



WORLD HEALTH ORGANIZATION

SIXTY-EIGHTH WORLD HEALTH ASSEMBLY

GENEVA, 18–26 MAY 2015

**RESOLUTIONS AND DECISIONS
ANNEXES**

GENEVA
2015

ABBREVIATIONS

Abbreviations used in WHO documentation include the following:

ACHR	– Advisory Committee on Health Research	OIE	– <i>Office International des Epizooties</i>
ASEAN	– Association of Southeast Asian Nations	PAHO	– Pan American Health Organization
CEB	– United Nations System Chief Executives Board for Coordination	UNAIDS	– Joint United Nations Programme on HIV/AIDS
CIOMS	– Council for International Organizations of Medical Sciences	UNCTAD	– United Nations Conference on Trade and Development
FAO	– Food and Agriculture Organization of the United Nations	UNDCP	– United Nations International Drug Control Programme
IAEA	– International Atomic Energy Agency	UNDP	– United Nations Development Programme
IARC	– International Agency for Research on Cancer	UNEP	– United Nations Environment Programme
ICAO	– International Civil Aviation Organization	UNESCO	– United Nations Educational, Scientific and Cultural Organization
IFAD	– International Fund for Agricultural Development	UNFPA	– United Nations Population Fund
ILO	– International Labour Organization (Office)	UNHCR	– Office of the United Nations High Commissioner for Refugees
IMF	– International Monetary Fund	UNICEF	– United Nations Children’s Fund
IMO	– International Maritime Organization	UNIDO	– United Nations Industrial Development Organization
INCB	– International Narcotics Control Board	UNRWA	– United Nations Relief and Works Agency for Palestine Refugees in the Near East
ITU	– International Telecommunication Union	WFP	– World Food Programme
OECD	– Organisation for Economic Co-operation and Development	WIPO	– World Intellectual Property Organization
		WMO	– World Meteorological Organization
		WTO	– World Trade Organization

The designations employed and the presentation of the material in this volume do not imply the expression of any opinion whatsoever on the part of the Secretariat of the World Health Organization concerning the legal status of any country, territory, city or area or of its authorities, or concerning the delimitation of its frontiers or boundaries. Where the designation “country or area” appears in the headings of tables, it covers countries, territories, cities or areas.

PREFACE

The Sixty-eighth World Health Assembly was held at the Palais des Nations, Geneva, from 18 to 26 May 2015, in accordance with the decision of the Executive Board at its 135th session.¹

¹ Decision EB135(8).

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A68/INF./6	[Document cancelled]
A68/INF./7	Proposed programme budget 2016–2017 Process, costing and financing

Diverse documents

A68/DIV./1 Rev.1	List of delegates and other participants
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OFFICERS OF THE HEALTH ASSEMBLY AND MEMBERSHIP OF ITS COMMITTEES

President

Mr Jagat Prasad NADDA (India)

Vice-Presidents

Dr LI Bin (China)

Mr John David Edward BOYCE
(Barbados)

Dr Ferozudin FEROUZ (Afghanistan)

Mr Francesco MUSSONI (San Marino)

Dr Awa Marie COLL SECK (Senegal)

Secretary

Dr Margaret CHAN, Director-General

Committee on Credentials

The Committee on Credentials was composed of delegates of the following Member States: Belgium, Colombia, Djibouti, Gabon, Guinea-Bissau, Honduras, Lesotho, Singapore, Switzerland, Tajikistan, Timor-Leste and Tonga.

Chairman: Mrs Muriel PENEVEYRE
(Switzerland)

Vice-Chairman: Dr Médard TOUNG MVE
(Gabon)

Secretary: Ms Joanne McKEOUGH, Principal
Legal Officer

General Committee

The General Committee was composed of the President and Vice-Presidents of the Health Assembly and the chairmen of the main committees, together with the delegates of the following Member States: Burkina Faso, Burundi, Comoros, Cuba, France, Ghana, Indonesia, Latvia, Montenegro, Oman, Peru,

Russian Federation, South Sudan, Syrian Arab Republic, United Kingdom of Great Britain and Northern Ireland, United States of America and Viet Nam.

Chairman: Mr Jagat Prasad NADDA (India)

Secretary: Dr Margaret CHAN, Director-General

MAIN COMMITTEES

Under Rule 33 of the Rules of Procedure of the World Health Assembly, each delegation is entitled to be represented on each main committee by one of its members.

Committee A

Chairman: Dr Eduardo JARAMILLO
NAVARRETE (Mexico)

Vice-Chairmen: Ms Dorcas MAKGATO
(Botswana) and Mr Bahar Idris ABU
GARDA (Sudan)

Rapporteur: Dr Liis ROVÄLI (Estonia)

Secretary: Dr Timothy ARMSTRONG,
Programme Manager, Surveillance and
Population-based Prevention

Committee B

Chairman: Mr Michael MALABAG (Papua
New Guinea)

Vice-Chairmen: Dr Raymond BUSUTTIL
(Malta) and Mr Khaga Raj ADHIKARI
(Nepal)

Rapporteur: Dr Guy FONES (Chile)

Secretary: Dr Clive ONDARI, Coordinator,
Safety and Vigilance

REPRESENTATIVES OF THE EXECUTIVE BOARD

Dr Mariyam SHAKEELA (Maldives)

Dr Dirk CUYPERS (Belgium)

Dr Walid AMMAR (Lebanon)

Dr Yankalbe Paboung MATCHOCK MAHOURI (Chad)

RESOLUTIONS AND DECISIONS

RESOLUTIONS

WHA68.1 Programme budget 2016–2017

The Sixty-eighth World Health Assembly,

Having considered the Proposed programme budget 2016–2017;¹

Recognizing the exceptional circumstances relating to the Ebola crisis, the additional work that will be required to ensure that WHO is ready to respond effectively to health emergencies, and to deliver reforms to enhance WHO's accountability, transparency, financial management, efficiency and results reporting,

1. APPROVES the programme of work, as outlined in the Proposed programme budget 2016–2017;
2. APPROVES the budget for the financial period 2016–2017, under all sources of funds, namely, assessed and voluntary contributions, of US\$ 4385 million;
3. ALLOCATES the budget for the financial period 2016–2017 to the following categories and other areas:
 - (1) Communicable diseases US\$ 765 million;
 - (2) Noncommunicable diseases US\$ 340 million;
 - (3) Promoting health through the life course US\$ 382 million;
 - (4) Health systems US\$ 594 million;
 - (5) Preparedness, surveillance and response US\$ 380 million;
 - (6) Enabling functions/corporate services US\$ 734 million;

Other areas:

Polio, Tropical disease research, and Research in human reproduction US\$ 986 million;

Outbreak and crisis response US\$ 204 million;

¹ Document A68/7.

4. RESOLVES that the budget will be financed as follows:
 - (1) by net assessments on Member States adjusted for estimated Member State non-assessed income for a total of US\$ 929 million;
 - (2) from voluntary contributions for a total of US\$ 3456 million;
5. FURTHER RESOLVES that the gross amount of the assessed contribution for each Member State shall be reduced by the sum standing to their credit in the Tax Equalization Fund; that the reduction shall be adjusted in the case of those Members that require staff members to pay income taxes on their WHO emoluments, taxes which the Organization reimburses to said staff members; the amount of such tax reimbursements is estimated at US\$ 27 million, resulting in a total assessment on Members of US\$ 956 million;
6. DECIDES that the Working Capital Fund shall be maintained at its existing level of US\$ 31 million;
7. AUTHORIZES the Director-General to use the assessed contributions together with the voluntary contributions, subject to the availability of resources, to finance the budget as allocated in paragraph 3, up to the amounts approved;
8. FURTHER AUTHORIZES the Director-General, where necessary, to make budget transfers among the six categories, up to an amount not exceeding 5% of the amount allocated to the category from which the transfer is made. Any such transfers will be reported in the statutory reports to the respective governing bodies;
9. FURTHER AUTHORIZES the Director-General, where necessary, to incur expenditures in the outbreak and crisis response component of the budget beyond the amount allocated for this component, subject to availability of resources, and requests the Director-General to report to the governing bodies on availability of resources and expenditures in this component;
10. FURTHER AUTHORIZES the Director-General, where necessary, to incur expenditures in the polio, Tropical disease research, and Research in human reproduction components of the budget beyond the amount allocated for those components, as a result of additional governance and resource mobilization mechanisms, as well as their budget cycle, which inform the annual/biennial budgets for these special programmes, subject to availability of resources, and requests the Director-General to report to the governing bodies on availability of resources and expenditures in these components;
11. REQUESTS the Director-General to submit regular reports on the financing and implementation of the budget as presented in document A68/7 and on the outcome of the financing dialogue, the strategic allocation of flexible resources and the results of the coordinated resource mobilization strategy, through the Executive Board and its Programme, Budget and Administration Committee, to the World Health Assembly.

(Eighth plenary meeting, 22 May 2015 –
Committee A, first report)

WHA68.2 Global technical strategy and targets for malaria 2016–2030¹

The Sixty-eighth World Health Assembly,

Having considered the report on malaria: draft global technical strategy: post 2015;²

Recalling resolutions WHA58.2 on malaria control, WHA60.18 on malaria, including proposal for establishment of World Malaria Day and WHA64.17 on malaria, and United Nations General Assembly resolutions 65/273, 66/289, 67/299 and 68/308 on consolidating gains and accelerating efforts to control and eliminate malaria in developing countries, particularly in Africa, by 2015;

Acknowledging the progress made towards the achievement of Millennium Development Goal 6 (Combat HIV/AIDS, malaria and other diseases), and towards the targets set by the Health Assembly in resolution WHA58.2 on malaria control;

Recognizing that these gains, when complemented by further investments in new cost-effective interventions, provide an opportunity to further reduce the high burden of malaria and accelerate progress towards elimination;

Noting that approximately 200 million cases of malaria are estimated to have occurred in 2013; that the disease led to more than 580 000 deaths in 2013, mostly in children under five years of age in Africa, and imposes a significant burden on households, communities and health services in high-burden countries; and that the number of cases and deaths will increase unless efforts to reduce the disease burden are intensified;

Recognizing that malaria interventions are highly cost-effective, yet there is a need to urgently address and overcome the barriers that hinder universal access of at-risk populations to vector-control measures, preventive therapies, quality-assured diagnostic testing and treatment for malaria;

Recognizing also that malaria-related morbidity and mortality throughout the world can be substantially reduced with political commitment and commensurate resources if the public is educated and sensitized about malaria and appropriate health services are made available, particularly in countries where the disease is endemic;

Deeply concerned by the regional and global health threats posed by the emergence and spread of insecticide and drug resistance, including artemisinin resistance, and the systemic challenges impeding further progress, including weak health and disease surveillance systems in many affected countries;

Cognizant of the grave economic and social burden that malaria inflicts on the most vulnerable and poorest communities in countries in which malaria is endemic, and of the disproportionate burden that is borne by countries in sub-Saharan Africa, and high-risk groups, including migrant and mobile populations;

Cognizant also that a reduction in the malaria burden can improve social conditions and lift communities out of poverty, and that it has a positive economic and social impact;

¹ See Annex 1 and, for the financial and administrative implications for the Secretariat of this resolution, Annex 8.

² Document A68/28.

Acknowledging that recent successes in malaria prevention and control are fragile and that further progress depends on action within and beyond the health sector, which requires long-term political and financial commitments, strong regional collaboration, the strengthening of health systems, and investments in innovation and research;

Recognizing that, in an interconnected and interdependent world, no country is risk-free in respect of malaria, including countries that have recently eliminated the disease and countries that are non-endemic for malaria,

1. ADOPTS the global technical strategy for malaria 2016–2030, with:
 - (1) its bold vision of a world free of malaria, and its targets to reduce malaria case incidence and mortality rates globally by at least 90% by 2030, to eliminate malaria in at least 35 further countries compared with 2015, and to prevent its re-establishment in countries that were free of malaria in 2015;
 - (2) its associated milestones for 2020 and 2025;
 - (3) its five principles addressing: acceleration of efforts towards elimination; country ownership and leadership, with the involvement and participation of communities; improved surveillance, monitoring and evaluation; equity in access to health services; and innovation in tools and implementation approaches;
 - (4) its three pillars of: ensuring universal access to malaria prevention, diagnosis and treatment; accelerating efforts towards elimination and attainment of malaria-free status; and transforming malaria surveillance into a core intervention;
 - (5) its two supporting elements of harnessing innovation and expanding research, and strengthening the enabling environment;
2. URGES Member States:¹
 - (1) to update national malaria strategies and operational plans consistent with the recommendations of the global technical strategy for malaria 2016–2030;
 - (2) to intensify national and regional efforts to reduce malaria morbidity and mortality in high-burden countries and accelerate progress towards elimination, and, where appropriate, maintain malaria-free status;
 - (3) to strengthen health systems, including both the public and private sectors, and devise plans for achieving and maintaining universal access on the part of at-risk populations to WHO-recommended core malaria interventions;
 - (4) to intensify national, cross-border, regional and subregional efforts to address the threat posed by rising insecticide and drug resistance, including artemisinin resistance;
 - (5) to promote multisectoral collaboration, educational programmes, and community involvement in order to strengthen efforts for malaria control and elimination;

¹ And, where applicable, regional economic integration organizations.

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- (6) to establish and strengthen, as appropriate, national malaria surveillance and response systems in order to improve the quality of data and the effectiveness and efficiency of national malaria responses;
 - (7) to develop a comprehensive cross-border malaria control and treatment model, where appropriate, strengthen cross-border collaboration, improve the effectiveness of malaria elimination using primary health care as the main platform, and integrate the model into broader health delivery systems;
 - (8) to promote basic and applied research into malaria and accelerate the rapid development and adoption of good-quality and cost-effective new tools, in particular vaccines, medicines, diagnostics, surveillance, insecticides and vector control tools to prevent and control malaria, and to collaborate on new approaches;
 - (9) to strengthen human resource capacity and infrastructure to improve the effectiveness, efficiency and sustainability of malaria responses, while ensuring integration and synergies with the wider health system;
 - (10) to consider the financial implications of this resolution in the broader context of health sector development, and increase national, regional and international funding for malaria interventions, and for cross-border and regional initiatives;
3. INVITES international, regional and national partners from within and beyond the health sector, in particular those in the Roll Back Malaria Partnership, to engage in and support the implementation of the global technical strategy for malaria 2016–2030;
 4. CALLS UPON WHO's international partners, including intergovernmental and international organizations, financing bodies, academic and research institutions, civil society and the private sector to support Member States,¹ as appropriate:
 - (1) to mobilize sufficient and predictable funding to enable an accelerated reduction of the malaria burden, particularly in high-burden countries, and progress towards elimination, in line with the milestones and targets proposed in the global technical strategy for malaria 2016–2030;
 - (2) to support knowledge generation, research and innovation to speed up the development of new vector-control tools, diagnostics, medicines and vaccines, and of new surveillance, data management, operational delivery and implementation solutions;
 - (3) to harmonize and integrate the provision of support to national malaria programmes for adopting and implementing WHO-recommended policies and strategies and promoting the long-term sustainability of malaria responses;
 5. REQUESTS the Director-General:
 - (1) to provide technical support and guidance to Member States¹ for the implementation, national adaptation and operationalization of the global technical strategy for malaria 2016–2030;
 - (2) to update regularly technical guidance on malaria prevention, care and elimination, as new evidence is gathered and new innovative tools and approaches become available;

¹ And, where applicable, regional economic integration organizations.

- (3) to monitor the implementation of the global technical strategy for malaria 2016–2030 and evaluate its impact in terms of progress towards set milestones and targets;
- (4) to strengthen the capacities of the Secretariat to enable it to increase its technical support to Member States,¹ in order to meet the global milestones and targets;
- (5) to ensure that all relevant parts of the Organization, at headquarters, regional and country levels, are actively engaged and coordinated in promoting and implementing the global technical strategy for malaria 2016–2030;
- (6) to report on the progress achieved to the Seventieth and Seventy-second World Health Assemblies, and at regular intervals thereafter, through the Executive Board.

(Eighth plenary meeting, 22 May 2015 –
Committee A, first report)

WHA68.3 Poliomyelitis²

The Sixty-eighth World Health Assembly,

Having considered the report on poliomyelitis³ and the course of action decided by the Executive Board at its 136th session;⁴

Recalling resolution WHA65.5 on poliomyelitis: intensification of the global eradication initiative, and that the Sixty-sixth World Health Assembly noted the Polio Eradication and Endgame Strategic Plan 2013–2018 and reviewed progress towards its implementation subsequently;⁵

Recalling that on 5 May 2014, the Director-General declared the international spread of wild poliovirus a public health emergency of international concern and issued temporary recommendations under the International Health Regulations (2005);⁶

Noting that more than 85% of all new cases in 2014 and 2015 have occurred in Pakistan, and commending the heroic efforts of the front-line health workers, Government, people and civil and religious leaders of Pakistan for their strengthened commitment to polio eradication, as evidenced by efforts to implement the low-transmission season plan for the first half of 2015, while faced with unique challenges;

Recalling United Nations General Assembly resolution 69/132 on global health and foreign policy, which “urges full respect for the rules and principles of international humanitarian law ... [and]

¹ And, where applicable, regional economic integration organizations.

² See Annex 8 for the financial and administrative implications for the Secretariat of this resolution.

³ Document A68/21.

⁴ See document EB136/2015/REC/2, summary record of the Executive Board at its 136th session, seventh meeting.

⁵ See document WHA66/2013/REC/3, summary record of Committee A of the Sixty-sixth World Health Assembly, ninth meeting, section 1.

⁶ WHO statement on the meeting of the International Health Regulations Emergency Committee concerning the international spread of wild poliovirus, available at <http://www.who.int/mediacentre/news/statements/2014/polio-20140505/en/> (accessed on 16 March 2015).

stresses the obligation ... to respect and protect medical personnel and humanitarian personnel ... and urges States to develop effective measures to prevent and address violence against such personnel”;

Recognizing the conclusions of the meeting of the Strategic Advisory Group of Experts on immunization (Geneva, 21–23 October 2014) that preparations are on track for the global withdrawal in April 2016 of the type 2 component of oral poliovirus vaccine; and, noting the progress achieved in introducing inactivated poliovirus vaccine by end-2015, in particular in coordination with partners such as The GAVI Alliance,

1. URGES Member States with poliovirus transmission:

(1) to stop all wild poliovirus transmission by fully implementing all strategic approaches outlined in the Polio Eradication and Endgame Strategic Plan 2013–2018 and national emergency action plans;

(2) to ensure that all necessary measures are in place for the safe access of health workers to all communities and ensure the safety of health workers, including through the appropriate engagement with and support of community leaders and relevant law enforcement, military, non-military and non-State entities;

(3) to implement fully the temporary recommendations under the International Health Regulations (2005) in order to reduce the risk of international spread of wild poliovirus;

(4) to intensify cross-border collaboration for improving both vaccination and surveillance activities;

2. URGES all Member States that currently use oral poliovirus vaccine to prepare for the global withdrawal of the type 2 component of oral poliovirus vaccine in April 2016, including by:

(1) developing national plans, by end-September 2015, for the withdrawal of the type 2 component of oral poliovirus vaccine through the replacement of trivalent oral poliovirus vaccine with the bivalent oral poliovirus vaccine;

(2) expediting the registration of bivalent oral poliovirus vaccine for use in routine immunization programmes and, if required and in the interim, authorizing its use on the basis of prequalification granted by WHO;

(3) implementing national policy for the appropriate destruction of residual trivalent vaccine stocks;

(4) completing the introduction of inactivated poliovirus vaccine optimally before the withdrawal of the type 2 component of oral poliovirus vaccine in April 2016;

3. URGES all Member States:¹

(1) to achieve and maintain certification-standard surveillance to detect polioviruses, and to respond fully to polioviruses detected from any source;² to immediately put in place national

¹ And, where applicable, regional economic integration organizations.

² For example, any positive sample from a case of acute flaccid paralysis or its contacts, environmental surveillance, and targeted stool surveys.

public health emergency measures, as appropriate, to respond to a new polio outbreak in a polio-free country following confirmation of detection of any circulating wild poliovirus, type 2 circulating vaccine-derived poliovirus or Sabin poliovirus following withdrawal of the type 2 component of the oral poliovirus vaccine; and by ensuring full implementation of revised outbreak response protocols¹ that build on the international outbreak response guidelines issued in resolution WHA59.1 on eradication of poliomyelitis;

(2) to support the global expansion of environmental surveillance in strategically-selected high-risk locations to supplement acute flaccid paralysis surveillance for prompt detection of polioviruses;

(3) to support those Member States experiencing poliovirus transmission in their eradication efforts, including through political engagement and the provision of additional support, as appropriate;

(4) to monitor for potential gaps in population immunity and to implement measures to fill such gaps and further boost population immunity through timely and complete routine immunization and, where necessary, high-quality supplementary immunization activities;

(5) to make available urgently the financial resources required for the full and continued implementation of the Polio Eradication and Endgame Strategic Plan 2013–2018, including through the rapid and full operationalization of pledged funds and the filling of the remaining funding gap;

(6) to lead the development of national plans to ensure that polio assets, lessons learnt and knowledge acquired are applied to support other national health priorities, notably to routine immunization, and ensure that the potential legacy of polio eradication is fully realized;

(7) to implement appropriate containment of type 2 wild polioviruses in essential facilities by the end of 2015 and of type 2 Sabin poliovirus within three months of global withdrawal of the type 2 component of oral poliovirus vaccine in April 2016;²

(8) to establish procedures to authorize the importing and use of monovalent oral poliovirus vaccine type 2 from the global stockpile after its release has been authorized by the Director-General in the event of an emergency; whereas the Strategic Advisory Group of Experts on immunization has advised to maintain only a global stockpile of monovalent oral poliovirus vaccine type 2, Member States that decide to establish a national stockpile of this vaccine should maintain the stockpile in conditions of containment that are verified by the Regional Certification Commission for Polio Eradication to be compliant with the containment Global Action Plan,² and seek the authorization of the Director-General of WHO before its release and use;

¹ Responding to a poliovirus outbreak. Standard operating procedures for a new polio outbreak in a polio-free country (February 2015), available at: <http://www.polioeradication.org/Portals/0/Document/Resources/PolioEradicators/1a.PolioOutbreakGuideline20150220.pdf> (accessed 17 March 2015).

² WHO global action plan to minimize poliovirus facility-associated risk after type-specific eradication of wild polioviruses and sequential cessation of OPV use. Geneva: World Health Organization; 2014, available at: http://www.polioeradication.org/Portals/0/Document/Resources/PostEradication/GAPIO_2014.pdf (accessed 17 March 2015).

4. REQUESTS the Director-General:

- (1) to continue to collaborate with all relevant actors, governments and administrators, in partnership with other organizations in the United Nations system and local and international nongovernmental organizations, to support national efforts for polio eradication to benefit children in all areas;
- (2) to continue to coordinate with all relevant partners, including vaccine manufacturers, to ensure that Member States are fully supported for a globally-coordinated phased removal of oral poliovirus vaccines from all immunization programmes, beginning with the type 2 component of oral poliovirus vaccine in April 2016, including by ensuring a sufficient global supply of inactivated poliovirus vaccine for use in all countries introducing the vaccine in their routine immunization schedules;
- (3) to ensure that prequalification of bivalent oral poliovirus vaccine for use in routine immunization programmes is done expeditiously in order to support its introduction by Member States;
- (4) to establish a mechanism that assures the Director-General's authority for the release of a global stockpile of monovalent oral poliovirus vaccine type 2¹ in a timely and equitable way to all Member States, and to develop a procedure for the authorization of release by the Director-General and for use of monovalent oral poliovirus vaccine type 2 by the countries that maintain national stockpiles of this vaccine;
- (5) to support Member States,² partners and stakeholders in developing plans that ensure that polio assets, lessons learnt and knowledge acquired are applied to support the broad immunization agenda and other health priorities and that the potential legacy of polio eradication is fully realized;
- (6) to report annually up to and including the Seventy-second World Health Assembly on progress made towards achieving a lasting polio-free world, and to provide timely and transparent financial information, including details of any budgetary constraints or changes that could adversely affect full implementation of the Polio Eradication and Endgame Strategic Plan 2013–2018.

(Ninth plenary meeting, 26 May 2015 –
Committee A, third report)

WHA68.4 Yellow fever risk mapping and recommended vaccination for travellers³

The Sixty-eighth World Health Assembly,

Having considered the report on implementation of the International Health Regulations (2005): responding to public health emergencies;⁴

¹ Operational Framework for Monovalent Oral Poliovirus Type 2 (mOPV2) deployment and replenishment (during the endgame period), available at: http://www.polioeradication.org/Portals/0/Document/Resources/PostEradication/mOPV2_Operational_Framework.pdf (accessed 5 May 2015).

² And, where applicable, regional economic integration organizations.

³ See Annex 8 for the financial and administrative implications for the Secretariat of this resolution.

⁴ Document A68/22.

Recalling the adoption by the Sixty-seventh World Health Assembly of the updated Annex 7 of the International Health Regulations (2005);¹ and the report of the Strategic Advisory Group of Experts on immunization,² which concluded that a single dose of yellow fever vaccine is sufficient to confer sustained immunity and life-long protection against yellow fever, that a booster dose of yellow fever vaccine is not needed, and that the validity of a certificate of vaccination against yellow fever shall extend for the life of the person vaccinated;

Highlighting the fact that States Parties may immediately apply these changes even though Annex 7 of the International Health Regulations (2005), as amended, is expected to enter into force in June 2016, in accordance with Article 59 of the Regulations;

Noting that, for the purposes of Annex 7 of the International Health Regulations (2005), vaccination against yellow fever may be required of any traveller leaving an area where the Organization has determined that a risk of yellow fever transmission is present,

1. URGES Members States:³

(1) during the interim period until June 2016, to inform WHO if they voluntarily accept to extend the validity of a certificate of vaccination against yellow fever for the life of the person vaccinated;

(2) to comply with the WHO recommendation for the definition of areas at risk of yellow fever and of the yellow fever vaccination recommendations for travellers;

2. REQUESTS the Director-General:

(1) to publish, and update in real time, an online list of countries accepting a certificate of vaccination against yellow fever for the life of the person vaccinated;

(2) to establish a formal scientific and technical advisory group on geographical yellow fever risk mapping, with the participation of countries with areas at risk of yellow fever: (i) to maintain up-to-date yellow fever risk mapping; and (ii) to provide guidance on yellow fever vaccination for travellers in ways that facilitate international travel.

(Ninth plenary meeting, 26 May 2015 –
Committee A, third report)

¹ See resolution WHA67.13 and document WHA67/2014/REC/1, Annex 5.

² Meeting of the Strategic Advisory Group of Experts on immunization, April 2013 – conclusions and recommendations. Weekly Epidemiological Record, 2013; 88(20): 201–216 (<http://www.who.int/wer/2013/wer8820.pdf?ua=1>, accessed 4 May 2015).

³ And, where applicable, regional economic integration organizations.

WHA68.5 The recommendations of the Review Committee on Second Extensions for Establishing National Public Health Capacities and on IHR Implementation¹

The Sixty-eighth World Health Assembly,

Having considered the report of the Review Committee on Second Extensions for Establishing National Public Health Capacities and on IHR Implementation;²

Reminding Member States of their rights and obligations under the International Health Regulations (2005) and their responsibility to the international community;

Recalling the final report of the Review Committee on the Functioning of the International Health Regulations (2005) in relation to Pandemic Influenza A (H1N1) 2009, transmitted by the Director-General to the Sixty-fourth World Health Assembly;³

Recognizing the establishment of a review committee as required under Articles 5 and 13 of the International Health Regulations (2005) and as provided for in Chapter III of Part IX of the said Regulations;

Commending the successful conclusion of the work of the Review Committee on Second Extensions for Establishing National Public Health Capacities and on IHR Implementation, the leadership of its chair, the dedication of its distinguished members, and the submission of its report to the Director-General for transmittal to the Sixty-eighth World Health Assembly,

1. URGES Member States to support the implementation of the recommendations contained in the report of the Review Committee on Second Extensions for Establishing National Public Health Capacities and on IHR Implementation;⁴

2. REQUESTS the Director-General:

(1) to present an update to the Sixty-ninth World Health Assembly on progress made in taking forward the recommendations of the Review Committee on Second Extensions for Establishing National Public Health Capacities and on IHR Implementation;

(2) to provide technical support to Member States in implementing the recommendations of the Review Committee on Second Extensions for Establishing National Public Health Capacities and on IHR Implementation.

(Ninth plenary meeting, 26 May 2015 –
Committee A, third report)

¹ See Annex 8 for the financial and administrative implications for the Secretariat of this resolution.

² Document A68/22 Add.1.

³ Document A64/10, considered by Committee A of the Sixty-fourth World Health Assembly in its second and third meetings, available in document WHA64/2011/REC/3.

⁴ See Annex 2.

WHA68.6 Global vaccine action plan¹

The Sixty-eighth World Health Assembly,

Having considered the report on the global vaccine action plan;²

Emphasizing the importance of immunization as one of the most effective interventions in public health and access to immunization as a key step towards access to health and universal health coverage;

Acknowledging the progress made in global immunization and the commitment under the Decade of Vaccines (2011–2020) to achieve immunization goals and milestones;

Recalling resolutions WHA58.15 and WHA61.15 on the global immunization strategy, resolution WHA65.17 on the global vaccine action plan, resolution WHA61.21 on the global strategy and plan of action on public health, innovation and intellectual property, resolution WHA54.11 on the WHO medicines strategy, and resolution WHA67.20 on regulatory system strengthening for medical products;

Noting with concern that, globally, immunization coverage has increased only marginally since the late 2000s, and that in 2013 more than 21 million children under one year of age did not complete the three-dose schedule of diphtheria-tetanus-pertussis vaccination;

Recognizing that the availability of new vaccines against important causes of vaccine-preventable diseases such as pneumonia, diarrhoea and cervical cancer can prevent leading causes of childhood or women's death;

Acknowledging that successful national immunization programmes require sustainable political and financial support of Member States;

Appreciating the contributions of WHO, UNICEF, The Gavi Alliance and all partners in their efforts to support the introduction of new vaccines in developing countries and strengthen immunization services;

Concerned that inequities between Member States are growing, inter alia, owing to the increased financial burden of new vaccines and the status of eligibility or ineligibility for financial and technical support from global partners;

Concerned that many low- and middle-income countries may not have the opportunity to access newer and improved vaccines, particularly because of the costs related to the procurement and introduction of these vaccines; and concerned at the increase of costs of overall immunization programmes because of the increase in price of the WHO-recommended vaccines;

Recognizing that publicly available data on vaccine prices are scarce, and that the availability of price information is important for facilitating Member States' efforts towards the introduction of new vaccines;

¹ See Annex 8 for the financial and administrative implications for the Secretariat of this resolution.

² Document A68/30.

Recalling many Member States' interventions on the Health Assembly's agenda item on immunization each year, in which they express concern over the unaffordable cost of new vaccines, and appealing to the global community to support strategies that will reduce prices;

Recalling the WHO global framework for expanding access to essential medicines, and its four components: the rational selection and use of medicines, reliable health and supply systems, sustainable financing, and affordable prices;

Taking into account the importance of competition to reduce prices and the need to expand the number of manufacturers, particularly in developing countries, that can produce WHO-prequalified vaccines and create a competitive market;

Stressing the crucial life-saving role of vaccines and immunization programmes and striving to make immunization available to all;

Noting with concern the global shortage of certain traditional routine vaccines, for example BCG vaccine and combined measles-rubella vaccine;

Acknowledging that shortages of vaccines are quite often an important cause of disruption of vaccination schedules and that therefore the establishment of effective and sustainable vaccine production, supply, procurement and delivery systems is essential to ensure access to all the necessary vaccines of assured quality at the right time;

Concerned that scepticism about vaccination is continuing to grow in society despite the proven efficacy and safety of modern vaccines, and that many children do not receive life-saving vaccines as a result of insufficient information to parents or health care workers or even of active anti-vaccination propaganda,

1. URGES Member States:¹

(1) to allocate adequate financial and human resources for the introduction of vaccines into national immunization schedules and for sustaining strong immunization programmes in accordance with national priorities;

(2) to strengthen efforts, as and where appropriate, for pooling vaccine-procurement volumes in regional and interregional or other groupings, as appropriate, that will increase affordability by leveraging economies of scale;

(3) to provide, where possible and available, timely vaccine price data to WHO for publication, with the goal of increasing affordability through improved price transparency, particularly for new vaccines;

(4) to seek opportunities for establishing national and regional vaccine manufacturing capacity, in accordance with national priorities, that can produce vaccines to national regulatory standards, including WHO prequalification;

(5) to create mechanisms to increase the availability of comparable information on government funding for vaccine development and work towards strategies that enhance public health benefit from government investments in vaccine development;

¹ And, where applicable, regional economic integration organizations.

(6) to support the ongoing efforts of various partners coordinated by WHO to design and implement the strategies to address the vaccine and immunization gaps faced by the low- and middle-income countries that request support;

(7) to improve and sustain vaccine purchasing and delivery systems in order to promote the uninterrupted and affordable safe supply of all the necessary vaccines and their availability to all immunization service providers;

(8) to strengthen immunization advocacy and provide training to health professionals and information to the public regarding immunization issues in order to achieve a clear understanding of the benefits and risks of immunization;

2. REQUESTS the Director-General:

(1) to explore ways to mobilize funding to fully support collaborative efforts with international partners, donors and vaccine manufacturers in order to support low- and middle-income countries in accessing affordable vaccines of assured quality in adequate supply;

(2) to continue developing and adequately managing publicly available databases on vaccine prices, such as that in WHO's Vaccine Product, Price and Procurement web platform, and working with Member States to increase availability of price information;

(3) to monitor vaccine prices through annual reporting of the global vaccine action plan;

(4) to provide technical support and facilitate financial resources for establishing pooled procurement mechanisms, where appropriate, for use by Member States;

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

(6) to report on technical, procedural and legal barriers that may undermine the robust competition that can enable price reductions for new vaccines, and address other factors that can adversely affect the availability of vaccines;

(7) to assist in mobilizing resources for countries that request support in the introduction of new vaccines in line with the global vaccine action plan and in accordance with national priorities;

(8) to continue to provide support to Member States to improve and sustain their vaccine delivery systems and to continue to provide technical support to Member States to strengthen the knowledge and skills of their health care professionals in vaccination programmes;

(9) to report on progress in implementing this resolution to the Health Assembly through the Executive Board in the annual report on the global vaccine action plan.

(Ninth plenary meeting, 26 May 2015 –
Committee A, fifth report)

WHA68.7 Global action plan on antimicrobial resistance¹

The Sixty-eighth World Health Assembly,

Having considered the summary report on progress made in implementing resolution WHA67.25 on antimicrobial resistance and the report on the draft global action plan on antimicrobial resistance;²

Recalling resolutions WHA39.27 and WHA47.13 on the rational use of drugs, resolution WHA51.17 on emerging and other communicable diseases: antimicrobial resistance, resolution WHA54.14 on global health security: epidemic alert and response, resolution WHA58.27 on improving the containment of antimicrobial resistance, resolution WHA60.16 on progress in the rational use of medicines, resolution WHA66.22 on follow up of the report of the Consultative Expert Working Group on Research and Development: Financing and Coordination, and WHA67.25 on antimicrobial resistance;

Aware that access to effective antimicrobial agents constitutes a prerequisite for most modern medicine; that hard-won gains in health and development, in particular those brought about through the health-related Millennium Development Goals, are put at risk by increasing resistance to antimicrobial agents; and that antimicrobial resistance threatens the sustainability of the public health response to many communicable diseases, including tuberculosis, malaria and HIV/AIDS;

Aware that the health and economic consequences of antimicrobial resistance constitute a heavy and growing burden on high-, middle- and low-income countries, requiring urgent action at national, regional and global levels, particularly in view of the limited development of new antimicrobial agents;

Recognizing that the main impact of antimicrobial resistance is on human health, but that both the contributing factors and the consequences, including economic ones, go beyond health, and that there is a need for a coherent, comprehensive and integrated approach at global, regional and national levels, in a “One Health” approach and beyond, involving different actors and sectors such as human and veterinary medicine, agriculture, finance, environment and consumers;

Aware that the inappropriate use of antimicrobial medicines in all relevant sectors continues to be an urgent and widespread problem in all countries, with serious consequences for increasing antimicrobial resistance in a wide range of pathogens including bacteria, viruses and parasites;

Noting that despite sustained efforts over a number of decades by Member States, the Secretariat and partners, most developing countries are still facing a multitude of challenges in improving affordability and universal access to quality, safe and effective antimicrobial medicines and diagnostic tools;

Recognizing that, although substantial investments have already been made to tackle antimicrobial resistance, significantly more resources need to be mobilized to support effective action at national, regional and global levels, including through the provision of technical assistance and financial support, particularly to low- and middle-income countries;

¹ See Annex 8 for the financial and administrative implications for the Secretariat of this resolution.

² Documents A68/19, A68/20 and A68/20 Corr.1.

Reaffirming the critical importance of enhancing infection prevention and control, including good sanitation and hygiene, in both community and health care settings;

Recognizing the importance of immunization as one of the most cost-effective public health interventions, and that vaccines play an important role in reducing antimicrobial resistance;

Underlining the pressing need to develop new antimicrobial medicines as well as effective, rapid and low-cost diagnostic tools, vaccines and other interventions, and recalling the global strategy and plan of action on public health, innovation and intellectual property and resolution WHA66.22 on follow up of the report of the Consultative Expert Working Group on Research and Development: Financing and Coordination, which address the failure of the medicines market;

Acknowledging the urgent need for a more coordinated and harmonized surveillance system to monitor antimicrobial resistance at national, regional and global levels, including the need to develop internationally agreed standards for data collection and reporting across the human health, medical, veterinary and agricultural sectors;

Underscoring the need to improve awareness and understanding of antimicrobial resistance through effective public communication programmes, education and training as well as in the human health, veterinary and agricultural sectors,

1. ADOPTS the global action plan on antimicrobial resistance;¹
2. URGES Member States:²
 - (1) to implement the proposed actions for Member States in the global action plan on antimicrobial resistance, adapted to national priorities and specific contexts;
 - (2) to mobilize human and financial resources through domestic, bilateral and multilateral channels in order to implement plans and strategies in line with the global action plan;
 - (3) to have in place, by the Seventieth World Health Assembly, national action plans on antimicrobial resistance that are aligned with the global action plan on antimicrobial resistance and with standards and guidelines established by relevant intergovernmental bodies;
3. INVITES international, regional and national partners to implement the necessary actions in order to contribute to the accomplishment of the five objectives of the global action plan on antimicrobial resistance;
4. REQUESTS the Director-General:
 - (1) to implement the actions for the Secretariat in the global action plan on antimicrobial resistance;
 - (2) to ensure that all relevant parts of the Organization, at headquarters, regional and country levels, are actively engaged and coordinated in promoting work on containing antimicrobial

¹ See Annex 3.

² And, where applicable, regional economic integration organizations.

resistance, including the tracking of resource flows for research and development on antimicrobial resistance in the new global health research and development observatory;

(3) to strengthen the tripartite collaboration between FAO, OIE and WHO for combating antimicrobial resistance in the spirit of the “One Health” approach;

(4) to work with the Strategic and Technical Advisory Group on antimicrobial resistance, Member States,¹ FAO, OIE, and other relevant partners, to develop a framework for monitoring and evaluation in line with principle five of the global action plan on antimicrobial resistance;

(5) to develop and implement, in consultation with Member States¹ and relevant partners, an integrated global programme for surveillance of antimicrobial resistance across all sectors in line with the global action plan on antimicrobial resistance;

(6) to establish a network of WHO collaborating centres to support surveillance of antimicrobial resistance and quality assessment in each WHO region;

(7) to develop, in consultation with Member States¹ and relevant partners, options for establishing a global development and stewardship framework to support the development, control, distribution and appropriate use of new antimicrobial medicines, diagnostic tools, vaccines and other interventions, while preserving existing antimicrobial medicines, and promoting affordable access to existing and new antimicrobial medicines and diagnostic tools, taking into account the needs of all countries, and in line with the global action plan on antimicrobial resistance, and to report to the Sixty-ninth World Health Assembly;

(8) to work with the United Nations Secretary-General and bodies in the United Nations system to identify the best mechanism(s) to realize the investment needed to implement the global action plan on antimicrobial resistance, particularly with regard to the needs of developing countries;

(9) to elaborate, in consultation with the United Nations Secretary-General, options for the conduct of a high-level meeting in 2016, on the margins of the United Nations General Assembly, including potential deliverables, and to report thereon to the Sixty-ninth World Health Assembly through the Executive Board at its 138th session;

(10) to provide support and technical assistance to countries, with a specific focus on low- and middle-income countries;

(11) to set aside adequate resources for the Secretariat, in line with the Programme budget 2016–2017 and the Twelfth General Programme of Work, 2014–2019, to implement the global action plan on antimicrobial resistance;

(12) to submit biennial reports on progress achieved in implementing this resolution to the Seventieth, Seventy-second and Seventy-fourth World Health Assemblies, and to produce an interim report to the Sixty-ninth World Health Assembly.

(Ninth plenary meeting, 26 May 2015 –
Committee A, fifth report)

¹ And, where applicable, regional economic integration organizations.

WHA68.8 Health and the environment: addressing the health impact of air pollution¹

The Sixty-eighth World Health Assembly,

Having considered the report on health and the environment: addressing the health impact of air pollution;²

Reaffirming its commitment to the outcome document³ of the United Nations Conference on Sustainable Development (in Rio de Janeiro, Brazil in June 2012), referred to as the Rio+20 Conference, in which all Member States of the United Nations committed to promoting sustainable development policies that support healthy air quality in the context of sustainable cities and human settlements, and recognized that reducing air pollution leads to positive effects on health;⁴

Noting with deep concern that indoor air pollution and outdoor air pollution are both among the leading avoidable causes of disease and death globally, and the world's largest single environmental health risk;⁵

Acknowledging that 4.3 million deaths occur each year from exposure to household (indoor) air pollution and that 3.7 million deaths each year are attributable to ambient (outdoor) air pollution, at a high cost to societies;⁶

Aware that exposure to air pollutants, including fine particulate matter, is a leading risk factor for noncommunicable diseases in adults, including ischaemic heart disease, stroke, chronic obstructive pulmonary disease, asthma and cancer, and poses a considerable health threat to current and future generations;

Concerned that half the deaths due to acute lower respiratory infections, including pneumonia in children aged less than five years, may be attributed to household air pollution, making it a leading risk factor for childhood mortality;

Further concerned that air pollution, including fine particulate matter, is classified as a cause of lung cancer by WHO's International Agency on Research for Cancer;⁷

Aware that both short- and long-term exposure to air pollution has a negative impact on public health, with a much greater impact resulting from long-term exposure and exposure at high levels,

¹ See Annex 8 for the financial and administrative implications for the Secretariat of this resolution.

² Document A68/18.

³ See the outcome document, Future We Want, at: <https://sustainabledevelopment.un.org/rio20/futurewewant> (10 August 2015).

⁴ United Nations General Assembly resolution 66/288.

⁵ Global Health Observatory <http://www.who.int/gho/phe/en/> (accessed 18 March 2015).

⁶ WHO. Burden of disease from ambient air pollution for 2012. http://www.who.int/phe/health_topics/outdoorair/databases/AAP_BoD_results_March2014.pdf?ua=1 (accessed 1 December 2014).

⁷ IARC Monographs Working Group on the Evaluation of Carcinogenic Risks to Humans on the following issues:

- Outdoor Air Pollution (2013, Volume 109);
- Diesel and gasoline exhausts and some nitroarenes (2012, Volume 105);
- Household use of solid fuels and high-temperature frying (2010, Volume 95);
- Indoor emissions from household combustion of coal (2012, Volume 100E);
- Tobacco smoke and involuntary smoking (2004, Volume 83).

causing chronic diseases such as cardiovascular diseases and respiratory diseases, including chronic obstructive pulmonary disease, and also that for many pollutants, such as particles, long-term exposure even at low levels (below the levels proposed in WHO's air quality guidelines) could result in some adverse health effects;

Noting the strong significance of air pollution and its health effects for the objectives and targets contained in WHO's Global Action Plan for the Prevention and Control of Noncommunicable Diseases 2013–2020, as well as the significance of the WHO Framework Convention on Tobacco Control, in particular Article 8 and its Guidelines relating to the protection from exposure to tobacco smoke, as applicable to the Parties of the Convention;

Noting that air pollution is a cause of global health inequities, affecting in particular women, children and older persons, as well as those in low-income populations who are often exposed to high levels of ambient air pollution or who live in homes in which there is no other choice than to be exposed to air pollution from cooking and heating, and that improving air quality is among the measures with the greatest potential impact on health equity;¹

Cognizant that most air pollutants are emitted as a result of the human activities identified as sources of air pollution² in the WHO guidelines on ambient and indoor air pollution, and that there are also naturally occurring phenomena that negatively affect air quality,³ and noting that there is a significant interrelation between outdoor and indoor air quality;

Aware that promoting energy efficiency and expanding the use of clean and renewable energy can have co-benefits for health and sustainable development, and stressing that the affordability of this energy will help to maximize these opportunities;

Underscoring that the root causes of air pollution and its adverse impacts are predominantly socioeconomic in nature, and cognizant of the need to address the social determinants of health related to development in urban and rural settings, including poverty eradication, as an indispensable element for sustainable development and for the reduction of the health impact of air pollution;

Emphasizing the importance of promotion, transfer and diffusion of environmentally sound technologies, particularly to developing countries, to address the health impact of air pollution;

Acknowledging recent global efforts to promote air quality, in particular United Nations Environment Assembly resolution 1/7 on air quality adopted in 2014,⁴ as well as the many national and regional initiatives to mitigate the health impacts of indoor and outdoor air pollution, and noting

¹ Burden of disease from ambient and household air pollution, see: http://www.who.int/phe/health_topics/outdoorair/databases/en/ (16 November 2015).

² WHO guidelines for air quality: global update 2005; WHO guidelines for indoor air quality: household fuel combustion. Geneva: World Health Organization; 2014; WHO guidelines for indoor air quality: select pollutants. Copenhagen, Regional Office for Europe, 2010; WHO guidelines for indoor air quality: dampness and mould. Copenhagen, Regional Office for Europe, 2009.

