The attached working paper highlights, from the perspective of the WHO South-East Asia Region, the most important and relevant resolutions endorsed by the Sixty-ninth World Health Assembly (held on 23–28 May 2016) and the 138th and 139th sessions of the Executive Board (held on 25–30 January 2016 and 30–31 May 2016, respectively). These resolutions are deemed to have important implications for the South-East Asia Region and merit follow-up action by both Member States as well as WHO at the regional and country levels.

The background of the selected resolutions, their implications on collaborative activities with Member States, as applicable, along with actions proposed for Member States and WHO have been summarized. All the resolutions of the Sixty-ninth World Health Assembly and the Regional One Voice (ROV) on Agenda items presented at the Health Assembly and 138th and 139th sessions of the WHO Executive Board are provided in the annex to this Working Paper.

The High-Level Preparatory Meeting held in New Delhi from 11–14 July 2016 reviewed the attached working paper and made the following recommendations:

**Action by Member States**

(1) Take necessary and appropriate follow-up action as requested by the Sixty-ninth World Health Assembly through its resolutions in the national context.

**Action by WHO**

(1) Take appropriate follow-up action at the regional and country levels and support Member States on the implementation of the specific issues as may be required.

This Working Paper and the HLP Meeting recommendations are submitted to the Sixty-ninth Session of the WHO Regional Committee for South-East Asia for its consideration and decision.
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Resolutions of the Sixty-ninth World Health Assembly and the Regional One Voice (ROV) on Agenda items presented at the Sixty-ninth Session of World Health Assembly and 138th and 139th sessions of the WHO Executive Board.
Introduction

1. The Sixty-ninth World Health Assembly and the 138th and 139th sessions of the WHO Executive Board endorsed a number of resolutions and decisions during the course of their deliberations. These decisions and resolutions relate to health matters as well as Programme Budget and financial matters.

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

3. Also annexed to this paper are copies of all the resolutions of the Sixty-ninth World Health Assembly (which also cover the subjects of technical resolutions adopted by the 138th and 139th sessions of the Executive Board) along with the text of the “Regional One Voice” presented in the World Health Assembly by the Member States of the South-East Asia Region on select Agenda items.
1. The Global Strategy and Action Plan on Ageing and Health 2016–2020: Towards a world in which everyone can live a long and healthy life (WHA69.3)

Background

4. In May 2014, the Sixty-seventh World Health Assembly requested the Director-General to develop, in consultation with Member States and other stakeholders, a comprehensive global strategy and plan of action on ageing and health.

5. WHO’s *World report on ageing and health* that articulates a new paradigm of healthy ageing and outlines a public health framework for action to foster it was published in 2015. At the Sixty-ninth World Health Assembly in 2016, the *global strategy and action plan on ageing and health 2016-2020: towards a world in which everyone can live a long and healthy life* was adopted.

6. The strategy renews the commitment to focus attention on the needs and rights of older persons and expands on previous policy instruments, setting this commitment within the new context of the Sustainable Development Goals. Some of the key actions outlined in the global strategy and action plan are (i) to create age-friendly environments; (ii) to align health systems to older persons’ needs; (iii) to develop long-term care systems; and (iv) to advance measuring, monitoring and research for healthy ageing.

Actions already taken by the SEA Region

7. In 2012, the Health Ministers of South-East Asia adopted the Yogyakarta Declaration on healthy ageing. The declaration called upon Member States to develop their national policy and action plan on healthy ageing. Based on that declaration and commitment, the *Regional strategy on healthy ageing 2013-2018* was developed.

8. A Regional meeting on older women: policy, service and legal support, was conducted in 2014.

9. A draft document on geriatric care for physicians at primary care level and a draft document on long-term care and palliative care are under preparation. Both documents are planned to be published in 2016.

Actions to be taken by the SEA Region

10. Some Member States are moving rapidly to put ageing at the centre of health development; the global strategy and action plan provides the opportunity for all Member States to develop concrete actions plans to address the health needs of the elderly.

11. Actions towards healthy ageing need multisectoral engagement and the perfect opportunity to do this is to integrate healthy ageing action plans in the overall national action plans towards the attainment of Sustainable Development Goals.
12. A mid-term progress report on the implementation of the global strategy and action plan on healthy ageing is expected to be submitted to the Seventy-first World Health Assembly. A global status report on healthy ageing is expected to be submitted to the Seventy-third World Health Assembly, and a Decade of Healthy Ageing, 2020-2030 launched thereafter. All Member States would be expected to provide important inputs to the above, and WHO will provide the technical support needed by Member States in translating the global strategy and action plan on healthy ageing into national action plans.

2. The role of the health sector in the Strategic Approach to International Chemicals Management towards the 2020 goal and beyond (WHA69.4)

Background

13. About 25% of the global burden of disease can be attributed to the environment, with exposure to chemicals contributing to a significant part of this burden. Increasing production and use of chemicals in Member States of the SEA Region, including highly hazardous pesticides and other chemicals of high public health concern, is particularly an issue of concern given the lack of necessary regulatory and policy frameworks and gaps in institutional capacities in many countries. The Sixty-ninth World Health Assembly considered the role of the health sector towards achieving the 2020 Strategic Approach to International Chemicals Management (SAICM) goal and beyond, including the emphasis given to the health impacts of chemicals in the Sustainable Development Goals 3, 6 and 12.

Main operative paragraph and implication on collaborative actions with Member States

14. The main operative paragraphs of the resolution concern strengthening the role of the health sector in Member States to prevent and manage the adverse impacts of chemicals on health, to take account of health sector priorities for sound management of chemicals, and to engage in multisectoral processes at the national, regional and international levels. Particular emphasis is given to engagement in SAICM, and its intersessional processes in the coming four-year period. Key actions for the secretariat include the development, in consultation with Member States, of a roadmap outlining concrete actions to enhance health sector engagement towards meeting the SAICM 2020 goal, and contributing towards relevant targets of the 2030 Agenda for Sustainable Development, particularly goals 3, 6 and 12, and the development of a report on the impacts of waste on health pursuant to resolution WHA63.25 on improvement of health through safe and environmentally sound waste management. The roadmap is required to be considered by the 140th session of the Executive Board in January 2017.

Actions already taken by the SEA Region

15. Several countries of the SEA Region have started to identify their health sector priorities to help attain the 2020 sound chemicals management goal envisaged by the SAICM. These include building capabilities of countries to deal with poisonings and chemical incidents and formulating strategies to prevent ill-health and disease, both critical to the implementation of the International Health Regulations (2005) and tackling the growing burden of noncommunicable diseases (NCDs).
Actions to be taken by the SEA Region

16. Member States are asked to consider the best way of providing inputs to the development of the roadmap. During the discussion on this at the Health Assembly, Canada, on behalf of Member States of the Region of the Americas, requested all six regions to consider placing the item on their respective Regional Committee agendas. In addition, it is understood that an electronic consultation with Member States will be held before the end of 2016.

3. Prevention and control of noncommunicable diseases: Response to specific assignments in preparation for the third High-Level Meeting of the United Nations General Assembly on the Prevention and Control of Noncommunicable diseases in 2018 (WHA69.6)

Background

17. The Secretariat reported to the Board on the status of responses to specific assignments given by the World Health Assembly and the United Nations General Assembly in preparation for the third High-Level Meeting of the United Nations General Assembly on the Prevention and Control of Noncommunicable Diseases, which is scheduled to be held in 2018. Among other things, the report focuses on the progress made between 2013 and 2015 in implementing the WHO Global Action Plan for the Prevention and Control of Noncommunicable diseases 2013–2020.

18. The World Health Assembly discussed the draft resolution, as adopted by the 138th Session of the Executive Board. The resolution is procedural in nature, with not much policy action content, and consisting of nine items. The most important part is on the process to update Appendix 3 of the Global Action Plan on NCD Prevention and Control. Monaco proposed two small amendments to the draft resolution on promoting the use of recommendations from the working groups of the Global Coordinating Mechanism (GCM/NCD). In addition, many Member States, including Botswana, Sri Lanka and Thailand, referred to the need for an international alcohol control tool.

Main operative paragraph and implication on collaborative actions with Member States

19. The resolution set up two important processes with timelines with which Member States of the South-East Asia Region should be engaged:

   i) To update Appendix 3 of the Global Action Plan on NCD Prevention and Control, to be submitted to the Seventieth World Health Assembly.

   ii) To develop a mechanism to register the contribution of Non-State Actors (NSA) and report the same to the Seventieth World Health Assembly.

Actions already taken by the SEA Region

i) Supported the engagement of experts from the SEA Region to participate in the process to update Appendix 3 of the Global Action Plan on NCD Prevention and Control.
ii) Compiled information on implementing Global Action Plan on NCD Prevention and Control, and contributed in the development of “Noncommunicable diseases progress monitor 2015”.

**Actions to be taken by the SEA Region**

i) Prepare for Member States of the Region and the Regional Office for South-East Asia to participate in the process to update Appendix 3 which requires guidance from SEARO Senior Management.

ii) Study the linkages between the Framework of engagement with non-State actors (FENSA) resolution (also passed by the Sixty-ninth World Health Assembly) on the approach to register contributions of NSA on the prevention and control of NCDs to be developed and reported to Seventieth World Health Assembly.

iii) Review and promote the use of the recommendations of the Global Coordination Mechanism on NCD Prevention and Control (GCM/NCD) working groups.

iv) Facilitate further discussion among Member States on the concept and necessity of the proposed Framework Convention on Alcohol Control.


**Background**

20. The resolution was adopted by the Sixty-ninth World Health Assembly in response to the recent United Nations General Assembly resolution proclaiming the UN Decade of Action on Nutrition 2016–2025 (A/70/L.42), and calls on the Food and Agriculture Organization of the United Nations (FAO) and WHO to lead the implementation of the Decade of Action. The World Health Assembly resolution takes into account the reports on maternal, infant and young child nutrition (MIYCN), the 2nd International Conference of Nutrition (ICN2) and its Framework for Actions (FFA), and the agenda within the Sustainable Development Goals on nutrition that calls for an end to hunger, food insecurity and malnutrition. The resolution aims to trigger intensified action to end hunger and all forms of malnutrition.

**Main operative paragraph and implication on collaborative actions with Member States**

21. By endorsing this recommendation, Member States reaffirmed their obligations to implement relevant international targets and action plans, including WHO’s Comprehensive Implementation Plan on MIYCN and the global nutrition targets for 2025, as well as the Global Action Plan for the Prevention and Control of Noncommunicable Diseases 2013–2020 and targets related to the Sustainable Development Goal 2.

22. Member States need to implement elements of the Framework for Action of the ICN2 which requires governments to address stunting, wasting, and underweight and overweight in children, and micronutrient deficiencies including anaemia in women and children, through a life-course and multisectoral approach. The resolution requests Member States to make significant policy and financial commitments for implementation of policy actions and report...
back on such measures taken. Emphasis is placed on universal access to safe and nutritious food that is sustainably produced, and policy coherence between nutrition, health and agriculture. The resolution calls on WHO and FAO to work in collaboration with other UN agencies and the Committee on World Food Security.

**Actions already taken by the SEA Region**

1. WHO has promoted and supported the development of multisectoral action plans for nutrition that can work collectively across sectors. However, implementation needs to be improved and actions on overweight and obesity need inclusion.
2. The Regional Office collaborated with FAO and ASEAN at a meeting where Member States (Indonesia, Myanmar, Thailand) identified mechanisms for nutrition-friendly agriculture. Sri Lanka and Timor-Leste have held workshops on ICN2 commitments.
3. The Draft Strategic Action Plan to Reduce the Double Burden of Malnutrition in the South-East Asia Region takes into account the requirements of ICN2 and the Decade of Action for Nutrition.

**Actions to be taken by the SEA Region**

1. The Regional Office must disseminate the Strategic Action Plan to Reduce the Double Burden of Malnutrition to give policy guidance for Member States to address all forms of malnutrition.
2. A joint regional meeting of FAO and WHO to promote policy coherence in agriculture and nutrition in furtherance of healthy diets is being planned in November 2016.
3. Member States need to develop national targets based on the global targets which are adapted to the national context. Data collection and a robust and disaggregated monitoring and evaluation mechanism needs to be supported by Member States.

**5. Ending inappropriate promotion of foods for infants and young children (WHA69.9)**

**Background**

23. The International Code on Marketing of Breast-milk Substitutes (also called “the Code” or “the WHO Code”) and relevant World Health Assembly resolutions govern the promotion of breast-milk substitutes (BMS). Other foods and beverages are covered by the Code only if they are marketed as replacements for breast milk. The guidance on inappropriate promotion of foods for infants and young children (hereafter called Guidance) is essential in the light of evidence that promotion of BMS and some commercial complementary foods and beverages for infants and young children undermine optimal infant and young child feeding (IYCF)\(^1\). The Sixty-third World Health Assembly urged Member States to end inappropriate promotion of foods for infants and young children (resolution WHA63.23). A related resolution (WHA65.6) requested WHO to provide detailed guidance on this. The finalized guidance was submitted in the form of

\(^1\) at http://www.hki.org/assessment-research-child-feeding-arch-project#.VyyDTyuUc-I The others are at: http://www.who.int/nutrition/topics/complementary_feeding/en/
a resolution to the Sixty-ninth World Health Assembly in 2016 which was welcomed by Member States.

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

24. The Guidance provides clarification and direction on inappropriate promotion of foods for infants and young children, with the aim of promoting breastfeeding, preventing obesity, curbing noncommunicable diseases, promoting healthy diets and ensuring that caregivers receive accurate information on feeding. The Guidance does not replace provisions in the Code but clarifies the inclusion of specific products that should be covered by the Code. It applies to all commercial products that are marketed as suitable for young children aged 6–36 months (in line with Codex). Follow-on food formulas and growing-up milk and food products aimed at infants and young children including those provided by both government and other supplementary feeding programmes are covered by the Guidance. Fortificants and home supplements are excluded. The resolution reiterates the need to promote and protect breastfeeding, urges Member States to take measures to end inappropriate promotion of substitutes and continue to implement and monitor the Code, and calls on industry to end all forms of inappropriate promotion.

**Actions already taken by the SEA Region**

i) The SEA Region has a 43% rate for six-month exclusive breastfeeding of infants. Legislation on the Code is available in six of 11 Member States, and is in progress in two more. WHO is providing technical support for the process.

ii) Three Member States have legislation in place that covers the age group of 6–24 months, and includes follow-on formulas and other food products. One Member State is attempting to put in place legislation covering the age group 6–36 months.

iii) The Guidance is included in the Draft Action Plan to Reduce the Double Burden of Malnutrition in the South-East Asia Region which is currently being finalized.

**Actions to be taken by the SEA Region**

i) Support Member States in implementing the Code, and extending its scope to include recommendations in the Guidance, as well as implement robust monitoring and evaluation processes.

ii) Promote and support implementation of WHO’s Recommendations on the Marketing of Food and Non-Alcoholic Beverages to children as requested in the Guidance.

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2 Codex guidelines on formulated complementary foods for older infants and young children (CAC/GL-8-1991, revised in 2013)
6. Framework of engagement with non-State actors (WHA69.10)

Background

25. As part of WHO’s Governance Reform, the Sixty-eighth World Health Assembly wished to finalize the draft Framework of engagement with non-State actors (FENSA) and requested the Director-General to convene an intergovernmental meeting as soon as possible and submit the finalized Framework to the Sixty-ninth World Health Assembly through the Executive Board for adoption. On the basis of the inputs received from discussions at the meetings of Governing Bodies and the Open-ended Intergovernmental Meetings held in 2015 and 2016, the revised Framework and draft resolution were submitted as Agenda item 11.3 to the Sixty-ninth World Health Assembly.

26. A drafting committee was constituted by Committee A as soon as the Agenda item was taken up for finalizing the overarching Framework as well as four specific policies on engagement with nongovernmental organizations, private sector entities, philanthropic foundations and academic institutions. After detailed discussions and negotiations, the overarching Framework and its four sub-policies as well as the resolution WHA69.10 were unanimously approved and adopted by the Sixty-ninth World Health Assembly in May 2016.

Main operative paragraph and implications on collaborative actions with Member States

27. The implementation of FENSA with immediate effect underscoring the full political commitment of all Member States towards the consistent and coherent implementation of the Framework across the three levels of the Organization.

28. FENSA shall replace the principles governing relations between WHO and NGOs and the guidelines on interaction with commercial enterprises to achieve health outcomes.

29. The report on the implementation of FENSA must be placed before the Executive Board at each of its January sessions under a standing Agenda item, through the Programme Budget and Administration Committee (PBAC), and to include in the report, when deemed necessary, any matter or types of engagement that would benefit from further consideration by the Executive Board through its PBAC, due to their unique characteristics and relevance.

30. Initial evaluation in 2019 of the implementation of FENSA and its impact on the work of WHO with a view to submitting the results, together with any proposals for revisions of the Framework, to the Executive Board in January 2020 through the PBAC;

31. The development, in consultation with Member States, of a set of criteria and principles for secondments from nongovernmental organizations, philanthropic foundations and academic institutions and to submit the criteria and principles for the consideration of and establishment by, as appropriate, the Seventieth World Health Assembly through the Executive Board.

Actions already taken by the SEA Region

i) Member States of the Region have actively provided inputs and suggestions at various forums such as Governing Body meetings, Open-ended Intergovernmental meetings,
informal consultations and written submissions to the Secretariat and actively contributed to finalizing the Framework/Resolution.

ii) The Resource Mobilization and Management System (RMMS), developed in the Region to capture resource projections and facilitate electronic approvals of draft agreements, will be integrated with the Global Engagement Management (GEM) along with the register of non-State Actors being developed by the Regional Office for the Western Pacific.

iii) The ongoing IT development project on GEM will allow WHO to better document, manage and report on different engagements, including coordinated resource mobilization. The Engagement Coordination Group (ECG) with regional and cluster involvement would be established to replace the Committee on Private Sector Collaboration (CPSC) as the “dedicated Secretariat mechanism” mandated by FENSA. In order to ensure coherent and consistent implementation of the Framework across all three levels of the Organization, the following activities are scheduled: development of the Guide for staff and Handbook for non-State actors; establishment of internal and external communication plan; roll out of FENSA procedures in GEM and conduct of training for selected staff at the three levels of the Organization.

iv) Being the developer of RMMS, the Regional Office for South-East Asia will be leading the integration of RMMS with GEM and has conducted consultations with the Western Pacific, African, European and Eastern Mediterranean regions and also with the Health Systems and Innovation (HIS) Cluster, Outbreaks and Humanitarian Emergencies (OHE) Clusters and Family, Women’s and Children’s Health (FWC) clusters in WHO headquarters. The Regional Office is working on “Business Process Mapping” which will lead to the development of the Business Requirements Document & further development of the solution.

**Actions to be taken by the SEA Region**

i) Now that the overarching Framework is approved, implementation may initially result in increased transaction costs in terms of manpower, time, effort and resources while at the same time could generate potential long-term benefits in terms of coherent, consistent and systematic work leading to better mapping of resources and partnerships. The adoption of FENSA would require the following actions in the Region:

ii) Briefing for all staff on FENSA and training for staff directly involved in its implementation.

iii) Identification of resources to meet the cost implications of implementing FENSA.

iv) Mechanisms to disseminate information and provide dedicated support to Budget Centres, country offices and Member States for FENSA implementation/evaluation and reporting on a regular basis as per the timelines agreed upon by the Member States.
v) Monitoring and evaluation mechanisms to generate feedback and proposed modifications, if any, related to due diligence, risk assessment/management, emergency response and the sub-policies related to such engagement.

7. Health in the 2030 Agenda for Sustainable Development (WHA69.11)

Background

32. The 2030 Agenda for Sustainable Development emphasizes the need for a more integrated and intersectoral approach to development, with a focus on the poor and most vulnerable. The health goal in the Sustainable Development Goals (SDG3) is to “Ensure healthy lives and promote well-being for all at all ages”. The links between health and other Sustainable Development Goals are emphasized. The 2030 Agenda and the World Health Assembly resolution WHA69.11 both emphasize that to achieve the overall health goal “we must achieve universal health coverage and access to quality health care”. SDG3 targets cover the unfinished MDG agenda; noncommunicable diseases; determinants of health and means of implementation through stronger health systems. Resolution WHA69.11 is broad, reflecting the breadth of the SDG health agenda, but also highlights some key issues such as the health workforce, community engagement, emergency preparedness and resilient health systems, and the importance of innovation in medical products. The focus is now on implementation, i.e. how to accelerate progress in health with a focus on equity and on how to monitor progress.

Main operative paragraph and implications on collaborative actions with Member States

33. The Sustainable Development Goals Agenda has already become a key point of reference in all discussions about health development in Member States of the SEA Region and within WHO, and will be so for the next 15 years.

34. Member States are urged to prioritize health system strengthening, including the health workforce, in order to achieve and sustain UHC; prioritize investments in health; and to support research, including on vaccines and medicines needed by developing countries.

35. The resolution flags the need for stronger dialogue between medical, veterinary and environmental communities with special attention to emerging and re-emerging diseases and antimicrobial resistance.

