This Working Paper highlights, from the perspective of the WHO South-East Asia Region, the resolutions endorsed and decisions adopted by the Seventy-fourth World Health Assembly (held on 24 May–1 June 2021) and the 148th and 149th sessions of the WHO Executive Board (held on 18–26 January 2021 and 2 June 2021, respectively) along with other important Agenda items. The issues are deemed to have important implications for the Member States of the WHO South-East Asia Region and the resolutions/decisions merit follow-up action by both Member States of the Region as well as the Organization at the regional and country levels.

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

The High-Level Preparatory Meeting held virtually in New Delhi on 19–21 July 2021 reviewed the attached Working Paper and noted the provisions of the selected resolutions endorsed and decisions adopted by the Seventy-fourth World Health Assembly and the 148th and 149th sessions of the WHO Executive Board and other Agenda items deemed to have important implications for the WHO South-East Asia Region and merit follow-up actions at the regional and country levels.
The HLP Meeting, following a review of the document, made the following recommendations:

**Action by Member States**

(1) To implement the related provisions of the select resolutions endorsed by the Seventy-fourth World Health Assembly and the 148th and 149th sessions of the WHO Executive Board which merit follow-up actions.

**Action by WHO**

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

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

<table>
<thead>
<tr>
<th>No.</th>
<th>Title</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Antimicrobial resistance</td>
<td>1</td>
</tr>
<tr>
<td>2</td>
<td>Working for health: five-year action plan for health employment and inclusive economic growth (2017–2021)</td>
<td>4</td>
</tr>
<tr>
<td>3</td>
<td>Global Strategic Directions for Nursing and Midwifery</td>
<td>6</td>
</tr>
<tr>
<td>4</td>
<td>Social Determinants of Health</td>
<td>8</td>
</tr>
<tr>
<td>5</td>
<td>WHO global plan of action to strengthen the role of the health system within a national multisectoral response to address interpersonal violence, in particular against women and girls, and against children</td>
<td>12</td>
</tr>
<tr>
<td>6</td>
<td>WHO reform: governance</td>
<td>17</td>
</tr>
<tr>
<td>7</td>
<td>WHO reform: World Health Days</td>
<td>19</td>
</tr>
<tr>
<td>8</td>
<td>Global technical strategy and targets for malaria 2016–2030</td>
<td>21</td>
</tr>
<tr>
<td>9</td>
<td>Process for the election of the Director-General of the World Health Organization</td>
<td>23</td>
</tr>
<tr>
<td>10</td>
<td>Human resources: annual report</td>
<td>27</td>
</tr>
<tr>
<td>11</td>
<td>Preventing sexual exploitation, abuse and harassment</td>
<td>29</td>
</tr>
</tbody>
</table>

## Annexures

1) Resolutions and Decisions of the Seventy-fourth World Health Assembly (which also cover the subjects of technical resolutions adopted by the 148th and 149th sessions of the Executive Board).

2) Regional One Voice (RoV) intervention(s) on “Antimicrobial resistance” made at the Seventy-fourth World Health Assembly.

3) Report by the WHO Director-General submitted to the Seventy-fourth World Health Assembly on “Human Resources: Annual report”.
Introduction

1. The Seventy-fourth World Health Assembly in May 2021 and the 148th and 149th sessions of the WHO Executive Board in January 2021 and June 2021 respectively endorsed a number of resolutions and decisions during the course of their deliberations. These decisions and resolutions relate to health matters as well as Programme Budget and financial matters.

2. The summaries of resolutions and decisions on technical matters that have significant implications for the South-East Asia Region along with other important Agenda items are presented in this Working Paper. Salient information on the implications of the issues, and actions already taken and to be taken, are also included herein.

3. Also annexed to this Working Paper are copies of all the resolutions and decisions of the Seventy-fourth World Health Assembly (which also cover the subjects of technical resolutions adopted by the 148th and 149th sessions of the Executive Board) and the text of the “Regional One Voice” presented to the Seventy-fourth Health Assembly by the joint delegation of the Member States of the South-East Asia Region on select Agenda items.
1) Antimicrobial resistance

Background

1. The WHO South-East Asia Region recognizes antimicrobial resistance (AMR) as a serious threat to public health. Long before AMR concerns emerged on the global stage, led by the WHO Regional Office for South-East Asia, the ministers of health of countries of the SEA Region met and issued the Jaipur Declaration on Antimicrobial Resistance in September 2011.

2. The vision and the commitment of the Member States received further impetus in the implementation of activities to prevent and control AMR by its inclusion as one of the eight Regional Flagship Priority Programmes of the Regional Director for South-East Asia in 2014.

3. It is estimated that by 2030, antimicrobial resistance could force up to 24 million people into extreme poverty, and by 2050 the estimated number of AMR-related deaths may reach up to 10 million. And this situation is further compromised with the ongoing COVID-19 pandemic. Antimicrobial resistance is a complex and intertwined issue covering human, animal, plant, and environment sectors and the food chain.

4. At the Seventy-fourth World Health Assembly, on behalf of the SEA Region Member States, Bangladesh, supported by DPR Korea, Indonesia and Thailand, conveyed the Regional One Voice (ROV) on AMR and made the following recommendations: (i) strengthening a collective action on AMR containment goals; (ii) taking advantage of the COVID-19 pandemic for promoting infection prevention and control (IPC) and strengthening surveillance capacity; (iii) providing sufficient and sustainable financing for AMR activities; (iv) ensuring equitable access to affordable, safe and effective antimicrobial medicines; and (v) promoting global awareness to battle AMR through political commitment and partnerships.

5. On 29 April 2021, a high-level dialogue on AMR was conducted at the UN General Assembly. Discussions included (i) AMR in the context of COVID-19; (ii) overview of global progress on AMR; (iii) tackling AMR at the country level; and (iv) ensuring sufficient and sustainable AMR financing.

6. WHO headquarters, supported by the Strategic and Technical Advisory Group (STAG) on AMR, is currently developing technical guidance for the implementation of AMR national action plans (NAP) to achieve more programmatic actions and responses by strengthening AMR governance and AMR surveillance. This initiative is in line with the fact that only 20% of countries are providing funding to their AMR NAPs.1

7. Recognizing that AMR is becoming a significant political and broader issue, strengthening collaboration and coordination using the “One Health” approach and strengthening the governance of AMR NAP implementation are becoming crucial to achieve the goal of AMR containment.

---

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

8. As a multisectoral collective product, NAPs should be viewed as a “plan of the plan” that have to be translated into action plans for the respective sectors involved, and to strive towards sustainable funding.

9. To improve the implementation of NAP, the structure of coordination and governance, such as the National Multisectoral Committee, National Task Force and the Working Group, as well as the subnational structures, need to be developed with clear and designated tasks and functions.

10. The five strategic objectives of NAP, namely, (i) awareness and understanding, (ii) surveillance and knowledge generation, (iii) optimized use of antimicrobials, (iv) infection prevention and control, and (v) investment in research, need clearer plans of action and must be implemented in programmatic fashion.

11. Better coordination and collaboration to handle AMR in human, animal, plant, food chain and environment sectors using the One Health approach is needed.

Actions already taken in the Region

12. All Member States in the WHO SEA Region have established NAP, but some of these NAPs have expired or will expire by the end of 2021 and they need to be updated. For assessment of NAP implementation, the Global Tripartite AMR Country Self-Assessment Survey (TrACSS) and One Health Situational Analysis of the progress of NAP implementation are now underway. In addition, the Regional Office in collaboration with WHO headquarters and the country office is pioneering the development of the AMR M&E framework in Indonesia.

13. In improving awareness, observance of World Antimicrobial Awareness Week (WAAW) and other related initiatives such as Hand Hygiene Day and World Toilet Day have been widely promoted in all Member States. SEARO also spearheaded the development of a curriculum for primary and secondary schools on AMR.

14. Regarding AMR surveillance, in 2021 all Member States have enrolled in the Global Antimicrobial Resistance and Use Surveillance System (GLASS), and have reported to GLASS-IT. Regional External Quality Assessment EQA was conducted in the National Reference Laboratories (NRLs) and in 50% of surveillance sites in Maldives and 100% of those in Bangladesh, Bhutan, India, Indonesia, Myanmar, Nepal, Sri Lanka and Thailand. Innovative models of One Health-integrated AMR surveillance (Tricycle) have been piloted in Bhutan, India, Indonesia, Myanmar and Nepal. Four (Indonesia, Maldives, Nepal and Timor-Leste) of the 11 Member States have formally enrolled in GLASS-AMC.

15. Antimicrobial stewardship programmes (AMSP) have been implemented in limited ways in the SEA Region. Stewardship has been further strengthened through advocacy and technical support for inclusion of AWaRe categorization in the national EMLs and/or the national formulary. Bangladesh, Bhutan, Indonesia, Maldives and Nepal have included or are in the process of adopting AWaRe categorization.
16. Infection prevention and control, and sanitation, including WASH, have been promoted and implemented through regional workshops and technical briefs on core components of IPC at the national and facility level. During the COVID-19 pandemic, policy dialogue and technical assistance was maintained on the adaptation of IPC guidelines for COVID-19.

17. In AMR research, technical support from TDR grants has been provided for operational research on AMR in three Member States (Nepal, Myanmar and Sri Lanka), with the aim of generating evidence for policy action.

**Actions to be taken in the Region**

18. To improve the governance of AMR containment, actions need to be pursued in more programmatic ways. The organizational structure needs to be strengthened and competent staff dealing with AMR activities should be assigned hierarchically at the regional, WHO country office and Member State levels.

19. In Member States, the governance structure, such as the national multisectoral committees, national task forces, national working groups, or subnational structures if available, should be strengthened to function more effectively.

20. To better implement NAP, its proposed planned activities should be translated into action by the respective sectors involved (ministries of healthy and agriculture, the national drugs authorities and the ministry of the environment). To better provide technical assistance, a roster of experts can be deployed to provide technical assistance, and this is being developed.

21. Updated NAPs should be referred to as NAP 2.0 through which the process of development should emphasize a multisectoral approach, participatory nature, a combination of top-down and bottom-up processes, and based on sound administration and management processes.

Background


23. The Secretariat’s report to the Seventy-fourth World Health Assembly (document A74/12) summarized progress on the W4H Action Plan and proposed recommendations for its continuation.

24. The World Health Assembly resolution WHA74.14 was adopted by the Seventy-fourth World Health Assembly to further the recommendations presented in the Secretariat Report.

25. The World Health Assembly resolution WHA74.14 is one of six health workforce-specific Health Assembly resolutions and/or decisions adopted over the last six years. The WHO Secretariat’s resource requirements for implementation, as presented to the Seventy-fourth World Health Assembly, is estimated at US$ 440 million for the period 2021–2030.

26. At the regional level, the Decade for Health Workforce Strengthening in the South-East Asia Region 2015–2024 is aligned with and central to advancing World Health Assembly resolution WHA74.14.

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

27. The operative paragraphs of resolution WHA74.14 present an ambitious agenda to expand health workforce investments and protection.

28. Nineteen actions are proposed for Member States, including focus on continued implementation of the Global Strategy on Human Resources for Health: Workforce 2030 and the WHO Global Code of Practice on the International recruitment of Health Personnel; prioritization of investments in the health workforce, especially the primary health care workforce; strengthening monitoring and reporting of health workforce information through the national health workforce accounts (NHWA); and taking the necessary steps to support and protect health and care workers.

29. The resolution further invites global health initiatives (GHIIs); professional associations, councils, regulatory bodies, trade unions, civil society, the private sector and political leaders; international financing institutions, regional development banks and other public and private financing institutions; as well as bilateral and multilateral partners and financing institutions to ensure strengthened investment in the health and care workforce.
30. The WHO Director-General is additionally requested to:

a. Develop, through a Member State-led process, an Agenda for 2022 to 2030 and Implementation Mechanism to accelerate investments in the health and care workforce, as well as provide recommendations to strengthen the MPTF in engaging with international financing institutions and to support alignment of relevant activities of GHIs and UN partners with this 2022–2030 agenda. The 2022–2030 Agenda and Implementation Mechanism is to be presented to the Seventy-fifth World Health Assembly.

b. Support Member States in implementing the Global Strategy on Human Resources for Health (GSHRH), including through national health workforce strategies and investment plans, and to mobilize catalytic funding for investing in the health workforce and health systems as needed to strengthen primary health care.

c. Develop a “Global Health and Care Worker Compact” with the aim to provide Member States and stakeholders with technical guidance on how to protect and safeguard health worker rights.

d. Expand NHWA for continuous monitoring of the health and care workforce.

e. Encourage and support Member States to report on the WHO Global Code and use information to address international health worker migration.

f. Submit reports to the Health Assembly in 2022, 2025 and 2028 on progress made in implementing the resolution.

Actions already taken in the Region

31. The work towards implementation and monitoring of the Decade for Health Workforce Strengthening in the South-East Asia Region 2015–2024 is well aligned with requested actions in resolution WHA74.14.

32. Significant efforts are being made to strengthen health workforce-related education, retention, governance and data in the Region, towards ensuring strengthened management of international health worker migration, and for the development of National HRH Strategies.

33. The SEA Region has been leading in the implementation of the National Health Workforce Accounts and the WHO Global Code of Practice. The SEA Region is also the first WHO region to systematically begin collecting information on the primary health care workforce, including community health workers and traditional and complementary health workers.

Actions to be taken in the Region

34. WHO SEARO, including through engagement of relevant Member States, will seek to ensure the development of an actionable agenda and implementation plan.

35. WHO SEARO will continue to advance implementation of the GSHRH, the WHO Global Code of Practice and related World Health Assembly resolutions as part of the Decade for Health Workforce Strengthening in South-East Asia.
3) Global Strategic Directions for Nursing and Midwifery

Background

36. The Global Strategic Directions for Nursing and Midwifery 2021–2025 (GSDNM) aligns closely with the Global Strategy for Human Resources for Health: Workforce 2030 (GSHRH) and the UN High-Level Commission on Health Employment and Economic Growth. It includes policy priorities related to education, jobs, leadership and service delivery. It also includes a monitoring and accountability framework.

37. The Seventy-fourth World Health Assembly adopted the GSDNM 2021–2025 through resolution WHA74.15. World Health Assembly resolution WHA 74.15 is one of six health workforce-specific Health Assembly resolutions and/or decisions adopted over the last six years. It is the first solely focused on nursing and midwifery since 2011. The WHO Secretariat’s resource requirements for implementation of resolution WHA74.15, as presented to the Seventy-fourth World Health Assembly, is estimated at US$ 34 million for the period 2021–2025.

38. At the regional level, the Regional Strategic Directions for Strengthening Midwifery in South-East Asia 2020–2024 and the Decade for Health Workforce Strengthening in the South-East Asia Region 2015–2024 are aligned with and central to advancing resolution WHA74.15.

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

39. The operative paragraphs present an ambitious agenda to advance the policy priorities presented in in the GSDNM, the GSHRH, and the WHO Global Code of Practice. Nineteen actions are aimed at Member States, with the focus on maximizing investments in and contribution of midwives and nurses; ensuring their protection and rights; strengthening leadership; and managing migration. A further six actions are called for from relevant stakeholders to support implementation of the GSDNM.

40. The WHO Director-General is requested to:

   a. optimize the contribution of midwifery and nursing through implementation of the GSDNM;

   b. strengthen the implementation of national health workforce accounts;

   c. mainstream new support initiatives aimed at COVID-19 that have had a positive impact on nursing and midwifery in Member States;

   d. develop technical guidance and global policy recommendations related to nursing and midwifery, including on rural retention and managing migration;

   e. scale up assistance to developing countries that face difficulties in educating and developing the midwifery and nursing sector;
f. engage Member States and all relevant stakeholders to develop a “Global Health and Care Compact” to provide guidance to Member States and stakeholders on how to protect and safeguard health worker rights;

g. support Member States in utilizing data to strengthen midwifery and nursing;

h. publish and regularly update a list of government chief nursing and midwifery officers on WHO’s website;

i. strengthen reporting and implementation of the WHO Global Code of Practice; and

j. report regularly to the Health Assembly on progress made in implementing the resolution (in 2022 and 2025).

Actions already taken in the Region

41. The focus in the Region towards implementation of the Decade for Health Workforce Strengthening in the South-East Asia Region 2015–2024 and the Regional Strategic Directions for Strengthening Midwifery in South-East Asia 2020–2024 are already advancing the key operative actions identified in resolution WHA74.15.

42. The 2020 Mid-Term Review of the Decade for Health Workforce Strengthening evidences successes and opportunities to strengthen nursing and midwifery in the Region. Significant work is underway with respect to data, education, retention, governance and migration of midwives and nurses, including both specific and as part of the broader health workforce. The Region has also been leading in the implementation of the national health workforce accounts and the WHO Global Code of Practice.

43. In 2017, SEARO conducted a regional survey on the midwifery and nursing workforce, which identified key issues in countries and highlighted areas for action. A regional competency assessment tool for midwifery and nursing educators, as well as for midwives, is being finalized. Support has been provided to evaluate India’s midwifery leadership programme and the development of a WHO SEA Region Midwifery Leadership Programme is in progress.

Actions to be taken in the Region

44. Consistent with global and regional mandates, and ensuring coordination across WHO’s three levels, the Regional Office will seek to further intensify efforts in the Region to strengthen midwifery and nursing education, jobs, leadership and service delivery.
4) Social determinants of health

Background

45. At the Seventy-fourth World Health Assembly in May 2021, a resolution on social determinants of health (SDH) was endorsed by Member States. The resolution expresses concerns that despite of achievements towards universal health coverage (including financial risk protection, access to quality health care services, and access to safe, effective, quality and affordable medicines and vaccines), their distribution has been vastly unequal and that inequities in many health outcomes exist both within and between countries. The ongoing COVID-19 pandemic intensified pre-existing social, gender and health inequities, and its impact has disproportionately affected those in vulnerable situations and those already suffering from poor health, having multiple vulnerabilities, and having been exposed to social and economic conditions that increase their morbidity and mortality as well as chances of facing an economic catastrophe. Stigma, negative stereotyping and negative attitudes create wider gaps of disparities affecting people’s health and overall well-being.

46. The resolution calls on Member States to increase their efforts to address social, economic and environmental determinants of health with the aim of reducing health inequities and accelerating progress to achieve the 2030 Agenda for Sustainable Development. Member States are called upon to have a rigorous monitoring system to monitor and analyse inequities using cross-sectoral data to inform national policies (health and non-health) to address the SDH applying the “health in all policies” approach. Social determinants of health should be considered in the recovery phase of the COVID-19 pandemic and encourage building resilience to both the current pandemic and future public health emergencies as well.

47. While Member States, international organizations and relevant stakeholders including NGOs, academia and the private sector mobilize financial, human and technological resources to enable monitoring and addressing of the SDH, WHO at all levels will support Member States to establish or strengthen monitoring systems, mechanisms and platforms as appropriate and produce an updated report on SDH knowledge, best practices, impacts on health and equity, and progress in addressing them.

48. WHO is requested to produce the report and recommendations for future actions to be submitted to the Seventy-sixth World Health Assembly in 2023, through the Executive Board at its 152nd Session. Upon the request of Member States, WHO is to provide technical knowledge and support in capacity-building, design and implementation of cross-sectoral strategies, policies and plans to address inequities in health and the social, economic and environmental determinants of health. WHO is to continue to strengthen collaboration with other United Nations Agencies and multisectoral organizations, civil society and private sector players to address SDH in all policies.

49. On behalf of the South-East Asia Region’s Member States, Thailand made a statement highlighting the commitment of WHO in building a fairer, healthier world as expressed in the principles of World Health Day 2021, and the Regional Director’s eight Flagship Priorities that include equity and fairness values in all of them. Three needed actions as enunciated below were mentioned to protect and promote health equities during the COVID-19 pandemic and beyond.
Main operative paragraph and implications on the collaborative activities with Member States

50. As expressed in the Seventy-fourth World Health Assembly, Member States supported this resolution on SDH as a collective means to address health inequities. Collective actions to protect and promote health equity are highlighted as three “MUSTs”:

a. MUST, building resilient, accessible and equitable health systems through primary health care and UHC to ensure access of COVID-19 health services, and vaccines, while maintaining essential health services for all, including the marginalized and vulnerable groups, without financial hardship.

b. MUST, mobilizing of whole-of-government and whole-of-society responses through the “Health in all Policies” approach. This requires a good balance between public health and socioeconomic perspectives. Experience shows that societal trust and support, and cost-effective interventions for specific vulnerable populations, are essential to reduce inequities.

c. MUST, effective monitoring of health inequities with the means to translate evidence into action. The prerequisite is timely and reliable health data that can be desegregated by age, gender, income, education and level of vulnerability. Information systems to share data among different stakeholders in the COVID-19 response will aid collective and timely decision-making.

51. Bangladesh, Bhutan, Indonesia and Thailand made interventions during the Seventy-fourth World Health Assembly to express the collective view on the importance of disaggregated data on age, sex, education, living conditions, economic status and vulnerabilities to better prepare to respond to public health emergencies as a lesson learnt from COVID-19, and on how to mitigate impacts. Member States around the world also expressed urgent attention to mitigate inequities during the ongoing pandemic and keep to the course even after. Several commitments from the Ottawa Charter to the Rio Political Declaration on social determinants of health are called upon. WHO and Member States called for building the momentum with the COVID-19 response phase to the recovery stage and build fairer and more equitable societies.

52. A whole-of-government, whole-of-society approach with health in all policies should be practiced throughout interventions to prepare, protect, respond and recover from the pandemic. Multisectoral actions need to be invested to tackle social determinants of health and mitigate the impacts from the socioeconomic, commercial and environmental determinants. Member States urged WHO to work with the UN system and non-State Actors to address inequities deriving from multiple determinants of health. Attention of Member States was drawn to work with non-State Actors to enhance actions to address stigma, discrimination and inequities faced by vulnerable groups, including marginalized populations, migrants, communities that are excluded, people who are victims of systematic discrimination from policies to interpersonal interaction, and thus victims of violence and abuse.

53. Social determinants of health and equity report will be an important tool to monitor actions to address the social determinants of health by countries.


**Actions already taken in the Region**

54. Documentation of equity concerns and social determinants of health during the COVID-19 pandemic identified multiple vulnerabilities, and pathways that worsened inequities were identified at the beginning of the pandemic. Additional study(ies) must be continued, since the pandemic continues in waves leading to a gamut of concerns, especially on equitable distribution of vaccines, capacity of health systems, and impacts of long-term public health measures on socioeconomic conditions of the population. The absence of disaggregated data from government agencies will be a challenge to systematically demonstrate evidences and the magnitude of inequities that persist throughout the pandemic.