³ These include, inter alia, radon (a carcinogenic gas), dust- and sand-storms, volcanic eruptions and forest fires.

⁴ United Nations Environment Assembly resolution 1/7 (<http://www.unep.org/unea/download.asp?ID=5171>, accessed 20 March 2015); Smith KR, Woodward A, Campbell-Lendrum D, Chadee DD, Honda Y, Liu Q et al. 2014: Human health: impacts, adaptation, and co-benefits. In: Climate Change 2014: Impacts, Adaptation, and Vulnerability. Part A: Global and Sectoral Aspects. Contribution of Working Group II to the Fifth Assessment Report of the Intergovernmental Panel on Climate Change. Cambridge, England, and New York: Cambridge University Press, 2014, pp. 709–754.

that regional and subregional cooperation frameworks provide good opportunities to address air quality issues according to the specific circumstances of each region;

Recognizing that in order to contribute to national policy choices that protect health and reduce health inequities, the health sector will need to engage in cross-sectoral approaches to health, including adopting a health-in-all policies approach;¹

Noting that WHO's guidelines for both ambient air quality (2005)² and indoor air quality (2014)³ provide guidance and recommendations for clean air that protect human health, and recognizing that these need to be supported by activities, such as the promotion and facilitation of implementation;

Acknowledging that, although many of the most important and cost-effective actions against outdoor and indoor air pollution require the involvement and leadership of national governments as well as regional and local authorities, cities are both particularly affected by the consequences of air pollution and well-placed to promote healthy city activities to reduce air pollution and its associated health impacts, and can develop good practices, complement and implement national measures;

Acknowledging that mobilizing national and, as appropriate, international resources is important for re-tooling relevant infrastructure that contributes to air pollution reduction is an integral element of global sustainable development, and that air pollution-related health impacts can be a health-relevant indicator for sustainable development policies;

Aware that promoting air quality is a priority to protect health and provide co-benefits for the climate, ecosystem services, biodiversity and food security;⁴

Acknowledging also the complexity of improving air quality and reducing emissions of warming climate-altering pollutants, and that there can be meaningful opportunities to achieve co-benefits resulting from these actions;

Underlining that higher temperatures, heatwaves, dust- and sand-storms, volcanic eruptions and forest fires can also exacerbate the impact of anthropogenic air pollution on health,

1. URGES Member States:⁵

(1) to redouble their efforts to identify, address and prevent the health impacts of air pollution, by developing and strengthening, as appropriate, multisectoral cooperation on the

¹ Taking into account the context of federated states.

² WHO air quality guidelines for particulate matter, ozone, nitrogen dioxide and sulfur dioxide – Global Update 2005: summary of risk assessment. Geneva: World Health Organization; 2006 (document WHO/SDE/PHE/OEH/06.02), available at http://whqlibdoc.who.int/hq/2006/WHO_SDE_PHE_OEH_06.02_eng.pdf?ua=1 (accessed 18 June 2015).

³ WHO guidelines for indoor air quality: household fuel combustion, 2014 available at <http://www.who.int/indoorair/publications/household-fuel-combustion/en/> (accessed 18 June 2015).

⁴ United Nations Environment Assembly resolution 1/7 (<http://www.unep.org/unea/download.asp?ID=5171>, accessed 20 March 2015); Smith KR, Woodward A, Campbell-Lendrum D, Chadee DD, Honda Y, Liu Q et al. 2014: Human health: impacts, adaptation, and co-benefits. In: Climate Change 2014: Impacts, Adaptation, and Vulnerability. Part A: Global and Sectoral Aspects. Contribution of Working Group II to the Fifth Assessment Report of the Intergovernmental Panel on Climate Change. Cambridge, England, and New York: Cambridge University Press, 2014, pp. 709–754.

⁵ And, where applicable, regional economic integration organizations.

health and of opportunities to reduce or avoid exposure, including by guiding preventive measures to help to reduce these health effects, to interact effectively with the relevant sectors and other relevant public and private stakeholders to inform them about sustainable solutions, and to ensure that health concerns are integrated into relevant national, regional and local policy, decision-making and evaluation processes, including public health prevention, preparedness and response measures, as well as health system strengthening;

(3) to facilitate relevant research, including: developing and utilizing databases on morbidity and mortality; health impact assessment; the use and costs of health care services and the societal costs associated with ill health; supporting identification of research priorities and strategies; engaging with academia to address knowledge gaps; and supporting the strengthening of national research institutions and international cooperation in research to identify and implement sustainable solutions;

(4) to contribute to an enhanced global response to the adverse health effects of air pollution in accordance with the national context, including by collecting and utilizing data relevant to the health outcomes of air quality, by contributing to the development of normative standards, dissemination of good practices and lessons learnt from implementation and by working towards harmonization of health-related indicators that could be used by decision-makers;

(5) to improve the morbidity and mortality surveillance for all illnesses related to air pollution, and optimize the linkage with monitoring systems of air pollutants;

(6) to take into account the WHO air quality guidelines and WHO indoor air quality guidelines and other relevant information in the development of a multisectoral national response to air pollution and carry out measures supporting the aims of those guidelines;

(7) to encourage and promote measures that will lead to meaningful progress in reducing levels of indoor air pollution such as clean cooking, heating and lighting practices and efficient energy use;

(8) to take effective steps, to address and to minimize as far as possible air pollution specifically associated with health care activities, including by implementing, as appropriate, relevant WHO guidelines;

(9) to develop policy dialogue, collaboration and information sharing between different sectors to facilitate a coordinated, multisectoral basis for future participation in regional and global processes to address the impact of air pollution on health;

(10) to strengthen international cooperation to address health impacts of air pollution, including through facilitating transfer of expertise, technologies and scientific data in the field of air pollution, as well as exchanging good practices;

(11) to identify, at the national level, actions by the health sector that reduce health inequities related to air pollution and to work closely with the communities at risk that can gain the most from effective equitable and sustained actions, so as to facilitate the full realization of the right to the enjoyment of the highest attainable standard of physical and mental health;

(12) to meet the commitments made at the High-level Meeting of the United Nations General Assembly on the Prevention and Control of Non-communicable Diseases (September 2011) and to use, as appropriate, the road map and policy options contained in the WHO global action plan for noncommunicable diseases;

(13) to meet the obligations of the WHO Framework Convention on Tobacco Control, if the Member State is a Party to this treaty;

(14) to collaborate with regional and international organizations in developing partnerships to promote access to adequate technical and financial resources to improve air quality;

2. REQUESTS the Director-General:

(1) to significantly strengthen WHO's capacities in the field of air pollution and health in order to provide:

(a) support and guidance to Member States in implementing the WHO air quality guidelines and WHO indoor air quality guidelines;

(b) support and guidance to Parties of the WHO Framework Convention on Tobacco Control in implementing the obligations under Article 8 of the treaty and its guidelines, in coordination with the Convention secretariat;

(c) enhanced technical support and guidance to Member States, including through appropriate capacities in regional and country offices to support country activities;

(d) further identification, development and regular updating of WHO air quality guidelines and cost-benefit tools, including monitoring systems, to support effective and efficient decision-making;

(e) enhanced technical capacity of WHO to collaborate, as appropriate, with relevant international, regional and national stakeholders, to compile and to analyse data on air quality, with particular emphasis on health-related aspects of air quality;

(f) support to Member States to increase awareness and communicate to the general public and stakeholders, in particular communities at risk, about the effects of air pollution and actions to reduce it;

(g) dissemination of evidence-based best practices on effective indoor and ambient air quality interventions and policies related to health;

(h) enhanced ability of WHO to convene, guide and influence research strategies in the field of air pollution and health, in conjunction with WHO's Global Health Observatory;

(i) appropriate advisory capacity and support tools to support the health and other sectors at all levels of government, especially the local level and in urban areas, taking into account different sources of pollution in tackling air pollution and their health effects;

(j) appropriate advisory capacity and support tools at regional and subregional levels to help Member States to address the health effects of air pollution and other challenges to air quality with a cross-border impact, and to facilitate coordination among Member States in this respect;

(2) to create, enhance and update, in cooperation with relevant United Nations agencies and programmes a public information tool of WHO analysis, including policy and cost-efficiency aspects, of specific and available clean air technologies to address the prevention and control of air pollution, and its impacts on health;

- (3) to exercise global health leadership and maximize synergies, avoiding duplication with relevant global efforts that promote health improvements related to air quality, and air pollution reduction, while continuing to work on other environmental challenges to health through, among others, the implementation of resolution WHA61.19 on climate change and health;
- (4) to work with other United Nations partners, programmes and agencies, in particular with reference to United Nations Environment Assembly resolution 1/7 on air quality;
- (5) to raise awareness of the public health risks of air pollution and the multiple benefits of improved air quality, in particular in the context of the discussions on the post-2015 development agenda;
- (6) to continue to exercise and enhance the leading role of WHO in the Strategic Approach to International Chemicals Management to foster the sound management of chemicals and waste with the objective of minimizing and, where possible, preventing significant adverse effects on health, including from air pollution;
- (7) to strengthen, and where applicable, forge links with existing global health initiatives that can benefit from air pollution reduction, including global efforts to reduce noncommunicable diseases and improve children's health;¹
- (8) to set aside adequate resources for the work of the Secretariat, in line with the Programme budget 2014–2015 and Programme budget 2016–2017 and the Twelfth General Programme of Work, 2014–2019;
- (9) to report to the Sixty-ninth World Health Assembly on the implementation of this resolution and its progress in mitigating the health effects of air pollution; and on other challenges to air quality;
- (10) to propose to the Sixty-ninth World Health Assembly a road map for an enhanced global response to the adverse health effects of air pollution.

(Ninth plenary meeting, 26 May 2015 –
Committee A, sixth report)

WHA68.9 Framework of engagement with non-State actors²

The Sixty-eighth World Health Assembly,

Having considered the reports on the draft framework of engagement with non-State actors and the revised draft framework of engagement with non-State actors;³

Acknowledging the importance to WHO of engagement with non-State actors that benefits from a robust management of the risks of such engagement for all three levels of the Organization,

¹ Examples of such efforts are the WHO global action plan for the prevention and control of noncommunicable diseases 2013–2020, WHO's integrated Global Action Plan for Pneumonia and Diarrhoea: ending preventable child deaths from pneumonia and diarrhoea by 2025 (2013), The Global Strategy for Women's, Children's and Adolescents' Health and the Every Woman Every Child movement.

² See Annex 8 for the financial and administrative implications for the Secretariat of this resolution.

³ Documents A68/5, Annex and A68/53.

1. WELCOMES the consensus reflected in many parts of the draft framework of engagement with non-State actors, including in its introduction, rationale, principles, benefits of engagement, risks of engagement, non-State actors, types of interaction as contained in the Appendix to this resolution;
2. REQUESTS the Director-General:
 - (1) to convene as soon as possible, and no later than October 2015, an open-ended intergovernmental meeting to finalize the draft framework of engagement with non-State actors on the basis of progress made during the Sixty-eighth World Health Assembly, as reflected in the Appendix to this resolution;
 - (2) to submit the finalized draft framework of engagement with non-State actors for consideration for adoption to the Sixty-ninth World Health Assembly, through the Executive Board at its 138th session;
 - (3) to develop the register of non-State actors in time for the Sixty-ninth World Health Assembly, taking into account progress made on the draft framework of engagement with non-State actors.

ANNEX

Draft resolution

[The Sixty-ninth World Health Assembly,

PP1 Having considered the report on the framework of engagement with non-State actors and the revised draft framework of engagement with non-State actors;

PP2 Recalling resolution WHA64.2 and decision WHA65(9) on WHO reform, and decisions WHA67(14) and EB136(3) on a framework of engagement with non-State actors;

PP3 Acknowledging the importance to WHO of engagement with non-State actors that benefits from a robust management of the risks of such engagement for all three levels of the Organization,

(OP1) 1. APPROVES the Framework of Engagement with non-State actors, as set out in the Annex to this resolution;¹

(OP2) 2. DECIDES that the Framework of Engagement with non-State actors shall replace the Principles governing relations between the World Health Organization and nongovernmental organizations² and Guidelines on interaction with commercial enterprises to achieve health outcomes;³

¹ Consisting of an overarching framework and four specific policies on engagement with nongovernmental organizations, private sector entities, philanthropic foundations and academic institutions.

² Adopted in resolution WHA40.25. See Basic documents, 48th ed. Geneva: World Health Organization; 2014.

³ Document EB107/20, Annex.

(OP3) 3. REQUESTS the Director General:

- (1) to implement the Framework of Engagement with non-State actors;
- (2) to establish the register of non-State actors in time for the Sixty-ninth World Health Assembly;
- (3) to report on the implementation of the Framework of Engagement with non-State actors to the Executive Board at each of its January sessions under a standing agenda item, through the Programme Budget and Administration Committee;
- (4) to conduct in 2018 an evaluation of the implementation of the Framework of Engagement with non-State actors and its impact on the work of WHO with a view to submitting the results, together with any proposals for revisions of the Framework, to the Executive Board in January 2019, through the Programme Budget and Administration Committee.]

Appendix

[DRAFT] FRAMEWORK OF ENGAGEMENT WITH NON-STATE ACTORS

DRAFT OVERARCHING FRAMEWORK OF ENGAGEMENT WITH NON-STATE ACTORS

***DOCUMENT AS AT THE CONCLUSION OF THE SIXTY-EIGHTH WORLD HEALTH ASSEMBLY**

REFLECTING THE WORK OF THE DRAFTING GROUP OF COMMITTEE A

EXPLANATION OF COLOUR CODE:

TEXT HIGHLIGHTED IN GREEN HAS BEEN AGREED AD REFERENDUM. TEXT HIGHLIGHTED IN YELLOW WAS CONSIDERED BUT NO CONSENSUS WAS REACHED. TEXT HIGHLIGHTED IN GREY IS THE CHAIRPERSON'S PROPOSAL FOR A COMPROMISE CONCERNING THE PRECEDING YELLOW HIGHLIGHTED PARAGRAPH. TEXT NOT HIGHLIGHTED HAS NOT BEEN CONSIDERED YET.

INTRODUCTION

1. The overarching framework for engagement with non-State actors and the WHO policy and operational procedures on management of engagement with non-State actors apply to all engagements with non-State actors at all levels of the Organization,¹ whereas the four specific policies and

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

operational procedures on engagement are limited in application to, respectively, nongovernmental organizations, private sector entities, philanthropic foundations and academic institutions.

ENGAGEMENT: RATIONALE, PRINCIPLES, BENEFITS AND RISKS

Rationale

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

3. The functions of WHO, as set out in Article 2 of its Constitution, include: to act as the directing and coordinating authority on international health work; to establish and maintain effective collaboration with diverse organizations; and to promote cooperation among scientific and professional groups which contribute to the advancement of health. The Constitution further mandates the Health Assembly or the Executive Board, and the Director-General, to enter into specific engagements with other organizations.¹ WHO shall, in relation to non-State actors, act in conformity with its Constitution and resolutions and decisions of the Health Assembly, and bearing in mind those of the United Nations General Assembly or the Economic and Social Council of the United Nations, if applicable.

4. **(DELETED)**

5. WHO's engagement with non-State actors supports implementation of the Organization's policies and recommendations as decided by the governing bodies, as well as the application of WHO's technical norms and standards. Such an effective engagement with non-State actors at global, regional and country levels, [in mutual respect,] also calls for due diligence and transparency measures applicable to non-State actors under this framework [, while exercising [particular] / [appropriate] caution when engaging with particular [industries] [and] / [entities].](DEL) In order to be able to strengthen its engagement with non-State actors for the benefit and interest of global public health, WHO needs simultaneously to strengthen its management of the associated potential risks. This requires a robust framework that enables engagement and serves also as an instrument to identify the risks, balancing them against the expected benefits, while protecting and preserving WHO's integrity, reputation and public health mandate.

Principles

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

Any engagement must:

(a) demonstrate a clear benefit to public health;

(a bis) conform with WHO's Constitution, mandate and general programme of work

¹ WHO Constitution, Articles 18, 33, 41 and 71.

- (b) respect the intergovernmental nature of WHO and the decision-making authority of Member States as set out in the WHO's Constitution;
- (c) support and enhance, without compromising, the scientific and evidence-based approach that underpins WHO's work;
- (d) Protect WHO from any undue influence, in particular on the processes in setting and applying policies, norms and standards;¹
- (e) not compromise WHO's integrity, independence, credibility and reputation;
- (f) be effectively managed, including by, where possible avoiding conflict of interest² and other forms of risks to WHO;
- (g) be conducted on the basis of transparency, openness, inclusiveness, accountability, integrity and mutual respect;

Benefits of engagement

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

- a) (DELETED)
- b) the contribution of non-State actors to the work of WHO
- c) the influence that WHO can have on non-State actors to enhance their impact on global public health or to influence the social, economic and environmental determinants of health
- d) the influence that WHO can have on non-State actors' compliance with WHO's policies, norms and standards
- e) the additional resources non-State actors can contribute to WHO's work
- f) the wider dissemination of and adherence by non-State actors to WHO's policies, norms and standards

[g) non-State actors engaging with WHO [fully implement]/[more readily conform with] WHO public health policies [, norms and standards], including in their own activities in the areas of food safety, chemical safety, ethical promotion of medicinal drug products, tobacco control and others.]

OR

g) alt [Improved understanding of and conformity with WHO's policies, norms and standards.] [by non-State actors]

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

² As set out in paragraphs 23 to 26)

Risks of engagement

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

- (a) conflicts of interest;
- (b) undue or improper influence exercised by a non-State actor on WHO's work, especially in, but not limited to, policies, norms and standard setting;¹
- (c) a negative impact on WHO's integrity, independence, reputation and credibility; and public health mandate;
- (d) the engagement being primarily used to serve the interests of the non-State actor concerned with limited or no benefits for WHO and public health;
- (e) the engagement conferring an endorsement of the non-State actor's name, brand, product, views or activity;²
- (f) the whitewashing of a non-State actor's image through an engagement with WHO;
- (g) a competitive advantage for a non-State actor.

NON-STATE ACTORS

9. For the purpose of this framework, [a non-State actor is an entity that [operates independently from the government]/[is not part of any State or public institution. N] (DEL) non-State actors include nongovernmental organizations, private sector entities, philanthropic foundations and academic institutions. [other international organizations]

CHAIR's PROPOSAL

9. alt For the purpose of this framework, a non-State actor is an entity that operates independently from the government is not part of any State or public institution. Non-State actors include nongovernmental organizations, private sector entities, philanthropic foundations and academic institutions.

10 Nongovernmental organizations are non-profit entities that operate independently of governments. They are usually membership-based, with non-profit entities or individuals as members exercising voting rights in relation to the policies of the nongovernmental organization, or are otherwise constituted with non-profit, public-interest goals. They are free from concerns which are primarily of a private, commercial or profit-making nature. They could include, for example, grassroots community organizations, civil society groups and networks, faith-based organizations, professional groups, disease-specific groups, and patient groups.

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

² Endorsement does not include established processes such as prequalifications or the WHO Pesticide Evaluation Scheme (WHOPES).

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

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

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

13 Academic institutions are entities engaged in the pursuit and dissemination of knowledge through research, education and training.²

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

TYPES OF INTERACTION

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

Participation

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

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

² This can include think tanks which are policy-oriented institutions, as long as they primarily perform research; while international associations of academic institutions are considered as non-governmental organizations, subject to paragraph 14.

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

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

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

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

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

- WHO jointly organizes the meeting with the non-State actor
- WHO cosponsors a meeting¹ organized by the non-State actor
- WHO staff make a presentation or act as panellists at a meeting organized by the non-State actor
- WHO staff attend a meeting organized by a non-State actor.

Resources

18. Resources [can be] / [include] funds, [personnel] OR [personnel for technical work or implementation of WHO's programmes and policies and emergency response,] or in-kind contributions. In-kind contributions include donations of medicines and other goods and free provision of services.

OR

New text to be proposed

AND/OR

18bis [SPECIFY TYPE OF PERSONNEL]

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

AND/OR

[ADD FOOTNOTE SPECIFYING PERSONNEL]

[ADD 18ter. The WHO could establish ceiling in the voluntary contribution from non-state actors. Any contribution beyond that amount should go to the core voluntary fund which gives enough freedom to the Secretariat to allocate resources to underfunded programmes. The Member States assessed contributions should be allocated to the programmes that are underfunded under voluntary contribution]/DELETE

CHAIR'S PROPOSAL

18alt: Resources include funds [ADD FOOTNOTE: [Non-State actors are urged to provide their contribution, as flexible as possible, in line with the General Programme of Work and the Programme Budget] personnel, [ADD FOOTNOTE: Personnel does not comprise WHO staff members, or secondments to WHO. Personnel may be accepted for emergency work. Personnel must never be used for activities related to policies, norms and standard setting.] or in-kind contribution. In-kind contribution include donations of medicines and other goods and free provision of services (ADD FOOTNOTE TO PERSONNEL: short-term contribution by persons employed by non-State actors other than staff secondments [This personnel do not represent the WHO, do not have badge..]) (TO BE READ IN CONJUNCTION WITH PARAGRAPH 7 OF THE NGO POLICY, PARAGRAPH 15 OF THE PRIVATE SECTOR POLICY, PARAGRAPH 7 OF THE PHILANTHROPIC FOUNDATION POLICY AND PARAGRAPH 8 OF THE ACADEMIC INSTITUTION POLICY)

ADD FOOTNOTE: [Non-State actors [are urged to]/[should] provide their [contribution]/[resources], as flexible [and non-earmarked] as possible. As any contribution, it has to be fully in line with the Programme Budget]

OR

[ADD FOOTNOTE: [Resources may only be provided in line with the General Programme of Work and Programme Budget and should be as flexible as possible]

OR

[WHO shall make available a detailed information with regard to the financial or in-kind resources received from non-State actors, including the name of donor, amount, the purpose and allocation.] (TO MOVE AFTER PARA 38)

[ADD FOOTNOTE: Personnel does not comprise WHO staff members, or secondments to WHO. Personnel may be accepted for emergency work. Personnel must never be used for activities related to policies, norms and standard setting.] or in-kind contribution.

Evidence

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

available, as appropriate, wherever possible. Scientific evidence generated should be made publicly available.

Advocacy

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

Technical collaboration

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

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

MANAGEMENT OF CONFLICT OF INTEREST AND OTHER RISKS OF ENGAGEMENT

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

- WHO needs to know the non-State actors that it engages with. Therefore each non-State actor is required to provide all relevant² information about itself and its activities, following which WHO conducts the necessary due diligence.
- WHO conducts a risk assessment in order to identify the specific risks of engagement associated with each engagement with a non-State actor.
- Risks of engagement need to be managed and communicated coherently in each of the three levels of the Organization and throughout the Organization. To that end, WHO manages engagement through a single, Organization-wide electronic tool.³

¹ The framework is designed to regulate institutional engagements; its implementation is closely coordinated with the implementation of other organizational policies regulating conflict of interest in respect of individuals (see paragraph 48).

² As defined in paragraph 38bis.

³ WHO uses an electronic tool for managing engagement. As described in footnote 1 of paragraph 38, the publicly visible part of the tool is the register of non-State actors; the tool also provides an electronic workflow for the internal management of engagement. A similar electronic tool is used for the management of individual conflicts of interest, in order to harmonize the implementation of the framework with the implementation of the policy on management of individual conflicts of interest for experts.

- [Member States [need to] exercise oversight over WHO's engagement with non-State actors. With this in mind, the Director-General reports [annually] on engagement involving non-State actors] [[focusing in particular] / [including] on [policy-related] (**DEL**) challenges arising from the [proposals of engagement referred to the] Engagement Coordination Group] [and to the Director-General] / [and the decision by the DG not to enter into engagement] [and makes it a standing agenda item for the PBAC] [to the [regular meetings of the] Executive Board] through the Programme, Budget and Administration Committee [to the [regular meetings of the] Executive Board] [and makes all engagements publicly known through the register of non-State actors.] (**DEL**) (ADD FOOTNOTE: See paragraph 38ter)
OR SPLIT PARA INTO TWO:
PROCESS
CONTENT OF THE REPORT OF THE DG
- **NEW CHAIRs PROPOSAL:** Member States exercise oversight over WHO's engagement with non-State actors in accordance with the provisions in paragraphs 64 and 65
- [Request the Independent Expert Oversight Advisory Committee to report annually on WHO's engagement with non-state actors, focusing particularly on cases handled by the Engagement Coordination Group, and to provide Member States with the opportunity to discuss the report with the Chairperson of the Independent Expert Oversight Advisory Committee prior to its adoption by the Programme, Budget and Administration Committee] (**DEL**)
- 38ter. [In addition to the publicly available information, Member States have electronic access to a summary report on due diligence of non-State actor, and risk assessments and risk management on engagement. Further details of the information used by the Secretariat to manage such engagement, can be made available for Member States to consult, upon request and as far as legally feasible.] [In addition, Member States have access to proposals of engagement referred to the Engagement Coordination Group and the Director-General.] (**DEL**)

[Conflict of interest] (NOTE: ENTIRE SECTION IN BRACKETS)

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

23bis. Individual conflicts of interests within WHO are those involving experts, regardless of their status, and staff members; these are addressed in accordance with the policies listed under paragraph 48 of the present framework.

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

25. In actively managing institutional conflict of interest and the other risks of engagement mentioned in paragraph 8 above, WHO aims to avoid allowing the conflicting interests of a non-State

actor to exert, or be reasonably perceived to exert, undue influence over the Organization's decision-making process or to prevail over its interests;

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

Due diligence and risk assessment

27. When the possibility of entering into an engagement is being considered, the relevant technical unit in the Secretariat conducts an initial examination in order to establish whether such an engagement would be in the interest of the Organization and in line with the principles of WHO's engagement with non-State actors in paragraph 6 and the priorities defined in the General Programme of Work and Programme budget. If this seems to be the case, the technical unit asks the non-State actor to provide its basic information. Using the Organization-wide electronic tool, the unit then complements this information with a description of the proposed engagement and its own assessment of the benefits and risks involved. This information is then transmitted to a specialized central unit which is responsible for analysing the information provided.

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

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

30. The core functions of due diligence are to:

- clarify the nature and purpose of the entity proposed to engage with WHO;
- clarify the interest and objectives of the entity in engaging with WHO and what it expects in return;
- determine the entity's legal status, area of activities, membership, governance, sources of funding, constitution, statutes, and by-laws and affiliation;
- define the main elements of the history and activities of the entity in terms of the following: health, human and labour issues; environmental, ethical and business issues; reputation and image; and financial stability;
- ORIGINAL CHAIR/S PROPOSAL Identify if the nature or activities of a NSA are incompatible with WHO/s work and mandate (e.g. links to be tobacco and arms industries) or if they require the Organization to exercise particular caution when engaging with the entity (e.g. links to other industries affecting human health or affected by WHO/s norms and standards (FOOTNOTE As described in paragraph 44)

OR

[Identify if the nature or activities of a non-State actor and the type of relationship foreseen with WHO are incompatible with WHO's work and mandate or if they require the Organization to exercise particular caution when engaging with the entity after applying the provisions of paragraphs 44 and 44bis]

OR

[Identify if the nature or activities of a non-State actor are incompatible with WHO/s work and mandate or if they require the Organization to exercise particular caution when engaging ...]

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

32. Risks are the expression of the likelihood and potential impact of an event that would affect the Organization's ability to achieve its objectives. A **risk assessment** on a proposed engagement is conducted in addition to due diligence. This involves the assessment of risks associated with an engagement with a non-State actor, in particular the risks described in paragraph 8.

Risk management

33. **Risk management** concerns the process leading to a management decision whereby the Secretariat decides explicitly and justifiably on entry into engagement,¹ continuation of engagement, engagement with measures to mitigate risks, non-engagement or disengagement from an existing or planned engagement with non-State actors. It is a management decision usually taken by the unit engaging with the non-State actor.

34. The specialized unit responsible for performing due diligence and risk assessment, as described in paragraph 27, formulates recommendations on the engagement-related options listed in paragraph 33 above, along with reasons for such recommendations. If the proposing unit agrees with the recommendations, it implements them. If there are disagreements, they can be referred to the Engagement Coordination Group. (FOOTNOTE: The **Engagement Coordination Group** is a Secretariat group appointed by the Director-General that includes representation from regional offices.)

35. The Engagement Coordination Group reviews referred proposals of engagement and recommends engagement, continuation of engagement, engagement with measures to mitigate risks, non-engagement or disengagement from an existing or planned engagement with non-State actors. In cases where the unit responsible for the engagement disagrees with this recommendation, the final decision rests with the Director-General.

36. In line with WHO's risk management framework,² WHO takes a risk-management approach to engagement, only entering into an engagement with a non-State actor when the benefits in terms of direct or indirect contributions to public health and the fulfilment of the Organization's mandate as mentioned in paragraph 7 outweigh any residual risks of engagement as mentioned in paragraph 8, as well as the time and expense involved in establishing and maintaining the engagement.

¹ Other than decisions related to official relations as set out in paragraphs 49 to 55.

² See document EB133/10.

Transparency

37. WHO's interaction with non-State actors [is]/[should be] managed transparently. WHO provides the governing bodies with annual reports on its engagement with non-State actors [, including the work of the Engagement Coordination Group] and makes publicly available basic information on the non-State actors it engages with and the individual engagements concerned.

OR

[WHO's interaction with non-State actors is managed transparently. WHO provides the governing bodies with annual reports on its engagement with non-State actors, [, including a summary information of the due diligence, risk assessment and risk management undertaken by the Secretariat.]
including the work of the Engagement Coordination Group, and makes publicly available appropriate information on the non-State actors it engages with and the individual engagements concerned.]
[, including a summary report of the due diligence, risk assessment and risk management undertaken by the Secretariat.]

(CHAIR'S PROPOSAL TO KEEP THE CHAIRS TEXT ONLY)

38. The **WHO register of non-State actors** is an Internet-based, publicly available electronic tool used by the Secretariat¹ to document and coordinate engagement with non-State actors. It contains the main standard information provided by non-State actors² and high-level descriptions of the engagement that WHO has with these actors (FOOTNOTE 3);

[FOOTNOTE 3: The register covers all three levels of the Organization – global, regional and country – and includes hosted partnerships and joint programmes]

38bis. Non-State actors engaging with WHO are required to provide information on their organization. This information includes: name, legal status, objective, governance structure, composition of main decision-making bodies, assets, annual income and funding sources, main relevant affiliations, webpage and one or more focal points for WHO contacts.

38bis. [Non-State actors engaging with WHO are required to provide information on their organization. This information includes: name, membership, legal status, objective, governance structure, composition of main decision-making bodies, assets, annual income and funding sources, main relevant affiliations, webpage and one or more focal points for WHO contacts.]

38ter [The due diligence reports, [including] (DELETE) the decisions related to risk assessment and risk management [, including decisions to refuse to engage] / (DELETE) will be made available to Member States] [and relevant information shall be made publicly available] / (DELETE) OR [The due diligence and risk assessment reports, as well as decisions on engagement-related options listed in paragraph 33, will be made available to Member States.]

¹ The register of non-State actors is the first level of a tool used by the Secretariat containing four levels of information: a publicly available level, a level made available to Member States, a working level for the Secretariat, and a level of confidential and sensitive information accessible to a limited number of individuals within the Secretariat.

² Information on financial contributions received from non-State actors is documented in this register and in the Programme Budget web portal.

38ter. OLD CHAIR's TEXT: [In addition to the publicly available information, Member States have electronic access to a summary report on due diligence of non-State actor, and risk assessments and risk management on engagement. Further details of the information used by the Secretariat to manage such engagement, can be made available for Member States to consult, upon request and as far as legally feasible.]

NEW CHAIR's TEXT: 38ter. In addition to the publicly available information, Member States have electronic access to a summary report on due diligence of non-State actor, and risk assessments and risk management on engagement. [Further details of the information used by the Secretariat to manage such engagement, can be made available for Member States to consult, upon request and as far as legally feasible.] Furthermore Member States can search for such information concerning cases considered by the engagement coordination group.

AND

[Add to resolution text a timeline for establishing and rolling out the register.]

(CHAIR'S PROPOSAL TO KEEP THE CHAIRS TEXT FOR 38, 38BIS AND 38TER. A REFERENCE TO THE ROLLING OUT OF THE REGISTER HAS BEEN ADDED TO THE RESOLUTION)

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

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

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

NOTE: The following text from paragraph 41 has been "parked" to serve as input for discussions on paragraph 48

[this shall be applied in conjunction with the framework] (DELETE:)

OR

[All the relevant WHO guidelines will be [aligned] / [coordinated] with this framework (FOOTNOTE: LIST ALL RELEVANT DOCUMENTS)]

OR

MOVE (AS FOOTNOTE) TO PARAGRAPH 48

(CHAIR'S PROPOSAL DELETE ALL YELLOW AS IT WILL BE DISCUSSED IN PARAGRAPH 48)

42. (DELETED)

43. (DELETED)

SPECIFIC PROVISIONS

44. WHO does not engage with the tobacco or arms industries [and its affiliates]

(CHAIR'S PROPOSAL TO ACCEPT "AND ITS AFFILIATES")

[Engagement with particular industries]/[non-state actors]

44bis. [WHO will exercise [particular]/[appropriate]/(DEL) caution [consistent with and subject to the rules of this framework] especially while conducting due diligence and risk assessment analyses when engaging with [non-state actors]/[other industries]/[private sector and some industries] [negatively] affecting human health, or affected by the WHO's norms and standards.][STOP HERE] [[such as]/[for example][, but not limited to,] alcohol and food and beverage industries]

CHAIRS PROPOSAL: 44 bis WHO will exercise particular caution especially while conducting due diligence and risk assessment when engaging with private sector entities or other non-State actors affected by WHO's policies, norms and standards.

Association with WHO's name and emblem

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

Secondments

46. [WHO does not accept secondments from non-State actors.] / (DELETE:)

OR

[WHO does not accept secondments from private sector entities. Secondments from other types of non-State actors shall be accepted, in accordance with WHA67/7.]

OR

[WHO can accept secondments from non-State actors for technical work or implementation of WHO's programmes and policies and emergency response.]

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

CHAIRS PROPOSAL: 46. WHO does not accept secondments from non-State actors

RELATION OF THE FRAMEWORK TO WHO'S OTHER POLICIES

47. This framework replaces the Principles Governing Relations between the World Health Organization and Nongovernmental Organizations¹ and the Guidelines on interaction with commercial enterprises to achieve health outcomes (noted by the Executive Board).²

48. The implementation of the framework for engagement with non-State actors is coordinated [and aligned] with the [related policies listed below. In the case of conflict, this framework will prevail.]/ [following related policies], ~~which remain valid. [In the case of conflict, this framework shall prevail over the policies listed below].~~

OR

[The implementation of the policies listed below will be coordinated and aligned with the framework of engagement with non-State actors.]

[[a) WHO's engagement with global health partnerships and hosting arrangements³]

[(i) Hosted partnerships derive their legal personality from WHO and are subject to the organizations rules and regulations. Therefore the framework applies to their engagement with non-State actors. They have a formal governance structure, separate from that of the WHO governing bodies, in which decisions are taken on direction, work plans and budgets; and their programmatic accountability frameworks are also independent from those of the Organization. In the same way the framework applies to other hosted entities which are subject to the Organizations Rules and Regulations.]

[(ii) WHO's involvement in external partnerships is regulated by the policy on WHO's engagement with global health partnerships and hosting arrangements. For the management of risks of WHO's engagement in these partnerships the present framework for engagement with non-State actors applies.]

OR

[(a) Partnerships and entities hosted by WHO will be subject to this framework as applicable for WHO.]

[For hosted partnership the framework of engagement with non-State actors will apply, subject to WHO's policy on engagement with global health partnerships and hosting arrangements (resolution WHA63.10).]

(b) The management of WHO's relations with individual experts is regulated by the Regulations for Expert Advisory Panels and Committees⁴ and the Guidelines for Declaration of Interests (WHO Experts).

¹ Basic documents, 47th ed. Geneva: World Health Organization; 2009: 81–86.

² See document EB107/2001/REC/2, summary record of the twelfth meeting.

³ Endorsed by the Health Assembly in resolution WHA63.10 on partnerships.

⁴ See Basic documents, 47th ed. Geneva: World Health Organization; 2009, pp 104–112 (<http://apps.who.int/gb/bd/PDF/bd47/EN/basic-documents-47-en.pdf>, accessed 1 December 2014).

(c) The Organization's Staff Regulations and Staff Rules and in particular the provisions of declaration of interest therein: according to Article 1.1 of the Staff Regulations of the World Health Organization, all staff members "pledge themselves to discharge their functions and to regulate their conduct with the interests of the World Health Organization only in view."

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

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

(f) Like any other financing of WHO, financing from non-State actors should be considered as part of the financing dialogue and is regulated by the Financial Rules and Financial Regulations; the decision on accepting such a financial contribution is regulated by this framework.

CHAIRS PROPOSAL: ACCEPT TEXT, DELETE TEXT IN SQUARE BRACKETS TO BE ADDRESSED IN THE RESOLUTION:

OR

[48a) alt. WHO's involvement in external partnerships is regulated by the policy on WHO's engagement with global health partnerships and hosting arrangements and the current framework, in a complementary way. In particular, for the purposes of due diligence, risk assessment and risk management of WHO's involvement in formal partnerships, the current framework will apply.]

OFFICIAL RELATIONS

49. "Official relations" is a privilege that the Executive Board may grant to nongovernmental organizations, international business associations and philanthropic foundations that have had and continue to have a sustained and systematic engagement³ in the interest of the Organization. The aims and activities of all these entities shall be in conformity with the spirit, purposes and principles of WHO's Constitution, and they shall contribute significantly to the advancement of public health. Organizations in official relations can attend governing body meetings of WHO but are otherwise subject to the same rules as other non-State actors when engaging with WHO.

50. [All entities in official relations shall have a constitution or similar basic document, an established headquarters, a directing or governing body, an administrative structure, and a regularly updated entry in the WHO register of non-State actors.]

OR

¹ Basic documents, 47th ed. Geneva: World Health Organization; 2009, pp.113–120.

² Basic documents, 47th ed. Geneva: World Health Organization; 2009, pp.87–97.

³ At least two years of systematic engagement as documented in the WHO register of non-State actors, assessed by both parties to be mutually beneficial. Participation in each other's meetings alone is not considered to be a systematic engagement.

50alt. [Entities in official relations (INSERT FOOTNOTE) are international in membership and/or scope. All entities in official relations shall have a constitution or similar basic document, an established headquarters, a directing or governing body, an administrative structure, and a regularly updated entry in the WHO register of non-State actors.]

[FOOTNOTE: Before working relations are established between WHO and a national NGO, and before a programme of collaboration with such an organization is agreed, appropriate measures will be taken to consult with the government concerned in accordance with article 71 of the WHO Constitution).]

OR

50alt OLD CHAIRS PROPOSAL Entities in official relations are international in membership and [/or] scope. All entities in official relations shall have a constitution or similar basic document, an established headquarters, a [directing] / [steering] or governing body, an administrative structure, and a regularly updated entry in the WHO register of non-State actors. (+ DELETION OF PARAGRAPH 55)

CHAIRS PROPOSAL NEW: Entities in official relations are international in membership and /or scope. All entities in official relations shall have a constitution or similar basic document, an established headquarters, a governing body, an administrative structure, and a regularly updated entry in the WHO register of non-State actors. (+ DELETION OF PARAGRAPH 55)

51. A plan for collaboration [with agreed objectives/results/targets and]

[based on mutually agreed objectives and] (DELETE)

outlining activities for the coming three-year period structured in accordance with the General Programme of Work and Programme budget shall form the basis of official relations between WHO and organizations in official relations. This plan shall also be published in the WHO register of non-State actors. These organizations shall provide annually a short report on the progress made in implementing the plan of collaboration and other related activities which will also be published in the WHO register.

CHAIRS PROPOSAL: Art. 51. Official relations shall be based on a plan for collaboration between WHO and the entity with agreed objectives and outlining activities for the coming three-year period structured in accordance with the General Programme of Work and Programme budget This plan shall also be published in the WHO register of non-State actors. These organizations shall provide annually a short report on the progress made in implementing the plan of collaboration and other related activities which will also be published in the WHO register.

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

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

- (a) the possibility to appoint a representative to participate, without right of vote, in meetings of WHO's governing bodies or in meetings of the committees and conferences convened under its authority;

(b) the possibility to make a statement if the Chairman of the meeting (i) invites them to do so or (ii) accedes to their request when an item in which the related entity is particularly interested is being discussed;

(c) the possibility to submit the statement referred to in subparagraph (b) above in advance of the debate for the Secretariat to post on a dedicated website.

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

55. [Entities in official relations are international in membership and/or scope. The organization or its affiliates can also attend meetings of the regional committees. Regional committees may decide on a procedure granting accreditation to their meetings to other non-State actors not in official relations as long as the procedure is managed in accordance with this framework.] (DISCUSS WITH P51)

(CHAIR PROPOSAL TO DELETE PARAGRAPH 55 SINCE IT IS MERGED WITH PARAGRAPH 50)

Procedure for admitting and reviewing organizations in official relations

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

57. A signed letter certifying the accuracy of the application for official relations submitted online shall reach WHO headquarters no later than the end of the month of July for submission to the Executive Board at its session the following January. Applications for official relations shall be reviewed to ensure that the established criteria and other requirements are fulfilled as set out in this framework. Applications should be transmitted to the Executive Board members by the Secretariat six weeks before the opening of the January session of the Executive Board at which they will be considered.

58. The entities in official relations and the Secretariat should name focal points for collaboration who are responsible for informing each other and their organizations of any developments in the implementation of the plan for collaboration and who are the first points of contact for any changes or problems. [MOVE PARA TO AFTER P61]

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

60. The Board, after considering the recommendations of the Committee, shall decide whether an organization is to be admitted into official relations with WHO. A reapplication from a non-State actor

shall not normally be considered until two years have elapsed since the Board's decision on the previous application.

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

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

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

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

[ACCREDITATION OF NGOS]

64 bis To be eligible for accreditation to the Health Assembly, Executive Board and committees and conferences convened under their authority, a nongovernmental organization shall:

- (a) have aims and purposes consistent with WHO's Constitution and in conformity with the policies of the Organization as well as resolutions and decisions adopted by the Executive Board and the World Health Assembly;
- (b) demonstrate competence in a field of activity related to the work of WHO;
- (c) have membership and/or activities that are international in scope;
- (d) be non-profit and public interest in nature, and in its activities and advocacy;
- (e) have an established structure, a constitutive act, and accountability mechanisms;
- (f) for a membership organization, have the authority to speak for its members and have a representative structure; The Membership should not contain private sector entities, individuals associated with private sector entities or philanthropic foundations and academic institutions not at arm's length with private sector;
- (g) have existed formally for at least three years as of date of receipt of the application by WHO;

(h) disclose information on its objectives, structure, membership of executive body, field of activities and source of financing, and, where applicable, its status with other entities of the United Nations system;

(i) agree to provide WHO regularly with updated information as well as to inform WHO of any changes with respect to its status as « non-governmental organization » as soon such changes take place.

Completed applications should reach WHO headquarters by the beginning of June in order to be considered by the Executive Board in January of the following year. Applications should be transmitted to Member States by the Secretariat two months in advance of the session at which they will be considered. A re-application from a “nongovernmental organization” shall not be considered until two years have elapsed since the Board’s decision on the original application. Once a nongovernmental organization is accredited, information gathered on its objectives, structure, membership of executive body, field of activities and source of funding, including updated information, shall be made publicly available. A report on accredited nongovernmental organizations shall be submitted every two years to the Executive Board.]

(CHAIRS PROPOSAL: DELETE)

OVERSIGHT OF ENGAGEMENT

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

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

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

(i) consideration of the annual report on engagement with non-State actors submitted by the Director-General which provides a summary of engagements and highlights challenges arising from such engagement.

AND

(i bis) [consideration of the annual report of the Independent Expert Oversight Advisory Committee on WHO’s engagement with non-State actors]

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

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

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

(ii) review of renewals of entities in official relations

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

CHAIRS PROPOSAL: KEEP TEXT INCLUDING ibis

NON-COMPLIANCE WITH THIS FRAMEWORK

67. Non-compliance can include *inter alia* the following: significant delays in the provision of information to the WHO register of non-State actors; the provision of wrong information; the use of the engagement with WHO for commercial, promotional, marketing and advertisement purposes; [engagement in [political activities]/[partisan politics];] misuse of WHO's name and emblem; and abuse of the privileges conferred by official relations.

CHAIRS PROPOSAL 67 alt: Non-compliance can include *inter alia* the following: significant delays in the provision of information to the WHO register of non-State actors; the provision of wrong information; the use of the engagement with WHO for commercial, promotional, marketing and advertisement purposes; misuse of WHO's name and emblem; misuse of the fact of engaging with WHO for other than public health purposes, and abuse of the privileges conferred by official relations.

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

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

MONITORING AND EVALUATION OF THE FRAMEWORK

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

71. Furthermore, the implementation of the framework should be periodically evaluated. The results of such evaluation, together with any proposals for revisions of the framework, shall also be submitted to the Executive Board through its Programme, Budget and Administration Committee. [PERIODICITY TO BE DECIDED BY THE RESOLUTION]

[New72. The following steps shall be taken for the effective implementation of the framework:

(a) Review existing list of non-State actors in official relation and to apply the categorization of non-State actors as set out in this framework.

(b) Review of WHO's existing external and hosted partnerships, collaborations in the light of this framework and to take appropriate measures to avoid and manage risk. Towards this purpose the Secretariat should invite comments from the public.

(c) Review and amend all the policies listed in Paragraph 48 of EB136/5 to fully align those policies with the existing framework. Towards this end, the Secretariat will hold web

consultations open for Member States and public to pinpoint the areas of the existing policies which need to be reviewed and amended in the light of framework;

(d) The non-State actors registry shall be made operational within six months of the adoption of the framework of engagement with non-State actors.] [MAKE REFERENCE TO THE RESOLUTION]

(CHAIRS PROPOSAL: DELETE 72 AS ISSUES ARE ADDRESSED IN THE RESOLUTION)

DRAFT WHO POLICY AND OPERATIONAL PROCEDURES ON ENGAGEMENT WITH NONGOVERNMENTAL ORGANIZATIONS

1. Nongovernmental organizations make important contributions to global health because they often have deep roots in local communities, have special flexibilities to respond to health needs, represent affected populations and other key groups, and promote innovative solutions. Therefore WHO engages with this group of key actors in global health in order to leverage their support in the fulfilment of WHO's mandate.

