

REGIONAL COMMITTEE

Provisional Agenda item 10.1

*Seventy-fifth Session  
Paro, Bhutan  
5–9 September 2022*SEA/RC75/15  
29 July 2022

**Governing Body matters:  
Key issues arising out of the  
Seventy-fifth World Health Assembly and the  
150th and 151st sessions of the WHO Executive Board**

This Working Paper highlights, from the perspective of the WHO South-East Asia Region, the resolutions endorsed, and decisions adopted, by the Seventy-fifth World Health Assembly (held on 22–28 May 2022) and the 150th and 151st sessions of the WHO Executive Board (held on 24–29 January 2022 and 30 May 2022, respectively) along with other important Agenda items. The issues are deemed to have important implications for the Member States of the WHO South-East Asia Region and the resolutions/decisions merit follow-up action by both Member States of the Region as well as the Organization at the regional and country levels.

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

The High-Level Preparatory Meeting held virtually in New Delhi on 18–20 July 2022 reviewed the attached Working Paper and noted the provisions of the selected resolutions endorsed and decisions adopted by the Seventy-fifth World Health Assembly and the 150th and 151st sessions of the WHO Executive Board and other Agenda items deemed to have important implications for the WHO South-East Asia Region and merit follow-up actions at the regional and country levels.

The HLP Meeting, following a review of the document, made the following recommendations.

**Action by Member States**

- (1) To implement the related provisions of the selected resolutions endorsed and Decisions adopted by the Seventy-fifth World Health Assembly and the 150th and 151st sessions of the WHO Executive Board which merit follow-up actions at the regional as well as country level.

**Action by WHO**

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

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

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## **Annexures**

- 1) Resolutions and Decisions of the Seventy-fifth World Health Assembly (which also cover the subjects of technical resolutions adopted by the 150th and 151st sessions of the Executive Board).
- 2) Regional One Voice (RoV) intervention(s) on select Agenda items delivered by Member States of the SE Asia Region during the Seventy-fifth World Health Assembly.
- 3) Report by the WHO Director-General on select Agenda items submitted to the Seventy-fifth World Health Assembly.

## Introduction

1. The Seventy-fifth World Health Assembly in May 2022 and the 150th and 151st sessions of the WHO Executive Board in January 2022 and May 2022 respectively endorsed a number of resolutions and decisions during the course of their deliberations. These decisions and resolutions relate to health matters as well as Programme Budget and financial matters.
2. The summaries of resolutions and decisions on technical matters that have significant implications for the South-East Asia Region along with other important Agenda items are presented in this Working Paper. Salient information on the implications of the issues, and actions already taken and/or yet to be taken, are also included herein.
3. Also annexed to this Working Paper are copies of all the relevant resolutions and decisions adopted by the Seventy-fifth World Health Assembly, the Director-General's report on select Agenda items presented to the Assembly and the text of the "Regional One Voice" statements delivered at the Seventy-fifth Health Assembly by the delegation of the Member States of the South-East Asia Region on select Agenda items, as applicable (*these also cover the subjects of technical resolutions adopted by the 150th and 151st sessions of the Executive Board*).



**1) Follow-up to the Political Declaration of the third High-Level Meeting of the UN General Assembly on the prevention and control of noncommunicable diseases:**  
**(g) Draft intersectoral Global Action Plan on epilepsy and other neurological disorders in support of universal health coverage**

## **Background**

1. Neurological disorders are the leading cause of disability and the second leading cause of death. The five largest contributors are stroke, migraine, dementia, meningitis and epilepsy. Much of the neurological disease burden is preventable, provided that broad public health responses in maternal and newborn health care, communicable disease control, injury prevention and cardiovascular health, are implemented.
2. Challenges and gaps in providing care and services for people with neurological disorders exist worldwide, and more so in low- and middle-income countries. At the resumed session of the Seventy-third World Health Assembly in November 2020, Member States endorsed resolution WHA73.10 titled “*Global actions on epilepsy and other neurological disorders*” calling for scaled-up and integrated action on epilepsy and other neurological disorders. Member States also asked for a 10-year intersectoral Global Action Plan to be developed for consideration at the Seventy-fifth World Health Assembly.
3. Accordingly, the intersectoral Global Action Plan on epilepsy and other neurological disorders (2022–2031), developed in response to global resolutions, decisions, reports and commitments (including resolution WHA68.20 titled “*Global burden of epilepsy and the need for coordinated action at the country level to address its health, social and public knowledge implications*”), was endorsed by the Seventy-fifth World Health Assembly.
4. The intersectoral Global Action Plan on epilepsy and other neurological disorders will address the gaps through integration of prevention, diagnosis, treatment and rehabilitation measures for neurological disorders within primary health care, which is critical to achieving universal health coverage.

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

5. The WHO Regional Office for South-East Asia attaches great importance in containing NCDs including epilepsy and neurological disorders. Prevention and control of NCDs is one of the eight Regional Flagship Priority Programmes of the Region. The Regional Office continues to provide technical support to Member States to build capacity in addressing the huge treatment gap in epilepsy and neurological disorders.

## **Actions already taken in the Region**

6. In July 2021, the Regional Office coordinated the discussion of the draft intersectoral Global Action Plan on epilepsy and neurological disorders with regional experts, country focal persons and nongovernmental organizations (NGOs). The draft was further reviewed internally by the technical teams at the SE Asia Regional and country offices with the technical team from WHO Headquarters through several online sessions.

7. The Regional Office has also published several documents on epilepsy and neurological disorders. These include:

- *Addressing mental and neurological disorders: Impact evaluation of ongoing projects to strengthen primary health care* – Report of the regional meeting of experts, December 2011;
- *Meeting of experts on community-based approaches to autism*, November 2011;
- *Strengthening primary care to address mental and neurological disorders*, November 2013;
- *Promotion of mental well-being: pursuit of happiness*, November 2013; and
- *Ageing gracefully: diversity of dementia*, June 2021.

8. The Regional Office regularly engages Member States through several regional-level workshops and consultation meetings and through distribution of publications on the subject. The Regional Office also collaborates closely with other international organizations such as the International League Against Epilepsy and the International Bureau for Epilepsy.

## **Actions to be taken in the Region**

9. The Regional Office has established a Regional Expert Group of 12 members including academics, opinion leaders, clinicians and public health experts from the Region and globally. The group will provide critical guidance and advice in moving forward the agenda of mental health, neurological disorders and substance use in the Region.

10. The Regional Office will provide necessary technical support and context-specific guidance for adoption, adaptation and implementation of the Intersectoral Global Action Plan on epilepsy and other neurological disorders.



**2) Follow-up to the Political Declaration of the third High-Level Meeting of the General Assembly on the prevention and control of noncommunicable diseases:**  
**(h) Draft Action Plan (2022–2030) to effectively implement the Global Strategy to reduce the harmful use of alcohol as a public health priority**

**Background**

11. In 2019, the Seventy-second World Health Assembly (vide decision WHA72(11)) extended the WHO's Global Action Plan for the prevention and control of noncommunicable diseases (NCD-GAP) 2013–2020 to 2030, ensuring its alignment with the 2030 Agenda for the Sustainable Development Goals. The NCD-GAP lists harmful use of alcohol as one of four key risk factors for major NCDs. It enables Member States and other stakeholders to identify and use opportunities for synergies to tackle more than one risk factor at the same time; strengthen coordination and coherence between measures for reducing the harmful use of alcohol and activities for preventing and controlling NCDs; and set voluntary targets for reducing the harmful use of alcohol and other risk factors for NCDs.

12. The 150th session of the Executive Board, in its decision EB150(4), recommended to the Seventy-fifth World Health Assembly to adopt the Action Plan 2022–2030 to effectively implement the Global Strategy to reduce the harmful use of alcohol as a public health priority. After detailed deliberations on the NCDs agenda and as recommended by the Executive Board, the Seventy-fifth World Health Assembly adopted Decision WHA75(11).<sup>1</sup> During the discussions on the proposed agenda and the Action Plan, more than 23 countries deliberated on the resolution, including three countries from the SE Asia Region – Indonesia, Sri Lanka and Thailand.

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

13. Since the endorsement of the Global Strategy, its implementation has been uneven across WHO regions as well as within the regions and countries. The number of countries with a written national alcohol policy has steadily increased and many countries have revised their existing alcohol policies. However, considerable challenges remain for the implementation of effective alcohol policies.

14. These challenges relate to the complexity of the problem; differences in cultural norms and contexts; the intersectoral nature of cost-effective solutions, including pricing strategies; associated limited levels of political will and leadership at the highest levels of government; and the influence of powerful commercial interests on policy-making and implementation.

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<sup>1</sup> Follow-up to the Political Declaration of the Third High-Level Meeting of the General Assembly on the prevention and control of noncommunicable diseases. Doc No. WHA75(11). Geneva: World Health Organization, 2022.  
[https://apps.who.int/gb/ebwha/pdf\\_files/WHA75/A75\(11\)-en.pdf](https://apps.who.int/gb/ebwha/pdf_files/WHA75/A75(11)-en.pdf) – accessed 27 June 2022

15. These challenges operate against a background of competing international economic commitments. The limited availability of comprehensive and reliable data on alcohol consumption and related harm, generated at the national level, presents additional challenges for the evaluation of the impact of implemented national policy responses in many countries. Coordination and cooperation at all levels for dealing with these challenges is further complicated by contexts in which the responsibility for actions to reduce the harmful use of alcohol is dispersed between different entities, including government departments and varied professions and technical areas.

16. During the Seventy-fifth World Health Assembly, countries from the SE Asia Region called for more investment and greater priority to be allocated to support the development and implementation of effective policies and actions in the Region. They expressed their concerns about rising alcohol use among youth, pervasive advertising and industry influence and lack of effective countermeasures against aggressive advertisement and commercial determinants. Absence of or weak intercountry treaties and regulations to curb cross-border trade and smuggling further compound the problem. Lessons learnt from tobacco control through the WHO Framework Convention on Tobacco Control (WHO FCTC) provide important lessons learnt for the Global Framework on alcohol control with binding international treaties that regulate alcohol trade, health warnings on alcohol bottles, more efficient data collection, analysis and use, concerted efforts for demand reduction through engagement of civil society as well as treatment and rehabilitation of people who are dependent on alcohol.

### **Actions already taken in the Region**

17. The Regional Office continues to provide technical support to Member States in the prevention and reduction of harm due to alcohol through advocacy and raising awareness, capacity-building and provision of evidence-based information and dissemination of global and regional guidance.

18. During the COVID-19 pandemic, in response to a surge in online advertising and supply of home alcohol, the Regional Office ran an online campaign on alcohol-related harm, support and care-seeking for those in need. The Regional Office also facilitated the survey on alcohol and tobacco taxation and use during the COVID-19 pandemic.

19. More than 10 technical publications on alcohol and related topics were produced and released during the last six years. These include:

- a. *Regional Action Plan to implement the Global Strategy to reduce harmful use of alcohol for the South-East Asia Region (2014–2025)*, June 2021;
- b. *Prevention of drug use in schools*, July 2021;
- c. *Voice of the Children: Alcohol in the eyes of the young*, August 2019;
- d. *Epidemiology of alcohol use in the WHO South-East Asia Region*, January 2018;
- e. *A Report on Alcohol Policy in the WHO South-East Asia Region*, November 2017;
- f. *Reducing harm from alcohol use: good practices*, May 2016;

- g. *Mental health and substance abuse, including alcohol in the South-East Asia Region of WHO – Public health problems caused by harmful use of alcohol: gaining less or losing more?*, April 2016;
- h. *Burden and socioeconomic impact of alcohol: the Bangalore study*, April 2016;
- i. *Alcohol control policies in the South-East Asia Region: selected issues*, April 2016; and
- j. *Alcohol use and abuse, what you should know*, April 2016.

### **Actions to be taken in the Region**

20. The Regional Office will continue to advocate with and urge Member States to prioritize and invest more in reducing alcohol-related harm including on health, social relationships and economic losses, and provide technical support for implementation of the Global Action Plan on reducing harm related to alcohol 2020–2030.

### **3) The Global Health Sector Strategies on, respectively, HIV, viral hepatitis and sexually transmitted infections**

#### **Background**

21. In response to Decision WHA74(20) adopted by the Seventy-fourth World Health Assembly, the draft Global Health Sector Strategies (GHSS) on HIV, viral hepatitis and sexually transmitted infections, 2022–2030, developed through a broad consultative process, were submitted to the 150th session of the WHO Executive Board. The Board decided that informal consultations will continue with a view to submit a revised final draft to the Seventy-fifth World Health Assembly.

22. The Seventy-fifth World Health Assembly was informed that informal and formal consultations with Member States had been held on issues pertaining to and the terminologies used for certain issues such as “sexual orientation”, “gender identification”, and “comprehensive sexuality education”, through a series of deliberations until April 2022, with opportunities made available for providing written feedback. Accordingly, a revised final version was shared in the public domain on 1 May 2022 and presented to the Health Assembly.

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

23. Member States, mostly from the Eastern Mediterranean Region proposed an amendment to remove the glossary from the scheduled annexes of the GHSS, and to add footnotes which broadly allowed to mention that countries’ adoption of sexual orientation, as mentioned in GHSS, will be in line with national legislations, and that the guidelines on comprehensive sexuality education referred to in the GHSS are yet to reach international consensus.

24. While calling for consensus, Mexico, backed by several other countries expressed disagreement with the above amendment and moved another amendment proposing three statements: (1) notes with appreciation the GHSS on, respectively, HIV, viral hepatitis and sexually transmitted infections, (2) reaffirms that in implementing the GHSS, the national contexts should be considered; and (3) requests the Director-General to report on the progress in 2024, 2026, 2028 and 2031, noting that the 2026 report will provide a mid-term review based in meeting the strategies’ 2025 targets towards achieving the 2030 goals.

25. Following extensive discussions and voting, the former amendment was rejected. Finally, the Decision on the Strategies was adopted by the World Health Assembly. Out of 183 Member States scheduled to vote, 30 were not present and 90 decided not to vote (though present). Of the 63 that voted, 61 voted in favour and two against.

26. The Seventy-fifth World Health Assembly (vide its resolution WHA75.20), noted with appreciation, the Global Health Sector Strategies on, respectively, HIV, viral hepatitis and sexually transmitted infections, for the period 2022–2030. The Director-General was requested for regular reporting to the Assembly during the implementation period.

## **Actions already taken in the Region**

27. Following a proposal submitted by Indonesia, the Seventy-fourth Session of the Regional Committee for South-East Asia adopted Decision SEA/RC74(4)<sup>2</sup> that requested the Regional Director to undertake a consultative process to develop an integrated Regional Action Plan (RAP) on viral hepatitis, HIV and STIs for 2022–2026, in alignment with the SDGs and GHSS, for the consideration of and endorsement by the Seventy-fifth Session of the Regional Committee in 2022.

28. Following the decision, the Secretariat organized wide-ranging consultations with Member States, communities and partners, and also through online surveys. Feedback received was incorporated and the revised draft of the RAP was shared again with Member States for further inputs from them to be submitted by 5 June 2022.

29. In preparing the draft RAP, utmost care has been taken to avoid any of the potentially controversial terms and terminology that lacked consensus among Member States at the Seventy-fifth World Health Assembly. None of the Member States from the Region have expressed any disagreement with the terms used in and tenor of the draft shared with them.

## **Actions to be taken in the Region**

30. In line with Decision SEA/RC74(4) of the Seventy-fourth session of the Regional Committee, the integrated Regional Action Plan for hepatitis, HIV and sexually transmitted infections for the period 2022–2026 has been finalized and is being submitted to the Seventy-fifth Session of the WHO Regional Committee for South-East Asia for adoption and dissemination.

31. The WHO Secretariat will provide contextually relevant technical support to Member States for advancing key actions in the Regional Action Plan towards the elimination targets and will submit a progress report to the Regional Committee in 2024 and 2026.

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<sup>2</sup> Beginning of the Decade of Action for ending viral hepatitis, HIV and STIs as public health threats by 2030 in the South-East Asia Region. Doc No. SEA/RC74(4). New Delhi: World Health Organization, Regional Office for South-East Asia, 2021.  
<https://apps.who.int/iris/bitstream/handle/10665/345273/sea-rc74-decisions-eng.pdf?sequence=1&isAllowed=y> – accessed 23 June 2022.

## 4) Roadmap for neglected tropical diseases 2021–2030

### Background

32. On 13 November 2020, the Seventy-third World Health Assembly adopted Decision WHA73(33) on “Roadmap for neglected tropical diseases 2021–2030”, by which it endorsed the new Roadmap for neglected tropical diseases 2021–2030, and requested the Director-General, *inter alia*, to report biennially to the Health Assembly, through the Executive Board, on the implementation of the Roadmap.

33. The new Roadmap, “Ending the neglect to attain the Sustainable Development Goals: a roadmap for neglected tropical diseases 2021–2030,”<sup>3</sup> was launched by WHO on 30 January 2021, coinciding with World Neglected Tropical Diseases Day.

34. The Roadmap’s key features include:

- It is designed to address critical gaps across multiple NTD programmes by integrating and mainstreaming approaches and actions within national health systems, and across sectors.
- It also provides opportunities to evaluate, assess and adjust programmatic actions as needed over the next decade, by setting clear targets and milestones.
- It moves away from the vertical, disease-centred approach to being people-focused.

35. The report provided data on indicators as of end 2020, only because most information for 2021 – the first year of the new Roadmap – will be available only later in 2022. Thus, these data are considered as the baseline for the new Roadmap.

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

36. The Executive Board at its 150th session noted the report on the Roadmap for neglected tropical diseases 2021–2030. During the discussions, the Board members drew attention to the impact of the COVID-19 pandemic on services that address neglected tropical diseases. Renewed efforts of Member States were needed to keep the Roadmap’s targets for neglected tropical diseases on track and ensure that services for those diseases remained a part of basic health care.

### Actions already taken in the Region

37. Despite the COVID-19 pandemic, key interventions for preventive chemotherapy for select NTDs were delivered in seven of the 11 Member countries endemic for NTDs during 2021 with support of WHO and other donors and partners.

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<sup>3</sup> Ending the neglect to attain the Sustainable Development Goals: a roadmap for neglected tropical diseases 2021–2030. Geneva: World Health Organization, 2020. <https://www.who.int/publications/i/item/9789240010352> – accessed 23 June 2022

38. Following the resolution, work began for the development of the new Regional Strategy for accelerating and sustaining kala-azar elimination in the South-East Asia Region 2022–2026 and the Action Plan for the control and prevention of snakebite envenoming in the South-East Asia Region 2022–2030 in line with the NTD Roadmap, through a consultative process with Member States, Regional Technical Advisory Groups (RTAG) and partners.

39. During the COVID-19 pandemic, the WHO Secretariat also continued to provide technical support to Member States and convened a series of meetings of the RTAG, and of experts and programme managers, including the RTAGs for dengue and kala-azar, the Regional Programme Review Groups for lymphatic filariasis, soil-transmitted helminth (STH) and schistosomiasis, and a Regional Consultation on yaws.

### **Actions to be taken in the Region**

40. The WHO Secretariat will continue to advocate for renewed efforts by Member States to catalyse innovation through a regional partnership of Member States, donors and stakeholders, and to provide contextually relevant technical support to Member States for advancing control and elimination of NTDs in the Region in line with the NTD Roadmap.

## 5) Immunization Agenda 2030

### Background

41. The Seventy-third World Health Assembly in 2020 adopted Decision WHA73(9) to endorse the new global vision and overarching strategy for vaccines and immunization that is contained in the Immunization Agenda 2030, or IA 2030.

42. At the Seventy-fourth World Health Assembly in May 2021, Member States expressed support for the implementation of IA 2030 through the Framework for Action. The Framework for Action detailed how coordinated operational planning, monitoring and evaluation, ownership and accountability, and communications and advocacy are key drivers for implementation and impact on the ground.

43. The *Global Report* on IA 2030 for 2021 was presented to the Seventy-fifth World Health Assembly. It included the baseline data that will be used to track progress in immunization up to 2030, as well as progress in implementation at country, regional and global levels. All Member States extended support for the implementation of IA 2030 and the Health Assembly noted the report.

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

44. Since 2010, major progress has been made in the SE Asia Region in the quest to achieve the targets of the Regional Vaccine Action Plan 2016–2021. Some of the significant successes in this regard have been maintaining polio-free status for the Region, sustaining elimination of maternal and neonatal tetanus in all countries, elimination of measles in three countries (Bhutan, DPR Korea and Timor-Leste), elimination of measles and rubella in two countries (Maldives and Sri Lanka) and verification of four countries for achieving hepatitis B control (Bangladesh, Bhutan, Nepal and Thailand).

45. Immunization coverage with the third dose of diphtheria–tetanus–pertussis vaccine (DTP3) had increased to 91% in 2019. This is the highest-ever immunization coverage achieved in the Region and all countries except Indonesia achieved DTP3 coverage of 90% or higher. However, the COVID-19 pandemic tangibly affected routine immunization services and vaccine-preventable disease surveillance in the Region. The DTP3 coverage decreased from 91% in 2019 to 85% in 2020 and more children became vulnerable to vaccine-preventable diseases.

46. Ten of the 11 countries rolled out COVID-19 vaccines in 2021. By the first week of July 2022, 64.1% of the entire population had received the primary doses of COVID-19 vaccines. And all 10 countries have reached the milestone of providing primary doses of the vaccine to 40% of the total population while four countries have reached the target of vaccinating 70% of their population.



## **Actions already taken in the Region**

47. The Strategic Framework of the SE Asia Region Vaccine Action Plan 2022–2030 as aligned with IA 2030 has been developed in consultation with national immunization programmes and partners and was endorsed by the Regional Committee at its Seventy-fourth session in 2021.

48. The SE Asia Region Vaccine Implementation Plan (RVIP) for the period 2022–2026 has been developed under the umbrella of the Strategic Framework, in collaboration with Member States and partners.

49. In 2022, all countries have taken specific actions to vaccinate children and mothers who had missed routine immunization during the pandemic. The Regional Office and WHO country offices provide technical assistance and monitor the achievements monthly.

## **Actions to be taken in the Region**

50. The immediate priority is to bring routine immunization coverage to pre-pandemic levels and close the immunity gaps that have been created during the pandemic through catch-up campaigns. COVID-19 vaccination will remain an important priority and integration of COVID-19-related and other routine immunization activities will be planned. Countries will be supported to align their multiyear immunization plans with the Regional Vaccine Implementation Plan 2022–2026.

51. National immunization programmes and national immunization technical advisory groups will send yearly reports to the Regional Immunization Technical Advisory Group (ITAG) meeting to be conducted in August 2022. Based on these reports ITAG will provide recommendations to the Regional Office and countries. The Regional Office through the Regional Working Group for Immunization Mechanism will coordinate partner support to implement the recommendations.

## 6) Infection prevention and control

### Background

52. The importance of infection prevention and control (IPC) in national health programmes is increasingly being recognized. The United Nations' Sustainable Development Agenda 2030 and its universal targets related to health and well-being (including maternal, neonatal and child mortality, HIV-AIDS, tuberculosis, waterborne diseases, other communicable diseases, access to safe medical products, UHC and WASH) are all conspicuously impacted by IPC. Patient safety, health worker safety, prevention of antimicrobial resistance and health-care acquired infections and the Global Health Security Agenda have all underscored the importance of IPC.

53. Investing in infection prevention and control is one of the most effective and cost-saving interventions available for safe care. Available data show that around 70% health-care associated infections can be averted by enforcing proper IPC measures. Hand hygiene and environmental hygiene in hospitals reduces the risk of mortality, morbidity and complications caused by multidrug-resistant pathogens by about 40%.

54. The Director-General's report presented to the 150th session of the WHO Executive Board in January 2022 summarized the status of IPC. The Board members underscored the importance and urgency of developing a Global Infection Prevention and Control Strategy to accelerate progress on implementation and monitoring in this area.

55. The Seventy-fifth World Health Assembly adopted the resolution WHA75.13,<sup>4</sup> titled "*Global Strategy on infection prevention and control*". The resolution was supported by Member States from all regions. From the South-East Asia Region, Bangladesh, Indonesia, Maldives and Thailand supported the resolution and Maldives also co-sponsored the event.

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

56. IPC has been accorded greater importance since the outbreak of the COVID-19 pandemic. IPC measures such as hand hygiene, social distancing, use of masks and PPEs as well as the provision of training on IPC for health workers have proven to have helped Member States to prevent and reduce the spread of the pandemic as well as other infections.

57. The 2021 WHO Global Survey on minimum requirements for infection prevention and control (IPC) programmes at the national level showed that six of the 11 Member States in the SE Asia Region had an active IPC programme, guidelines and dedicated budget, and a third of them had a national IPC focal point. Four out of every five countries which participated in the survey globally had plans in place for health-care associated infection surveillance and around 67% of countries had reporting and feedback mechanisms operational (*Global Report on IPC 2022*).

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<sup>4</sup> Global Strategy on infection prevention and control. Doc. No. WHA75.13. Geneva: World Health Organization, 2022. [https://apps.who.int/gb/ebwha/pdf\\_files/WHA75/A75\\_R13-en.pdf](https://apps.who.int/gb/ebwha/pdf_files/WHA75/A75_R13-en.pdf) – accessed 27 June 2022

58. Typically, IPC is addressed independently under several health programmes. However, the majority of Member States do not have an integrated IPC plan that includes national IPC policy, strategy, implementation frameworks, and programmes with designated IPC focal points that should help advance IPC.

### **Actions already taken in the Region**

59. The following actions have already been taken in the SE Asia Region:
- Member States have participated in the global minimum IPC WHO core component requirements survey.
  - The WHO Regional Office has submitted its contributions to the Global IPC Report 2022.
  - International Hand Hygiene Day was observed with full rigour by WHO and Member States on 5 May 2022.
  - Virtual IPC global training modules/guidance documents have been developed and prepared by WHO.
60. The following meetings/consultations have also been held in the Region:
- Virtual Informal Regional Consultation to align the Global Patient Safety Action Plan 2021–2030 (GPSAP) with the WHO Regional Strategy for patient safety in the WHO South-East Asia Region (2016–2025), 31 March–1 April 2021;
  - Virtual Regional Informal Consultation on implementing the Global Patient Safety Action Plan 2021–2030 (GPSAP), 25–26 April 2022;
  - Virtual training on quality in testing transfusion-transmitted infections in blood, 27–29 April 2022; and
  - Virtual training on patient safety incident reporting and learning systems in Maldives, 19 & 28 April 2022.

### **Actions to be taken in the Region**

61. The following actions are proposed to be taken in the Region:
- Member States are due to participate in the consultative process to draft the Global IPC Strategy.
  - Member States will ensure the implementation of the minimum requirements (core components) for IPC at each level of their health-care systems.
  - Member States will strive towards the establishment of HAI surveillance at the national level.
  - An integrated approach with programmes such as AMR, quality of care, patient safety, WASH, UHC, health emergencies, blood safety, tuberculosis, acute respiratory infections, VPDs, STIs, MNCAH, etc. as appropriate, will be adopted for the national contexts by the Member States.

- Member States will also ensure that IPC is a part of the curriculum for the continuous medical education (CME) of national medical/health-care workers.
- WHO and Member States also plan to conduct in collaboration advocacy and awareness activities on the availability of clean, quality, affordable care at each level. These will involve policy-makers, health-care workers and the community.

62. The Regional Office will consult with Member States through regional/global consultations or through the online portals to provide inputs towards the:

- development of the draft Global IPC Strategy for submission to the Seventy-sixth World Health Assembly in 2023 through the 152nd Session of the WHO Executive Board in January 2023;
- development of the draft IPC Global Action Plan based on the Global Strategy for submission to the Seventy-seventh World Health Assembly in 2024; and
- reporting on progress and results to the Seventy-eighth World Health Assembly in 2025 and thereafter every two years until 2031.

## 7) Global Roadmap on defeating meningitis by 2030

### Background

63. Meningitis is a deadly and debilitating disease with serious health, economic and social consequences. It affects people of all ages in all countries of the world. Bacterial meningitis can cause epidemics and lead to death within 24 hours of infection and, when they do not become a cause of death, leave one in five persons affected with lifelong disability after infection. However, many cases and deaths are preventable through vaccination and effective vaccines are either available or are under development.

64. The first Global Roadmap on defeating meningitis by 2030 set out a path to tackle the main causes of acute bacterial meningitis (meningococcus, pneumococcus, haemophilus influenzae (Hib) and group B streptococcus). This focus is based on: (i) evidence that these four organisms were responsible for over 50% of the 290 000 deaths from all causes of meningitis in 2017; and (ii) the impact that this draft Global Roadmap could have on diminishing the burden of disease by 2030.

65. The three visionary goals of the draft Global Roadmap to be achieved by 2030 are to:

- eliminate epidemics of bacterial meningitis;
- reduce the number of cases and deaths from vaccine-preventable bacterial meningitis; and
- reduce disability and improve quality of life after meningitis due to any cause.

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

66. In January 2022, during the 150th session of the Executive Board, Member States reviewed the progress in the implementation of the Roadmap (Report by the Director-General to the 150th session of the Executive Board – EB150/13). They expressed support for the establishment of a strategic support group to facilitate the implementation of the Roadmap and emphasized the relevance of strengthening the integration of meningitis prevention and management in primary health care. Member States requested for technical assistance from WHO to sustain essential immunization activities and to conduct background assessment for integrating the goals and pillars of the Roadmap into their national immunization strategies and epidemic preparedness and response plans.

### Actions already taken in the Region

67. All countries in the SE Asia Region have introduced the *haemophilus influenzae type b* (Hib) vaccine as part of the combined DTP–HepB–Hib vaccine regimen. Five countries (Bangladesh in 2015, Bhutan in 2019, India in 2021, Myanmar in 2016 and Nepal in 2015) have introduced the pneumococcus conjugate vaccine (PCV) nationwide. PCV has also been introduced in some provinces in Indonesia and Thailand. In several countries, the vaccine against meningococcus is offered to special populations such as travellers and pilgrims.

68. The Regional Office supports invasive bacterial disease (IBD) surveillance in six countries, which provides genotyping data needed to make decisions for the introduction of Hib, PCV and meningococcus vaccine and vaccine impact assessment, as well as useful data on antibiotic-sensitivity for effective and efficient case management.

### **Actions to be taken in the Region**

69. Priority countries are being supported to introduce or expand vaccine introductions and improve coverage. IBD surveillance will be expanded and strengthened. A baseline situational analysis will be conducted by WHO, followed by the preparation of a Regional Implementation Plan aligned with the Global Roadmap on defeating meningitis by 2030.

## 8) Standardization of nomenclature of medical devices

### Background

70. A standardized medical devices nomenclature (MDN) is essential for defining and naming innovative technologies, classifying medical devices for regulatory approval and streamlining procurement. Standardized naming of medical devices is required when describing devices needed for the health services-related benefits packages that are in place to provide universal health coverage to the people. A standardized international classification, coding and nomenclature for medical devices available to all Member States will support:

- patient safety,
- access to medical devices for universal health coverage,
- emergency preparedness and response, and
- efforts to increase quality of health care.

71. As of 1 June 2022, 75 Member States reported not using any particular MDN, 15 Member States used more than one MDN system (by different agencies of government and industry) and 32 Member States used a nationally developed MDN. The Member States in the South-East Asia Region have expressed the need for a standardized MDN. A standardized MDN is essential for improving access to medical products, which will support attainment of the Triple Billion targets.

72. Prior to the Seventy-fifth World Health Assembly, several informal consultations and behind-the-scenes meetings had been conducted to achieve consensus on the proposed text of the draft resolution on “Standardization of Medical Devices Nomenclature”. Several Member States with well-established medical devices development ecosystems opposed WHO’s initiative to proceed with MDN standardization, on account of concerns that this would unfavourably impact their investments made in the private MDN systems that they use (one such case in point is GMDN, the Global Medical Device Nomenclature).

73. Other Member States, both with and without well-established medical device ecosystems, emphasized that the standardized MDN must be of a non-commercial nature, as a public good solely within WHO’s control, similar to the processes involving the International Classification of Diseases (ICD). Many other Member States, especially lower-income countries and those with smaller populations, expressed an urgent need for MDN and requested that work on this proceed without delay.

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

74. The operative paragraph of the decision is “to integrate available information related to medical devices, including terms, codes and definitions, in the web-based database and clearinghouse established in line with resolution WHA60.29 of 2007 and now available as the Medical Devices Information System (MEDEVIS);<sup>5</sup> and to link this to other WHO platforms, such as the International Classification of Diseases (ICD-11)<sup>6</sup> to serve as a reference for stakeholders and Member States.”

### **Actions already taken in the Region**

75. Member States of the SE Asia Region were briefed in advance of the Seventy-fifth World Health Assembly about the proposed resolution and ongoing discussions held at the informal consultations and behind-the-scenes meetings. Three Member States (India, Indonesia and Maldives) delivered statements during the discussions held at the Seventy-fifth World Health Assembly.

### **Actions to be taken in the Region**

76. Work on MDN is being conducted at WHO headquarters and the results will be available on the WHO platforms identified as above. For countries already using a particular MDN, they have no problem continuing with it. For countries using more than one, there is a flowchart to help guide the various agencies to determine one MDN. For countries without a nomenclature, it is recommended that they can use the free and publicly available system, European Medical Device Nomenclature (EMDN). Technical assistance will be provided to any Member State requesting assistance in selecting a standardized medical devices nomenclature.

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<sup>5</sup> MeDeVIS . Geneva: World Health Organization. <https://medevis.who-healthtechnologies.org/> – accessed 1 Aug 2022.

<sup>6</sup> International Statistical Classification of Diseases and Related Health Problems (ICD): ICD 11. Geneva: World Health Organization, 2022. <https://www.who.int/standards/classifications/classification-of-diseases> – accessed 1 Aug 2022.



## **9) Outcome of the Special Session of the World Health Assembly to consider developing a WHO convention, agreement or other international instrument on pandemic preparedness and response**

### **Background**

77. Based on the experience of the COVID-19 pandemic, Member States identified various key issues that go beyond the International Health Regulations and other available mechanisms. These key issues were placed under the streams of Equity, Systems & Tools, Financing and Governance.

78. Based on the recommendations of various reviews and deliberations and the report of the Member States' Working Group on strengthening WHO preparedness and response to health emergencies (WGPR), a Special Session of the World Health Assembly was held from 29 November to 1 December 2021 to consider developing a WHO convention, agreement or other international instrument on pandemic preparedness and response.

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

79. This second-ever Special Session of the World Health Assembly in end-2021 decided:

- a) to establish, in accordance with Rule 41 of its Rules of Procedure, an intergovernmental negotiating body open to all Member States and Associate Members (or the "INB") to draft and negotiate a WHO convention, agreement or other international instrument on pandemic prevention, preparedness and response, with a view to adoption under Article 19, or under other relevant provisions, of the WHO Constitution as may be deemed appropriate by the INB;
- b) that the first meeting of the INB shall be held no later than 1 March 2022, in order to elect two Co-Chairs, reflecting a balance of developed and developing countries, and four Vice-Chairs, one from each of the six WHO regions, and to define and agree on its working methods and timelines, consistent with this decision and based on the principles of inclusiveness, transparency, efficiency, Member State leadership and consensus;
- c) that as part of its working methods, the INB shall determine an inclusive Member State-led process, to be facilitated by the Co-Chairs and Vice-Chairs, to first identify the substantive elements of the instrument and then begin the development of a working draft to be presented, on the basis of progress achieved, for the consideration of the INB at its second meeting to be held no later than 1 August 2022, at the end of which the INB will identify the provision of the WHO Constitution under which the instrument should be adopted in line with paragraph (a) of this section;

- d) that the process referred to in paragraph (c) should be informed by evidence and should take into account the discussions and outcomes of the Member States' Working Group on strengthening WHO preparedness and response to health emergencies, considering the need for coherence and complementarity between the process of developing the new instrument and the ongoing work under resolution WHA74.7, and particularly with regard to implementation and strengthening of the IHR (2005), which will be further discussed by the Member States' Working Group on Amendments to the International Health Regulations (2005); and
- e) that the INB shall submit a progress report to the Seventy-sixth World Health Assembly in 2023 and present its outcomes for consideration by the Seventy-seventh World Health Assembly in 2024.

80. The INB started its work and identified substantive elements through discussions with and surveys of Member States and stakeholders through its digital platform. Public hearings were held in mid-April and the last meeting of INB was held during 15–17 June 2022.

### **Actions already taken in the Region**

81. Dr Viroj Tangcharoensathien from Thailand has been nominated by the Region as the Vice-Chair of the INB.
82. Nine out of 10 invited Member States from the SE Asia Region responded on the INB digital platform. Member States also regularly participated in the INB meetings and discussions.
83. The Regional Office for South-East Asia regularly shares technical updates, draft reports and other details on the INB discussions with Member States.

### **Actions to be taken in the Region**

84. The Secretariat will continue to facilitate and support Member States on the following:
- written suggestions and inputs by Member States and relevant stakeholders, to be submitted through email;
  - participation in the Bureau Meeting(s) to develop a working draft, based on all the inputs provided; and
  - finalize the English version of the working draft for distribution to Member States by 1 July 2022, to be followed by translated versions.
85. The Second Meeting of the INB will be held on 18–22 July 2022 for consideration of the working draft on the basis of progress achieved and identification of the provision of the WHO Constitution under which the instrument should be adopted.

## **10) Strengthening clinical trials to provide high-quality evidence on health interventions and to improve research quality and coordination**

### **Background**

86. Well-designed and well-implemented clinical trials are indispensable for assessing the safety and efficacy of health interventions and informing associated comparative cost-effectiveness evaluations vis-à-vis existing interventions. Clinical trials on new health interventions are likely to produce the clearest results when carried out in diverse settings, including all major population groups the intervention is intended to benefit, with a particular focus on under-represented populations.

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

87. The Seventy-fifth World Health Assembly held in May 2022 adopted the resolution WHA75.8<sup>7</sup> on “*Strengthening clinical trials to provide high-quality evidence on health interventions and to improve research quality and coordination*”, which calls on Member States, in accordance with their national legal and regulatory frameworks and contexts, to prioritize the development and strengthening of national clinical trial capabilities and bolster clinical trial policy frameworks, particularly in developing countries.

### **Actions already taken in the Region**

88. The WHO Regional Office for South-East Asia has been assisting the SE Asia Region Member States in research prioritization and also in generation of timely and relevant research evidence by supporting public health research including well-designed and well-implemented clinical trials. It has been contributing to strengthening the overall research ecosystem by providing support for research governance, research ethics and research prioritization. During the COVID-19 pandemic, the WHO Regional Office has contributed to the WHO COVID-19 Solidarity therapeutics trial as part of the WHO-led global clinical trials to generate best evidence on treatment of the virus.

### **Actions to be taken in the Region**

89. The WHO Regional Office will participate in the stakeholders’ consultations to identify best practices and other measures to strengthen the global clinical trial ecosystem. It will also review the existing legal and policy frameworks, infrastructure, guidance and initiatives available in its Member States. It will provide guidance to Member States, on their request and taking into account national contexts, for developing legislation, infrastructure and capabilities required for clinical trials, including the implementation of the guidelines of the International Conference on Harmonization of Good Clinical Practices and of the registration of clinical trials in a publicly accessible database (once approved), in accordance with the WHO International Clinical Trials Registry Platform.

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<sup>7</sup> Strengthening clinical trials to provide high-quality evidence on health interventions and to improve research quality and coordination. Doc. No. WHA75.8. Geneva: World Health Organization, 2022.  
[https://apps.who.int/gb/ebwha/pdf\\_files/WHA75/A75\\_R8-en.pdf](https://apps.who.int/gb/ebwha/pdf_files/WHA75/A75_R8-en.pdf) – accessed 24 June 2022

## **11) Implementation of the International Health Regulations (2005)**

### **Background**

90. The report on the implementation of the IHR by the Director-General to the Seventy-fifth World Health Assembly was submitted in response to resolution WHA61.2 of 2008, and to Decision WHA71(15) of 2018, calling for a report on the progress in implementation of IHR (2005) and the Global Strategic Plan to improve public health preparedness and response. With consideration for the proposal on IHR amendments, the Seventy-fifth World Health Assembly adopted the resolution WHA75.12<sup>8</sup> on “Amendment to the International Health Regulations (2005)”.

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

91. The meetings of the IHR Emergency Committees on polio and COVID-19 were conducted periodically, and both maintained the status of a public health emergency of international concern and issued revised temporary recommendations. The Review Committee on the Functioning of the IHR (2005) conducted its work until April 2021 and produced a report with 40 recommendations. Two State Parties submitted the proposed amendments to the Regulations for consideration by the Seventy-fifth World Health Assembly, which agreed to establish a Working Group on Amendments to the International Health Regulations (2005) (WRIHR) to review it as well as other such proposals.

92. The Secretariat continued to provide technical support for strengthening national IHR capacities related to event management, laboratory, risk communication and information about compliance over several requirements of the Regulations, including additional health measures, event notification and verification, points of entry and yellow fever vaccination.

93. The majority of the Member States endorsed the proposal for amendments of the IHR (2005), which could be limited in scope and targeted towards maintaining the main architecture of the IHR. The Seventy-fifth World Health Assembly adopted the amendments to Article 59, and the consequent necessary updates to Articles 55, 61, 62, and 63, of the International Health Regulations (2005). The main implication was that amendments to these Regulations shall enter into force 12 months after the date of notification under Article 59 instead of 18 months as before.

### **Actions already taken in the Region**

94. Actions already taken in the Region include:

- Member States’ have maintained active involvement in the IHR Monitoring and Evaluation Framework (MEF) including 100% compliance with SPAR.

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<sup>8</sup> Amendments to the International Health Regulations (2005). Doc. No. WHA75.12. Geneva: World Health Organization, 2022. [https://apps.who.int/gb/ebwha/pdf\\_files/WHA75/A75\\_R12-en.pdf](https://apps.who.int/gb/ebwha/pdf_files/WHA75/A75_R12-en.pdf) – accessed 27 June 2022

- IHR capacity strengthening activities have been implemented along the provisions of the Delhi Declaration in 2019.
- Regional meetings on strengthening implementation of the Risk Communication Strategy for public health emergencies, specifically focusing on risk communication and community engagement (RCCE) and on the lessons learnt from the COVID-19 response, were held in August and October 2021 respectively.
- PoE assessments were conducted in Bangladesh, Bhutan, India and Nepal in 2021.
- Piloting of the Universal Health and Preparedness Review (UHPR) in Thailand was completed on 21–29 April 2022.
- The Regional meeting on the “South-East Asia Regional Roadmap for diagnostic preparedness, integrated laboratory networking and genomic surveillance (2023–2027)” was held virtually on 28–29 June 2022. MoH representatives of all Member States except Myanmar and DPR Korea participated in the meeting. In addition, relevant colleagues from WHO country offices, various key international development partners and select experts who were invited also participated, with the number of attendees numbering about 90. The meeting discussed the draft roadmap and provided feedback and suggestions for its finalization. The advanced draft incorporating feedback was presented to and considered by the distinguished delegates at the HLP Meeting. Based on the discussions and recommendations made by the HLP Meeting, the final Roadmap will be presented to the Seventy-fifth Session of the Regional Committee for its consideration and adoption.
- The Meeting on the “Regional Strategic Roadmap on Health Security and Health System Resilience for Emergencies 2023–2027” was held in hybrid mode from 29 June to 1 July 2022. MoH representatives from all Member States except Myanmar and DPR Korea, numbering more than 100, participated in the meeting. In addition, relevant colleagues from the departments of Health Emergencies, Health Systems Development and Communicable Diseases at the Regional Office and from country offices, key colleagues from WHO headquarters and key international development partners, as well as invited experts, joined the meeting. They deliberated on the draft Roadmap presented and provided feedback and suggestions for its finalization. The advanced draft incorporating all feedback and comments was presented at the HLP Meeting. Recommendations made by the HLP Meeting were incorporated in the final Roadmap that will be presented to the Seventy-fifth Session of the Regional Committee for its consideration and adoption.

## **Actions to be taken in the Region**

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

- A regional IHR monitoring and evaluation meeting is due to be held.
- The National Rapid Response Teams Learning Programme is scheduled tentatively to be held in Nepal.