55. Urban governance for health and well-being and the healthy city concept has been initiated to support local governments to address determinants of health and promote health and well-being and enhance whole-of-local government and whole-of-society approach in city development. The “Healthy city” concept embraces multisectoral actions and policies to generate those social, economic and environmental conditions and enabling factors that promote health and well-being of the populations in cities, and mitigate negative impacts of urban life, such as making the city greener and accessible for physical activities, having safe spaces for all, creating healthy market places for healthy choices, preventing traffic injuries, and so on.

56. Lessons learnt from COVID-19 indicated that cities have been highly affected by the pandemic and vulnerable populations, particularly urban slums, daily wage workers and domestic workers, are not able to comply with public health and social measures. Several social, economic and environmental factors have determined their livelihood in cities which worsened due to the pandemic. Thus, this initiative is aimed to support local governments to tackle these determinants of health and bring equity into their respected settings.

57. Visual documentation on the “voices of the voiceless” or vulnerable groups across societies about their plight and difficulties during the COVID-19 pandemic are being collected. These also feature their human spirit to survive, strengthen social solidarity by helping others, and thrive. This documentation also includes the work of nongovernmental organizations, civil society groups, communities and individuals who empowered communities to protect themselves and others.

58. In collaboration with several UN agencies, namely UN Habitat, UN Department of Economic and Social Affairs, International Labour Organization, and ASEAN, the WHO Regional Office provided a series of capacity-building exercises, and technical advice on social and economic determinants of health, social protection mechanisms and multiple vulnerabilities.

59. Using the “health promoting schools” approach, WHO SEARO is advocating for healthier students, teachers, parents, school staff and communities in all types of education facilities, particularly to those vulnerable groups of children and communities.
**Actions to be taken in the Region**

60. An informal technical meeting with a group of experts has been planned for August 2021 to brainstorm on immediate and future actions on social determinants of health. The meeting will also be an opportunity for preparatory work for the SDH report due in 2022–2023.

61. Cross-sectoral actions and regional mechanisms to mitigate impacts of COVID-19 by international agencies in the Region that support government actions to address social determinants of health must be identified to optimize multisectoral collaboration.

62. The regional laboratory on urban governance for health and well-being will be established in Chulalongkorn University, Bangkok, Thailand, to enhance healthy city networks to promote equities across cities and strengthen governance to tackle health inequities in their respected network. The regional laboratory will also serve as a regional hub for exchange of urban health information and assessment tools, and provide technical support to the designation of healthy cities that meet WHO norms and standards of healthy settings. In collaboration with the Swiss Development Corporation, urban governance for health and well-being are being piloted in five cities. The regional laboratory will harness models and capacity-building tools from the network to support countries for the next biennium.

63. A high-level inter-ministerial meeting to revitalize school health programme implementation and standards will be organized virtually in October 2021 to strengthen intersectoral collaboration to promote health for all children in all schools and educational facilities.

64. The Regional Office is engaging with academic institutions, foundations and non-profit civil society groups to map non-State Actors in the South-East Asia Region that will champion the cause of slum populations and urban vulnerable groups.

65. Community engagement capacity-building packages that address gender, equity and social determinants of health, and strengthen public health emergency operations, is being developed.

66. Scoping of commercial determinants of health and NCD risk factors in South-East Asia is being considered in collaboration with expert groups.

67. Disaggregated data and reporting system in 185 health facilities in Bhutan (piloting SDH health equity report for national and subnational health facilities) with support of the Norwegian Fund is being strengthened.
WHO Global Plan of Action to strengthen the role of the health system within a national multisectoral response to address interpersonal violence, in particular against women and girls, and against children

**Background**

68. Interpersonal violence affects hundreds of millions of people, with multiple short- and long-term health and social consequences. In May 2016, the Sixty-ninth World Health Assembly adopted decision WHA69.5 endorsing the WHO Global Plan of Action to strengthen the role of the health system within a national multisectoral response to address interpersonal violence, in particular against women and girls, and against children, which extends till 2030, consistent with the SDG implementation term. The decision included requests for an interim progress report to the Seventy-first World Health Assembly in 2018, and a full report to the Seventy-fourth World Health Assembly in 2021.

69. The resolution calls upon Member States to, inter alia, establish an interministerial coordination process, strengthen health system leadership and governance and enhance international cooperation to bridge the financial gaps to address comprehensively the issue of interpersonal violence against women, girls and children. Similarly the resolution calls upon the Director-General to, inter alia, prepare a second and third Global Status Report on preventing violence against children to assess the national violence prevention status, in 2025 and 2030, provide technical knowledge and support, and strengthen collaboration with other mandated United Nations entities, multilateral organizations and civil society to prevent and address violence against children, including sexual- and gender-based violence, through a multisectoral approach.

70. Against this background, presented below is a summary of actions taken by WHO and Member States towards fulfilment of the objectives highlighted by the new resolution passed by the Seventy-fourth World Health Assembly in May 2021.

**Actions already taken in the Region**

71. WHO country offices in the SEA Region are active in supporting policies and activities by Member States to address violence against women, with other UN partners. Some illustrative examples are given below:

- **Bangladesh (Cox’s Bazar):** The WHO Health Sector, in collaboration with UNFPA and the Sexual and Reproductive Health Working Group, implemented two batches of 4-day-long trainings on “Clinical Management of Rape and Intimate Partner Violence” for 55 frontline health-care workers working in the refugee camps to help address the needs of gender-based violence (GBV) survivors due to increased risk of such incidences during the COVID-19 pandemic-induced confinement during lockdowns as well as other factors.
b. India: The NGO CEHAT conducted an implementation research study, with support from the Department of Human Reproduction Programmes (HR) at WHO headquarters, to integrate the health sector response to violence against women (VAW) in two medical colleges in Maharashtra state that were part of a project on gender in medical education. Building on this experience, training of medical officers from seven premier medical institutes is being initiated, with funding from the Multi-Partner Trust Fund. A review is being conducted of preparedness, challenges and good practices during COVID-19 in India’s 2000+ “one-stop centres”. In addition, the development of digital and non-digital packages of IEC material for use by adolescents and children, women, families and communities to create awareness and generate help-seeking behaviours for women, adolescents and children who face such violence is in progress.

c. Maldives: Awareness about domestic violence and its prevention is being created through a national campaign and the response to gender-based violence is being strengthened through a dedicated hotline.

d. Myanmar: Scale-up of “one-stop crisis centres” (OSCCs) is being planned in four more general hospitals, bringing the total to six in the country.

e. Nepal: The Country Office is supporting the inclusion of VAW indicators in the health management information systems, including on one-stop crisis centres; and expansion of such centres is ongoing to cover all districts.

f. Sri Lanka: A campaign on intimate partner violence was conducted on Valentine’s Day 2021. Strengthening the health sector response to violence against women is also ongoing through (i) virtual training programmes to introduce newly-developed guidelines on the health sector response to such violence and standard operating procedures on providing care to survivors while adhering to public health and social measures in preventing COVID-19, including infection prevention and control; (ii) translation and dissemination of locally adopted guidelines and SOPs to field health staff, including 6000 public health midwives and 350 medical officers is ongoing; (iii) development of a compendium of promising practices on the health sector response to violence against women to share innovative and creative approaches in supporting survivors in accessing support and care services is in progress.

g. Timor-Leste: The national guidelines on the health sector response to VAW were disseminated with UNFPA support. Training of health professionals has begun in five referral hospitals in the country.

72. A rapid review was conducted through SEA Region country offices of the adaptation/adoptions of WHO guidance documents on VAW in various countries. The information collected is given in the Table 1.
Table 1. Adaptation/adoption of WHO clinical guidelines/handbook, training on VAW: information about SEA Region countries (as on January 2021)

<table>
<thead>
<tr>
<th>Member State</th>
<th>Information</th>
</tr>
</thead>
</table>
| **1. Bangladesh**  | National level: No available information about any government agencies adapting/adopting WHO clinical guidelines/handbook or training manual. However, an International NGO, ACF International, has translated the WHO clinical guidelines on ‘Mental health and psychosocial support for conflict-related sexual violence: principles and interventions’ into the Bengali language.  
**Cox’s Bazaar:** The Cox’s Bazaar humanitarian response adopted the WHO clinical handbook and health systems manual (printed and disseminated to health partners) and further used them to develop health sector SOPs on GBV, specific to the forcibly displaced Myanmar nationals/Rohingya response. WHO’s Clinical management of rape and IPV for humanitarian settings has also been translated. |
| **2. Bhutan**  | Bhutan has developed the ‘National Guideline for management of victims of intimate partner violence and sexual violence in health-care settings in Bhutan’ (2017), mostly adapted from WHO, UN Women and UNFPA’s ‘Health care for women subjected to intimate partner violence or sexual violence: A clinical handbook’. |
| **3. DPR Korea**  | No information available. |
| **4. India**  | In 2014, WHO supported MoHFW to launch the national guidelines on responding to sexual violence. MoHFW and WHO conducted five regional workshops to roll out these guidelines and protocol and for orienting state officials.  
Currently, there are no national policies or guidelines for integrating VAW response in health-care settings. This critical gap was identified in a national workshop held in Bangalore by the Country Office for India, MoHFW and the NGO CEHAT for state-level ministries and NGOs working on the health response to VAW. Meanwhile, CEHAT conducted an implementation research study, with support from HRP in WHO headquarters, to integrate domestic violence response in two medical colleges in the state of Maharashtra that were part of a project on gender in medical education. HRP has urged them to evaluate this effort to create India-specific evidence to help move forward in other settings and at the national level.  
UNFPA has also developed some training material based on the clinical handbook, trainings, manager’s manual, etc. to build capacity of medical officers in the state of Orissa. |
<p>| <strong>5. Indonesia</strong>  | Country Office staff currently lack viable information on this issue. Among the handbooks/guidelines issued by MoH and the Directorate of Family Health, none are on VAW. |</p>
<table>
<thead>
<tr>
<th>Member State</th>
<th>Information</th>
</tr>
</thead>
</table>
| **6. Maldives** | Maldives developed the ‘Health Sector Response to GBV: National Guideline on providing care and prevention for health-care providers’ (2014) with support from UNFPA. This document uses WHO’s Clinical Guidelines for Rape Survivors.  
*Note:* In a January 2021 meeting, national programme staff expressed interest to develop an orientation package on the health sector response to GBV, based on WHO material. But this is still in the discussion stage and tangible work will commence in the third quarter of 2021. |
| **7. Myanmar** | Based on discussions of Country Office staff with their government counterparts, there are no documents/guidelines adapted for VAW. In 2018, WHO headquarters facilitated a training on WHO tools for health managers, providers and the police with a focus on staff from the two hospitals that were to implement the one-stop centre. |
| **8. Nepal** | Nepal has developed the following documents related to the WHO clinical guidelines/handbook and training manuals:  
(i) Clinical Protocol for GBV 2019 (revised)  
(ii) Health sector response to GBV, Sri Lanka, 2019: Standard operating procedures for health care providers at the first point of contact.  
(iii) Health sector response to GBV, Sri Lanka, 2019: National Guideline for health-care providers at the first point of contact.  
(iv) Addressing sexual harassment in health institutions (English)  
(v) Guidelines to address sexual harassment at workplaces. |
| **10. Thailand** | Thailand has not adapted/adopted the WHO clinical guidelines for responding to VAW or its derivative products (e.g. clinical handbook, trainings, manager’s manual, etc.) or used content from these to update national protocols. |
| **11. Timor-Leste** | WHO headquarters supported colleagues from LaTrobe University, Australia, who were developing a midwifery curriculum, to adapt WHO material and integrate them into trainings for midwives. |
Actions to be taken in the Region

73. The Regional Office has disseminated and conducted policy advocacy on WHO guidance, including on COVID-19 and VAW. In July 2020, a rapid review was undertaken to track the inclusion of VAW and SRHR services among those identified for continuity on priority among SEA Region Member States.

74. The Regional Office supports Member States, through the country offices, on the annual “16-Day Campaign against Gender-Based Violence (24 November–10 December)”. In 2020, among other activities, SEARO participated at a webinar organized by the WHO Country Office for Myanmar, with partners, on this issue. A media statement by the Regional Director was also released.

75. From February to April 2021, the Regional Office partnered with WHO headquarters and the UN Women’s Asia-Pacific Regional Office to pilot the rollout of the RESPECT Implementation Package on VAW prevention in three countries (Bangladesh, India and Nepal) through a series of weekly workshops with a range of participants from each country, comprising government, civil society organizations and UN agencies.

76. Nine Member States from the SEA Region participated in the Global Status Report for preventing violence against children, which was published in 2020.

77. SEARO is in discussions with UNFPA’s Asia-Pacific Regional Office to build capacity among facility managers and clinicians in select SEA Region countries on the health sector response to VAW. SEARO is also having talks with WHO HQ and UN Women to plan a release of the regional estimates on VAW.

78. Regional meetings/events held in the last five years include the pilot rollout of the RESPECT Implementation Package on prevention of violence against women in three countries (Bangladesh, India and Nepal) from February to April 2021, in collaboration with the UN Women’s Regional Office for Asia and the Pacific and WHO headquarters.
6) WHO reform: governance

Background

79. The Executive Board at its 148th Session in January 2021 noted the report on “WHO reform: Governance” and also adopted Decision EB148(9) to recommend to the Seventy-fourth World Health Assembly to adopt a decision outlining the various resolutions, their reporting requirements and criteria for sunsetting.

80. To promote more strategic decision-making in the context of WHO reform, the WHO Governing Bodies have been discussing options to improve their working methods since 2012, including measures to reduce the number of Agenda items for their meetings, thereby allowing more time for discussions on WHO’s strategic priorities.

81. In response to Decision EB146(21), the Secretariat held internal consultations to make recommendations on: (i) end dates for reporting on resolutions and decisions with unspecified reporting requirements; (ii) consolidation and streamlining of reporting requirements; and (iii) criteria for proposing exceptions to the six-year limitation on reporting.

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

82. The background document EB148/33 Add. 1 provided a tabulated financial and administrative analysis including the link to Programme Budget 2020–2021, resource implications and requirements, and level of available resources for the Secretariat, to implement the proposed decision on WHO Reform: Governance.

83. For improved transparency and predictability, the Secretariat proposed to clearly indicate to the Governing Bodies when a final report on progress is presented for Member States to provide guidance on future reporting requirements, if any.

84. The discussions stipulated the need for clear reporting requirements against all resolutions and decisions, including reporting cycles of up to six years with biennial reports, unless otherwise advised by the Director-General.

85. The Decision WHA 74(17) provided a list of resolutions and decided to:

   a. sunset reporting on the resolutions with the understanding that the mandates have been completed or superseded by new mandates on the same subject matter (a total of 26 resolutions).

   b. sunset reporting on the resolutions with the understanding that the subject matter will be systematically incorporated into future reports on a related subject matter (a total of 21 resolutions)

   c. specify end dates for reporting on 10 resolutions with unspecified reporting requirements.
**Actions already taken in the Region**

86. A step-by-step approach was followed to discuss the phasing out of the Regional Committee resolutions from the past 15 years, as per the following:

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

   b. Informal Working Group on past Regional Committee resolutions met on 14–15 March 2016 and discussed the criteria and time frame for sun-setting past resolutions.

   c. Technical consultation of Member States of the SEA Region to review past Regional Committee resolutions that pertained to a 15-year period dating from 2000 to 2015, held in the Regional Office on 7–8 June 2016.

   d. Discussion at RC69, 2016 and adoption of decision SEA/RC69 (2)

**Actions to be taken in the Region**

87. During the Regional Committee deliberations, efforts are being made to add reporting lines to the resolutions and decisions to allow clear monitoring and the enumeration of indicative reporting timelines for end dates/sun-setting.
7) **WHO reform: World Health Days**

**Background**

88. The WHO Executive Board at its 144th Session in 2019 considered the initial report (EB 144/39 Rev. 1) by the Secretariat on World Health Days. The Board analysed the mandates and current practice, the rationale and objectives of observing such days, and provided a summary of world days, weeks, years and decades related to health within WHO and the United Nations system. The report also provided a preliminary assessment of the evaluation, costs, impact, possible benchmarks and the way forward should the Executive Board decide to monitor and evaluate the matter in greater depth.

89. The Board requested the Secretariat to create a mechanism, guidance tool or criteria for the selection of themes for World Health Days and develop a strategy on the same for submission to Member States for further discussions.

90. The Executive Board at its 148th Session held in January 2021 noted the report (EB148/34) on WHO reform: World Health Days and requested the Secretariat to organize an intersessional meeting before the Seventy-fourth World Health Assembly to discuss the criteria for the observance of World Health Days. The Board also adopted the decision EB148(10) recommending to the Health Assembly to consider further adoption of the decision on celebrating the ‘World Neglected Tropical Diseases Day’ on 30 January every year.

91. The Department of Governing Body Services at WHO headquarters (GBS-HQ) organized a virtual half-day Informal Consultation regarding World Health Days for all Member States on 15 March 2021. During this consultation, Member States considered a more structured process to observe globally days, weeks, months, years and decades related to public health (referred to as observances), that was requested by them at the 148th Session of the WHO Executive Board held in January 2021. The report was presented to the Seventy-fourth World Health Assembly in May 2021 for reviewing the list of observances currently marked by the Secretariat and provide guidance on sunsetting observances mandated by the Health Assembly if they are deemed less relevant to the work of the Secretariat in achieving WHO’s General Programme of Work.

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

92. At the Informal Consultation on World Health Days held virtually on 15 March 2021, Member States reviewed the list of observances currently marked by the Secretariat and discussed how to strike a balance between motivation, technical requirements and purpose in order to set up a mechanism for agreeing on future observances.
93. Member States agreed with the Secretariat’s assessment of the current observances marked by the Secretariat. There is considerable variability in the observances in terms of their profiles and characteristics. Regarding the process of future observances, Member States suggested the following process for considering new proposed “observances”:

   a. If a Member State wishes to propose a new observance of a thematic health day, a detailed written proposal should be submitted to the Director-General at least three months before the start of the next World Health Assembly. The proposal should make it clear that the observance meets the required criteria.

   b. Submission of the proposal in advance of the World Health Assembly would allow all Member States and other stakeholders to consider the proposal and prepare for the discussions at the Health Assembly. It would also allow a thorough assessment of the proposal by the competent organs.

   c. A decision on the proposal would then be taken by the World Health Assembly. If the Health Assembly decides to establish the observance, as a practical matter, the observance would start the calendar year following the World Health Assembly’s decision.

   d. No observance should be established before basic arrangements for its financing and organization have been made. These include the effective coordination of the activities of all stakeholders to avoid duplication, as well as procedures for monitoring and evaluating the impact of the proposed observance in implementing WHO’s General Programme of Work.

94. The Seventy-fourth World Health Assembly noted the report A74/9 (Add. 2) and adopted Decision WHA74(18) through which it decided to welcome the Secretariat’s support of initiatives that celebrate 30 January as the day dedicated to neglected tropical diseases, and invited Member States and relevant stakeholders to consider taking appropriate measures to continue the observance on that day.

**Actions already taken in the Region**

95. The SEA Region observes thematic health days at the regional as well as country level. The communications team provides regular updates on various events held to commemorate the thematic health days on the Internet and social media webpages. An email message form the Regional Director is sent to all staff for all thematic health days being commemorated by the Regional Office.

96. The responsibility of designing campaigns and producing advocacy materials, usually with ad hoc budgets, lies with respective technical departments and/or country offices.

**Actions to be taken in the Region**

97. Implementation of Decision WHA74(18) on celebrating 30 January as a day dedicated to neglected tropical diseases. Finishing the task of eliminating neglected tropical diseases and other diseases on the verge of elimination is one of the Regional Director’s Flagship Priority Programmes since 2014.

98. The Regional Office for South-East Asia and country offices will support Member States and relevant stakeholders in taking appropriate measures to continue celebrating the thematic world health days.
8) Global Technical Strategy and targets for malaria 2016–2030

Background

99. The Global Technical Strategy (GTS) for Malaria 2016–2030, adopted by the World Health Assembly in May 2015 set ambitious goals for reduction in case incidence and death rates by at least 90% by 2030, eliminating malaria in 35 countries with milestones at each 5-year mark to track progress.

100. While the updated strategy, adopted on 27 May 2021 by Member States, retains the goals and milestones endorsed by the World Health Assembly in 2015, it is more closely aligned with WHO’s Thirteenth Global Programme of Work 2019–2023 and “Triple Billion” targets, as well as the global universal health coverage agenda.

101. The Strategy’s guiding principles have been reordered to place a greater emphasis on the importance of country leadership of malaria responses, a stronger focus on the need for equitable and resilient health systems, innovation in tools and approaches, and data-driven strategies tailored to local conditions.

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

102. The Strategy urges Member States to:

   a. accelerate the pace of implementation, according to national contexts and priorities;

   b. extend investment and support to health services using technology-based solutions at facility and community levels to ensure that “no one is left behind”;

   c. Sustain and scale up as appropriate the funding of the global response against malaria; and

   d. extend investment in the innovation of new tools and implementation research.

Actions already taken in the Region

103. In 2017, the WHO SEA Region launched its “Regional Action Plan 2017–2030: towards a malaria-free Southeast Asia Region” that advocated a highly ambitious effort with country-specific transitional milestones for each of its Member States. The Ministerial Declaration that would ensure the goal of elimination is realized in their countries by 2030 was also signed by all Member countries.

104. The WHO SEA Region continues to make rapid and sustained progress towards achieving zero malaria cases and zero malaria deaths, in accordance with WHO’s Global Technical Strategy for Malaria. Between 2010 and 2019 the Region reduced estimated malaria cases and deaths by 74% and 76%, respectively.
**Actions to be taken in the Region**

105. The countries with the highest burden of malaria — India and Indonesia — need to promote subnational elimination and establish the infrastructure required to achieve it. Provinces and districts must be encouraged to take ownership of malaria control efforts.

106. Countries which are very near elimination, namely Bhutan and Timor-Leste, have the risk of importation of malaria across their borders. Accelerating action at the peripheries, especially near the international borders, and cross-border collaboration is critical to prevent setbacks.

107. Implementing sustainable domestic financing models integrating malaria programme functions into existing health system functions is important.

108. There is the need to be vigilant and strengthen programme functions amid the COVID-19 response, and countries should continue to advance the high-level political, scientific and public health commitment required to eliminate malaria once and for all.
9) Process for the election of the Director-General of the World Health Organization

Background

109. The process for the election of the Director-General of the World Health Organization is governed by the Constitution of the World Health Organization, the relevant rules of procedure of the World Health Assembly and the Executive Board as well as several resolutions and decisions of both these organs. The current process is based on the revisions made by the Executive Board and the World Health Assembly through decisions EB146(22) (2020), EB147(12) (2020), WHA73(16) (2020) and WHA73(27) (2020).

110. In accordance with Rule 62 of the Rules of Procedure of the Executive Board as well as World Health Assembly resolution WHA66.18 (2013), as amended by Decision WHA73(27) (2020), two candidates’ forums, open to all Member States and Associate Members, will be convened by the Secretariat as standalone events to enable each of the candidates to make themselves and their vision known to Member States.