(CHAIR'S PROPOSAL TO KEEP THE PARAGRAPH)

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

PARTICIPATION

Participation by nongovernmental organizations in WHO meetings²

3. WHO can invite nongovernmental organizations to participate in consultations, hearings or other meetings in accordance with paragraph 16 of the overarching framework. Consultations and hearings can be electronic or in person.

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

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

¹ See paragraphs 15–21 of the overarching framework for the five types of interaction.

² Other than sessions of the governing bodies, which are regulated by the policy on management of engagement.

Involvement of the Secretariat in meetings organized by nongovernmental organizations

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

Operational procedures

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

RESOURCES

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

KEEP TEXT; ADD FOOTNOTE TO PERSONNEL: Contribution of personnel are only acceptable for short term assignments that do not involve normative work and if potential risks are managed in accordance with this framework.

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

Specific policies and operational procedures

9. Any acceptance of resources from a nongovernmental organization is handled in accordance with the provisions of this framework and relevant other rules such as the Staff Regulations and Staff Rules, the Financial Regulations and Financial Rules and WHO's policies governing procurement.

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

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

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

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

EVIDENCE

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

ADVOCACY

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

16. WHO favours independent monitoring functions and therefore engages with nongovernmental organizations working in this field. Nongovernmental organizations are encouraged to disseminate WHO's policies, guidelines, norms and standards and other tools through their networks so as to extend WHO's own reach.

TECHNICAL COLLABORATION

17. The Secretariat is encouraged to undertake technical collaboration with nongovernmental organizations, provided that it is in the interests of the Organization and managed in accordance with the framework for engagement with non-State actors.

DRAFT WHO POLICY AND OPERATIONAL PROCEDURE ON ENGAGEMENT WITH PRIVATE SECTOR ENTITIES

1. Private sector entities are key players in global health as providers, both within and beyond the health sector, of goods and services that can have important effects on health. Therefore WHO engages with this group of key actors in global health to improve their positive contribution, limit their negative effects on health and leverage their support in the fulfilment of WHO's mandate.

AND

[This policy is applicable to private sector firms, international business associations, academic institutions and philanthropic foundations not at arm's length with the private sector and other not-for-profit organizations, which are not qualified as NGOs under the overarching framework on the engagement of non-State actors.]

CHAIR PROPOSAL: KEEP FIRST VERSION ALTERNATIVE

2. This policy regulates specifically WHO's engagement with private sector entities by type of interaction.¹ The general provisions of the framework also apply to all engagements with private sector entities.

CHAIR PROPOSAL: KEEP TEXT

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

CHAIR PROPOSAL: KEEP TEXT

PARTICIPATION

Participation by private sector entities in WHO meetings²

4. WHO can invite private sector entities to participate in consultations, hearings or other meetings in accordance with paragraph 16 of the overarching framework. Consultations and hearings can be electronic or in person.

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

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

Involvement of the Secretariat in meetings organized by private sector entities

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

Specific policies and operational procedures

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

¹ See paragraphs 15–21 of the overarching framework for the five types of interaction.

² Other than sessions of the governing bodies, which are regulated by the policy on management of engagement.

8. WHO does not cosponsor meetings organized wholly or partly by private sector entities. It may, however, cosponsor a meeting for which the scientific initiators have hired a commercial conference organizer to deal with the logistical aspects, provided that the commercial organizer makes no contribution to the scientific content of the meeting.
9. WHO does not cosponsor meetings organized by other actors where one or more health-related private sector entities are also cosponsors. Other instances of cosponsorship of meetings organized by other actors where non health-related private sector entities are also cosponsors should be reviewed on a case-by-case basis and are subject to the provisions of this framework.
10. There shall be no commercial exhibitions on WHO premises and at WHO's meetings.
11. WHO does not cosponsor commercial exhibitions, whether as part of meetings organized by private sector entities or as part of meetings organized by other actors.

RESOURCES

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

(a) Funds may be accepted from private sector entities whose business is unrelated to that of WHO, provided they are not engaged in any activity [or affiliated with any entity] that is incompatible with WHO's mandate and work.

(b) Funds may not be sought or accepted from private sector entities that have, themselves or through their affiliated companies, a direct commercial interest in the outcome of the project toward which they would be contributing, unless approved in conformity with the provisions for clinical trials or product development (see paragraph 38 below).

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

[(d) WHO shall not receive financial resources from private sector entities as well as non-state actors with links to private sector entities whose activities [or advocacy] are undermining the mandate of WHO as stated in its Constitution]/DISCUSS WITH PARA 44

[(e) The WHO should establish ceiling in the voluntary contribution from non-state actors. Any contribution beyond that amount should go to the core voluntary fund which gives enough freedom to the Secretariat to allocate resources to underfunded programmes. The Member States assessed contributions should be allocated to the programmes that are underfunded under voluntary contribution]/OR MOVE TO 18ter in the overarching framework/DELETE

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

DELETE d) AND e)

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

- (a) the contribution is not used for normative work;
- (b) if a contribution is used for activities other than normative work in which the private sector entity could have a commercial interest, the public health benefit of the engagement needs clearly to outweigh its potential risks;
- (c) the proportion of funding of any activity coming from the private sector cannot be such that the programme's continuation would become dependent on this support;
- (d) the acceptance of the contribution does not constitute an endorsement by WHO of the private sector entity, or its activities, products or services;
- (e) the contributor may not use the results of WHO's work for commercial purposes or use the fact of its contribution in its promotional material;
- (f) the acceptance of the contribution does not afford the contributor any privilege or advantage;
- (g) the acceptance of the contribution does not offer the contributor any possibility for advising, influencing, participating in, or being in command of the management or implementation of operational activities;
- (h) WHO keeps its discretionary right to decline a contribution, without any further explanation.

14. [The Director-General can set up mechanisms for pooling contributions from multiple sources, if the mechanisms are designed in such a manner as to avoid any perceived influence from the contributors on WHO's work; if the mechanism is open to all interested contributors; and if the mechanism is subject to the conditions in paragraph 12 above and transparency is achieved through the WHO register of non-State actors and the Programme budget web portal].

CHAIRS PROPOSAL KEEP TEXT*Specific policies and operational procedures*

15. Any acceptance of financial, personnel or in-kind contribution from private sector entities shall be managed in accordance with this framework and based on a signed agreement.

KEEP TEXT; ADD FOOTNOTE TO PERSONNEL: Contribution of personnel are only acceptable for short term assignments that do not involve normative work and if potential risks are managed in accordance with this framework.

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

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

18. Contributions received from private sector entities, are listed in the financial report and audited financial statements of WHO as well as the Programme budget web portal and the register of non-State actors.

[18bis. Any donation received by WHO which is subsequently discovered to be noncompliant with this framework shall be returned to the donor.]

CHAIR PROPOSAL: DELETE AS IT IS COVERED BY OVERARCHING FRAMEWORK PARAGRAPH 69

19. Private sector entities may not use [WHO’s logo] / [[such] / [the] results of WHO’s work for commercial purposes] and may not use the fact that they have made a contribution in their promotional materials. However, they may make reference to their contribution in their corporate annual reports or similar documents. In addition they may mention the contribution in a transparency listing on their websites, in special non-promotional or product-related corporate responsibility pages on their website and in similar publications provided that the content and context have been agreed with WHO.

CHAIRS PROPOSAL Art. 19 alt: Private sector entities may not use the results of WHO’s work to which they have contributed for commercial purposes and may not use the fact that they have made a contribution in their promotional materials. However, they may make reference to their contribution in their corporate annual reports or similar documents. In addition they may mention the contribution in a transparency listing on their websites, in special non-promotional or product-related corporate responsibility pages on their website and in similar publications provided that the content and context have been agreed with WHO.

(COMMENT: USE OF NAME AND EMBLEM IS REGULATED BY REGULATED BY PARAGRAPH 45 OF THE OVERARCHING FRAMEWORK)

Donations of medicines and other health technologies¹

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

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

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

¹ Such donations shall be in line with interagency guidelines: World Health Organization, Ecumenical Pharmaceutical Network, International Pharmaceutical Federation, International Federation of Red Cross and Red Crescent Societies, International Health Partners, The Partnership for Quality Medical Donations, et al. Guidelines for medicine donations – revised 2010. Geneva: World Health Organization; 2011.

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

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

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

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

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

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

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

Financial contributions for clinical trials

22. Except as provided in paragraph 38 below on product development, financial contributions from a commercial enterprise for a clinical trial arranged by WHO on that company's proprietary product are considered on a case-by-case basis and always decided by the Engagement coordination group. In this connection, it should be ensured that:

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

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

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

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

Contributions for WHO meetings

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

25. Contributions may be accepted to support the overall costs of a meeting.
26. WHO receptions and similar functions shall not be paid for by private sector entities.

Contributions for WHO staff participating in external meetings

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

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

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

Contributions for publications

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

Contributions for financing staff salaries

29. [Funds designated to support the salary of specific staff members or posts (including short-term consultants) may not be accepted from private sector entities] [STOP HERE]

[if they could give rise to a real or perceived conflict of interest in relation to WHO's work.]

(DELETE)

OR

(DELETE PARAGRAPH)

CHAIR PROPOSAL: DELETE PARAGRAPH

Cost recovery

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

EVIDENCE

31. Private sector entities may provide their up-to-date information and knowledge on technical issues, and share their experience with WHO, as appropriate, subject to the provisions of the overarching framework, and this specific policy and operational procedures, and other applicable

WHO rules, policies and procedures. Such contribution should be made publicly available, as appropriate, wherever possible. Scientific evidence generated should be made publicly available.

[31bis. If information gathering is done in the preparation of the development of norms and standards, private sector entities can only be involved in the form of hearings]/(DEL)

32. Individuals working for interested private sector entities are excluded from participating in expert groups; however, expert groups need to be able, where appropriate, to conduct hearings with such individuals in order to access their knowledge.

CHAIRS PROPOSAL KEEP TEXT

ADVOCACY

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

34. Private sector entities can only collaborate with WHO in advocacy for the implementation of a WHO norm or standard if they commit themselves to implement these norms and standards in their entirety. No partial or selective implementation is acceptable. [SUBJECT TO AGREEMENT ON SPECIFIC PARAGRAPHS IN THE FOUR SPECIFIC POLICIES]

CHAIRS PROPOSAL KEEP TEXT IN THIS POLICY ONLY

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

TECHNICAL COLLABORATION

36. Technical collaboration with the private sector is welcomed if potential risks of engagement are managed or mitigated and provided that the normative work of WHO is protected from any undue influence and there is no interference with WHO's advisory function to Member States.

OR

[Technical collaboration with the private sector is welcomed provided that it is in the interests of the Organization and managed in accordance with the framework for engagement with non-State actors.] [and [in particular] provided that the normative work of WHO is protected from any undue influence and there is no interference with WHO's advisory function to Member States.]

CHAIR PROPOSAL 36 alt: Technical collaboration with the private sector is welcomed provided that it is in the interests of the Organization and managed in accordance with this framework and in particular provided that the normative work of WHO is protected from any undue influence and there is no interference with WHO's advisory function to Member States.]

Specific policies and operational procedures

37. If WHO has drawn up official specifications for a product, it may provide technical advice to manufacturers for development of their product in accordance with these specifications, provided that

all private sector entities known to have an interest in such a product are given the opportunity to collaborate with WHO in the same way.

Product development

38. WHO collaborates with private sector entities in the development of health-related technology, either by conducting research and development on their products and supporting transfers and licensing of technology or by licensing its intellectual property to such enterprises. Collaborative research and development, technology transfer and licensing should, as a general rule, be undertaken only if WHO and the entity concerned have concluded an agreement cleared by the Office of the Legal Counsel that ensures that the final product will ultimately be made widely available [and] [,] accessible, [and affordable,] (DELETE) including to [~~the public sector~~] (DELETE) of low- and middle-income countries [~~at a preferential price~~] (DELETE). If such an agreement is concluded, financing may be accepted from the private sector entity for a clinical trial arranged by WHO on the product in question, as contractual commitments obtained from the entity in the public interest outweigh any potential conflict of interest in accepting the financial contribution. These contributions should be distinguished from the acceptance of contributions for a clinical trial arranged by WHO on a proprietary product as described in paragraph 23.

OR

[ALTERNATIVE LANGUAGE AT HIGHER LEVEL]

OR

[CHAIR'S PROPOSAL]

38alt. WHO collaborates with private sector entities in the development of health-related technology, either by conducting research and development on their products and supporting transfers and licensing of technology or by licensing its intellectual property to such enterprises based on an agreement cleared by the Office of the Legal Counsel. Such collaboration must contribute to increasing access to quality, safe, efficacious and affordable medical products. If such an agreement is concluded, financing may be accepted from the private sector entity for a clinical trial arranged by WHO on the product in question, as contractual commitments obtained from the entity in the public interest outweigh any potential conflict of interest in accepting the financial contribution. These contributions should be distinguished from the acceptance of contributions for a clinical trial arranged by WHO on a proprietary product as described in paragraph 23.

(COMMENT TO CHAIR'S PROPOSAL ON PARAGRAPH: THE TEXT "increasing access to quality, safe, efficacious and affordable medical products" COMES FROM THE AGREED LEADERSHIP PRIORITIES OF THE 12TH GENERAL PROGRAMME OF WORK)

DRAFT WHO POLICY AND OPERATIONAL PROCEDURES ON ENGAGEMENT WITH PHILANTHROPIC FOUNDATIONS

1. Philanthropic foundations are making significant contributions to global health in general, and to WHO's work in particular, in many areas ranging from innovation to capacity-building and to service delivery. Therefore WHO engages with this group of key actors in global health to leverage their support in the fulfilment of WHO's mandate.

(CHAIR'S PROPOSAL TO KEEP THE PARAGRAPH)

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

PARTICIPATION**Participation by philanthropic foundations in WHO meetings²**

3. WHO can invite philanthropic foundations to participate in consultations, hearings or other meetings in accordance with paragraph 16 of the overarching framework. Consultations and hearings can be electronic or in person.

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

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

Involvement of the Secretariat in meetings organized by philanthropic foundations

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

Operational procedures

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

RESOURCES

7. WHO can accept funds, personnel and in-kind contributions from philanthropic foundations as long as such contributions fall within WHO's General Programme of Work, do not create conflicts of

¹ See paragraphs 15–21 of the overarching framework for the five types of interaction.

² Other than sessions of the governing bodies, which are regulated by the policy on management of engagement.

interest, are managed in accordance with the framework, and comply with other relevant regulations, rules and policies of WHO.

KEEP TEXT; ADD FOOTNOTE TO PERSONNEL: Contribution of personnel are only acceptable for short term assignments that do not involve normative work and if potential risks are managed in accordance with this framework.

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

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

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

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

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

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

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

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

Specific policies and operational procedures

12. Any acceptance of resources from a philanthropic foundation is handled in accordance with the provisions of this framework and relevant other rules such as the Staff Regulations and Staff Rules, the Financial Regulations and Financial Rules and WHO's policies governing procurement.

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

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

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

16. Philanthropic foundations may not use the fact that they have made a contribution in their promotional materials. However, they may make reference to the contribution in their annual reports

or similar documents. In addition, they may mention the contribution in a transparency listing on their websites, in special non-promotional pages of their website and similar publications, provided that the content and context have been agreed with WHO.

EVIDENCE

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

ADVOCACY

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

TECHNICAL COLLABORATION

19. The Secretariat is encouraged to undertake technical collaboration with philanthropic foundations provided that it is in the interests of the Organization and managed in accordance with the framework for engagement with non-State actors.

DRAFT WHO POLICY AND OPERATIONAL PROCEDURES ON ENGAGEMENT WITH ACADEMIC INSTITUTIONS

1. Academic institutions contribute to global health through education, research, clinical care and the generation, synthesis and analysis of evidence. Therefore, WHO engages with this group of key actors in global health to leverage their support in the fulfilment of WHO's mandate.

(CHAIR'S PROPOSAL TO KEEP THE PARAGRAPH)

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

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

¹ See paragraphs 15–21 of the overarching framework for the five types of interaction.

PARTICIPATION

Participation by academic institutions in WHO meetings

4. WHO can invite academic institutions to participate in consultations, hearings or other meetings in accordance with paragraph 16 of the overarching framework. Consultations and hearings can be electronic or in person.

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

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

Involvement of the Secretariat in meetings organized by academic institutions

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

Operational procedures

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

RESOURCES

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

KEEP TEXT; ADD FOOTNOTE TO PERSONNEL: Contribution of personnel are only acceptable for short term assignments that do not involve normative work and if potential risks are managed in accordance with this framework.

9. WHO can provide resources to an academic institution for implementation of particular work (such as research, a clinical trial, laboratory work and preparation of a document). This can be either for a project of the institution which WHO considers merits support and is consistent with WHO's

programme of work, or for a project organized or coordinated by WHO. The former constitutes a grant, the latter a service.

Specific policies and operational procedures

10. Any acceptance of resources from an academic institution is handled in accordance with this framework and relevant other rules such as the Staff Regulations and Staff Rules, the Financial Regulations and Financial Rules and WHO's policies governing procurement.

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

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

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

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

EVIDENCE

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

16. Intellectual property arising from collaborations with academic institutions is regulated by the agreement with the academic institution. This should be addressed in consultation with the Office of the Legal Counsel.

ADVOCACY

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

TECHNICAL COLLABORATION

18. The Secretariat is encouraged to undertake technical collaboration with academic institutions, provided that it is in the interests of the Organization and managed in accordance with the framework for engagement with non-State actors.

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

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

(Ninth plenary meeting, 26 May 2015 –
Committee A, sixth report)

WHA68.10 Financial report and audited financial statements for the year ended 31 December 2014

The Sixty-eighth World Health Assembly,

Having considered the financial report and audited financial statements for the year ended 31 December 2014;²

Having noted the report of the Programme, Budget and Administration Committee of the Executive Board to the Sixty-eighth World Health Assembly,³

ACCEPTS the Director-General's financial report and audited financial statements for the year ended 31 December 2014.

(Ninth plenary meeting, 26 May 2015 –
Committee B, second report)

WHA68.11 Status of collection of assessed contributions, including Member States in arrears in the payment of their contributions to an extent that would justify invoking Article 7 of the Constitution

The Sixty-eighth World Health Assembly,

Having considered the reports on status of collection of assessed contributions, including Member States in arrears in the payment of their contributions to an extent that would justify invoking Article 7 of the Constitution, and special arrangements for settlement of arrears;⁴

Noting that, at the time of opening of the Sixty-eighth World Health Assembly, the voting rights of Central African Republic, Comoros, Guinea-Bissau, Somalia and Ukraine were suspended, such

¹ Basic documents, 48th ed. Geneva: World Health Organization; 2014, pp 131–138.

² Documents A68/38 and A68/INF./1.

³ Document A68/57.

⁴ Documents A68/39 and A68/58.

suspension to continue until the arrears of the Members concerned have been reduced, at the present or future Health Assemblies, to a level below the amount that would justify invoking Article 7 of the Constitution;

Noting that Cabo Verde, Cameroon, Guinea, Haiti, Kyrgyzstan, Timor-Leste and Yemen were in arrears at the time of the opening of the Sixty-eighth World Health Assembly to such an extent that it was necessary for the Health Assembly to consider, in accordance with Article 7 of the Constitution, whether the voting privileges of those countries should be suspended – for Kyrgyzstan at the opening of the Sixty-eighth World Health Assembly, and for the remaining six Member States at the opening of the Sixty-ninth World Health Assembly,

DECIDES:

(1) that in accordance with the statement of principles set out in resolution WHA41.7 if, by the time of the opening of the Sixty-ninth World Health Assembly, Cabo Verde, Cameroon, Guinea, Haiti, Timor-Leste and Yemen are still in arrears in the payment of their contributions to an extent that would justify invoking Article 7 of the Constitution, their voting privileges shall be suspended as from the said opening; and in accordance with resolution WHA61.8 if, by the time of the opening of the Sixty-eighth World Health Assembly, Kyrgyzstan is still in arrears in the payment of its assessment, its voting privileges shall be suspended automatically;

(2) that any suspension that takes effect as set out in paragraph (1) above shall continue at the Sixty-ninth World Health Assembly and subsequent Health Assemblies, until the arrears of Cabo Verde, Cameroon, Guinea, Haiti, Kyrgyzstan, Timor-Leste and Yemen have been reduced to a level below the amount that would justify invoking Article 7 of the Constitution;

(3) that this decision shall be without prejudice to the right of any Member to request restoration of its voting privileges in accordance with Article 7 of the Constitution.

(Ninth plenary meeting, 26 May 2015 –
Committee B, second report)

WHA68.12 Scale of assessments for 2016–2017

The Sixty-eighth World Health Assembly,

Having considered the report on the scale of assessments for 2016–2017,¹

ADOPTS the scale of assessments of Members and Associate Members for the biennium 2016–2017 as set out below.

Members and Associate Members	WHO scale for 2016–2017
	%
Afghanistan	0.0050
Albania	0.0100
Algeria	0.1370
Andorra	0.0080

¹ Document A68/40.

Members and Associate Members	WHO scale for 2016–2017 %
Angola	0.0100
Antigua and Barbuda	0.0020
Argentina	0.4320
Armenia	0.0070
Australia	2.0741
Austria	0.7981
Azerbaijan	0.0400
Bahamas	0.0170
Bahrain	0.0390
Bangladesh	0.0100
Barbados	0.0080
Belarus	0.0560
Belgium	0.9981
Belize	0.0010
Benin	0.0030
Bhutan	0.0010
Bolivia (Plurinational State of)	0.0090
Bosnia and Herzegovina	0.0170
Botswana	0.0170
Brazil	2.9342
Brunei Darussalam	0.0260
Bulgaria	0.0470
Burkina Faso	0.0030
Burundi	0.0010
Cabo Verde	0.0010
Cambodia	0.0040
Cameroon	0.0120
Canada	2.9842
Central African Republic	0.0010
Chad	0.0020
Chile	0.3340
China	5.1484
Colombia	0.2590
Comoros	0.0010
Congo	0.0050
Cook Islands	0.0010
Costa Rica	0.0380
Côte d'Ivoire	0.0110
Croatia	0.1260
Cuba	0.0690

Members and Associate Members	WHO scale for 2016–2017
	%
Cyprus	0.0470
Czech Republic	0.3860
Democratic People's Republic of Korea	0.0060
Democratic Republic of the Congo	0.0030
Denmark	0.6750
Djibouti	0.0010
Dominica	0.0010
Dominican Republic	0.0450
Ecuador	0.0440
Egypt	0.1340
El Salvador	0.0160
Equatorial Guinea	0.0100
Eritrea	0.0010
Estonia	0.0400
Ethiopia	0.0100
Fiji	0.0030
Finland	0.5190
France	5.5935
Gabon	0.0200
Gambia	0.0010
Georgia	0.0070
Germany	7.1416
Ghana	0.0140
Greece	0.6380
Grenada	0.0010
Guatemala	0.0270
Guinea	0.0010
Guinea-Bissau	0.0010
Guyana	0.0010
Haiti	0.0030
Honduras	0.0080
Hungary	0.2660
Iceland	0.0270
India	0.6660
Indonesia	0.3460
Iran (Islamic Republic of)	0.3560
Iraq	0.0680
Ireland	0.4180
Israel	0.3960
Italy	4.4483

Members and Associate Members	WHO scale for 2016–2017
	%
Jamaica	0.0110
Japan	10.8338
Jordan	0.0220
Kazakhstan	0.1210
Kenya	0.0130
Kiribati	0.0010
Kuwait	0.2730
Kyrgyzstan	0.0020
Lao People's Democratic Republic	0.0020
Latvia	0.0470
Lebanon	0.0420
Lesotho	0.0010
Liberia	0.0010
Libya	0.1420
Lithuania	0.0730
Luxembourg	0.0810
Madagascar	0.0030
Malawi	0.0020
Malaysia	0.2810
Maldives	0.0010
Mali	0.0040
Malta	0.0160
Marshall Islands	0.0010
Mauritania	0.0020
Mauritius	0.0130
Mexico	1.8421
Micronesia (Federated States of)	0.0010
Monaco	0.0120
Mongolia	0.0030
Montenegro	0.0050
Morocco	0.0620
Mozambique	0.0030
Myanmar	0.0100
Namibia	0.0100
Nauru	0.0010
Nepal	0.0060
Netherlands	1.6541
New Zealand	0.2530
Nicaragua	0.0030
Niger	0.0020

Members and Associate Members	WHO scale for 2016–2017 %
Nigeria	0.0900
Niue	0.0010
Norway	0.8511
Oman	0.1020
Pakistan	0.0850
Palau	0.0010
Panama	0.0260
Papua New Guinea	0.0040
Paraguay	0.0100
Peru	0.1170
Philippines	0.1540
Poland	0.9211
Portugal	0.4740
Puerto Rico	0.0010
Qatar	0.2090
Republic of Korea	1.9941
Republic of Moldova	0.0030
Romania	0.2260
Russian Federation	2.4382
Rwanda	0.0020
Saint Kitts and Nevis	0.0010
Saint Lucia	0.0010
Saint Vincent and the Grenadines	0.0010
Samoa	0.0010
San Marino	0.0030
Sao Tome and Principe	0.0010
Saudi Arabia	0.8641
Senegal	0.0060
Serbia	0.0400
Seychelles	0.0010
Sierra Leone	0.0010
Singapore	0.3840
Slovakia	0.1710
Slovenia	0.1000
Solomon Islands	0.0010
Somalia	0.0010
South Africa	0.3720
South Sudan	0.0040
Spain	2.9732
Sri Lanka	0.0250

Members and Associate Members	WHO scale for 2016–2017 %
Sudan	0.0100
Suriname	0.0040
Swaziland	0.0030
Sweden	0.9601
Switzerland	1.0471
Syrian Arab Republic	0.0360
Tajikistan	0.0030
Thailand	0.2390
The former Yugoslav Republic of Macedonia	0.0080
Timor-Leste	0.0020
Togo	0.0010
Tokelau	0.0010
Tonga	0.0010
Trinidad and Tobago	0.0440
Tunisia	0.0360
Turkey	1.3281
Turkmenistan	0.0190
Tuvalu	0.0010
Uganda	0.0060
Ukraine	0.0990
United Arab Emirates	0.5950
United Kingdom of Great Britain and Northern Ireland	5.1794
United Republic of Tanzania	0.0090
United States of America	22.0000
Uruguay	0.0520
Uzbekistan	0.0150
Vanuatu	0.0010
Venezuela (Bolivarian Republic of)	0.6270
Viet Nam	0.0420
Yemen	0.0100
Zambia	0.0060
Zimbabwe	0.0020
Total	100.0000

(Ninth plenary meeting, 26 May 2015 –
Committee B. second report)

WHA68.13 Report of the External Auditor

The Sixty-eighth World Health Assembly,

Having considered the report of the External Auditor to the Sixty-eighth World Health Assembly;¹

Having noted the report of the Programme, Budget and Administration Committee of the Executive Board to the Sixty-eighth World Health Assembly,²

ACCEPTS the report of the External Auditor to the Sixty-eighth World Health Assembly.

(Ninth plenary meeting, 26 May 2015 –
Committee B, second report)

WHA68.14 Appointment of the External Auditor

The Sixty-eighth World Health Assembly,

Having considered the report on the appointment of the External Auditor,³

RESOLVES that the Chairman of the Commission on Audit of the Republic of the Philippines be appointed External Auditor of the accounts of the World Health Organization for a four-year period from 2016 to 2019 and that he audits in accordance with the principles incorporated in Regulation XIV of the Financial Regulations and the Appendix to the Financial Regulations, provided that, should the necessity arise, he may designate a representative to act in his absence.

(Ninth plenary meeting, 26 May 2015 –
Committee B, second report)

WHA68.15 Strengthening emergency and essential surgical care and anaesthesia as a component of universal health coverage⁴

The Sixty-eighth World Health Assembly,

Having considered the report on strengthening emergency and essential surgical care and anaesthesia as a component of universal health coverage;⁵

Recognizing that each year more than 234 million surgical procedures are performed globally for a wide range of common conditions requiring surgical care, affecting all age groups – including obstructed labour, birth defects, cataracts, cancer, diabetes, acute abdominal conditions, and burns and

¹ Document A68/41.

² Document A68/59.

³ Document A68/43.

⁴ See Annex 8 for the financial and administrative implications for the Secretariat of this resolution.

⁵ Document A68/31.

injuries from domestic, industrial and road accidents – and that conditions for which surgery is one of the primary clinical solutions are expected to become increasingly common in the coming years;

Noting that many surgically treatable diseases are among the top 15 causes of physical disability worldwide and that 11% of the world's burden of disease stems from conditions that could be treated successfully through surgery, with low- and middle-income countries being the most affected;

Recognizing that each year more than 100 million people sustain injuries globally, more than five million people die from violence and injury, and that 90% of the global burden of violence and injury mortality occurs in low- and middle-income countries;

Noting that more than 289 000 women die every year in childbirth and that about one quarter of maternal deaths, as well as infant deaths and disabilities that result from obstructed labour, haemorrhage and infection, could be avoided if safe surgery and anaesthesia were universally available;

Noting also that the sustainable provision of emergency and essential surgical care and anaesthesia is a critical part of integrated primary health care, lowers mortality and disability, reduces deaths resulting from birth defects, and prevents other adverse health outcomes arising from the burden of injuries and noncommunicable diseases;

Noting further the relevance of emergency and essential surgical care and anaesthesia in achieving the health-related Millennium Development Goals and for attending to the unfinished business post-2015, including universal health coverage;

Recognizing the importance of timely referral and the existence of standards and protocols, such as those defined in the WHO Integrated Management for Emergency and Essential Surgical Care toolkit, in the continuum of care, and recalling that resolution WHA55.18 on quality of care: patient safety urges Member States to establish and strengthen science-based systems, necessary for improving patients' safety and the quality of health care, including the monitoring of medicines, medical equipment and technology;

Recognizing also that emergency and essential surgical care and anaesthesia are neglected but efficacious and cost-effective additions to the basic package of health services, and that strengthening emergency and essential surgical capacity together with anaesthesia, particularly at the first-level referral hospitals, is a highly cost-efficient solution to the global burden of disease;

Noting the importance of analgesia in surgery and anaesthesia, and that a large proportion of the global population has limited access to opioid analgesics for pain relief; that patients with moderate and severe pain often do not receive the treatment they need; that 5500 million people (83% of the world's population) live in countries with low to non-existent access to analgesics; that 250 million (4%) have moderate access; that 460 million (7%) have adequate access; and that insufficient data on access to analgesics are available for 430 million people (7%);

Recognizing that balanced policies and regulations for improving access to controlled medicines, while preventing their misuse, have been successfully implemented in a number of countries;

Emphasizing the need for Member States,¹ with the support of the Secretariat, the United Nations Office on Drugs and Crime and the International Narcotics Control Board, to ensure that efforts to prevent diversion and abuse of narcotic drugs and psychotropic substances under international control, pursuant to the United Nations international drug control conventions, do not result in inappropriate regulatory barriers to medical access to such medicines;²

Recalling that resolution WHA56.24 on implementing the recommendations of the *World report on violence and health* requested the Director-General to provide technical support for strengthening trauma and care services to survivors or victims of violence, and that resolution WHA57.10 on road safety and health recommended Member States to strengthen emergency and rehabilitation services for victims of road traffic injuries;

Recognizing that 15% of the world's population lives with a disability, and recalling that resolution WHA58.23 on disability, including prevention, management and rehabilitation urged Member States to promote early intervention and take necessary steps for the reduction of risk factors contributing to disabilities, especially for women during pregnancy and for children, and to put into practice the most effective actions to prevent disabilities, which include timely and effective surgery where required;

Aware of the critical importance of health system strengthening for providing access to quality, safe, effective and affordable emergency and essential surgical care and anaesthesia, and recalling resolution WHA60.22 on health systems: emergency-care systems, which recognized that improved organization and planning for the provision of trauma and emergency care, including surgery, is an essential part of integrated health care delivery;

Recalling also resolution WHA64.6 on health workforce strengthening, which urges Member States¹ to prioritize, in the context of global economic conditions, public sector spending on health, as appropriate, to ensure that sufficient financial resources are available for the implementation of policies and strategies to scale up and retain the health workforce, particularly in developing countries, and to recognize it as an investment in the health of the population that contributes to social and economic development, including access to emergency and essential surgical and anaesthesia services;

Recalling further resolution WHA66.10 on the follow-up to the Political Declaration of the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases, which calls for action to prevent and control cardiovascular diseases, cancer, diabetes and chronic respiratory diseases, and noting the important role of surgical care for diagnosis, treatment and cure of a significant portion of these diseases;

Aware of the critical importance of access to and responsible use of effective antimicrobial agents for safe surgery, and recalling resolution WHA67.25 on antimicrobial resistance, which urges Member States¹ to take urgent action to combat antimicrobial resistance;

Recalling resolution WHA67.19 on strengthening of palliative care as a component of comprehensive care throughout the life course, which urges Member States¹ to promote collaborative action to ensure adequate supply of essential medicines in palliative care, and requests the Director-General to explore ways to increase the availability and accessibility of medicines used in palliative care through consultation with Member States, relevant networks and civil society, as well as other international stakeholders, as appropriate;

¹ And, where applicable, regional economic integration organizations.

² See resolution WHA67.19.

Acknowledging the work already done by the WHO Global Initiative for Emergency and Essential Surgical Care in the WHO programme for emergency and essential surgical care, the World Alliance for Patient Safety and the Alliance's second global patient safety challenge: safe surgery saves lives;

Concerned that inadequate investment in the infrastructure of health systems, inadequate training of the surgical care health workforce, and the absence of a stable supply of surgical equipment and necessities in many countries impede progress in improving delivery of emergency and essential surgical care and anaesthesia;

Recognizing that relevant, meaningful and reliable measures of safe emergency and essential surgery and anaesthesia are needed for assessment and monitoring, and to foster political and public support;

Acknowledging that many countries are unable to meet the threshold of 2.28 skilled health professionals per 1000 population, and many surgical procedures, including basic suturing, episiotomies and draining of abscesses, can be successfully completed by other trained health care workers through task-sharing at the district and subdistrict levels;¹

Considering that additional efforts are required globally to strengthen the provision of emergency and essential surgical care and anaesthesia so as to ensure timely and effective delivery to those who need such care in the overall context of the health system, and related health and health-promotion initiatives,

1. URGES Member States:²

- (1) to identify and prioritize a core set of emergency and essential surgery and anaesthesia services at the primary health care and first-referral hospital level, and to develop methods and financing systems for making quality, safe, effective and affordable emergency and essential surgical care and anaesthesia services accessible to all who need them, including promoting timely referral and more effective use of the health care workforce through task-sharing, as appropriate, as part of an integrated surgical care network in order to achieve universal health coverage;
- (2) to integrate emergency and essential surgical care and anaesthesia in primary health care facilities and first-referral hospitals, and to promote emergency and essential surgery and anaesthesia capacity as components integral to achieving universal health coverage;
- (3) to promote the provision of emergency and essential surgical care and anaesthesia and ensure that health ministries take a leading role in, and that intersectoral coordination mechanisms, including among all health care providers, are in place for, reviewing and strengthening the provision of such care;
- (4) to promote access to essential medicines, including controlled medicines, antibiotics, medical devices and diagnostics used in anaesthesiology and surgery that are of quality, safe, efficacious and affordable, and that are used responsibly and appropriately and that are in line with WHO's guidelines;

¹ The world health report 2006. Working together for health. Geneva: World Health Organization; 2006.

² And, where applicable, regional economic integration organizations.

- (5) to carry out regular monitoring and evaluation of the emergency and essential surgical care and anaesthesia capacity of health care facilities in order to identify unmet infrastructural needs, human resource needs, and training and supply needs;
- (6) to collect and compile data on number, type and indications of surgical procedures performed, referrals and perioperative mortality rates in their respective countries, and to share such data as appropriate;
- (7) to strengthen infection prevention and control as a critical element of ensuring quality and safety of emergency and essential surgical care and anaesthesia;
- (8) to develop and implement surgical care and anaesthesia policies to assure minimum standards for a skilled workforce, adequate equipment, infrastructure and supplies, and documentation, monitoring and evaluation of access to and quality of services, to be embedded in programmes and legislation based on current knowledge and considerations promoting the right to the enjoyment of the highest attainable standard of health;
- (9) to ensure that appropriate core competencies are part of relevant health curricula, training and education of students from various relevant disciplines such as medicine, nursing, midwifery and other surgical care providers, as well as part of continuing education for professionals involved in provision of surgical care and anaesthesia;

2. REQUESTS the Director-General:

- (1) to foster multisectoral networks and partnerships, multidisciplinary policies and action plans, and to support national, regional and global efforts to develop science-based approaches to prevention, screening, and implementation of emergency and essential surgical care and anaesthesia and to enhance teaching and training programmes;
- (2) to facilitate collaboration among Member States¹ to share and exchange information, skills and technology essential to strengthening surgery and anaesthesia services;
- (3) to raise awareness of cost-effective options to reduce morbidity and mortality and prevent or treat disability and deformity through improved organization and planning of provision of anaesthesia and surgical care that is appropriate for resource-constrained settings, and continue to organize regular expert meetings in order to further technical exchange and build capacity in this area;
- (4) to establish mechanisms to collect emergency and essential surgical and anaesthesia case log data in order to increase understanding of unmet needs and improve the global capacity for surgery and anaesthesia in the context of universal health coverage;
- (5) to devise relevant, meaningful and reliable measures of access to and safety of emergency and essential surgery and anaesthesia, to make available a means of performing risk adjustment of indicators such as the perioperative mortality rate, and to ensure the reporting and benchmarking of these measures;
- (6) to collect, assess and report related cost data on the delivery of emergency and essential surgical care and anaesthesia, as well as the economic impact of their availability;

¹ And, where applicable, regional economic integration organizations.

(7) to support Member States¹ in the development and implementation of policies and regulations for ensuring access to quality, safe, efficacious and affordable essential medicines, including controlled medicines for pain management, medical devices and diagnostics that are used in emergency and essential surgical care and anaesthesia;

(8) to continue, through WHO's access to controlled medicines programme, to support Member States in reviewing and improving national legislation and policies with the objective of ensuring a balance between the prevention of misuse, diversion and trafficking of controlled substances and appropriate access to controlled medicines, in line with United Nations international drug control conventions;

(9) to work with the International Narcotics Control Board, the United Nations Office on Drugs and Crime, health ministries and other relevant authorities at global, regional and national levels in order to promote the availability and balanced control of controlled medicines for essential and emergency surgical care and anaesthesia;

(10) to further cooperate with the International Narcotics Control Board to support Member States¹ in establishing accurate estimates in order to enable the availability of medicines for emergency and essential and surgical care and anaesthesia, including through better implementation of the guidance on estimating requirements for substances under international control;

(11) to support Member States¹ to devise policies and strategies that enhance the skills of the appropriate health workforce for emergency and essential surgical care and anaesthesia, especially at primary health care and first-referral hospital levels;

(12) to set aside adequate resources for the Secretariat, in line with the approved Programme budget 2016–2017 and the Twelfth General Programme of Work, 2014–2019 for strengthening emergency and essential surgical care and anaesthesia as a component of universal health coverage;

(13) to work with Member States and other relevant partners to design strategies that provide support to Member States for mobilizing adequate resources to achieve the objectives of strengthening emergency and essential surgical care and anaesthesia as a component of universal health coverage;

(14) to report to the Seventieth World Health Assembly in 2017 on progress in the implementation of this resolution.

(Ninth plenary meeting, 26 May 2015 –
Committee B, third report)

¹ And, where applicable, regional economic integration organizations.

WHA68.16 Salaries of staff in ungraded posts and of the Director-General

The Sixty-eighth World Health Assembly,

Noting the recommendations of the Executive Board with regard to remuneration of staff in ungraded posts and of the Director-General,¹

1. ESTABLISHES the salaries of Assistant Directors-General and Regional Directors at US\$ 174 371 gross per annum with a corresponding net salary of US\$ 135 560 (dependency rate) or US\$ 122 754 (single rate);
2. ESTABLISHES the salary of the Deputy Director-General at US\$ 191 856 gross per annum with a corresponding net salary of US\$ 147 799 (dependency rate) or US\$ 133 012 (single rate);
3. ESTABLISHES the salary of the Director-General at US\$ 235 889 gross per annum with a corresponding net salary of US\$ 178 622 (dependency rate) or US\$ 158 850 (single rate);
4. DECIDES that those adjustments in remuneration shall take effect on 1 January 2015.

(Ninth plenary meeting, 26 May 2015 –
Committee B, fourth report)

WHA68.17 Amendments to the Staff Regulations²

The Sixty-eighth World Health Assembly,

Noting the recommendations of the Executive Board with regard to the appointment, transfer, reassignment and promotion of staff members, and separation from service,³

1. ADOPTS the amendments to Staff Regulations 4.1, 4.2, 4.3, 4.4 and 9.2;⁴
2. DECIDES that these amendments shall take effect upon the entry into force of the Organization's mobility policy.

(Ninth plenary meeting, 26 May 2015 –
Committee B, fourth report)

¹ See document EB136/2015/REC/1, resolution EB136.R12.

² See Annex 8 for the financial and administrative implications for the Secretariat of this resolution.

³ See document EB136/2015/REC/1, resolution EB136.R15.

⁴ See Annex 4.

WHA68.18 Global strategy and plan of action on public health, innovation and intellectual property¹

The Sixty-eighth World Health Assembly,

Having considered the report by the Secretariat on the global strategy and plan of action on public health, innovation and intellectual property;²

Having also considered the recommendations of the Executive Board to the Sixty-eighth World Health Assembly contained in decision EB136(17);

Recalling resolutions WHA61.21 and WHA62.16 on the global strategy and plan of action on public health, innovation and intellectual property that aims to promote new thinking on innovation and access to medicines, as well as, based on the recommendation of the report of the Commission on Intellectual Property Rights, Innovation and Public Health, provide a medium-term framework to secure an enhanced and sustainable basis for needs-driven, essential health research and development relevant to diseases that disproportionately affect developing countries, proposing clear objectives and priorities for research and development, and estimating funding needs in this area;

Recognizing the central role that the global strategy and plan of action on public health, innovation and intellectual property plays in directing and coordinating WHO's policies and programme of work on public health, innovation and intellectual property;

Welcoming resolution EBSS3.R1, on Ebola: ending the current outbreak, strengthening global preparedness and ensuring WHO's capacity to prepare for and respond to future large-scale outbreaks and emergencies with health consequences, which reaffirms the global strategy and plan of action on public health, innovation and intellectual property;

Concerned about the pace of implementation of the global strategy and plan of action on public health, innovation and intellectual property by stakeholders as defined in the Appendix of the global strategy,

1. DECIDES:

(1) to extend the time frame of the plan of action on public health, innovation and intellectual property from 2015 until 2022;

(2) to extend the deadline of the overall programme review of the global strategy and plan of action on public health, innovation and intellectual property, focusing on its achievements, remaining challenges and recommendations on the way forward to 2018, recognizing that it was not presented to the Health Assembly in 2015 as requested by resolution WHA62.16;

¹ See Annex 8 for the financial and administrative implications for the Secretariat of this resolution.

² Document A68/35.

(3) to undertake the comprehensive evaluation and overall programme review of the global strategy and plan of action on public health, innovation and intellectual property separately in a staggered manner as set out in document A68/35¹ and its Annex, in consultation with Member States,² subject to the process and provisions set out below;

2. REQUESTS the Director-General:

(1) to initiate, in line with the WHO evaluation policy and guided by the *WHO evaluation practice handbook*,³ the comprehensive evaluation of the implementation of the global strategy and plan of action on public health, innovation and intellectual property in June 2015, pursuant to the terms of reference specified in document A68/35; to present the inception report and comments of the evaluation management group to the Executive Board for consideration at its 138th session in January 2016; and to submit the final comprehensive evaluation report to the Seventieth World Health Assembly for consideration in 2017, through the Executive Board;

(2) to convene an ad hoc evaluation management group to assist the comprehensive evaluation composed of six independent external subject matter experts, and two evaluation experts from the United Nations Evaluation Group;

(3) to select the six independent external subject matter experts in line with guidelines for selection of members for ad hoc evaluation management groups included in the *WHO evaluation practice handbook*, including through consultation with the regional directors;

(4) to establish a panel of 18 experts respecting gender balance, equal regional representation, and diversity of technical competence and expertise to conduct the overall programme review, with a broad and balanced mix of expertise, practical experience and backgrounds covering the eight elements of the global strategy and plan of action on public health, innovation and intellectual property, and including experts from developed and developing countries;

(5) to invite Member States to nominate experts, including through the regional directors, for the roster beginning immediately following the 139th session of the Executive Board from which the Director-General will select the panel of 18 members for the overall programme review;

(6) to present the terms of reference of the overall programme review for approval by the Executive Board at its 140th session in January 2017, and to present the composition of the overall programme review panel for consideration by the officers of the Executive Board in February 2017;

¹ See Annex 5.

² And, where applicable, regional economic integration organizations.

³ WHO evaluation practice handbook. Geneva: World Health Organization; 2013.

(7) to present the final report of the overall programme review of the global strategy and plan of action on public health, innovation and intellectual property, focusing on its achievements, remaining challenges and recommendations on the way forward to the Seventy-first World Health Assembly in 2018 through the Executive Board at its 142nd session.

(Ninth plenary meeting, 26 May 2015 –
Committee B, fourth report)

WHA68.19 Outcome of the Second International Conference on Nutrition¹

The Sixty-eighth World Health Assembly,

Having considered the report on the outcome of the Second International Conference on Nutrition,²

1. ENDORSES the Rome Declaration on Nutrition, as well as the Framework for Action,³ which provides a set of voluntary policy options and strategies for use by governments;
2. CALLS on Member States⁴ to implement the commitments of the Rome Declaration on Nutrition through a set of voluntary policy options within the Framework for Action;
3. REQUESTS the Director-General, in collaboration with the Director-General of the Food and Agriculture Organization and other United Nations agencies, funds and programmes and other relevant regional and international organizations, to prepare a biennial report to the Health Assembly on the status of implementation of commitments of the Rome Declaration on Nutrition.