36. Monitoring – with an emphasis on monitoring equity trends – will receive considerable attention. The health indicators are drawn from existing international agreements. WHO is asked to engage with the UN Inter-agency Expert Group to finalize the health indicators. WHO is also asked to report at least every two years, starting with the Seventieth World Health Assembly, on global and regional progress towards achieving the health goal (SDG 3) as a whole as well as its inter-linked targets.
Actions already taken by the SEA Region

i) A Ministerial Roundtable on the SDGs was organized at the Sixty-eighth session of the Regional Committee in Dili, Timor-Leste, in 2015.

ii) National consultations have been held or are planned in several countries in 2016.

iii) A regional consultation on “Health, the SDGs and the role of UHC: Next steps in the South-East Asia Region” was held in New Delhi, India, in March 2016.

Actions to be taken by the SEA Region

i) Developing or updating comprehensive, integrated national health plans to encompass the SDGs.

ii) Bolstering the national capacity of countries to work with multiple sectors and to monitor progress.

iii) A SEA regional report on the status of the SDG health indicators will be ready for the Sixty-ninth Session of the Regional Committee in Colombo. The Ministerial Roundtable at the session will discuss the SDGs and UHC with a firm focus on implementation.

8. Global health sector strategies on HIV, viral hepatitis and sexually transmitted infections for the period 2016–2021 (WHA69.22)

Background


38. All three strategies:

i) follow a common structure and framework incorporating universal health coverage, continuum of services and public health approach;

ii) are aligned with the 2030 Agenda for Sustainable Development; and

iii) have five strategic directions – information and focused action, interventions for impact, delivery for equity, financing for sustainability and innovation for acceleration.

Goals and targets:

39. HIV

- Goal: To end the AIDS epidemic as a public health threat by 2030 (SDG 3.3 and 3.7).

- Targets for 2020:
- reduction of new infections to less than 500,000; and zero new infections among infants;
- reduce HIV-related deaths to below 500,000; and
- achieve 90% people living with HIV to be tested; 90% treated and 90% virally suppressed.

40. Viral hepatitis

- Goal: To eliminate viral hepatitis as a major public health threat by 2030 (SDG 3.3).
- Targets by 2020:
  - achieve 30% reduction in incidence of new cases of chronic viral hepatitis B and C infections;
  - achieve 10% reduction in mortality due to viral hepatitis B and C;
  - achieve 90% coverage of hepatitis B childhood vaccination (3rd dose);
  - achieve 50% hepatitis B virus birth-dose vaccination coverage or other approach to prevent mother-to-child transmission;
  - ensure 50% injections are administered with safety-engineered devices in and out of health facilities;
  - have 95% of blood donations screened in a quality-assured manner;
  - enable 30% people with hepatitis B and C know their status; and
  - achieve five million people receiving hepatitis B and three million people receiving hepatitis C treatment.

41. Sexually transmitted Infections

- Goal: Ending STI epidemics as major public health concerns (SDG 3.3, 3.7 and 5.6)
- Milestones for 2020:
  - 70% of countries have STI surveillance systems in place;
  - 70% of countries have at least 95% of pregnant women screened for syphilis and 90% tested for HIV and 95% of HIV positive pregnant women receiving effective treatment;
  - 70% of countries providing STI services or links to such services in all primary, HIV, reproductive health, family planning and antenatal and postnatal care services;
  - 70% of countries deliver HPV vaccines through the national immunization programme;
  - 70% of countries report on antimicrobial resistance in N. gonorrhoeae; and
  - 70% of key populations have access to a full range of STI and HIV services, including condoms.

42. Implications on collaborative activities with Member States

- The estimated total global cost for full implementation of:
  - viral hepatitis strategy for the period of 2016–2021 is US$ 11.9 billion.
STI strategy is US$ 18.1 billion.

- Member States have committed to ending HIV and combating hepatitis and STIs as part of the SDG goals.
- This would require continued resource mobilization. As external development aid is shrinking in the Region, more reliance should be placed on sustainability through domestic resource allocations. Therefore, all attempts should be made to ensure that the necessary commitment and resources are available to reach the endgame for HIV, HEP and STIs.
- It is also important to link and integrate the disease responses within the UHC package.

**Actions already taken by the SEA Region**

43. **HIV**

- Review and evaluation of the implementation of the Regional HIV Health Sector Strategy 2011–2015.
- The Regional Strategic Action Plan based on the Global Health Sector Strategy is being finalized.
- The Regional Validation Mechanism for Elimination of Mother-to-Child Transmission of HIV in the Asia-Pacific Region has been set up. Thailand was certified as having eliminated mother-to-child transmission of HIV and syphilis in June 2016.
- The Framework for addressing HIV in the context of universal health coverage has been developed.

44. **Viral hepatitis**

- The Regional Action Plan on Viral Hepatitis based on the Global Health Sector Strategy is being finalized following discussions with Member States at the Regional Workshop for Developing the Regional Action Plan for Hepatitis in the WHO SEA Region in Jakarta, Indonesia, on 26–28 April 2016.
- Efforts on resource mobilization for hepatitis in the Asia-Pacific Region are ongoing in collaboration with the WHO Regional Office for the Western Pacific.

45. **Sexually transmitted infections**

- STI surveillance and its linkage with HIV surveillance has been strengthened.
- Capacity-building of Member States to establish the Gonococcal Antimicrobial Susceptibility Programme is ongoing.

**Actions to be taken by the SEA Region**

46. **HIV**

- Mathematical modelling and projections for fast-tracking the HIV response towards ending AIDS in all Member States.
• Fast-tracking the elimination of mother-to-child transmission (EMTCT) in at least three Member States with the potential of achieving the elimination targets.
• Establishing the regional intelligence platform for monitoring the HIV response across the Region.

47. Viral hepatitis
• Adaptation and adoption of the Regional Action Plan on Viral Hepatitis for developing national action plans in Member States.
• Support to Member States in price negotiations and access to affordable antivirals for hepatitis C and B.
• Mathematical modelling to be in place for setting up priorities within programmes and estimating the cost impact of interventions for disease control.

48. Sexually transmitted infections
• Build capacity of Member States to strengthen the Gonococcal Antimicrobial Susceptibility Programme.
• Strengthen STI prevention and management in Member States in the context of the Regional Action Plan for HIV based on the Global Health Sector Strategies for HIV and STIs.


Background

49. In 2013 the World Health Assembly resolution WHA66.22 endorsed a strategic workplan to improve monitoring and coordination of, and ensure sustainable funding for, health research and development (R&D) for diseases that disproportionately affect developing countries. Recommended actions included: (i) establishing a global health research and development observatory; (ii) facilitating the implementation of a few health R&D demonstration projects; (iii) reviewing existing mechanisms and their suitability to coordinate health R&D; and iv) exploring effective financing mechanisms. An open-ended meeting of the Consultative Expert Working Group on Research and Development (CEWG) was held in May 2016 to review progress with the implementation of the workplan. The report was presented to the Sixty-ninth World Health Assembly, and, following the negotiations of the drafting group, a new resolution WHA69.23 was adopted.

Main operative paragraph and implications on collaborative actions with Member States

50. Resolution WHA69.23 acknowledges the commitment in the 2030 Sustainable Development Goals Agenda to support research and development (R&D) on vaccines and medicines for diseases primarily affecting developing countries.
51. The role of the health R&D Observatory is extended beyond disease of Types I, II and III to include monitoring and analysis of information related to R&D on antimicrobial resistance and emerging infectious diseases that are likely to cause epidemics, as part of efforts to promote research policy coherence.

52. Concern is expressed about the continued significant gap in funding for the workplan, including for the six demonstration projects.

53. Member States are urged to make concerted efforts, including through adequate funding, to implement the workplan agreed upon in resolution WHA66.22. Operationalizing national health R&D observatories is a key element in this workplan.

54. The resolution requests the Director-General to undertake 12 actions, including three submissions to the Seventieth World Health Assembly in 2017: a costed workplan and terms of reference for the global R&D Observatory; ToRs for a WHO Expert Committee on health R&D, plus a proposal for a voluntary pooled fund. WHO has also been asked to include the strategic workplan in WHO health financing dialogues.

**Actions already taken by the SEA Region**

- Member States adopted the Regional Committee resolution SEA/RC65/R3 on the CEWG in 2012.
- One of the demonstration projects is led by the Translational Health Science and Technology Institute, India, and is supported by SEARO.
- The Government of India has contributed US$ 1 million for the development of demonstration projects. India co-chaired the open-ended meeting and the drafting group during the World Health Assembly. The Regional Office is actively supporting global developments in this area as well as in Member States.

**Actions to be taken by the SEA Region**

- Continued engagement of Member States from the Region in the CEWG, building on the “One Voice” statement made at the Sixty-ninth World Health Assembly in 2016.
- Member States will review the progress report on resolution SEA/RC65/R3 at the Sixty-ninth Session of the Regional Committee.
- The Regional Office will continue to support the engagement of Member States from the Region in global negotiations.

**10. Strengthening integrated, people-centred health services (WHA69.24)**

**Background**

55. WHO has developed a strategic framework to deliver integrated people-centred health services. It has five strategic directions: (a) empowering and engaging people; (b) strengthening governance and accountability; (c) reorienting the model of care; (d) coordinating services; and
(e) creating an enabling environment. This strategic framework was adopted through resolution WHA69.24 during the Sixty-ninth World Health Assembly.

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

56. The resolution acknowledges the Sustainable Development Goal 3 (“ensure healthy lives and promote well-being for all at all ages”) including Target 3.8, which deals with achieving universal coverage, including financial risk protection, access to quality and essential health-care services, and access to safe, effective quality and affordable essential medicines and vaccines for all. It urges Member States to implement, as appropriate, the framework on integrated, people-centred health services at the regional and country levels in accordance with the national context and priorities.

**Actions already taken by the SEA Region**

57. The Regional Office has taken several initiatives to strengthen the integrated people-centred service delivery model over the last 2–3 years. Some key regional meetings have been on: strengthening health systems to address co-morbidities (October 2014); strengthening community-based health services (June 2015); and strengthening health systems response to address NCDs in the South-East Asia Region (June 2016).

58. In addition the Regional Committee adopted several key resolutions to support integrated service delivery: patient safety contributing to sustainable universal health coverage; community based health services (CBHS) and their contributions to universal health coverage and the Regional Strategy for Universal Health Coverage are some examples.

**Actions to be taken by the SEA Region**

59. Countries may review this strategic framework and identify areas that need further strengthening and adapt appropriately.


**Background**

60. The Sixty-eighth World Health Assembly in May 2015 endorsed a Global Action Plan (GAP) to tackle antimicrobial resistance (AMR). Member States committed to have in place by May 2017 national action plans (NAPs) aligned with GAP.

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

61. At the Sixty-ninth World Health Assembly, the Secretariat reported on the development of NAPs. For the South-East Asia Region, NAPs are under development in Bangladesh, Bhutan, Indonesia, Myanmar, Nepal and Thailand. Their alignment with the GAP on AMR is yet to be confirmed. A recent public awareness survey, conducted in 12 countries including India and
Indonesia in the SEA Region, confirmed the need to improve public awareness and understanding of AMR. The first World Antibiotic Awareness Week was observed on 16–22 November 2015, and is slated to be an annual event. The Global AMR Surveillance System (GLASS) was introduced by WHO in March 2016. Member States are encouraged to contribute surveillance data to a global system to measure global progress on AMR.

62. The UN Secretary-General is scheduled to propose an advocacy document to support the development of NAPs and catalyse the progress of the GAP on AMR as an outcome of the UN’s High-Level Meeting in September 2016.

63. The potential development of the Global Antibiotic Research and Development Facility supported by WHO and DNDi (Drugs for Neglected Diseases Initiative) was approved at the Sixty-ninth World Health Assembly. This facility will focus on developing the Stewardship Framework for antimicrobial medicines (preservation, new technologies and promotion of affordable access).

Actions already taken by the SEA Region

64. Since 2010 the Region has adopted several Regional Committee resolutions on the prevention and containment of antimicrobial resistance, including the 2011 Jaipur Declaration on Antimicrobial Resistance. In 2014 the Regional Director called for building national capacity to combat antimicrobial resistance as a Regional Flagship Priority Area, with a focus on achieving clear deliverables at both regional and country levels.

65. In 2016 high-level advocacy meetings were held in New Delhi, India, and Tokyo, Japan, to secure the engagement of key sectors for the antimicrobial resistance agenda at the national and regional levels. These meetings achieved notable results, including: (i) a regional roadmap for the development of national action plans was proposed by the meeting on Combating Antimicrobial Resistance: Public Health Challenge and Priority, held in New Delhi, India, on 23–25 February 2016; and (ii) the Biregional Communiqué on AMR, which mainly prioritized the development of NAPs and the associated AMR agenda in tandem with the UN Sustainable Development Goals (Tokyo, 14–16 April).

66. Country situation analyses are required as part of the NAP development process supported at two high-level ministerial meetings. The first situation analysis in the SEA Region and first national workshop supported by WHO on the development of a GAP-aligned NAP were conducted in Jakarta, Indonesia, in May 2016.

Actions to be taken by the SEA Region

- A joint situation analysis has been requested by many countries and a regional workshop on the development of GAP-aligned NAPs has been proposed to Member States to be held in Bangkok, Thailand, in September 2016.
- Situation analysis results will be compiled and presented in the form of a regional report and serve as baseline data to measure progress.
- Advocacy activities will continue building on GAP-aligned NAPs. The Regional Office is currently undertaking special studies to assess the status of antimicrobial resistance in the environment, policy-wise in the animal sector, and best practices for national public awareness campaigns. SEARO will also propose a roadmap to strengthen national AMR surveillance.
12. WHO Reform on Emergency Management  
(WHA69 Agenda 14.9)

Background

67. Following the outbreak of Ebola Virus Disease in West Africa, there has been a global call for Emergency Reform in WHO. A Special Session of the WHO Executive Board on Ebola passed a special resolution in January 2015 calling for an assessment by an Ebola Interim Assessment panel (comprising external independent experts). The Director-General also constituted an Advisory Group on WHO’s Work in Outbreaks and Emergencies chaired by Dr David Nabarro to recommend the core elements of the reform that is needed.

68. Several evaluations also completed their reports around the same time. At the Executive Board session on 24 January 2016, an information session was organized on the several high-level evaluations on Ebola that were carried out by various groups. They include (i) Institute of Medicine of the National Academy of Sciences, (ii) Harvard School of Public Health and the London School of Hygiene and Tropical Medicine, (iii) the Stocking Report, and (iv) Advisory Group on Emergency Reform. The discussions also touched on the report of the IHR Review Committee on emergency reform. There were discussions and comments on the papers but the session was only for information and no output was expected from it.

Main operative paragraph and implications on collaborative actions with Member States

69. The new WHO Health Emergency (WHE) Programme is aligned with the principles of a single programme, with one clear line of authority, one workforce, one Budget, one set of rules and processes, and one set of standard performance metrics.

70. The common structure reflects WHO’s major functions in health emergency risk management as follows:
   
i) Infectious hazards management, which includes high-threat pathogens, expert networks and, at headquarters, the Pandemic Influenza Preparedness (PIP) Secretariat;

   ii) Country health emergency preparedness and the International Health Regulations (2005), which includes monitoring and evaluation of national preparedness capacities, planning and capacity-building for critical capacities and, at headquarters, the IHR Secretariat;

   iii) Health emergency information and risk assessments, includes event detection and verification, health emergency operations monitoring, and data management and analytics;

   iv) Emergency operations, includes incident management functions, operational partnerships and readiness, and operations support and logistics; and

   v) Emergency operations management and administration and external relations.

71. The WHE programme will be headed by an Executive Director reporting to the Director-General, serving at the level of Deputy Director-General, and recruited through an international competitive process. The Regional Directors are central to the success and implementation of
the Programme, particularly in providing leadership in the application and enforcement of 
Programme standards, government and regional intergovernmental relations, interagency and 
partner relations at the regional level, and the day-to-day management of emergency 
management activities in their regions. The Executive Director and Regional Directors will jointly 
recruit the Regional Emergency Directors who will have delegated authority for emergency 
activities in their regions, and form part of the global management team of the new Programme.

72. The ultimate authority for WHO’s work in emergencies rests with the Director-General 
with day-to-day oversight and management of major outbreaks and health emergencies – 
including WHO Grade-3 emergencies, public health emergencies of international concern 
(PHEICs) and Level-3 crises under the Inter-Agency Standing Committee (IASC) – delegated to 
the Executive Director.

73. On a day-to-day basis the Regional Emergency Directors will report to their respective 
Regional Directors on the implementation of these emergency management activities in their 
regions and to the Executive Director on issues of policy, strategy and operational planning 
related to such activities.

74. WHO’s work in support of Member State preparedness will be aligned with the 
recommendations of the International Health Regulations (2005) Review Committee and the 
Sendai Framework for Disaster Risk Reduction.

75. The development of a unified set of emergency business rules and systems for operating 
rapidly and on a “no-regrets” basis in the areas of planning, human resource management, 
procurement and finance is in progress. Emergency finances are being made available 
immediately, through a minimum-burden application process to the new WHO Contingency 
Fund for Emergencies.

76. On 29 March 2016, the Director-General established the Emergencies Oversight and 
Advisory Committee to provide oversight and monitoring of the development and performance 
of the WHO Health Emergencies Programme, guide the Programme’s activities, and report 
findings through the Executive Board to the World Health Assembly. The Committee consists of 
eight members who have extensive experience in a broad range of disciplines, including public 
health, infectious diseases, humanitarian crises, public administration, emergency management, 
community engagement, partnerships and development. Reports of the Committee will be 
shared with the Secretary-General of the United Nations and with the Inter-Agency Standing 
Committee.

77. Having completed the design of the new WHO Health Emergencies Programme, the 
Organization is initiating a transition phase, with the goal of establishing the new structure and 
positions across headquarters, all six regional offices and the first set of priority countries by 1 
July 2016, and completing the transition of existing staff into the new structure by 1 October 
2016.

78. Financing the work of the new WHO Health Emergencies Programme will require a 
combination of core financing for baseline staff and activities levels at the three levels of the 
Organization, full financing of the WHO Contingency Fund for Emergencies to rapidly initiate 
operations in acute emergencies, and crisis-specific financing for activities in protracted crises 
(e.g. for the health component of Humanitarian Response Plans). The WHO Programme Budget 
2016–2017 includes US$ 334 million in Budget space for activities and staff that would be 
transitioned to the new WHO Health Emergencies Programme. This figure includes US$ 93
million of the 8% increase in the 2016–2017 Programme Budget that was agreed on by the Sixty-eighth World Health Assembly.

79. Implementing the new Health Emergencies Programme against the planned timeline requires an additional US$ 160 million in core financing during the 2016–2017 biennium (US$ 60 million in 2016 and US$ 100 million in 2017) to meet the total budget of US$ 494 million for the new Programme in this biennium. The core budget to fully implement the planned capacities and activities of the new Programme in 2018–2019 is US$ 630 million.

80. As of 22 April 2016, WHO has received US$ 140 million against the US$ 494 million core budget required for its Health Emergencies Programme in 2016–2017, and US$ 26.9 million in funding and pledges against the US$ 100 million capitalization target for the new Contingency Fund for Emergencies. Further financing is required.

**Decision**

81. The Sixty-ninth World Health Assembly, having considered the report on the reform of WHO’s work in health emergency management, decided:

i) to welcome the progress made in the development of the new Health Emergencies Programme, the elaboration of an implementation plan and timeline for the new Programme, and the establishment of the Emergencies Oversight and Advisory Committee;

ii) to encourage ongoing collaboration with the United Nations Office for the Coordination of Humanitarian Affairs to enhance humanitarian system-wide coordination of the response to large-scale infectious hazards in the future;

iii) to note that the overall budget for the Health Emergencies Programme and its new operational capacities will be US$ 494 million for the biennium 2016–2017, representing a US$ 160 million increase over the current budget for WHO’s primarily normative and technical work in health emergency management;

iv) to approve an increase of US$ 160 million for the Programme budget 2016–2017 to initiate the implementation plan for the new Health Emergencies Programme, and to authorize the Director-General to mobilize additional voluntary contributions to meet this financial need for the biennium 2016–2017;

v) to request the Director-General to report to the Seventieth World Health Assembly, through the Executive Board, on progress made and experience gained in establishing and operationalizing the Health Emergencies Programme.

**Actions to be taken by the SEA Region**

82. Revision of the human resources and budgets attached to Category 5 work needs to be handled in a coordinated manner across all offices.

83. The summary process of how to implement within this biennium and how the planning process will be for the next biennium is as follows:

i) The results framework for Category 5 will be maintained for the 2016–2017 biennium with some possible revisions. Two new outcomes (with new outputs and
deliverables) will be added to reflect the new elements in the Emergencies Programme (EP) results framework;

ii) The new outcomes, outputs and deliverables will represent the new work of the Emergencies Programme and will reflect the requested 2016–2017 Programme Budget increase of US$ 160 million;

iii) Budget allocations will be adjusted accordingly as the Programme Budget increase has been approved by the World Health Assembly for 2016–2017.

iv) For the 2018–2019 biennium, the Category 5 results framework will be replaced by a new results framework for the Emergencies Programme;

v) The Emergencies Programme will have its own planning process separate from the process that is ongoing for Categories 1-4, with the exceptions of outputs for 5.2.3 (Antimicrobial resistance), 5.4 (Food safety) and 5.5 (Polio), that will continue to plan as part of the regular planning process;

84. The minimum critical capacity that is needed at the country office level in the light of the differential vulnerabilities of the SEA Region Member States needs to be incorporated in the HR and activity workplan.

