ensure that polio infrastructure and capacities continue to maintain polio functions and strengthen health systems; and

   d) commitment to the polio eradication goal through strengthening immunization systems based on long-term sustainability.

**Actions taken in the Region**

5. A very high degree of commitment has been assured from the ministries of health for implementation of GPEI Endgame Strategy 2019–2023 and for transition of polio assets.

6. National polio outbreak response plans and routine immunization programmes that include inactivated poliovirus vaccine (IPV) are in place in all countries of the Region, and progress is being made towards poliovirus containment.

7. The Government of Indonesia has responded aggressively to a recent detection of circulating vaccine-derived poliovirus in the country.

8. Polio transition plans have been finalized for five SEA Region Member States – Bangladesh, India, Indonesia, Myanmar and Nepal.
9. Transition plans have been endorsed by the respective national governments in Bangladesh and India, while plans of Indonesia, Myanmar and Nepal are under consideration by the respective national governments.

**Actions to be taken in the Region**

10. The following actions are proposed to be taken in the Region:

   a) Implementation of GPEI Endgame Strategy 2019–2023 by all Member States;
   b) Issuing a call to Indonesia, Myanmar and Nepal to endorse their polio transition plans;
   c) Operationalization of transition plans by all five priority countries – Bangladesh, India, Indonesia, Myanmar and Nepal;
   d) Mobilization of domestic resources for long-term sustainability of polio assets; and
   e) Ensuring optimal funding for polio transition in high-priority countries by the engagement of new partners such as Gavi.
2. **Primary health care towards universal health coverage**  
(resolution WHA72.2 titled ‘Primary health care’ and Regional One Voice intervention made at the Seventy-second World Health Assembly)

**Background**

11. The report presented to the Seventy-second World Health Assembly summarizes the renewed commitment to primary health care (PHC) through the Declaration of Astana, and why PHC should be the cornerstone of sustainable health systems for universal health coverage (UHC) and the health-related Sustainable Development Goals (SDGs). It argues for PHC to remain strong and that the prospects for progress are greater now than in previous calls for the renewal of PHC. The Declaration of Astana focuses on three elements of PHC: comprehensive, integrated primary care services and essential public health functions; multisectoral action on determinants of health; and empowered people and communities. An operational framework has been developed. Action on PHC will align with existing initiatives including the Global Action Plan for healthy lives and well-being for all, and the High-Level Meeting on UHC at the UN General Assembly in September 2019. Indonesia presented the Regional One Voice to the Health Assembly in support of the Resolution.

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

12. The Resolution urges Member States to implement the vision and commitments of the Declaration of Astana; asks other stakeholders to align their support behind implementing that vision; and requests WHO to ensure that the operational framework of PHC is fully taken into account in the Thirteenth WHO General Programme of Work. It also calls for reporting regularly to the World Health Assembly as part of all reporting mechanisms on progress towards achieving UHC by 2030.

**Actions taken in the Region**

13. In 2008, a WHO-SEARO Expert Group on Revitalising PHC found many “misperceptions” about PHC and observed that public frontline and population health services are often under-resourced. The resolution passed by the Sixty-first session of the Regional Committee for South-East Asia on “Revitalising primary health care (SEA/RC61/R3)” recognized the need to link primary care services with other parts of the health system and ensure equitable financing strategies. In 2012, the Regional Strategy for UHC positioned PHC-oriented systems as the “underpinning concept” for UHC. In 2018, the Regional Office for South-East Asia produced a paper for the Global Conference on PHC – Primary Health Care at forty: reflections from South-East Asia.

14. Many SEA Region countries are introducing or extending reforms in primary care, driven by the rise in NCDs and the ageing of their populations, with more emphasis on continuing care.

**Actions to be taken in the Region**

15. Member States are continuing to review and adapt their frontline services. Real-time documentation of progress and results will help with any policy adjustments necessary and also facilitate cross-country sharing of lessons learnt.

16. A Regional Consultation on Strengthening Frontline Services for UHC will be held on 23–25 July 2019 in New Delhi wherein future priorities for the Region will be outlined.
3. Community health workers delivering primary health care: opportunities and challenges (resolution WHA72.3 titled ‘Community health workers delivering primary health care: opportunities and challenges’ and Regional One Voice intervention made at the Seventy-second World Health Assembly)

Background

17. Health workers are critical for delivering quality primary health services and to achieve UHC. Community health workers (CHWs) are part of the PHC interdisciplinary workforce in many countries. There is growing recognition that CHWs are effective in the delivery of a range of preventive, promotive and curative health services, and that they can contribute to reducing inequities in access to care.

18. WHO has reviewed the evidence on what is required to facilitate the proper integration of community health workers in health systems and communities and developed the “WHO Guideline on health policy and system support to optimize community health worker programmes”. The purpose of the guidelines is to assist national governments and national and international partners to improve the design, implementation, performance and evaluation of CHW programmes, contributing to the progressive realization of universal health coverage.

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

19. The World Health Assembly resolution on “Community health workers delivering primary health care: opportunities and challenges” takes note of the WHO guideline on health policy and system support to optimize community health worker programmes, urges Member States to apply its recommendations, and invites partners to support the implementation of the guidelines.

Actions already taken in the Region

20. The following actions have been taken in the SEA Region:

i. Community health workers are now considered when developing National Human Resources for Health Strategies;

ii. Some countries, such as Bangladesh, have conducted studies on community health clinics and the community health workers; and

iii. The SEA Region is currently engaging with countries to capture data on frontline health workers, including CHWs.

Actions to be taken in the Region

21. The following actions are proposed to be taken in the SEA Region:

i. Include relevant elements of the CHW guidelines and resolution when developing or updating the national health sector strategies and/or national HRH strategies.

ii. In countries conducting health labour market analysis, ensure that CHWs are explicitly included if relevant to context
iii. Organize an advocacy event on CHWs. The guideline recommendations can also be presented during the next Regional HRH Meeting to be held in April 2020.

iv. Strengthening the health workforce information system while ensuring disaggregation by occupational group should also include CHWs, in order to inform national decision-making and contribute to the monitoring and accountability framework to assess progress in implementation of the resolution.
4. **Preparation for the High-Level Meeting of the United Nations General Assembly on universal health coverage** (resolution WHA72.4 titled ‘Preparation for the high-level meeting of the United Nations General Assembly on universal health coverage’ and Regional One Voice intervention made at the Seventy-second World Health Assembly)

**Background**

22. In 2017 the United Nations General Assembly decided to hold a one-day High-Level Meeting on Universal Health Coverage. The meeting is scheduled to be held on 23 September 2019. The theme of the meeting is “Universal Health Coverage: moving together to build a healthier world”. A political declaration will be presented at the meeting, for which intergovernmental negotiations are now taking place.

23. The High-Level Meeting is designed to mobilize a wider group of stakeholders in and beyond the health sector that are needed to accelerate progress on UHC.

24. Member States have been briefed about this meeting on several occasions. The Regional One Voice at the World Health Assembly supported the resolution.

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

25. The resolution urges Member States to act in 15 areas, including to accelerate progress on UHC; support the preparations for the High-Level Meeting; mobilize adequate resources for UHC; support better prioritization and decision-making; invest in primary health care; gender-sensitive health services; the health workforce; access to quality medicines; promoting health literacy; stronger prevention and health promotion; strengthening monitoring; and making best use of the annual “International UHC Day”. It also calls upon other partners to harmonize and enhance their support for the objectives of Member countries. It asks the Director-General to submit biennial reports on progress in implementing the resolution.

**Actions taken in the Region**

26. Universal health coverage is one of the eight Regional Flagships in South-East Asia. The two SDG-UHC indicators show mixed progress in the SEA Region. Essential service coverage is improving in all Member States, but at current rates of progress, projections suggest that less than half of the countries will reach 80% essential service coverage by 2030. The SEA Region has the second highest rate of catastrophic spending among all the six WHO regions.

27. The focus on UHC is maintained through the Regional Committee decision SEA/RC70(1), which requires an annual report on monitoring progress on UHC and the health-related SDGs to be included as a substantive Agenda item for the Regional Committee every year till 2030. Technical support for advancing UHC in the SEA Region includes strengthening the health workforce and access to medicines. There is growing inter-country collaboration, for example, through the South-East Asia Regulatory Network; together with approaches to health financing that improve service coverage and financial protection by mobilizing resources, getting better value for money, and monitoring progress.

**Actions to be taken in the Region**

28. The Regional Committee for South-East Asia will continue to monitor progress on UHC annually until 2030.
29. Member States are committed to maintain and intensify actions to advance UHC, including strengthening their health workforce and access to medicines by their populations, improve financial protection and adapt their frontline services to deliver health care that responds to today’s needs.

30. High-level participation from the Member States of the SEA Region in the High-Level Meeting on UHC will be encouraged.
5. **Health, environment and climate change** *(decisions WHA72(9) titled ‘WHO global strategy on health, environment and climate change: the transformation needed to improve lives and well-being sustainably through healthy environments’ and WHA72(10) titled ‘Plan of action on climate change and health in small island developing States’ and Regional One Voice intervention made at the Seventy-second World Health Assembly)*

**Background**

31. The 142nd session of the Executive Board, through its decision EB142(5), requested WHO, in consultation with Member States, to develop two policy papers: (i) Global Strategy on Health, Environment and Climate Change; and (ii) Global Action Plan on Climate Change and Health in Small Island Developing States (SIDS).

32. The Strategy aimed to transform the way the world and the health community tackled environmental risks to health by including health-in-all policies and scaling up disease prevention and health promotion.

33. The Global Plan of Action for SIDS was developed as per the recommendations of the third Global Conference on Health and Climate held in 2018 to provide support and evidence to national health authorities in small island developing states to implement regional plans.

34. Both papers were discussed and approved at the 144th session of the Executive Board, with further amendments based on online and face-to-face comments from Member States, prior to the Seventy-second World Health Assembly. Both papers are consistent with the 2030 Sustainable Development Agenda and WHO’s Thirteenth General Programme of Work (GPW13). Moreover, both are in line with and will support the implementation of multilateral environmental agreements, including the UN Framework Convention on Climate Change and the Convention on Biological Diversity.

35. Bangladesh made the SEA Regional One Voice (ROV) intervention, discussing about the vulnerabilities of SEA Region Member States, and encouraged WHO to mobilize resources for environmental health technical programmes by accelerating the accreditation process of existing global funding mechanisms.

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

36. The Seventy-second World Health Assembly, in May 2019, adopted the following:
   a) Global Strategy on Health, Environment and Climate Change; and
   b) Global Action Plan on Climate Change and Health in Small Island Developing States (SIDS).
Actions taken in the Region

37. The following actions have been taken in the SEA Region:
   i. Recognizing the impact of climate change on health and vulnerability of the Region, the health ministers endorsed the Male’ Declaration and Framework for Action for Building Health Systems Resilience to Climate Change at the Seventieth session of the Regional Committee in 2017;
   ii. The WHO Regional Office for South-East Asia supported the participation of Maldives and Timor-Leste in the development of the Global Action Plan on Climate Change and Health in Small Island Developing States;
   iii. The Regional Meeting on Air Quality and Health was held in, Bangkok, Thailand, on 18–20 June 2018, which assisted in the preparations for the First Global Conference on Air Pollution and Health.
   iv. Member States of the SEA Region participated actively in the first Global Conference and proposed certain commitments that were included in the Geneva Action Plan for Air Pollution and Health.

Actions to be taken in the Region

38. The following actions are proposed to be taken in the SEA Region:
   i. Align the SEA Regional Action Plan for Environmental Health with the Global Strategy on Health, Environment and Climate Change and table the regional plan at the Seventy-second session of the Regional Committee; and
   ii. Monitor and follow up on the implementation of Global Action Plan on Climate Change and Health in Small Island Developing States such as Maldives and Timor-Leste.
6. **Access to medicines and vaccines** (resolution WHA72.8 titled ‘Improving the transparency of markets for medicines, vaccines and other health products’ and Regional One Voice intervention made at the Seventy-second World Health Assembly)

**Background**

39. Assuring access to medicines is key to advancing universal health coverage. During the discussions on Agenda item 11.7 held at the Seventy-second World Health Assembly, Member States expressed wide support for the “WHO Access Roadmap for Medicines, Vaccines and other health products”, which will determine WHO’s work for the next five years on this area.

40. The World Health Assembly also adopted a resolution on “Improving the Transparency of Markets for Medicines, Vaccines and Other Health Products” in an effort to expand access. The draft resolution was sponsored originally by Italy and finally proposed by a total of 19 countries, including India and Sri Lanka from the South East Asia Region.

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

41. The resolution urges Member States to enhance public sharing of information on actual prices paid by governments and other buyers for health products. It also calls for greater transparency on pharmaceutical patents, clinical trial results and other determinants of pricing along the value chain from laboratory to patient.

42. The resolution requests the WHO Secretariat to support efforts towards transparency by collecting and analysing price information of health products and monitoring the impact of transparency on affordability and availability of health products.

43. The aim is to improve access to medicines by helping Member States to make more informed decisions when purchasing health products and to increase their capacity to negotiate more affordable prices.

**Actions taken in the Region**

44. The WHO Access Roadmap broadly corresponds with main targets of the Delhi Declaration on “Improving access to essential medical products in the South-East Asia Region and beyond” that was adopted by the Regional Committee in September 2018. The Regional One Voice related to the Agenda item has highlighted this alignment and welcomed the main targets providing strategic directions that are focused on quality and access in the WHO Access Roadmap, together with the use of a health system approach.

45. The Delhi Declaration, in line with the World Health Assembly resolution, calls for “information sharing on availability, prices and quality of medical products”. An online platform exists for Member States to share information, either publicly or confidentially, on public procurement prices of essential medicines in the South-East Asia Region (the PIEMED platform). Compilation of procurement price information from national and subnational procurement agencies is in progress. In addition, the South-East Asia Regulatory Network (SEARN) is developing an information sharing platform for national regulatory authorities (NRAs) that will help increase access to information on the marketing approval status and quality of health products.
46. The “Initiative for Coordinated Antidotes Procurement in the South-East Asia Region” (iCAPS) fosters regional collaboration in procurement, as a first step to improving access to these essential life-saving products.

Actions to be taken in the Region

47. The following actions are proposed to be taken in the SEA Region:

a) WHO to continue to support Member States in developing and implementing effective policies and actions to improve access to essential health products within the overall targets highlighted both in the WHO Access Roadmap and the Delhi Declaration; and

b) the Regional Office for South-East Asia will also continue to:

   a) support implementation of national policies (on selection, pricing procurement and others) aimed at increasing affordability and availability of essential health products and conducting in-depth policy analysis and impact evaluation;

   b) strengthen national regulatory capacities and regional regulatory collaboration via SEARN to accelerate access to quality essential health products; and

   c) support regular monitoring and reporting of data on prices, availability and affordability by using new digital tools for data collection and analysis.
7. **Follow-up to the High-Level Meeting of the United Nations General Assembly on antimicrobial resistance** (resolution WHA72.5 titled ‘Antimicrobial resistance’ and Regional One Voice intervention made at the Seventy-second World Health Assembly)

**Background**

48. Health ministers of countries of the Region adopted the “Jaipur Declaration on Antimicrobial Resistance” in September 2011. In May 2015, the World Health Assembly through its resolution WHA68.7 adopted the Global Action Plan (GAP) on antimicrobial resistance and requested Member States to prepare their national action plans (NAP).


50. After considering the report by the WHO Director-General on the follow-up actions to the UNGA-AMR deliberations, the Executive Board at its 144th session recommended resolution EB144.R11 on antimicrobial resistance for adoption by the Seventy-second World Health Assembly. The Seventy-second World Health Assembly in May 2019 adopted the resolution on antimicrobial resistance.

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

51. Resolution WHA72.5 on AMR calls for continued high-level commitment to implement and adequately resource multisectoral national action plans.

52. The resolution urges Member States to strengthen infection prevention and control measures including water sanitation and hygiene; enhance participation in the Global Antimicrobial Surveillance System; ensure prudent use of quality-assured antimicrobials; and support the multisectoral annual self-assessment survey.

53. The resolution requests the WHO Director-General to significantly enhance support to countries in implementing their national action plans and help in mobilizing the required financial resources, in collaboration with other UN agencies and partners.

54. Mindful of the need to address antimicrobial resistance and also its important role in the achievement of the 2030 Agenda for Sustainable Development, it is important to implement the NAPs on time, using the multisectoral “One health” approach.

55. This resolution will strengthen the ongoing AMR containment efforts being carried out in the Region and will ensure continued high-level political commitment to combat AMR in South-East Asia.

**Actions taken in the Region**

56. Ten of the 11 SEA Region Member States have enrolled in the Global Antimicrobial Resistance Surveillance System (GLASS) as of 2019.

58. Countries of the SEA Region have initiated the process to adopt the “Access/Watch/Reserve (AWaRe) classification” in their national medicines lists.

59. National regulatory authorities in four Member States have taken steps to reduce over-the-counter sale of antimicrobials through improved labelling, inspections and public education.

60. National reference laboratories (NRLs) are being strengthened to ensure production of quality data for GLASS.

61. WHO is continuously working with relevant stakeholders to mobilize and allocate necessary resources for the implementation of NAP and for research and development.

62. All 11 Member States participated in the AMR self-assessment exercise since 2016. Some of the highlights of self-assessment survey of 2018–2019 are as follows:

a) All Member States have their AMR national action plans, and relevant policies and regulatory frameworks for antimicrobial resistance are in place.

b) Most of the Member States have:

   a) multisectoral working group(s) or coordination committee(s) on AMR established with government leadership;

   b) activities/guidelines for infection prevention and control (IPC);

   c) imparted training and professional education on antimicrobial resistance in the human sector; and

   d) mechanisms for optimizing antimicrobial use in human health that are in place to a certain extent.

**Actions to be taken in the Region**

63. Support has to be extended for scaling up the implementation of national action plans with continued high-level commitment from policy-makers, annual allocation of funds, provision of technical expertise and the “One health” approach.

64. Facilitation for the effective functioning of multisectoral steering committees in Member States.
8. **Follow-up to the High-Level Meeting of the United Nations General Assembly on prevention and control of noncommunicable diseases** (decision WHA72(11) titled ‘Follow-up to the political declaration of the third High-Level Meeting of the General Assembly on the prevention and control of noncommunicable diseases’ and Regional One Voice intervention made at the Seventy-second World Health Assembly)

**Background**

65. The third High-Level Meeting of the United Nations General Assembly on noncommunicable diseases was held in September 2018 with the theme of “Scaling up multistakeholder and multisectoral responses for the prevention and control of noncommunicable diseases in the context of the 2030 Agenda for Sustainable Development”. The Political Declaration of the third High-Level Meeting – titled “Time to deliver: Accelerating our response to address NCDs for the health and well-being of present and future generations” – was accepted in the opening segment of the third High-Level Meeting and adopted by the UN General Assembly on 10 October 2018.

66. During the Seventy-second World Health Assembly in May 2019, WHO reported (document A72/19) on mandates given to the Organization by the Political Declaration on NCD prevention and control from the third High-Level Meeting of the UN General Assembly. This includes the expansion of the NCD agenda to cover air pollution and mental health, now called the “5x5 agenda”, and the extension of the Global Action Plan on NCD prevention and control and the Comprehensive Mental Health Action Plan, both from 2020 to 2030. The 144th session of the Executive Board passed the draft decision EB144(1) to the Seventy-second World Health Assembly for its consideration.

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

67. The Seventy-second World Health Assembly adopted the decision WHA72(11) with the following major action points for WHO:

   a) Propose updates to appendices of the WHO Global Plan of Action on NCD prevention and control (especially Appendix 3 on “best buys”), as appropriate;

   b) Develop best buys interventions for mental health that will be presented at the Seventy-third World Health Assembly in May 2020;

   c) Develop best buys interventions for air pollution to be presented at the Seventy-third World Health Assembly in May 2020;

   d) Review the 10-year implementation of the Global Strategy to Reduce Harmful Use of Alcohol and present the findings at the Seventy-third World Health Assembly in May 2020;

   e) Synchronize the progress report on NCD-related resolutions for 2020–2030;

   f) Develop guidance on health literacy to be presented at the Seventy-fourth World Health Assembly in May 2021;

   g) Present successful approaches for multisectoral action at the Seventy-fourth World Health Assembly in May 2021; and

   h) Present best practices to address overweight and obesity at the Seventy-fourth World Health Assembly in May 2021.
**Actions taken in the Region**

68. The Regional Office conducted the South-East Asia Regional Forum to accelerate NCD prevention and control in the context of the SDGs (also known as the Flagship 2 Forum) in Thailand in October 2017. Subsequently a regional meeting of the national NCD programme managers in the South-East Asia Region was convened in Indonesia in November 2018.

69. Collaboration between Member States and the United Nations System is progressing well through the existing Global Coordinating Mechanism for NCD prevention and control (GCM/NCD), UN Interagency Taskforce on NCD prevention and control (UNIATF) and the UN Country Framework systems. The Regional Office continues to contribute through these frameworks to enhance multisectoral engagement for NCD prevention and control.

