



WORLD HEALTH ORGANIZATION

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# **SIXTY-SEVENTH WORLD HEALTH ASSEMBLY**

**GENEVA, 19–24 MAY 2014**

**RESOLUTIONS AND DECISIONS  
ANNEXES**

GENEVA  
2014

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## ABBREVIATIONS

Abbreviations used in WHO documentation include the following:

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

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

## **PREFACE**

The Sixty-seventh World Health Assembly was held at the Palais des Nations, Geneva, from 19 to 24 May 2014, in accordance with the decision of the Executive Board at its 133rd session.<sup>1</sup>

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<sup>1</sup> Decision EB133(10).



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  - 1.1 Appointment of the Committee on Credentials
  - 1.2 Election of the President
  - 1.3 Election of the five Vice-Presidents, the Chairmen of the main committees, and establishment of the General Committee
  - 1.4 Adoption of the agenda and allocation of items to the main committees
2. Report of the Executive Board on its 133rd and 134th sessions
3. Address by Dr Margaret Chan, Director-General
4. Invited speaker
5. [Deleted]
6. Executive Board: election
7. Awards
8. Reports of the main committees
9. Closure of the Health Assembly

## **COMMITTEE A**

10. Opening of the Committee<sup>2</sup>
11. WHO reform
  - 11.1 Progress report on reform implementation
  - 11.2 Improved decision-making by the governing bodies

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<sup>1</sup> Adopted at the second plenary meeting.

<sup>2</sup> Including election of Vice-Chairmen and the Rapporteur.

- 11.3 Framework of engagement with non-State actors
- 11.4 Follow-up to the financing dialogue
- 11.5 Strategic resource allocation
- 11.6 Financing of administrative and management costs
- 12. Communicable diseases
  - 12.1 Draft global strategy and targets for tuberculosis prevention, care and control after 2015
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- 13. Noncommunicable diseases
  - 13.1 Prevention and control of noncommunicable diseases
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      - The action plan for the global strategy for the prevention and control of noncommunicable diseases 2008–2013
      - WHO’s role in the preparation, implementation and follow-up to the United Nations General Assembly comprehensive review and assessment in 2014 of the progress achieved in the prevention and control of noncommunicable diseases
    - Consideration of:
      - Terms of reference for the global coordination mechanism on the prevention and control of noncommunicable diseases
      - Terms of reference for the United Nations Interagency Task Force on the Prevention and Control of Non-communicable Diseases
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  - 13.2 Maternal, infant and young child nutrition
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14. Promoting health through the life course
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    - B. Eradication of dracunculiasis (resolution WHA64.16)
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    - E. Female genital mutilation (resolution WHA61.16)
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G. Implementation of the recommendations of the United Nations Commission on Life-Saving Commodities for Women and Children (resolution WHA66.7)

H. Climate change and health (resolution EB124.R5)

Health systems

I. Global strategy and plan of action on public health, innovation and intellectual property (resolution WHA61.21)

J. Availability, safety and quality of blood products (resolution WHA63.12)

K. Human organ and tissue transplantation (resolution WHA63.22)

L. WHO strategy on research for health

Preparedness, surveillance and response

M. WHO's response, and role as the health cluster lead, in meeting the growing demands of health in humanitarian emergencies (resolution WHA65.20)

Corporate services/enabling functions

N. Multilingualism: implementation of action plan (resolution WHA61.12)

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18. Opening of the Committee<sup>1</sup>

19. Health conditions in the occupied Palestinian territory, including east Jerusalem, and in the occupied Syrian Golan

20. Programme budget and financial matters

20.1 Programme budget 2012–2013: performance assessment

20.2 Financial report and audited financial statements for the year ended 31 December 2013

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

20.4 [Deleted]

20.5 [Deleted]

20.6 [Deleted]

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<sup>1</sup> Including election of Vice-Chairmen and the Rapporteur.

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- 21. Audit and oversight matters
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  - 21.2 Report of the Internal Auditor
- 22. Staffing matters
  - 22.1 Human resources: annual report
  - 22.2 Report of the International Civil Service Commission
  - 22.3 Amendments to the Staff Regulations and Staff Rules
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- 23. Management and legal matters
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- 15. Health systems
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  - 15.8 Follow-up of the Recife Political Declaration on Human Resources for Health: renewed commitments towards universal health coverage
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A67/2	Report of the Executive Board on its 133rd and 134th sessions
A67/3	Address by Dr Margaret Chan, Director-General, to the Sixty-seventh World Health Assembly
A67/4	Progress report on reform implementation
A67/5	Improved decision-making by the governing bodies <sup>2</sup>
A67/5 Add.1	Report on financial and administrative implications for the Secretariat of resolutions proposed for adoption by the Executive Board or Health Assembly <sup>3</sup>
A67/6	Framework of engagement with non-State actors
A67/7	Follow-up to the financing dialogue
A67/8	Follow-up to the financing dialogue Independent evaluation
A67/9	Strategic resource allocation Report of the Programme, Budget and Administration Committee of the Executive Board to the Sixty-seventh World Health Assembly
A67/10	Financing of administrative and management costs
A67/11	Draft global strategy and targets for tuberculosis prevention, care and control after 2015 <sup>4</sup>
A67/12	Global vaccine action plan
A67/13	Improving the health of patients with viral hepatitis
A67/13 Add.1	Report on financial and administrative implications for the Secretariat of resolutions proposed for adoption by the Executive Board or Health Assembly <sup>3</sup>
A67/14	Prevention and control of noncommunicable diseases

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<sup>1</sup> See page ix.

<sup>2</sup> See Annex 2.

<sup>3</sup> See Annex 6.

<sup>4</sup> See Annex 1.

A67/14 Add.1	Terms of reference for the global coordination mechanism on the prevention and control of noncommunicable diseases
A67/14 Add.2	High-level meeting of the United Nations General Assembly
A67/14 Add.3 Rev.1	Proposed work plan for the global coordination mechanism on the prevention and control of noncommunicable diseases covering the period 2014–2015
A67/15 and A67/15 Add.1	Maternal, infant and young child nutrition
A67/16	Draft WHO global disability action plan 2014–2021: Better health for all people with disability <sup>1</sup>
A67/17	Comprehensive and coordinated efforts for the management of autism spectrum disorders
A67/17 Add.1	Report on financial and administrative implications for the Secretariat of resolutions proposed for adoption by the Executive Board or Health Assembly <sup>2</sup>
A67/18	Psoriasis
A67/18 Add.1	Report on financial and administrative implications for the Secretariat of resolutions proposed for adoption by the Executive Board or Health Assembly <sup>2</sup>
A67/19	Monitoring the achievement of the health-related Millennium Development Goals
A67/20	Health in the post-2015 development agenda
A67/21 and A67/21 Corr.1	Newborn health: draft action plan <sup>3</sup>
A67/22	Addressing the global challenge of violence, in particular against women and girls, and against children
A67/23	Multisectoral action for a life course approach to healthy ageing
A67/24	Public health impacts of exposure to mercury and mercury compounds: the role of WHO and ministries of public health in the implementation of the Minamata Convention
A67/25	Contributing to social and economic development: sustainable action across sectors to improve health and health equity

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<sup>1</sup> See Annex 3.

<sup>2</sup> See Annex 6.

<sup>3</sup> See Annex 4.



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A67/27	Follow-up of the report of the Consultative Expert Working Group on Research and Development: Financing and Coordination
A67/28	Follow-up of the report of the Consultative Expert Working Group on Research and Development: Financing and Coordination Health research and development demonstration projects
A67/28 Add.1	Meetings of stakeholders for selected health research and development demonstration projects, 7–10 May 2014
A67/29	Substandard/spurious/falsely-labelled/falsified/counterfeit medical products
A67/30	Access to essential medicines
A67/31	Strengthening of palliative care as a component of integrated treatment throughout the life course
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A67/33	Health intervention and technology assessment in support of universal health coverage
A67/34	Follow-up of the Recife Political Declaration on Human Resources for Health: renewed commitments towards universal health coverage
A67/35 and A67/35 Add.1	Implementation of the International Health Regulations (2005) <sup>1</sup>
A67/36	Pandemic Influenza Preparedness: sharing of influenza viruses and access to vaccines and other benefits
A67/36 Add.1	Report of the meeting of the Pandemic Influenza Preparedness Framework Advisory Group
A67/37	Smallpox eradication: destruction of variola virus stocks
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A67/40	Progress reports
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<sup>1</sup> See Annex 5.