- PoE assessments in Indonesia and Timor-Leste have to be completed.
- A regional risk communication meeting to discuss the challenges of mis-information and the infodemic and also develop a regional plan on combating misinformation is also due to be held.
- Regional contributions to various committees and working groups related to IHR (2005) and the new instrument on pandemic preparedness and response are being provided.

## **12) Influenza preparedness**

### **Background**

96. The Seventy-third World Health Assembly in 2020 vide Decision WHA73(14) released the WHO Global Influenza Strategy 2019–2030.<sup>9</sup> It promotes coordinated synergies between influenza preparedness and response capacity-building, the provisions of the International Health Regulations (2005) and immunization programmes. Implementation of the Strategy will enable the achievement of two high-level outcomes: better global tools and stronger country capacities.

97. The Global Influenza Strategy aims to approach influenza preparedness holistically through the establishment of new and strengthening of existing capacities to prevent, control and prepare for influenza at the global, regional and national levels. To do that it has two outcomes: Outcome one – better global tools for the prevention, detection, control and treatment of influenza; Outcome two – stronger country capacities such that every country has an evidence-based influenza programme that meets national needs and is integrated within the efforts to achieve health security and universal health coverage.

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

98. As mandated by the Strategy, countries are supported to establish national seasonal influenza prevention and control programmes for building stronger country capacities. WHO together with partner agencies under the Global Influenza Surveillance and Response System (GISRS) is developing better global tools for universal use. The Pandemic Influenza Preparedness (PIP) Framework acts as the key guidance parameter for pandemic influenza preparedness and response in the Region. WHO uses a standard criterion to prioritize countries for receiving PIP Partnership Contribution (PC) funds. The “most critical” seven Member States in the SE Asia Region – the most vulnerable countries that need more support for development of PIP capacities relative to the other four Member States – are additionally supported by WHO through targeted PIP partnership contribution funds. This is to ensure capacity enhancement for pandemic influenza preparedness in these seven countries.

99. WHO collaborates with Member States in promoting a holistic approach to prevention and control, preparedness and response to influenza epidemics and pandemics through the national programmes. Rapid sharing of influenza viruses of pandemic potential is a major aspect of this collaboration. In this regard, WHO as the Secretariat needs to work on potential solutions to address systemic problems of access to benefits-sharing. Another aspect is technical collaboration for establishing sustainable surveillance for respiratory viruses of pandemic potential including demands of better diagnostics.

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<sup>9</sup> Global Influenza Strategy 2019–2030. Geneva: World Health Organization, 2019.  
<https://apps.who.int/iris/bitstream/handle/10665/311184/9789241515320-eng.pdf?sequence=18&isAllowed=y> – accessed 27 June 2022

100. The Nagoya Protocol provides normative tools to promote efficient and equitable international access and benefit-sharing arrangements for pathogens. However, the next steps for addressing public health implications of the Nagoya Protocol (including opportunities to advance both public health and the principle of equitable sharing of benefits) by Member States and WHO as the Secretariat are critical for advancement of public health and improving harmonization between the Nagoya Protocol and existing pathogen-sharing systems in countries.

101. The current regional association in the field of genomic sequencing can easily be applied to influenza within the proposed Regional Strategy on genomic surveillance and sequencing in the SE Asia Region. This Regional Strategy is based on the Global Strategy, and a consultation among regional Member States prior to its finalization was held on 26–28 April. Influenza vaccines are the best interventions. Yet the collaborative association with Member States requires to look at widespread use of this tool at least for selected target groups with WHO regularly looking into needs of regional production, supply and distribution systems.

### **Actions already taken in the Region**

102. The following actions have already been taken in the Region:

- a. WHO's South-East Asia and Western Pacific regions have been organizing an annual bi-regional meeting of Influenza Surveillance and National Influenza Centres with participation of Member States, WHO collaborating centres and partners. WHO has used this as a bi-regional platform for establishment and sustenance of policy guidance and strategic directions for influenza control, prevention and pandemic preparedness in the two WHO regions.
- b. A Regional Consultation with Member States on sustainable integrated surveillance for respiratory viruses of pandemic potential has been held virtually in New Delhi, India, in April 2022, for feeding into the global guidance (finalized during a consultation held in Geneva in May 2022).
- c. Technical guidance and support has been provided to establish and strengthen the national influenza programmes in all Member States. It has been ensured that these national influenza programmes of Member States have joined the Global Influenza Surveillance and Response System (GISRS).
- d. Technical support has been provided for implementation of the PIP Framework and Influenza Global Strategy under WHO's Country Support Plan and the Thirteenth General Programme of Work.
- e. Member States have been provided sustainable funding support through PIP partnership contribution funds (the most critical seven countries as mentioned earlier in this section) and WHO's funds including through the Regional Office's Cooperative Agreement with the United States Centers for Disease Prevention and Control (US CDC).
- f. Facilitation, coordination and monitoring of virus-sharing with WHO collaborating centres has been ongoing.
- g. Technical assistance has been provided for national influenza pandemic preparedness planning based on lessons learnt from the COVID-19 pandemic, either as a standalone influenza pandemic preparedness plan in countries or as a contingency plan under the National Action Plan for Health Security (NAPHS).



## **Actions to be taken in the Region**

103. The following actions are planned to be taken in the Region:

- a. Continuation of the annual bi-regional platform (with the Western Pacific Region) for Member States, WHO collaborating centres and partners for shaping the dynamic policy and strategic changes needed in the Asia-Pacific.
- b. WHO plans to support Member States on a systematic approach to plan for mitigating the public health impact of the implications of the Nagoya Protocol in the countries.
- c. Support for virus-sharing by Member States in the Region with the GISRS will continue by addressing systemic issues faced by countries. In this regard, the Regional Office intends to request WHO headquarters to include Member States of the Region in the proposed consultation to be conducted by the WHO Working Group on virus-sharing. This will enable Member States to understand systemic issues related to virus-sharing and access to benefits and consider them in the recommendations document that they plan to submit to the PIP Advisory Group.
- d. Technical support will be provided to Member States to roll out the forthcoming WHO guidance on sustainable integrated surveillance for respiratory viruses of pandemic potential.

## **13) Global Health for Peace Initiative**

### **Background**

104. Peace has been an integral part of WHO's work, and the Constitution of WHO states that "the health of all peoples is fundamental to the attainment of peace and security". In 1986, the Ottawa Charter for Health Promotion listed peace as the first of a list of prerequisites for health. In 1997, WHO created the "Health as a Bridge for Peace" Programme to link health interventions with peacebuilding in conflict-affected settings.

105. Following recent changes at the global policy level such as the twin 2016 resolutions on "Sustaining the Peace Agenda" of the United Nations (passed by the UN Security Council and General Assembly) and the Global Strategic Direction of the Humanitarian-Peace Nexus or "Triple Nexus", all UN agencies including WHO are expected to maximize their contributions to peace within their agendas while working towards collective outcomes agreed upon by all stakeholders in humanitarian, development and peacebuilding activities.

106. With the launch of Global Health for Peace Initiative (GHPI) in November 2019, WHO has renewed and advanced its efforts to position the health sector and itself as an influencer to achieve peace. This initiative aims to adopt health interventions that are conflict-sensitive and deliver peace dividends in conflict-affected and fragile settings.

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

107. During the Seventy-fifth World Health Assembly in May 2022, Member States welcomed the report on the Global Health for Peace Initiative and expressed appreciation of the progress made in advancing health for peace activities. Member States also requested WHO to develop a roadmap for implementation of GHPI and build capacities of Member States to adopt conflict-sensitive health interventions that deliver peace dividends. Further, Member States opined that to implement the GHPI's activities, it is critical for WHO to secure adequate financial resources, strengthen partnerships and enhance advocacy.

108. Thailand considered the link between health and peace as very important and has since long been an advocate for a comprehensive report on peace-building and health. Thailand has also offered to contribute actively in developing a roadmap for GHPI implementation and engaging constructively with WHO on this.

109. Indonesia recognized the importance of Global Health for Peace Initiative and supported its adoption by the WHO Executive Board. Indonesia also highlighted the need for further discussion in developing a roadmap for implementation on GHPI.

110. Member States also acknowledged that for GHPI to be successful, a collective action is required to align national, regional and global efforts by all partners in health sectors. Member States agreed that the "Health for Peace" approach is not only relevant to fragile, conflict-affected and vulnerable settings (countries impacted by emergency and insecurities) but is equally relevant for all countries as the health and well-being of all people is fundamental to the attainment of peace and security worldwide. The Region too stands to benefit from GHPI.

### **Actions already taken in the Region**

111. The Regional Office for South-East Asia has been supporting the GHPI roll-out through dissemination of technical briefs to Member States of the Region and engaging with countries to support peace-building approaches that are already ongoing.

### **Actions to be taken in the Region**

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

- a. A roadmap for the implementation of GHPI along with a practical guide on health for peace are being developed.
- b. Support to Member States in mainstreaming peace-building approaches in health programmes that will be critical in achieving the Triple Billion targets continues.
- c. Financial resources to implement GHPI activities must be secured.
- d. Focus on building and strengthening capacities of Member States to progress in delivering on objectives of the Health for Peace Initiative is reaffirmed.

## **14) Polio transition planning and polio post-certification**

### **Background**

113. The Director-General's report to the Seventy-fifth World Health Assembly provided an update on the implementation of the Strategic Action Plan on Polio Transition 2018–2023 within the context of the COVID-19 pandemic. The report highlighted that the focus of polio transition efforts were at the country level with emphasis on integration and sustainability.

114. A mid-term evaluation of the Strategic Action Plan was conducted by an external independent evaluation team. An executive summary of the evaluation report was submitted to the Seventy-fifth World Health Assembly.

115. The fifth report of the Polio Transition Independent Monitoring Board (TIMB) focused on increasing interdependence between eradication and transition, making recommendations for actions by programmes to move forward the eradication and transition agendas.

116. The South-East Asia Region has a single integrated network for surveillance and immunization that provides support not only for polio eradication, but also for measles and rubella elimination, surveillance for vaccine-preventable diseases, strengthening immunization and responding to emergencies. The integrated network makes the Region most advanced among WHO regions for polio transition.

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

117. Actions in the Region will be drawn noting that the Seventy-fifth World Health Assembly has:

- a. reaffirmed commitment to integrate polio assets into national health systems to strengthen broad disease surveillance, outbreak response capacities and immunization services;
- b. urged Member States to ensure that domestic resources are available to finance the Polio Eradication Strategy (2022–2026) of the Global Polio Eradication Initiative (GPEI), including response to emergencies/pandemics including polio;
- c. appreciated the role of polio infrastructure in COVID-19 response that was a demonstration of the capacities that can be achieved when programmes are used in an integrated way focused on the right to health and where there is the necessary political will, and noted that it is also an example of the possibilities that will emerge once we eradicate polio and complete the transition; and
- d. noted the recommendations of the mid-term evaluation of the implementation of the Strategic Action Plan on Polio Transition 2018–2023 and urged WHO that these be addressed as a priority.

### **Actions already taken in the Region**

118. All five countries in the Region prioritized for polio transition (Bangladesh, India, Indonesia, Myanmar and Nepal) have developed their national transition plans adopting a country-centric approach and steps are being taken towards financial sustainability.

119. The Regional Steering Committee for Polio Transition (formed in 2019) continues to provide oversight to the transition process.

120. A regional publication 'NeXtwork' was developed in 2021 to comprehensively document the role of integrated surveillance and immunization infrastructure in COVID-19 response.

121. Polio transition and post-certification continue to be placed as Agenda items in key regional meetings.

### **Actions to be taken in the Region**

122. Broadening the scrutiny of national transition plans, as recommended in the fifth report of the Polio Transition Independent Monitoring Board (TIMB), is necessary.

123. The Regional Action Plan on Polio Transition needs to be developed by the end of 2023, as recommended in the mid-term evaluation report.

## **15) WHO Implementation Framework for the Billion 3 – Outcome of the SIDS Summit for Health: For a healthy and resilient future in small island developing states**

### **Background**

124. Climate change threatens the health of the people of all Member States, but the populations of small island developing states (SIDS) are among the first and hardest hit and most vulnerable. SIDS share grave health and sustainable development challenges posed by the impact of natural and man-made hazards, environmental degradation and rising sea levels due to global warming, health emergencies, loss of biodiversity and the effects of the COVID-19 pandemic. Recognizing that SIDS are disproportionately impacted by climate change, which undermines the progress towards their achievement of the 2030 Agenda for Sustainable Development, including Sustainable Development Goal 3 on health and well-being, the Seventy-fifth World Health Assembly adopted resolution WHA75.18<sup>10</sup> titled “*Outcome of the SIDS Summit for Health: For a healthy and resilient future in small island developing states*”.

125. The resolution called for the Secretariat to continue to pursue the commitments made before and at the SIDS Summit for Health, which was held virtually on 28–29 June 2021, and requested for:

- a. support to establish a SIDS Leaders’ Group for Health for high-level advocacy and to drive further attention globally to the health challenges and initiatives of SIDS with collaboration across Member States and partners to better support the mechanism to address urgent health challenges of such states; and
- b. a report to be presented to the Seventy-seventh World Health Assembly in 2024 on the progress made in implementing this resolution as well as the outcomes of the second SIDS Summit for Health due to be held in 2023.

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

126. There are two nations classified as SIDS in the SE Asia Region, Maldives and Timor-Leste. Both have their country plans and activities prioritized to their needs and receive continued technical support from WHO. Though there is no anticipation on any new implication on the collaborative activities or on the implementation of the actions and support outlined in the resolution, trained human resources remains a challenge in both countries.

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<sup>10</sup> Outcome of the SIDS Summit for Health: for a healthy and resilient future in small island developing states. Doc. No. WHA75.18. Geneva: World Health Organization, 2022. [https://apps.who.int/gb/ebwha/pdf\\_files/WHA75/A75\\_R18-en.pdf](https://apps.who.int/gb/ebwha/pdf_files/WHA75/A75_R18-en.pdf) – accessed 24 June 2022

## **Actions already taken in the Region**

127. Climate health profiles for both Maldives and Timor-Leste have been completed, health national adaptation plans developed and capacity-building on a vulnerability adaptation assessment through virtual training was provided in 2021. A Regional Plan of Action for SIDS in the African and South-East Asian Regions<sup>11</sup> was developed in 2019.

## **Actions to be taken in the Region**

128. A “regional readiness proposal” is to be submitted to the Green Climate Fund in 2022 and both countries have been included in the project proposal. Technical support will be provided to both countries in the implementation of the Regional Plan of Action for SIDS in the African and South-East Asian Regions.

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<sup>11</sup> Climate change and health in small island developing states – Regional Plan of Action for SIDS in the African and South-East Asian Regions. World Health Organization, Regional Office for Africa and Regional Office for South-East Asia, 2019.  
[http://apps.who.int/iris/handle/10665/312262?search-result=true&query=Climate+change+and+health+in+small+island+developing+States&scope=&rpp=10&sort\\_by=score&order=desc](http://apps.who.int/iris/handle/10665/312262?search-result=true&query=Climate+change+and+health+in+small+island+developing+States&scope=&rpp=10&sort_by=score&order=desc) – assessed on 1 Aug 2022.

## **16) WHO Implementation Framework for Billion 3 – Well-being and health promotion**

### **Background**

129. Health and well-being of the population is associated with peace, security, stability, economic growth and fair distribution of power and resources within and between countries. Social, economic and environmental conditions impact the health of societies, communities and people differently. Governments have direct responsibility for the health of their peoples, which can be adequately fulfilled only by the provision of adequate health and social measures. Promoting health and well-being requires environmentally and financially sustainable investment by multiple sectors within governments and contribution from wider society including social and economic actors among individuals, communities, NGOs and the private sector.

130. Promoting physical and mental health, social well-being, and Healthy life expectancy [<https://www.who.int/data/gho/data/themes/topics/indicator-groups/indicator-group-details/GHO/life-expectancy-and-healthy-life-expectancy>] for all is part of the UN General Assembly resolution (A/RES/70/1)<sup>12</sup> titled “*Transforming our world: the 2030 Agenda for Sustainable Development*”. Multisectoral action on social, environmental and economic determinants of health for entire populations and specifically disadvantaged people in vulnerable settings is essential to create inclusive, equitable, economically productive and resilient healthy choices for individuals as well as healthy societies. Health promotion and protection and disease prevention requires responsive health systems with skilled, well trained and motivated workforces in adequate numbers with capacities to address broad public health measures and the determinants of health through policies across sectors, and the promotion of health literacy among the population.

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

131. The Seventy-fifth World Health Assembly, considering the report by the Director-General, adopted resolution WHA75.19<sup>13</sup> titled “*Well-being and health promotion*”. The resolution urges Member States to strengthen health promotion and disease prevention through high-impact public policies to address health determinants and reduce risk factors, including through appropriate regulation, and use health and equity impact assessments in their development. Responsive health systems will require the development of interventions at population, community and individual level to increase health literacy and improve capacity for health-informed decisions and health-seeking behaviours using innovative approaches, communication channels and technologies, and by the use of evidence guided by social and behavioural sciences.

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<sup>12</sup> Transforming our world: the 2030 Agenda for Sustainable Development. Doc. No. A/RES/70/1. New York: United Nations, 2015. [https://www.un.org/en/development/desa/population/migration/generalassembly/docs/globalcompact/A\\_RES\\_70\\_1\\_E.pdf](https://www.un.org/en/development/desa/population/migration/generalassembly/docs/globalcompact/A_RES_70_1_E.pdf) – accessed 1 Aug 2022

<sup>13</sup> Well-being and health promotion. Doc. No. WHA75.19. Geneva: World Health Organization, 2022. [https://apps.who.int/gb/ebwha/pdf\\_files/WHA75/A75\\_R19-en.pdf](https://apps.who.int/gb/ebwha/pdf_files/WHA75/A75_R19-en.pdf) – accessed 1 Aug 2022



132. Provision of continuous training on health promotion, disease prevention and health communication (including innovative technologies) is expected to strengthen health systems and empower the health workforce at all levels of health services ensuring that people in vulnerable situations have access to information. As appropriate, Member States are urged to consider establishing governmental, regional, subregional and local structures responsible for population-level health promotion, with sustainable financing and continuous reporting, and also strengthen population-based health promotion implementation and ensure resilience of the whole government/public structures.

133. Promoting health and well-being needs coordinated and multisectoral action throughout the life course addressing the conditions that affect people's lives. Social participation and the empowerment of people in adopting important health decisions and assuming responsibility for their health and well-being will require actions from the public sector as well as good governance at all levels. Developing enabling environments conducive to health, particularly healthy, safe and resilient communities, makes it easier for individuals to make healthy choices.

### **Actions already taken in the Region**

134. All countries in the South-East Asia Region have taken steps to include basic health information and education in their curricula to ensure that health-care-related workers have appropriate levels of health literacy to implement quality and people-centred care and services throughout the life-course. The health workforce in preventive medicine- and community-based health services has been trained in health promotion, health education, disease prevention and health communication. Several countries have strengthened people-centred health services and endeavoured towards providing quality essential medicine and mental health services, vaccines, diagnostics and health technologies. At the same time, health promotion needs to go beyond health education, disease prevention and health communication.

135. The modicum of health promotion training varies widely among and between countries. Some Member States and institutions conduct training over limited sessions. Others may have credit courses lasting over a semester. The curriculum also varies across countries and institutions. Few health promotion officers in countries are fully trained and concrete estimates from ministries of health are not available. The curriculum also varies across countries and institutions. WHO has consistently urged Member States to give due importance to a robust training regimen.

136. Thailand has been leading in promoting health and well-being throughout the life-course and across sectors, with strong coordination between national and subnational government structures and whole-of-society approaches in response to the needs of people in vulnerable situations. The "health in all policies" approach is applied in addressing health and development, as well as in leading multisectoral actions addressing NCDs in Bhutan, Nepal, Sri Lanka and Thailand. Two SIDS countries, Maldives and Timor-Leste, developed national adaptation plans and capacity-building on vulnerability adaptation assessment to address climate change, as part of the response to the outcomes of the "SIDS Summit for Health: For a healthy and resilient future in small island developing states".

137. Promoting health and well-being in the South-East Asia Region has been progressing in key healthy settings, namely workplaces, schools and cities/communities. The Seventy-fourth session of Regional Committee for South-East Asia adopted the resolution SEA/RC74/R3<sup>14</sup> on *“Revitalizing the school health programme and health-promoting schools in the South-East Asia Region”*. The resolution urged Member States to make every school a “health-promoting school” by 2030. The ministries of health and education in the South-East Asia Region have signed the Call for Action on the subject.

138. The Regional Directors of WHO, UNESCO, UNICEF, UNFPA and WFP released the Joint-Statement committed to promote health and well-being of students, teachers and staff in schools. Inclusive and transformative education for health and well-being was further endorsed by the Second Asia-Pacific Regional Education Minister’s Conference (APREMC II) in Bangkok on 5–7 June 2022. The Roadmap to support implementation of health-promoting schools has been developed in consultation with Member States. Maldives has scheduled a national conference for health-promoting schools in August 2022 which will further enhance health and well-being of students and teachers in the country while working across sectors.

139. The WHO Regional Office collaborated with Member States to strengthen effective actions on healthy cities through the regional laboratory on urban governance for health and well-being, ensuring that an enabling environment for health is accessible to all age groups and is responsive to people in vulnerable situations. Cities in Bangladesh, Bhutan, India, Indonesia, Maldives, Nepal, Sri Lanka and Thailand were engaged through multisectoral coordination and guidance for achieving healthier and fairer societies during COVID-19 and beyond were provided. This guidance was provided by WHO to train city officials in selected cities through a series of virtual meetings. Technical guidance and checklists of actions expected to be performed at the city level were provided.

140. A National Healthy City Network has been established in Indonesia. Commitments made and plan of actions for healthy cities have been initiated in Bhutan. Urban leadership and implementation of urban governance for health and well-being is progressing in Bangladesh. Draft framework for urban health equity and health interventions for cities initiatives in India are being pursued to address health of the urban poor, people with disabilities, age-friendly environment, and healthy settings within cities. Multisectoral partners have been invited to contribute to address the issues and design interventions suitable for their city contexts and a list of suggested interventions to achieve urban health equity has been prepared.

## **Actions to be taken in the Region**

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

- a. Continuation of health promotion education for health workforces to be responsive to broader determinants of health (physical environment, social, cultural and economic determinants of health) and risk factors, and to be sensitive to people’s health literacy while developing generic disease prevention and health communication abilities. Currently many of the health messages are not necessarily corresponding to health literacy at the population level and thus behavioural changes are not being achieved. Health literacy is key to health promotion.

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<sup>14</sup> Revitalizing the school health programme and health-promoting schools in the South-East Asia Region. Doc. No. SEA/RC73/R3. New Delhi: World Health Organization, Regional Office for South-East Asia, 2021.  
<https://apps.who.int/iris/bitstream/handle/10665/345269/sea-rc74-r3-eng.pdf?sequence=1&isAllowed=y> – accessed 1 Aug 2022

- b. Strengthening the role of health promotion and enhancing capacities of health professionals to promote health and well-being throughout the life-course and particularly among people in vulnerable situations and engage with communities, local governments, and multiple sectors, where it is applicable, on a regular basis while ensuring that surge capacities are identified for emergency situations.
- c. Provision of adequate resources to orient public systems and infrastructures enabling health literacy, including understanding of health impacts and health equity, across sectors and particularly through healthy settings.
- d. Development of a framework on achieving well-being, building on the 2030 Agenda for Sustainable Development, and identifying the role that health promotion plays within this.
- e. Development of the implementation and monitoring plans of the Framework, and providing technical support to Member States in strengthening their governance, financing, human resources, evidence generation, data disaggregation and research structures, for overall well-being and health promotion of the population.
- f. Promotion and recommendation of scientifically sound interdisciplinary research to develop the evidence base for interventions for the promotion of health and well-being.

## 17) WHO Global Strategy for food safety

### Background

142. The Seventy-third World Health Assembly had endorsed resolution WHA73.5 titled “Strengthening efforts on food safety”. Through the resolution, Member States requested the Director-General to update the WHO Global Strategy for food safety, which was finalized through a series of consultations with experts, Member States and partners.

143. The 150th session of the WHO Executive Board held in January 2022 considered the reports on the “WHO Global Strategy for food safety” ([EB150/25](#)) and “Reducing public health risks associated with the sale of live wild animals of mammalian species in traditional food markets – infection prevention and control” ([EB150/26](#)). The Board noted the reports and recommended two decisions for consideration of the World Health Assembly.

144. The Seventy-fifth World Health Assembly, vide its decision WHA75(22)<sup>15</sup> adopted the updated WHO Global Strategy for food safety. The Assembly, vide its decision WHA75(23)<sup>16</sup>, recommended that an interim guidance on reducing public health risks associated with the sale of live wild animals of mammalian species in traditional food markets needs to be updated and supported with a country implementation plan.

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

145. The choice of strategic priorities should be tailored to the respective country situation and Member States should modify, redesign or strengthen their national food safety systems as appropriate based upon the strategic priorities identified in the updated strategy.

146. There is a need to develop the country implementation roadmaps with availability of financial resources to support such work.

### Actions already taken in the Region

147. The National Food Safety Authorities in Member States of the WHO South-East Asia Region have been implementing the ‘Framework for Action on Food Safety in WHO South-East Asia Region (2020–2025)’, which will complement updated Global Strategy for food safety.

148. The Regional Framework for Action on Food Safety covers all aspects of the Global Strategy for food safety and major emphasis is given for strengthening national food control systems.

149. There is a tripartite coordination group in the Asia-Pacific Region and food safety is one of the priority areas for multisectoral collaboration.

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<sup>15</sup> WHO Global Strategy for food safety. Doc No. WHA75(22). Geneva: World Health Organization, 2022.  
[https://apps.who.int/gb/ebwha/pdf\\_files/WHA75/A75\(22\)-en.pdf](https://apps.who.int/gb/ebwha/pdf_files/WHA75/A75(22)-en.pdf) – accessed 1 Aug 2022

<sup>16</sup> Reducing public health risks associated with the sale of live wild animals of mammalian species in traditional food markets – infection prevention and control. Doc No. WHA75(23). Geneva: World Health Organization, 2022.  
[https://apps.who.int/gb/ebwha/pdf\\_files/WHA75/A75\(23\)-en.pdf](https://apps.who.int/gb/ebwha/pdf_files/WHA75/A75(23)-en.pdf) – accessed 1 Aug 2022

150. The Codex Trust Fund has supported Bhutan, India, Maldives, Nepal and Timor-Leste to strengthen Codex activities in these countries.

151. The WHO Regional Offices for South-East Asia and the Western Pacific have worked together and developed a manual on mitigating public health risks in traditional food markets.

### **Actions to be taken in the Region**

152. Member States will be supported to develop the country implementation plan for strengthening food safety in line with the Regional Framework for Action on Food Safety and the Global Strategy for food safety.

153. Considering the importance of traditional food markets in the Asia-Pacific Region, the WHO Regional Office for South-East Asia is supporting pilot projects on mitigating public health risks in selected Member States based on the WHO Manual for food safety.

## **18) Prevention of sexual exploitation, abuse and harassment**

### **Background**

154. The Seventy-fifth World Health Assembly discussed the Director-General's report on the Agenda item on "Prevention of sexual exploitation, abuse and harassment" ([A75/29](#)) along with the Report of the Programme Budget and Administration Committee (PBAC) of the WHO Executive Board to the Assembly on the Agenda ([A75/50](#)).

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

155. The Member States of the SE Asia Region (in particular Bhutan, India, Indonesia and Thailand) and others expressed strong commitment to prevention of and response to sexual exploitation, abuse and harassment (PRSEAH) and acknowledged WHO's comprehensive efforts thus far. Member States:

- a. reiterated their commitment to zero tolerance on sexual exploitation, abuse and harassment (SEAH);
- b. requested access to UN-wide ClearCheck screening database by Member States to prevent (re-)hiring of confirmed perpetrators;
- c. requested WHO to build a culture of reporting, investigation and timely action;
- d. requested coordination between WHO, partners and stakeholders, and updates on pending complaints and transparent sharing of information on new complaints;
- e. recognized the need to strengthen PRSEAH, especially in preparedness and response to health emergencies, scale up prevention, and strengthen health system capacities to safeguard victims;
- f. drew attention to the implications of SEAH on the achievement of the SDGs, especially SDG 5, and urged WHO to lead by example in the UN System.

### **Actions already taken in the Region**

156. The Regional Director accords high priority to PRSEAH in the SE Asia Region. Actions taken so far include at the Regional Office level:

- a. a PRSEAH Working Group has been established in the Region comprising members from technical departments in the Regional Office, select WHO country offices and the Staff Association; and
- b. creation of activity workplan in the WHO Planning Portal to allocate the funds received for implementation of the proposed activities – US\$ 2.5 million from the United States Government's COVID-19 grant and approximately US\$ 250 000 from the assessed contributions.

157. The following actions have also been taken at the Country Office level:

- a. a briefing of all WHO Representatives held in March 2022;
- b. appointment of focal points on PRSEAH in each WHO country office;
- c. distribution of funds to country offices for supporting PRSEAH activities;
- d. finalization of the post-descriptions of dedicated full-time PRSEAH staff in select country offices in the Region (a P4 position in the Cox's Bazar Office; NPOs in other select country offices) and draft terms of reference shared for consultant positions in other country offices;
- e. sharing of guidance, tools and resources on country-level implementation of PRSEAH;
- f. one-on-one planning/briefing meetings held to support workplan development and implementation; and
- g. orientation of staff in select country offices.

158. Other actions taken at the Regional Office level:

- a. orientation sessions have been held for over 200 staff from all departments;
- b. the global *#NoExcuse Campaign* was observed during Goals Week in 2022 with all staff mandated to include PRSEAH in the "Team objectives" section of their annual electronic appraisal mechanism (ePMDS);
- c. timely completion of the mandatory staff trainings has been achieved;
- d. an activity workplan in the WHO Planning portal has been created, a consultant has been hired, and timely implementation of the activities has been initiated;
- e. HR positions at P5 level at the Regional Office and P4 level at the Cox's Bazar Field Office in Bangladesh have been included in the global roster with participation of the Regional Office in the selection process; and
- f. use of ClearCheck, an UN-wide database for screening candidates before recruitment and prevent the (re-)hiring of confirmed perpetrators across the UN System, has been initiated;
- g. a mission by the Department of Internal Oversight Services (IOS) of headquarters to the Regional Office in July 2022; and
- h. a Townhall meeting by the Regional Director, held on 25 July 2022, attended by the Regional and Country Office Staff.

## **Actions to be taken in the Region**

159. Other planned and ongoing activities in the Region include:

- a. a Regional Directors' Summit or meeting of focal points of the regional UN country teams to strengthen alignment and collaboration among UN partners;
- b. tailoring of standard training and orientation packages to the regional context and roll-out of the same;

- c. development of PRSEAH communication materials and its use to support planned activities;
- d. capacity enhancement of the WHO Country Office focal points, implementing partners and communities; and
- e. organization of a training of trainers' workshop on strengthening the health sector response to gender-based violence.

160. At the country office level, planned activities include:

- a. development of country-specific risk assessment and mitigation plans;
- b. strengthening capacity and systems among implementing partners; and
- c. adaptation, translation and use of tailored training/orientation and communications materials.



## 19) Global Strategy and Plan of Action on public health, innovation and intellectual property

### Background

161. The Global Strategy and Plan of Action (GSPA) on public health, innovation and intellectual property provided several recommendations and progress indicators were developed to foster innovation and improve access to health products.

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

162. In May 2022, the Seventy-fifth World Health Assembly, noting the consolidated report submitted by the WHO Director-General (WHA75/10 Rev.1) and considering the decision of the WHO Executive Board adopted at its 150th session in January 2022 ([EB150\(11\)](#)), adopted the resolution WHA75.14<sup>17</sup> titled '*Global Strategy and Plan of Action on public health, innovation and intellectual property*', thus extending the timeframe of the Global Plan of Action on public health, innovation and intellectual property from 2020 to 2030.

### Actions already taken in the Region

163. Many meetings have been held and actions taken for the implementation of the GSPA on public health, innovation and intellectual property in the Region. Meetings organized in the SE Asia Region in the previous five years are summarized in the table below:

**Table 1.** Meetings held by Member States in the SE Asia Region on GSPA

1–14 December 2020	Current good manufacturing practices (cGMP) online workshop for pharmaceutical manufacturers in active pharmaceutical ingredients (API) and formulations for access to quality-assured medical products
28 August 2020	SEARN: Virtual regulatory brief on vaccine clinical trial solidarity protocol
7 May 2020	SEARN virtual meeting on regulatory updates on COVID-19 pandemic
19–21 November 2019, New Delhi, India	World Conference on Access to Medical Products: Achieving the SDGs 2030
19–20 November 2019, Bangkok, Thailand	International Trade and Health Conference 2019: ASEAN trade and health – seeking a common ground towards SDGs
23–25 April 2019, New Delhi, India	Third Annual Meeting of South-East Asia Regulatory Network

<sup>17</sup> Global strategy and plan of action on public health, innovation and intellectual property. Doc. No. WHA75.14. Geneva: World Health Organization, 2022. [https://apps.who.int/gb/ebwha/pdf\\_files/WHA75/A75\\_R14-en.pdf](https://apps.who.int/gb/ebwha/pdf_files/WHA75/A75_R14-en.pdf) – accessed 1 Aug 2022

15–16 November 2018, Bangkok, Thailand	International Trade and Health Conference 2018: Belt and Road Initiative – Opportunities and challenges for health
9–11 October 2018, New Delhi, India	2nd World Conference on Access to Medical Products: Achieving the SDGs 2030
21–23 March 2018, Colombo, Sri Lanka	Second Annual Meeting of South-East Asia Regulatory Network
28–29 November 2017 Bangkok, Thailand	International Trade and Health Conference 2017: Looking into the future, assessing the current situation
21–23 November 2017, New Delhi, India	First World Conference on Access to Medical Products and International Laws on Trade and Health, in the context of the 2030 Agenda for Sustainable Development
11–12 April 2017, New Delhi, India	First Annual Meeting of South-East Asia Regulatory Network
2016 and 2017	SE Asia Region Member States participated in the evaluation and programme review of GSPA

164. The International Trade and Health (ITH) Conference in Thailand, organized by the National Commission on International Trade and Health Studies (NCITHS) together with the International Trade and Health Programmes, on 24–26 November 2021, on “Future international trade and health: Post COVID-19 pandemic” explored the impact of COVID-19 on international trade and health aspects. The Conference developed new thinking on:

- revisiting the international trade and health aspect of COVID-19;
- making vaccines, medicines and diagnostics related to COVID-19 and other health emergencies global public goods; and
- new global governance of international trade and health.

165. In addition, in 2021 and 2022, first-of-their-kind online workshops on current good manufacturing practices (cGMP) were organized and implemented by all three levels of WHO (country offices, Regional Office and headquarters) in collaboration with the Ministry of Health and Family Welfare, Government of India, and other partners. The cGMP online workshops also address COVID-19 challenges to access to medical products. These workshops are summarized in Table 2.

**Table 2.** Virtual Workshops on current good manufacturing practices (cGMP) for access to quality-assured medical products (medicines, vaccines, diagnostics and devices) WHO-JSS Mysuru – IPA

Workshop	Category	Dates 2020–2021	Number of participating units	Number of participants	Duration (in days)	Details on current Good Manufacturing Practices (cGMP) online workshops for pharmaceutical units is published on both South-East Asia Region and headquarters websites:  1. South-East Asia Region: <a href="https://www.who.int/south-eastasia/health-topics/universal-health-coverage">https://www.who.int/south-eastasia/health-topics/universal-health-coverage</a>  2. WHO HQ <a href="https://www.who.int/south-eastasia/news/detail/10-12-2021-current-good-manufacturing-practices-(cgmpr)-online-workshops-for-pharmaceutical-units">https://www.who.int/south-eastasia/news/detail/10-12-2021-current-good-manufacturing-practices-(cgmpr)-online-workshops-for-pharmaceutical-units</a>
<b>Pilot</b>	Formulation	1–14 December	33	101	12	
1.	Formulation	5–18 May	40	143	12	
2.	APIs	24 May–5 June	35	139	12	
3.	APIs	14–26 June	49	166	12	
4.	Medical devices	5–9 July	51	165	05	
5.	APIs	19–30 July	115	310	12	
Total			323	1115		
<b>Pilot Mentorship Programme</b>		August–December 2021	33 units			
<b>Mentorship Programme</b>	All	March–August 2022	In progress			

## Actions to be taken in the Region

166. Activities under the GSPA must be continued and support to Member States in effective implementation of GSPA provided with interplay among public health, innovation and intellectual property sectors.

## **20) Traditional medicine**

### **Background**

167. Given the importance of traditional medicine in the national health systems, World Health Assembly resolution WHA67.18 of 2014 urged Member States to adapt, adopt and implement the WHO Traditional Medicine Strategy 2014–2023, which has two goals: to harness the potential contribution of traditional medicine to health, wellness and people-centred health care, and to promote the safe and effective use of traditional medicine through appropriate regulation. The Strategy's three objectives include building a knowledge base; strengthening quality assurance, safety and efficacy; and promoting UHC through integration. The Strategy tenure will end in the year 2023.

168. A steady progress is observed in the global implementation of the Strategy and resolution in terms of policy, regulation, national programmes, research, health insurance and integration across Member States.

169. Given the importance of traditional medicine in primary health care (PHC), a number of resolutions in this context have been adopted by the Member States. These include the 2018 Declaration of Astana on primary health care, UNGA Resolution 69/131(2014) on celebrating 21 June as International Day of Yoga, and UNGA Resolution 74/2(2019) on the integration of safe and evidence-based traditional medicine services within health systems, particularly at the primary health care level.

170. A memorandum of understanding (MoU) between the Ministry of Ayush, Government of India, and the World Health Organization, for setting up the WHO Global Centre for Traditional Medicine (WHO-GCTM) was signed on 25 March 2022. The groundbreaking ceremony in India was attended by the honourable Prime Minister of India, H.E. Mr Narendra Modi, and the WHO Director-General, Dr Tedros A. Ghebreyesus, on 19 April 2022 at Jamnagar in the state of Gujarat, India.

171. The Seventy-fifth World Health Assembly noted the Director-General's report on the implementation of the WHO Traditional Medicine Strategy 2014–2023 and resolution WHA67.18 of 2014. A total of 19 Member States including four Member States from the SE Asia Region (Bhutan, India, Indonesia and Thailand) presented their interventions. The Assembly adopted Decision WHA75(19) requesting the Director-General to submit a final progress report to the Seventy-sixth World Health Assembly in May 2023 through the Executive Board at its 152nd Session in January 2023.

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

172. Despite a steady progress in implementing the Global Strategy, Member States still face key challenges such as lack of research evidence and data, financial support and inadequate mechanisms to monitor and regulate traditional medicines practice, products and practitioners.

173. Member States have requested for policy and technical guidance and support from WHO on integration of traditional medicine into the health-care delivery system, traditional medicines research and evaluation, and regulatory framework, and on setting up a platform for information sharing on regulatory issues, capacity-building, research databases, and enhancing cross-sectoral coordination and collaboration for sustainable development of traditional medicines.

### **Actions already taken in the Region**

174. The Regional Action Plan with four priority areas: (1) system performance monitoring; (2) safety monitoring for traditional medicines products; (3) research capacity-building; and (4) integration of traditional medicines into the health-care delivery system, was developed in October 2015.

175. The following actions have been taken under the four priority areas:

- a) development of standard core and reference indicators and their metadata;
- b) development of a web-based data collection tool and dashboard for monitoring performance of the traditional medicine system;
- c) conduct of several regional training workshops on pharmacovigilance for safety monitoring of traditional medicines;
- d) collation of case studies from several countries on pharmacovigilance for traditional medicines;
- e) conduct of a regional hands-on training on laboratory-based quality control activities on traditional/herbal products in the year 2022;
- f) conduct of a regional workshop on research methodologies for traditional medicine, and development of research methodologies;
- g) conduct of several country case studies on traditional medicine research including research projects in the context of COVID-19;
- h) conduct of a regional workshop on appropriate integration of traditional medicine into the national health system and review on progress in traditional medicines for 2014–2019; and
- i) publication of a regional compendium titled *“Traditional medicine in the WHO South-East Asia Region: review of progress 2014–2019”* in 2021.

### **Actions to be taken in the Region**

176. The current priority areas remain relevant to the Region. The Regional Office for South-East Asia will take advantage of the establishment of the WHO-GCTM in Jamnagar, India, to amplify regional efforts on traditional medicine research capacity-building and evidence synthesis for people's health.

177. The Regional Office will also continue to provide policy and technical guidance and support to Member States through implementation of the WHO Strategy and learn from and build on the progress achieved, specifically in traditional medicines research, regulation and integration into health systems, towards achieving universal health coverage, the Triple Billion targets of the GPW13 and the SDGs.

## 21) Public health dimension of the world drug problem

### Background

178. As per the World Drug Report 2021, around 275 million people reportedly used psychoactive drugs during the year 2020 [*World drug report 2021, United Nations Office on Drugs and Crime (UNODC)*]. This is expected to rise by 11% worldwide and 40% in Africa alone by the year 2030. With an estimated 36 million people living with drug use disorders globally, the scope of global public health problems related to drug use, drug use disorders and associated health conditions continues to be very high.

179. In 2017, The Seventieth World Health Assembly adopted decision WHA70(18), among others, to recognize the need for intensified efforts in addressing and countering the world drug problem. A public health approach is widely recognized as essential to addressing the global drug problem at all levels.

180. Effective progress towards the achievement of target 3.5 and other health-related targets of the Sustainable Development Goals requires enhanced and sustained WHO actions aimed at promoting and supporting prevention, early identification and effective management of substance use disorders; improving access to controlled medicines; reducing the burden of drug-related infectious diseases and prevention of the harms associated with drug use; effective monitoring of the health consequences of drug use, as well as public health policy and programme responses; and promoting a public health approach to the global drug problem.

181. The Seventy-fifth World Health Assembly, having considered the report of the Director-General and vide Decision WHA75(20),<sup>18</sup> decided to request the Director-General to continue to report to the Health Assembly every two years until 2030 on WHO's activities to address the public health dimensions of the world drug problem and progress made in the implementation of Decision WHA70(18) of 2017.

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

182. Regions highlighted their concern with the increase in the number of people using psychoactive drugs and their effect on communities.

183. Member States acknowledged WHO's collaboration with the United Nations Office on Drugs and Crime (UNODC) and the International Narcotics Control Board. WHO has expanded the scope of collaboration with UNODC further to include the prevention, detection and response to substandard and falsified medical products at the global level, which is another area of collaborative work between WHO and UNODC.

184. The COVID-19 pandemic has had a significant impact on the provision of health services for substance use disorders, as evidenced by the results of the WHO rapid assessment in 2020 of the impact of COVID-19 on mental, neurological and substance use services.

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<sup>18</sup> Public health dimension of the world drug problem. Doc. No. WHA75(20). Geneva: World Health Organization, 2022.  
[https://apps.who.int/gb/ebwha/pdf\\_files/WHA75/A75\(20\)-en.pdf](https://apps.who.int/gb/ebwha/pdf_files/WHA75/A75(20)-en.pdf) – accessed 1 Aug 2022

185. Member States expressed concern at the low access to medication for moderate and severe pain, particularly in low- and middle-income countries, and recognized that the need for access to pain relief must be viewed in the context of concerns about the harm arising from the misuse of select medications, including opioids.

186. Member States in the SE Asia Region highlighted the continued lack of access to opioid treatment in the Region and called on the Secretariat to support access to opioid medicines. Punitive measures and aggressive laws still inhibit access to opioid therapy.

187. There is need for bolstering the training of health-care workers on the use of opioids to reduce stigma. Essential opioid medicines are still not included in the essential medicines lists (EML) of a number of countries.

188. Maldives presented a Regional One Voice statement and supported the recommendations presented by the WHO Expert Committee on drug dependence under the Commission on Narcotic Drugs as well as the interagency work being facilitated by WHO.

