The attached working paper highlights, from the perspective of the WHO South-East Asia Region, the most important and relevant resolutions endorsed by the Sixty-eighth World Health Assembly (held on 18–26 May 2015) and the 136th and 137th Sessions of the Executive Board (held on 26 January–3 February 2015 and 27–28 May 2015, respectively). These resolutions are deemed to have important implications for the Region and merit follow-up action by both Member States as well as WHO at the regional and country levels.

The background of the selected resolutions, their implications on collaborative activities with Member States, as applicable, along with actions proposed for Member States and WHO have been summarized. All the resolutions of the Sixty-eighth World Health Assembly are provided in the annex to this working paper.

The High-Level Preparatory (HLP) Meeting held in the WHO Regional Office in New Delhi from 29 June to 2 July 2015 reviewed the attached working paper and made the following recommendation:

**Action by WHO**

(1) Prepare concise and analytical write-ups on each of the resolutions included in the working paper for submission to the Sixty-eighth Session of the Regional Committee for consideration and noting.

The working paper and HLP recommendation are submitted to the Sixty-eighth Session of the Regional Committee for its consideration.
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Annex

1. Resolutions of the Sixty-eighth World Health Assembly
Introduction

The Sixty-eighth World Health Assembly and the 136th and 137th Sessions of the WHO Executive Board endorsed a number of resolutions and decisions during the course of their deliberations. These decisions and resolutions relate to health matters as well as Programme Budget and financial matters.

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

Copies of all the resolutions of the Sixty-eighth World Health Assembly which also cover the subjects of technical resolutions adopted by the 136th Session of the Executive Board, have been annexed to this paper.
1. **Global technical strategy and targets for malaria 2016–2030 (WHA68.2)**

**Background**

- The Sixty-eighth World Health Assembly endorsed in May 2015 Resolution WHA68.2 on Global technical strategy (GTS) and targets for malaria 2016–2030.
- The goals and targets by 2030 are as follows:
  - reduce malaria mortality rates globally compared with 2015 by at least 90%;
  - reduce malaria case incidence globally compared with 2015 by at least 90%;
  - eliminate malaria in at least 35 countries where it was transmitted in 2015; and
  - prevent re-emergence of malaria in all countries that are malaria-free.
- In the South-East Asia Region, between 2000–2013, the reported number of malaria deaths decreased from 5500 to 776; confirmed malaria cases decreased from 2.9 to 1.5 million; and the decrease in incidence of confirmed cases in six countries was >75%. Two countries are on track to achieve a decrease of 50–75% in case incidence by 2015. Sri Lanka has already eliminated malaria (i.e. zero indigenous case since November 2012).

**Implications on collaborative activities with Member States**

- In order to achieve the targets set in GTS, the key areas where collaborative activities with Member States need to be further improved include the following: (a) strengthening technical and managerial capacities of the national malaria control programme in the context of the health system of the country; (b) ensuring universal coverage of malaria interventions; (c) generating strategic information for decision-making; (d) sustaining domestic and international political and financial support; and (e) facilitating multisectoral and intercountry collaboration.

**Actions already taken in the Region**

- A strategy for malaria elimination in the Greater Mekong Sub-region 2015–2030 has been developed jointly with the Western Pacific Region.
- Myanmar and Thailand have updated their national strategic plans (NSP) for malaria.
- Operational plan to implement malaria GTS for 2016–2017 has been developed.
Actions to be taken in the Region

- Joint meeting of malaria programme managers and RTAG to be organized to adapt malaria GTS.
- Technical support to be provided to Member States to update the malaria NSP in line with malaria GTS.
- Progress towards national malaria elimination in (Bhutan and Sri Lanka) and sub-national elimination in (India, Indonesia and Thailand) to be assessed, documented and lessons learned shared. The feasibility of malaria elimination in Timor-Leste to be assessed and malaria NSP updated to reflect the goal of malaria elimination.
- Advocacy to be intensified and collaboration strengthened with partners/networks in support of malaria elimination to:
  (a) develop policies in support of eliminating malaria and preventing re-introduction of malaria transmission;
  (b) increase domestic funding for universal coverage of malaria interventions and health system strengthening;
  (c) increase the investments of development partners to scale up malaria interventions and support operational research;
  (d) encourage intercountry collaboration for malaria elimination; and
  (e) promote investments in health system strengthening that would help ensure delivery of health services including malaria prevention and case management, particularly in hard-to-reach malaria-endemic areas.

2. Poliomyelitis (WHA68.3)

Background

- The Sixty-fifth World Health Assembly in 2012 endorsed a landmark resolution WHA 68.3 on Poliomyelitis declaring the completion of polio eradication as a programmatic emergency for global public health. Following this, the Polio Eradication and Endgame Strategic Plan: 2013–2018 was developed with the goal of completing the eradication, containment and certification of all wild- and vaccine-related polioviruses. One of the key elements of the Polio Eradication and Endgame Strategic Plan is the global withdrawal of the type 2 component of oral polio vaccine in April 2016 in order to eliminate the risks of paralysis associated with the use of OPV. Withdrawal of the type 2 component will imply switching from the trivalent oral polio vaccine (tOPV) to the bivalent oral polio vaccine (bOPV) by all Member States.
Implications on collaborative activities with Member States

- It is essential that the following key preparatory activities are completed by all Member States prior to the switch:
  
  (a) introduction of inactivated poliovirus vaccine (IPV), optimally before the tOPV to bOPV switch in April 2016;
  
  (b) development of national switch plans by September 2015;
  
  (c) expediting the registration of bOPV for use in routine immunization programmes and, if required and in the interim, authorize its use on the basis of pre-qualification granted by WHO;
  
  (d) implementing national policy for appropriate destruction of residual tOPV stocks; and
  
  (e) implementing 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 the global switch from tOPV to bOPV in April 2016.