- A67/42 Programme budget 2012–2013: performance assessment
- A67/43 Financial Report and Audited Financial Statements for the year ended 31 December 2013
- A67/43 Add.1 Proposal in respect of supplementary funding for real estate and longer-term staff liabilities
- A67/44 Status of collection of assessed contributions, including Member States in arrears in the payment of their contributions to an extent that would justify invoking Article 7 of the Constitution
- A67/45 Report of the External Auditor
- A67/46 Report of the Internal Auditor
- A67/47 Human resources: annual report
- A67/48 Report of the International Civil Service Commission
- A67/49 Amendments to the Staff Regulations and Staff Rules
- A67/50 Appointment of representatives to the WHO Staff Pension Committee
- A67/51 Follow-up on the report of the Working Group on the election of the Director-General of the World Health Organization
- A67/52 Real estate: update on the Geneva buildings renovation strategy
- A67/53 Collaboration within the United Nations system and with other intergovernmental organizations
- A67/54 WHO reform  
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- A67/55 Programme budget 2012-2013: performance assessment  
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- A67/56 Financial report and audited financial statements for the year ended 31 December 2013  
Report of the Programme, Budget and Administration Committee of the Executive Board to the Sixty-seventh World Health Assembly
- A67/57 Status of collection of assessed contributions, including Member States in arrears in the payment of their contributions to an extent that would justify invoking Article 7 of the Constitution  
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A67/58	Report of the External Auditor Report of the Programme, Budget and Administration Committee of the Executive Board to the Sixty-seventh World Health Assembly
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A67/60	Human resources: annual report Report of the Programme, Budget and Administration Committee of the Executive Board to the Sixty-seventh World Health Assembly
A67/61	Real estate: update on the Geneva buildings renovation strategy Report of the Programme, Budget and Administration Committee of the Executive Board to the Sixty-seventh World Health Assembly
A67/62	First report of Committee A
A67/63	Committee on Credentials
A67/64	Second report of Committee A
A67/65	Third report of Committee A
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A67/67	Election of Members entitled to designate a person to serve on the Executive Board
A67/68	Fourth report of Committee A
A67/69	Second report of Committee B
A67/70	Fifth report of Committee A
A67/71	Third report of Committee B
A67/72	Sixth report of Committee A
A67/73	Fourth report of Committee B

### **Information documents**

A67/INF./1	Reform implementation plan
A67/INF./2	Health conditions in the occupied Palestinian territory, including east Jerusalem, and in the occupied Syrian Golan Statement of the Government of Israel

- A67/INF./3 Health conditions in the occupied Palestinian territory, including east Jerusalem, and in the occupied Syrian Golan  
Report by the Ministry of Health of the Syrian Arab Republic
- A67/INF./4 Health conditions in the occupied Palestinian territory, including east Jerusalem, and in the occupied Syrian Golan  
Report of the Director of Health, UNRWA
- A67/INF./5 Health conditions in the occupied Palestinian territory, including east Jerusalem, and in the occupied Syrian Golan  
Report at the request of the Permanent Observer of Palestine to the United Nations and Other International Organizations at Geneva

**Diverse documents**

- A67/DIV./1 Rev.1 List of delegates and other participants
- A67/DIV./2 Guide for delegates to the World Health Assembly
- A67/DIV./3 Decisions and list of resolutions
- A67/DIV./4 List of documents
- A67/DIV./5 Address by Her Excellency Dr Christine Kaseba-Sata, First Lady of the Republic of Zambia, to the Sixty-seventh World Health Assembly
- A67/DIV./6 Address by Melinda Gates, Bill & Melinda Gates Foundation, to the Sixty-seventh World Health Assembly

## OFFICERS OF THE HEALTH ASSEMBLY AND MEMBERSHIP OF ITS COMMITTEES

### **President**

Dr Roberto MORALES OJEDA (Cuba)

### **Vice-Presidents**

Dr Neil SHARMA (Fiji)

Mr François IBOVI (Congo)

Mr Maithripala Yapa SIRISENA (Sri Lanka)

Dr Vytenis Povilas ANDRIUKAITIS (Lithuania)

Mr Sadiq bin Abdul Karim AL-SHEHABI (Bahrain)

### **Secretary**

Dr Margaret CHAN, Director-General

### **Committee on Credentials**

The Committee on Credentials was composed of delegates of the following Member States: Chile, Democratic People's Republic of Korea, Dominican Republic, Ethiopia, Iceland, Iraq, Japan, Malaysia, Monaco, Mozambique, Portugal and Zambia.

**Chairman:** Dr Feisul Idzwan MUSTAPHA (Malaysia)

**Vice-Chairman:** Dr Guy FONES (Chile)

**Secretary:** Mr Xavier DANEY (Senior Legal Officer)

### **General Committee**

The General Committee was composed of the President and Vice-Presidents of the Health Assembly and the Chairmen of the main committees, together with delegates of the following Member States: Afghanistan, Angola, Benin, Cabo Verde, China, Costa Rica, Equatorial Guinea, France, Greece, Guyana, Republic of Korea, Russian Federation, Timor-

Leste, Tunisia, United Kingdom of Great Britain and Northern Ireland, United States of America and Uruguay.

**Chairman:** Dr Roberto MORALES OJEDA (Cuba)

**Secretary:** Dr Margaret CHAN, Director-General

### **MAIN COMMITTEES**

Under Rule 35 of the Rules of Procedure of the World Health Assembly, each delegation was entitled to be represented on each main committee by one of its members.

#### **Committee A**

**Chairman:** Dr Pamela RENDI-WAGNER (Austria)

**Vice-Chairmen:** Professor PE THET KHIN (Myanmar) and Dr Jorge VILLAVICENCIO (Guatemala)

**Rapporteur:** Dr Helen MBUGUA (Kenya)

**Secretary:** Dr Timothy ARMSTRONG, Coordinator, Surveillance and Population-based Prevention

#### **Committee B**

**Chairman:** Dr Ruhakana RUGUNDA (Uganda)

**Vice-Chairmen:** Dr Mohsen ASADI-LARI (Islamic Republic of Iran) and Dr Siale AKAUOLA (Tonga)

**Rapporteur:** Dr Dipendra Raman SINGH (Nepal)

**Secretary:** Dr Clive ONDARI, Coordinator, Safety and Vigilance

## REPRESENTATIVES OF THE EXECUTIVE BOARD

Professor Jane HALTON (Australia)

Professor Ogtay SHIRALIYEV (Azerbaijan)

Dr Mohsen ASADI-LARI (Islamic Republic of Iran)

Professor PE THET KHIN (Myanmar)



## **RESOLUTIONS AND DECISIONS**





## RESOLUTIONS

### **WHA67.1 Global strategy and targets for tuberculosis prevention, care and control after 2015<sup>1</sup>**

The Sixty-seventh World Health Assembly,

Having considered the report on the draft global strategy and targets for tuberculosis prevention, care and control after 2015;<sup>2</sup>

Acknowledging the progress made towards the achievement of Millennium Development Goal 6 (Combat HIV/AIDS, malaria and other diseases) for 2015 following the United Nations Millennium Declaration and related 2015 tuberculosis targets, through the adoption of the directly observed treatment, short course (DOTS) strategy, the Stop TB Strategy and the Global Plan to Stop TB 2006–2015, as well as the financing of national plans based on those frameworks, as called for, inter alia, in resolution WHA60.19 on tuberculosis control;

Concerned by the persisting gaps and the uneven progress made towards current targets, and in addition that some regions, Member States, communities and vulnerable groups require specific strategies and support to accelerate progress in preventing disease and deaths, and to expand access to needed interventions and new tools;

Further concerned that, even with significant progress, an estimated three million people who contract tuberculosis each year will not have their disease detected or will not receive appropriate care and treatment;

Cognizant of the serious economic and social consequences of tuberculosis and of the burden borne by many of those affected when seeking care and adhering to tuberculosis treatment;

Considering resolution WHA62.15 on prevention and control of multidrug-resistant tuberculosis and extensively drug-resistant tuberculosis, and its appeal for action; aware that the response to the crisis to date has been insufficient despite the introduction of new rapid diagnostic tests and efforts to scale up disease management; aware also that the vast majority of those in need still lack access to high-quality prevention, treatment and care services; and alarmed at the grave individual and public health risks posed by multidrug-resistant tuberculosis;

Aware that HIV coinfection is the main reason for the failure to meet tuberculosis control targets in high-HIV prevalence settings and that tuberculosis is a major cause of deaths among people living with HIV, and recognizing the need for substantially enhanced joint action in addressing the dual epidemics of tuberculosis and HIV/AIDS through increasing integration of primary care services in order to improve access to care;

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<sup>1</sup> See Annex 6 for the financial and administrative implications for the Secretariat of this resolution.