**Actions to be taken in the Region**

70. The following actions are proposed to be taken in the SEA Region:

   a) conduct activities to monitor and evaluate progress in NCD prevention and control in the Region;

   b) announce the expansion of the NCD Agenda to cover mental health and air pollution (5x5 model);

   c) consider fine-tuning the SEA Region Flagship #2 in detail and work with Member States through WHO country offices on the new 5x5 model; and

   d) SEA Region Member States to participate in the process to review the implementation of the Global Strategy to Reduce Harmful Use of Alcohol.
9. Pandemic Influenza Preparedness Framework for the sharing of influenza viruses and access to vaccines and other benefits (decision WHA72(12) titled ‘Pandemic Influenza Preparedness Framework for the sharing of influenza viruses and access to vaccines and other benefits’)

Background

71. The Seventy-first World Health Assembly, through its decision WHA71(11), recommended strengthening critical pandemic preparedness by implementing the ‘Partnership Contribution (PC) Preparedness High-Level Implementation Plan II 2018–2023”, which will support strengthening of laboratory, surveillance and regulatory capacities as well as burden-of-disease studies. There is also a request for 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.

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

72. All Member States are supportive of the progress around the PIP framework and agree with the recommendations of its review. Countries discussed and raised issues around the following: information sharing including genetic sequence data (GSD); the implications of the Nagoya Protocol and the inclusion of seasonal influenza regarding which there were opposing views.

73. Member States agreed to revise the wording in Footnote 1 in the Standard Material Transfer Agreement 2 (SMTA2), PIP Framework Annex¹, in order to close the loophole that permits companies that use viruses or GSD through third parties (either other companies or research/academic institutions). This topic was discussed in the Executive Board in January 2019 and by the Health Assembly in May 2019.

74. All Member States were committed to improved reporting, increased sharing, and enhancing the functioning of GISRS from Member States through to WHO collaborating centres. Sri Lanka and Thailand were supportive of the PIP Framework and the work done around it and supported the changes in the wording of the decisions.

Actions taken in the Region

75. There are six Member States which receive funding from the PIP framework and work is continuing in the six main outputs – laboratory and surveillance, burden of influenza, regulatory capacity-building, risk communication/community engagement, vaccine development and pandemic preparedness planning for supported countries. There is good progress in the implementation of the work funded by contributions of the PIP Framework partners. Regular Bi-Regional meetings with national influenza centres are held annually (in Nepal in 2018 and in Mongolia in July 2019).

¹ The Amendment is as follows: Recipients are receivers of “PIP Biological Materials” from the WHO global influenza surveillance and response system (GISRS), such as manufacturers of influenza vaccines, diagnostics, pharmaceuticals and other products relevant to pandemic preparedness and response, as well as biotechnology firms, research institutions and academic institutions. Recipients shall select from among the commitments identified in SMTA2 Article 4.1.1 (a) to (c) based on their nature and capacities; those that are not manufacturers shall only have to consider contributing to the measures set out in SMTA2 Article 4.1.1(c). Any manufacturer that enters into any contracts or formal agreements with recipients or GISRS laboratories for the purpose of using PIP Biological Materials on the manufacturer’s behalf for commercialization, public use or regulatory approval of that manufacturer’s vaccines, diagnostics, or pharmaceuticals shall also enter into an SMTA2 and select from among the commitments identified in Article 4.1.1 (a) to (c) based on their nature and capacities.
76. Member States of the SEA Region are represented among the members of the PIP Framework’s Advisory Group, and participated in the “WHO Consultation on Implementation of Decision WHA70(10)8(b)” held in Geneva on 15–16 October 2018.

**Action to be taken in the Region**

77. Continue implementation of the PIP Framework in Member States of the SEA Region. Virus-sharing should be strengthened among countries and the implications of the Nagoya Protocol should be considered elaborately.
10. Promoting the health of refugees and migrants (decision WHA72(14) titled ‘Promoting the health of refugees and migrants’ and Regional One Voice intervention made at the Seventy-second World Health Assembly)

Background

78. The 144th session of the WHO Executive Board in January 2019 considered the report on the health of refugees and migrants. In the light of the discussions, the Secretariat had modified the report by including the Global Action Plan (GAP) on Health of Refugees and Migrants (2019–2023), and submitted it to the Seventy-Second World Health Assembly in May 2019. The Health Assembly considered it under Agenda 12.4 and adopted a decision. The Member States of the WHO South-East Asia Region also made a Regional One Voice (RoV) intervention on this Agenda item.

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

79. The Seventy-Second World Health Assembly, having considered the report on promoting the health of refugees and migrants decided:

(1) to take note of the WHO Global Action Plan on promoting the health of refugees and migrants, 2019–2023; and

(2) to request the Director-General to report back on progress in the implementation of the WHO Global Action Plan on promoting the health of refugees and migrants, 2019–2023, including relevant information provided by Member States on a voluntary basis and United Nations agencies as appropriate, to the Seventy-fourth and Seventy-sixth World Health Assemblies.

80. The objective of the GAP is to promote the health and well-being of refugees and migrants in collaboration with IOM and UNHCR and other international partner organizations, Member States and relevant stakeholders. GAP set out six priority options for the Secretariat in response to requests by Member States.

81. WHO action will be focused on achieving UHC for refugees and migrants and host populations within the context of Thirteenth General Programme of Work 2019–2023, promoting and achieving “Health for All” and UHC within the context of the 2030 Agenda for Sustainable Development and its associated goals, while leaving no one behind.

82. GAP is voluntary, is intended solely for the Secretariat, and will not have any financial implications for Member States. The Secretariat will provide support to Member States only upon request and in accordance with national legislation and country contexts.

Actions taken in the Region

83. The Sixty-ninth session of the WHO Regional Committee for South-East Asia noted the need for migrant-sensitive legislation, policies and health systems, emphasizing that the focus on migrant health in the health sector must be comprehensive, covering all public health functions and health system strengthening, and have focused interventions and tailored services to address the special needs of different migrant groups.

84. Three Member States from the Region currently have national migration health policies/strategies or action plans in place.
85. Health interventions for refugees and migrants were coordinated by Member States and WHO in the matter of the Bangladesh-Myanmar refugee crisis, wherein major disease outbreaks were averted and thousands of lives were saved, though many thousands continue to remain vulnerable.

86. Targeted programmes for elimination of communicable diseases and specific cross-border management of infections have been strengthened. Last mile programmes and zero transmission have been maintained through inclusiveness of the migrant population.

87. **Neglected tropical diseases**: The Regional Programme Review Group (RPRG) in 2018 recommended to expand lymphatic filariasis surveillance to migrant communities to look into possibilities of resurgence through migrants coming in from endemic countries that have eliminated the disease.

88. **Tuberculosis**: The Delhi Call for Action signed in March 2017 at the Ministerial Meeting towards ending TB in the South-East Asia Region recognizes the need for TB control among migrants as an important component of the overall End TB strategy.

89. **Malaria**: The Ministerial Declaration on Accelerating and Sustaining Malaria Elimination of November 2017 pledged to ensure universal access to quality-assured prompt diagnosis and treatment, and effective prevention to all vulnerable and at-risk populations including the disadvantaged communities, communities in border and conflict areas, and refugees and migrants. In May 2018, the Ministerial Call for Action to Eliminate Malaria in the Greater Mekong Subregion before 2030, largely in response to antimalarial drug resistance in the region, highlighted the importance of access to malaria interventions for indigenous, mobile and migrant populations, and cross-border collaboration.

90. **HIV**: National strategic plans of several countries of the SEA Region have highlighted migrants as one of the priority populations apart from other three key populations, i.e. men having sex with men (MSM) which includes transgender (TG) population, female sex workers (FSW), and people who inject drugs (PWID).

**Actions to be taken in the Region**

91. The following actions are proposed to be taken in the Region:

   i. Adapt GAP to address regional specific issues;

   ii. Incorporate GAP priority options into existing technical programmes, including those on cross-border collaboration; and

   iii. Strengthen disaggregated health information systems with robust epidemiological data on migration and health.
11. Global action on patient safety (resolution WHA72.6 titled ‘Global action on patient safety’ and Regional One Voice intervention made at the Seventy-second World Health Assembly)

Background

92. This Agenda item followed a request from 34 countries, including Sri Lanka and Thailand. In 2002, World Health Assembly resolution WHA55.18 on “Quality of care: patient safety” urged Member States to “pay the closest possible attention to the problem of patient safety”. The Fourth Ministerial Meeting on Patient Safety in March 2019 focused on patient safety issues in low- and middle-income countries. A high-level Forum on Global Action on Patient Safety at Wilton Park, in the United Kingdom of Great Britain and Northern Ireland, in May 2019 helped maintain the global momentum and secure high-level commitment and support for the World Health Assembly resolution. Thailand presented the Regional One Voice in support of the resolution.

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

93. The resolution endorses the establishment of an annual World Patient Safety Day (17 September) to increase public awareness. It urges 14 actions from Member States that together will make patient safety an essential component of health system strengthening for UHC, including better data and reporting of incidents, and embedding patient safety in all programmes and health worker training.

94. It invites other stakeholders to support patient safety initiatives in Member States. It requests WHO to make patient safety a priority across the UHC agenda, and provide guidance, technical support, strengthen networks and global learning; launch Global Patient Safety Challenges; formulate a global patient safety action plan to be submitted to the 148th session of the Executive Board in 2021, and to report on progress every two years to the World Health Assembly.

Actions taken in the Region


96. Patient safety assessments have been conducted in almost all SEA Region Member States, using a tool developed by SEARO. These found that most Member States have high-level mechanisms, indicators and national action plans for antimicrobial resistance, blood, laboratory and medication safety. The weakest areas include adverse event monitoring; competent workforce; and patient safety risk management.

97. Since 2012, the South-East Asia Regional Office has partnered with the Western Pacific Regional Office and the Organization for Economic Cooperation and Development to set up the Asia Pacific Healthcare Quality Improvement Network. This has also conducted a survey in 2013 on national quality improvement strategies, collecting information on the policies, legal frameworks, indicators, error reporting systems, accreditation systems, infection prevention and control, and public reporting of quality of care.

98. In March 2019, an informal expert consultation on cleaner, safer health facilities in New Delhi identified some possible priorities for an expanded programme of work on patient safety and quality.
Actions to be taken in the Region

99. The suggested priority actions for an intensified programme of work on patient safety will be discussed at the Regional Consultation on Strengthening Frontline Services for UHC in the South-East Asia in July 2019. A draft “clean safe facility” dashboard will be presented.

100. A WHO Infection Prevention and Control workshop will be held in Thailand in August.

12. Water, sanitation and hygiene in health-care facilities
(resolution WHA72.7 titled ‘Water, sanitation and hygiene in health care facilities’ and Regional One Voice intervention made at the Seventy-second World Health Assembly)

Background

102. The 144th session of the Executive Board recommended to the Seventy-second World Health Assembly in May 2019 to adopt a resolution on this agenda. The domain of water, sanitation and hygiene (WASH) in health-care facilities consists of five action areas: water, sanitation, hygiene, waste management and environmental friendliness (green energy, etc). A few major issues were raised, including the role of WHO to promote coordination across sectors at the country level, and integration of WASH in health-care facilities into the national health policies. Bhutan led the Regional One Voice intervention, identifying vulnerabilities and gaps in the Region and calling for robust implementation of the resolution.

103. WHO is working to improve WASH in health-care facilities, including safe management of health-care waste, together with UNICEF. A set of global targets were established to achieve universal access to WASH in health-care facilities. The WHO-UNICEF Joint Monitoring Programme established a global reporting and monitoring mechanism for WASH in health-care facilities. The new report launched by WHO and UNICEF on 3 April 2019 provided the global baseline report for 2019 on the status of WASH in health-care facilities. Only national representative data could be accessed from facility assessments since WASH information is collected scarcely in health management information systems.

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

104. The resolution adopted by the Seventy-second World Health Assembly requests WHO to promote both internal and external collaborations, particularly in the area of antimicrobial resistance and infection prevention and control, and to continue collaboration with UNICEF through the joint monitoring programmes to report on the situation and the achievement of targets on WASH in health-care facilities.

Actions taken in the Region

105. The SEA Region has a high number of health-care facilities without proper WASH services; thus stepwise progress should be planned both at the health-care level and WASH services across the five action areas listed above.

106. In collaboration with UNICEF, the Regional Office has started to implement the WASH FIT instrument, a capacity-building technical assessment tool that follows a risk-based management approach to help health facilities assess and plan the improvement of hygiene and the reduction of potential drivers of infection and antimicrobial resistance.

107. The Australian Department of Foreign Affairs and Trade is currently providing funding support for Bhutan and Indonesia for strengthening quality and sustainability of water, sanitation and hygiene services in health-care facilities.
108. WASH in health-care facilities is a core component of the Regional Framework for Action, as annexed to the Male’ Declaration on Building Health System Resilience to Climate Change that was adopted by the Regional Committee in September 2017. Activities on climate resilience therefore also align themselves with this aspect.

Actions to be taken in the Region

109. The following actions are proposed to be taken in the Region:

a) Raise awareness for WASH in health-care facilities as a priority area for the SEA Region, including integrating this agenda for the health system development plan.

b) Continue to work with UNICEF at regional and national level for joint monitoring programmes.

c) Continue to strengthen national capacity to address WASH in health-care facilities, including health-care waste management.
13. **Emergency and trauma care** (resolution WHA72.16 titled ‘Emergency care systems for universal health coverage: ensuring timely care for the acutely ill and injured’)

**Background**

110. Emergency care is an integrated platform to deliver time-sensitive health-care services for acute illness across the life course. Emergency care is an essential element of universal health coverage. The emergency services cover a broad range of other health demands and conditions beyond injuries; including infections, exacerbations of NCDs, acute conditions and complications of pregnancy. A strong emergency care system has the potential to save millions of lives; around half of the deaths and disease burden in low- and middle-income countries (LMICs) can be managed at the prehospital and emergency care level. The lack of organized and integrated emergency care in LMICs leads to unnecessary and preventable deaths and disabilities.

111. The Seventy-second World Health Assembly adopted a resolution on emergency care systems for universal health coverage through series of informal discussions among Member States prior to the Health Assembly. Many Member States requested WHO to support advocacy and capacity strengthening in this area.

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

112. WHO to support Member States:

a) in their efforts to strengthen and integrate quality and comprehensive emergency care into the primary health care system under universal health coverage (including in demand assessment); and

b) to promote engagement of communities and civil society organizations, particularly for pre-hospital care domain, and integration of emergency care and collaboration across all health-care levels through promoting capacity of primary health care system.

**Actions taken in the Region**

113. Following actions have been taken in the SEA Region:

a) Support for integration of trauma and emergency care at the PHC level of care.

b) The Regional Office conducted a consultation with WHO collaborating centres on the integration of emergency and trauma care systems, capacity-building of emergency and trauma care management, and strengthening of emergency nursing.

c) The Regional Office organized an expert group consultation to develop the Regional Strategy to integrate emergency and trauma care systems into primary health care in the SEA Region in Thailand on 23–25 August 2018 in collaboration with the Thai Health Promotion Foundation.

**Actions to be taken in the Region**

114. The Department of Health Systems Development in the SEA Regional Office will lead the coordination across departments in the Regional Office on the emergency care system under UHC and consider building up on the work of the Department of Noncommunicable Diseases and Environmental Health on promoting trauma care at the primary health care level.
14. The public health implications of implementation of the Nagoya Protocol (decision WHA72(13) titled ‘The public health implications of implementation of the Nagoya Protocol’)

Background

115. The Executive Board at its 144th session in January 2019 agreed to include an item on the public health implications of implementation of the Nagoya Protocol in the draft provisional agenda for the Seventy-second World Health Assembly (Agenda item 12.10).

116. A central conclusion was that the Nagoya Protocol has public health implications, particularly the importance of timely pathogen sharing. Examining how the sharing of benefits arising from their use has been, and will increasingly be, important both for public health reasons and in the light of the entry into force and implementation of the Nagoya Protocol and the development of policies and legislature in countries around access benefit sharing (ABS).

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

117. All Member States are supportive of leveraging the Nagoya Protocol for public health work and potential emergencies. Although there are issues that can impede public health needs due to certain access and benefit sharing (ABS) policies and legislation, there are still ways and windows of opportunity to ensure this in countries. Member States requested for technical assistance on this matter and highlighted the need for ministries of health to engage with the environment sector, especially when national polices on ABS are developed. Partners such as UNEP, FAO and OIE also need to be engaged continuously. In recent discussions these organizations expressed commitment to improve/accommodate public health needs in ABS policy and legislation.

118. The Health Assembly recommended to the Director-General to provide information on current pathogen-sharing practices and arrangements, the implementation of access and benefit-sharing measures under the Nagoya Protocol, and the potential public health outcomes and implications.

Action taken in the Region

119. All activities related to the public health implications of the Nagoya Protocol are done through activities in the PIP Framework. It is to be noted that five Member States of the SEA Region are among the 177 signatories to the Nagoya Protocol. Two of these countries have policies around ABS.

Action to be taken in the Region

120. Countries in the Region need to (i) engage with the environment sector to develop more robust ABS policies that cover public health needs well; and (ii) assist in providing evidence on delays in pathogen sharing practices and arrangements due to the Nagoya Protocol.
15. **WHO reform processes, including the Transformation Agenda, and implementation of United Nations Development System reform**

*(decisions WHA72(21), WHA72(22) and WHA72(23) titled ‘WHO reform: amendments to the Rules of Procedure of the World Health Assembly’)*

**Background**

121. Updates on the various subjects under WHO Reform have been continually presented to the Executive Board and the World Health Assembly for noting and/or decision-making by the Member States.

122. In this context, the Seventy-second World Health Assembly adopted three decisions on Agenda 18.1: WHO reform processes, including the Transformation Agenda, and implementation of United Nations development system reform. All the three decisions decided to amend the Rules of Procedure of the World Health Assembly.

123. The above decisions were led by the deliberations at the 143rd and 144th sessions of the Executive Board. A brief chronology describing the content of the deliberations at the Governing Body meetings and the respective decisions therein, are provided in the next section.

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

**143rd Session of the Executive Board in May 2018**

124. As a part of series of reports on WHO Reform, the Executive Board at its 143rd session adopted decision EB143(7), which, inter alia, recommended that the Seventy-second World Health Assembly adopt a series of amendments to its Rules of Procedure in order to:

   a) allow for the possibility of electronic voting for recorded votes, where appropriate systems are available;

   b) allow for the possibility of submitting credentials electronically;

   c) clarify that only delegates and alternates may be designated to vote in plenary meetings of the Health Assembly, while any member of the delegation may be designated to vote in Committee meetings; and

   d) formalize the practice of suspending a debate on a matter under consideration by making provisions in the Rules of Procedure for a “motion to suspend the debate”.

**144th Session of the Executive Board in January 2019**

125. The Executive Board at its 144th session in January 2019 reviewed a series of reports on WHO reform processes. In this context two decisions were adopted: EB144(3) and EB144(4). The decisions presented the amendments to the Rules of Procedure of the Executive Board and also recommended to the Seventy-second World Health Assembly the various amendments to its Rules of Procedure.
126. Excerpts from the background documents presented to the Executive Board, clarifying the context of the adopted decisions are as below:

- The background document EB144/33 was a report from the Director-General on the amendment of Rules of Procedure to replace or supplement the gender-specific language in the Governing Bodies so as to indicate both feminine and masculine forms in the English language only and to follow United Nations practice for the other five official and working languages of WHO’s Governing Bodies.

127. The Executive Board, having considered the report, adopted the decision EB144(4) indicating that the amendments shall come into effect when the Director-General renumbers the Rules of Procedure of the Executive Board in accordance with decision EB143(7)2018. The decision also recommended that the Seventy-second World Health Assembly amend its Rules of Procedure in line with the examples set out in the Annex to document EB144/33.

- The background document EB 144/34 was a report by the Executive Board Chairperson on the outcome of the informal consultations on governance reform held on 13–14 September and 23–24 October 2018. The document outlined proposed amendments to the Rules of Procedure in the context of time limits for tabling draft resolutions and/or decisions to the Executive Board or World Health Assembly and the alignment of the terminology used in the Rules of Procedure of the Governing bodies with that used in the Framework of Engagement with Non-State Actors.

128. The Executive Board, having considered the report of the EB Chairperson on the outcome of the informal consultation, adopted the decision EB144(3). The decision, inter alia, also recommended a draft decision for adoption by the Seventy-second World Health Assembly.

Seventy-second World Health Assembly, May 2019

129. With the above background and in line with the continued discussion on the WHO reform process, the Seventy-second World Health Assembly considered the relevant reports from the Director-General vide background documents A72/50, A72/51 and A72/52 and adopted three decisions WHA72(21), WHA72 (22) and WHA72 (23), thus amending the Rules of Procedure of the World Health Assembly.

130. These decisions requested the Director-General to renumber the Rules of Procedure of the World Health Assembly on account of the amendments adopted.

Actions taken in the Region

131. In the context of background document A72/51 and adopted decision WHA72 (22), it is imperative to note that in the South-East Asia Region, a step-by-step approach was followed to discuss the phasing out of the Regional Committee resolutions from the past 15 years, as per the following:

- Discussion at the Sixty-eighth session of the WHO Regional Committee for South-East Asia, 2015: Review of the Regional Committee resolutions: SEA/RC68/21 – paper presented at the Sixty-eighth session of the WHO Regional Committee for South-East Asia in 2015 to seek guidance from Member States on the resolutions adopted in the previous years.

- Informal working group on past Regional Committee resolutions, 14–15 March 2016: Criteria and time-frame for “sunset” of select past resolutions were discussed.
• The Technical Consultation of Member States of the SEA Region to review past Regional Committee resolutions that pertained to a 15-year period dating from 2000–2015 was held in the Regional Office on 7–8 June 2016.

• Discussions at the Sixty-ninth session of the Regional Committee in 2016 and adoption of decision SEA/RC69(2).