Actions already taken in the Region

- IPV has been introduced by four Member States – Bangladesh, Democratic People’s Republic of Korea, Maldives and Nepal. Plans for IPV introduction have been finalized by the remaining Member States.

- The process of development of national switch plans has been initiated by all Member States.

- A dry-run of the tOPV to bOPV switch has been conducted in India to identify challenges/barriers and potential solutions. Lessons learned from the dry run are being applied for development of national switch plans by other Member States.

Actions to be taken in the Region

- IPV to be introduced by all Member States before the tOPV to bOPV switch.

- Detailed national switch plans to be finalized by all Member States by September 2015.

- Member States to complete all other preparatory activities prior to the globally-coordinated switch in April 2016.
3. Yellow fever risk mapping and recommended vaccination for travellers (WHA68.4)

Background

- Yellow fever is a mosquito-borne viral disease of humans and other primates. It is endemic in 44 countries in Africa and South America. Globally, there are 200,000 cases with 30,000 deaths from yellow fever each year. The majority of cases and deaths occur in sub-Saharan Africa. No country in the South-East Asia Region is endemic for yellow fever. An effective single dose live attenuated vaccine against yellow fever has been available for years. Previously, a booster dose was recommended every ten years.

- Yellow fever vaccination is performed for three reasons: (1) to protect populations living in areas subject to endemic and epidemic disease; (2) to protect travellers visiting these areas; and (3) to prevent international spread by viraemic travellers. Regulations require certification of yellow fever vaccination to enter non-endemic countries from an endemic area.

- In 2013, WHO’s Strategic Advisory Group of Experts (SAGE) on immunization recommended that a single dose of yellow fever vaccine provides life-long immunity to the disease, making boosters unnecessary. WHO published a new position paper on yellow fever vaccine in 2013 incorporating this recommendation (Vaccines and vaccination against yellow fever WHO Position Paper – June 2013, 5 July 2013, No. 27, 2013, 88, 269–284). Based on this, the Sixty-eighth World Health Assembly endorsed resolution WHA68.4 on Yellow fever risk mapping and recommended vaccination for travelers, stating that changes to the regulations recognizing the adequacy of a single dose of the vaccine will come into force in June 2016.

Implications on collaborative activities with Member States

- Member States of the Region have noted this upcoming change in the Regulations concerning the yellow fever vaccine schedule. They will need to incorporate this new recommendation that a single dose of yellow fever vaccine provides life-long protection into their advice to travellers to yellow fever-endemic countries and into their screening protocols of travellers arriving from a yellow fever-endemic country.

Actions already taken in the Region

- Member States do not face any extraordinary challenges in implementing this change in recommendation to the yellow fever vaccination schedule and screening protocol of travellers from a yellow fever-endemic country.
Action to be taken in the Region

- As with any change in the vaccination schedule, Member States to disseminate this information effectively to responsible government agencies and professional societies, travellers and concerned citizens; plan for implementation by 2016; and monitor the implementation of this new recommendation. The Regional Office can assist them in any or all of these activities if required.

4. Recommendations of the Review Committee on second extensions for establishing national public health capacities and on IHR implementation (WHA68.5)

Background

- The IHR Review Committee met in November 2014 to review the second extension for establishing national public health capacities and IHR implementation. The initial target date for establishment of these capacities was June 2012. At that time, 42 of 193 States Parties declared that they had met their core capacity requirements. As provided in the Regulations, 118 States Parties requested and were granted a two-year extension of the deadline up to June 2014. Articles 5(2) and 13(2) of the Regulations provide that, in exceptional circumstances, and supported by a new implementation plan, States Parties may request a second extension, not exceeding two years.

- At the time of the IHR Review Committee meeting, 64 States Parties had indicated that they met the minimum core capacity standards; 81 States Parties had requested an additional two-year extension of the implementation deadline; and 48 had not communicated their intentions to WHO.

- The following major recommendations were made by the Review Committee.
  - All States Parties that have requested a second extension (or do so at a future date) to be granted the extension for 2014–2016.
  - All States Parties to review, strengthen and empower national focal points (NFP) to enable effective performance of key IHR functions; support the formation of multidisciplinary outbreak investigation and response teams; foster an operational approach between countries; use a risk assessment approach to prioritize public health threats and gaps; and build the confidence of health-care workers through policy measures that promote protection of and respect for their rights.
  - States Parties to urgently strengthen the current self-assessment system and in parallel, the Secretariat to develop 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.
• The Review Committee urged Member States to support implementation of the recommendations and also requested the Director-General 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, including technical support to Member States in implementing the recommendations.

• All extension requests were granted by the Director-General following the recommendation of the Review Committee on second extensions for establishing national public health capacities and on IHR (2005) implementation.

**Implications on collaborative activities with Member States**

• Considerable progress has been made in implementation of IHR with key achievements including: establishment and functionality of NFP; increased transparency in reporting events through systematic use of early warning systems; better communication and collaboration between animal and human health sectors; coordinated collective efforts of countries and partners to build capacities (e.g. the Asia–Pacific Strategy for Emerging Diseases (2010), Integrated disease surveillance and response); establishment of emergency response coordination structures; and better international mechanisms to share information for rapid response. These achievements result from the significant efforts made by States Parties, WHO, and donor programmes.

**Actions already taken in the Region**

• All except two States Parties in the Region requested an extension to establish and strengthen their core capacities. States Parties provided their implementation plans along with this request.