<sup>2</sup> Document A67/11.

Recognizing that further progress on tuberculosis and other health priorities identified in the United Nations Millennium Declaration must be made in the decades beyond 2015, and that progress on all of those priorities requires overall commitment to health system strengthening and progress towards universal health coverage;

Acknowledging that progress against tuberculosis depends on action within and beyond the health sector in order to address the social and economic determinants of disease, including expansion of social protection and overall poverty reduction;

Guided by resolution WHA61.17 on the health of migrants and its appeal for action, and recognizing the need for increased collaboration between high- and low-incidence countries and regions in strengthening tuberculosis monitoring and control mechanisms, including with regard to the growing mobility of labour;

Noting the need for increased investment in accelerated implementation of innovations at country level as well as in the research and development of new tools for tuberculosis care and prevention that are essential for the elimination of tuberculosis,

1. ADOPTS the global strategy and targets for tuberculosis prevention, care and control after 2015,<sup>1</sup> with:

(1) its bold vision of a world without tuberculosis, and its targets of ending the global tuberculosis epidemic by 2035 through a reduction in tuberculosis deaths by 95% and in tuberculosis incidence by 90% (or to fewer than 10 tuberculosis cases per 100 000 population), and elimination of associated catastrophic costs for tuberculosis-affected households;

(2) its associated milestones for 2020, 2025 and 2030;

(3) its principles addressing: government stewardship and accountability; coalition-building with affected communities and civil society; equity, human rights and ethics; and adaptation to fit the needs of each epidemiological, socioeconomic and health system context;

(4) its three pillars of: integrated, patient-centred care and prevention; bold policies and supportive systems; and intensified research and innovation;

2. URGES all Member States:<sup>2</sup>

(1) to adapt the strategy in line with national priorities and specificities;

(2) to implement, monitor and evaluate the strategy's proposed tuberculosis-specific health sector and multisectoral actions with high-level commitment and adequate financing, taking into account the local settings;

(3) to seek, with the full engagement of a wide range of stakeholders, to prevent the persistence of high incidence rates of tuberculosis within specific communities or geographical settings;

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<sup>1</sup> See Annex 1.

<sup>2</sup> And, where applicable, regional economic integration organizations.

3. INVITES international, regional, national and local partners from within and beyond the health sector to engage in, and support, the implementation of the global strategy and targets for tuberculosis prevention, care and control after 2015;
4. REQUESTS the Director-General:
  - (1) to provide guidance to Member States on how to adapt and operationalize the global strategy and targets for tuberculosis prevention, care and control after 2015, including the promotion of cross-border collaboration to address the needs of vulnerable communities, including migrant populations, and the threats posed by drug resistance;
  - (2) to coordinate and contribute to the implementation of the strategy, working with Member States, the Global Fund to Fight AIDS, Tuberculosis and Malaria, the International Drug Purchase Facility (UNITAID), and other global and regional financing institutions, as well as all constituencies of the Stop TB Partnership and the additional multisectoral partners required to achieve the goal and objectives of the strategy;
  - (3) to further develop and update global normative and policy guidance on tuberculosis prevention, care and control, as new evidence is gathered and innovations are developed, adding to the tools and strategic approaches that are available for ending the global epidemic and moving far more rapidly towards tuberculosis elimination;
  - (4) to support Member States upon request in the adaptation and implementation of the strategy, as well as in the development of nationally appropriate indicators, milestones and targets to contribute to local and global achievement of the 2035 targets;
  - (5) to monitor the implementation of the strategy, and evaluate impact in terms of progress towards set milestones and targets;
  - (6) to promote the research and knowledge generation required to end the global tuberculosis epidemic and eliminate tuberculosis, including accelerated discovery and development of new or improved diagnostics, treatment and preventive tools, in particular efficient vaccines, and the stimulation of the uptake of resulting innovations;
  - (7) to promote equitable access to new tools and medical products for the prevention, diagnosis and treatment of tuberculosis and multidrug-resistant tuberculosis as they become available;
  - (8) to work with the Stop TB Partnership, including active support of the development of the global investment plan, and, where appropriate, seeking out new partners who can leverage effective commitment and innovation within and beyond the health sector in order to implement the strategy effectively;
  - (9) to report on the progress achieved to the Seventieth and Seventy-third World Health Assemblies, and at regular intervals thereafter, through the Executive Board.

(Sixth plenary meeting, 21 May 2014 –  
Committee A, first report)

**WHA67.2 Improved decision-making by the governing bodies<sup>1</sup>**

The Sixty-seventh World Health Assembly,

Having considered the report on improved decision-making by the governing bodies,<sup>2</sup>

1. DECIDES to introduce webcasting of future public meetings of committees A and B of the Health Assembly, as well as of its plenary meetings, to all internet users through a link on the WHO website, subject to resolution of any relevant technical issues and the availability of financial resources;
2. APPROVES the recommendation of the Executive Board, contained in decision EB134(3), to rent a cost-effective and secure electronic voting system for the nomination and appointment of the Director-General, and to test such a system in advance through mock votes by the governing bodies before the election of the next Director-General;
3. DELETES Rule 49 and REPLACES Rule 48 of the Rules of Procedure of the World Health Assembly, with effect from the closure of the Sixty-seventh World Health Assembly, with the following text:

“Formal proposals relating to items of the agenda may be introduced until the first day of a regular session of the Health Assembly and no later than two days before the opening of a special session. All such proposals shall be referred to the committee to which the item of the agenda has been allocated, except if the item is considered directly in a plenary meeting.”;<sup>3</sup>
4. FURTHER DECIDES that progress reports shall henceforth be considered only by the Health Assembly and no longer by the Executive Board.

(Eighth plenary meeting, 23 May 2014 –  
Committee A, second report)

**WHA67.3 Financial report and audited financial statements for the year ended 31 December 2013**

The Sixty-seventh World Health Assembly,

Having considered the financial report and audited financial statements for the year ended 31 December 2013;<sup>4</sup>

Having noted the report of the Programme, Budget and Administration Committee of the Executive Board to the Sixty-seventh World Health Assembly,<sup>5</sup>

ACCEPTS the Director-General’s financial report and audited financial statements for the year ended 31 December 2013.

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<sup>1</sup> See Annex 6 for the financial and administrative implications for the Secretariat of this resolution.

<sup>2</sup> Document A67/5.

<sup>3</sup> See Annex 2.

<sup>4</sup> Document A67/43.

<sup>5</sup> Document A67/56.