13. Climate Change (EB139 Agenda 6.4)

Background

85. The most recent assessments by the Intergovernmental Panel on Climate Change (IPCC), WHO and other agencies have further added to the corpus of evidence that climate change is a continuing phenomenon that is contributing to significant health risks globally. While 2015 was recorded as the hottest year, 2011–2015 was the hottest five-year period, since global temperature records have been maintained\(^1\). Countries of the WHO South-East Asia Region are most vulnerable to climate change impacts from cyclones, floods, droughts, heat waves, rising sea levels and glacial lake outbursts. Climate change is conservatively expected to cause an additional 250 000 deaths annually by 2030, mainly by impeding the progress that is being made against significant causes of mortality such as undernutrition, malaria and diarrhoea and also through the increasing risks of heat waves and other extreme events\(^2\). At the same time, many of the drivers of carbon emissions to the atmosphere, such as inefficient and polluting energy and transport systems, also directly harm human health. The largest and most directly connected of these risks is air pollution, which causes over seven million deaths each year, or one in eight of all deaths\(^3\).

86. The 2015 Paris Global Climate Agreement for Health: In December 2015 Parties to the UN Framework Convention on Climate Change (UNFCCC) reached the first global climate agreement\(^4\). This set an ambitious goal of keeping global warming to well below 2 °C, with a target of 1.5 °C. It is also legally binding, with differentiated responsibilities; recognizing the responsibilities of the richest countries but also including actions by developing countries.

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\(^1\) WMO. 2015 is the hottest year on record. Geneva: World Meteorological Organization; 2016


includes a commitment to mobilize a minimum of US$ 100 billion a year in international climate financing by 2020 for both climate mitigation (reducing the scale of climate change, mainly through cutting greenhouse gas emissions) and adaptation (reducing or managing the negative impacts of climate change that do occur). Overall, the agreement provides the basis for strong international action to address climate change, as well as providing the specific entry points to support action to protect and promote health, both through increasing health resilience to climate risks and through prioritizing mitigation actions that also improve health.

**Actions already taken by the SEA Region**

i) Significant progress has been made in raising awareness, advocacy levels and capacity development and initiating pilots on the adaptation of health to climate change in Member States. Several high-level regional conferences have been organized in the last two years. A comprehensive training package on health and climate change has been developed for the Region.

ii) Most Member States have established focal points for health and climate in their ministries of health.

iii) All nine Member States that have submitted their Intended Nationally Determined Contributions (INDC) to the recent Paris Global Climate Agreement have cited health in the INDCs.

iv) All six least developed countries of the Region have included health in their National Adaptation Plan of Action.

v) Several health adaptation projects are ongoing in Bangladesh, Nepal and Maldives and one has been completed in Bhutan. For example, Bhutan has piloted an integrated surveillance for climate sensitive diseases; Bangladesh and Nepal are developing climate-resilient water and sanitation facilities; and Maldives is implementing a low emission climate-resilient project in Laamu atoll.

vi) The climate and health profiles for nine Member States have been prepared and the remaining two are in progress.

**Actions to be taken by the SEA Region**

i) The Regional Office will continue to support implementation of the Regional Committee resolution titled “Climate Change and Human Health” (SEA/RC62/R2). These would be in the areas of capacity development, scaling up health adaptation programmes (such as resilient health facilities, health early warning systems), sustained raising of awareness among health stakeholders, relevant sectors and the general public, strengthening evidence base and knowledge sharing, and mainstreaming climate risks in health policies and programmes.

ii) With regard to financing, the Regional Office with support from headquarters will mobilize funds from the Global Environment Facility (GEF), Department for International Development (DFID) of the United Kingdom and the Green Climate Fund for health adaptation in several Member States.

iii) A draft roadmap for an enhanced global response to the adverse health effects of air pollution was prepared for the Sixty-ninth World Health Assembly. This roadmap will be used to guide the development of additional WHO technical support to Member States, as necessary actions will include addressing the co-benefits of action on climate change and air pollution in the areas of energy and urban health.
Annexures
The 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;¹

Recalling resolution WHA52.7 (1999) on active ageing and resolution WHA58.16 (2005) on strengthening active and healthy ageing, both of which called upon 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;

Having considered 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;

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

Recalling 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,² 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;

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,\(^1\) 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 ability\(^2\) 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 strategies and frameworks\(^3\) in this area,

1. ADOPTS the Global strategy and action plan on ageing and health;\(^4\)

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;

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\(^2\) 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) 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
A69/VR/8

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The role of the health sector in the Strategic Approach to International Chemicals Management towards the 2020 goal and beyond

The Sixtieth World Health Assembly,

Having considered the report on the role of the health sector in the sound management of chemicals;¹

Recalling resolution WHA59.15 (2006), in which the Health Assembly welcomed the Strategic Approach to International Chemicals Management adopted by the International Conference on Chemicals Management (Dubai, United Arab Emirates, 4–6 February 2006) with its overall objective to achieve “the sound management of chemicals throughout their life cycle so that, by 2020, chemicals are used and produced in ways that lead to the minimization of significant adverse effects on human health and the environment”, as inspired by paragraph 23 of the Johannesburg Plan of Implementation of the World Summit on Sustainable Development (Johannesburg, South Africa, 26 August–4 September 2002);

Reaffirming its commitment to the outcome document of the 2012 United Nations Conference on Sustainable Development (Rio+20), entitled “The future we want”;²

Further recalling paragraph 213 of the outcome document “The future we want”, which states that “[w]e reaffirm our aim to achieve, by 2020, the sound management of chemicals throughout their life cycle and of hazardous waste in ways that lead to minimization of significant adverse effects on human health and the environment, as set out in the Johannesburg Plan of Implementation”;  

Recalling also, paragraph 214 of “The future we want”, which calls for “the effective implementation and strengthening of the Strategic Approach to International Chemicals Management as part of a robust, coherent, effective and efficient system for the sound management of chemicals throughout their life cycle”;

Noting the limited time remaining to make progress toward the 2020 goal, and the urgent need for practical action and technical cooperation within the health sector, as well as with other sectors;

Acknowledging that chemicals contribute significantly to the global economy, living standards and health but that unsound management of chemicals throughout their life cycle contributes

¹ Document A69/19.
significantly to the global burden of disease, and that much of this burden is borne by developing countries;

Noting that annually 12.6 million deaths (22.7% of all deaths) and 596 million disability-adjusted life years (21.8% of all disease burden in disability-adjusted life years) are thought to be linked to modifiable environmental factors, including chemical exposures, and that in 2012 1.3 million deaths (2.3% of all deaths) and 43 million disability-adjusted life years (1.6% of all disease burden in disability-adjusted life years) were attributable to exposures to a number of selected chemicals;\(^1\) noting also that, among these, addressing lead exposure would prevent 9.8% of intellectual disability, 4% of ischaemic heart disease and 4.6% of stroke in the population; and that unintentional poisonings killed an estimated 193,000 people in 2012, 85% in developing countries where such poisonings are strongly associated with excessive exposure to, and inappropriate use of, toxic chemicals; and recognizing that due to the complex nature of the issue, disease burden information is only available for a very small number of chemical exposures and that people are exposed to many more chemicals in their daily lives;

Concerned about acute, chronic and combined adverse effects that can result from exposure to chemicals and waste, and that the risks are often unequally distributed and can be more significant for some vulnerable populations, especially women, children, and, through them, future generations;

Underlining the need to address the social, economic, and environmental determinants of health to improve health outcomes and achieve sustainable development;

Underscoring the importance of protecting health and reducing health inequities, including by the reduction of adverse health impacts from chemicals and waste, by adopting health-in-all policies and whole-of-government approaches, as appropriate;

Recalling WHO’s longstanding recognition of the importance of sound chemicals management for human health, the key role of WHO in providing leadership on the human health aspects of the sound management of chemicals throughout their life cycle, and the necessity of health sector participation in, and contribution to, these efforts as set out in resolution WHA59.15 (2006) on the Strategic Approach to International Chemicals Management; resolution WHA63.25 (2010) on improvement of health through safe and environmentally sound waste management; resolution WHA63.26 on improvement of health through sound management of obsolete pesticides and other obsolete chemicals; resolution WHA67.11 (2014) on public health impacts of exposure to mercury and mercury compounds; and resolution WHA68.8 (2015) on health and the environment: addressing the health impact of air pollution;

Recalling further the health-related outcomes of the second, third and fourth sessions of the International Conference on Chemicals Management, which drew attention to the need for greater involvement of the health sector and resulted in the adoption of a strategy for strengthening engagement of the health sector in the implementation of the Strategic Approach,\(^2\) which details the key roles and responsibilities of the health sector in sound chemicals management;

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Recalling also paragraph 1 of International Conference on Chemicals Management resolution IV/1, adopted by the fourth session of the International Conference on Chemicals Management, which endorsed the overall orientation and guidance for achieving the 2020 goal as a voluntary tool that will assist in the prioritization of efforts for the sound management of chemicals and waste as a contribution to the overall implementation of the Strategic Approach, and mindful of the invitation in paragraph 5 to “the organizations of the Inter-Organization Programme for the Sound Management of Chemicals and of the United Nations Environment Management Group that have not already done so to issue, where possible by 1 July 2016, a declaration signalling their commitment to promote the importance of the sound management of chemicals and waste both within and outside their organizations, including the actions planned within their own mandates to meet the 2020 goal”;

Acknowledging with appreciation WHO’s extensive activities in this regard, including, but not limited to, supporting countries to implement the International Health Regulations (2005) in relation to chemical incidents, the establishment in 2013 of the WHO Chemical Risk Assessment Network, participation in the development of the Inter-Organization Programme for the Sound Management of Chemicals Toolbox for Decision Making in Chemicals Management, joint leadership of the Global Alliance to Eliminate Lead Paint, and engagement with relevant chemicals- and waste-related multilateral environmental agreements;

Also acknowledging initiatives undertaken at the national and regional levels, and through other bodies of the United Nations system and other relevant stakeholders, and the important contribution that these initiatives make to protecting health from hazardous chemicals and waste;


Concerned that, despite these efforts, more progress has to be made towards minimizing the significant adverse effects on human health that may be associated with chemicals and waste, and recognizing that there is an urgent need to address existing gaps between the capacities of different countries;

Recognizing the need for enhanced cooperation aimed at strengthening the capacities of developing countries for the sound management of chemicals and hazardous wastes and promoting adequate transfer of cleaner and safer technology to those countries;

Emphasizing the importance of bringing into force the Minamata Convention on Mercury as soon as possible;

Welcoming the outcome of WHO’s survey of the priorities of the health sector towards achievement of the 2020 goal of sound chemicals management, which builds on the Strategy for strengthening the engagement of the health sector in the implementation of the Strategic Approach;

Recognizing paragraph 1 of the Dubai Declaration on International Chemicals Management (2006), which states that “the sound management of chemicals is essential if we are to achieve sustainable development, including the eradication of poverty and disease, the improvement of human health and environment, the promotion of economic viability and social cohesion”.

1 Document SAICM/ICCM.4/INF/11.
health and the environment and the elevation and maintenance of the standard of living in countries at all levels of development”;

Welcoming the 2030 Agenda for Sustainable Development, in particular Sustainable Development Goal 3, target 3.9 (to substantially reduce the number of deaths and illnesses from hazardous chemicals and air, water and soil pollution and contamination by 2030), and further recognizing Goal 12, target 12.4 (to achieve, by 2020, the environmentally sound management of chemicals and all wastes throughout their life cycle, in accordance with agreed international frameworks), as well as other goals and targets relevant to health aspects of chemicals and waste management, such as Goal 6, target 6.3, on the improvement of water quality;

Convinced that the achievement of sound management of chemicals and waste throughout their life cycle requires a multisectoral approach within which the health sector has a critical role in achieving the 2020 goal and in setting priorities for chemicals and waste for the post–2020 period;

Stressing the responsibility of industry to make available to stakeholders such data and information on health and environmental effects of chemicals as are needed safely to use chemicals and the products made from them;

Welcoming the integrated approach to financing the sound management of chemicals and wastes developed by UNEP,\(^1\) which is applicable to the Strategic Approach and underscores that the three components of an integrated approach, namely mainstreaming, industry involvement and dedicated external financing, are mutually reinforcing and are all important for the financing of the sound management of chemicals and waste at all levels;

Aware that strengthening of health systems and appropriately trained health workforce is a key factor for facilitating the health sector to more effectively contribute to the sound management of chemicals and waste;

Aware also of the need to strengthen the role of the health sector so as to ensure its contribution to multisectoral efforts to meet the 2020 goal and beyond, and that this would be facilitated by the development of a road map outlining concrete actions for the health sector,

1. **URGES Member States:**\(^2\)

   (1) to engage proactively, including by strengthening the role of the health sector, in actions to soundly manage chemicals and waste at the national, regional and international levels in order to minimize the risk of adverse health impacts of chemicals throughout their life cycle;

   (2) to develop and strengthen, as appropriate, multisectoral cooperation at the national, regional and international levels in order to minimize and prevent significant adverse impacts of chemicals and waste on health, including within the health sector itself;

   (3) to take account of the Strategic Approach’s overall orientation and guidance towards the 2020 goal, including the health sector priorities, as well as the strategy for strengthening

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\(^1\) Sound management of chemicals: UNEP’s contribution to the achievement of the 2020 goal (http://www.unep.org/chemicalsandwaste/Portals/9/Mainstreaming/Sound%20Management%20of%20Chemicals/SoundManagementofChemicals.pdf, accessed 19 May 2016).

\(^2\) And, where applicable, regional economic integration organizations.
engagement of the health sector, and consider Emerging Policy Issues and Other Issues of Concern,\(^1\) and to take immediate action where possible and where appropriate to accelerate progress towards the 2020 goal;

(4) to encourage all relevant stakeholders of the health sector to participate in the Strategic Approach and to ensure appropriate linkages with their national and regional Strategic Approach focal points, and to participate in the reports on progress for the Strategic Approach;

(5) to strengthen individual, institutional and networking capacities at the national and regional levels to ensure successful implementation of the Strategic Approach;

(6) to encourage health sector participation in the intersessional process established through the fourth session of the International Conference on Chemicals Management to prepare recommendations regarding the Strategic Approach and the sound management of chemicals and waste beyond 2020, including in the third meeting of the Open Ended Working Group;

(7) to continue and, where feasible, increase support, including financial or in-kind scientific and logistic support to the WHO Secretariat’s regional and global efforts on chemicals safety and waste management, as appropriate;

(8) to pursue additional initiatives aimed at mobilizing national and, as appropriate, international resources, including for the health sector, for the sound management of chemicals and waste;

(9) to strengthen international cooperation to address health impacts of chemicals and waste, including through facilitating transfer of expertise, technologies and scientific data to implement the Strategic Approach, as well as exchanging good practices;

2. REQUESTS the Director-General:

(1) to develop, in consultation with Member States,\(^2\) bodies of the United Nations system, and other relevant stakeholders, a road map for the health sector at the national, regional and international levels towards achieving the 2020 goal and contributing to relevant targets of the 2030 Agenda for Sustainable Development, taking into account the overall orientation and guidance of the Strategic Approach to International Chemicals Management, and the intersessional process to prepare recommendations regarding the Strategic Approach and the sound management of chemicals and waste beyond 2020 established through the fourth session of the International Conference on Chemicals Management, and building on WHO’s existing relevant work, as well as the strategy for strengthening the engagement of the health sector in the implementation of the Strategic Approach, and with particular emphasis on the following areas:

(a) health sector participation in and support for the establishment and strengthening of relevant national legislative and regulatory frameworks;

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\(^1\) **Emerging policy issues:** lead in paint, chemicals in products, hazardous substances within the life cycle of electrical and electronic products, nanotechnologies and manufactured nanomaterials, endocrine-disrupting chemicals, and environmentally persistent pharmaceutical pollutants; **Other issues of concern:** Perfluorinated chemicals and the transition to safer alternatives, and highly hazardous pesticides (http://www.saicm.org/index.php?option=com_content&view=article&id=452&Itemid=685, accessed 20 May 2016).

\(^2\)And, where applicable, regional economic integration organizations.
(b) supporting the establishment or strengthening of national, regional or international coordinating mechanisms, as appropriate for multisectoral cooperation, and in particular enhancing engagement of all relevant health sector stakeholders;

(c) strengthening communication and access to relevant, understandable and up-to-date information to increase interest in and awareness of the importance to health of the sound management of chemicals and waste, particularly for vulnerable populations, especially women, children, and through them, future generations;

(d) participating in bilateral, regional or international efforts to share knowledge and best practices for the sound management of chemicals, including the WHO Chemicals Risk Assessment Network;

(e) participating actively in ongoing work on the Strategic Approach’s Emerging Policy Issues and Other Issues of Concern, as well as the intersessional process established through the fourth session of the International Conference on Chemicals Management to prepare recommendations regarding the Strategic Approach and the sound management of chemicals and waste beyond 2020;

(f) encouraging implementation of the strategy for strengthening the engagement of the health sector in the implementation of the Strategic Approach, including the review of the health sector’s own role to the extent that it is a user of chemicals and a producer of hazardous waste;

(g) mainstreaming gender as a component in all policies, strategies and plans for the sound management of chemicals and waste, considering gender differences in exposure to and health effects of toxic chemicals, while ensuring participation of women as agents of change in policy and decision making; and

(h) strengthening efforts on implementation of the updated health sector priorities;

(2) to build on and enhance implementation of actions pursuant to resolution WHA63.25 on improvement of health through safe and environmentally sound waste management, and to develop a report on the impacts of waste on health, the current work of WHO in this area, and possible further actions that the health sector, including WHO, could take to protect health;

(3) to continue to exercise and enhance the leading role of WHO in the Strategic Approach to foster the sound management of chemicals throughout their life cycle with the objective of minimizing and, where possible, preventing significant adverse effects on health;

(4) to support the strengthening of capacities at all levels for the production, availability and analysis of quality, accessible, timely, reliable and appropriately disaggregated data for the adequate measurement of progress towards Goal 3, target 3.9, of the 2030 Agenda for Sustainable Development and to improve, where appropriate, evidence-based data;

(5) to continue current efforts to engage the health sector in chemicals management and make progress in chemical safety in particular in the implementation of the International Health Regulations (2005);
(6) to support Member States by providing technical support, including at the regional and country levels, for strengthening the role of the health sector towards meeting the 2020 goal, including by enhancing capacities at individual, institutional and networking levels and by dissemination of evidence-based best practices;

(7) to support Member States to strengthen coordination for the health sector in responding to existing international efforts and, in so doing, avoid duplication;

(8) to set aside adequate resources and personnel for the work of the Secretariat, in line with the Programme budget 2016–2017 and the Twelfth General Programme of Work, 2014–2019, and taking into account the recent call at the fourth session of the International Conference on Chemicals Management and the invitation conveyed at the first session of the United Nations Environment Assembly on support for the Strategic Approach; and to work in collaboration with the secretariat of the Strategic Approach to find means to increase that secretariat’s capacity to support activities related to the health sector;

(9) to present to the Seventieth World Health Assembly:

   (a) a road map outlining concrete actions to enhance health sector engagement towards meeting the 2020 goal and contributing to relevant targets of the 2030 Agenda for Sustainable Development, as requested in operative subparagraph 2(1) above; and

   (b) a progress report on the preparation of the report requested in operative subparagraph 2(2) above;

(10) to update the road map according to the outcome of the intersessional process to prepare recommendations regarding the Strategic Approach and the sound management of chemicals and waste beyond 2020.
Prevention and control of noncommunicable diseases: responses to specific assignments in preparation for the third High-level Meeting of the United Nations General Assembly on the Prevention and Control of Non-communicable Diseases in 2018

The Sixty-ninth World Health Assembly,

Having considered the report on prevention and control of noncommunicable diseases: responses to specific assignments in preparation for the third High-level Meeting of the United Nations General Assembly on the Prevention and Control of Non-communicable Diseases in 2018;¹


1. NOTES the process to update, in 2016, Appendix 3 of the global action plan for the prevention and control of noncommunicable diseases 2013–2020;

2. ENDORSES the process to further develop, in 2016, an approach that can be used to register and publish contributions of non-State actors to the achievement of the nine voluntary global targets for noncommunicable diseases;

3. URGES Member States to continue to implement the road map of national commitments included in United Nations General Assembly resolutions 66/2 and 68/300, including the four time-bound national commitments for 2015 and 2016, and other key commitments such as developing or strengthening surveillance systems to track social disparities in respect of noncommunicable diseases and their risk factors and pursuing and promoting gender-based approaches for the prevention of noncommunicable diseases in preparation for a third High-level Meeting of the United Nations General Assembly on the Prevention and Control of Non-communicable Diseases in 2018, taking into account the technical note published by WHO on 1 May 2015, which sets out the progress indicators that the Director-General will use to report to the United Nations General Assembly in 2017 on the progress achieved in the implementation of national commitments;

4. NOTES that the Director-General has received two reports of the working groups of the WHO global coordination mechanism on the prevention and control of noncommunicable diseases that

¹ Document A69/10.
recommend ways and means of encouraging Member States to realize the commitments included in paragraphs 44 and 45(d) of the 2011 Political Declaration of the High-level Meeting of the United Nations General Assembly on the Prevention and Control of Non-communicable Diseases;¹

5. REQUESTS the Director-General:

   (1) to submit an updated Appendix 3 of the global action plan for the prevention and control of noncommunicable diseases 2013–2020, through the Executive Board, to the Seventieth World Health Assembly in 2017, in accordance with the timeline contained in Annex 2 of document A69/10;

   (2) to submit a report setting out an approach that can be used to register and publish contributions of non-State actors to the achievement of the nine voluntary global targets for noncommunicable diseases, through the Executive Board, to the Seventieth World Health Assembly in 2017, in accordance with the timeline contained in Annex 4 of document A69/10;

   (3) to continue to provide, upon request, technical support to Member States to strengthen their efforts to implement national noncommunicable disease responses, including in the areas covered by the two reports of the working groups of the WHO global coordination mechanism on the prevention and control of noncommunicable diseases, within the parameters set out in the Programme budget.