• State Party IHR core capacity self-monitoring reports for 2014 are currently available from all countries in the Region. All Member States are making progress with improvement in establishment of NFP; and increased legislation, coordination and transparency in reporting events. Better communication, collaboration and improved international mechanisms have strengthened sharing of information for rapid response.

• Initiatives aimed at accelerating progress on IHR implementation have been taken and reviewed at the regional IHR meeting and the Sixty-seventh Session of the Regional Committee in 2014. During those meetings, preparedness on Ebola virus disease in relation to IHR was discussed.
Actions to be taken in the Region

- The challenges illustrated by the current ongoing Ebola virus disease (EVD) outbreak has provided the non-affected countries with an opportunity to invest in capacities to better prevent, detect and respond rapidly to such public health events as Ebola virus disease, Middle East respiratory syndrome coronavirus, poliomyelitis (maintaining the status) and avian influenza A(H5N1) and A(H7N9). Capacities of concern in the Region are: establishment of effective surveillance and response at points of entry (PoE) and laboratory biosafety and biosecurity practices. The capacities of four of the nine countries that requested extension are still a concern in this regard.

- Activities to strengthen infection prevention and control in the designated hospitals, training on medical preparedness to radiation emergencies, assessing readiness and preparedness of Member States on EVD in the context of IHR, strengthening PoE capacities and emergency operation centres (EOC), building capacities on quality management system including biosafety, biosecurity, and bio-risk management in laboratories in Member States are taking place.

- The Region is working towards developing an action plan with the sole objective of ensuring that all Member States comply with IHR (2005) requirements.

5. Global vaccine action plan (WHA68.6)

Background

- In May 2012, the Sixty-fifth World Health Assembly endorsed resolution WHA65.17 on the Global vaccine action plan (GVAP) and requested the Director-General to monitor progress and report annually, through the Executive Board, to the Health Assembly, until the Seventy-first World Health Assembly, on progress towards achievement of global immunization targets, using the proposed accountability framework to guide discussions and future actions.

- In May 2013, the Sixty-sixth World Health Assembly noted the Secretariat’s report with its proposed framework for monitoring, evaluation and accountability as well as the process for reviewing and reporting progress under the independent oversight of the strategic advisory group of experts (SAGE) on immunization.

- In accordance with the monitoring, evaluation and accountability process, SAGE reviewed the progress against each of the indicators for the goals and strategic objectives of GVAP, based on data from 2013, and prepared the 2014 assessment report of GVAP.
Implications on collaborative activities with Member States

- Based on this, the Sixty-eighth World Health Assembly endorsed this resolution urging Member States to:

  1. 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. 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. 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. seek opportunities for establishing national and regional vaccine manufacturing capacity, in accordance with national priorities, that can produce to national regulatory standards, including WHO-prequalification;

  5. 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;

  6. 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 assistance;

  7. 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; and

  8. 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.

- Member States of the Region have noted the required actions and will be taking appropriate steps as relevant to the individual country.

Actions already taken in the Region

- Member States see many challenges in implementing these suggested actions and request WHO to facilitate the deliberations at country level through national immunization technical groups (NITAG) and at the regional level through the SEAR immunization technical advisory group (ITAG).
Actions to be taken in the Region

- SEAR ITAG to discuss this further in the regional context and liaise with national level technical advisory bodies on immunization for further action.

6. **Global action plan on antimicrobial resistance (WHA68.7)**

**Background**

- During the past seven decades, antimicrobial agents have played a critical role in reducing the burden of communicable diseases all over the world. The emergence of resistance and its rapid spread is negating the impact of these drugs, obstructing progress towards achievement of the Millennium Development Goals and hindering effective application of modern technologies in mitigating human misery. If urgent and comprehensive steps are not taken to combat antimicrobial resistance (AMR), the world shall slip into a “post-antibiotic era” where mortality and morbidity due to infectious diseases shall be at par with those that were seen in the “pre-antibiotic era”. The health and economic consequences of AMR constitute a heavy and growing burden on countries, requiring urgent action at national, regional and global levels.

- The importance of this topic led to the endorsement of a resolution on AMR at the Sixty-seventh World Health Assembly in 2014. Member States supported the resolution and urged for WHO leadership for the development of a comprehensive global action plan for endorsement by the Health Assembly in 2015. The global action plan was submitted to the Sixty-eighth World Health Assembly and endorsed through resolution WHA68.R7.

**Implications on collaborative activities with Member States**

- Member States will have in place, by the Seventieth World Health Assembly, national action plans on AMR that are aligned with the global action plan. They will implement the proposed actions in the global action plan on AMR adapted to national priorities, and mobilize human and financial resources through domestic, bilateral and multilateral channels.

- WHO will provide technical support in implementation of the global action plan on AMR and work with the strategic technical advisory group (STAG), relevant partners, and stakeholders to develop a framework for monitoring and evaluation in line with principle five of the global action plan.

- WHO will also develop and implement, in consultation with Member States and relevant partners, an integrated global programme for surveillance of AMR in line with the global action plan and establish a network of WHO collaborating centres to support quality assessment and surveillance of AMR. WHO will develop a 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 AMR. WHO will 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 AMR, particularly with regard to the needs of developing countries.

**Actions already taken in the Region**

- SEA Regional Strategy on Prevention and Control of AMR (2010)
- SEA Regional Committee Resolution (RC/63/R4) on AMR (2010)
- Jaipur Declaration on AMR by the Health Ministers of SEAR (2011)
- AMR commemorated as theme for World Health Day 2011
- Regional flagship priority area
- SEA Regional Technical Advisory Group on AMR convened and first meeting conducted in June 2015
- Meeting of national focal points on AMR conducted in 2015.