(Eighth plenary meeting, 23 May 2014 –  
Committee B, first report)

#### **WHA67.4      Supplementary funding for real estate and longer-term staff liabilities**

The Sixty-seventh World Health Assembly,

Having considered the financial report and audited financial statements for the year ended 31 December 2013;<sup>1</sup>

Having noted the report of the Programme, Budget and Administration Committee of the Executive Board to the Sixty-seventh World Health Assembly;<sup>2</sup>

1. APPROVES the use of US\$ 40 million of the balance of the Member States' Assessed Contributions Fund as at 31 December 2013 as follows:

(a) US\$ 25 million to the Real Estate Fund for building up the reserve needed for capital financing;

(b) US\$ 15 million to cover longer-term staff liabilities (for separation costs);

2. REQUESTS the Director-General to report to the Sixty-eighth World Health Assembly and subsequent Health Assemblies on use of these funds, through the financial reports and audited financial statements, beginning with the report for the year ended 31 December 2014.

(Eighth plenary meeting, 23 May 2014 –  
Committee B, first report)

#### **WHA67.5      Status of collection of assessed contributions, including Member States in arrears in the payment of their contributions to an extent that would justify invoking Article 7 of the Constitution**

The Sixty-seventh World Health Assembly,

Having considered the report on status of collection of assessed contributions, including Members States in arrears in the payment of their contributions to an extent that would justify invoking Article 7 of the Constitution;<sup>3</sup>

Having noted the report of the Programme, Budget and Administration Committee of the Executive Board to the Sixty-seventh World Health Assembly;<sup>4</sup>

Noting that, at the time of opening of the Sixty-seventh World Health Assembly, the voting rights of Central African Republic, Comoros, Grenada, Guinea-Bissau and Somalia were suspended, such suspension to continue until the arrears of the Members concerned have been reduced, at the

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<sup>1</sup> Documents A67/43 and A67/43 Add.1.

<sup>2</sup> Document A67/56.

<sup>3</sup> Document A67/44.

<sup>4</sup> Document A67/57.

present or future Health Assemblies, to a level below the amount that would justify invoking Article 7 of the Constitution;

Noting that the voting rights of Antigua and Barbuda were suspended during the Sixty-sixth World Health Assembly, effective from the Sixty-seventh World Health Assembly and to continue until the arrears of the Members concerned have been reduced, at the present or future Health Assemblies, to a level below the amount that would justify invoking Article 7 of the Constitution;

Noting that Lesotho, Mauritania, Saint Vincent and the Grenadines, South Sudan, Suriname and Ukraine were in arrears at the time of the opening of the Sixty-seventh World Health Assembly to such an extent that it was necessary for the Health Assembly to consider, in accordance with Article 7 of the Constitution, whether the voting privileges of those countries should be suspended – for Ukraine at the opening of the Sixty-seventh World Health Assembly, and for the remaining five Member States at the opening of the Sixty-eighth World Health Assembly,

DECIDES:

(1) that in accordance with the statement of principles set out in resolution WHA41.7 if, by the time of the opening of the Sixty-eighth World Health Assembly, Lesotho, Mauritania, Saint Vincent and the Grenadines, South Sudan and Suriname are still in arrears in the payment of their contributions to an extent that would justify invoking Article 7 of the Constitution, their voting privileges shall be suspended as from the said opening; and in accordance with resolution WHA64.20 if, by the time of the opening of the Sixty-seventh World Health Assembly, Ukraine is still in arrears in the payment of its rescheduled assessments, its voting privileges shall be suspended automatically;

(2) that any suspension that takes effect as set out in paragraph (1) above shall continue at the Sixty-eighth World Health Assembly and subsequent Health Assemblies, until the arrears of Lesotho, Mauritania, Saint Vincent and the Grenadines, South Sudan, Suriname and Ukraine have been reduced to a level below the amount that would justify invoking Article 7 of the Constitution;

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

(Eighth plenary meeting, 23 May 2014 –  
Committee B, first report)

## **WHA67.6      Viral hepatitis<sup>1</sup>**

The Sixty-seventh World Health Assembly,

Having considered the report on hepatitis;<sup>2</sup>

Reaffirming resolution WHA63.18, adopted in 2010 by the Sixty-third World Health Assembly, which recognized viral hepatitis as a global public health problem and the need for governments and populations to take action to prevent, diagnose and treat viral hepatitis, and which requested the

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<sup>1</sup> See Annex 6 for the financial and administrative implications for the Secretariat of this resolution.

<sup>2</sup> Document A67/13.

Director-General, inter alia, to establish the necessary strategies to support these efforts, and expressing concern at the slow pace of implementation;

Recalling also resolution WHA45.17 on immunization and vaccine quality, which urged Member States to include hepatitis B vaccine in national immunization programmes, and expressing concern that currently the global hepatitis B vaccine coverage for infants is estimated at 79%, and is therefore below the 90% global target;

Recalling further resolution WHA61.21, which adopted the global strategy and plan of action on public health, innovation and intellectual property;

Noting with deep concern that viral hepatitis is now responsible for 1.4 million deaths every year (compared to 1.6 million deaths from HIV/AIDS, 1.3 million deaths from tuberculosis and 600 000 deaths from malaria), that around 500 million people are currently living with viral hepatitis and some 2000 million have been infected with hepatitis B virus, and considering that most people with chronic hepatitis B or C are unaware of their infection and are at serious risk of developing cirrhosis or liver cancer, contributing to global increases in both of those chronic diseases;

Also noting that millions of acute infections with hepatitis A virus and hepatitis E virus occur annually and result in tens of thousands of deaths almost exclusively in lower- and middle-income countries;

Considering that although hepatitis C is not preventable by vaccination, current treatment regimens offer high cure rates that are expected to further improve with upcoming new treatments; and that although hepatitis B is preventable with a safe and effective vaccine, there are 240 million people living with hepatitis B virus infection and available effective therapies could prevent cirrhosis and liver cancer among many of those infected;

Expressing concern that preventive measures are not universally implemented and that equitable access to and availability of quality, effective, affordable and safe diagnostics and treatment regimens for both hepatitis B and C are lacking in many parts of the world, particularly in developing countries;

Recognizing the role of health promotion and prevention in the fight against viral hepatitis, and emphasizing the importance of strengthening vaccination strategies as high-impact and cost-effective actions for public health;

Noting with concern that globally the birth dose coverage rate with hepatitis B vaccine remains unacceptably low;

Acknowledging also that, in Asia and Africa, hepatitis A and E continue to cause major outbreaks while a safe, effective hepatitis A vaccine has been available for nearly two decades, that hepatitis E vaccine candidates have been developed but not yet certified by WHO, that lack of basic hygiene and sanitation promotes the risks of hepatitis A virus and hepatitis E virus transmission, and that most vulnerable populations do not have access to those vaccines;

Taking into account the fact that injection overuse and unsafe practices account for a substantial burden of death and disability worldwide, with an estimated 1.7 million hepatitis B virus infections and 320 000 hepatitis C virus infections in 2010;

Recognizing the need for safe blood to be available to blood recipients, as established by resolution WHA28.72 on utilization and supply of human blood and blood products, in which the Health Assembly recommended the development of national public services for blood donation, and by resolution WHA58.13, in which the Health Assembly agreed to the establishment of an annual

World Blood Donor Day, and considering that one of the main routes of transmission of hepatitis B virus and hepatitis C virus is parenteral;

Further recognizing the need to strengthen health systems and integrate collaborative approaches and synergies between prevention and control measures for viral hepatitis and those for HIV and other related sexually transmitted and bloodborne infections and other mother-to-child transmitted infections, as well as for cancer and noncommunicable disease programmes;

Noting that hepatitis B virus, and particularly hepatitis C virus, disproportionately impact people who inject drugs, and that of the 16 million people who inject drugs around the world, an estimated 10 million are living with hepatitis C virus infection and 1.2 million are living with hepatitis B virus infection;

Recalling United Nations General Assembly resolution 65/277, paragraph 59(h), which recommends “giving consideration, as appropriate, to implementing and expanding risk- and harm-reduction programmes, taking into account the *WHO, UNODC, UNAIDS Technical Guide for Countries to Set Targets for Universal Access to HIV Prevention, Treatment and Care for Injecting Drug Users*,<sup>1</sup> in accordance with national legislation”,<sup>2</sup> as important components of both hepatitis B and hepatitis C prevention, diagnosis and treatment programmes and that access to these remains limited or absent in many countries that have a high burden of infection with hepatitis B virus and hepatitis C virus;