### **Actions already taken in the Region**

189. The Region is committed to enabling access to essential opioids in Member States. A standardized assessment was conducted last year on the status of policies and programmes in the 11 countries. This led to structured documentation of barriers and enablers in implementation. Most countries in the Region have limited access to essential opioids necessary for moderate to severe pain relief mostly due to heavy regulations over their access.

### **Actions to be taken in the Region**

190. Continued support will be provided to Member States for enabling access to essential opioids in the Region. A regional publication on the situation in countries with regard to access to opioids is currently being produced.

## **22) Standing Committee on Health Emergency (Pandemic) Prevention, Preparedness and Response**

### **Background**

191. The work of WHO in health emergencies has expanded considerably over the last two decades, as reflected under one of the four pillars of the Thirteenth General Programme of Work (GPW13). This expansion has increased the demands on the Governing Bodies, leading to concerns that Member States do not have adequate opportunities to address the work of the Organization in this key area.

192. Member States agreed to establish a Standing Committee on Health Emergency (Pandemic) Prevention, Preparedness and Response, as a sub-committee of the Executive Board. Accordingly, the WHO Executive Board, at its 151st session held in May 2022, adopted Decision EB151(2)<sup>19</sup> to establish such a committee with agreed terms of reference.

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

193. The key terms of reference of the Standing Committee, as agreed by the WHO Executive Board, include:

- a. Composition of the Standing Committee:
  - i. The Committee shall comprise 14 members, two from each Region, selected from among members of the WHO Executive Board, reflecting a balanced representation of developed and developing countries, as well as the Chair and the Vice-Chair of the Executive Board, who will be ex-officio members. Members of the Standing Committee shall serve for a term of two years.
  - ii. There shall be two Officebearers: a Chairperson and a Vice-Chairperson, who shall be appointed from among the Committee members, and shall serve for a one-year term. The committee may invite observers and experts, as appropriate.
- b. Functions:
  - i. In the event of a public health emergency of international concern (PHEIC), provide guidance to the Executive Board and advice to the Director-General on health emergency prevention, preparedness and response, and immediate capacities of the WHE Programme.
  - ii. Beyond and outside of PHEIC: review, provide guidance and make recommendations to the Executive Board regarding the strengthening and oversight of the WHE Programme and for effective health emergency prevention, preparedness and response.

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<sup>19</sup> Standing Committee on Health Emergency (Pandemic) Prevention, Preparedness and Response. Doc No. EB151(2). Geneva: World Health Organization, 2022. [https://apps.who.int/gb/ebwha/pdf\\_files/EB151/B151\(2\)-en.pdf](https://apps.who.int/gb/ebwha/pdf_files/EB151/B151(2)-en.pdf) – accessed 1 Aug 2022.



- iii. Work in a manner respectful of and complementary to the technical scientific advice provided by the IHR Emergency Committee.
- c. Conduct of sessions:
  - i. The Standing Committee shall meet at least twice annually for regular work. In the event of a PHEIC, the Director-General shall convene an extraordinary meeting of the Standing Committee as soon as reasonably practicable, and ideally within 24 hours following the determination of the PHEIC. The Board may decide to convene extraordinary meetings of the Standing Committee.
  - ii. The Standing Committee shall conduct its business on the basis of consensus and transparency. It shall provide a report on each of its meetings to the Executive Board. The meetings of the Standing Committee shall be open for all Member States.
  - iii. The Standing Committee will hold its first meeting after each WHO Region has nominated its members and the Executive Board formally appoints the members through a silence procedure, ideally before the end of October 2022.

### **Actions already taken in the Region**

194. The Regional Office for South-East Asia regularly updates the Member States of the Region about the developments regarding various governance-related matters of the WHE Programme, including discussions held by the Independent Oversight and Advisory Committee (IOAC) of the WHE, the global architecture proposals of the Director-General, the Member States Working Group on Strengthening WHO Preparedness and Response to Health Emergencies (WGPR) and the Intergovernmental Negotiating Body (INB).

### **Actions to be taken in the Region**

195. The nomination process of the two Member States from the SE Asia Region (who are members of the Executive Board) for the Standing Committee will be taken up during the upcoming Governing Body meetings.



# **Annexures**



## **Follow-up to the political declaration of the third high-level meeting of the General Assembly on the prevention and control of non-communicable diseases**

The Seventy-fifth World Health Assembly, having considered the consolidated report by the Director-General,<sup>1</sup>

Decided:

- (1) to note the consolidated report by the Director-General and its annexes;<sup>2,3,4</sup>
- (2) to adopt:
  - the implementation road map 2023–2030 for the global action plan for the prevention and control of noncommunicable diseases 2013–2030;<sup>5</sup>
  - the recommendations to strengthen and monitor diabetes responses within national noncommunicable disease programmes, including potential targets;<sup>6</sup>
  - the global strategy on oral health;<sup>7</sup>
  - the recommendations on how to strengthen the design and implementation of policies, including those for resilient health systems and health services and infrastructure, to treat people living with noncommunicable diseases and to prevent and control their risk factors in humanitarian emergencies;<sup>8</sup>

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<sup>1</sup> Document A75/10 Rev.1.

<sup>2</sup> Document A75/10 Add.3 (Annex 5).

<sup>3</sup> Document A75/10 Add.5 (Annex 11).

<sup>4</sup> Document A75/10 Add.6 (Annex 12).

<sup>5</sup> Document A75/10 Add.8 (Annex 1).

<sup>6</sup> Document EB150/7 (Annex 2).

<sup>7</sup> Document A75/10 Add.1 (Annex 3).

<sup>8</sup> Document A75/10 Add.2 (Annex 4).

- the intersectoral global action plan on epilepsy and other neurological disorders 2022–2031;<sup>1</sup>
- the action plan (2022–2030) to effectively implement the global strategy to reduce the harmful use of alcohol as a public health priority;<sup>2</sup>
- the recommendations for the prevention and management of obesity over the life course, including considering the potential development of targets in this regard;<sup>3</sup>
- the workplan for the global coordination mechanism on the prevention and control of noncommunicable diseases 2022–2025;<sup>4</sup>

(3) to request the Director-General to report on the progress made towards the achievement of global obesity targets, as part of reporting requirements under the acceleration plan, on a biennial basis until 2030.

Eighth plenary meeting, 28 May 2022  
A75/VR/8

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<sup>1</sup> Document A75/10 Add.4 (Annex 7).

<sup>2</sup> Document EB150/7, Annex 8; see also document EB150/7 Add.1, which contains the Appendix to Annex 8.

<sup>3</sup> Document EB150/7, Annex 9.

<sup>4</sup> Document EB150/7, Annex 10.

## South-East Asia Regional One Voice (ROV): Delivered by Sri Lanka

### 75<sup>th</sup> World Health Assembly (WHA 75)

#### Agenda Item 14.1(c): Draft global strategy on oral health and (h) Draft action plan (2022–2030) to effectively implement the global strategy to reduce the harmful use of alcohol as a public health priority

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First of all, it is my pleasure to speak on behalf of the South East Asia region which represent over a quarter of the world's population.

Though we are at different stages of development in individual countries, on the prevention of Non-Communicable Diseases, we have a common goal to effectively implement global strategies to accelerate prevention and control activities on Non-Communicable Diseases. Utilizing the time period, I am emphasizing on major aspects.

##### 1. Draft global strategy on oral health

Oral health is an integral part of wellbeing. Therefore, we strongly recommend integration of oral health into primary healthcare, which often is not happen, due to the fact that treatment of dental problems is of high cost across the world. Also, it is to be mentioned that Oral Health should be an integral part of National Health Policy as we look forward to shift from curative approach to preventive approach, to yield potential benefits. It is important not only to have a global strategy, but a plan of action with inbuilt mechanism to monitor the progress in achieving set targets when implementing the action plan on Oral Health.

##### 2. Regarding reducing the harmful effects of alcohol

Our region is concerned that even after a decade since adoption of WHO global strategy, a significant progress could not be yielded. Therefore, we need to focus on attainment of progress as the goal of a comprehensive, effective and sustainable alcohol policy can only be attained by **ensuring the active and committed involvement of all relevant stakeholders**. Alcohol control strategies need a high degree of public awareness and support in order to be implemented successfully.

We need to have clear formulation and effective implementation of a rational, integrated and comprehensive alcohol control policy.

We strongly encourage an effective monitoring mechanism with regular reviews of national action plans at the regional level and evaluation at the global level in order to implement actions to achieve set targets.

We commend the leadership of Madam RD SEARO which had implemented policy not to serve alcoholic beverage at any of official meetings organized by SEARO and Country Offices since 2010. This is the best example of WHO as the global role model in de-normalizing the use of alcohol.



## **The global health sector strategies on, respectively, HIV, viral hepatitis and sexually transmitted infections**

The Seventy-fifth World Health Assembly,

Having considered the consolidated report by the Director-General,<sup>1</sup>

1. NOTES WITH APPRECIATION the global health sector strategies on, respectively, HIV, viral hepatitis and sexually transmitted infections, for the period 2022–2030;
2. REAFFIRMS that in implementing the global health sector strategies on, respectively, HIV, viral hepatitis and sexually transmitted infections, for the period 2022–2030, the national context should be considered;
3. REQUESTS the Director-General to report on the progress made in the implementation of the global health sector strategies on, respectively, HIV, viral hepatitis and sexually transmitted infections, for the period 2022–2030 to the Health Assembly in 2024, 2026, 2028 and 2031, noting that the 2026 report will provide a mid-term review based on the progress made in meeting the strategies' 2025 targets and the progress made towards achieving the 2030 goals.

Ninth plenary meeting, 28 May 2022  
A75/VR/9

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<sup>1</sup> Document A75/10 Rev.1.

## **Consolidated report by the Director-General<sup>1,2</sup>**

### **PILLAR 1: ONE BILLION MORE PEOPLE BENEFITING FROM UNIVERSAL HEALTH COVERAGE**

#### **14. Review of and update on matters considered by the Executive Board**

##### **14.1 Political declaration of the third high-level meeting of the General Assembly on the prevention and control of non-communicable diseases**

**(a) Draft implementation road map 2023–2030 for the global action plan for the prevention and control of noncommunicable diseases 2013–2030**

**(b) Draft recommendations to strengthen and monitor diabetes responses within national noncommunicable disease programmes, including potential targets**

**(c) Draft global strategy on oral health**

**(d) Draft recommendations on how to strengthen the design and implementation of policies, including those for resilient health systems and health services and infrastructure, to treat people living with noncommunicable diseases and to prevent and control their risk factors in humanitarian emergencies**

**(e) Progress in the implementation of the global strategy to accelerate the elimination of cervical cancer as a public health problem and in the achievement of its associated goals and targets for the period 2020–2030**

**(f) Progress achieved in the prevention and control of noncommunicable diseases and the promotion of mental health**

**(g) Draft intersectoral global action plan on epilepsy and other neurological disorders in support of universal health coverage**

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<sup>1</sup> In the present document the texts under each agenda item should be read in conjunction with the corresponding reports considered by the Executive Board at its 149th or 150th session, as appropriate. The summary records of those sessions are available at the following link: <http://apps.who.int/gb/or/>.

<sup>2</sup> See also document A75/INF./8 for a note by the Secretariat concerning the various documents on the follow-up to the political declaration of the third high-level meeting of the General Assembly on the prevention and control of noncommunicable diseases.

**(h) Draft action plan (2022–2030) to effectively implement the global strategy to reduce the harmful use of alcohol as a public health priority**

**(i) Draft recommendations for the prevention and management of obesity over the life course, including potential targets**

**(j) Draft workplan for the global coordination mechanism on the prevention and control of noncommunicable diseases**

At its 150th session, the Executive Board noted the reports in documents EB150/7 and EB150/7 Add.1 and adopted decision EB150(4) on the political declaration of the third high-level meeting of the General Assembly on the prevention and control of noncommunicable diseases.

In response to requests made during the discussions,<sup>1</sup> the Secretariat has slightly revised Annexes 1, 3, 4, 5 and 7,<sup>2</sup> and has added an additional Annex 11<sup>3</sup> on the preparatory process leading to the fourth high-level meeting of the General Assembly on the prevention and control of noncommunicable diseases in 2025 and an Annex 12<sup>4</sup> on the acceleration plan to support Member States in implementing the recommendations for the prevention and management of obesity over the life course.

#### **14.2 The global health sector strategies on, respectively, HIV, viral hepatitis and sexually transmitted infections**

The Executive Board at its 150th session noted the report on the global health sector strategies on, respectively, HIV, viral hepatitis and sexually transmitted infections.<sup>5</sup> It also adopted resolution EB150.R3, in which it decided that informal consultations on the draft global health sector strategies on respectively, HIV, viral hepatitis and sexually transmitted infections for the period 2022–2030 would continue to be facilitated by the Secretariat prior to the Seventy-fifth World Health Assembly. Additional information on the development process of the strategies, including the informal consultations and the resulting final versions of the strategies in the six official languages, is available online.<sup>6</sup>

#### **14.3 Global strategy for tuberculosis research and innovation**

The Executive Board at its 150th session noted the report on the global strategy for tuberculosis research and innovation.<sup>7</sup> In the discussions, Board members underscored the impact of the COVID-19

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<sup>1</sup> See the summary records of the Executive Board at its 150th session, sixth meeting, section 2, seventh meeting, and eighth meeting, section 1.

<sup>2</sup> Documents A75/10 Add.8, A75/10 Add.1, A75/10 Add.2, A75/10 Add.3 and A75/10 Add.4, respectively.

<sup>3</sup> Document A75/10 Add.5.

<sup>4</sup> Document A75/10 Add.6.

<sup>5</sup> Document EB150/8; see also the summary records of the Executive Board at its 150th session, eighth meeting, section 2.

<sup>6</sup> <https://www.who.int/teams/global-hiv-hepatitis-and-stis-programmes/strategies/global-health-sector-strategies/developing-ghss-2022-2030> (accessed 5 April 2022).

<sup>7</sup> Document EB150/9; see also the summary records of the Executive Board at its 150th session, eighth meeting, section 2.

pandemic on the fight against tuberculosis and the importance of restoring essential tuberculosis services as quickly as possible. They called for more domestic and international resources to be mobilized in order to accelerate the implementation of the global strategy and achieve faster progress towards global tuberculosis targets.

#### **14.4 Road map for neglected tropical diseases 2021–2030**

The Executive Board at its 150th session noted the report on the road map for neglected tropical diseases 2021–2030.<sup>1</sup> In the discussions, Board members drew attention to the impact of the COVID-19 pandemic on neglected tropical diseases services. The renewed efforts of Member States were needed to keep the road map targets for neglected tropical diseases on track and ensure that services for those diseases remained part of basic health care.

#### **14.5 Immunization Agenda 2030**

The Executive Board at its 150th session noted the report on the Immunization Agenda 2030,<sup>2</sup> which summarized the draft global report on the Immunization Agenda 2030 for 2021.<sup>3</sup> In the discussions, Board members called for strengthened collaboration between Member States and partners to implement global, regional and national strategies, so as to mitigate the lost momentum in immunization due to the COVID-19 pandemic and renew progress towards the impact goals of the Immunization Agenda 2030.

#### **14.6 Infection prevention and control**

The Executive Board at its 150th session noted the report on infection prevention and control.<sup>4</sup> In the discussions, Board members underscored the importance and urgency of developing a global infection prevention and control strategy to accelerate progress on implementation and monitoring in that area.

#### **14.7 Global road map on defeating meningitis by 2030**

The Executive Board at its 150th session noted the report on the global road map on defeating meningitis by 2030.<sup>5</sup> In the discussions, Board members expressed support for the establishment of a strategic support group to facilitate the implementation of the road map and emphasized the relevance of strengthening the integration of meningitis prevention and management in primary health care.

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<sup>1</sup> Document EB150/10; see also the summary records of the Executive Board at its 150th session, eighth meeting, section 2.

<sup>2</sup> Document EB150/11; see also the summary records of the Executive Board at its 150th session, eighth meeting, section 3, and ninth meeting, section 1.

<sup>3</sup> Sustaining and advancing the Immunization Agenda 2030 during the COVID-19 pandemic: IA2030 global report 2021 (<http://www.immunizationagenda2030.org/global-report>, accessed 14 April 2022).

<sup>4</sup> Document EB150/12; see also the summary records of the Executive Board at its 150th session, eighth meeting, section 3, and ninth meeting, section 1.

<sup>5</sup> Document EB150/13; see also the summary records of the Executive Board at its 150th session, eighth meeting, section 3, and ninth meeting, section 1.

## **PILLAR 2: ONE BILLION MORE PEOPLE BETTER PROTECTED FROM HEALTH EMERGENCIES**

### **16. Public health emergencies: preparedness and response**

#### **16.2 Strengthening WHO preparedness for and response to health emergencies**

The Executive Board at its 150th session noted the reports on strengthening WHO preparedness for and response to health emergencies.<sup>1</sup> It also adopted decision EB150(3).

#### **16.3 WHO's work in health emergencies**

The Executive Board at its 150th session noted the report on WHO's work in health emergencies.<sup>2</sup> In the discussions, Board members drew attention to the importance of strengthening the WHO Health Emergencies Programme and the Contingency Fund for Emergencies, and of boosting sustainable financing for the Programme and WHO's emergency functions more broadly.

### **17. Review of and update on matters considered by the Executive Board**

#### **17.1 Influenza preparedness**

The Executive Board at its 150th session noted the report on influenza preparedness.<sup>3</sup> In the discussions, Board members requested the Secretariat to continue reporting on influenza virus-sharing trends and propose solutions to address any disruptions in virus-sharing, and to provide an assessment of the practical, administrative and financial implications for Member States of the proposed expansion of the WHO Global Influenza Surveillance and Response System.

#### **17.2 Global Health for Peace Initiative**

The Executive Board at its 150th session noted the report on the Global Health for Peace Initiative.<sup>4</sup> It also adopted decision EB150(5).

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<sup>1</sup> Documents EB150/15 and EB150/16; see also the summary records of the Executive Board at its 150th session, fourth meeting, section 4, fifth meeting, and sixth meeting, section 1.

<sup>2</sup> Document EB150/18; see also the summary records of the Executive Board at its 150th session, ninth meeting, section 2.

<sup>3</sup> Document EB150/19; see also the summary records of the Executive Board at its 150th session, ninth meeting, section 2.

<sup>4</sup> Document EB150/20; see also the summary records of the Executive Board at its 150th session, ninth meeting, section 2.

## **PILLAR 3: ONE BILLION MORE PEOPLE ENJOYING BETTER HEALTH AND WELL-BEING**

### **18. Review of and update on matters considered by the Executive Board**

#### **18.1 Maternal, infant and young child nutrition**

The Executive Board at its 150th session noted the report on maternal, infant and young child nutrition.<sup>1</sup> It also adopted decision EB150(7). Additional information on sustaining the elimination of iodine deficiency disorders is provided in a separate document.<sup>2</sup>

#### **18.2 WHO implementation framework for Billion 3**

The Executive Board at its 150th session noted the report on WHO's implementation framework for Billion 3.<sup>3</sup> In the discussions, Board members considered one draft resolution on the outcome of the SIDS Summit for Health: For a healthy and resilient future in small island developing States, and one draft resolution on health promotion and well-being. The Board decided that consultations on both resolutions should continue in the intersessional period.

##### **• WHO global strategy for food safety**

The Executive Board at its 150th session noted the report on the WHO global strategy for food safety.<sup>4</sup> It also adopted decisions EB150(8) and EB150(9).

## **PILLAR 4: MORE EFFECTIVE AND EFFICIENT WHO PROVIDING BETTER SUPPORT TO COUNTRIES**

### **21. Review of and update on matters considered by the Executive Board**

#### **Financial matters**

#### **21.2 Scale of assessments 2022–2023**

The Executive Board at its 150th session noted the report on scale of assessments 2022–2023.<sup>5</sup> It also adopted resolution EB150.R5.

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<sup>1</sup> Document EB150/23; see also the summary records of the Executive Board at its 150th session, tenth meeting, section 4.

<sup>2</sup> Document A75/10 Add.7.

<sup>3</sup> Document EB150/24; see also the summary records of the Executive Board at its 150th session, tenth meeting, section 5, and eleventh meeting, section 1.

<sup>4</sup> Documents EB150/25 and EB150/26; see also the summary records of the Executive Board at its 150th session, tenth meeting, section 5, and eleventh meeting, section 1.

<sup>5</sup> Document EB150/31; see also the summary records of the Executive Board at its 150th session, eleventh meeting, section 2.

## **Governance matters**

### **21.6 Global strategies and plans of action that are scheduled to expire within one year**

- **Global strategy and plan of action on public health, innovation and intellectual property, for the period 2008–2022**

The Executive Board at its 150th session noted the report on the global strategy and plan of action on public health, innovation and intellectual property, for the period 2008–2022.<sup>1</sup> It also adopted decision EB150(11).

## **Staffing matters**

### **21.8 Amendments to the Staff Regulations and Staff Rules**

Having considered the report on amendments to the Staff Regulations and Staff Rules,<sup>2</sup> the Board adopted resolutions EB150.R7, EB150.R8 and EB150.R9.

### **21.9 Report of the International Civil Service Commission**

The Executive Board at its 150th session noted the report on the International Civil Service Commission.<sup>3</sup>

## **ACTION BY THE HEALTH ASSEMBLY**

The Health Assembly is invited to note this report and the reports contained in documents A75/10 Add.1, Add.2, Add.3, Add.4, Add.5, Add.6, Add.7 and Add.8. The Health Assembly is further invited:

- under item 14.1, to adopt the decision recommended by the Executive Board in decision EB150(4) and to consider the following draft decision in relation to the report contained in document A75/10 Add.6:

The Seventy-fifth World Health Assembly, having considered the consolidated report of the Director-General and the corresponding Annex 12,<sup>4</sup>

Decided to request the Director-General to report on the progress made towards the achievement of global obesity targets, as part of reporting requirements under the acceleration plan, on a biannual basis until 2030.

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<sup>1</sup> Document EB150/36; see also the summary records of the Executive Board at its 150th session, eleventh meeting, section 2.

<sup>2</sup> Document EB150/46 Rev.1; see also the summary records of the Executive Board at its 150th session, twelfth meeting, section 2.

<sup>3</sup> Document EB150/47; see also the summary records of the Executive Board at its 150th session, twelfth meeting, section 2.

<sup>4</sup> Documents A75/10 and A75/10 Add.6.

- under item 14.2, following further informal consultations, to adopt the resolution recommended by the Executive Board in resolution EB150.R3;
- under item 14.6, to provide guidance on the way forward in developing a global infection prevention and control strategy;
- under item 17.2, to adopt the decision recommended by the Executive Board in decision EB150(5);
- under item 18.1, to adopt the decision recommended by the Executive Board in decision EB150(7);
- under item 18.2, first bullet, to adopt the decisions recommended by the Executive Board in decisions EB150(8) and EB150(9);
- under item 21.2, to adopt the resolution recommended by the Executive Board in resolution EB150.R5;
- under item 21.6, first bullet, to adopt the resolution recommended by the Executive Board in decision EB150(11);
- under item 21.8, to adopt the resolution recommended by the Executive Board in resolution EB150.R8.

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# **Road map for neglected tropical diseases 2021–2030**

## **Report by the Director-General**

1. In 2020 the Seventy-third World Health Assembly issued decision WHA73(33), in which it endorsed the new road map for neglected tropical diseases 2021–2030 and requested the Director-General, inter alia, to report biennially to the Health Assembly, through the Executive Board, on the implementation of the road map. This report is submitted in response to that decision.

### **CONTEXT**

2. The coronavirus disease (COVID-19) pandemic has disrupted planning and ongoing activities for neglected tropical diseases globally, regionally and nationally. Progress in implementing the road map must therefore be considered in this context.

3. As the results of most of the indicators for 2021 – the first year of the new road map – will be available only in 2022, this report includes their status as of 2020 or the latest year for which data are available. These data may be considered as the baseline for the new road map and the outcomes of the first road map 2012–2020.

4. The sections below summarize progress in implementing the three pillars of the road map.

### **PROGRESS IN IMPLEMENTING THE ROAD MAP FOR NEGLECTED TROPICAL DISEASES 2021–2030**

#### **Pillar 1. Accelerate programmatic action**

##### **Indicators for the overarching global targets for 2030**

5. The indicator used to track the percentage reduction in people requiring interventions against neglected tropical diseases is also indicator 3.3.5 of the Sustainable Development Goals (number of people requiring interventions against neglected tropical diseases). In 2019, 1.74 billion people required interventions. The highest proportion was in the South-East Asia Region (53%), followed by the African (34%), Eastern Mediterranean (5%), Western Pacific (4%), Americas (3%) and European (1%) regions. This was almost 20% less than the 2.19 billion people requiring interventions in 2010, and about 12 million people fewer than reported in 2018.<sup>1</sup>

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<sup>1</sup> Global health observatory. Reported number of people requiring interventions against NTDs. Available at <https://www.who.int/data/gho/data/indicators/indicator-details/GHO/reported-number-of-people-requiring-interventions-against-ntds>, accessed 8 November 2021.

6. Estimates of disability-adjusted life years are available for 14<sup>1</sup> of the 20 diseases. In 2019, the last year for which estimates are available,<sup>2</sup> the disability-adjusted life years related to neglected tropical diseases were 14.5 million, down from 16.3 million in 2015, and decreased in all regions.

7. By 2020, 42 countries had eliminated at least one neglected tropical disease. In 2021, Gambia became the 43rd country, by being validated as having eliminated trachoma as a public health problem.<sup>3</sup>

8. In 2020, 732 million people were treated for at least one neglected tropical disease requiring preventive chemotherapy, across 62 countries, achieving global coverage of 42%, down from 66% in 2019, across 81 countries, with a total of 1.1 billion treated. These reductions were among the effects of disruptions to services resulting from the COVID-19 pandemic.

## **Impact on disease-specific targets**

### *Diseases targeted for eradication*

9. In 2020, six countries reported a total of 27 human cases of dracunculiasis and 1600 infections in animals (mainly among dogs), a reduction of 50% and 20% respectively from 2019. From January to August 2021, eight human cases were reported, a 67% reduction from the comparable period in 2020, and a 57% reduction was reported in the number of infected animals. Five endemic countries (Angola, Chad, Ethiopia, Mali and South Sudan) and two countries that are no longer reporting cases (Democratic Republic of the Congo and Sudan) remain to be certified. Donated azithromycin facilitated mass drug administration for yaws and active surveillance in some endemic countries in the African and Western Pacific regions; laboratory networks are being set up to monitor any potential drug resistance. India remains the only country certified as having interrupted transmission.

### *Diseases targeted for elimination (interruption of transmission)*

10. In 2020, 565 cases of gambiense human African trypanosomiasis were reported, a 98% reduction since 2000. Reports on leprosy were received from 133 countries, of which 31 reported zero cases. Globally, 127 572 new cases were reported; 8626 (7%) were in children. By 2020, the number of new cases had decreased by 10%, as had the numbers of affected children and patients with new disabilities. Four countries in the Region of the Americas were verified as having interrupted transmission of onchocerciasis. Treatment continues in endemic countries in all affected regions.

### *Diseases targeted for elimination as a public health problem*

11. Progress against Chagas disease included global advocacy through the inaugural World Chagas Disease Day held on 14 April 2020. A global virtual event<sup>4</sup> focused on health promotion, public

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<sup>1</sup> African trypanosomiasis, Chagas disease, cysticercosis, dengue, echinococcosis, food-borne trematodes, leishmaniasis, leprosy, lymphatic filariasis, onchocerciasis, rabies, schistosomiasis, soil-transmitted helminthiasis (ascariasis, trichuriasis and hookworm disease) and trachoma.

<sup>2</sup> Global health observatory. Global health estimates 2019: Leading causes of DALYs. Available at <https://www.who.int/data/gho/data/themes/mortality-and-global-health-estimates/global-health-estimates-leading-causes-of-dalys>, accessed 8 November 2021.

<sup>3</sup> WHO Alliance for the Global Elimination of Trachoma by 2020: progress report on elimination of trachoma, 2020. Wkly Epidemiol Rec. 2021;96(31):353–64.

<sup>4</sup> World Chagas Disease Day. 14 April 2021 (<https://www.who.int/campaigns/world-chagas-disease-day/2021>, accessed 18 November 2021).

information and education, advocacy for action and the need to address discrimination and stigma associated with the disease. Held in the early months of the pandemic, the online event brought together countries, regional offices, donors, partners, patients and patient organizations, and health care providers. It was widely reported in the press, with high uptake on social media platforms. A five-year programme to eliminate congenital Chagas disease was endorsed by member countries of the Organization of Ibero-American States. Interruption and control of domiciliary vector transmission and universal screening for Chagas disease in blood donors was maintained in the Region of the Americas.

12. Despite an outbreak of rhodesiense human African trypanosomiasis in 2019–2020 resulting in 214 cases, the trend in the number of cases from 2000 to 2020 shows a decrease of 84%. In 2020, the number of reported cases of visceral leishmaniasis fell to 12 739, the lowest number since 1998. In the South-East Asia Region, 98% of implementation units achieved the epidemiological threshold of elimination as a public health problem. By 2020, cumulative reductions of 74% in lymphatic filariasis infections and 49% in the population requiring mass treatment had been achieved. Seventeen countries or territories<sup>1</sup> have been validated for eliminating this disease as a public health problem. Deworming against soil-transmitted helminthiasis continued at a reduced pace because of COVID-19-related closures of schools and vaccination services. Since 2020, one additional country (Gambia) has been validated as having eliminated trachoma as a public health problem, bringing the total to 11 countries validated as having eliminated this disease. The estimated global total number of people with trachomatous trichiasis was 1.8 million on 21 June 2021, down from 2.0 million cases on 1 May 2020.

#### *Diseases targeted for control*

13. Nine diseases or groups of diseases<sup>2</sup> are targeted for control. Progress has been made in different areas, including support to pilot interventions for echinococcosis, foodborne trematodiasis and taeniasis/cysticercosis in selected countries; supply of medicines for case management of cutaneous leishmaniasis, especially in crisis-affected countries in the Eastern Mediterranean Region; and follow-up with partners and donors on the evaluation of a new medicine for mycetoma (fosravuconazole) and on the improvement of access to existing treatment for chromoblastomycosis and scabies. With regard to snakebite envenoming, the Snakebite Information and Data Platform<sup>3</sup> was launched in September 2021 and includes information on the world's venomous snake species and their distribution, as well as an up-to-date database on antivenoms and their manufacturers.

14. Efforts are also being made to address the growing challenge of Aedes-borne arboviral diseases, including review of country-level activities and build-up of preparedness and response for dengue, given that in 2019 many countries were affected by this disease. WHO is working on a Global Arbovirus Initiative, focusing initially on Aedes-borne arboviral diseases, which will strengthen the coordination, communication, capacity-building, research, preparedness and response necessary to mitigate the growing risk of epidemics due to arboviral diseases.

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<sup>1</sup> Malawi and Togo (African Region); Maldives, Sri Lanka and Thailand (South-East Asia Region); Egypt and Yemen (Eastern Mediterranean Region); Cambodia, Cook Islands, Kiribati, Marshall Islands, Niue, Palau, Tonga, Vanuatu, Viet Nam, and Wallis and Futuna (Western Pacific Region).

<sup>2</sup> Buruli ulcer; dengue; echinococcosis; foodborne trematodiasis; leishmaniasis (cutaneous); mycetoma, chromoblastomycosis and other deep mycoses; scabies and other ectoparasitoses; snakebite envenoming; and taeniasis and cysticercosis.

<sup>3</sup> Available at <https://www.who.int/teams/control-of-neglected-tropical-diseases/snakebite-envenoming/snakebite-information-and-data-platform>, accessed 18 November 2021.

## Challenges and the way forward

15. Interventions and activities were significantly disrupted due to the COVID-19 pandemic across the entire spectrum of essential health services. According to a recent survey,<sup>1</sup> as of early 2021, services for neglected tropical diseases were the second most frequently disrupted (44% of countries; 48/109), after those targeting mental, neurological and substance use disorders. Some 60% of countries reported disruption to preventive chemotherapy. The main public health consequences of these disruptions are delays in achieving the global, regional and national public health goals set for relevant diseases.

16. Delays in manufacture, supply chain issues, shipment and delivery of medicines and consumables to and within target countries exacerbated challenges in ensuring the availability and timely utilization of medicines. Medicines with a short shelf life, such as praziquantel, are especially vulnerable to expiration as a result of disrupted delivery channels.

17. The following measures were taken to mitigate the impact of the COVID-19 pandemic on services for neglected tropical diseases:

(a) Technical guidance was developed for national health authorities and implementers on adapting activities to enable their safe implementation in the context of the pandemic. Global guidance was further adapted by WHO regional offices and implementation partners as tools and other resources;

(b) Guidance documents were issued on the safe adaptation of both community-based<sup>2</sup> and health facility-based services for neglected tropical diseases,<sup>3</sup> as well as on the resumption of community-based activities relying on a risk-based approach;<sup>4</sup>

(c) An online training course dedicated to neglected tropical diseases in the context of the pandemic<sup>5</sup> was made available on the OpenWHO platform in Arabic, English, French, Spanish and Portuguese; updated guidance was also issued on the use of masks in community outreach activities;<sup>6</sup>

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<sup>1</sup> Second round of the national pulse survey on continuity of essential health services during the COVID-19 pandemic, January–March 2021: interim report, 22 April 2021. Geneva: World Health Organization, 2021 (<https://apps.who.int/iris/handle/10665/340937>, accessed 8 November 2021).

<sup>2</sup> Community-based health care, including outreach and campaigns, in the context of the COVID-19 pandemic: interim guidance, May 2020. Geneva: World Health Organization; 2020 (<https://apps.who.int/iris/handle/10665/331975>, accessed 8 November 2021).

<sup>3</sup> Maintaining essential health services: operational guidance for the COVID-19 context, interim guidance 1 June 2020. Geneva: World Health Organization; 2020 (<https://apps.who.int/iris/handle/10665/332240>, accessed 8 November 2021).

<sup>4</sup> Considerations for implementing mass treatment, active case-finding and population-based surveys for neglected tropical diseases in the context of the COVID-19 pandemic: interim guidance, 27 July 2020. Geneva: World Health Organization; 2020 (<https://apps.who.int/iris/handle/10665/333499>, accessed 8 November 2021).

<sup>5</sup> Available at <https://openwho.org/courses/covid-19-ntd-en> (accessed 8 November 2021).

<sup>6</sup> Aide memoire: use of medical and non-medical/fabric masks for community outreach activities during the COVID-19 pandemic, based on current WHO guidance, 31 May 2021. Geneva: World Health Organization; 2020 (<https://apps.who.int/iris/handle/10665/341570>, accessed 8 November 2021).

(d) Review of requests and re-scheduling of plans prevented loss of medicines with short shelf-lives from expiring; production, shipment, delivery and distribution of medicines and other medical consumables was closely followed up with all relevant actors;

(e) In collaboration with academic institutions, mathematical modelling exercises were conducted to assess the impact of disruptions on timelines for achieving public health targets for selected diseases, and the benefits of remedial strategies.<sup>1</sup>

## **Pillar 2. Intensify cross-cutting approaches**

18. Work at global and national levels is helping to better position services for neglected tropical diseases within health systems and primary health care. Interventions against neglected tropical diseases are included in the compendium of universal health care. Linkages with other health services are being promoted where diseases overlap in distribution and potentially impact one another.

19. To effectively tackle the burden of neglected tropical diseases of the skin, a framework was published to guide relevant national programmes in integrating their management at primary health care level. In addition, WHO developed a smartphone App aimed at assisting health workers in the identification of skin conditions through a visual inspection of the lesions and the assessment of their associated signs and symptoms.<sup>2</sup>

20. There are strong epidemiological associations between inadequate access to water, sanitation and hygiene and a wide range of conditions, including several neglected tropical diseases. Nevertheless, 1.6 billion people still lack access to safe drinking-water at home, 2.8 billion do not have access to safe sanitation and 1.9 billion lack basic domestic hand-washing facilities.<sup>3</sup>

21. The strategic objectives of the updated global strategy on water, sanitation and hygiene<sup>4</sup> are to increase awareness of the co-benefits of joint action and engagement; use data on water, sanitation and hygiene in neglected tropical disease programmes, and vice versa to guide informed decision-making; strengthen evidence and establish best practice on integrated approaches; and jointly plan, deliver and evaluate programmes.

22. Most neglected tropical diseases occur at the human–animal interface. Implementing One Health approaches to prevent and manage these diseases generates momentum for substantial long-term gains. Attending to diseases strengthens health systems and builds baseline data to better manage both the endemic diseases with a human–animal interface and the emerging infectious diseases and pandemic threats. Activities focus on multisectoral approaches and practices to drive policy, behaviour change and

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<sup>1</sup> Impact of the COVID-19 pandemic on seven neglected tropical diseases: a model-based analysis. Geneva: World Health Organization; 2021 (<https://apps.who.int/iris/handle/10665/343993>, accessed 8 November 2021).

<sup>2</sup> Available for Android at [https://play.google.com/store/apps/details?id=com.universaldocor.skin\\_ntds&hl=en&gl=US](https://play.google.com/store/apps/details?id=com.universaldocor.skin_ntds&hl=en&gl=US), and for iOS at <https://apps.apple.com/us/app/skin-ntds-app/id1499080526>.

<sup>3</sup> Progress on household drinking water, sanitation and hygiene 2000–2020: five years into the SDGs. Geneva: World Health Organization; 2021 (<https://apps.who.int/iris/handle/10665/345081>, accessed 8 November 2021).

<sup>4</sup> Ending the neglect to attain the Sustainable Development Goals. A Global strategy on water, sanitation and hygiene to combat neglected tropical diseases 2021–2030. Geneva: World Health Organization; 2021 (<https://www.who.int/publications/i/item/9789240022782>, accessed 8 November 2021).

surveillance, and build capacities to prevent and control priority health risks that occur at the human-animal interface, with the involvement of all sectors and partners nationally and locally.

23. Many neglected tropical diseases are vector-borne and benefit from the Global Vector Control Response 2017–2030, welcomed by the Seventieth World Health Assembly in resolution WHA70.16 (2017). A Joint Action Group is coordinating the implementation of this strategy at regional and country levels. An online platform for monitoring progress was established in 2020. All regions developed a related policy, strategy or recommendations. Country-level support was provided. A global survey indicated that the response is on track for some priority activities, for example vector control strategic plans, but milestones were not reached for other activities such as vector-control needs assessments. Impact indicators showed a 9.7% reduction in global mortality. Overall, progress in implementation remained modest due to funding shortfalls and insufficient human resources at all levels.

### **Pillar 3. Change operating models and culture to facilitate country ownership**

24. A framework to guide countries in developing sustainable plans for the control and elimination of neglected tropical diseases was published. WHO's regional and country offices, in close collaboration with health ministries and partners, provided technical support to frame sustainable annual and multi-year programmes. Partnership and donor engagement remain crucial. Medicine donations and financial agreements were renewed with pharmaceutical companies and other partners.

### **Other actions taken in support of the road map**

25. The road map was disseminated in all six official languages, in print, online and as a smartphone App;<sup>1</sup> and three companion documents were published to provide further guidance on the strategic shifts advocated in the road map.

26. Global online webinars were organized by WHO to advocate for the continued and safe implementation of activities on neglected tropical diseases in the context of the COVID-19 pandemic. These webinars started in 2020 and continued in 2021 with a stronger focus on the road map, supported by relevant news releases, infographics and audio-visual products. Virtual meetings of national programme managers and partners organized by regional offices provided further exposure to the road map and its operating principles.

27. New online courses aimed at strengthening capacities and facilitating implementation of the road map at global and country levels are currently being developed. A channel dedicated to neglected tropical diseases was launched on the Open WHO platform,<sup>2</sup> with courses on mycetoma, podoconiosis, rabies/One Health, scabies and tungiasis, in addition to the above-mentioned course on neglected tropical diseases and COVID-19.

28. **Overcoming the diagnostics gaps.** The Diagnostic Technical Advisory Group on neglected tropical diseases is addressing the existing critical gaps in diagnostics. Target product profiles were published for prioritized use cases for human African trypanosomiasis (rhodesiense) lymphatic filariasis, onchocerciasis, soil-transmitted helminthiasis and are in development for human African trypanosomiasis (gambiense) and neglected tropical diseases of the skin. Regulatory and manufacturing pathways to facilitate prequalification and regulatory approval of in-vitro diagnostics are being explored.

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<sup>1</sup> Available for iOS at <https://apps.apple.com/us/app/ntd-road-map-2021-2030/id1549823959>, and for Android at <https://play.google.com/store/apps/details?id=org.who.NTDROADMAP>.

<sup>2</sup> Available at <https://openwho.org/channels/ntd> (accessed 8 November 2021).

A group of donors and partners has been engaged to advocate for the required investment to translate the target product profiles into diagnostic products and to address the access issues.

29. **Monitoring and evaluation.** The monitoring, evaluation and research working group, under the aegis of the Strategic Technical and Advisory Group for Neglected Tropical Diseases, endorsed a framework to support implementation of the road map in the context of national routine health information systems.

30. **Ensuring access and logistics for medicines and health products.** Quality-assured medicines and health products remain the cornerstone of successful interventions against neglected tropical diseases.

31. Three formulations of albendazole, praziquantel and ivermectin were prequalified in 2021, bringing to nine the total number of medicinal products for treatment of neglected tropical diseases in the WHO prequalified list.

32. Technical advice and guidance were provided to manufacturers, product development partnerships and academic institutions on prequalification requirements and access strategy through the collaborative procedure for accelerated registration of WHO-prequalified finished pharmaceutical products.

33. Donated medicines and health products have strengthened support to neglected tropical disease programmes in affected countries. During 2020–2021, over 4.7 billion medicines and health products were made available to 112 Member States free of charge.

## **ACTION BY THE EXECUTIVE BOARD**

34. The Board is invited to note the report; in its discussions it is further invited to provide guidance on sustaining implementation of the road map and ensuring that interventions against neglected tropical diseases are considered as part of essential health services in the context of the COVID-19 pandemic.

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# **Immunization Agenda 2030**

## **Report by the Director-General**

1. The Seventy-third World Health Assembly, having adopted the written silence procedure through decision WHA73(7) (2020), decided *inter alia*:<sup>1</sup> (1) to endorse the new global vision and overarching strategy for vaccines and immunization: Immunization Agenda 2030; (2) to request the Director-General to continue to monitor progress and to report biennially as a substantive agenda item to the Health Assembly, through the Executive Board, on the achievements made in advancing towards the global goals of the Immunization Agenda 2030, starting with the Seventy-fifth World Health Assembly.

2. The draft global report on the Immunization Agenda 2030 for 2021, summarized here, compiles the baseline data that will be used to track progress in immunization up to 2030, reports progress towards the Immunization Agenda 2030 goals set in 2020, and details the implementation status of the Immunization Agenda 2030 at country, regional and global levels.

### **PROGRESS TOWARDS THE IMMUNIZATION AGENDA 2030 GOALS**

3. The Immunization Agenda 2030 includes seven indicators that track progress towards its three impact goals:

- (a) reduce mortality and morbidity from vaccine-preventable diseases for everyone throughout the life course;
- (b) leave no one behind, by increasing equitable access and use of new and existing vaccines; and
- (c) ensure good health and well-being for everyone by strengthening immunization within primary health care and contributing to universal health coverage and sustainable development.

4. In 2020, compared to the 2019 baseline data, disruption caused by the coronavirus disease (COVID-19) pandemic led to regression in many immunization indicators (Annex 1). COVID-19 caused significant supply-side disruption, including staff shortages due to ill-health or redeployment, interruption of service delivery and disruption of supply chains, and had demand-side consequences, with reduced take-up of health services.

5. Key consequences included a decline in vaccination coverage for most vaccines, with global coverage of DTP3 (diphtheria, tetanus and pertussis-containing vaccine, third dose) falling from 86% in

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<sup>1</sup> Decision WHA73(9) (2020).



2019 to 83% in 2020. The number of zero-dose children (not receiving any DTP doses) rose by 3.5 million, from 13.6 million in 2019 to 17.1 million in 2020, the first increase in a decade.