Eighth plenary meeting, 28 May 2016
A69/VR/8

¹ See document A69/10, Annex 5: action 3.1, footnote 4; action 5.1, footnote 5.

The Sixty-ninth World Health Assembly,

Having considered the reports on maternal, infant and young child nutrition;¹


Reaffirming the commitments to implement relevant international targets and action plans, including WHO’s global nutrition targets for 2025 and the WHO’s global action plan for the prevention and control of noncommunicable diseases 2013–2020;

Recalling resolution WHA65.6 (2012) in which the Member States endorsed the comprehensive implementation plan on maternal, infant and young child nutrition and requested the Director-General to assess progress towards reaching the goals;

Recalling United Nations General Assembly resolution 70/1 (2015), entitled “Transforming our world: the 2030 Agenda for Sustainable Development”, acknowledging the integrated dimension of the goals and recognizing that to end all forms of malnutrition and address nutritional needs throughout the life course, it is necessary to give universal access to safe and nutritious food that is sustainably produced, and to ensure universal coverage of essential nutrition actions;

Recalling that the Sustainable Development Goals and targets are integrated and indivisible and balance the three dimensions of sustainable development, and acknowledging the importance of reaching Sustainable Development Goal 2, which aims to end hunger, achieve food security and improved nutrition and promote sustainable agriculture, as well as the interlinked targets of other Goals;

Welcoming United Nations General Assembly resolution 70/259 (2016), entitled “United Nations Decade of Action on Nutrition (2016–2025)”; which calls upon FAO and WHO to lead the implementation of the United Nations Decade of Action on Nutrition (2016–2025), in collaboration with the WFP, IFAD and UNICEF, and to identify and develop a work programme based on the Rome Declaration on Nutrition and its Framework for Action, along with its means of implementation for 2016–2025, using coordination mechanisms such as the Standing Committee on Nutrition and multistakeholder platforms such as the Committee on World Food Security, in line with its mandate,

¹ Documents A69/7, A69/7 Add.1 and A69/7 Add.2.
and in consultation with other international and regional organizations, platforms and movements such as the Scaling up Nutrition;

Reaffirming the commitment to eradicate hunger and prevent all forms of malnutrition worldwide, particularly undernourishment, stunting, wasting, underweight and overweight in children under 5 years of age and anaemia in women and children, among other micronutrient deficiencies; as well as to halt the rising trends in overweight and obesity and reduce the burden of diet-related noncommunicable diseases in all age groups;

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

Expressing concern that only 49% of countries have adequate nutrition data to assess progress towards the global nutrition targets,

1. CALLS UPON all relevant United Nations funds, programmes, specialized agencies, civil society and other stakeholders:

   (1) to work collectively across sectors and constituencies to guide, support, and implement nutrition policies, programmes, and plans under the umbrella of the United Nations Decade of Action on Nutrition (2016–2025);

   (2) to support mechanisms for monitoring and reporting of the commitments;

2. URGES Member States:

   (1) to develop and/or implement strategies on maternal, infant and young child nutrition that comprehensively respond to nutrition challenges, span different sectors and include robust and disaggregated monitoring and evaluation;

   (2) to consider developing, when appropriate, policies and financial commitments that are specific, measurable, achievable, relevant and time-bound (SMART) in respect of the Rome Declaration on Nutrition and the voluntary options contained in the Framework for Action of the Second International Conference on Nutrition as well as the Comprehensive Implementation Plan on Maternal, Infant and Young Child Nutrition;

   (3) to consider the definition of national targets based on global targets adapted to national priorities and specific parameters;

   (4) to consider allocating adequate funding taking into account the local context;

   (5) to provide information on a voluntary basis on their efforts to implement the commitments of the Rome Declaration on nutrition through a set of voluntary policy options within the Framework for Action including their policy and investments for effective interventions to improve people's diets and nutrition, including in emergency situations;
3. REQUESTS the Director-General:

(1) to work with the Director-General of FAO:

   (a) to support Member States, upon request, in developing, strengthening and implementing their policies, programmes and plans to address the multiple challenges of malnutrition, and convene periodic meetings of inclusive nature to share best practices, including consideration of commitments that are specific, measurable, achievable, relevant and time-bound (SMART) within the framework of the Decade of Action on Nutrition (2016–2025);

   (b) to maintain an open access database of commitments for public accountability and include an analysis of the commitments made in the biennial reports on implementation of the outcome document of the Second International Conference on Nutrition and the Framework for Action;

(2) to continue to provide technical support to Member States for the implementation of the United Nations Decade of Action on Nutrition (2016–2025) and of the Comprehensive Implementation Plan on Maternal, Infant and Young Child Nutrition;

(3) to continue supporting the Breastfeeding Advocacy Initiative to increase political commitment to and investment in breastfeeding as the cornerstone of child nutrition, health and development;

(4) to support Member States in strengthening the nutrition component of national information systems, including data collection and analysis for evidence-informed policy decision-making.

Eighth plenary meeting, 28 May 2016
A69/VR/8
Ending inappropriate promotion of foods for infants and young children

The Sixty-ninth World Health Assembly,

Having considered the reports on maternal, infant and young child nutrition;¹


Further recalling resolution WHA65.6 (2012) on maternal, infant and young child nutrition, in which the Health Assembly requested the Director-General to provide guidance on the inappropriate promotion of foods for infants and young children cited in resolution WHA63.23;

Convinced that guidance on ending the inappropriate promotion of foods for infants and young children is needed for Member States, the private sector, health systems, civil society and international organizations;

Reaffirming the need to promote exclusive breastfeeding practices in the first 6 months of life, and the continuation of breastfeeding up to 2 years and beyond, and recognizing the need to promote optimal complementary feeding practices for children from ages 6–36 months based on WHO² and FAO dietary guidelines and in accordance with national dietary guidelines;

Recognizing that the Codex Alimentarius Commission is an intergovernmental body which is the principal organ of the joint FAO/WHO food standards programme and that it is the appropriate body for establishing international standards on food products, and that reviews of Codex standards and guidelines should give full consideration to WHO guidelines and recommendations, including the International Code of Marketing of Breast-milk Substitutes and relevant Health Assembly resolutions,

1. WELCOMES with appreciation the technical guidance on ending the inappropriate promotion of foods for infants and young children;

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¹ Documents A69/7 and A69/7 Add.1.

2. URGES Member States\textsuperscript{1,2,3} in accordance with national context;

(1) to take all necessary measures in the interest of public health to end the inappropriate promotion of foods for infants and young children, including, in particular, implementation of the guidance recommendations while taking into account existing legislation and policies, as well as international obligations;

(2) to establish a system for monitoring and evaluation of the implementation of the guidance recommendations;

(3) to end inappropriate promotion of food for infants and young children, and to promote policy, social and economic environments that enable parents and caregivers to make well informed infant and young child feeding decisions, and further support appropriate feeding practices by improving health and nutrition literacy;

(4) to continue to implement the International Code of Marketing of Breast-milk Substitutes and WHO recommendations on the marketing of foods and non-alcoholic beverages to children;

3. CALLS UPON manufacturers and distributors of foods for infants and young children to end all forms of inappropriate promotion, as set forth in the guidance recommendations;

4. CALLS UPON health care professionals to fulfil their essential role in providing parents and other caregivers with information and support on optimal infant and young child feeding practices and to implement the guidance recommendations;

5. URGES the media and creative industries to ensure that their activities across all communication channels and media outlets, in all settings and using all marketing techniques, are carried out in accordance with the guidance recommendations on ending the inappropriate promotion of foods for infants and young children;

6. CALLS UPON civil society to support ending inappropriate promotion of foods for infants and young children, including activities to advocate for, and monitor, Member States’ progress towards the guidance’s aim;

7. REQUESTS the Director-General:

(1) to provide technical support to Member States in implementing the guidance recommendations on ending the inappropriate promotion of foods for infants and young children and in monitoring and evaluating their implementation;

(2) to review national experiences with implementing the guidance recommendations in order to build the evidence on their effectiveness and consider changes, if required;

(3) to strengthen international cooperation with relevant United Nations funds, programmes and specialized agencies and other international organizations, in promoting national action to

\textsuperscript{1} And, where applicable, regional economic integration organizations.

\textsuperscript{2} Taking into account the context of federated States.

\textsuperscript{3} Member States could take additional actions to end inappropriate promotion of foods for infants and young children.
end the inappropriate promotion of foods for infants and young children, taking into consideration the WHO guidance recommendations;

(4) to report on implementation of the guidance recommendations on ending the inappropriate promotion of foods for infants and young children as part of the report on progress in implementing the comprehensive implementation plan on maternal, infant and young child nutrition to the Seventy-first and Seventy-third World Health Assemblies in 2018 and 2020, respectively.

Eighth plenary meeting, 28 May 2016
A69/VR/8
Framework of engagement with non-State actors

The Sixty-ninth World Health Assembly,

Having considered the report on the framework of engagement with non-State actors and the revised draft framework of engagement with non-State actors;\(^1\)

Having noted the report of the Programme, Budget and Administration Committee of the Executive Board to the Sixty-ninth World Health Assembly;\(^2\)


Recalling also United Nations General Assembly resolution 70/1 “Transforming our world: the 2030 Agenda for Sustainable Development”, and the equally important Goals, targets and means of implementation contained therein, which calls, inter alia, for a revitalized global partnership for sustainable development, based on the spirit of strengthened global solidarity, focused in particular on the needs of the poorest and most vulnerable and with participation of all countries, all stakeholders and all people;

Recalling also United Nations General Assembly resolution 69/313 on the Addis Ababa Action agenda of the Third International Conference on Financing for Development (Addis Ababa, 13–16 July 2015), which is an integral part of the 2030 Agenda for Sustainable Development;

Recalling further the Rome Declaration on Nutrition and the Framework for Action on Nutrition adopted by the Second International Conference on Nutrition (Rome, 19–21 November 2014);

Underscoring the full political commitment of all Member States towards the consistent and coherent implementation of the framework of engagement with non-State actors across the three levels of the Organization,

1. ADOPTS the Framework of Engagement with Non-State Actors, as set out in the Annex to this resolution;\(^3\)

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\(^1\) Document A69/6.
\(^2\) Document A69/60.
\(^3\) Consisting of an overarching framework and four specific policies on engagement with nongovernmental organizations, private sector entities, philanthropic foundations and academic institutions.
2. DECIDES that the Framework of Engagement with Non-State Actors shall replace the Principles governing relations between the World Health Organization and nongovernmental organizations\(^1\) and Guidelines on interaction with commercial enterprises to achieve health outcomes;\(^2\)

3. REQUESTS the Director General:

   (1) to immediately start implementation of the Framework of Engagement with Non-State Actors;

   (2) to take all necessary measures, working with Regional Directors, to fully implement the Framework of Engagement with Non-State Actors in a coherent and consistent manner across all three levels of the Organization, with a view to achieving full operationalization within a two-year timeframe;

   (3) to expedite the full establishment of the register of non-State actors in time for the Seventieth World Health Assembly;

   (4) to report on the implementation of the Framework of Engagement with Non-State Actors to the Executive Board at each of its January sessions under a standing agenda item, through the Programme Budget and Administration Committee;

   (5) to include in the report on the implementation of the Framework of Engagement with Non-State Actors, when deemed necessary, any matter or types of engagement with non-State actors that would benefit from further consideration by the Executive Board, through its Programme Budget and Administration Committee, due to their unique characteristics and relevance;

   (6) to conduct an initial evaluation in 2019 of the implementation of the Framework of Engagement with Non-State Actors and its impact on the work of WHO with a view to submitting the results, together with any proposals for revisions of the Framework, to the Executive Board in January 2020, through its Programme Budget and Administration Committee;

   (7) to include in the guide to staff, measures that pertain to application of the relevant provisions contained in the existing WHO policies on conflict of interest, with a view to facilitating the implementation of the Framework of Engagement with Non-State Actors;

   (8) to develop, in consultation with Member States, a set of criteria and principles for secondments from nongovernmental organizations, philanthropic foundations and academic institutions and to submit the criteria and principles for the consideration of and establishment by, as appropriate, the Seventieth World Health Assembly, through the Executive Board, taking into account, amongst others, the following identified issues:

      (a) specific technical expertise needed and excluding managerial and/or sensitive positions;


(b) the promotion of equitable geographical distribution;
(c) transparency and clarity regarding positions sought, including public announcements;
(d) secondments are temporary in nature not exceeding two years;
(9) to make reference to secondments from non-State actors in the annual report on engagement with non-State actors to be submitted, including justification behind secondments;

4. REQUESTS the Independent Expert Oversight Advisory Committee, in accordance with its current terms of reference, to include a section on the implementation of the Framework of Engagement with Non-State Actors in its report to the Programme, Budget and Administration Committee of the Executive Board at each January session;

5. REQUESTS the Seventieth World Health Assembly to review progress on the implementation at the three levels of the Organization, with a view to taking any decisions necessary to enable the full, coherent and consistent implementation of the Framework of Engagement with Non-State Actors.
ANNEX

FRAMEWORK OF ENGAGEMENT WITH NON-STATE ACTORS

(adopted in resolution WHA69.10)

OVERARCHING FRAMEWORK OF ENGAGEMENT WITH NON-STATE ACTORS

INTRODUCTION

1. The overarching framework of engagement with non-State actors and the WHO policy and operational procedures on management of engagement with non-State actors apply to all engagements with non-State actors at all levels of the Organization, whereas the four specific policies and operational procedures on engagement are limited in application to, respectively, nongovernmental organizations, private sector entities, philanthropic foundations and academic institutions.

ENGAGEMENT: RATIONALE, PRINCIPLES, BENEFITS AND RISKS

Rationale

2. WHO is the directing and coordinating authority in global health in line with its constitutional mandate. The global health landscape has become more complex in many respects; among other things, there has been an increase in the number of players including non-State actors. WHO engages with non-State actors in view of their significant role in global health for the advancement and promotion of public health and to encourage non-State actors to use their own activities to protect and promote public health.

3. The functions of WHO, as set out in Article 2 of its Constitution, include: to act as the directing and coordinating authority on international health work; to establish and maintain effective collaboration with diverse organizations; and to promote cooperation among scientific and professional groups which contribute to the advancement of health. The Constitution further mandates the Health Assembly or the Executive Board, and the Director-General, to enter into specific engagements with other organizations. WHO shall, in relation to non-State actors, act in conformity with its Constitution and resolutions and decisions of the Health Assembly, and bearing in mind those of the United Nations General Assembly or the Economic and Social Council of the United Nations, if applicable.

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1 Headquarters, regional offices and country offices, entities established under WHO, as well as hosted partnerships. For hosted partnerships the framework of engagement with non-State actors will apply, subject to the policy on WHO’s engagement with global health partnerships and hosting arrangements (resolution WHA63.10). Hosted, as well as external partnerships are explained in paragraph 48.

2 WHO Constitution, Articles 18, 33, 41 and 71.
4. WHO’s engagement with non-State actors supports implementation of the Organization’s policies and recommendations as decided by the governing bodies, as well as the application of WHO’s technical norms and standards. Such an effective engagement with non-State actors at global, regional and country levels, also calls for due diligence and transparency measures applicable to non-State actors under this framework. In order to be able to strengthen its engagement with non-State actors for the benefit and interest of global public health, WHO needs simultaneously to strengthen its management of the associated potential risks. This requires a robust framework that enables engagement and serves also as an instrument to identify the risks, balancing them against the expected benefits, while protecting and preserving WHO’s integrity, reputation and public health mandate.

**Principles**

5. WHO’s engagement with non-State actors is guided by the following overarching principles.

Any engagement must:

(a) demonstrate a clear benefit to public health;

(b) conform with WHO’s Constitution, mandate and general programme of work

(c) respect the intergovernmental nature of WHO and the decision-making authority of Member States as set out in the WHO’s Constitution;

(d) support and enhance, without compromising, the scientific and evidence-based approach that underpins WHO’s work;

(e) protect WHO from any undue influence, in particular on the processes in setting and applying policies, norms and standards;¹

(f) not compromise WHO’s integrity, independence, credibility and reputation;

(g) be effectively managed, including by, where possible avoiding conflict of interest² and other forms of risks to WHO;

(h) be conducted on the basis of transparency, openness, inclusiveness, accountability, integrity and mutual respect.

**Benefits of engagement**

6. WHO’s engagement with non-State actors can bring important benefits to global public health and to the Organization itself in fulfilment of its constitutional principles and objectives, including its directing and coordinating role in global health. Engagements range from major, longer-term collaborations to smaller, briefer interactions. Benefits arising from such engagement can also include:

(a) the contribution of non-State actors to the work of WHO

¹ Policies, norms and standard setting includes information gathering, preparation for, elaboration of and the decision on the normative text.

² As set out in paragraphs 22 to 26.
the influence that WHO can have on non-State actors to enhance their impact on global public health or to influence the social, economic and environmental determinants of health

c) the influence that WHO can have on non-State actors’ compliance with WHO’s policies, norms and standards

d) the additional resources non-State actors can contribute to WHO’s work

e) the wider dissemination of and adherence by non-State actors to WHO’s policies, norms and standards

Risks of engagement

7. WHO’s engagement with non-State actors can involve risks which need to be effectively managed and, where appropriate, avoided. Risks relate inter alia to the occurrence in particular of the following:

(a) conflicts of interest;

(b) undue or improper influence exercised by a non-State actor on WHO’s work, especially in, but not limited to, policies, norms and standard setting;¹

c) a negative impact on WHO’s integrity, independence, credibility and reputation; and public health mandate;

(d) the engagement being primarily used to serve the interests of the non-State actor concerned with limited or no benefits for WHO and public health;

(e) the engagement conferring an endorsement of the non-State actor’s name, brand, product, views or activity;²

(f) the whitewashing of a non-State actor’s image through an engagement with WHO;

(g) a competitive advantage for a non-State actor.

NON-STATE ACTORS

8. For the purpose of this framework, non-State actors are nongovernmental organizations, private sector entities, philanthropic foundations and academic institutions.

9. Nongovernmental organizations are non-profit entities that operate independently of governments. They are usually membership-based, with non-profit entities or individuals as members exercising voting rights in relation to the policies of the nongovernmental organization, or are otherwise constituted with non-profit, public-interest goals. They are free from concerns which are

¹ Policies, norms and standard setting includes information gathering, preparation for, elaboration of and the decision on the normative text.

² Endorsement does not include established processes such as prequalifications or the WHO Pesticide Evaluation Scheme (WHOPES).
primarily of a private, commercial or profit-making nature. They could include, for example, grassroots community organizations, civil society groups and networks, faith-based organizations, professional groups, disease-specific groups, and patient groups.

10. **Private sector** entities are commercial enterprises, that is to say businesses that are intended to make a profit for their owners. The term also refers to entities that represent, or are governed or controlled by, private sector entities. This group includes (but is not limited to) business associations representing commercial enterprises, entities not “at arm’s length”\(^1\) from their commercial sponsors, and partially or fully State-owned commercial enterprises acting like private sector entities.

*International business associations* are private sector entities that do not intend to make a profit for themselves but represent the interests of their members, which are commercial enterprises and/or national or other business associations. For the purposes of this framework, they shall have the authority to speak for their members through their authorized representatives. Their members shall exercise voting rights in relation to the policies of the international business association.

11. **Philanthropic foundations** are non-profit entities whose assets are provided by donors and whose income is spent on socially useful purposes. They shall be clearly independent from any private sector entity in their governance and decision-making.

12. **Academic institutions** are entities engaged in the pursuit and dissemination of knowledge through research, education and training.\(^2\)

13. For each of the four groups of entities above, the overarching framework and the respective specific policy on engagement apply. WHO will determine through its due diligence if a non-State actor is subject to the influence of private sector entities to the extent that the non-State actor has to be considered itself a private sector entity. Such influence can be exerted through financing, participation in decision making or otherwise. Provided that the decision-making processes and bodies of a non-State actor remain independent of undue influence from the private sector, WHO can decide to consider the entity as a nongovernmental organization, a philanthropic foundation or an academic institution, but may apply relevant provisions of the WHO’s policy and operational procedures on engagement with private sector entities, such as not accepting financial and in-kind contributions for use in the normative work.