Cognizant of the fact that 4–5 million people living with HIV are coinfecting with hepatitis C virus and more than 3 million are coinfecting with hepatitis B virus, which has become a major cause of disability and mortality among those receiving antiretroviral therapy;

Taking into account the fact that viral hepatitis is a major problem within indigenous communities in some countries;

Welcoming the development by WHO of a global strategy, within a health systems approach, on the prevention and control of viral hepatitis infection;<sup>3</sup>

Considering that most Member States lack adequate surveillance systems for viral hepatitis to enable them to take evidence-based policy decisions;

Taking into account that a periodic evaluation of implementation of the WHO strategy is crucial to monitoring the global response to viral hepatitis and the fact that the process was initiated with the publication in 2013 of the *Global policy report on the prevention and control of viral hepatitis in WHO Member States*;<sup>4</sup>

Acknowledging the need to reduce liver cancer mortality rates and that viral hepatitis is responsible for 78% of cases of primary liver cancer, and welcoming the inclusion of an indicator on hepatitis B vaccination in the comprehensive global monitoring framework adopted in resolution

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<sup>1</sup> Available from [www.who.int/hiv/pub/idu/targetsetting/en/index.html](http://www.who.int/hiv/pub/idu/targetsetting/en/index.html).

<sup>2</sup> WHO, UNODC, UNAIDS technical guide for countries to set targets for universal access to HIV prevention, treatment and care for injecting drug users. Geneva: World Health Organization; 2009.

<sup>3</sup> Prevention and control of viral hepatitis infection: framework for global action. Geneva: World Health Organization; 2012.

<sup>4</sup> Global policy report on the prevention and control of viral hepatitis in WHO Member States. Geneva: World Health Organization; 2013.



WHA66.10 on the Follow-up to the Political Declaration of the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases;

Acknowledging the need to fight and eliminate stigmatization of, and discrimination against, people living with or affected by viral hepatitis, and determined to protect and safeguard their human rights,

1. URGES Member States:<sup>1</sup>

- (1) to develop and implement coordinated multisectoral national strategies for preventing, diagnosing, and treating viral hepatitis based on the local epidemiological context;
- (2) to enhance actions related to health promotion and prevention of viral hepatitis, while stimulating and strengthening immunization strategies, including for hepatitis A, based on the local epidemiological context;
- (3) to promote the involvement of civil society in all aspects of preventing, diagnosing and treating viral hepatitis;
- (4) to put in place an adequate surveillance system for viral hepatitis in order to support decision-making on evidence-based policy;
- (5) to strengthen the system for collection of blood from low-risk, voluntary, non-remunerated donors; for quality-assured screening of all donated blood to avoid transmission of HIV, hepatitis B, hepatitis C and syphilis; and for good transfusion practices to ensure patient safety;
- (6) to strengthen the system for quality-assured screening of all donors of tissues and organs to avoid transmission of HIV, hepatitis B, hepatitis C and syphilis;
- (7) to reduce the prevalence of chronic hepatitis B infection as proposed by WHO regional committees, in particular by enhancing efforts to prevent perinatal transmission through the delivery of the birth dose of hepatitis B vaccine;
- (8) to strengthen measures for the prevention of hepatitis A and E, in particular the promotion of food and drinking water safety and hygiene;
- (9) to strengthen infection control in health care settings through all necessary measures to prevent the reuse of equipment designed only for single use, and cleaning and either high-level disinfection or sterilization, as appropriate, of multi-use equipment;
- (10) to include hepatitis B vaccine for infants, where appropriate, in national immunization programmes, working towards full coverage;
- (11) to make special provision in policies for equitable access to prevention, diagnosis and treatment for populations affected by viral hepatitis, particularly indigenous people, migrants and vulnerable groups, where applicable;

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

(12) to consider, as necessary, national legislative mechanisms for the use of the flexibilities contained in the Agreement on Trade-Related Aspects of Intellectual Property Rights in order to promote access to specific pharmaceutical products;<sup>1</sup>

(13) to consider, whenever necessary, the use of administrative and legal means in order to promote access to preventive, diagnostic and treatment technologies against viral hepatitis;

(14) to implement comprehensive hepatitis prevention, diagnosis and treatment programmes for people who inject drugs, including the nine core interventions,<sup>2</sup> as appropriate, in line with the *WHO, UNODC, UNAIDS technical guide for countries to set targets for universal access to HIV prevention, treatment and care for injecting drug users*,<sup>3</sup> and in line with the global health sector strategy on HIV/AIDS, 2011–2015, and United Nations General Assembly resolution 65/277, taking into account the domestic context, legislation and jurisdictional responsibilities;

(15) to aim to transition by 2017 to the exclusive use, where appropriate, of WHO prequalified or equivalent safety-engineered injection devices, including reuse-prevention syringes and sharp injury prevention devices for therapeutic injections, and develop related national policies;

(16) to review, as appropriate, policies, procedures and practices associated with stigmatization and discrimination, including the denial of employment, training and education, as well as travel restrictions, against people living with and affected by viral hepatitis, or impairing their full enjoyment of the highest attainable standard of health;

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

(1) to include prevention, diagnosis and treatment of viral hepatitis in their respective work programmes and work in close collaboration;

(2) to identify and disseminate mechanisms to support countries in the provision of sustainable funding for the prevention, diagnosis and treatment of viral hepatitis;

3. REQUESTS the Director-General:

(1) to provide the necessary technical support to enable Member States to develop robust national viral hepatitis prevention, diagnosis and treatment strategies with time-bound goals;

(2) to develop specific guidelines on adequate, effective and affordable algorithms for diagnosis in developing countries;

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<sup>1</sup> The WTO General Council in its Decision of 30 August 2003 (Implementation of paragraph 6 of the Doha Declaration on the TRIPS Agreement and Public Health) decided that “‘pharmaceutical product’ means any patented product, or product manufactured through a patented process, of the pharmaceutical sector needed to address the public health problems as recognized in paragraph 1 of the Declaration. It is understood that active ingredients necessary for its manufacture and diagnostic kits needed for its use would be included.”

<sup>2</sup> Needle and syringe programmes; opioid substitution therapy and other drug dependence treatment; HIV testing and counselling; antiretroviral therapy; prevention and treatment of sexually transmitted infections; condom programmes for people who inject drugs and their sexual partners; targeted information, education and communication for people who inject drugs and their sexual partners; vaccination, diagnosis and treatment of viral hepatitis; prevention, diagnosis and treatment of tuberculosis.

<sup>3</sup> WHO, UNODC, UNAIDS technical guide for countries to set targets for universal access to HIV prevention, treatment and care for injecting drug users. Geneva: World Health Organization; 2009.

- (3) to develop, in consultation with Member States, a system for regular monitoring and reporting on the progress in viral hepatitis prevention, diagnosis and treatment;
- (4) to provide technical guidance on cost-effective ways to integrate the prevention, testing, care and treatment of viral hepatitis into existing health care systems and make best use of existing infrastructure and strategies;
- (5) to work with national authorities, upon their request, to promote comprehensive and equitable access to prevention, diagnosis and treatment of viral hepatitis in national plans, with particular attention to needle and syringe programmes and opioid substitution therapy or other evidence-based treatments for people who inject drugs, taking into consideration national policy context and procedures and to support countries, upon request, to implement these measures;
- (6) to provide technical guidance on prevention of transfusion-transmitted hepatitis B and C through safe donation from low-risk, voluntary, non-remunerated donors; counselling, referral and treatment of infected donors; and effective blood screening;
- (7) to examine the feasibility of and strategies needed for the elimination of hepatitis B and hepatitis C with a view to potentially setting global targets;
- (8) to estimate global, regional and domestic economic impact and burden of viral hepatitis in collaboration with Member States and relevant organizations, taking into due account potential and perceived conflicts of interest;
- (9) to support Member States with technical assistance in the use of the flexibilities in the Agreement on Trade-Related Aspects of Intellectual Property Rights when needed, in accordance with WHO's global strategy and plan of action on public health, innovation and intellectual property;
- (10) to lead a discussion and work with key stakeholders to facilitate equitable access to quality, effective, affordable and safe hepatitis B and C treatments and diagnostics;
- (11) to provide support to Member States to ensure equitable access to quality, effective, affordable and safe hepatitis B and C treatments and diagnostics, in particular in developing countries;
- (12) to maximize synergies between viral hepatitis prevention, diagnosis and treatment programmes and ongoing work to implement the WHO global action plan for the prevention and control of noncommunicable diseases 2013–2020;
- (13) to report to the Sixty-ninth World Health Assembly, or earlier if needed, through the Executive Board, on the implementation of this resolution.