132. In addition, during the Regional Committee discussions, efforts are now being made to add reporting lines to all resolutions and decisions wherever applicable.

Action to be taken in the Region

133. The South-East Asia Region will seek to align itself with the various reform initiatives from WHO headquarters.

Background

134. Participation of non-State actors in WHO’s Governing Bodies is regulated through “official relations”, which “is a privilege that the Executive Board may grant to nongovernmental organizations, international business associations and philanthropic foundations that have had and continue to have a sustained and systematic engagement in the interest of the Organization.”

135. This participation without the right to vote is foreseen by the Constitution of the World Health Organization (Article 18(h)) and has been the case since the time of the International Health Conference in New York in 1946 wherein the Constitution was drafted and adopted.

136. The relevant normative framework is now provided by the “Framework of Engagement with Non-State Actors” (FENSA) and the rules of procedure of both the World Health Assembly and the Executive Board.

137. Currently, WHO has 214 non-State actors in official relations with it. Regional committees have increased the involvement of non-State actors in official relations in accordance with their respective rules of procedures. All regional offices invite non-State actors to participate in the sessions of the regional committees and in other events and provide them opportunities to speak.

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

138. In January 2019 the WHO Executive Board in its decision EB144(3) on the WHO reform processes requested the Director-General “to elaborate a report and make recommendations to be submitted to the 145th session of the Executive Board about an informal meeting or forum to bring together Member States and non-State actors in official relations”.

139. The deliberations on WHO’s current reforms have shown that the involvement of non-State actors in the governance of WHO can be improved with a package of measures and if combined with an overall strengthening of WHO’s engagement with non-State actors in line with the Thirteenth General Programme of Work and in accordance with the Framework of Engagement with Non-State Actors.

140. The imposition of limits on the number of delegates in the delegation of a non-State actor in official relations or on the number of interventions by non-State actors, or both, might be balanced by measures that would make their participation more meaningful.

141. The agenda was discussed at the 145th session of the WHO Executive Board held in May 2019. It was proposed to the Member States that among the three groups of non-State actors eligible for official relations,

- international business associations and philanthropic foundations could be asked to form one constituency each;
- the diversity of nongovernmental organizations would justify up to three further constituencies on either a permanent or a case-by-case basis;
• These constituencies could then meet prior to the Governing Bodies to decide on which Agenda items they wanted to deliver constituency statements at the beginning or during the debate; and

• Individual non-State actors in official relations could still post their statements on a dedicated website, two weeks before the session of the Executive Board in January and the Health Assembly in May.

142. The Board noted the report and the proposal to organize a web consultation with non-State actors around the margins of the regional committees, to further elaborate on the proposal for its consideration by the 146th session of the Executive Board.

**Actions taken in the Region**

143. The South-East Asia Region extends invitations to non-State actors to attend its Regional Committee sessions every year and affords them the opportunity to deliver oral statements during the session. The transcripts of such statements find mention in the report of the Regional Committee. There is also active engagement with non-State actors through other events and programmes at regional and country levels.

144. At the Seventy-first session of the WHO Regional Committee for South-East Asia in New Delhi in 2018, 112 non-State actors in official relations with WHO were invited to participate.

145. A total of 33 delegates representing 19 non-State actors in official relations participated in the Regional Committee session and 10 non-State actors in official relations made 14 statements on six Agenda items.

**Action to be taken in the Region**

146. The South-East Asia Regional Office is in discussions with the Partnerships and non-State actors (PNA) Unit in WHO headquarters for the revised paper or proposal to take forward the process of consultation and to obtain inputs from Member States and non-State actors on their meaningful participation.
17. Digital health (resolution WHA71.7 titled ‘Digital health’)

Background

147. Recognizing the need to strengthen digital health implementation, the Seventy-first World Health Assembly in May 2018 passed resolution WHA71.7 on digital health. The resolution requested the Director-General “to develop in close consultation with Member States and with inputs from stakeholders, a global strategy on digital health, identifying priority areas including where the World Health Organization should focus its efforts”.

148. The WHO Secretariat through internal consultations drafted the first version of this Global Strategy. The strategy document was posted for global public consultation from 26 March to 30 April 2019.

149. The second version of the Global Strategy will be ready for further review and inputs by Member States during all upcoming regional committee sessions. It will be discussed at the Seventy-third World Health Assembly in May 2020 for adoption by Member States.

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

150. The purpose of the Global Strategy is to advance and apply digital health towards furtherance of the vision of “health for all”. It is also intended to support and respond to the growing needs of countries to implement appropriate digital technologies to address their health priorities, make progress towards universal health coverage and the health-related SDGs. The Global Strategy sets out a vision, strategic objectives and a framework for action to advance digital health, globally and in countries. It aims to encourage international collaborations and to support countries in their national programmes. It also aims to promote research, improve evidence and share information as well as best practices on digital health to assure its solid foundation. The Global Strategy is expected to lead to concrete actions within the five-year timeframe from 2020 to 2024.

Actions taken in the Region

151. A Regional Strategy for Strengthening eHealth in the South-East Asia Region 2014–2020 was endorsed and signed by the SEA Region Member States during a Regional High-Level Meeting held in Bangkok, Thailand, in November 2013.

152. Ten of the 11 Member States have already developed and are implementing their digital health, or eHealth, national strategies and plans.

153. The Regional Technical Consultation on Digital Health Policy and Practice was held in February 2019 in New Delhi, India, to review actions already being taken in our Region in detail and agree on priorities for regional action. It also was used to inform the development of the Global Strategy on Digital Health ensuring that the regional context is considered.

Action to be taken in the Region

154. Member States are continuing to strengthen country capacity for improving digital health governance, planning, management, interoperability, scaling up, innovation and its effective use as part of the overall national health strategy and to make progress towards UHC and the achievement of the health SDGs.
18. Global Strategy and Action Plan on ageing and health 2016–2020: towards a world in which everyone can live a long and healthy life
(resolution WHA69.3 titled ‘Global Strategy and Action Plan on ageing and health 2016–2020: towards a world in which everyone can live a long and healthy life’)

Background

155. In resolution WHA69.3 the World Health Assembly requested the Director-General to leverage the experience and lessons learnt from the implementation of the Global Strategy and Action Plan on ageing and health (Global Strategy) to develop a proposal for a “Decade of Healthy Ageing 2020–2030” with Member States and with inputs from partners, including United Nations agencies, other international organizations and nongovernmental organizations.

156. The decade is aligned with the vision of “a world in which all people can live longer and healthier lives”, and adheres to the Global Strategy, is also linked to the Madrid International Plan of Action on Ageing (MIPAA), and reflects the vision of the Sustainable Development Goals of leaving no one behind. A UN Decade of Healthy Ageing, led by WHO, has the potential to build on and strengthen existing synergies, align with UN reform and effectively foster longer and healthier lives and harness the opportunities that population ageing provides.

157. In accordance with decision WHA65(9) on WHO reforms – wherein the regional committees were asked to comment on and provide inputs to all global strategies, policies and legal instruments such as conventions, regulations and codes – the draft proposal for a Decade of Healthy Ageing will be presented for discussions at the Seventy-second Session of the WHO Regional Committee for South-East Asia in September 2019.

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

158. As part of the global consultation on the draft Decade of Healthy Ageing 2020–2030, Member States of the WHO South-East Asia Region are requested to provide comments and inputs on the draft Proposal for a Decade of Healthy Ageing 2020–2030 in the following highlighted areas:

i. Three action areas that are intended to improve the lives of older people, families and their communities.

ii. Activities over the decade will focus on the second half of life, be crafted in ways that overcome inequities, address current challenges for older people and take place at local, national, regional and global levels.

iii. A platform to be established building on existing partnerships and alliances of ageing and focusing on four enablers across three action areas, which include a) voices and engagement of older people, b) leadership and capacity, c) research and innovation, and d) connecting stakeholders.

Actions taken in the Region

159. The Regional Framework on Healthy Ageing 2018–2022 which aligns with the Global Strategy was developed in collaboration and consultations with Member States and has been released.
160. Technical support is provided to Member States to develop their national policy/strategy/plan on healthy ageing in line with the Regional Framework on Healthy Ageing.

161. Nine out of 11 Member States have a national policy/strategy/plan on ageing and health, and seven out of 11 Member States have a policy/plan/strategy/framework on long-term care as reported in the Global Strategy Medium-term Progress Report in 2018.

162. Initiatives on long-term care for older people in Member States of the South-East Asia Region have been reviewed and documented.

163. Manuals for training primary care physicians and training packages for nurses in the provision of care for older people have been developed by Member States.

164. Expert panels on healthy ageing were constituted to provide guidance to the Regional Director on how best to develop/strengthen, implement and monitor national programmes on healthy ageing, and chart progress towards the Decade of Healthy Ageing 2020–2030.

**Actions to be taken in the Region**

165. The following actions need to be taken in the Region towards implementing the Decade of Healthy Ageing 2020–2030:

   i. Secure a very high degree of commitment from the ministries of health for the Decade of Healthy Ageing 2020–2030.

   ii. Achieve sensitization within/beyond health sectors to build a platform for the Decade of Healthy Ageing at national and regional levels.

   iii. Mobilize domestic resources for development, implementation and monitoring of national policies/strategies or plans on healthy ageing.

   iv. Conduct advocacy with donors and partners to address the concept, functions and impact of healthy ageing.

   v. Review and update the Regional Framework on Healthy Ageing for 2023 onwards based on the situation and needs of Member States and aligning with the goals of the Decade of Healthy Ageing 2020–2030.
ANNEXURE
Regional One Voice (RoV) intervention made by the
Member States of the WHO South-East Asia Region

WHA72 Agenda 11.3: Polio: Eradication and Transition
Lead country: Myanmar Supporting country: DPR Korea

Myanmar delivers this statement on behalf of 11 Member States of the South East Asia Region.

1. The South-East Asia Region notes the current global polio situation and urges the Member States with continued poliovirus transmission to fully implement their action plans to achieve a polio free world. The Region also urges that high population immunity against polio, sensitive surveillance for poliovirus detection and strong outbreak response capacity should continue to be maintained by all Member States.

2. The South-East Asia Region also notes the Global Polio Eradication Initiative Endgame Strategy 2019-2023 and is committed to fully implement the same. The Region has remained free of all wild polioviruses since January 2011, thanks to the strong and sustained efforts made by all countries, especially India. An aggressive response was mounted by Indonesia in response to a recently detected circulating vaccine derived poliovirus.

3. IPV is being administered in all countries of the Region under the routine immunization programme. Poliovirus containment activities as per the WHO Global Action Plan III are steadily progressing. All Member States in the Region have national outbreak response plans.

4. Mindful of the Strategic Action Plan on polio transition, presented to the Seventy-first World Health Assembly in May 2018, the Region notes the progress report submitted by the secretariat this year.
Five Member States of the Region, namely Bangladesh, India, Indonesia, Myanmar and Nepal, are putting in place comprehensive polio transition plans with country-centric approach to make best use of the polio assets deployed over the past two decades. The national governments acknowledge the value of the polio funded assets, which include human workforce, infrastructure, equipment and systems, to their country programmes. These countries are pioneering the utilization of polio assets for other health activities like strengthening routine immunization, introduction of new vaccines, surveillance for other vaccine preventable diseases and capacity for implementation of IHR.

Polio assets have played a key role in responding to health emergencies, for example during the earthquake in Nepal in 2015 and during the displaced person crisis at Bangladesh/Myanmar border.

While countries are making good efforts towards polio transition, advocacy with donors and partners remains critical to ensure that polio infrastructure and capacities continue to maintain polio functions and strengthen health systems. There is a need for countries to mobilize domestic resources for long-term sustainability. However, optimal levels of funding should continue in high priority countries during the transition period. In this regard, Member States of the South-East Asia Region welcome engagement of new partners in Polio, such as GAVI. With Polio becoming more “integrated”, we are looking towards a broader donor base.

The Region remains committed to the polio eradication goal through strengthening immunization systems based on long term sustainability.

Thank you.
Primary health care

The Seventy-second World Health Assembly,

Having considered the report on universal health coverage: primary health care towards universal health coverage;

Recalling the 2030 Agenda for Sustainable Development, adopted in 2015, in particular Sustainable Development Goal 3, which calls on stakeholders to ensure healthy lives and promote well-being for all individuals at all ages;

Reaffirming the ambitious and visionary Declaration of Alma-Ata (1978) in pursuit of health for all;

Welcoming the convening of the Global Conference on Primary Health Care: from Alma-Ata towards universal health coverage and the Sustainable Development Goals (Astana, 25 and 26 October 2018), during which Member States renewed their commitment to primary health care through a whole-of-society approach around primary health care as a cornerstone of a sustainable health system for universal health coverage and the health-related Sustainable Development Goals, in particular target 3.8 on achieving universal health coverage;

Recalling the approach regarding primary health care and universal health coverage contained in resolution WHA69.11 (2016) on health in the 2030 Agenda for Sustainable Development,

1. WELCOMES the Declaration of Astana adopted at the Global Conference on Primary Health Care in Astana on 25 October 2018;

2. URGES Member States\(^2\) to take measures to share and implement the vision and commitments of the Declaration of Astana according to national contexts;

3. CALLS UPON all relevant stakeholders:

   (1) to align their actions and support to national policies, strategies and plans in the spirit of partnership and effective development cooperation in implementing the vision and commitments of the Declaration of Astana;

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1 Document A72/12.

2 And, where applicable, regional economic integration organizations.
(2) to provide support to Member States in mobilizing human, technological, financial and information resources to help to build strong and sustainable primary health care, as envisaged in the Declaration of Astana;

4. REQUESTS the Director-General:

(1) to support Member States, as appropriate, in strengthening primary health care, including the implementation of the vision and commitments of the Declaration of Astana in coordination with all relevant stakeholders;

(2) to develop, in consultation with, and with the involvement of more expertise from, Member States, and in time for consideration by the Seventy-third World Health Assembly, an operational framework for primary health care, to be taken fully into account in the WHO general programmes of work and programme budgets in order to strengthen health systems and support countries in scaling-up national implementation efforts on primary health care;

(3) to ensure that WHO promotes the vision and commitments in the Declaration of Astana in its work and overall organizational efforts, and enhances institutional capacity and leadership across WHO at all levels of the Organization, including regional and country offices, in order to support Member States in strengthening primary health care;

(4) to report regularly through the Executive Board to the Health Assembly on progress made in strengthening primary health care, including implementation of the vision and commitments of the Declaration of Astana, as part of all reporting on progress towards achieving universal health coverage by 2030.

Sixth plenary meeting, 24 May 2019
A72/VR/6
Regional One Voice (RoV) intervention made by the Member States of the WHO South-East Asia Region

WHA72 Agenda 11.5: Primary health care towards universal health coverage

Lead country: Indonesia Supporting country: Bangladesh

Thank you, Chair.

1) Indonesia speaks on behalf of 11 Member States of the South East Asia Region.

2) We appreciate the WHO Secretariat’s work for this report.

3) PHC is the cornerstone for achieving UHC and health-related SDGs. We fully endorse resolution EB144/R9 to strengthen PHC for universal health coverage. The resolution addresses the challenges that over 800 million people in SEAR still lack coverage to essential health services, while 65 million people are pushed into extreme poverty by paying for health care.

4) In strengthening PHC, it is essential to focus on preventive and promotive approaches to reach all people in all communities, including the vulnerable and people living in poverty and remote areas. This approach ensures that not only the sick but also the healthy receive essential preventive health services. It is also important to not only involve the health sector, but also other related sectors by integrating and covering comprehensive health care services, ensuring at least minimum quality standards of health care delivery at the district level and enhancing the implementation of UHC.

5) There is also a need to improve the competencies of frontline health workers at the primary health care level for effective responses to rapid demographic and epidemiological transitions. They need to manage family, community, and public health care through the PHC education and training. Recognizing the important role of frontline health workers, proper measures are
needed to improve their retention. The frontline health workers could function as care coordinators for health promotion and disease prevention at the primary and secondary levels. They should focus on patients including their supporting system, namely family and community.

6) We support the accreditation of PHC facilities which will undoubtedly improve the quality of health services and patient safety, and enhance the performance of PHC facilities including the protection for frontline health workers. Since 2015, Indonesia has accredited 75% of the total 9,993 Community Health Centres.

Thank you, Chair.
Community health workers delivering primary health care: opportunities and challenges

The Seventy-second World Health Assembly,

Having considered the report on community health workers delivering primary health care: opportunities and challenges,¹ and the associated WHO guideline on health policy and system support to optimize community health worker programmes;²

Inspired by the ambition of the 2030 Agenda for Sustainable Development, with its vision to leave no one behind, its 17 indivisible goals and its 169 targets;

Recognizing that universal health coverage is central to achievement of the Sustainable Development Goals, and that a strong primary health care sector is one of the cornerstones of a sustainable health system;

Emphasizing that health workers are integral to building strong, resilient and safe health systems that contribute to the achievement of the Sustainable Development Goals and targets related to nutrition, education, health, gender, employment and the reduction of inequalities;

Noting in particular that Sustainable Development Goal 3 (Ensure healthy lives and promote well-being for all at all ages) and its targets will be advanced through substantive and strategic investments in the global health workforce, as well as a substantial shift in health workforce-related planning, education, deployment, retention, management and remuneration, supported by strong systems that enable and empower the health workforce to deliver safe and high-quality care for all;

Recognizing the need for more coherent and inclusive approaches to safeguard and expand primary health care as a pillar of universal health coverage in emergencies, ensuring the continuum and provision of essential health services and public health functions, in line with humanitarian principles;

Concerned by the threats against humanitarian personnel and health workers, hospitals and ambulances, which severely restrict the provision of life-saving assistance and hinder the protection of populations at risk;

¹ Document A72/13.

Expressing deep concern at the significant security risks faced by humanitarian and health personnel, United Nations and associated personnel, as they operate in increasingly high-risk environments;

Noting further the importance of health workers to the realization of the three interconnected strategic priorities in WHO’s Thirteenth General Programme of Work, 2019–2023, namely: achieving universal health coverage, addressing health emergencies and promoting healthier populations;

Reaffirming resolution WHA69.19 (2016) on the global strategy on human resources for health: workforce 2030, in which the Health Assembly adopted WHO’s Global Strategy on Human Resources for Health: Workforce 2030, with the Global Strategy identifying the opportunity to optimize the performance, quality and impact of community health workers for the achievement of universal health coverage and the Sustainable Development Goals;

Reaffirming also resolution WHA70.6 (2017) on human resources for health and implementation of the outcomes of the United Nations’ High-Level Commission on Health Employment and Economic Growth, including its call to “stimulate investments in creating decent health and social jobs with the right skills, in the right numbers and in the right places, particularly in countries facing the greatest challenges in attaining universal health coverage” and to strengthen the progressive development and implementation of national health workforce accounts;

Recalling the Declaration of Alma-Ata (1978) and the Declaration of Astana from the Global Conference on Primary Health Care (Astana, 25 and 26 October 2018) through which participating governments reaffirmed people-centred health care services, recognized human resources for health as a key component of successful primary health care, and committed themselves to “create decent work and appropriate compensation for health professionals and other health personnel working at the primary health care level to respond effectively to people’s health needs in a multidisciplinary context”;

Emphasizing further that investment in universal health coverage, including investment in the education, employment and retention of the health workforce, is a major driver of economic growth;

Acknowledging that gaps in human resources and community health workforces within health systems have to be addressed, notably through a multisectoral and community-centred approach, in order to assure that universal health coverage and comprehensive health services reach difficult-to-access areas and vulnerable populations;

Recognizing that globally seven out of every 10 jobs in the health and social sectors are held by women and that accelerating investments in job creation and decent work in primary health care will have a positive impact on women and youth, thereby supporting achievement of Sustainable Development Goal 5 (Achieve gender equality and empower all women and girls) and Goal 8 (Promote sustained, inclusive and sustainable economic growth, full and productive employment and decent work for all);

Noting the launch in 2018 of the World Bank Group’s Human Capital Project, which calls for more and better investment in the education, health and skills of people to accelerate progress towards the Sustainable Development Goals, and its potential to leverage new investments in the health workers who provide primary health care services;
Recognizing the published evidence and WHO’s existing guidelines, as consolidated in the WHO guideline on health policy and system support to optimize community health worker programmes, on the role, effectiveness and cost-effectiveness of community health workers;

Highlighting the role of community health workers in advancing equitable access to safe, comprehensive health services in urban and rural areas and the reduction of inequities, including with respect to residence, gender, education and socioeconomic position, as well as their role in gaining the trust and engagement of the communities served;

Noting with concern the uneven integration of community health workers into health systems, as well the limited use of evidence-informed policies, international labour standards and best practices to inform the education, deployment, retention, management and remuneration of community health workers, and noting the negative impact this may have on access to services, quality of health services and patient safety;

Reaffirming the WHO Global Code of Practice on the International Recruitment of Health Personnel, which calls upon Member States to provide equal rights, terms of employment, and conditions of work for domestic and migrant health workers;

Noting that community health workers are an integral part of all phases of an emergency health response (prevention, detection and response) in their own communities and are indispensable for contributing to ongoing primary health care services during emergencies,

1. TAKES NOTE OF the WHO guideline on health policy and system support to optimize community health worker programmes;

2. URGES all Member States, as appropriate to local and national contexts and with the objective of the success of primary health care and the achievement of universal health coverage:

   (1) to align the design, implementation, performance and evaluation of community health worker programmes, by means including the greater use of digital technology, with the consolidated evidence presented in the WHO guideline on health policy and system support to optimize community health worker programmes, with specific emphasis on implementing these programmes in order to enable community health workers to deliver safe and high-quality care;