111. The first candidates’ forum will be held prior to the session of the Board at which the nomination of candidates for the post of Director-General will take place. The second candidates’ forum will be held prior to the World Health Assembly at which the appointment of the Director-General will take place. The candidates’ forums will not be convened in the event that there is only one candidate for the post of Director-General.

112. At the Seventy-third World Health Assembly, Member States requested the Secretariat to provide greater visibility to the Code of Conduct for the Election of the Director-General of the World Health Organization and reinforce observance of its following provisions:

   a. Paragraph A.III (Responsibilities) of the Code of Conduct for the election of the Director-General of the World Health Organization ("the Code"): It is the responsibility of Member States and candidates for the post of Director-General of the World Health Organization to observe and respect this Code.

   b. Paragraph B.I (Submission of proposals) of the Code: Member States should include in their proposal a statement to the effect that they and the persons proposed by them pledge to observe the provisions of the Code.

113. The Executive Board requested the Secretariat to conduct a study on voting machines that are able to read, and immediately tabulate votes, cast on ballot papers. In view of the specialized nature of the study, the Secretariat commissioned external experts in eGovernance and electronic voting to consider the voting process for the election of the Director-General, identified scenarios and options for the use of voting technologies, and analysed the costs and benefits of each option.
114. The study concluded that the use of optical scanners (machines used to read the ballot papers) during the election of the Director-General does not ensure sufficient time-saving to outweigh the additional cost and risks incurred. Also, of the three scenarios, only the use of an automated counter is likely to result in a marginal reduction of time. All scenarios bring additional risks with respect to configuration and operation. It was, therefore, recommended that the practice of counting votes manually should continue.

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

115. At its 148th Session, the WHO Executive Board considered it advisable to provide financial support to the candidates for the post of Director-General given its statutory nature. The Board further considered it advisable to require the nominated candidates to address the Health Assembly before the vote if the Board nominates more than one candidate. Although Member States will already have had an opportunity to familiarize themselves with the candidates and their electoral platforms through the web forum, the candidates’ forum and the interviews at the Executive Board, Member States may feel that hearing the candidates one last time at the end of the electoral process may assist their consideration of the Board’s nomination.

116. The Seventy-fourth World Health Assembly held in May 2021 and the 149th Session of the WHO Executive Board held in June 2021 adopted four decisions concerning the election of the Director-General of the World Health Organization:

- a. Decision WHA74(21): In respect of the upcoming and subsequent elections, candidates nominated by the Executive Board for the post of the Director-General of WHO shall address the Health Assembly before the vote for the appointment of the Director-General, on the understanding that: (a) statements shall be limited to a maximum of 15 minutes each; (b) the order of statements shall be decided by lot; (c) there shall be no questions and answers after statements; (d) statements shall be webcast on the WHO website in all WHO official languages (not to be applied if only one candidate is nominated by the Executive Board; and that financial travel support, consisting of an economy-class airline ticket and a *per diem* (allowance) for the time necessary for the interview, shall be provided to all candidates participating in the candidates’ forums.

- b. Decision EB149(4): In the event more than one candidate is proposed for the post of the Director-General, the first candidates’ forum shall be held starting 22 November 2021 and the second candidates’ forum shall be held starting 16 March 2022. The interviews of the candidates will be held at the first forum in accordance with the detailed arrangement set out in DEB149(4).

- c. Decision WHA74(22): In the event that the Seventy-fifth World Health Assembly were to be held in person, the secret ballot vote for the appointment of the Director-General would be conducted following a paper-based system, in accordance with Decision WHA73(16) (2020). However, in the event of a virtual meeting, the appointment of the Director-General shall take place in accordance with the contingency arrangements decided by the Executive Board, through a “Written Silence” procedure, based on a proposal by the Officers of the Board, following consultation with all Member States.
d. Decision EB149(5): In the event that the 150th Session of the Executive Board were to be held in person, the secret ballot vote for the nomination of the Director-General would be conducted following a paper-based system, in accordance with Decision EB146(22) of 2020. However, in the event of a virtual session, the nomination of candidates for the position of Director-General shall take place in accordance with the contingency arrangements decided by the Executive Board, through a “Written Silence” procedure, based on a proposal by Officers of the Board following consultation with Member States.

**Actions already taken in the Region**

117. The report on the evaluation of the election of the Director-General of the World Health Organization was presented to the 146th Session of the WHO Executive Board held in February 2020. The Board, while noting the report, decided to agree to the recommendations contained in the report and requested the Secretariat to hold informal consultations with Member States concerning the length of the campaign period for formulating further recommendations.

118. During the informal consultations, Member States further requested the Secretariat to calculate the total cost of the activities to be undertaken during the course of the campaign, to better estimate the financial and administrative implications of the decision(s)/resolution(s) proposed to be adopted by the Governing Bodies. All regional offices were requested to provide an estimate of the cost of organizing such event(s) for the candidates on the sidelines of each Regional Committee Session preceding the Board Session at which the nomination will take place.

119. The WHO South-East Asia Region, upon review of the documents and internal consultations, had the following observations and comments:

a. **Web forum and publication of information on Candidates**: While supporting the enhancement of opportunities for Member States to engage with candidates through an improved web forum, the Region did not anticipate any additional cost implication for the Region, with the understanding that the interactive web forum(s) will be created, hosted and managed by WHO headquarters.

b. **Interaction of the Candidates for the post of Director-General with the Member States on the sidelines of the sessions of the WHO Regional Committees prior to the year in which the election takes place**: In line with the “arm’s length” role of the Secretariat in the election process, the Region was of the considered opinion that while facilitating the interactions of the candidates with Member State delegations during the Regional Committee sessions, the Region should not bear any costs related to the travel, stay or *per diem* allowance of the candidates and/or their entourage, as candidates proposed by Member States usually are supported by their governments/embassies during their campaign-related travel. Since the space and equipment required for the candidate to campaign before the delegates during the Regional Committee are already in place during the Regional Committee Session, there will not be any additional cost involved.
Actions to be taken in the Region

120. The WHO Regional Office for South-East Asia will facilitate the proposed engagement and interaction of the Member States with the candidate(s) nominated for the post of the Director-General of the World Health Organization, through web forums, publication of information or interactions during the Regional Committee Session.
10) Human resources: Annual report

Background


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

122. The global “HR Annual Report” was presented to Seventy-fourth World Health Assembly for noting by the Member States. It did not contain any elements that had any implications per se on the collaborative activities with Member States of the SEA Region.

123. The report provided updates on the various elements of Human Resources Management, namely attracting talent, the Global Internship Programme, performance management, staff learning and development, career pathways and career development, mobility, an enabling working environment including the internal justice system, flexible working arrangements and prevention of abusive conduct.

124. Information was also provided on staff health and well-being considering that this directly underpins the Organization’s ability to achieve its strategic goals and are essential components of Organizational success.

125. During the deliberations at the Seventy-fourth World Health Assembly, Member States reaffirmed the importance of building a working environment that is safe, inclusive and respectful, and appreciated the Organization’s initiative to declare 2021 as the Year of the WHO Workforce. Additionally, Member States expressed interest in the positive trends towards gender equality and geographical representation that are emerging and advised the Secretariat to devise innovative ways to take on board competent interns. WHO’s efforts to attract professionals bearing in mind mobility and diversity of staff were commended.

Actions already taken in the Region

126. Participants from the SEA Region to the global Governing Bodies meetings (World Health Assembly, Executive Board and Programme, Budget and Administration Committee) were briefed on the global HR Annual Report, which included a regional perspective on the staffing profile of WHO in the SEA Region, including aspects of gender and diversity (as of 31 December 2020).

127. Additionally, the Region has been fully aligned with the initiatives and policy guidelines by WHO headquarters on the various elements of human resources management.
Actions to be taken in the Region

128. The WHO Regional Office for South-East Asia will continue to update the Member States on global and regional trends related to the various elements of human resources management, viz. “attracting talent”, “retaining talent” and creating an “enabling work environment”.

11) Preventing sexual exploitation, abuse and harassment

Background

129. The Report on “Preventing sexual exploitation, abuse and harassment” submitted to the Seventy-fourth World Health Assembly held in May 2021 (document A74/36), provided an overview of both WHO’s policies and the actions that the Organization has taken to prevent and respond to sexual exploitation and abuse and sexual harassment, as well as further improvements needed and the key next steps.

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

130. The Report on “Preventing sexual exploitation, abuse and harassment” was presented to the Seventy-fourth World Health Assembly for noting by the Member States. It did not contain any elements that has any implications per se on the collaborative activities with Member States of the SEA Region.

Actions already taken in the Region

131. Participants to the Seventy-fourth World Health Assembly, 149th Session of the WHO Executive Board and the Thirty-fourth Meeting of the Programme Budget and Administration Committee (PBAC) from the SEA Region were briefed on the report on “Preventing sexual exploitation, abuse and harassment (Document A74/36)”, including on the various actions taken/proposed to be taken by SEARO in promoting the Organization’s new policy on Preventing and Addressing Abusive Conduct (PAAC) in the SEA Region. Actions taken included:

a. On 24 May 2021, the policy was formally introduced by the Regional Director to staff members at the regional and country office levels, encouraging them to familiarize themselves with the new policy and emphasizing that there shall be “zero tolerance” by the Region’s Senior Management towards acts of discrimination, abuse of authority and harassment, including sexual harassment.

b. In addition, the Director-General presided over an All-Staff (virtual) Seminar organized by the Office of the Director-General on 21 June 2021, during which representatives of different resource offices (Human Resources and Talent Management (HRT), Office of Compliance, Risk Management and Ethics (CRE), Office of the Ombudsman (OMB), Office of Internal Oversight Services (IOS), and Staff Health & Wellbeing Services (SHW)) and the Staff Associations came together to introduce WHO’s new policy on “Preventing and Addressing Abusive Conduct”, including briefing staff on the action plan for implementing the policy across the Organization and answering questions from staff members on the policy.
c. The Regional Office for South-East Asia has appointed Administrative Officers in WHO country offices and National Professional Officers in the technical departments of the Regional Office as focal points for reporting on prevention measures undertaken in their respective offices. The focal points would be required to complete a specific checklist on an annual basis which will allow both Regional Office and country offices to identify gaps in implementation on an ongoing basis so that they can address them early.

**Actions to be taken in the Region**

132. The following actions are proposed to be taken in the Region in the coming months:

   a. The Human Resources and Talent Management Unit in the Regional Office proposes to hold training/orientation sessions on the new policy on “Preventing and Addressing Abusive Conduct” for all staff members in the Regional Office and for each of the country offices through videoconferencing.

   b. The Staff Development and Learning (SDL) Unit in Regional Office will identify suitable trainings available through the iLearn platform to be taken up by the staff members.

   c. Informational posters and brochures about preventing abusive conduct and/or how to address possible abusive conduct are proposed to be displayed in the Office.

   d. Contracts for consultants, interns and procurement, etc. will include the obligation to comply with the policy on “Preventing and Addressing Abusive Conduct”. The policy will be included in the induction packages of staff and non-staff personnel.
Annexures
Regional One Voice (RoV) intervention made by Member States of the WHO South-East Asia Region

WHA74 Agenda 13.5 - Antimicrobial resistance

Delivered by: Bangladesh

01 Thank you, Madam Chair,

02. Bangladesh is delivering this statement on behalf of all WHO Member States in the South East Asia Region.

03. Antimicrobial Resistance is a significant public health concern for humans, animals, plants and environment. This menace has blunted effectiveness of the current antimicrobials and has potential for threatening the future ones in pipeline and clinical development.

04. Our region appreciates WHO for its continued efforts to fight against AMR. We recognize the progress made by WHO towards achieving the objectives of the Global Action Plan, even during the COVID-19 pandemic. We commend WHO, FAO and OIE for their joint initiative to establish a ‘One Health Global Leaders Group on Antimicrobial Resistance’ to reinvigorate global political momentum on AMR. We thank the Prime Ministers of Bangladesh and Barbados for providing an essential leadership role to the Group as the able co-chairs.

05. We are delighted to see that a total of 144 countries have already developed national action plans on AMR. At the same time, we are concerned that many countries, particularly the low- and middle-income ones, are facing many challenges in the implementation of the action plans.
Madam Chair,

06. We are now witnessing the devastating pandemic of COVID-19. However, AMR may cause even more lethal pandemics in the future. Of course, we must not introduce another global crisis due to lack of preparedness on AMR. Hence, we wish to put forth some suggestions as ways forward:

   First, to collectively drive global, regional, and national actions to achieve the goals of Antimicrobial Resistance Containment and SDG 3.D.2 for addressing to priority bacteria in blood stream infections and SDG 3.B.3 for equitable access to essential antimicrobial medicines;

   Second, to take advantages of the current global pandemic by strengthening surveillance capacities and by improving infection and prevention control to address both COVID-19 and AMR as well as to develop guidelines, policies and programmatic actions;

   Third, to provide sufficient and sustainable financing for AMR-specific and AMR-sensitive actions, with a special focus on low- and middle-income countries and to encourage public-private partnerships for investment in AMR containment;

   Fourth, to ensure equitable access to affordable and safe & effective antimicrobials through technology transfer and scientific-knowledge sharing;

   And finally, to promote global public awareness to battle AMR through political commitment and partnership among the Member States.

I thank you, Madam Chair.
Protecting, safeguarding and investing in the health and care workforce

The Seventy-fourth World Health Assembly,

Having considered the Director General’s report on working for health: five-year action plan for health employment and inclusive economic growth (2017–2021);¹

Deeply concerned about the detrimental impact that coronavirus disease (COVID-19) has had across the health and social care sectors;²

Expressing highest appreciation of, and support for, the dedication, efforts and sacrifices, above and beyond the call of duty of health professionals, health workers and other relevant frontline workers in responding to the COVID-19 pandemic;

Recalling decision WHA73(30) (2020) to designate 2021 as the International Year of Health and Care Workers;

Guided by the 2030 Agenda for Sustainable Development, including its strong multisectoral dimension to achieve universal health coverage, and its call in Sustainable Development Goal 3, target 3.c to “substantially increase health financing and the recruitment, development, training and retention of the health workforce in developing countries, especially in least developed countries and small island developing States”;

Recognizing the need for political commitment, policies and international cooperation, including strong Sustainable Development Goal partnerships at national, regional and global levels, to tackle health inequities and inequalities within and among countries, in line with non-discriminatory laws, and including within the health and care workforce, and how health workforce constraints impact equity of service delivery;

Recognizing the twenty-fifth anniversary of the Beijing Declaration and Platform for Action marked by the Generation Equality Forum, and the Gender Equal Health and Care Workforce Initiative, to advance equity for women in the health and care sector that acknowledges a pivotal moment for the realization of gender equality and the empowerment of all women and girls, everywhere;

¹ DocumentA74/12.

Recalling the Political Declaration of the United Nations high-level meeting on universal health coverage\(^1\) with commitments to scale up efforts to promote the recruitment and retention of competent, skilled and motivated health and care workers, and to secure equitable distribution in rural, hard-to-reach areas, including by providing decent and safe working conditions and appropriate remuneration;

Acknowledging the agreed conclusions and recommendations adopted by the Economic and Social Council forum on financing for development follow-up in April 2021, which underscores that investments in resilient health infrastructure, health systems and universal health coverage, aligned with the 2030 Agenda for Sustainable Development, are key to sustainable development and alleviating poverty, and which resolved to take action to prioritize spending, among others, on essential health functions and social protection measures;\(^2\)

Recognizing that primary health care is the cornerstone of a sustainable health system for universal health coverage, requiring a multidisciplinary team of health and care workers;

Recognizing the fifth anniversary of United Nations Security Council resolution 2286 (2016)\(^3\) on protection of the wounded and sick, medical personnel and humanitarian personnel in armed conflict, and acknowledging resolution WHA70.6 (2017), which recognized the need to substantially increase the protection and security of health and social workers and health facilities in all settings, including in acute and protracted public health emergencies and humanitarian settings;

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

Bearing in mind the recommendations of the Report of the WHO Expert Advisory Group on the Relevance and Effectiveness of the WHO Global Code of Practice on the International Recruitment of Health Personnel on the need for the full implementation of the Global Code as well as health workforce- and health systems-related support and safeguards through strengthened international cooperation, particularly to countries facing the greatest challenges;

Reaffirming resolution WHA69.19 (2016) on the global strategy on human resources for health: workforce 2030 and its objectives to expand and transform the recruitment, development, education, training, distribution, retention and financing of the health and care workforce;

---


Also acknowledging the call for progressive implementation of national health workforce accounts\(^1\) in order to strengthen the availability, quality and completeness of health workforce data, further underscored by the COVID-19 pandemic response;

Recalling United Nations General Assembly resolution 71/159 (2016), which underlines that health workers are the cornerstone of a resilient health system and that the domestic health workforce is the primary responder in all countries, including those with fragile health systems, and is key to building resilient health systems with the objective to achieve universal health coverage, and which urged Member States to consider the recommendations of the United Nations High-Level Commission on Health Employment and Economic Growth, including the development of intersectoral plans and investment in education and job creation in the health and social sectors, recognizing that provision of decent work opportunities and career pathways, particularly for young people and women, is fundamental for inclusive and sustainable economic and social recovery; and thereafter resolution WHA70.6 (2017), which adopted the Working for Health five-year action plan mechanism;

Acknowledging resolution WHA69.1 (2016), which urged Member States to invest in the education, training, recruitment and retention of a fit-for-purpose and responsive public health and care workforce that is effectively and equitably deployed to contribute to effective and efficient delivery of essential public health functions based on population needs;

Recalling United Nations General Assembly resolution 75/157 (2020) on women and girls and the response to the coronavirus disease (COVID-19) and emphasizing the critical role that women, who represent almost 70% of health workers, play in the context of the COVID-19 pandemic;\(^2\)

Recalling WHA73.1 (2020) on COVID-19 response, which calls on Member States, in the context of the COVID-19 pandemic, to provide health professionals, health and care workers and other relevant frontline workers, including humanitarian workers with heightened risk of exposure to COVID-19, with access to personal protective equipment and other necessary commodities and training, including through the provision of psychosocial support; and to take immediate measures for their protection at work, facilitating their access to work and ensuring their adequate remuneration;

Acknowledging that the physical and mental health and well-being of health and care workers is impacted by health worker and skills shortages that can contribute to increased stress, workload, and burnout, and decreased health worker productivity, performance and retention – resulting in enduring effects on the functioning, efficiency and resiliency of health systems; and concerned that the world, if the current trends continue, could suffer from a projected shortfall of 18 million health workers in 2030, primarily in low- and lower-middle-income countries;

Noting the disruptions to pre-service education and life-long learning as a result of the COVID-19 pandemic and the increased demand for digital, competency-based education to provide all health and care workers with sufficient access to evidence, quality education and learning;

Noting the essential role of the research response during the COVID-19 pandemic, including implementation science, the importance of basic and clinical research, the translation of research into evidence-based strategies, the role of public health researchers in the early detection, response and

---


recovery efforts to health emergencies and support for the mental and psychosocial well-being of health and care workers,

1. CALLS ON Member States, in accordance with national context and priorities:¹

   (1) to continue implementation of the Global Strategy on Human Resources for Health: Workforce 2030, including through the Global Health Workforce Network, including:

   (i) to advance the health and care workforce investment agenda, with a special focus on the primary health care workforce in order to accelerate universal health coverage;

   (ii) to accelerate measurement, monitoring and reporting, at an appropriate frequency, to support national workforce planning based on disaggregated demographic data, including sex and other characteristics, on the health and care workforce through further implementation of national health workforce accounts to ensure sufficient number, distribution, competency, utilization, employment, safeguarding and protection of health and care workers, including its capacity and readiness to provide strong integrated public health functions to strengthen preparedness, prevention, detection and response to health emergencies and support the implementation of the International Health Regulations (2005);

   (iii) to carry out an assessment of health and care workforce implications and requirements in all health policies, strategies, plans and programmes to ensure sustained support and investment, optimal utilization of available workers across public and private sectors, coordinated leadership, enhanced workforce performance, and a safe workplace and practice environment;

   (iv) to continue to implement the WHO Global Code of Practice on the International Recruitment of Health Personnel and the recommendations of the WHO Expert Advisory Group on the Relevance and Effectiveness of the WHO Global Code of Practice on the International Recruitment of Health Personnel in 2020,² to equitably strengthen health systems worldwide, to mitigate the negative effects of health personnel migration and to safeguard the rights of all health personnel, with particular attention to the 47 countries identified on the WHO Health Workforce Support and Safeguards List (2020),³ and to report triennially to the Health Assembly, through the Executive Board, on the Global Code’s implementation, including data on international health workforce migration, such as the level and country of the professional examination data from health personnel information systems, and measures taken, results achieved and difficulties encountered in implementing the Global Code;

---

¹ And, as appropriate, regional economic integration organizations.
(v) to facilitate national and subnational capacity for an effective intersectoral coordination mechanism to manage health and care workforce agendas;

(2) to engage relevant sectors and promote intersectoral mechanisms at the subnational, national and regional levels as appropriate for efficient investment in and effective implementation of health workforce policies, using a gender-based and inclusive approach;

(3) to prioritize investments and the efficient and effective use of sustained domestic and international financing for the recruitment and retention, education and training, skills, jobs, safeguarding and protection needed to build resilient health systems capacities, competencies and capabilities, through a health and care workforce that is equitably distributed, deployed, utilized, retained, empowered, protected and supported to deliver national priorities and targets for population health, to contribute to better understanding and managing of health worker migration through improved data and information for the achievement of universal health coverage, and for the effective implementation of essential public health functions;

(4) to develop, finance, implement, monitor, specifying the method, national health and care workforce strategies and investment plans in line with population health needs now and in the future, and job, skills and education and training opportunities, with specific attention to equity, gender, diversity and inclusion in the health and care sector;

(5) to enrich the career paths open to health and care workers in all countries by encouraging the development of both laboratory capabilities for diagnosis and surveillance and research programmes that combine local knowledge with up-to-date scientific understanding and methodology;

(6) to take the necessary steps to safeguard and protect health and care workers at all levels, through the equitable distribution of personal protective equipment, therapeutics, vaccines and other health services, effective infection prevention control and occupational safety and health measures within a safe and enabling work environment that is free from racial and all other forms of discrimination;

(7) to recognize and condemn increasing incidents of attacks against health and care workers, including those attacks that are motivated by fear and stigma associated with COVID-19, and fully comply with their obligations under international law, including international human rights law, as applicable, and international humanitarian law and implement the existing international legal framework for protecting the provision of and access to health care in armed conflicts and other emergencies, including the current COVID-19 pandemic;