(Ninth plenary meeting, 26 May 2015 -
Committee B, fourth report)

WHA68.20 Global burden of epilepsy and the need for coordinated action at the country level to address its health, social and public knowledge implications¹

The Sixty-eighth World Health Assembly,

Having considered the report on the global burden of epilepsy and the need for coordinated action at the country level to address its health, social and public knowledge implications;⁵

Considering resolution WHA66.8, in which the Health Assembly adopted the comprehensive mental health action plan 2013–2020, and resolution WHA67.22 on access to essential medicines;

¹ See Annex 8 for the financial and administrative implications for the Secretariat of this resolution.

² Document A68/8.

³ See Annex 6.

⁴ And, where applicable, regional economic integration organizations.

⁵ Document A68/12.

Acknowledging United Nations General Assembly resolution 68/269 and resolution WHA57.10 on road safety and health, resolution WHA66.12 on neglected tropical diseases, resolution WHA67.10 on the newborn health action plan, resolution WHA67.15 on strengthening the role of the health system in addressing violence, in particular against women and girls, and against children, and the discussions on the control of neurocysticercosis and its association with epilepsy at the Fifty-sixth World Health Assembly;¹

Noting the Political Declaration of the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases,² in which Heads of State and Government recognized that mental and neurological disorders are an important cause of morbidity and contribute to the global noncommunicable disease burden, necessitating provision of equitable access to effective programmes and health care interventions;

Considering the health-related Millennium Development Goals, the outcome document of the United Nations Conference on Sustainable Development entitled “The future we want”,³ and the report of the Open Working Group on Sustainable Development Goals, established pursuant to United Nations General Assembly resolution 66/288, which proposes Goal 3 (Ensure healthy lives and promote well-being for all at all ages) and target 3.4 (by 2030 reduce by one-third premature mortality from noncommunicable diseases through prevention and treatment, and promote mental health and well-being);⁴

Recognizing that epilepsy is one of the most common serious chronic neurological diseases, affecting 50 million people of all ages globally, and that people with epilepsy are often subjected to stigmatization and discrimination because of ignorance, misconceptions and negative attitudes surrounding the disease, and that they face serious difficulties in, for example, education, employment, marriage and reproduction;

Noting with concern that the magnitude of epilepsy affects people of all ages, gender, race and income levels, and, further, that poor populations and those living in vulnerable situations, in particular in low- and middle-income countries, bear a disproportionate burden, posing a threat to public health and economic and social development;

Cognizant that large differences exist in the level of epilepsy management in different countries, with, for example, the median number of neurologists in low-income countries standing at only 3 per 10 million population, that the essential antiepileptic medicines are often unavailable, that the treatment gap is estimated to be more than 75% in low-income countries and to be substantially wider in rural areas than in urban areas;

Noting that most people with epilepsy can be kept free from seizures when appropriately treated with cost-effective, affordable antiepileptic medicines;

Recognizing in addition that certain causes of epilepsy can be prevented and that such preventive action can be promoted in the health sector and in sectors outside health;

¹ See document WHA56/2003/REC/3, summary record of the fourth meeting of Committee A.

² United Nations General Assembly resolution 66/2.

³ United Nations General Assembly resolution 66/288.

⁴ Document A/68/970.

Aware that in 1997, WHO and two international nongovernmental organizations, the International League Against Epilepsy and the International Bureau for Epilepsy, launched the Global Campaign against Epilepsy – “Out of the Shadows”, and that in 2008 WHO launched its mental health gap action programme mhGAP, which provided a sound basis for WHO to further lead and coordinate global development work on epilepsy;

Aware also that practice in China and some other low-income countries has proved that country-level coordinated action may be very effective in controlling the disease and improving the quality of life of millions of people with epilepsy at little cost;

Recognizing the remarkable progress made recently in the technology of epilepsy management, from basic research to diagnosis and treatment;

Considering that international governmental organizations, nongovernmental organizations, academic societies and other bodies have recently enhanced their investment in epilepsy management and have undertaken a significant amount of work in collaboration with national governments, such as the International League Against Epilepsy and the International Bureau for Epilepsy, which are in official relations with WHO and have been collaborating with WHO in epilepsy management for several decades;

Recognizing the role of WHO to demonstrate further leadership and coordination and take effective action for epilepsy management, in view of the large public health impact,

1. URGES Member States:¹

(1) to strengthen effective leadership and governance, for policies on general health, mental health and noncommunicable diseases that include consideration of the specific needs of people with epilepsy, and to make the financial, human and other resources available that have been identified, as necessary, to implement evidence-based plans and actions;

(2) to introduce and implement, where necessary and in accordance with international human rights norms and standards, national health care plans of action for epilepsy management, aiming to overcome inequalities and inequities in health, social and other related services, paying special attention to people with epilepsy living in conditions of vulnerability, such as those living in poor and remote areas, including by strengthening public health care services, and by training local human resources in proper techniques;

(3) to integrate epilepsy management, including health and social care, particularly community-based services, within the context of universal health coverage, including community-based rehabilitation, into primary health care, where appropriate, in order to help to reduce the epilepsy treatment gap, by ensuring that non-specialist health care providers have the basic knowledge for the management of epilepsy so that epilepsy can be diagnosed, treated and followed up as much as possible in primary health care settings, as well as by empowering people with epilepsy and their carers to make greater use of specified self- and home-care programmes, by ensuring a strong and functional referral system and by strengthening health information and surveillance systems to routinely collect, report, analyse and evaluate trends on epilepsy management;

¹ And, where applicable, regional economic integration organizations.

-
- (4) to support the establishment and implementation of strategies for the management of epilepsy, particularly to improve accessibility to and promote affordability of safe, effective and quality-assured antiepileptic medicines and include essential antiepileptic medicines into national lists of essential medicines;
- (5) to ensure public awareness of and education about epilepsy, in particular in primary and secondary schools, in order to help to reduce the misconceptions, stigmatization and discrimination regarding people with epilepsy and their families that are widespread in many countries and regions;
- (6) to promote actions to prevent the causes of epilepsy, using evidence-based interventions, within the health sector and in other sectors outside health;
- (7) to improve investment in epilepsy research and increase research capacity;
- (8) to engage with civil society and other partners in the actions referred to in subparagraphs 1(1) to 1(7) above;
2. INVITES international, regional, national and local partners from within the health sector and beyond to engage in, and support, the implementation of the actions set out in subparagraphs 1(1) to 1(8) above;
3. REQUESTS the Director-General:
- (1) to review and evaluate the actions relevant to epilepsy that WHO has been leading, coordinating and supporting in order to identify, summarize and integrate the relevant best practices with a view to making this information widely available, especially in low- and middle-income countries;
- (2) to develop, in consultation with relevant stakeholders, on the basis of work requested in operative paragraph 1, a set of technical recommendations guiding Member States in the development and implementation of epilepsy programmes and services, and to provide technical support to Member States in actions for epilepsy management, especially low- and middle-income countries;
- (3) to report to the Seventy-first World Health Assembly on progress in the implementation of this resolution.

(Ninth plenary meeting, 26 May 2015 –
Committee B, fifth report)

WHA68(4) Establishment of the General Committee

The Sixty-eighth World Health Assembly elected the delegates of the following 17 countries as members of the General Committee: Burkina Faso, Burundi, Comoros, Cuba, France, Ghana, Indonesia, Latvia, Montenegro, Oman, Peru, Russian Federation, South Sudan, Syrian Arab Republic, United Kingdom of Great Britain and Northern Ireland, United States of America and Viet Nam.

(First plenary meeting, 18 May 2015)

WHA68(5) Adoption of the agenda

The Sixty-eighth World Health Assembly adopted the provisional agenda prepared by the Executive Board at its 136th session, with the deletion of three items and the transfer of one item from Committee A to Committee B. One further item was deferred for consideration by the Executive Board at its 137th session.

(Second plenary meeting, 18 May 2015)

WHA68(6) Verification of credentials

The Sixty-eighth World Health Assembly recognized the validity of the credentials of the following delegations: Afghanistan; Albania; Algeria; Andorra; Angola; Antigua and Barbuda; Argentina; Armenia; Australia; Austria; Azerbaijan; Bahamas; Bahrain; Bangladesh; Barbados; Belarus; Belgium; Benin; Bhutan; Bolivia (Plurinational State of); Bosnia and Herzegovina; Botswana; Brazil; Brunei Darussalam; Bulgaria; Burkina Faso; Burundi; Cabo Verde; Cambodia; Cameroon; Canada; Central African Republic; Chad; Chile; China; Colombia; Comoros; Congo; Cook Islands; Costa Rica; Côte d'Ivoire; Croatia; Cuba; Cyprus; Czech Republic; Democratic People's Republic of Korea; Democratic Republic of the Congo; Denmark; Djibouti; Dominican Republic; Ecuador; Egypt; El Salvador; Equatorial Guinea; Eritrea; Estonia; Ethiopia; Fiji; Finland; France; Gabon; Gambia; Georgia; Germany; Ghana; Greece; Grenada; Guatemala; Guinea; Guinea-Bissau; Haiti; Honduras; Hungary; Iceland; India; Indonesia; Iran (Islamic Republic of); Iraq; Ireland; Israel; Italy; Jamaica; Japan; Jordan; Kazakhstan; Kenya; Kiribati; Kuwait; Kyrgyzstan; Lao People's Democratic Republic; Latvia; Lebanon; Lesotho; Liberia; Libya; Lithuania; Luxembourg; Madagascar; Malawi; Malaysia; Maldives; Mali; Malta; Mauritania; Mauritius; Mexico; Monaco; Mongolia; Montenegro; Morocco; Mozambique; Myanmar; Namibia; Nauru; Nepal; Netherlands; New Zealand; Nicaragua; Niger; Nigeria; Norway; Oman; Pakistan; Panama; Papua New Guinea; Paraguay; Peru; Philippines; Poland; Portugal; Qatar; Republic of Korea; Republic of Moldova; Romania; Russian Federation; Rwanda; Saint Kitts and Nevis; Samoa; San Marino; Sao Tome and Principe; Saudi Arabia; Senegal; Serbia; Seychelles; Sierra Leone; Singapore; Slovakia; Slovenia; Solomon Islands; Somalia; South Africa; South Sudan; Spain; Sri Lanka; Sudan; Suriname; Swaziland; Sweden; Switzerland; Syrian Arab Republic; Tajikistan; Thailand; The former Yugoslav Republic of Macedonia; Timor-Leste; Togo; Tonga; Trinidad and Tobago; Tunisia; Turkey; Turkmenistan; Tuvalu; Uganda; Ukraine; United Arab Emirates; United Kingdom of Great Britain and Northern Ireland; United Republic of Tanzania; United States of America; Uruguay; Uzbekistan; Vanuatu; Venezuela (Bolivarian Republic of); Viet Nam; Yemen; Zambia; Zimbabwe.

(Sixth plenary meeting, 20 May 2015)

WHA68(7) Election of Members entitled to designate a person to serve on the Executive Board

The Sixty-eighth World Health Assembly, after considering the recommendations of the General Committee, elected the following as Members entitled to designate a person to serve on the Executive Board: Canada, Congo, Dominican Republic, France, Jordan, Kazakhstan, Malta, New Zealand, Pakistan, Philippines, Sweden and Thailand.

(Eighth plenary meeting, 22 May 2015)

WHA68(8) Health conditions in the occupied Palestinian territory, including east Jerusalem, and in the occupied Syrian Golan

The Sixty-eighth World Health Assembly, mindful of the basic principle established in the Constitution of the World Health Organization, which affirms that the health of all peoples is fundamental to the attainment of peace and security, and stressing that unimpeded access to health care is a crucial component of the right to health; also taking note of the report of the Secretariat on health conditions in the occupied Palestinian territory, including east Jerusalem, and in the occupied Syrian Golan,¹ and noting also the report of a field assessment of health conditions in the occupied Palestinian territory,² requested the Director-General,

(1) to report on the health conditions in the occupied Palestinian territory, including east Jerusalem, and in the occupied Syrian Golan, to the Sixty-ninth World Health Assembly, through a field assessment conducted by the World Health Organization, with special focus on:

- (a) barriers to health access in the occupied Palestinian territory, including as a result of movement restrictions and territorial fragmentation, as well as progress made in the implementation of the recommendations contained in WHO's 2014 report, *Right to health: crossing barriers to access health in the occupied Palestinian territory, 2013*;³
- (b) physical injuries and disabilities, and damage to and destruction of medical infrastructure and facilities as well as impediments to the safety of health care workers;
- (c) access to adequate health services on the part of Palestinian prisoners;
- (d) the effect of prolonged occupation and human rights violations on mental and physical health, particularly the health consequences of the Israeli military detention system on Palestinian prisoners and detainees, especially child detainees, and of insecure living conditions in the occupied Palestinian territory, including east Jerusalem;

¹ Document A68/37.

² See document WHO-EM/OPT/006/E, available at http://applications.emro.who.int/docs/Cons_Rep_2015_EN_16311.pdf (accessed 1 June 2015).

³ Right to health: crossing barriers to access health in the occupied Palestinian territory, 2013, available at http://www.emro.who.int/images/stories/palestine/documents/WHO_-_RTH_crossing_barriers_to_access_health.pdf?ua=1 (accessed 20 May 2015).

- (e) the effect of impeded access to water and sanitation, as well as food insecurity, on health conditions in the occupied Palestinian territory, particularly in the Gaza Strip;
 - (f) the provision of financial and technical assistance and support by the international donor community, and its contribution to improving health conditions in the occupied Palestinian territory;
- (2) to provide support to the Palestinian health services, including capacity building programmes;
 - (3) to provide health-related technical assistance to the Syrian population in the occupied Syrian Golan;
 - (4) to continue providing necessary technical assistance in order to meet the health needs of the Palestinian people, including prisoners and detainees, in cooperation with the efforts of the International Committee of the Red Cross, as well as the health needs of handicapped and injured people;
 - (5) to provide support to the Palestinian health sector in preparing for emergency situations and scaling up emergency preparedness and response capacities and in reducing shortages in life-saving drugs and medical disposables;
 - (6) to support the development of the health system in the occupied Palestinian territory, including development of human resources.

(Eighth plenary meeting, 22 May 2015)

WHA68(9) Poliomylitis

The Sixty-eighth World Health Assembly, having considered the report of the Secretariat on poliomyelitis,¹

- (1) endorsed the continuation of the management of the public health emergency of international concern through temporary recommendations issued by the Director-General under the International Health Regulations (2005) in connection with the public health emergency of international concern arising from the international spread of wild poliovirus; and
- (2) requested the Director-General to report on progress towards reduction in the risk of international spread of wild poliovirus to the Sixty-ninth World Health Assembly.

(Ninth plenary meeting, 26 May 2015)

¹ Document A68/21 Add.3.

WHA68(10) 2014 Ebola virus disease outbreak and follow-up to the Special Session of the Executive Board on the Ebola Emergency

The Sixty-eighth World Health Assembly, having recalled the resolution adopted by the Executive Board at its Special Session on the Ebola Emergency on 25 January 2015,¹

Interim assessment

1. Welcomed the preliminary report of the Ebola Interim Assessment Panel appearing in document A68/25;
2. Thanked the Ebola Interim Assessment Panel for its work to date;
3. Requested the Ebola Interim Assessment Panel to continue its work as mandated by the Executive Board at its Special Session on the Ebola Emergency,¹ and to issue a final report to be made available to the Director-General not later than 31 July 2015;

International Health Regulations (2005)

1. Requested the Director-General to establish a Review Committee under the International Health Regulations (2005) to examine the role of the International Health Regulations (2005) in the Ebola outbreak and response, with the following objectives:
 - (a) to assess the effectiveness of the International Health Regulations (2005) with regard to the prevention, preparedness and response to the Ebola outbreak, with a particular focus on notification and related incentives, temporary recommendations, additional measures, declaration of a public health emergency of international concern, national core capacities, and context and links to the Emergency Response Framework² and other humanitarian responsibilities of the Organization;
 - (b) to assess the status of implementation of recommendations from the previous Review Committee in 2011³ and related impact on the current Ebola outbreak;
 - (c) to recommend steps to improve the functioning, transparency, effectiveness and efficiency of the International Health Regulations (2005), including WHO response, and to strengthen preparedness and response for future emergencies with health consequences, with proposed timelines for any such steps;
2. Requested the Director-General to convene the International Health Regulations (2005) Review Committee as provided by the International Health Regulations (2005) in August 2015, and to report on its progress to the Sixty-ninth World Health Assembly in May 2016;
3. Agreed to support west and central African States and other at-risk States to achieve full implementation of the International Health Regulations (2005), including meeting the requirements of the core capacities, by June 2019;

¹ See resolution EBSS3.R1.

² See resolution WHA65.20.

³ See document A64/10.

4. Noted the recommendation of the Ebola Interim Assessment Panel for WHO to propose a plan with resourcing requirements to be shared with Member States and other relevant stakeholders to develop the core public health capacities for all countries in respect of the International Health Regulations (2005), and, further, to explore mechanisms and options for objective analysis through self-assessment and, on a voluntary basis, peer review and/or external evaluation for the requesting Member States;

Global health emergency workforce

1. Welcomed the Director-General's efforts to provide an initial conceptual plan for a global health emergency workforce to respond to outbreaks and emergencies with health consequences, as part of the dedicated structure and functions of the wider emergency response programme, which would unite and direct all WHO outbreak and emergency response operations within WHO's mandate across the three levels of the Organization, and under the direct supervision of the Director-General, in support of countries' own response;¹

2. Reiterated that WHO's emergency response at all levels shall be exercised according to international law, in particular with Article 2(d) of the Constitution of the World Health Organization and in a manner consistent with the principles and objectives of the Emergency Response Framework, and the International Health Regulations (2005), and shall be guided by an all-hazards health emergency approach, emphasizing adaptability, flexibility and accountability; humanitarian principles of neutrality, humanity, impartiality, and independence; and predictability, timeliness, and country ownership;

3. Emphasized the importance of WHO building capacity in its areas of comparative advantage and drawing extensively on the capacities of other United Nation agencies, funds and programmes, the Global Outbreak Alert and Response Network, foreign medical teams and stand-by partners² and the lead role of WHO in the Global Health Cluster;

4. Requested the Director-General to report on progress on the establishment, coordination and management of the emergency response programme, including the global health emergency workforce, to the Sixty-ninth World Health Assembly through the Executive Board at its 138th session in January 2016;

Contingency fund

1. Welcomed the parameters described in document A68/26, which include the guiding principles that must govern the fund, such as: size, scope, sustainability, operations, voluntary sources of financing and accountability mechanisms;

2. Decided to create a specific, replenishable contingency fund to rapidly scale up WHO's initial response to outbreaks and emergencies with health consequences,³ that merges the existing two WHO funds⁴ with a target capitalization of US\$ 100 million fully funded by voluntary contributions, flexible within the fund's scope;

¹ See document A68/27, paragraph 44.

² See document A68/27, paragraph 15.

³ Using the objective criteria set out in the Emergency Response Framework.

⁴ WHO's Rapid Response Account and WHO-Nuclear Threat Initiative Emergency Outbreak Response Fund.

3. Agreed that the contingency fund will reliably and transparently, including with regard to financial reporting and accountability, provide financing, for a period of up to three months,¹ emphasizing predictability, timeliness, and country ownership; humanitarian principles of neutrality, humanity, impartiality, and independence; and practices of good humanitarian donorship;²
4. Decided that the contingency fund would be under the authority of the Director-General, with disbursement at his or her discretion;
5. Requested the Director-General to review the scope and criteria of the contingency fund after two years of implementation, and include, in a report to be presented at the Seventieth World Health Assembly in May 2017, proposals to improve the fund's performance and sustainability;
6. Thanked Member States for contributions already committed to the contingency fund;
7. Requested the Director-General to approach donors to encourage contribution to the contingency fund, including through the next round of the financing dialogue;
8. Requested the Director-General to report on the performance of the contingency fund, including the amount raised and spent, and the value added and for what purpose, to the Sixty-ninth World Health Assembly in May 2016, through the Executive Board at its 138th session in January 2016;
9. Requested the Director-General to prioritize in-field operations in affected countries when using the contingency fund.

Research and development

1. Appreciated the key coordination role played by WHO for ongoing work in the development of vaccines, diagnostics and medicines for the Ebola virus disease;
2. Welcomed the development of a blueprint, in consultation with Member States and relevant stakeholders, for accelerating research and development in epidemics or health emergency situations where there are no, or insufficient, preventive and curative solutions, taking into account other relevant work streams within WHO;
3. Reaffirmed the global strategy and plan of action on public health, innovation and intellectual property.

¹ This may be extended by the Director-General if needed, for an additional period of up to three months to support continuity, only if other funding cannot be mobilized by that time.

² See United Nations General Assembly and Economic and Social Council: document A/58/99/-E/2003/94, annex II.

Health system strengthening

1. Welcomed the development of the robust, costed national health system recovery plans for Guinea, Liberia and Sierra Leone, which were presented at the World Bank Spring Meetings on 17 April 2015, as the basis for donor coordination and strategic investments;
2. Requested WHO to continue its coordination role in support of national administrations as they prepare for the United Nations Secretary General's high-level pledging conference on Ebola, to be held on 10 July 2015;
3. Acknowledged the leadership shown by the health ministries of the three countries in focusing on, with the support of WHO country offices, early recovery through emphases on infection prevention and control, reactivation of essential services, immediate health workforce priorities and integrated disease surveillance;
4. Requested the Director-General to continue and to enhance the work of the Secretariat in supporting Member States to be better prepared to respond to emergencies with health consequences by strengthening national health systems;

Way forward

1. Welcomed the Director-General's commitment to reform the work and culture of WHO in emergencies with health consequences, and in particular to establish effective and clear command and control across the three levels of the Organization;
2. Welcomed the Director-General's proposal to establish a small, focused expert advisory group to guide and support the further development of reform of WHO's work in emergencies with health consequences;
3. Requested the Director-General to report on progress on these reforms, and on the other decisions taken herein, to the Sixty-ninth World Health Assembly in May 2016, through the Executive Board at its 138th session in January 2016, and reiterated the request to the Director-General to report annually to the Health Assembly on all Grade 3 and United Nations Inter-Agency Standing Committee Level 3 emergencies where WHO has taken action.

(Ninth plenary meeting, 26 May 2015)

WHA68(11) WHO Global Code of Practice on the International Recruitment of Health Personnel¹

The Sixty-eighth World Health Assembly, having reviewed the report of the Expert Advisory Group on the Relevance and Effectiveness of the WHO Global Code of Practice on the International Recruitment of Health Personnel (2010),²

- (1) recognized the relevance of the WHO Global Code of Practice on the International Recruitment of Health Personnel (2010) in the context of growing regional and interregional

¹ See Annex 8 for the financial and administrative implications for the Secretariat of this decision.

² Document A68/32 Add.1.

labour mobility, and of demographic and epidemiological transition that increases demand for health workforce;

(2) urged Member States and other stakeholders to expand awareness and implementation of the WHO Global Code of Practice on the International Recruitment of Health Personnel (2010), in particular by strengthening of institutional capacity and resources to complete the second round of national reporting by 31 July 2015;

(3) requested the Secretariat at the global, regional and country levels to expand its capacity to raise awareness, provide technical support and promote effective implementation and reporting of the WHO Global Code of Practice on the International Recruitment of Health Personnel (2010) within the approved Programme budget;

(4) decided that the further assessment of the relevance and effectiveness of the WHO Global Code of Practice on the International Recruitment of Health Personnel (2010) should be considered in line with the third round of national reporting in 2018 and the scheduled progress report to the Seventy-second World Health Assembly in 2019.

(Ninth plenary meeting, 26 May 2015)

WHA68(12) Substandard/spurious/falsely-labelled/falsified/counterfeit medical products

The Sixty-eighth World Health Assembly, having considered the report on substandard/spurious/falsely-labelled/falsified/counterfeit medical products¹ and decision EB136(1), decided to postpone the review of the Member State mechanism by one year, to 2017, as proposed by the mechanism in its report.²

(Ninth plenary meeting, 26 May 2015)

WHA68(13) Appointment of representatives to the WHO Staff Pension Committee³

The Sixty-eighth World Health Assembly nominated Dr Michel Tailhades of the delegation of Switzerland as a member for a three-year term until May 2018.

(Ninth plenary meeting, 26 May 2015)

¹ Document A68/33.

² Document A68/33, Annex.

³ Document A68/48.

WHA68(14) Maternal, infant and young child nutrition: development of the core set of indicators

The Sixty-eighth World Health Assembly, having considered the report on maternal, infant and young child nutrition: development of the core set of indicators,¹ decided:

- (1) to approve the additional core indicators for the global monitoring framework on maternal, infant and young child nutrition;²
- (2) to recommend that Member States report on the entire core set of indicators starting in 2016, with the exception of process indicators 1,³ 4⁴ and 6⁵ and policy environment and capacity indicator 1,⁶ which will be reviewed by the Executive Board once available, for approval, and which will be reported on from 2018 onwards;
- (3) to request the Director-General to provide additional operational guidance on how to generate the necessary data for indicators in different country contexts;
- (4) to request the Director-General to review the indicators for the extended set and provide details of the definitions of those indicators, the availability of data and the criteria for their applicability to different country contexts;
- (5) to recommend a review of the global nutrition monitoring framework in 2020.

(Ninth plenary meeting, 26 May 2015)

WHA68(15) Selection of the country in which the Sixty-ninth World Health Assembly would be held

The Sixty-eighth World Health Assembly, in accordance with Article 14 of the Constitution, decided that the Sixty-ninth World Health Assembly would be held in Switzerland.

(Ninth plenary meeting, 26 May 2015)

¹ Document A68/9.

² See Annex 7.

³ Proportion of children aged 6 to 23 months who receive a minimum acceptable diet.

⁴ Proportion of pregnant women receiving iron and folic acid supplements.

⁵ Proportion of mothers of children aged 0–23 months who have received counselling, support or messages on optimal breastfeeding at least once in the last year.

⁶ Number of trained nutrition professionals per 100 000 population.

ANNEXES

ANNEX 1

Global technical strategy for malaria 2016–2030¹

[A68/28 — 20 March 2015]

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¹ See resolution WHA68.2.

GLOBAL TECHNICAL STRATEGY AT A GLANCE

Vision – A world free of malaria			
Goals	Milestones		Targets
	2020	2025	2030
1. Reduce malaria mortality rates globally compared with 2015	≥40%	≥75%	≥90%
2. Reduce malaria case incidence globally compared with 2015	≥40%	≥75%	≥90%
3. Eliminate malaria from countries in which malaria was transmitted in 2015	At least 10 countries	At least 20 countries	At least 35 countries
4. Prevent re-establishment of malaria in all countries that are malaria-free	Re-establishment prevented	Re-establishment prevented	Re-establishment prevented
<p>PRINCIPLES</p> <ul style="list-style-type: none"> • All countries can accelerate efforts towards elimination through combinations of interventions tailored to local contexts. • Country ownership and leadership, with involvement and participation of communities, are essential to accelerating progress through a multisectoral approach. • Improved surveillance, monitoring and evaluation, as well as stratification by malaria disease burden, are required to optimize the implementation of malaria interventions. • Equity in access to health services especially for the most vulnerable and hard-to-reach populations is essential. • Innovation in tools and implementation approaches will enable countries to maximize their progression along the path to elimination. 			
<p>STRATEGIC FRAMEWORK – comprising three major pillars, with two supporting elements: (1) innovation and research and (2) a strong enabling environment</p>			
<p>Maximize impact of today’s life-saving tools</p> <ul style="list-style-type: none"> • Pillar 1. Ensure universal access to malaria prevention, diagnosis and treatment • Pillar 2. Accelerate efforts towards elimination and attainment of malaria-free status • Pillar 3. Transform malaria surveillance into a core intervention 			
<p>Supporting element 1. Harnessing innovation and expanding research</p> <ul style="list-style-type: none"> • Basic research to foster innovation and the development of new and improved tools • Implementation research to optimize impact and cost-effectiveness of existing tools and strategies • Action to facilitate rapid uptake of new tools, interventions and strategies 			

Supporting element 2. Strengthening the enabling environment

- Strong political and financial commitments
- Multisectoral approaches, and cross-border and regional collaborations
- Stewardship of entire health system including the private sector, with strong regulatory support
- Capacity development for both effective programme management and research

BACKGROUND

1. Malaria is caused by parasites of the *Plasmodium* family and transmitted by female *Anopheles* mosquitoes. There are four different human malaria species (*P. falciparum*, *P. vivax*, *P. malariae* and *P. ovale*), of which *P. falciparum* and *P. vivax* are the most prevalent and *P. falciparum* the most dangerous. *P. knowlesi* is a zoonotic plasmodium that is also known to infect humans.

2. Despite being preventable and treatable, malaria continues to have a devastating impact on people's health and livelihoods around the world. According to the latest available data, about 3200 million people were at risk of the disease in 97 countries, territories and areas in 2013, and an estimated 198 million cases occurred (range: 124 million–283 million). In the same year, the disease killed about 584 000 people (range: 367 000–755 000), mostly children aged under 5 years in sub-Saharan Africa.¹ In most countries where malaria is endemic, the disease disproportionately affects poor and disadvantaged people, who have limited access to health facilities and can barely afford the recommended treatment.

3. Between 2001 and 2013, a substantial expansion of malaria interventions contributed to a 47% decline in malaria mortality rates globally, averting an estimated 4.3 million deaths. In the WHO African Region, the malaria mortality rate in children under 5 years of age was reduced by 58%. During the same period, the global incidence of malaria was reduced by 30%.¹ Target 6.C of Millennium Development Goal 6, namely "Have halted by 2015 and begun to reverse the incidence of malaria and other major diseases", has already been reached, and 55 of the 106 countries that had malaria transmission in 2000 are on track to achieve the goal of reducing malaria incidence by 75% by 2015, as set by the Health Assembly in 2005 in resolution WHA58.2 on malaria control.

4. Despite this progress, the disease remains endemic in all six WHO regions and the burden is heaviest in the African Region, where an estimated 90% of all malaria deaths occur. Two countries – the Democratic Republic of the Congo and Nigeria – account for about 40% of estimated mortality due to malaria worldwide. Around the world, millions of people remain without access to malaria prevention and treatment, and most cases and deaths go unregistered and unreported. Given the projected growth in the size of the world's population by 2030, more people will be living in countries where malaria is a risk, putting further strains on health systems and national malaria programme budgets.

¹ World malaria report 2014. Geneva: World Health Organization; 2014.

NEED FOR A POST-2015 TECHNICAL STRATEGY

5. In the early part of the 21st century, malaria received worldwide recognition as a priority global health issue. This renewed attention ended an era of neglect between the 1960s and the late 1990s, and reversed dramatic rises in malaria morbidity and mortality rates. In order to ensure that malaria trends remain on a downward trajectory, unremitting political commitment, substantial and predictable financing, and increased regional collaboration are necessary. A powerful and coordinated global response together with continued investment in research and development will rid entire continents of the disease and eventually eradicate malaria from the world.

6. Although the implementation of core interventions expanded greatly between 2000 and 2014, the gains achieved are fragile and unevenly distributed. The human toll of malaria and the global risk it still poses remain unacceptably high. In many affected countries, social unrest, conflict and humanitarian disasters are major obstacles to progress. The recent outbreak of Ebola virus disease in West Africa, which affected countries that are highly endemic for malaria, has had a devastating impact on basic health service delivery, including the ability to control malaria. Recent outbreaks of malaria in countries that had been malaria-free, and resurgences in countries that have made important progress in reducing malaria morbidity and mortality rates in the past decade, highlight the continual threat of re-establishment and resurgence and the need for vigilance to ensure that these areas of transmission are promptly identified and rapidly contained.

7. Given the association between malaria transmission and climate, long-term malaria efforts will be highly sensitive to global climatic changes in the world's climate. It is expected that – without mitigation – climate change will result in an increase in the malaria burden in several regions of the world that are endemic for the disease, particularly in densely-populated tropical highlands. Increasing economic development, urbanization and deforestation are also expected to contribute to changes in transmission dynamics, while projected population growth in areas where malaria poses a high risk will increase the need to optimize coverage of interventions.

8. Malaria interventions are highly cost-effective and demonstrate one of the highest returns on investment in public health. In countries where the disease is endemic, efforts to reduce and eliminate malaria are increasingly viewed as high-impact strategic investments that generate significant returns for public health, help to alleviate poverty, improve equity and contribute to overall development.

9. The world has reached a critical juncture in the fight against malaria. There is both an opportunity and an urgent need to accelerate progress by reducing morbidity and mortality in all countries, by increasing the number of malaria-free countries, territories and areas, and by identifying approaches that aim to reduce transmission. Progress can be hastened through a major expansion of existing interventions, by making the response to malaria a higher technical, financial and political priority, and by ensuring that the development and use of new tools and solutions are maximized.

10. Efforts to prevent and control malaria contribute to and benefit from sustainable development. The objectives of reducing the disease burden and eliminating malaria are closely linked to several of the sustainable development goals being considered for the post-2015 period. Well-established linkages and factors include the contribution of malaria to the poverty cycle, the concentration of disease in vulnerable populations and those with poor access to health services, and its detrimental impact on education through missed school days and the cognitive effects of chronic anaemia.

11. The Malaria Policy Advisory Committee, established in 2011 to provide independent strategic advice to WHO on developing policy recommendations on malaria, recommended to the Director-General the development of a draft post-2015 global technical strategy on malaria. Member States at the Sixty-sixth World Health Assembly in 2013 expressed support for its preparation.¹ The strategy, adopted by the Sixty-eighth World Health Assembly in May 2015 in resolution WHA68.2, succeeds the previous WHO global malaria strategy, which was endorsed by the Ministerial Conference on Malaria (Amsterdam, The Netherlands, 1992) in the World Declaration on Malaria. Adoption of the strategy by the Health Assembly provides the basis for ensuring that WHO is well equipped to support the completion of the unfinished health-related Millennium Development Goals agenda, which is one of the Organization's six leadership priorities for the period 2014–2019.²

12. **Opportunities.** Since 2000, eight countries have eliminated malaria and many others have reduced transmission to low levels. The knowledge gained from these efforts will be informative in designing programmes in the future. The next 15 years are likely to be strongly shaped by: technological advances; innovations in medicines, vaccines and vector control; and improved strategies for delivering commodities. Some of the new tools are expected to have significant additional impact, and, once validated, will need to be swiftly incorporated into national malaria responses.

13. **Challenges.** The fight against malaria is being prolonged, and in some places slowed down, by several interconnected challenges. The greatest of these is the lack of robust, predictable and sustained international and domestic financing. This is compounded by the difficulty in maintaining political commitment and ensuring regional collaboration at the highest levels. The second important challenge is biological: the emergence of parasite resistance to antimalarial medicines and of mosquito resistance to insecticides. This double threat has the potential to weaken seriously the effectiveness of malaria responses and to erode the gains recently achieved.

14. Other challenges that need to be met in order to accelerate progress are systemic and technical. They include: the inadequate performance of health systems, for instance weak management of supply chains and the unregulated private health sector in many countries, which allows the use of ineffective antimalarial medicines or vector control products; weak systems for surveillance, monitoring and evaluation, which compromise the ability to track gaps in programme coverage and changes in disease burden; the lack of adequate technical and human resource capacities to sustain and scale up efforts; the disproportionate risk of malaria among hard-to-reach populations, including high-risk occupational groups, migrants, people in humanitarian crises, and rural communities with poor access to health services; and the lack of adequate tools to diagnose and treat effectively infections due to *P. vivax* and other non-falciparum malaria parasites.

15. Another important challenge is that many people who are infected with malaria parasites remain asymptomatic or undiagnosed and are therefore invisible to the health system. Further, in some settings the density of parasitaemia is so low in a substantial proportion of individuals that it cannot be detected with current routine diagnostic tools. These people unwittingly contribute to the cycle of malaria transmission. If future disease control and elimination strategies are to succeed, they will need to take into account this large “infectious parasite reservoir”. The expected development and

¹ See the summary records of the Sixty-sixth World Health Assembly, eleventh meeting of Committee A, section 1 (document WHA66/2013/REC/3).

² See the Twelfth General Programme of Work, 2014–2019, available at: http://apps.who.int/iris/bitstream/10665/112792/1/GPW_2014-2019_eng.pdf (accessed 10 March 2015).

availability over the next decade of new tools and approaches should help the detection and targeting of this reservoir and the clearing of plasmodia from asymptomatic carriers.

16. The emergence of drug and insecticide resistance is compounded by additional biological challenges, which need to be tackled by national malaria programmes. In some parts of the world, existing vector control tools cannot effectively protect against the disease given the diversity of malaria vectors and differences in their behaviours. In countries where both *P. falciparum* and *P. vivax* are present, the burden of disease due to *P. vivax* is more difficult to reduce because the parasite forms in the liver a dormant hypnozoite stage which is currently undetectable and leads to relapses, thereby contributing to disease transmission. In addition, human infection with zoonotic plasmodia such as *P. knowlesi* presents new challenges to malaria control and elimination.

17. This technical strategy provides a framework for the development of tailored programmes to accelerate progress towards malaria elimination. This framework should be the foundation of strategies for national and subnational malaria programmes. It defines a clear and ambitious path both for countries in which malaria is endemic and for their global partners in malaria control and elimination for the next 15 years. It emphasizes the need for universal coverage of core malaria interventions for all populations at risk, and highlights the importance of using high-quality surveillance data for decision making in order to drive tailored responses consistent with national or subnational goals. The strategy identifies areas where innovative solutions will be essential for attaining its goals. It summarizes the estimated costs of implementing the strategy and provides an estimate of the research and development costs for innovative new tools.

STRATEGY DEVELOPMENT PROCESS

18. Following the support expressed by Member States at the Sixty-sixth World Health Assembly for the development of a draft global malaria strategy for the post-2015 period, the Secretariat held seven regional consultations.¹ Input was gathered from more than 400 experts representing national malaria programmes, health ministries, research organizations and implementing partners. The process, led by the Secretariat, was supported by both the Malaria Policy Advisory Committee and a dedicated Steering Committee for the Global Technical Strategy, consisting of leading malaria experts, scientists and representatives of countries in which malaria is endemic, who provided additional extensive inputs to the initial draft document. Following these consultations, a revised draft was prepared by the Secretariat for an online consultation, which was open for comment between 11 July and 15 August 2014.

VISION, GOALS AND PRINCIPLES

19. The vision of WHO and the global malaria community is a world free of malaria. As part of this vision, the strategy sets ambitious yet feasible global targets for 2030 with milestones for measuring progress for 2020 and 2025. Countries will set their own national or subnational targets, which may differ from the global targets. The goals, milestones and targets are set out in Table 1.

¹ See the meeting reports in the WHO Global Malaria Programme, Global Technical Strategy. Geneva: World Health Organization; 2014.

Table 1. Goals, milestones and targets for the global technical strategy for malaria 2016–2030

Vision – A world free of malaria			
Goals	Milestones		Targets
	2020	2025	2030
1. Reduce malaria mortality rates globally compared with 2015	≥40%	≥75%	≥90%
2. Reduce malaria case incidence globally compared with 2015	≥40%	≥75%	≥90%
3. Eliminate malaria from countries in which malaria was transmitted in 2015	At least 10 countries	At least 20 countries	At least 35 countries
4. Prevent re-establishment of malaria in all countries that are malaria-free	Re-establishment prevented	Re-establishment prevented	Re-establishment prevented

20. These goals apply to all types of human malaria and have been developed after reviewing: (1) the targets of national malaria programmes as stated in their national strategic plans; (2) the magnitude of decreases in the number of cases and deaths due to malaria between 2000 and 2012, as reported to WHO; and (3) the results of mathematical modelling of transmission of falciparum malaria in order to estimate the potential impact of applying different combinations of recommended interventions between 2016 and 2030.

21. Modelling suggests that, if coverage of malaria interventions remains at current levels, incidence could increase moderately as a result of a partial loss of malaria immunity among populations that have experienced marked reductions in transmission intensity. However, this rise and its consequences could be averted through a concerted effort to optimize the use of currently available tools, particularly vector control, at levels above 80% coverage of at-risk populations, which could significantly reduce incidence of and deaths due to malaria. Given that reaching this level of coverage will be operationally difficult, further innovations in tools and approaches are needed for the elimination of transmission in areas where transmission rates are high; they are also needed in areas and for population groups that are presently hard to reach with current interventions.

22. Five principles underlie the draft technical strategy for malaria. All countries can accelerate efforts towards elimination through combinations of interventions tailored to local contexts. Country ownership and leadership, with the involvement and participation of communities, are essential to accelerating progress through a multisectoral approach. Improved surveillance, monitoring and evaluation, as well as stratification by malaria burden, are required to optimize the implementation of malaria interventions. Equity in access to health services, especially for the most vulnerable and hard-to-reach populations, is essential. Finally, innovation in tools and implementation approaches will enable countries to maximize their progression along the path to elimination.

PATH TO MALARIA ELIMINATION

23. Progression towards malaria-free status is a continuous process, and not a set of independent stages. Countries, subnational areas and communities are situated at different points on the path towards malaria elimination, and their rate of progress will differ and depend on the level of investment, biological determinants (related to the affected populations, the parasites and the vectors), environmental factors, the strength of health systems as well as social, demographic, political and economic realities.

24. At all levels of endemicity, the risk of malaria varies significantly within a country or area, and the same strategy is not necessarily appropriate for all settings within a country. As intervention coverage is increased and malaria incidence is reduced, the heterogeneity in incidence and transmission rates is likely to increase further. A key approach to optimizing malaria responses within a country will be structuring programmes in response to stratification by malaria burden and based on an analysis of past malaria incidence data, risk determinants related to the human host, parasites, vectors and the environment, together with an analysis of access to services.

25. The performance of national health systems and their adaptability to new opportunities are two of the key determinants of the rate of progress along the path. As malaria programmes reduce transmission to low or very low rates, they should shift the focus from preventing, detecting and treating clinical cases to preventing, detecting and treating every malaria infection. This change requires strengthened and sustained epidemiological and entomological surveillance systems, a requirement that can be satisfied only through substantial long-term financial and political commitment as well as significant structural and organizational changes in malaria programmes.

26. The first priority for all countries where transmission rates of malaria are high or moderate is to ensure maximal reduction of morbidity and mortality through sustained provision of universal access to quality-assured and appropriate vector control measures, diagnostics and antimalarial medicines, together with the implementation of all WHO-recommended preventive therapies that are appropriate for that epidemiological setting. These activities must be backed up by efficient disease surveillance systems, robust entomological and drug efficacy surveillance, as well as strong public health communication and behavioural change programmes.

27. In countries where the potential for malaria transmission is high, optimal application of all appropriate interventions will result in marked falls in morbidity and mortality rates, but these may not be sufficient to eliminate malaria. In these settings, additional tools will be needed to accelerate progress. Many new tools are already in development and could be available within the next five to 10 years (see paragraphs 79–95 on harnessing innovation and expanding research).

28. Once programmes have reduced transmission to very low levels, they should assess the technical, operational and financial feasibility of elimination and the programmatic capacity, including the ability of surveillance systems to track and manage every case of malaria infection, needed in order to eliminate every malaria infection. In addition to domestic considerations, available resources and preparedness, the situation in neighbouring countries and the risk of imported infections should be taken into account.

29. As programmes approach elimination or work to prevent re-establishment of transmission, all cases of malaria infection need to be detected and managed by general health services, both public and private, and reported as a notifiable disease to a national malaria registry. Patients diagnosed with malaria must be treated promptly with effective antimalarials in order to avoid preventable deaths and

to decrease the probability of onward transmission in the community. In addition, entomological surveillance systems should be maintained so that appropriate vector control interventions can be introduced or modified as necessary.

STRATEGIC FRAMEWORK

30. In order to accelerate progress towards elimination, WHO urges affected countries and the global malaria community to maximize the impact of existing life-saving tools and strategies. Until new and improved tools and approaches become available, there is an urgent need to adopt and expand implementation of all WHO-recommended strategies so as to increase the effectiveness of responses and end preventable malaria deaths. The strategy is built on three pillars with two supporting elements that guide global efforts to move closer to malaria elimination. These are summarized below.

31. **Pillar 1. Ensure universal access to malaria prevention, diagnosis and treatment.** The WHO-recommended package of core interventions – namely, quality-assured vector control, chemoprevention, diagnostic testing and treatment – can dramatically reduce morbidity and mortality. In areas of moderate-to-high transmission, ensuring universal access of populations at risk to interventions should be a principal objective of national malaria programmes. The metrics of success are the reductions in malaria case incidence and malaria mortality rates. WHO recommends implementing two sets of interventions in a complementary way: (1) prevention strategies based on vector control, and, in certain settings and in some population groups, administration of chemoprevention; and (2) universal diagnosis and prompt effective treatment of malaria in public and private health facilities and at community level. Structuring programmes in response to stratification of malaria by disease burden and including an analysis of past malaria incidence data, risk determinants related to the human host, parasites, vectors and the environment that, together with an analysis of access to services, will enable the tailoring of interventions to the local context and ensure efficient use of resources.

32. **Pillar 2. Accelerate efforts towards elimination and attainment of malaria-free status.** Countries need to intensify efforts to reduce onward transmission of new infections in defined geographical areas, particularly in settings where transmission is low. In addition to core interventions, attaining this objective will entail targeting both parasites and vectors in well-defined transmission foci, guided by active case detection and case investigations as part of a malaria surveillance and response programme. In some settings, the achievement of elimination may require the use of medicines for prophylaxis, or other possible new approaches to remove the infectious reservoir once those are recommended by WHO. The development and adoption of innovative solutions will be essential to respond to the spread of insecticide resistance and residual transmission, and to target the hypnozoite reservoirs of *P. vivax*.

33. **Pillar 3. Transform malaria surveillance into a core intervention.** Strengthening malaria surveillance is fundamental to programme planning and implementation and is a crucial factor for accelerating progress. All countries where malaria is endemic and those susceptible to the re-establishment of malaria should have an effective health management and information system in place for helping national malaria programmes to direct resources to the most affected populations, identify gaps in programme coverage, detect outbreaks, and assess the impact of interventions in order to guide changes in programme orientation. At very low levels of transmission, surveillance should trigger a locally-tailored response to every detected infection, the detection of gaps in programme coverage, declines in the effectiveness of tools, or the occurrence of outbreaks.