6. **Impact goal 1.1: Future deaths averted.** Modelling indicates that an estimated 51 million future deaths in total will be averted by vaccination between 2021 and 2030, if coverage targets are met. The decline in vaccination coverage seen in 2020 raises serious questions about the achievability of this target, unless major catch-up vaccination efforts are put in place.

7. **Impact goal 1.2: Number of countries achieving regional or global control, elimination and eradication targets:**

(a) In 2020, Nigeria was certified polio-free after three years without detection of wild poliovirus, leading to certification of the entire African continent by the Africa Regional Certification Commission for Polio Eradication. This was a major achievement in the fight for a world free of polio. However, wild poliovirus remains endemic in Afghanistan and Pakistan;

(b) The number of countries having achieved measles elimination reached 81 in 2019 (full data for 2020 are not yet available). However, during 2016–2020, transmission was re-established in 10 countries that had previously achieved elimination. Furthermore, compared to 2019, an additional three million children did not receive any measles-containing vaccine (MCV), leaving 22.3 million children unprotected. A further 18.2 million children received only one dose of MCV and remain at risk of measles;

(c) Two additional countries achieved elimination of rubella in 2020. All countries achieving rubella elimination have sustained it.

8. **Impact goal 1.3: Number of large or disruptive vaccine-preventable disease outbreaks.** The number of circulating vaccine-derived poliovirus (cVDPV) outbreaks increased from 22 in 2019 to 33 in 2020. Measles outbreaks fell substantially, from 76 in 2019 to 26 in 2020. This could reflect several factors, including COVID-19 public health and social measures, disrupted surveillance, and protection of children affected by measles outbreaks in preceding years. The numbers of outbreaks of other vaccine-preventable diseases remained mostly stable.

9. **Impact goal 2.1: Numbers of zero-dose children.** The numbers of zero-dose children increased from 13.6 million in 2019 to 17.1 million in 2020. Such a large backwards step has not been seen for more than a decade.

10. **Impact goal 2.2: Introduction of new or under-utilized vaccines in low- and middle-income countries.** Only 22 vaccine introductions into the national immunization schedules of low- and middle-income countries were reported in 2020, the lowest number of annual introductions in the past decade. This decrease probably reflects pandemic pressures on health systems, limited capacity to mobilize funding, and de-prioritization of expansion of services.

11. **Impact goal 3.1: Vaccination coverage across the life course.** Coverage for three of the four indicators used to assess vaccination coverage at different life stages<sup>1</sup> declined globally between 2019 and 2020: DTP3 from 86% to 83%, MCV2 from 71% to 70%, and HPV from 15% to 13%. PCV3 coverage increased marginally from 48% to 49%. New PCV3, MCV2 and HPV introductions added to

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<sup>1</sup> DTP3 (year 1), MCV2 (year 2), third dose of pneumococcal conjugate vaccine (PCV3, childhood), and the complete course of human papillomavirus vaccine (HPVc, adolescence).

global coverage, offsetting drops in coverage in other countries. Despite new introductions in 2020, global HPV vaccine coverage decreased for the first time in 2020, leaving an estimated additional 1.5 million girls unprotected against cervical cancer.

12. **Impact goal 3.2: Universal health coverage service coverage index.** This indicator tracks immunization's contribution to enhancing primary health care and universal health coverage. Data are not yet available for 2020. However, the 2020 Goalkeepers Report assessed global progress using an alternative index of tracer interventions and found substantial regression in the coverage of essential health services in 2020 due to COVID-19.

13. **Strategic priority indicators:** The 15 global strategic priority objectives indicators track performance at country, regional and global levels, to identify potential root causes of success and failure and possible actions for improvement. No global targets have been set, due to wide country and regional variations.

14. As many indicators are new, some 2020 data are not available. Annex 2 shows baseline and 2020 data where they are available.

15. Data on vaccination coverage in 2020 across the life course showed limited or no improvement. Average coverage for vaccines targeting 11 diseases across multiple age ranges stood at 69%, compared with 70% in 2019.

16. At subnational levels, coverage in the 20% of worst-performing districts fell for DTP3 (74% to 71%), MCV1 (72% to 69%) and MCV2 (65% to 60%). These falls were greater than those seen for global coverage, suggesting that poor-performing districts fell further behind in 2020, increasing inequities in vaccination coverage.

17. Overall, immunization took a step backwards in 2020. Despite the tireless efforts of countless immunization programme staff working to ensure the availability of vaccination services, vaccination coverage globally fell for the first time in a decade. Catch-up of lost ground and regenerating the momentum towards universal vaccination coverage are therefore critical priorities for the years ahead.

## IMPLEMENTATION OF THE IMMUNIZATION AGENDA 2030

18. At the Seventy-fourth World Health Assembly in May 2021, Member States expressed overwhelming support for the implementation of the Immunization Agenda 2030 through the Framework for Action.<sup>1,2</sup> The Framework for Action detailed how coordinated operational planning, monitoring and evaluation, ownership and accountability, and communications and advocacy are key drivers for implementation and impact on the ground. It emphasizes the particular role of regions and countries.

19. Regions have finalized, or are developing, **regional strategies** aligned with the Immunization Agenda 2030. Following consultations with regional immunization technical advisory groups, either regional Immunization Agenda 2030 strategies or frameworks to develop regional strategies for Africa,

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<sup>1</sup> See the summary records of the Seventy-fourth World Health Assembly, Committee A, seventh meeting, (section 2) and ninth meeting.

<sup>2</sup> Implementing the Immunization Agenda 2030: A Framework for Action through Coordinated Planning, Monitoring & Evaluation, Ownership & Accountability, and Communications & Advocacy (<http://www.immunizationagenda2030.org/framework-for-action>).

the Americas, Europe, South-East Asia and the Western Pacific regions have been approved by WHO regional committees.

20. Regions are also developing **implementation plans**, generally up to 2025. Regions are continuing the Immunization Agenda 2030's collaborative approach through co-creation with countries and partners. For example, the African, South-East Asia, European and Western Pacific regions conducted regional surveys and/or convened discussions with countries to establish priorities.

21. Regional implementation plans are typically focusing on the twin aims of COVID-19 vaccine introduction and recovery and scale-up of immunization activities to recover lost ground and to “build back better”.

22. To support countries in strategy development and ensure alignment with the Immunization Agenda 2030, WHO and partners have developed a new strategic framework within the **national immunization strategy** initiative. Four countries piloted national immunization strategy development using the new guidelines in 2020–2021.

23. Thirteen **working groups** are taking forward technical work across the seven Immunization Agenda 2030 strategic priorities. Others are focusing on areas such as monitoring and evaluation, and communications and advocacy (Annex 3).

24. Working groups will undertake “consultative engagement” with regional partners and country implementers, to explore local challenges and innovative new practices. They will provide an annual commentary on data relating to their specialist areas and make recommendations to countries, partners and others.

25. The outputs of working groups will be a critical technical resource for regions, countries and partners. They will provide much of the “fuel” to help drive change at the country level.

26. The **Immunization Agenda 2030 Partnership Council** convened for an inaugural session on 22 September 2021. It will meet twice a year and sign off on the Immunization Agenda 2030 reporting to the World Health Assembly biannually, starting in 2022. It is composed of 10 to 12 senior leaders, including representatives of countries, regions and civil society.

27. The day-to-day management of the Immunization Agenda 2030 is the responsibility of the **Immunization Agenda 2030 Coordination Group**, which has met monthly since May 2021, supported by a small virtual Immunization Agenda 2030 secretariat. The coordination group has nine director-level members from partner organizations and is co-chaired by WHO and UNICEF.

28. Annex 4 provides an overview of key implementing bodies involved in Immunization Agenda 2030. The Agenda's global-level partnership is described in detail in Annex 2 to the Framework for Action.

29. The Immunization Agenda 2030 was formally launched during World Immunization Week 2021. Launch activities engaged many partners and leveraged multiple platforms, communicating the Agenda's vision and objectives to global audiences.

30. The Seventy-fourth World Health Assembly in May 2021 presented an opportunity for governments to publicly commit to the Immunization Agenda 2030, galvanizing other countries to follow suit. A historic cross-regional statement was made on behalf of the six WHO regions and

50 countries, reiterating the Agenda's targets and key messages and calling on world leaders to make explicit and sustainable commitments to the Agenda.

31. A virtual Immunization Agenda 2030 United Nations General Assembly event was organized in September 2021 and further communications and advocacy activities are planned to sustain this momentum.

32. As the Immunization Agenda 2030 structures are still being put in place, 2021 is a transitional year for reporting of immunization data. Future Immunization Agenda 2030 reporting will be novel in several ways.

(a) Regions and countries will tailor their monitoring and evaluation frameworks to their specific needs, and only a minimum of impact and strategic priority indicators will be followed at global level.

(b) Indicator reporting at the global level will be led by the Immunization Agenda 2030 working groups and will include comprehensive data analysis and recommendations for action.

(c) Monitoring, evaluation and action cycles will be defined to link reporting to ownership and accountability, and to communications and advocacy, to drive actions by all stakeholders.

(d) Feedback loops will be established to monitor follow-up of recommendations made by groups such as the Strategic Advisory Group of Experts on Immunization (SAGE) and regional immunization technical advisory groups.

33. SAGE will be provided with an annual Immunization Agenda 2030 technical progress report and updates from WHO regional offices. It will provide feedback to the working groups, regions and countries, the Immunization Agenda 2030 Coordination Group, and the Immunization Agenda 2030 Partnership Council.

## **CONCLUSIONS AND NEXT STEPS**

34. Following a decade of only limited progress, the COVID-19 pandemic has had a highly damaging impact on immunization. Millions more young children are now at risk of life-threatening infectious diseases.

35. With the world in emergency mode, immunization staff working at all levels nationally, regionally and globally have been diverted to COVID-19 responses. It is time to establish more sustainable COVID-19 responses while restoring financial and human resources to essential immunization services, including surveillance at every level.

36. To achieve the Immunization Agenda 2030 vision and goals, the global community needs to act urgently to enable countries to halt and reverse the declines in coverage seen in 2020 and to re-energize progress towards Immunization Agenda 2030 targets.

37. Partners working at country, regional and global levels need to work collaboratively to enable countries to:

- (a) perform country-by-country analyses of current strengths and weaknesses and the areas most affected by COVID-19-related disruption. Such analyses will indicate gaps and needs in each country and priority areas for action;
- (b) plan tailored actions at country, regional and global levels to respond to the underlying reasons for underperformance in each country. These should include targeted campaigns to reduce the immediate risk of outbreaks; and
- (c) use the momentum generated by political and societal interest in COVID-19 vaccines to build public and political support for the strengthening of immunization programmes. This will require strong advocacy at global, regional and country levels to prioritize immunization services across all relevant organizations.

38. The near term will inevitably be dominated by a continuing focus on COVID-19 vaccine roll-outs. Nevertheless, it is vital that these activities are also used to increase capacity, strengthen vaccine delivery infrastructure, improve data systems and enhance disease surveillance. This will help revitalize the fight against all vaccine-preventable diseases and lay the foundation for further progress over the next decade.

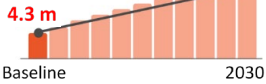
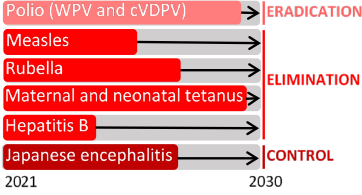
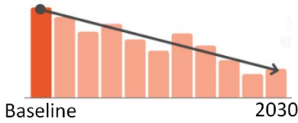


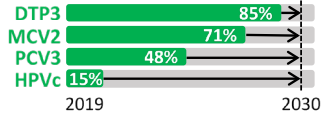

## **ACTION BY THE EXECUTIVE BOARD**

39. The Board is invited to note the report; in its discussions it is further invited to provide guidance on:

- accelerating development and implementation by Member States of national immunization strategies; and
- strengthening collaboration between Member States and partners to implement global, regional and national strategies in order to mitigate lost momentum in immunization due to the COVID-19 pandemic and renew progress towards the impact goals of the Immunization Agenda 2030;

## ANNEX 1:

# IMMUNIZATION AGENDA 2030 IMPACT GOAL INDICATORS AND TARGET, BASELINE AND 2020 DATA\*

		Baseline (year)	2020
<b>1.1</b> Number of future deaths averted by immunization	50 million future deaths averted by immunization in 2021–2030 	4.3 million (2019)	N/A Midpoint review expected in 2025
<b>1.2</b> Number and % of countries achieving endorsed regional or global vaccine-preventable disease control, elimination and eradication targets	All countries achieve endorsed targets 	Baseline data for 2021 will be reported in 2022 Provisional 2019 data for a subset of vaccine-preventable diseases: WPV 191 (98.5%) cVDPV pending Measles 81 (55.1%) Rubella 88 (69.8%) MNT pending Hepatitis B pending JE pending	Provisional 2020 data for a subset of vaccine-preventable diseases: WPV 192 (99.0%) cVDPV pending Measles 80 (54.4%) Rubella 90 (71.4%) MNT pending Hepatitis B pending JE pending
<b>1.3</b> Number of large or disruptive vaccine-preventable disease outbreaks	Declining trend in the annual number of large or disruptive vaccine-preventable disease outbreaks 	Cholera 1 Ebola virus 1 Measles 51 Meningococcus 2 cVDPV 21 WPV 2 Yellow fever 4 (average annual number of outbreaks over 2018–2020)	Cholera 1 Ebola virus 1 Measles 26 Meningococcus 0 cVDPV 33 WPV 2 Yellow fever 5
<b>2.1</b> Number of zero-dose children	50% reduction in number of zero-dose children 	13.6 million (2019)	17.1 million
<b>2.2</b> Introductions of new or under-utilized vaccines in low- and middle-income countries	500 vaccine introductions by end of 2030 	A baseline is not applicable for this indicator, which will count the cumulative number of vaccine introductions between 2021 and 2030 (An average of 54 annual introductions were reported during 2011–2020)	22 introductions**
<b>3.1</b> Vaccination coverage across the life course	90% coverage of full course for selected vaccines 	DTP3 86% MCV2 71% PCV3 48% HPVc 15% (2019)	DTP3 83% MCV2 70% PCV3 49% HPVc 13%
<b>3.2</b> Universal health coverage service coverage index	Universal health coverage increase in all countries, regions, and globally 	Global 64.0 Africa 47.0 Americas 73.0 Eastern Med 61.6 Europe 75.5 South-East Asia 60.2 Western Pacific 65.4 (2017, pending 2019 data)	N/A

\*Full details of each indicator can be found in Annex 1 of the Immunization Agenda 2030 Framework for Action.

\*\*In addition, seven low- and middle-income countries began to use COVID-19 vaccines in 2020.

**Key:** WPV: wild poliovirus; cVDPV: circulating vaccine-derived poliovirus; MNT: maternal and neonatal tetanus; JE: Japanese encephalitis; DTP3: diphtheria, tetanus and pertussis-containing vaccine, third dose; MCV2: measles containing vaccine, second dose; PCV: pneumococcal conjugate vaccine; HPVc: human papillomavirus vaccine, complete series

## ANNEX 2

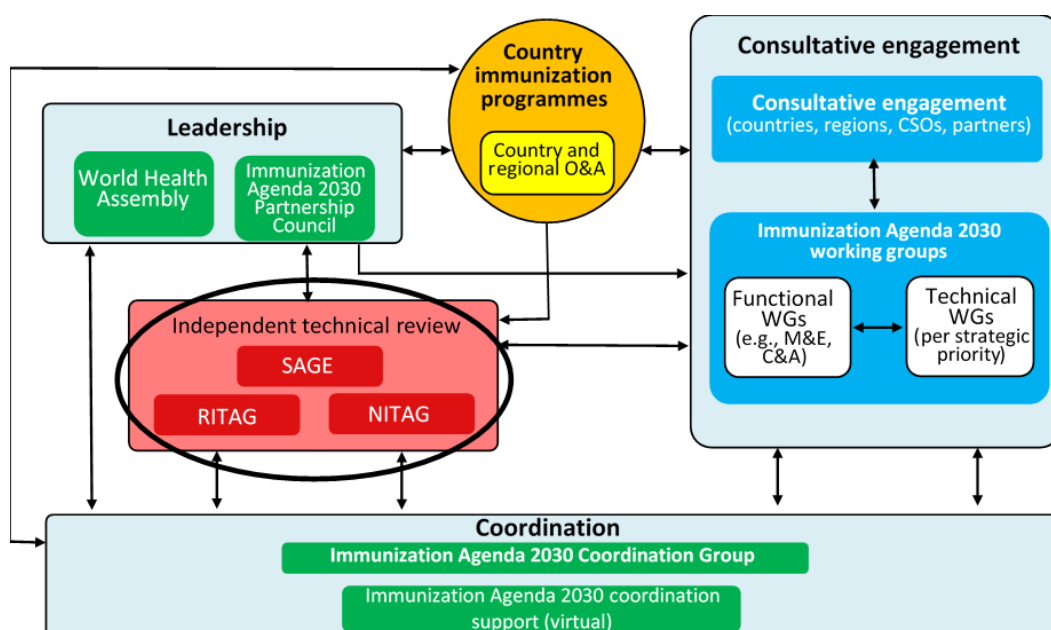
# IMMUNIZATION AGENDA 2030 STRATEGIC PRIORITY (SP) INDICATORS – BASELINE AND 2020 DATA

Indicator (data source)	Baseline (year)	2020
SP 1.1: Proportion of countries with evidence of adopted mechanism for monitoring, evaluation and action at national and subnational levels (WHO/UNICEF electronic Joint Reporting Form (eJRF) – pilot testing of questions in 2021)	Data expected to be available in June 2022 (2021)	Next reporting year is 2022
SP 1.2: Density of physicians, nurses and midwives per 10,000 population (WHO National Health Workforce Accounts)	Physicians: 17.4 Nurses and midwives: 39 (2019)	2020 data expected to be available in December 2021
SP 1.3: Proportion of countries with on-time reporting from 90% of districts for suspected cases of all priority vaccine-preventable diseases included in nationwide surveillance (eJRF – pilot testing of questions in 2021)	Data expected to be available in June 2022 (2021)	Next reporting year is 2022
SP 1.4: Proportion of time with full availability of DTP-containing vaccine (DTPcv) and MCV at service delivery level (eJRF – pilot testing of questions in 2021)	Data expected to be available in June 2022 (2021)	Next reporting year is 2022
SP 1.6: Proportion of countries with at least one documented (with reporting form and/or line-listed) individual serious adverse event following immunization; case safety report per million total population (WHO global database VigiBase)	54 of 194 countries (2019)	52 of 194 countries
SP 2.1: Proportion of countries with legislation in place that is supportive of immunization as a public good (eJRF – pilot testing of questions in 2021)	Data expected to be available in June 2022 (2021)	Next reporting year is 2022
SP 2.2: Proportion of countries that have implemented behavioural or social strategies (in other words, demand generation strategies) to address under-vaccination (eJRF – pilot testing of questions in 2021)	Data expected to be available in June 2022 (2021)	Next reporting year is 2022
SP 3.2: DTP3, MCV1, and MCV2 coverage in the 20% of districts with lowest coverage (mean across countries) (eJRF)	DTP3: 74% MCV1: 72% MCV2: 65% (2019)	DTP3: 71% MCV1: 69% MCV2: 60% (2020)
SP 4.1: Breadth of protection (mean coverage for all WHO-recommended vaccine antigens) (eJRF; WHO and UNICEF Estimates of National Immunization Coverage (WUENIC))	70% (2019)	69%
SP 5.1: Proportion of polio, measles, meningococcus, yellow fever, cholera and Ebola virus outbreaks with timely detection and response (International Coordinating Group (ICG); Measles and Rubella Initiative; Global Polio Eradication Initiative (GPEI); WHO, national immunization and disease surveillance programmes)	Data expected to be available in June 2022 (2021)	Next reporting year is 2022
SP 6.1 Health of vaccine markets, disaggregated by vaccine antigens and country typology (UNICEF/WHO via the Marketing Information for Access to Vaccines (MI4A) initiative; Gavi, the Vaccine Alliance secretariat, Bill & Melinda Gates Foundation)	Healthy: 3 Unhealthy: 3 (2019)	Unhealthy: 3 Concerning: 6 Healthy: 3
SP 6.2: Proportion of countries where domestic government and donor expenditure on primary health care increased or remained stable (WHO Global Health Expenditure Database (GHED))	Data expected to be available in December 2021 (2019)	Data not yet available
SP 6.3: Proportion of countries where the share of national immunization schedule vaccine expenditure funded by domestic government resources increased or remained stable (eJRF)	19 out of 36 low and low-middle income countries* (2019)	24 out of 36 countries
SP 7.1: Proportion of countries with an immunization research agenda (eJRF – pilot testing of questions in 2021)	Data expected to be available in June 2022 (2021)	Next reporting year is 2022
SP 7.2: Progress towards global research and development targets (literature review)	Data expected to be available October 2022 (2021–2022)	

\*Only 36 low- and lower-middle-income countries reported data during 2018–2020.

## ANNEX 3

# RELATIONSHIPS BETWEEN KEY IMMUNIZATION AGENDA 2030 STAKEHOLDERS



**Key.** SAGE: Strategic Advisory Group of Experts on Immunization; RITAG: Regional immunization technical advisory group; NITAG: national immunization technical advisory group; WGs: working groups; O&A: ownership and accountability; M&E: monitoring and evaluation; C&A: communications and advocacy; CSOs: civil society organizations



## ANNEX 4

## STATUS OF OPEN AUDIT RECOMMENDATIONS AS AT 19 JANUARY 2021

Focus area	Lead partner	Key deliverables planned 2021–2022
<b>SP1: Primary health care/universal health coverage</b>	United States Agency for International Development (USAID)	<ul style="list-style-type: none"> <li>• Contribute to WHO Toolkit of three integrated primary health care resources</li> <li>• Develop resource on strengthening immunization programmes and primary health care during COVID-19 vaccine roll-out and organize learning webinar</li> <li>• Convene consultation on integrating immunization into primary health care/universal health coverage</li> <li>• Jointly develop a conceptual framework for integrating primary health care and connecting across the Immunization Agenda 2030 strategic priorities and with broader universal health care/primary health care</li> </ul>
<b>SP2: Commitment and demand</b>	WHO/Jon Snow Inc.	<ul style="list-style-type: none"> <li>• Publish action-oriented policy brief to support country-level and multistakeholder efforts to mobilize domestic and other funding sources</li> <li>• Facilitate webinars to: (1) promote best practices; and (2) identify mechanisms at all levels through which to build shared accountability toward renewed commitment for immunization</li> <li>• Establish high-level plan and monitoring framework to track dimensions of commitment and facilitate continued learning</li> <li>• Carry out a rapid gap mapping to assess current activities and guidance available on demand and to identify any unmet needs or areas of activity</li> <li>• Establish a joint plan with the Vaccination Demand Hub for a desk review and annual documentation of learning, successes and best practices</li> <li>• Launch crowd-sourced initiative to generate “bottom-up” inputs and facilitate a workshop on accountability mechanisms to identify examples of implementation and explore potential opportunities for testing in the area of demand</li> </ul>
<b>SP3: Coverage and equity</b>	WHO/UNICEF	<ul style="list-style-type: none"> <li>• Prepare briefing package</li> <li>• Organize webinar series/consultations</li> <li>• Develop coverage and equity analysis tool</li> <li>• Develop immunization programme resources database</li> </ul>
<b>SP4: Life course and integration</b>	Center for Disease Control and Prevention (CDC)	<ul style="list-style-type: none"> <li>• Contribute to regional guidance and recommendations on the life course and integration approach and support regions ready to develop action plans</li> <li>• Increase awareness of key focus areas, particularly around missed opportunities for vaccination, delivery approaches and policy needs</li> <li>• Conduct seminars and participate in existing workshops to disseminate SP4 objectives.</li> <li>• Contribute to generating evidence on barriers and facilitators of the life course and integration strategy, particularly using COVID-19 vaccine roll-out as an opportunity to further this agenda</li> <li>• Generate research agenda for reaching life course and integration objectives, map the evidence gaps and support existing research efforts</li> </ul>

Focus area	Lead partner	Key deliverables planned 2021–2022
<b>SP5a: Emergencies</b>	International Federation of Red Cross and Red Crescent Societies (IFRC)	<ul style="list-style-type: none"> <li>• Support rapid and equitable COVID-19 vaccine roll-out and scale-up in humanitarian settings (including the COVAX Facility Humanitarian Buffer, working with the Global Health Cluster)</li> <li>• Produce theory of change on reducing the numbers of zero-dose children in fragile and conflict settings</li> <li>• Support mapping of zero-dose communities in priority countries and identify drivers to guide investments at subnational levels</li> <li>• Facilitate sharing and peer-to-peer learning across the COVID-19 vaccine implementation plans of all regions through workshops on lessons learned in fragile, conflict and vulnerable settings</li> </ul>
<b>SP5b: Outbreaks</b>	WHO	Working group being formed
<b>SP6a: Supply security</b>	UNICEF	<ul style="list-style-type: none"> <li>• Track supply of essential vaccines, given potential COVID-19 disruptions</li> <li>• Vaccine forecasting, procurement and supply: Improve global supply, work across partners on national-level forecasting</li> <li>• Ensure that the supply of, and access to, new vaccines meet country needs and that vaccines are introduced in a timely manner – particularly in light of COVID-19 impact</li> <li>• Middle-income countries (MICS): COVAX Facility experience with MICS is providing opportunities to improve options</li> </ul>
<b>SP6b: Financial sustainability</b>	World Bank	<ul style="list-style-type: none"> <li>• Share information on ongoing work related to sustainable financing; identify and prioritize gaps; stimulate work to address gaps; identify 1–2 priority reports or guidance that working groups could collectively produce</li> <li>• Work to improve data quality and comprehensiveness in monitoring and evaluation indicators</li> <li>• Through consultative engagements, bring in views of countries, regions, civil society organizations, the private sector and donors to inform policy recommendations and advise global partners</li> </ul>
<b>SP7: Research and innovation</b>	PATH (PATH Health Tech Program)	<ul style="list-style-type: none"> <li>• Accelerate and expand the COVAX Facility research and development agenda for variant targeting and programmatically optimized vaccines</li> <li>• Support low- and middle-income countries in expanding, strengthening and/or establishing local and regional capacities for immunization research and innovation</li> <li>• Develop mechanism to align country-, regional- and global-level stakeholders on priority diseases for which new vaccines are needed</li> <li>• Establish 2025 and 2030 Immunization Agenda 2030 SP7 working group objectives to sustain progress, based on country-led research and development priorities</li> </ul>
<b>Middle-income countries</b>	WHO	<ul style="list-style-type: none"> <li>• Update middle-income countries' partner landscape</li> <li>• Identify opportunities to input into normative guidance</li> <li>• Identify and initiate priority interventions based on existing analysis</li> <li>• Engage regional middle-income countries' initiatives</li> </ul>
<b>Data strengthening and use</b>	WHO	<ul style="list-style-type: none"> <li>• Provide guidance to WHO/UNICEF on upcoming Gavi, the Vaccine Alliance funding request</li> <li>• Organize "year 0" initial priority-setting meeting</li> <li>• Begin implementation of initial three-year priority investments and alignment with funding</li> <li>• Organize quarterly progress check and alignment meetings</li> </ul>
<b>Measles and rubella</b>	Measles and Rubella Initiative	Working group being formed
<b>Disease-specific initiatives</b>	UNICEF	Working group being formed

Focus area	Lead partner	Key deliverables planned 2021–2022
Monitoring and evaluation	CDC	<ul style="list-style-type: none"> <li>• Develop process for technical progress reporting by indicator owners/champions</li> <li>• Support development of annual Immunization Agenda 2030 technical report, including regional and country engagement</li> <li>• If requested, support regions in the development of regional monitoring and evaluation frameworks</li> <li>• Provide guidance and support to the Immunization Agenda 2030 Coordination Group and Immunization Agenda 2030 Partnership Council to further improve and make periodic revisions to the Immunization Agenda 2030 monitoring and evaluation framework.</li> </ul>
Communications and advocacy	WHO/UNICEF/ United Nations Foundation	<ul style="list-style-type: none"> <li>• Mobilize Immunization Agenda 2030 partners for action around annual data release</li> <li>• Engage religious leaders on Immunization Agenda 2030</li> <li>• Engage parliamentarians on Immunization Agenda 2030, targeting annual Inter-Parliamentary Union conference</li> <li>• Plan communications around September “champions” event</li> <li>• Begin regional outreach and content development</li> </ul>
Resource mobilization	TBD	TBD

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## **Global strategy on infection prevention and control**

The Seventy-fifth World Health Assembly,

Having considered the consolidated report by the Director-General;<sup>1</sup>

Recalling resolutions WHA48.7 (1995) on revision and updating of the International Health Regulations, WHA58.27 (2005) on improving the containment of antimicrobial resistance, WHA69.1 (2016) on strengthening essential public health functions in support of the achievement of universal health coverage, WHA70.7 (2017) on improving the prevention, diagnosis and clinical management of sepsis, WHA72.6 (2019) on global action on patient safety, WHA72.7 (2019) on water, sanitation and hygiene in health care facilities, WHA73.1 (2020) on the COVID-19 response, WHA73.8 (2020) on strengthening preparedness for health emergencies: implementation of the International Health Regulations (2005) and WHA74.7 (2021) on strengthening WHO preparedness for and response to health emergencies, within which infection prevention and control is a critical component;

Reaffirming the 2030 Agenda for Sustainable Development and its targets, which are universal, indivisible and interlinked, and referring in particular to the following targets of the Sustainable Development Goals: 3.1 on reducing global maternal mortality, 3.2 on ending preventable deaths of newborns and children under 5 years of age, 3.3 on ending the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases and combating hepatitis, waterborne diseases and other communicable diseases, and 3.8 on achieving universal health coverage, including access to quality essential health care services and access to safe, effective, quality and affordable essential medicines and vaccines for all, and recognizing the important intersections between infection prevention and control and other Sustainable Development Goals, including Goal 6 (Ensure availability and sustainable management of water and sanitation for all);

Noting the Declaration of Alma-Ata<sup>2</sup> on primary health care and the Declaration of Astana<sup>3</sup> on high-quality and safe primary health care and health services and recognizing that to achieve it, preventing harm from infection transmission at the entry point to and at all points in the health system is paramount;

Recognizing the critical importance of infection prevention and control in the human and animal health sectors and that it is a clinical and public health discipline based on a scientific approach, providing proactive, responsive and practical preventive and control measures grounded in infectious

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<sup>1</sup> Document A75/10 Rev.1.

<sup>2</sup> Primary health care: report of the International Conference on Primary Health Care, Alma-Ata, USSR, 6-12 September 1978. Geneva: World Health Organization; 1978 (<https://apps.who.int/iris/handle/10665/39228>).

<sup>3</sup> Declaration of Astana: Global Conference on Primary Health Care, Astana, Kazakhstan, 25 and 26 October 2018. Geneva: World Health Organization; 2019 (<https://apps.who.int/iris/handle/10665/328123>).

diseases, epidemiology, social, engineering and implementation science, and health systems strengthening that requires a dedicated specialist health work force;

Noting that comprehensive infection prevention and control programmes, which take the One Health approach into account, at national, subnational and facility levels are essential to produce science-based evidence and support, facilitate and/or oversee the correct, evidence-based and risk-informed implementation of infection prevention and control, as well as the resources and material support required (such as personal protective equipment);

Concerned that the COVID-19 pandemic and the recent large outbreaks of Ebola virus disease in West Africa and the Democratic Republic of the Congo have shown the devastating consequences of the lack of preparedness and substandard, insufficient and/or inadequate implementation of infection prevention and control programmes, even in high-income countries, and have brought infection prevention and control to the forefront;

Recognizing that in addition to outbreaks, at any point in time<sup>1</sup> of every 100 patients, seven in high-income countries and 15 in low- and middle-income countries acquire at least one health care-associated infection during their stay in acute-care hospitals, and a quarter of health care facilities lacked basic water services in 2019, exposing 1.8 billion people, including health care workers and patients, to greater risk of infections,<sup>2</sup> highlighting the major gaps in water, sanitation and hygiene services in health care facilities, which play a critical role in infection prevention and control, and noting the modest costs for achieving minimal water, sanitation and hygiene safety, which range from US\$ 6.5 billion to US\$ 9.6 billion in the 46 least developed countries, which represent 4–6% of these countries' recurrent health spending;

Although no precise analysis is possible due to lack of comprehensive data, noting that WHO has estimated that hundreds of millions of patients are affected by health care-associated infections leading to deaths in one in 10 infected patients every year, and noting further that in acute-care hospitals, of every 100 patients, seven in high-income countries and 15 in low- and middle-income countries will acquire at least one health care-associated infection during their hospital stay, and that up to 30% of patients in intensive care are affected by health care-associated infections, with an incidence that is two to 20 times higher in low- and middle-income countries than in high-income countries;<sup>3</sup>

Noting the added costs of health care-associated infections, which may vary from US\$ 1000 to US\$ 12 000 on average per episode depending on the country,<sup>4</sup> result in a significant economic burden on health systems and out-of-pocket expenses for patients and families; and that the mortality among patients affected by health care-associated sepsis was 24.4%, increasing up to 52.3% among patients

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<sup>1</sup> Allegranzi B, Bagheri Nejad S, Combescure C, Graafmans W, Attar H, Donaldson L, et al. Burden of endemic health-care-associated infection in developing countries: systematic review and meta-analysis. *Lancet*. 2011 Jan 15;377(9761):228–41. doi: 10.1016/S0140-6736(10)61458-4.

<sup>2</sup> WHO and UNICEF. (2020). Global progress report on water, sanitation and hygiene in health care facilities: fundamentals first. Geneva: World Health Organization; 2020. (<https://apps.who.int/iris/handle/10665/337604>).

<sup>3</sup> Global report on the epidemiology and burden of sepsis: current evidence, identifying gaps and future directions. Geneva: World Health Organization; 2020 (<https://apps.who.int/iris/handle/10665/334216>).

<sup>4</sup> Forrester JD, Maggio PM, Tennakoon L. Cost of health care-associated infections in the United States. *J Patient Saf*. 2022 Mar 1;18(2):e477–e479. doi: 10.1097/PTS.0000000000000845.

treated in an intensive care unit and at least two to three times higher among those infected with antimicrobial-resistant organisms, in neonates and in low- and middle-income countries;<sup>1</sup>

Noting that most antibiotic-resistant infections are acquired in health care facilities, 75% of disability-adjusted life years attributable to antimicrobial resistance are due to health care-associated infections.<sup>2</sup> Each year, antimicrobial resistance costs health care systems around US\$ 1.2 billion. For example, up to 75% of prescriptions for antimicrobial medicines in long-term care facilities are inappropriate, yet policies to tackle inappropriate antimicrobial use and antimicrobial resistance, such as antimicrobial stewardship and infection prevention and control, remain underused or suboptimal;<sup>3</sup>

Noting that a recent systematic analysis and predictive statistical models by antimicrobial resistance collaborators showed that in 2019 the estimated number of deaths associated with bacterial antimicrobial resistance was 4.95 million (95% uncertainty interval: 3.62–6.57) globally, including 1.27 million (95% uncertainty interval: 0.911–1.71) deaths attributable to bacterial antimicrobial resistance and reflect the burden of antimicrobial resistance as a leading cause of death globally, with a high impact in low-resource settings;<sup>4</sup>

Observing that most cost-effective interventions to limit the spread of antimicrobial resistance in health care are those aimed at improving all hospital-associated drivers, including hygiene and antimicrobial stewardship, with the potential to prevent three of four attributable deaths;<sup>5</sup>

Noting that public health emergencies have demonstrated that infection prevention and control, together with core capacities required by the International Health Regulations (2005), play a critical role in preventing and responding timely and effectively to public health risks and emergencies of national and international concern;

Recognizing that the COVID-19 pandemic has also demonstrated the critical role of health system resiliency in providing essential health services and maintaining functional health systems and that the cornerstone of health system resiliency is keeping health care workers, patients and visitors safe through a series of measures, including infection prevention and control, best practices and essential infrastructure, including transmission-based precautions and water, sanitation and waste management wherever health care is provided;

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<sup>1</sup> Markwart R, Saito H, Harder T, Tomczyk S, Cassini A, Fleischmann-Struzek C, et al. Epidemiology and burden of sepsis acquired in hospitals and intensive care units: a systematic review and meta-analysis. *Intensive Care Med.* 2020 Aug;46(8):1536-1551. doi: 10.1007/s00134-020-06106-2.

<sup>2</sup> Cassini A, Högberg LD, Plachouras D, Quattrocchi A, Hoxha A, Simonsen GS, et al.. Attributable deaths and disability-adjusted life-years caused by infections with antibiotic-resistant bacteria in the EU and the European Economic Area in 2015: a population-level modelling analysis. *Lancet Infect Dis.* 2019 Jan;19(1):56-66. doi: 10.1016/S1473-3099(18)30605-4.

<sup>3</sup> Eze N, Cecchini M, Oliveira Hashiguchi T. Antimicrobial resistance in long-term care facilities. OECD Health Working Papers, No. 136. Paris: OECD Publishing; 2022, <https://doi.org/10.1787/e450a835-en>.

<sup>4</sup> Antimicrobial Resistance Collaborators. Global burden of bacterial antimicrobial resistance in 2019: a systematic analysis. *Lancet.* 2022 Feb 12;399(10325):629-655. doi: 10.1016/S0140-6736(21)02724-0.

<sup>5</sup> European Centre for Disease Control and Prevention and OECD. Antimicrobial resistance. Tackling the burden in the European Union. Briefing note for EU/EAA countries. 2019. (<https://www.oecd.org/health/health-systems/AMR-Tackling-the-Burden-in-the-EU-OECD-ECDC-Briefing-Note-2019.pdf>).

Recognizing the unique opportunity to harness the experience of the heightened global awareness of infection prevention and control and investments made during the COVID-19 pandemic for sustained improvements in infection prevention and control,

1. CALLS ON Member States:<sup>1</sup>

- (1) to take steps to support and/or to ensure that infection prevention and control is one of the key components of global health preparedness, prevention and response;
- (2) to acknowledge that clean, high-quality, safe, affordable care should be universally available and that no one should be unnecessarily exposed to infection due to suboptimal infection prevention and control practices;
- (3) to take steps to support and/or to ensure that science-based functional infection prevention and control programmes exist – for both community-acquired and health care-associated infections, taking into account the One Health approach – are implemented, monitored and updated at national, subnational, and/or facility levels, as appropriate to national contexts and in line with the WHO core components of such programmes;<sup>2</sup>
- (4) to take steps to support relevant authorities and/or ensure that at least the minimum requirements for infection prevention and control programmes at the national, subnational and health care facility levels are implemented and monitored, inclusive of environmentally conscious and appropriate waste management to reduce further impact on human, animal and environmental health;
- (5) to support and ensure that transmission-based precautions for infection prevention and control are implemented with fidelity and quality at national and facility levels, and functional administrative, environmental and personal protection measures are in place to prevent and/or halt further transmission;
- (6) to take steps to support and/or to ensure that sustainable infection prevention and control and water, sanitation and hygiene infrastructures and resources are in place and utilized across all health care facilities, including in primary health care, home and community-based settings, and long-term care settings as appropriate to the national context;
- (7) to take steps to recognize the value of having infection prevention and control professionals across a variety of settings, with appropriate competencies, skills, career pathways and empowerment with a clear mandate and authority, while being held accountable, and who work within the clinical governance framework of their organizations for implementation and reporting the impact of infection prevention and control programmes as appropriate to the national context;
- (8) to take steps toward creating and implementing accredited infection prevention and control curricula within pre-graduate, post-graduate and in-service continuous education, where and as appropriate in national contexts, for all health care workers and all relevant disciplines;

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<sup>1</sup> And, where applicable, regional economic integration organizations.

<sup>2</sup> Guidelines on core components of infection prevention and control programmes at the national and acute health care facility level. Geneva: World Health Organization; 2016 (<https://apps.who.int/iris/handle/10665/251730>).

(9) to take steps to ensure that infection prevention and control programmes are integrated and aligned with programmes on antimicrobial resistance, quality of care, patient safety, water, sanitation and hygiene, construction and remodelling of the infrastructure of health care facilities, and health emergencies programmes, as well as programmes on bloodborne infectious diseases, tuberculosis, acute respiratory infections, vaccine-preventable diseases, neglected tropical diseases, occupational health, sexual and reproductive health, and maternal, neonatal and child health, and other relevant programmes where and as appropriate for national contexts;

(10) to provide decisive and visible political commitment and leadership engagement at the highest levels to sustain and improve implementation of functional infection prevention and control programmes at the regional, national, local and facility levels, including encouraging allocation of national and local dedicated budgets where and as appropriate and guided by domestic context;

(11) to introduce guidance, regulations and/or legal frameworks to enforce infection prevention and control requirements, policies and implementation of best practices through systems for accrediting health facilities and other mechanisms, as appropriate and guided by domestic context;

(12) to undertake as appropriate to national contexts, regular, detailed and multilevel assessments of infection prevention and control programmes, practices and surveillance of health care-associated infections and antimicrobial resistance in order to generate and share data to be used for action and improving outcomes;

(13) to continue to encourage investments in research on infection prevention and control;

## 2. REQUESTS the Director-General:

(1) to develop, in consultation with Member States and regional economic integration organizations, a draft global strategy – in alignment with other strategies on infection prevention and control efforts, such as the global action plan on antimicrobial resistance – on infection prevention and control in both health and long-term care settings, for consideration by the Seventy-sixth World Health Assembly in 2023, through the Executive Board at its 152nd session;

(2) to translate the global strategy on infection prevention and control in both health and long-term care settings into an action plan for infection prevention and control, including a framework for tracking progress, with clear measurable targets to be achieved by 2030, for consideration by the Seventy-seventh World Health Assembly in 2024, through the Executive Board at its 154th session;

(3) to continue to update and develop as required technical guidance on infection prevention and control programmes and practices for health and long-term care settings;

(4) to report on progress and results to the Seventy-eighth World Health Assembly in 2025, and thereafter every two years until 2031.

Eighth plenary meeting, 28 May 2022  
A75/VR/8

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# **Infection prevention and control**

## **Report by the Director-General**

### **BACKGROUND**

1. This report outlines the impact caused by the spread of infection and antimicrobial resistance acquired in health care facilities, the global situation of infection prevention and control programmes at the national and facility levels, as well as gaps and challenges in implementation of infection prevention and control. It also provides an overview of WHO's recent activities on infection prevention and control and proposes some priorities and actions aimed at improving implementation of infection prevention and control programmes.

### **BURDEN AND IMPACT OF INFECTIONS, SEPSIS AND ANTIMICROBIAL RESISTANCE ACQUIRED IN HEALTH CARE**

2. Over the past decade, the Secretariat and other agencies have demonstrated the significant global burden of health care-associated infections, many of which are caused by multidrug-resistant organisms and/or can cause outbreaks in health care facilities and in community settings. In acute care hospitals, out of every 100 patients, 7 in high-income countries and 15 in low- and middle-income countries will acquire at least one health care-associated infection during their hospital stay. Among intensive care patients, the incidence of health care-associated infections is 2 to 20 times higher in low- and middle-income countries than in high-income countries. Although no precise analysis is possible due to lack of comprehensive data, WHO has estimated that hundreds of millions of patients are affected by health care-associated infections leading to death in 1 in 10 infected patients every year. The coronavirus disease (COVID-19) pandemic has demonstrated how critical infection prevention and control is to maintaining essential health services and ensuring patient and health worker safety.

3. In most cases, both health care-associated infections and the spread of antimicrobial resistance in health care settings are a consequence of poor-quality care delivery and inadequate health infrastructure combined with inexistent or defective infection prevention and control programmes. In particular, key determinants are low compliance with hand hygiene and aseptic technique practices, contaminated medical equipment and supplies, inadequate environmental cleaning, lack of trained infection prevention and control professionals and limited opportunities for staff training, exceeded bed occupancy, understaffing and limited or suboptimal infrastructure for patient isolation.