(Ninth plenary meeting, 24 May 2014 –  
Committee A, fourth report)

**WHA67.7 WHO global disability action plan 2014–2021: better health for all people with disability<sup>1</sup>**

The Sixty-seventh World Health Assembly,

Having considered the *World report on disability 2011*,<sup>2</sup> the report on disability,<sup>3</sup> and the draft WHO global disability action plan 2014–2021: better health for all people with disability,

1. ADOPTS the WHO global disability action plan 2014–2021: better health for all people with disability;<sup>4</sup>
2. URGES Member States to implement the proposed actions for Member States in the WHO global disability action plan 2014–2021: better health for all people with disability, adapted to national priorities and specific contexts;
3. INVITES international, regional and national partners to implement the necessary actions to contribute to the accomplishment of the three objectives of the WHO global disability action plan 2014–2021: better health for all people with disability;
4. REQUESTS the Director-General:
  - (1) to implement the actions for the Secretariat in the WHO global disability action plan 2014–2021: better health for all people with disability;
  - (2) to submit reports on the progress achieved in implementing the action plan to the Seventieth and Seventy-fourth World Health Assemblies.

(Ninth plenary meeting, 24 May 2014 –  
Committee A, fifth report)

**WHA67.8 Comprehensive and coordinated efforts for the management of autism spectrum disorders<sup>1</sup>**

The Sixty-seventh World Health Assembly,

Having considered the report on comprehensive and coordinated efforts for the management of autism spectrum disorders;<sup>5</sup>

Recalling the Universal Declaration of Human Rights; the Convention on the Rights of the Child; the Convention on the Rights of Persons with Disabilities; United Nations General Assembly resolution 62/139 declaring 2 April as World Autism Awareness Day; and United Nations General

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<sup>1</sup> See Annex 6 for the financial and administrative implications for the Secretariat of this resolution.

<sup>2</sup> World Health Organization, World Bank. *World report on disability 2011*. Geneva: World Health Organization; 2011.

<sup>3</sup> Document A67/16.

<sup>4</sup> See Annex 3.

<sup>5</sup> Document A67/17.

Assembly resolution 67/82 on addressing the socioeconomic needs of individuals, families and societies affected by autism spectrum disorders, developmental disorders and associated disabilities;

Further recalling, as appropriate, resolution WHA65.4 on the global burden of mental disorders and the need for a comprehensive, coordinated response from health and social sectors at the country level and resolution WHA66.9 on disability; resolution SEA/RC65/R8 adopted by the Regional Committee for South-East Asia on comprehensive and coordinated efforts for the management of autism spectrum disorders (ASD) and developmental disabilities; resolution EUR/RC61/R5 adopted by the Regional Committee for Europe on the WHO European Declaration and Action Plan on the Health of Children and Young People with Intellectual Disabilities and their Families; and resolution EM/RC57/R.3 adopted by the Regional Committee for the Eastern Mediterranean on maternal, child and adolescent mental health: challenges and strategic directions 2010–2015, all of which emphasize a strong response to the needs of persons with developmental disorders including autism spectrum disorders;

Reiterating commitments to safeguard citizens from discrimination and social exclusion on the grounds of disability irrespective of the underlying impairment, whether physical, mental, intellectual or sensory, according to the Convention on the Rights of Persons with Disabilities; and promoting all persons' basic necessities of life, education, health care and social security, as well as ensuring attention to vulnerable persons;

Noting that globally an increasing number of children are being diagnosed with autism spectrum disorders and other developmental disorders and that it is likely that still more persons remain unidentified or incorrectly identified in society and in health facilities;

Highlighting that there is no valid scientific evidence that childhood vaccination leads to autism spectrum disorders;

Understanding that autism spectrum disorders are developmental disorders and conditions that emerge in early childhood and, in most cases, persist throughout the lifespan and are marked by the presence of impaired development in social interaction and communication and a restricted repertoire of activity and interest, with or without accompanying intellectual and language disabilities; and that manifestations of the disorder vary greatly in terms of combinations and levels of severity of symptoms;

Further noting that persons with autism spectrum disorders continue to face barriers in their participation as equal members of society, and reaffirming that discrimination against any person on the basis of disability is inconsistent with human dignity;

Deeply concerned that individuals with autism spectrum disorders and their families face major challenges including social stigmatization, isolation and discrimination, and that children and families in need, especially in low-resource contexts, often have poor access to appropriate support and services;

Acknowledging the comprehensive mental health action plan 2013–2020<sup>1</sup> and, as appropriate, the policy measures recommended in resolution WHA66.9 on disability, which can be particularly instrumental for developing countries in the scaling-up of care for autism spectrum disorders and other developmental disorders;

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<sup>1</sup> See document WHA66/2013/REC/1, Annex 3.

Recognizing the need to create or strengthen, as appropriate, health systems that support all persons with disabilities or mental health or developmental disorders, without discrimination,

1. URGES Member States:

- (1) to give appropriate recognition to the specific needs of individuals affected by autism spectrum disorders and other developmental disorders in policies and programmes related to early childhood and adolescent development, as part of a comprehensive approach to address child and adolescent mental health and developmental disorders;
- (2) to develop or update and implement relevant policies, legislation, and multisectoral plans, as appropriate, in line with resolution WHA65.4 on the global burden of mental disorders, and supported by sufficient human, financial and technical resources to address issues related to autism spectrum disorders and other developmental disorders, as part of a comprehensive approach to supporting all persons living with mental health issues or disabilities;
- (3) to support research and campaigns to raise public awareness and remove stigmatization, consistent with the Convention on the Rights of Persons with Disabilities;
- (4) to increase the capacity of health and social care systems, as appropriate, to provide services for individuals and families with autism spectrum disorders and other developmental disorders;
- (5) to mainstream into primary health care services the promotion and monitoring of child and adolescent development in order to ensure timely detection and management of autism spectrum disorders and other developmental disorders according to national circumstances;
- (6) to shift systematically the focus of care away from long-stay health facilities towards community-based, non-residential services;
- (7) to strengthen different levels of infrastructure for comprehensive management of autism spectrum disorders and other developmental disorders, as appropriate, including care, education, support, intervention, services and rehabilitation;
- (8) to promote sharing of best practices and knowledge about autism spectrum disorders and other developmental disorders;
- (9) to promote sharing of technology to support developing countries in the diagnosis and treatment of autism spectrum disorders and other developmental disorders;
- (10) to provide social and psychological support and care to families affected by autism spectrum disorders, including persons with autism spectrum disorders and developmental disorders and their families in disability benefit schemes, where available and as appropriate;
- (11) to recognize the contribution of adults living with autism spectrum disorders in the workforce, continuing to support workforce participation in partnership with the private sector;
- (12) to identify and address disparities in access to services for persons with autism spectrum disorders and other developmental disorders;

(13) to improve health information and surveillance systems that capture data on autism spectrum disorders and other developmental disorders, conducting national level needs assessment as part of the process;

(14) to promote context-specific research on the public health and service delivery aspects of autism spectrum disorders and other developmental disorders, strengthening international research collaboration to identify causes and treatments;

2. REQUESTS the Director-General:

(1) to collaborate with Member States and partner agencies in order to provide support for strengthening national capacities to address autism spectrum disorders and other developmental disorders as part of a well-balanced approach that strengthens systems addressing mental health and disability and is in line with existing, related action plans and initiatives;

(2) to engage with autism-related networks, and other regional initiatives, as appropriate, supporting networking with other international stakeholders for autism spectrum disorders and other developmental disorders;

(3) to work with Member States, facilitating resource mobilization in different regions and particularly in resource-poor countries, in line with the approved programme budget, which addresses autism spectrum disorders and other developmental disorders;

(4) to implement resolution WHA66.8 on the comprehensive mental health action plan 2013–2020, as well as resolution WHA66.9 on disability, in order to scale up care for individuals with autism spectrum disorders and other developmental disorders, as applicable, and as an integrated component of the scale-up of care for all mental health needs;

(5) to monitor the global situation of autism spectrum disorders and other developmental disorders, evaluating the progress made in different initiatives and programmes in collaboration with international partners as part of the existing monitoring efforts embedded in related action plans and initiatives;

(6) to report on progress made with regard to autism spectrum disorders, in a manner that is synchronized with the reporting cycle on the comprehensive mental health action plan 2013–2020, to the Sixty-eighth, Seventy-first and Seventy-fourth World Health Assemblies.