**Actions to be taken in the Region**

- Technical support to be provided to all Member States in development and implementation of national action plans in line with the global action plan and Jaipur Declaration on AMR as guiding principles.

**7. Health and the environment: addressing the health impact of air pollution (WHA68.8)**

**Background**

- The Sixty-Eighth World Health Assembly addressed the health impact of air pollution and endorsed a historic resolution highlighting the key role of national health authorities if air pollution is to be addressed effectively. Air pollution (including household and ambient air pollution) is one of the main avoidable causes of disease globally associated with one in eight of all deaths. The South-East Region faces particularly large air pollution burdens associated with significant health inequities. Most air pollutants are emitted as by-products of human activity. Linkages with urban development and climate change are recognized as exacerbating factors.
Implications on collaborative activities with Member States

- The main operative paragraphs call upon Member States to redouble their efforts to identify, address and prevent the health impacts of air pollution; enhance international cooperation by data collection, monitoring, research, development of normative standards and guidelines; and share the best practices and lessons from implementation. The resolution calls upon health systems to take a leading role in raising awareness among the public and stakeholders and effective steps to address and minimize air pollution associated with health-care activities. The Director-General is called upon to significantly strengthen WHO capacities in the field of air pollution, support Member States inter alia in implementing air quality guidelines and to provide adequate resources for the work in the Secretariat.

Actions already taken in the Region

- The need to tackle household air pollution has been recognized by ministers of health in the “Regional action plan for the prevention and control of noncommunicable diseases 2013–2020” which includes a specific target that Member States are addressing in their national NCD action plans. A regional workshop on air quality and human health was held in New Delhi on the 11–12 December 2014 and introduced the new WHO Guidelines for indoor air pollution: household fuel combustion. A number of Member States in the Region have begun to increase consideration of the health impacts of air pollution, notably India, Indonesia, Maldives and Thailand.

Action to be taken in the Region

- A road map for an enhanced global response to the adverse health effects of air pollution will be proposed to the Sixty–ninth World Health Assembly in 2016.

- Planned regional and country actions need to be identified to contribute to this global road-map.

- Programme Budget 2016–2017 includes an increase in resources for this area of work, including in the Regional Office, and makes provision for a number of pilot projects in selected Member States.

8. Framework of engagement with non-State actors (WHA68.9)

Background

- The governing bodies requested the Director-General to develop an overarching framework as well as separate policies on WHO’s engagement with different groups of non-State actors.
On the basis of the inputs received from debates at the meetings of governing bodies and consultations, the Secretariat submitted a revised version of the draft overarching framework as well as separate policies on WHO’s engagement with different groups of non-State actors to the Sixty-eighth World Health Assembly in May 2015.

Implications on collaborative activities with Member States

- The Sixty-eighth World Health Assembly acknowledged the importance of engagement at all levels of WHO with non-State actors that benefits from the robust management of risks.
- It welcomed the progress made and consensus reflected in many parts of the draft framework of engagement with non-State actors, particularly the sections on introduction, rationale, principles, benefits and risks of engagement, non-State actors, and types of interaction.

Actions already taken in the Region

- Member States of the Region have been actively providing inputs and suggestions for necessary improvements in the draft framework at various forums such as governing body meetings, informal consultations and written submissions to the Secretariat, including at the Sixty-seventh Session of the WHO Regional Committee for South-East Asia in September 2014.

Actions to be taken in the Region

- Member States will participate in an open-ended intergovernmental meeting scheduled from 8–10 July 2015 in Geneva, to finalize the draft framework of engagement with non-State actors.
- Members of the Executive Board from the Region will review the finalized draft framework of engagement with non-State actors at the 138th Session of the EB in January 2016.
- Member States will contribute to the discussions and adoption of the finalized framework of engagement with non-State actors at the Sixty-ninth World Health Assembly in May 2016.
9. Strengthening emergency and essential surgical care and anaesthesia as a component of universal health coverage (WHA68.15)

Background

- Every year, more than 234 million surgical procedures are performed 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, burns, and injuries from domestic, industrial and road-traffic accidents, among others. Many surgically treatable conditions are among the top 15 causes of physical disability worldwide. More than 289,000 women die every year in childbirth and approximately 25% of these maternal deaths, infant deaths and disabilities are due to obstructed labour. Many of these deaths are taking place in low- and middle-income countries and most of them could be prevented if adequate emergency, surgical and anaesthesia services were available.

Implications on collaborative activities with Member States

- Resolution WHA68.15 urges Member States 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 and anaesthesia services to all who need them, including promoting timely referral and more effective use of the health-care workforce through task-shifting, as appropriate, as part of an integrated surgical care network in order to achieve universal health coverage.

Actions already taken in the Region

- The Region promoted the “clean care is safe care” campaign designed to address the first global challenge in patient safety. Under this programme, “hand hygiene save lives” campaigns for prevention of health-care associated infections were promoted and multi-professional patient safety curriculum developed and adopted.

- Now the second challenge, safe surgical care programme, is being implemented in the Region and under this, a safe surgery checklist was developed and adopted by many Member States and surgical site infection prevention, safe clinical and bio-waste disposal, and hand hygiene programmes are being carried out in Member States.
Actions to be taken in the Region

- Member States may consider adopting the requirements proposed by this resolution and facilitate provision of country prioritized core set of emergency and essential surgery and anaesthesia services at the primary health care and first-referral hospital level.

- Well-coordinated multisectoral networks and partnerships, multidisciplinary policies, strategies, action plans and science-based approaches have to be developed to support national and sub-national efforts for establishing/expanding/strengthening emergency and essential surgical care and anaesthesia in Member States.