4. In the European Union and European Economic Area, up to 8.9 million health care-associated infections occur every year in acute and long-term care facilities; a population-based modelling study estimated that the six most common health care-associated infections generate almost twice the total burden of disability-adjusted life years of all other 32 communicable diseases combined. In the European Union and European Economic Area, antibiotic-resistant microorganisms are responsible for most

infections and 75% of disability-adjusted life years attributable to antimicrobial resistance are due to health care-associated infections.

5. Obstetric infections are the third most frequent cause of maternal sepsis, which is responsible for 10.7% of maternal deaths. Almost all maternal deaths due to obstetric infections occur in low- and middle-income countries. Caesarean section is the single most important risk factor for maternal infection after childbirth.

6. Severe neonatal infections, including neonatal sepsis, represent a significant cause of neonatal mortality and long-term morbidity. The highest neonatal sepsis incidence rates are in low- and middle-income countries, particularly in the WHO African Region. The survival of preterm, small (low birthweight) and sick infants has improved over time. However, such infants often require hospital care, which exposes them to the risk of hospital-acquired infections and late-onset sepsis. Newborns in developing countries are at higher risk of acquiring health care-associated infections, with infection rates 3 to 20 times higher than in high-income countries.

7. Several studies during the continuing COVID-19 pandemic have reported severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) infections acquired by patients in health care settings, ranging from 0% to 41% of inpatients. Among health workers, the prevalence of SARS-CoV-2 seropositivity has ranged between 0.3% and 39.6% and the incidence of infection has varied from 0.4% to 49.6%; however, huge variations over time and by country have been observed and it is very difficult to distinguish between community- and health care-acquired infections. According to the WHO global surveillance database (the WHO coronavirus (COVID-19) dashboard), COVID-19 cases among health workers slightly exceeded 10% in the first wave of the pandemic in March 2020, decreased to less than 5% by early June 2020 and further decreased to 2.5% by September 2020, suggesting that improvements in implementation of infection prevention and control made after the initial spread of the virus may have contributed to reducing health workers' exposure.

## **OPPORTUNITIES: HOW INFECTION PREVENTION AND CONTROL CAN CONTRIBUTE TO ACHIEVING SAFE CARE DELIVERY AND HEALTH SECURITY**

8. Infection prevention and control is a clinical and public health specialty that is based on a scientific approach, providing practical solutions grounded in infectious diseases, epidemiology, social and implementation science, and health systems strengthening. It is designed to prevent harm due to infection to patients, health workers and visitors in health care settings.

9. Infection prevention and control programmes at national, subnational and facility levels are essential to oversee the correct, evidence-based implementation of infection prevention and control and the resources and material support (such as, personal protective equipment) required. It should be noted, however, that correct use of personal protective equipment is just one small component of a comprehensive package of infection prevention and control measures and within an overall infection prevention and control programme responsible for training, oversight and monitoring to prevent the transmission of infectious agents in health care settings.

10. The COVID-19 pandemic, as well as other large-scale health emergencies, have demonstrated that infection prevention and control, together with other core capacities required by the International Health Regulations (2005), plays a critical role in detecting, assessing, notifying and reporting events, and responding to public health risks and emergencies of national and international concern. The pandemic has also demonstrated the critical role of health system resiliency in providing essential health

services and maintaining health systems functioning. The cornerstone of health system resiliency is keeping health workers, patients and visitors safe through a series of measures, including infection prevention and control best practices.

11. Evidence-based infection prevention and control interventions have been shown to be effective in preventing 35–70% of health care-associated infections, and having an active infection prevention and control programme can reduce health care-associated infections by 30%. Whether implemented as a standalone intervention or integrated into multifaceted interventions, hand hygiene has been highlighted as the most critical and proven measure in reducing transmission of microorganisms and lowering the incidence of health care-associated infections in health care settings.

12. A report by OECD showed that the most cost-saving interventions to limit the spread of antimicrobial resistance in health care were those aimed at improving hospital hygiene and antimicrobial stewardship, with the potential to prevent three out of four attributable deaths.<sup>1</sup> It also showed that the increasing availability of infection prevention and control equipment and infrastructure (such as alcohol-based handrubs) at the point of care and isolation beds are associated with a proportionate reduction of the most common patterns of antimicrobial resistance that are associated with health care.

13. Implementation and monitoring of infection prevention and control programmes contribute to meeting targets of the Sustainable Development Goals (3.1, 3.2, 3.3 and 3.8, and those of Goal 6), as well as to reducing the indicator 3.d.2 concerning antimicrobial resistance. Infection prevention and control is also recommended as critical interventions in several Health Assembly resolutions. Infection prevention and control is a practical and evidence-based approach with demonstrated impact on quality of care and patient safety across all levels of the health system: it is therefore paramount to achieve quality care for all (resolution WHA69.1 (2016)). Furthermore, strategy 3.3 of the global patient safety action plan 2021–2030 focuses on infection prevention and control (resolution WHA72.6 (2019)). Infection prevention and control is also at the core of objective 3 of the global action plan on antimicrobial resistance because it reduces both the spread of antimicrobial-resistant organisms and the occurrence of infection and thus the need for antimicrobials use, which then has an impact on the emergence of antimicrobial resistance (resolution WHA58.27 (2005)). The existence of strong infection prevention and control programmes and capacity constitutes the foundation of adequate preparedness and response to outbreaks, and thus is key for the prevention of health emergencies, including fulfilment of the International Health Regulations (2005) (resolutions WHA48.7 (1995), WHA73.1 (2020), WHA73.8 (2020), WHA74.7 (2021)). Infection prevention and control is complementary to water, sanitation and hygiene efforts (resolution WHA72.7 (2019)) and provides implementation approaches for achieving behavioural change among health workers and people in the community. Lastly, embedding infection prevention and control practices within maternal and neonatal care pathways contributes to improving maternal and neonatal health given that sepsis is a major cause of morbidity and mortality (including health care-associated morbidity and mortality) in these fragile populations (resolution WHA70.7 (2017)).

14. On the basis of scientific evidence, expert consensus and country experience, and with the support of many international partners, in 2016 WHO issued recommendations on the core components of effective infection prevention and control programmes for the national and acute care health facility

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<sup>1</sup> Stemming the superbug tide: just a few dollars more. Paris: Organisation for Economic Co-operation and Development; 2018 (<https://doi.org/10.1787/9789264307599-en>, accessed 23 November 2021).

levels.<sup>1</sup> A comprehensive package of implementation and monitoring resources accompanied the issue of these WHO guidelines. In 2019, WHO further specified the minimum requirements for infection prevention and control programmes, with the aim of supporting stepwise implementation towards full achievement of the requirements of the infection prevention and control core components.<sup>2</sup>

15. WHO regional offices have set up cross-cutting teams to support implementation of infection prevention and control programmes and contribute to a number of health priorities in an integrated manner. Country offices make considerable efforts to provide support for infection prevention and control; however, this is often hampered by the burden of other competing priorities and the availability of human resources and limited technical expertise.

## **CHALLENGES IN IMPLEMENTATION OF INFECTION PREVENTION AND CONTROL**

16. Despite the demonstrated impact of infection prevention and control, countries struggle to prioritize, invest in, establish and implement the core components of infection prevention and control programmes, even their minimum requirements.

17. Indeed, according to the annual tripartite antimicrobial resistance country self-assessment survey in 2020–2021, 33% of countries surveyed reported having no national infection prevention and control programme or the programme had not been implemented. Conversely, in only 37% of countries had infection prevention and control programmes been correctly implemented and monitored in health care facilities nationwide. Compared with low-income countries, high-income countries were 8.29 times more likely to have a more advanced infection prevention and control implementation status. According to a WHO global survey carried out in 2019, only 15.7% of health care facilities met all WHO infection prevention and control minimum requirements, ranging from 0% in low-income countries to 27.4% of primary and 10.7% of secondary and tertiary health care facilities in high-income countries. Although high-income countries have better established infection prevention and control programmes, the COVID-19 pandemic has shown that even the wealthiest countries have to build more resilient health care systems with effective infection prevention and control to avoid or mitigate the impact of outbreaks.

18. A significant gap in implementation is the critical problem. A WHO global survey in 2018 at the national level demonstrated that while national guidelines on infection prevention and control practices existed in 50% of low-income countries and 69–77% of middle- and high-income countries, only 20% of low-income countries and 29–57% of middle- and high-income countries had implementation plans and strategies. Overall, only 22% of all countries monitored implementation roll-out and impact. In this survey, only 26% of countries reported having a dedicated budget for infection prevention and control supported by the national authorities; of these, most were high-income countries (65%); only one was a low-income country.

19. At the facility level, a WHO global survey in 2019 showed that the core components related to the built environment, materials and equipment for infection prevention and control and guidelines on infection prevention and control were best implemented, whereas those related to workload, staffing and bed occupancy, and infection prevention and control education and training, were the most defective.

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<sup>1</sup> Guidelines on core components of infection prevention and control programmes at the national and acute health care facility level. Geneva: World Health Organization; 2016 (<https://apps.who.int/iris/handle/10665/251730>, accessed 24 November 2021).

<sup>2</sup> Minimum requirements for infection prevention and control programmes. Geneva: World Health Organization; 2019 (<https://apps.who.int/iris/handle/10665/330080>, accessed 24 November 2021).

Among low-income countries, surveillance and monitoring of health care-associated infections, and audit of infection prevention and control practices and feedback, were the least implemented. Similar results have been reported recently by WHO regional offices with the exception that countries are progressing in establishing infection prevention and control programmes and developing national infection prevention and control guidelines.

20. Low-income countries in particular struggle to have an appropriate built environment to support infection prevention and control programmes and clean care delivery. In 2020, WHO reported that one in four health care facilities worldwide do not have basic water services and one in three lack hand hygiene supplies at the point of care, with alcohol-based handrubs continuously available in 75% of facilities in high-income countries, but in only 17% of facilities in low-income countries.

21. Over the past year, much progress has been made by building infection prevention and control minimum requirements and improving practices to fight against COVID-19; however, in a WHO pulse survey in 2020 on the impact of the COVID-19 pandemic on essential health services in low- and middle-income countries, lack of infection prevention and control supplies and best practices was identified as a major reason for service disruption (for example, interruption of routine vaccination programmes) by 44% of countries.

## **PRIORITIES TO ADDRESS INFECTION PREVENTION AND CONTROL IN NATIONAL AND INTERNATIONAL HEALTH AGENDAS**

22. All countries should acknowledge that clean, high-quality, safe care should be universally available to every person worldwide. No one, health workers in particular, should be unnecessarily exposed to infection during health care delivery due to suboptimal infection prevention and control practices, or lack of personal protective equipment or of available vaccines.

23. The COVID-19 pandemic and the recent large outbreaks of Ebola virus disease in West Africa and the Democratic Republic of the Congo have shown the devastating consequences of a lack of preparedness and defective infection prevention and control programmes, even in high-income countries, and have brought infection prevention and control to the forefront. Infection prevention and control should be a central component of pandemic and global health security planning in all countries.

24. In order to achieve the Sustainable Development Goals and implement the Health Assembly resolutions cited in paragraph 13, countries should ensure that functional infection prevention and control programmes exist at the national and facility levels, according to the WHO core components of such programmes,<sup>1</sup> and that sustainable infection prevention and control and water, sanitation and hygiene infrastructures and resources are in place in all health care facilities, including in primary care. Despite the huge efforts made globally to enhance infection prevention and control interventions in the past decade, and especially during the COVID-19 pandemic, sustainability is at risk as the newly built infection prevention and control programmes and water, sanitation and hygiene infrastructures could be progressively dismantled, and the attention and resources dedicated to infection prevention and control are likely to decrease as soon as the pandemic is over.

25. At least the minimum requirements for infection prevention and control programmes at the national and health care facility level should be in place in all countries, and their implementation

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<sup>1</sup> Guidelines on core components of infection prevention and control programmes at the national and acute health care facility level. Geneva: World Health Organization; 2016 (<https://apps.who.int/iris/handle/10665/251730>, accessed 24 November 2021).

demonstrated by monitoring key indicators for infection prevention and control and water, sanitation and hygiene in the context of the infection prevention and control core components, the International Health Regulations (2005) and the WHO/UNICEF Joint Monitoring Programme for Water Supply, Sanitation and Hygiene. It should be noted that fulfilling the minimum requirements for infection prevention and control has become an essential parameter to be met within the 2021 edition of the State Party self-assessment annual reporting and the joint external evaluation tools.

26. While the existence of specific infection prevention and control programmes supported by dedicated trained infection prevention and control professionals is paramount, infection prevention and control activities must be integrated and aligned with those related to antimicrobial resistance, quality of care, patient safety, water, sanitation and hygiene, and health emergencies programmes, as well as HIV, tuberculosis, malaria, and maternal and child health, and other programmes, in order to emphasize the horizontal nature of infection prevention and control and to avoid duplication or vertical implementation. In particular, efforts to improve infection prevention and control practices should be contextualized within quality improvement and the spirit of the safety climate by which all facilities should be pervaded.

27. Decisive and visible political commitment and leadership engagement at the highest levels are needed to sustain and improve implementation of functional infection prevention and control programmes at the national and facility levels, including considering infection prevention and control as a priority for allocation of national and local health budgets. Member States, the Secretariat and global partners should identify targets for infection prevention and control investment, based on a percentage of overall health care expenditure, that is a reasonable amount to commit for safe and clean provision of care. Progress made towards achieving these targets should be publicly available.

28. Regulations and legal frameworks are needed to enforce infection prevention and control requirements and policies through systems for accrediting health facilities and other mechanisms for accountability agreed on at international level and adapted locally. These mechanisms should enforce, among other things, key infrastructural minimum requirements such as those pertaining to overcrowding, understaffing and the built environment including water, sanitation and hygiene.

29. The infection prevention and control core components cannot be implemented without competent infection prevention and control professionals and frontline health workers understanding infection prevention and control principles and practices. Thus, creation and implementation of accredited infection prevention and control curricula within pre-graduate health courses and in-service continuous education is essential. Similarly, infection prevention and control post-graduate curricula and courses are needed to create local infection prevention and control expertise; the WHO infection prevention and control core competencies can be used as a template.<sup>1</sup> Furthermore, the lack of human resources dedicated to infection prevention and control as well as adequate health care staffing at the facility level should be urgently tackled in countries, given that their adequate numbers and ratios with patient beds have been demonstrated to correlate with prevention of health care-associated infections and spread of antimicrobial resistance, in particular during outbreaks. Infection prevention and control professionals should be offered a recognized career pathway and empowered with a clear mandate and authority, while being held accountable for implementation and reporting the impact of infection prevention and control programmes. Inclusion of infection prevention and control professionals into the structure of executive

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<sup>1</sup> Core competencies for infection prevention and control professionals. Geneva: World Health Organization; 2020 (<https://apps.who.int/iris/handle/10665/335821>, accessed 24 November 2021).

hospital boards and senior management will ensure that infection prevention and control and water, sanitation and hygiene are prioritized.

30. Establishing the local epidemiology of health care-associated infections and promptly detecting epidemic- and pandemic-prone and emerging antimicrobial-resistant microorganisms are critical functions to tackle patient harm and health worker infection risks. Thus, functioning and quality-controlled systems for surveillance of health care-associated infections and antimicrobial resistance should be established, in line with the Global Antimicrobial Resistance and Use Surveillance System and other standardized surveillance systems for health care-associated infections and antimicrobial resistance (such as the ones coordinated by the European Centre for Disease Prevention and Control). Good-quality laboratory diagnostics and services are critical to enable identification of pathogens and inform surveillance of antimicrobial resistance, health care-associated infections and early detection of outbreaks.

31. High-level data on infection prevention and control (such as the existence of an infection prevention and control programme) are monitored by most countries through regular surveys coordinated by WHO and partners. However, they often do not reflect actual functioning, implementation and impact of infection prevention and control programmes. Thus, more detailed and multilevel assessments of such programmes should be undertaken regularly. The new WHO global infection prevention and control portal<sup>1</sup> offers the opportunity to undertake this type of monitoring, in a protected confidential space, using standardized tools.

32. Data collection must be used for action and improving outcomes. Infection prevention and control monitoring results and surveillance data should be streamlined and used locally to identify the existing strengths and critical gaps so that targeted and feasible improvement plans can be collectively elaborated and implemented. Thus, evaluation feedback to all involved key players – from senior managers to all concerned frontline staff – should be ensured, including using modern technologies that facilitate automatic reporting and point-of-care feedback.

## **ACTION BY THE EXECUTIVE BOARD**

33. The Board is invited to note the report and provide further guidance on action that could be taken by the Organization in response to the burden of infections and antimicrobial resistance acquired in health care.

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<sup>1</sup> <https://ipcportal.who.int/>, accessed 11 December 2021.

# **Global road map on defeating meningitis by 2030**

## **Report by the Director-General**

1. In resolution WHA73.9 (2020) concerning the global road map on defeating meningitis by 2030, the Seventy-third World Health Assembly requested the Director-General, inter alia, to submit a report to the Executive Board at its 150th session on progress in implementing the resolution, and a report to the Seventy-sixth World Health Assembly, through the Executive Board at its 152nd session, to review the global meningitis situation and assess efforts made in meningitis prevention and control. This document provides a summary of WHO activities in that respect since November 2020.
2. As at September 2021, action had been taken to strengthen strategic leadership and coordination with partners; develop regional implementation frameworks; and prepare the monitoring and evaluation plan, business case and official launch of the global road map on defeating meningitis by 2030.<sup>1</sup>
3. The WHO Technical Taskforce on defeating meningitis by 2030, composed of partners and international experts engaged in long-term meningitis control, played an essential role in the development of the global road map and will be responsible for leading and coordinating its global and regional implementation via a forum for technical exchange and cooperation on meningitis. Membership of the Technical Taskforce may be further extended to include new institutions and new advisers, where appropriate and taking into account regional relevance. The Secretariat will regularly review the Technical Taskforce's composition and assess whether any rotation of its members is necessary. The term of membership will be for an initial period of three years, renewable once for a further three years.
4. The Secretariat is also planning to establish a strategic support group to support WHO and its partners in the global and regional implementation of the global road map and the achievement of its objectives. The main roles and responsibilities of the members of the strategic support group will include: providing political and/or financial support for implementation and monitoring of the global road map; advocating and acting as ambassadors for meningitis prevention and control; and raising public awareness of the burden of meningitis. The strategic support group will consist of representatives from global and regional donors, ministries of health and civil society organizations who are highly committed to defeating meningitis by 2030. The Secretariat will regularly review the composition of the group and assess whether any rotation of members is necessary. The term of membership will be for an initial period of three years, renewable once for a further three years.

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<sup>1</sup> On 28 September 2021, the World Health Organization launched its first global road map to defeat meningitis by 2030: <https://www.who.int/news-room/events/detail/2021/09/28/default-calendar/launch-of-the-defeating-meningitis-roadmap>. (accessed 9 November 2021).



5. The main activities and milestones of the global road map have been integrated into an operational workplan for 2021. An updated workplan for 2022–2023 is being finalized. Under these workplans, some key activities of the global road map have already started, including: (i) development of policies, guidelines and strategies pertaining to the prevention, treatment and detection, as well as the monitoring and management of meningitis and its sequelae; (ii) conducting of outcome-oriented research to inform policy and strategy development; (iii) improvement of the functioning and use of emergency meningitis vaccine stockpiles, including through the repurposing of unused doses for outbreak response; and (iv) strengthening of communication methods to enhance awareness of meningitis and raise its global profile on the global health agenda, including by promoting the integration of meningitis into universal health coverage and primary health care.

6. As a foundation for developing regional implementation frameworks and national meningitis action plans aligned with other related national, regional and global initiatives, the six WHO regions are conducting high-level landscape analyses of key data on meningitis burden and health services by country. The African Region has already finalized its high-level landscape analysis as well as its implementation framework, which was adopted by Member States at the seventy-first session of the Regional Committee for Africa in August 2021.

7. As an additional basis to support and integrate regional and national implementation, it is proposed that the global road map should serve as an illustrative example of how to use the primary health care levers of the operational framework for primary health care for action on meningitis. This, in turn, would help to drive efforts aimed at strengthening the integration of meningitis prevention, diagnosis, treatment and care including management of sequelae into primary health care by increasing service coverage and access to essential medicines, improving surveillance and critical research, and addressing the discrimination and stigma facing people affected by meningitis.

8. The monitoring and evaluation plan of the global road map has been drafted and is expected to be finalized by the end of 2021. The plan is based on the theory of change that underpins the global road map and includes output, outcome and impact indicators that are in line with the global road map's objectives and goals. Since the global road map will reinforce and be integrated with wider initiatives related to strengthening primary health care and health systems, increasing immunization coverage, improving global health security, fighting antimicrobial resistance and ensuring the rights and inclusion of persons with disabilities, the monitoring and evaluation plan has been similarly devised to align with the monitoring and evaluation plans of related initiatives.

9. The drafting of the business case to support the implementation of the global road map is at an advanced stage. The objective of the business case is to promote the global road map and ensure that sufficient resources are available for its implementation at the national, regional and global levels. To this end, it makes the case for financing the road map by: (i) describing the current meningitis situation and the overall health and socioeconomic impact of meningitis on individuals, health systems and society; (ii) showing how the global road map will address current gaps in meningitis control and how it will drive change; (iii) highlighting that the global road map has far-reaching and achievable objectives; (iv) demonstrating that the global road map will bring benefits beyond meningitis; (v) estimating the financial resources necessary for the implementation of each category of activities under the global road map; and (vi) setting out the interest and value of investing in the implementation of the global road map.

10. On 28 September 2021, the Director-General officially launched the global road map via a virtual event, with the aim of increasing awareness of its provisions and strengthening the engagement of stakeholders in its implementation. With a rich, diverse and moving programme, the event addressed those personally affected by meningitis as well as country representatives, implementing

partners and other stakeholders, and included contributions from meningitis advocates, donors and key technical partners.

### **ACTION BY THE EXECUTIVE BOARD**

11. The Board is invited to note the report. In its discussions, it is further invited to provide comments and guidance on the Secretariat's proposed approach, in particular on:

- the proposed establishment of a strategic support group to strengthen coordination and engagement and to raise the profile of meningitis on the global public health agenda; and
- the proposed use of the primary health care levers of the operational framework for primary health care for action on meningitis, including on how to strengthen the integration of meningitis prevention and management in primary health care.

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## **Standardization of medical devices nomenclature**

The Seventy-fifth World Health Assembly, having considered the reports by the Director-General,<sup>1,2</sup> and re-affirming WHO's role in the development, in a transparent and evidence-based way, of norms, standards and a standardized glossary of definitions relating to medical devices, as requested in resolution WHA60.29 (2007),

Decided to request the Director General:

- (1) to integrate available information related to medical devices, including terms, codes and definitions, in the web-based database and clearinghouse established in line with resolution WHA60.29 (2007) and now available as the Medical Devices Information System (MEDEVIS);<sup>3</sup> and to link this to other WHO platforms, such as the International Classification of Diseases (ICD-11),<sup>4</sup> to serve as a reference to stakeholders and Member States;
- (2) to submit a substantive report on progress made in implementing this decision to the Executive Board at its 152nd session in January 2023 and its 156th session in January 2025.

Eighth plenary meeting, 28 May 2022  
A75/VR/8

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<sup>1</sup> Document A75/11.

<sup>2</sup> Document A75/11 Add.1.

<sup>3</sup> MeDevIS is available at <https://medevis.who-healthtechnologies.org/> (accessed 13 May 2022).

<sup>4</sup> ICD-11 is available at <https://www.who.int/standards/classifications/classification-of-diseases> (accessed 13 May 2022).

## **Strengthening WHO preparedness for and response to health emergencies**

The Seventy-fifth World Health Assembly, having considered the report of the Member States Working Group on Strengthening WHO Preparedness and Response to Health Emergencies,<sup>1</sup>

Decided:

- (1) to welcome the report;
- (2) with respect to targeted amendments to the International Health Regulations (2005):
  - (a) to continue the Working Group on Strengthening WHO Preparedness and Response to Health Emergencies, with a revised mandate, including as appropriate and if agreed within each region, the rotation of the Bureau, and name (the “Working Group on Amendments to the International Health Regulations (2005)” (WGIHR)) to work exclusively on consideration of proposed targeted amendments to the International Health Regulations (2005), consistent with decision EB150(3) (2022), for consideration by the Seventy-seventh World Health Assembly in 2024;
  - (b) to request the Director-General to convene a Review Committee on the International Health Regulations (2005) (IHR Review Committee), as early as possible but no later than 1 October 2022, in accordance with Part IX, Chapter III, of the International Health Regulations (2005), in particular Article 50, paragraphs 1(a) and 6, with particular attention to be paid to the fulfilment of the letter and spirit of Article 51, paragraph 2, to make technical recommendations on the proposed amendments referred to in subparagraph (c) below, with a view to informing the work of the WGIHR;
  - (c) to invite proposed amendments to be submitted by 30 September 2022, with all such proposed amendments being communicated by the Director-General to all States Parties without delay;
  - (d) to request the WGIHR to convene its organizational meeting no later than 15 November 2022, and to coordinate with the process of the Intergovernmental Negotiating Body (INB) to draft and negotiate a WHO convention, agreement or other international instrument on pandemic prevention, preparedness and response, including through regular coordination between the two Bureaus and alignment of meeting schedules and workplans, as both the International Health Regulations (2005) and the new instrument are expected to play central roles in pandemic prevention, preparedness and response in the future;

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<sup>1</sup> Document A75/17.

- (e) to request that the IHR Review Committee submit its report to the Director-General no later than 15 January 2023, with the Director-General communicating it without delay to the WGIHR;
  - (f) to request the WGIHR to establish a programme of work, consistent with decision EB150(3), and taking into consideration the report of the IHR Review Committee, to propose a package of targeted amendments, for consideration by the Seventy-seventh World Health Assembly, in accordance with Article 55 of the International Health Regulations (2005);
- (3) to encourage Member States to continue to review and consider the possible actions contained in Appendix 3 of document A75/17, in relation to health emergency prevention, preparedness and response, including through relevant ongoing WHO governing bodies processes, while noting that those possible actions are complementary and additional to existing mandates already under implementation by the Secretariat;
- (4) to request the Director-General:
- (a) to submit a report to the Seventy-sixth World Health Assembly, under a substantive agenda item, on:
    - (i) the Secretariat's progress to implement actions that have been previously mandated by WHO's governing bodies and that are related to the activities mentioned in paragraph 3, in accordance with existing reporting requirements;
    - (ii) as appropriate, views from the WHO Secretariat on possible modalities for carrying forward the activities mentioned in paragraph 3 that are not presently under implementation;
  - (b) to support the WGIHR, by:
    - (i) convening its first meeting no later than 15 November 2022, and subsequent meetings at the request of the co-chairs as frequently as necessary;
    - (ii) providing the WGIHR with the necessary services and facilities for the performance of its work, and complete, relevant and timely information and advice.

Seventh plenary meeting, 27 May 2022  
A75/VR/7

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## **Strengthening clinical trials<sup>1</sup> to provide high-quality evidence on health interventions and to improve research quality and coordination**

The Seventy-fifth World Health Assembly,

Recalling resolutions WHA58.34 (2005) acknowledging that high-quality, ethical research and the generation and application of knowledge are critical in achieving internationally agreed health-related development goals, WHA63.21 (2010) outlining WHO's role and responsibilities in health research, WHA66.22 (2013) and WHA69.23 (2016) on the follow-up of the report of the Consultative Expert Working Group on Research and Development: Financing and Coordination, WHA67.20 (2014) on regulatory system strengthening for medical products, WHA67.23 (2014) on health intervention and technology assessment in support of universal health coverage, WHA74.6 (2021) on strengthening local production of medicines and other health technologies to improve access, and WHA74.7 (2021) on strengthening WHO preparedness for and response to health emergencies, which notes the importance of basic and clinical research and recognizes the critical role of international collaboration in research and development, including in multicountry clinical and vaccine trials, as well as rapid diagnostics test and assay development, while acknowledging the need for further rigorous scientific evidence;

Noting the recommendations made by the Independent Panel for Pandemic Preparedness and Response in their review "COVID-19: make it the last pandemic"<sup>2</sup> relating to health research and development, including clinical trials;

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<sup>1</sup> "A clinical trial is defined by WHO as any research study that prospectively assigns human participants or groups of humans to one or more health-related interventions to evaluate the effects on health outcomes. Clinical trials may also be referred to as interventional trials. Interventions include but are not restricted to drugs, cells and other biological products, surgical procedures, radiologic procedures, devices, behavioural treatments, process-of-care changes, preventive care, etc. This definition includes Phase I to Phase IV trials." Joint statement on public disclosure of results from clinical trials, 2017 (<https://www.who.int/news/item/18-05-2017-joint-statement-on-registration>, accessed 25 May 2022).

<sup>2</sup> Independent Panel for Pandemic Preparedness and Response. COVID-19: make it the last pandemic, 2021 ([https://theindependentpanel.org/wp-content/uploads/2021/05/COVID-19-Make-it-the-Last-Pandemic\\_final.pdf](https://theindependentpanel.org/wp-content/uploads/2021/05/COVID-19-Make-it-the-Last-Pandemic_final.pdf), accessed 25 May 2022).

Recognizing that well-designed<sup>1</sup> and well-implemented clinical trials are indispensable for assessing the safety and efficacy of health interventions;

Noting the role of clinical trials in the development of safe and efficacious new health interventions, and in informing associated comparative cost–effectiveness evaluations vis-à-vis existing interventions with a view to promoting the affordability of health products;

Noting also that clinical trials on new health interventions are likely to produce the clearest result when carried out in diverse settings, including all major population groups the intervention is intended to benefit, with a particular focus on under-represented populations;

Recognizing the potential benefits available from collaboration, coordination and the exchange of information between public and non-public funders of clinical trials, while actively preventing and managing conflicts of interest, and noting the potential benefits from public and non-public funders of clinical trials taking steps to ensure funding is targeted towards well-designed and well-implemented clinical trials that will produce actionable evidence regarding health interventions that address public health priorities and in particular the health needs of developing countries, such as neglected tropical diseases, while seeking to strengthen the capability in developing countries to conduct scientifically and ethically sound clinical trials;

Recognizing also the essential contribution of clinical trial participants;

Underscoring that clinical trials should be health-needs driven, evidence based, well designed and well implemented and be guided by established ethical guidance, including principles of fairness, equity, justice, beneficence and autonomy; and that clinical trials should be considered a shared responsibility;

Acknowledging the importance of promoting equity in clinical trial capability, including by enhancing the core competencies of research personnel, ensuring human subject protections from the risks of clinical trials and acknowledging the shared benefits from the results generated from clinical research and development, including clinical trials, both by strengthening the clinical trial global ecosystem to evaluate health interventions and by working to strengthen country capacities to conduct clinical trials that provide the highest protections to human subjects and meet relevant regulations and internationally harmonized standards by considering: (a) systematic assessment of country-level clinical trial capabilities to promote the ability to conduct rigorous clinical trials compliant with international guidelines and the ability to safeguard human subjects; (b) strengthened global clinical trial capabilities, in coordination with existing organizations and structures, in order to promote well-designed and well-implemented clinical trials that produce high-quality evidence, as well as to ensure trials are designed to reflect the heterogeneity of those who will ultimately use or benefit from the intervention being evaluated, and are conducted in diverse settings, including all major population groups the intervention is intended to benefit, with a particular focus on under-represented populations; (c) where possible, inclusion of all trial stakeholders, including representatives of patient groups, according to best practices in the development of clinical trials with affected communities to ensure that the health interventions address their needs, such as solutions on neglected tropical diseases; (d) that clinical trial participants include all major population groups that the intervention is intended to benefit;

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<sup>1</sup> Throughout this resolution “well-designed trials” refers to trials that are scientifically and ethically appropriate. For submission to medical product regulatory authorities, trials should adhere to International Council for Harmonisation of Technical Requirements for Pharmaceuticals for Human Use guidelines and some Member States may consider International Coalition of Medicines Regulatory Authorities guidelines. In order to generate evidence that is robust enough to support decision-making, such as widespread use of therapeutics or preventives, trials should be designed, conducted, analysed and reported appropriately. A well-designed trial must also be practically feasible to conduct.

(e) promoting transparent and voluntary sharing, while ensuring information and data security, of both well-designed clinical trial methodologies and the results of clinical trials, including negative results, through open-source methods internationally to enable capability-building in diverse settings; and (f) that regulatory measures and other related processes be solidly defined and implemented, including for public health emergencies of international concern;

Recognizing that data from clinical trials play an important role in informing cost-effectiveness assessments of new health interventions and their comparison with existing interventions in order to assess their affordability within the context of national health systems,

1. CALLS ON Member States,<sup>1</sup> in accordance with their national and regional legal and regulatory frameworks and contexts and, as appropriate:

- (1) to prioritize the development and strengthening of national clinical trial capabilities able to comply with international standards of trial design and conduct and human subject protections as well as strengthening and developing national regulatory and quality-control frameworks and authorities;
- (2) to increase clinical trial capability, and strengthen clinical trials policy frameworks, particularly in developing countries, to enable a greater number of clinical trial sites that can conduct well-designed and well-implemented clinical trials, and to ensure readiness for coordination of trials through existing, new or expanded clinical trial networks that meet relevant regulations and internationally harmonized standards, promoting sharing of information and best practices on efficient and ethical clinical trial design and delivery, and in designing, preparing and conducting clinical trials;
- (3) to coordinate clinical trials research priorities based on public health needs of Member States including collaborative and, as appropriate, multicountry and multiregional clinical trials when mutually beneficial, while avoiding unnecessary duplication of work, taking into account that aligning clinical trials across countries will require preparatory work, including the coordination, as appropriate, in national regulatory practices and funding frameworks;
- (4) to collaborate with private-sector funders and academic institutions, while actively preventing and managing conflicts of interest, to encourage the targeting of clinical trials towards the development of health interventions that address public health priorities and concerns of global, regional and national importance, including communicable and noncommunicable diseases, with a focus on the health needs of developing countries, and that evaluate the safety and efficacy of health interventions, including having special regard to common diseases in low- and middle-income countries, unmet medical needs, rare diseases and neglected tropical diseases;
- (5) to note and, as appropriate, benefit from the potential role of regional organizations in coordinating clinical trials and recruiting participants;
- (6) to encourage research funding agencies to prioritize and fund clinical trials that are well-designed and well-implemented, conducted in diverse settings and include all major population groups the intervention is intended to benefit, and have adequate statistical power, and relevant control groups and interventions in order to generate the scientifically robust and

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<sup>1</sup> And, where applicable, regional economic integration organizations.



actionable evidence needed to inform public health policy, regulatory decisions and medical practice while preventing underpowered, poorly designed clinical trials and avoiding the exposure of clinical trials participants to unjustified and unnecessary risk, in normal times as well as in public health emergencies of international concern, including through:

- (a) encouraging investment in well-designed clinical trials, including through clinical trials networks that are developed in collaboration with affected communities, with a view to addressing their public health needs and with the potential for trials to contribute to clinical trial capabilities, including strengthening the core competencies of research personnel, particularly in developing countries;
  - (b) introducing grant conditions for funding clinical trials to encourage the use of standardized data protocols where available and appropriate and to mandate registration in a publicly available clinical trial registry within the WHO International Clinical Trials Registry Platform or any other registry that meets its standards;
  - (c) promoting, as appropriate, measures to facilitate the timely reporting of both positive and negative interpretable clinical trial results in alignment with the joint statement on public disclosure of results from clinical trials<sup>1</sup> and the International Coalition of Medicines Regulatory Authorities and WHO joint statement on transparency and data integrity,<sup>2</sup> including through registering the results on a publicly available clinical trial registry within the WHO International Clinical Trials Registry Platform and encouraging timely publication of the trial results, preferably in an open-access publication;
  - (d) promoting transparent translation of results, including comparison with existing treatments and data on effectiveness, based on thorough assessment, into clinical guidelines where appropriate;
  - (e) exploring measures during public health emergencies of international concern to encourage researchers to rapidly and responsibly share interpretable results of clinical trials, including negative results, with national regulatory bodies or other appropriate authorities, including WHO, for clinical guideline development and emergency use listing, to support rapid regulatory decision-making and emergency adaptation of clinical and public health guidelines as appropriate, including through pre-print publication;
- (7) to support ethics committees and regulatory authorities to enable efficient governance processes to focus on the fundamental scientific and ethical principles that underpin randomized controlled trials, maintaining patient and other trial participant protections, including personal data protection and acting proportionately to risk, to best support well-designed and well-implemented clinical trials and facilitate the development of preparedness for clinical trials including, when appropriate, multicountry trials during public health emergencies of international concern, where scientifically appropriate, while embracing flexibility and innovation;

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<sup>1</sup> Joint statement on public disclosure of results from clinical trials, 2017 (<https://www.who.int/news/item/18-05-2017-joint-statement-on-registration>, accessed 25 May 2022).

<sup>2</sup> International Coalition of Medicines Regulatory Authorities and WHO joint statement on transparency and data integrity, 2021 ([https://www.who.int/news/item/07-05-2021-joint-statement-on-transparency-and-data-integrityinternational-coalition-of-medicines-regulatory-authorities-\(icmra\)-and-who](https://www.who.int/news/item/07-05-2021-joint-statement-on-transparency-and-data-integrityinternational-coalition-of-medicines-regulatory-authorities-(icmra)-and-who), accessed 25 May 2022).

(8) to support new and existing mechanisms to facilitate rapid regulatory decision-making during public health emergencies of international concern, so that:

- (a) safe, ethical, well-designed clinical trials can be approved and progress quickly;
- (b) data from clinical trials can be assessed rapidly, including through WHO Emergency Use Listing procedure, and health interventions deemed safe and effective swiftly authorized;

(9) to facilitate – while protecting confidentiality of information when appropriate, in normal times as well as in public health emergencies of international concern – sharing among regulatory authorities of:

- (a) their assessments of clinical trial protocols to enable the implementation of rigorous protocols in practice;
- (b) assessment reports on health interventions with potential significance and public health importance to inform, when possible, decision-making processes in other countries, including for potential regulatory assessments and decisions related to the inclusion of health interventions in their national health system, as well as for safety monitoring;

(10) to support new and existing mechanisms to facilitate the rapid interpretation of data from clinical trials to develop or amend, as necessary, relevant guidelines during public health emergencies of international concern;

(11) to facilitate collaboration and synergies among actors, institutions and networks in the clinical evidence ecosystem throughout the continuum from clinical research to utilization of data from clinical trials in clinical practice through comparative evidence evaluations, evidence synthesis, health technology assessments, regulatory decisions, comparative cost-effectiveness analysis vis-à-vis existing health interventions and, as appropriate, development of evidenced based guidelines and monitoring of implementation in clinical practice;

2. INVITES international nongovernmental organizations and other relevant stakeholders to explore opportunities to coordinate research priorities, and promote investments in clinical trial research and the effective, equitable and timely deployment of resources and funding, while actively preventing and managing conflicts of interest, to support robust, quality clinical trials as well as to strengthen clinical trial research capacities globally, particularly in developing countries and for diseases disproportionately affecting developing countries;

3. REQUESTS the Director-General:

(1) to organize, in a transparent manner, stakeholder consultations, in line with the Framework of Engagement with Non-State Actors, with Member States, nongovernmental organizations including patient groups, private-sector entities including international business associations, philanthropic foundations and academic institutions, as appropriate, on the respective roles of the WHO Secretariat, Member States<sup>1</sup> and non-State actors, and to identify and propose to Member

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<sup>1</sup> And, where applicable, regional economic integration organizations.

States, for consideration by the governing bodies, best practices and other measures to strengthen the global clinical trial ecosystem, taking into account relevant initiatives where appropriate;

(2) to review existing guidance and develop, following the standard WHO processes, new guidance as needed on best practices for clinical trials, including on strengthening the infrastructure needed for clinical trials, to be applied in normal times and with provisions for application during a public health emergency of international concern, taking into account relevant initiatives and guidelines as appropriate, such as those led by the International Council for Harmonisation of Technical Requirements for Pharmaceuticals for Human Use and other organizations by providing, as appropriate:

(a) guidance on best practices to help to guide Member States' implementation of scientifically and ethically sound clinical trials within their national and regional contexts;

(b) guidance on best practices for non-State actors in the design and conduct of clinical trials and in strengthening the global clinical trial ecosystem to meet the needs of major population groups that the intervention is intended to benefit, with a particular focus on under-represented populations, developed in consultation with Member States<sup>1</sup> and relevant non-State actors;

(3) to provide to Member States, on their request, guidance, taking into account relevant initiatives and guidelines, as appropriate, on best practices for developing the legislation, infrastructure and capabilities required for clinical trials, taking into account national and regional contexts;

(4) to engage with, as appropriate, relevant non-State actors in line with the Framework of Engagement with Non-State Actors to strengthen clinical trial capabilities, particularly in developing countries, on innovations that meet the needs of major population groups that the intervention is intended to benefit, with a particular focus on under-represented populations;

(5) to present a substantive report outlining progress in the activities requested of the Director-General in this resolution for consideration by the Seventy-sixth World Health Assembly in 2023 through the Executive Board at its 152nd session.

Seventh plenary meeting, 27 May 2022  
A75/VR/7

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<sup>1</sup> And, where applicable, regional economic integration organizations.

# **Implementation of the International Health Regulations (2005)**

## **Report by the Director-General**

1. This document is submitted in response to resolution WHA61.2 (2008), and to decision WHA71(15) (2018) on Implementation of the International Health Regulations (2005): five-year global strategic plan to improve public health preparedness and response, 2018–2023, in which the Health Assembly requests the Director-General “to submit every year a single report to the Health Assembly on progress made in implementation of the International Health Regulations (2005), containing information provided by States Parties and details of the Secretariat’s activities, pursuant to paragraph 1 of Article 54 of the International Health Regulations (2005)”. Pursuant to the request in resolution WHA74.7 (2021) on strengthening WHO preparedness for and response to health emergencies, a report on implementation of the resolution<sup>1</sup> is submitted separately.

## **EVENT MANAGEMENT**

### **Event-related information**

2. Information on events monitored by the Secretariat comes from a variety of sources, including national government agencies, National IHR Focal Points, WHO offices, news media and other organizations or partners. The Secretariat routinely requests verification of information on such events under Article 10 of the Regulations. Delays continued to be observed in 2021 in States Parties’ notification of events to the Secretariat as well as their response to requests for event verification under Articles 6 and 10 of the Regulations.

3. In 2021, events monitored by the Secretariat resulted in 104 publications on the Event Information Site for National IHR Focal Points (EIS), relating to 57 country-specific public health events. Most event updates concerned acute hepatitis E, cholera, influenza due to identified avian or animal influenza viruses, Ebola virus disease, Middle East respiratory syndrome, yellow fever and monkeypox. In parallel, 127 announcements were published on the EIS, mainly relating to additional health measures in response to coronavirus disease (COVID-19) and to variants of concern of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2). Additional reporting on COVID-19 was undertaken through weekly epidemiological updates, with 53 such updates published in 2021. WHO also published on its website 38 updates on new and ongoing confirmed public health events as disease outbreak news in 2021, related to 21 events in 22 countries.

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<sup>1</sup> Document A75/10.

## Emergency committees

4. The IHR Emergency Committee regarding ongoing events and context involving transmission and international spread of poliovirus is entering its eighth year of existence following the initial determination by the Director-General that the event constituted a public health emergency of international concern in April 2014. In 2021, it continued to meet on a quarterly basis.<sup>1</sup> At its thirty-first meeting on 28 February 2022, multiple outbreaks of circulating vaccine-derived poliovirus remained a concern, as well as the continued potential effects of COVID-19 on polio eradication. On the advice of the Committee, the Director-General maintained the status of a public health emergency of international concern and issued revised temporary recommendations.