**TYPES OF INTERACTION**

14. The following are categories of interaction in which WHO engages with non-State actors. Each type of interaction can take different forms, be subject to different levels of risk and can involve different levels and types of engagement by the Organization.

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1 An entity is “at arm’s length” from another entity if it is independent from the other entity, does not take instructions and is clearly not influenced or clearly not reasonably perceived to be influenced in its decisions and work by the other entity.

2 This can include think tanks which are policy-oriented institutions, as long as they primarily perform research; while international associations of academic institutions are considered as nongovernmental organizations, subject to paragraph 13.
Participation

15. Non-State actors may attend various types of meetings organized by WHO. The nature of their participation depends on the type of meeting concerned. The format, modalities, and the participation of non-State actors in consultations, hearings, and other meetings is decided on a case-by-case basis by the WHO governing bodies or by the Secretariat.

(a) **Meetings of the governing bodies.** This type 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.

(b) **Consultations.** This type includes any physical or virtual meeting, other than governing body sessions, organized for the purpose of exchanging information and views. Inputs received from non-State actors shall be made publicly available, wherever possible.

(c) **Hearings.** These are meetings in which the participants can present their evidence, views and positions and be questioned about them but do not enter into a debate. Hearings can be electronic or in person. All interested entities should be invited on the same basis. The participants and positions presented during hearings shall be documented and shall be made publicly available, wherever possible.

(d) **Other meetings.** These are meetings that are not part of the process of setting policies, norms or standards: examples include information meetings, briefings, scientific conferences, and platforms for coordination of actors.

16. WHO’s involvement in meetings organized wholly or partly by a non-State actor can – subject to the provisions of this framework, its four specific policies and operational procedures, and other applicable WHO rules, policies and procedures – consist of any one of the following possibilities:

- WHO jointly organizes the meeting with the non-State actor
- WHO cosponsors a meeting\(^1\) organized by the non-State actor
- WHO staff make a presentation or act as panellists at a meeting organized by the non-State actor
- WHO staff attend a meeting organized by a non-State actor.

Resources

17. Resources are financial or in-kind contributions. In-kind contributions include donations of medicines and other goods and free provision of services\(^2\) on a contractual basis.

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\(^1\) Cosponsorship of a meeting means: (1) another entity has the primary responsibility for organizing the meeting; and (2) WHO supports and contributes to the meeting and its proceedings; and (3) WHO reserves the right to clear the agenda of the meeting, the list of participants and the outcome documents of the meeting.

\(^2\) With the exception of secondments, which are covered in paragraph 47.
Evidence

18. For the purposes of this framework, evidence refers to inputs based on up-to-date information, knowledge on technical issues, and consideration of scientific facts, independently analysed by WHO. Evidence generation by WHO includes information gathering, analysis, generation of information and the management of knowledge and research. Non-State actors may provide their up-to-date information and knowledge on technical issues, and share their experience with WHO, as appropriate, subject to the provisions of this framework, its four specific policies and operational procedures, and other applicable WHO rules, policies and procedures. Such contribution should be made publicly available, as appropriate, wherever possible. Scientific evidence generated should be made publicly available.

Advocacy

19. Advocacy is action to increase awareness of health issues, including issues that receive insufficient attention; to change behaviours in the interest of public health; and to foster collaboration and greater coherence between non-State actors where joint action is required.

Technical collaboration

20. For the purpose of this framework, technical collaboration refers to other collaboration with non-State actors, as appropriate, in activities that fall within the General Programme of Work, including:

• product development
• capacity-building
• operational collaboration in emergencies
• contributing to the implementation of WHO’s policies.

MANAGEMENT OF CONFLICT OF INTEREST AND OTHER RISKS OF ENGAGEMENT

21. Managing, including by, where appropriate, avoiding, conflict of interest and other risks of engagement requires a series of steps, as set out below:¹

• WHO needs to know the non-State actors that it engages with. Therefore each non-State actor is required to provide all relevant² information about itself and its activities, following which WHO conducts the necessary due diligence.

• WHO conducts a risk assessment in order to identify the specific risks of engagement associated with each engagement with a non-State actor.

¹ The framework is designed to regulate institutional engagements; its implementation is closely coordinated with the implementation of other organizational policies regulating conflict of interest in respect of individuals (see paragraph 49).
² As defined in paragraph 39.
• Risks of engagement need to be managed and communicated coherently in each of the three levels of the Organization and throughout the Organization. To that end, WHO manages engagement through a single, Organization-wide electronic tool.¹

• Member States exercise oversight over WHO’s engagement with non-State actors in accordance with the provisions in paragraphs 67 and 68.

Conflict of interest

22. A conflict of interest arises in circumstances where there is potential for a secondary interest (a vested interest in the outcome of WHO’s work in a given area) to unduly influence, or where it may be reasonably perceived to unduly influence, either the independence or objectivity of professional judgement or actions regarding a primary interest (WHO’s work). The existence of conflict of interest in all its forms does not as such mean that improper action has occurred, but rather the risk of such improper action occurring. Conflicts of interest are not only financial, but can take other forms as well.

23. Individual conflicts of interests within WHO are those involving experts, regardless of their status, and staff members; these are addressed in accordance with the policies listed under paragraph 49 of the present framework.

24. All institutions have multiple interests, which means that in engaging with non-State actors WHO is often faced with a combination of converging and conflicting interests. An institutional conflict of interest is a situation where WHO’s primary interest as reflected in its Constitution may be unduly influenced by the conflicting interest of a non-State actor in a way that affects, or may reasonably be perceived to affect, the independence and objectivity of WHO’s work.

25. In actively managing institutional conflict of interest and the other risks of engagement mentioned in paragraph 7 above, WHO aims to avoid allowing the conflicting interests of a non-State actor to exert, or be reasonably perceived to exert, undue influence over the Organization’s decision-making process or to prevail over its interests.

26. For WHO, the potential risk of institutional conflicts of interest could be the highest in situations where the interest of non-State actors, in particular economic, commercial or financial, are in conflict with WHO’s public health policies, constitutional mandate and interests, in particular the Organization’s independence and impartiality in setting policies, norms and standards.

Due diligence and risk assessment

27. When the possibility of entering into an engagement is being considered, the relevant technical unit in the Secretariat conducts an initial examination in order to establish whether such an engagement would be in the interest of the Organization and in line with the principles of WHO’s engagement with non-State actors in paragraph 5 and the priorities defined in the General Programme of Work and Programme budget. If this seems to be the case, the technical unit consults the WHO Register on non-State actors and as needed asks the non-State actor to provide its basic information.

¹ WHO uses an electronic tool for managing engagement. As described in footnote 1 of paragraph 38, the publicly visible part of the tool is the register of non-State actors; the tool also provides an electronic workflow for the internal management of engagement. A similar electronic tool is used for the management of individual conflicts of interest, in order to harmonize the implementation of the framework with the implementation of the policy on management of individual conflicts of interest for experts.
Using the Organization-wide electronic tool, the unit then complements this information with a description of the proposed engagement and its own assessment of the benefits and risks involved, as needed.

28 The technical unit makes an initial assessment. If the engagement is of low risk, for example because of its repetitive nature\(^1\) or because it does not involve policies, norms and standard setting, a simplified due diligence and risk assessment modulating the procedures in paragraphs 29 to 36 as well as 39 can be performed by the technical unit and the risk management decision taken, taking such steps as are necessary to ensure full compliance with paragraphs 5 to 7.\(^2\) For all other engagements full procedures apply.

29. Before engaging with any non-State actor, WHO, in order to preserve its integrity, conducts due diligence and risk assessment. Due diligence refers to the steps taken by WHO to find and verify relevant information on a non-State actor and to reach a clear understanding of its profile. While due diligence refers to the nature of the non-State actor concerned, risk assessment refers to the assessment of a specific proposed engagement with that non-State actor.

30. Due diligence combines a review of the information provided by the non-State actor, a search for information about the entity concerned from other sources, and an analysis of all the information obtained. This includes a screening of different public, legal and commercial sources of information, including: media; the entity’s website companies’ analyst reports, directories and profiles; and public, legal and governmental sources.

31. The core functions of due diligence are to:

- clarify the nature and purpose of the entity proposed to engage with WHO;

- clarify the interest and objectives of the entity in engaging with WHO and what it expects in return;

- determine the entity’s legal status, area of activities, membership, governance, sources of funding, constitution, statutes, and by-laws and affiliation;

- define the main elements of the history and activities of the entity in terms of the following: health, human and labour issues; environmental, ethical and business issues; reputation and image; and financial stability;

- identify if paragraph 44 or 45 should be applied.

32. Due diligence also allows the Secretariat for the purpose of its engagement to categorize each non-State actor in relation to one of the four groups of non-State actors on the basis of its nature, objectives, governance, funding, independence and membership. This categorization is indicated in the register of non-State actors.

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\(^1\) Provided that due diligence and risk assessment have already been carried out and the nature of engagement has remained unchanged.

\(^2\) The simplified due diligence and risk assessment, and information to be provided by non-State actors as well as the criteria of low risk engagements are described in the guide for staff.
33. Risks are the expression of the likelihood and potential impact of an event that would affect the Organization’s ability to achieve its objectives. A risk assessment on a proposed engagement is conducted in addition to due diligence. This involves the assessment of risks associated with an engagement with a non-State actor, in particular the risks described in paragraph 7 and is to be conducted without prejudice to the type of non-State actor.

Risk management

34. Risk management concerns the process leading to a management decision whereby the Secretariat decides explicitly and justifiably on entry into engagement, continuation of engagement, engagement with measures to mitigate risks, non-engagement or disengagement from an existing or planned engagement with non-State actors. It is a management decision usually taken by the unit engaging with the non-State actor based on a recommendation of the specialized unit responsible for performing due diligence and risk assessment.

35. A dedicated secretariat mechanism reviews proposals of engagement referred to it and recommends engagement, continuation of engagement, engagement with measures to mitigate risks, non-engagement or disengagement from an existing or planned engagement with non-State actors. The Director-General, working with the Regional Directors, ensures coherence and consistency in implementation and interpretation of this Framework across all levels of the Organization.

36. WHO takes a risk-management approach to engagement, only entering into an engagement with a non-State actor when the benefits in terms of direct or indirect contributions to public health and the fulfilment of the Organization’s mandate as mentioned in paragraph 6 outweigh any residual risks of engagement as mentioned in paragraph 7, as well as the time and expense involved in establishing and maintaining the engagement.

Transparency

37. WHO’s interaction with non-State actors is managed transparently. WHO provides an annual report to the governing bodies on its engagement with non-State actors, including summary information on due diligence, risk assessment and risk management undertaken by the Secretariat. WHO also makes publicly available appropriate information on its engagement with non-State actors.

38. The WHO register of non-State actors is an Internet-based, publicly available electronic tool used by the Secretariat to document and coordinate engagement with non-State actors. It contains the main standard information provided by non-State actors and high-level descriptions of the engagement that WHO has with these actors.

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1 Other than decisions related to official relations as set out in paragraphs 50 to 57.
2 The register of non-State actors is the first level of a tool used by the Secretariat containing four levels of information: a publicly available level, a level made available to Member States, a working level for the Secretariat, and a level of confidential and sensitive information accessible to a limited number of individuals within the Secretariat.
3 Information on financial contributions received from non-State actors is documented in this register and in the Programme Budget web portal.
4 The register covers all three levels of the Organization – global, regional and country – and includes hosted partnerships and joint programmes.
Non-State actors engaging with WHO are required to provide information on their organization. This information includes: name, membership, legal status, objective, governance structure, composition of main decision-making bodies, assets, annual income and funding sources, main relevant affiliations, webpage and one or more focal points for WHO contacts.

When the Secretariat decides on an engagement with a non-State actor, a summary of the information submitted by that entity and held in the WHO register of non-State actors is made public. The accuracy of the information provided by the non-State actor and published in the register is the responsibility of the non-State actor concerned and does not constitute any form of endorsement by WHO.

Non-State actors described in the register must update the information provided on themselves annually or upon the request of WHO. Information in the WHO register of non-State actors will be dated. Information on entities that are no longer engaged with WHO or that have not updated their information will be marked as “archived”. Archived information from the WHO register of non-State actors can be considered in relation to future applications for engagement, where relevant.

In addition to the publicly available information, Member States have electronic access to a summary report on due diligence of each non-State actor and their respective risk assessment and risk management on engagement. Member States also have access, on demand, to the associated full report through a remote secure access platform.

WHO maintains a handbook to guide non-State actors in their interaction with WHO in line with this framework. A guide for staff is also maintained on the implementation of the framework of engagement with non-State actors.

SPECIFIC PROVISIONS

WHO does not engage with the tobacco industry or non-State actors that work to further the interests of the tobacco industry. WHO also does not engage with the arms industry.

Engagement where particular caution should be exercised

WHO will exercise particular caution, especially while conducting due diligence, risk assessment and risk management, when engaging with private sector entities and other non-State actors whose policies or activities are negatively affecting human health and are not in line with WHO’s policies, norms and standards, in particular those related to noncommunicable diseases and their determinants.

Association with WHO’s name and emblem

WHO’s name and emblem are recognized by the public as symbols of integrity and quality assurance. WHO’s name, acronym and emblem shall not, therefore, be used for, or in conjunction with, commercial, promotional marketing and advertisement purposes. Any use of the name or emblem needs an explicit written authorization by the Director-General of WHO.¹

¹ See http://www.who.int/about/licensing/emblem/en/.
Secondments

47. WHO does not accept secondments from private sector entities.

RELATION OF THE FRAMEWORK TO WHO’S OTHER POLICIES

48. This framework replaces the Principles Governing Relations between the World Health Organization and Nongovernmental Organizations and the Guidelines on interaction with commercial enterprises to achieve health outcomes (noted by the Executive Board).

49. The implementation of the policies listed below as they relate to WHO’s engagement with non-State actors will be coordinated and aligned with the framework of engagement with non-State actors. In the event that a conflict is identified, it will be brought to the attention of the Executive Board through its Programme, Budget and Administration Committee.

(a) Policy on WHO’s engagement with global health partnerships and hosting arrangements.
   
   (i) Hosted partnerships derive their legal personality from WHO and are subject to the Organization’s rules and regulations. Therefore the Framework of engagement with non-State actors applies to their engagement with non-State actors. They have a formal governance structure, separate from that of the WHO governing bodies, in which decisions are taken on direction, workplans and budgets; and their programmatic accountability frameworks are also independent from those of the Organization. In the same way the framework applies to other hosted entities which are subject to the Organizations Rules and Regulations.
   
   (ii) WHO’s involvement in external partnerships is regulated by the policy on WHO’s engagement with global health partnerships and hosting arrangements. The framework of engagement with non-State actors also applies to WHO’s engagement in these partnerships.
   
(b) Regulations for Expert Advisory Panels and Committees and the Guidelines for Declaration of Interests (WHO Experts). The management of WHO’s relations with individual experts is regulated by the Regulations for Expert Advisory Panels and Committees and the Guidelines for Declaration of Interests (WHO Experts).

(c) Staff Regulations and Staff Rules. All staff are subject to the Organization’s Staff Regulations and Staff Rules, noting in particular the provisions of declaration of interest therein:

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2 See document EB107/2001/REC/2, summary record of the twelfth meeting.
3 Endorsed by the Health Assembly in resolution WHA63.10 on partnerships and its Annex 1.
4 The Codex Alimentarius Commission is an intergovernmental body which is the principal organ of the joint FAO/WHO food standards programme for which the administration is not solely provided by WHO. The Commission is supported by subsidiary bodies including Codex committees, regional coordinating committees and task forces. Meetings of the Commission, Committees, including independent expert committees, and Task Forces are regulated by the Rules of Procedure and other decisions adopted by the Codex Alimentarius Commission.
according to Article 1.1 of the Staff Regulations of the World Health Organization, all staff members “pledge themselves to discharge their functions and to regulate their conduct with the interests of the World Health Organization only in view.”

(d) Regulations for Study and Scientific Groups, Collaborating Institutions and other Mechanisms of Collaboration. Scientific collaborations are regulated by the Regulations for Study and Scientific Groups, Collaborating Institutions and other Mechanisms of Collaboration.¹


(i) The procurement of goods and services is regulated by the Financial Rules and Financial Regulations;² it is not covered by the framework of engagement with non-State actors, although pro-bono contributions from non-State actors are covered.

(ii) Like any other financing of WHO, financing from non-State actors is regulated by the Financial Rules and Financial Regulations and the decision on accepting such financial contributions is also regulated by this framework.

OFFICIAL RELATIONS

50. “Official relations” 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 engagement³ in the interest of the Organization. The aims and activities of all these entities shall be in conformity with the spirit, purposes and principles of WHO’s Constitution, and they shall contribute significantly to the advancement of public health. Organizations in official relations can attend governing body meetings of WHO but are otherwise subject to the same rules as other non-State actors when engaging with WHO.

51. Entities in official relations are international in membership and/or scope. All entities in official relations shall have a constitution or similar basic document, an established headquarters, a governing body, an administrative structure, and a regularly updated entry in the WHO register of non-State actors.

52. Official relations shall be based on a plan for collaboration between WHO and the entity with agreed objectives and outlining activities for the coming three-year period structured in accordance with the General Programme of Work and Programme budget and consistent with this framework. This plan shall also be published in the WHO register of non-State actors. These organizations shall provide annually a short report on the progress made in implementing the plan of collaboration and other related activities which will also be published in the WHO register. These plans shall be free from concerns which are primarily of a commercial or profit-making nature.

³ At least two years of systematic engagement as documented in the WHO register of non-State actors, assessed by both parties to be mutually beneficial. Participation in each other’s meetings alone is not considered to be a systematic engagement.
53. For nongovernmental organizations working on global health issues, sustained and systematic engagement could include research and active advocacy around WHO meetings and WHO’s policies, norms and standards. Official relations may be considered for such nongovernmental organizations based on at least three years of their activities and future work plan on research and advocacy on global public health issues.

54. The Executive Board shall be responsible for deciding on the admission of organizations into official relations with WHO and shall review this status every three years. The Director-General may propose international nongovernmental organizations, philanthropic foundations and international business associations for admission. The Director-General can also propose an earlier review based on the experience in the collaboration with the organization concerned.

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.

**Procedure for admitting and reviewing organizations in official relations**

58. The application for admission into official relations shall be based on the up-to-date entries in the WHO register of non-State actors, providing all the necessary information as requested on the non-State actor’s nature and activities. The application shall include a summary of past engagement as documented in the register of non-State actors and a three-year plan for collaboration with WHO that has been developed and agreed on jointly by the non-State actor and WHO.

59. A signed letter certifying the accuracy of the application for official relations submitted online shall reach WHO headquarters no later than the end of the month of July for submission to the Executive Board at its session the following January. Applications for official relations shall be reviewed to ensure that the established criteria and other requirements are fulfilled as set out in this framework.

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1 In accordance with WHO Constitution, Article 71.
framework. Applications should be transmitted to the Executive Board members by the Secretariat six weeks before the opening of the January session of the Executive Board at which they will be considered.

60. During the Board’s January session, the Programme, Budget and Administration Committee of the Executive Board shall consider applications submitted and shall make recommendations to the Board. A representative of an applicant organization may be invited by the Committee to speak before it in connection with that organization’s application. Should the applicant organization be considered not to meet the established criteria, and bearing in mind the desirability of ensuring a valuable continuing partnership based on defined objectives and evidenced by a record of successful past engagement and a framework for future collaborative activities, the Committee may recommend postponement of consideration or rejection of an application.

61. The Board, after considering the recommendations of the Committee, shall decide whether an organization is to be admitted into official relations with WHO. A reapplication from a non-State actor shall not normally be considered until two years have elapsed since the Board’s decision on the previous application.

62. The Director-General shall inform each organization of the Board’s decision on its application. The Director-General shall document decisions taken within the Secretariat and by the Executive Board on applications from non-State actors, reflect this status in the WHO register of non-State actors, and maintain a list of the organizations admitted into official relations.

63. The entities in official relations and the Secretariat should name focal points for collaboration who are responsible for informing each other and their organizations of any developments in the implementation of the plan for collaboration and who are the first points of contact for any changes or problems.

64. The Board, through its Programme, Budget and Administration Committee, shall review collaboration with each non-State actor in official relations every three years and shall decide on the desirability of maintaining official relations or defer the decision on the review to the following year. The Board’s review shall be spread over a three-year period, one third of the entities in official relations being reviewed each year.

65. The Director-General can propose earlier reviews of a non-State actor’s official relations with WHO by the Executive Board through its Programme, Budget and Administration Committee in case of issues such as non-fulfilment of the entity’s part in the plan of collaboration, lack of contact, failure by the non-State actor to fulfil its reporting requirements or changes in the nature or activities of the organization concerned, the non-State actor ceasing to fulfil the criteria for admission, or any potential new risks for the collaboration.