(8) to provide equitable access to vaccines, therapeutics and diagnostics, including for all health and care workers at the forefront of the COVID-19 response and other future outbreaks,

epidemics and pandemics; and ensure their personal protection and safeguarding through relevant occupational health and safety and infection prevention and control guidelines and measures;¹²

(9) to support, with due respect for collective bargaining, decent work, working conditions, pay equity and other labour protections, promote respect for fundamental principles and rights at work, for all health and care workers, and support the prevention of violence, discrimination and harassment, including sexual harassment against health and care workers, the majority of whom (almost 70%) are women, and create opportunities for women in the health and care workforce, that support their full and meaningful participation and representation, including in senior leadership and decision-making roles;

2. INVITES international, regional, and national partners and stakeholders to engage in and support the catalytic investment, protection and safeguarding of the health and care workforce, through a coordinated national workforce investment agenda and action plan, specifically calling for:

(1) relevant global health initiatives and partners to invest in human resources for health and in health and care workforce readiness, education, training, skills and competencies, including to manage the current pandemic and strengthen provision of uninterrupted essential health services; and build capacities for health preparedness and response;

(2) professional associations, councils, regulatory bodies, trade unions, civil society, the private sector and political leaders to mobilize collective action and advocacy for supporting investments in health and care workforce job creation, skills, education and training; to invest in national education centres, including but not limited to collaboration with the WHO Academy, safeguarding and protection; and to highlight the critical role of health and care workers in accelerating economic recovery, health systems strengthening, societal well-being and social protection;

(3) international financing institutions, regional development banks and other public and private financing institutions to supplement domestic financing for health workforce and to support prioritized sustainable, scalable catalytic investment in education, skills and jobs in the health and care sectors as part of economic recovery, and to build preparedness, readiness and health systems capabilities to align their health and care workforce investments and contributions with the Working for Health Multi-Partner Trust Fund mechanism;³

(4) bilateral and multilateral partners and financing institutions to integrate and provide medium- to long-term catalytic funding support to ensure sustained levels of investment in the health and care workforce and health systems;


(5) all partners to support WHO’s efforts on the International Year of Health and Care Workers, and to join its campaign to #Protect, #Invest, #Together, as well as the Gender Equal Health and Care Workforce Initiative;

3. REQUESTS the Director-General:

(1) to implement the recommendations in the Director-General’s report to the Seventy-fourth World Health Assembly on working for health: five-year action plan for health employment and inclusive economic growth (2017–2021), including:

(i) to develop through a Member State-led process, a clear set of actions, a 2022–2030 agenda and implementation mechanism to be presented to the Seventy-fifth World Health Assembly in 2022, for accelerating investments in health and care worker education, skills, jobs, safeguarding and protection, building on the joint support of WHO, ILO and OECD and the existing Working for Health Multi-Partner Trust Fund;

(ii) to develop recommendations for strengthening the Working for Health Multi-Partner Trust Fund mechanism and its ability to engage with international financing institutions to leverage sustainable and innovative financing for all aspects of the multisectoral health and care workforce agenda and action plan: 2022–2030;

(iii) to support Member States, upon request, to implement the Global Strategy on Human Resources for Health: Workforce 2030 and to mobilize catalytic funding for investing in the workforce and health systems support needed to strengthen primary health care for achieving universal health coverage, including strong integrated public health functions to strengthen preparedness, prevention, detection and response to health emergencies, through the progressive implementation of a multisectoral health and care workforce agenda and action plan: 2022–2030, and with particular emphasis on promoting multisectoral policy dialogue and sectoral social dialogue, the application of quality reliable data and analysis for evidence-based decisions and investments, and resource mobilization;

(2) to develop, in consultation with Member States, a succinct compilation document under the name of “global health and care worker compact”, following up on resolution WHA73.1 (2020) and decision WHA73(30) (2020), based on already existing documents of relevant international organizations (in any case WHO and ILO), which aims at providing Member States, stakeholders and relevant other organizations with technical guidance on how to protect health and care workers and safeguard their rights, and to promote and ensure decent work, free from racial and all other forms of discrimination and a safe and enabling practice environment, in line with the WHO Global Code of Practice on the International Recruitment of Health Personnel;

(3) to facilitate cooperation between United Nations agencies and programmes, and other relevant global health initiatives and stakeholders, for aligning resourcing and investments with the multisectoral health and care workforce agenda and action plan: 2022–2030, and in particular for the effective implementation of national workforce strategies and plans, including strategies that address the specific challenges for hiring, training, supporting and protecting the health and care workforce in public health, protracted emergencies and humanitarian settings;

(4) to accelerate the health-related Sustainable Development Goals, the Thirteenth General Programme of Work, 2019–2023 and the COVID-19 response by supporting the health and care workforce with equitable access to competency-based education and lifelong learning, with
innovative fit-for-purpose and digital learning, including on health emergency preparedness and response, through, but not limited to, the WHO Academy, as well as educational opportunities that can be offered by academia, nongovernmental organizations and Member States;

(5) to utilize and expand national health workforce accounts for accelerating the continuous measurement and monitoring of the number, status, skills, distribution, utilization, financing, safeguarding and protection of the health and care workforce, including the collection of data pertaining to health and care workers’ morbidity and mortality, in the context of their work responding to epidemics and/or pandemics, including quantifying and measuring the workforce needed for the provision of uninterrupted essential health services, public health functions and health emergency preparedness and response in line with the International Health Regulations (2005);

(6) to encourage and support all Member States to report triennially on the implementation of the WHO Global Code of Practice on the International Recruitment of Health Personnel, and urge Member States’ accountability, in accordance with national context and priorities, to their reporting commitments;

(7) to disseminate and encourage the use of information to address the international migration of health workforces;

(8) to submit a report to the Health Assembly on the progress made in implementing this resolution, integrated with reporting on the Global Strategy on Human Resources for Health: Workforce 2030 and aligned with the WHO Global Code of Practice on the International Recruitment of Health Personnel in 2022, 2025 and 2028.

Seventh plenary meeting, 31 May 2021
A74/VR/7
Strengthening nursing and midwifery: investments in education, jobs, leadership and service delivery

The Seventy-fourth World Health Assembly,

Having considered the Director-General’s report on the global strategic directions for nursing and midwifery 2021–2025;

Recalling the Seventy-second World Health Assembly decision to designate 2020 as the International Year of the Nurse and the Midwife to increase appreciation of and investments in the nursing and midwifery workforces;

Commending the leadership, commitment and professionalism of nurses and midwives, who continue to provide essential health services and remain on the front line in the fight against the coronavirus disease (COVID-19) pandemic and in humanitarian emergencies;

Deeply concerned with the COVID-19 pandemic and the detrimental impact that this has had on health and care workers, including nurses and midwives who account for nearly 50% of the global health workforce;

Recognizing that protecting, safeguarding and investing in the health and care workforce is fundamental for building health systems resilience, maintaining essential health services and public health functions, including in preparing for, implementing and evaluating COVID-19 vaccine rollout, to enable economic and social recovery;

Recalling resolution WHA64.10 (2011) on strengthening national health emergency and disaster management capacities and the resilience of health systems, which recognizes the domestic health workforce as the primary responder in all countries, including those with fragile health systems, and is key to building resilient health systems that contribute to the achievement of the Sustainable Development Goals;

Reaffirming resolution WHA69.11 (2016) on health in the 2030 Agenda for Sustainable Development, which recognizes 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;

1 DocumentA74/13.

Reaffirming resolution WHA69.19 (2016) on the global strategy on human resources for health: workforce 2030 and the objectives to expand and transform the development, education and training, distribution and retention of the health and care workforce especially nurses and midwives;

Noting the disruptions to education and life-long learning as a result of the global pandemic and the increased demand for digital, competency-based education to provide all nurses and midwives with sufficient access to evidence, quality education and learning;

Taking note of the Director-General’s report detailing the shortage and maldistribution of the nursing and midwifery workforces, and the prominent inequities that are projected to remain through 2030 unless decisive action is taken to improve education, increase economic demand for the creation of jobs in particular in rural areas, develop nursing and midwifery leadership, and protect and enable nurses and midwives in their service delivery environments;

Recognizing that the COVID-19 pandemic has had a disproportionate impact on the poorest and the most vulnerable populations, with repercussions on health and development gains, in particular in developing countries, especially least developed countries and small island developing states, thus hampering the achievement of universal health coverage and the strengthening of primary health care;

Recognizing that primary health care is the cornerstone of a sustainable health system for universal health coverage, and that the health and care workforce is a fundamental pillar of primary health care;\textsuperscript{1,2,3}

Further recognizing the crucial contribution of the nursing and midwifery professions to strengthening health systems, to increasing access to comprehensive and patient-centred health services for the people they serve across the lifespan, mindful of cultural contexts, and to the efforts to achieve the internationally agreed health-related development goals, including the 2030 Agenda for Sustainable Development and those of WHO’s programmes;

Recognizing the differences between nursing and midwifery and that while the two professions share many of the same challenges, they maintain their own specific scopes of practice;

Acknowledging that the health, well-being, lives and safety of nurses and midwives, particularly for those providing front-line services, were already affected by health workforce and skills shortages in many countries, and that this is further exacerbated by the COVID-19 pandemic, resulting in increased stress, strain and burn-out and reduced productivity and performance, and impacting workforce retention and therefore the functioning, efficiency and resilience of health systems;

Further acknowledging the importance shown by the COVID-19 pandemic of strengthening health worker protection and employees’ well-being, including through tailored approaches for psychosocial support, additional training and support for new practices for recovery and continuous monitoring of employee well-being, and ensuring respectful work environments that are free from racial and all other forms of discrimination;

\textsuperscript{1} https://www.who.int/docs/default-source/primary-health/declaration/gcphc-declaration.pdf.


\textsuperscript{3} https://www.who.int/hrh/resources/A62_12_EN.pdf.
Concerned at the long-standing shortages and maldistribution of nurses and midwives in many countries, particularly in rural and remote settings, and the impact of this on health and development outcomes, which are inextricably linked, and recognizing the need for effective planning of the education, deployment and retention of health professionals – including through the collaboration of authorities responsible for health, education and employment – to educate, employ and retain an additional 5.7 million nurses and 750 000 midwives by the year 2030 in order to realize Sustainable Development Goal 3 (Ensure healthy lives and promote well-being for all at all ages);

Recalling the 2030 Agenda for Sustainable Development, including Sustainable Development Goal 3, target 3.8 on achieving universal health coverage and target 3.c to “substantially increase health financing and the recruitment, development, training and retention of the health workforce in developing countries, especially in least developed countries and small island developing States”;

Noting also with concern that factors negatively affecting the recruitment and retention of general and specialized nursing and midwifery personnel persist and have been exacerbated during the COVID-19 pandemic, thereby hindering the capacity of countries, in particular developing countries, especially least developed countries and small island developing States, to deliver efficient and effective quality health care and services;

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

Acknowledging that applying the WHO Global Code of Practice on the International Recruitment of Health Personnel is crucial to ensuring the proper and ethical management of international recruitment, and health personnel international migration, and that this can make a contribution to the development and strengthening of health systems, while bearing in mind the necessity of mitigating their impact in countries of origin;

Reiterating the importance of continued and concerted efforts, and the provision of development assistance; and further recognizing with deep concern, the impact of high debt levels on countries’ ability to withstand the impact of the COVID-19 shock;

Noting the specific needs and special circumstances of developing countries, especially least developed countries and small island developing States, and those in fragile, conflict-affected and vulnerable settings, due to their vulnerabilities and capacity constraints, and their need for sustained technical and financial assistance aimed at strengthening health systems, including nursing and midwifery workforce development;

Recognizing further the deliberations by Member States at the three High-Level Events on Financing for Development in the Era of COVID-19 and Beyond and the necessity to expand support for the most vulnerable, including through social and financial protection, and education and health systems, so that no one is left behind, as part of economic recovery at all levels;

Acknowledging the importance of initiatives that promote gender equality, such as the Beijing Platform for Action (Beijing +25), Generation Equality Forum and the Gender Equal Health and Care Workforce Initiative, bearing in mind that women account for 90% of the global nursing and midwifery workforce;
Mindful of previous resolutions to strengthen nursing and midwifery, as well as previous global strategic directions on nursing and midwifery, including the most recent iteration for 2016–2020;

Recalling also decision WHA73(30) (2020), which requested the Director-General to update the Global Strategic Directions for Nursing and Midwifery 2016–2020 and submit the update to the Seventy-fourth World Health Assembly for its consideration;

Reaffirming Member States’ commitment to strengthen nursing and midwifery by investing in education, jobs, leadership and service delivery, including the role of nurses and midwives in the health, social and educational systems,

1. ADOPTS the global strategic directions for nursing and midwifery 2021–2025;

2. CALLS ON Member States to:

   (1) to the extent possible, to implement the policy priorities of the global strategic directions for nursing and midwifery 2021–2025 related to education, jobs, leadership and service delivery as relevant to national health and socioeconomic development strategies, aiming to achieve the four strategic directions and the enabling monitoring mechanisms;

   (2) to invest in, inter alia, workplace policies, strategic planning, capacity-building, domestic resource mobilization, additional budgetary allocation as applicable, with a view to ensuring the enhanced status of and the protection and welfare of nurses and midwives, taking into account possible and future emergencies, disasters and conflicts;

   (3) to maximize the contributions of nurses and midwives in service delivery environments by seeking to ensure that practice regulations are up to date in order that nurses and midwives may practice at the pinnacle of their capability and that workplaces provide decent work, fair remuneration and working conditions, including appropriate leave entitlements, gender equity and balance, labour protection and rights, mental health and the prevention of violence and harassment, including sexual harassment and abuse;

   (4) to ensure that nurses and midwives are supported, protected, motivated, sufficiently aided, trained and equipped to safely and effectively contribute in their practice settings and remove barriers to their practice, including impediments to gender equality, and mitigate their exposure to violence and harassment;

---

1 https://apps.who.int/gb/ebwha/pdf_files/WHA64/A64_R7-en.pdf.
3 https://www.who.int/hrh/resources/WHA54-12.pdf.
4 https://www.who.int/hrh/retention/WHA49-1.pdf?ua=1.
5 https://www.who.int/hrh/resources/WHA45-5.pdf?ua=1.
7 And, where applicable, regional economic integration organizations.
8 Taking into account the context of federated States where health is a shared responsibility between national and subnational authorities.
(5) to equip nurses and midwives with the requisite competencies, and professionalism, aiming to fully meet health system needs, through a scale-up of education tailored to current and future population health needs, including, but not limited to, collaborating with the WHO Academy;

(6) to facilitate the practice of nursing and midwifery professionals to the full extent of their education and training while also providing for sufficient oversight and mentoring and for lifelong in-service training and further skills development in the workplace;

(7) to enhance the capacity of educational institutions to deliver competency-based clinical and professional development programmes and develop research capacity, including evidence-based approaches in partnership with its teaching institutions;

(8) as applicable, to increase access to health services by sustainably creating nursing and midwifery jobs with fair remuneration, effectively recruiting and retaining nurses and midwives where they are needed most, and ethically managing international mobility and migration in accordance with the WHO Global Code of Practice on the International Recruitment of Health Personnel;

(9) to establish and strengthen national and subnational senior leadership roles for nurses and midwives with authority and responsibility for management of nursing and midwifery workforces and input into health decision-making, including as regulators of nursing and midwifery education and practice;

(10) to consider appointing government chief nursing and midwifery officers as per the recommendations in the global strategic directions for nursing and midwifery 2021–2025 and aligned, where appropriate, with the WHO guidance on their roles and responsibilities;

(11) as applicable, to strengthen institutional mechanisms for country coordination among senior nursing and midwifery leaders and their counterparts in academia, professional associations and regulatory bodies; and foster future generations of nursing and midwifery leaders through supported leadership skills development programmes;

(12) to facilitate the monitoring of implementation of the global strategic directions for nursing and midwifery 2021–2025 via, inter alia, the annual reporting through national health workforce accounts (resolution WHA69.19 (2016)) and the biennial WHO Global Forum for Government Chief Nursing and Midwifery Officers;

(13) to provide, to the extent possible, technical and financial assistance to developing countries, especially least developed countries and the small island developing States and humanitarian settings, aimed at strengthening health systems health personnel development, including specialized training on nursing and midwifery and investments in information systems, to assist with addressing workforce shortages and/or capacity-related challenges;

(14) as applicable, to align official development assistance for nursing and midwifery education and employment with national health workforce and health sector development strategies;

2 https://www.who.int/hrh/nursing_midwifery/cnow/en/.
(15) to provide, to the extent possible, appropriate financial and technical support related to nursing and midwifery workforce capacities to developing countries with special circumstances, including fragile health systems that are also battling the COVID-19 pandemic;

(16) to aim to complete the commemorative activities under the International Year of the Nurse and the Midwife, which would have been disrupted due to the COVID-19 pandemic and cooperate with national nurses and midwives associations to plan and execute commemorative activities to end the International Year of the Nurse and the Midwife in 2021;

(17) to continue to implement the WHO Global Code of Practice on the International Recruitment of Health Personnel and the latest recommendations of the WHO Expert Advisory Group on the Relevance and Effectiveness of the WHO Global Code of Practice on the International Recruitment of Health Personnel to equitably strengthen health systems worldwide, to mitigate the negative effects of health personnel migration on the health systems of countries and to report to the WHO Secretariat on the implementation of the WHO Global Code of Practice on the International Recruitment of Health Personnel, including data on international health workforce migration, data from health personnel information systems, and measures taken, results achieved and difficulties encountered in implementation;

(18) to encourage and facilitate, as appropriate, the establishment and strengthening of professional councils for nursing and midwifery as relevant to context;

(19) to take part in the Gender Equal Health and Care Workforce Initiative;

3. CALLS ON international, regional, national and local partners and stakeholders from within the health sector and beyond to engage in and support implementation of the global strategic directions for nursing and midwifery 2021–2025, specifically calling for:

(1) to the extent possible, educational and other institutions within and outside the health systems to adapt their programmes and instructional modalities aiming at providing competency-based education and learning inclusive of appropriate technology, interprofessional learning and culturally competent care; to work in synergy with accrediting bodies to address capacity gaps and faculty development needs; and to collect and share institutional data essential for national health labour market analyses and informed health workforce planning;

(2) professional councils and regulatory bodies to update and strengthen professional nursing and midwifery policies, regulations and standards, as applicable, and enhance regulatory capacity, including through the collaboration of authorities responsible for health, education and employment, where indicated; modernize registries and information systems, as applicable, to enable the sharing of updated and accurate data on nurses and midwives and facilitate safe and efficient mobility across jurisdictions;

(3) private recruitment agencies and other relevant actors to employ ethical recruitment practices, as well as assist in addressing maltreatment of migrant health workers in the recruitment process and strengthening the relevance, effectiveness and implementation of the WHO Global Code of Practice on the International Recruitment of Health Personnel;

(4) professional associations and trade unions to mobilize collective action and advocacy for investments in nursing and midwifery education, jobs, leadership and service delivery; to engage
in data, dialogue and decision-making forums; and advance the ILO’s Decent Work Agenda for safe and equitable workplaces;

(5) donors and development partners, along with international financing institutions, regional development banks, and other public and private financing and lending institutions, to prioritize sustainable and scalable investments in education, jobs, leadership and quality service delivery in the health and care sectors, including the nursing and midwifery workforce;

(6) private sector entities to support investments in competency-based education, scholarships and training, and upgrading qualifications, in order to meet changing health system demands and population health needs;

(7) partners to continue to support initiatives and campaigns such as the Nursing Now Challenge and the Young Midwifery Leaders Programme, which raise the status and profile of nursing and midwifery in order to, inter alia, achieve greater investment in improving education, professional development and employment conditions, as well as to enhance the influence of nurses and midwives on global and national health policy, as supported by the International Year of the Nurse and the Midwife;

(8) all partners to support WHO’s efforts on the International Year of Health and Care Workers for 2021, and to join its campaign to: #Protect, #Invest, #Together;

(9) partners to take part in the Gender Equal Health and Care Workforce Initiative;

4. REQUESTS the Director-General:

(1) to provide support to Member States, upon request, to optimize the contributions of nursing and midwifery towards national health policies and the Sustainable Development Goals, including implementing and monitoring the global strategic directions for nursing and midwifery 2021–2025;

(2) to strengthen the progressive development and implementation of national health workforce accounts to improve the availability, quality and completeness of health workforce data as the basis for evidence-informed policy dialogue and decision-making;

(3) to mainstream in WHO, new support initiatives implemented as a result of the COVID-19 pandemic, and which have had a positive impact on nursing and midwifery services and health care services delivery generally in Member States;

(4) to develop technical guidelines and global policy recommendations related to nursing and midwifery, including on rural retention and managing migration, taking into account lessons learned and experience sharing from the COVID-19 pandemic;

(5) to scale up assistance to developing countries especially least developed countries and small island developing States, and in humanitarian settings that face particular difficulties in educating, and developing the nursing and midwifery sector, and retaining nurses and midwives, through, inter alia, advocacy, evidence-based studies and data reporting;
(6) to engage Member States and all relevant stakeholders to develop, in consultation with Member States, a succinct compilation document under the name of “global health and care worker compact”, following up on resolution WHA73.1 (2020) and decision WHA73(30) (2020), based on already existing documents of relevant international organizations (in any case WHO and ILO), which aims at providing Member States, stakeholders and other relevant organizations with technical guidance on how to protect health and care workers, safeguard their rights, and to promote and ensure decent work, safe and enabling practice environments free from racial and all other forms of discrimination, particularly in respect of the equity and gender-based challenges faced by the global nursing and midwifery workforce, in line with the WHO Global Code of Practice on the International Recruitment of Health Personnel;

(7) to support Member States, and senior government nursing and midwifery leaders in particular, to leverage the national nursing and midwifery workforce data for intersectoral policy dialogue and evidence-based decision-making on how to strengthen nursing and midwifery towards population health goals, including participating in the biennial WHO Global Forum for Government Chief Nursing and Midwifery Officers;

(8) with their prior consent, to publish the list of government chief nursing and midwifery officers on the WHO website and take responsibility for its regular updating;

(9) to strengthen the relevance, effectiveness and implementation of the WHO Global Code of Practice on the International Recruitment of Health Personnel, including by continuously fostering bilateral and multilateral dialogue and cooperation to promote mutuality of benefits deriving from the international mobility of health workers, as well as strengthening engagement with non-State actors, including recruiters;

(10) to encourage and support all Member States to report on the implementation of the WHO Global Code of Practice on the International Recruitment of Health Personnel, and urge Member States’ accountability, in accordance with national context and priorities, to their reporting commitments;

(11) to report regularly to the Health Assembly on the progress made in implementing this resolution, integrated with reporting on the Global Strategy on Human Resources for Health: Workforce 2030 and aligned with reporting requirements of the WHO Global Code of Practice on the International Recruitment of Health Personnel in 2022 and 2025.