   (2) to adapt as appropriate and support implementation of the WHO guideline on health policy and system support to optimize community health worker programmes at national level as part of national health workforce and broader health sector, employment and economic development strategies, in line with national priorities, resources, and specificities;

   (3) to strengthen the relevance, effectiveness and implementation of the WHO Global Code of Practice on the International Recruitment of Health Personnel, including cooperation with health ministries, civil service commissions, and employers to deliver fair terms for health workers and a positive practice environment to enable their effective deployment, retention and adequate motivation to deliver high-quality care and build a positive relationship with patients;

   (4) to allocate, as part of broader health workforce strategies and financing, adequate resources from domestic budgets and from a variety of sources, as appropriate, to the capital and recurrent costs required for the successful implementation of community health worker programmes and
for the integration of community health workers into the health workforce in the context of investments in primary health care, health systems and job creation strategies, as appropriate;

(5) to improve and maintain the quality of health services provided by community health workers in line with the consolidated evidence presented in the WHO guideline on health policy and system support to optimize community health worker programmes, including appropriate pre-service selection and training, competency-based certification, and supportive supervision;

(6) to strengthen voluntary collection and sharing of data, based on national legislation, on community health workers and on community health worker programmes, through the use of national health workforce accounts, as appropriate, thus enabling national reporting on Sustainable Development Goal indicator 3.c.1 on the density and distribution of their health workforce;

(7) to ensure the respect and protection of all medical personnel and humanitarian personnel exclusively engaged in medical duties, their means of transport and equipment, as well as hospitals and other medical facilities;

3. INVITES international, regional, national and local partners to support implementation of the WHO guideline on health policy and system support to optimize community health worker programmes, taking into account national context, and to contribute to monitoring and evaluation of implementation;

4. ALSO INVITES global health initiatives, bilateral and multilateral financing agencies and development banks to support the national community health worker programmes in line with the approach of the WHO guideline on health policy and system support to optimize community health worker programmes with programme development and financing decisions to support human capital and health workforce development, as appropriate to national context and national resources;

5. REQUESTS the Director-General:

(1) to continue to collect and evaluate data on community health worker performance and impacts, in order to ensure a strong evidence base for their promotion, especially in the context of low- and middle-income countries;

(2) to integrate and monitor the implementation of the WHO guideline on health policy and system support to optimize community health worker programmes in its normative and technical cooperation activities in support of universal health coverage, primary health care, health systems, and disease and population health priorities, including patient safety, as relevant to the Thirteenth General Programme of Work, 2019–2023;

(3) to provide support to Member States, upon request, with respect to implementation of the WHO guideline on health policy and system support to optimize community health worker programmes in alignment with national health labour markets and health care priorities;

(4) to support both information exchange and technical cooperation and implementation research between Member States and relevant stakeholders – including South–South cooperation – in respect of community health workers, primary health care teams and supportive supervision, including supervision performed by, inter alia, senior community health workers and other health professionals (for example clinical officers, midwives, nurses, pharmacists and physicians);
(5) to recognize the role of community health workers in an emergency, and support Member States on how to integrate them within emergency response, as appropriate to local and national context and national resources;

(6) to strengthen WHO’s capacity and leadership on human resources for health at all levels of the Organization through engagement with all relevant stakeholders and provision of high-quality and timely technical assistance from global, regional and country levels to accelerate implementation of resolution WHA69.19 (2016) on the global strategy on human resources for health and resolution WHA70.6 (2017) in which the Health Assembly adopted “Working for Health”: the ILO, OECD, WHO five-year action plan for health employment and inclusive economic growth (2017–2021), and future work on community health worker programmes;

(7) to submit a report every three years to the Health Assembly on progress made in implementing this resolution, integrated with the regular progress reporting on implementation of resolution WHA69.19 (2016) on global strategy on human resources for health: workforce 2030.

Sixth plenary meeting, 24 May 2019
A72/VR/6
Seventy-second World Health Assembly
Geneva, 20–28 May 2019

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

WHA72 Agenda 11.5: Community health workers delivering primary health care: opportunities and challenges

Lead country: Timor-Leste Supporting country: India

Thank you, Chair person

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

1) Having considered the Report by the Director-General on Community health workers delivering primary health care: opportunities and challenges and the progress made on the implementation of the WHO Global Strategy on Human Resources for Health: workforce 2030, along with the implementation of the “UN High-Level Commission on Health Employment and Economic Growth”;

2) Recognizing that community health workers play an important role in providing preventive, promotive, community level curative care, and rehabilitative frontline services in many South-East Asia Member States, and are often the first point of contact for communities in emergencies;

3) We, the Member States of South-East Asia Region, are fully aware that integration of Community Health Workers in the national health system is critical to improve access to health care and sustainability of frontline services.

4) The scope of practice and level of training of Community Health Workers across South-East Asia Region varies. We acknowledge the need to set up quality training systems and supportive supervisory systems for Community Health Workers.

5) Primary health care delivery systems can benefit greatly from the insightful-knowledge and cultural awareness that Community Health Workers possesses in order to connect with those who are the most at risk of poor health outcomes;

6) We also acknowledge that communities’ expectations of who they see for health care has changed over time, therefore, we welcome these guidelines, which have been developed based on best evidence and are systematic, and will be a useful reference; We propose that the guidelines further highlight modalities of on-the-job training in addition to pre-service training and appropriate use of digital technology.

7) We recognize the importance of considering Community Health Workers as part of the whole health workforce, and urge that they receive the required levels of training and support to deliver frontline health services as part of the primary health care team. These changes may take time, and must be adjusted to country reality;

8) We acknowledge that data on community health workers is limited and not standardized, which makes it hard to know how policies on Community health workers are working, especially focused on care continuum, and that more research is needed as we push the agenda for integrating CHW into Primary Health Care.

9) Finally, reiterating the commitment of the South-East Asia Region Member States toward improving systems for Community Health Workers, including availability of data, we fully support the resolution EB144.R4.

Thank you, Chairperson.
Preparation for the high-level meeting of the United Nations General Assembly on universal health coverage

The Seventy-second World Health Assembly,

Having considered the Director-General’s report on preparation for the high-level meeting of the United Nations General Assembly on universal health coverage;¹

Recalling the Constitution of the World Health Organization, which recognizes that the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition;

Recalling also United Nations General Assembly resolution 70/1 (2015) entitled “Transforming our world: The 2030 Agenda for Sustainable Development,” by which Member States adopted a comprehensive, far-reaching and people-centred set of universal and transformative sustainable development goals and targets that are integrated and indivisible; and recognizing that achieving universal health coverage will greatly contribute to ensuring healthy lives and well-being for all at all ages;

Recognizing that health is a precondition for and an outcome and indicator of all three dimensions – economic, social and environmental – of sustainable development;

Acknowledging that the Sustainable Development Goals are aimed at realizing the human rights of all, leaving no one behind and reaching those farthest behind first by, inter alia, achieving gender equality and empowerment of women and girls;

Recognizing that through the adoption of the 2030 Agenda and its Sustainable Development Goals in September 2015, Heads of State and Government made a bold commitment to achieve universal health coverage by 2030, including financial risk protection, access to quality essential health care services and access to safe, effective, quality and affordable essential medicines and vaccines for all;

Recognizing also that Heads of State and Government committed themselves to ensuring, by 2030, universal access to sexual and reproductive health care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes;

¹ Document A72/14.
Recalling resolution WHA69.11 (2016) on health in the 2030 Agenda for Sustainable Development, which recognizes that universal health coverage implies that all people have access, without discrimination, to nationally determined sets of the needed promotive, preventive, curative, rehabilitative and palliative essential health services, and essential, safe, affordable, effective, and quality medicines and vaccines, while ensuring that the use of these services does not expose the users to financial hardship, with a special emphasis on the poor, vulnerable, and marginalized segments of the population;

Recalling also United Nations General Assembly resolution 67/81 of 12 December 2012, entitled “Global health and foreign policy,” which urges governments, civil society organizations and international organizations to collaborate and to promote the inclusion of universal health coverage as an important element on the international development agenda, and a means of promoting sustained, inclusive and equitable growth, social cohesion and the well-being of the population, as well as achieving other milestones for social development;

Recognizing the responsibility of governments to urgently and significantly scale up efforts to accelerate the transition towards universal access to affordable and quality health care services, and reaffirming the primary responsibility of Member States to determine and promote their own paths towards achieving universal health coverage;

Recalling United Nations General Assembly resolution 69/313 on the Addis Ababa Action Agenda of the Third International Conference on Financing for Development, adopted on 27 July 2015, which reaffirmed the strong political commitment to address the challenge of financing and create an enabling environment at all levels for sustainable development in the spirit of global partnership and solidarity, and which encouraged countries to consider setting nationally appropriate spending targets for quality investments in health and better alignment of global health initiatives’ programmes to national systems;

Recalling also United Nations General Assembly resolution 72/139 of 12 December 2017, entitled “Global health and foreign policy: addressing the health of the most vulnerable for an inclusive society”, in which Member States decided to hold a high-level meeting of the General Assembly in 2019 on universal health coverage;


Reaffirming WHO Member States’ commitment in resolution WHA71.1 (2018) on the Thirteenth General Programme of Work, 2019–2023 to support the work towards achieving the vision of the “triple billion” goals, including one billion more people benefitting from universal health coverage, one billion more people better protected from health emergencies, as well as further contributing to one billion more people enjoying better health and well-being;

Recalling United Nations General Assembly resolution 73/2 of 10 October 2018 on the political declaration of the third high-level meeting of the General Assembly on the prevention and control of non-communicable diseases, which committed to promote increased access to affordable, safe, effective and quality medicines and diagnostics and other technologies, reaffirming the World Trade Organization Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS Agreement), as amended, and also reaffirming the Doha Declaration on the TRIPS Agreement and Public Health (2001), which recognizes that intellectual property rights should be interpreted and implemented in a manner
supportive of the right of Member States to protect public health and, in particular, to promote access to medicines for all, and which notes the need for appropriate incentives in the development of new health products;

Reiterating that health research and development should be needs-driven, evidence-based, guided by the core principles of affordability, effectiveness, efficiency and equity and considered a shared responsibility;

Recalling all previous Health Assembly resolutions aimed at promoting physical and mental health and well-being, as well as contributing to the achievement of universal health coverage;

Noting with great concern that the current slow progress in achieving universal health coverage means that many countries are not on track to achieve target 3.8 of the Sustainable Development Goals on achieving universal health coverage;

Noting also that health is a major driver of economic growth;

Noting further that current government spending on and available resources for health, particularly in many low- and middle-income countries, are not adequate for achieving universal health coverage, including financial risk protection of the population;

Acknowledging the important role and necessary contribution of nongovernmental organizations, private sector entities, philanthropic foundations, and academic institutions, as appropriate, to the achievement of national objectives for universal health coverage, and the need in this regard for synergy and collaboration among all relevant stakeholders;

Recognizing the role of parliamentarians in advancing the universal health coverage agenda;

Noting that investment is essential for strong, transparent, accountable, and effective health service delivery systems, including an adequately distributed, skilled, motivated, and fit-for-purpose health workforce;

Recognizing that effective and financially sustainable implementation of universal health coverage is based on a resilient and responsive health system with capacities for broad public health measures, disease prevention, health protection, health promotion, and addressing of determinants of health through policies across sectors, including promotion of the health literacy of the population;

Noting that the increasing number of complex emergencies is hindering the achievement of universal health coverage, and that coherent and inclusive approaches to safeguard universal health coverage in emergencies are essential, including through international cooperation, ensuring the continuum and provision of essential health services and public health functions, in line with humanitarian principles;

Recognizing the fundamental role of primary health care in achieving universal health coverage and other health-related Sustainable Development Goals and targets, as envisioned in the Declaration of Astana from the Global Conference on Primary Health Care (Astana, Kazakhstan, 25 and 26 October 2018), and in providing equitable access to a comprehensive range of services and care that are people-centred, gender-sensitive, high quality, safe, integrated, accessible, available and affordable, and that contribute to the health and well-being of all;
Recognizing also that patient safety, strengthening health systems, and access to quality promotive, preventive, curative, as well as rehabilitation, services, together with palliative care, are essential to achieving universal health coverage,

1. **URGES** Member States:\(^1\)

   (1) to accelerate progress towards achieving Sustainable Development Goal target 3.8 on universal health coverage by 2030, leaving no one behind, especially the poor, the vulnerable and marginalized populations;

   (2) to support the preparation for the high-level meeting of the United Nations General Assembly in 2019 on universal health coverage, participating at the highest possible level, preferably at the level of Head of State and Government, and to engage in the development of the action-oriented, consensus-based political declaration;

   (3) to continue to mobilize adequate and sustainable resources for universal health coverage, as well as ensuring efficient, equitable and transparent resource allocation through good governance of health systems; and to ensure collaboration across sectors, as appropriate, with a special focus on reducing health inequities and inequalities;

   (4) to support better prioritization and decision-making, notably by strengthening institutional capacities and governance on health intervention and technology assessment, in order to achieve efficiencies and evidence-based decisions, while respecting patient privacy and promoting data security; and to encourage the greater and systematic utilization of new technologies and approaches, including digital technologies and integrated health information systems as a means of promoting equitable, affordable, and universal access to health and to inform policy decisions in support of universal health coverage;

   (5) to continue investing in and strengthening primary health care as a cornerstone of a sustainable health system, to achieve universal health coverage and other health-related Sustainable Development Goals, with a view to providing a comprehensive range of services and care that are people-centred, of high quality, safe, integrated, accessible, available and affordable, as well as providing public health functions as envisioned in the Declaration of Astana from the Global Conference on Primary Health Care (Astana, Kazakhstan, 25 and 26 October 2018) and implementing the commitments of that Declaration;

   (6) to continue investing in and strengthening gender-sensitive health care services that address gender-related barriers to health and secure women and girls’ equitable access to health, in order to realize the right to the enjoyment of the highest attainable standard of health for all and achieve gender equality and the empowerment of women and girls;

   (7) to invest in an adequate, competent and committed health workforce and promote the recruitment, development, training, and retention of the health workforce in developing countries, especially in least developed countries and small island developing States, by active implementation of the Global Strategy on Human Resources for Health: Workforce 2030;

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\(^1\) And, where applicable, economic integration organizations.
(8) to promote access to affordable, safe, effective, and quality medicines, vaccines, diagnostics, and other technologies;

(9) to support research and development on medicines and vaccines for communicable and noncommunicable diseases, including neglected tropical diseases, particularly those that primarily affect developing countries;

(10) to consider integrating, as appropriate, safe and evidence-based traditional and complementary medicine services within national and/or subnational health systems, particularly at the level of primary health care, according to national context and priorities;

(11) to promote more coherent and inclusive approaches to safeguard universal health coverage in emergencies, including through international cooperation, ensuring the continuum and provision of essential health services and public health functions, in line with humanitarian principles;

(12) to promote health literacy in the population, especially among vulnerable groups, in order to strengthen patient involvement in clinical decision-making with a focus on health professional–patient communication, and to further invest in easily accessible, accurate, understandable, and evidence-based health information, including through the Internet;

(13) to continue to strengthen prevention and health promotion by addressing the determinants of health and health equity through multisectoral approaches involving the whole of government and the whole of society, as well as the private sector;

(14) to strengthen monitoring and evaluation platforms to support regular tracking of the progress made in improving equitable access to a comprehensive range of services and care within the health system and to financial risk protection and make best use of such platforms for policy decisions;

(15) to make the best use of the annual International Universal Health Coverage Day, including by considering appropriate activities, in accordance with national needs and priorities;

2. CALLS UPON all development cooperation partners and stakeholders from the health sector and beyond to harmonize, synergize, and enhance their support to countries’ objectives in achieving universal health coverage, and to encourage the engagement of such partners and stakeholders in, as appropriate, the development of the global action plan for healthy lives and well-being for all in order to accelerate the progress on Sustainable Development Goal 3 (Ensure healthy lives and promote health and well-being for all at all ages) and other health-related Sustainable Development Goals and targets in order to achieve the Agenda 2030 for Sustainable Development;

3. REQUESTS the Director-General:

(1) to fully support Member States’ efforts, in collaboration with the broader United Nations system and other relevant stakeholders, towards achieving universal health coverage by 2030, in particular with regard to health systems’ strengthening, including by strengthening WHO’s normative work and the Organization’s capacity to provide technical support and policy advice to Member States;
(2) to work closely with the Inter-Parliamentary Union to raise further awareness among parliamentarians about universal health coverage and fully engage them both in advocacy and for sustained political support towards achieving universal health coverage by 2030;

(3) to facilitate and support the learning from, and sharing of, universal health coverage experiences, best practices and challenges across WHO Member States, including by engaging relevant non-State actors, as appropriate, as well as initiatives such as the International Health Partnership for Universal Health Coverage 2030, and in support of the preparatory process and the high-level meeting of the United Nations General Assembly on universal health coverage;

(4) to produce a report on universal health coverage as a technical input to facilitate informed discussions at the high-level meeting of the United Nations General Assembly on universal health coverage;

(5) to make the best use of International Universal Health Coverage Day to drive the universal health coverage agenda, including by encouraging increased political commitment to universal health coverage;

(6) to submit biennial reports on progress made in implementing this resolution, starting with the Seventy-third World Health Assembly in 2020 and ending with the Eighty-third World Health Assembly in 2030, as part of existing reporting on resolution WHA69.11 (2016).

Sixth plenary meeting, 24 May 2019
A72/VR/6

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

**WHA72 Agenda 11.5:** Preparation for the high-level meeting of the United Nations General Assembly on universal health coverage

Lead country: **Thailand**
Supporting country: **Bangladesh**

**Thailand** makes this statement on behalf of 11 Member States of the WHO South-East Asia Region.

We appreciate the report by the Secretariat.

Chair,

1) At national level, we emphasize the importance to continue to develop and implement policies and strategies to advance UHC in ways that achieve equity and efficiency. We need to enhance institutional capacity to compile, share, disaggregate, analyse, disseminate, and use UHC indicators, particularly to monitor trends and assess health inequalities.

2) In 2017, SEA Regional Committee Meeting adopted the Decision SEA/RC70(1) on annual progress monitoring of UHC and health related SDGs. The Committee requested the Regional Director, Dr Poonam Khetrapal Singh, first, to include an “Annual report on monitoring progress on UHC and health-related SDGs” as a substantive Agenda item of the Regional Committee until 2030, and second, to link relevant elements of health-related SDGs, including UHC, to be discussed at the Ministerial Roundtable at the Regional Committee annually until 2030. This demonstrates SEAR’s concrete actions to advance UHC in our region.

3) At the global level, this WHA is a crucial step for all Member States to foster UHC commitment from health constituencies to the UNGA High-Level Meeting, at head of state level. It is an opportune time to fully contribute to the key elements of the Political Declaration on UHC.
4) In order to take things forwards at the global level, we highlight that SEAR agrees with the exiting IAEG-SDG’s indicator for SDG 3.8.1, and a formal platform for inter-governmental review of the current UHC situation and progress, which is essential to guide us on how close or how far we are going to be in reaching SDG 3.8 by 2030.

5) South East Asia whole-heartedly supports adoption of the resolution EB144.R10 without hesitation. We also invite other Member States to adopt it.

6) The journey to UHC may be long and rough, but we know we are not alone.

Thank you, Chair.
WHO global strategy on health, environment and climate change: the transformation needed to improve lives and well-being sustainably through healthy environments

The Seventy-second World Health Assembly, having considered the report on health, environment and climate change: draft WHO global strategy on health, environment and climate change – the transformation needed to improve lives and well-being sustainably through healthy environments,1 decided:

(1) to note the WHO global strategy on health, environment and climate change;

(2) to request the Director-General to report back on progress in the implementation of the WHO global strategy on health, environment and climate change to the Seventy-fourth World Health Assembly.

Seventh plenary meeting, 28 May 2019
A72/VR/7

1 Document A72/15.
Plan of action on climate change and health in small island developing States

The Seventy Second World Health Assembly, having considered the draft plan of action on climate change and health in small island developing States,\(^1\) decided:

(1) to note the plan of action on climate change and health in small island developing States;

(2) to request the Director-General to report back on progress in the implementation of the plan of action on climate change and health in small island developing States to the Seventy-fourth World Health Assembly.

Seventh plenary meeting, 28 May 2019
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\(^1\) Document A72/16.
Regional One Voice (RoV) intervention made by the Member States of the WHO South-East Asia Region

WHA72 Agenda 11.6: Health, environment and climate change

Lead country: Bangladesh

Supporting country: Maldives

Thank you, Mr. Chair,

1) **Bangladesh** delivers this statement on behalf of SEA Region. We recognize that almost one quarter of the global burden of disease, and approximately 13 million deaths each year, are attributable to modifiable environmental factors. Member states in South-East Asia Region are particularly vulnerable to the adverse impacts of climate change, and suffer from over 40% of global mortality in health emergency conditions, particularly extreme weather events resulting from climate changes.

2) However, the effective preventive and preparedness measures, including early warning and evacuation systems, under the strong leadership of Bangladesh and India, are paying tremendous results as seen in the low mortality from the recent super cyclone ‘FANI’, the strongest cyclone in the decade.