66. The Board may discontinue official relations if it considers that such relations are no longer appropriate or necessary in the light of changing programmes or other circumstances. Similarly, the Board may suspend or discontinue official relations if an organization no longer meets the criteria that applied at the time of the establishment of such relations, fails to update its information and report on the collaboration in the WHO register on non-State actors or fails to fulfil its part in the agreed programme of collaboration.
OVERSIGHT OF ENGAGEMENT

67. The Executive Board, through its Programme, Budget and Administration Committee, oversees the implementation of WHO’s framework of engagement with non-State actors, proposes revisions to the framework and can grant the privileges of official relations to international nongovernmental organizations, philanthropic foundations and international business associations.

68. The Programme Budget and Administration Committee of the Executive Board shall review, provide guidance and, as appropriate, make recommendations to the Executive Board on:

(a) oversight of WHO’s implementation of the framework of engagement with non-State actors including:

(i) consideration of the annual report on engagement with non-State actors submitted by the Director-General

(ii) any other matter on engagement referred to the Committee by the Board

(b) entities in official relations with WHO, including:

(i) proposals for admitting non-State actors into official relations

(ii) review of renewals of entities in official relations

(c) any proposal, when needed, for revisions of the framework of engagement with non-State actors.

NON-COMPLIANCE WITH THIS FRAMEWORK

69. Non-compliance can include inter alia the following: significant delays in the provision of information to the WHO register of non-State actors; provision of wrong information; use of the engagement with WHO for purposes other than protecting and promoting public health, such as for commercial, promotional, marketing and advertisement purposes; misuse of WHO’s name and emblem; attempt at undue influence; and abuse of the privileges conferred by official relations.

70. Non-compliance by a non-State actor with the provisions of this framework can have consequences for the entity concerned after due process including a reminder, a warning, a cease-and-desist letter, a rejection of renewal of engagement and termination of engagement. The review of the status of official relations by the Executive Board can be anticipated and non-compliance can be the reason for non-renewal of official relations. Except in the case of important and intentional cases of non-compliance the non-State actor concerned should not be automatically excluded from other engagements with WHO.

71. Any financial contribution received by WHO that is subsequently discovered to be non-compliant with the terms of this framework shall be returned to the contributor.
IMPLEMENTATION

72. Consistent with the principles identified in paragraph 5, this framework will be implemented in its entirety in a manner that manages and strengthens WHO’s engagement with non-State actors towards the attainment of public health objectives, including through multistakeholder partnerships, whilst protecting and preserving WHO’s integrity, independence, credibility and reputation;

73. The Director-General, in the application of this framework, when responding to acute public health events described in the International Health Regulations (2005) or other emergencies with health consequences, will act according to the WHO Constitution1 and the principles identified in this framework. In doing so, the Director-General may exercise flexibility as might be needed in the application of the procedures of this framework in those responses, when he/she deems necessary, in accordance with WHO’s responsibilities as health cluster lead, and the need to engage quickly and broadly with non-State actors for coordination, scale up and service delivery2. The Director-General will inform Member States through appropriate means,3 including in particular written communication, without undue delay when such a response requires exercise of flexibility, and include summary information with justification on the use of such flexibility in the annual report on engagement with non-State actors.

MONITORING AND EVALUATION OF THE FRAMEWORK

74. The implementation of the framework will be constantly monitored internally and by the Executive Board through its Programme, Budget and Administration Committee in the annual report on engagement with non-State actors and the assessment of information available in the register of non-State actors.

75. Furthermore, the implementation of the framework should be periodically evaluated. The results of such evaluation, together with any proposals for revisions of the framework, shall also be submitted to the Executive Board through its Programme, Budget and Administration Committee.

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1 Including Article 2(d) of the WHO Constitution.
2 Taking into account resolution WHA65.20 (WHO’s response, and role as the health cluster lead, in meeting the growing demands of health in humanitarian emergencies).
3 Including as described in United Nations General Assembly resolution 46/182 (Strengthening of the coordination of humanitarian assistance of the United Nations), which establishes the Secretary-General’s emergency relief coordinator, and the International Health Regulations (2005).
WHO POLICY AND OPERATIONAL PROCEDURES ON ENGAGEMENT
WITH NONGOVERNMENTAL ORGANIZATIONS

1. This policy regulates specifically WHO’s engagement with nongovernmental organizations by type of interaction.¹ The provisions of the overarching framework also apply to all engagements with nongovernmental organizations.

PARTICIPATION

Participation by nongovernmental organizations in WHO meetings²

2. WHO can invite nongovernmental organizations to participate in consultations, hearings or other meetings in accordance with paragraph 15 of the overarching framework. Consultations and hearings can be electronic or in person.

3. Participation in other meetings is on the basis of discussion of an item in which the nongovernmental organization has a particular interest and where its participation adds value to the deliberations of the meeting. Such participation is for the exchange of information and views, but never for the formulation of advice.

4. The nature of participation of nongovernmental organizations depends on the type of meeting concerned. The format, modalities, and the participation of nongovernmental organizations in consultations, hearings, and other meetings is decided on a case-by-case basis by the WHO governing bodies or by the Secretariat. Participation and inputs received from nongovernmental organizations shall be made publicly available, wherever possible. Nongovernmental organizations do not take part in any decision-making process of the Organization.

Involvement of the Secretariat in meetings organized by nongovernmental organizations

5. WHO can organize joint meetings, or cosponsor meetings organized by nongovernmental organizations, as long as the integrity, independence and reputation of the Organization are preserved, and as long as this participation furthers WHO’s objectives as expressed in the General Programme of Work. WHO staff members may participate in meetings organized by nongovernmental organizations in accordance with the internal rules of the Organization. The nongovernmental organization shall not misrepresent WHO’s participation as official WHO support for, or endorsement of, the meeting, and shall agree not to use WHO’s participation for promotional purposes.

Specific policies and operational procedures

6. The participation of WHO in meetings organized by nongovernmental organizations as co-organizers, cosponsors, panellists or speakers shall be managed according to the provisions of this Framework.

¹ See paragraphs 14–20 of the overarching framework for the five types of interaction.
² Other than sessions of the governing bodies, which are regulated by the policy on management of engagement.
RESOURCES

7. WHO can accept financial and in-kind contributions from nongovernmental organizations as long as such contributions fall within WHO’s General Programme of Work, do not create conflicts of interest, are managed in accordance with the framework, and comply with other relevant regulations, rules and policies of WHO.

8. The acceptance of contributions (whether in cash or in kind) should be made subject to the following conditions:

   (a) the acceptance of a contribution does not constitute an endorsement by WHO of the nongovernmental organization;

   (b) the acceptance of a contribution does not confer on the contributor any privilege or advantage;

   (c) the acceptance of a contribution as such does not offer the contributor any possibility for advising, influencing, participating in, or being in command of the management or implementation of operational activities;

   (d) WHO keeps its discretionary right to decline a contribution, without any further explanation.

9. WHO can provide resources to a nongovernmental organization for implementation of particular work in accordance with the Programme Budget, the Financial Regulations and Financial Rules and other applicable rules and policies. The resources concerned can be either for a project of the institution which WHO considers merits support and is consistent with WHO’s general programme of work, or for a project organized or coordinated by WHO. The former constitutes a grant, the latter a service.

Specific policies and operational procedures

10. Any acceptance of resources from a nongovernmental organization is handled in accordance with the provisions of this framework and relevant other WHO rules and guidelines such as the Staff Regulations and Staff Rules, the Financial Regulations and Financial Rules and policies governing procurement, as well as WHO’s guidelines for medicine donations and WHO’s guidelines for health care equipment donations;

11. For reasons of transparency, contributions from nongovernmental organizations must be publicly acknowledged by WHO in accordance with its policies and practices.

12. Acknowledgements shall usually be worded along the following lines: “The World Health Organization gratefully acknowledges the financial contribution of [Nongovernmental organization] towards [description of the outcome or activity]”.

13. Contributions received from nongovernmental organizations are listed in the financial report and audited financial statements of WHO as well as the Programme budget web portal and the WHO register of non-State actors.
14. Nongovernmental organizations may not use the fact that they have made a contribution in their materials used for commercial, promotional, marketing and advertisement purposes. However, they may make reference to the contribution in their annual reports or similar documents. In addition, they may mention the contribution on their websites, and in special non-promotional publications, provided that the content and context have been agreed with WHO.

EVIDENCE

15. Nongovernmental organizations may provide their up-to-date information and knowledge on technical issues, and share their experience with WHO, as appropriate, subject to the provisions of the overarching framework, and this specific policy and operational procedures, and other applicable WHO rules, policies and procedures. Such contribution should be made publicly available, as appropriate, wherever possible. Scientific evidence generated should be made publicly available.

ADVOCACY

16. WHO collaborates with nongovernmental organizations on advocacy for health and increasing awareness of health issues; for changing behaviours in the interest of public health; and for fostering collaboration and greater coherence between non-State actors where joint action is required.

17. Nongovernmental organizations are encouraged to disseminate WHO’s policies, guidelines, norms and standards and other tools through their networks.

18. WHO encourages nongovernmental organizations to implement and advocate for the implementation of WHO’s policies, norms and standards. WHO engages in dialogue with nongovernmental organizations in order to promote the implementation of WHO’s policies, norms and standards.2

19. Nongovernmental organizations can only collaborate with WHO in advocacy for the implementation of WHO policies norms or standards if they commit themselves to implement these policies, norms or standards in their entirety. No partial or selective implementation is acceptable.

TECHNICAL COLLABORATION

20. WHO may engage with the nongovernmental organizations for technical collaboration as defined in the overarching framework paragraph 20. Technical collaboration with nongovernmental organizations is encouraged. This collaboration must be in the interest of WHO, and managed in accordance with the overarching framework and this policy to protect WHO, and in particular, its normative work, from any undue influence or conflict of interest and to ensure there is no interference with WHO’s advisory function to Member States.

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1 In accordance with paragraph 46 of the overarching framework.
2 Nongovernmental organizations working with WHO will be expected to conform to WHO’s public health policies in areas such as food safety, chemical safety, ethical promotion of medicinal drug products, tobacco control, noncommunicable diseases, as well as health and safety at work.
WHO POLICY AND OPERATIONAL PROCEDURES ON ENGAGEMENT WITH PRIVATE SECTOR ENTITIES

1. This policy regulates specifically WHO’s engagement with private sector entities by type of interaction.\(^1\) The provisions of the overarching framework also apply to all engagements with private sector entities.

2. When engaging with private sector entities, it should be borne in mind that WHO’s activities affect the commercial sector in broader ways, through, among others, its public health guidance, its recommendations on normative standards, or other work that might indirectly or directly influence product costs, market demand, or profitability of specific goods and services.

3. In engaging with private sector entities, WHO will aim to operate on a competitively neutral basis.

PARTICIPATION

Participation by private sector entities in WHO meetings\(^2\)

4. WHO can invite private sector entities to participate in consultations, hearings or other meetings in accordance with paragraph 15 of the overarching framework. Consultations and hearings can be electronic or in person.

5. Participation in other meetings is on the basis of discussion of an item in which the private sector entity has a particular interest and where its participation adds value to the deliberations of the meeting. Such participation is for the exchange of information and views, but never for the formulation of advice.

6. The nature of participation of private sector entities depends on the type of meeting concerned. The format, modalities, and the participation of private sector entities in consultations, hearings, and other meetings is decided on a case-by-case basis by the WHO governing bodies or by the Secretariat. Participation and inputs received from private sector entities shall be made publicly available, wherever possible. Private sector entities do not take part in any decision making process of the Organization.

Involvement of the Secretariat in meetings organized by private sector entities

7. WHO staff members may participate in meetings organized by a private sector entity as long as the integrity, independence and reputation of the Organization are preserved and as long as this participation furthers WHO’s objectives as expressed in the General Programme of Work. The private sector entity shall not misrepresent WHO’s participation as official WHO support for, or endorsement of, the meeting, and shall agree not to use WHO’s participation for commercial and/or promotional purposes.

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\(^1\) See paragraphs 14–20 of the overarching framework for the five types of interaction.

\(^2\) Other than sessions of the governing bodies, which are regulated by the policy on management of engagement.
Specific policies and operational procedures

8. The participation of WHO staff members in meetings of private sector entities as panellists, speakers or in any other capacity shall be managed according to the provisions of the overarching framework and this specific policy.

9. WHO does not cosponsor meetings organized wholly or partly by private sector entities. It may, however, cosponsor a meeting for which the scientific initiators have hired a commercial conference organizer to deal with the logistical aspects, provided that the commercial organizer makes no contribution to the scientific content of the meeting.

10. WHO does not cosponsor meetings organized by other actors where one or more health-related private sector entities are also cosponsors. Other instances of cosponsorship of meetings organized by other actors where non-health-related private sector entities are also cosponsors should be reviewed on a case-by-case basis and are subject to the provisions of this framework.

11. There shall be no commercial exhibitions on WHO premises and at WHO’s meetings.

12. WHO does not cosponsor commercial exhibitions, whether as part of meetings organized by private sector entities or as part of meetings organized by other actors.

RESOURCES

13. The level of risk associated with the acceptance of resources from private sector entities depends on the field of activity of the private sector entity, the WHO activity for which the resources are used and the modalities of the contributions.

   (a) Financial contributions may be accepted from private sector entities whose business is unrelated to that of WHO, provided they are not engaged in any activity or have close ties with any entity that is incompatible with WHO’s mandate and work.

   (b) Financial contributions may not be sought or accepted from private sector entities that have, themselves or through their affiliated companies, a direct commercial interest in the outcome of the project toward which they would be contributing, unless approved in conformity with the provisions for clinical trials or product development (see paragraph 36 below).

   (c) The provisions set out in paragraph 13(b) shall be without prejudice to specific mechanisms, such as the Pandemic Influenza Preparedness Framework (“PIP Framework”), set up by the Health Assembly that involve the receipt and pooling of resources.¹

   (d) Caution should be exercised in accepting financial contributions from private sector entities that have even an indirect interest in the outcome of the project (i.e. the activity is related to the entities’ field of interest, without there being a conflict as referred to above). In such an event, other commercial enterprises having a similar indirect interest should be invited to contribute, and the reason clearly described if this does not prove possible. The larger the proportion of the contribution from any one source, the greater the care that should be taken to

¹ In accordance with paragraph 17 of the overarching framework.
avoid the possibility of a conflict of interest or appearance of an inappropriate association with one contributor.

14. Financial and in-kind contributions from private sector entities to WHO’s programmes are only acceptable in the following conditions:

(a) the contribution is not used for normative work;

(b) if a contribution is used for activities other than normative work in which the private sector entity could have a commercial interest, the public health benefit of the engagement needs clearly to outweigh its potential risks;

(c) the proportion of funding of any activity coming from the private sector cannot be such that the programme’s continuation would become dependent on this support;

(d) the acceptance of the contribution does not constitute an endorsement by WHO of the private sector entity, or its activities, products or services;

(e) the contributor may not use the results of WHO’s work for commercial purposes or use the fact of its contribution in its promotional material;

(f) the acceptance of the contribution does not afford the contributor any privilege or advantage;

(g) the acceptance of the contribution does not offer the contributor any possibility for advising, influencing, participating in, or being in command of the management or implementation of operational activities;

(h) WHO keeps its discretionary right to decline a contribution, without any further explanation.

15. Any acceptance of resources from private sector entities is handled in accordance with the provisions of this framework and relevant other WHO rules and guidelines such as the Staff Regulations and Staff Rules, the Financial Regulations and Financial Rules and policies governing procurement, as well as WHO’s guidelines for medicine donations and WHO’s guidelines for health care equipment donations;

16. For reasons of transparency, contributions from private sector entities must be publicly acknowledged by WHO in accordance with its policies and practices.

17. Acknowledgements shall usually be worded along the following lines: “The World Health Organization gratefully acknowledges the financial contribution of [Private sector entity] towards [description of the outcome or activity]”.

18. Contributions received from private sector entities, are listed in the financial report and audited financial statements of WHO as well as the Programme budget web portal and the register of non-State actors.
19. Private sector entities may not use the fact that they have made a contribution in their materials used for commercial, promotional, marketing and advertisement purposes.\(^1\) However, they may make reference to the contribution in their annual reports or similar documents. In addition, they may mention the contribution on their websites, and in special non-promotional publications, provided that the content and context have been agreed with WHO.

Donations of medicines and other health technologies\(^2\)

20. In determining the acceptability of large-scale donations of medicines and other health-related products, the following criteria should be met.

(a) Sound evidence exists of the safety and efficacy of the product in the indication for which it is being donated. The product is approved or otherwise authorized by the recipient country for use in that indication; it should also preferably appear in the WHO Model List of Essential Medicines for that indication.

(b) Objective and justifiable criteria for the selection of recipient countries, communities or patients have been determined. In emergency situations, flexibilities may be required.

(c) A supply system is in place and consideration is given to means of preventing waste, theft and misuse (including leakage back into the market).

(d) A training and supervision programme is in place for all personnel involved in the efficient administration of supply, storage and distribution at every point from the donor to the end-user.

(e) A donation of medicines and other health-related products is not of a promotional nature, either with regard to the company itself or insofar as it creates a demand for the products that is not sustainable once the donation has ended.

(f) WHO does not accept products at the end of their shelf life.

(g) A phase-out plan for the donation has been agreed upon with recipient countries.

(h) A system for monitoring adverse reactions to the product has been set up with the participation of the donating company.

21. In consultation with the department responsible for financial matters in WHO, the value of donations of medicines and other health-related products is determined and is formally recorded in the audited statements and the WHO register of non-State actors.

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\(^1\) In accordance with paragraph 46 of the overarching framework.

Financial contributions for clinical trials

22. Except as provided in paragraph 36 below on product development, financial contributions from a private sector entity for a clinical trial arranged by WHO on that company’s proprietary product are considered on a case-by-case basis. In this connection, it should be ensured that:

(a) the research or development activity is of public health importance;

(b) the research is conducted at WHO’s request and potential conflicts of interest are managed;

(c) WHO only accepts such financial contributions, if the research would not take place without WHO’s involvement or if WHO’s involvement is necessary in order to ensure that the research is undertaken in conformity with internationally accepted technical and ethical standards and guidelines.

23. If the above-mentioned requirements are met, a financial contribution may be accepted from a company having a direct commercial interest in the trial in question, provided that appropriate mechanisms are put in place to ensure that WHO controls the conduct and the dissemination of the outcomes of the trials, including the content of any resulting publication, and that the trial results are free from any inappropriate influence or perceived influence from the company concerned.

Contributions for WHO meetings

24. For meetings convened by WHO, a contribution from a private sector entity may not be accepted if it is designated to support the participation of specific invitees (including such invitees’ travel and accommodation), regardless of whether such contribution would be provided directly to the participants or channelled through WHO.

25. Contributions may be accepted to support the overall costs of a meeting.

26. WHO receptions and similar functions shall not be paid for by private sector entities.

Contributions for WHO staff participating in external meetings

27. An external meeting is one convened by a party other than WHO. Support from private sector entities for travel of WHO staff members to attend external meetings or conferences may fall into two categories:

(a) meetings held by the private sector entity paying for travel: financing for travel may be accepted in accordance with WHO’s rules if the private sector entity is also supporting the travel and ancillary expenses of other participants in the meeting, and the risk of a conflict of interest has been assessed and managed;

(b) meetings held by a third party (i.e. a party other than the private sector entity proposing to pay for the travel): financing for travel may not be accepted from a private sector entity.
Contributions for publications

28. Financial contributions may be accepted from private sector entities for meeting the printing costs of WHO publications, as long as no conflict of interest arises. In no event may commercial advertisements be placed in WHO publications;

Cost recovery

29. In cases where a WHO evaluation scheme is in place (i.e. to evaluate certain products, processes or services against official WHO guidelines), the Organization may charge private sector entities for such services on the basis of cost recovery. The purpose of WHO’s evaluation schemes is always to provide advice to governments and/or international organizations for procurement. Evaluation does not constitute endorsement by WHO of the product(s), process or service in question.

EVIDENCE

30. Private sector entities may provide their up-to-date information and knowledge on technical issues, and share their experience with WHO, as appropriate, subject to the provisions of the overarching framework, and this specific policy and operational procedures, and other applicable WHO rules, policies and procedures. Such contribution should be made publicly available, as appropriate, wherever possible. Scientific evidence generated should be made publicly available.

ADVOCACY

31. WHO encourages private sector entities to implement and advocate for the implementation of WHO’s policies, norms and standards. WHO engages in dialogue with private sector entities in order to promote the implementation of WHO’s policies, norms and standards.¹

32. Private sector entities can only collaborate with WHO in advocacy for the implementation of WHO policies norms or standards if they commit themselves to implement these policies, norms or standards in their entirety. No partial or selective implementation is acceptable.

33. International business associations are encouraged to work with their members in order to improve their public health impact and the implementation of WHO policies, norms and standards.

TECHNICAL COLLABORATION

34. WHO may engage with the private sector for technical collaboration as defined in the overarching framework paragraph 20. Technical collaboration with private sector entities is encouraged. This collaboration must be in the interest of WHO, and managed in accordance with the overarching framework and this policy to protect WHO, and in particular, its normative work, from any undue influence or conflict of interest and to ensure there is no interference with WHO’s advisory function to Member States.

¹ Private sector entities working with WHO will be expected to conform to WHO’s public health policies in areas such as food safety, chemical safety, ethical promotion of medicinal drug products, tobacco control, noncommunicable diseases, as well as health and safety at work.
Specific policies and operational procedures

35. If WHO has drawn up official specifications for a product, it may provide technical advice to manufacturers for development of their product in accordance with these specifications, provided that all private sector entities known to have an interest in such a product are given the opportunity to collaborate with WHO in the same way.