10. **Global strategy and plan of action on public health, innovation and intellectual property (WHA68.18)**

**Background**

- The purpose of Resolution WHA68.18 on Global strategy and plan of action on public health, innovation and intellectual property (GSPA, Resolution WHA61.21) is to comprehensively evaluate and assess the status of implementation of the eight elements of GSPA: (1) prioritizing research and development needs; (2) promoting research and development; (3) building and improving innovative capacity, transfer of technology; (4) application and management of intellectual property to contribute to innovation and promote public health; (5) improving delivery and access; (6) promoting sustainable financing mechanisms; and (7) establishing monitoring and reporting systems.

**Implications on collaborative activities with Member States**

Member States agreed that evaluation of GSPA would be taken up in the following manner.

- The evaluation will be guided by the processes and methodology proposed in the WHO evaluation practice handbook, 2013, with the intention of documenting achievements, gaps and remaining challenges and making recommendations on the way forward.

- The overall programme review will be more policy-oriented and consider the findings of the comprehensive evaluation, together with other technical and managerial aspects of the programme (including possibilities for broader engagement of different stakeholders at various stages of the process), with a view to identifying what needs to be improved and modified in the next stages of GSPA.

- An ad hoc evaluation management group would be convened to assist in selecting the evaluation team, reviewing the evaluation inception and draft evaluation reports, and ensuring that the final draft meets appropriate quality standards.
The programme review would be conducted by a panel of experts with a broad mix of expertise, practical experience and backgrounds covering the eight elements of the strategy, including experts from developed and developing countries for which adequate regional representation would be ensured.

It is proposed to start the programme review in November 2016. A progress report will be presented to the Seventieth World Health Assembly in May 2017, and the final report of the comprehensive review, which will be presented to the Executive Board at its 142nd session in January 2018 and to the Seventy-first World Health Assembly in May 2018, will make specific recommendations on the way forward for implementation of GSPA until 2022.

Actions already taken in the Region

During the Sixty-seventh Session of the Regional Committee, the Member States decided to undertake an assessment to provide inputs for informed decision-making at the Sixty-eighth World Health Assembly in 2015. Hence, a regional meeting was held for assessment of progress in implementing GSPA for South-East Asia from 16–18 December 2014, followed by a meeting of national focal points in Bangkok, Thailand on 10 March 2015.

Actions to be taken in the Region

This assessment is currently under way and is work in progress with the Member States. It is hoped that these outcomes will inform decision-making on the next steps for implementation of GSPA until 2022.

11. Outcome of the Second International Conference on Nutrition (WHA68.19)

Background

The Second International Conference on Nutrition (ICN2) focused global attention on malnutrition and resulted in the Rome Declaration which called for an increase in effective actions to improve nutrition security, including coherence between food supply systems and nutrition to eradicate hunger and prevent all forms of malnutrition, with a view to achieving WHO’s global nutrition targets by 2025. The Framework for Action guides implementation of commitments of the Rome Declaration, with 60 voluntary policy options.
Implications on collaborative activities with Member States

- The policy/strategies include options on nutrition, health, agriculture and development plans to achieve multisectoral enabling environments to improve nutrition. These are particularly relevant for the Region with its high double burden of malnutrition. Food systems are unsustainable and unhealthy. Improving food and nutrition security in the Region to achieve the global targets is a challenge. While many options stated in the framework such as multisectoral mechanisms to promote nutrition security, breastfeeding, complementary feeding and guidance on healthy diets are operational in Member States, programmes need scaling up. Advocacy to Member States to recognize nutrition as a key pillar of national development is vital and would improve nutrition governance and capacity. Promoting universal health coverage to enable national health systems to address access to nutrition interventions, more focus on the double burden of malnutrition, better coherence between nutrition and social protection; improvements in water, sanitation, and food safety need attention.

Actions already taken in the Region

- Intersectoral, multi-stakeholder mechanisms for food security have been established, but implementation issues exist.
- Member States have implemented the WHO Global Strategy on Infant and Young Child Feeding (IYCF), while some have also incorporated WHO’s Comprehensive Implementation Plan on Maternal, Infant and Young Child Nutrition 2012–2025 into their action plans.
- Most Member States have enacted legislation on the International Code of Marketing of Breast-milk Substitutes.
- Nutrition education and information activities and capacity-building in nutrition is ongoing throughout the Region. Food-based dietary guidelines are available in all Member States.
- Enhancing micronutrient intake through supplementation and fortification programmes are being stepped up.
- Ten Member States are members of Codex Alimentarius.

Actions to be taken in the Region

- A regional nutrition strategy/action plan to implement the strategies in the ICN 2 Framework to be drafted.
- The extent and quality of nutrition programmes across all countries to be scaled up.
- Multisectoral mechanisms to promote nutrition security to be improved.
• Nutrition surveillance systems to be established/revised with indicators to reflect the global targets.
• Actions to improve monitoring and implementation of the Breastfeeding Code to be developed/established.
• WHO recommendations for dietary prevention of childhood obesity and NCD to be implemented.
• Interagency dialogue to be promoted to create enabling environments for sustainable food systems, and capacity built for nutrition across sectors (e.g. agriculture, education).
• The visibility of nutrition delivery programmes in UHC frameworks to be increased.

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

   Background
   • Epilepsy is a common serious chronic neurological disease.
   • More than 50 million people worldwide, including about 15 million in the Region suffer from epilepsy.
   • Epilepsy treatment with first-line antiepileptic medicines is among the identified “best buys”. The cost of treatment with phenobarbital is as low as US$ 5 per person per year.