34. **Supporting element 1. Harnessing innovation and expanding research.** In support of these three pillars, countries where malaria is endemic and the global malaria community should harness innovation and increasingly engage in basic, clinical and implementation research. Successful innovation in product development and service delivery will make a major contribution to accelerating progress. Basic research is essential for a better understanding of the parasites and the vectors, and to develop more effective diagnostics and medicines, improved and innovative vector control methods, and other tools such as vaccines. Implementation research will be fundamental to optimizing impact and cost-effectiveness, and facilitating rapid uptake in populations at risk.

35. **Supporting element 2. Strengthening the enabling environment.** Strong political commitment, robust financing and increased multisectoral collaboration are key factors for further progress. To optimize national malaria responses, an overall strengthening of health systems and improvement in the enabling environment are also crucial. Strong health systems, both public and private, are important for reducing both the disease burden and the potential for onward transmission of parasites, and enable the adoption and introduction of new tools and strategies within the shortest possible time frame. In turn, the expansion of malaria interventions can be used as an entry point for strengthening health systems, including maternal and child health programmes and laboratory services, and to build stronger systems for health information and for disease and entomological surveillance. Finally, the empowerment of communities, capacity building and supportive supervision for a strong health workforce and regulatory frameworks are important in ensuring achievement of the vision, goals and milestones in this strategy.

THREE PILLARS OF THE STRATEGY

Pillar 1. Ensure universal access to malaria prevention, diagnosis and treatment

36. The WHO-recommended package of core interventions to prevent infection and reduce morbidity and mortality comprises vector control, chemoprevention, diagnostic testing and treatment. These elements are detailed in the following paragraphs.

Vector control

37. *Maximize the impact of vector control.* Vector control is an essential component of malaria control and elimination. The capacity of vectors to transmit parasites and their vulnerability to vector control measures vary by mosquito species and are influenced by local environmental factors. Vector control must be implemented on the basis of local epidemiological and entomological data. At present, the two core, broadly-applicable vector control interventions are long-lasting insecticidal nets and indoor residual spraying.¹

38. National malaria programmes need to ensure that all people living in areas where the risk of malaria is high are protected through the provision, use and timely replacement of long-lasting insecticidal nets or, where appropriate, the application of indoor residual spraying. A second core intervention should not be introduced as a means of compensating for deficiencies in the

¹ WHO recommendations for achieving universal coverage with long-lasting insecticidal nets in malaria control, September 2013 (revised March 2014). Geneva: World Health Organization; 2013. An operational manual for indoor residual spraying (IRS) for malaria transmission, control and elimination. Geneva: World Health Organization; 2013.

implementation of the first.¹ However, spraying may be added in certain situations in order to either prevent or mitigate resistance in areas where nets are routinely used – the decision being informed by local data. When those two interventions are deployed together, an insecticide with a different mode of action to that used on nets should be used for spraying. Supplementary methods may be appropriate in specific settings, for instance larval source management where mosquitoes' aquatic habitats are few, fixed and findable.² Effective planning, application and monitoring of larval source management require specialized capacity that is currently lacking in most malaria programmes. This capacity needs to be built.

39. Numerous situations exist where transmission of malaria parasites continues even when universal coverage with insecticidal nets or spraying has been achieved.³ For optimal impact of these interventions, programmes should ensure that vectors are exposed and susceptible to the insecticides used. Long-lasting insecticidal nets counter late-night and indoor-biting mosquitoes, and indoor residual spraying targets indoor-resting mosquitoes. This means that mosquitoes that bite in the early evening, or which are outdoor biting or resting, can evade the most frequently used interventions, leading to residual malaria transmission. Transmission can continue when people are away from houses or otherwise not under nets at the times and places where malaria vectors prefer to bite. To maximize the impact of current vector control tools where they are appropriate, countries should implement such tools effectively and should not compromise on quality through poor implementation or use of substandard products.

40. *Maintain adequate entomological surveillance and monitoring.* To enable an effective vector control response, entomological surveillance and monitoring of coverage and impact of vector control interventions must be included in national surveillance systems. Vector control should be guided by local epidemiological and entomological data including insecticide resistance and vector behaviour. Countries should collect data across all settings, including those areas that are malaria-free but at risk of the re-establishment of malaria.

41. Entomological surveillance must include periodic assessment of vector species present, their abundance and seasonality, time and place of biting, resting and host preference (vector behaviour), insecticide susceptibility status and underlying resistance mechanisms in order to predict vulnerability to interventions. Also essential is routine monitoring of coverage and impact of interventions, the physical condition of long-lasting insecticidal nets, the actual use of nets and their perceived usefulness by end users, and the residual effect of insecticides. The data generated should be used to inform decisions on the timing of spraying activities, contribute to net-replacement strategies, and guide the development and deployment of tools including behavioural change communication activities.

¹ WHO guidance for countries on combining indoor residual spraying and long-lasting insecticidal nets. Geneva: World Health Organization; 2014.

² WHO interim position statement: the role of larviciding for malaria control in sub-Saharan Africa. Geneva: World Health Organization; 2012. Larval source management – a supplementary measure for malaria vector control: an operational manual. Geneva: World Health Organization; 2013.

³ Control of residual malaria parasite transmission: guidance note, available at: <http://www.who.int/malaria/publications/atoz/technical-note-control-of-residual-malaria-parasite-transmission-sep14.pdf> (accessed 10 March 2015).

42. *Manage insecticide resistance and residual transmission.* Even though core vector control interventions continue to be effective in most areas, growing physiological resistance of mosquitoes to insecticides and the combination of vector and human behaviour that sustains continued transmission are major challenges that require an urgent and coordinated response. If left unchecked, insecticide resistance could lead to substantial increases in malaria incidence and mortality, with devastating public health consequences. All countries where malaria is endemic, including those where resistance has yet to be detected, are urged to develop and implement plans for monitoring and managing insecticide resistance.¹ Strategic use of current tools preserves their efficacy. Methods of managing resistance include use of insecticides with different modes of action through either periodic changes (rotations) between rounds of indoor residual spraying or multiple combined interventions. Vector behaviour that compromises the effectiveness of core interventions must be tackled through the use of new tools. The cost of vector control products is a major barrier to the implementation of strategies to prevent and mitigate insecticide resistance and reduce residual transmission. Countries should better forecast vector control product requirements and support pooled procurement. Such steps should enhance manufacturers' confidence, help to stabilize the market, lead to price reductions and encourage innovation.

43. *Strengthen capacity for evidence-driven vector control.* For effective delivery and monitoring of vector control interventions, national malaria programmes need to invest in human resources and organizational and infrastructural development that will boost capacity to generate and analyse essential data.² A long-term strategic plan should be developed for building sustainable human resource capacity and establishing career structures and systems to ensure optimal delivery of vector control interventions. Such capacity underpins all activities for malaria control and elimination, and prevention of the re-establishment of the disease.

44. *Implement malaria vector control in the context of integrated vector management.* To maximize the impact of malaria vector control – including maintaining adequate entomological surveillance and monitoring, managing insecticide resistance and strengthening capacity for evidence-based vector control – national malaria programmes should apply the principles of integrated vector management. Integrated vector management is a rational decision-making process for the optimal use of resources for vector control. It seeks to improve the efficiency, cost-effectiveness, ecological soundness and sustainability of disease-vector control with the ultimate goal of preventing the transmission of vector-borne diseases. Countries should develop and implement national plans on integrated vector management as part of their broader strategy to control malaria. Implementation of vector control involves different sectors, thus countries should also strengthen intersectoral coordination for maximum impact.

Chemoprevention

45. *Expand preventive treatment to prevent disease in the most vulnerable groups.* Preventive treatment strategies are key elements of the multipronged strategy to reduce disease burden and transmission, and they need to be substantially expanded to help countries to reduce their malaria burden. This intervention suppresses existing infections and prevents the consequences of

¹ WHO Global Malaria Programme. Global plan for insecticide resistance management in malaria vectors. Geneva: World Health Organization; 2012. Test procedures for insecticide resistance monitoring in malaria vector mosquitoes. Geneva: World Health Organization 2013.

² WHO guidance note on capacity building in malaria entomology and vector control, available at: http://www.who.int/malaria/publications/atoz/who_guidance_capacity_building_entomology.pdf (accessed 10 March 2015).

parasitaemia, including disease and death. The strategies for preventive treatment vary, depending on the intensity of transmission and the level of parasite resistance to antimalarial medicines in a given region.

46. WHO-recommended preventive treatment against malaria presently includes intermittent preventive treatment of pregnant women, intermittent preventive treatment of infants, and seasonal chemoprevention for children aged under 5 years.¹ These interventions are recommended in areas of moderate-to-high malaria transmission in sub-Saharan Africa, with seasonal malaria chemoprevention being recommended only in areas of highly seasonal transmission across the Sahel subregion. Preventive treatment strategies currently target falciparum malaria and need to be developed for other types of human malaria.

47. *Protect all non-immune travellers and migrants.* Chemoprophylaxis is the administration of subtherapeutic doses of antimalarial medicines at regular intervals sufficient to prevent malaria disease. Chemoprophylaxis should be given to individuals exposed to high malaria risk in combination with advice about measures to reduce vector bites, particularly non-immune travellers, who are more susceptible to malaria illness and death. It is also recommended for travellers within countries from malaria-free areas to areas with high malaria risk.

Diagnostic testing and treatment

48. *Ensure universal diagnostic testing of all suspected malaria cases.* All patients who are suspected to have malaria should have the diagnosis confirmed by parasite detection methods such as quality-assured microscopy or a rapid diagnostic test. Both public and private sector health services should confirm diagnosis before administering antimalarial treatment. Every confirmed case should be tracked and reported in the surveillance system in order to inform programme planning. Ensuring universal diagnostic testing will reduce the over-use of artemisinin-based combination therapies – the first-line treatment for uncomplicated malaria – and reduce the drug pressure on parasites.²

49. Expansion of diagnostic testing will provide timely and accurate surveillance data based on confirmed rather than suspected cases. Additionally, it will lead to improved identification and management of the many non-malarial febrile illnesses presumed to be malaria solely on the basis of the presence of fever. Expanding access to prompt diagnostic testing has lagged behind vector-control prevention efforts, but strengthening diagnosis and treatment in all settings will help to reduce malaria morbidity and mortality. WHO recognizes that the safe and effective testing and radical treatment of vivax malaria currently requires two diagnoses: the presence of *P. vivax* parasites and glucose-6-phosphate dehydrogenase status.

50. *Provide quality-assured treatment to all patients.* Ensuring universal access to WHO-recommended antimalarial medicines is crucial in all settings in order to prevent the progression of uncomplicated malaria to severe illness and death. After diagnostic confirmation, every patient with

¹ Updated WHO policy recommendation: intermittent preventive treatment of malaria in pregnancy using sulfadoxine-pyrimethamine (IPTp-SP). Geneva: World Health Organization; 2012. WHO policy recommendation on intermittent preventive treatment during infancy with sulphadoxine-pyrimethamine (SP-IPTi) for *Plasmodium falciparum* malaria control in Africa. Geneva: World Health Organization; 2010. WHO policy recommendation: seasonal malaria chemoprevention (SMC) for *Plasmodium falciparum* malaria control in highly seasonal transmission areas of the Sahel sub-region in Africa. Geneva: World Health Organization; 2013.

² Universal access to malaria diagnostic testing: an operational manual. Geneva: World Health Organization; 2011.

uncomplicated *P. falciparum* malaria should be treated with quality-assured artemisinin-based combination therapy. In areas where chloroquine-susceptible *P. vivax* is present, uncomplicated non-falciparum malaria should be treated with either chloroquine or an artemisinin-based combination therapy known to be effective in the area. In addition to the artemisinin-based combination therapy or chloroquine, all non-pregnant adults and children with *P. vivax* or *P. ovale* who are not glucose-6-phosphate dehydrogenase deficient should receive a 14-day course of primaquine to prevent future relapses. Every severe case of malaria caused by *P. falciparum*, *P. vivax* or *P. knowlesi* should be treated parenterally with artesunate or artemether, followed by a full oral course of an artemisinin-based combination therapy. Severe malaria requires urgent medical attention. WHO's detailed recommendations have been made available to countries.¹

51. Malaria programmes should develop detailed national treatment guidelines that take into account local antimalarial drug resistance patterns and health service capacities. Countries should select WHO-recommended artemisinin-based combination therapies with more than 95% efficacy demonstrated through therapeutic efficacy monitoring in local sites. Fixed-dose formulations (combining two different active ingredients co-formulated in one tablet) are strongly recommended, as they facilitate adherence to treatment and reduce the potential misuse of individual components of co-blistered medicines. Oral artemisinin-based monotherapy should never be used for the treatment of uncomplicated malaria as this may promote the development of resistance to artemisinin.

52. *Scale up community-based diagnostic testing and treatment.* Training and deployment of community health workers and volunteers can substantially complement and extend the reach of public health services, particularly in rural and remote areas, where health infrastructures tend to be the weakest and malaria transmission the highest. The strategic use of community health workers and volunteers in malaria prevention and care not only bridges health system gaps, but ensures a continuum of care for the most disadvantaged populations. National malaria programmes should expand integrated community case management of malaria, pneumonia and diarrhoea, with a focus on children under 5 years of age.

53. *Monitor safety and efficacy of antimalarial medicines and manage antimalarial drug resistance.* Enhanced pharmacovigilance and surveillance of the efficacy of antimalarial medicines are essential in order to detect unexpected adverse events and reduced efficacy in order that the most appropriate combinations can be selected for national treatment policies. Countries should monitor every two years the efficacy of first-line malaria therapies – against both falciparum and vivax malaria – using the standard WHO protocol for therapeutic efficacy studies.² A treatment failure rate exceeding 10% should prompt a change in the national antimalarial treatment policy. For the time being, artemisinin-based combination therapies remain highly effective, provided that the partner medicines remain efficacious. Caution is required, however, as the emergence of artemisinin resistance increases the risk of resistance to the partner medicines in the combination.

54. *Contain antimalarial drug resistance.* Protecting the efficacy of artemisinin-based combination therapies and developing new combinations should be a top priority both for countries where malaria

¹ See the WHO publications, Guidelines for the treatment of malaria, third edition. Geneva: World Health Organization; 2015; and Management of severe malaria: a practical handbook, third edition. Geneva: World Health Organization; 2013.

² Methods for surveillance of antimalarial drug efficacy. Geneva: World Health Organization; 2009.

is endemic and for the global malaria community.¹ In countries and areas where artemisinin and artemisinin-based combination therapies continue to be fully effective, there is a need to promote correct medicine use with special attention to expanding diagnostic testing and quality-assured treatment and to extend all basic malaria interventions, including vector control, in order to reduce the potential emergence of resistance. Countries where artemisinin resistance is reported are urged to intensify malaria control in order to reduce the burden of the disease and delay or prevent spread of resistance. In areas of low transmission but where resistance to artemisinin is present, countries should target rapid elimination of falciparum malaria.

55. *Eliminate falciparum malaria from the Greater Mekong subregion.* *P. falciparum* resistance to artemisinin has emerged independently in multiple geographical locations in the Greater Mekong subregion in South-East Asia. The situation is worst along the Cambodia–Thailand border, where *P. falciparum* has become resistant to almost all available antimalarial medicines. The emergence of multidrug resistance could seriously threaten progress achieved in this region to date, and could lead to a rise in the disease burden in other parts of the world.² Elimination of *P. falciparum* malaria is the only strategy that can prevent the spread of resistance; this should be an urgent priority in the Greater Mekong subregion, while current tools are effective.

56. *Remove all inappropriate antimalarial medicines from markets.* All countries in which malaria is endemic should ensure that all inappropriate antimalarial medicines are removed from private sector markets. National regulatory authorities are urged to regulate against production, marketing authorization, export, import and use of oral artemisinin-based monotherapies. Countries should also take decisive steps, including surveillance and regulatory action as well as stringent follow-up, to remove ineffective antimalarial medicines from health facilities and pharmacies, including their provision through informal providers. These efforts will be crucial for preserving the efficacy of artemisinin-based combination therapies, and will make a substantial contribution to accelerating progress on the path to elimination.

Pillar 2. Accelerate efforts towards elimination and attainment of malaria-free status

57. All countries should aim to eliminate malaria. Attaining this objective will entail targeting both the vectors and parasites. Preventing contact between people and vectors will reduce onward transmission of new infections, while clearing the parasites from the large number of people with undiagnosed infections will speed declines in transmission. Over the next decade, new tools and approaches will become available that will help to target the infectious parasite reservoir in humans. The main technical recommendations summarized under this pillar are based on existing tools and approaches but the recommendations are expected to be expanded within 2–3 years.

58. *Refocus programmes.* Once the number of malaria cases has been reduced to low levels in a given country or subnational area, the malaria programmes' priorities and activities may need to be readjusted to complete the final phase of elimination. Thus, in addition to the interventions mentioned under Pillar 1, programmes should enhance surveillance to ensure that every infection is detected, implement targeted measures for attacking both parasites and vectors in order to interrupt local

¹ Global Partnership to Roll Back Malaria. Global plan for artemisinin resistance containment. Geneva: World Health Organization; 2011.

² Emergency response to artemisinin resistance in the Greater Mekong subregion: regional framework for action 2013–2015. Geneva: World Health Organization; 2013.

transmission, eliminate all parasites from humans, and manage the risk of re-establishment through imported malaria.

59. *Enact legislation.* New legislation is needed in order to support changes in programme prioritization, namely to ensure that the over-the-counter sale of antimalarial medicines is banned and that surveillance is further strengthened to include compulsory notification of all confirmed cases of infection detected in both public and private health care facilities. In addition, health ministries – with the support of relevant authorities – need to assume direct oversight of supply management for malaria medicines; build a centralized reporting system for epidemiological surveillance of malaria, for vector control data, outbreak reporting, and preparedness and response; and intensify coordination among public, private and community-based agencies and services.

60. *Renew political commitment and deepen regional collaboration.* The final phase of elimination needs strong political commitment, predictable long-term financing, and increased collaboration between neighbouring countries. In many countries, there is an urgent need to expand efforts to support at-risk communities in low-transmission areas, especially in remote and hard-to-reach areas. Solutions should be found for protecting itinerant population groups and migrant workers within and across countries by informing them of the potential dangers of the disease, and providing access to prevention tools and treatment through accessible health clinics.

61. *Reduce the number of undetected infections.* Ensuring that malaria parasites are fully cleared from infected people through public health interventions will require new approaches that are not yet part of the WHO-recommended arsenal of tools. Strategies such as mass administration of medicines have been successfully used in the past, and are currently being explored in a range of transmission settings. Research is evaluating the potential role of administering transmission-blocking medicines in high-transmission settings in order to accelerate progress towards elimination. Other research is evaluating the impact and longer-term effect of administration of effective antimalarials to either an entire population or targeted population groups, including treatment of infected individuals screened for malaria parasites with highly sensitive tests.

62. *Implement targeted malaria vector control.* As transmission decreases to low levels in countries or subnational areas, universal coverage of populations at risk of malaria with vector control interventions should be maintained in most settings to prevent resurgences. For a given area, the defined population at risk will likely differ as programmes proceed along the path to elimination. A shift from universal coverage to targeting of vector control to specific populations or areas may be justified in circumstances where the inherent transmission potential is low, surveillance systems are strong, there is a high level of preparedness and the ability exists to respond quickly in the event of a resurgence. Targeted indoor residual spraying plays an important role in some settings as a response to outbreaks and resurgences, or to eliminate transmission foci. As transmission declines there may be an increased need for supplementary measures such as larval source management.

63. *Prevent re-establishment of local malaria transmission.* Even after the disease has been eliminated from a country or subnational area, continued importation of malaria cases means that the quality of case detection must remain high. Vigilance for possible renewed local transmission is a responsibility of the general health services as part of their normal function in communicable disease control, in collaboration with other relevant sectors (such as agriculture, environment, industry and tourism). Individuals who plan to travel to areas where malaria is endemic should be provided with health information, chemoprophylaxis and advice about measures to protect against mosquito bites, aimed at reducing the importation of parasites. Visitors and migrants from endemic areas should be informed of the risks of malaria and given easy access to free-of-charge diagnostic and treatment facilities. Vector control must continue to be used to contain local outbreaks and protect areas that are

known to be receptive to the resumption of transmission as well as exposed to frequent importation of malaria parasites. The patterns of vigilance that need to be applied in order to ensure the successful maintenance of the malaria-free status depend on the vulnerability and receptivity of an area. The programme for prevention of re-establishment of transmission has an unlimited duration. Thus, surveillance should be maintained in countries that no longer have transmission.

64. *Implement transmission-blocking chemotherapy.* Transmission-blocking chemotherapy is the use of effective antimalarial medicines to reduce the transmission of gametocytes, the sexual stage of plasmodia that are infectious to mosquito vectors, thereby interrupting the malaria transmission cycle. WHO recommends transmission-blocking chemotherapy to reduce malaria transmission, particularly in areas threatened by resistance of *P. falciparum* to artemisinin and as part of strategies to eliminate *P. falciparum*.¹ This intervention is currently recommended in areas with low transmission and where treatment coverage is high. Transmission-blocking strategies are currently available for falciparum malaria but have not been developed for other malaria parasites.

65. *Detect all infections to attain elimination and prevent re-establishment.* In settings where the rate of transmission is very low, active detection and investigation of infections in addition to free malaria care and notification at health facilities are important for clearing residual foci of transmission.² Case investigations and detection of infections among people who share the living environment with someone diagnosed with malaria at a health facility will provide information on potential exposure to the same sources of infection in order to determine whether local transmission is occurring or if cases have been imported.

66. *Use of medicines to reduce the parasite pool.* Use of antimalarial medicines is an element of the elimination strategy, as they can eliminate the parasite pool in the treated population and, when used preventively, reduce both the pool of susceptible individuals and transmissibility of gametocytes. In the future, WHO will assess the potential role of medicines in killing mosquitoes before they are able to transmit malaria parasites, and their potential role in treating all infections regardless of clinical symptoms or health-seeking behaviour. In work aimed at elimination, all patients with laboratory-confirmed vivax or ovale malaria should be treated with a regimen for a radical cure to clear all remaining hypnozoites, which could later cause a relapse.

67. *Devise P. vivax-specific strategies.* For elimination to succeed, greater attention must be given to *P. vivax*, a parasite less well understood than *P. falciparum*. Vivax malaria presents multiple challenges and needs specific strategies. The challenges include the following:

- *P. vivax* tolerates a wider range of environmental conditions than *P. falciparum* and therefore has a wider geographical range;
- *P. vivax* can be transmitted from humans to mosquitoes before infected people develop symptoms;

¹ The updated WHO policy recommendation on single dose primaquine as a gametocytocide in *Plasmodium falciparum*. Geneva: World Health Organization; 2012.

² Disease surveillance for malaria elimination: an operational manual. Geneva: World Health Organization; 2012. Policy brief on malaria diagnostics in low-transmission settings. Geneva: World Health Organization; 2014.

- conventional vector control methods (long-lasting insecticide-treated nets and indoor residual spraying) may be less effective against *P. vivax* because, in many areas where *P. vivax* predominates, vectors bite early in the evening, obtain blood meals outdoors and rest outdoors;
- dormant hypnozoites are more difficult to detect because the parasitaemia is typically low and because the dormant hypnozoites residing in the liver cannot be detected with existing diagnostic tests;
- hypnozoites can give rise to multiple relapses and contribute to significant morbidity and onward transmission;
- *P. vivax* hypnozoites can only be eliminated through a 14-day course of primaquine, which can produce serious side effects (haemolytic anaemia) in patients who have glucose-6-phosphate dehydrogenase deficiency, and such treatment is contraindicated in vulnerable population groups such as infants and pregnant or breastfeeding women;
- testing for glucose-6-phosphate dehydrogenase deficiency is challenging and not available in many settings;
- chloroquine-resistant vivax malaria is spreading.

68. *Use surveillance as an intervention in elimination programmes.* As malaria programmes progress towards elimination, the aim of surveillance is to detect all malaria infections, whether symptomatic or not; to investigate each individual case of infection, differentiating imported cases from those acquired locally; and to ensure that each detected case is promptly treated in order to prevent secondary infections. Although infections occur sporadically or in distinct foci, surveillance systems must cover an entire country, with particular attention to areas with ongoing or a recent history of transmission. Countries should monitor imported infections, which represent a significant proportion of all infections in the elimination phase and may pose a risk for re-establishment of transmission in areas in which it had previously been interrupted.¹

Pillar 3. Transform malaria surveillance into a core intervention

69. Irrespective of where countries are on the path to elimination, surveillance of malaria should be upgraded to a core intervention in national and subnational malaria strategies. Surveillance as an intervention encompasses tracking of disease and programmatic responses and taking action in response to data received. At present, most high-burden countries are not in a position to capture essential malaria data on a continuing basis, thereby making it difficult to optimize responses, assess disease trends and respond to outbreaks. Surveillance may function most intensively as an intervention when programmes are closest to elimination, but effective surveillance is required at all points on the path to elimination. The benefits of effective surveillance and the actions needed to transform surveillance are described below.

70. Strong malaria surveillance enables programmes to optimize their operations, by empowering programmes:

¹ Disease surveillance for malaria elimination: an operational manual, available at: http://apps.who.int/iris/bitstream/10665/44852/1/9789241503334_eng.pdf (accessed 10 March 2015).

- to advocate investment from domestic and international sources, commensurate with the malaria disease burden in a country or subnational area;
- to allocate resources to populations most in need and to interventions that are most effective, in order to achieve the greatest possible public health impact;
- to assess regularly whether plans are progressing as expected or whether adjustments in the scale or combination of interventions are required;
- to account for the impact of funding received and enable the public, their elected representatives and donors to determine if they are obtaining value for money;
- to evaluate whether programme objectives have been met and learn what has worked and not worked so that more efficient and effective programmes can be designed.

71. *Surveillance in areas of high transmission.* Data analysis and programme monitoring are based on aggregate numbers, and actions are undertaken at a population level to ensure that all populations have access to services and there are no adverse disease trends.¹ Accurate and timely information on numbers of and trends in malaria-associated deaths is a key requirement for tracking the progress of malaria control. Concerted efforts should be made to ensure that all admissions for malaria to hospitals and health centres and deaths from malaria therein are confirmed by a parasitological test and reported through a national surveillance system. The representativeness of hospital data should be characterized in selected sites with well-defined catchment populations and that continuously track the cause of death.

72. *Surveillance in areas of low transmission.* In areas where rates of transmission are low or moderate, there is appreciable heterogeneity in the distribution of malaria and it becomes increasingly important to identify the population groups most susceptible to disease, and to target interventions appropriately. Malaria can be concentrated in marginalized populations, such as those living in remote or border areas, itinerant and migrant workers, and tribal populations with limited access to services. It may be necessary to take diagnostic testing and treatment services directly to populations without access to services (i.e. to undertake proactive case detection and treatment). As the immunity of populations at risk wanes as interventions take effect, it is important for programmes to be vigilant against potential outbreaks, with intensified reporting (e.g. weekly) of the incidence of infections and the monitoring of major determinants of transmission, such as meteorological data.

73. *Surveillance in areas targeted for elimination of malaria.* Malaria-specific reporting systems are increasingly needed to satisfy the additional information demands for targeting and monitoring interventions in particular risk groups and foci. As progress is made towards elimination, it becomes necessary to investigate individual cases of infection or clusters of cases in order to understand risk factors and eliminate foci of transmission. It also becomes increasingly important to ensure that surveillance systems capture data on cases detected by private sector care providers, both formal and informal. Increasing resources and capacity is required in order to run and maintain malaria surveillance systems that become more complex and resource-intensive in moving to the elimination phase; additional skills, training and activities will have to be provided for the personnel involved. Strong surveillance systems need to be maintained to sustain the status of elimination once it is

¹ Disease surveillance for malaria control: an operational manual, available at: http://apps.who.int/iris/bitstream/10665/44851/1/9789241503341_eng.pdf (accessed 10 March 2015).

achieved; countries also need to monitor the risk of importation (vulnerability) and the transmission potential in risk areas (receptivity).¹

74. *Invest in routine information systems.* Routine information systems are crucial for surveillance at all stages of malaria control and form the basis for monitoring of malaria programme activities. Sufficient investments must be made in the management and use of data from improved routine information systems in order to generate the information needed for programme planning, implementation and evaluation. Adequate financial and logistical support is needed for the provision of office supplies and equipment, training and retraining of staff, supervision of health facilities, and communications. Data reporting requires management with quality controls in place and good follow-up. Building the technical capacity of staff for data analysis and interpretation is the overriding need in order to enable programmes to use surveillance information most effectively.

75. *Collect necessary data for understanding disease trends and overall programme performance.* Necessary information includes data on resources available for malaria control (programme financing, staff and commodities), existing levels of service provision (access to services and intervention coverage), and trends in health services utilization. It also covers data on populations affected, including malaria parasite prevalence rates and factors that are associated with a higher risk of acquiring malaria. Multiple sources of data include routine information systems (to track finances, commodity flows, service delivery, and disease trends), health facility surveys (to track implementation of services delivered by health facilities), household surveys to track programme coverage and parasite prevalence (in populations), and findings of implementation research. Entomological monitoring systems are required to update information periodically on vectors and their behaviour and susceptibility to insecticides. Therapeutic efficacy studies are essential for detecting resistance to antimalarial medicines. The weight given to different data sources will vary according to the level of malaria transmission and the maturity and capacities of a malaria programme.

76. *Develop national strategic plans that take into account the epidemiology and heterogeneity of malaria in a country.* As intervention coverage is increased and malaria incidence is reduced, the heterogeneity in incidence and transmission rates increases. A key approach to optimizing malaria responses within a country or territory will be stratification, in which a country or area is divided into smaller units where different combinations of interventions may need to be delivered. National strategic plans should take into account the readiness of health systems to expand malaria programmes and identify the resources required to achieve intended levels of coverage and impact. They should define the role of different stakeholders in the implementation of the plan and set targets for monitoring progress and ensuring accountability.

77. *Monitor the implementation of national malaria strategic plans at regular intervals.* In particular, annual reviews should be undertaken before budgets are prepared; mid-term reviews may be conducted to assess interim progress; and a final programme review should be undertaken before development of the next strategic plan. Feedback showing the status of selected key indicators should be communicated to districts and health facilities on a monthly or quarterly basis and include private health facilities. It is important that data are summarized in ways that staff in health facilities and districts can readily assess the facilities' performance. Programme monitoring and surveillance should not be confined to malaria programme managers and implementers. Other government departments, elected leaders, community members and donors have a stake in ensuring high quality malaria

¹ Disease surveillance for malaria elimination: an operational manual, available at: http://apps.who.int/iris/bitstream/10665/44852/1/9789241503334_eng.pdf (accessed 10 March 2015).

programmes and need to be able to scrutinize the operations they are supporting. If involved in the review process, they can help to ensure that malaria programmes are responsive to populations' needs and that malaria control and elimination are promoted as a development priority.

78. *Ensure the surveillance system is monitored.* Routine health information systems and well-functioning disease surveillance enable programmes to monitor malaria financing, intervention coverage and disease trends. It is important that performance of the surveillance system itself is also monitored through metrics such as the percentage of health facilities submitting monthly reports, the proportion of health facilities receiving quarterly feedback, and, in the advanced phase of malaria elimination, the proportion of cases and deaths investigated. Other important characteristics that should be evaluated periodically include timeliness, accuracy, representativeness and validity. Monitoring the surveillance system itself will identify weaknesses and enable actions to be taken to improve surveillance, which in turn can improve the performance of the malaria programme and accelerate progress towards malaria elimination.

SUPPORTING ELEMENT 1. HARNESSING INNOVATION AND EXPANDING RESEARCH

79. Important new tools are expected to become available within the lifetime of this strategy. These include new and more effective medicines, new combinations of medicines, improved diagnostics, new vaccines, new insecticides and other innovative vector-control tools. Until new tools are available, programmes should undertake implementation research to refine approaches to applying existing interventions most effectively and efficiently in local contexts. Implementation research will need to focus in particular on population coverage and compliance in the short and long terms as well as human resource issues. These studies should be designed to provide results of sufficient quality to provide evidence for policy recommendations. As candidate tools and approaches become available, they will be reviewed and advised upon by WHO and national regulatory bodies. Countries should ensure the existence of a regulatory environment that facilitates rapid assessment, and appropriate uptake of validated tools is critical. Bottlenecks to the introduction of new tools must be identified through implementation research and removed early in order to facilitate immediate use once the evidence base is available to define the appropriate conditions for their deployment. The priorities in five different areas are outlined below.

Vector control

80. Numerous potential tools and approaches are under development for overcoming the specific challenges of vector insecticide resistance and residual transmission. These include new insecticides, formulations or methods of application, new attractants and repellents, new bioactive agents (e.g. fungi or endo-symbionts), new mosquito life-cycle targets (e.g. sugar feeding, mating or oviposition phases), and genetically-modified mosquitoes. New strategies are also being explored to improve the delivery of interventions, such as the novel use of mobile telephone technology and digital mapping. Tools are also needed for protection of people when they are outside of homes protected by core interventions owing to occupational or other reasons.

81. The improvement of existing core vector control interventions is a priority area that requires further attention, given the expected continued large expenditures on these tools. Beside the integration of new active ingredients into these interventions, the development and validation of nets with improved or prolonged residual effect and physical integrity as well as usefulness are important. Countries should therefore continue to implement operational research to improve access, ownership

and usage of nets and quality and uptake of indoor residual spraying, including components of behavioural change communication.

82. It is vital that options are urgently explored to ensure timely and affordable access to improved vector control tools, including those to mitigate insecticide resistance and residual transmission. Countries and the global community must work with industry and research institutions to identify and validate markers of insecticide resistance, assess the extent and drivers of residual transmission, and evaluate candidate tools. Clear definition of the evidence needed to validate new tools is required along with a recognized process for recommending programmatic implementation.

83. Quality assurance of existing and new vector control products and equipment is crucial for sustained efficacy and safety. As global and national capacity to conduct quality control assessments is currently limited, countries must invest in building sufficient expertise and necessary facilities.

Diagnostic testing and treatment

84. Research is required to develop tools that can more readily detect low-level parasitaemia in asymptomatic carriers and ascertain the effectiveness of different screening strategies both at higher transmission levels, in order to appropriately target interventions, and when countries enter the elimination phase. Better species-specific point-of-care rapid diagnostic tests are needed for all non-falciparum malaria parasites; diagnostics for hypnozoites of *P. vivax* are also needed.

85. Simple, point-of-care rapid diagnostic tests are needed to establish the glucose-6-phosphate dehydrogenase status of individuals in order to expand access to the treatment of vivax malaria with 8-aminoquinoline antimalarials.

86. A robust pipeline of new candidate therapeutic agents is required because the long-term usefulness of any medicine or combination is threatened by the emergence and spread of resistance. The ideal combination would be a safe, effective and affordable single-dose treatment that can produce a radical cure, reduce transmissibility of gametocytes with prophylactic effect for both *P. falciparum* and *P. vivax* infections, and can be used during pregnancy and in people with glucose-6-phosphate dehydrogenase deficiency. New regimens of medicines that are safe, well-tolerated, affordable, avoid promoting resistance and demonstrate a broad spectrum of activity need to be developed for the treatment of confirmed clinical cases and for potential mass use against the parasite reservoir, including the sexual stages of both *P. falciparum* and *P. vivax*. New regulatory pathways will need to be created to develop novel chemoprophylactic agents as well as clear research strategies for developing antimalarial medicines for preventive treatment.

87. Reliable, easily applied and interpretable tests for molecular markers of drug resistance for all components of medicine combinations are urgently required. The identification and validation of molecular markers will improve our ability to monitor the emergence and spread of resistance to each medicine compound individually. In addition to molecular markers detecting resistance of *P. falciparum*, markers are also needed to detect resistance of *P. vivax*. The monitoring of molecular markers for drug resistance, once they become available, will be useful particularly in areas of low transmission where therapeutic efficacy studies are becoming increasingly difficult to perform.

88. Context-specific strategies are required to understand better the treatment-seeking behaviours of people in regions with continuing transmission in order to increase demand for treatment, testing and recommended therapy. Innovative methods should be devised in order to ensure that both public and private providers, and those outside the formal health system, adhere to standard guidelines for detecting, treating and recording all malaria cases.

Malaria vaccines

89. Malaria vaccines are expected to be an important addition to the arsenal of tools in the future. Several vaccine candidates, with different modes of action, are currently in various stages of development to prevent *P. falciparum* and *P. vivax* infections. At least one of these (RTS,S) is close to licensure and review for policy recommendation. The global health community has called for the development and licensing, by 2030, of malaria vaccines with protective efficacy of at least 75%. Malaria vaccines are currently envisaged as a complementary tool that should not replace the core package of interventions.

Surveillance

90. Advances in information technology and communications offer prospects of increased timeliness of reporting, better sharing of data (between information systems and different levels of a health system) and enhanced data analyses. Information technology can be applied to optimize and improve procurement and supply management, early warning systems, and the mapping of gaps in service delivery. Moreover, adoption of new technologies should offer the chance to improve management of systems and strengthening capacities and the human resources involved.

91. Efforts are needed to enable better sharing of results of interventions and drug-sensitivity testing and information about advances in surveillance and research that are often generated and held by multiple institutions. All agreements for research or service delivery should include a provision for data sharing, possibly through open-access portals.

92. Research is needed to identify which strategies are most effective in detecting cases, and to assess the effectiveness of response packages once cases have been detected.

Elimination

93. Research is required to define the range of transmission settings in which reducing transmission by targeting the parasite reservoir is an effective intervention. This research will need also to define optimum combinations of approaches and to optimize intervals between treatments and methods for monitoring the effectiveness of this intervention. The latter includes assessment of highly sensitive submicroscopic diagnostic assays for detecting both *P. falciparum* and *P. vivax* parasitaemia.

94. Relapses of infection with *P. vivax* contribute to a significant proportion of transmission of vivax malaria from its hypnozoites in the liver. Strategies aimed at this parasite reservoir need to be developed as part of vivax elimination strategies, including those for people not eligible for primaquine therapy.

95. Basic research is needed to develop new tools to prevent transmission, including vaccines that target different stages of the parasite life cycle and may be effective in preventing all infections, or by directly targeting the sexual stages and preventing infection of and from mosquitoes.

SUPPORTING ELEMENT 2. STRENGTHENING THE ENABLING ENVIRONMENT

96. Malaria interventions need to be embedded in, and supported through, a strong enabling environment that can ensure that efforts are expanded in an effective and sustainable manner. The main activities to contribute to this enabling environment are as follows.

97. *Increase international and domestic financing.* There is an urgent need to increase and sustain high-level political commitment and the availability of predictable and long-term financing for malaria programmes. International donors are encouraged to maintain and increase commitments to malaria goals and programmes; new financing solutions should be conceived to tap into emerging development financing and private sector resources. Countries where malaria is endemic are urged to increase the domestic resources directed to strengthening health systems and combating the disease. Robust and predictable financing is also essential to sustain recent successes: if countries were to fall back on existing levels of intervention coverage, because of lack of funding, some of the recent gains in global malaria efforts could be lost. Maintenance of robust malaria programmes and capacities is paramount at every step along the path to elimination and in preventing re-establishment of transmission.

98. *Ensure robust health sector response.* In many countries in which malaria is endemic, inadequate health system capacities are a major obstacle to accelerate progress. Substantial investments are needed to strengthen health systems, particularly basic health infrastructures, commodity-delivery systems, pharmaceutical regulation, human resources, and vital registration systems in order to improve the environment in which national malaria programmes operate. Strong collaboration between malaria programmes and other health programmes – such as reproductive health, maternal and child programmes, laboratory services and regulatory authorities (for diagnostic devices, medicines and insecticides) – is essential for the successful implementation of malaria interventions.

99. *Strengthen health workforce and malaria expert base.* In most countries where malaria is endemic, the shortage of skilled health professionals is chronic, clinical practices are outdated, surveillance systems are inadequate, and monitoring and evaluation programmes are weak. Malaria programmes operate in a complex environment, with a continuous need to adjust responses in line with outbreaks and resurgences, changing transmission patterns, and development of drug and insecticide resistance. Robust expansion of malaria interventions requires significantly expanded human resource capacities at national, district and community levels. The education, training and motivation of health workers, programme staff and malaria researchers – including adequate mentoring, supervision and compensation – is the key to ensuring programme effectiveness. There are several new tools on the horizon, whose introduction will require new skills and even further investments in capacity building. A strengthening of the workforce should be recognized as an essential part of health systems strengthening.

100. *Ensure the sustainability of malaria responses.* To do this and to maximize the potential of malaria investments, national malaria strategic plans should be embedded in a broader health systems approach. A stronger focus on improved supply chains for quality-assured diagnostics, medicines and vector control tools, well-planned procurement, the harnessing of new technologies for data collection and management, and better regulation and oversight of the activities of private sector pharmaceutical vendors are all crucial to making systemic improvements. High quality and efficient provision of malaria prevention and care – in both the public and private health sectors – will benefit from, and help to build, stronger health systems.

101. *Improve government stewardship and cross-border collaboration of malaria programmes.* Given the large number of stakeholders and the important role in malaria programmes of development partners, private industry, research and academia, private sector health facilities, nongovernmental organizations and community health workers, national public health programmes in countries in which malaria is endemic should improve their overall coordination of the work on malaria. Effective cross-border collaboration between national programmes must be initiated and strengthened in order to ensure optimal coverage of intervention in these areas. National programmes should ensure that all

work on programme implementation and elimination is fully in line with national strategic priorities and complies with WHO recommendations, and that appropriate regulatory frameworks exist to ensure safe use of quality-assured tools by appropriately trained personnel.

102. *Strengthen multisectoral collaboration.* Collaboration with non-health sectors needs to be augmented. National malaria programmes should become an integral part of poverty-reduction strategies, national development plans and regional development cooperation strategies. The response should be elevated from a single-disease approach to a health-in-all-policies approach. The engagement of ministries of finance, education, environment, industry, transport and tourism is especially important, as is the active contribution of regulatory authorities. For vector control, integrated vector management sometimes offers the appropriate platform for efficient delivery of interventions.

103. *Encourage private sector participation.* The private health sector, including industry, health facilities and other actors, has a vital role in the development and delivery of commodities and services, for instance through the development of new tools and interventions and bringing them to market. A stronger engagement will be essential to improve the quality of interventions, including formal and informal private sector provision of patient care and the appropriate reporting to the national surveillance systems of all malaria cases, treatment outcomes and deaths. New and improved partnerships are needed to improve the supply chain for commodities. These partnerships can also play an important role in protecting workers who are recruited for major development projects and treating those who become infected.

104. *Empower communities and engage with nongovernmental organizations.* Close collaboration with community leaders and nongovernmental implementing partners is an essential factor for success. Malaria interventions cannot succeed unless communities adopt governmental guidance on the use of prevention tools and recommended therapies. Integrated, people-centred community services are needed, and these should be introduced in coordination with health care providers in the public and private sectors. Populations living in remote or hard-to-reach areas and with limited access to health facilities can only be supported through community-based approaches, often in partnership with nongovernmental implementing partners. Well-planned public health communication and behavioural change programmes are essential to educating affected communities about the benefits, and correct use, of malaria prevention tools.

COST OF IMPLEMENTING THE GLOBAL TECHNICAL STRATEGY

105. In order to achieve the milestones and goals set out in this strategy, malaria investments, including both international and domestic contributions, need to increase substantially above the current annual spending of US\$ 2700 million. The annual investment will need to increase to an estimated total of US\$ 6400 million per year by 2020 to meet the first milestone of a 40% reduction in malaria incidence and mortality rates. This should then be further increased to an annual investment of an estimated US\$ 7700 million by 2025 to meet the second milestone of a 75% reduction. To achieve the 90% reduction goal, the total annual malaria spending will need to reach an estimated US\$ 8700 million by 2030.¹ The cost of implementation has been estimated from the quantities of goods required for expanding interventions, multiplied by the estimated unit cost for the provider of delivering each intervention, and an analysis of surveillance and financing data available in national

¹ The confidence interval for these estimates is 95%.

strategic plans and WHO's annual world malaria reports.¹ Additional funding of an average of US\$ 673 million (which ranges from US\$ 524 million to US\$ 822 million) will be needed annually for research and development. This estimate stems from a risk-adjusted portfolio model of malaria research and innovation needs until 2030.

MEASURING GLOBAL PROGRESS AND IMPACT

106. Global progress in reducing mortality and morbidity and finally eliminating malaria will be based on countries' surveillance efforts. Progress will be measured using multiple data sources, including routine information systems, household and health facility surveys and longitudinal studies. Progress should be monitored through a minimal set of 14 outcome and impact indicators (see Table 2) drawn from a larger set of indicators recommended by WHO and routinely tracked by malaria programmes. Certain indicators are applicable only to subsets of countries, which are defined by levels of malaria endemicity (e.g. intermittent preventive treatment of malaria for pregnant women in sub-Saharan Africa) or by the position on the path to elimination (e.g. investigation of cases and foci for programmes engaged in malaria elimination activities). For other indicators, such as those for vector control, the population at risk who may benefit from the intervention may be defined differently for programmes at different points along the path to elimination. Countries should ensure that a baseline for at least these 14 indicators where appropriate is available for 2015 so that it is possible to monitor progress through the course of the strategy.

Table 2. Indicators for the post-2015 global technical strategy for malaria 2016–2030

Outcome
<ul style="list-style-type: none"> • Proportion of population at risk who slept under an insecticide-treated net the previous night • Proportion of population at risk protected by indoor residual spraying within the past 12 months • Proportion of pregnant women who received at least three or more doses of intermittent preventive treatment of malaria while attending antenatal care during their previous pregnancy (sub-Saharan Africa only) • Proportion of patients with suspected malaria who receive a parasitological test • Proportion of patients with confirmed malaria who receive first-line antimalarial treatment according to national policy • Proportion of expected health facility reports received at national level • Proportion of malaria cases detected by surveillance systems • Proportion of cases investigated (programmes engaged in elimination) • Proportion of foci investigated (programmes engaged in elimination)
Impact
<ul style="list-style-type: none"> • Parasite prevalence: proportion of the population with evidence of infection with malaria parasites • Malaria case incidence: number of confirmed malaria cases per 1000 persons per year

¹ All world malaria reports are available at: http://www.who.int/malaria/publications/world_malaria_report/en/ (accessed 10 March 2015).