5. The IHR Emergency Committee for COVID-19 met on four occasions in 2021, in line with decision WHA74(15). At its eleventh and latest meeting on 11 April 2022, the Director-General followed the advice of the Committee and maintained the status of a public health emergency of international concern, issuing updated temporary recommendations under the International Health Regulations (2005).<sup>2</sup>

## Review Committee on the Functioning of the International Health Regulations (2005) during the COVID-19 Response

6. The Review Committee was convened by the Director-General on 8 September 2020 and conducted its work until April 2021, supported throughout by the IHR Secretariat. The Committee's mandate, based on resolution WHA73.1 (2020) and in accordance with Article 50 of the International Health Regulations (2005), was to review the functioning of the Regulations during the COVID-19 response, with reference to the provisions of the Regulations as appropriate. In this regard, the Review Committee undertook an article-by-article assessment of the functioning of the Regulations to examine whether the perceived shortcomings in their effectiveness during the COVID-19 response were due to the design of the Regulations or from challenges in their implementation. Overall, the Review Committee noted that the design of the Regulations fulfils its original aim as the agreed framework for global health protection, and no major amendments are needed at this stage. However, the interpretation and implementation of the Regulations by both the WHO Secretariat and States Parties is suboptimal.

7. The Review Committee's report,<sup>3</sup> which includes 40 recommendations in ten areas to strengthen implementation of and compliance with the International Health Regulations (2005), was presented by the Director-General to the Seventy-fourth World Health Assembly in May 2021. As decided by the Health Assembly in resolution WHA74.7, the findings and recommendations of the Review Committee are to be considered by the newly established Member States Working Group on Strengthening WHO Preparedness and Response to Health Emergencies, together with those of the Independent Panel for Pandemic Preparedness and Response and of the Independent Oversight and Advisory Committee for the WHO Health Emergencies Programme. Pursuant to the same resolution, the Working Group will submit a report with proposed actions for the WHO Secretariat, Member States and non-State actors, as

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<sup>1</sup> See <https://www.who.int/news/item/11-03-2022-statement-of-the-thirty-first-polio-ihr-emergency-committee> (accessed 30 March 2022).

<sup>2</sup> See [https://www.who.int/news/item/13-04-2022-statement-on-the-eleventh-meeting-of-the-international-health-regulations-\(2005\)-emergency-committee-regarding-the-coronavirus-disease-\(covid-19\)-pandemic](https://www.who.int/news/item/13-04-2022-statement-on-the-eleventh-meeting-of-the-international-health-regulations-(2005)-emergency-committee-regarding-the-coronavirus-disease-(covid-19)-pandemic) (accessed 19 April 2022).

<sup>3</sup> Document A74/9 Add.1.

appropriate, for consideration by the Seventy-fifth World Health Assembly through the Executive Board at its 150th session.

8. In addition, in accordance with Article 55 of the International Health Regulations (2005), one State Party submitted proposed amendments to the Regulations, which were communicated by the Director-General to all States Parties on 20 January 2022 for consideration by the Seventy-fifth World Health Assembly.<sup>1</sup> In accordance with decision EB150(3), the Member States Working Group on Strengthening WHO Preparedness and Response to Health Emergencies will include, as part of its ongoing work, dedicated time to allow for discussions on strengthening of the International Health Regulations (2005), including through implementation, compliance and potential amendments.

## STRENGTHENING NATIONAL CORE CAPACITIES

9. In 2021, the Secretariat developed and published the second edition of the State Party Self-Assessment Annual Reporting tool, taking into account the lessons learned from the COVID-19 pandemic, and continued to provide the tool in an electronic format that allows States Parties to report online, thereby facilitating the reporting by States Parties, as well as providing transparency, enabling real-time monitoring of reports submitted and offering opportunities for quality checks of data provided. Up-to-date data for the 2021 cycle are available on WHO's electronic State Parties Self-Assessment Annual Reporting portal.<sup>2</sup>

10. The Secretariat continued to work with States Parties to strengthen their laboratory core capacities, by leveraging short-term preparedness, readiness and response activities for COVID-19 in order to improve longer-term laboratory capacities for other epidemic-prone diseases and high threat pathogens. Technical assistance has been provided to national public health laboratory networks through both online and on-site workshops, training and mentoring visits. The investments made in sequencing platforms for SARS-CoV-2 should benefit other pathogens of epidemic and pandemic potential. Laboratory workforces have been strengthened through the increased implementation of the Global Laboratory Leadership Programme,<sup>3</sup> a unique learning and mentoring programme for laboratory managers and leaders aimed at strengthening laboratory systems through a One Health approach.

11. The Secretariat continued to provide technical support for enhancing core risk communication capacities by leveraging and coordinating the efforts of key international and national agencies and partners, spanning the public health and humanitarian sectors. The Collective Service for Risk Communication and Community Engagement is a coordination mechanism involving WHO, UNICEF, the International Federation of Red Cross and Red Crescent Societies and the Global Outbreak Alert and Response Network.<sup>4</sup> The Collective Service, which was established during the COVID-19 pandemic, created a comprehensive data repository and global dashboard on social behavioural information in relation to COVID-19 drawing from over 200 social and behavioural surveys. The Collective Service also developed interim guidance, COVID-19 materials and products and two online training courses ("risk communication and community engagement challenges" and "social and behavioural insights COVID-19 data collection tool for Africa"), available on the OpenWHO platform.

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<sup>1</sup> See document A75/1 Add.1.

<sup>2</sup> See e-SPAR platform (<https://extranet.who.int/e-spar/>, accessed 30 March 2022).

<sup>3</sup> See <https://www.who.int/initiatives/global-laboratory-leadership-programme> (accessed 9 February 2022).

<sup>4</sup> See <https://www.rcce-collective.net/the-collective-service/> (accessed 9 February 2022).

## COMPLIANCE WITH REQUIREMENTS OF THE REGULATIONS

12. This section provides information about compliance with several requirements of the Regulations, including those in the areas of additional health measures; event notification and verification; the establishment and maintenance of National IHR Focal Points; and key provisions in relation to points of entry and yellow fever vaccination.

### Additional health measures

13. The Secretariat has continued to implement a structured approach in coordination with the regional offices for monitoring States Parties' compliance regarding additional health measures. In accordance with Article 43 of the Regulations, the Secretariat shared information about these measures, and, when available, the public health rationale, with all States Parties on a weekly basis, through 48 updates published on the secure platform of the Event Information Site for National IHR Focal Points. The Secretariat's analysis of these measures has regularly informed the deliberations of the IHR Emergency Committee for COVID-19.

14. As at 28 January 2022, the Secretariat has received reports of more than 9000 new measures that significantly interfere with international travel or trade, comprising extensions, revisions or terminations of such measures. The measures include air, land and maritime border closures for one or more countries, quarantine requirements, testing before, during or after arrival and, more recently, requirement of proof of vaccination against COVID-19 as a condition for travel.

15. As of 28 January 2022, 38 countries introduced requirements of proof of vaccination against COVID-19 as the only condition for travel, at least for specific population groups (such as non-nationals and non-immunized or non-essential travellers) or types of travel (for example, travel to or from red-zone countries), against the temporary recommendations issued by the Director-General on the advice of the Emergency Committee since its sixth meeting in January 2021,<sup>1</sup> and extended at all subsequent meetings, including at the latest meeting in January 2022.<sup>2</sup>

16. The rationale provided by States Parties who reported the measures to WHO during 2021 include uncertainties about the epidemiology of new variants of concern and their transmissibility (Delta in early 2021 and Omicron in late 2021), their impact on the clinical profile of the disease, limited or unknown effectiveness of treatments and vaccines, as well as the vulnerabilities of public health response systems in case of importation of the disease.

17. Following WHO's designation on 26 November 2021 of the SARS-CoV-2 variant B.1.1.529 as a variant of concern, named Omicron, WHO issued updated travel advice, stating that "[b]lanket travel bans will not prevent the international spread, and they place a heavy burden on lives and livelihoods. In addition, they can adversely impact global health efforts during a pandemic by disincentivizing countries to report and share epidemiological and sequencing data."<sup>3</sup> Despite this, 56 countries

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<sup>1</sup> See [https://www.who.int/news/item/15-01-2021-statement-on-the-sixth-meeting-of-the-international-health-regulations-\(2005\)-emergency-committee-regarding-the-coronavirus-disease-\(covid-19\)-pandemic](https://www.who.int/news/item/15-01-2021-statement-on-the-sixth-meeting-of-the-international-health-regulations-(2005)-emergency-committee-regarding-the-coronavirus-disease-(covid-19)-pandemic) (accessed 30 March 2022).

<sup>2</sup> See [https://www.who.int/news/item/19-01-2022-statement-on-the-tenth-meeting-of-the-international-health-regulations-\(2005\)-emergency-committee-regarding-the-coronavirus-disease-\(covid-19\)-pandemic](https://www.who.int/news/item/19-01-2022-statement-on-the-tenth-meeting-of-the-international-health-regulations-(2005)-emergency-committee-regarding-the-coronavirus-disease-(covid-19)-pandemic) (accessed on 7 February 2022).

<sup>3</sup> See <https://www.who.int/news-room/articles-detail/who-advice-for-international-traffic-in-relation-to-the-sars-cov-2-omicron-variant> (accessed 7 January 2022).

introduced temporary travel restrictions concerning South Africa, where the variant was first reported, and other countries, primarily affecting between six and eight countries in southern Africa. By 10 December 2021, 112 State Parties had reported such measures, including denial of entry, flight suspension and additional testing and/or quarantine for travellers arriving from those countries. As at 10 February 2022, 36 countries still applied a travel or flight restriction due to the variant of concern, mainly involving southern African countries.

### **Event notification and verification and National IHR Focal Points**

18. Several WHO regional offices have continued the monitoring and reporting of States Parties' compliance with obligations under the Regulations with regard to event notification and verification.

19. The Secretariat has continued to facilitate the round-the-clock accessibility of all National IHR Focal Points and WHO's IHR Contact Points. In 2021, 66% of National IHR Focal Points confirmed or updated their contact information. By the end of 2021, there were 992 country-designated users of the Event Information Site for National IHR Focal Points, of whom 143 were new users and 443 were updated accounts. Responding to requests by the Secretariat concerning the contact details of the Focal Points and users of the Site remains a challenge in a number of States Parties.

20. The Secretariat continued to support the learning of National IHR Focal Points and others involved in implementation of the Regulations, notably by boosting access to the Health Security Learning Platform and related online courses. In 2021, several new initiatives were launched to this end, including an National IHR Focal Points onboarding learning package, a training course on the Event Information Site and a training course on the IHR monitoring and evaluation framework, all of which are available on the learning platform. The Global and Regional Knowledge Networks for National IHR Focal Points and national rapid response teams continued to facilitate the sharing of experiences and peer-to-peer learning among their respective members.

21. Two IHR introduction workshops were organized remotely for the National IHR Focal Points in two European countries in 2021. A training course on the Epidemic Intelligence from Open Sources initiative was organized for public health intelligence teams in two European countries (one was held in person and the other remotely). Relevant technical guidance on COVID-19 issues has been shared with Focal Points in Europe in a timely manner through the COVID-19 Surveillance Pillar.

### **Points of entry**

22. Since 2007, 112 of a total of 152 coastal States Parties and four landlocked States Parties with inland ports have sent WHO the list of ports authorized to issue ship sanitation certificates, as required by the Regulations. The global list of authorized ports is now 1872.<sup>1</sup>

23. The Secretariat continued efforts to foster collaboration with its partners to promote the implementation of the Regulations at points of entry for international travel and transport, during routine periods and health emergencies. The Secretariat supported the International Maritime Organization in its process of reviewing and updating the Annex of the Convention on Facilitation of International Maritime Traffic, in an effort to ensure its alignment with relevant provisions of the Regulations. In the context of the COVID-19 pandemic, as well as other health emergencies such as the Ebola virus disease outbreak in the Democratic Republic of the Congo, extensive and regular coordination has been

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<sup>1</sup> See the list of ports authorized to issue ship sanitation certificates  
([https://extranet.who.int/ihr/poedata/data\\_entry/ctrl/portListPDFCtrl.php](https://extranet.who.int/ihr/poedata/data_entry/ctrl/portListPDFCtrl.php), accessed on 9 February 2022).



maintained with global partner organizations in the areas of travel, transport, economic development, migration and tourism, with the aim of sharing scientific knowledge and public health surveillance data, and promoting a coordinated multisectoral response to health emergencies, including with regard to the protection of essential transport workers. Key partners included, among others, ICAO, ILO, IMO, IOM, OECD and the World Tourism Organization.

24. In collaboration with partners, the Secretariat has produced and updated policy and technical guidance and operational tools, and organized global and regional webinars, consultations and training to support countries in implementing a risk-based approach to international traffic during health emergencies, and strengthening public health measures and capacities under the Regulations at points of entry, including in the context of the COVID-19 pandemic.

25. The Secretariat continued to conduct regular systematic reviews to gather the evidence available on the effectiveness of travel-related measures to minimize the exportation, importation and onwards transmission of SARS-CoV-2, as well as their broader impact on international travellers.

26. In July 2021, the Secretariat updated its interim guidance documents on considerations to implement a risk-based approach to international travel in the context of COVID-19, incorporating the emergence of new variants in the risk assessment and factoring COVID-19 vaccination into the overall risk management process. Other updated sectoral guidance documents include the implementation guide for the management of COVID-19 on board cargo ships and fishing vessels.

27. Regional offices have supported countries in strengthening capacities and implementing public health measures at points of entry in the context of COVID-19 and beyond. The WHO Regional Office for Europe has supported online consultations with Member States and organized assessments of and training on points of entries for several countries. It also published an operational framework for international travel-related public health measures in the context of COVID-19 to improve coordinated national decision-making regarding additional health measures that significantly interfere with international traffic under Article 43 of the International Health Regulations (2005). The WHO Regional Office for Europe has published three public health checklists for controlling the spread of COVID-19 at ground crossings, in aviation and in ships, sea ports and inland ports.

## **Yellow fever vaccination**

28. Information about States Parties' requirements for vaccination against yellow fever is collected annually through a questionnaire sent by the Secretariat to all National IHR Focal Points. The information is published in Annex 1 of WHO's report on international travel and health.<sup>1</sup> In addition, the WHO Secretariat also each year publishes State Parties' requirements and WHO's recommendations on vaccination and prophylaxis for international travellers, particularly for yellow fever, malaria and poliomyelitis.<sup>2</sup> Currently, 120 States Parties and territories request a certificate of vaccination against yellow fever for incoming travellers. In 2020, 122 countries confirmed that international certificates of vaccination against yellow fever, using WHO-approved vaccines, are now accepted as valid for the life of the person vaccinated, which they should be in accordance with Annex 7 of the Regulations, as

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<sup>1</sup> Annex 1, Countries with risk of yellow fever transmission and countries requiring yellow fever vaccination (May 2021) ([https://www.who.int/publications/m/item/countries-with-risk-of-yellow-fever-transmission-and-countries-requiring-yellow-fever-vaccination-\(may-2021\)](https://www.who.int/publications/m/item/countries-with-risk-of-yellow-fever-transmission-and-countries-requiring-yellow-fever-vaccination-(may-2021))), accessed 8 February 2022).

<sup>2</sup> Vaccination requirements and recommendations for international travellers; and malaria situation per country – 2021 edition (<https://www.who.int/publications/m/item/vaccination-requirements-and-recommendations-for-international-travellers-and-malaria-situation-per-country-2021-edition>), accessed 8 February 2022).

amended by resolution WHA67.13 (2014) on implementation of the Regulations. The survey for 2022 is ongoing and results will be published in the latter part of 2022.

## **ACTIVITIES BY THE SECRETARIAT IN SUPPORT OF STATES PARTIES TO IMPLEMENT THE REGULATIONS**

29. The Secretariat has continued to provide sustained support to States Parties to enhance preparedness for all hazards.

30. In 2021, the Secretariat continued to provide the State Party Self-Assessment Annual Reporting tool in an electronic format that allows States Parties to report online, thereby facilitating the reporting by States Parties, as well as providing transparency, enabling the real-time monitoring of reports submitted and offering opportunities for quality checks of data provided. In March 2021, the Secretariat hosted a global consultation followed by a series of technical working group meetings to review the State Party Self-Assessment Annual Reporting and joint external evaluation tools and processes in order to incorporate lessons learned from the COVID-19 pandemic in ways that make these national preparedness assessments more reflective of the performance of country capacities to detect and respond to severe epidemic and pandemic threats. This will also facilitate and strengthen the development, review and implementation of national action plans for health security.

31. As at 14 January 2022, 110 COVID-19 intra-action reviews had been carried out by 71 countries, 114 joint external evaluations had been completed, 170 simulation exercises undertaken and 68 after-action reviews conducted. The Secretariat also developed intra-action review and simulation exercise packages<sup>1</sup> on vaccination to support countries in strengthening their functional capacities in order to address critical gaps during the COVID-19 pandemic.<sup>2</sup> The intra-action review package is available in all of WHO's six official languages as well as in Portuguese. In June 2021, the Secretariat supported an after-action review of the response to the ninth, tenth, eleventh and twelfth outbreaks of Ebola virus disease in the Democratic Republic of the Congo.

32. In 2021, the Secretariat published the WHO Strategic Toolkit for Assessing Risks (STAR),<sup>3</sup> which is a comprehensive toolkit to support countries in identifying all-hazard preparedness and disaster risks. The Toolkit also facilitates the development of robust policies, strategies and plans to address the vulnerabilities that countries can face in terms of health emergencies and disasters.

33. In 2021, the Secretariat developed technical and procedural guidance for Member States to undertake voluntary pilots of the Universal Health and Preparedness Review, which has been proposed as a means of increasing accountability, solidarity and transparency among countries in health emergency preparedness gap identification and capacity-building. The Universal Health and Preparedness Review is a voluntary peer-to-peer review mechanism, led and owned by Member States, to promote greater, more effective international cooperation and global solidarity by bringing countries and stakeholders together to enhance preparedness. In September 2021, WHO established a technical advisory group, comprising 21 international experts, to advise on the conceptual development of the mechanism. In accordance with resolution WHA74.7, a detailed concept note on the proposed Universal Health and Preparedness Review mechanism has been developed and submitted for consideration by the

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<sup>1</sup> See <https://www.who.int/emergencies/diseases/novel-coronavirus-2019/training/simulation-exercise> (accessed 9 February 2022).

<sup>2</sup> See the COVID-19 Strategic Preparedness and Response Plan (<https://www.who.int/publications/i/item/WHO-WHE-2021.02>, accessed 4 January 2022).

<sup>3</sup> See <https://www.who.int/publications/i/item/9789240036086> (accessed 9 February 2022).

Seventy-fifth World Health Assembly following a consultation process with all Member States in April 2022.<sup>1</sup> Four country pilot tests were conducted between December 2021 and May 2022 in Central African Republic, Iraq, Portugal and Thailand and were facilitated by a WHO support mission. As at 4 May 2021, 21 Member States have expressed interest in piloting the Universal Health and Preparedness Review

34. To further support States Parties in the strengthening of their One Health capacities, the Secretariat, jointly with the World Organisation for Animal Health and the Food and Agriculture Organization of the United Nations, continued to support States Parties to strengthen multisectoral collaboration at the human-animal-environment interface. National bridging workshops were organized to facilitate countries' reviews of their gaps in coordination for zoonotic events and to develop operational road maps to improve multisectoral capacities. The workshops were organized in four additional countries in 2021, with the total number of workshops completed across all countries standing at 36 as at 14 January 2022. To support the implementation of activities in the national bridging workshop road maps, 10 WHO country offices have recruited national bridging workshop catalysts (national One Health experts). In addition, in 2021 multiple countries received support on using the principles and best practices set out in the Tripartite Zoonoses Guide.<sup>2</sup> This included launching online training, publishing the Joint Risk Assessment Operational Tool and piloting the Multisectoral Coordination Mechanism Operational Tool and the Surveillance and Information Sharing Operational Tool.

35. The Secretariat has also made progress in developing a dynamic preparedness metric framework to address the need for more dynamic measures to reflect current and changing risks and countries' corresponding preparedness status, including hazards and threats, vulnerabilities and capacities. The framework will bring together current preparedness assessment tools and metrics with other relevant interdependencies in order to more effectively identify national strengths and gaps and prioritize capacity-building actions, including those relating to the WHO benchmarks for capacities under the International Health Regulations (2005).<sup>3</sup>

36. The Secretariat has undertaken a review of the cost estimates for improving health emergency preparedness at the national and global levels. This work will inform and facilitate the development of investment cases to better – and more sustainably – finance preparedness and capacity-building.

37. The Secretariat has launched a series of small research grants to document, synthesize and disseminate knowledge on existing national best practices for implementation of the Regulations. So far, the Secretariat has facilitated 13 grants across nine countries in the Eastern Mediterranean Region, with further support across more regions planned for the near future.<sup>4</sup>

38. In 2021, the Secretariat published “Health Systems for Health Security”,<sup>5</sup> a framework to support countries and partners in bringing together the capacities required for implementation of the Regulations, as well as the components of health systems and other sectors needed to ensure effective multisectoral

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<sup>1</sup> Document A75/21.

<sup>2</sup> See <https://www.who.int/initiatives/tripartite-zoonosis-guide> (accessed 9 February 2022).

<sup>3</sup> See <https://www.who.int/publications/i/item/9789241515429> (accessed 9 February 2022).

<sup>4</sup> See Supporting research on health security preparedness in the Eastern Mediterranean Region (<https://tdr.who.int/newsroom/news/item/03-11-2021-supporting-research-on-health-security-preparedness-in-the-eastern-mediterranean-region>, accessed 7 February 2022).

<sup>5</sup> See <https://www.who.int/publications/i/item/9789240029682> (accessed 9 February).

and multidisciplinary preparedness for and management of health emergencies. The framework is an innovative approach that complements existing concepts and tools for global health security capacity-building and that facilitates more synergistic working relationships between stakeholders in health security, health systems and other sectors to ensure multisectoral and multidisciplinary health emergency preparedness. It also contains a list of 22 thematic areas for consideration in building country capacities towards health security.

39. The Secretariat continued to support States Parties in applying the WHO benchmarks for capacities under the International Health Regulations (2005) in order to support emergency preparedness capacity-building. The benchmarks and corresponding actions can strengthen countries' emergency preparedness through the development and implementation of national action plans for health security. The Secretariat has also developed a benchmarks reference library to provide States Parties, partners and public health stakeholders with direct access to relevant guidance, tools and materials that support the implementation of proposed capacity-building actions in relation to the benchmarks.

40. The Secretariat, in 2021, advanced progress towards establishing and piloting the Global Strategic Preparedness Network in line with resolution WHA73.8 (2020) on strengthening preparedness for health emergencies: implementation of the International Health Regulations (2005), including through extensive strategic and technical consultations with Member States, international organizations, multisectoral networks and partners. The network will facilitate implementation of national health security plans and capacity-building through a network of technical experts that can work with countries in addressing identified preparedness gaps.

41. In 2021, the Secretariat revamped and enhanced WHO's portal for the Strategic Partnership for IHR and Health Security. The portal now has expanded functionalities that can be used to scale up multisector coordination and collaboration for preparedness and to better track and monitor national preparedness investments in relevant capacity-building activities, including those contained in national action plans for health security.

42. The Secretariat also further expanded the implementation of the WHO Resource Mapping (REMAP) tool and process to support countries in identifying all nationally available technical and financial resources that can be used to strengthen preparedness. Through REMAP, over 3450 different activities representing a total of over US\$ 7.89 billion in disclosed contributions from 62 donors and partners have been tracked and displayed on WHO's portal for the Strategic Partnership for IHR and Health Security. The portal's partner matching capabilities have also enabled donors, partners and countries to mobilize multisectoral resources to support emergency preparedness strengthening at the national level.

43. In 2021, the Secretariat developed an e-learning version of the training course on the IHR monitoring and evaluation framework. The course comprises four modules to support public health stakeholders in enhancing their capacity to implement monitoring and evaluation activities, carry out capacity-building planning through national action plans for health security and strengthen national capacities to prevent, detect and respond to health emergency threats like COVID-19.

44. The Secretariat continued to support the development of preparedness case studies to document all best practices, challenges and opportunities for enhancing national health emergency management capacities. In 2021, 12 articles from WHO regional offices were published in a supplement edition of the *Weekly Epidemiological Record*, six country case studies were published on WHO's portal for the Strategic Partnership for IHR and Health Security and three interviews with IHR champions were conducted to share knowledge about best practices related to strengthening preparedness against Ebola

virus disease in Guinea, the implementation of strategic risk assessments in the European Region and the application of information and computing technology for preparedness in Rwanda.

45. In the context of country readiness strengthening, WHO continued to support the capacity-building of national rapid response teams. The Secretariat assessed the impact of the national rapid response team training delivered between 2015 to 2020 and the mechanisms contributing to these impacts at the individual, team and organizational levels. The COVID-19 National Rapid Response Teams Online Learning Programme was updated and now comprises eight separate modules offered in English, French and Spanish.

46. Strengthening health emergency preparedness and response is one of the most important health priorities in the South East Asia Region. Throughout the response to COVID-19, Member States, the Secretariat and other partners have worked together through various platforms, including Regional Committee meetings, to identify priority actions to further strengthen health emergency preparedness and response capacities while building national health security systems that are linked to resilient health systems. In the context of COVID-19, the region also regularly communicates with Member States; four virtual meetings have been held with National IHR Focal Points and the Regional Knowledge Network for National IHR Focal Points, to facilitate the exchange of information, experiences and lessons learned.

## **CONCLUSION**

47. The implementation of the International Health Regulations (2005) continued to be a challenge in 2021 due to the COVID-19 pandemic. It is expected that the discussions surrounding the potential adoption of a WHO convention, agreement or other international instrument on pandemic prevention, preparedness and response and proposed amendments to the Regulations will contribute in a meaningful way to strengthen the current global architecture and governance for efficient and effective health protection and security.

## **ACTION BY THE HEALTH ASSEMBLY**

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

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## **Influenza preparedness**

### **Report by the Director-General**

#### **Background**

1. In August 2020, the Seventy-third World Health Assembly adopted decision WHA73(14) on influenza preparedness. The decision included a request to the Director-General to report on implementation of the decision to the Seventy-fifth World Health Assembly through the Executive Board at its 150th session.
2. This report describes progress in strengthening influenza preparedness, notably in implementing the actions requested in decision WHA73(14), and areas where the capacities and systems developed for influenza preparedness have supported the coronavirus disease (COVID-19) pandemic response.

#### **Engagement with Member States and stakeholders**

3. The Secretariat used different opportunities to reach out to Member States and relevant stakeholders and to provide them with updates on progress in implementing decision WHA73(14). Examples include developing a pre-recorded briefing on key achievements and challenges in implementing the decision, which was distributed to Member States and relevant stakeholders in July 2021, and distributing a questionnaire to seek feedback on WHO's implementation of the decision, including specific operative paragraphs.

#### **Operative paragraph (1): Global Influenza Strategy 2019–2030**

4. In decision WHA73(14), the Health Assembly noted the release of the Global Influenza Strategy 2019–2030. The Secretariat is developing the first biennial report on its implementation, which will provide details on activities undertaken to date towards achieving the Strategy's two high-level outcomes: better global tools and stronger country capacities. The report is expected to be published by the end of 2021 and will be available online.

#### **Operative paragraph (2)(a): National influenza pandemic preparedness plans and vaccination programmes**

5. Through its guidance on pandemic influenza risk management published in 2017,<sup>1</sup> WHO encourages countries to develop, test and update national influenza pandemic preparedness plans to

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<sup>1</sup> Pandemic influenza risk management: a WHO guide to inform and harmonize national and international pandemic preparedness and response. Geneva: World Health Organization; 2021 (<https://apps.who.int/iris/handle/10665/259893>, accessed 20 October 2021).

reflect a risk-based approach so that national plans are flexible, account for national risk assessments, and take into consideration global risk assessments conducted by WHO.

6. The Secretariat previously developed a package of tools for use by countries in developing and updating their national influenza pandemic preparedness plans and in conducting simulation exercises.<sup>1</sup> The Secretariat has begun a process to review its pandemic influenza risk management guidance in order to identify areas that can be strengthened based on lessons learned from the COVID-19 pandemic response.

7. In 2013, the Pandemic Influenza Preparedness (PIP) Framework Advisory Group identified five areas of work for focused investments by WHO with the Partnership Contribution preparedness funds. A sixth area on planning for pandemic influenza was added in 2018. Through the sixth area of work, and in alignment with the guidance on pandemic influenza risk management, the Secretariat provides support to countries to develop, test and update their national influenza pandemic preparedness plans. As of June 2021, of the 63 countries that received PIP Partnership Contribution Preparedness funds for pandemic influenza preparedness planning in the 2020–2021 biennium, 35 countries had a plan based on pandemic influenza risk management. Additionally, all 40 countries that received 2018–2019 PIP Partnership Contribution preparedness funds for pandemic influenza preparedness planning were able to develop a COVID-19 response plan in 2020, and 36 of them developed their plans based on their national influenza pandemic preparedness plan within four months after the declaration of the public health emergency of international concern.

8. Safe and efficacious seasonal influenza vaccines are critical to influenza prevention and control efforts, and WHO recommends annual seasonal influenza vaccination as the best intervention for preventing disease and reducing disease severity and societal burden due to influenza. In 2012, WHO released its seasonal influenza vaccination position paper, which recommended the vaccination of priority target groups, including pregnant women, children aged 6–59 months, older adults, individuals with specific chronic medical conditions, and health workers.<sup>2</sup>

9. The Secretariat has developed an influenza vaccination toolbox, which includes relevant tools and guidance related to influenza vaccine programme development and strengthening for use by Ministry of Health officials, vaccinators, health workers, researchers and other stakeholders.<sup>3</sup>

10. In addition, the Secretariat is providing support to countries to develop or expand their seasonal influenza vaccination policies and programmes by addressing influenza vaccine hesitancy through understanding and assessing influenza vaccine acceptance, demand and uptake.

### **Operative paragraph (2)(b): Seasonal influenza vaccines, diagnostics and treatments**

11. Seasonal influenza prevention and control is possible due to a comprehensive package of interventions, including public health and social measures (such as hand hygiene, physical distancing and respiratory hygiene/etiquette), vaccines, diagnostics and treatments.

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<sup>1</sup> The relevant resources are available at <https://www.who.int/teams/global-influenza-programme/public-health-preparedness> (accessed 20 October 2021).

<sup>2</sup> The position paper is available at [https://apps.who.int/iris/bitstream/handle/10665/241993/WER8747\\_461-476.PDF?sequence=1&isAllowed=y](https://apps.who.int/iris/bitstream/handle/10665/241993/WER8747_461-476.PDF?sequence=1&isAllowed=y) (accessed 20 October 2021).

<sup>3</sup> The toolbox is available at <https://www.who.int/teams/global-influenza-programme/vaccines/influenza-vaccination-toolbox> (accessed 20 October 2021).

12. The Global Influenza Strategy 2019–2030 encourages all countries to establish seasonal influenza prevention and control programmes to protect the vulnerable and contribute to universal health coverage by ensuring access to all available tools. Additionally, the Secretariat has provided support to countries to ensure optimal management of influenza during the COVID-19 pandemic, including by providing recommendations for maintaining influenza surveillance, prevention and control, clinical management, protection of specific populations, and risk communications and community engagement.<sup>1</sup>

13. Since early 2020, global influenza transmission has been at historic lows, likely due to the preventive measures put in place for COVID-19. The Secretariat has engaged in a series of projects to review and synthesize the available evidence of the impact of public health and social measures on COVID-19. The outcomes will guide and strengthen the collective approach to public health and social measures as a part of epidemic and pandemic preparedness, including for influenza.

14. Safe and efficacious influenza antivirals are available to support the clinical management of patients with or at risk for severe influenza. The Secretariat is updating its guidelines for the clinical management of severe influenza illness to guide clinicians in the care of patients with, or at risk of, severe influenza illness, including those caused by seasonal, zoonotic and pandemic influenza viruses. The guidelines will provide recommendations for treatment with antivirals and adjunctive therapies and the use of diagnostic testing strategies to guide clinical management.

15. Work is being undertaken under the PIP Framework to negotiate voluntary supply agreements with different antiviral manufacturers. In so doing, WHO is putting in place options for access to antivirals that may prove useful against the next influenza virus with pandemic potential.

### **Operative paragraph (2)(c): Pandemic Influenza Preparedness Framework**

16. Between January 2012 and September 2021, US\$ 241 million have been collected under the PIP Partnership Contribution. Of that, US\$ 134 million have been allocated to preparedness and over US\$ 102 million have been implemented to date. Approximately US\$ 61 million is available in the Pandemic Response Fund, which will be available immediately upon the declaration of the next influenza pandemic.

17. WHO has concluded 14 Standard Material Transfer Agreements 2 with vaccine manufacturers. All commitments under the Agreements are made as a percentage of real-time production. In terms of quantities, the Standard Material Transfer Agreements 2 provide guaranteed access by WHO to a little more than 10% of future pandemic influenza vaccine production, most of which will be donated to WHO.

18. Through the Partnership Contribution preparedness fund, WHO is supporting countries to improve capacities to detect, understand and respond to the emergence of a new influenza virus that could cause a pandemic. Projects have been implemented in 83 countries to address one or more of these objectives, including for example strengthening surveillance, conducting disease burden studies and ensuring efficient regulatory systems for vaccine emergency authorization.

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<sup>1</sup> The readiness for influenza during the COVID-19 pandemic policy brief is available at <https://www.who.int/publications/i/item/WHO-2019-nCoV-Influenza-readiness-COVID-19-2020.1> (accessed 20 October 2021).



19. Influenza capacities strengthened since 2014 have had a significant impact in the COVID-19 response. As reported every six months in the PIP Framework progress reports,<sup>1</sup> highlights include the following:

- (a) 66 countries integrated COVID-19 into their sentinel surveillance systems for influenza and use an established influenza platform to report and share COVID-19 data;
- (b) 45 of 48 PIP target countries for the regulatory area of work, which were selected based on their gaps during the 2009 pandemic, were able to authorize COVID-19 vaccines within the first 15 days after WHO issued emergency use listing;
- (c) the OpenWHO platform that was created and supported under the PIP Framework through 2018 is now institutionalized and has been used extensively for COVID-19 knowledge transfer, with over 5 million enrolments across 33 different courses.

### **Operative paragraph (2)(d): Global Influenza Surveillance and Response System**

20. As of 2020, the Global Influenza Surveillance and Response System had grown to over 150 institutions in 125 countries. This includes 147 National Influenza Centres in 123 countries, seven WHO Collaborating Centres, four WHO Essential Regulatory Laboratories, and 13 WHO H5 Reference Laboratories.

21. When the virus responsible for COVID-19, severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2), emerged in 2019, the Global Influenza Surveillance and Response System was rapidly leveraged to respond and has continued to support the global response to the COVID-19 pandemic.

22. The Global Influenza Surveillance and Response System has provided significant virus detection and sequencing capacities to the COVID-19 pandemic response. As at June 2021:

- (a) Over 90% of National Influenza Centres were testing for COVID-19; and
- (b) 92 Global Influenza Surveillance and Response System laboratories from 75 countries had submitted whole genome sequences of SARS-CoV-2 to GISAID, thereby vastly expanding the geographic representation of SARS-CoV-2 genomic sequences.

23. In line with the recommendations of the International Health Regulations (2005) Emergency Committee for COVID-19, the Secretariat encourages countries to leverage influenza capacities for COVID-19 and to support an integrated, end-to-end approach to sentinel surveillance of influenza and SARS-CoV-2 that encompasses sampling all the way to genetic sequencing and sequence data sharing.

24. Further to this integrated approach, the Secretariat is exploring opportunities for systematically enhancing the Global Influenza Surveillance and Response System to serve as an integrated system for surveillance and monitoring of respiratory viruses with epidemic and pandemic potential. This vision for an expanded Global Influenza Surveillance and Response System, referred to as “GISRS+”, builds upon the success of leveraging the System for the COVID-19 pandemic response as well as the previous integration of respiratory syncytial virus surveillance and monitoring into it in 2015. The Secretariat has engaged with Member States, Global Influenza Surveillance and Response System members and

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<sup>1</sup> PIP Framework progress reports are available at <https://www.who.int/initiatives/pandemic-influenza-preparedness-framework/partnership-contribution> (accessed 20 October 2021).

stakeholders to solicit initial feedback on the strengths, challenges, opportunities and priorities for GISRS+.

25. The Secretariat continues to encourage the rapid, systematic and timely sharing of seasonal influenza viruses and influenza viruses with pandemic potential. Instances where national regulations, legislation or other administrative measures have had an impact on virus sharing within the Global Influenza Surveillance and Response System have previously been described.<sup>1</sup>

26. Additional instances have emerged where national access and benefit-sharing requirements have affected the sharing of seasonal influenza virus, including among countries that are parties to the Nagoya Protocol to the Convention on Biological Diversity.<sup>2</sup> Uncertainties have arisen as to whether the terms of reference of Global Influenza Surveillance and Response System institutions fully address the use of seasonal influenza viruses for the development of candidate vaccine viruses, which are precursors for seasonal influenza vaccine production.

27. The Secretariat is engaging with Member States, Global Influenza Surveillance and Response System members and the secretariat of the Convention on Biological Diversity to identify solutions and seek greater clarity on the sharing and use of seasonal influenza viruses.

**Operative paragraph (2)(e): Synergies among influenza preparedness and response, International Health Regulations (2005) and immunization programmes**

28. Through the Global Influenza Strategy, WHO promotes synergies among influenza preparedness and response capacity-building, International Health Regulations (2005) and immunization programmes.

29. The Secretariat has developed a pandemic influenza vaccine response operational plan, which expands upon the pandemic influenza risk management guidance and clarifies the roles, responsibilities, processes and triggers for vaccine response at the beginning of an influenza pandemic. The plan identifies WHO's declaration of an influenza pandemic as a critical trigger for the vaccine response, including triggering the PIP Framework benefit-sharing mechanisms. At this time, the process associated with, and the requirements for, an influenza pandemic declaration by WHO need greater clarity. The Secretariat intends to build upon existing work, including the pandemic influenza vaccine response operational plan, to identify and advance opportunities for clarifying the processes and requirements for declaring an influenza pandemic. This work will be done in collaboration with the Global Influenza Surveillance and Response System, seeking advice from the PIP Advisory Group and other experts, and will provide the Director-General with options for strengthening the policy basis for declaring an influenza pandemic.

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<sup>1</sup> Document EB146/18.

<sup>2</sup> Nagoya Protocol on Access to Genetic Resources and the Fair and Equitable Sharing of Benefits Arising from their Utilization to the Convention on Biological Diversity: text and annex. Available at <https://www.cbd.int/abs/doc/protocol/nagoya-protocol-en.pdf> (accessed 1 November 2021).

### **Operative paragraph (2)(f): Global influenza vaccine production capacity, supply chains and distribution networks**

30. The Secretariat regularly monitors global influenza vaccine production capacity, and in 2021, published updated figures based on a 2019 survey.<sup>1</sup>

31. To address the Assembly's request in paragraph (2)(f) of decision WHA73(14), the Secretariat sought feedback from Member States and other stakeholders, through an online questionnaire, on gaps in and priorities for influenza vaccine production capacity, supply chains and distribution networks.

32. The Secretariat will continue to consult with Member States and relevant stakeholders on this issue and identify a path forward, which will support the Global Influenza Strategy's high-level outcome on better global tools.

### **ACTION BY THE EXECUTIVE BOARD**

33. The Executive Board is invited to note this report. In its discussions, the Board may wish to focus on:

- suggestions for expanding the Global Influenza Surveillance and Response System to include other respiratory viruses with epidemic and pandemic potential; and
- guidance for further sensitizing Member States to the importance of timely influenza virus sharing and use.

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<sup>1</sup> Sparrow E, Wood JG, Chadwick C, Newall AT, Torvaldsen S, Moen A et al. Global production capacity of seasonal and pandemic influenza vaccines in 2019. *Vaccine*. 2021;39:512–20. doi:10.1016/j.vaccine.2020.12.018.

## **Global Health for Peace Initiative**

The Seventy-fifth World Health Assembly, having considered the consolidated report by the Director General,<sup>1</sup>

Recalling that the WHO Constitution recognizes that the health of all peoples is fundamental to the attainment of peace and security, and recalling resolution WHA34.38 (1981), which recognized the role of physicians and other health workers in the preservation and promotion of peace as the most significant factor for the attainment of health for all;

Reiterating the commitment of Member States to the 2030 Agenda for Sustainable Development, which emphasized, inter alia, that there can be no sustainable development without peace and no peace without sustainable development; and emphasizing the importance of ensuring healthy lives, promoting well-being for all at all ages, and promoting just, peaceful and inclusive societies;

Noting the role of WHO within its mandate as the directing and coordinating authority on international health matters,

Decided:

(1) to note the report;

(2) to request the Director-General to consult with Member States<sup>2</sup> and Observers<sup>3</sup> on the implementation of the proposed ways forward contained in document EB150/20 on the Global Health for Peace Initiative, and to then develop – in full consultation with Member States<sup>2</sup> and Observers,<sup>3</sup> and in full collaboration with other organizations of the United Nations system and relevant non-State actors in official relations with WHO – a road map for the Initiative, for consideration by the Seventy-sixth World Health Assembly in 2023 through the Executive Board at its 152nd session.

Eighth plenary meeting, 28 May 2022  
A75/VR/8

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<sup>1</sup> Document A75/10 Rev.1.

<sup>2</sup> And, where applicable, regional economic integration organizations.

<sup>3</sup> As described in paragraph 3 of document EB146/43.

# **Poliomyelitis**

## **Polio transition planning and polio post-certification**

### **Report by the Director-General**

1. The Executive Board at its 150th session noted an earlier version of this report.<sup>1</sup> The present report provides an update on the implementation of the Strategic Action Plan on Polio Transition (2018–2023)<sup>2</sup> at the start of 2022, within the context of the coronavirus disease (COVID-19) pandemic.
2. The focus of polio transition is at the country level, and activities gained pace in 2021 with a focus on integration and sustainability. The Secretariat continued to work with the priority countries<sup>3</sup> to revise and implement their national plans for polio transition within the context of the COVID-19 pandemic, to sustain the gains of polio eradication, to avoid backsliding on immunization gains, and to strengthen emergency preparedness, detection and response capacities.
3. The Steering Committee on Polio Transition continues to provide strategic guidance and oversight to ensure that polio transition activities are aligned with programmatic and technical priorities. A Joint Corporate Workplan for Polio Transition sets the framework for coordinated action and joint accountability. Despite the challenges posed by the COVID-19 pandemic, 91% of planned deliverables of the 2020–2021 Joint Corporate Workplan were completed or have progressed. The 2021–2022 Workplan reflects the specific priorities of each region, with a strong focus on moving forward the country agendas, resource mobilization, strategic communications and high level advocacy. As of January 2022, 77% of planned deliverables of the 2021–2022 Workplan were on track or had been delivered.
4. The COVID-19 pandemic has once again demonstrated the importance of surveillance, and the role of the polio surveillance network as a building block to strengthen surveillance systems. As a step to reinforce these efforts, the Secretariat has developed a methodology and tools to support countries to accurately plan and budget the appropriate level of financial resources required to sustain and strengthen disease surveillance as part of their national health systems. Under the umbrella of the Universal Health

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<sup>1</sup> Document EB150/22 and summary records of the Executive Board at its 150th session, ninth meeting, section 5 and tenth meeting, section 2.

<sup>2</sup> See document A71/9 and the summary records of the Seventy-first World Health Assembly, Committee A, sixth and eighth meetings (see <https://apps.who.int/iris/handle/10665/325993>).

<sup>3</sup> The 16 global polio transition priority countries by region are: African Region – Angola, Cameroon, Chad, Democratic Republic of the Congo, Ethiopia, Nigeria and South Sudan; South-East Asia Region – Bangladesh, India, Indonesia, Myanmar and Nepal; and Eastern Mediterranean Region – Afghanistan, Pakistan, Somalia and Sudan. Additionally, the Regional Office for the Eastern Mediterranean has prioritized four additional countries (Iraq, Libya, Syrian Arab Republic and Yemen) owing to their fragility and high-risk status.

Coverage Partnership, and complementing existing strategies,<sup>1</sup> the aim is to support countries to identify the critical cost components of their surveillance systems and ensure the integration of these costs into their national budgets and strategic plans. The tools were piloted in India and Sudan in 2021. Lessons learned from these pilot countries will inform subsequent implementation.