(Ninth plenary meeting, 24 May 2014 –  
Committee A, fifth report)

**WHA67.9 Psoriasis<sup>1</sup>**

The Sixty-seventh World Health Assembly,

Having considered the report on psoriasis;<sup>2</sup>

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<sup>1</sup> See Annex 6 for the financial and administrative implications for the Secretariat of this resolution.

<sup>2</sup> Document A67/18.

Recalling all relevant resolutions and decisions adopted by the World Health Assembly on the prevention and control of noncommunicable diseases, and underlining the importance for Member States to continue addressing key risk factors for noncommunicable diseases through the implementation of the WHO global action plan for the prevention and control of noncommunicable diseases 2013–2020;<sup>1</sup>

Recognizing the urgent need to pursue multilateral efforts to promote and improve human health, providing access to treatment and health care education;

Recognizing also that psoriasis is a chronic, noncommunicable, painful, disfiguring and disabling disease for which there is no cure;

Recognizing further that in addition to the pain, itching and bleeding caused by psoriasis, many affected individuals around the world experience social and work-related stigmatization and discrimination;

Underscoring that those with psoriasis are at an elevated risk for a number of co-morbid conditions, namely, cardiovascular diseases, diabetes, obesity, Crohn disease, ulcerative colitis, metabolic syndrome, stroke and liver disease;

Underscoring also that up to 42% of those with psoriasis also develop psoriatic arthritis, which causes pain, stiffness and swelling at the joints and can lead to permanent disfigurement and disability;

Underscoring that too many people in the world suffer needlessly from psoriasis owing to incorrect or delayed diagnosis, inadequate treatment options and insufficient access to care;

Recognizing the advocacy efforts of stakeholders, in particular through activities held every year on 29 October in many countries, to raise awareness regarding the disease of psoriasis, including awareness of the stigmatization suffered by those with psoriasis;

Welcoming the consideration of psoriasis issues by the Executive Board at its 133rd session,

1. ENCOURAGES Member States to engage further in advocacy efforts to raise awareness regarding the disease of psoriasis, fighting stigmatization suffered by those with psoriasis, in particular through activities held every year on 29 October in Member States;

2. REQUESTS the Director-General:

(1) to draw attention to the public health impact of psoriasis, publishing a global report on psoriasis, including its global incidence and prevalence, emphasizing the need for further research on psoriasis, and identifying successful approaches for integrating the management of psoriasis into existing services for noncommunicable diseases for stakeholders, in particular policy-makers, by the end of 2015;

(2) to include information about psoriasis diagnosis, treatment and care on the WHO website, with the aim of raising public awareness of psoriasis and its shared risk factors, and to provide an opportunity for education and greater understanding of psoriasis.

(Ninth plenary meeting, 24 May 2014 –  
Committee A, fifth report)

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<sup>1</sup> See document WHA66/2013/REC/1, Annex 4.



**WHA67.10 Newborn health action plan<sup>1</sup>**

The Sixty-seventh World Health Assembly,

Having considered the reports on the newborn health: draft action plan,<sup>2</sup> monitoring the achievement of the health-related Millennium Development Goals,<sup>3</sup> and health in the post-2015 development agenda;<sup>4</sup>

Recalling resolution WHA58.31 on working towards universal coverage of maternal, newborn and child health interventions, resolution WHA63.15 on monitoring of the achievement of the health-related Millennium Development Goals, resolution WHA64.9 on sustainable health financing structures and universal coverage, resolution WHA64.13 on working towards the reduction of perinatal and neonatal mortality, and resolution WHA65.7 on implementation of the recommendations of the Commission on Information and Accountability for Women's and Children's Health;

Acknowledging the pledges and commitments made by a large number of Member States and partners to the United Nations Secretary-General's Global Strategy for Women's and Children's Health, which aims to save 16 million lives by 2015;

Recognizing that millions of children and women die needlessly each year during and around the time of childbirth, and that effective interventions are available and feasible for implementation at scale to end preventable maternal, newborn and child deaths;

Recognizing that ending preventable maternal mortality will accelerate the achievement of the newborn mortality target;

Concerned that there has been insufficient and uneven progress towards achieving Millennium Development Goal 5 (Improve maternal health);

Also concerned that, although progress has been made towards achieving Millennium Development Goal 4 (Reduce child mortality) in terms of the overall reduction of child mortality, the reduction of perinatal and neonatal mortality has stagnated and the proportion of neonatal deaths among all child deaths is increasing;

Recognizing the need to intensify action urgently in order to end preventable neonatal deaths and preventable stillbirths, especially by improving access to and quality of health care for women and newborns, particularly of those at risk, including those belonging to high-risk groups and including the prevention of the transmission of HIV from mother to child, within the continuum of care for reproductive, maternal, newborn and child health,

1. ENDORSES the newborn health action plan,<sup>5</sup>

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<sup>1</sup> See Annex 6 for the financial and administrative implications for the Secretariat of this resolution.

<sup>2</sup> Document A67/21.

<sup>3</sup> Document A67/19.

<sup>4</sup> Document A67/20.

<sup>5</sup> See Annex 4.

2. URGES Member States<sup>1</sup> to put into practice the newborn health action plan, through steps that include:

- (1) reviewing, revising and strengthening their national strategies, policies, plans and guidelines for reproductive, maternal, newborn and child health in line with the goal, targets and indicators defined in the newborn health action plan, and strongly committing to their implementation with particular focus on high-risk groups;
- (2) committing themselves, according to their capacities, to allocating adequate human and financial resources to improve the access to and the quality of care, particularly care for the mother and the newborn during labour, around birth and the first week, and achieve the national newborn health targets in line with the global action plan;
- (3) strengthening health information systems so as better to monitor quality of care and to track progress towards ending preventable maternal and neonatal deaths and stillbirths;
- (4) sharing information on lessons learnt, progress made, remaining challenges and updated actions to reach the national newborn and maternal health targets;

3. REQUESTS the Director-General:

- (1) to foster alignment and coordination of all stakeholders to support the implementation of the newborn health action plan;
- (2) to identify and mobilize, within approved current and subsequent programme budgets, more human and financial resources for the provision of technical support to Member States in implementing the newborn health component of national plans and monitoring their impact;
- (3) to prioritize the finalization of the more detailed monitoring plan with coverage and outcome metrics to track progress of the newborn health action plan;
- (4) to take into due account the views expressed at the Sixty-seventh World Health Assembly as well as the domestic context when supporting the implementation of the action plan at the national level;
- (5) to monitor progress and report, periodically until 2030, to the Health Assembly on progress towards achievement of the global goal and targets using the proposed monitoring framework to guide discussion and future actions.