   Implications on collaborative activities with Member States
   • Pilot projects conducted in Bangladesh, Bhutan, Myanmar and Timor-Leste to reduce the treatment gap of epilepsy have conclusively demonstrated that the treatment gap of epilepsy can be substantially reduced by strengthening the existing primary health-care system. In the projects, the primary health-care providers were trained in the identification, treatment and referral of epilepsy cases. Provision of first line antiepileptic medicines was ensured. On impact evaluation, the treatment gaps of epilepsy in the pilot areas were seen to decrease from 80–90% to 5%.

   Actions already taken in the Region
   • Epilepsy treatment gap projects were piloted in five Member States (Bangladesh, Bhutan, Myanmar, Thailand and Timor-Leste).
• Validated screening instrument for the identification of generalized tonic-clonic seizure (GTCS) was developed.

• Manuals for physicians, community-based health-care providers on identification and care of GTCS, a validated clinical case definition of GTCS were developed.

• The WHO Mental Health Gap Action Programme (mhGAP) which addresses epilepsy has been implemented in nine Member States of the Region.

• Advocacy programmes and information materials were developed on the myths and stigma surrounding epilepsy.

**Actions to be taken in the Region**

• Epilepsy research capacity to be strengthened.

• Surveillance for comprehensive accurate epidemiological estimates of the burden of epilepsy in the Region to be improved.

• Scaling up the epilepsy treatment gap projects in the Member States where it has been piloted to be advocated and pilots initiated in the remaining Member States.

• Non-specialist health-care providers to also be trained in the prevention and management of epilepsy.

• A strong, functional referral system on epilepsy case management to be developed.

• Accessibility, availability and affordability of antiepileptic medicines to be improved.

• Country-specific strategies to be developed for the prevention of epilepsy.
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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
A68/VR/8

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Global technical strategy and targets for malaria 2016–2030

The Sixty-eighth World Health Assembly,

Having considered the report on malaria: draft global technical strategy: post 2015;¹

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;

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 threat 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;

¹ Document A68/28.
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;

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 the 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 incidence and mortality rates globally by at least 90% by 2030, to eliminate the disease in at least 35 new countries, 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;

¹ And, where applicable, regional economic integration organizations.
(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;

(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;

1 And, where applicable, regional economic integration organizations.
(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 States\(^1\) for the implementation, national adaptation and operationalization of the global technical strategy for malaria 2016–2030;

(2) to update technical guidance on malaria prevention, care and elimination regularly, as new evidence is gathered and new innovative tools and approaches become available;

(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 Secretariat’s capacities 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.

Eighth plenary meeting, 22 May 2015
A68/VR/8

\(^1\) And, where applicable, regional economic integration organizations.
Poliomyelitis

The Sixty-eighth World Health Assembly,

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

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;

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);

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] 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 of the type 2 component in oral poliovirus vaccine in April 2016; 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 Document A68/21.
2 See the summary record of the Executive Board at its 136th session, seventh meeting.
3 See document WHA66/2013/REC/3, summary record of Committee A, ninth meeting, section 2.
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 the 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 and its replacement 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) 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 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 in the oral poliovirus vaccine; and by ensuring full implementation of revised

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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.
outbreak response protocols\(^1\) that build on the international outbreak response guidelines issued in resolution WHA59.1;

(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 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 in 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 authorization of the Director-General of WHO before its release and use;

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;

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(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 in 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 2 in a timely and equitable way to all Member States, and develop a procedure for 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, 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 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
A68/VR/9

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2 And, where applicable, regional economic integration organizations.
Yellow fever risk mapping and recommended vaccination for travellers

The Sixty-eighth World Health Assembly,

Having considered the report on implementation of the International Health Regulations (2005): responding to public health emergencies;¹

Recalling the adoption by the Sixty-seventh World Health Assembly of the updated Annex 7 of the International Health Regulations (2005);² and the report of the Strategic Advisory Group of Experts on immunization,³ 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:⁴

   (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;

¹ See document A68/22.
² See resolution WHA67.13 and document WHA67/2014/REC/1, Annex 5.
⁴ And, where applicable, regional economic integration organizations.
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, to: (i) maintain up-to-date yellow fever risk mapping; and (ii) provide guidance on yellow fever vaccination for travellers in ways that facilitate international travel.
The recommendations of the Review Committee on Second Extensions for Establishing National Public Health Capacities and on IHR Implementation

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;¹

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) and on Pandemic Influenza A (H1N1) 2009 transmitted by the Director-General to the Sixty-fourth World Health Assembly;²

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;

¹ Document A68/22 Add.1.
² Document A64/10.
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
A68/VR/9
Global vaccine action plan

The Sixty-eighth World Health Assembly,

Having considered the report on the global vaccine action plan;\(^1\)

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 2011–2020 Decade of Vaccines 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 series of diphtheria-tetanus-pertussis (DTP) vaccine;

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 and 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, due to the increased financial burden of new vaccines and based upon those that are eligible or ineligible for financial and technical support from global partners;

\(^1\) Document A68/30.
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 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 introduction of new vaccines;

Recalling many Member States’ interventions on the Health Assembly’s immunization agenda item each year, expressing 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 drugs, 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 critical 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 against 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) 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;

\[1\] And, where applicable, regional economic integration organizations.
(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 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;

(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 assistance;

(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 vaccine price databases, like the WHO Vaccine Product, Price and Procurement project, 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 upon 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 assistance in the introduction of new vaccines in line with the global vaccine action plan and in accordance with national priorities;

(8) to continue to assist 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
A68/VR/9
Global action plan on antimicrobial resistance

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;¹

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 and 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 antimicrobials; 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 and others, 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 high-, middle- and low-income countries, with serious consequences for increasing antimicrobial resistance in a wide range of pathogens including bacteria, viruses and parasites;