- Malaria mortality rate: number of malaria deaths per 100 000 persons per year
- Number of countries that have newly eliminated malaria since 2015
- Number of countries that were malaria-free in 2015 in which malaria was re-established

ROLE OF THE SECRETARIAT

107. The Secretariat will continue to provide support to Member States and work closely with organizations in the United Nations system, donors, intergovernmental organizations, institutions of research and academia and all other technical partners whose work is fundamental to a successful implementation of this strategy. The Secretariat will undertake the following activities to help to achieve global, regional and national targets for malaria control and elimination.

108. The Secretariat will continue to set, communicate and disseminate normative guidance, policy advice and implementation guidance to support country action. It will ensure that its policy-setting process – which includes the Malaria Policy Advisory Committee – is responsive to the rapidly changing malaria context and that its global technical guidance is regularly updated to incorporate innovative tools and strategies that are proven effective. The Secretariat will continue to assess and pre-qualify vector control products, diagnostics and antimalarial medicines.

109. The Secretariat will provide guidance and technical support to Member States in reviewing and updating their national malaria strategies in line with the priority actions outlined in this strategy. It will ensure that its own capacities are strengthened at the global, regional and country levels to enable it to lead a coordinated global effort to reduce the disease burden by at least 90% by 2030, and to support the implementation of all recommendations in this strategy. It will work with Member States to develop regional implementation plans, where appropriate.

110. The Secretariat will support countries in strengthening their national malaria surveillance systems in order to improve the quality, availability and management of malaria data, and to optimize the use of such data for decision making and programmatic responses. It will monitor implementation of the strategy and regularly evaluate progress towards the milestones and goals set for 2020, 2025 and 2030. It will also provide support to countries for developing nationally appropriate targets and indicators to facilitate the subregional monitoring of progress.

111. In line with its core roles, the Secretariat will continue to monitor regional and global malaria trends, and make these data available to countries and global malaria partners. It will support efforts to monitor the efficacy of medicines and vector control interventions, and – to this end – maintain global databases for efficacy of medicines and insecticide resistance. It will regularly report to the regional and global governing bodies of the Organization, the United Nations General Assembly, and other United Nations bodies.

112. WHO will promote the research and knowledge generation that is required to accelerate progress towards a world free of malaria.

113. The strategy will be updated at regular intervals in order to ensure linkage with the latest policy recommendations and complementary technical guidance.

ANNEX 2

Recommendations contained in the Report to the Director-General of the Review Committee on Second Extensions for Establishing National Public Health Capacities and on IHR Implementation¹

[A68/22 Add.1, Annex 1 – 27 March 2015]

Recommendation 1

States Parties that have indicated they have met the minimum core capacity requirements should be commended for their considerable efforts. At the same time, they should be reminded that implementation of the IHR is a dynamic, ongoing process that must be continually assessed, maintained and strengthened, as needed. These countries should be urged to continue their efforts to maintain and strengthen their core capacities, and to consider providing support to other States Parties that face technical, financial, political or other obstacles in establishing core capacities.

Recommendation 2

All States Parties that have requested a second extension (or do so at a future date) should be granted the extension for 2014–2016. In granting this extension, the Director-General should note if the request was accompanied by an implementation plan and if so, whether or not the plan adequately addressed the criteria for the extensions noted by the Sixty-sixth World Health Assembly. In communicating with the State Party, the Director-General may also take into account other relevant information that relates to the core capacities for that country. The Director-General's communication with the State Party could also be used by WHO regional and country offices to engage with the State Party and where appropriate, serve as a basis for priority setting, establishing next steps, and resource mobilization. WHO (at headquarters, regional and country levels) should continue to support these countries, as needed, in their efforts to implement core capacities.

Recommendation 3

States Parties that have not communicated their intentions to WHO should be reminded of the importance of transparency in relation to both the letter and the spirit of the IHR. These States Parties probably represent a diverse group ranging from those that may have met the requirements for core capacities but not reported to that effect, to those that have made limited progress. WHO should make further attempts to contact these States Parties, offer assistance, and provide them with the opportunity to: request an extension if it is needed; or indicate that they have met the minimum requirements under International Health Regulations (2005), Annex 1 and that, therefore, no extension is necessary.

¹ See resolution WHA68.5.

Recommendation 4

States Parties, stakeholders, and donor programmes should be encouraged to provide technical and financial assistance as needed. States Parties should be encouraged to use guidelines and tools that WHO has developed, or may in the future develop, to support implementation of the IHR.

Recommendation 5

The Committee recommends States Parties to:

- (a) Review, and where appropriate, strengthen and empower National IHR Focal Point entities to enable effective performance of key IHR functions, facilitate decision making and ensure high level support for multisectoral communication and cooperation;
- (b) Support the formation of multidisciplinary outbreak investigation and response teams, including animal health expertise, where appropriate;
- (c) Foster an operational approach in which cooperation between countries results in practical and sustainable solutions to surveillance, laboratory, and other capacities in small islands and other small States;
- (d) Use a risk assessment approach to prioritize public health threats, capacity gaps and to identify priority points of entry for designation and capacity building;
- (e) Build the confidence of health care workers through policy measures that promote the protection of and respect for the rights of health care workers.

Recommendation 6

The Committee also recommends to the Director-General to consider establishing technical working groups to:

- (a) Strengthen data management capacities and practices; and
- (b) Review the lessons learnt from current and past experience with public health measures that have had negative implications for travel, transport and trade.

Recommendation 7

The Review Committee recommends that the Director-General consider a variety of approaches for the shorter- and longer-term assessment and development of IHR core capacities as follows:

States Parties should urgently:

- (i) strengthen the current self-assessment system (e.g. if not already done, the annual self-assessment reports and planning processes should be enhanced through multisectoral and multistakeholder discussions); and
- (ii) implement in-depth reviews of significant disease outbreaks and public health events. This should promote a more science or evidence-based approach to assessing effective core capacities under “real-life” situations. Simultaneously, the Secretariat should promote a series of regional formal evaluations or meta-evaluations of the outbreak reviews, managed by the

regional offices, to facilitate cross-region learning and to distil lessons learnt for future IHR programming.

In parallel, and with a longer term vision, the Secretariat should develop, through regional consultative mechanisms, options to move from exclusive self-evaluation to approaches that combine self-evaluation, peer review and voluntary external evaluations involving a combination of domestic and independent experts. These additional approaches should consider, among other things, strategic and operational aspects of the IHR, such as the need for high-level political commitment, and whole of government/multi-sectoral engagement. Any new monitoring and evaluation scheme should be developed with the active involvement of WHO regional offices and subsequently proposed to all States Parties through the WHO governing bodies process.

Recommendation 8

A comprehensive, time-phased, prioritized plan for continued implementation and maintenance of the IHR to guide longer-term capacity development for the IHR should be developed based on the outcomes of the consultative process, analytic reviews and analyses mentioned above. Such a plan should be both realistic and with aspirational components, taking into account the wide disparities in States Parties' capacities and resources. Consideration should be given to delineating the basic core capacities that should be in place for all countries.

Recommendation 9

The Review Committee recommends that the Director-General encourage dialogue among States Parties and public and private partners, including large nongovernmental organizations, to improve cooperation and assistance:

- (a) Obtain support for the sustained development and maintenance of national capacities over the long term, with particular attention to countries requesting extensions/countries with significant capacity gaps;
- (b) Create a response fund, as recommended by the first Review Committee,¹ for use in public health emergencies of international concern that can be readily available for future events; and
- (c) Create a more extensive global, public health reserve workforce that can be mobilized as part of a sustained response to a public health emergency of international concern.

Recommendation 10

The Review Committee encourages the States Parties to support WHO through financial and staffing resources in preparation for, and during, public health emergencies of international concern.

¹ See document A64/10, recommendation 13.

ANNEX 3

Global action plan on antimicrobial resistance¹

[A68/20 – 27 March 2015]

INTRODUCTION

1. When microbes become resistant to medicines, the options for treating the diseases they cause are reduced. This resistance to antimicrobial medicines is happening in all parts of the world for a broad range of microorganisms with an increasing prevalence that threatens human and animal health. The direct consequences of infection with resistant microorganisms can be severe, including longer illnesses, increased mortality, prolonged stays in hospital, loss of protection for patients undergoing operations and other medical procedures, and increased costs. Antimicrobial resistance affects all areas of health, involves many sectors and has an impact on the whole of society.

2. The indirect impact of antimicrobial resistance, however, extends beyond increased health risks and has many public health consequences with wide implications, for instance on development. Antimicrobial resistance is a drain on the global economy with economic losses due to reduced productivity caused by sickness (of both human beings and animals) and higher costs of treatment. To counter it needs long-term investment, such as financial and technical support for developing countries and in development of new medicines, diagnostic tools, vaccines and other interventions, and in strengthening health systems to ensure more appropriate use of and access to antimicrobial agents.

3. The development of this global action plan on antimicrobial resistance, requested by the Health Assembly in resolution WHA67.25 in May 2014, reflects a global consensus that antimicrobial resistance poses a profound threat to human health. It reflects the input received to date from broad multisectoral and Member States' consultations.

4. The goal of the global action plan is to ensure, for as long as possible, continuity of successful treatment and prevention of infectious diseases with effective and safe medicines that are quality-assured, used in a responsible way, and accessible to all who need them. It is expected that countries will develop their own national action plans on antimicrobial resistance in line with the global plan.

5. To achieve this goal, the global action plan sets out five strategic objectives: (1) to improve awareness and understanding of antimicrobial resistance; (2) to strengthen knowledge through surveillance and research; (3) to reduce the incidence of infection; (4) to optimize the use of antimicrobial agents; and (5) to ensure sustainable investment in countering antimicrobial resistance. These objectives can be attained through the implementation of clearly identified actions by Member States, the Secretariat, and international and national partners across multiple sectors. The actions to optimize use of antimicrobial medicines and to renew investment in research and development of new products must be accompanied by actions to ensure affordable and equitable access by those who need them.

¹ See resolution WHA68.7.

6. With this approach, the main goal of ensuring treatment and prevention of infectious diseases with quality-assured, safe and effective medicines is achievable.

SCOPE

7. **Antibiotic resistance** develops when bacteria adapt and grow in the presence of antibiotics. The development of resistance is linked to how often antibiotics are used. Because many antibiotics belong to the same class of medicines, resistance to one specific antibiotic agent can lead to resistance to a whole related class. Resistance that develops in one organism or location can also spread rapidly and unpredictably, through, for instance, exchange of genetic material between different bacteria, and can affect antibiotic treatment of a wide range of infections and diseases. Drug-resistant bacteria can circulate in populations of human beings and animals, through food, water and the environment, and transmission is influenced by trade, travel and both human and animal migration. Resistant bacteria can be found in food animals and food products destined for consumption by humans.

8. Some of these features also apply to medicines that are used to treat viral, parasitic and fungal diseases; hence the broader term **antimicrobial resistance**.

9. The global action plan covers antibiotic resistance in most detail but also refers, where appropriate, to existing action plans for viral, parasitic and bacterial diseases, including HIV/AIDS, malaria and tuberculosis.¹ Many of the actions proposed in this plan are equally applicable to antifungal resistance in addition to resistance in those other microorganisms.

10. Antimicrobial resistance (and particularly antibiotic resistance) is spreading, and there are few prospects for the development of new classes of antibiotics in the short term. However, there is today considerable awareness of the need for, and political support for, action to combat antimicrobial resistance. Support is multisectoral, and there is increasing collaboration among the relevant sectors, in particular, human health, animal health and agriculture (including a tripartite collaboration agreed by FAO, OIE and WHO²). The need for urgent action is consistent with a precautionary approach,³ and national and international multisectoral action and collaboration should not be impeded by gaps in knowledge.

11. This global action plan provides the framework for national action plans to combat antimicrobial resistance. It sets out the key actions that the various actors involved should take, using an incremental approach over the next 5–10 years to combat antimicrobial resistance. These actions are structured around the five strategic objectives set out in paragraphs 29–47.

¹ World Health Organization global strategy for the surveillance and monitoring of HIV drug resistance. Geneva: World Health Organization; 2012. Guidelines for surveillance of drug resistance in tuberculosis, fourth edition. Geneva: World Health Organization; 2009. Companion handbook to the WHO guidelines for the programmatic management of drug-resistant tuberculosis. Geneva: World Health Organization; 2014. Global plan for artemisinin resistance containment. Geneva: World Health Organization; 2011. Emergency response to artemisinin resistance in the Greater Mekong subregion. Geneva: World Health Organization; 2013. See also resolution WHA62.15.

² The FAO-OIE-WHO Collaboration: sharing responsibilities and coordinating global activities to address health risks at the animal-human-ecosystems interfaces – a tripartite concept note, 2010, available at http://www.who.int/influenza/resources/documents/tripartite_concept_note_hanoi_042011_en.pdf (accessed 20 November 2014).

³ Section IV: Risk analysis, paragraph 11. In: Joint FAO/WHO Food Standards Programme. Codex Alimentarius Commission: procedural manual, twenty-third edition. Rome: Food and Agriculture Organization of the United Nations; 2015:110.

THE CHALLENGE

12. Improvements in global health over recent decades are under threat because the microorganisms that cause many common human diseases and medical conditions – including tuberculosis, HIV/AIDS, malaria, sexually transmitted diseases, urinary tract infections, pneumonia, blood-stream infections and food poisoning – have become resistant to a wide range of antimicrobial medicines. Doctors must increasingly use “last-resort” medicines that are more costly, may have more side effects and are often unavailable or unaffordable in low- and middle-income countries. Some cases of tuberculosis and gonorrhoea are now resistant even to antibiotics of last resort.

13. Resistance develops more rapidly through the misuse and overuse of antimicrobial medicines. Antibiotic use for human health is reported to be increasing substantially. Surveys in a wide range of countries show that many patients believe that antibiotics will cure viral infections that cause coughs, colds and fever. Antibiotics are needed to treat sick animals but are also widely used in healthy animals to prevent disease and, in many countries, to promote growth through mass administration to herds. Antimicrobial agents are commonly used in plant agriculture and commercial fish and seafood farming. The potential impact of antimicrobials in the environment is also of concern to many.

14. Antimicrobial resistance can affect all **patients and families**. Some of the commonest childhood diseases in developing countries – malaria, pneumonia, other respiratory infections, and dysentery – can no longer be cured with many older antibiotics or medicines. In lower-income countries, effective and accessible antibiotics are crucial for saving the lives of children who have those diseases, as well as other conditions such as bacterial blood infections. In all countries, some routine surgical operations and cancer chemotherapy will become less safe without effective antibiotics to protect against infections.

15. **Health care workers** have a vital role in preserving the power of antimicrobial medicines. Inappropriate prescribing and dispensing can lead to their misuse and overuse if medical staff lack up-to-date information, cannot identify the type of infection, yield to patient pressure to prescribe antibiotics, or benefit financially from supplying the medicines. Inadequate hygiene and infection prevention and control in hospitals help to spread infections. Hospital patients infected with methicillin-resistant *Staphylococcus aureus* have a higher risk of dying than those infected by a non-resistant form of the bacteria.

16. For **farmers, animal husbandry and the food industry**, the loss of effective antimicrobial agents to treat sick animals damages food production and family livelihoods. An additional risk for livestock workers is exposure to animals carrying resistant bacteria. For example, farmers working with cattle, pigs and poultry that are infected with methicillin-resistant *Staphylococcus aureus* have a much higher risk of also being colonized or infected with these bacteria. Food is one of the possible vehicles for transmission of resistant bacteria from animals to human beings and human consumption of food carrying antibiotic-resistant bacteria has led to acquisition of antibiotic-resistant infections. Other risks for infection with resistant organisms include exposure to crops treated with antimicrobial agents or contaminated by manure or slurry, and farmyard run-offs into groundwater.

17. Reducing antimicrobial resistance will require the **political will** to adopt new policies, including controlling the use of antimicrobial medicines in human health and animal and food production. In most countries, antibiotics can be purchased in markets, shops, pharmacies or over the Internet without prescription or involvement of a health professional or veterinarian. Poor quality medical and veterinary products are widespread, and often contain low concentrations of active ingredients, encouraging emergence of resistant microbes. Laws to ensure that medicines are of assured quality, safe, effective and accessible to those who need them need to be enacted and enforced.

18. The World Economic Forum has identified antibiotic resistance as a global risk beyond the capacity of any organization or nation to manage or mitigate alone,¹ but in general there is little awareness of the potential social, economic and financial impacts of drug resistance. In developed economies, these include higher health care costs and decreases in labour supply, productivity, household incomes, and national income and tax revenues. In the European Union alone, a subset of drug-resistant bacteria is responsible annually for some 25 000 deaths, with extra health care costs and lost productivity due to antimicrobial resistance amounting to at least €1500 million. Similar analyses are needed for low- and middle-income countries. Resistance to common veterinary antimicrobial medicines also causes food production losses, poor animal welfare and extra costs. Antimicrobial resistance is sapping the global economy and the full economic case needs to be made for long-term sustainable investment to tackle the problem, including the ensuring of access to financial and technical support for developing countries.

19. For the **pharmaceutical sector**, medicines that are no longer effective lose their value. Industry leaders are important partners in combating antimicrobial resistance, both by supporting the responsible use of medicines in order to prolong their effectiveness and through research and development of innovative medicines and other tools to combat resistance. No major new class of antibiotics has been discovered since 1987 and too few antibacterial agents are in development to meet the challenge of multidrug resistance. New concepts are needed for providing incentives for innovation and promoting cooperation among policy-makers, academia and the pharmaceutical industry to ensure that new technologies are available globally to prevent, diagnose and treat resistant infections. Public sector partnerships with the private sector are also important to help to ensure equitable access to quality-assured products and other related health technologies, through fair pricing and donations for the poorest populations.

THE WAY FORWARD

20. Despite proposals and initiatives over many years to combat antimicrobial resistance, progress has been slow, in part because of, on the one hand, inadequate monitoring and reporting at national, regional and global levels, and, on the other, inadequate recognition by all stakeholders of the need for action in their respective areas.

21. At the national level, operational action plans to combat antimicrobial resistance are needed to support strategic frameworks.² All Member States are urged to have in place, within two years of the endorsement of the action plan by the Health Assembly, national action plans on antimicrobial resistance that are aligned with the global action plan and with standards and guidelines established by intergovernmental bodies such as the Codex Alimentarius Commission, FAO and OIE. These national action plans are needed to provide the basis for an assessment of the resource needs, and should take into account national and regional priorities. Partners and other stakeholders, including FAO, OIE, the World Bank, industry associations and foundations, should also put in place and implement action plans in their respective field of responsibility to counter antimicrobial resistance, and report progress as part of their reporting cycles. All action plans should reflect the following principles:

¹ Howell L, Ed. Global risks 2013: eighth edition. Geneva: World Economic Forum, 2013.

² The Secretariat has worked with Member States to collate information on the status of national action plans on antimicrobial resistance and on regulations and policies for use of antimicrobial medicines. A report based on these data provides a baseline against which future progress at national and global levels can be monitored and reported, see <http://www.who.int/drugresistance/documents/situationanalysis/en/> (accessed 9 September 2015).

(1) **Whole-of-society engagement including a one-health approach.** Antimicrobial resistance will affect everybody, regardless of where they live, their health, economic circumstances, lifestyle or behaviour. It will affect sectors beyond human health, such as animal health, agriculture, food security and economic development. Therefore, everybody – in all sectors and disciplines – should be engaged in the implementation of the action plan, and in particular in efforts to preserve the effectiveness of antimicrobial medicines through conservation and stewardship programmes.

(2) **Prevention first.** Every infection prevented is one that needs no treatment. Prevention of infection can be cost effective and implemented in all settings and sectors, even where resources are limited. Good sanitation, hygiene and other infection prevention measures that can slow the development and restrict the spread of difficult-to-treat antibiotic-resistant infections are a “best buy”.

(3) **Access.** The aim to preserve the ability to treat serious infections requires both equitable access to, and appropriate use of, existing and new antimicrobial medicines. Effective implementation of national and global action plans to address antimicrobial resistance depends also on access, inter alia, to health facilities, health care professionals, veterinarians, preventive technologies, diagnostic tools including those which are “point of care”, and to knowledge, education and information.

(4) **Sustainability.** All countries should have a national action plan on antimicrobial resistance that includes an assessment of resource needs. The implementation of these plans will require long-term investment, for instance in surveillance, operational research, laboratories, human and animal health systems, competent regulatory capacities, and professional education and training, in both the human and animal health sectors. Political commitment and international collaboration are needed to promote the technical and financial investment necessary for effective development and implementation of national action plans.

(5) **Incremental targets for implementation.** Member States are at very different stages in terms of developing and implementing national plans to combat antimicrobial resistance. To enable all countries to make the most progress towards implementing the global action plan on antimicrobial resistance, flexibility will be built into the monitoring and reporting arrangements in order to allow each country to determine the priority actions that it needs to take in order to attain each of the five strategic objectives and to implement the actions in a stepwise manner that meets both local needs and global priorities.

CONSULTATIVE PROCESS

22. In May 2014, the Sixty-seventh World Health Assembly adopted resolution WHA67.25 on antimicrobial resistance, in which it requested, inter alia, the Director-General, to develop a draft global action plan to combat antimicrobial resistance, including antibiotic resistance, and to submit the draft to the Sixty-eighth World Health Assembly, through the Executive Board.

23. To initiate the preparation of a draft global action plan, the Secretariat used the recommendations of the Strategic and Technical Advisory Group on antimicrobial resistance,¹ existing national and regional action plans, WHO’s guidance and action plans on related subjects, as well as

¹ Details of the Strategic and Technical Advisory Group on antimicrobial resistance and its recommendations are available at: <http://www.who.int/drugresistance/stag/en/> (accessed 18 November 2014).

other available evidence and analysis.¹ The Secretariat regularly consulted FAO and OIE, for example through meetings as part of the tripartite collaboration and through their participation in other consultations, to ensure a one-health approach and consistency with Codex Alimentarius and OIE international standards and guidelines.

24. At its second meeting (Geneva, 14–16 April 2014),² the Strategic and Technical Advisory Group considered input from more than 30 additional participants, including representatives of intergovernmental organizations, civil society, public health and regulatory agencies, industry associations, professional organizations and patient groups. At a subsequent meeting (Geneva, 17 October 2014), the Advisory Group reviewed the text of the draft global action plan. The Strategic and Technical Advisory Group recently held its fourth meeting (Geneva, 24 and 25 February 2015) in order to provide advice to the Secretariat on finalization of the draft global action plan.

25. During July and August 2014 the Secretariat held a web-based consultation for Member States and other relevant stakeholders, attracting 130 comments and contributions, including 54 from Member States, 40 from nongovernmental organizations and 16 from private-sector entities.

26. Between June and November 2014, Member States, stakeholders and the Secretariat convened additional high-level technical, political and interagency discussions to contribute to the action plan.³ These included the Ministerial Conference on Antibiotic Resistance: joining forces for future health (The Hague, 25 and 26 June 2014); a meeting on the Global Health Security Agenda, including antimicrobial resistance (Jakarta, 20 and 21 August 2014); an informal Member States consultation to provide direct input on the draft plan (Geneva, 16 October 2014); a meeting on the responsible use of antibiotics (Oslo, 13 and 14 November 2014); and a meeting on global surveillance capacity, systems and standards (Stockholm, 2 and 3 December 2014).

STRATEGIC OBJECTIVES

27. The overall goal of the action plan is to ensure, for as long as possible, continuity of the ability to **treat and prevent infectious diseases with effective and safe medicines** that are quality-assured, used in a responsible way, and accessible to all who need them.

28. To achieve this overall goal, five strategic objectives have been identified. These are set out in paragraphs 29–47 with the corresponding actions for Member States, the Secretariat (including actions for FAO, OIE and WHO within the tripartite collaboration), and international organizations and other partners, in the table following paragraph 50. It is expected that countries will develop their own national action plans on antimicrobial resistance in line with the global plan.

Objective 1: Improve awareness and understanding of antimicrobial resistance through effective communication, education and training

29. Steps need to be taken immediately in order to raise awareness of antimicrobial resistance and promote behavioural change, through public communication programmes that target different

¹ Details of national and regional action plans, WHO guidance and action plans for specific diseases and health topics including antimicrobial resistance, standards and guidelines established by intergovernmental organizations such as FAO and OIE, and other information taken into account are documented in supplementary material, see <http://www.who.int/drugresistance/documents/situationanalysis/en/> (accessed 9 September 2015).

² The report of the meeting is available at: http://apps.who.int/iris/bitstream/10665/128675/1/WHO_HSE_PED_AIP_2014.4_eng.pdf?ua=1&ua=1 (accessed 18 November 2014).

³ Information on these consultations is available at: <http://www.who.int/drugresistance/en/> (accessed 9 March 2015).

audiences in human health, animal health and agricultural practice as well as consumers. Inclusion of the use of antimicrobial agents and resistance in school curricula will promote better understanding and awareness from an early age.

30. Making antimicrobial resistance a core component of professional education, training, certification, continuing education and development in the health and veterinary sectors and agricultural practice will help to ensure proper understanding and awareness among professionals.

Objective 2: Strengthen the knowledge and evidence base through surveillance and research

31. Actions and investments to tackle antimicrobial resistance should be supported by clear rationales of their benefit and cost-effectiveness. National governments, intergovernmental organizations, agencies, professional organizations, nongovernmental organizations, industry and academia have important roles in generating such knowledge and translating it into practice.

32. Particularly important gaps in knowledge that need to be filled include the following:

- Information on: the incidence, prevalence, range across pathogens and geographical patterns related to antimicrobial resistance is needed to be made accessible in a timely manner in order to guide the treatment of patients; to inform local, national and regional actions; and to monitor the effectiveness of interventions;
- Understanding how resistance develops and spreads, including how resistance circulates within and between humans and animals and through food, water and the environment, is important for the development of new tools, policies and regulations to counter antimicrobial resistance;
- The ability rapidly to characterize newly emerged resistance in microorganisms and elucidate the underlying mechanisms; this knowledge is necessary to ensure that surveillance and diagnostic tools and methods remain current;
- Understanding social science and behaviour, and other research needed to support the achievement of Objectives 1, 3 and 4, including studies to support effective antimicrobial stewardship programmes in human and animal health and agriculture;
- Research, including clinical studies conducted in accordance with relevant national and international governance arrangements, on treatments and prevention for common bacterial infections, especially in low resource settings;
- Basic research and translational studies to support the development of new treatments, diagnostic tools, vaccines and other interventions;

- Research to identify alternatives to nontherapeutic uses of antimicrobial agents in agriculture and aquaculture, including their use for growth promotion and crop protection;
- Economic research, including the development of models to assess the cost of antimicrobial resistance and the costs and benefits of this action plan.

33. WHO's global report on surveillance of antimicrobial resistance¹ also revealed many gaps in information on antimicrobial resistance in pathogens of major public health importance. International standards on harmonization of national antimicrobial resistance surveillance and monitoring programmes were adopted by OIE's members in 2012, but there are no internationally agreed standards for collection of data and reporting on antibacterial resistance in human health, and no harmonizing standards across medical, veterinary and agricultural sectors. In addition, there is no global forum for the rapid sharing of information on antimicrobial resistance.

34. In 2013, some Member States of the European Union published a strategic research agenda on antimicrobial resistance through a joint programming initiative.² This initiative, which includes some countries outside the European Union, could provide an initial framework for further development of a global strategic research agenda.

Objective 3: Reduce the incidence of infection through effective sanitation, hygiene and infection prevention measures

35. Many of the most serious and difficult-to-treat antibiotic-resistant infections occur in health care facilities, not only because that is where patients with serious infections are admitted but also because of the intensive use therein of antibiotics. Although the development of resistance in such situations may be a natural consequence of necessary antimicrobial use, inadequate measures to prevent and control infection may contribute to the spread of microorganisms resistant to antimicrobial medicines.

36. Better hygiene and infection prevention measures are essential to limit the development and spread of antimicrobial-resistant infections and multidrug-resistant bacteria. Effective prevention of infections transmitted through sex or drug injection as well as better sanitation, hand washing, and food and water safety must also be core components of infectious disease prevention.

37. Vaccination, where appropriate as an infection prevention measure, should be encouraged. Immunization can reduce antimicrobial resistance in three ways:

- Existing vaccines can prevent infectious diseases whose treatment would require antimicrobial medicines;
- Existing vaccines can reduce the prevalence of primary viral infections, which are often inappropriately treated with antibiotics, and which can also give rise to secondary infections that require antibiotic treatment;
- Development and use of new or improved vaccines can prevent diseases that are becoming difficult to treat or are untreatable owing to antimicrobial resistance.

¹ Antimicrobial resistance: global report on surveillance 2014. Geneva: World Health Organization; 2014.

² Strategic Research Agenda: Joint Programming Initiative on Antimicrobial Resistance. The Hague, JPIAMR, 2013.

38. Much antibiotic use is linked to animal production. Antibiotics are sometimes used to prevent infections, to prevent the spread of diseases within a herd when infection occurs, and as a growth stimulant, and are often administered through feed and water. Sustainable husbandry practices, including the use of vaccines, can reduce infection rates and dependence on antibiotics as well as the risk that antibiotic-resistant organisms will develop and spread through the food chain.

Objective 4: Optimize the use of antimicrobial medicines in human and animal health

39. Evidence that antimicrobial resistance is driven by the volume of use of antimicrobial agents is compelling. High antibiotic use may reflect over-prescription, easy access through over-the-counter sales, and more recently sales via the Internet which are widespread in many countries. Despite measures taken by some Member States, antibiotic use in humans, animals and agriculture is still increasing globally. The projected increase in demand for animal food products may lead to yet further increases in antibiotic use.

40. Data on antibiotic use are collected and analysed in many high- and middle-income countries and OIE is developing a database on antibiotic use in animals. However, data are lacking on antibiotic use in human beings at the point of care and from lower-income countries.

41. More widespread recognition of antimicrobial medicines as a public good is needed in order to strengthen regulation of their distribution, quality and use, and encourage investment in research and development. In some cases, industry spending on promoting products is greater than governmental investment in promoting rational use of antimicrobial medicines or providing objective information.

42. Decisions to prescribe antibiotics are rarely based on definitive diagnoses. Effective, rapid, low-cost diagnostic tools are needed for guiding optimal use of antibiotics in human and animal medicine, and such tools should be easily integrated into clinical, pharmacy and veterinary practices. Evidence-based prescribing and dispensing should be the standard of care.

43. Regulation of the use of antimicrobial agents is inadequate or poorly enforced in many areas, such as over-the-counter and Internet sales. Related weaknesses that contribute to development of antimicrobial resistance include poor patient and health care provider compliance, the prevalence of substandard medicines for both human and veterinary use, and inappropriate or unregulated use of antimicrobial agents in agriculture.

Objective 5: Develop the economic case for sustainable investment that takes account of the needs of all countries, and increase investment in new medicines, diagnostic tools, vaccines and other interventions

44. The economic case must reflect the need for capacity development, including training in low-resource settings, and the need for the evidence-based use of interventions across human and animal health care systems including medicines, diagnostic tools and vaccines.

45. Economic impact assessments are needed on the health and broader socioeconomic burden of antimicrobial resistance, and should compare the cost of doing nothing against the cost and benefit of action. Lack of such data hindered implementation of the 2001 Global Strategy for Containment of

Antimicrobial Resistance.¹ The few studies on the economic cost of antimicrobial resistance are limited chiefly to developed countries.

46. Investment in the development of new antimicrobial medicines, as well as in diagnostic tools and vaccines, is needed urgently. Lack of such investment reflects, in part, fears that resistance will develop rapidly and that returns on investment will be limited because of restrictions in use. Thus research and development of new antibiotics is seen as a less attractive business investment than that of medicines for chronic diseases. Currently most major pharmaceutical companies have stopped research in this area, a situation described by WHO's Consultative Expert Working Group on Research and Development: Financing and Coordination² as "a serious market failure" and "a particular cause for concern". New processes are needed both to facilitate renewed investment in research and development of new antibiotics, and to ensure that use of new products is governed by a public health framework of stewardship that conserves the effectiveness and longevity of such products. The cost of investment in research and development may need to be de-linked from price and the volume of sales to facilitate equitable and affordable access to new medicines, diagnostic tools, vaccines and other results from research and development in all countries. Many forums have been created in recent years to discuss these issues.³

47. Antibiotics must also be supplemented by affordable, point-of-care diagnostic tools to inform health practitioners and veterinarians of the susceptibility of the pathogens to available antibiotics. The applicability and affordability of these techniques in low- and middle-income countries must be considered.

FRAMEWORK FOR ACTION ON ANTIMICROBIAL RESISTANCE

48. The framework presented below tabulates the actions that the Member States, Secretariat and international and national partners need to take in order to attain the goal and meet the objectives of the global plan.

49. All Member States are urged to have in place, within two years of the endorsement of the action plan by the Health Assembly, national action plans on antimicrobial resistance that are aligned with the global action plan and with standards and guidelines established by intergovernmental bodies such as the Codex Alimentarius Commission, FAO and OIE. These national action plans should provide the basis for an assessment of the resource needs, take into account national and regional priorities, and address relevant national and local governance arrangements. The Secretariat will facilitate this work by:

- Supporting countries to develop, implement and monitor national plans;
- Leading and coordinating support to countries for assessment and implementation of investment needs, consistent with the principle of sustainability (subparagraph 21(4) above);

¹ Implementation workshop on the WHO global strategy for containment of antimicrobial resistance. Geneva: World Health Organization; 2003.

² Research and development to meet health needs in developing countries: strengthening global financing and coordination. Report of the consultative expert working group on research and development: financing and coordination. Geneva: World Health Organization; 2012.

³ Several existing initiatives were reviewed at WHO's Technical Consultation on Innovative Models for New Antibiotics' Development and Preservation (Geneva, 13 May 2014) (http://www.who.int/phi/implementation/consultation_imnnp/en/, accessed 20 November 2014).

- Monitoring development and implementation of action plans by Member States and other partners;
- Publishing biennial progress reports, including an assessment of countries and organizations that have plans in place, their progress in implementation, and the effectiveness of action at regional and global levels; and including an assessment of progress made by FAO, OIE and WHO in implementing actions undertaken within the organizations' tripartite collaboration will also be included in these reports.

50. The Secretariat will also work with the Strategic and Technical Advisory Group on antimicrobial resistance, Member States, FAO and OIE, and other relevant partners to develop a framework for monitoring and evaluation, including the identification of measurable indicators of implementation and effectiveness of the global action plan. Examples of such indicators of effectiveness (impact) that could be applied for each of the strategic objectives are shown in the tabulated framework.

Objective 1: Improve awareness and understanding of antimicrobial resistance through effective communication, education and training		
Potential measures of effectiveness: extent of reduction in global human consumption of antibiotics (with allowance for the need for improved access in some settings), and reduction in the volume of antibiotic use in food production		
Member State action	Secretariat action	International and national partners' action
<p>Increase national awareness of antimicrobial resistance through public communication programmes that target the different audiences in human health, animal health and agricultural practice, including participation in an annual world antibiotic awareness campaign.</p> <p>Establish antimicrobial resistance as a core component of professional education, training, certification and development for the health and veterinary sectors and agricultural practice.</p> <p>Include antimicrobial use and resistance in school curricula in order to promote better understanding and awareness, and provide the public media with accurate and relevant information so that public information and reporting reinforce key messages.</p>	<p>Develop and implement global communication programmes and campaigns, including an annual world antibiotic awareness campaign, building on existing regional and national campaigns and in partnership with other organizations (e.g. UNESCO and UNICEF). Provide core communication materials and tools (including those for social media and for assessing public awareness and understanding) that can be adapted and implemented by Member States and others.</p> <p>Develop, with FAO and OIE through the tripartite collaboration, core communication, education and training materials that can be adapted and implemented regionally and nationally, on subjects that include the need for responsible use of antibiotics, the importance of infection prevention</p>	<p>Professional organizations and societies should establish antimicrobial resistance as a core component of education, training, examination, professional registration or certification, and professional development.</p> <p>OIE should continue to support its members in implementing OIE standards including veterinary professional standards and training, applying its Performance of Veterinary Services Pathway¹ and updating of legislation.</p> <p>FAO should support awareness-raising on antimicrobial resistance and promote good animal production and hygiene practices among animal production and health workers, animal producers, and other stakeholders in the food and agriculture sectors.</p> <p>Intergovernmental organizations, including FAO, OIE and the</p>

¹ See: <http://www.oie.int/support-to-oie-members/pvs-evaluations/> (accessed 20 November 2014).

<p>Recognize antimicrobial resistance as a priority need for action across all government ministries through inclusion in national risk registers or other effective mechanisms for cross-government commitment.</p> <p>Promote and support establishment of multisectoral (one-health) coalitions to address antimicrobial resistance at local or national level, and participation in such coalitions at regional and global levels.</p>	<p>in human and animal health and agricultural practice, and measures to control spread of resistant organisms through food and the environment. Provide support to Member States with the integration of education on antimicrobial resistance into professional training, education and registration.</p> <p>Publish regular reports on progress in implementing the global action plan and progress towards meeting impact targets, in order to maintain commitment to reducing antimicrobial resistance.</p> <p>Maintain antimicrobial resistance as a priority for discussion with Member States through the regional committees, the Executive Board and Health Assembly, and with other intergovernmental organizations, including the United Nations.</p>	<p>World Bank, should raise awareness and understanding of antimicrobial resistance and, in collaboration with WHO, should mirror the actions of the Secretariat within their constituencies.</p> <p>Other stakeholders – including civil society organizations, trade and industry bodies, employee organizations, foundations with an interest in science education, and the media – should help to promote public awareness and understanding of infection prevention and use of antimicrobial medicines across all sectors.</p> <p>WHO, FAO, OIE and other international stakeholders should encourage and support Member States in forging in-country as well as regional/global coalitions and alliances.</p>
<p>Objective 2: Strengthen the knowledge and evidence base through surveillance and research</p>		
<p>Potential measure of effectiveness: extent of reduction in the prevalence of antimicrobial resistance, based on data collected through integrated programmes for surveillance of antimicrobial resistance in all countries</p>		
Member State action	Secretariat action	International and national partners' action
<p>Develop a national surveillance system for antimicrobial resistance that:</p> <ul style="list-style-type: none"> includes a national reference centre with the ability systematically to collect and analyse data – including those on a core set of organisms and antimicrobial medicines from both health care facilities and the community – in order to inform national policies and decision-making; includes at least one reference laboratory capable of susceptibility testing to fulfil the core data requirements, using standardized tests for identification of resistant microorganisms and operating to agreed quality standards; strengthens surveillance in animal health and agriculture sectors by implementation of 	<p>Develop and implement a global programme for surveillance of antimicrobial resistance in human health, including surveillance and reporting standards and tools, case definitions, external quality assessment schemes, and a network of WHO Collaborating Centres to support surveillance of antimicrobial resistance and external quality assessment in each WHO region.</p> <p>Develop, in consultation with Member States and other multisectoral stakeholders, standards for the reporting, sharing and publication of data on antimicrobial resistance that take into account established practices for global disease surveillance and reporting, as well as legal and ethical requirements.</p> <p>Report regularly on global and regional trends in the prevalence</p>	<p>FAO, with WHO, should review and update regularly the FAO/WHO Codex Alimentarius Code of Practice to minimize and contain antimicrobial resistance and the Codex Alimentarius guidelines for risk analysis of foodborne antimicrobial resistance.</p> <p>The international research community and FAO should support studies to improve understanding of the impact of antimicrobial resistance on agriculture, animal production and food security, as well as the impacts of agricultural practices on development and spread of antimicrobial resistance, and to reduce non-therapeutic use of antimicrobial agents in agriculture through the development of sustainable husbandry practices.</p>

<p>the recommendations of the WHO Advisory Group on Integrated Surveillance of Antimicrobial Resistance for antimicrobial susceptibility testing of foodborne pathogens,¹ the standards published in the OIE terrestrial and aquatic animal codes including the monitoring of resistance and antimicrobial use;^{2,3} the FAO/WHO Codex Alimentarius Code of Practice to Minimize and Contain Antimicrobial Resistance⁴ and the Codex Alimentarius Guidelines for Risk Analysis of Foodborne Antimicrobial Resistance;</p> <ul style="list-style-type: none"> • promotes participation in regional and global networks and sharing of information so that national, regional and global trends can be detected and monitored; • has the capacity to detect and report newly emerged resistance that may constitute a public health emergency of international concern, as required under the International Health Regulations (2005). <p>Collect and report data on use of antimicrobial agents in human and animal health and agriculture so that trends can be monitored and the impact of action plans assessed.</p> <p>Consider implementing an agreed global public health research agenda on antimicrobial resistance, including: research to promote responsible use of antimicrobial medicines; defining</p>	<p>of antimicrobial resistance in human health.</p> <p>Work with FAO and OIE, within the tripartite collaboration, to support integrated surveillance and reporting of antimicrobial resistance in human and animal health and agriculture, and develop measures of antimicrobial resistance in the food chain for use as indicators of risk to human health.</p> <p>Develop a framework for monitoring and reporting on antimicrobial consumption in human health, including standards for collection and reporting of data on use in different settings, building on the work of OECD.⁵</p> <p>With FAO and OIE, within the tripartite collaboration, collect, consolidate and publish information on the global consumption of antimicrobial medicines.</p> <p>Consult Member States and other multisectoral stakeholders for the development of a global public health research agenda for filling major gaps in knowledge on antimicrobial resistance, including methods to assess the health and economic burdens of antimicrobial resistance, cost-effectiveness of actions, mechanisms of development and spread of resistance, and research to underpin development of new interventions, diagnostic tools and vaccines. Monitor and report on implementation of the research agenda, for instance through the use of WHO's Global Health</p>	<p>OIE should regularly update the terrestrial and aquatic animal codes (particularly with reference to antimicrobial resistance), revise the guideline on laboratory methods for bacterial antimicrobial susceptibility testing, and support the establishment of veterinary laboratory services through its Performance of Veterinary Services Pathway.</p> <p>Global health donors, international development bodies, and aid and technical agencies should support developing countries to build capacity to collect and analyse data on the prevalence of antimicrobial resistance and share or report such data.</p> <p>Research funding organizations and foundations should support implementation of the agreed global public health research agenda on antimicrobial resistance.</p>
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¹ Integrated surveillance on antimicrobial resistance: guidance from a WHO advisory group. Geneva: World Health Organization; 2013.

² See document CAC/GL 77-2011 at: <http://www.codexalimentarius.org/standards/list-of-standards/en/> (accessed 20 November 2014).

³ See: <http://www.oie.int/en/our-scientific-expertise/veterinary-products/antimicrobials> (accessed 20 November 2014).

⁴ See: <http://www.codexalimentarius.org/committees-task-forces//?provide=committeeDetail&idList=6> (accessed 20 November 2014).

⁵ Prescribing in primary care. In: Health at a glance 2013: OECD Indicators. Paris: Organisation for Economic Co-operation and Development; 2013.

<p>improved practices for preventing infection in human and animal health and agricultural practice; and encouraging development of novel diagnostic tools and antimicrobial medicines.</p>	<p>Research and Development Observatory.</p> <p>Work with partners to establish a sustainable repository for information on antimicrobial resistance and on the use and efficacy of antimicrobial medicines that is integrated with the global health research and development observatory and with a programme for independent evidence assessment and evaluation.</p>	
<p>Objective 3: Reduce the incidence of infection through effective sanitation, hygiene and infection prevention measures</p> <p>Potential measures of effectiveness: extent of reduction in the prevalence of preventable infections, and in particular the incidence of drug-resistant infections in health care settings</p>		
<p>Member State action</p>	<p>Secretariat action</p>	<p>International and national partners' action</p>
<p>Member States may consider the following actions:</p> <ul style="list-style-type: none"> • take urgent action to implement and strengthen hygiene and infection prevention and control; • include training and education in hygiene and infection prevention and control as core (mandatory) content in training and education for health care and veterinary professionals and in their continuing professional development and accreditation or registration. • develop or strengthen national policies and standards of practice regarding infection prevention and control activities in health facilities and monitor implementation of and adherence to these national policies and standards. <p>Include within national surveillance of antimicrobial resistance the collection and reporting of data on antimicrobial susceptibility of microorganisms causing health care-associated infections.</p> <p>Strengthen animal health and agricultural practices through implementation of the standards</p>	<p>Facilitate the design and implementation of policies and tools to strengthen hygiene and infection prevention and control practices, particularly to counter antimicrobial resistance, and promote the engagement of civil society and patient groups in improving practices in hygiene and infection prevention and control.</p> <p>Ensure that policy recommendations for new and existing vaccines take into account the prospects for restricted treatment options because of antimicrobial resistance, and the additional benefits of reduced use of antimicrobial agents, including antibiotics.</p> <p>Work with partners and other organizations to facilitate the development and clinical evaluation of specific priority vaccines for the prevention of difficult-to-treat or untreatable infections.</p> <p>Work with FAO and OIE, within the tripartite collaboration, to develop recommendations for the use of vaccines in food-producing animals, including recommendations for new vaccines, as a means to prevent</p>	<p>Professional societies and accreditation bodies should support training and education on infection-prevention measures as a mandatory requirement in professional development, accreditation and registration.</p> <p>OIE should update its codes and manuals to take account of new developments in vaccines.</p> <p>FAO should continue to engage and support producers and stakeholders in the food and agriculture sectors in adopting good practices in animal husbandry and health aimed at reducing the use of antibiotics and the risk of development and spread of antimicrobial resistance.</p>

<p>published in the OIE Terrestrial and Aquatic Animal Health Codes¹ and FAO/WHO Codex Alimentarius Code of Practice to Minimize and Contain Antimicrobial Resistance.²</p> <p>Promote vaccination as a method of reducing infections in food animals.</p>	<p>foodborne diseases in humans and animals and reduce antimicrobial use.</p>	
<p>Objective 4: Optimize the use of antimicrobial medicines in human and animal health</p> <p>Potential measure of effectiveness: extent of reduction in global human consumption of antibiotics (with allowance for the need for improved access in some settings), the consumption of antibiotics used in food production (terrestrial and aquatic livestock, and other agricultural practices), and the use of medical and veterinary antimicrobial agents for applications other than human and animal health</p>		
Member State action	Secretariat action	International and national partners' action
<p>Develop and implement comprehensive action plans on antimicrobial resistance that incorporate the following elements:</p> <ul style="list-style-type: none"> • distribution, prescription, and dispensing of antimicrobials is carried out by accredited health or veterinary professionals under statutory body supervision or other suitably trained person authorized in accordance with national legislation; • marketing authorization is given only to antimicrobial agents that are quality assured, safe and efficacious; • development and implementation of national and institutional essential medicine lists guided by the WHO Model Lists of Essential Medicines, reimbursement lists and standard treatment guidelines to guide purchasing and prescribing of antimicrobial medicines, and regulation and control of promotional practices by industry; 	<p>Strengthen and align, within the tripartite collaboration with FAO and OIE, the concepts of critically important antibiotics for human and animal health, and ensure that these concepts include use of new antibiotics so that a common position on restriction of antimicrobial medicines for human use can be established.</p> <p>Provide support to Member States in the development and enforcement of relevant regulations so that only, quality assured, safe and effective antimicrobial products reach users.</p> <p>Develop technical guidelines and standards to support access to, and evidence-based selection and responsible use of, antimicrobial medicines, including follow-up to treatment failure.</p> <p>Provide leadership to strengthen medicines regulatory systems at national and regional levels, so that appropriate practices for optimizing use of antimicrobial medicines are supported by appropriate and enforceable</p>	<p>OIE should regularly update its Terrestrial and Aquatic Animal Health Codes, particularly with reference to antimicrobial resistance.</p> <p>FAO, in collaboration with WHO, should regularly review and update the FAO/WHO Codex Alimentarius Code of Practice to Minimize and Contain Antimicrobial Resistance to take into account not only residues in food but also the need for standards to minimize and control use of antimicrobial agents in agricultural practice.</p> <p>OIE, supported by FAO and WHO within the tripartite collaboration, should build and maintain a global database on the use of antimicrobial medicines in animals.</p> <p>The research community in both the public and private sectors, including the pharmaceutical industry, should invest in the development of effective and low-cost tools for diagnosis of infectious diseases and antimicrobial susceptibility testing for use in human and animal</p>

¹ See: <http://www.oie.int/en/our-scientific-expertise/veterinary-products/antimicrobials> (accessed 20 November 2014).