Seventh plenary meeting, 31 May 2021
A74/VR/7
Social determinants of health

The Seventy-fourth World Health Assembly,

Having considered the consolidated report by the Director-General;¹

Recalling the Constitution of the World Health Organization, which recognizes that health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, and that the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition;

Recalling also resolution WHA62.14 (2009) on reducing health inequities through action on the social determinants of health, and resolution WHA65.8 (2012) on the outcome of the World Conference on Social Determinants of Health;


Also recalling United Nations General Assembly resolution 74/2 (2019), entitled “Political declaration of the high-level meeting on universal health coverage”, which acknowledges the need to tackle health inequities and inequalities within and among countries through political commitment, policies and international cooperation, including those that address social, economic and environmental and other determinants of health;

Further recalling the report of the WHO Commission on Social Determinants of Health;²

Recalling also the Rio Political Declaration on Social Determinants of Health (2011) and acknowledging its tenth anniversary in 2021;

Reiterating the collective determination to reduce health inequities by taking action on social determinants of health, as called for by the Health Assembly;

Recognizing the need to do more at all levels to accelerate progress in addressing the unequal and inequitable distribution of health, as well as conditions damaging to health;

¹ Document A74/9.

Recognizing also that achieving health equity requires the engagement and collaboration of all sectors of government, all segments of society, and all members of the international community, in all-for-equity and health-for-all global actions;

Recognizing further the benefits of achieving universal health coverage, including financial risk protection, access to quality health care services and access to safe, effective, quality and affordable medicines and vaccines, in enhancing health equity and reducing impoverishment;

Reaffirming the political will to make health equity a national, regional and global goal and to address current challenges, such as: eradicating hunger and poverty; ensuring food security and improved nutrition; ensuring inclusive and equitable quality education; addressing gender-, age- and disability-related inequalities in health; ensuring access to health promotion, preventative and community health services; ensuring access to safe, effective, quality and affordable medicines and vaccines; ensuring access to safe and affordable drinking water, and adequate and equitable sanitation and hygiene; fostering employment and decent work and social protection; protecting the environment and addressing ambient and household air pollution; ensuring access to safe and affordable housing; and promoting sustained, inclusive and sustainable economic growth through resolute action on social determinants of health across all sectors and at all levels;

Stressing that stigma and negative stereotyping and attitudes can affect health, including by creating and enhancing health disparities between persons;

Appreciating the tremendous health gains achieved over the past century, but expressing concern that, despite the achievements towards universal health coverage, their distribution has been vastly unequal, and that inequities in many health outcomes exist both within and between countries;

Recognizing that the ongoing COVID-19 pandemic has highlighted and even intensified pre-existing social, gender and health inequities within and among countries, and has also highlighted the need to strengthen the efforts to address social determinants of health as an integral part of the national, regional and international response to the health and socioeconomic crises generated by the current pandemic and to future public health emergencies;

Concerned that the impact of the COVID-19 pandemic has disproportionately affected those in vulnerable situations and those already suffering from poor health, and has exacerbated their vulnerability and exposure to socioeconomic drivers, leading to increases in morbidity and mortality, as well as economic damage at the individual and community levels;

Recognizing the consequence of the adverse impact of climate change, natural disasters and extreme weather events as well as other environmental determinants of health – such as clean air, safe drinking water, sanitation, safe, sufficient and nutritious food, and secure shelter – for health; and, in this regard, underscoring the need to foster health in climate change adaptation efforts, underlining that resilient and people-centred health systems are necessary to protect the health of all people, in particular those who are vulnerable or in vulnerable situations, particularly those living in small island developing States;

Recognizing also the need to establish, strengthen and maintain existing monitoring systems, including platforms and mechanisms, such as observatories,1 that provide disaggregated data, to assess

---

1 Platforms and mechanisms for gathering, harmonizing, analysing and disseminating data and information.
inequities in health, their relation to social determinants of health and the impacts of policies on the social determinants of health at the national, regional and global levels,

1. CALLS ON Member States\(^1\) to strengthen their efforts on addressing the social, economic and environmental determinants of health with the aim of reducing health inequities, and to accelerate progress in addressing the unequal distribution of health resources within and among countries, as well as conditions detrimental to health at all levels and in support of the 2030 Agenda for Sustainable Development;

2. FURTHER CALLS ON Member States\(^2\) to monitor and analyse inequities in health using cross-sectoral data in order to inform national policies that address social determinants of health, to which end Member States may establish monitoring systems of social determinants of health, including platforms and mechanisms, such as observatories, or rely on, or strengthen, as appropriate, existing structures, such as national public health institutes or national statistical offices;

3. ENCOURAGES Member States\(^2\) to integrate considerations related to social determinants of health into public policies and programmes, by applying a Health in All Policies approach, and in order to improve population health and reduce health inequities;

4. INVITES Member States,\(^2\) international organizations and other relevant stakeholders, including intergovernmental and nongovernmental organizations, academia and the private sector, to mobilize financial, human and technological resources to enable the monitoring and addressing of social determinants of health;

5. CALLS ON Member States\(^2\) to consider social, economic and environmental determinants of health in their recovery from the ongoing COVID-19 pandemic and in boosting resilience to both the current pandemic and future public health emergencies;

6. REQUESTS the Director-General:

   (1) to support Member States, upon request, in the establishment or strengthening of monitoring systems of social determinants of health and health inequities, including, as appropriate, platforms and mechanisms, such as observatories;

   (2) to prepare, building on the report of the WHO Commission on Social Determinants of Health (2008) and subsequent work, an updated report based on scientific evidence, knowledge and best practices on social determinants of health, their impact on health and health equity, progress made so far in addressing them, and recommendations on future actions, and to submit it for consideration by the Seventy-sixth World Health Assembly in 2023, through the Executive Board at its 152nd session;

   (3) to prepare, in consultation with Member States and other relevant stakeholders, an operational framework, building on the work of the WHO Commission on Social Determinants of Health, and building on existing resources and tools and subsequent work, for the measurement, assessment and addressing, from a cross-sectorial perspective, of the social determinants of health and health inequities, as well as their impact on health outcomes, and to submit it for consideration by the Seventy-sixth World Health Assembly in 2023, through the Executive Board at its 152nd session;

\(^1\) And, where applicable, regional economic integration organizations.
to provide Member States, upon their request, with technical knowledge, and support, including for capacity-building in the design and implementation of cross-sectoral strategies, policies and plans to address inequities in health and the social, economic and environmental determinants of health;

(5) to foster and facilitate knowledge exchange among Member States and relevant stakeholders on best practices for intersectoral action on the social, economic and environmental determinants of health in order to achieve health equity and gender equality for all;

(6) to continue to strengthen collaboration with other United Nations agencies and other multilateral organizations, civil society and the private sector to address, from a cross-sectoral perspective, as appropriate, the social determinants of health in support of the 2030 Agenda for Sustainable Development, including through universal health coverage and in the response to the COVID-19 pandemic, including its recovery phase;

(7) to work collaboratively with academic institutions and scientific researchers to generate and make available scientific evidence and best practices on cross-sectoral interventions addressing the social, economic and environmental determinants of health and their impact on health inequities and health outcomes, as well as on the well-being of the population;

(8) to report on the implementation of this resolution to the Seventy-sixth World Health Assembly in 2023, through the Executive Board at its 152nd session.

Seventh plenary meeting, 31 May 2021
A74/VR/7
Ending violence against children through health systems strengthening and multisectoral approaches

The Seventy-fourth World Health Assembly,

Having considered the report¹ on the WHO global plan of action to strengthen the role of the health system within a national multisectoral response to address interpersonal violence, in particular against women and girls, and against children;²

Recalling that all children have the right to the enjoyment of the highest attainable standard of physical and mental health;

Also recalling that all children should be free from violence, and resolution WHA49.25 (1996) on prevention of violence, which declared violence a leading worldwide public health problem, resolution WHA56.24 (2003) on implementing the recommendations of the World report on violence and health, resolution WHA61.16 (2008) on the elimination of female genital mutilation, and resolution WHA67.15 (2014) on strengthening the role of the health system in addressing violence, in particular against women and girls, and against children;

Cognizant of efforts across the United Nations system to address the challenge of violence against children including through the Convention on the Rights of the Child, as applicable, its optional protocols and its committee, the Special Representative of the Secretary-General on Violence against Children, the 2030 Agenda for Sustainable Development and specifically Sustainable Development Goal target 16.2 (end abuse, exploitation, trafficking and all forms of violence against and torture of children) and other relevant targets of the Sustainable Development Goals, and mindful of the importance of multisectoral engagement and collaboration in preventing and responding to violence against children;

Noting that violence is defined by WHO as “the intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community that either results in or has a high likelihood of resulting in injury, death, psychological harm, maldevelopment or deprivation”;³

Recalling resolution WHA67.15 on strengthening the role of the health system in addressing violence, in particular against women and girls, and against children, which noted that interpersonal violence, distinguished from self-inflicted violence and collective violence, is divided into family and partner violence and community violence, and includes forms of violence throughout the life course,

¹ Document A74/21.
² Children are classed as all persons under 18 years of age.
such as child abuse, partner violence, abuse of the elderly, family members, youth violence, random acts of violence, rape or sexual assault, and violence in institutional settings such as schools, workplaces, prisons and nursing homes;

Also noting that violence against children involves all forms of violence against people under 18 years old, and includes, inter alia, but is not limited to, child maltreatment involving physical, sexual and psychological violence, and neglect of children by parents, caregivers and other authority figures, bullying (including cyberbullying) at the hands of other children, sexual violence including rape, sexual trafficking, online exploitation and non-contact violence such as sexual harassment, and psychological violence such as denigration, threats and intimidation, and other non-physical forms of hostile treatment;¹,² and further noting concern over harmful practices, such as child, early and forced marriage and female genital mutilation;

Deeply concerned that each year violence affects an estimated one billion children with many early, acute and lifelong, intergenerational consequences on physical and mental health, risk-taking behaviours and overall quality of life, including mental health conditions, physical injuries, impairments and death;

Recognizing that violence against women and girls, and against children, is a violation of human rights that further exacerbates gender inequalities by exposing individuals to heightened risk of violent behaviour and an increased risk of being subjected to violence at a later stage in life, and that ending violence against children is essential to the long-term prevention of violence;

Also recognizing that exposure to a mother’s abuse by a partner has similar mental and physical health impacts on children to maltreatment, and that violence against children and against women can occur in the same households, and that it is therefore critical to address the intersections of these two forms of violence and eliminate common risk factors, as a prerequisite to long-term prevention of violence against women and violence against children;

Further recognizing that over the course of their lifetime children exposed to all forms of violence are at increased risk of delayed cognitive development, mental health conditions, high-risk and health-harming behaviours, and further interpersonal and self-directed violence, and that as a result of these they are more likely to suffer from noncommunicable diseases, sexually transmitted diseases, reproductive health problems, and other negative social consequences including educational under-attainment;

Noting that violence against children costs the world economy between US$ 1.49 and 6.9 trillion annually, that many of the economic costs fall to the health sector as it provides treatment for the acute and long-term consequences, and that this likely represents an underestimation³ of the full costs of violence against children since it does not consider the long-term impacts on future human capital formation of children exposed to violence;

Also noting with concern that the growing economic and financial burden aggravated by COVID-19 will further exacerbate inequalities, increase poverty, and hunger and reverse the hard-won developmental gains including in the health sector;

Further noting that the COVID-19 pandemic has triggered significant new needs and magnified pre-existing inequalities and vulnerabilities, leading to an increased risk of violence involving children and women, and increases in harmful practices and crimes resulting from, inter alia, closures of schools and protective services, increased isolation, emotional and economic burden on households, and mental health conditions, that threaten multiple aspects of children’s physical, psychological, sexual and reproductive health;

Recognizing that state institutions can also be sites of violence, including violence in schools perpetrated by teachers and peers, noting that children face various forms of online violence as well as violence facilitated by information and communications technology (ICT), and that online and ICT-facilitated violence is disproportionately affecting women and girls;

Concerned about the occurrence of bullying, both online and offline, in all parts of the world and the fact that children who are victimized by such practices may be at heightened risk of compromising their health, emotional well-being and academic work and a wide range of physical and/or mental health conditions, as well as about the potential long-term effects on the individual’s ability to realize his or her own potential;

Also recognizing that violence against girls is based on discrimination, gender norms and gender inequalities and includes sexual and gender-based violence, child maltreatment, child, early and forced marriage, sexual harassment, female genital mutilation, partner violence, trafficking, and sexual exploitation and abuse, all of which requires specific attention by society, including health providers;

Further recognizing that close interlinkages exist between the different forms of discrimination, violence and inequalities faced by children;

Stressing that discrimination based on gender or age often overlaps with other forms of discrimination, as well as a range of social determinants, and that this may affect a child’s vulnerability to violence and often compounds the impacts of crisis and conflict on children;

Recognizing also that children with disabilities are more likely than other children to experience physical, psychological, sexual and gender-based violence and neglect;

Recognizing further the special needs of and risks faced by migrant children, especially unaccompanied migrant children or children separated from their families, particularly with regard to all forms of violence, discrimination and exploitation, including sexual and gender-based violence, physical and psychological abuse, human trafficking and contemporary forms of slavery;

Noting that victims of all forms of violence frequently suffer traumatic consequences that require care and treatment, and that psychosocial support needs to be provided to both victims and perpetrators to mitigate risks of violence in the future;

Recognizing also that health systems are often not adequately addressing the problem of violence and the risk factors and determinants that cut across all forms of interpersonal violence, including violence against children, and not always contributing to a comprehensive, coordinated and multi-sectoral prevention and response to violence against children, and that strengthening health systems and
achieving universal health coverage are essential to addressing both the risk factors/determinants of violence against children and its consequences;

Recognizing further that violence against children needs continuous, coordinated and multisectoral action for detection, monitoring, prevention and response;

Concerned that violence against children is often exacerbated in humanitarian emergencies and in countries in conflict and post-conflict situations, and recognizing that health systems have an important role to play in preventing and responding to its consequences, underlining the need to protect health care from attacks to ensure the delivery of health care services;

Also recognizing that ensuring safe access and safeguarding the right to education, including in humanitarian emergencies and in countries in conflict and post-conflict situations, provides an environment that protects against violence and is an entry point for basic health and nutrition interventions;

Acknowledging the need for greater international cooperation and technical assistance at all levels to address the issue of violence against children including in humanitarian emergencies and in countries in conflict and post-conflict situations;

Stressing the importance of scaling up evidence-based preventive measures in line with obligations under the Convention on the Rights of the Child, including appropriate legislative, administrative, social and educational measures, to protect children from all forms of violence, including parent and caregiver support programmes and school-based community-based interventions and public health and other measures to positively promote respectful child-rearing, free from violence, for all children, and to target the root cause of violence at the levels of the child, family, perpetrator, community, institution and society, and noting that these measures can be delivered by and with the health and other relevant sectors and civil society organizations,

1. URGES Member States:¹

(1) to establish an interministerial coordination process to prevent and eliminate violence against children following an evidence-based approach based on respect for human rights to coordinate a gender-sensitive strategy to address violence against children with clear support from the highest levels of government;

(2) to include children, as appropriate to their evolving capacities, in advocacy, policy development and action, taking into account their experiences and needs, in the prevention and elimination of violence against children and to provide accessible and age-appropriate information to children;

(3) to promote an intercultural perspective while addressing violence against children in order to adapt effective interventions and meet the needs of different contexts, and to strengthen the capacities of community health workers, communities and families to prevent risk situations;

(4) to strengthen health system leadership and governance to prevent violence against children, including by creating or designating where appropriate, a unit or focal point within ministries of health to address issues related to violence against children, and liaising with other competent

¹ And, where applicable, regional economic integration organizations.
national ministries, departments and agencies, and where applicable, with national child protection institutions, taking into consideration a Health in All Policies approach to prevent and respond to violence against children;

(5) to take stock of their legislative policy and response frameworks for prevention of violence against children as well as implementation channels, and to strengthen these where necessary including by ensuring they are gender- and age-sensitive and prioritizing improved disaggregated data collection as well as monitoring and using relevant data to set prevention and response measures and targets;

(6) to allocate the necessary budget for the prevention of and response to violence against children in relevant national plans and policies;

(7) to enhance international cooperation for the provision of requisite resources and bridging the financial gaps for the implementation of strategies and policies to prevent and counter violence against children and to promote their well-being by responding to the consequences of violence;

(8) to strengthen their efforts to support the implementation of evidence-based approaches consistent with the INSPIRE framework1 to preventing violence against children to accelerate progress in achieving the target of WHO’s Thirteenth General Programme of Work, 2019–2023, to reduce violence against children by 20% by the year 2025, including taking into account the WHO-developed RESPECT women framework, in accordance with the national context;

(9) to increase the capacity of health systems to identify violence against children, inter alia, by strengthening health information systems to capture age- and sex-disaggregated data about violence against children, and equipping health and other relevant service providers with the skills to recognize the risks of violence against children and the signs, symptoms and consequences of child maltreatment and all other forms of violence against children, with particular attention to the needs of children with disabilities, children in vulnerable situations such as migrant children, and children in armed conflict, and to provide evidence-based, trauma-informed first-line support, reporting and referral, with the best interests of the child as a primary consideration and free of abuse, disrespect and discrimination;

(10) to establish policies and monitoring mechanisms on safeguarding children and child protection for all government and non-government staff that come into contact with children, as well as to support coordinated efforts across all sectors to train and equip, among others, teachers, school administrators, religious leaders, parents and their representative organizations, justice and social welfare sector actors, detention officers, prison staff, health practitioners and sports workers and community and faith-based groups with the skills to prevent, identify and respond to violence against children, especially adolescent girls, who, owing to negative social norms, are more likely to be subject to gender-based violence, and face a greater risk of harmful practices, such as child, early and forced marriage, and female genital mutilation, and other factors of great importance such as trafficking in persons, child labour and unintended pregnancies, which may also lead to girls leaving school before the completion of their education and never returning to school as a result;

(11) to ensure that child protection, including social protection and mental health services, is recognized as essential and that it continues to be provided and be accessible and available to all children at all times, including during lockdowns, quarantines and other types of confinement and public health measures;

(12) to strengthen implementation of WHO’s global plan of action to strengthen the role of the health system within a national multisectoral response to address interpersonal violence, in particular against women and girls, and against children, in accordance with national legislation, capacities and priorities, and specific national circumstances, to ensure that all people at risk and/or affected by violence benefit from prevention and timely, safe, effective, and affordable access to health care services;

(13) to respect, protect, promote and fulfil the human rights of all women and girls, and to adopt and expedite the implementation of laws, policies and programmes that protect and enable the enjoyment by them of all human rights and fundamental freedoms, including with regard to sexual and reproductive health;

(14) to develop strategies, or include in existing strategies measures for the prevention and elimination of all forms of violence against children with disabilities, who are particularly vulnerable to, inter alia, cruel, inhuman, degrading treatment, medical or scientific experimentation, and sexual and physical violence, including bullying and cyberbullying, and to develop and introduce child- and gender-sensitive, accessible, safe and confidential reporting and complaints mechanisms;

(15) to develop and/or improve epidemiological surveillance systems capable of ongoing and timely identification and description of epidemiological behaviour, monitoring trends, identifying risk factors and recommending and adopting measures for the prevention and response of violence, as well as for assessing the impact of multisectoral measures and interventions;

2. REQUESTS the Director-General:

(1) to prepare a second and third Global status report on preventing violence against children to assess national violence prevention status in 2025 and 2030, respectively, and to support nationally representative surveys on the extent of all forms of violence against children and its consequences in all settings;

(2) to provide Member States and humanitarian actors with technical knowledge and support, including to collect data and to train health, care and other relevant service providers in identifying and responding to violence against children, and capacity-building in the design and implementation of evidence-based strategies to prevent and respond to violence against children consistent with the INSPIRE framework and the national context, noting also the need to address violence against children, including gender-based violence, among persons and populations in humanitarian emergencies and in countries in conflict and post-conflict situations;

(3) to support Member States in developing and implementing evidence-based parenting programmes to prevent child maltreatment and promote healthy child development, and contribute to reducing inequalities in health consistent with the INSPIRE framework and the national context, and as requested, to also support Member States in the involvement of children, as appropriate to their evolving capacities, in developing implementation plans, taking into account their experiences and needs, and in following up on these programmes;
(4) to foster and facilitate knowledge exchange among academic institutions, scientific researchers, practitioners, individuals with lived experiences, and children, as appropriate to their evolving capacities, at the country, regional and global levels on best practices to prevent violence against children;

(5) to further strengthen collaboration with other mandated United Nations entities and multilateral organizations and civil society to prevent and address violence against children, including sexual- and gender-based violence through a multisectoral approach, and support implementation of relevant strategies, consistent with the INSPIRE framework and the national context, in support of the 2030 Agenda for Sustainable Development and in the response to the COVID-19 pandemic and its recovery phase;

(6) to strengthen the violence prevention capacity of WHO’s regional and country offices; and

(7) to report on the implementation of this resolution to the Seventy-sixth World Health Assembly in 2023, through the Executive Board at its 152nd session, and thereafter be included in reporting on resolution WHA69.5 (2016) on the WHO global plan of action to strengthen the role of the health system within a national multisectoral response to address interpersonal violence, in particular against women and girls, and against children, in 2025 and 2030, respectively.