3) Member States with support of WHO and partners have already laid the foundations for adapting to impacts of climate change on health. Based on the Male’ Declaration, adopted in the 70th Regional committee session, Member States decided to further strengthen health systems resilience to climate change during the 71st Regional Committee and the draft regional action plan will be discussed at the 72nd RC this year.
4) South East Asia has three comments on the draft Global Strategy on Health, Environment and Climate Change:

i. **First**, there needs a balance between adaptation, mainly through health systems resilience, and mitigation actions, which are contributed by other relevant sectors. As there are major health and economic consequences from climate change, priorities should address the environmental determinants of health and introduction of primary prevention. In addition, the progress report should cover all dimensions of the challenges.

ii. **Second**, the issue of mainstreaming health sector inputs in national climate change processes has yet to deserve adequate attention in the draft Global Strategy. SEA appreciates that the draft Global Plan of Action on Climate Change and Health has adequately emphasized and addressed the health issues in small islands developing states and least developed countries. We also appreciate the draft Global Plan of Action on Climate Change and Health in SIDS, giving apt emphasis on addressing health issues in national adaption plans, national communications, and nationally determined contributions under UNFCCC.

iii. **Third**, health sector can take a leading role in coordination for environmental protection through Planetary Health and Health in All Policy approaches. Resilient health systems are the key platform for effective responses to challenges from climate and environmental changes in emergency and crisis situations.

5) We appreciate the efforts being made by WHO regarding international climate funding mechanisms such as the Green Climate Fund and the recent development of GEF LDC funded project in 4 SEA countries (namely, Bangladesh, Myanmar, Nepal and Timor-Leste). We request the Director-General to accelerate the process of accreditation for global climate funding mechanisms, and urge other partners to support resource mobilization and strategic deployment of resources to implement actions at country-level.

6) Finally, South East Asia supports the adoption of the global strategy on health, environment and climate change as well as the global plan of action on climate change and health in small island developing states as contained in A72/15 and A72/16.

Thank you Chair.
Improving the transparency of markets for medicines, vaccines, and other health products¹

The Seventy-second World Health Assembly,

Having considered the report by the Director-General on access to medicines and vaccines² and its annex entitled “draft road map for access to medicines, vaccines, and other health products, 2019–2023” and the report by the Director-General on medicines, vaccines and health products: cancer medicines,³ pursuant to resolution WHA70.12 (2017) on cancer prevention and control in the context of an integrated approach;

Recognizing the critical role played by health products¹ and services innovation in bringing new treatments and value to patients and health care systems around the world;

Recognizing also that improving access to health products is a multidimensional challenge that requires action across, and adequate knowledge of, the entire value chain and life cycle, from research and development to quality assurance, regulatory capacity, supply chain management and use;

Seriously concerned about high prices for some health products, and inequitable access to such products within and among Member States, as well as the financial hardships associated with high prices which impede progress towards achieving universal health coverage;

Recognizing that the types of information publicly available on data across the value chain of health products, including prices effectively paid by different actors and costs, vary among Member States and that the availability of comparable price information may facilitate efforts towards affordable and equitable access to health products;

Seeking to enhance the publicly available information on the prices applied in different sectors, in different countries and the access to and use of this information, while recognizing different national and regional legal frameworks and contexts and acknowledging the importance of differential pricing;

Taking note of the productive discussions at the second Fair Pricing Forum (Johannesburg, South Africa, 11–13 April 2019) regarding the promotion of greater transparency around prices of health

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¹ For the purposes of this resolution, health products include medicines, vaccines, medical devices, diagnostics, assistive products, cell- and gene-based therapies, and other health technologies.

² Document A72/17.

³ Document EB144/18.
products, especially through sharing of information to stimulate the development of functional and competitive global markets;

Noting the importance of both public- and private-sector funding for research and development of health products, and seeking to improve the transparency of such funding across the value chain;

Seeking to progressively enhance the publicly available information on inputs across the value chain of health products, the public reporting of the relevant patents and their status, and the availability of information on the patents landscape covering a particular health product as well as its marketing approval status;

Noting the latest Declaration of Helsinki (2013), which promotes making publicly available the results of clinical trials, including negative and inconclusive as well as positive results, and noting that public access to comprehensive data on clinical trials is important for promoting advancement in science and successful treatment of patients, while protecting personal patient information;

Agreeing that policies that influence the pricing of health products and that reduce barriers to access can be better formulated and evaluated when there are reliable, comparable, transparent and sufficiently detailed data\(^1\) across the value chain,

1. **URGES** Member States in accordance with their national and regional legal frameworks and contexts:

   (1) to take appropriate measures to publicly share information on the net prices\(^2\) of health products;

   (2) to take the necessary steps, as appropriate, to support dissemination and enhanced availability of, and access to, aggregated results data and, if already publicly available or voluntarily provided, costs from human subject clinical trials regardless of outcomes or whether the results will support an application for marketing approval, while ensuring patient confidentiality;

   (3) to work collaboratively to improve the reporting of information by suppliers on registered health products, such as reports on sales revenues, prices, units sold, marketing costs, and subsidies and incentives;

   (4) to facilitate improved public reporting of patent status information and the marketing approval status of health products;

   (5) to improve national capacities, including through international cooperation and open and collaborative research and development and production of health products, especially in developing countries and low- and middle-income countries (LMICs), including health products for the diseases that primarily affect them, as well as for product selection, cost-effective procurement, quality assurance, and supply chain management;

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\(^1\) Including but not limited to data on: availability, especially in small markets; units sold and patients reached in different markets; and the medical benefits and added therapeutic value of these products.

\(^2\) For the purposes of this resolution, “net price,” “effective price,” “net transaction price” or “manufacturer selling price” are the amount received by manufacturers after subtraction of all rebates, discounts, and other incentives.
2. REQUESTS the Director-General to:

(1) to continue to support Member States, upon their request, in collecting and analysing information on economic data across the value chain for health products and data for relevant policy development and implementation towards achieving universal health coverage;

(2) to continue supporting Member States, especially LMICs, in developing and implementing their national policies relevant to the transparency of markets for health products, including national capacities for local production, rapid and timely adoption of generic and biosimilar products, cost-effective procurement, product selection, quality assurance and supply-chain management of health products;

(3) to support research on and monitor the impact of price transparency on affordability and availability of health products, including its effect on differential pricing, especially in LMICs and small markets, and provide analysis and support to Member States in this regard as appropriate;

(4) to analyse the availability of data on inputs throughout the value chain, including data on clinical trials and price information, with a view to assessing the feasibility and potential value of establishing a web-based tool to share information relevant to the transparency of markets for health products, including information on investments, incentives, and subsidies;

(5) to continue WHO’s efforts to biennially convene the Fair Pricing Forum with Member States and all relevant stakeholders to discuss the affordability and transparency of prices and costs relating to health products;

(6) to continue supporting existing efforts to determine the patent status of health products and promote publicly available user-friendly patent status information databases for public health actors, in line with the global strategy and plan of action on public health, innovation and intellectual property, and to work with other relevant international organizations and stakeholders to improve international cooperation, avoid duplication of work, and promote relevant initiatives;

(7) to submit a report on progress made to the Seventy-fourth World Health Assembly, through the Executive Board at its 148th session.

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1) SEAR Member States have reaffirmed commitment to universal accessibility and affordability of essential medical products in the Delhi Declaration on “IMPROVING ACCESS TO ESSENTIAL MEDICAL PRODUCTS IN THE SOUTH-EAST ASIA REGION AND BEYOND” in September 2018. While it covered medicines, vaccines, devices and diagnostics, the Access to medicines and vaccines roadmap refers to ‘Health products’ – which enhances the scope of work.

2) The Delhi Declaration, adopted by all Ministers of Health in the South East Asia Regional Committee, highlighted several aspects included in the “DRAFT ROAD MAP FOR ACCESS TO MEDICINES, VACCINES AND OTHER HEALTH PRODUCTS, 2019–2023”.

3) The WHO South-East Asia Region Member countries launched SEARN to enhance information sharing, collaboration and convergence of medical products regulatory practices across the Region for access to high-quality medical products (medicines, vaccines, diagnostics and devices). SEARN Member States meet annually for the following priority areas:

   a) Quality assurance and standards of medical products, including labs;
   b) Good Regulatory Practices (GRP) including GMP, GDP etc.;
   c) Vigilance for medical products;
   d) Information Sharing Platform; and
   e) Medical Device and Diagnostics.
4) The Information Sharing Platform was launched and made operational on 9th October 2018 by the Union Health Minister of India and Regional Director, WHO South-East Asia Region.

5) SEA Region concurs that the following two strategic areas are extremely important:

- Ensuring the quality, safety and efficacy of health products;
- Improving equitable access to health products.

The health system approach to improving access is welcome.

6) Urgent efforts should be made to make advances in new, affordable, safe and quality health products and medical devices widely available in developing countries, including leveraging international intellectual property agreements, which contain flexibilities that could facilitate increased access to pharmaceutical products by developing countries, as recommended in the Report of the Commission on Intellectual Property Rights, Innovation and Public Health.

7) Innovations in public health and funding mechanisms should be promoted particularly with regard to stimulating research and development related to Type II and Type III diseases and the specific research and development needs of developing countries in relation to Type I diseases.

8) The Region recommends exploring a range of incentive mechanisms, including where appropriate, addressing the de-linkage of the costs of research and development and the price of health products. Methods for tailoring the optimal mix of incentives with the objective of addressing diseases that disproportionately affect developing countries could urgently include the issue of voluntary licenses for new medicines by the patent holder, especially for diseases like HIV, HCV, TB, and Malaria.

9) The Region further recommends that WHO should continue supporting member countries in their efforts to further strengthen their national regulatory capacities and the rational use of medicines.
10) WHO is also requested to act on the suggestion made in the 4th Global Forum on Medical Devices for establishing a Technical Expert / Advisory Group to address safety, efficacy and appropriate use of medical devices.

11) South East Asia region is home to major manufacturers of essential medical products, especially generic medicines, and notes that generic competition can improve accessibility, affordability and quality of medical products within and beyond the region.

12) In this view, the Region is committed to fully contribute to the negotiations in the drafting group.

Thank you, Chair.
Antimicrobial resistance

The Seventy-second World Health Assembly,

Having considered the report by the Director-General on follow-up to the high-level meetings of the United Nations General Assembly on health-related issues: antimicrobial resistance;¹

Recalling resolution 71/3 (2016), the political declaration of the high-level meeting of the General Assembly on antimicrobial resistance, and acknowledging the establishment of the Interagency Coordination Group on Antimicrobial Resistance to provide practical guidance and recommendations for necessary approaches to ensure sustained and effective global action to address antimicrobial resistance;

Recognizing the importance of addressing growing antimicrobial resistance to contribute to the achievement of the 2030 Agenda for Sustainable Development;

Reiterating the need to address antimicrobial resistance through a coordinated, multisectoral, One Health approach;

Recalling resolution WHA68.7 (2015) in which the Health Assembly adopted the global action plan on antimicrobial resistance, which lays out five strategic objectives (improve awareness and understanding of antimicrobial resistance; strengthen knowledge through surveillance and research; reduce the incidence of infection; optimize the use of antimicrobial agents; and develop the economic case for sustainable investment), and noting the progress made in establishing the Global Antimicrobial Resistance Surveillance System (GLASS);

Recognizing the pressing need for investing in high-quality research and development, including basic research for antimicrobials, diagnostic technologies, vaccines and alternative preventive measures across sectors, and for ensuring adequate access to those in need of quality, safe, efficacious and affordable existing and new antimicrobials, diagnostic technologies and vaccines, while promoting effective stewardship;

Acknowledging the threat posed by resistant pathogens to the continuing effectiveness of antimicrobials, especially for ending the epidemics of HIV/AIDS, tuberculosis, and malaria;

Acknowledging also the positive effect of immunization, including vaccination, and other infection prevention and control measures, such as adequate water, sanitation and hygiene (WASH), in reducing antimicrobial resistance;

¹ Document A72/18.
Recognizing the need to maintain the production capacity of relevant older antibiotics and promote their prudent use;


Noting the importance of providing opportunities for Member States to engage meaningfully with and provide input into reports, recommendations, and relevant actions from WHO, FAO, and OIE, together with UNEP, and from the Interagency Coordination Group on Antimicrobial Resistance aimed at combating antimicrobial resistance;

Reaffirming the global commitment to combat antimicrobial resistance with continued, high-level political efforts as a coordinated international community, emphasizing the critical need to accelerate Member States’ development and implementation of their national action plans with a One Health approach,

1. WELCOMES the new tripartite agreement on antimicrobial resistance, and encourages the Tripartite agencies (WHO, FAO, OIE) and UNEP to establish clear coordination for its implementation and to align reporting to their governing bodies on progress under the joint workplan, according to their respective mandates;

2. URGES Member States:

   (1) to remain committed at the highest political level to combating antimicrobial resistance, using a One Health approach, and to reducing the burden of disease, mortality, and disability associated with it;

   (2) to increase efforts to implement the actions and attain the strategic objectives of the global action plan on antimicrobial resistance, and take steps to address emerging issues;

   (3) to further enhance the prudent use of all antimicrobials, and consider developing and implementing clinical guidelines and criteria according to which critically important antimicrobials should be used, in accordance with national priorities and context, in order to slow the emergence of drug resistance and sustain the effectiveness of existing drugs;

   (4) to conduct post-market surveillance of antimicrobials and take appropriate action to eliminate substandard and falsified antimicrobials;

   (5) to strengthen efforts to develop, implement, monitor, and update, adequately resourced multisectoral national action plans;

   (6) to participate in the annual antimicrobial resistance country self-assessment survey administered by the Tripartite;

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1 And, where applicable, regional economic integration organizations.
(7) to develop or strengthen monitoring systems that will contribute to the annual antimicrobial resistance country self-assessment survey administered by the Tripartite and to participation in the Global Antimicrobial Resistance Surveillance System (GLASS), and to use this information to improve implementation of the national action plans;

(8) to enhance cooperation at all levels for concrete action towards combating antimicrobial resistance, including through: health system strengthening; capacity-building, including for research and regulatory capacity; and technical support, including, where appropriate, through twinning programmes that build on best practices, emerging evidence and innovation;

(9) to support technology transfer on voluntary and mutually agreed terms for controlling and preventing antimicrobial resistance;

3. INVITES international, regional, and national partners, and other relevant stakeholders:

(1) to continue to support Member States in the development and implementation of multisectoral national action plans in line with the five strategic objectives of the global action plan on antimicrobial resistance;

(2) to coordinate efforts in order to avoid duplication and gaps and leverage resources more effectively;

(3) to increase efforts and enhance multistakeholder collaboration to develop and apply tools to address antimicrobial resistance following a One Health approach, including through coordinated, responsible, sustainable and innovative approaches to research and development, including but not limited to quality, safe, efficacious and affordable antimicrobials, and alternative medicines and therapies, vaccines and diagnostic tools, adequate water, sanitation and hygiene (WASH), including infection prevention and control measures;

(4) to consider antimicrobial resistance priorities in funding and programmatic decisions, including innovative ways to mainstream antimicrobial resistance-relevant activities into existing international development financing;

4. REQUESTS the Director-General:

(1) to accelerate the implementation of the actions of, and advance the principles defined in, the global action plan on antimicrobial resistance, through all levels of WHO, including through a comprehensive review to enhance current work in order to ensure that antimicrobial resistance activities are well coordinated, including those with relevant United Nations agencies and other relevant stakeholders, and that they are efficiently implemented across WHO;

(2) to significantly enhance support and technical assistance provided to countries in collaboration with relevant United Nations agencies for developing, implementing, and monitoring their multisectoral national action plans, with a specific focus on countries that have yet to finalize a multisectoral national action plan;

(3) to support Member States to develop and strengthen their integrated surveillance systems, including by emphasizing the need for the national action plans to include the collection, reporting, and analysis of data on sales and use of antimicrobials as a deliverable that would be integrated into reporting on the WHO indicators;
(4) to keep Member States regularly informed of WHO’s work with the Tripartite and UNEP, as well as with other United Nations organizations to ensure a coordinated effort on workstreams, and of their progress in developing and implementing multisectoral approaches;

(5) to consult regularly with Member States, and other relevant stakeholders, to adjust the process and scope of the global development and stewardship framework,\(^1\) considering the work of the Interagency Coordination Group on Antimicrobial Resistance to ensure a unified and non-duplicative effort;

(6) to support Member States to mobilize adequate predictable and sustained funding and human and financial resources and investment through national, bilateral and multilateral channels to support the development and implementation of national action plans, research and development on existing and new antimicrobial medicines, diagnostics, and vaccines, and other technologies, and strengthening of related infrastructure, including through engagement with multilateral development banks and traditional and voluntary innovative financing and investment mechanisms, based on priorities and local needs set by governments and on ensuring public return on investment;\(^2\)

(7) to collaborate with the World Bank and other financial institutions, OECD, and regional economic communities, in order to continue to make and apply the economic case for sustainable investment in antimicrobial resistance;

(8) to facilitate, in consultation with the United Nations Secretary-General and the Tripartite and UNEP, the development of a process to allow Member States to consider the Secretary-General’s report requested in United Nations General Assembly resolution 71/3 (2016);

(9) to maintain and systematically update the WHO list of Critically Important Antimicrobials for human medicine;

(10) to submit consolidated biennial reports on progress achieved in implementing this resolution and resolution WHA68.7 (2015) to the Seventy-fourth, Seventy-sixth, and Seventy-eighth World Health Assemblies, through the Executive Board, incorporating this work into existing antimicrobial resistance reporting, in order to allow Member States to review and evaluate efforts made.

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\(^1\) As requested in paragraph 4(7) of resolution WHA68.7 and called for in paragraph 13 of the political declaration of the high-level Meeting of the General Assembly on antimicrobial resistance.

\(^2\) Paragraph 12b of United Nations General Assembly resolution 71/3.
Regional One Voice (RoV) intervention made by the Member States of the WHO South-East Asia Region

WHA72 Agenda 11.8: Follow-up to the high-level meetings of the United Nations General Assembly on Antimicrobial resistance

Lead country: Bangladesh Supporting country: India

Thank you, Chair.

1) Bangladesh delivers this statement on behalf of all 11 SEA Region Member States.

2) We welcome this report and appreciate WHO’s actions at all levels with all relevant stakeholders.

3) Member States of our region have highest level of political commitment to fight against AMR. SEA Region’s Health Ministers adopted the “Jaipur Declaration on AMR” in 2011 towards prevention and containment of AMR to improve public health.

4) SEA Region Member States highlighted the need for strengthening and integrating surveillance system among human, animal, food safety and environment sectors. We encourage the tripartite plus (WHO/FAO/OIE/UNEP) to support AMR data across human-animal and environment sectors.

5) All SEAR Member States have fully participated in the AMR Country Self-assessment Survey since 2016. We continue to carry out public communications to raise awareness about AMR in the general public and SEAR Member States have participated in World Antibiotic Awareness Week.
6) Some SEA Region Member States have already adopted Access/Watch/Reserve classification of antibiotics in the Essential Medicine List, while others are in process of adopting it. We recognize the importance of this concept to contain AMR, and the need for effective enforcement. SEAR Member States also participated in a training on the use of WHO methodology to monitor antimicrobial consumption. Thailand has produced the first Antimicrobial Consumption report, which combines consumption and AMR in human, animal and food chains, and will be produced annually.

7) SEA region faces various challenges along the supply chain which require comprehensive system management. The global framework being developed is needed as a guiding approach. The Region calls upon the Secretariat to accelerate the implementation of OP 2(7) of the WHA68.7 for “Global Action Plan on Antimicrobial Resistance”, and finalize such stewardship framework as soon as possible.

8) SEA Region reiterates the need for rapid R&D of alternatives which can replace antibiotics such as herbal medicines, pro-biotics, and vaccines to optimize antibiotic use.

9) We insist on the importance of effective post-marketing surveillance and regulatory action to eliminate substandard and falsified antimicrobials.

10) We join our hands together in the fight against AMR and will continue to accord the high level of political commitment to save our future from AMR threats.

11) We, therefore, support the adoption of the draft resolution recommended by the Executive Board in resolution EB144.R11.