² See: <http://www.codexalimentarius.org/committees-task-forces/?provide=committeeDetail&idList=6> (accessed 29 October 2014).

<ul style="list-style-type: none"> • laboratory capacity to identify pathogens and their antimicrobial susceptibility in order to guide optimal use of antimicrobial medicines in clinical practice; • provision of stewardship programmes that monitor and promote optimization of antimicrobial use at national and local levels in accordance with international standards in order to ensure the correct choice of medicine at the right dose on the basis of evidence; • identification and elimination of economic incentives in all sectors that encourage inappropriate use of antimicrobial agents, and introduction of incentives to optimize use; • effective and enforceable regulation and governance for licensing, distribution, use and quality assurance of antimicrobial medicines in human and animal health, including a regulatory framework for preservation of new antibiotics; • policies on use of antimicrobial agents in terrestrial and aquatic animals and agriculture, including: implementation of Codex Alimentarius and OIE international standards and guidelines as well as WHO/OIE guidance on the use of critically important antibiotics; phasing out of use of antibiotics for animal growth promotion and crop protection in the absence of risk analysis; and reduction in nontherapeutic use of antimicrobial medicines in animal health. 	<p>regulation, and that promotional practices can be adequately regulated.</p> <p>Consult with Member States and pharmaceutical industry associations on innovative regulatory mechanisms for new antimicrobial medicines, for example considering them as a class of medicine that will require a different set of regulatory controls, and on new approaches to product labelling that focus on public health needs rather than marketing claims, in order to address the need for preservation of effectiveness and for global access.</p> <p>Develop standards and guidance (within the tripartite collaboration with FAO and OIE), based on best available evidence of harms, for the presence of antimicrobial agents and their residues in the environment, especially in water, wastewater and food (including aquatic and terrestrial animal feed).</p>	<p>health at points of care and dispensing (pharmacies).</p> <p>Donors, philanthropic and other nongovernmental organizations and civil society should ensure that their efforts to increase access to antimicrobial medicines are accompanied by measures to protect the continued efficacy of such medicines.</p> <p>Professional bodies and associations, including industry associations, health insurance providers and other payers, should develop a code of conduct for appropriate training in, education about, and marketing, purchasing, reimbursement and use of antimicrobial agents. This code should include commitment to comply with national and international regulations and standards, and to eliminate dependence on the pharmaceutical industry for information and education on medicines and, in some cases, income.</p>
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Objective 5: Develop the economic case for sustainable investment that takes account of the needs of all countries, and increase investment in new medicines, diagnostic tools, vaccines and other interventions

Potential measures of effectiveness: extent of increase in sustainable investment in capacity to counter antimicrobial resistance for all countries, including investment in development of new medicines, diagnostics and other interventions

Member State action	Secretariat action	International and national partners' action
<p>Member States should consider assessing investment needs for implementation of their national action plans on antimicrobial resistance, and should develop plans to secure and apply the required financing.</p> <p>Member States are encouraged to participate in international collaborative research to support the development of new medicines, diagnostic tools and vaccines through:</p> <ul style="list-style-type: none"> • prioritization and support of basic scientific research on infectious diseases, and promoting partnerships between research institutions in developed and developing countries; • collaboration, based on fair and equitable benefit sharing as mutually agreed, in the investigation of natural sources of biodiversity and biorepositories as sources for the development of new antibiotics; • strengthening existing and creating new public–private partnerships for encouraging research and development of new antimicrobial agents and diagnostics; • piloting of innovative ideas for financing research and development and for the adoption of new market models to encourage investment and ensure access to new antimicrobial products. 	<p>Work with the United Nations Secretary-General and bodies in the United Nations system to identify the best mechanism(s) to realize the investment needed to implement the global action plan on antimicrobial resistance, particularly with regard to the needs of developing countries.</p> <p>Work with the World Bank and with other development banks to develop and implement a template or models to estimate the investment needed to implement national action plans on antimicrobial resistance, and to collate and summarize these needs.</p> <p>Work with the World Bank and with FAO and OIE, within the tripartite collaboration, to assess the economic impact of antimicrobial resistance and of implementation of the action plan in animal health and agriculture.</p> <p>Explore with Member States, intergovernmental organizations, industry associations and other stakeholders, options for the establishment of a new partnership or partnerships:</p> <ul style="list-style-type: none"> • to coordinate the work of many unlinked initiatives aiming to renew investment in research and development of antibiotics (including follow-up initiatives from the Consultative Expert Working Group on Research and Development¹); 	<p>Partners in the finance and economic sectors should define the economic case for national and global investment in combating antimicrobial resistance, including an assessment of the cost of implementing this action plan and the consequential cost of no action; this work could be led by the World Bank.</p> <p>FAO, OIE and other partners should support appropriate analyses to establish the case for investment and to inform the selection of interventions to improve animal husbandry, management, health, hygiene and biosecurity practices aimed at reducing antimicrobial use (and antimicrobial resistance) in different production settings.</p>

¹ Research and development to meet health needs in developing countries: strengthening global financing and coordination. Report of the consultative expert working group on research and development: financing and coordination. Geneva: World Health Organization; 2012.

	<ul style="list-style-type: none">• to identify priorities for new treatments, diagnostics and vaccines on the basis of emergence and prevalence of serious or life-threatening infections caused by resistant pathogens;• to act as the vehicle(s) for securing and managing investment in new medicines, diagnostics, vaccines and other interventions;• to facilitate affordable and equitable access to existing and new medicines¹ and other products while ensuring their proper and optimal use;• to establish open collaborative models of research and development in a manner that will support access to the knowledge and products from such research, and provide incentives for investment.	
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¹ Many of the actions that can support affordable and equitable access to medicines are set out in the Global strategy and plan of action on public health, innovation and intellectual property. Geneva: World Health Organization; 2011.

ANNEX 4

Text of the amended Staff Regulations¹

[A68/46 – 17 April 2015]

STAFF REGULATIONS – ARTICLE IV

Appointment, Transfer, Reassignment and Promotion

- 4.1 The Director-General shall appoint, transfer, reassign and promote staff members as required without regard to race, sex or religion.
- 4.2 The paramount consideration in the appointment, transfer, reassignment or promotion of staff members shall be the necessity of securing the highest standards of efficiency, competence and integrity. Due regard shall be paid to the importance of recruiting staff members on as wide a geographical basis as possible.
- 4.3 So far as is practicable, selection shall be made on a competitive basis; however, the foregoing shall not apply to the filling of positions by transfer or reassignment of a staff member without promotion in the interest of the Organization.
- 4.4 Without prejudice to the inflow of fresh talent, posts shall be filled by reassignment of staff members, as defined by, and under conditions established by, the Director-General, in preference to other persons. This preference shall also be applied, on a reciprocal basis, to the United Nations and specialized agencies brought into relationship with the United Nations.

...

STAFF REGULATIONS – ARTICLE IX

Separation from Service

...

- 9.2 The Director-General may terminate the appointment of a staff member in accordance with the terms of his appointment, if the necessities of the service require abolition of the post or reduction of the staff, if the services of the staff member prove unsatisfactory, if he refuses, or fails to take up, a reasonable reassignment or if he is, for reasons of health, incapacitated for further service.

...

¹ Text amended in accordance with resolution WHA68.17.

ANNEX 5

Global strategy and plan of action on public health, innovation and intellectual property: terms of reference of the comprehensive evaluation¹

[A68/35, paragraphs 12–17 – 15 May 2015]

[Paragraphs 1–11 set out the background and introduce the options for consideration.]

12. The overall purpose of the comprehensive evaluation is to assess the status of implementation of the eight elements of the global strategy:

- (a) prioritizing research and development needs
- (b) promoting research and development
- (c) building and improving innovative capacity
- (d) transfer of technology
- (e) application and management of intellectual property to contribute to innovation and promote public health
- (f) improving delivery and access
- (g) promoting sustainable financing mechanisms
- (h) establishing monitoring and reporting systems.

13. Covering the period 2008–2015, the evaluation would document achievements, gaps and remaining challenges and make recommendations on the way forward. It would also inform the overall programme review.

14. The scope of the evaluation would cover implementation of the eight elements of the strategy itself and the 108 specific actions defined in the action plan. It would look at such implementation by all stakeholders listed in the action plan at different levels (global, regional and national), including looking at implementation by national governments, the Secretariat and other relevant stakeholders.

15. The evaluation would comply with the WHO evaluation policy. It would be commissioned and managed by the WHO Evaluation Office, supported by an ad hoc evaluation management group.

16. The evaluation would be conducted by an external independent evaluator, selected through an open tender. The evaluator would be an independent external organization or team with appropriate knowledge of the subject of the evaluation and skill mix, as well as relevant experience in performing

¹ See resolution WHA68.18.

evaluations involving innovation strategies in public health and access to medical products and technologies.

17. The evaluation would be conducted using a combination of methods in order to answer the evaluation questions adequately, including: a review of available literature; use of existing data and information from various existing sources; collection of qualitative and quantitative data, including through questionnaires to stakeholders listed in the action plan; and country case studies, as appropriate. The evaluation methodology will be further elaborated by the evaluation team in its inception report and discussed with the ad hoc evaluation management group. ...

ANNEX 6

Outcome of the Second International Conference on Nutrition¹

[A68/8, Annexes 1 and 2 – 24 April 2015]

ROME DECLARATION ON NUTRITION

E

SECOND INTERNATIONAL CONFERENCE ON NUTRITION



Food and Agriculture
Organization of the
United Nations



World Health
Organization

Viale delle Terme di Caracalla, 00153 Rome, Italy - Tel: (+39) 06 57051 - Fax: (+39) 06 5705 4593 - E-mail: ICN2@fao.org - www.fao.org/icn2

Second International Conference on Nutrition
Rome, 19-21 November 2014
Conference Outcome Document: Rome Declaration on Nutrition

Welcoming the participation of Heads of State and Government and other high-level guests,

1. We, Ministers and Representatives of the Members of the Food and Agriculture Organization of the United Nations (FAO) and the World Health Organization (WHO), assembled at the Second International Conference on Nutrition in Rome from 19 to 21 November 2014, jointly organized by FAO and WHO, to address the multiple challenges of malnutrition in all its forms and identify opportunities for tackling them in the next decades.
2. Reaffirming the commitments made at the first International Conference on Nutrition in 1992, and the World Food Summits in 1996 and 2002 and the World Summit on Food Security in 2009, as well as in relevant international targets and action plans, including the WHO 2025 Global Nutrition Targets and the WHO Global Action Plan for the Prevention and Control of Noncommunicable Diseases 2013-2020.

¹ See resolution WHA68.19.

3. Reaffirming the right of everyone to have access to safe, sufficient, and nutritious food, consistent with the right to adequate food and the fundamental right of everyone to be free from hunger consistent with the International Covenant on Economic, Social and Cultural Rights and other relevant United Nations instruments.

Multiple challenges of malnutrition to inclusive and sustainable development and to health

4. Acknowledge that malnutrition, in all its forms, including undernutrition, micronutrient deficiencies, overweight and obesity, not only affects people's health and wellbeing by impacting negatively on human physical and cognitive development, compromising the immune system, increasing susceptibility to communicable and noncommunicable diseases, restricting the attainment of human potential and reducing productivity, but also poses a high burden in the form of negative social and economic consequences to individuals, families, communities and States.

5. Recognize that the root causes of and factors leading to malnutrition are complex and multidimensional:

- a) poverty, underdevelopment and low socio-economic status are major contributors to malnutrition in both rural and urban areas;
- b) the lack of access at all times to sufficient food, which is adequate both in quantity and quality which conforms with the beliefs, culture, traditions, dietary habits and preferences of individuals in accordance with national and international laws and obligations;
- c) malnutrition is often aggravated by poor infant and young child feeding and care practices, poor sanitation and hygiene, lack of access to education, quality health systems and safe drinking water, foodborne infections and parasitic infestations, ingestion of harmful levels of contaminants due to unsafe food from production to consumption;
- d) epidemics, such as of the Ebola virus disease, pose tremendous challenges to food security and nutrition.

6. Acknowledge that different forms of malnutrition co-exist within most countries; while dietary risk affects all socio-economic groups, large inequalities exist in nutritional status, exposure to risk and adequacy of dietary energy and nutrient intake, between and within countries.

7. Recognize that some socioeconomic and environmental changes can have an impact on dietary and physical activity patterns, leading to higher susceptibility to obesity and noncommunicable diseases through increasing sedentary lifestyles and consumption of food that is high in fat, especially saturated and trans-fats, sugars, and salt/sodium.

8. Recognize the need to address the impacts of climate change and other environmental factors on food security and nutrition, in particular on the quantity, quality and diversity of food produced, taking appropriate action to tackle negative effects.

9. Recognize that conflict and post conflict situations, humanitarian emergencies and protracted crises, including, *inter alia*, droughts, floods and desertification as well as pandemics, hinder food security and nutrition.
10. Acknowledge that current food systems are being increasingly challenged to provide adequate, safe, diversified and nutrient rich food for all that contribute to healthy diets due to, *inter alia*, constraints posed by resource scarcity and environmental degradation, as well as by unsustainable production and consumption patterns, food losses and waste, and unbalanced distribution.
11. Acknowledge that trade is a key element in achieving food security and nutrition and that trade policies are to be conducive to fostering food security and nutrition for all, through a fair and market-oriented world trade system, and reaffirm the need to refrain from unilateral measures not in accordance with international law, including the Charter of the United Nations, and which endanger food security and nutrition, as stated in the 1996 Rome Declaration.
12. Note with profound concern that, notwithstanding significant achievements in many countries, recent decades have seen modest and uneven progress in reducing malnutrition and estimated figures show that:
- a) the prevalence of undernourishment has moderately declined, but absolute numbers remain unacceptably high with an estimated 805 million people suffering chronically from hunger in 2012-2014;
 - b) chronic malnutrition as measured by stunting has declined, but in 2013 still affected 161 million children under five years of age, while acute malnutrition (wasting) affected 51 million children under five years of age;
 - c) undernutrition was the main underlying cause of death in children under five, causing 45% of all child deaths in the world in 2013;
 - d) over two billion people suffer from micronutrient deficiencies, in particular vitamin A, iodine, iron and zinc, among others;
 - e) overweight and obesity among both children and adults have been increasing rapidly in all regions, with 42 million children under five years of age affected by overweight in 2013 and over 500 million adults affected by obesity in 2010;
 - f) dietary risk factors, together with inadequate physical activity, account for almost 10% of the global burden of disease and disability.

A common vision for global action to end all forms of malnutrition

13. We reaffirm that:
- a) the elimination of malnutrition in all its forms is an imperative for health, ethical, political, social and economic reasons, paying particular attention to the special needs of children, women, the elderly, persons with disabilities, other vulnerable groups as well as people in humanitarian emergencies;

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- b) nutrition policies should promote a diversified, balanced and healthy diet at all stages of life. In particular, special attention should be given to the first 1,000 days, from the start of pregnancy to two years of age, pregnant and lactating women, women of reproductive age, and adolescent girls, by promoting and supporting adequate care and feeding practices, including exclusive breast feeding during the first six months, and continued breastfeeding until two years of age and beyond with appropriate complementary feeding. Healthy diets should be fostered in preschools, schools, public institutions, at the workplace and at home, as well as healthy eating by families;
 - c) coordinated action among different actors, across all relevant sectors at international, regional, national and community levels, needs to be supported through cross-cutting and coherent policies, programmes and initiatives, including social protection, to address the multiple burdens of malnutrition and to promote sustainable food systems;
 - d) food should not be used as an instrument for political or economic pressure;
 - e) excessive volatility of prices of food and agricultural commodities can negatively impact food security and nutrition, and needs to be better monitored and addressed for the challenges it poses;
 - f) improvements in diet and nutrition require relevant legislative frameworks for food safety and quality, including for the proper use of agrochemicals, by promoting participation in the activities of the Codex Alimentarius Commission for the development of international standards for food safety and quality, as well as for improving information for consumers, while avoiding inappropriate marketing and publicity of foods and non-alcoholic beverages to children, as recommended by resolution WHA63.14;
 - g) nutrition data and indicators, as well as the capacity of, and support to all countries, especially developing countries, for data collection and analysis, need to be improved in order to contribute to more effective nutrition surveillance, policy making and accountability;
 - h) empowerment of consumers is necessary through improved and evidence-based health and nutrition information and education to make informed choices regarding consumption of food products for healthy dietary practices;
 - i) national health systems should integrate nutrition while providing access for all to integrated health services through a continuum of care approach, including health promotion and disease prevention, treatment and rehabilitation, and contribute to reducing inequalities through addressing specific nutrition-related needs and vulnerabilities of different population groups;
 - j) nutrition and other related policies should pay special attention to women and empower women and girls, thereby contributing to women's full and equal access to social protection and resources, including, *inter alia*, income, land, water, finance, education, training, science and technology, and health services, thus promoting food security and health.

14. We recognize that:

- a) international cooperation and Official Development Assistance for nutrition should support and complement national nutrition strategies, policies and programmes, and surveillance initiatives, as appropriate;
- b) the progressive realization of the right to adequate food in the context of national food security is fostered through sustainable, equitable, accessible in all cases, and resilient and diverse food systems;
- c) collective action is instrumental to improve nutrition, requiring collaboration between governments, the private sector, civil society and communities;
- d) non-discriminatory and secure access and utilization of resources in accordance with international law are important for food security and nutrition;
- e) food and agriculture systems, including crops, livestock, forestry, fisheries and aquaculture, need to be addressed comprehensively through coordinated public policies, taking into account the resources, investment, environment, people, institutions and processes with which food is produced, processed, stored, distributed, prepared and consumed;
- f) family farmers and small holders, notably women farmers, play an important role in reducing malnutrition and should be supported by integrated and multisectoral public policies, as appropriate, that raise their productive capacity and incomes and strengthen their resilience;
- g) wars, occupations, terrorism, civil disturbances and natural disasters, disease outbreaks and epidemics, as well as human rights violations and inappropriate socio-economic policies, have resulted in tens of millions of refugees, displaced persons, war affected non-combatant civilian populations and migrants, who are among the most nutritionally vulnerable groups. Resources for rehabilitating and caring for these groups are often extremely inadequate and nutritional deficiencies are common. All responsible parties should cooperate to ensure the safe and timely passage and distribution of food and medical supplies to those in need, which conforms with the beliefs, culture, traditions, dietary habits and preferences of individuals, in accordance with national legislation and international law and obligations and the Charter of the United Nations;
- h) responsible investment in agriculture¹, including small holders and family farming and in food systems, is essential for overcoming malnutrition;
- i) governments should protect consumers, especially children, from inappropriate marketing and publicity of food;
- j) nutrition improvement requires healthy, balanced, diversified diets, including traditional diets where appropriate, meeting nutrient requirements of all age groups, and all groups with special nutrition needs, while avoiding the excessive intake of saturated fat, sugars and salt/sodium, and virtually eliminating trans-fat, among others;

¹ The term agriculture includes crops, livestock, forestry and fisheries.

- k) food systems should provide year-round access to foods that cover people's nutrient needs and promote healthy dietary practices;
- l) food systems need to contribute to preventing and addressing infectious diseases, including zoonotic diseases, and tackling antimicrobial resistance;
- m) food systems, including all components of production, processing and distribution should be sustainable, resilient and efficient in providing more diverse foods in an equitable manner, with due attention to assessing environmental and health impacts;
- n) food losses and waste throughout the food chain should be reduced in order to contribute to food security, nutrition, and sustainable development;
- o) the United Nations system, including the Committee on World Food Security, and international and regional financial institutions should work more effectively together in order to support national and regional efforts, as appropriate, and enhance international cooperation and development assistance to accelerate progress in addressing malnutrition;
- p) EXPO MILANO 2015, dedicated to "feeding the planet, energy for life", among other relevant events and fora, will provide an opportunity to stress the importance of food security and nutrition, raise public awareness, foster debate, and give visibility to the ICN2 outcomes.

Commitment to action

15. We commit to:

- a) eradicate hunger and prevent all forms of malnutrition worldwide, particularly undernourishment, stunting, wasting, underweight and overweight in children under five years of age; and anaemia in women and children among other micronutrient deficiencies; as well as reverse the rising trends in overweight and obesity and reduce the burden of diet-related noncommunicable diseases in all age groups;
- b) increase investments for effective interventions and actions to improve people's diets and nutrition, including in emergency situations;
- c) enhance sustainable food systems by developing coherent public policies from production to consumption and across relevant sectors to provide year-round access to food that meets people's nutrition needs and promote safe and diversified healthy diets;
- d) raise the profile of nutrition within relevant national strategies, policies, actions plans and programmes, and align national resources accordingly;
- e) improve nutrition by strengthening human and institutional capacities to address all forms of malnutrition through, *inter alia*, relevant scientific and socio-economic research and development, innovation and transfer of appropriate technologies on mutually agreed terms and conditions;

- f) strengthen and facilitate contributions and action by all stakeholders to improve nutrition and promote collaboration within and across countries, including North-South cooperation, as well as South-South and triangular cooperation;
- g) develop policies, programmes and initiatives for ensuring healthy diets throughout the life course, starting from the early stages of life to adulthood, including of people with special nutritional needs, before and during pregnancy, in particular during the first 1,000 days, promoting, protecting and supporting exclusive breastfeeding during the first six months and continued breastfeeding until two years of age and beyond with appropriate complementary feeding, healthy eating by families, and at school during childhood, as well as other specialized feeding;
- h) empower people and create an enabling environment for making informed choices about food products for healthy dietary practices and appropriate infant and young child feeding practices through improved health and nutrition information and education;
- i) implement the commitments of this Declaration through the Framework for Action which will also contribute to ensuring accountability and monitoring progress in global nutrition targets;
- j) give due consideration to integrating the vision and commitments of this Declaration into the post-2015 development agenda process including a possible related global goal.

16. We call on FAO and WHO, in collaboration with other United Nations agencies, funds and programmes, as well as other international organizations, to support national governments, upon request, in developing, strengthening and implementing their policies, programmes and plans to address the multiple challenges of malnutrition.

17. We recommend to the United Nations General Assembly to endorse the Rome Declaration on Nutrition, as well as the Framework for Action which provides a set of voluntary policy options and strategies for use by governments, as appropriate, and to consider declaring a Decade of Action on Nutrition from 2016 to 2025 within existing structures and available resources.

FRAMEWORK FOR ACTION

SECOND INTERNATIONAL CONFERENCE ON NUTRITION



Food and Agriculture
Organization of the
United Nations



World Health
Organization

Viale delle Terme di Caracalla, 00153 Rome, Italy - Tel: (+39) 06 57051 - Fax: (+39) 06 5705 4593 - E-mail: ICN2@fao.org - www.fao.org/icn2

Second International Conference on Nutrition
Rome, 19-21 November 2014
Conference Outcome Document: Framework for Action

FROM COMMITMENTS TO ACTION

Background

1. There has been a significant improvement in reducing hunger and malnutrition of the world's population since the 1992 International Conference on Nutrition (ICN). Yet, progress in reducing hunger and undernutrition has been uneven and unacceptably slow. The fundamental challenge today is to sustainably improve nutrition through implementation of coherent policies and better coordinated actions across all relevant sectors.

Purpose and targets

2. The nature of this Framework for Action is voluntary. Its purpose is to guide the implementation of the commitments of the Rome Declaration on Nutrition adopted by the Second International Conference on Nutrition held in Rome, Italy, on 19-21 November 2014. Building on existing commitments, goals and targets, this Framework for Action provides a set of policy options and strategies which governments¹, acting in cooperation with other stakeholders, may incorporate, as appropriate, into their national nutrition, health, agriculture², development and investment plans, and consider in negotiating international agreements to achieve better nutrition for all.

3. As governments have primary responsibility for taking action at country level, in dialogue with a wide range of stakeholders, including affected communities, the recommendations are principally addressed to government leaders. They will consider the appropriateness of the recommended policies and actions in relation to national needs and conditions, as well as regional and national priorities, including in legal frameworks. For the purpose of accountability, this Framework for Action adopts

¹ The term "governments" is understood to include the European Union and other regional organizations on matters of their competency.

² In this document, the term "agriculture" comprises crops, livestock, forestry and fisheries.

existing global targets for improving maternal, infant and young child nutrition¹ and for noncommunicable disease risk factor reduction² to be achieved by 2025.

Recommended set of policy and programme options

4. The following set of policy and programme options are recommended to create an enabling environment and to improve nutrition in all sectors.

Recommended actions to create an enabling environment for effective action

- Recommendation 1: Enhance political commitment and social participation for improving nutrition at the country level through political dialogue and advocacy.
- Recommendation 2: Develop – or revise, as appropriate – and cost National Nutrition Plans, align policies that impact nutrition across different ministries and agencies, and strengthen legal frameworks and strategic capacities for nutrition.
- Recommendation 3: Strengthen and establish, as appropriate, national cross-government, inter-sector, multi-stakeholder mechanisms for food security and nutrition to oversee implementation of policies, strategies, programmes and other investments in nutrition. Such platforms may be needed at various levels, with robust safeguards against abuse and conflicts of interest.
- Recommendation 4: Increase responsible and sustainable investment in nutrition, especially at country level with domestic finance; generate additional resources through innovative financing tools; engage development partners to increase Official Development Assistance in nutrition and foster private investments as appropriate.
- Recommendation 5: Improve the availability, quality, quantity, coverage and management of multisectoral information systems related to food and nutrition for improved policy development and accountability.
- Recommendation 6: Promote inter-country collaboration, such as North-South, South-South and triangular cooperation, and information exchange on nutrition, food, technology, research, policies and programmes.
- Recommendation 7: Strengthen nutrition governance and coordinate policies, strategies and programmes of United Nations system agencies, programmes and funds within their respective mandates.

Recommended actions for sustainable food systems promoting healthy diets

- Recommendation 8: Review national policies and investments and integrate nutrition objectives into food and agriculture policy, programme design and implementation, to enhance nutrition sensitive agriculture, ensure food security and enable healthy diets.

¹ Namely: (1) 40% reduction of the global number of children under five who are stunted; (2) 50% reduction of anaemia in women of reproductive age; (3) 30% reduction of low birth weight; (4) no increase in childhood overweight; (5) increase exclusive breastfeeding rates in the first six months up to at least 50%; and (6) reduce and maintain childhood wasting to less than 5%.

² Namely: (1) to reduce salt intake by 30%; and (2) to halt the increase in obesity prevalence in adolescents and adults.

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- Recommendation 9: Strengthen local food production and processing, especially by smallholder¹ and family farmers, giving special attention to women’s empowerment, while recognizing that efficient and effective trade is key to achieving nutrition objectives.
 - Recommendation 10: Promote the diversification of crops including underutilized traditional crops, more production of fruits and vegetables, and appropriate production of animal-source products as needed, applying sustainable food production and natural resource management practices.
 - Recommendation 11: Improve storage, preservation, transport and distribution technologies and infrastructure to reduce seasonal food insecurity, food and nutrient loss and waste.
 - Recommendation 12: Establish and strengthen institutions, policies, programmes and services to enhance the resilience of the food supply in crisis-prone areas, including areas affected by climate change.
 - Recommendation 13: Develop, adopt and adapt, where appropriate, international guidelines on healthy diets.
 - Recommendation 14: Encourage gradual reduction of saturated fat, sugars and salt/sodium and trans-fat from foods and beverages to prevent excessive intake by consumers and improve nutrient content of foods, as needed.
 - Recommendation 15: Explore regulatory and voluntary instruments – such as marketing, publicity and labelling policies, economic incentives or disincentives in accordance with Codex Alimentarius and World Trade Organization rules – to promote healthy diets.
 - Recommendation 16: Establish food or nutrient-based standards to make healthy diets and safe drinking water accessible in public facilities such as hospitals, childcare facilities, workplaces, universities, schools, food and catering services, government offices and prisons, and encourage the establishment of facilities for breastfeeding.

Recommended actions in international trade and investment

- Recommendation 17: Encourage governments, United Nations agencies, programmes and funds, the World Trade Organization and other international organizations to identify opportunities to achieve global food and nutrition targets, through trade and investment policies.
- Recommendation 18: Improve the availability and access of the food supply through appropriate trade agreements and policies and endeavour to ensure that such agreements and policies do not have a negative impact on the right to adequate food in other countries².

Recommended actions for nutrition education and information

- Recommendation 19: Implement nutrition education and information interventions based on national dietary guidelines and coherent policies related to food and diets, through improved

¹ Smallholder farmers include agriculture and food workers, artisanal fisherfolk, pastoralists, indigenous peoples and the landless (Committee on World Food Security, Global Strategic Framework for Food Security and Nutrition, 2013).

² United Nations General Assembly resolution A/RES/68/177, paragraph 25.

school curricula, nutrition education in the health, agriculture and social protection services, community interventions and point-of-sale information, including labelling.

- Recommendation 20: Build nutrition skills and capacity to undertake nutrition education activities, particularly for front line workers, social workers, agricultural extension personnel, teachers and health professionals.
- Recommendation 21: Conduct appropriate social marketing campaigns and lifestyle change communication programmes to promote physical activity, dietary diversification, consumption of micronutrient-rich foods such as fruits and vegetables, including traditional local foods and taking into consideration cultural aspects, better child and maternal nutrition, appropriate care practices and adequate breastfeeding and complementary feeding, targeted and adapted for different audiences and stakeholders in the food system.

Recommended actions on social protection

- Recommendation 22: Incorporate nutrition objectives into social protection programmes and into humanitarian assistance safety net programmes.
- Recommendation 23: Use cash and food transfers, including school feeding programmes and other forms of social protection for vulnerable populations to improve diets through better access to food which conforms with the beliefs, culture, traditions, dietary habits and preferences of individuals in accordance with national and international laws and obligations, and which is nutritionally adequate for healthy diets.
- Recommendation 24: Increase income for the most vulnerable populations by creating decent jobs for all, including through the promotion of self-employment.

Recommended actions for strong and resilient health systems

- Recommendation 25: Strengthen health systems and promote universal health coverage¹, particularly through primary health care, to enable national health systems to address malnutrition in all its forms.
- Recommendation 26: Improve the integration of nutrition actions into health systems through appropriate strategies for strengthening human resources, leadership and governance, health system financing and service delivery, as well as the provision of essential medicines, information and monitoring.
- Recommendation 27: Promote universal access to all direct nutrition actions and relevant health actions impacting nutrition through health programmes.
- Recommendation 28: Implement the WHO Global Strategy on Infant and Young Child Feeding, the WHO Comprehensive Implementation Plan on Maternal, Infant and Young Child Nutrition 2012-2025, and the WHO Global Action Plan for the Prevention and Control of Noncommunicable Diseases 2013-2020 through commensurate financing and adequate policies.

¹ In accordance with preambular paragraph 9 of resolution WHA67.14, universal health coverage implies that all people have access without discrimination to nationally determined sets of the needed promotive, preventive, curative, palliative and rehabilitative essential health services and essential, safe, affordable, effective and quality medicines, while ensuring that the use of these services does not expose the users to financial hardship with a special emphasis on the poor, vulnerable and marginalized segments of the population.

Recommended actions to promote, protect and support breastfeeding

- Recommendation 29: Adapt and implement the International Code of Marketing of Breast-milk Substitutes and subsequent relevant World Health Assembly resolutions.
- Recommendation 30: Implement policies and practices, including labour reforms, as appropriate, to promote protection of working mothers¹.
- Recommendation 31: Implement policies, programmes and actions to ensure that health services promote, protect and support breastfeeding, including the Baby-Friendly Hospital Initiative.
- Recommendation 32: Encourage and promote – through advocacy, education and capacity building – an enabling environment where men, particularly fathers, participate actively and share responsibilities with mothers in caring for their infants and young children, while empowering women and enhancing their health and nutritional status throughout the life course.
- Recommendation 33: Ensure that policies and practices in emergency situations and humanitarian crises promote, protect and support breastfeeding.

Recommended actions to address wasting

- Recommendation 34: Adopt policies and actions, and mobilize funding, to improve coverage of treatment for wasting, using the community-based management of acute malnutrition approach and improve the integrated management of childhood illnesses.
- Recommendation 35: Integrate disaster and emergency preparedness into relevant policies and programmes.

Recommended actions to address stunting

- Recommendation 36: Establish policies and strengthen interventions to improve maternal nutrition and health, beginning with adolescent girls and continuing through pregnancy and lactation.
- Recommendation 37: Establish health policies, programmes and strategies to promote optimal infant and young child feeding, particularly exclusive breastfeeding up to six months, followed by adequate complementary feeding (from six to 24 months).

Recommended actions to address childhood overweight and obesity

- Recommendation 38: Provide dietary counselling to women during pregnancy for healthy weight gain and adequate nutrition.
- Recommendation 39: Improve child nutritional status and growth, particularly by addressing maternal exposure to the availability and marketing of complementary foods, and by improving supplementary feeding programmes for infants and young children.

¹ As specified in the International Labour Organization's Maternity Protection Convention No. 183 and corresponding Recommendation 191.

- Recommendation 40: Regulate the marketing of food and non-alcoholic beverages to children in accordance with WHO recommendations.
- Recommendation 41: Create a conducive environment that promotes physical activity to address sedentary lifestyle from the early stages of life.

Recommended actions to address anaemia in women of reproductive age

- Recommendation 42: Improve intake of micronutrients through consumption of nutrient-dense foods, especially foods rich in iron, where necessary, through fortification and supplementation strategies, and promote healthy and diversified diets.
- Recommendation 43: Provide daily iron and folic acid and other micronutrient supplementation to pregnant women as part of antenatal care; and intermittent iron and folic acid supplementation to menstruating women where the prevalence of anaemia is 20% or higher, and deworming, where appropriate.

Recommended actions in the health services to improve nutrition

- Recommendation 44: Implement policies and programmes to ensure universal access to and use of insecticide-treated nets, and to provide preventive malaria treatment for pregnant women in areas with moderate to high malaria transmission.
- Recommendation 45: Provide periodic deworming for all school-age children in endemic areas.
- Recommendation 46: Implement policies and programmes to improve health service capacity to prevent and treat infectious diseases¹.
- Recommendation 47: Provide zinc supplementation to reduce the duration and severity of diarrhoea, and to prevent subsequent episodes in children.
- Recommendation 48: Provide iron and, among others, vitamin A supplementation for pre-school children to reduce the risk of anaemia.
- Recommendation 49: Implement policies and strategies to ensure that women have comprehensive information and access to integral health care services that ensure adequate support for safe pregnancy and delivery.

Recommended actions on water, sanitation and hygiene

- Recommendation 50: Implement policies and programmes using participatory approaches to improve water management in agriculture and food production.²

¹ Including prevention of mother-to-child transmission of HIV, immunization against measles and antibiotic treatment for girls with urinary infections.

² Including by reducing water wastage in irrigation, strategies for multiple use of water (including wastewater), and better use of appropriate technology.

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- Recommendation 51: Invest in and commit to achieve universal access to safe drinking water, with the participation of civil society and the support of international partners, as appropriate.
 - Recommendation 52: Implement policies and strategies using participatory approaches to ensure universal access to adequate sanitation¹ and to promote safe hygiene practices, including hand washing with soap.

Recommended actions on food safety and antimicrobial resistance

- Recommendation 53: Develop, establish, enforce and strengthen, as appropriate, food control systems, including reviewing and modernizing national food safety legislation and regulations to ensure that food producers and suppliers throughout the food chain operate responsibly.
- Recommendation 54: Actively take part in the work of the Codex Alimentarius Commission on nutrition and food safety, and implement, as appropriate, internationally adopted standards at the national level.
- Recommendation 55: Participate in and contribute to international networks to exchange food safety information, including for managing emergencies².
- Recommendation 56: Raise awareness among relevant stakeholders on the problems posed by antimicrobial resistance, and implement appropriate multisectoral measures to address antimicrobial resistance, including prudent use of antimicrobials in veterinary and human medicine.
- Recommendation 57: Develop and implement national guidelines on prudent use of antimicrobials in food-producing animals according to internationally recognized standards adopted by competent international organizations to reduce non-therapeutic use of antimicrobials and to phase out the use of antimicrobials as growth promoters in the absence of risk analysis as described in Codex Code of Practice CAC/RCP61-2005.

Recommendations for accountability

- Recommendation 58: National governments are encouraged to establish nutrition targets and intermediate milestones, consistent with the timeframe for implementation (2016-2025), as well as global nutrition and noncommunicable disease targets established by the World Health Assembly. They are invited to include – in their national monitoring frameworks – agreed international indicators for nutrition outcomes (to track progress in achieving national targets), nutrition programme implementation (including coverage of interventions) and the nutrition policy environment (including institutional arrangements, capacities and investments in nutrition)³. Monitoring should be conducted, to the fullest possible extent, through existing mechanisms.

¹ Including by implementing effective risk assessment and management practices on safe wastewater use and sanitation.

² FAO/WHO International Network of Food Safety Authorities (http://www.who.int/foodsafety/areas_work/infosan/en/).

³ Monitoring frameworks may be developed based on the Global Monitoring Framework for Maternal, Infant and Young Child Nutrition, the Monitoring Framework for the Global Action Plan on Noncommunicable Diseases, as well as indicators for monitoring food security (FAO prevalence of undernutrition, food insecurity experience scale, and other widely used indicators).

- Recommendation 59: Reports on implementation of the commitments of the Rome Declaration on Nutrition will be compiled jointly by FAO and WHO, in close collaboration with other United Nations agencies, funds and programmes and other relevant regional and international organizations, as appropriate, based on country self-assessments as well as information available through other monitoring and accountability mechanisms (e.g. Scaling Up Nutrition self-assessment reports, reports to the FAO Conference and the World Health Assembly, and the Global Nutrition Report).

 - Recommendation 60: The governing bodies of FAO and WHO, and other relevant international organizations are requested to consider the inclusion of reports on the overall follow-up to ICN2 on the agendas of the regular FAO and WHO governing body meetings, including FAO regional conferences and WHO regional committee meetings, possibly on a biennial basis. The Directors-General of FAO and WHO are also requested to transmit such reports to the United Nations General Assembly as appropriate.
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ANNEX 7

Additional core indicators for the global monitoring framework on maternal, infant and young child nutrition ¹

[A68/9 – 15 May 2015]

	Indicator
	<i>Intermediate outcome indicators, monitoring conditions on the causal pathways to the targets</i>
IO1	Prevalence of diarrhoea in children under 5 years of age ²
IO2	Proportion of women aged 15–49 years with low body mass index ³
IO3	Number of births during a given reference period to women aged 15–19 years/1000 females aged 15–19 years
IO4	Proportion of overweight and obese women aged 18+ years ⁴
IO5	Proportion of overweight and obesity ⁵ in school-age children and adolescents (5–18 years)
	<i>Process indicators, monitoring programmes and situation-specific progress</i>
PR1	Proportion of children aged 6 to 23 months who receive a minimum acceptable diet ⁶
PR2	Proportion of population using a safely managed drinking water service
PR3	Proportion of population using a safely managed sanitation service
PR4	Proportion of pregnant women receiving iron and folic acid supplements ⁶
PR5	Percentage of births in baby friendly facilities
PR6	Proportion of mothers of children aged 0–23 months who have received counselling, support or messages on optimal breastfeeding at least once in the last year ⁶
	<i>Policy environment and capacity indicators, measuring political commitment</i>
PE1	Number of trained nutrition professionals per 100 000 population ⁶
PE2	Country has legislation/regulations fully implementing the International Code of Marketing of Breast-milk Substitutes (resolution WHA34.22) and subsequent relevant resolutions adopted by the Health Assembly
PE3	Country has maternity protection laws or regulations in place in line with the ILO Maternity Protection Convention, 2000 (No. 183) and Recommendation No. 191

¹ See decision WHA68(14).

² Countries in which the prevalence of stunting and wasting is lower than 2.3% may consider reporting against this indicator using routine clinical data.

³ Less than –2 standard deviations (SD) from the body mass index for age median (WHO 2007 growth reference) in women aged 15–18 years and less than 18.5 kg/m² in women aged 19 years and above.

⁴ Body mass index above 25 kg/m².

⁵ More than one standard deviation above the median body mass index for age and sex (WHO 2007 growth reference, <http://www.who.int/growthref/en/>).

⁶ Reporting is delayed until 2018 (see decision WHA68(14), paragraph 2).

ANNEX 8

Financial and administrative implications for the Secretariat of resolutions and decisions adopted by the Health Assembly

<p>1. Resolution WHA68.2 Global technical strategy and targets for malaria 2016–2030</p>
<p>2. Linkage to the Proposed programme budget 2016–2017 (see document A68/7 http://apps.who.int/gb/ebwha/pdf_files/WHA68/A68_7-en.pdf)</p> <p>Category: 1. Communicable diseases</p> <p>Programme area(s): Malaria</p> <p>Outcome: 1.3 Outputs: 1.3.1 and 1.3.2</p> <p>How would this resolution contribute to the achievement of the outcome(s) of the above programme area(s)?</p> <p>The resolution adopts the global technical strategy for malaria 2016–2030, and will therefore enable the Secretariat to strengthen its capacity to support Member States in implementing the principles and pillars described in the strategy, while maintaining a robust and evidence-based policy-making process.</p> <p>Does the Proposed programme budget already include the outputs and deliverables requested in this resolution? (Yes/no)</p> <p>Yes.</p>
<p>3. Estimated cost and staffing implications in relation to the Proposed programme budget</p> <p>(a) Total cost</p> <p>Indicate (i) the lifespan of the resolution during which the Secretariat’s activities would be required for implementation and (ii) the cost of those activities (estimated to the nearest US\$ 10 000).</p> <p>(i) The resolution time frame is consistent with the United Nations post-2015 development agenda and many activities set out in the resolution will be ongoing.</p> <p>(ii) A process to update the programme area plan has begun in order to ensure that the three levels of the Secretariat are strengthened to have the capacity to support Member States to implement the vision articulated in the strategy.</p> <p>The resolution includes elements that go beyond the previously-agreed budget for malaria, particularly in supporting Member States to accelerate their national malaria programmes towards malaria elimination.</p> <p>(b) Cost for the biennium 2014–2015</p> <p>Indicate how much of the cost indicated in 3(a) is for the biennium 2014–2015 (estimated to the nearest US\$ 10 000).</p> <p>US\$ nil (staff: US\$ nil; activities: US\$ nil)</p> <p>Indicate at which levels of the Organization the costs would be incurred, identifying specific regions where relevant.</p> <p>Not applicable.</p> <p>Is the estimated cost fully included within the approved Programme budget 2014–2015? (Yes/no)</p> <p>Not applicable.</p>

If “no”, indicate how much is not included.

(c) Cost for the biennium 2016–2017

US\$ 121.5 million (staff: US\$ 65.4 million; activities: US\$ 56.1 million)

Indicate at which levels of the Organization the costs would be incurred, identifying specific regions where relevant.

All three levels of the Organization.

Is the estimated cost fully included within the proposed Programme budget 2016–2017? (Yes/no)

Yes.

If “no”, indicate how much is not included.

(d) Staffing implications

Could the resolution be implemented by existing staff? (Yes/no)

No.

If “no”, indicate how many additional staff – full-time equivalents – would be required, identifying specific regions and noting the necessary skills profile(s), where relevant.

The additional staff required to implement the resolution is as follows:

African Region: nine staff members at P.4 level (malaria drug resistance and research – one technical officer; malaria elimination – one medical officer; prevention – four technical officers (entomology); strategic information and planning – two medical officers; malaria case management – one medical officer).

Region of the Americas: three professional staff members (malaria elimination in Belize and Bolivarian Republic of Venezuela), one national professional officer (Plurinational State of Bolivia).

South-East Asia Region: 13 national professional officers (six entomologists, two monitoring and evaluation specialists, three laboratory specialists, one public health specialist and one pharmaceutical specialist) and four staff members at grade P.4 (three malariologists and one entomologist).

Eastern Mediterranean Region: three staff members at grade P.4 (Afghanistan, Sudan and Yemen), two staff members at grade P.2 (one case management and drug resistance medical officer, 0.5 data management specialist), three national professional officers (Afghanistan, Sudan and Yemen).