Seventh plenary meeting, 31 May 2021
A74/VR/7
WHO reform: governance

The Seventy-fourth World Health Assembly, having considered the consolidated report by the Director-General,¹

Decided:

(1) to sunset reporting on the following resolutions on the understanding that the mandates have been completed or superseded by a new mandate on the same subject matter:

5. WHA40.24 (1987) – Effects of nuclear war on health and health services;
6. WHA40.32 (1987) – Use of alcohol in medicines;
7. WHA44.5 (1991) – Eradication of dracunculiasis;
8. WHA44.27 (1991) – Health development in urban areas;
9. WHA44.36 (1991) – International programme on the health effects of the Chernobyl accident;
10. WHA47.32 (1994) – Onchocerciasis control through ivermectin distribution;
12. WHA48.13 (1995) – Communicable diseases prevention and control: new, emerging, and re-emerging infectious diseases;

¹ Document A74/9.
14. WHA50.13 (1997) – Promotion of chemical safety, with special attention to persistent organic pollutants;
15. WHA50.29 (1997) – Elimination of lymphatic filariasis as a public health problem;
21. WHA58.27 (2005) – Improving the containment of antimicrobial resistance;
22. WHA60.22 (2007) – Health systems: emergency-care systems;
23. WHA63.15 (2010) – Monitoring of the achievement of the health-related Millennium Development Goals;
24. WHA65.21 (2012) – Elimination of schistosomiasis;
25. WHA66.24 (2013) – eHealth standardization and interoperability;

(2) to sunset reporting on the following resolutions on the understanding that the subject matter will be systematically incorporated into future reports on a related subject matter:
27. WHA37.18 (1984) – Prevention and control of vitamin A deficiency and xerophthalmia;
28. WHA42.40 (1989) – Prevention and control of salmonellosis;
29. WHA44.42 (1991) – Women, health and development;
30. WHA45.22 (1992) – Child health and development: health of the newborn;
31. WHA48.12 (1995) – Control of diarrhoeal diseases and acute respiratory infections: integrated management of the sick child;
32. WHA50.16 (1997) – Employment and participation of women in the work of WHO;
33. WHA54.18 (2001) – Transparency in tobacco control;
34. WHA58.22 (2005) – Cancer prevention and control;
35. WHA58.29 (2005) – Enhancement of laboratory biosafety;
36. WHA58.31 (2005) – Working towards universal coverage of maternal, newborn and child health interventions;

37. WHA60.16 (2007) – Progress in the rational use of medicines;

38. WHA60.20 (2007) – Better medicines for children;

39. WHA60.21 (2007) – Sustaining the elimination of iodine deficiency disorders;

40. WHA60.27 (2007) – Strengthening of health information systems;

41. WHA61.16 (2008) – Female genital mutilation;

42. WHA64.6 (2011) – Health workforce strengthening;

43. WHA64.7 (2011) – Strengthening nursing and midwifery;

44. WHA64.9 (2011) – Sustainable health financing structures and universal coverage;

45. WHA64.28 (2011) – Youth and health risks;

46. WHA65.20 (2012) – WHO’s response, and role as the health cluster lead, in meeting the growing demands of health in humanitarian emergencies;

47. WHA67.4 (2014) – Supplementary funding for real estate and longer-term staff liabilities;

(3) to specify end dates for reporting on 10 resolutions with unspecified reporting requirements:

1. WHA63.12 (2010) – Availability, safety and quality of blood products;

2. WHA63.22 (2010) – Human organ and tissue transplantation;


4. WHA67.18 (2014) – Traditional medicine;

5. WHA68.2 (2015) – Global technical strategy and targets for malaria 2016–2030;


7. WHA69.2 (2016) – Committing to implementation of the Global Strategy for Women’s, Children’s and Adolescents’ Health;

8. WHA69.24 (2016) – Strengthening integrated, people-centred health services;

---

1 Proposed end dates for reporting on the 10 resolutions are indicated in document EB148/33, Annex 2.
9. WHA70.6 (2017) – Human resources for health and implementation of the outcomes of the United Nations’ High-Level Commission on Health Employment and Economic Growth;

10. WHA70.13 (2017) – Prevention of deafness and hearing loss

Seventh plenary meeting, 31 May 2021
A74/VR/7
WHO reform: World health days

Report by the Director-General

INTRODUCTION

1. In November 2020, the Seventy-third World Health Assembly requested the Secretariat to hold informal consultations and consider a more structured process to observing world health days, weeks, months, years and decades related to health (hereafter referred to as observances). This item should be considered in the light of an analysis submitted by the Secretariat to the Seventy-third World Health Assembly, which includes a mapping of current observances marked by the Secretariat and an evaluation of their effectiveness, together with an examination of possible alternatives to such events.

2. An earlier report submitted by the Secretariat to the Executive Board at its 144th session in 2019 analysed the mandates and current practice, and the rationale and objectives of such observances, and provided a summary of observances in WHO and the United Nations system. This earlier report also gave a preliminary assessment of the evaluation, costs, impact, possible benchmarks and the way forward.

INFORMAL CONSULTATION WITH MEMBER STATES

3. An informal consultation was held on 15 March 2021 in which Member States reviewed the list of observances currently marked by the Secretariat and discussed how to strike a balance between motivation, technical requirements and purpose in order to set up a mechanism for agreeing on future observances.

4. Member States were in agreement with the Secretariat’s assessment of the current observances marked by the Secretariat. There is considerable variability among the observances in terms of their profiles and characteristics, as outlined below.

(a) Purpose. Despite good intentions, the majority of the campaigns related to observances are planned within a short time frame, without defined goals or objectives. Some have not been successful: some have even had detrimental effects.

---

1 See the summary records of the Seventy-third World Health Assembly, Committee B, first and second meetings, section 2.
2 Document A73/19.
3 Document EB144/39 Rev.1. Note that the Annex to document A73/19 supersedes Table 1 in document EB144/39 Rev.1.
4 See document A73/19, Annex.
(b) Evaluation. Evaluation mechanisms have not been an integral component of all observances, making comparison across campaigns and over time very difficult.

(c) Resources. The Secretariat estimates that about US$ 150 000 would be needed annually per observance. Such resources are, however, rarely available. As an example, in 2019, headquarters’ spending on most Health Assembly-mandated observances was between US$ 15 000 and US$ 50 000.

(d) Politically driven or public health interest. Some observances were set up more in response to political inclinations than evidence-based public health criteria. Most observances marked by the Secretariat were not mandated by the Health Assembly.¹

**Future observances**

**Process**

5. In their deliberations, Member States suggested the following process for considering new proposed “observances”:

(a) If a Member State wishes to propose a new observance, a detailed written proposal should be submitted to the Director-General at least three months before the start of the next Health Assembly. The proposal should make it clear that the observance meets the required criteria.

(b) Submission of the proposal in advance of the Health Assembly would allow all Member States and other stakeholders to consider the proposal and prepare for the discussions at the Health Assembly. It would also allow a thorough assessment of the proposal by the competent organs.

(c) A decision on the proposal would then be taken by the Health Assembly. If the Health Assembly decides to establish the observance, as a practical matter, the observance would start the calendar year following the Health Assembly’s decision.

(d) No observance should be established before basic arrangements for its financing and organization have been made. These include the effective coordination of the activities of all stakeholders to avoid duplication, as well as procedures for monitoring and evaluating the impact of the proposed observance in implementing WHO’s General Programme of Work.

**Criteria**

6. A group of Member States also proposed the following criteria for new observances.

(a) The subject of a proposed observance should be consistent with the purposes and principles of WHO, as stated in its Constitution.

(b) A proposed observance should focus on: emerging priorities and global health challenges; priorities highlighted in WHO’s General Programme of Work; or health issues on which there has been insufficient progress despite the existence of a Health Assembly-endorsed global strategy or action plan, in particular those affecting developing countries.

¹ See document A73/19, Annex.
(c) A proposed observance should contribute to furthering the work of the Organization and implementation of the strategic visions of the respective General Programme of Work. The proposal should also contain set time frames, including evaluation of the observance’s cost-effectiveness (globally, regionally and locally) and its contribution to the WHO brand as well as to increased knowledge of global public goods for health.

**Prerequisites**

7. Member States also discussed the following prerequisites that should be in place before a new observance is established.

   (a) The basic arrangements for financing the observance must have been made. Such financing should, in principle, be based on voluntary contributions.

   (b) If an observance is expected to be funded by voluntary contributions, the sources of funding should be indicated.

   (c) Ensure that adequate funds for the observance are predicted (at least partially) in each programme budget.

   (d) There should be an estimate of the human resources needed to ensure sufficient capacity for the management of the observance, including communication teams (handling translations and social media procedures) and its monitoring and evaluation.

   (e) The proposal for an observance should not include a request for reports on the observance.

**Monitoring and evaluation**

8. A group of Member States also suggested that a monitoring and evaluation framework for observances should be developed. They proposed that the following elements should be part of the framework:

   (a) public awareness of the observance, as well as Member States’ and stakeholders’ perceptions;

   (b) the benefits of the observance on health, human rights and sustainable development (medium- and long-term outcomes);

   (c) the extent of media coverage of the observance (determined, for example, through citations);

   (d) policy dialogues held, documents published and policy changes;

   (e) Member States’ and stakeholders’ engagement and activities;

   (f) resource mobilization;

   (g) service coverage (if applicable);

   (h) further analysis of the impact of the observance; and
(i) development of benchmarks, to assess the results of observances. These could include, for example, assessing the human and financial resources required for the observance in the light of the resources needed in providing technical support to countries. Such benchmarks could also be used to identify observances for which no action has been taken by the Secretariat and which could therefore be considered for sunsetting.

ACTION BY THE HEALTH ASSEMBLY

9. The Health Assembly is invited to note the report and review the list of observances currently marked by the Secretariat\(^1\) and provide guidance on sunsetting observances mandated by the Health Assembly if they are deemed less relevant to the work of the Secretariat in achieving WHO’s General Programme of Work.

10. The Health Assembly is also invited to provide further guidance on the process, criteria and prerequisites for establishing new observances and their subsequent monitoring and evaluation.

\(^1\) See document A73/19, Annex.
World Neglected Tropical Diseases Day

The Seventy-fourth World Health Assembly, having considered the consolidated report by the Director-General,¹

Decided to welcome the Secretariat's support of initiatives that celebrate the date of 30 January as a day dedicated to neglected tropical diseases, and invites Member States and relevant stakeholders to consider taking appropriate measures to continue celebrating that day.

Seventh plenary meeting, 31 May 2021
A74/NR/7

¹ Document A74/9.
Recommitting to accelerate progress towards malaria elimination

The Seventy-fourth World Health Assembly,

Having considered the report on the global technical strategy and targets for malaria 2016–2030;¹


Noting the report of the WHO Strategic Advisory Group on Malaria Eradication entitled Malaria eradication: benefits, future scenarios and feasibility;

Noting with concern that two of the four Global Technical Strategy for Malaria 2016–2030 interval milestones for 2020 were not met, as reported in the World Malaria Report 2020, as the world has not been successful in reducing malaria mortality rates globally by 40% or in reducing malaria case incidence globally by 40%, compared to 2015 baselines, while welcoming the realization of country-level milestones on achieving national elimination in ten countries and preventing reintroduction of malaria in all eliminating countries;

Recognizing that sustainable, equitable malaria control requires resilient health systems and the achievement of universal health coverage, and that the ongoing coronavirus disease (COVID-19) pandemic and other recent past epidemics have negatively affected health systems’ functioning and the production and delivery of life-saving malaria interventions in environments safe for both health workers and communities;

Taking into account the 1955 Health Assembly resolution WHA8.30 which decided “that the World Health Organization should take the initiative, provide technical advice, and encourage research and coordination of resources in the implementation of a programme having as its ultimate objective the world-wide eradication of malaria,” and acknowledging the 2020 African Leaders Malaria Alliance’s call for elimination on the African continent and the 2015 East Asia Summit commitment to eliminate malaria across Asia-Pacific,

¹ DocumentA74/55.
1. **RECOMMITS** to the goal of malaria eradication and affirms that this goal will be incorporated into the post-2030 iteration of the global technical strategy for malaria;

2. **ADOPTS** the updated global technical strategy for malaria 2016–2030 which emphasizes country ownership and promotes equitable and resilient health systems to deliver quality services, which are adaptive to local situations and which recognizes the need for capacity-strengthening so that countries can generate, analyse and use high-quality data, including surveillance data for making decisions and tailoring responses to leave no one behind so that countries can improve the effectiveness and quality of health services, introducing additional highly effective interventions into the existing package where this is cost-effective and aligned with country priorities; and better addressing the wider determinants that potentially disrupt or facilitate the reach and quality of services, particularly for women and for children under 5 years of age;

3. **URGES** Member States:
   
   (1) to accelerate the pace of implementation, according to national contexts and priorities and their malaria strategies and operational plans consistent with the updated framework and principles of the global technical strategy for malaria 2016–2030 and the WHO Guidelines for malaria;

   (2) to extend investment in and support to health services, including integrated, accessible, affordable and quality prevention, detection, diagnosis and treatment including through the use of technology-based solutions at facility and community levels ensuring no one is left behind including to improve access for the most rural remote, and marginalized populations that have the lowest access and coverage of interventions;

   (3) to sustain and scale up as appropriate, sufficient funding of the global response against malaria;

   (4) to extend investment in the development of new tools and support for implementation research and innovation to enable the efficient delivery and equitable access with a view to maximize impact and cost-effectiveness;

4. **URGES** international, regional and national partners from within and beyond the health sector, in particular those in the Roll Back Malaria Partnership to End Malaria, to strengthen their support for and further engage in implementation of the global technical strategy for malaria 2016–2030 and align this with existing health strategies and plans;

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

   (1) to continue to provide technical support and guidance to Member States\(^1\) for the national adaptation, implementation and operationalization of the updated global technical strategy for malaria 2016–2030;

   (2) to update regularly technical guidance on malaria prevention, care and control and elimination, as new evidence is gathered and innovative tools and approaches become available and support countries to adopt and implement this guidance effectively;

---

\(^1\) And, where applicable, regional economic integration organizations.
(3) to monitor the implementation of the updated global technical strategy for malaria 2016–2030 and evaluate its impact in terms of progress towards set milestones and targets;

(4) to work with Member States,\textsuperscript{1} civil society and other partners to increase investment in and efforts towards research to optimize current tools, develop and validate new, safe and affordable malaria-related medicines, products and technologies, including the R&D blueprint and foster the generation, translation and dissemination of normative, technical and operational guidance;

(5) to provide a status report to the Seventy-seventh World Health Assembly in 2024, and a full progress report to the Seventy-ninth World Health Assembly in 2026, followed by a final status report to the Eighty-first World Health Assembly in 2028.

Seventh plenary meeting, 31 May 2021
A74/VR/7

\textsuperscript{1} And, where applicable, regional economic integration organizations.
Process for the election of the Director-General of the World Health Organization: candidates’ statements and travel support

The Seventy-fourth World Health Assembly, having considered the report on the process for the election of the Director-General of the World Health Organization,¹

Decided:

(1) that, in respect of the present and subsequent elections, candidates nominated by the Executive Board for the post of Director-General of the World Health Organization shall address the Health Assembly before the vote for the appointment of the Director-General, on the understanding that:
   
   (a) statements shall be limited to a maximum of 15 minutes each;
   
   (b) the order of statements shall be decided by lot;
   
   (c) there shall be no questions and answers after statements;
   
   (d) statements shall be webcast on the WHO website in all WHO official languages;

(2) that paragraph 1 shall not apply in the event that only one candidate is nominated by the Executive Board for the post of Director-General;

(3) that financial travel support, consisting of an economy-class airline ticket and a per diem for the time necessary for the interview, shall be provided to all candidates participating in the candidates’ forums.

Seventh plenary meeting, 31 May 2021
A74/VR/7

¹ Document A74/24.
Process for the election of the Director-General of the World Health Organization: contingency arrangements

The Seventy-fourth World Health Assembly, having considered the report on the process for the election of the Director-General of the World Health Organization: contingency arrangements,\(^1\)

Decided:

(1) that, in the event that the Seventy-fifth World Health Assembly were to be held in person, the secret ballot vote for the appointment of the Director-General would be conducted following a paper-based system, in accordance with decision WHA73(16) (2020);

(2) that, in the event that limitations to physical meetings preclude the holding of the Seventy-fifth World Health Assembly as envisaged, the appointment of the Director-General shall take place in accordance with the contingency arrangements decided by the Executive Board, through a written silence procedure, based on a proposal by the Officers of the Board, following consultation with all Member States.

Seventh plenary meeting, 31 May 2021
A74/NR/7

\(^1\) Document A74/24 Add.2.
Process for the election of the Director-General of the World Health Organization

The Executive Board, having considered the report on the process for the election of the Director-General of the World Health Organization,¹

Decided:

(1) that in the event that more than one candidate is proposed for the post of Director-General, the first candidates’ forum shall be held starting on 22 November 2021 for a duration that shall be further decided by the Officers of the Board depending on the number of candidates; and the second candidates’ forum shall be held starting on 16 March 2022 for a duration that shall be further decided by the Officers of the Board depending on the number of nominated candidates;

(2) that the interviews of candidates at the first candidates' forum shall be conducted in accordance with the detailed arrangements set out in the Annex to this decision;

(3) that the interpretations recalled in paragraph 9 of document EB149/4 shall be applied, if applicable, during the nomination of candidate(s) that will take place at the 150th session of the Executive Board and any subsequent nominations.

¹ Document EB149/4.
ANNEX

DETAILED ARRANGEMENTS FOR CONDUCTING INTERVIEWS
AT THE FIRST CANDIDATES’ FORUM

Seating arrangements

1. In the event that participants physically attend the candidates’ forum, participants from Member States and Associate Members will be invited to take seats in the Executive Board Room according to their respective regional membership.

Presentation by candidates

2. The presentation by each candidate shall not exceed 10 minutes. Visual aids, including electronic presentation tools, shall not be used.

Selection of questions

3. Each Member State and Associate Member present at the candidates’ forum will be given colour-coded tokens, one for each candidate to be interviewed, bearing the Member’s name. Member States and Associate Members present will be invited to indicate if they wish to ask a question by placing their token(s) in one of six receptacles (one for each). Once all tokens have been collected by the Secretariat, the Chair will pull one token from each receptacle, following the order of regions that he or she has previously determined by lot. After six questions, one from each region, have been asked, the contents of the six receptacles will be merged into one and the selection of those invited to ask questions will continue, one-by-one, on a fully random basis until the time available for each candidate has been exhausted.

Questions and answers

4. Member States and Associate Members will have up to one minute to ask one question only. Multiple-part questions will not be permitted. Candidates will have up to three minutes to respond to each question. Each interview will conclude after 60 minutes have elapsed, even if there are still questions pending. A candidate will, however, be permitted to complete his or her answer to the question being addressed when the 60 minutes elapse. Should there still be time available when the questions have been exhausted, the candidate may, if he or she wishes, make additional remarks within the remaining time.

Timekeeping

5. It is expected that a traffic light system or other electronic timekeeping system will be used to help participants to keep within the time limits during both parts of the interview.

Second meeting, 2 June 2021
EB149/SR/2
Process for the election of the Director-General of the World Health Organization: contingency arrangements

The Executive Board, having considered the report on the process for the election of the Director-General of the World Health Organization: contingency arrangements,\(^1\)

Decided:

(1) that in the event that the 150th session of the Executive Board were to be held in person, the secret ballot vote for the nomination of the Director-General would be conducted following a paper-based system, in accordance with decision EB146(22) (2020);

(2) that in the event that limitations to physical meetings preclude the holding of the 150th session of the Executive Board as envisaged, the nomination of candidates for the position of Director-General shall take place in accordance with the contingency arrangements decided by the Executive Board, through a written silence procedure, based on a proposal by the Officers of the Board, following consultation with all Member States.

Second meeting, 2 June 2021
EB149/SR/2

\(^1\) Document EB149/4 Add.1.
Human resources: annual report

Report by the Director-General

INTRODUCTION

1. In addition to the workforce data as at 31 December 2020 made available on the WHO website on 16 March 2021, this report provides a summary of the trends in the workforce and of related activities with respect to the three pillars of the human resources strategy: attracting talent, retaining talent, and fostering an enabling working environment.

TRENDS IN THE WORKFORCE

2. As at 31 December 2020, the total number of WHO staff members was 8447 (see Fig. 1 in this report and Table 1 in the workforce data available online), a 2.6% increase compared with the total as at 31 December 2019 (8233). Of the total, the percentage of staff members employed at each of the three levels of the Organization between December 2019 and December 2020 changed as follows: the percentage of staff employed at headquarters increased from 30.1% in December 2019 to 31.2% in December 2020; the percentage of staff employed at regional offices decreased from 25% in December 2019 to 24.5% in December 2020; and at country offices the percentage decreased slightly to 44.3%, from 44.9% in December 2019 (Fig. 2). The proportion of staff members holding long-term appointments in the professional and higher categories increased at the country office level during the same period. The distribution as at December 2020 (and December 2019) was as follows: 48.2% (49.2%) at headquarters, 32% (32.8%) in regional offices and 19.8% (18%) in country offices.

3. For the period from 1 January to 31 December 2020, staff costs amounted to US$ 1389 million or 39% of the Organization’s total expenditure of US$ 3562 million (32% for the period January–December 2019).

4. Regarding other contractual arrangements, the number of consultants and individuals on agreements for performance of work (see workforce data, Table 20) increased from 1575 full-time equivalents in January–December 2019 to 1674 in January–December 2020. At the same time, the number of individuals hired on special services agreements increased from 4128 in January–December 2019 to 4408 in January–December 2020.

---


2 All figures include staff in special programmes and collaborative arrangements hosted by WHO. They do not include staff working with the Pan American Health Organization, the International Agency for Research on Cancer or any agencies administered by WHO.
Fig. 1. Distribution of WHO staff as at 31 December 2020, by major office

Total number of staff: 8447

Fig. 2. Distribution of WHO staff as at 31 December 2020, by level
As at 31 December 2020, women accounted for 45.9% of staff members in the professional and higher categories holding long-term appointments (see Fig. 3 and workforce data, Table 3), representing an increase since December 2019 (45.8%). During the same period, the number of women at the P4 grade and above across the Organization has remained stable. The number of women holding positions graded P6, D1 and D2 at headquarters also increased, as compared with December 2019. The Secretariat continues taking steps to increase the number of qualified women on the roster for heads of country offices. As at 31 December 2020, 37.1% of heads of country offices were women, representing a decrease since December 2019 (37.4%), although there is an increase of 2.1 percentage points since 2017. Women accounted for 35.5% of staff at the P6, D1 and D2 grades as at 31 December 2020—a slight decrease compared to December 2019 (35.7%), while noting that there has been an increase of 4.1 percentage points since 2017 (see Fig. 4).

**Fig. 3. Percentage of women in the professional and higher categories, by major office**

![Chart showing percentage of women in professional and higher categories by major office from July 2017 to December 2020.]

<table>
<thead>
<tr>
<th>Indicator</th>
<th>As at July 2017</th>
<th>As at December 2017</th>
<th>As at July 2018</th>
<th>As at December 2018</th>
<th>As at July 2019</th>
<th>As at December 2019</th>
<th>As at July 2020</th>
<th>As at December 2020</th>
<th>Changes between July 2017 and December 2020</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage of women in the professional and higher categories holding long-term appointments</td>
<td>43.7%</td>
<td>44.4%</td>
<td>44.7%</td>
<td>45.4%</td>
<td>45.6%</td>
<td>45.8%</td>
<td>46.2%</td>
<td>45.9%</td>
<td>Increase of 2.2 percentage points since July 2017</td>
</tr>
<tr>
<td>Percentage of women at the P4 grade and above</td>
<td>41.1%</td>
<td>41.9%</td>
<td>42.5%</td>
<td>43.4%</td>
<td>43.5%</td>
<td>43.5%</td>
<td>43.8%</td>
<td>43.5%</td>
<td>Increase of 2.4 percentage points since July 2017</td>
</tr>
<tr>
<td>Percentage of women as heads of country offices</td>
<td>35%</td>
<td>33.3%</td>
<td>33.1%</td>
<td>35.8%</td>
<td>39.3%</td>
<td>37.4%</td>
<td>37.9%</td>
<td>37.1%</td>
<td>Increase of 2.1 percentage points since July 2017</td>
</tr>
<tr>
<td>Percentage of women at the P6, D1 and D2 grades</td>
<td>31.4%</td>
<td>35.1%</td>
<td>37%</td>
<td>35.4%</td>
<td>37.5%</td>
<td>35.7%</td>
<td>36.1%</td>
<td>35.5%</td>
<td>Increase of 4.1 percentage points since July 2017</td>
</tr>
</tbody>
</table>
6. As at 31 December 2020, 30.1% of Member States (or 59 of the 196 Member States)\(^1\) were either unrepresented or underrepresented (see Fig. 5 and workforce data, Table 4). This percentage shows an improvement compared to last year when 31.6% of Member States were either unrepresented or underrepresented (62 of the 196 Member States).\(^1\) Regarding changes in the composition, six Member States moved from or to the desirable range in terms of representation.