5. The polio workforce continues to be engaged in COVID-19 vaccination and immunization recovery efforts, which once again shows the value of this workforce for broader public health priorities. According to real-time data collected in the African Region, over 500 polio workers were engaged in COVID-19 vaccination activities across 33 countries during 2021. In the South-East Asia Region, the integrated polio and immunization surveillance networks have taken on key roles in COVID-19 vaccination guideline development, cold chain management, training of health workers and the facilitation of real-time reporting and data management during campaigns. In the Eastern Mediterranean Region, polio personnel have been involved in a wide range of activities, such as recruiting and training vaccinators, developing microplans and conducting surveillance for adverse events following COVID-19 vaccination. These efforts have been comprehensively documented in a recent report on the contributions of the polio network to COVID-19 vaccination and immunization recovery across the three regions.

6. Cross-programmatic integration has further accelerated and is leveraging experience with the pandemic response to build back resilient immunization programmes. The Global Polio Eradication Initiative Strategy 2022–2026 contains a strong commitment to integration, to reach chronically missed “zero-dose” children in key areas. Similarly, the Immunization Agenda 2030 Framework for Action places strong emphasis on coordinated planning, action and monitoring.

7. There is strong recognition of the need to communicate effectively about the risks, benefits and opportunities that polio transition presents to health systems. The Secretariat has developed a strategic communications framework to support advocacy efforts and to better communicate the value of the polio network for the broader health agenda. The implementation of the framework is assisting in fostering greater ownership, especially at the global and regional levels.

## **COUNTRY-LEVEL PROGRESS**

### **African Region**

8. The certification of the eradication of the wild poliovirus in August 2020 accelerated polio transition in the African Region. The countries of the Region are committed to capitalizing on this achievement to stop the transmission of all types of polioviruses by the end of 2023, and to integrate polio assets into national health systems in order to strengthen broader disease surveillance, outbreak response capacities and immunization services.

9. The Region has a two-phased approach to polio transition: in order to mitigate the ongoing risk of circulating vaccine-derived poliovirus outbreaks, the 10 polio high risk countries in the Region<sup>2</sup> will continue to receive support from the Global Polio Eradication Initiative until the end of 2023, with a view to making a full transition as of 2024. The remaining 37 low risk countries have accelerated implementation, and transitioned out of Global Polio Eradication Initiative support in January 2022. In

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<sup>1</sup> WHO. Immunization Agenda 2030: a global strategy to leave no one behind, Draft Four – 2 April 2020 ([https://www.who.int/immunization/immunization\\_agenda\\_2030/en/](https://www.who.int/immunization/immunization_agenda_2030/en/), accessed 11 October 2021).

<sup>2</sup> Angola, Cameroon, Chad, Democratic Republic of the Congo, Guinea, Ethiopia, Kenya, Nigeria, Niger, South Sudan.

the low risk countries, the polio assets and infrastructure have been fully integrated into other public health programmes. Lessons learned from these 37 countries will inform implementation in the 10 high risk countries.

10. The Regional Office for Africa has aligned the implementation of polio transition to the outcomes of the functional reviews of the WHO country offices, which respond to the evolving priorities of Member States. Polio transition offers an opportunity to accelerate both the implementation of the functional reviews and the integration of polio functions in a horizontal manner with a primary health care lens.

11. The priority countries of the Region are revising and implementing their national polio transition plans in the context of COVID-19. In Angola, with support from the World Bank and Gavi, the Vaccine Alliance, provincial support teams are being established to ensure the continuity of polio functions, such as active surveillance, case detection and investigation, while monitoring maternal and child health interventions. A mission is planned for 2022 to monitor implementation and provide additional support. In Chad, the transition plan has been revised to align with the COVID-19 context, and a workshop is being planned for its review and validation. In Cameroon, Democratic Republic of the Congo and South Sudan, the plans are being reviewed under the leadership of the national governments. In Ethiopia, a high level advocacy plan is in place to ensure sustainable financing. In Nigeria, a national transition business case has been endorsed by the Interagency Coordination Committee, with a focus on primary health care revitalization, disease surveillance and outbreak response and routine immunization, and plans are in place to mobilize domestic and external resources for its implementation.

12. The Region is placing strong emphasis on high level advocacy to ensure that polio tools, skills and assets are integrated into national health programmes in a sustainable manner. Polio transition was discussed at the seventy-first session of the Regional Committee for Africa, where Member States declared their strong commitment to integrate polio capacities and key functions into their health systems. As a part of these efforts, a scorecard was introduced at the Regional Committee to monitor national progress in surveillance, immunization, outbreak response and polio transition activities.

### **South-East Asia Region**

13. The South-East Asia Region has a single integrated network for surveillance and immunization that provides support not only for polio eradication, but also for measles and rubella elimination, surveillance for vaccine-preventable diseases, strengthening immunization and responding to emergencies. The integrated network makes the South-East Asia Region the most advanced among WHO regions in terms of polio transition. The first steps for financial sustainability, including cost sharing and domestic funding, were taken long before polio transition came onto the global agenda.

14. Among the five priority countries, India, which has the largest network in the Region, is implementing its transition plan in line with the outcomes of the 2020 mid-term review. The Government of India has committed domestic resources to support phase 2 of the implementation of the transition plan, which extends the scope of the network to wider public health functions, including emergency response, and measles and rubella elimination, while continuing support to routine immunization. As a step towards aligning the scope of work to future needs and priorities, the national polio surveillance project has been renamed as the national public health support programme. In the other four countries, steps are being taken towards financial sustainability. In Bangladesh, part of the operational costs of the surveillance and immunization medical officers have been included in the government operational plans. This reflects the intention to ensure the long-term financial sustainability of functions, with full transfer to the government planned for 2026. Indonesia and Myanmar have been able to maintain much smaller

networks, though expansion has stalled due to COVID-19. Discussions have been re-initiated with the Government of Nepal to explore the options for sustainable financing.

15. The Region has developed a comprehensive document on the role and contributions of the integrated surveillance network to the COVID-19 response in each of the five polio transition priority countries. Launched at the seventy-fourth session of the Regional Committee for South-East Asia, the report is the first in-depth account of the network's broader contributions to public health in the region, highlighting its value as a public health good, especially in the context of COVID-19 response and recovery.<sup>1</sup>

### **Eastern Mediterranean Region**

16. The Eastern Mediterranean Region hosts the two remaining polio-endemic countries, Afghanistan and Pakistan. While reaching eradication remains of utmost importance, the Region is carefully balancing eradication and transition efforts. The regional workplan for polio transition has five workstreams: developing national transition plans in priority countries, operationalizing integrated public health teams, resource mobilization, integrated vaccine-preventable disease surveillance, and coordination and monitoring.

17. The Region hosts many conflict-affected countries that require a risk-based approach to transition. Cross-programmatic integration, with a smooth handover of polio assets to other public health programmes, is equally important. All WHO country offices in the priority countries have conducted a full mapping of their human resources to optimize the use of their workforce, and multi-disciplinary teams have been set up to foster cross-programmatic integration.

18. In this context, the Regional Office for the Eastern Mediterranean is prioritizing the operationalization of integrated public health teams as an interim strategy to sustain essential polio functions and respond to outbreaks and other public health emergencies until they are systematically integrated into national health systems.

19. All priority countries have developed transition/integration plans to be implemented in the form of integrated public health teams. Operationalization began in January 2022. In Somalia, a three-phased plan has been developed that envisions building capacity at the regional and district level to gradually integrate functions into the national health system to strengthen surveillance and primary health care. In Sudan, the transition plan and rollout of the integrated public health teams aims to support strengthening of vaccine-preventable disease surveillance, immunization and early warning response systems. While the integration of functions into the national health system has been delayed due to economic, political, and access challenges, the rollout of integrated public health teams will facilitate implementation. In the other four countries (Iraq, Libya, Syrian Arab Republic and Yemen) with much smaller and integrated polio infrastructures, the objective is to sustain this integration and to ensure programmatic and financial sustainability. In Iraq, polio field presence has been reduced by 33% since 2019 by integrating polio and immunization functions, with efforts being made to strengthen immunization and surveillance while sustaining polio essential functions. In Libya, the acute flaccid paralysis reporting system is already a part of the Early Warning, Alert and Response Network (EWARN) disease surveillance system. In the Syrian Arab Republic, field staff initially recruited for polio eradication have supported numerous health emergencies and immunization activities over the years, and the focus is to ensure sustainability. In

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<sup>1</sup> NeXtwork – The role and contribution of the integrated surveillance and immunization network to the COVID-19 response in the WHO South-East Asia Region (Bangladesh, India, Indonesia, Myanmar and Nepal). New Delhi: WHO Regional Office for South-East Asia; 2021 (<https://apps.who.int/iris/handle/10665/344902>, accessed 11 October 2021).



Yemen, the national transition plan foresees the building of national capacity on integrated disease surveillance, alongside strengthening routine immunization and outbreak preparedness and response.

## **BUDGET, PLANNING, RESOURCE MOBILIZATION AND HUMAN RESOURCES**

### **Planning and resource mobilization for polio transition within the context of WHO's Programme budget 2022–2023**

20. As part of planning for the development of the programme budget for 2022–2023, the Secretariat conducted a detailed review with each of the six regional offices to cost the essential functions that WHO will support to advance the three key objectives of the Strategic Action Plan. These essential functions were integrated into the appropriate technical outputs and outcomes of the base segment of the proposed programme budget.<sup>1</sup> Member States were fully supportive of this strategic shift and approved the Proposed programme budget 2022–2023 at the Seventy-fourth World Health Assembly.<sup>2</sup>

21. As part of operationalization of the Programme budget 2022–2023, all major offices validated their plans to reflect most recent developments, also in relation to lessons learnt from COVID-19 pandemic and further discussions with the Global Polio Eradication Initiative to best ensure synergies. Adjustments were made where necessary, and the workplans are now fully operational for implementation.

22. The Secretariat is accelerating resource mobilization efforts, aligned with the vision and priorities of the Thirteenth General Programme of Work, 2019–2023. The aim is to ensure continuity of expertise and capacity where it is most needed. With respect to funding, 2022–2023 will be a bridge biennium, with the high risk countries continuing to receive support through the Global Polio Eradication Initiative to preserve core capacities to prevent and respond to polio outbreaks, whereas the low risk countries will receive technical support from the Secretariat to fully integrate polio functions into immunization, disease surveillance, emergency preparedness and response, and primary health care programmes. As a first step, the financial resources required to safeguard essential functions in regions and countries that will no longer receive funding from the Global Polio Eradication Initiative have been secured for 2022. The Secretariat will continue to monitor the needs and gaps, taking the necessary mitigation measures. Resource mobilization to sustain the essential functions is a shared responsibility across the three levels of the Organization, and constitutes an integral part of the discussions of the intergovernmental Working Group on Sustainable Financing. In parallel, the Secretariat is continuing to advocate for domestic resources as the most sustainable long-term strategy to maintain core capacities and essential functions at the country level.

### **Update on human resources**

23. The Secretariat continues to monitor the polio programme staffing through a dedicated database. There has been a 53% decrease in the number of filled positions funded by the Global Polio Eradication Initiative since 2016 (Table),<sup>3</sup> many of which have been absorbed by other programmes, reflecting the

<sup>1</sup> See document A74/5 Rev.1 for more detail on verified final costs for each major office.

<sup>2</sup> See resolution WHA74.3 (2021).

<sup>3</sup> For more detailed information see the WHO website HR planning and management (<https://www.who.int/teams/polio-transition-programme/HR-planning-and-management>, accessed 11 October 2021).  
Annex 1 – WHO staff members funded by the Global Polio Eradication Initiative aggregated by contract type;  
Annex 2 – WHO staff members funded by the Global Polio Eradication Initiative aggregated in major offices, aggregated by grade and contract type.

implementation of transition plans in regions and countries as they become less at risk for polio. The year 2022 is a major milestone, with 57 countries transitioning from Global Polio Eradication Initiative support; henceforth staff and resources of the Global Polio Eradication Initiative will be concentrated only in the African and Eastern Mediterranean regions, in order to focus on the achievement of the two goals of the Polio Eradication Strategy 2022–2026 by the end of 2023.

24. The African Region, which has the highest number of polio funded staff positions, has taken specific measures to address the impact of the declining financial resources from the Global Polio Eradication Initiative. The Regional Office for Africa has incorporated these essential functions into the implementation of the functional reviews in 47 country offices. The results of this process align with the programmatic needs and priorities of the two-phased transition planned in the Region. The outcomes of the transition will support both the implementation of the functional reviews and the continuation of polio activities in all countries, while balancing the reduction in long-term contracts and organizational liabilities with the need to maintain critical capacity through the use of alternative contractual modalities.

**Table. Number of polio staff positions supported by the Global Polio Eradication Initiative, by major office (2016–2022)**

Major office	2016	2017	2018	2019	2020	2021	2022 <sup>a</sup>	Variation between 2016 and 2022
Headquarters	77	76	70	72	71	66	71	-8%
Regional Office for Africa	826	799	713	663	594	524	297 <sup>b</sup>	-64%
Regional Office for South-East Asia	39	39	39	36	36	35	— <sup>c</sup>	-100%
Regional Office for Europe	9	8	4	5	4	2	— <sup>c</sup>	-100%
Regional Office for the Eastern Mediterranean (majority of positions located in Afghanistan and Pakistan)	155	152	153	170	146	143	152	-2%
Regional Office for the Western Pacific	6	6	5	3	3	2	— <sup>c</sup>	-100%
<b>Total</b>	<b>1 112</b>	<b>1 080</b>	<b>984</b>	<b>949</b>	<b>854</b>	<b>772</b>	<b>520</b>	<b>-53%</b>

<sup>a</sup> As of January 2022. Source: Global Polio Eradication Initiative global human resource database.

<sup>b</sup> The figures reflect the two-phased transition planned in the African Region. As of 1 January 2022, the Global Polio Eradication Initiative will support only the staff positions in the 10 high risk countries and the Polio Coordination Unit in the Regional Office. All other positions have been transitioned to other programmatic areas.

<sup>c</sup> In the South-East Asia, Europe and Western Pacific regions, staff positions funded from the base budget sources will continue to ensure that polio eradication is sustained in these regions.

## MONITORING AND EVALUATION

25. Progress is being regularly monitored through the monitoring and evaluation dashboard, with specific output indicators aligned with the three objectives of the Strategic Action Plan.<sup>1</sup> The dashboard has been updated with the three-year time-series of country indicators (2018–2020), and available data from 2021. The regional offices have additional tools to complement the monitoring of programmatic performance.

26. The fifth report of the Polio Transition Independent Monitoring Board<sup>2</sup> focuses on increasing interdependence between eradication and transition, making recommendations for actions by programmes to move forward the eradication and transition agendas. The Secretariat is currently outlining a way forward to address the recommended actions, in coordination with Member States and partners.

27. The Strategic Action Plan on Polio Transition (2018–2023) includes a provision for a mid-term evaluation by the WHO Evaluation Office within the polio transition road map that was prepared to support its implementation. This evaluation was also included in the biennial evaluation workplan 2020–2021 approved by the Executive Board at its 146th session in February 2020. The evaluation was conducted by an external independent evaluation team that was selected by the Evaluation Office through an open tender. The evaluation team undertook its main work during the fourth quarter of 2021 and first quarter of 2022, and delivered its report in early April 2022. An executive summary of the evaluation report will be submitted to the Health Assembly.<sup>3</sup>

## ACTION BY THE HEALTH ASSEMBLY

28. The Health Assembly is invited to note the report, and to provide guidance on:

- (a) accelerating the implementation of country plans in the context of COVID-19, ensuring the financial sustainability of transitioned functions; and
- (b) mitigating programmatic risks and recognizing opportunities in countries that are transitioning out of support from the Global Polio Eradication Initiative.

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<sup>1</sup> WHO. Polio transition programme: monitoring and evaluation dashboard. In WHO/Teams [website]. Geneva: World Health Organization; 2021 (<https://www.who.int/teams/polio-transition-programme/polio-transition-dashboard>, accessed 11 October 2021).

<sup>2</sup> Building stronger resilience: the essential path to a polio-free world. Polio Transition Independent Monitoring Board fifth report, December 2021 (<https://polioeradication.org/wp-content/uploads/2022/01/5th-TIMB-report-Building-stronger-resilience-20211231.pdf>, accessed 22 March 2022).

<sup>3</sup> Document A75/INF./7.

## **Outcome of the SIDS Summit for Health: For a Healthy and Resilient Future in Small Island Developing States**

The Seventy-fifth World Health Assembly,

Having considered the consolidated report by the Director-General;<sup>1</sup>

Noting that climate change, a persistent crisis, threatens the health of the people of all Member States, but that the populations of the small island developing States are among the first and hardest hit;

Noting also that, besides climate change, small island developing States share grave health and sustainable development challenges posed by the impacts of natural and man-made hazards, environmental degradation, health emergencies, loss of biodiversity, the coronavirus disease (COVID-19) pandemic, external economic shocks, malnutrition, noncommunicable diseases and mental health conditions;

Recognizing that small island developing States are disproportionately impacted by climate change, which undermines the progress towards their achievement of the 2030 Agenda for Sustainable Development, including Sustainable Development Goal 3 on good health and well-being;

Further recognizing that the vulnerabilities of small island developing States to extreme weather events, including natural and man-made hazards, and other external economic shocks, underscore the importance of strong and resilient health systems, underpinned by universal health coverage, that focus on equitable access, quality, as well as financial protection and financing for development in the era of COVID-19 and beyond;

Recalling United Nations General Assembly resolution 69/15 (2014), which set forth the SIDS Accelerated Modalities of Action (SAMOA) Pathway for an accelerated development plan in small island developing States, and General Assembly resolution 70/1 (2015), which adopted the 2030 Agenda for Sustainable Development with the collective aim towards a transformative step for a sustainable and resilient path in ensuring that no one is left behind, and noting the correlation between high levels of vulnerability and impacts on progress towards achieving the Sustainable Development Goals;

Recalling also WHO's Memorandum of Understanding with the United Nations Framework Convention on Climate Change in the margins of the twenty-third session of the Conference of the Parties to the Convention, and the launch of the special initiative to protect people living in small island

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<sup>1</sup> Document A75/10 Rev.1 (item 18.2, WHO's implementation framework for Billion 3).

developing States and the report submitted to the Seventy-third World Health Assembly in May 2020 on the implementation of the plan;

Welcoming the initiative of the Director-General to host the first SIDS Summit for Health: For a Healthy and Resilient Future in Small Island Developing States on 28 and 29 June 2021;

Noting with appreciation the outcome statement of the SIDS Summit for Health<sup>1</sup> agreed upon by the small island developing States that are Member States of WHO;

Noting the actions proposed in the SIDS Summit for Health outcome statement for all partners to small island developing States to guide them in pursuing key actions needed to prevent and respond to the urgent threats faced by small island developing States;

Acknowledging the commitments made by the Director-General to pursue the actions requested of the Secretariat in response to the SIDS Summit for Health outcome statement, including on the establishment of a SIDS Leaders Group for Health, and organizing a second SIDS Summit for Health in 2023;

Taking note of the SIDS Summit for Health outcome statement, which emphasizes the urgent health challenges and needs of small island developing States with the aim of amplifying small island developing States' voice, promoting collaborative action and strengthening health and development partnerships and financing,

1. URGES Member States<sup>2</sup> to strengthen their collaboration and partnership in support and recognition of the unique vulnerabilities of small island developing States in addressing the various health needs and priorities as highlighted in the SIDS Summit for Health outcome statement and assisting the small island developing States' response to address persistent health, climate change and development challenges that they encounter including through the implementation of the SIDS Accelerated Modalities of Action (SAMOA) Pathway;
2. CALLS UPON all international, regional and national partners, from within and beyond the health sector, to pursue the actions called for in the SIDS Summit for Health outcome statement and to promote the needs and required actions needed for small island developing States;
3. DECIDES to propose a Voluntary Health Trust Fund for small island developing States with the terms of reference to be tabled, in conjunction with a report from the Secretariat on current practices for funding participation of Member States in WHO meetings, at the Seventy-sixth World Health Assembly in 2023, with a view, inter alia, to facilitate the participation of small island developing States in WHO meetings and to support technical and capacity-building in their favour on issues of direct relevance to their situation and encourage all States and partners to make voluntary contributions to the Voluntary Health Trust Fund for small island developing States;

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<sup>1</sup> SIDS Summit for Health outcome statement: For a Healthy and Resilient Future in Small Island Developing States ([https://cdn.who.int/media/docs/default-source/sids-summit/sids-summit-for-health---final-outcome-statement.pdf?sfvrsn=7a5db89f\\_5](https://cdn.who.int/media/docs/default-source/sids-summit/sids-summit-for-health---final-outcome-statement.pdf?sfvrsn=7a5db89f_5), accessed 13 May 2022).

<sup>2</sup> And, where applicable, regional economic integration organizations.

4. REQUESTS the Director-General:

(1) to continue to pursue the commitments made before and at the SIDS Summit for Health, including:

(a) support for the SIDS Leaders Group for Health for high-level advocacy and driving further attention globally on the health challenges and initiatives of the small island developing States and collaboration across Member States and partners;

(b) support for the leveraging of improved multisectoral and innovative financing for small island developing States and strengthening platforms to better support small island developing States on urgent health challenges;

(c) facilitating greater collaboration for cooperation frameworks with other entities of the United Nations system, Member States<sup>1</sup> and partners;

(2) to report to the Seventy-seventh World Health Assembly in 2024 on the progress made in implementing this resolution as well as the outcomes of the second SIDS Summit for Health.

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<sup>1</sup> And, where applicable, regional economic integration organizations.

## **Well-being and health promotion**

The Seventy-fifth World Health Assembly,

Having considered the consolidated report by the Director-General;<sup>1</sup>

Considering the vast implications that current economic, environmental and social conditions have on the health of societies, communities and people and the potential that health promotion, health protection and disease prevention have on enhancing the capacities of people to protect and improve their health and well-being, in addition to health and social measures by governments;

Reaffirming that health is a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity;

Reaffirming also, as enshrined in the WHO Constitution, that the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition;

Further reaffirming that the objective of WHO shall be the attainment by all peoples of the highest possible level of health;

Reaffirming that governments have a responsibility for the health of their peoples, which can be fulfilled only by the provision of adequate health and social measures;

Recalling United Nations General Assembly resolution 70/1 (2015) on transforming our world: the 2030 Agenda for Sustainable Development, which identified as part of the new Agenda, that to promote physical and mental health and well-being, and to extend life expectancy for all, we must achieve universal health coverage and access to quality health care, and affirmed that no one must be left behind;

Recalling also United Nations General Assembly resolution 67/81 (2012), which recognized that effective and financially sustainable implementation of universal health coverage is based on a resilient and responsive health system that provides comprehensive primary health care services, with extensive geographical coverage, including in remote and rural areas, and with a special emphasis on access to populations most in need, and has an adequate skilled, well-trained and motivated workforce, as well as capacities for broad public health measures, health protection and addressing determinants of health through policies across sectors, including promoting the health literacy of the population;

Further recalling the 2008 report of the Commission on Social Determinants of Health and the three overarching recommendations of the Commission: to improve daily living conditions, to tackle

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<sup>1</sup> Document A75/10 Rev.1 (item 18.2, WHO's implementation framework for Billion 3).

the inequitable distribution of power, money and resources; and to measure and understand the problem and assess the impact of action;

Recalling also the Thirteenth General Programme of Work, 2019–2025 and the target of one billion people enjoying better health and well-being by 2025;

Building on the legacy of the Ottawa Charter for Health Promotion, 1986 and noting the outcomes of other previous global conferences on health promotion;

Acknowledging that the health and well-being of the population is associated with peace, security, stability, improved productivity and economic growth and that socially and economically unfair and largely avoidable inequities within and between countries may have a reverse impact;

Noting that health is produced and that it can be endangered in all environments of society, which is why promoting health and well-being requires environmentally and financially sustainable action and investment by multiple sectors of government and input from wider society, including multisectoral engagement with social and economic actors, from individuals, communities, nongovernmental organizations and the private sector;

Acknowledging that successful promotion of health and well-being builds on complementary and essential approaches, including: a Health in All Policies approach, emphasizing that public policies and decisions made in policy areas other than health impact citizens' health and its determinants; a whole-of-government approach, referring to the joint activities performed by diverse ministries, public administrations and public agencies in order to provide common solutions; as well as a whole-of-society approach, stressing the role of participatory governance and partnerships with different non-State actors at all levels, including the private sector, nongovernmental organizations, communities and individuals;

Acknowledging also that the promotion of health and well-being can address determinants of health and/or risk factors at population, community, specific group or individual levels and in different contexts, taking into account the specific needs of people in vulnerable situations, including the removal of attitudinal, institutional and environmental barriers encountered by persons with disabilities;

Noting the increasing impact on premature mortality from noncommunicable diseases, the continued burden caused by communicable diseases and the new demands they both put on governments in the protection and promotion of health in order to achieve health equity and ensuring universal health coverage;

Emphasizing that in order to have capacity for health-informed decisions and health-seeking behaviours individuals must have achieved an appropriate level of health literacy;

Stressing that the development of interventions at population, community and individual levels to further increase health literacy and improve health outcomes must be guided by evidence, in particular from social and behavioural science, with consideration given to using innovative approaches, communication channels and technologies;

Noting that many persons with disabilities, particularly girls and women, face barriers in accessing information and education, including with regard to sexual and reproductive health and reproductive rights as agreed in accordance with the Programme of Action of the International Conference on Population and Development and the Beijing Platform for Action and the outcome documents of their review conferences as adopted by the United Nations General Assembly;



Recalling that multisectoral action on social, environmental and economic determinants of health, for the entire population and proportionate to the level of disadvantage of people in vulnerable situations, is essential to create inclusive, equitable, economically productive, resilient and healthy societies with healthy environments that make healthy options the easy options to choose;

Acknowledging the importance of national, international and global cooperation and solidarity for the equitable benefit of all people and the important role that relevant multilateral organizations, under the leadership of WHO, have in articulating and promoting norms and guidelines and identifying and sharing good practices for supporting actions on social, environmental and economic determinants of health;

Considering that positioning human health and well-being as one of the key features of what constitutes a successful, inclusive and fair society in the 21st century is consistent with our commitment to human rights at national, regional and international levels,

1. URGES Member States:

- (1) to strengthen health promotion and disease prevention through high-impact public policies, based on scientific evidence and best available knowledge, across sectors, developed through participatory processes; to strengthen health systems and to address health determinants and reduce risk factors, including through appropriate regulation; and to use health and health equity impact assessments in their development in order to achieve equitable outcomes;
- (2) to strengthen the health system and empower the health workforce, including by base and continuous training, in the provision of health promotion, disease prevention and health communication at all levels of health services, including by using innovative approaches, communication channels and technologies, ensuring that people in vulnerable situations have access to information;
- (3) to develop enabling environments conducive to health by addressing determinants of health across sectors and by reducing risk factors and thus make it easier for individuals to make healthy choices to support the realization of healthy, safe and resilient communities;
- (4) to accelerate efforts to ensure healthy lives and promote well-being and universal health coverage by 2030 for all throughout the life course, and in this regard re-emphasize our resolve to cover one billion additional people by 2025 with quality essential health and mental health services, quality, safe and effective essential medicines, vaccines, diagnostics and health technologies, and essential and quality health information, with a view to cover all people by 2030;
- (5) to ensure the implementation of country- and context-specific essential public health functions to protect and promote health and to prevent diseases;
- (6) to ensure universal access to sexual and reproductive health care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes;
- (7) to consider taking steps to include basic health knowledge in curricula to ensure that everybody has an appropriate level of health literacy and implement effective, high-impact, quality-assured, people-centred, gender-, disability- and health literacy-responsive,

equity-oriented and evidence-based interventions, mindful of cultural contexts to meet the health needs of all throughout the life course, and in particular of persons with disabilities and people in vulnerable situations, ensuring universal access to nationally determined sets of integrated quality health services at all levels of care for health promotion, disease prevention, diagnosis, treatment and care, and rehabilitation in a timely manner, including promoting return-to-work programmes;

(8) to support establishment, as appropriate, of mechanisms for generating, gathering and sharing evidence for developing high-impact policies to promote and protect people's physical, mental and social well-being and comprehensively address structural, social, economic, environmental and other determinants of health by working across all sectors through a whole-of-government, whole-of-society and Health in All Policies approach;

(9) to consider, as appropriate, establishing governmental, regional, subregional and local structures responsible for population-level health promotion, with sustainable financing, and continuous reporting; and to strengthen population-based health promotion implementation and ensure its resilience;

(10) to promote health and well-being through coordinated and multisectoral action throughout the life course and by providing conditions for people to access and enjoy clean and safe water, healthy food from sustainable food systems, clean air, tobacco-free environments and social participation, free from all forms of discrimination and inequalities and where all people are able and empowered to take responsibility for their own health and well-being;

(11) to design and orient public systems and infrastructures, including health systems that serve people's needs, that are accessible and affordable to all to ensure health equity contributing to sustainable and resilient economic development;

## 2. REQUESTS the Director-General:

(1) to develop, within the mandate of WHO, a framework on achieving well-being, building on the 2030 Agenda for Sustainable Development with its 17 Sustainable Development Goals and identify the role that health promotion plays within this, in consultation with Member States, for consideration by the Seventy-sixth World Health Assembly in 2023, through the Executive Board at its 152nd session;

(2) to develop as part of that framework an implementation and monitoring plan that includes identifying and supporting the translation into practice of innovative approaches for well-being using health promotion tools, new technologies and approaches to contribute to the WHO general programme of work;

(3) to provide technical support to Member States in strengthening their governance, financing, human resources, evidence generation, data disaggregation and research structures for well-being and health promotion;

(4) to promote and recommend scientifically sound interdisciplinary research to develop the evidence base for interventions for the promotion of health and well-being at population, community and individual levels, including by using big data, building on the measurement systems of the Sustainable Development Goals;

(5) to report on the implementation of this resolution to the Seventy-seventh World Health Assembly in 2024, the Seventy-ninth World Health Assembly in 2026 and the Eighty-fourth World Health Assembly in 2031, through the relevant sessions of the Executive Board.

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## **WHO global strategy for food safety**

The Seventy-fifth World Health Assembly, having considered the consolidated report by the Director-General,<sup>1</sup>

Decided:

- (1) to adopt the updated WHO global strategy for food safety;
- (2) to call on Member States to develop national implementation road maps or reflect actions to implement the strategy within existing food safety policies and programmes and to make appropriate financial resources available to support such work;
- (3) to request the Director-General to report on progress in the implementation of the updated WHO global strategy for food safety to the Seventy-seventh World Health Assembly in 2024 and thereafter every two years until 2030.

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<sup>1</sup> Document A75/10 Rev.1.

## **Reducing public health risks associated with the sale of live wild animals of mammalian species in traditional food markets – infection prevention and control**

The Seventy-fifth World Health Assembly, having considered the consolidated report by the Director-General,<sup>1</sup>

Decided to request the Director-General:

- (1) to update the interim guidance on reducing public health risks associated with the sale of live wild animals of mammalian species in traditional food markets in order to answer questions on the scope of the guidance, including the species that the guidance covers (mammalian species or mammalian species plus other species) and farmed or wild live animals;
- (2) to develop plans to support country implementation of the interim guidance on reducing public health risks associated with the sale of live wild animals of mammalian species in traditional food markets – infection prevention and control;
- (3) to report on progress made in updating the interim guidance on reducing public health risks associated with the sale of live wild animals of mammalian species in traditional food markets – infection prevention and control and the country support plans to the Seventy-seventh World Health Assembly in 2024 and thereafter every two years until 2030, in parallel with reporting on the progress in implementing the WHO global strategy for food safety.

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<sup>1</sup> Document A75/10 Rev.1.

## **Prevention of sexual exploitation, abuse and harassment**

### **Report by the Director-General**

1. This report provides an update of the actions taken by the Secretariat in response to decision EB148(4) (2021) on preventing sexual exploitation, abuse and harassment, adopted by the Executive Board at its 148th session, as well as the broader steps taken to strengthen the Organization's efforts to address this matter during the period June 2021 to February 2022. An earlier version of this report was considered by the Executive Board at its 150th session in January 2022.<sup>1</sup> At that session, the Board adopted decision EB150(23), in which it decided to suspend Financial Rule XII, 112.1 in order to support investigations of sexual exploitation and abuse or abusive conduct.

2. Two significant events influenced the progress of WHO's work in this area during the period under review: the establishment by the Director-General of dedicated core capacity in the Secretariat to coordinate the work on prevention of and response to sexual exploitation and abuse and sexual harassment; and the publication of the management response to the report of the Independent Commission to investigate allegations of sexual exploitation and abuse during the tenth outbreak of Ebola virus disease in the provinces of North Kivu and Ituri, the Democratic Republic of the Congo.<sup>2</sup>

3. On 1 July, 2021, the Director-General initiated steps to build capacity to urgently implement the institutional changes needed to strengthen effective prevention of and response to sexual exploitation and abuse and sexual harassment across the Organization by appointing a Director ad interim for the matter, reporting directly to him. He also established an Organization-wide task team currently comprising 38 senior officials from all accountability and enabling functions, the WHO Health Emergencies Programme, the Senior Advisor on Gender, the Office of the Ombudsman, the Global Polio Eradication Programme and representatives of each of the six Regional Directors drawn from different functions, including Heads of WHO country offices. Since August 2021 the task team developed, and has been implementing, a workplan that encompasses actions to address prevention and response, aligned with actions requested in decision EB148(4), as well as promoting best practice drawn from across the United Nations system and the development and humanitarian sectors.

4. The report of the Independent Commission to investigate allegations of sexual exploitation and abuse during the tenth Ebola virus disease outbreak in the provinces of North Kivu and Ituri, the

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<sup>1</sup> Documents EB150/33 and EB150/33 Add.1.

<sup>2</sup> WHO. Preventing & responding to sexual exploitation and abuse: WHO management response to the Report of the Independent Commission to investigate allegations of sexual abuse and exploitation during the response to the 10th Ebola Virus Disease epidemic in the provinces of North Kivu and Ituri, the Democratic Republic of the Congo, of 28 September 2021. Geneva: World Health Organization; 2021 ([https://cdn.who.int/media/docs/default-source/ethics/who-management-response-20211020-finalv2.pdf?sfvrsn=591a9adf\\_12&download=true](https://cdn.who.int/media/docs/default-source/ethics/who-management-response-20211020-finalv2.pdf?sfvrsn=591a9adf_12&download=true), accessed 29 March 2022).

Democratic Republic of the Congo, issued on 28 September 2021,<sup>1</sup> concluded that: sexual exploitation and abuse happened in the context of the response to that outbreak and the Organization did not take adequate actions to prevent it, actions that included conducting a comprehensive risk assessment, putting in place preventive measures, enabling outreach to local populations and reporting of incidents from the outset of the emergency operations; and that there was a failure or lack of mechanisms in the Organization to identify and appropriately address potential opportunities for or instances of sexual exploitation and abuse. The Independent Commission's report made recommendations in eight areas, some of which were specific to the country and others which were applicable to WHO overall. The Secretariat has been transparent in its communication of the report with all key stakeholders: Member States, staff members, media, the public and representatives of the alleged victims and survivors. The release of the report was accompanied by a rapid and comprehensive consultation with Member States, all regional offices and senior managers in the Organization so as to facilitate the drafting of the WHO Management Response Plan.<sup>2</sup> The Plan and its accompanying implementation plan<sup>3</sup> have been posted on WHO's website to ensure continued transparency and accountability, and are now being implemented. An update to the Implementation plan was published in March 2022.<sup>3</sup>

## **A UNIFIED FRAMEWORK FOR WORK ON PREVENTION OF AND RESPONSE TO SEXUAL EXPLOITATION AND ABUSE AND SEXUAL HARASSMENT**

5. The WHO Management Response Plan presents a unified framework that outlines WHO's actions to respond to all recommendations made in the Independent Commission's report, implement decision EB148(4), respond to recommendations made in the report of the Independent Oversight and Advisory Committee for the WHO Health Emergencies Programme's Subcommittee for the Prevention and Response to Sexual Exploitation, Abuse and Harassment<sup>4</sup> and promote best practices from other entities in the United Nations system and nongovernmental organizations. The Plan brings together the Organization's work on prevention of and response to sexual exploitation and abuse and its efforts to implement its policies and procedures on addressing abusive conduct.<sup>5</sup> It dovetails with the many Organization-wide actions under the Respectful Workplace Initiative. The Plan is a living document and will be implemented in two phases. It addresses the recommendations of the Independent Commission and lays the foundation for effective work while a longer-term strategy is developed for the period 2023–2025. It will contribute towards reaching the goals of zero tolerance for sexual exploitation and abuse and sexual harassment, and for inaction in preventing and addressing it.

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<sup>1</sup> Independent Commission on Allegations of Sexual Exploitation and Abuse during the Response to the 10th Ebola Outbreak in DRC. Final Report of the Independent Commission on the review of sexual abuse and exploitation during the response to the 10th Ebola virus disease epidemic in DRC. Geneva: World Health Organization; September 2021 (<https://www.who.int/publications/m/item/final-report-of-the-independent-commission-on-the-review-of-sexual-abuse-and-exploitation-ebola-drc>, accessed 29 March 2022).

<sup>2</sup> WHO Management Response Plan: meeting report. Geneva: World Health Organization; 2021 (<https://www.who.int/publications/m/item/who-management-response-plan>, accessed 29 March 2022).

<sup>3</sup> Implementation Plan (IP) of the WHO Management Response to the Report of the Independent Commission to investigate allegations of sexual abuse and exploitation during the response to the 10th Ebola Virus Disease epidemic in the provinces of North Kivu and Ituri, the Democratic Republic of the Congo. Geneva: World Health Organization; Version 2, March 2022. (<https://www.who.int/publications/m/item/who-implementation-plan>, accessed 29 March 2022).

<sup>4</sup> Document EB150/34.

<sup>5</sup> WHO. Policy: Preventing and Addressing Abusive Conduct: Policy and Procedures Concerning Harassment, Sexual Harassment, Discrimination, and Abuse of Authority. Geneva: World Health Organization; 2021. (<https://www.who.int/publications/m/item/preventing-and-addressing-abusive-conduct>, accessed 29 March 2022).

6. In the short term (mid-October 2021 to March 2022), the Management Response Plan has prioritized: complementing the investigation of the allegations of sexual exploitation and abuse outlined in the Independent Commission's report with assistance from the United Nations Office for Internal Oversight Services; conducting an investigation into alleged professional negligence by WHO personnel; ensuring support is provided to survivors and victims of sexual exploitation and abuse and sexual harassment perpetrated by WHO personnel; conducting an audit of the management of cases by WHO's accountability functions; and mobilizing WHO's entire workforce for the implementation of the Plan.

7. To put these actions into operation, the Secretariat has agreed with the Independent Expert Oversight and Advisory Committee that the latter will oversee the implementation of the recommendations of the implementation plan, which include the recommendations of the Independent Commission. WHO has contracted an independent supplier to undertake an audit of the Secretariat's case management of allegations and complaints of sexual exploitation and abuse and sexual harassment. The audit will cover all allegations and complaints of sexual exploitation and abuse and sexual harassment, together with a random sample of allegations and/or complaints of harassment, received by the Compliance, Risk Management and Ethics Department or the Office of Internal Oversight Services of the Secretariat during the period 1 August 2018 to 30 September 2021. The audit will also be overseen by the Independent Expert Oversight and Advisory Committee. In addition, WHO and the United Nations Office for Internal Oversight Services have agreed that the latter will complement the investigations conducted by the Independent Commission and its external investigative team in order to positively identify additional alleged perpetrators, in compliance with WHO's investigative requirements and, under the oversight of the Independent Expert Oversight and Advisory Committee, to review whether there has been failure on behalf of WHO's management to initiate investigative processes where warranted.

8. WHO is using the "Clear Check" screening database, which is a centralized database that permits the sharing of information amongst United Nations entities on former United Nations staff members with records of sexual exploitation and abuse or sexual harassment, with the aim of preventing their re-employment within the United Nations system. WHO enters the names and details of former WHO staff members against whom allegations of sexual exploitation and abuse or sexual harassment have been confirmed and, under certain conditions, former personnel who are the subject of pending allegations of sexual exploitation and abuse or sexual harassment. Where applicable, this includes the names of alleged perpetrators identified in the report of the Independent Commission. By end February 2022 a total of 14 names of alleged perpetrators from the report had been entered into the database. The use of the database to vet individuals considered for employment, engagement or deployment by the Organization is being extended across the Organization. For example, it was used to screen personnel deployed during the thirteenth outbreak of Ebola virus disease in the Beni Health Zone in North Kivu Province of the Democratic Republic of the Congo in October 2021, and to complete the vetting of all the polio experts in the database of 2400 staff members. Additionally, in December 2021, all WHO staff members were vetted against the Clear Check database.

9. Concerning victim and survivor support, in November 2021 WHO and UNICEF jointly led an Inter-Agency Standing Committee's Mission to Goma and Kinshasa, Democratic Republic of the Congo, with representatives from the United Nations Population Fund (UNFPA) and the United Nations Office of the Victims' Rights Advocate. Members of the mission team met with various stakeholders, including the humanitarian country team, partner agencies, government officials, nongovernmental and community-based organizations, victims and survivors, and donor organizations. The objectives of the mission included the implementation of relevant actions from WHO's Management Response Plan, assessment of progress made since the previous mission of the Inter-Agency Standing Committee a year



before, and formulation of recommendations for the further strengthening of work on preventing and responding to sexual exploitation and abuse and sexual harassment in the country.

10. The mission also advanced support to victims of sexual exploitation and abuse from the tenth Ebola virus disease outbreak in the Democratic Republic of the Congo and the finalization of a memorandum of understanding between WHO and UNFPA to ensure that all victims and survivors receive the support they need. WHO has provided the funding required to support 92 victims and survivors of actions perpetrated by individuals identified by the Independent Commission, as well as the children born as a result. The Secretariat mapped the services already accessed by the victims, using data provided by UNFPA and the Office of the Victims' Rights Advocate. The memorandum of understanding covers activities, funded by WHO and implemented under the supervision of UNFPA, to assess the current medical, psychological, legal, socioeconomic and reintegration needs of victims and survivors and to examine the needs of children born as a result of sexual exploitation and abuse. WHO is collaborating with a well-established, women-led legal aid nongovernmental organization in the country to ensure that the victims who want to pursue legal action are supported to do so. Initially, this nongovernmental organization will be contracted to provide full legal aid to up to 25 victims and survivors of sexual exploitation and abuse in 2022. The Secretariat will in addition support integrated and holistic services for victims through nongovernmental organizations, including HEAL Africa. The United Nations humanitarian country team is developing a standard framework for victim-support services and the Secretariat will align with this framework once it is validated by the Office of the Victims' Rights Advocate. Members of the mission also met: the Provincial Governor of North Kivu in Goma; the national Minister of Public Health, Hygiene and Prevention in Kinshasa to discuss government action related to sexual exploitation and abuse and sexual harassment and the newly-formed National Commission on the subject; the Vice-Minister of Public Health, Hygiene and Prevention to discuss the strengthening of referral services for gender-based violence that any victim can access; and the Minister of Gender, Family and Children for scaling up protection and legal aid for victims of gender-based violence and sexual exploitation and abuse.

11. In the medium term (November 2021 to December 2022) WHO's Management Response Plan seeks: to define, internalize and operationalize a victim- and survivor-centred approach to preventing and responding to sexual exploitation, abuse and sexual harassment across the Organization; to develop and enforce an accountability framework for all personnel that is accompanied by training and building capacity and outlining enhanced responsibilities for supervisors, managers and senior managers; and to reform WHO's culture, structures, policies, processes and practices to enable effective work in the area. A three-year Organization-wide strategy for the period 2023–2025 on tackling sexual exploitation, abuse and sexual harassment will be a major longer-term result of the Management Response Plan.

12. By the end of March 2022, 86% of activities in the Management Response Plan had been completed or were in progress. Additionally, all the inputs provided during the relevant agenda items of the 150th session of the Executive Board, along with recommendations from the report of the Independent Oversight and Advisory Committee for the WHO Health Emergencies Programme's Subcommittee for the Prevention and Response to Sexual Exploitation, Abuse and Harassment had been integrated into the Management Response Plan, to maintain a single unified framework for the prevention of and response to sexual exploitation and abuse and sexual harassment across WHO.