Thank you, Chair.
Follow-up to the political declaration of the third high-level meeting of the General Assembly on the prevention and control of non-communicable diseases

The Seventy-second World Health Assembly, having considered the report on follow-up to the high-level meetings of the United Nations General Assembly on health-related issues: prevention and control of noncommunicable diseases,¹ describing the outcomes of the third high-level meeting of the General Assembly on the prevention and control of non-communicable diseases, decided:

(1) to welcome the political declaration of the third high-level meeting of the General Assembly on the prevention and control of non-communicable diseases adopted by the United Nations General Assembly in resolution 73/2 (2018), and to request the Director-General to provide support to Member States in its implementation;

(2) to confirm the objectives of WHO’s global action plan for the prevention and control of noncommunicable diseases 2013–2020 and WHO’s comprehensive mental health action plan 2013–2020 as a contribution towards the achievement of 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) and other noncommunicable disease-related goals and targets, and to extend the period of the action plans to 2030 in order to ensure their alignment with the 2030 Agenda for Sustainable Development;

(3) to request the Director-General:

(a) to propose updates to the appendices of WHO’s global action plan for the prevention and control of noncommunicable diseases 2013–2020 and WHO’s comprehensive mental health action plan 2013–2020, as appropriate, in consultation with Member States and taking into account the views of other stakeholders,² ensuring that the action plans remain based on scientific evidence for the achievement of previous commitments for the prevention and control of noncommunicable diseases, including 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) and other related goals and targets;

(b) building on the work already under way, to prepare and update, as appropriate, a menu of policy options and cost-effective interventions to support Member States in implementing the commitments included in the political declaration of the third high-level

¹ Document A72/19.
² In accordance with WHO’s Framework of Engagement with Non-State Actors.
meeting of the General Assembly on the prevention and control of non-communicable diseases (2018) to promote mental health and well-being, for consideration by the Health Assembly in 2020, through the Executive Board;

(c) building on the work already under way, to prepare a menu of policy options and cost-effective interventions to provide support to Member States in implementing the commitments included in the political declaration of the third high-level meeting of the General Assembly on the prevention and control of non-communicable diseases (2018) to reduce the number of premature deaths from noncommunicable diseases attributed to air pollution, while recognizing the importance of addressing all environmental determinants, for consideration by the Seventy-third World Health Assembly in 2020, through the Executive Board;

(d) to report to the Seventy-third World Health Assembly in 2020, through the Executive Board, on the implementation of WHO’s global strategy to reduce the harmful use of alcohol during the first decade since its endorsement, and the way forward;

(e) to consolidate reporting on the progress achieved in the prevention and control of noncommunicable diseases and the promotion of mental health with an annual report to be submitted to the Health Assembly through the Executive Board, from 2021 to 2031, annexing reports on implementation of relevant resolutions, action plans and strategies,\textsuperscript{1,2} in line with existing reporting mandates and timelines;

(f) to provide further concrete guidance to Member States in order to strengthen health literacy through education programmes and population-wide targeted and mass- and social-media campaigns to reduce the impact of all risk factors and determinants of noncommunicable diseases, to be presented to the Seventy-fourth World Health Assembly in 2021;

(g) to present, in the consolidated report to the Seventy-fourth World Health Assembly in 2021, based on a review of international experiences, an analysis of successful approaches to multisectoral action for the prevention and control of noncommunicable diseases, including those that address the social, economic and environmental determinants of such diseases;


\textsuperscript{2} Including reports on the findings of a mid-point and final evaluation in accordance with paragraph 60 of WHO’s global action plan for the prevention and control of noncommunicable diseases 2013–2020, and on the findings of a preliminary and final evaluation in accordance with paragraph 19 of the terms of reference of the WHO Global Coordination Mechanism on the Prevention and Control of Noncommunicable Diseases.
(h) to collect and share best practices for the prevention of overweight and obesity, and in particular to analyse how food procurement in schools and other relevant institutions can be made supportive of healthy diets and lifestyles in order to address the epidemic of childhood overweight and obesity and reduce malnutrition in all its forms, for inclusion in the consolidated report to be presented in 2021 in line with paragraph 3(e);

(i) to provide the necessary technical support to Member States in integrating the prevention and control of noncommunicable diseases and the promotion of mental health into primary health care services, and in improving noncommunicable disease surveillance;

(j) to make available adequate financial and human resources to respond to the demand from Member States for technical support in order to strengthen their national efforts for the prevention and control of noncommunicable diseases, including by identifying voluntary innovative funding mechanisms, such as a multi-donor trust fund, building on ongoing relevant work.

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

WHA72 Agenda 11.8:  Follow-up to the high-level meetings of the United Nations General Assembly on Prevention and control of noncommunicable diseases

Lead country:  Sri Lanka Supporting country:  Indonesia

Chairperson,

Sri Lanka is making this statement on behalf of eleven Member States of South-East Asia Region.

1) We welcome the outcomes of the third High Level meeting on NCD prevention and control in 2018. SEAR also welcomes the 5 by 5 NCD model. Mental health and well-being and air pollution are highly relevant to our Region.

2) Despite NCD best buys interventions having been declared as a SEARO Flagship priority, countries in the Region have seen uneven progress in achievement of NCD targets. The 2017 WHO NCD progress report¹ shows that increasing tax on alcohol and tobacco and advertising bans are lagging behind.

3) We appreciate WHO’s initiative to introduce NCD accelerators and request WHO to provide tailored guidance on prioritization and adaptation of these best buys and accelerators to fit country contexts.

4) SEA region would like to register two major concerns:

a. **First**, we request WHO to intensify support on managing NCDs through primary health care approach by strengthening its governance and introducing innovative fiscal policies for health, including taxes on tobacco, alcohol and sugary beverages.

b. **Second**, alcohol consumption and related problems have increased in the Region, in particular among women and young people. Between 2010 and 2017, per-capita consumption in the Region increased by 34% from 3.5 to 4.7 litres. Instead of achieving 10% reduction by 2025, alcohol consumption in the South-East Asia Region will double itself by 2030, as published by Lancet\(^2\) this month.

5) With the fast growth of alcohol consumption through aggressive market promotion, little progress has been made in all WHO regions to achieve the ten percent reduction target. Since evidence confirms “**no safe level of alcohol consumption**”, South East Asia Region calls for urgent attention.

Chairperson,

6) On the Decision EB144 (1) para 3 (d), we request WHO DG to convene a working group with **strong engagement of Member States** to fulfill the mandate in the decision item 3(d). The working group should review if WHO global strategy is fit for purpose as required by the SDG 3.5 on alcohol. **In the context of aggressive market promotion; more purposeful interventions are needed.**

7) **South-East Asia, therefore, proposes a friendly amendment to paragraph 3(d) in order to strengthen the decision. It may be worded as follows:**

“**(d) to convene a technical working group comprising two Member States from each of the six WHO regions to review progress and challenges in** the implementation of WHO’s global strategy to reduce the harmful use of alcohol during the first decade since its endorsement, and the way forward and report to the Health Assembly in 2020, through the Executive Board;”

Thank you chair.

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

The Seventy-second World Health Assembly, having considered the reports on implementation of decision WHA71(11) (2018),1 and taking note of the PIP Advisory Group’s recommendations to the Director-General, 2 decided:

(1) to request the Director-General:

(a) to work with the Global Influenza Surveillance and Response System (GISRS) and other partners, such as Other Authorized Laboratories and relevant institutions, to collect, analyse, and present data on influenza virus sharing in a way that enables a deeper understanding of the challenges, opportunities and implications for public health associated with virus sharing under the GISRS, including by identifying: specific instances where influenza virus sharing has been hindered; and how such instances may be mitigated;

(b) to prepare a report, with inputs from Member States3 and stakeholders, as appropriate, on the treatment of influenza virus sharing and the public health considerations thereof by existing relevant legislation and regulatory measures, including those implementing the Nagoya Protocol, in consultation with the Secretariat of the Convention on Biological Diversity as appropriate;

(c) to provide more information on the functioning, usefulness and limitations of the prototype search engine;

(d) to explore, including through soliciting input from Member States, possible next steps in raising awareness of the PIP Framework among relevant databases and initiatives, data providers and data users, and in promoting the acknowledgment of data providers and collaboration between data providers and data users;

(e) to continue providing information on new challenges posed and opportunities provided by new technologies in the context of the Pandemic Influenza Preparedness Framework for the sharing of influenza viruses and access to vaccines and other benefits and possible approaches to them;

1 Documents A72/21 and A72/21 Add.1.


3 And, where applicable, regional economic integration organizations.
(2) to revise Footnote 1 in the Standard Material Transfer Agreement 2 (SMTA2), in Annex 2 to the PIP Framework, as set out in the Annex to this decision, with effect from the closure of the Seventy-second World Health Assembly;

(3) to further request the Director-General to report on implementation of the foregoing to the Seventy-third World Health Assembly in 2020 through the 146th session of the Executive Board.
ANNEX

AMENDMENTS TO FOOTNOTE 1 OF ANNEX 2 OF THE PIP FRAMEWORK

Recipients are receivers of “PIP Biological Materials” from the WHO global influenza surveillance and response system (GISRS), such as manufacturers of influenza vaccines, diagnostics, pharmaceuticals and other products relevant to pandemic preparedness and response, as well as biotechnology firms, research institutions and academic institutions. Recipients shall select from among the commitments identified in SMTA2 Article 4.1.1 (a) to (c) based on their nature and capacities; those that are not manufacturers shall only have to consider contributing to the measures set out in SMTA2 Article 4.1.1(c).

Any manufacturer that enters into any contracts or formal agreements with recipients or GISRS laboratories for the purpose of using PIP Biological Materials on the manufacturer’s behalf for commercialization, public use or regulatory approval of that manufacturer’s vaccines, diagnostics, or pharmaceuticals shall also enter into an SMTA2 and select from among the commitments identified in Article 4.1.1 (a) to (c) based on their nature and capacities.

Seventh plenary meeting, 28 May 2019
A72/VR/7
Promoting the health of refugees and migrants

The Seventy-second World Health Assembly, having considered the report on promoting the health of refugees and migrants\(^1\) decided:

(1) to take note of the WHO global action plan on promoting the health of refugees and migrants, 2019–2023;

(2) to request the Director-General to report back on progress in the implementation of the WHO global action plan on promoting the health of refugees and migrants, 2019–2023, including relevant information provided by Member States on a voluntary basis and United Nations agencies as appropriate, to the Seventy-fourth and Seventy-sixth World Health Assemblies.

Seventh plenary meeting, 28 May 2019
A72/VR/7

\(^1\) Document A72/25 Rev.1.
Thank you Chair,

Sri Lanka is presenting this statement on behalf of the 11 Member States of SEA Region.

1) Our region understands the importance of the Global Action Plan (GAP) to address health of Migrants and Refugees, in the context of the General Program of Work (GPW), UHC and sustainable development.

2) We acknowledge that the entitlement and access to health services by refugees and migrants vary by country and are determined by national law. Implementation of the GAP, will need to take account of country specific situations and be in accordance with national legislations, priorities and circumstances.

3) When we consider the UHC parameters, there is a need to ensure that migrant communities are included in the denominators when estimating coverage and provided quality essential health care services through long-term solutions as part of society. One of the main pillars for achieving UHC being population coverage, SEA Region supports the full inclusion and coverage of migrant communities, irrespective of their migration status, so that no one is left behind in our efforts to attain global UHC targets.

4) Being concerned about exclusion of migrant communities from UHC and including them in measurements relevant to priority area-5 in GAP, we wish to recommend to the Secretariat to assist Member States in clearer understanding of vulnerability issues and mapping of vulnerable
populations in general. The secretariat can assist the Member States to address the need for reliable and robust data on migration and health, particularly in relation to undocumented migrants and those not accessing formal services.

5) Our region firmly believes that strengthening international cooperation and respecting the core principle of responsibility and burden sharing would be key in addressing the health issues of migrants and refugees. In the similar vein, we feel that the issue of resource mobilization should be given further importance across all the priority areas.

6) Overall the Global Action Plan is comprehensive, but we need to address the bottom line issue of inclusiveness and assessment before it is taken for Regional adaptation. We are a region with over 11 million international migrations in the SEA region. We appreciate the efforts of the regional office in supporting Member States in facing the major and continued migration challenges, including the refugee situations.

7) Certain public health risks continue to affect the region, especially in controlling TB and malaria elimination. Vulnerabilities related to maternal and child health will also need inclusive attention. This calls for more focused regional adaptation of the Global Action Plan.

8) Our region notes the report and extends its support to the secretariat in implementing the draft decision stated in para 36 of the document A72/25 Rev 1, while urging all Member States to do the same.

Thank you Chair.
Global action on patient safety

The Seventy-second World Health Assembly,

Having considered the report by the Director-General on global action on patient safety;¹

Recalling resolution WHA55.18 (2002), which urged Member States to “pay the closest possible attention to the problem of patient safety; and to establish and strengthen science-based systems, necessary for improving patients’ safety and the quality of health care”; recognizing that patient safety is a critical element of, and the foundation for, delivering quality health care; and welcoming the inclusion of the need for patient safety in the Thirteenth General Programme of Work, 2019–2023;

Recognizing that patient safety cannot be ensured without access to: safe infrastructure, technologies and medical devices, and their safe use by patients, who need to be well informed; and a skilled and committed health workforce, in an enabling and safe environment;

Noting that patient safety builds on quality, basic and continued education and training of health professionals that ensures that they have the adequate professional skills and competencies in their respective roles and functions;

Recognizing that access to safe, effective, quality and affordable medicines and other commodities, and their correct administration and use, also contribute to patient safety;

Noting further the importance of hygiene for patient safety and the prevention of health care-associated infections, and for reducing antimicrobial resistance;

Noting that ensuring patient safety is a key priority in providing quality health services and considering that all individuals should receive safe health services, regardless of where they are delivered;

Reaffirming the principle of “First do no harm” and recognizing the benefits to be gained and the need to promote and improve patient safety across health systems at all levels, sectors and settings relevant to physical and mental health, especially at the level of primary health care, but also including, for example, emergency care, community care, rehabilitation and ambulatory care;

Recognizing that the safety of patients during the provision of health services that are safe and of high quality is a prerequisite for strengthening health care systems and making progress towards

¹ Document A72/26.
effective universal health coverage under Sustainable Development Goal 3 (Ensure healthy lives and promote health and well-being for all at all ages);

Acknowledging that instilling a safety culture, a patient-centred approach, and improving and ensuring patient safety require capacity-building, strong leadership, systemic and systematic approaches, adequate human and other resources, robust data, sharing of best practices, mutual learning, trust and accountability, which can be strengthened, as appropriate, by international cooperation and collaboration;

Recognizing that improving and ensuring patient safety is a growing challenge to health service delivery globally and that unsafe health care causes a significant level of avoidable patient harm and human suffering, places a considerable strain on health system finances and leads to a loss of trust in health systems;

Concerned that the burden of injuries and other harm to patients from adverse events is likely one of the top 10 causes of death and disability in the world, comparable to that of tuberculosis and malaria, and that available evidence suggests that most of this burden falls on low- and middle-income countries, where 134 million health care-associated adverse events occur annually in hospitals, due to unsafe care, contributing to 2.6 million deaths;

Recognizing that most adverse events can potentially be avoided with effective prevention and mitigation strategies, including, as appropriate, improved policies, data systems, redesigned processes of care (including addressing human factors, including training), environmental hygiene and infrastructure, better organizational culture to improve practices, supportive and effective regulatory systems and improved communication strategies, and that solutions can often be simple and inexpensive, with the value of prevention outweighing the cost of care;

Recognizing the success, pioneering work and dedication of governments in many Member States in developing strategies and policies to support and improve patient safety, and in implementing safety and quality programmes, initiatives and interventions, such as insurance arrangements, patient ombudspersons, creating a patient safety culture throughout the health system, transparent incident reporting systems that allow learning from mistakes, and no-fault and no-blame handling of adverse events and their consequences; and a patient-centred approach to patient safety;

Concerned at the lack of overall progress in improving the safety of health care and that, despite global efforts to reduce the burden of patient harm, the overall situation over the past 17 years indicates that significant improvement can be made and that safety measures – even those implemented in high-income settings – have had limited or varying impact, and that most have not been adapted for successful application in low- and middle-income countries;

Recognizing the importance of robust patient safety measurement to promote more resilient health systems, better and more focused preventive work to promote safety and risk awareness, transparent incident reporting, data analysis and learning systems, at all levels, alongside education, training and continuous professional development to build and maintain a competent, compassionate and committed health care workforce operating within a supportive environment to make health care safe, and the importance of engaging and empowering patients and families in improving the safety of care for better health outcomes;

Recognizing also that improving and ensuring patient safety calls for addressing the gaps in knowledge, policy, design, delivery and communication at all levels,
1. **ENDORSES** the establishment of World Patient Safety Day, to be marked annually on 17 September in order to increase public awareness and engagement, enhance global understanding, and work towards global solidarity and action by Member States to promote patient safety;

2. **URGES** Member States:¹

   (1) to recognize patient safety as a health priority in health sector policies and programmes, making it an essential component for strengthening health care systems in order to achieve universal health coverage;

   (2) to assess and measure the nature and magnitude of the problem of patient safety including risks, errors, adverse events and patient harm at all levels of health service delivery including through reporting, learning and feedback systems that incorporate the perspectives of patients and their families, and to take preventive action and implement systematic measures to reduce risks to all individuals;

   (3) to develop and implement national policies, legislation, strategies, guidance and tools, and deploy adequate resources, in order to strengthen the safety of all health services, as appropriate;

   (4) to work in collaboration with other Member States, civil society organizations, patients’ organizations, professional bodies, academic and research institutions, industry and other relevant stakeholders to promote, prioritize and embed patient safety in all health policies and strategies;

   (5) to share and disseminate best practices and encourage mutual learning to reduce patient harm through regional and international collaboration;

   (6) to integrate and implement patient safety strategies in all clinical programmes and risk areas, as appropriate, to prevent avoidable harm to patients related to health care procedures, products and devices, for example, medication safety, surgical safety, infection control, sepsis management, diagnostic safety, environmental hygiene and infrastructure, injection safety, blood safety and radiation safety, as well as to minimize the risk of inaccurate or late diagnosis and treatment, and to pay special attention to at-risk groups;

   (7) to promote a safety culture by providing basic training to all health professionals, developing a blame-free patient safety incident reporting culture through open and transparent systems that identify and learn from examining causative and contributing factors of harm, addressing human factors, and building leadership and management capacity and efficient multidisciplinary teams, in order to increase awareness and ownership, improve outcomes for patients and reduce the costs related to adverse events at all levels of health systems;

   (8) to build sustainable human resource capacity, through multisectoral and interprofessional competency-based education and training, based on the WHO patient safety curricula and continuous professional development, to promote a multidisciplinary approach, and to build an appropriate working environment that optimizes the delivery of safe health services;

   (9) to promote research, including translational research, to support the provision of safer health services and long-term care;

¹ And, where applicable, regional economic integration organizations.
(10) to promote the use of new technologies, including digital technologies, for health, including to build and scale up health information systems and to support data collection for surveillance and reporting of risks, adverse events and other indicators of harm at different levels of health services and health-related social care, while ensuring the protection of personal data, and to support the use of digital solutions to provide safer health care;

(11) to consider the use of traditional and complementary medicine, as appropriate, in the provision of safer health care;

(12) to put in place systems for the engagement and empowerment of patients’ families and communities (especially those who have been affected by adverse events) in the delivery of safer health care, including capacity-building initiatives, networks and associations, and to work with them and civil society, to use their experience of safe and unsafe care positively in order to build safety and harm-minimization strategies, as well as compensation mechanisms and schemes, into all aspects of the provision of health care, as appropriate;

(13) to mark World Patient Safety Day annually on 17 September to promote all aspects of patient safety including progress towards reaching national milestones, in collaboration with relevant stakeholders;

(14) to consider participating in the annual Global Ministerial Summits on Patient Safety;

3. INVITeS international organizations and other relevant stakeholders to collaborate with Member States in promoting and supporting patient safety initiatives, including marking World Patient Safety Day annually;

4. REQUESTS the Director-General:

(1) to emphasize patient safety as a key strategic priority in WHO’s work across the universal health coverage agenda;

(2) to develop normative guidance on minimum standards, policies, best practice and tools for patient safety, including on safety culture, human factors, hygienic infrastructure, clinical governance and risk management;

(3) to provide technical support to Member States, especially low- and middle-income countries, where appropriate and where requested, to help to build national capacities in their efforts to assess, measure and improve patient safety, in collaboration with professional associations, as appropriate, and to create a safety culture, as well as ensuring effective prevention of health care-associated harm, including infections, by building capacity in leadership and management, and open and transparent systems that identify and learn from the causes of harm;

(4) to provide support to Member States, on request, in establishing and/or strengthening patient safety surveillance systems;

(5) to strengthen global patient safety networks to share best practice and learning and foster international collaboration including through a global network of patient safety trainers, and to work with Member States, civil society organizations, patients’ organizations, professional associations, academic and research institutions, industry and other relevant stakeholders in building safer health care systems;
(6) to provide, on request, technical support and normative guidance on the development of human resource capacity in Member States through interprofessional competency-based education and training based on WHO patient safety curricula, and, in consultation with Member States, develop “training-of-trainers” programmes for patient safety education and training, and develop global and regional networks of professional educational councils to promote education on patient safety;

(7) to develop and manage, in consultation with Member States, systems for global sharing of learning from patient safety incidents, including through reliable and systematic reporting, data analysis and dissemination systems;

(8) to design, launch and support Global Patient Safety Challenges’, and to develop and implement strategies, guidance and tools to support Member States in implementing each Challenge, using the best available evidence;

(9) to promote and support the application of digital technologies and research, including translational research for improving the safety of patients;

(10) to provide support to Member States, upon request, in putting into place systems to support the active engagement, participation and empowerment of patients, families and communities in the delivery of safer health care; and in establishing and strengthening networks for engagement of patients, communities, civil society and patient associations;

(11) to work with Member States, international organizations and other relevant stakeholders to promote World Patient Safety Day;

(12) to formulate a global patient safety action plan in consultation with Member States\(^1\) and all relevant stakeholders, including in the private sector, for submission to the Seventy-fourth World Health Assembly in 2021 through the 148th session of the Executive Board;

(13) to submit a report on progress in the implementation of this resolution, for the consideration of the Seventy-fourth, Seventy-sixth and Seventy-eighth World Health Assemblies.

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\(^1\) And, where applicable, regional economic integration organizations.
Seventy-second World Health Assembly

Geneva, 20–28 May 2019

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

WHA72 Agenda 12.5: Global action on patient safety

Lead country: Thailand
Supporting country: Sri Lanka

Chair,

1) Thailand makes this statement on behalf of eleven Member States of the WHO South-East Asia Region. South East Asia Regional Committee adopted a resolution on “Patient safety contributing to sustainable universal health coverage” in 2015, which endorsed the Regional Strategy on Patient Safety (2016–2025)\(^1\) to support development and implementation of national patient safety policies.

2) Self-assessment, conducted by almost all SEA Region countries, have resulted in the launch of evidence-based plan to improve patient safety.