![Fig. 5. Distribution of WHO Member States\(^1\) as at 31 December 2020, by geographical representation](image)

### Fig. 6. Geographic representation – trends over time from July 2017 to December 2020

<table>
<thead>
<tr>
<th>Indicator</th>
<th>As at July 2017</th>
<th>As at December 2017</th>
<th>As at July 2018</th>
<th>As at December 2018</th>
<th>As at July 2019</th>
<th>As at December 2019</th>
<th>As at July 2020</th>
<th>As at December 2020</th>
<th>Changes between July 2017 and December 2020</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage of Member States either unrepresented or underrepresented</td>
<td>32.1%</td>
<td>32.1%</td>
<td>31.6%</td>
<td>32.1%</td>
<td>31.6%</td>
<td>31.6%</td>
<td>30.6%</td>
<td>30.1%</td>
<td>Decrease of 2 percentage points since July 2017</td>
</tr>
<tr>
<td>Percentage of staff in the professional and higher categories (including staff on temporary contracts) from developing countries</td>
<td>43%</td>
<td>43%</td>
<td>42.8%</td>
<td>42.5%</td>
<td>43.4%</td>
<td>44.5%</td>
<td>44.1%</td>
<td>44.2%</td>
<td>Increase of 1.2 percentage points since July 2017</td>
</tr>
<tr>
<td>Percentage of staff in the professional and higher categories holding long-term appointments from developing countries</td>
<td>40.8%</td>
<td>40.7%</td>
<td>41.1%</td>
<td>41.1%</td>
<td>41.7%</td>
<td>42.6%</td>
<td>43.3%</td>
<td>43.8%</td>
<td>Increase of 3 percentage points since July 2017</td>
</tr>
</tbody>
</table>

\(^1\) Including two Associate Members.
The proportion of staff in the professional and higher categories (including staff on temporary contracts) from developing countries has increased since July 2017, and specifically over the last 12-month period for long-term appointments (from 42.6% to 43.8%) (Fig. 6). Organization-wide, the percentage of staff members at the D1 and D2 levels from developing countries has increased from 34.6% in December 2019 to 37.3% in December 2020. Figure 7 provides a comparison of the percentage of international professional staff from developing countries between July 2017 and December 2020, broken down by major office.

Human resources workforce data Table 11 has been expanded, and Table 11b added, to allow for trend analysis of applications from female candidates in Table 11, and applications based upon the geographic representation category of candidates in Table 11b. These tables show that there has been a slight increase in the percentage of female applicants over the past four years, but little progress in increasing applications from nationals of countries that are unrepresented or underrepresented (recognizing that the categorization of countries themselves also changes over time). While significant efforts have been made across the Organization to bridge the gender gap, further expansion is planned from 2021, including more investment in improving geographic representation (see paragraphs 10 and 25 below).

**Fig. 7. Comparison of percentage of international professional staff from developing countries between July 2017 and December 2020, by major office**

<table>
<thead>
<tr>
<th>Indicator</th>
<th>As at July 2017</th>
<th>As at December 2017</th>
<th>As at July 2018</th>
<th>As at December 2018</th>
<th>As at July 2019</th>
<th>As at December 2019</th>
<th>As at July 2020</th>
<th>As at December 2020</th>
<th>Changes between July 2017 and December 2020</th>
</tr>
</thead>
<tbody>
<tr>
<td>Organization-wide, percentage of staff members at the D1 and D2 levels from developing countries</td>
<td>32.2%</td>
<td>31.7%</td>
<td>30.8%</td>
<td>33.5%</td>
<td>33.8%</td>
<td>34.6%</td>
<td>35.9%</td>
<td>37.3%</td>
<td>Increase of 5.1 percentage points since July 2017</td>
</tr>
<tr>
<td>Headquarters, percentage of staff members at the D1 and D2 levels from developing countries</td>
<td>12.5%</td>
<td>10.9%</td>
<td>13.8%</td>
<td>16.4%</td>
<td>15.9%</td>
<td>15.6%</td>
<td>19.1%</td>
<td>21.1%</td>
<td>Increase of 8.6 percentage points since July 2017</td>
</tr>
</tbody>
</table>
9. The number of senior management staff (P6 and above) has increased from 275 in July 2017 to 289 in December 2020 (+5%) (Fig.8), reflecting the strategic direction of WHO’s transformation.

Fig. 8. Comparison of numbers of senior management staff between July 2017 and December 2020, by major office

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Africa</td>
<td>41</td>
<td>33</td>
<td>-20%</td>
<td>1</td>
<td>2</td>
<td>100%</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>0%</td>
<td>43</td>
<td>36</td>
<td>-16%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eastern Mediterranean</td>
<td>28</td>
<td>27</td>
<td>-4%</td>
<td>4</td>
<td>11</td>
<td>175%</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>0%</td>
<td>33</td>
<td>39</td>
<td>18%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Europe</td>
<td>25</td>
<td>27</td>
<td>8%</td>
<td>1</td>
<td>0</td>
<td>-100%</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>0%</td>
<td>27</td>
<td>28</td>
<td>4%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Headquarters</td>
<td>86</td>
<td>80</td>
<td>-7%</td>
<td>29</td>
<td>43</td>
<td>48%</td>
<td>12</td>
<td>19</td>
<td>38</td>
<td>58%</td>
<td>127</td>
<td>142</td>
<td>12%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>South-East Asia</td>
<td>23</td>
<td>20</td>
<td>-13%</td>
<td>2</td>
<td>2</td>
<td>0%</td>
<td>1</td>
<td>1</td>
<td>0%</td>
<td>0%</td>
<td>26</td>
<td>23</td>
<td>-12%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Western Pacific</td>
<td>16</td>
<td>18</td>
<td>13%</td>
<td>2</td>
<td>2</td>
<td>0%</td>
<td>1</td>
<td>1</td>
<td>0%</td>
<td>0%</td>
<td>19</td>
<td>21</td>
<td>11%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>219</td>
<td>208</td>
<td>-6%</td>
<td>39</td>
<td>60</td>
<td>54%</td>
<td>17</td>
<td>24</td>
<td>41%</td>
<td>275</td>
<td>289</td>
<td>5%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

ATTRACTION TALENT

Sourcing and outreach

10. To date, outreach initiatives have been implemented in collaboration with Member States, in particular to improve gender parity. Targeted efforts continue through career counselling, mentorship and leadership pathway programmes to build the capacities of female staff members at junior levels to prepare them for higher-level managerial positions. Additional investments have been made in 2020 in new agreements with external service providers to conduct targeted outreach and recruitment campaigns, in order to improve performance against targets for diversity, in particular with respect to gender parity and improving geographic representation. From late 2020, WHO is expanding its work with Member States and external service providers to participate in virtual career fairs, with the aim to reach female candidates, candidates from underrepresented and unrepresented countries, as well as young professionals. WHO initiated a pilot for a Young Professionals Programme in 2021, which will also contribute to increasing the diversity of the workforce.

Recruitment and selection

11. In recognition of the ambitious strategic and organizational shifts demanded by WHO’s Thirteenth General Programme of Work, 2019–2023, the Director-General initiated a review of WHO’s core processes to determine their effectiveness. An analysis of the recruitment process identified several areas that could be streamlined and improved.

12. A pilot recruitment initiative began in early 2019 with the aim of reducing overall time-to-recruit from 156 days on average to 80 days. The main focus was to reduce the administrative burden on hiring managers and selection panels by providing candidate screening services for long-listing and through asynchronous interviewing. The pilot initiative coincided with the organizational changes implemented through the transformation, thus time-to-recruit remained on average 160 days in 2019 with a range of 64 to 376 days. However, in 2020 we have seen improvements, with an average time-to-recruit of 126 days and a range of 36 to 216 days. In both time periods, staff for senior positions have taken longer to recruit, while rostered positions have taken the least time to fill.

13. The lessons learned from the pilot initiative are currently being documented and will be presented to the Director-General with recommendations for the next phase of the pilot, which will explore
additional new tools, including artificial intelligence and psychometric testing, as well as approaches to address bottlenecks.

GLOBAL INTERNSHIP PROGRAMME

14. As requested by the Health Assembly in resolution WHA71.13 (2018), the human resources annual report includes statistics on applicants’ and accepted interns’ demographic data, including gender and country of origin. Statistics on WHO interns are provided in Tables 16, 17 and 18 in the workforce data.

15. It is important to review this update within the larger overview of changes to the internship programme and progress in the implementation of resolution WHA71.13 from 2018 to July 2020. It should be noted that the total number of interns decreased from 511 in 2019 to 91 in 2020. In 2020, 18.7% of the interns were based in a country office, 26.4% in a regional office and 54.9% worked at headquarters, compared with 16.4%, 29.4% and 54.2%, respectively, in 2019. The overall decrease in the number of interns in 2020 is mostly due to the impact of the pandemic of coronavirus disease (COVID-19) across headquarters, regional and country offices. Additional factors contributing to the decrease at headquarters, from 277 interns in 2019 to 50 in 2020, include the changes made to the application and recruitment process for all 2020 internships (with the exceptional completion of 2019 internships in December 2019 and no carry-over of interns into January 2020). Account must also be taken of the restructuring exercise in headquarters that took place at the end of 2019, and which resulted in delayed planning and recruitment for 2020 internships pending the finalization of the new structure of departments and units.

16. The global COVID-19 pandemic context in 2020 has impacted operations in the internship programme. The situation in March regarding lockdowns in many countries and associated sudden closures of international borders and restrictions to travel, necessitated a temporary suspension of the arrival of some interns who had already been recruited, and of any new internship recruitments. During the small window of time before border closures and travel restrictions were implemented, some interns already in duty stations chose to return rapidly to their respective countries, while others chose to remain in the duty station, continuing their internships, where possible, from their local accommodation.

17. The global situation was closely monitored by the programme throughout the subsequent months. International borders and travel restrictions began slowly to open from June to September. During this period, internship programme resources were focused on facilitating and supporting interns for their return to their respective countries. For some situations, exceptional measures were provided as part of this facilitation and support. A formal decision was taken in July to suspend the programme for the remainder of 2020 and to continue to monitor the situation to determine how the programme would approach internships in 2021. During the first quarter of 2021, the COVID-19 pandemic context required the suspension of the programme to be maintained until further notice and further monitoring of the situation globally to be continued. WHO is not offering remote internships.

18. Bearing in mind that resolution WHA71.13 requests that by 2022 at least 50% of accepted interns originate from least developed and middle-income countries, the increase of nearly four percentage points in the percentage of interns coming from these countries in 2019 was very encouraging (29.6% compared with 25.7% in 2018). In 2020, the percentage increased to 35.2%. Additionally, it is very encouraging to see that the percentage at headquarters has increased substantially with a new record high of 48% in July 2020, up almost 19 percentage points from the previous high of 29.6% reached in December 2019. Table 17 in the workforce data shows the geographical distribution of interns by nationality for the period January–July 2020. A total of 44 nationalities were represented in 2020, a
decrease of 38 compared with 82 nationalities in 2019 due to the current context. However, of the 44 intern nationalities represented in 2020, almost half (48%) came from least developed and middle-income countries. Women accounted for 80.2% of all interns (compared with 75.1% in 2019).

19. In January 2020, WHO began providing living allowances to interns who receive little or no external assistance. In addition, medical insurance is provided to all interns across the Organization and lunch vouchers continue to be provided in some duty stations to all interns, irrespective of their financial needs. Each technical unit that hosts an intern provides the Department of Human Resources and Talent Management with an equivalent sum per intern, and payments of living allowances are managed centrally. In this way, no advantage is given to candidates who receive external assistance, thus promoting an unbiased selection process. From March to September, financial and in-kind support continued to be provided to interns that had remained in the duty station through the period of lockdown and subsequent travel restrictions. In situations where continued travel restrictions prevented an intern from exiting the duty station and returning to their country at the end of their internship, WHO intervened with the host country authorities, and facilitated extended exceptional authorization for the individual to stay on the territory. During these extended periods, living and/or meal allowances continued to be provided until the intern was able to exit the duty station.

RETAINING TALENT

Performance management

20. Performance management is essential to building the workforce of excellence required to achieve the ambitious goals set out under the Thirteenth General Programme of Work, 2019–2023. Effective performance management is based on a strong performance culture and a healthy workplace ecosystem, supported by individual and management capabilities and accountabilities. An analytical review (with a report issued in March 2019 as one of the process analyses conducted in the context of the transformation) of WHO’s practice within the key areas of performance management revealed a number of challenges when benchmarked against other organizations.

21. Several recommendations from the report have been implemented, such as: Goals Week, new awards for service, and the expansion of the Regional Office for Africa’s Pathway to Leadership for Health Transformation Programme, which includes 360 degree feedback as a developmental tool, combined with emotional intelligence and strength-finder tests. WHO is also currently working on a specific new proposal to implement 360 degree feedback more broadly for the workforce. The recommendations to modernize and enhance the performance management tool and to define an alternate rating approach are yet to be implemented and are being assessed in the context of the project to replace the enterprise resource planning system.

22. Starting in 2019, WHO used the performance management process to align each individual staff member’s objectives with the “triple billion” goals during Goals Week. This was achieved by linking each objective in the Electronic Performance Management and Development System (ePMDS) with an output from the Programme budget. Staff and managers were asked to discuss and agree on team and individual goals in the context of the Thirteenth General Programme of Work, 2019–2023, and Programme budget outputs and, in 2019, staff entered the relevant output number which corresponded to the description of their own objectives in their ePMDS form.

23. WHO introduced changes to the ePMDS tool for 2020 to allow outputs to be selected from a drop-down menu, and to enable staff to estimate the percentage of time that would be spent on each SMART objective throughout the year. This can be benchmarked at the year-end review against actual
time spent on each objective. By early 2021, it will be possible to generate reports on the performance of staff by organizational unit and major office based on the ePMDS assessments, linking individual performance to the organization-wide outputs and goals.

24. More recently, the rapid implementation of extensive, large-scale teleworking in the context of COVID-19 has given rise to new challenges for managers and members of the workforce alike, bringing new requirements under flexible working arrangements that WHO will need to take into account in the future approach to management performance.

**Staff learning and development**

25. For the 2020–2021 biennium, 12 global and 40 regional learning initiatives have been approved for implementation. The global initiatives include the Leadership, Women and the United Nations course organized by the United Nations System Staff College and targeting female staff at P4/P5 level globally. Fifty-nine seats have been allocated for this course in 2020. From 2015 to 2019, it had been taken by 81 female staff members. There is also the Pathway to Leadership for Transformation of Health in Africa Programme which is being led and coordinated by the Regional Office for Africa (see paragraphs 31 and 32).

26. WHO’s corporate tool for learning and development, iLearn, is accessible by the entire WHO workforce, and had more than 18,000 users in 2020. By the end of 2020, training course registrations for that year only had peaked with more than 115,000 registrations globally (excluding registrations for mandatory training). iLearn is also being used to provide access to WHO mandatory training to external users such as emergency and polio personnel.

27. A coherent and global approach to mandatory training courses was implemented via iLearn in May 2018, allowing managers and programme owners to track compliance with mandatory training requirements. WHO’s compliance rate for staff remains above 90% for both the United Nations training course on the prevention of harassment, sexual harassment and abuse of authority (93.3% compliance), and the United Nations training course “To serve with pride – zero tolerance for sexual exploitation and abuse by our own staff” (96.5% compliance). These courses have been extended to the entire WHO workforce. Additional mandatory training courses on various topics are being introduced in iLearn to improve the quality of services and enhance staff members’ performance. These include United Nations Department of Safety and Security BSAFE (completed by over 7000 staff to date), Cybersecurity Essentials (88% compliance), Global Procurement, Risk Management, and Finance and Accountability.

28. WHO entered into a new contract with LinkedIn Learning in 2019 under a United Nations system-wide umbrella agreement. The LinkedIn Learning content is fully integrated into iLearn and may thus be accessed by the entire WHO workforce, with courses available in 7 languages (English, Chinese, French, German, Japanese, Portuguese and Spanish) and 70 new courses added each week, of which about 50% are in English, with the remaining 50% divided between the other languages. During 2020, 20,000 courses and 180,000 videos were viewed by WHO staff, key areas of interest being: working remotely, work-life balance, Microsoft Teams, Power BI, interpersonal communication, emotional intelligence and time management.

29. In order to provide learning support to the WHO workforce during the COVID-19 restrictions, the Human Resources and Talent Management Department collaborated with LinkedIn Learning to create new playlists, in English and in French, available to staff and non-staff via both desktop and mobile devices. Topics include work-life balance, working remotely, resilience, change management, mindful meditation for work and life, creating a healthy working environment/ergonomics, workplace
from Facebook, United Nations leadership in times of uncertainty, and WHO information technology systems (Jabber, OneDrive, OneNote, Microsoft Teams, vConnect, WebEx).

30. The Department of Human Resources and Talent Management is working closely with the WHO Academy, taking part in the WHO Academy Learning Technologies Internal Coordination Group and the WHO Learning Strategy Advisory Group and United Nations Learning Group:

- The WHO Academy Learning Technologies Internal Coordination Group brings current WHO digital learning and learning technologies management system leads, focal points and managers together to support the WHO Academy learning experience platform and learning technologies development.

- The WHO Learning Strategy Advisory Group and United Nations Learning Group. The scope of the WHO Learning Strategy is to address, through the lens of learning and training, future challenges to the health of the world’s population. It will propose a framework and approach by WHO on learning and training for its own workforce, and on how the Organization will support learning externally, across diverse sectors, for the achievement of global, national and individual health goals, to ensure people achieve the best levels of health possible.

31. Through the Regional Office for Africa’s Pathway to Leadership for Transformation of Health in Africa Programme, launched in November 2018, over 180 staff members at different levels were trained. The programme has improved staff skills in the areas of organizational, team and personal leadership, and analytical and strategic thinking skills. A women’s leadership programme was also launched, which focused on overcoming barriers to career progression among female staff in the Regional Office. The Pathway to Leadership Programme has now been adopted Organization-wide. The programme for the Eastern Mediterranean and European Regional Offices are in final preparatory phases and will be launched at the beginning of 2021.

32. The Regional Office for Africa’s Pathway to Leadership for Transformation of Health in Africa Programme has led to a notable increase in overall staff engagement at the unit level, as a result of changes adopted in leadership practice and improved managerial skills and abilities among participants. The programme is also part of the strategy to nurture future WHO leaders through an approach that combines the right skill sets and qualities with customized training. In view of the current situation and constraints posed by COVID-19, the programme was adapted to continue responding to leadership needs. Additional coaching was provided to new leaders, particularly in the area of managing in a time of crisis, managing remote teams, fostering team resilience and agility. The evaluation of the global transformation will provide more detailed information on the impact of the programme and how to maximize the effectiveness of WHO leaders and managers in an environment of increasing uncertainty and complexity. The WHO global mentoring programme is part of an organizational development approach that aims to support staff in career development, learning on the job, knowledge-sharing and capacity-building. Since its formal global launch in December 2019, with the presence of the Director-General, the number of mentors has risen to more than 180 and 22 new mentor pairs have been coached and supported along their mentoring path in 2020. Confident career conversations for mentors and mentees have been introduced to facilitate career development discussions through a train-the-trainer approach. Sixty-four mentors and managers have taken part in this training, which involves a coaching approach and a useful toolkit for facilitating fruitful career and development conversations. In February 2021, thanks to a collaboration with the United Nations Secretariat, a first cohort of 25 WHO staff members were offered the opportunity to take part in the United Nations Together Mentoring Programme, hence expanding the networking and development opportunities for our staff members globally. With regard to WHO’s global mentoring programme, this year already, seven new mentor/mentees pairs have connected since January.
34. In the African Region, to strengthen organizational effectiveness, transform organizational culture and establish a robust leadership programme, complementary developmental programmes targeting staff in non-leadership positions were designed. Two people-centred initiatives have since been developed. The first initiative is the WHO Regional Office for Africa’s mentorship programme, under which senior or more experienced staff support junior staff to develop professionally and enhance their performance. The objective of the programme is both to strengthen collaboration among staff and to empower junior staff. To date, the first cohort (July–December 2020) consisted of 33 senior staff mentors who were successfully trained and paired with 65 junior staff mentees. The mentorship initiative is a six-month programme conducted using a virtual platform. A second cohort was launched in February 2021. One hundred and fifteen mentors (including staff from other regions) and 249 mentees have been trained and paired on the basis of their selected individual and professional values. The second initiative is the team performance programme. Based on the WHO competencies framework, this programme consists of 32 training modules and individual coaching, and aims to develop high-performing teams and enhance collaboration within and across technical areas in the Regional Office and country offices. To date, 58 staff members have benefited from this capacity-building initiative. Four workshops and 30 sessions of individual coaching have been delivered to 21 technical and operational staff.

**Career pathways and career development**

35. The career pathways initiative comprises a global career development programme linked to enhancements and reforms in performance assessment, succession planning, mobility, learning and development (including the work of the WHO Academy) and other related initiatives.

36. An all-staff seminar on career pathways took place in November 2020, during which the WHO high-level career-management framework and architecture was presented together with an updated action plan to be carried out in 2020–2022. The action plan includes the scaling up of the Leadership Pathways Programme and its 360 degree feedback component to support the strategic priorities of the Organization as outlined in the Thirteenth General Programme of Work, 2019–2023. As part of the staff engagement approach, an all-staff survey on career paths was launched in February 2021. It will be followed by focus groups discussions with selected participants aimed at elaborating the specific career paths in the identified career streams and thematic areas of public health and operations. Communication activities are taking place on a monthly basis to update all staff on the progress made in this programme of work.

37. Career management activities, coaching, mentoring, team building, and career counselling continued to be offered in 2020 and 2021 through on-line remote modalities, hence allowing a truly global reach. These initiatives are focused on developing competencies, enhancing self-awareness, preparing staff members to undertake higher-level responsibilities and ensuring that the right attitudes and mindsets are in place to ensure optimal performance. Short-term developmental assignments were provided from a distance, due to COVID-19 travel restrictions, allowing staff members from various duty stations and regions to benefit from professional development and on-the-job learning. Following the Director-General’s participation in a masterclass on emotional intelligence in the workplace on October 2020, addressed to all staff, this topic has now been introduced globally through various initiatives aimed at increasing staff members’ self-awareness, collaboration and performance.