Western Pacific Region: one staff member at grade P.5 (Papua New Guinea), three staff at grade P.4 (one laboratory specialist, one malaria elimination specialist and one entomologist), one staff member at grade P.2 (programme management), one National Professional Officer (Philippines), two general service staff members (database manager, secretary).

Headquarters: four staff members at grade P.5 (one technical support and capacity building team leader; one elimination team leader; one surveillance team leader; and one entomologist), six staff members at grade P.4 (one technical support officer, one capacity building officer, one burden of disease modeler, one database manager, one elimination officer and one entomologist), seven staff at grade P.3 (one vaccine access officer, one diagnosis officer, one surveillance training officer, one data manager, two project management officers and one communications technical officer) and three assistants at grade G.5.

4. Funding

The cost of the work performed by the Secretariat in relation to implementing the resolution will be financed through Organization-wide resource mobilization efforts.

<p>1. Resolution WHA68.3 Poliomyelitis</p>
<p>2. Linkage to the Programme budget 2014–2015 (see document A66/7 http://apps.who.int/gb/ebwha/pdf_files/WHA66/A66_7-en.pdf)</p> <p>Category: 5. Preparedness, surveillance and response</p> <p>Programme area: Polio eradication</p> <p>Outcome: 5.5</p> <p>Outputs: 5.5.1, 5.5.2, 5.5.3 and 5.5.4</p> <p>How would this resolution contribute to the achievement of the outcome(s) of the above programme area(s)?</p> <p>Full implementation of the resolution would support achievement of a lasting polio-free world, based on the interruption of transmission of wild and vaccine-derived polioviruses.</p> <p>Does the Programme budget already include the outputs and deliverables requested in this resolution? (Yes/no)</p> <p>Yes.</p>
<p>3. Estimated cost and staffing implications in relation to the Programme budget</p> <p>(a) Total cost</p> <p>Indicate (i) the lifespan of the resolution during which the Secretariat's activities would be required for implementation and (ii) the cost of those activities (estimated to the nearest US\$ 10 000).</p> <p>(i) Four years (covering the period 2015–2018).</p> <p>(ii) There is no incremental cost – for either activities or staffing – associated with the resolution, as the related costs were already included in the Polio Eradication and Endgame Strategic Plan 2013–2018 requested by the Executive Board in resolution EB130.R10.</p> <p>(b) Cost for the biennium 2014–2015</p> <p>Indicate how much of the cost indicated in 3(a) is for the biennium 2014–2015 (estimated to the nearest US\$ 10 000).</p> <p>Total: US\$ nil (staff: US\$ nil; activities: US\$ nil) as per section 3 (a) (ii) above.</p> <p>Indicate at which levels of the Organization the costs would be incurred, identifying specific regions where relevant.</p> <p>Not applicable as per section 3 (a) (ii) above.</p> <p>Is the estimated cost fully included within the approved Programme budget 2014–2015? (Yes/no)</p> <p>Not applicable as per section 3 (a) (ii) above.</p> <p>If “no”, indicate how much is not included.</p> <p>(c) Staffing implications</p> <p>Could the resolution be implemented by existing staff? (Yes/no)</p> <p>Yes.</p> <p>If “no”, indicate how many additional staff – full-time equivalents – would be required, identifying specific regions and noting the necessary skills profile(s), where relevant.</p>
<p>4. Funding</p> <p>Is the estimated cost for the biennium 2014–2015 indicated in 3 (b) fully funded? (Yes/no)</p> <p>Not applicable.</p> <p>If “no”, indicate the funding gap and how the funds would be mobilized (provide details of expected source(s) of funds).</p> <p>Not applicable.</p>

1. Resolution WHA68.4 Yellow fever risk mapping and recommended vaccination for travellers

2. Linkage to the Programme budget 2014–2015 (see document A66/7 http://apps.who.int/gb/ebwha/pdf_files/WHA66/A66_7-en.pdf)

Category: 5. Preparedness, surveillance and response

Programme area: Alert and response capacities

Programme area: Epidemic-prone and pandemic-prone diseases

Outcome:

5.1. All countries have the minimum core capacities required by the International Health Regulations (2005) for all-hazard alert and response

Output:

5.1.1. Countries enabled to develop core capacities required under International Health Regulations (2005).

How would this resolution contribute to the achievement of the outcome(s) of the above programme area(s)?

It would facilitate and reinforce guidance for international travel vaccination.

Does the Programme budget already include the outputs and deliverables requested in this resolution? (Yes/no)

Yes.

3. Estimated cost and staffing implications in relation to the Programme budget

(a) Total cost

Indicate (i) the lifespan of the resolution during which the Secretariat's activities would be required for implementation and (ii) the cost of those activities (estimated to the nearest US\$ 10 000).

(i) The resolution is not time-bound, with implementation involving a yearly meeting of a scientific and technical advisory group on geographical yellow fever risk mapping.

(ii) Total: US\$ 100 000 per year (cost of yearly meeting of the advisory group).

(b) Cost for the biennium 2014–2015

Indicate how much of the cost indicated in 3(a) is for the biennium 2014–2015 (estimated to the nearest US\$ 10 000).

Total: US\$ 100 000 (cost of first meeting of the advisory group)

Indicate at which levels of the Organization the costs would be incurred, identifying specific regions where relevant.

Headquarters

Is the estimated cost fully included within the approved Programme budget 2014–2015? (Yes/no)

No.

If "no", indicate how much is not included.

US\$ 100 000.

(c) Staffing implications

Could the resolution be implemented by existing staff? (Yes/no)

Yes.

If “no”, indicate how many additional staff – full-time equivalents – would be required, identifying specific regions and noting the necessary skills profile(s), where relevant.

4. Funding

Is the estimated cost for the biennium 2014–2015 indicated in 3(b) fully funded? (Yes/no)

No.

If “no”, indicate the funding gap and how the funds would be mobilized (provide details of expected source(s) of funds).

US\$ 100 000. It will be tackled through the Organization-wide coordinated resource mobilization plan for dealing with funding shortfalls in the Programme budget 2014–2015.

1. Resolution WHA68.5 The recommendations of the Review Committee on Second Extensions for establishing National Public Health Capacities and on IHR Implementation

2. Linkage to the Programme budget 2014–2015 (see document A66/7 http://apps.who.int/gb/ebwha/pdf_files/WHA66/A66_7-en.pdf)

Category: 5

Programme area(s): 5.1 and 5.2

Outcomes:

5.1. All countries have the minimum core capacities required by the International Health Regulations (2005) for all-hazard alert and response

5.2. Increased capacity of countries to build resilience and adequate preparedness to mount a rapid, predictable and effective response to major epidemics and pandemics

Outputs:

5.1.1. Countries enabled to develop core capacities required under International Health Regulations (2005)

5.2.1. Countries are enabled to develop and implement operational plans, in line with WHO recommendations on strengthening national resilience and preparedness covering pandemic influenza and epidemic and emerging diseases

How would this resolution contribute to the achievement of the outcome(s) of the above programme area(s)?

This will provide impetus to the implementation of the Review Committee recommendations.

Does the Programme budget already include the outputs and deliverables requested in this resolution? (Yes/no)

Yes.

3. Estimated cost and staffing implications in relation to the Programme budget

(a) Total cost

Indicate (i) the lifespan of the decision during which the Secretariat's activities would be required for implementation and (ii) the cost of those activities (estimated to the nearest US\$ 10 000).

(i) One year (covering 2015)

(ii) Total: US\$ 2 100 000 (staff: US\$ 1 500 000; activities: US\$ 600 000)

(b) Cost for the biennium 2014–2015

Indicate how much of the cost indicated in 3(a) is for the biennium 2014–2015 (estimated to the nearest US\$ 10 000).

Total: US\$ 2 100 000 (staff: US\$ 1 500 000; activities: US\$ 600 000)

Indicate at which levels of the Organization the costs would be incurred, identifying specific regions where relevant.

Headquarters and the six regions

Is the estimated cost fully included within the approved Programme budget 2014–2015? (Yes/no)

No.

If “no”, indicate how much is not included.

US\$ 2 100 000 – the costs are currently not foreseen in the Programme budget 2014–2015; however, we will reprioritize activities among the category network and request additional space if necessary.

(c) Staffing implications

Could the decision be implemented by existing staff? (Yes/no)

No.

If “no”, indicate how many additional staff – full-time equivalents – would be required, identifying specific regions and noting the necessary skills profile(s), where relevant.

– one full-time staff, P4, one year in each region

– one full-time staff, P4, six months at headquarters

4. Funding

Is the estimated cost for the biennium 2014–2015 indicated in 3 (b) fully funded? (Yes/no)

No.

If “no”, indicate the funding gap and how the funds would be mobilized (provide details of expected source(s) of funds).

US\$ 2 100 000; source(s) of funds: The funding gap will be addressed through the Organization-wide coordinated resource mobilization effort.

1. Resolution WHA68.6 Global vaccine action plan

2. Linkage to the Programme budget 2014–2015 (see document A66/7
http://apps.who.int/gb/ebwha/pdf_files/WHA66/A66_7-en.pdf)

Category: 1. Communicable diseases

Programme area: Vaccine preventable diseases

Outcome: 1.5

Outputs: 1.5.1 and 1.5.3

How would this resolution contribute to the achievement of the outcome(s) of the above programme area(s)?

This resolution would contribute to accelerating progress towards the targets set in the global vaccine action plan by facilitating access to reliable supplies of affordable vaccines to all Member States. In particular, this resolution will address challenges faced by many middle-income countries in securing reliable supplies of the newer, more expensive, vaccines at prices they can afford.

Does the Programme budget already include the outputs and deliverables requested in this resolution? (Yes/no)

Yes.

3. Estimated cost and staffing implications in relation to the Programme budget

(a) Total cost

Indicate (i) the lifespan of the resolution during which the Secretariat's activities would be required for implementation and (ii) the cost of those activities (estimated to the nearest US\$ 10 000).

(i) 5.5 years (covering the period 2015–2020)

(ii) Total (2015–2020): US\$ 107.80 million (staff: US\$ 31.63 million; activities: US\$ 76.18 million)

(iii) The total cost of the resolution assumes additional funding and the Programme budget of US\$ 5.12 million per year for 2016–2020 (total additional for 2016–2020 staff: US\$ 4.00 million; activities: US\$ 21.60 million).

(b) Cost for the biennium 2014–2015

Indicate how much of the cost indicated in 3(a) is for the biennium 2014–2015 (estimated to the nearest US\$ 10 000).

Total: US\$ 13.80 million (staff: US\$ 2.88 million; activities: US\$ 10.92 million)

Indicate at which levels of the Organization the costs would be incurred, identifying specific regions where relevant.

Is the estimated cost fully included within the approved Programme budget 2014–2015? (Yes/no)

Yes.

If “no”, indicate how much is not included.

Not applicable.

(c) Staffing implications

Could the resolution be implemented by existing staff? (Yes/no)

No.

If “no”, indicate how many additional staff – full-time equivalents – would be required, identifying specific regions and noting the necessary skills profile(s), where relevant.

Additional staff would be required in 2016–2020 at global and regional levels to support the activities (estimated full-time equivalents: one global staff member and two regional staff members).

4. Funding

Is the estimated cost for the biennium 2014–2015 indicated in 3(b) fully funded? (Yes/no)

Yes.

If “no”, indicate the funding gap and how the funds would be mobilized (provide details of expected source(s) of funds).

Not applicable.

1. Resolution WHA68.7 Global action plan on antimicrobial resistance

2. Linkage to the Programme budget 2014–2015 and the Proposed programme budget 2016–2017 (see documents: http://apps.who.int/gb/ebwha/pdf_files/WHA66/A66_7-en.pdf and http://apps.who.int/gb/ebwha/pdf_files/WHA68/A68_7-en.pdf)

Categories: 1, 3, 4 and 5

Programme areas: various (particularly in categories 4 and 5)

Outcome: 4.2, 4.3, 4.4, 5.2 and 5.4
Output: 5.2.3

How would this resolution contribute to the achievement of the outcomes of the above programme areas?

The development of this global action plan on antimicrobial resistance, requested in resolution WHA67.25, reflects a global consensus that antimicrobial resistance poses a profound threat to human health.

The goal of the global action plan is to ensure, for as long as possible, continuity of successful treatment and prevention of infectious diseases with effective and safe medicines that are quality-assured, used in a responsible way, and accessible to all who need them. It is expected that countries will develop their own national action plans on antimicrobial resistance, within the next two years, in line with the global action plan.

The adoption of this global action plan by the Sixty-eighth World Health Assembly will confirm the commitment from all Member States to address this threat to global public health, through the development of national action plans as set out in outcome 5.2 and output 5.2.3.

Does the Proposed programme budget already include the outputs and deliverables requested in this resolution? (Yes/no)

Yes. The Programme budget 2016–2017 includes outputs and deliverables for all relevant programme areas, in line with the proposed actions for the Secretariat that are set out in the global action plan. Specific deliverables in the relevant programme areas that contribute to the implementation of the antimicrobial resistance global action plan have been included in the Programme budget 2016–2017.

3. Estimated cost and staffing implications in relation to the Programme budget 2014–2015 and for the Proposed programme budget 2016–2017

(a) Total cost

Indicate (i) the lifespan of the resolution during which the Secretariat's activities would be required for implementation and (ii) the cost of those activities (estimated to the nearest US\$ 10 000).

- (i) The global action plan is not time-bound.
- (ii) The initial five-year implementation of the global action plan will require in total: US\$ 115 million.

(b) (i) Cost for the biennium 2014–2015

Indicate how much of the cost indicated in 3(a) is for the biennium 2014–2015 (estimated to the nearest US\$ 10 000).

Total: US\$ 15 million

Indicate at which levels of the Organization the costs would be incurred, identifying specific regions where relevant.

All three levels.

Is the estimated cost fully included within the approved Programme budget 2014–2015? (Yes/no)
Yes.

If "no", indicate how much is not included.

Not applicable.

(b) (ii) Cost for the biennium 2016–2017

Indicate how much of the cost indicated in 3(a) is for the biennium 2016–2017 (estimated to the nearest US\$ 10 000).

The total cost of the Secretariat's work on the implementation of the global action plan has been estimated at US\$ 53 million across the Organization, of which half is for activities and the other half for staff.

Indicate at which levels of the Organization the costs would be incurred, identifying specific regions where relevant.

All three levels.

Is the estimated cost fully included within the approved Programme budget 2016–2017? (Yes/no)

Yes. The full costs of US\$ 53 million for implementation by the Secretariat of the global action plan on antimicrobial resistance have been incorporated into the Programme budget 2016–2017.

(c) Staffing implications

Could the resolution be implemented by existing staff? (Yes/no)

No.

If "no", indicate how many additional staff – full-time equivalents – would be required, identifying specific regions and noting the necessary skills profile(s), where relevant.

The Secretariat currently has the equivalent of about 19 full-time staff members in the professional category. Based on initial estimates, about 40 staff members will be needed across the major offices, but this will be confirmed during operational planning for the biennium 2016–2017.

4. Funding

Is the estimated cost for the biennium 2014–2015 indicated in 3 (b) fully funded? (Yes/no)

No, however, several activities that are being implemented during the current biennium that are relevant to the global action plan will continue, including its current financing.

If “no”, indicate the funding gap and how the funds would be mobilized (provide details of expected source(s) of funds).

Source of funds: the requirements will be financed through the regular Organization-wide resource mobilization process, including the financing dialogue.

1. Resolution WHA68.8 Health and the environment: addressing the health impact of air pollution

2. Linkage to the Programme budget 2014–2015 (see document A66/7 http://apps.who.int/gb/ebwha/pdf_files/WHA66/A66_7-en.pdf)

Category: 3. Promoting health through the life course

Programme area: Health and the environment

Outcome: 3.5

Outputs: 3.5.1, 3.5.2, 3.5.3

How would this resolution contribute to the achievement of the outcome of the above programme area?

The resolution will strengthen capacity of the health sector and health systems to prevent diseases and the seven million deaths each year due to air pollution.

Does the Programme budget already include the outputs and deliverables requested in this resolution? (Yes/no)

Yes.

3. Estimated cost and staffing implications in relation to the Programme budget

(a) Total cost

Indicate (i) the lifespan of the resolution during which the Secretariat’s activities would be required for implementation and (ii) the cost of those activities (estimated to the nearest US\$ 10 000).

(i) The initial estimate covers the period 2015–2019, in line with the period covered by the Twelfth General Programme of Work, 2014–2019. Work on air pollution and health is likely to continue beyond 2019. However, the next general programme of work will be developed and a review undertaken in parallel, which may result in modifications to the programme budget depending on changes to the Organization’s wider priorities.

(ii) Total: US\$ 35.49 million¹ (staff: US\$ 12.41 million;² activities: US\$ 23.08 million).

(b) Cost for the biennium 2014–2015

Indicate how much of the cost indicated in 3(a) is for the biennium 2014–2015 (estimated to the nearest US\$ 10 000).

Total: US\$ 3.64 million (staff: US\$ 1.31 million; activities: US\$ 2.33 million).

Indicate at which levels of the Organization the costs would be incurred, identifying specific regions where relevant.

All levels of the Organization.

¹ Figures are inclusive of programme support costs (13%).

² Staff cost figures are based on post cost averages for the biennium 2016–2017 plus programme support costs.

Is the estimated cost fully included within the approved Programme budget 2014–2015? (Yes/no)
Yes.

If “no”, indicate how much is not included.

(c) Staffing implications

Could the resolution be implemented by existing staff? (Yes/no)

Yes, for the biennium 2014–2015. However, additional staff will be required to implement the resolution from 2016 onwards.

If “no”, indicate how many additional staff – full-time equivalents – would be required, identifying specific regions and noting the necessary skills profile(s), where relevant.

As indicated, for the biennium 2014–2015, current staffing levels are adequate. However, from 2016 onwards it is expected that two additional technical staff at grade P.4 and one at grade G.5 will be needed at headquarters, and one additional technical staff at grade P.4 will be needed in each of the regional offices. One part-time national professional officer will also be needed in each of the six countries that are hosting pilot programmes on enhanced cooperation.

4. Funding

Is the estimated cost for the biennium 2014–2015 indicated in 3(b) fully funded? (Yes/no)

Yes.

If “no”, indicate the funding gap and how the funds would be mobilized (provide details of expected source(s) of funds).

1. Resolution WHA68.9 Framework of engagement with non-State actors

2. Linkage to the Programme budget 2014–2015 (see document A66/7 http://apps.who.int/gb/ebwha/pdf_files/WHA66/A66_7-en.pdf)

Category: 6. Corporate services/enabling functions

Programme area: Leadership and governance

Outcome: 6.1

Output: 6.1.2

How would this resolution contribute to the achievement of the outcome of the above programme area?

The adoption of the framework would provide a solid basis for the ongoing strengthening of due diligence and risk assessment.

Does the Programme budget already include the outputs and deliverables requested in this resolution? (Yes/no)

Yes.

3. Estimated cost and staffing implications in relation to the Programme budget

(a) Total cost

Indicate (i) the lifespan of the resolution during which the Secretariat’s activities would be required for implementation and (ii) the cost of those activities (estimated to the nearest US\$ 10 000).

(i) The resolution covers the period 2014–2019

(ii) Total: US\$ 10 508 800 (staff: US\$ 8 238 300; activities: US\$ 2 270 500)

(b) Cost for the biennium 2014–2015

Indicate how much of the cost indicated in 3(a) is for the biennium 2014–2015 (estimated to the nearest US\$ 10 000).

Total: US\$ 3 250 600 (staff: US\$ 2 396 100; activities: US\$ 854 500)

Indicate at which levels of the Organization the costs would be incurred, identifying specific regions where relevant.

The specific costs are incurred at headquarters. The implementation of the framework will, however, impact work processes at all three levels of the Organization.

Is the estimated cost fully included within the approved Programme budget 2014–2015? (Yes/no)

Yes.

If “no”, indicate how much is not included.

Not applicable.

(c) Staffing implications

Could the resolution be implemented by existing staff? (Yes/no)

No.

If “no”, indicate how many additional staff – full-time equivalents – would be required, identifying specific regions and noting the necessary skills profile(s), where relevant.

The plan is to increase the team conducting due diligence and managing interaction with non-State actors from four full-time professional staff members to five.

4. Funding

Is the estimated cost for the biennium 2014–2015 indicated in 3(b) fully funded? (Yes/no)

Yes.

If “no”, indicate the funding gap and how the funds would be mobilized (provide details of expected source(s) of funds).

Not applicable.

1. Resolution WHA68.15 Strengthening emergency and essential surgical care and anaesthesia as a component of universal health coverage

2. Linkage to the Programme budget 2014–2015 (see document A66/7 http://apps.who.int/gb/ebwha/pdf_files/WHA66/A66_7-en.pdf)

Category: 4. Health systems

Programme area(s): Integrated people-centred health services

Outcome: 4.2. Policies, financing and human resources are in place to increase access to integrated people-centred health services

Outputs: 4.2.1. Policy options, tools and technical support to countries for equitable people-centred integrated service delivery and strengthening of public health approaches

4.2.2. Countries enabled to plan and implement strategies that are in line with WHO’s global strategy on human resources for health and the WHO Global Code of Practice on the International Recruitment of Health Personnel

4.2.3. Guidelines, tools and technical support to countries for improved patient safety and quality of services, and for patient empowerment

How would this resolution contribute to the achievement of the outcome(s) of the above programme area(s)?

The resolution will support the achievement of timely, safe access to emergency and essential surgical care and anaesthesia in primary health care facilities and first referral hospitals as an integral component of universal health coverage. It will foster multisectoral networks and partnerships, multidisciplinary policies and action plans, and support national, regional and global efforts to scale up a skilled health workforce and measures for access to, and safety of, emergency and essential surgery and anaesthesia services.

Does the Programme budget already include the outputs and deliverables requested in this resolution? (Yes/no)
Yes.

3. Estimated cost and staffing implications in relation to the Programme budget

(a) Total cost

Indicate (i) the lifespan of the resolution during which the Secretariat's activities would be required for implementation and (ii) the cost of those activities (estimated to the nearest US\$ 10 000).

- (i) Five years (covering the period 2014–2018).
- (ii) Total: US\$ 22.98 million (staff: US\$ 10.48 million; activities: US\$ 12.50 million).

(b) Cost for the biennium 2014–2015

Indicate how much of the cost indicated in 3(a) is for the biennium 2014–2015 (estimated to the nearest US\$ 10 000).

Total: US\$ 9.20 million (staff: US\$ 4.20 million; activities: US\$ 5.00 million).

Indicate at which levels of the Organization the costs would be incurred, identifying specific regions where relevant.

Headquarters and all six regional offices.

Is the estimated cost fully included within the approved Programme budget 2014–2015? (Yes/no)

Yes.

If "no", indicate how much is not included.

(c) Staffing implications

Could the resolution be implemented by existing staff? (Yes/no)

No.

If "no", indicate how many additional staff – full-time equivalents – would be required, identifying specific regions and noting the necessary skills profile(s), where relevant.

During the biennium 2016–2017, at least one additional staff member at grade P.4 at headquarters and one at grade P.4 in each of the six regional offices would be required.

4. Funding

Is the estimated cost for the biennium 2014–2015 indicated in 3 (b) fully funded? (Yes/no)

No.

If "no", indicate the funding gap and how the funds would be mobilized (provide details of expected source(s) of funds).

The funding gap is US\$ 2.98 million for the period from May to December 2015 inclusive (eight months). It will be tackled through the Organization-wide coordinated resource mobilization plan for dealing with funding shortfalls in the Programme budget 2014–2015.

1. Resolution WHA68.17 Amendments to the Staff Regulations

2. Linkage to the Programme budget 2014–2015 (see document A66/7 http://apps.who.int/gb/ebwha/pdf_files/WHA66/A66_7-en.pdf)

Category: 6. Corporate services/enabling functions

Programme area(s): Management and administration

Outcome: 6.4

Output: 6.4.2

How would this resolution contribute to the achievement of the outcome(s) of the above programme area(s)?

The amendments outlined in document EB136/47 contribute to the above programme area by simplifying and clarifying several Staff Rules; by providing the Organization with greater flexibility when imposing disciplinary measures; and by putting in place the statutory basis for the Organization's mobility policy.

Does the Programme budget already include the outputs and deliverables requested in this resolution? (Yes/no)

Yes.

3. Estimated cost and staffing implications in relation to the Programme budget

(a) Total cost

Indicate (i) the lifespan of the resolution during which the Secretariat's activities would be required for implementation and (ii) the cost of those activities (estimated to the nearest US\$ 10 000).

(i) The resolution is not time-bound.

(ii) The total cost to establish and implement the Organization's mobility policy would be approximately US\$ 9.2–10.2 million during the biennium 2016–2017 when implementation starts. Of this amount, US\$ 8–9 million would be costs related to the increased movement of staff members. Approximately US\$ 1.2 million would be staff costs to employ people to help to manage the implementation of the policy.

(b) Cost for the biennium 2014–2015

Indicate how much of the cost indicated in 3(a) is for the biennium 2014–2015 (estimated to the nearest US\$ 10 000).

Total: US\$ nil (staff: US\$ nil; activities: US\$ nil).

Indicate at which levels of the Organization the costs would be incurred, identifying specific regions where relevant.

Not applicable.

Is the estimated cost fully included within the approved Programme budget 2014–2015? (Yes/no)

Not applicable.

If "no", indicate how much is not included.

(c) Staffing implications

Could the resolution be implemented by existing staff? (Yes/no)

Yes, for the biennium 2014–2015. However, two additional staff members at grade P.3 and one at grade G.5 will be needed in the Department of Human Resources Management at headquarters during the initial phase of implementation during the biennium 2016–2017. Additional staffing the Department of Human Resources Management, the Global Service Centre and human resources departments in the regional offices may be required from 2018 onwards. A more precise cost estimate will be prepared during 2015 when the implementation plan is finalized.

If "no", indicate how many additional staff – full-time equivalents – would be required, identifying specific regions and noting the necessary skills profile(s), where relevant.

4. Funding

Is the estimated cost for the biennium 2014–2015 indicated in 3(b) fully funded? (Yes/no)

Not applicable.

If "no", indicate the funding gap and how the funds would be mobilized (provide details of expected source(s) of funds).

Not applicable.

1. Resolution WHA68.18 Global strategy and plan of action on public health, innovation and intellectual property

2. Linkage to the Programme budget 2014–2015 (see document A66/7 http://apps.who.int/gb/ebwha/pdf_files/WHA66/A66_7-en.pdf)

Category: 4. Health systems

Programme areas: Access to medicines and health technologies and strengthening regulatory capacity

Outcome: 4.3. Improved access to and rational use of safe, efficacious and quality medicines and health technologies

Output: 4.3.2. Implementation of the global strategy and plan of action on public health, innovation and intellectual property

How would this resolution contribute to the achievement of the outcome of the above programme areas?

The global strategy and plan of action on public health, innovation and intellectual property aims to increase research and development needed for products for diseases that disproportionately affect developing countries, where access to needed medical technologies is hindered by market failures. By extending the time frame of the global strategy and plan of action, WHO will be able to keep its momentum and continue to advocate the implementation of policies and activities that increase the availability of the most needed products. The results of the evaluation exercise will help the Health Assembly to determine new policies to improve the current strategy and ensure the effectiveness of WHO's actions.

Does the Programme budget already include the outputs and deliverables requested in this resolution? (Yes/no)

Yes.

3. Estimated cost and staffing implications in relation to the Programme budget

(a) Total cost

Indicate (i) the lifespan of the resolution during which the Secretariat's activities would be required for implementation and (ii) the cost of those activities (estimated to the nearest US\$ 10 000).

(i) The global strategy and plan of action will be extended, covering the period 2015–2022; the evaluation of the global strategy and plan of action will be for the period from June 2015 to May 2017; overall programme review, covering the period 2017–2018.

(ii) Extension of the global strategy and plan of action: US\$ 100 million (staff: US\$ 60 million; activities: US\$ 40 million).

Evaluation of the global strategy and plan of action: US\$ 470 000 (staff: US\$ 70 000; activities: US\$ 400 000).

Overall programme review: US\$ 1.6 million (staff: US\$ 1.1 million; activities US\$ 500 000)

Total: US\$ 102.07 million.

(b) Cost for the biennium 2014–2015

Indicate how much of the cost indicated in 3(a) is for the biennium 2014–2015 (estimated to the nearest US\$ 10 000).

Evaluation of the global strategy and plan of action: US\$ 250 000 (staff: US\$ 30 000; activities: US\$ 220 000)

Total: US\$ 250 000

Indicate at which levels of the Organization the costs would be incurred, identifying specific regions where relevant.

The majority of the activities will take place at headquarters and in the regional offices.

Is the estimated cost fully included within the approved Programme budget 2014–2015? (Yes/no)

Yes.

If “no”, indicate how much is not included.

(c) **Staffing implications**

Could the resolution be implemented by existing staff? (Yes/no)

No.

If “no”, indicate how many additional staff – full-time equivalents – would be required, identifying specific regions and noting the necessary skills profile(s), where relevant.

For the implementation of the strategy from 2015 to 2022, nine additional full-time equivalent staff members in the professional and higher categories and three full-time equivalent staff members in the general service category will be required at headquarters, and two full-time equivalent staff members in the professional and higher categories and one full-time equivalent staff member in the general service category will be required in each regional office. For the programme review, two full-time equivalent staff members in the professional and higher categories and one full-time equivalent staff member in the general service category will be required for 18 months at headquarters.

4. Funding

Is the estimated cost for the biennium 2014–2015 indicated in 3(b) fully funded? (Yes/no)

No.

If “no”, indicate the funding gap and how the funds would be mobilized (provide details of expected source(s) of funds).

The funding gap is US\$ 250 000. It will be tackled through the Organization-wide coordinated resource mobilization plan for dealing with funding shortfalls in the Programme budget 2014–2015.

1. Resolution WHA68.19 Outcome of the Second International Conference on Nutrition

2. Linkage to the Programme budget 2014–2015 (see document A66/7

http://apps.who.int/gb/ebwha/pdf_files/WHA66/A66_7-en.pdf)

Category: 2. Noncommunicable diseases

Programme area: Nutrition

Outcome: 2.5. Reduced nutritional risk factors

Outputs: 2.5.1. Countries enabled to develop, implement and monitor action plans based on the maternal, infant and young child nutrition comprehensive implementation plan

2.5.2. Norms and standards on maternal, infant and young child nutrition, population dietary goals, and breastfeeding updated, and policy options for effective nutrition actions for stunting, wasting and anaemia developed

How would this resolution contribute to the achievement of the outcome(s) of the above programme area(s)?

The resolution will raise the profile of the programme area in Member States’ policy-making and highlights priorities for action for the Secretariat and partners.

Does the Programme budget already include the outputs and deliverables requested in this resolution? (Yes/no)

Yes. The approved Programme budget 2016–2017 also includes the outputs and deliverables requested.

3. Estimated cost and staffing implications in relation to the Programme budget**(a) Total cost**

Indicate (i) the lifespan of the resolution during which the Secretariat's activities would be required for implementation and (ii) the cost of those activities (estimated to the nearest US\$ 10 000).

(i) Ten years (covering the period 2015–2024).

(ii) Total: US\$ 250 million (staff: US\$ 113.62 million; activities: US\$ 136.38 million).

(b) Cost for the biennium 2014–2015

Indicate how much of the cost indicated in 3(a) is for the biennium 2014–2015 (estimated to the nearest US\$ 10 000).

Total: US\$ 31 million (staff: US\$ 14.09 million; activities: US\$ 16.91 million).

Indicate at which levels of the Organization the costs would be incurred, identifying specific regions where relevant.

Currently, 44% of costs would be incurred at headquarters, 25% would be incurred in the African Region, and between 4% and 6% in each of the other regions.

Is the estimated cost fully included within the approved Programme budget 2014–2015? (Yes/no)
Yes.

If "no", indicate how much is not included.

(c) Staffing implications

Could the decision be implemented by existing staff? (Yes/no)

Yes.

If "no", indicate how many additional staff – full-time equivalents – would be required, identifying specific regions and noting the necessary skills profile(s), where relevant.

4. Funding

Is the estimated cost for the biennium 2014–2015 indicated in 3(b) fully funded? (Yes/no)

No.

If "no", indicate the funding gap and how the funds would be mobilized (provide details of expected source(s) of funds).

The funding gap is estimated at US\$ 13.83 million. It will be tackled through the Organization-wide coordinated resource mobilization plan for dealing with funding shortfalls in the Programme budget 2014–2015.

1. Resolution WHA68.20 Global burden of epilepsy and the need for coordinated action at the country level to address its health, social and public knowledge implications

2. Linkage to the Programme budget 2014–2015 (see document A66/7
http://apps.who.int/gb/ebwha/pdf_files/WHA66/A66_7-en.pdf)

Category: 2. Noncommunicable diseases

Programme area(s): Mental health and substance abuse

Outcome: 2.2. Increased access to services for mental health and substance use disorders

Output: 2.2.2. Mental health promotion, prevention, treatment and recovery services improved through advocacy, better guidance and tools on integrated mental health services

How would this resolution contribute to the achievement of the outcome(s) of the above programme area(s)?

The review and evaluation of actions for epilepsy prevention and control, which WHO has been leading, coordinating and supporting, will establish a set of best practices to Member States, and especially to low- and middle-income countries. In addition, the introduction and implementation of national epilepsy programmes and services will provide technical and, wherever possible, financial support to Member States for epilepsy prevention and control. Most importantly, the implementation of actions as proposed in the resolution – strengthening of leadership, governance and implementation of policies and plans for epilepsy prevention and control; integration of epilepsy management in primary health care; increased awareness; investments in research; monitoring of the progress of Member States’ coordinated country-level actions for epilepsy prevention and control and the establishment of international partnerships – will altogether increase access to services for mental health and substance use disorders (Outcome 2.2).

Does the Programme budget already include the outputs and deliverables requested in this resolution? (Yes/no)

Yes.

3. Estimated cost and staffing implications in relation to the Programme budget**(a) Total cost**

Indicate (i) the lifespan of the resolution during which the Secretariat’s activities would be required for implementation and (ii) the cost of those activities (estimated to the nearest US\$ 10 000).

(i) Five and a half years (covering the period July 2015–December 2020, in accordance with the duration of the comprehensive mental health action plan 2013–2020).

(ii) Total: US\$ 25 million (staff: US\$ 11 million; activities: US\$ 14 million).

(b) Cost for the biennium 2014–2015

Indicate how much of the cost indicated in 3(a) is for the biennium 2014–2015 (estimated to the nearest US\$ 10 000).

Total: US\$ 700 000 (staff: US\$ 200 000; activities: US\$ 500 000).

Indicate at which levels of the Organization the costs would be incurred, identifying specific regions where relevant.

Headquarters.

Is the estimated cost fully included within the approved Programme budget 2014–2015? (Yes/no)

Yes.

If “no”, indicate how much is not included.

(c) Staffing implications

Could the resolution be implemented by existing staff? (Yes/no)

No.

If “no”, indicate how many additional staff – full-time equivalents – would be required, identifying specific regions and noting the necessary skills profile(s), where relevant.

No additional staff will be required for the biennium 2014–2015. WHO staff will lead the conceptualization and introduction and formulate the timeline of the epilepsy programme for which implementation will begin in 2016. From January 2016, the following staff additions will be required: at headquarters: 1.5 staff members (one international expert in public health and neurology (100% full-time equivalent) at grade P.4, and one secretary (50% full-time equivalent) at grade G.5); in each of the six regions: 0.5 staff members (six international experts in public health and neurology with knowledge of the needs in their respective regions (50% full-time equivalent; grade P.4)).

4. Funding

Is the estimated cost for the biennium 2014–2015 indicated in 3(b) fully funded? (Yes/no)

No.

If “no”, indicate the funding gap and how the funds would be mobilized (provide details of expected source(s) of funds).

US\$ 500 000 needs to be mobilized to cover the implementation of activities on the prevention and control of epilepsy from July to December 2015 through the Organization’s coordinated resource mobilization plan for dealing with funding shortfalls in the Programme budget 2014–2015. WHO collaborating centres and a network of experts and civil society stakeholders will be utilized for taking forward the activities. For the second half of 2015, implementation will be with existing staff, and additional qualified staff will be recruited from January 2016.

1. Decision WHA68(8) Health conditions in the occupied Palestinian territory, including east Jerusalem, and in the occupied Syrian Golan

2. Linkage to the Programme budget 2014–2015 (see document A66/7 http://apps.who.int/gb/ebwha/pdf_files/WHA66/A66_7-en.pdf)

Category: All

Programme areas: The decision links to programme areas in all categories	Outcome: All Output: All
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How would this decision contribute to the achievement of the outcomes of the above programme areas?

The actions requested in the decision would contribute to all the programmatic outcomes.

Does the Programme budget already include the outputs and deliverables requested in this decision? (Yes/no)

Yes.

3. Estimated cost and staffing implications in relation to the Programme budget

(a) Total cost

Indicate (i) the lifespan of the decision during which the Secretariat’s activities would be required for implementation and (ii) the cost of those activities (estimated to the nearest US\$ 10 000).

(i) 1 year (covering the period May 2015 to May 2016).

(ii) Total: US\$ 11 110 000 (staff: US\$ 3 860 000; activities: US\$ 7 250 000).

(b) Cost for the biennium 2014–2015

Indicate how much of the cost indicated in 3(a) is for the biennium 2014–2015 (estimated to the nearest US\$ 10 000).

Total: US\$ 6 480 000 (staff: US\$ 2 250 000; activities: US\$ 4 230 000).

Indicate at which levels of the Organization the costs would be incurred, identifying specific regions where relevant.

The activities will be implemented through the WHO Office in Jerusalem responsible for WHO's cooperation programme with the Palestinian Authority. WHO's work at country-level will be supported by the Regional Office for the Eastern Mediterranean and by headquarters.

Is the estimated cost fully included within the approved Programme budget 2014–2015? (Yes/no)

Yes.

If “no”, indicate how much is not included.

Not applicable.

(c) Staffing implications

Could the decision be implemented by existing staff? (Yes/no)

Yes.

If “no”, indicate how many additional staff – full-time equivalents – would be required, identifying specific regions and noting the necessary skills profile(s), where relevant.

Not applicable.

4. Funding

Is the estimated cost for the biennium 2014–2015 indicated in 3 (b) fully funded? (Yes/no)

No.

If “no”, indicate the funding gap and how the funds would be mobilized (provide details of expected source(s) of funds).

US\$ 1 390 000; source(s) of funds: funding will continue to be sought through voluntary contributions, including against the Strategic Response Plan.

1. Decision WHA68(10) 2014 Ebola virus disease outbreak and follow-up to the Special Session of the Executive Board on the Ebola Emergency

**2. Linkage to the Programme budget 2014–2015 (see document A66/7
http://apps.who.int/gb/ebwha/pdf_files/WHA66/A66_7-en.pdf)**

Programme areas: Health systems information and evidence; alert and response capacities; outbreak and crisis response	Outcomes: 4.4, 5.1, 5.6 Outputs: 4.4.1, 4.4.4, 5.1.1, 5.6.1
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How would this decision contribute to the achievement of the outcomes of the above programme areas?

This decision implements the requests of the Executive Board in the resolution EBSS3.R1 it adopted at its Special Session on the Ebola Emergency, held on 25 January 2015. The foundation for building WHO's capacity to respond to emergencies with health consequences will be in: (a) the work of the Ebola Interim Assessment Panel; (b) the creation of a contingency fund; (c) the establishment, coordination and management of the Global Health Emergency Workforce; (d) the evaluation provided by an IHR Review Committee focused on the International Health Regulations (2005) in the context of the Ebola response; (e) a framework for advancing research and development of medical products for infectious diseases of epidemic potential; and (f) enhancing the work of the Secretariat in supporting Member States to be better prepared to respond to emergencies with health consequences by strengthening national health systems.

Does the Programme budget already include the outputs and deliverables requested in this decision? (Yes/no)

Yes.

3. Estimated cost and staffing implications in relation to the Programme budget

(a) Total cost

Indicate (i) the lifespan of the decision during which the Secretariat's activities would be required for implementation and (ii) the cost of those activities (estimated to the nearest US\$ 10 000).

- (i) The elements of the decision cover varying time frames (in order of date of completion):
- a. WHO support to national administrations as they prepare for the United Nations Secretary General's 10 July 2015 high-level pledging conference on Ebola will be completed in the biennium 2014–2015;
 - b. the Ebola Interim Assessment Panel's work will be concluded in the biennium 2014–2015;
 - c. the IHR Review Committee under the International Health Regulations (2005) will begin its work in the biennium 2014–2015, and complete its work in the biennium 2016–2017;
 - d. development of a framework for advancing research and development of medical products for other infectious diseases of epidemic potential will begin in the biennium 2014–2015, and continue into the biennium 2016–2017;
 - e. support to west and central African States and other at-risk States to achieve full implementation of the International Health Regulations (2005) by 2019 will take place in three bienniums: 2014–2015, 2016–2017 and 2018–2019;
 - f. continuation and enhancement of the Secretariat's support to Member States to be better prepared to respond to emergencies with health consequences by strengthening national health systems will continue indefinitely;
 - g. establishment, coordination and management of the Global Health Emergency Workforce will be initiated in the biennium 2014–2015 and will continue indefinitely;
 - h. establishment, management and maintenance of the contingency fund will be initiated in the biennium 2014–2015 and will continue indefinitely.

- (ii) The costs of implementing the decision:

The costs of the outcomes and outputs in Categories 4 and 5 will fall within the approved Programme budget 2016–2017. A thorough operational planning exercise will be undertaken in the last half of 2015 and the results, including staffing and budget implications, will be reported.

The work taking place in the biennium 2014–2015 under outcomes 4.4 and 5.1 falls within the Programme budget 2014–2015. Under outcome 4.4, the costs are minimal; under outcome 5.1, the work supporting west and central African States and other at-risk States to achieve full implementation of the International Health Regulations (2005) will cost US\$ 1 000 000.

The total cost for the biennium 2014–2015 is as follows:

- supporting Member States to prepare for the July 2015 pledging conference: US\$ 1 000 000
- the remainder of the Ebola Interim Assessment Panel's work: US\$ 500 000
- establishing the contingency fund and developing the report on its performance for consideration by the Executive Board at its 138th session in January 2016: US\$ 300 000
- establishing and staffing the secretariat of the Global Health Emergency Workforce: US\$ 1 000 000
- establishing and supporting the IHR Review Committee under the International Health Regulations (2005): US\$ 500 000.

(b) Cost for the biennium 2014–2015

Indicate how much of the cost indicated in 3(a) is for the biennium 2014–2015 (estimated to the nearest US\$ 10 000).

Total: US\$ 4.3 million (staff: US\$ 2.7 million; activities: US\$ 1.6 million).

Indicate at which levels of the Organization the costs would be incurred, identifying specific regions where relevant.

All three levels of the Organization.

Is the estimated cost fully included within the approved Programme budget 2014–2015? (Yes/no)

Yes.

If "no", indicate how much is not included.

(c) Staffing implications**Could the decision be implemented by existing staff?**

Though much of the decision will be implemented by existing staff, starting in biennium 2014–2015, four additional staff positions will be required for the secretariat of the Global Health Emergency Workforce.

For the remainder of the decision, additional staffing will be required for next biennium. The number of positions is to be determined as part of the operational planning exercise mentioned above.

4. Funding**Is the estimated cost for the biennium 2014–2015 indicated in 3(b) fully funded?**

No.

If “no”, indicate the funding gap and how the funds would be mobilized (provide details of expected source(s) of funds).

The funding gap is US\$ 4.3 million, which will be mobilized from those donors who: have contributed to WHO’s work in outbreaks and emergencies with health consequences; have expressed interest in so doing; and are yet to be identified through concerted resource mobilization efforts.

Capitalizing the contingency fund will also require resource mobilization to an initial US\$ 100 000 000 with continuous mobilization to replenish the fund when monies have been drawn down to support emergency response. Two Member States have announced pledges that amount to US\$ 11 000 000.

1. Decision WHA68(11) WHO Global Code of Practice on the International Recruitment of Health Personnel**2. Linkage to the Programme budget 2016–2017 (see document http://apps.who.int/gb/ebwha/pdf_files/WHA68/A68_7-en.pdf)**

Category: 4. Health systems

Programme area: Integrated people-centred health services

Outcome: 4.2

Output: 4.2.2

How would this decision contribute to the achievement of the outcomes of the above programme area?

It will contribute to supporting countries to a full implementation of the WHO Global Code of Practice on the International Recruitment of Health Personnel.

Does the Programme budget already include the outputs and deliverables requested in this decision? (Yes/no)

Yes.

3. Estimated cost and staffing implications in relation to the Programme budget**(a) Total cost**

Indicate (i) the lifespan of the decision during which the Secretariat’s activities would be required for implementation and (ii) the cost of those activities (estimated to the nearest US\$ 10 000).

(i) Four years (covering the period 2016–2019)

(ii) Total: US\$ 6.25 million (staff: US\$ 1.75 million; activities: US\$ 4.5 million)

(b) Cost for the biennium 2016–2017

Indicate how much of the cost indicated in 3(a) is for the biennium 2016–2017 (estimated to the nearest US\$ 10 000).

Total: US\$ 3.125 million (staff: US\$ 0.875 million; activities: US\$ 2.25 million)

Indicate at which levels of the Organization the costs would be incurred, identifying specific regions where relevant.

Regional and subregional offices, 80%; and headquarters, 20%.

Is the estimated cost fully included within the approved Programme budget 2016–2017? (Yes/no)

Yes.

If “no”, indicate how much is not included.

(c) Staffing implications

Could the decision be implemented by existing staff? (Yes/no)

Yes, provided that current vacancies at headquarters and the regional offices are filled.

If “no”, indicate how many additional staff – full-time equivalents – would be required, identifying specific regions and noting the necessary skills profile(s), where relevant.

4. Funding

Is the estimated cost for the biennium 2016–2017 indicated in 3(b) fully funded? (Yes/no)

No.

If “no”, indicate the funding gap and how the funds would be mobilized (provide details of expected source(s) of funds).

In the biennium 2016–2017, the gap is estimated at US\$ 1.25 million (US\$ 2.5 million for the four-year period 2016–2019). This funding gap will be tackled as part of the Organization-wide coordinated resource mobilization plan to deal with funding shortfalls in the Programme budget 2016–2017.