¹ Documents A68/19, A68/20 and A68/20 Corr.1.
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 and financial assistance, particularly to low- and middle-income countries;

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 drug market failure;

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;

2. URGES Member States:¹

(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 on antimicrobial resistance;

(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;

¹ And, where applicable, regional economic integration organizations.
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 resistance, including through 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, Members States, FAO and 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 States 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 States 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 to the Sixty-ninth World Health Assembly through the 138th Executive Board;

1 And, where applicable, regional economic integration organizations.
(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 for implementing 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
A68/VR/9

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Health and the environment: addressing the health impact of air pollution

The Sixty-eighth World Health Assembly,

Having considered the report on health and the environment: addressing the health impact of air pollution;¹

Reaffirming its commitment to the outcome document of the Rio+20 Conference “The future we want”, in which all States Members 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;²

Noting with deep concern that indoor 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;³

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;⁴

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;

¹ Document A68/18.
² UNEA resolution 1/7, PP6.
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;¹

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, 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 WHO air quality guidelines proposed levels) 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 the WHO 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 related 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 old persons, as well as low-income populations who are often exposed to high levels of ambient air pollution, or live in homes that have 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;²

Cognizant that most air pollutants are emitted as a result of the human activities identified as sources of air pollution³ in the WHO guidelines on ambient and indoor air pollution, and that there are also naturally occurring phenomena that negatively affect air quality,⁴ 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 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;

¹ 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);
² WHO Burden of Disease, Indoor and Outdoor Air Pollution, 2014.
⁴ These include, inter alia, Radon, [a carcinogenic], dust- and sandstorms, volcanic eruptions and forest fires.
Acknowledging recent global efforts to promote air quality, in particular the 2014 United Nations Environment Assembly resolution on air quality, as well as the many national and regional initiatives to mitigate the health impacts of indoor and outdoor air pollution, and noting 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;

Noting that WHO’s air quality guidelines for both ambient air quality\(^2\) (2005) and indoor air quality\(^3\) (2014) 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 while 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;

Acknowledging also the complexity between 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 sandstorms, volcanic eruptions and forest fires can also exacerbate the impact of anthropogenic air pollution on health,

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1. Taking into account the context of federated states.
3. WHO indoor air quality guidelines: household fuel combustion; 2014; (http://www.who.int/indoorair/guidelines/hhfc/en/).
1. URGES Member States: ¹

(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 international, regional and national levels, and through targeted, multisectoral measures in accordance with national priorities;

(2) to enable health systems, including health protection authorities, to take a leading role in raising awareness in the public and among all stakeholders of the impacts of air pollution on health and of opportunities to reduce or avoid exposure, including by guiding preventive measures to help 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;

¹ And, where applicable, regional economic integration organizations.
(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 work closely with the communities at risk who 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 United Nations High-level Meeting on 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 for Member States in implementing the WHO air quality guidelines and WHO indoor air quality guidelines;

   (b) support and guidance for 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 analyse data on air quality, with particular emphasis on health-related aspects of air quality;

   (f) assistance 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 the WHO Global Health Observatory;

(i) appropriate advisory capacity and support tools to assist 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 level to help Member States 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, while 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 the United Nations Environment Assembly resolution 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 approved 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;

¹ Examples of such efforts are the WHO global action plan for noncommunicable diseases, Integrated Global Action Plan for the Prevention and Control of Pneumonia and Diarrhoea (GAPPD), The Global Strategy for Women’s, Children’s and Adolescents’ Health and the Every Woman Every Child Movement.
(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
A68/VR/9

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Framework of engagement with non-State actors

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;

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. 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;

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;

(2) to submit the finalized draft framework of engagement with non-State actors 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.

1 Documents A68/5, Annex and A68/53.
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

(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.]

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


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

ENGAGEMENT: RATIONALE, PRINCIPLES, BENEFITS AND RISKS

Rationale

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

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1 Headquarters, regional offices and country offices, entities established under WHO, as well as hosted partnerships. For hosted partnerships the framework of engagement with non-State actors will apply, subject to the policy on WHO’s engagement with global health partnerships and hosting arrangements (resolution WHA63.10). Hosted, as well as external partnerships are explained in paragraph 48.
The functions of WHO, as set out in Article 2 of its Constitution, include: to act as the directing and coordinating authority on international health work; to establish and maintain effective collaboration with diverse organizations; and to promote cooperation among scientific and professional groups which contribute to the advancement of health. The Constitution further mandates the Health Assembly or the Executive Board, and the Director-General, to enter into specific engagements with other organizations. WHO shall, in relation to non-State actors, act in conformity with its Constitution and resolutions and decisions of the Health Assembly, and bearing in mind those of the United Nations General Assembly or the Economic and Social Council of the United Nations, if applicable.

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

(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;²

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

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

² Policies, norms and standard setting includes information gathering, preparation for, elaboration of and the decision on the normative text.
(f) be effectively managed, including by, where possible avoiding conflict of interest\(^1\) 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]

**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;\(^2\)

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

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\(^1\) As set out in paragraphs 23 to 26

\(^2\) Policies, norms and standard setting includes information gathering, preparation for, elaboration of and the decision on the normative text.
(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;

(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 and is not part of any State or public institution. Non-State actors include nongovernmental organizations, private sector entities, philanthropic foundations and academic institutions.

CHAIR’S PROPOSAL

9. alt For the purpose of this framework, a non-State actor is an entity that operates independently from the government and 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.

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” 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.

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

2 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.
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.¹

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.

(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.

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

**Resources**

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]

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

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

- WHO needs to know the non-State actors that it engages with. Therefore each non-State actor is required to provide all relevant 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.