## **INSTITUTIONAL CAPACITY FOR PREVENTION, DETECTION AND RESPONSE TO SEXUAL EXPLOITATION AND ABUSE AND SEXUAL HARASSMENT**

13. Strong leadership is essential to achieve zero tolerance for sexual exploitation and abuse and sexual harassment. The Director-General and the six Regional Directors lead the Organization's work

on the matter. A new WHO public website on the subject was launched in July 2021, providing easy access to key documents, including the report of the Independent Commission, the Management Response Plan, the implementation plan and a monthly newsletter on progress, which promotes greater transparency and accountability.<sup>1</sup>

14. A comprehensive review of WHO's relevant policies and procedures has been launched to identify gaps and inconsistencies in relation to the WHO regulatory framework as well as with regard to existing best practice in this area and to address specific concerns identified in the findings of the Independent Commission. In the interim, WHO's new Policy Directive on protection from sexual exploitation and sexual abuse came into effect on 3 December 2021 with the aim of clarifying and aligning with the key elements of the United Nations Secretary-General's Bulletin 2003/13, including definitions of sexual exploitation and abuse,<sup>2</sup> as well as the Inter-Agency Standing Committee core principles<sup>3</sup> and minimum operating standards<sup>4</sup> and the clause on the subject recently adopted by WHO and 15 donor Member States. The Directive also aligns with the United Nations protocol on assistance to victims of sexual exploitation and abuse<sup>5</sup> and the United Nations protocol on allegations of sexual exploitation and abuse involving implementing partners.<sup>6</sup>

15. As set out in the Management Response Plan, the Secretariat is making progress towards creating a comprehensive, up-to-date, easy-to-use policy framework that will consolidate all relevant revised policies, accompanied by procedures and implementation guidance. An information note on the Policy Directive on Protection from sexual exploitation and abuse was issued in December 2021.<sup>7</sup> In 2022, the focus is on revising and updating the WHO code of Ethics and Professional Conduct.

16. WHO's Policy on Preventing and Addressing Abusive Conduct,<sup>8</sup> which covers sexual harassment in addition to other forms of harassment, discrimination and abuse of authority, came into effect on

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<sup>1</sup> WHO. Preventing and responding to sexual exploitation, abuse and harassment. Geneva: World Health Organization; 2021 (<https://www.who.int/initiatives/preventing-and-responding-to-sexual-exploitation-abuse-and-harassment>, accessed 29 March 2022).

<sup>2</sup> United Nations Secretariat. Secretary-General's Bulletin: special measures for protection from sexual exploitation and sexual abuse. Document ST/SGB/2003/13. New York: United Nations; 2003 (<https://www.securitycouncilreport.org/un-documents/document/se-st-sgb-2003-13.php>, accessed 29 March 2022).

<sup>3</sup> Inter-Agency Standing Committee. IASC six core principles relating to sexual exploitation and abuse, 2019. New York: United Nations; 2019 (<https://interagencystandingcommittee.org/inter-agency-standing-committee/iasc-six-core-principles-relating-sexual-exploitation-and-abuse>, accessed 29 March 2022).

<sup>4</sup> Inter-Agency Standing Committee. Minimum operating standards (MOS-PSEA). New York: United Nations; 2016 (<https://interagencystandingcommittee.org/iasc-task-team-accountability-affected-populations-and-protection-sexual-exploitation-and-abuse/minimum-operating-standards-mos-psea>, accessed 29 March 2022).

<sup>5</sup> United Nations Protocol on the Provision of Assistance to Victims of Sexual Exploitation and Abuse. New York; United Nations; 2019 ([https://www.un.org/en/pdfs/UN%20Victim%20Assistance%20Protocol\\_English\\_Final.pdf](https://www.un.org/en/pdfs/UN%20Victim%20Assistance%20Protocol_English_Final.pdf), accessed 29 March 2022).

<sup>6</sup> United Nations Protocol on Allegations of Sexual Exploitation and Abuse involving Implementing Partners. New York; United Nations (<https://psea.interagencystandingcommittee.org/sites/default/files/UN%20Protocol%20on%20SEA%20Allegations%20involving%20Implementing%20Partners.pdf>, accessed 29 March 2022).

<sup>7</sup> WHO Information on Policy Directive on Protection from sexual exploitation and sexual abuse (SEA), Information note, 6 December 2021 ([https://cdn.who.int/media/docs/default-source/ethics/information-on-policy-directive-on-protection-from-sexual-exploitation-and-sexual-abuse.pdf?sfvrsn=8926f2fa\\_19&download=true](https://cdn.who.int/media/docs/default-source/ethics/information-on-policy-directive-on-protection-from-sexual-exploitation-and-sexual-abuse.pdf?sfvrsn=8926f2fa_19&download=true), accessed 29 March 2022).

<sup>8</sup> WHO. Preventing and addressing abusive conduct: Policy and procedures concerning harassment, sexual harassment, discrimination, and abuse of authority. Geneva: World Health Organization; 2021 (<https://www.who.int/publications/m/item/preventing-and-addressing-abusive-conduct>, accessed 31 March 2022).

1 March 2021. The policy, which revised and updated the Organization's previous harassment policy, strengthens the coherence of the complaints process, while taking into account the need to pay particular attention to claims and allegations relating to sexual harassment. Its accompanying implementation plan includes the dissemination of new communication materials and resources for the workforce; the creation of guidance tools for managers and supervisors; the development and delivery of new training sessions tailored to the needs of different audiences; and the updating of related human resources instruments and processes. Particular emphasis is being placed on ensuring that the necessary training and other forms of support are in place across the Organization. Moreover, a system has been established to ensure the implementation of the policy's prevention measures in all offices. In addition, the recently established Prevention and Response to Sexual Misconduct department is coordinating efforts to build institutional capacity to ensure the effective prevention of and response to sexual harassment.

17. The Secretariat's core capacity to receive and investigate complaints and allegations of sexual exploitation and abuse and sexual harassment is being strengthened. A Head of Investigations ad interim was appointed in November 2021 to focus on sexual misconduct cases and strengthen the specialized expertise needed to handle such cases effectively and efficiently within WHO. In addition, the reporting hotline (the "Integrity Hotline") was moved into the Investigations unit and is being streamlined. Safe and accessible reporting mechanisms that incur no fear of retaliation are essential for both the WHO workforce and the communities that the Organization serves, and will be essential to building trust and countering perceptions of impunity for perpetrators of sexual exploitation and abuse and sexual harassment. As such, the Secretariat is reviewing the internal reporting mechanisms and the entire process from suspicions, raising alerts, complaints, investigations to administrative actions as a whole, informed by an independent external audit. The Secretariat will report aggregate figures to Member States on a quarterly basis.

18. Decision EB150(23), containing the provision requiring the temporary suspension of Financial Rule XII, 112.1, provides the Head, Investigations with the authority for all investigations of sexual exploitation and abuse, sexual harassment and other abusive conduct covered under the WHO Policy on Preventing and Addressing Abusive Conduct. In this capacity the Head, Investigations has the same reporting lines, the same type of access, the same channels for reporting the results of work undertaken, including to the Executive Board, and the same authority as those currently granted to the Director, Internal Oversight Services in this area. This has allowed for increased effectiveness and efficiencies in the management of sexual exploitation and abuse and sexual harassment investigations. The backlog of cases relating to sexual exploitation and abuse and sexual harassment has been addressed, with all cases either assigned or completed. In addition, all outstanding harassment cases are being assigned. Efforts will be made to investigate all new cases of sexual exploitation and abuse and sexual harassment within a period of 120 days. A new, globally dispersed team of 15 experts in conducting sexual misconduct investigations, has been established (70% of the team is composed of women). A victim and survivor-centred approach has been introduced into case management and case investigation. The WHO Survivor Assistance Fund has been used in countries to provide immediate and urgent medical and psychosocial support for alleged victims, and for such logistics as their transport to locations where services can be accessed.

19. Although progress is being made, and the increasing numbers of complaints suggest that trust in the system is being strengthened, the institutional capacity for investigation of sexual exploitation and abuse and sexual harassment remains fragile. Several measures are required to achieve stability and sustainability. As per recommendation 2.2 of document EB150/34, the Report of the Independent Oversight and Advisory Committee for the WHO Health Emergencies Programme's Subcommittee for the Prevention and Response to Sexual Exploitation, Abuse and Harassment, a dedicated and independent unit within the Office of Internal Oversight Services at headquarters has been established to investigate allegations of sexual exploitation and abuse and sexual harassment. Investigations are

conducted confidentially, and are sensitive to the capacities, rights and needs of survivors and communities, taking into account age, gender, sex, disability, ethnicity/race, language and socioeconomic status and other characteristics.

20. The Secretariat has completed a review of United Nations agency and inter-agency sexual exploitation and abuse risk assessment tools and guidance. While working with the United Nations country team and humanitarian country team joint risk assessments where they exist, WHO has prioritized the need to develop an agency-specific risk assessment tool for sexual exploitation and abuse and sexual harassment. Such a tool would allow monitoring and management of sexual exploitation and abuse and sexual harassment risk in all countries where WHO is operational. It would also support accountability and compliance with relevant policies, procedures and practices. The tool will be used to conduct an annual assessment in every country of the prevailing risk resulting from factors within the country: risks of sexual exploitation and abuse and sexual harassment in country offices and in all operations and programme activities that are community-facing. It will include a compliance checklist to be completed by each Head of WHO country offices to reduce sexual exploitation and abuse and sexual harassment risks. The Secretariat will test and pilot the tool in several priority countries in 2022 before integrating it into the Organization's broader enterprise-wide risk management framework. Furthermore, the reporting on relevant control measures will be fully integrated into the questionnaire accompanying the annual internal control self-assessment checklist.

21. The request for an initial core budget of US\$ 50 million allocated to work on preventing and responding to sexual exploitation and abuse and sexual harassment for the biennium 2022–2023 has been included in the proposed revision of the Programme budget 2022–2023. Additional resources will need to be mobilized for prevention, detection and response activities in field operations and community-facing programmes. As at the end of February 2022 WHO had a network of more than 60 country focal points on the subject in 30 countries, who are being supported with capacity-building and training activities. Guidance has been developed and disseminated to all Heads of WHO country offices to assign a prevention of and response to sexual exploitation and abuse and sexual harassment focal point in every country office. The allocation of the programme portion of the funds for the implementation of the Management Response Plan, amounting to approximately US\$ 30 million, will be made with country impact in mind, with 46% of the funds being allocated to country offices, 18% to regional offices, 13% to headquarters and 23% to cross-Organization activities for all levels of the Organization, including a victims' assistance fund. Approximately US\$ 10 million will be allocated to creating strong institutional capacity for investigation services for sexual exploitation and abuse and sexual harassment and other forms of abusive conduct, and the remainder for reforming, streamlining and strengthening related accountability functions across the Organization. Guidance has been drafted outlining 10 core activities for preventing and responding to sexual exploitation and abuse and sexual harassment at country level and the global team is supporting regional offices to include these and related budgeting into public health and health emergency programmes and initiatives.

## **TACKLING SEXUAL EXPLOITATION AND ABUSE AND SEXUAL HARASSMENT IN HIGH-RISK SETTINGS**

22. Sexual exploitation and abuse can happen in any setting, but the risk is significantly increased during health emergencies and in any programme that brings WHO personnel into direct contact with communities in need of assistance. WHO is prioritizing interventions to prevent sexual exploitation, and abuse and sexual harassment as its primary strategy, while scaling up detection and response operations across the WHO Health Emergencies Programme and at operational level. WHO's prevention and response capacities, especially in high-risk settings, including the polio eradication programme, is being strengthened in several ways. Due to the increased risk of sexual exploitation and abuse and sexual

harassment, and its specific characteristics, steps have been taken to fully embed prevention of and response to sexual exploitation and abuse and sexual harassment interventions into the WHO Health Emergencies Programme and in emergency operations. To this end, a cell on preventing and responding to sexual exploitation and abuse and sexual harassment has been established within the Programme and is responsible for overseeing integration of policies and recommendations into emergency operations. The cell interacts and works closely with the relevant programmes and units at headquarters and in the regions, to support countries' efforts to operationalize the prevention of and response to sexual exploitation and abuse and sexual harassment policies in emergency settings and operations, while engaging with other relevant agencies and stakeholders.

23. As part of embedding prevention of and response to sexual exploitation and abuse and sexual harassment in WHO emergency operations, a range of interventions are being streamlined and integrated into graded emergency response operations. These include:

- embedding a prevention of and response to sexual exploitation and abuse and sexual harassment technical expert within the Incident Management Response Team for the event;
- ensuring that a plan of action, informed by a risk and capacity assessment is integrated within the emergency response framework, response strategy and budget, advocacy and resource mobilization plan;
- implementing recruitment and pre-deployment safeguarding measures, including screening through Clear Check, signing a code of conduct, ensuring that a prevention of sexual exploitation and abuse and sexual harassment clause is inserted in all contracts, and that all staff members undertake mandatory prevention of and response to sexual exploitation and abuse and sexual harassment training, including in induction and refresher training courses;
- working with other partners to streamline reporting and referral pathways, build capacities for service provision to survivors and victims of sexual exploitation and abuse, enhance community awareness and engagement on rights and services as components of the prevention of sexual exploitation and abuse network plan of actions, where prevention of sexual exploitation and abuse network partners are in existence.

24. Many of these measures were implemented during the thirteenth Ebola virus disease outbreak response; and are currently being implemented in the north-eastern Ethiopia crisis response, the response to Lassa fever outbreak in Nigeria, the response to flooding in Malawi, and will become be applied systematically within the WHO Health Emergencies Programme. All funding requests for preliminary emergency response operations benefitting from the WHO Contingency Fund for Emergencies are required to include a budget line on prevention of and response to sexual exploitation and abuse and sexual harassment, with clearly articulated activities for implementation during the initial response period. At least 10 requests for Contingency Fund for Emergencies funding in 2022 thus far have responded to this requirement. Notable examples include: WHO responses to disease outbreaks in Cameroon, Nigeria and Afghanistan; flooding in South Sudan and Madagascar; conflict in Ukraine; civil unrest in Sudan; COVID-19 in Guinea and Sierra Leone; and to flooding and poliomyelitis in Malawi. In the Democratic Republic of the Congo, WHO contributed to the joint operational review of prevention of and response to sexual exploitation and abuse and sexual harassment measures post containment of the thirteenth Ebola virus disease outbreak. This approach, with its enhanced focus on embedding prevention of and response to sexual exploitation and abuse and sexual harassment in all emergency operations, must be allocated adequate funding and sufficient human resource capacities, if it is to be sustained.

25. The review of prevention of and response to sexual exploitation and abuse and sexual harassment during the thirteenth outbreak of Ebola virus disease in the Beni Health Zone in the Democratic Republic of the Congo showed that several safeguarding measures had been undertaken by the humanitarian community, including the subregional Inter-Agency Standing Committee coordinator responsible for this area of work, whose position is funded by WHO. These measures included screening by WHO of all personnel deployed for the response through the Clear Check database, the training of responders including governmental and national responders, the assignment of a government focal point for prevention of and response to sexual exploitation and abuse and sexual harassment, the sensitization of communities regarding standards of behaviour to expect from responders, and the establishment of community-based complaint mechanisms linked to the national hotline.

26. The measures and interventions outlined as part of embedding the prevention of and response to sexual exploitation and abuse and sexual harassment in WHO emergency programmes will inform the development of a plan of action for emergency contexts, aligned with the global efforts and policy framework, and the finalization of the WHO's Emergency Response Framework.

27. The WHO Health Emergencies Programme and the polio eradication programme and the Prevention and Response to Sexual Misconduct department are establishing full-time capacity for prevention of and response to sexual exploitation and abuse and sexual harassment, using a risk-based approach. New staff positions have been provided for in 12 priority countries, identified primarily through the Inter-Agency Standing Committee and the polio programme. In addition a senior coordinator post, that will work closely with the global team, is being established in each of the six Regional Director's offices. Each Regional Director has a team of senior staff members working on the matter in close collaboration with the global team. The WHO Health Emergencies Programme holds monthly meetings with Heads of WHO country offices in fragile and conflict-affected countries to provide guidance and support, resolve issues and strengthen leadership and senior management commitment in this area.

28. A prevention of and response to sexual exploitation and abuse and sexual harassment learning pathway for all WHO Health Emergencies Programme staff members and focal points was introduced in January 2022. There are ongoing efforts to further mainstream and integrate prevention of and response to sexual exploitation and abuse and sexual harassment in all health cluster coordination platforms; to ensure improved gender balance in WHO Health Emergency Programme operations; and to mitigate the risks of sexual exploitation and abuse and sexual harassment. To strengthen human resource capacities in prevention of and response to sexual exploitation and abuse and sexual harassment to cope with its multiple emergency response operations, WHO is reinforcing its collaboration and partnerships with the standby partner mechanisms to support deployment of experts to high-risk graded emergency operations.

## **STAFF ENGAGEMENT, AWARENESS AND CAPACITY-BUILDING**

29. WHO introduced the new United Nations mandatory training on prevention of and response to sexual exploitation and abuse and sexual harassment in October 2021. All staff members must complete the training within three months, and all new personnel working in emergencies must complete it before they can work in or be deployed to the field. By February 2022 the training had been assigned to around 15 400 persons – staff and non-staff – with a global completion rate of 90%. An interim WHO-specific training is available and is being used to brief and train staff members across the Organization. The WHO-specific training has been piloted among 100 personnel across the world, and is due to be launched globally and will be made mandatory for all staff during the second half of 2022. A module on the subject has been introduced for the first time into staff induction briefings in 2021 and will

continue to be a stand-alone session in 2022. Materials are being developed for introduction into pre-deployment training for health emergency responders, country readiness training, Health Cluster Coordinator training, front-line polio worker training and training for Emergency Medical Teams, the Global Outbreak and Alert Response Network and other networks and partners associated with WHO, including the WHO Global Emergency Operations Centres Network, applying lessons-learned and best practices from the United Nations system and the Inter-Agency Standing Committee. In March 2022, WHO assigned to its workforce a new United Nations mandatory training course – United to Respect: Preventing Sexual Harassment and Other Prohibited Conduct.

30. The engagement of personnel for prevention of and response to sexual exploitation and abuse and sexual harassment will intensify throughout 2022. This is part of a #NoExcuse engagement campaign that will ensure that each and every person working for and with WHO knows the zero-tolerance goals related to sexual exploitation and abuse and sexual harassment, knows and acts on their responsibility to report any suspicions, and is aware of the enhanced responsibilities of supervisors and managers. The #NoExcuse campaign increases the awareness of managers concerning their responsibility to create and maintain an environment that prevents sexual exploitation and abuse and sexual harassment and that promotes timely action and response to incidents, including reporting to WHO's investigational services. WHO vacancy notices and procurement contracts now outline WHO's position and conditions regarding prevention of and response to sexual exploitation and abuse and sexual harassment. The #NoExcuse campaign is observed by all WHO personnel during WHO's Goals Week (28 February–4 March) where staff and supervisors discussed performance goals and objectives for the year including those related to the prevention and response to sexual exploitation, abuse and harassment. The week was launched with a leadership letter written by the Director-General and all six Regional Directors to each member of the WHO workforce outlining their expectations related to zero tolerance for sexual exploitation and abuse and sexual harassment and for inaction against it. For the 2022 electronic performance management and development system (ePMDS), all WHO supervisors were required to hold at least one team meeting in which to discuss prevention of and responding to sexual exploitation and abuse and sexual harassment and, with their teams, to select a team goal to be achieved in that area. Staff members will be offered a series of learning, capacity development and engagement activities throughout 2022, and all staff must re-affirm their commitment to relevant policies before being able to submit their ePMDS forms. At the end of the year, supervisors will be required to attest that everyone under their supervision has completed all mandatory training, which currently includes the United Nations mandatory training in prevention of sexual exploitation and abuse, the United Nations training on addressing sexual harassment, as well as WHO's own agency-specific training on prevention of and response to sexual exploitation and abuse and sexual harassment.

31. Following the introduction of WHO's Policy on Preventing and Addressing Abusive Conduct on 1 March 2021, the Secretariat implemented a communication campaign to raise the workforce's awareness of abusive conduct, the support available within the Organization, and the mechanisms through which reports may be made and offenders held accountable. Actions to promote engagement have included Organization-wide information sessions, dissemination of communication and guidance materials, and ongoing training at all levels of the Organization. Special emphasis has been placed on the role of managers and supervisors and the empowerment of all members of the workforce to immediately intervene or to report instances of abusive conduct. Since the policy's adoption, an estimated 4000 staff members have attended the information sessions and training.

32. The global team on prevention of and response to sexual exploitation and abuse and sexual harassment held briefings and training sessions for more than 8500 staff members between July 2021 and February 2022, reaching personnel across all levels of the Organization, including Heads of WHO country offices and their staff members, incident managers from the African, European, Eastern Mediterranean and the Western Pacific regions, members of the network of country focal points on

prevention of and response to sexual exploitation and abuse and sexual harassment, staff members from technical departments and the United Nations global prevention of sexual exploitation and abuse focal point network.

33. Thus, WHO is reaffirming with all staff and partners that they have not only an obligation to abstain from any behaviour that may constitute sexual exploitation and abuse and sexual harassment, but also an obligation to report any suspected incidents through established reporting processes. Managers, senior managers, Heads of country offices all have an added role to play to create the systems and environment for effective prevention, early detection, safe reporting and support to victims and survivors.

## **ENGAGING STAKEHOLDERS ACROSS THE UNITED NATIONS SYSTEM**

34. WHO has taken concrete measures to learn from and align efforts on prevention of and response to sexual exploitation and abuse and sexual harassment with initiatives taken by other organizations in the United Nations system and the Inter-Agency Standing Committee, in order to strengthen significantly the Organization's inputs into system-wide efforts. WHO has been working with the Special Coordinator on improving the United Nations response to sexual exploitation and abuse; the Office of the Victims' Rights Advocate; the Inter-Agency Standing Committee; the Office of the Special Representative of the Secretary-General on Sexual Violence in Conflict; and other entities in the United Nations system.

35. Lessons have been drawn from the experiences of partner agencies and concrete priority areas of collaboration have been identified with organizations in the United Nations system (including the International Organization for Migration, UNESCO, UNFPA, UNHCR, UNICEF and the World Food Programme); various nongovernmental organizations and professional associations (including Oxfam and the Fédération Internationale de Football Association) and multilateral and international organizations (including the World Bank, The Global Fund to Fight AIDS, Tuberculosis and Malaria, GAVI – the Vaccine Alliance, and Unitaid). The aim is to ensure WHO's alignment within the existing framework of United Nations entities and other interagency mechanisms, and to collaborate on current best practices for prevention and response to sexual exploitation, abuse and harassment. Priority bilateral collaborations with partner agencies include a commitment to closer country-level collaboration with UNHCR on risk assessment; with IFRC, UNICEF and more than 50 agencies that make up the Risk Communication and Community Engagement collaborative service on integrating prevention of and response to sexual exploitation and abuse and sexual harassment in their work with communities, including for the COVID-19 vaccine rollout; and with World Vision, which this year assumed the Inter-Agency Standing Committee Championship on Prevention from Sexual Exploitation and Abuse and Sexual Harassment: on (i) defining, standardizing, and operationalizing a survivor-centred approach to prevention work, investigations, and response to sexual exploitation and abuse and sexual harassment violations; (ii) supporting the deployment of Inter-Agency Standing Committee coordinators in prevention of sexual exploitation and abuse in highest risk contexts; and (iii) continuing the process of culture change, ensuring a zero-tolerance approach for inaction.

36. Since July 2021 WHO has intensified its collaboration with other bodies in the United Nations system, for instance in the areas of victim- and survivor-centred approaches and frameworks, risk assessment and management, capacity-building, dealing with sexual exploitation, abuse and harassment in health emergencies, application of the United Nations Protocol on Allegations of Sexual Exploitation and Abuse involving Implementing Partners, and reporting through the Secretary-General's electronic incident reporting form among others.



37. The findings of the external review of the Inter-Agency Standing Committee's approach to prevention of and response to sexual exploitation and abuse and sexual harassment, released in November 2021, which examined the body's past 10 years of work, identified some of the main barriers to inter-agency collaboration. These included: the failure of some entities to adopt a victim- and survivor-centred approach; the length of time it takes, across the United Nations system, to conduct and conclude investigations into sexual exploitation and abuse and sexual harassment; the overengineering of community-based complaint mechanisms, and the lack of confidence in them; and the lack of long-term cultural and attitudinal change to all forms of sexual misconduct. The report and these findings indicate that achieving the desired changes requires a long-term vision, strategy, collaboration, capacity and resources; this includes WHO becoming a strong participant in international efforts to safeguard its programmes and operations against sexual exploitation and abuse.

38. In the first quarter of 2022, the Director-General has reported to the United Nations Secretary-General on progress on prevention of and response to sexual exploitation and abuse and sexual harassment; WHO has completed the implementation of the 2021 Action Plan on prevention of and response to sexual exploitation and abuse and sexual harassment, managed by the Office of the Special Coordinator on improving the United Nations response to sexual exploitation and abuse; and the Secretariat has contributed to the United Nations Secretary-General's special measures report to the United Nations General Assembly.

## OVERSIGHT

39. The Secretariat has provided quarterly updates to Member States as requested by the Board in decision EB148(4), together with ad hoc updates and briefings to Member States individually and in groups upon request.

40. Following the establishment of the task team (see paragraph 3) the Director-General invited the Chair of the Independent Oversight and Advisory Committee for the WHO Health Emergencies Programme to establish a subcommittee of its members to consider how the Organization's current policies and procedures on the prevention of and response to sexual exploitation and abuse and sexual harassment could be improved to achieve best-in-class status and to oversee, guide and monitor the Secretariat's work in this regard.<sup>1</sup> The subcommittee constituted and consulted a reference group of interested Member States to advise on good practices in safeguarding against sexual exploitation, abuse and harassment and held a series of consultations with various external stakeholders and WHO staff members to compare WHO's policies, procedures, structures and resources with international best-in-class standards. The subcommittee recommends urgent action by the Secretariat in five priority areas: (1) clarifying accountabilities, lines of responsibility and delegation of authority across the three levels of the Organization and strengthen the accountability framework for emergency response and other field operations, including for preventing and responding to sexual exploitation, abuse and harassment; (2) reforming the Organization's management structure for preventing and responding to sexual exploitation, abuse and harassment, and accelerating the scale-up of organizational capacity to implement a victim/survivor-centred approach to preventing and responding to sexual exploitation, abuse and harassment; (3) investing in preventing and responding to sexual exploitation, abuse and harassment as an essential function; (4) developing and implementing a context-specific, risk-informed, risk-management strategy for preventing and responding to sexual exploitation, abuse and harassment in field operations; and (5) promoting, advocating for and institutionalizing culture change in order to

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<sup>1</sup> WHO. IOAC sub-committee on the prevention of sexual exploitation, abuse and harassment (PRSEAH). Geneva: World Health Organization; 2021 (<https://www.who.int/groups/independent-oversight-and-advisory-committee/sub-committee-on-prseah>, accessed 30 March 2022).

strengthen prevention of and response to sexual exploitation, abuse and harassment, including greater gender and racial diversity, improved performance management and a renewed commitment to WHO values.

41. As noted above, progress has been made in the implementing recommendations (2), (3) and (4) of the Independent Oversight Advisory Committee's subcommittee's recommendations. Recommendation (1) is being addressed as a matter of priority and recommendation (5) will be addressed in the medium and long term partly by aligning with initiatives underway in human resources and talent management, and initiatives on diversity, equity and inclusion. In addition a new leadership coaching programme will be supported for the area of prevention of and response to sexual exploitation and abuse and sexual harassment, to support female leadership development.

42. As noted in paragraph 7, the Independent Expert Oversight and Advisory Committee will provide oversight of the implementation of the Independent Commission's recommendations which are now integrated into the WHO Management Response Plan for prevention of and response to sexual exploitation and abuse and sexual harassment.

## **CHALLENGES**

43. Tackling sexual exploitation and abuse and sexual harassment is a shared responsibility. WHO has made good progress in strengthening its engagement and participation with other United Nations and humanitarian actors to address the matter in countries. However, to achieve greatest impact, the Secretariat needs to intensify its engagement with and support to governments and authorities in countries where WHO has programmes and operations. This includes the strengthening of gender-based violence referral services so that all victims and survivors, including those affected by sexual exploitation and abuse can safely access the support they need. The role of WHO Member States should be clearly articulated in the proposed three-year WHO strategy on prevention of and response to sexual exploitation and abuse and sexual harassment to be developed in 2022.

44. The Organization has committed core funds for the establishment of institutional capacity for prevention and response, but further funding and institutional capacity are required for safeguarding WHO's community-facing programmes and response operations. As such, all emergency operations and their respective humanitarian appeals and resourcing mechanisms will have to allocate an agreed percentage of their overall budgets to supporting this area of work. Such investment is needed to implement effective prevention efforts and avert further incidents, and should be applied to other large community-facing programmes, such as the polio eradication programme.

45. Addressing the systemic issues that provide opportunities for sexual exploitation, abuse and sexual harassment to happen within the Organization and transforming the Organization's culture require long-term and sustained action. There is need to invest in the broader, Organization-wide accountability functions and approaches that promote a respectful workplace. This includes strengthening and stabilizing investigation function capacity, including with dedicated expertise for conducting trauma-informed case investigations into sexual exploitation and abuse and sexual harassment and other forms of abusive conduct that incorporate a victim- and survivor-centred approach, and to report out anonymized data to track progress.

46. As the Organization expands its own capacity to tackle this matter, it relies on delivering results through implementing partners. Therefore, it needs to provide support to partners so that they have the necessary human and technical capacity to effectively implement adequate safeguarding measures. The lack of expertise to fill the major gap in the human resources needed within the Secretariat and across

the United Nations system is already evident. Prevention of and response to sexual exploitation, abuse and harassment is a new area of expertise that draws on many disciplines without a well-defined educational or professional path. Existing pools of experts are limited in size, difficult to access and resource. The Secretariat proposes that efforts are made within WHO and across the United Nations system to professionalize this area of expertise and to contribute to the development of a global pool of expertise, using modern adult-learning approaches, which can support work in countries, programmes and operations.

## **CONCLUSION**

47. WHO reaffirms its commitment to zero tolerance for sexual exploitation and abuse and sexual harassment and for inaction against it. Sexual exploitation and abuse of the people served by WHO is a grave failure of the Organization to do no harm and to protect the vulnerable. Sexual harassment and sexual abuse within the Secretariat is a fundamental failure of the Organization's duty of care to its workforce and a failure to provide a safe and respectful environment in which to serve. WHO is committed to providing a respectful work environment and to promoting and enforcing policies that respect the inherent dignity of all persons, including those whom the Organization serves. WHO has an abiding responsibility to prevent and respond to discrimination, abuse of authority, harassment, including sexual harassment, and sexual exploitation and abuse.

## **ACTION BY THE HEALTH ASSEMBLY**

48. The Health Assembly is invited to note the report.

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

The Seventy-fifth World Health Assembly,

Having considered the consolidated report by the Director-General;<sup>1</sup>

Recalling resolutions WHA61.21 (2008), WHA62.16 (2009), WHA68.18 (2015) and WHA72.8 (2019) and decisions WHA71(9) (2018) and WHA73(11) (2020) 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;

Reiterating the essential role that the global strategy and plan of action on public health, innovation and intellectual property plays in directing and coordinating WHO's policies and programme on this interface, including the WHO–WIPO–WTO trilateral cooperation;

Stressing that the relationship, including the balance, between public health, innovation and intellectual property is a critical component of sustainable and resilient health systems, as well as but not limited to the prevention of, preparedness for and response to health emergencies, including the continuing pandemic of coronavirus disease (COVID-19) and future pandemics;

Acknowledging the continued value of the principles and elements of work enshrined in the global strategy and plan of action on public health, innovation and intellectual property, which guide and frame the work of WHO on access to medicines and other health products;

Reaffirming the goals and objectives of the global strategy and plan of action on public health, innovation and intellectual property, and recognizing the important contribution and prioritization effort made by the overall programme review of the global strategy and plan of action on public health, innovation and intellectual property;<sup>2</sup>

Renewing the expression of Member States' shared concern 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 global strategy,<sup>3</sup> which was further hindered by the challenges posed by the COVID-19 pandemic;

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<sup>1</sup> Document A75/10 Rev.1.

<sup>2</sup> Overall programme review of the global strategy and plan of action on public health, innovation and intellectual property. Report of the review panel. November 2017 ([https://cdn.who.int/media/docs/default-source/essential-medicines/intellectual-property/gspa/gspa-phi3011rev.pdf?sfvrsn=c66f768b\\_5](https://cdn.who.int/media/docs/default-source/essential-medicines/intellectual-property/gspa/gspa-phi3011rev.pdf?sfvrsn=c66f768b_5), accessed 6 April 2022).

<sup>3</sup> Document A61/9, Appendix to Annex 1; see also resolution WHA61.21 (2008), Annex, resolution WHA62.16 (2009) and document A62/16 Add.3.

Noting the contribution that several activities within the plan of action on public health, innovation and intellectual property might have in helping to meet targets set in the Sustainable Development Goals,

1. DECIDES to extend the time frame of the plan of action on public health, innovation and intellectual property from 2022 to 2030;

2. URGES Member States:

(1) to reinforce the implementation, as appropriate and taking into account national contexts, of the recommendations of the review panel that are addressed to Member States to the extent they are consistent with the global strategy and plan of action on public health, innovation and intellectual property;

(2) to identify and share, through informal consultations to be convened by the WHO Secretariat at least every two years, best practices related to the implementation of actions within the global strategy and plan of action on public health, innovation and intellectual property;

3. REITERATES to the Director-General the importance of allocating the necessary resources to implement the recommendations of the review panel of the overall programme review of the global strategy and plan of action on public health, innovation and intellectual property<sup>1</sup> addressed to the Secretariat as prioritized by the review panel, to the extent they are consistent with the global strategy and plan of action on public health, innovation and intellectual property;

4. REQUESTS the Director-General:

(1) to continue to provide technical assistance and share knowledge that could enable countries to implement actions consistent with the global strategy and plan of action on public health, innovation and intellectual property;

(2) to promote collaboration and coordination within and among countries and with relevant stakeholders, for the implementation of actions consistent with the global strategy and plan of action on public health, innovation and intellectual property;

(3) to identify potential synergies in and challenges to ongoing work within the Secretariat for the implementation of actions consistent with the global strategy and plan of action on public health, innovation and intellectual property;

(4) to conduct, in 2023, a review of the indicators included in the overall programme review of the global strategy and plan of action on public health, innovation and intellectual property<sup>1</sup> in consultation with Member States,<sup>2</sup> and to develop proposed revisions to align indicators with the new term of validity of the plan of action;

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<sup>1</sup> Overall programme review of the global strategy and plan of action on public health, innovation and intellectual property. Report of the review panel. November 2017 ([https://cdn.who.int/media/docs/default-source/essential-medicines/intellectual-property/gspa/gspa-phi3011rev.pdf?sfvrsn=c66f768b\\_5](https://cdn.who.int/media/docs/default-source/essential-medicines/intellectual-property/gspa/gspa-phi3011rev.pdf?sfvrsn=c66f768b_5), accessed 6 April 2022).

<sup>2</sup> And, where applicable, regional economic integration organizations.

(5) to report to the Health Assembly in 2024, 2026 and 2028 on the implementation of the global strategy and plan of action on public health, innovation and intellectual property and the present resolution;

5. ENCOURAGES non-State actors in official relations with WHO to engage with countries in the implementation of actions consistent with the global strategy and plan of action on public health, innovation and intellectual property.

Eighth plenary meeting, 28 May 2022  
A75/VR/8

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## **Traditional medicine**

The Seventy-fifth World Health Assembly, having considered the report by the Director-General,<sup>1</sup>

Decided to request the Director-General to submit a final report on progress made in the implementation of resolution WHA67.18 (2014) to the Seventy-sixth World Health Assembly in 2023, through the Executive Board at its 152nd session, by means of a consolidated document that responds also to the request made in decision WHA73(15) (2020) in respect of global strategies or action plans that are scheduled to expire within one year.

Eighth plenary meeting, 28 May 2022  
A75/VR/8

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<sup>1</sup> Document A75/42.

## **Public health dimension of the world drug problem**

The Seventy-fifth World Health Assembly, having considered the report by the Director-General,<sup>1</sup>

Decided to request the Director-General to continue to report to the Health Assembly every two years until 2030 on WHO's activities to address the public health dimensions of the world drug problem and progress made in the implementation of decision WHA70(18) (2017).

Eighth plenary meeting, 28 May 2022  
A75/VR/8

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<sup>1</sup> Document A75/43.





## **South-East Asia Regional One Voice (ROV): Delivered by Maldives**

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### **75<sup>th</sup> World Health Assembly (WHA 75)**

#### **Agenda Item 27.4: Public health dimension of the world drug problem**

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Thank you, Chair.

Maldives delivers this statement on behalf of SEAR Member States.

SEAR appreciate the WHO's efforts on strengthening the prevention and treatment of drug use disorders. We note the report by the Director General and support the decision.

Public health problems related to substance use, substance use disorders and related health conditions is to a large extent preventable, however, estimated 583000 deaths are either directly or indirectly related to drug use and about 275 million people use psychoactive drugs, with an estimated 11% rise.

SEAR acknowledges the adoption of recommendations by the WHO Expert Committee on Drug dependence by the Commission on Narcotic Drugs, the Stop Overdose Safety (SOS) initiative and the newly established inter-agency working group on prevention of drug use and treatment of drug use disorders.

**Chair,**

The growing substance production and trading industry poses a global challenge with the increased availability and usage of a broader range of illicit drugs. The expansion of domestic drug markets has placed a huge burden on substance use treatment and increased pressure to provide adequate and effective treatment in addition to added burden on related health services.

SEAR is concerned by the very low access of medication for moderate and severe pain and recognize the need for access to pain relief must be balanced with concerns about the harm arising from the misuse and balanced national policies are crucial.



While some SEAR countries have made progress in amending National Essential Medicine list to include opioids and other psychotropic drugs to improve access there is disparity in access within the countries, in addition to oppressive laws, punitive actions for stock management errors, and fear and stigma of opioid use creating barriers to access.

**Chair,**

COVID-19 pandemic has had a significant impact on provision of health services, especially for persons with substance use disorders. SEAR recommends addressing substance use disorders within the context of primary care aimed at promoting and supporting prevention, early identification and effective management; improved access and availability of opioids at all levels of health care; reducing the burden of drug-related infectious diseases; prevention of the harm associated with drug use; effective monitoring of the health consequences of drug use and promoting a multi-sectoral, whole of government, whole of society multidisciplinary and comprehensive approach in addressing the problem.

**Chair,**

SEAR request WHO to intensify its effort in limiting common barriers for integrated substance-use care; address public health issues of substance-use within the context of universal health coverage; Invest in developing human resources, implement and integrate evidenced based interventions for substance use disorder at health care facilities, assist in developing information management systems, promote community management and family-based care, address substance-use disorders in pregnancy and support further action at legislative and policy level for both prevention, treatment of substance use disorders

Thank you, Chair.

## **Standing Committee on Health Emergency Prevention, Preparedness and Response**

The Executive Board, having considered the report on the Standing Committee on Health Emergency (Pandemic) Prevention, Preparedness and Response;<sup>1</sup> and taking into account decision EB150(6) (2022), including the request to the Director-General to report on the functioning and impact of the Standing Committee and submit the results and proposed recommendations based thereon for the consideration of the Executive Board at its 156th session in January 2025,

Decided:

- (1) in accordance with Rule 18 of the Rules of Procedure of the Executive Board, to establish a Standing Committee on Health Emergency Prevention, Preparedness and Response;
- (2) to approve the terms of reference set out in the Annex to this decision; and
- (3) that the Standing Committee on Health Emergency Prevention, Preparedness and Response will hold its first meeting after each WHO region has nominated its members and the Executive Board formally appoints the members through a silence procedure, ideally before the end of October 2022.

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<sup>1</sup> Document EB151/3.

## ANNEX

### **TERMS OF REFERENCE OF THE STANDING COMMITTEE ON HEALTH EMERGENCY PREVENTION, PREPAREDNESS AND RESPONSE**

#### **Composition and attendance**

1. The Standing Committee on Health Emergency Prevention, Preparedness and Response (“the Standing Committee”) shall be composed of 14 members, two from each region, selected from among Executive Board members, as well as the Chair and a Vice-Chair of the Board, ex officio, in line with the principles set out in Rule 18 of the Rules of Procedure of the Executive Board reflecting a balanced representation of developed and developing countries. Members of the Standing Committee shall serve for two years.
2. There shall be two office-bearers: a Chair and a Vice-Chair, who shall be appointed among the Committee members, in line with the principles set out in Rule 18 of the Rules of Procedure of the Executive Board, and shall serve for a one-year term.
3. The Chair and the Vice-Chair, in collective consultation with the Director-General, may invite observers<sup>1</sup> to attend a meeting of the Standing Committee without the right to vote if they consider that this would enhance the work of the Standing Committee on a specific item or items on the agenda of the meeting. Furthermore, the Chair and the Vice-Chair, in consultation with the Director-General, may invite experts to attend a meeting of the Standing Committee to provide advice, as appropriate. Members of the Standing Committee can also propose the invitation of relevant experts.
4. Member States in whose territory an event arises shall be invited to present their views to the Standing Committee.

#### **Functions**

5. The Standing Committee shall act as follows:
  - (a) In the event a public health emergency of international concern (PHEIC) is determined pursuant to the International Health Regulations (2005): Consider information provided by the Director-General about the event that has been determined to constitute a PHEIC as well as information and needs expressed by the Member State in whose territory an event arises and, as appropriate, provide guidance to the Executive Board and advice to the Director-General, through the Executive Board, including through a special session as needed, on matters regarding health emergency prevention, preparedness and response, and immediate capacities of the WHO Health Emergencies Programme.

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<sup>1</sup> For the purposes of attending and addressing the Standing Committee reference to “observers” is understood as referring to the Holy See; Palestine; Gavi, the Vaccine Alliance; the Order of Malta; the International Committee of the Red Cross; the International Federation of Red Cross and Red Crescent Societies; the Inter-Parliamentary Union; the Global Fund to Fight AIDS, Tuberculosis and Malaria; the United Nations and other intergovernmental organizations with which WHO has established effective relations under Article 70 of the Constitution; the European Union; and any other body so authorized for these purposes by the Executive Board.

(b) Outside of the cases where a PHEIC is determined pursuant to the International Health Regulations (2005): Review, provide guidance and, as appropriate, make recommendations to the Executive Board regarding the strengthening and oversight of the WHO Health Emergencies Programme and for effective health emergency prevention, preparedness and response.

6. In performing its functions, the Standing Committee shall take into account the work of other relevant WHO instruments and bodies, as appropriate. The Standing Committee shall work in a manner respectful of and complementary to the technical scientific advice provided by the Emergency Committee in accordance with the International Health Regulations (2005).

### **Conduct of sessions**

7. The Standing Committee shall meet at least twice annually for the conduct of its regular work. Decisions on the format<sup>1</sup> of the meeting shall be made by the Chair and Vice-Chair of the Standing Committee, in consultation with the Director-General.

8. In the event a PHEIC is determined pursuant to the International Health Regulations (2005), the Director-General shall convene an extraordinary meeting of the Standing Committee as soon as reasonably practicable, and ideally within 24 hours following the determination of the PHEIC.

9. The Executive Board may decide to convene extraordinary meetings of the Standing Committee in order to deal with urgent matters that fall within its terms of reference and are deemed necessary to be considered between its regular meetings.

10. The Standing Committee shall conduct its business on the basis of consensus and transparency. The Standing Committee will provide a report of each of its meetings to the Executive Board. In the event of inability to reach consensus, the difference in views shall be reported to the Board.

11. The meetings of the Standing Committee shall be open for all Member States.

Second meeting, 30 May 2022  
EB151/SR/2

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<sup>1</sup> In person, virtual or hybrid.