3) These country implementation experiences include the adoption of National Incidence Reporting and Learning System; Facility Certification Improvement of WASH; and strengthening infection prevention and control to address AMR. Some countries are also implementing surgical safety check list.

4) Most importantly, strengthening safer public and private healthcare system through the adoption of Patient and Personnel Safety policy and strategies which engage patients, health personnel and stakeholders help cultivate safety culture and raising safety awareness. This is achieved through inter-professional education, effective communication and coordinated care among health personnel.

\(^1\) Regional strategy for patient safety in the WHO South-East Asia Region, SEA-HSD-378 https://bit.ly/2vKzBg0
5) Accelerating progress towards patient safety can address the basic, simple and in-expensive actions such as availability of clean water and sanitation in health facilities, supporting hand hygiene and safe medication.

6) WHO and partners should support cross country learning and sharing best experiences and improve data for evidence informed policy decisions to achieve universal health coverage, promote concerted global action and strengthen collaboration with focus on low- and middle-income countries.

7) Chair, South East Asia endorses the establishment of World Patient Safety Day, on 17 September annually.

8) However, we propose one friendly amendment to EB144 R12; OP 2 (13) to be read as “To mark World Patient Safety Day annually on 17 September to promote all aspects of patient safety including progress on national milestones, in collaboration with relevant stakeholders”.

Thank you, Chair.
Water, sanitation and hygiene in health care facilities

The Seventy-second World Health Assembly,

Having considered the report on patient safety: water, sanitation and hygiene in health care facilities;

Recalling the Declaration of Astana from the Global Conference on Primary Health Care (Astana, 25 and 26 October 2018) which envisages strengthening primary health care as the most inclusive, effective and efficient approach to enhance people’s physical and mental health, as well as social well-being, and that primary health care is a cornerstone of a sustainable health system for effective universal health coverage and health-related Sustainable Development Goals;

Recalling also resolution WHA64.24 (2011) on drinking water, sanitation and health, which emphasizes the tenets of primary health care as set out in the Declaration of Alma-Ata on Primary Health Care and other resolutions recalled therein (WHA35.17 (1982), WHA39.20 (1986), WHA42.25 (1989), WHA44.28 (1991), WHA45.31 (1992), WHA51.28 (1998) and WHA63.23 (2010)) and resolution WHA70.7 (2017) which stressed the role of improving safe drinking water, sanitation facilities, health care waste management and hygiene practices in primary health care;


Noting that without sufficient and safe water, sanitation and hygiene services in health care facilities, countries will not achieve the targets set out in Sustainable Development Goal 3 (Ensure healthy lives and promote health and well-being for all at all ages) and Goal 6 (Ensure availability and sustainable management of water and sanitation for all), including reducing maternal and newborn mortality and achieving effective universal health coverage, and those in Sustainable Development Goals 1 (End poverty in all its forms everywhere), 7 (Ensure access to affordable, reliable, sustainable and modern energy for all.), 11 (Make cities and human settlements inclusive, safe, resilient and sustainable) and 13 (Take urgent action to combat climate change and its impacts);

Noting also that the provision of safe water, sanitation and hygiene services is fundamental for patient safety and has been shown to reduce the risk of infection for patients, carers, health workers and surrounding communities, and noting that progress towards the provision of those services in health care facilities would also allow for effective and timely prevention of cholera, and care for patients with the

1 Document A72/27.
disease, in addition to diarrhoeal and other diseases, as recognized in resolution WHA71.4 (2018) on cholera prevention and control;

Recalling WHA68.7 (2015) on the global action plan on antimicrobial resistance, which underscores the critical importance of safe water, sanitation and hygiene services in community and health care settings for better hygiene and infection prevention measures to limit the development and spread of antimicrobial-resistant infections and to limit the inappropriate use of antimicrobial medicines, ensuring good stewardship;

Noting the findings of the joint WHO and UNICEF report, *WASH in health care facilities: global baseline report 2019*,¹ which revealed that one in four health care facilities lack basic water services, one in five have no sanitation service and 42% have no hygiene facilities at point of care; underscoring the implications of not having these basics in these places, including the spread of infections in places that are supposed to promote health and basic hygiene for disease prevention; and stressing the implications for the dignity of patients and other users who seek health care services, particularly women in labour and their newborn babies;

Recalling the statement of the United Nations Secretary-General, making a global call for action for water, sanitation and hygiene in all health care facilities;

Noting that the Director-General’s report to the Seventy-first World Health Assembly on health, environment and climate change² identified global driving forces, including population growth, urbanization and climate change, which are expected to significantly affect the availability and quality of, and access to, water and sanitation services and freshwater resources, and the urgent need for addressing the links between climate, energy, safe water, sanitation and hygiene and health,

1. **URGES** Member States:³

   (1) to conduct comprehensive assessments according to the national context and, where appropriate, to quantify: the availability and quality of, and needs for, safe water, sanitation and hygiene in health care facilities; and infection prevention and control status, using existing regional and global protocols or tools⁴,⁵ and in collaboration with the global effort to improve provision of safe water, sanitation and hygiene in health care facilities;⁶

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² Document A71/11.

³ And, where applicable, regional economic integration organizations.


⁶ WHO and UNICEF are jointly coordinating the global efforts to improve safe water, sanitation and hygiene (WASH) in health care facilities. Action is focused on a number of key areas, including national assessments. More information can be found on the knowledge portal on WASH in health care facilities – global action to provide universal access by 2030: www.washinhcf.org (accessed 7 February 2019).
(2) to develop and implement a road map according to national context so that every health care facility in every setting has, commensurate with its needs: safely managed and reliable water supplies; sufficient, safely managed and accessible toilets or latrines for patients, caregivers and staff of all sexes, ages and abilities; appropriate core components of infection prevention and control programmes, including good hand hygiene infrastructure and practices; routine, effective cleaning; safe waste management systems, including those for excreta and medical waste disposal; and, whenever possible, sustainable and clean energy;

(3) to establish and implement, according to national context, minimum standards for safe water, sanitation and hygiene and infection prevention and control in all health care settings and build standards for safe water, sanitation and hygiene and infection prevention and control into accreditation and regulation systems; and establish accountability mechanisms to reinforce standards and practice;

(4) to set targets within health policies and integrate indicators for safe water, sanitation and hygiene and infection prevention and control\(^1\) into national monitoring mechanisms to establish baselines, track progress, and track health system performance on a regular basis;

(5) to integrate safe water, sanitation and hygiene into health programming, including into nutrition and maternal, child and newborn health within the context of safe, quality and integrated people-centred health services, effective universal health coverage, infection prevention and control, and containment of antimicrobial resistance;

(6) to identify and address inequities and interruptions in the availability of adequate safe water, sanitation and hygiene services in health facilities, especially in facilities that provide maternity services and in primary health care facilities;

(7) to align their strategies and approaches with the global effort for safe water, sanitation and hygiene in health care facilities\(^2\) and contribute to the realization of Sustainable Development Goal 3 (Ensure healthy lives and promote health and well-being for all at all ages) and Goal 6 (Ensure availability and sustainable management of water and sanitation for all);

(8) to have procedures and funding in place to operate and maintain services for safe water, sanitation and hygiene and for infection prevention and control in health facilities, and to make continuous upgrades and improvements based on needs so that infrastructure continues to operate and resources are made available to help facilities to access other sources of safe water in the event of failures in the normal water supply, so that environmental and other impacts are minimized and in order to maintain hygiene practices;

(9) to educate and raise awareness, in line with regional agreements, on water, sanitation and hygiene, with a particular focus on maternity, hospital facilities and settings used by mothers and children; and to conduct ongoing education campaigns on the risks of poor sanitation, including

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open defecation, to discourage this practice and encourage community support for use of toilets and safe management of faecal waste by health workers;

(10) to establish strong multisectoral coordination mechanisms with the active involvement of all relevant ministries, particularly those responsible for health, finance, water and energy; to align and strengthen collaborative efforts and ensure adequate financing to support the delivery of all aspects of safe water, sanitation and hygiene and infection prevention and control across the health system; and to invest in a sufficient and well-trained health workforce, including health care workers, cleaners and engineers to manage safe water, sanitation and hygiene services, provide ongoing maintenance and operations and perform appropriate safe water, sanitation and hygiene and infection prevention and control practices, including strong pre-service and ongoing in-service education and training programmes for all levels of staff;

(11) to promote a safe and secure working environment for every health worker, including working aids and tools, safe water, sanitation and hygiene services and cleaning and hygiene supplies, for efficient and safe service delivery;

2. INVITES international, regional and local partners:

(1) to raise the profile of safe water, sanitation and hygiene and infection prevention and control in health care facilities, in health strategies and in flexible funding mechanisms, and thereby direct efforts towards strengthening health systems as a whole, rather than focusing on vertical or siloed programming approaches;

(2) to support government efforts to empower communities to participate in the decision-making concerning the provision of better and more equitable safe water, sanitation and hygiene services in health facilities, including their reporting to authorities about insufficient or inadequate safe water, sanitation and hygiene services;

3. REQUESTS the Director-General:

(1) to continue to provide global leadership and pursue the development of technical guidance to achieve the targets set out in this resolution;

(2) to report on the global status of access to safe water, sanitation and hygiene in health care facilities as part of efforts to achieve Sustainable Development Goal 6 (Ensure availability and sustainable management of water and sanitation for all), including through the Joint Monitoring Programme, and to include safe water, sanitation and hygiene and infection prevention and control in health care facilities within effective universal health coverage, primary health care and efforts to monitor the quality of care;

(3) to catalyse the mobilization of domestic and external resources from the public and private sectors, and to support the development of national business cases for investment in safe water, sanitation and hygiene and infection prevention and control in health care facilities;

(4) to continue to raise the profile of safe water, sanitation and hygiene and infection prevention and control in health care facilities within WHO and at high-level political forums, and to work with other United Nations agencies in order to respond to the United Nations Secretary-General’s call to action in a coordinated manner;
(5) to work with Member States and partners to review, update and implement the global action plan and support Member States in the development of national road maps and targets for safe water, sanitation and hygiene in health care facilities;

(6) to work with partners to adapt existing reporting mechanisms and, if necessary, develop new such mechanisms in order to capture and monitor progress on the coordination, implementation, financing, access, quality and governance of safe water, sanitation and hygiene and infection prevention and control in health care facilities, according to established indicator reporting methodology for Sustainable Development Goal 6 (Ensure availability and sustainable management of water and sanitation for all);¹

(7) to support coordination and implementation of safe water, sanitation and hygiene and basic infection prevention and control measures in health care facilities and triage centres in times of crisis and humanitarian emergencies through the Health and WASH clusters, leveraging partnerships to prevent disease outbreaks in these contexts;

(8) to report on progress in the implementation of the present resolution to the Health Assembly in 2021 and 2023.

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¹ Includes protocols, methods and reporting conducted by the WHO/UNICEF Joint Monitoring Programme and the WHO-led UN-Water Global Analysis and Assessment of Sanitation and Water.
WHA72 Agenda 12.5: Water, sanitation and hygiene in health care facilities

Lead country: Bhutan Supporting country: Myanmar

Thank you, Chair,

1) Bhutan takes great pleasure and honour to present this statement on behalf of all the 11 Member States of the South-East Asia Region.

2) We note with appreciation the Director General’s comprehensive report on this agenda. We appreciate WHO for its continuous efforts and drive towards improving access to WASH facilities at the global, regional and national levels, particularly in areas of advocacy, developing national standards, generating harmonized global data, and improving intersectoral collaboration, among other things.

3) In our Region, WASH in healthcare facilities is increasingly getting attention, whereby it is increasingly integrated into strategies to improve quality of care.

4) Chair, it is deeply concerning to note that 45% of health facilities lacked water and 35% did not have materials for health and hygiene\(^1\) in low- and middle-income countries, globally. This is highly unacceptable, particularly in a place where vulnerable people come to seek care and services.

5) Inadequate access to WASH services in health settings hinders efforts to maintain clean environment and facilitates hospital acquired infections (HAI). Furthermore, it is well-established that poor WASH in health facilities leads to antimicrobial resistance; - Chair, ladies and gentlemen, as we all know, AMR is a growing threat to global public health and health security.

\(^1\) First ever global assessment done by UNICEF and WHO available online at http://apps.who.int/gb/ebwha/pdf_files/WHA72/A72_27-en.pdf
6) We recognize and acknowledge the UN Secretary General’s timely global call for action on having functional WASH services and practices in all health care settings. Its effective implementation will greatly contribute towards advancing universal health coverage and achieving the triple billion goals. Chair, South-East Asia, therefore, calls on the international community to welcome and implement the “global work plan and architecture on WASH in health care facilities” led by the WHO and UNICEF to respond to the Secretary General’s call and to “expand international cooperation and capacity-building support to developing countries in water- and sanitation-related activities and programmes”2.

7) Chair, Bhutan, on behalf of the 11 Member States of WHO-SEA Region, supports the adoption of the draft resolution EB 144.R5.

Emergency care systems for universal health coverage: ensuring timely care for the acutely ill and injured

The Seventy-second World Health Assembly,

Having considered the report on emergency care systems for universal health coverage: ensuring timely care for the acutely ill and injured;¹

Noting the importance of the organization of the health system as a whole, including by distinguishing between elective services and care, non-elective services and care, and emergency services and care in order to address the health needs of populations in a sustainable, effective and appropriate manner;

Recognizing that many proven health interventions are time-dependent and that emergency care is an integrated platform for delivering accessible, quality and time-sensitive health care services for acute illness and injury across the life course;

Emphasizing that timeliness is an essential component of quality, and that millions of deaths and long-term disabilities from injuries, infections, mental disorders and other mental health conditions, acute exacerbations of noncommunicable diseases, acute complications of pregnancy, and other emergency conditions could be prevented each year if emergency care services exist and patients reach them in time;

Noting that injury alone accounts for nearly 5 million deaths per year and that road traffic injury is the top killer of all those in the age group of 5–29 years;²

Noting also that emergency care is an essential part of health service delivery in health systems, and that well-designed emergency services facilitate timely recognition, treatment management and, when needed, continued treatment of the acutely ill at the appropriate level of the health system;

Acknowledging Sustainable Development Goal 3 (Ensure healthy lives and promote well-being for all at all ages), and recognizing that well-organized, safe and high-quality emergency care is a key mechanism for achieving a range of associated targets – including those on universal health coverage, road safety, maternal and child health, noncommunicable diseases, mental health, and infectious disease;

¹ Document A72/31.

Acknowledging further Sustainable Development Goal 11 (Make cities and human settlements inclusive, safe, resilient and sustainable) and Goal 16 (Promote peaceful and inclusive societies for sustainable development, promote access to justice for all and build effective, accountable and inclusive institutions at all levels), and noting that a strong and well-prepared everyday emergency care system is vital for mitigating the impact of disasters and mass casualty events and for maintaining delivery of health services in fragile situations and conflict-affected areas;


Recalling also the mandate of WHO’s Thirteenth General Programme of Work, 2019–2023 to improve integrated service delivery and to serve in particular the most disadvantaged, marginalized and hard-to-reach populations, to ensure that no one is left behind;

Noting that providing non-discriminatory access to all people in need of timely care in well organized, safe and high-quality emergency care services can contribute to the reduction of health inequalities;

Noting further that in many countries the emergency care system serves as the major health system safety net and the primary point of access to health services, in particular for marginalized populations, which is not an optimal use of health system resources;

Recognizing that the lack of organized emergency care in many countries leads to wide global discrepancies in outcomes across the range of emergency conditions;

Noting that many emergency care interventions are both effective and cost effective, and that integrated emergency care delivery can save lives and maximize impact across the health system;

Concerned that the lack of investment in frontline emergency care is compromising effectiveness, limiting impact and increasing cost in other parts of the health system;

Acknowledging that frontline health workers, nurses in particular, provide care for the acutely ill and injured, often without the benefit of dedicated training in the management of emergency conditions, and with limited possibilities for consultations;

Noting that improving outcomes requires an understanding of the potential and actual utilization of emergency care, and that existing data do not provide adequate support for effective planning and resource allocation for emergency care;

Considering that WHO has a range of guidance that allows policy-makers, planners and administrators to develop action plans that are best suited to their national contexts, along with resources for training, as well as standards for essential emergency care services and resources at each level of the health system,

1. CALLS FOR near-term additional efforts globally to strengthen the provision of emergency care as part of universal health coverage so as to ensure the timely and effective delivery of life-saving health care services to those in need;¹

2. URGES Member States:²

   (1) to create policies for sustainable funding, effective governance and universal access to safe, high-quality, needs-based emergency care for all, without regard to sociocultural factors, without requirement for payment prior to care, and within a broader health system that provides quality essential care and services and financial risk protection as part of universal health coverage;

   (2) as appropriate, to conduct voluntary assessments using the WHO emergency care system assessments tool to identify gaps and context-relevant action priorities;

   (3) to work towards, or promote, at appropriate levels of governance, the inclusion of routine prehospital and hospital emergency unit care into health strategies, and in other relevant planning documents, such as emergency response plans and obstetric and surgical plans;

   (4) to develop a governance mechanism, as appropriate to their national context, for the coordination of routine prehospital and hospital-based emergency care services, including linkages with other relevant actors for disaster and outbreak preparedness and response, including the capacity of personnel in other sectors;

   (5) to promote more coherent and inclusive approaches to safeguard effective emergency care systems as a pillar of universal health coverage in fragile situations and conflict-affected areas, ensuring the continuum and provision of essential health services, and public health functions, in line with humanitarian principles;

   (6) to promote as appropriate, according to the level of health care services, from first level and above, the establishment of a dedicated area or unit for emergency services and care with appropriate equipment and capacity for management and diagnosis;

   (7) to promote access to timely prehospital care for all, by using informal or formal systems, as resources allow, including by establishing, where they do not exist, toll-free universal access numbers that meet international standards;

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² And, where applicable, regional economic integration organizations.
(8) to implement key processes and protocols as identified in WHO guidance on emergency care systems, such as triage and checklists,\(^1\) as appropriate;

(9) to provide dedicated training in the management of emergency conditions for all relevant types of health providers, including developing post-graduate training programmes for doctors and nurses, training frontline providers in basic emergency care, and integrating dedicated emergency care training into undergraduate nursing and medical curricula, and establishing certification pathways for prehospital providers, as appropriate to their national context;

(10) to increase awareness and capacity in communities to deal with emergency situations, including through campaigns, and through training of standard practices across educational and occupational settings, adapted to their corresponding target populations, so they can identify, mitigate and refer potential emergencies;

(11) to implement mechanisms for standardized data collection to characterize the local acute disease burden and identify high-yield mechanisms for improving the coordination, safety and quality of emergency care;

(12) to support efforts to ensure, based on local risks, that prehospital and hospital emergency units have plans in place to protect providers, patients and infrastructure from violence and to protect providers and patients from discrimination; and that they have in place clear protocols for the prevention and management of hazardous exposures;

3. REQUESTS the Director-General:

(1) to enhance WHO’s capacity at all levels to provide necessary technical guidance and support for the efforts of Member States and other relevant actors to strengthen emergency care systems, including to ensure preparedness in all relevant contexts;

(2) to foster multisectoral networks, partnerships and action plans, and to facilitate collaboration among Member States, to support the effective dissemination and implementation of best practices in emergency care;

(3) to promote equitable and non-discriminatory access to safe, quality emergency care services for all people as part of universal health coverage;

(4) to renew efforts outlined in resolution WHA60.22 to provide support to Member States, upon request, for needs assessments, facility inspection, quality- and safety-improvement programmes, review of legislation, and other aspects of strengthening the provision of emergency care;

(5) to support Member States to expand policy-making, administrative and clinical capacity in the area of emergency care, by the provision of policy options and technical guidance, supported by educational strategies and materials for providers and planners;

(6) to strengthen the evidence base for emergency care by encouraging research on the burden of acute disease and emergency care delivery, and by providing tools, protocols, indicators and other needed standards to support the collection and analysis of data, including on cost-effectiveness;

(7) to facilitate awareness and international and domestic resource mobilization, in line with the Addis Ababa Action Agenda of the Third International Conference on Financing for Development\(^1\) by providing advocacy resources;

(8) to report to the Seventy-fourth World Health Assembly in 2021 on progress in the implementation of this resolution.

Seventh plenary meeting, 28 May 2019

\(^1\) United Nations General Assembly resolution 69/313 (2015).
The public health implications of implementation of the Nagoya Protocol

The Seventy-second World Health Assembly, recalling the Convention on Biological Diversity and its objectives and principle, and the Nagoya Protocol on Access to Genetic Resources and the Fair and Equitable Sharing of Benefits Arising from their Utilization to the Convention on Biological Diversity and its objective; reaffirming the WHO Constitution and the International Health Regulations (2005); and having considered the report by the Director-General on the public health implications of implementation of the Nagoya Protocol,\(^1\) decided to request the Director-General, to broaden engagement with Member States, the Secretariat of the Convention on Biological Diversity, relevant international organizations and relevant stakeholders:

(1) to provide information on current pathogen-sharing practices and arrangements, the implementation of access and benefit-sharing measures, as well as the potential public health outcomes and other implications; and

(2) to provide a report to the Seventy-fourth World Health Assembly, through the Executive Board at its 148th session, as well as an interim report to the Executive Board at its 146th session.