38. Talent pools of qualified and pre-assessed candidates will be established and used to fill long-term positions or temporary needs arising in operational/technical and administrative areas. This initiative will be piloted first for the general service category in the operational career pathways stream while building on and further expanding the current roster mechanism. Talent Pools will be managed through a new and integrated talent management platform which will enable WHO to integrate information on
learning and mentoring programmes, job opportunities, staff profiles and individual career plans to be used for career development purposes.

Mobility

39. The number of staff members in the professional and higher categories holding long-term appointments who moved from one duty station to another for the period January–December 2020 (see workforce data, Tables 14 and 15) is 162 (6.8% of all the staff members in those categories), a significant decrease compared with the period January–December 2019 (192 staff members). However, there has been an increase in the percentage of moves from one major office to another: 47% of total moves compared with 36% in 2019.

40. A task force on mobility comprising staff members from all three levels of the Organization was established by the Director-General in April 2019. The goal of the task force was to develop guidelines on the mandatory mobility practices outlined in WHO’s geographical mobility policy. It carried out extensive consultations with staff members, conducted a benchmarking exercise against the policies and practices of other United Nations agencies and partners, and prepared recommendations. The recommendations were reviewed by WHO’s global human resources community and the Global Staff/Management Council and served as a basis for updating the geographical mobility policy for the consideration of the Global Policy Group. A simulation exercise was launched in October 2020 to validate the accuracy of the data currently available on staff and positions and to test implementation of the major components of the proposed policy and governance mechanisms. The conclusions from the simulation exercise will be reported in May 2021.

41. Additional investments were made in improving the human resources dashboard tool for mobility, which provides up-to-date information on staff members and their mobility data. In early October 2020 an all-staff meeting on mobility was followed by an invitation to 1051 staff members globally, who had reached or exceeded their standard duration of assignment to invite them to participate in the simulation exercise. Of those, 128 staff members replied positively and have participated in the application process as well as the deferral process between November 2020 and January 2021. The Mobility Advisory Board will meet in early 2021 to formulate its recommendations to Senior Management. Extensive feedback was received from the staff members participating in the simulation exercise, which will inform the final mobility policy.

ENABLING WORKING ENVIRONMENT

Diversity and inclusion strategy

42. In 2020 the first draft of a diversity and inclusion strategy for the WHO workforce and accompanying action plan were produced. The purpose of the strategy is to lay the foundation of the policies, processes and action plans (i) to attract and retain a diverse workforce and (ii) to create a work environment welcoming to all, where everyone feels valued and can perform at their best. The strategy will focus on improving diversity and inclusion with respect to the following five areas: gender equality; gender identity and sexual orientation; geographical representation; persons with disabilities; and age and education diversity. The strategy and first version of the action plan are undergoing additional review in the context of a broader programme of work for the Organization, and publication is planned for 2021.
Prevention of abusive conduct, including sexual harassment

43. Further to the previous recommendations from governing bodies, including the report of the Programme, Budget and Administration Committee to the 146th session of the Executive Board in February 2020,¹ in close coordination with the Office of Compliance, Risk Management and Ethics, the current harassment policy has been revised and updated to include all forms of abusive conduct, covering harassment, sexual harassment, discrimination and abuse of authority. The revised policy provides coherence to the intake process for complaints, while recognizing the attention and escalation necessary for sexual harassment. The provisions on sexual harassment are in line with the United Nations System Model Policy on Sexual Harassment. The policy was issued in early 2021, and the initial implementation plan is being rolled out. Particular emphasis is being placed on the implementation plan to ensure that the necessary training and other forms of support are in place across the Organization.

Internal justice system

44. The Secretariat continues to monitor the reform of the internal justice system launched in 2016; the resulting improvements include a greater emphasis on the informal resolution of disputes, which has significantly reduced the number of appeals. The Secretariat looks forward to a review of the internal justice system reforms of 2016 for further improvements based upon lessons learned. The Office of the Ombudsman continues to collaborate in the development and delivery of informal resolution mechanisms aimed at improving working relationships and promoting a more respectful workplace.

Flexible working arrangements

45. Starting in mid-March 2020, WHO implemented teleworking under special conditions related to the COVID-19 situation and the measures implemented by national authorities. In 2020, WHO offices conducted staff surveys and internal reviews of the impact of COVID measures on the workforce. While most of the workforce has had a generally positive experience, there are specific areas where concerns need to be addressed. WHO is both reflecting on the lessons learned in real time, while discussing fundamental issues on the nature of the workplace, how we work in the evolving environment, how we take care of our workforce, and how these experiences will be taken into account moving forward. Specifically, WHO is using task forces to focus on issues such as the return to the premises including on-site safety and security, flexible working arrangements, contractual modalities and the mental health of the workforce. These task forces will guide both the immediate next steps and inform longer-term thinking on the future of work.

Human Resources Global Operations

46. Over the past year a number of innovations have been introduced through Global Human Resources Operations within the Global Service Centre in Kuala Lumpur. This includes: the introduction of seven on-line calculators to make staff self-reliant for obtaining estimates related to salary compensation; enhancements to the human resources case management tool, using cloud-based software “service now” for improved monitoring of human resources transaction processing and client communication; and process simplification along with Global Management System enhancement for emergency staff rest and recuperation leave. Global Human Resource Operations introduced second shift operations to guarantee extended hours of support during weekdays and weekends, particularly in respect of emergency operations. Additional human resources services such as staff onboarding and

¹ Document EB146/3.
salary step determination were consolidated with the Service Center to improve monitoring and the overall quality and value of service delivery.

Staff health and well-being

47. The health and well-being of the workforce directly underpin the Organization’s ability to achieve its strategic goals and are essential components of organizational success. Recognizing that healthy organizations achieve more, WHO is aligning its health and well-being strategy with its new operating model at all levels of the Organization to ensure a healthy work environment for all.

48. To achieve a healthy working environment, WHO’s Staff Health and Well-being Department has contributed to various programmes and initiatives, including the United Nations system-wide occupational health and safety forum chaired by WHO, and to revitalizing and rebranding the Organization’s Health, Safety and Well-being Committee and the implementation of the United Nations System Mental Health and Well-being Strategy.

49. WHO’s Department of Staff Health and Well-being Services plays an essential enabling role during outbreak and emergency response activities by protecting and promoting the health and well-being of WHO’s global workforce. During the current response to the COVID-19 pandemic, the Department has contributed to business continuity planning at headquarters and occupational safety and health measures including: the drafting of communications to staff; the development of standard operating procedures for medical and security staff; the implementation of infection prevention and control measures within WHO premises; and the holding of psychosocial and psychological counselling sessions and webinars. With the support of WHO experts, the Department has also developed guidance and standard operating procedures for COVID-19 risk assessments, prevention measures on the premises and contact tracing for personnel. In the current context, the Department is actively monitoring the health status of all business continuity personnel on a daily basis and responding to thousands of queries by personnel.

50. Additionally, as part of the global COVID-19 response, the Department of Staff Health and Well-being Services has taken the lead within the global United Nations System-wide Task Force on Medical Evacuations in response to COVID-19 to establish a MEDEVAC Medical Coordination Unit. Beginning in May 2020, the Unit operates 24 hours a day, seven days a week, and is responsible for overseeing the clinical and operational management of evacuations, including identifying the receiving hospital and coordinating air ambulances with the United Nations Strategic Air Operations Centre and the World Food Programme. The Unit has coordinated with United Nations colleagues to establish a dedicated United Nations COVID-19 treatment facility in Accra, Ghana, and in Nairobi, Kenya. The Unit also communicates and interacts with Resident Coordinators, WHO representatives and country focal points, to develop new agreements with countries to accept MEDEVAC patients. As of early March 2021, 241 MEDEVAC cases have been processed from 51 different departing countries to 20 receiving countries for COVID-19 treatment.

51. At the same time, the Department of Staff Health and Well-being Services continued to support the response to the second largest outbreak of Ebola virus disease in the Democratic Republic of the Congo. The outbreak was declared over on 25 June 2020. During the response, the Department provided ongoing medical, psychosocial and psychological support; established a vaccination clinic; conducted health risk assessments; provided medical evacuation training; and evaluated local health care facilities. In collaboration with internal and external partners, the Department also led the development and training of emergency response plans, including those for responding to mass casualty incidents. On 7 February 2021, a further outbreak of Ebola in the Democratic Republic of the Congo was declared,
and the Department of Staff Health and Well-being Services has been providing ongoing support to deployed personnel.

**ACTION BY THE HEALTH ASSEMBLY**

52. The Health Assembly is invited to note the report.
Preventing sexual exploitation, abuse and harassment

Report by the Director-General

1. At its 148th session, the Executive Board adopted decision EB148(4) on Preventing sexual exploitation, abuse and harassment. Within the context of the decision, this report provides an overview of both WHO’s policies and the actions the Organization has taken to prevent and respond to sexual exploitation and abuse and sexual harassment, as well as further improvements needed and key next steps. Subject to Member State approval, suitable standing agenda items will be proposed for the Executive Board and Health Assembly to enable holistic discussion of the prevention of sexual exploitation, abuse and harassment.

2. WHO is committed to providing a respectful work environment, and to promoting and enforcing policies that respect the inherent dignity of all persons, including those we serve. WHO has an abiding responsibility to prevent and respond to discrimination, abuse of authority, and harassment, including sexual harassment and exploitation.

3. WHO’s approaches to the prevention of and response to sexual exploitation and abuse and sexual harassment aim to reflect a United Nations system-wide common approach. WHO’s policies, guidance and actions relating to prevention of and response to sexual exploitation and abuse and sexual harassment include: promotion of a safe and empowering environment; prevention of abusive behaviour; early detection and intervention; handling of formal complaints; provision of support to affected individuals; investigation of credible allegations; enforcement of disciplinary and judicial sanctions that are commensurate to the misconduct; and collection, use and reporting of anonymized data. Further action is required, and additional measures are being implemented across the three levels of the Organization, to ensure the full compliance and consistent implementation of these policies and guidance.

4. In addition to internal policies and actions, the Secretariat develops and promotes policies and evidence-based guidance for countries and supports their implementation in order to prevent and respond to sexual exploitation and abuse and sexual harassment and to care for those affected, within the context of public health.

PROMOTING A RESPECTFUL WHO WORKPLACE

5. WHO has designated 2021 as the Year of the WHO Workforce, with initiatives and actions aimed at building a working culture and environment that is inclusive, safe and respectful. It not only aims to protect and empower staff but to also enhance the Secretariat’s work in countries and the communities it serves. The activities for the Year centre around four themes: (1) promoting diversity, equity and inclusion; (2) creating an enabling working environment; (3) fulfilling the potential of the workforce; and (4) people caring about people. Strengthening these four areas will improve WHO’s
ability to prevent sexual exploitation and abuse and sexual harassment both within the Secretariat and in the communities that the Organization serves.

6. The Secretariat is in the process of developing a diversity, equity and inclusion road map for implementation across the Organization in order to create a work environment that is welcoming to all and where everybody feels valued and respected and performs at their best regardless of age, gender identity, disability, race, ethnicity, nationality, religion, sexual orientation and any other status or affiliation. The road map will also sensitize staff to such issues in the communities they serve.

7. In March 2021, WHO launched a new policy on Preventing and Addressing Abusive Conduct which updates and expands on the Policy on the Prevention of Harassment at WHO dating from 2010. The new policy adopts a survivor-centred approach and further clarifies actions for reporting, managing and responding to allegations of abusive conduct, including clarifying roles and responsibilities within the Secretariat as well as those who partner with the Organization.

8. In terms of training, the compliance rate for WHO’s staff members remains very high for both the United Nations course on the prevention of harassment, sexual harassment and abuse of authority (93.3% compliance) and the United Nations course “To serve with pride – zero tolerance for sexual exploitation and abuse by our own staff” (96.5% compliance). Additional briefings and training will be provided in due course, in particular to help managers and supervisors to deal with possible abusive conduct in their teams. WHO contracts and agreements across the Organization now include a clause pertaining to the prevention of sexual exploitation and abuse and will be revised to make specific reference to WHO’s policy on preventing and addressing abusive conduct. The Secretariat also expects its collaborating partners to adhere to WHO policies on the prevention of sexual exploitation and abuse when working together with WHO.

SAFE, ACCESSIBLE AND CONFIDENTIAL RESOLUTION MECHANISMS AND PROCEDURES

9. The new policy on Preventing and Addressing Abusive Conduct and WHO’s Code of Ethics and Professional Conduct outline the procedures for the receipt and handling of both informal and formal complaints within WHO involving WHO staff members, non-staff personnel and collaborators. The policy and procedures set out in the WHO Sexual Exploitation and Abuse: Prevention and Response issued in 2017 outline the resolution mechanisms related to complaints of sexual exploitation and abuse made against WHO staff members and collaborators towards third parties, referred to as “beneficiary” populations.

10. WHO’s Integrity Hotline provides an independent and confidential reporting service for both WHO staff and non-staff personnel to report concerns of any wrongdoing in WHO, including sexual exploitation and abuse and sexual harassment. Additional work is needed to ensure that staff and non-staff personnel are aware of this service.

11. WHO affords high priority to assessing and responding to allegations of sexual exploitation and abuse and sexual harassment. In early 2021, the Secretariat assessed the Organization’s capacity to
manage sexual exploitation and abuse and sexual harassment and to move forward with strengthening investigative functions, including recruiting more personnel. The Secretariat has also provided support to networks of sexual exploitation and abuse liaison officers at country level.

PREVENTING AND RESPONDING IN EMERGENCIES

12. Following allegations made in September 2020 of sexual exploitation and abuse during the response to the tenth Ebola virus disease outbreak in the Democratic Republic of the Congo in 2018, the Director-General established a special external independent commission to review these allegations of sexual exploitation and abuse; to investigate possible cases, to identify and support victims and to hold perpetrators to account. This novel approach also aims to identify the root causes and systemic weaknesses within the system and provide recommendations to WHO for action to strengthen the prevention of sexual exploitation and abuse. The Independent Commission is guided in its work by the principles of independence (both from WHO and the broader United Nations system), integrity, impartiality and transparency. The co-Chairs finalized the composition of the Commission by identifying three additional members and the Commission is supported by a secretariat, including a Coordinator, based in Goma since March 2021. The work of the Independent Commission is supported by an external supplier, selected by the Commission through a competitive bidding process. A multidisciplinary team of experts from the external supplier started the outreach, fact-finding and investigation mission in the eastern region of the Democratic Republic of the Congo on 1 May 2021. A second mission is expected to be conducted at the end of June or beginning of July. The work of the external supplier is expected to be completed by the end of August 2021. The findings and files from the United Nations Office of Internal Oversight Services investigations in the Democratic Republic of the Congo, relevant to allegations implicating WHO, as well as other relevant documents, were shared with the Commission’s investigations team by WHO in a manner that respects confidentiality and process rights. The Commission submitted its first and second reports to the Director-General, respectively in January 2021 and May 2021. The work of the Commission is expected to be completed by 30 August 2021, at which time the Commission will submit its final report to WHO. Pending the outcome of the investigation, the WHO Secretariat is taking further action to strengthen its policies, practices, capacities and actions to prevent and respond to sexual exploitation and abuse, including in emergency settings.

13. The WHO Secretariat participated in the Inter-Agency Standing Committee mission to the Democratic Republic of the Congo in October 2020, which recommended the establishment of a system-wide strategy for preventing sexual exploitation and abuse. The Director-General has committed himself to implementing these recommendations, which will contribute to ensuring an overall survivor-centred approach – in the deployment of vetted and sensitized personnel in emergencies, in reporting and investigating cases, in applying survivor protection measures, and enhancing an Organization-wide framework for accountability. To date the WHO Secretariat has deployed two prevention of sexual exploitation and abuse coordinators at the Inter-agency level, one in the Democratic Republic of the Congo, and one in Ukraine to support the implementation of Inter-Agency actions for prevention and response to sexual exploitation and abuse under the coordination and leadership of the United Nations Population Fund.

14. To strengthen dedicated capacity for the prevention of sexual exploitation and abuse in emergencies, a working group has been established in the Office of the Health Emergencies Response Division. Additionally, a Prevention of Sexual Exploitation and Abuse Unit has been established in the Division, and the recruitment of three staff personnel has been initiated. The working group has mapped the implementation of prevention of sexual exploitation and abuse policies in WHO and
compared WHO’s practices with those of other Inter-Agency Standing Committee partners in order to identify gaps and best practices. The recommendations of the working group will be used to strengthen policy implementation and monitor compliance during emergency operations. A rapid assessment of WHO capacities for prevention and response to sexual exploitation and abuse during graded emergencies was initiated on 31 March 2021 to prioritize immediate actions for mitigating risks related to sexual exploitation and abuse and to ensure that more sustainable preventive measures are developed. Existing training on the prevention of sexual exploitation and abuse across the United Nations system has been reviewed and a learning plan drafted with a modular approach for induction training of all WHO personnel and collaborators deployed. Modules on prevention of sexual exploitation and abuse, and sexual harassment will be developed and integrated into all leadership training for health emergency personnel across all three levels of WHO.

15. The revised version of the Emergency Response Framework includes a new chapter on sexual exploitation and abuse and sexual harassment, which highlights all relevant policy issues, outlines actions and processes for integrating prevention and response interventions into broader emergency response operations and provides a framework for continuous monitoring and evaluation.

16. Prevention of sexual exploitation and abuse has been included as a standing agenda item for the emergency programme’s monthly meetings with the heads of WHO country offices in fragile and vulnerable States. This regular consideration contributes to the strengthening of country programmes and the monitoring of progress to mitigate and prevent sexual exploitation and abuse as part of the WHO Accountability Framework, including accountability to affected populations. The Secretariat has strengthened operational capacities for prevention and response to sexual exploitation and abuse and sexual harassment in ongoing emergency operations and in fragile and vulnerable states, including for on-going emergency response operations in the Democratic Republic of the Congo.

17. The Regional Office for Africa has been working with other United Nations agencies, including United Nations Population Fund and United Nations Children’s Fund to conduct joint awareness campaigns in Butembo, Democratic Republic of the Congo, on the prevention of sexual exploitation and abuse, reaching over 300 members of civil society, non-governmental organizations and government personnel. A focal point for the prevention of sexual exploitation and abuse has been deployed to emergency operations in the Democratic Republic of the Congo and Guinea to systematically orient all staff and contractors and to regularly conduct briefings on the prevention of sexual exploitation and abuse. In addition virtual awareness sessions have been provided for personnel in countries with complex humanitarian emergencies.

ALIGNING POLICIES AND PROCEDURES ACROSS WHO AND WITH THE UNITED NATIONS SYSTEM

18. WHO is committed to aligning its policies and procedures with and implementing United Nations system-wide and Inter-Agency Standing Committee (IASC) initiatives, policies, guidelines and recommendations, which promote a survivor-centred approach.

19. Specifically, WHO’s policies and procedures are aligned with the Inter-Agency Standing Committee Minimum Operating Standards for Protection from Sexual Exploitation and Abuse for

---


20. WHO is also implementing the measures recommended by the Chief Executives Board for Coordination Task Force on addressing Sexual Harassment within the Organizations of the United Nations system, including the use of the ClearCheck screening database.

PROVIDING GUIDANCE AND SUPPORT TO COUNTRIES

21. Sexual exploitation and abuse and sexual harassment, in their various forms, are public health problems affecting all countries and are associated with violence, unintended pregnancies, HIV and other sexually transmitted infections, depression, anxiety and suicide. As a result of stigmatization and discrimination, individuals affected by sexual exploitation and abuse and sexual harassment may experience barriers to accessing essential health services. The Secretariat provides support to countries to address this issue through high-level advocacy, collection and dissemination of strategic information, development of normative guidance and tools, provision of technical assistance for country implementation, and collaborative actions with partners and stakeholders.

22. The Secretariat collects, analyses and disseminates data relevant to sexual exploitation and abuse and sexual harassment; its work includes building the evidence base on the extent and type of violence against women in different settings and supporting countries’ efforts to document and measure this violence and its consequences. Its analysis of prevalence data from 2000 to 2018 across 161 countries and areas found that 30% of women worldwide have been subjected to physical and/or sexual violence by an intimate partner or non-partner sexual violence or both. Globally, 6% of women report having been sexually assaulted by someone other than a partner. In 2018, The Secretariat commissioned a systematic review of violence motivated by perception of sexual orientation and gender identity. In 2020, WHO issued guidance for collection of data on the impact of COVID-19 on violence against women and girls.

---

23. WHO Secretariat produces guidelines and implementation tools for strengthening health services relevant to the prevention, detection and management of sexual exploitation and abuse and sexual harassment. For example, in 2020 it published guidance developed with the United Nations Population Fund and the United Nations High Commissioner for Refugees on the clinical management of survivors of rape and intimate partner violence for use in humanitarian settings.¹ In recent years, WHO has produced multiple guidelines, tools and examples of good practice on the prevention, diagnosis, treatment and care of HIV and other sexually transmitted infections for key populations, including sex workers, transgender people, and men who have sex with men, with these key populations being at very high risk of sexual exploitation and abuse and sexual harassment.²,³ WHO’s guidance and tools have been designed to empower health care providers to prevent female genital mutilation and to provide care for girls and women who are affected.⁴

**A HOLISTIC APPROACH TO PREVENTING AND RESPONDING TO SEXUAL EXPLOITATION AND ABUSE AND SEXUAL HARASSMENT**

24. Upholding, promoting, and enforcing zero-tolerance policies on sexual exploitation and abuse and sexual harassment is crucial in all WHO’s operations in all countries. Such policies are particularly relevant in the context of emergency operations, where recruitment needs to be processed rapidly and where decisions are taken quickly in order to perform life-saving humanitarian operations.

25. WHO promotes a holistic approach, applying measures to promote a respectful workplace and respectful engagement with communities; to prevent exploitation, abuse and harassment; to identify those affected and intervene early and provide them with care and support, through counselling, peer support mechanisms and enforcement of the whistle-blower policy; and to take appropriate action against those found to have perpetrated abuses.

26. WHO recognizes that sexual exploitation and abuse and sexual harassment are global problems, requiring coordinated partnerships, multisectoral action at all levels and the engagement of communities to advance social and cultural norms that ensure safe and supportive environments for all. It is women and children, the poorest and most marginalized who are the most vulnerable and require the greatest protection. WHO promotes public health measures that play a key role in creating supportive environments, including those for populations at high risk of exploitation and abuse and for first responders and service providers for survivors, and in providing the crucial people-centred services required to prevent and respond to sexual exploitation and abuse and sexual harassment.

ACTION BY THE HEALTH ASSEMBLY

27. The Health Assembly is invited to note this report.