36. WHO may collaborate with private sector entities in the research and development of health related technologies that contribute to increasing access to quality, safe, efficacious and affordable medical products. Collaborative research and development should, as a general rule, be undertaken only if WHO and the private sector entity have concluded an agreement which ensures that the final product will ultimately be widely available, including to the public sector of developing countries at a preferential price. If such an agreement is concluded, financing may be accepted from the private sector entity for a trial arranged by WHO on the product in question, on the basis that contractual commitments obtained from the private sector entity outweigh any potential conflict of interest in accepting such financing.
WHO POLICY AND OPERATIONAL PROCEDURES ON ENGAGEMENT WITH PHILANTHROPIC FOUNDATIONS

1. This policy regulates specifically WHO’s engagement with philanthropic foundations by type of interaction.¹ The provisions of the overarching framework also apply to all engagements with philanthropic foundations.

PARTICIPATION

Participation by philanthropic foundations in WHO meetings²

2. WHO can invite philanthropic foundations to participate in consultations, hearings or other meetings in accordance with paragraph 15 of the overarching framework. Consultations and hearings can be electronic or in person.

3. Participation in other meetings is on the basis of discussion of an item in which the philanthropic foundation has a particular interest and where its participation adds value to the deliberations of the meeting. Such participation is for the exchange of information and views, but never for the formulation of advice.

4. The nature of participation of philanthropic foundations depends on the type of meeting concerned. The format, modalities, and the participation of philanthropic foundations in consultations, hearings, and other meetings is decided on a case-by-case basis by the WHO governing bodies or by the Secretariat. Participation and inputs received from philanthropic foundations shall be made publicly available, wherever possible. Philanthropic foundations do not take part in any decision making process of the Organization.

Involvement of the Secretariat in meetings organized by philanthropic foundations

5. WHO can organize joint meetings, or cosponsor meetings organized by philanthropic foundations, as long as the integrity, independence and reputation of the Organization are preserved, and as long as this participation furthers WHO’s objectives as expressed in the General Programme of Work. WHO staff members may participate in meetings organized by philanthropic foundations in accordance with the Organization’s internal rules. The philanthropic foundations shall not misrepresent WHO’s participation as official WHO support for, or endorsement of, the meeting, and shall agree not to use WHO’s participation for promotional purposes.

Specific policies and operational procedures

6. The participation of WHO in meetings organized by philanthropic foundations as co-organizers, cosponsors, panellists or speakers shall be managed according to the provisions of the framework for engagement with non-State actors.

¹ See paragraphs 14–20 of the overarching framework for the five types of interaction.
² Other than sessions of the governing bodies, which are regulated by the policy on management of engagement.
RESOURCES

7. WHO can accept financial and in-kind contributions from philanthropic foundations as long as such contributions fall within WHO’s General Programme of Work, do not create conflicts of interest, are managed in accordance with the framework, and comply with other relevant regulations, rules and policies of WHO.

8. As for all contributors, philanthropic foundations shall align their contributions to the priorities set by the Health Assembly in the approved Programme budget.

9. Philanthropic foundations are invited to participate in the financing dialogue, which is designed to improve the alignment, predictability, flexibility and transparency of WHO’s funding and to reduce budgetary vulnerability.

10. WHO’s programmes and offices should strive to ensure that they do not depend on one single source of funding.

11. The acceptance of contributions (whether in cash or in kind) should be made subject to the following conditions:

   (a) the acceptance of a contribution does not constitute an endorsement by WHO of the philanthropic foundation;

   (b) the acceptance of a contribution does not confer on the contributor any privilege or advantage;

   (c) the acceptance of a contribution as such does not offer the contributor any possibility for advising, influencing, participating in, or being in command of the management or implementation of operational activities;

   (d) WHO keeps its discretionary right to decline a contribution, without any further explanation.

Specific policies and operational procedures

12. Any acceptance of resources from a philanthropic foundation is handled in accordance with the provisions of this framework and relevant other WHO rules and guidelines such as the Staff Regulations and Staff Rules, the Financial Regulations and Financial Rules and policies governing procurement, as well as WHO’s guidelines for medicine donations and WHO’s guidelines for health care equipment donations.

13. For reasons of transparency, contributions from philanthropic foundations must be publicly acknowledged by WHO in accordance with its policies and practices.

14. Acknowledgements shall usually be worded along the following lines: “The World Health Organization gratefully acknowledges the financial contribution of [Philanthropic foundation] towards [description of the outcome or activity]”.


15. Contributions received from philanthropic foundations are listed in the financial report and audited financial statements of WHO as well as the Programme budget web portal and the WHO register of non-State actors.

16. Philanthropic foundations may not use the fact that they have made a contribution in their materials used for commercial, promotional, marketing and advertisement purposes. However, they may make reference to the contribution in their annual reports or similar documents. In addition, they may mention the contribution on their websites, and in special non-promotional publications, provided that the content and context have been agreed with WHO.

EVIDENCE

17. Philanthropic foundations may provide their up-to-date information and knowledge on technical issues, and share their experience with WHO, as appropriate, subject to the provisions of the overarching framework, and this specific policy and operational procedures, and other applicable WHO rules, policies and procedures. Such contribution should be made publicly available, as appropriate, wherever possible. Scientific evidence generated should be made publicly available.

ADVOCACY

18. WHO collaborates with philanthropic foundations on advocacy for health and increasing awareness of health issues; for changing behaviours in the interest of public health; and for fostering collaboration and greater coherence between non-State actors where joint action is required. Philanthropic foundations are encouraged to disseminate WHO’s policies, guidelines, norms and standards and other tools through their networks so as to extend WHO’s own reach.

19. WHO encourages philanthropic foundations to implement and advocate for the implementation of WHO’s policies, norms and standards. WHO engages in dialogue with Philanthropic foundations in order to promote the implementation of WHO’s policies, norms and standards.

20. Philanthropic foundations can only collaborate with WHO in advocacy for the implementation of WHO policies norms or standards if they commit themselves to implement these policies, norms or standards in their entirety. No partial or selective implementation is acceptable.

TECHNICAL COLLABORATION

21. WHO may engage with the philanthropic foundations for technical collaboration as defined in the overarching framework paragraph 20. Technical collaboration with philanthropic foundations is encouraged. This collaboration must be in the interest of WHO, and managed in accordance with the overarching framework and this policy to protect WHO, and in particular, its normative work, from any undue influence or conflict of interest and to ensure there is no interference with WHO’s advisory function to Member States).

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1 In accordance with paragraph 46 of the overarching framework.

2 Philanthropic foundations working with WHO will be expected to conform to WHO’s public health policies in areas such as food safety, chemical safety, ethical promotion of medicinal drug products, tobacco control, noncommunicable diseases, as well as health and safety at work.
WHO POLICY AND OPERATIONAL PROCEDURES ON ENGAGEMENT WITH ACADEMIC INSTITUTIONS

1. This policy regulates specifically WHO’s engagement with academic institutions by type of interaction. The provisions of the overarching framework also apply to all engagements with academic institutions.

2. The engagement with academic institutions at the institutional level has to be distinguished from the collaboration with individual experts working for academic institutions.

PARTICIPATION

Participation by academic institutions in WHO meetings

3. WHO can invite academic institutions to participate in consultations, hearings or other meetings in accordance with paragraph 15 of the overarching framework. Consultations and hearings can be electronic or in person.

4. Participation in other meetings is on the basis of discussion of an item in which the academic institution has a particular interest and where its participation adds value to the deliberations of the meeting. Such participation is for the exchange of information and views, but never for the formulation of advice.

5. The nature of participation of academic institution depends on the type of meeting concerned. The format, modalities, and the participation of academic institution in consultations, hearings, and other meetings is decided on a case-by-case basis by the WHO governing bodies or by the Secretariat. Participation and inputs received from academic institutions shall be made publicly available, wherever possible. Academic institutions do not take part in any decision-making process of the Organization.

Involvement of the Secretariat in meetings organized by academic institutions

6. WHO can organize joint meetings, or cosponsor meetings organized by academic institutions, as long as the integrity, independence and reputation of the Organization are preserved, and as long as this participation furthers WHO’s objectives as expressed in the General Programme of Work. WHO staff members may participate in meetings organized by academic institutions in accordance with the Organization’s internal rules. The academic institution shall not misrepresent WHO’s participation as official WHO support for, or endorsement of, the meeting, and shall agree not to use WHO’s participation for promotional purposes.

Specific policies and operational procedures

7. The participation of WHO in meetings organized by academic institutions as co-organizers, cosponsors, panellists or speakers shall be managed according to the provisions of this framework.

1 See paragraphs 14–20 of the overarching framework for the five types of interaction.
RESOURCES

8. WHO can accept financial and in-kind contributions from academic institutions as long as such contributions fall within WHO’s General Programme of Work, do not create conflicts of interest, are managed in accordance with the framework, and comply with other relevant regulations, rules and policies of WHO.

9. WHO can provide resources to an academic institution for implementation of particular work (such as research, a clinical trial, laboratory work and preparation of a document), in accordance with the Financial Regulations and Financial Rules and other applicable rules and policies. This can be either for a project of the institution which WHO considers merits support, based on a clear public health interest, and is consistent with WHO’s General Programme of Work, or for a project organized or coordinated by WHO. The former constitutes a grant, the latter a service.

Specific policies and operational procedures

10. Any acceptance of resources from an academic institution is handled in accordance with the provisions of this framework and relevant other WHO rules and guidelines such as the Staff Regulations and Staff Rules, the Financial Regulations and Financial Rules and policies governing procurement, as well as WHO’s guidelines for medicine donations and WHO’s guidelines for health care equipment donations;

11. For reasons of transparency, contributions from academic institutions must be publicly acknowledged by WHO in accordance with its policies and practices.

12. Acknowledgements shall usually be worded along the following lines: “The World Health Organization gratefully acknowledges the financial contribution of [academic institution] towards [description of the outcome or activity].”

13. Contributions received from academic institutions are listed in the financial report and audited financial statements of WHO as well as the Programme budget web portal and the WHO register of non-State actors.

14. Academic institutions may not use the fact that they have made a contribution in their materials used for commercial, promotional, marketing and advertisement purposes. However, they may make reference to the contribution in their annual reports or similar documents. In addition, they may mention the contribution on their websites, and in special non-promotional publications, provided that the content and context have been agreed with WHO.

EVIDENCE

15. Academic institutions may provide their up-to-date information and knowledge on technical issues, and share their experience with WHO, as appropriate, subject to the provisions of the overarching framework, and this specific policy and operational procedures, and other applicable WHO rules, policies and procedures. Such contribution should be made publicly available, as appropriate, wherever possible. Scientific evidence generated should be made publicly available.

1 In accordance with paragraph 46 of the overarching framework.
16. Intellectual property arising from collaborations with academic institutions is regulated by the agreement with the academic institution. This should be addressed in consultation with the Office of the Legal Counsel.

ADVOCACY

17. WHO collaborates with academic institutions on advocacy for health and increasing awareness of health issues; for changing behaviours in the interest of public health; and for fostering collaboration and greater coherence between non-State actors where joint action is required. Academic institutions are encouraged to disseminate WHO’s policies, guidelines, norms and standards and other tools through their networks so as to extend WHO’s own reach.

18. WHO encourages academic institutions to implement and advocate for the implementation of WHO’s policies, norms and standards. WHO engages in dialogue with academic institutions in order to promote the implementation of WHO’s policies, norms and standards.¹

19. Academic institutions can only collaborate with WHO in advocacy for the implementation of WHO policies norms or standards if they commit themselves to implement these policies, norms or standards in their entirety. No partial or selective implementation is acceptable.

TECHNICAL COLLABORATION

20. WHO may engage with academic institutions for technical collaboration as defined in the overarching framework paragraph 20. Technical collaboration with academic institutions is encouraged. This collaboration must be in the interest of WHO, and managed in accordance with the overarching framework and this policy to protect WHO, and in particular, its normative work, from any undue influence or conflict of interest and to ensure there is no interference with WHO’s advisory function to Member States.

21. Scientific collaborations are regulated by the Regulations for Study and Scientific Groups, Collaborating Institutions and other Mechanisms of Collaboration.²

22. Academic institutions or parts thereof can be designated as WHO collaborating centres in accordance with the Regulations mentioned above. In this context, before granting the status of WHO collaborating centre a due diligence and risk assessment in accordance with this framework is conducted. The collaboration with these collaborating centres is regulated by the aforementioned regulations and reflected in the register of non-State actors.

Eighth plenary meeting, 28 May 2016
A69/VR/8

¹ Academic institutions working with WHO will be expected to conform to WHO’s public health policies in areas such as food safety, chemical safety, ethical promotion of medicinal drug products, tobacco control, noncommunicable diseases, as well as health and safety at work.

Health in the 2030 Agenda for Sustainable Development

The Sixty-ninth World Health Assembly,

Reaffirming WHO’s Constitution, which states 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;

Reaffirming also United Nations General Assembly resolution 70/1 (2015), entitled “Transforming our world: the 2030 Agenda for Sustainable Development”, in which the General Assembly adopted the outcome document of the United Nations summit for the adoption of the post-2015 development agenda, recognizing that eradicating poverty in all its forms and dimensions, including extreme poverty, is the greatest global challenge and an indispensable requirement for sustainable development, and envisaging a world free of poverty, hunger, disease and want, a world of universal respect for human rights and human dignity that includes equitable and universal access to health care and social protection, and where physical, mental and social well-being are assured;

Reaffirming United Nations General Assembly resolution 69/313 (2015) on the Addis Ababa Action Agenda of the Third International Conference on Financing for Development, which is an integral part of the 2030 Agenda for Sustainable Development, supports and complements it, helps to contextualize its means of implementing targets with concrete policies and actions, and reaffirms the strong political commitment to addressing the challenge of financing and creating an enabling environment at all levels for sustainable development in the spirit of global partnership and solidarity;

Recognizing the achievements of the Millennium Development Goals in galvanizing collective action at global level for better health outcomes, in particular in meeting global targets for HIV, tuberculosis, and malaria, and in reducing child mortality by 53% and maternal mortality by 44%, reductions which are cause for celebration, despite being short of the targets of the Goals;

Recalling resolutions WHA66.11 (2013) and WHA67.14 (2014) on health in the post-2015 development agenda which point to the importance of health in meeting broader sustainable development goals and the need for accelerated progress towards the unfinished business of the Millennium Development Goals;

Recognizing the importance of the numerous WHO strategies and action plans relating to health, health systems, and public health as useful tools in taking forward the work on the 2030 Agenda for Sustainable Development, and stressing that the Organization’s support to countries in implementing these strategies should be provided in a coherent way, aligned to national needs, contexts and priorities, and in efficient coordination with other United Nations agencies;
Recognizing also the opportunity provided by the 2030 Agenda for Sustainable Development for adopting a more integrated and multisectoral approach to health, health promotion and well-being that acknowledges health systems as a coherent entity made up of functions and services rather than a series of discrete disease- or subject-specific initiatives;

Recognizing further that universal health coverage implies that all people have access without discrimination to nationally determined sets of the needed promotive, preventive, curative, palliative, and rehabilitative 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;¹

Recognizing that health workers and the public health workforce are integral to building strong and resilient health systems that contribute to the achievement of the Sustainable Development Goals;

Recalling resolution EBSS3.R1 (2015) on Ebola, in which the Executive Board recognized the urgency for all countries of having strong, resilient and integrated health systems capable of fully implementing the International Health Regulations (2005), and of having the capacity for health-related emergency preparedness and progress towards universal health coverage that promotes universal, equitable access to health services and ensures affordable, good-quality service delivery;

Recognizing the importance of strengthening health systems and building capacities for broad public health measures, health protection and promotion and work to tackle social, economic, and environmental determinants of health, in support of ensuring healthy lives and promoting well-being for all at all ages;

Recalling further the importance of fostering alignment and coordination of global health interventions in the area of health systems strengthening, including at the primary health care level, and recognizing the important role WHO should play in this regard;

Taking note of the significant infrastructure, assets and human resources of the global polio eradication initiative, and the ongoing legacy process across countries as appropriate;

Emphasizing the need for community engagement to focus attention on more rational and forward-looking integration of health workers at community level into functional health systems aligned with country objectives and actions, and on recognizing them as key players to extend and deliver basic health services directly to communities to achieve the Goals of the 2030 Agenda for Sustainable Development;

Goals

Reaffirming that the Goals and targets of the 2030 Agenda for Sustainable Development are integrated and indivisible, balance the three dimensions of sustainable development (the economic, social, and environmental), seek to achieve gender equality and the empowerment of women and girls, are global in nature and universally applicable, taking into account different national realities, capacities and levels of development and respecting national policy space and priorities;

¹ See resolution WHA67.14 (2014).
Welcoming the 2030 Agenda for Sustainable Development, including inter alia Sustainable Development Goal 3, “Ensure healthy lives and promote well-being for all at all ages”, and reaffirming its specific and interlinked targets as well as other health-related Goals and targets and emphasizing the importance of health systems strengthening as it is critical to the achievement of all targets;

Reaffirming also the specific commitments to promoting physical and mental health and well-being, and to extending life expectancy for all, contained in the 2030 Agenda for Sustainable Development, including: achievement of universal health coverage and access to quality health care; ensuring that no one is left behind; acceleration of the progress made to date in reducing newborn, child and maternal mortality by ending all such preventable deaths before 2030; universal access to sexual and reproductive health-care services, including for family planning, information and education; ending the epidemics of HIV/AIDS, tuberculosis and malaria as well as acceleration of the fight against hepatitis, Ebola and other communicable diseases and epidemics, including by addressing growing antimicrobial resistance and the problem of neglected tropical diseases affecting developing countries; and prevention and treatment of noncommunicable diseases, including behavioural, developmental and neurological disorders, which constitute a major challenge for sustainable development;

Asserting that health is not just an end in itself, but is a means of reaching other targets under the Goals of the 2030 Agenda for Sustainable Development, and noting that investments in health contribute to sustainable, inclusive economic growth, social development, environmental protection, and the eradication of poverty and hunger, and to reducing inequality, and also acknowledging the reciprocal benefits between the attainment of the health Goal and the achievement of all other Goals;

Reaffirming the Global strategy and plan of action on public health, innovation and intellectual property;¹

Means of implementation

Recognizing also that the 2030 Agenda for Sustainable Development, including the Sustainable Development Goals, can be met within the framework of a revitalized global partnership for sustainable development, supported by the concrete policies and actions outlined in the Addis Ababa Action Agenda, which is an integral part of the 2030 Agenda for Sustainable Development, and which supports, complements and helps contextualize the 2030 Agenda’s means of implementing targets, including its Technology Facilitation Mechanism, and which relates to domestic public resources, domestic and international private business and finance, international development cooperation, international trade as an engine for development, debt and debt sustainability, addressing systemic issues and science, technology, innovation and capacity building, and data, monitoring and follow-up;

Reiterating that the means of implementation of the targets under Sustainable Development Goal 17 and under the other Sustainable Development Goals are key to realizing the Agenda and are of equal importance with the other Goals and targets, and also reaffirming targets 3a, 3b, 3c and 3d, as well as other interlinked targets essential to achieving the 2030 Agenda for Sustainable Development;

Reaffirming that the scale and ambition of the 2030 Agenda for Sustainable Development requires a revitalized global partnership for sustainable development to mobilize the necessary means to ensure its implementation, noting that this partnership will work in a spirit of global solidarity, in

¹ Adopted in resolutions WHA61.21 (2008) and WHA62.16 (2009).
particular solidarity with the poorest and with people in vulnerable situations, and that it will facilitate an intensive global engagement in support of implementation of all the Goals and targets, bringing together governments, the private sector, civil society, the United Nations system and other actors and mobilizing all available financial and non-financial resources;

Follow-up and review

Recalling paragraph 48 of United Nations General Assembly resolution 70/1”, to assist governments in their follow-up and review of the Goals and targets, including the means of implementation, and affirming the health sector’s commitment to contributing to and supporting that process, in particular the commitment to strengthening statistical capacities in developing countries;

Recognizing that the High-level Political Forum under the auspices of the General Assembly and the Economic and Social Council will have the central role in overseeing, follow-up and review at the global level,

1. URGES Member States:¹

(1) to scale up comprehensive action at the national, regional and global levels, to achieve the Goals and targets of the 2030 Agenda for Sustainable Development relating to health by 2030;

(2) to prioritize health system strengthening, including ensuring an adequately skilled and compensated health workforce, in order to achieve and sustain universal health coverage, defined as universal access to quality promotion, prevention, treatment, rehabilitation and palliation services, including access to safe, effective, quality and affordable essential medicines and vaccines for all, ensuring financial protection from out-of-pocket expenditure on health for all with a special emphasis on the poor, vulnerable, and marginalized segments of the population² as fundamental to the achievement of the 2030 Agenda for Sustainable Development;

(3) to emphasize the need for cooperative action at the national, regional, and global levels across and within all government sectors to tackle social, environmental and economic determinants of health, to reduce health inequities, in particular through the empowerment of women and girls, and contribute to sustainable development, including “Health in All Policies” as appropriate;