Seventh plenary meeting, 28 May 2019
A72/VR/13

\(^{1}\) Document A72/32.
WHO reform: amendments to the Rules of Procedure of the World Health Assembly

The Seventy-second World Health Assembly, having considered the report by the Director-General on WHO reform,¹ decided:

(1) to amend its Rules of Procedure in line with the examples set out in the Annex to document A72/50 in order to replace or supplement gender-specific language so as to indicate both feminine and masculine forms in the English language only and to follow United Nations’ practice for the other five official and working languages of WHO’s governing bodies, in accordance with Rule 119 of the Rules of Procedure of the World Health Assembly;

(2) that the amendments shall come into effect at the moment when the Director-General renumbers the Rules of Procedure of the World Health Assembly in accordance with decision WHA72(23) (2019).

Seventh plenary meeting, 28 May 2019
A72/VR/7

¹ Document A72/50.
WHO reform: amendments to the Rules of Procedure of the World Health Assembly

The Seventy-second World Health Assembly, having considered the report by the Director-General on the report of the Executive Board Chairperson on the outcome of the informal consultation on governance reform,1 decided:

(1) to amend Rules 5, 11, and 12 of the Rules of Procedure of the World Health Assembly as set out in the Annex to document A72/51, in accordance with Rule 119 of the Rules of Procedure of the World Health Assembly, with effect from the closure of its Seventy-second session; and to recommend that the explanatory memorandum referred to in the third paragraph of Rule 5 of the Rules of Procedure of the World Health Assembly, as amended, be limited to 500 words;

(2) to amend Rule 48 of the Rules of Procedure of the World Health Assembly as set out in the Annex to document A72/51, in accordance with Rule 119 of the Rules of Procedure of the World Health Assembly, with effect from the closure of its Seventy-second session;

(3) to amend the definitions at the beginning of the Rules of Procedure of the World Health Assembly, Rules 3, 14, 19, 22, the heading between Rule 43 and Rule 44, and Rule 47 of the Rules of Procedure of the World Health Assembly as set out in the Annex to document A72/51, in accordance with Rule 119 of the Rules of Procedure of the World Health Assembly, with effect from the closure of its Seventy-second session;

(4) that resolutions and decisions should provide for clear reporting requirements, including reporting cycles of up to six years, with biennial reports, unless otherwise advised by the Director-General.

Seventh plenary meeting, 28 May 2019
A72/VR/7

1 Document A72/51.
WHO reform: amendments to the Rules of Procedure of the World Health Assembly

The Seventy-second World Health Assembly, having considered the report by the Director-General on WHO reform: governance,¹ decided:

(1) to adopt the amendments to the Rules of Procedure of the World Health Assembly, as set out in the Annex to document A72/52, in accordance with Rule 119 of the Rules of Procedure of the World Health Assembly, with effect from the closure of that session of the Health Assembly;

(2) to request the Director-General to renumber the Rules of Procedure of the World Health Assembly, at an appropriate time, taking into account the amendments adopted through this decision.

Seventh plenary meeting, 28 May 2019
A72/VR/7

¹ Document A72/52.
WHO governance reform processes

Involvement of non-State actors

Report by the Director-General

1. In January 2019, the Board in its decision EB144(3) on WHO reform processes, including the transformation agenda, and the implementation of United Nations development system reform requested the Director-General “to elaborate a report and make recommendations to be submitted to the 145th session of the Executive Board about an informal meeting or forum to bring together Member States and non-State actors in official relations”. The discussion of the report of the Executive Board Chairperson on the outcome of the informal consultation on governance reform identified several aspects of the involvement of non-State actors in WHO’s governance that have to be considered together. This report responds to the Board’s request.

2. The participation of non-State actors in WHO’s governing bodies without the right to vote is foreseen by the Constitution of the World Health Organization (Article 18(h)) and has been the case since the International Health Conference at which the Constitution was drafted and adopted. The constitutional mandate had first been implemented through the Principles governing Relations between the World Health Organization and Nongovernmental Organizations. Following their

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1 Document EB144/34.

2 See the summary records of the Executive Board at its 144th session, second meeting, section 4.

replacement in 2016 by the Framework of Engagement with Non-State Actors, the relevant normative framework is now provided by that instrument and the rules of procedure of both the World Health Assembly and the Executive Board.

3. In order to achieve its objectives and advance its work, WHO needs to engage with non-State actors. They need to be able to voice their contributions for consideration by Member States through their involvement without the right to vote in sessions of WHO’s governing bodies. As described in the Thirteenth General Programme of Work, 2019–2023 (paragraph 78), “WHO is and will remain a Member State organization; however, current conceptions of global governance also include a range of non-State actors.” The modalities of the involvement of non-State actors have indeed evolved since the inception of the Organization. Participation in governing bodies is regulated through Official relations, which “is a privilege that the Executive Board may grant to nongovernmental organizations, international business associations and philanthropic foundations that have had and continue to have a sustained and systematic engagement in the interest of the Organization.”

4. The practice of non-State actors in official relations addressing WHO’s governing bodies at the end of a debate has served the Organization well during several decades. However, the increased interest reflected by the greater numbers of non-State actors participating and requests for interventions has not led to a more meaningful involvement. When a large number of non-State actors intervene in sequence

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1 Adopted by the Health Assembly in resolution WHA69.10. Paragraphs of the framework dealing with participation include the following:

15(a) Meetings of the governing bodies. This type of interaction involves sessions of the World Health Assembly, the Executive Board and the six regional committees. Non-State actors’ participation is determined by the governing bodies’ respective rules of procedure, policies and practices as well as the section of this framework that deals with official relations.

55. Entities in official relations are invited to participate in sessions of WHO’s governing bodies. This privilege shall include:

(a) the possibility to appoint a representative to participate, without right of vote, in meetings of WHO’s governing bodies or in meetings of the committees and conferences convened under its authority;
(b) the possibility to make a statement if the Chairman of the meeting (i) invites them to do so or (ii) accedes to their request when an item in which the related entity is particularly interested is being discussed;
(c) the possibility to submit the statement referred to in subparagraph (b) above in advance of the debate for the Secretariat to post on a dedicated website.

56. Non-State actors participating in WHO governing bodies’ meetings shall designate a head of their delegation and declare the affiliations of their delegates. This declaration shall include the function of each delegate within the non-State actor itself and, where applicable, the function of that delegate within any affiliated organization.

57. Regional committees may also decide on a procedure granting accreditation to their meetings to other international, regional, and national non-State actors not in official relations with WHO as long as the procedure is managed in accordance with this framework.

2 The proposed amended text of Rule 47 of the Rules of Procedure of the World Health Assembly (see document A72/52) reads: “Representatives of non-State actors, international business associations and philanthropic foundations in official relations, may be invited to attend plenary meetings and meetings of the main committees of the Health Assembly and to participate without vote therein in accordance with the Framework of Engagement with Non-State Actors, when invited to do so by the President of the Health Assembly or by the chairman of a main committee, respectively.”

Rule 4 of the Rules of Procedure of the Executive Board reads. “Subject to the terms of any relevant agreement, representatives of the United Nations and of other intergovernmental organizations with which the Organization has established effective relations under Article 70 of the Constitution may participate without vote in the deliberations of meetings of the Board and its committees. Such representatives may also attend and participate without vote in the deliberations of the meetings of subcommittees or other subdivisions if so invited.

Representatives of nongovernmental organizations, international business associations and philanthropic foundations in official relations with the Organization may participate in the deliberations of the Board as is provided for in the Framework of Engagement with Non-State Actors.”

at the end of a debate after representatives of Member States have taken the floor, their interventions no longer have any impact on the outcome of the debate. Dissatisfaction with the current system has been expressed by Member States and echoed for different reasons in communications from non-State actors.

5. In 2002, there were 189 nongovernmental organizations in official relations. This number increased to 214 non-State actors in official relations in 2018. From 1998 to 2002, on average 16 entities made a statement at the Health Assembly and 11 at the Executive Board. Over the years, more non-State actors have made interventions and some non-State actors have intervened on more different topics. In 2018, non-State actors made a total of 236 statements at the Seventy-first World Health Assembly, with some entities intervening on 15 different agenda items; some agenda items attracted up to 36 statements from non-State actors.

6. With regard to participation in sessions of the governing bodies, records showed that 444 delegates representing 88 nongovernmental organizations in official relations attended the Fifty-fifth World Health Assembly (2002) whereas 1500 delegates representing 127 non-State actors in official relations attended the Seventy-first World Health Assembly (2018).

7. In addition to those organized by Member States, official side events may also be organized during the Health Assembly by non-State actors in official relations. Thus, in 2018 the Secretariat confirmed eight official side events from the 20 applications received from non-State actors in official relations.

8. Since 2016, and before the entry into force of the Framework of Engagement with Non-State Actors, entities in official relations have had the possibility to submit their statements in advance for online posting on a dedicated website. This action was intended to allow Member States to review these inputs while crafting their own statements, but it is much perceived by some non-State actors in official relations as an additional constraint although others seize this opportunity to advocate their activities. For non-State actors that have published their statements in advance it can be even more frustrating if their speaking time is shortened at short notice to sometimes only one minute.

9. Regional committees have also increased the involvement of non-State actors in official relations in accordance with their respective rules of procedures, as have regional offices for the meetings they convene. All regional offices invite non-State actors to participate in the sessions of the regional committees and in other events and provide opportunities to speak. The Regional Office for the Americas has adjusted its official relations process after the adoption of the Framework of Engagement with Non-State Actors by PAHO’s 55th Directing Council\(^1\) and non-State actors continue to be admitted into official relations with PAHO. The Regional Office for Europe has introduced an accreditation system as foreseen by paragraph 57 of the Framework and actively works with non-State actors, posting written and recorded oral statements on the regional committee’s website in addition to the statements delivered during sessions of the regional committee. The Regional Office for Africa organized its second WHO Africa Health Forum (held in Praia, 26–28 March 2019)\(^2\) to promote partnerships and provide an opportunity for dialogue on the further development and adoption of joint innovation strategies for addressing the goal of achieving universal health coverage in Africa. The regional offices for Europe and the Western Pacific each offer an informal briefing to non-State actors on items on the respective regional committee’s provisional agenda before sessions.

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\(^1\) Resolution CD55.R3 (2016).

IN Volvement of non-state actors in the governance of other organizations in the united nations system and intergovernmental organizations

10. The United Nations uses a different model from WHO with a simple accreditation not based on concrete engagements. Currently, 5,161 nongovernmental organizations enjoy active consultative status with the United Nations Economic and Social Council, which allows them access to the Council, its many subsidiary bodies, major conferences, mechanisms and other events.¹

11. The World Trade Organization organizes an annual Public Forum.² This three-day event, with a different theme each year, brings together 2000–3000 participants from Member States and non-State actors; for 2019, it has been extended to a four-day event. The Public Forum is served by a secretariat within the World Trade Organization and draws on resources from across the Organization.

12. The Food and Agriculture Organization of the United Nations has 110–115 international nongovernmental organizations with consultative status granted by the Organization’s Conference and others with specialized consultative status or liaison status granted by the Director-General. International nongovernmental organizations are briefed by the Secretariat before the annual Conference and nominate between three and five representatives for the main conferences and meetings.

13. The Committee on World Food Security has set up a separate mechanism: civil society has organized itself into 11 constituencies and the chair of the Committee’s meetings allocates three to four speaking slots to civil society during the debates of Member States. Civil society is also involved in the Food and Agriculture Organization’s regional consultations and organizes itself in a civil society mechanism which has to raise its own resources.

WHO’S PREVIOUS MECHANISMS AND PROPOSALS

14. Between 2000 and 2003, the Secretariat organized Meetings of Interested Parties³ in the last quarter of each year for one week around WHO’s programme of work. Attendance at the last such meeting, in 2003, included 56 nongovernmental organizations in official relations and other parties not in official relations.⁴ The proposal for a civil society mechanism was abandoned in 2003.

15. In the context of the previous WHO reform programme the creation of a world health forum was proposed in 2011.⁵ Its intended purpose was “to explore, in an informal and multistakeholder setting, ways in which the major actors in global health can work more effectively together – globally and at country level – to increase effectiveness, coherence and accountability and to reduce fragmentation and duplication of effort”. The proposal did not find sufficient support and was not pursued at that time.

WHO’S CURRENT REFORM

16. So far, the deliberations on WHO’s current reforms have shown that the involvement of non-State actors in the governance of WHO can be improved only with a package of measures and combined with an overall strengthening of WHO’s engagement with non-State actors in line with the Thirteenth General Programme of Work and in accordance with the Framework of Engagement with Non-State Actors. Improving the engagement of non-State actors in WHO’s governance should respect the following objectives:

(a) respect the intergovernmental nature of WHO;

(b) become more meaningful;

(c) increase the efficiency and effectiveness of interactions;

(d) respect the diversity of non-State actors.

17. The imposition of limits on the number of delegates in the delegation of a non-State actor in official relations or on the number of interventions by non-State actors, or both, might be balanced by measures that would make their participation more meaningful. One possibility is for non-State actors to provide consolidated input at the opening of discussion on agenda items or during the debate, as practiced by the Food and Agriculture Organization which places a limit on the number of constituency statements.

18. Among the three groups of non-State actors eligible for official relations, international business associations and philanthropic foundations could be asked to form one constituency each. The diversity of nongovernmental organizations would justify up to three further constituencies on either a permanent or a case-by-case basis. Individual non-State actors in official relations could still post their statements on a dedicated website two weeks before the session of the Executive Board in January and the Health Assembly in May. They could then meet prior to the governing bodies, for instance in parallel to the meetings of the Programme, Budget and Administration Committee of the Executive Board around those two governing body events to decide on which agenda items they wanted to deliver constituency statements at the beginning or during the debate.

19. As Member States shape their positions before governing body sessions, a more structured interaction between Member States and non-State actors before those sessions could add value to the discussions and improve the involvement of non-State actors in the work of the governing bodies and thus WHO’s governance.

20. A world health forum could be organized along similar lines to the World Trade Organization’s Public Forum. Such a world health forum could be an annual stand-alone event in November each year, as with the Meetings of Interested Parties. It could be organized in January before the session of the Executive Board to allow for broader participation at lower cost. Alternatively, it could be held every second year with the recently-inaugurated WHO Partners’ Forum1 or in the alternate years, or it could become a larger event hosted by a Member State every four to five years.

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21. These proposed changes should not be introduced in isolation but combined with measures by Member States and the Secretariat to enhance the engagement of non-State actors. More Member States could follow the example of those that hold consultations with non-State actors before sessions of the Executive Board and the Health Assembly at national level and/or include civil society and youth representatives in their delegations. The Secretariat will also strengthen its engagement with non-State actors through an engagement strategy based on the Thirteenth General Programme of Work through a unit explicitly responsible for the coordination and promotion of that engagement. Conferences organized by WHO will continue to strongly involve non-State actors. The Secretariat could also improve the flow of information towards non-State actors in official relations by measures such as the webcasting of the information sessions it organizes for missions based in Geneva.

**ACTION BY THE EXECUTIVE BOARD**

22. The Board is invited to note this report and provide guidance on whether the Secretariat should refine these proposals and organize a web consultation with non-State actors before discussion of the issue at the next session of each of the regional committees, with a view to elaborating a proposal for consideration by the Board at its 146th session.
Digital health

The Seventy-first World Health Assembly,

Having considered the report on mHealth;

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, WHO and partner organizations;

Acknowledging previous experience 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

(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;

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
A71/VR/7
Global strategy and action plan on ageing and health 2016–2020: towards a world in which everyone can live a long and healthy life

The Sixty-ninth World Health Assembly,

Having considered the report on multisectoral action for a life course approach to healthy ageing: draft global strategy and plan of action on ageing and health;

Recalling resolution WHA52.7 (1999) on active ageing and resolution WHA58.16 (2005) on strengthening active and healthy ageing, both of which encouraged Member States to take measures that ensure the highest attainable standard of health and well-being for the rapidly growing numbers of older persons;

Recalling further United Nations General Assembly resolution 57/167 (2002), which endorsed the Madrid International Plan of Action on Ageing, 2002, as well as other relevant resolutions and other international commitments related to ageing;

Recalling resolution WHA65.3 (2012) on strengthening noncommunicable disease policies to promote active ageing, which notes that as noncommunicable diseases become more prevalent among older persons there is an urgent need to prevent disabilities related to such diseases and to plan for long-term care;

Recalling also resolution WHA67.19 (2014) on strengthening of palliative care as a component of comprehensive care throughout the life course;

Recalling further resolution WHA64.9 (2011) on sustainable health financing structures and universal coverage, which calls for investing in and strengthening health systems, in particular primary health care and services, including preventive services, adequate human resources for health and health information systems, in order to ensure that all citizens have equitable access to health care and services;

Welcoming the 2030 Agenda for Sustainable Development, which includes an integrated, indivisible set of global goals for sustainable development that offer the platform to deal with the challenges and opportunities of population ageing and its consequences in a comprehensive manner, pledging that no one will be left behind;

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1 Document A69/17
Noting that populations around the world, at all income levels, are rapidly ageing; yet, that the extent of the opportunities that arise from older populations, their increasing longevity and active ageing will be heavily dependent on good health;

Noting also that healthy ageing is significantly influenced by social determinants of health, with people from socioeconomically disadvantaged groups experiencing markedly poorer health in older age and shorter life expectancy;

Further noting the importance of healthy, accessible and supportive environments, which can enable people to age in a place that is right for them and to do the things they value;

Recognizing that older populations make diverse and valuable contributions to society and should experience equal rights and opportunities, and live free from age-based discrimination;

Welcoming WHO’s first Ministerial Conference on Global Action Against Dementia (Geneva, 16 and 17 March 2015), taking note of its outcome, and welcoming with appreciation all other international and regional initiatives aimed at ensuring healthy life for older persons;

Welcoming also the World report on ageing and health,³ that articulates a new paradigm of Healthy Ageing and outlines a public health framework for action to foster it;

Recognizing the concept of Healthy Ageing, defined as the process of developing and maintaining the functional ability⁴ that enables well-being in older age;

Having considered the draft global strategy and action plan on ageing and health in response to decision WHA67(13) (2014), which builds on and extends WHO’s regional strategies⁵ and frameworks in this area,

1. ADOPTS the Global strategy and action plan on ageing and health;⁶

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⁴ This functional ability is determined by the intrinsic capacity of individuals, the environments they inhabit and the interaction between them. Moreover, Healthy Ageing is a process that spans the entire life course and that can be relevant to everyone, not just those who are currently free of disease.
2. CALLS ON partners, including international, intergovernmental and nongovernmental organizations, as well as self-help and other relevant organizations:

(1) to support and contribute to the accomplishment of the Global strategy and action plan on ageing and health and in doing so, to work jointly with Member States and with the WHO Secretariat, where appropriate;

(2) to improve and support the well-being of older persons and their caregivers through adequate and equitable provision of services and assistance;

(3) to support research and innovation and gather evidence on what can be done to foster healthy ageing in diverse contexts, including increased awareness of the social determinants of health and their impact on ageing;

(4) to support the exchange of knowledge and innovative experiences, including through North–South, South–South and triangular cooperation, and regional and global networks;

(5) to actively work on advocacy for healthy ageing over the life course and combat age-based discrimination;

3. URGES Member States:

(1) to implement the proposed actions in the Global strategy and action plan on ageing and health through a multisectoral approach, including establishing national plans or mainstreaming those actions across government sectors, adapted to national priorities and specific contexts;

(2) to establish a focal point and area of work on ageing and health, and to strengthen the capacity of relevant government sectors to deal with the healthy ageing dimension in their activities through leadership, partnerships, advocacy and coordination;

(3) to support and contribute to the exchange between Member States at global and regional levels of lessons learned and innovative experiences, including actions to improve measurement, monitoring and research of healthy ageing at all levels;

(4) to contribute to the development of age-friendly environments, raising awareness about the autonomy and engagement of older people through a multisectoral approach;

4. REQUESTS the Director-General:

(1) to provide technical support to Member States to establish national plans for healthy ageing, to develop health and long-term care systems that can deliver good-quality integrated care; to implement evidence-based interventions that deal with key determinants of healthy ageing; and to strengthen systems to collect, analyse, use and interpret data on healthy ageing over time;
(2) to implement the proposed actions for the Secretariat in the Global strategy and action plan on ageing and health in collaboration with other bodies of the United Nations system;

(3) to leverage the experience and lessons learned from the implementation of the Global strategy and action plan on ageing and health in order to better develop a proposal for a Decade of Healthy Ageing 2020–2030 with Member States and with inputs from partners, including United Nations agencies, other international organizations, and nongovernmental organizations;

(4) to prepare a global status report on healthy ageing for submission to the Seventy-third World Health Assembly, reflecting agreed standards and metrics and new evidence on what can be done in each strategic theme, to inform and provide baseline data for a Decade of Healthy Ageing 2020–2030;

(5) to convene a forum to raise awareness of Healthy Ageing and strengthen international cooperation on actions outlined in the Global strategy and action plan on ageing and health;

(6) to develop, in cooperation with other partners, a global campaign to combat ageism in order to add value to local initiatives, achieve the ultimate goal of enhancing the day-to-day experience of older people and optimize policy responses;

(7) to continue to develop the WHO Global Network of Age-friendly Cities and Communities as a mechanism to support local multisectoral action on healthy ageing;

(8) to support research and innovation to foster healthy ageing, including developing: (i) evidence-based tools to assess and support clinical, community, and population-based efforts to enhance intrinsic capacity and functional ability; and (ii) cost-effective interventions to enhance functional ability of people with impaired intrinsic capacity;

(9) to report on mid-term progress on implementation of the Global strategy and action plan on ageing and health, reflecting agreed quantifiable indicators, standards and metrics, and new evidence on what can be done in each strategic objective, to the Seventy-first World Health Assembly.

Eighth plenary meeting, 28 May 2016
Committee A, third report