- [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)

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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.
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, 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, 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.

Transparency

37. 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

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1 Other than decisions related to official relations as set out in paragraphs 49 to 55.
2 See document EB133/10.
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 Secretariat\(^1\) to document and coordinate engagement with non-State actors. It contains the main standard information provided by non-State actors\(^2\) 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, 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.]

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

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\(^1\) 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.
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.

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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
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.

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

1 See http://www.who.int/about/licensing/emblem/en/.
WHO can accept secondments from non-State actors for technical work or implementation of WHO’s programmes and policies and emergency response.

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 Organizations and the Guidelines on interaction with commercial enterprises to achieve health outcomes (noted by the Executive Board).

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.

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 arrangements

[(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).]

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2 See document EB107/2001/REC/2, summary record of the twelfth meeting.
3 Endorsed by the Health Assembly in resolution WHA63.10 on partnerships.
The management of WHO’s relations with individual experts is regulated by the Regulations for Expert Advisory Panels and Committees and the Guidelines for Declaration of Interests (WHO Experts).

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.”

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

The procurement of goods and services is regulated by the Financial Rules and Financial Regulations; it is covered by the framework for engagement with non-State actors, although pro-bono contributions from non-State actors are covered.

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

“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 engagement 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.

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4 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.
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

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]
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.

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.

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.

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.

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.

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]**

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

- 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;

- 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 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]

[New]72. 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 ADDRESSSED 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. The generic provisions of the framework also apply to all engagements with nongovernmental organizations.

PARTICIPATION

Participation by nongovernmental organizations in WHO meetings

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.

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.

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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.
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. 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 meetings

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.

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.
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.

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 technologies

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

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

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

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

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

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

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

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

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

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

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

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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] [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
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. The generic provisions of the framework also apply to all engagements with philanthropic foundations.

PARTICIPATION

Participation by philanthropic foundations in WHO meetings

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.

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.
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 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. 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.

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.

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


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
A68/VR/9

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

Ninth plenary meeting, 26 May 2015
A68/VR/9

¹ Documents A68/38 and A68/INF./1.
² Document A68/57.
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 Members 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;¹

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 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

¹ Documents A68/39 and A68/58.
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
A68/VR/9
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.

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¹ Document A68/40.
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Ninth plenary meeting, 26 May 2015
A68/VR/9
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
A68/VR/9

¹ Document A68/41.
² Document A68/59.
Appointment of the External Auditor

The Sixty-eighth World Health Assembly,

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
A68/VR/9
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;¹

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, burns and 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 approximately a 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;

¹ Document A68/31.
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, 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 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, 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;

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 live 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 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

1 And, where applicable, regional economic integration organizations.

2 See resolution WHA67.19.
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 States\(^1\) 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 United Nations 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 States\(^1\) 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 States\(^1\) 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;

Acknowledging the work already done by 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 sub-district levels;\(^2\)

\(^1\) And, where applicable, regional economic integration organizations.

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:**

   (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 guidelines;

   (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 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 documenting, 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.

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1 And, where applicable, regional economic integration organizations.
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 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 States\(^1\) 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 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;

(7) to support Member States\(^1\) 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;

\(^1\) And, where applicable, regional economic integration organizations.
(10) to further cooperate with the International Narcotics Control Board to support Member States\(^1\) 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 States\(^1\) 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
A68/VR/9

\(^1\) And, where applicable, regional economic integration organizations.
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
A68/VR/9

¹ See document EB136/2015/REC/1, resolution EB136.R12.
Amendments to the Staff Regulations

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,1

1. ADOPTS the proposed amendments to Staff Regulations 4.1, 4.2, 4.3, 4.4 and 9.2;

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
A68/VR/9

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Global strategy and plan of action on public health, innovation and intellectual property

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;¹

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 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 entitled “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 frames of the plan of action on public health, innovation and intellectual property from 2015 until 2022;

¹ Document A68/35.
(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;

(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 A68/35 and its Annex, in consultation with Member States to 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, 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 bureau of the Executive Board in February 2017;

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1 And, where applicable, regional economic integration organizations.

(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 142nd session of the Executive Board.

Ninth plenary meeting, 26 May 2015
A68/VR/9
Outcome of the Second International Conference on Nutrition

The Sixty-eighth World Health Assembly,

Having considered the report on outcome of the Second International Conference on Nutrition,¹

1. ENDORSES 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;

2. CALLS on Member States² 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
A68/VR/9

¹ Document A68/8.
² And, where applicable, regional economic integration organizations.
Global burden of epilepsy and the need for coordinated action at the country level to address its health, social and public knowledge implications

The Sixty-eighth World Health Assembly,

Having considered the report by the Secretariat 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;¹

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;

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;²

Noting the Political Declaration of the High-level Meeting of the United Nations General Assembly on the Prevention and Control of Non-communicable Diseases,³ 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”,⁴ 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

¹ Document A68/12.
² See document WHA56/2003/REC/3, summary record of the fourth meeting of Committee A.
³ United Nations General Assembly resolution 66/2.
from non-communicable diseases through prevention and treatment, and promote mental health and well-being);\(^1\)

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 0.03/100 000 population, that the essential antiepileptic medicines are often unavailable, that the treatment gap is estimated to be over 75% in low-income countries and to be substantially wider in rural areas than in urban areas;

Noting that the majority of people with epilepsy can be kept free from seizures if 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;

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, 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;

\(^1\) Document A/68/970.
1. URGES Member States:  

(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 with 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 training non-specialist health care providers in order to provide them with 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;  

(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;  

1 And, where applicable, regional economic integration organizations.
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 in 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
A68/VR/9

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