(4) to appropriately prioritize investments in health and strengthen the mobilization and effective use of domestic and international resources for health in accordance with the broad multisectoral impact that health investments can have on economies and communities;

(5) to support the research and development of vaccines and medicines for the communicable and noncommunicable diseases that primarily affect developing countries, to provide access to affordable essential medicines and vaccines, in accordance with the Doha Declaration on the TRIPS Agreement and Public Health, which affirms the right of developing countries to use to the full the provisions in the Agreement on Trade Related Aspects of Intellectual Property

¹ And, where applicable, regional economic integration organizations.
² See resolution WHA67.14.
Rights regarding flexibilities to protect public health, and, in particular, to provide access to medicines for all;¹

(6) to strengthen the dialogue between the medical, veterinary and environmental communities with special attention to emerging and re-emerging diseases, along with the emergence of antimicrobial resistant pathogens, in a way that fosters strengthened and improved surveillance, research, preventive measures and training to ensure or to build capacities to address and manage these global health challenges;

(7) to develop, on the basis of existing mechanisms wherever possible, quality, inclusive, transparent national accountability processes, consistent with national policies, plans and priorities, for regular monitoring and review of progress towards the Goals and targets of the 2030 Agenda for Sustainable Development, which should form the basis for global and regional progress assessment;

2. REQUESTS the Director-General:

(1) to promote a multisectoral approach and the active engagement of WHO at all levels to coordinated implementation of the Goals of the 2030 Agenda for Sustainable Development with regard to health, pursuant to the principle that the Goals of the 2030 Agenda for Sustainable Development are integrated and indivisible, including through alignment and improved collaboration across WHO programmes;

(2) to engage, in the context of United Nations system-wide strategic planning, implementation and reporting, in order to ensure coherent and integrated support to implementation of the 2030 Agenda for Sustainable Development;

(3) to take a proactive role in supporting integrated implementation of the 2030 Agenda for Sustainable Development at the national, regional and global levels and, in consultation with Member States, develop a long-term plan for maximizing the impact of the contributions of WHO at all levels towards the achievement of the 2030 Agenda for Sustainable Development;

(4) to work with the Inter-Agency and Expert Group on Sustainable Development Goal Indicators, as appropriate, for the further development and finalization of the health-related Sustainable Development Goal indicators;

(5) to take steps to ensure that needed capacities and resources, at all levels of the Organization, are developed and maintained for the successful achievement of the 2030 Agenda for Sustainable Development, particularly to support comprehensive and integrated national plans for health as part of implementation of the 2030 Agenda for Sustainable Development, recognizing that needed competencies include the ability to work with multiple sectors, responding to a broader set of health priorities, including supporting progress towards universal health coverage, and providing capacity building or technical support;

(6) to support Member States in strengthening research and development of new technologies and tools, as well as health technology assessment, paying special attention to the health research and development needs of developing countries, building on relevant strategies, action plans and programmes, in particular on the basis of the Global strategy and plan of action on

¹ See Sustainable Development Goal 3, target 3b.
public health, innovation and intellectual property and its follow-up processes for achievement of the 2030 Agenda for Sustainable Development, in particular for achieving access for all to quality, safe, effective, and affordable vaccines and medicines and diagnostics for communicable and noncommunicable diseases;

(7) to support Member States to undertake health systems research to develop more effective approaches to ensuring and delivering universal access to health services, paying special attention to the needs of developing countries;

(8) to facilitate enhanced North–South, South–South and triangular regional and international cooperation on and access to health-related science, technology and innovation, and enhance knowledge sharing on mutually agreed terms, including through improved coordination among existing mechanisms, in particular at the United Nations level, and through a global technology facilitation mechanism;

(9) to work with Member States to ensure that WHO shall effectively contribute to the follow-up to the 2030 Agenda for Sustainable Development, within its existing mandate, by supporting the thematic reviews of progress on the Sustainable Development Goals, including cross-cutting issues, where possible, feeding into and being aligned with the cycle of the High-level Political Forum, according to the modalities to be established by the General Assembly and the Economic and Social Council in the context of the High-level Political Forum;

(10) to report to Member States on a regular basis, at least every two years, on global and regional progress towards achieving the health Goal as a whole and its interlinked targets, as well as other health-related Goals and targets of the 2030 Agenda for Sustainable Development, including a focus on universal health coverage and equity;

(11) to support Member States in strengthening national statistical capacity at all levels, in particular in developing countries, in order to ensure high-quality, accessible, timely, reliable, and disaggregated health data, including through, where appropriate, the Health Data Collaborative;

(12) to support Member States to strengthen reporting on the 2030 Agenda on Sustainable Development, in particular the health Goal and its interlinked targets;

(13) to take the 2030 Agenda for Sustainable Development into consideration in the development of the Programme budget and the General Programme of Work, as appropriate;

(14) to report on progress in implementing this resolution to the Seventieth World Health Assembly, reporting to future Health Assemblies at least once every two years thereafter.

Eighth plenary meeting, 28 May 2016
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Global health sector strategies on HIV, viral hepatitis and sexually transmitted infections, for the period 2016–2021

The Sixty-ninth World Health Assembly,

Having considered the reports by the Secretariat on the draft global health sector strategies on, respectively, HIV, viral hepatitis and sexually transmitted infections, for the period 2016–2021;¹


Noting the targets identified in Transforming our world: the 2030 Agenda for Sustainable Development² on HIV, viral hepatitis, sexual and reproductive health and universal health coverage,

1. ADOPTS the global health sector strategies on, respectively, HIV, viral hepatitis and sexually transmitted infections, for the period 2016–2021;

2. URGES Member States to implement the proposed actions for Member States as outlined in the global health sector strategies on, respectively, HIV, viral hepatitis and sexually transmitted infections, for the period 2016–2021, adapted to national priorities, legislation and specific contexts;

3. INVITES international, regional and national partners to implement the necessary actions to contribute to meeting the targets of the global health sector strategies on, respectively, HIV, viral hepatitis and sexually transmitted infections, for the period 2016–2021;

4. REQUESTS the Director-General:

   (1) to implement the actions for the Secretariat as outlined in the global health sector strategies on, respectively, HIV, viral hepatitis and sexually transmitted infections, for the period 2016–2021;

   (2) to submit reports on the progress achieved in implementing the global health sector strategies on, respectively, HIV, viral hepatitis and sexually transmitted infections, for the period 2016–2021;

¹ Documents A69/31, A69/32 and A69/33.


Eighth plenary meeting, 28 May 2016
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Follow-up of the report of the Consultative Expert Working Group on Research and Development: Financing and Coordination

The Sixty-ninth World Health Assembly,

Having considered the report on follow-up to the report of the Consultative Expert Working Group on Research and Development: Financing and Coordination – report of the open-ended meeting of Member States;¹

Recalling WHA66.22 (2013) and subsequent Health Assembly decisions on the follow-up of the report of the Consultative Expert Working Group on Research and Development: Financing and Coordination, and noting progress made in the implementation of the strategic workplan endorsed in resolution WHA66.22;

Acknowledging that the 2030 Agenda for Sustainable Development includes the commitment to support the research and development of vaccines and medicines for the communicable and noncommunicable diseases that primarily affect developing countries, provide access to affordable medicines and vaccines, in accordance with the Doha Declaration on the TRIPS Agreement and Public Health, which affirms the right of developing countries to use to the full the provisions in the Agreement on Trade-Related Aspects of Intellectual Property Rights regarding flexibilities to protect public health, and, in particular, provide access to medicines for all;

Recalling the global strategy and plan of action on public health, innovation and intellectual property and its aims to promote innovation, build capacity, improve access and mobilize resources to address diseases that disproportionately affect developing countries;

Noting with particular concern that for millions of people the right to the enjoyment of the highest attainable standard of physical and mental health, including access to medicines, remains a distant goal, that especially for children and those living in poverty, the likelihood of achieving this goal is becoming increasingly remote;

Noting the establishment of the High-Level Panel on Access to Medicines convened by the United Nations Secretary-General;

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

¹ Document A69/40.
Acknowledging the central role of the Global Observatory on Health Research and Development to consolidate, monitor and analyze relevant information on health research and development activities related to Type II and Type III diseases and on the specific research and development needs of developing countries in relation to Type I diseases, as well as needs for information on potential areas where market failures exist, and also on antimicrobial resistance and emerging infectious diseases likely to cause major epidemics, building on national and regional observatories (or equivalent functions) and existing data collection mechanisms, with a view to contributing to the identification and the definition of gaps and opportunities for health research and development priorities, and supporting coordinated actions on health research and development;

Expressing concern at the significant gap in funding the strategic workplan endorsed in resolution WHA66.22, including the six selected demonstration projects,

1. **URGES** Member States:

   (1) to make concerted efforts, including through adequate and sustainable funding, to fully implement the strategic workplan endorsed in resolution WHA66.22;

   (2) to create, operationalize and strengthen, as appropriate, national health research and development observatories, or equivalent functions for tracking and monitoring of relevant information on health research and development, and to provide regular information on relevant health research and development activities to the Global Observatory on Health Research and Development or to other existing data collection mechanisms that provide regular reports to the Global Observatory on Health Research and Development;

   (3) to provide support to the Director-General for the development of sustainable financing mechanisms for the full implementation of the strategic workplan endorsed in resolution WHA66.22;

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

   (1) to expedite the full implementation of the strategic workplan endorsed in resolution WHA66.22;

   (2) to expedite the further development of a fully functional Global Observatory on Health Research and Development;

   (3) to submit terms of reference and a costed workplan of the Global Observatory on Health Research and Development to the Seventieth World Health Assembly, through the Executive Board at its 140th session, under the agenda item on the Consultative Expert Working Group on Research and Development: Financing and Coordination;

   (4) to expedite, as part of the development of the Global Observatory on Health Research and Development, the development of norms and standards for classification of health research and development, including common reporting formats, building on existing sources, in consultation with Member State experts and relevant stakeholders in order to collect and collate information systematically;

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1 And, where applicable, regional economic integration organizations.
(5) to promote the Global Observatory on Health Research and Development among all stakeholders, including through regular open-access publications and outreach activities, and encourage all stakeholders to regularly share relevant information on health research and development with the Global Observatory on Health Research and Development;

(6) to support Member States in their endeavours to establish or strengthen health research and development capacities, including the monitoring of relevant information on health research and development;

(7) to establish a WHO Expert Committee on Health Research and Development to provide technical advice on the prioritization of health research and development for Type II and Type III diseases and specific research and development needs of developing countries in relation to Type I diseases, as well as for potential areas where market failure exists based, inter alia, on the analyses provided by the Global Observatory on Health Research and Development, with the Expert Committee consulting, as needed, with all relevant stakeholders in carrying out its work as specified in its terms of reference, which will be formulated and submitted for consideration by the Executive Board at its 140th session;

(8) to take into account the study conducted by the UNICEF/UNDP/World Bank/WHO Special Programme for Research and Training in Tropical Diseases and, on the basis of the report of the Consultative Expert Working Group on Research and Development: Financing and Coordination, present a proposal with goals and an operational plan for a voluntary pooled fund to support research and development for Type III and Type II diseases and specific research and development needs of developing countries in relation to Type I diseases, to be submitted to the Seventieth World Health Assembly, through the Executive Board at its 140th session;

(9) to ensure that the plan describes how the WHO Global Observatory on Health Research and Development, the WHO Expert Committee on Health Research and Development and the Scientific Working Group of a pooled fund will work together, with specific disease examples, and in line with the core principles of affordability, effectiveness, efficiency, equity and the principle of delinkage; and that the plan provides options for sustainable funding;

(10) to promote and advocate for sustainable and innovative financing for all aspects of the strategic workplan endorsed in resolution WHA66.22 and to include, as appropriate, the strategic workplan in WHO financing dialogues for mobilizing sufficient resources to meet the objectives of resolution WHA66.22;

(11) to promote policy coherence within WHO on its research and development-related activities, such as those in relation to the Research and Development Blueprint for Emerging Pathogens and the Global Action Plan on Antimicrobial Resistance in terms of application of the core principles of affordability, effectiveness, efficiency and equity and the objective of delinkage identified in resolution WHA66.22;

(12) to report to the Seventieth World Health Assembly on the implementation of this resolution, and request the Seventieth World Health Assembly to consider convening another open-ended meeting of Member States in order to assess progress and continue discussions on the remaining issues in relation to monitoring, coordination and financing for health research and development, taking into account relevant analyses and reports.

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A69/VR/8
Strengthening integrated, people-centred health services

The Sixty-ninth World Health Assembly,

Having considered the follow-up of the report on the framework on integrated, people-centred health services;¹

Acknowledging Sustainable Development Goal 3 (Ensure healthy lives and promote well-being for all at all ages) including target 3.8, which addresses achieving universal health coverage, 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;

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

Reaffirming resolution WHA62.12 (2009) on primary health care, including health system strengthening, which requested the Director-General to prepare implementation plans for four broad policy directions, including putting people at the centre of service delivery, and also reaffirming the need to continue to prioritize progress on the implementation plans on the other three broad policy directions included in resolution WHA62.12: (1) dealing with inequalities by moving towards universal coverage; (2) multisectoral action and health in all policies; and (3) inclusive leadership and effective governors for health;

Recalling resolution WHA63.16 (2010) on the WHO Global Code of Practice on the International Recruitment of Health Personnel and its recognition that an adequate and accessible health workforce is fundamental to an integrated and effective health system, and to the provision of health services;

Recalling also resolution WHA64.7 (2011) on strengthening nursing and midwifery, which emphasized the implementation of strategies for enhancement of interprofessional education and collaborative practice as part of people-centred care, and resolution WHA66.23 (2013) on transforming health workforce education in support of universal health coverage;

Reaffirming resolution WHA60.27 (2007) on strengthening health information systems, which acknowledged that sound information is critical in framing evidence-based health policy and making

¹ Document A69/39.
decisions, and fundamental for monitoring progress towards internationally agreed health-related
development goals;

Recalling resolution WHA67.20 (2014) on regulatory system strengthening for medical
products, resolution WHA67.21 (2014) on access to biotherapeutic products, including similar
biotherapeutic products, and ensuring their quality, safety and efficacy, resolution WHA67.22 (2014)
on access to essential medicines, resolution WHA67.23 (2014) on health intervention and technology
assessment in support of universal health coverage and resolution WHA67.18 (2014) on traditional
medicine,

1. ADOPTS the framework on integrated, people-centred health services;

2. URGES Member States:

   (1) to implement, as appropriate, the framework on integrated, people-centred health services
       at regional and country levels, in accordance with national contexts and priorities;

   (2) to implement proposed policy options and interventions for Member States in the
       framework on integrated, people-centred health services in accordance with nationally set
       priorities towards achieving and sustaining universal health coverage, including with regard to
       primary health care as part of health system strengthening;

   (3) to make health care systems more responsive to people’s needs, while recognizing their
       rights and responsibilities with regard to their own health, and engage stakeholders in policy
       development and implementation;

   (4) to promote coordination of health services within the health sector and intersectoral
       collaboration in order to address the broader social determinants of health, and to ensure a
       holistic approach to services, including health promotion, disease prevention, diagnosis,
       treatment, disease-management, rehabilitation and palliative care services;

   (5) to integrate, where appropriate, traditional and complementary medicine into health
       services, based on national context and knowledge-based policies, while assuring the safety,
       quality and effectiveness of health services and taking into account a holistic approach to health;

3. INVITES international, regional and national partners to take note of the framework on
   integrated, people-centred health services;

4. REQUESTS the Director-General:

   (1) to provide technical support and guidance to Member States for the implementation,
       national adaptation and operationalization of the framework on integrated, people-centred health
       services, paying special attention to primary health services as part of health system
       strengthening;

   (2) to ensure that all relevant parts of the Organization, at headquarters, regional and country
       levels, are aligned, actively engaged and coordinated in promoting and implementing the
       framework on integrated, people-centred health services;
(3) to perform research and development on indicators to trace global progress on integrated people-centred health services;

(4) to report on progress on the implementation of the framework on integrated people-centred health services to the Seventy-first and Seventy-third World Health Assemblies and at regular intervals thereafter.

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Thank you, Chair.

Thailand speaks on behalf of the 11 member states of the South East Asia Region. We appreciate WHO Secretariat for the comprehensive progress summary and the options for establishing a global and stewardship framework.

2016 is a portal year that AMR will make its mark in a high level meeting at UNGA. SEAR member states support to move the AMR agenda and discussion to the UNGA 2016, as it is multi-sectoral. We expect that the UNGA will come up with the global political commitment at the level of the heads of states. This high level political commitment would lead not only to the sustainable multi-sectoral actions on AMR, but also the sufficient and sustainable resource to tackle the challenges.

The draft global development and stewardship framework provides a good starting point for discussions. The objectives are clear and we fully endorse. We have three comments to advance this draft as follows.

First, to demystify the complexity of framework, we propose to formulate a set of important, yet common scenarios based on the analysis of real situations. The proposed scenarios should take the antibiotic prioritization and the differences of countries’ health systems capacity, especially for antibiotic R&D, stewardship, distribution, regulation and access into account. This approach would help in narrowing down options for establishing a global and stewardship framework while capturing different countries’ health systems contexts.

Second, there is a real need for a effective global mechanism and tools to make sure that every member states and all partners really ‘walk the talk’ on the GAP-AMR. Both this global mechanisms and tools and a joint assessment mechanism should be part of the framework.

Third, the role of pharmaceutical companies in the stewardship framework, especially their roles in promoting rational use of antibiotics, needs to be revisited and discussed. Evidence indicates that not only promotion activities but also educational activities provided by pharmaceutical companies such as continued professional development (CPD) and information for the public can influence prescribing behavior as well.

Thank you, Chair.
Thank you Chair.

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

We note the DG’s comprehensive Report on the topic. We especially appreciate the Reform as an effort to bring speed and predictability to WHO’s emergency work, using an all-hazards approach, promoting collective action, and encompassing preparedness, readiness, response and early recovery activities. We welcome a single programme, with a common structure across WHO to optimize coordination, operations and information flow and also welcome an implementation plan as well as the Emergencies Oversight and Advisory Committee that has been established to guide activities.

We have three comments for consideration to further strengthen the Reform effort:

First, **on Programme design**: country capacities must be the center of activities, resource allocation and focus of investments. Emergencies whether global, regional or national, all of these have been responded to with national capacities and nearby regional support. Financial, operational and technical support need to be decentralized. This applies for both WHO Country Office as well as, importantly, with respect to modalities to engage Member States with the new Programme.

Second, **on funding**: assuming there are no donor commitments for voluntary contributions, our concern is how the Programme will function given the expectations for the Organization to prepare and rapidly respond and recover from emergencies? Events can happen any time. Moreover, if funding is to be based on re-allocation of existing resources, it is important for us to question how this will affect other priority programmes.

Third, **on Programme focus**: as Member States we are concerned that the bulk of resources is channeled toward a response instead of a **balance between prevention and preparedness, and response** (eg the Global Health emergency workforce, partnerships for response etc). Investing in prevention and preparedness prevents emergencies from becoming disasters - after all Ebola began as an outbreak in one district.

Thank you Chair.
Thank you Mr. Chair

On behalf of the Member states of SEA Region, Nepal wishes to deliver this statement on Health and Climate Change.

The countries of the South East Asia remain very vulnerable to impacts of climate change and the resulting effects to the health of their populations. Large proportions of the populations in our countries are constantly faced with cyclones, floods, droughts, heat waves, and sea level rise and glacier lake outbursts. Effects of climate change are hampering the progress made by the region combating under nutrition, controlling malaria and diarrhoeal diseases while increasing the risk of heat waves and other extreme weather conditions.

Mr. Chair,
Recent assessments by the Intergovernmental Panel on Climate Change (IPCC), WHO and other agencies show that climate change is continuing to add significant health risks. At the same time the environment and atmosphere is made hazardous with continued carbon emissions and pollutants from inefficient energy and transport systems.

Mr. Chair,
Member nations of the South East Asia Region have taken initiatives, regional and national measures. Following the regional committee resolution in 2009, our member states are working to implement the resolution recommendations, in close collaboration with our WHO Regional Office. Significant progress has been made in the region in terms of raising awareness, advocacy, and capacity development and in initiating pilots on health adaptation. Partnerships among the Ministries of Health and Environment have been forged and we hope to strengthen it further through Regional mechanism to promote multisectoral collaboration on Environment and Health, that WHO-SEARO is to establish soon.

Mr Chair,
I am glad to report that our Member States have submitted and highlighted health as a core component in the Intended Nationally Determined Contributions to the recent Paris Agreement on Climate Change. Further, SEAR Member States have included and prioritized health in their National Adaptation Plan of Action. Health adaptation plans are in implementation in Bangladesh, Bhutan, Maldives and Nepal. We also appreciate the leadership and work carried out by the Maldives as chair of the Alliance of Small Island States and advocating stronger consideration of the health implications of climate change.
Mr. Chair,

On a final note, SEAR Member States welcome and gratefully note the health implication of the Paris Agreement on Climate Change, adopted in 2015 the first-ever universal, legally binding global climate. All countries, rich and poor alike, now have to act upon and rightfully take their responsibilities to address climate change, specifically actions to protect and promote health.

Thank you Chair.