(Ninth plenary meeting, 24 May 2014 –  
Committee A, sixth report)

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

**WHA67.11 Public health impacts of exposure to mercury and mercury compounds: the role of WHO and ministries of public health in the implementation of the Minamata Convention<sup>1</sup>**

The Sixty-seventh World Health Assembly,

Having considered the report on public health impacts of exposure to mercury and mercury compounds: the role of WHO and ministries of public health in the implementation of the Minamata Convention;<sup>2</sup>

Recalling World Health Assembly resolutions WHA60.17 on oral health: action plan for promotion and integrated disease prevention, WHA63.25 on the improvement of health through safe and environmentally sound waste management, and WHA59.15 on the Strategic Approach to International Chemicals Management, as well as the strategy for strengthening the engagement of the health sector in the implementation of the strategic approach adopted by the International Conference on Chemicals Management at its third session;

Recognizing the importance of dealing effectively with the health aspects of the challenges that chemicals and wastes, including mercury, may pose, particularly to vulnerable populations, especially women, children, and, through them, future generations;

Recalling the renewed commitments on sustainable development set out in the outcome document of the United Nations Conference on Sustainable Development, Rio+20 (Rio de Janeiro, Brazil, 20–22 June 2012) entitled “The future we want”,<sup>3</sup> as well as the Adelaide Statement on Health in All Policies, of 2010, and the 8th Global Conference on Health Promotion, held in Helsinki in 2013, which promoted collaboration across all sectors to achieve healthy populations;

Taking note that negotiations on the text of a new multilateral environmental agreement on mercury were concluded in October 2013 with the adoption of the Minamata Convention on Mercury, being the first time that a multilateral environmental agreement includes a specific article on health, as well as other relevant provisions, and that the Convention places certain obligations on Parties that will require action, as applicable, by the health sector, together with other competent sectors, including the progressive phase-out, resulting from banning the manufacture, import or export by 2020, of mercury thermometers and sphygmomanometers, of mercury-containing cosmetics, including skin-lightening soaps and creams, and mercury-containing topical antiseptics, measures to be taken to phase down mercury-added dental amalgam, and the development of public health strategies on the exposure to mercury of artisanal and small-scale gold miners and their communities;

Recalling that the objective of the Minamata Convention on Mercury is to protect human health and the environment from anthropogenic emissions and releases of mercury and mercury compounds;

Bearing in mind that the Minamata Convention on Mercury encourages Parties to: (a) promote the development and implementation of strategies and programmes to identify and protect populations at risk, particularly vulnerable populations, and which may include adopting science-based health guidelines relating to the exposure to mercury and mercury compounds, setting targets for mercury exposure reduction, where appropriate, and public education, with the participation of public health

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<sup>1</sup> See Annex 6 for the financial and administrative implications for the Secretariat of this resolution.

<sup>2</sup> Document A67/24.

<sup>3</sup> United Nations General Assembly resolution 66/288, Annex.

and other involved sectors; (b) promote the development and implementation of science-based educational and preventive programmes on occupational exposure to mercury and mercury compounds; (c) promote appropriate health care services for prevention, treatment and care for populations affected by the exposure to mercury or mercury compounds; and (d) establish and strengthen, as appropriate, the institutional and health professional capacities for the prevention, diagnosis, treatment and monitoring of health risks related to the exposure to mercury and mercury compounds;

Noting that the Minamata Convention on Mercury states that the Conference of the Parties, in considering health-related activities, should consult, collaborate and promote cooperation and exchange of information with WHO, ILO and other relevant intergovernmental organizations, as appropriate;

Thanking the Secretariat for its preparatory work, during the negotiations, analysing different risks and available substitutes, as well as analysing and identifying areas requiring additional or new effort, under the Minamata Convention, and encouraging further and continuous analysis and other efforts as may be needed,

1. WELCOMES the formal adoption by Parties of the Minamata Convention on Mercury in October 2013;
2. ENCOURAGES Member States:<sup>1</sup>
  - (1) to take the necessary domestic measures promptly to sign, ratify and implement the Minamata Convention on Mercury, which sets out internationally legally binding measures to address the risks of mercury and mercury compounds to human health and the environment;
  - (2) to participate actively in national, regional and international efforts to implement the Minamata Convention on Mercury;
  - (3) to address the health aspects of exposure to mercury and mercury compounds in the context of their health sector uses, and also the other negative health impacts that should be prevented or treated, by ensuring the sound management of mercury and mercury compounds throughout their life cycle;
  - (4) to recognize the interrelation between the environment and public health in the context of the implementation of the Minamata Convention on Mercury and sustainable development;
  - (5) to promote appropriate health care services for prevention, treatment and care for populations affected by the exposure to mercury or mercury compounds, including effective risk communication strategies targeted at vulnerable groups, such as children and women of childbearing age, especially pregnant women;
  - (6) to ensure close cooperation between ministries of health and ministries of environment, as well as ministries of labour, industry, economy, agriculture and other ministries responsible for the implementation of aspects of the Minamata Convention on Mercury;

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

(7) to facilitate the exchange of epidemiological information concerning health impacts associated with exposure to mercury and mercury compounds, in close cooperation with WHO and other relevant organizations, as appropriate;

3. REQUESTS the Director-General:

(1) to facilitate WHO's efforts to provide advice and technical support to Member States to support the implementation of the Minamata Convention on Mercury in all health aspects related to mercury, consistent with WHO's programme of work, in order to promote and protect human health;

(2) to provide support to Member States in developing and implementing strategies and programmes to identify and protect populations at risk, particularly vulnerable populations, which may include adopting science-based health guidelines relating to exposure to mercury and mercury compounds, setting targets for mercury exposure reduction, where appropriate, and public education, with the participation of health and other involved sectors;

(3) to cooperate closely with the Minamata Convention Intergovernmental Negotiating Committee, the Conference of the Parties and other international organizations and bodies, mainly UNEP, to fully support the implementation of the health-related aspects of the Minamata Convention on Mercury and to provide information to the Committee and Conference of the Parties on the progress made in this regard;

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

(Ninth plenary meeting, 24 May 2014 –  
Committee A, sixth report)

**WHA67.12 Contributing to social and economic development: sustainable action across sectors to improve health and health equity<sup>1</sup>**

The Sixty-seventh World Health Assembly,

Having considered the report on contributing to social and economic development: sustainable action across sectors to improve health and health equity;<sup>2</sup>

Reaffirming the principles of the Constitution of the World Health Organization stating 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;

Reaffirming the right of every human being without distinction of any kind to the enjoyment of the highest attainable standard of physical and mental health, and to a standard of living adequate for the health and well-being of oneself and one's family, including adequate food, clothing and housing and to the continuous improvement of living conditions;

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<sup>1</sup> See Annex 6 for the financial and administrative implications for the Secretariat of this resolution.

<sup>2</sup> Document A67/25.

Recalling the Declaration of Alma-Ata on Primary Health Care, 1978 and the Global Strategy of Health for All by the Year 2000, and their calls for coordination, cooperation and intersectoral action for health;

Acknowledging the outcome document of the United Nations Conference on Sustainable Development, Rio+20 (Rio de Janeiro, Brazil, 20–22 June 2012) entitled “The future we want”,<sup>1</sup> and in particular its recognition that health is a precondition for and an outcome and indicator of all three dimensions of sustainable development and the call for the involvement of all relevant sectors for coordinated multisectoral action to address urgently the health needs of the world’s population;

Recalling resolution WHA42.44 on health promotion, public information and education for health, resolution WHA51.12 on health promotion, resolution WHA57.16 on health promotion and healthy lifestyles, resolution WHA60.24 on health promotion in a globalized world, and resolution WHA65.8 on social determinants of health, and taking note of the outcome documents of the seven global WHO conferences on health promotion,<sup>2</sup> in particular the Ottawa Charter, the Adelaide Statement and the Nairobi Call for Action;

Reaffirming commitments made to global health in the context of foreign policy and reiterating the request to consider universal health coverage in the discussions on the post-2015 development agenda, also considering broad public health measures, health protection and addressing determinants of health through policies across sectors;

Recalling the Political Declaration of the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases<sup>3</sup> and the WHO’s global strategy for the prevention and control of noncommunicable diseases and action plan for the prevention and control of noncommunicable diseases 2013–2020,<sup>4</sup> which recognize the primary role of governments in responding to the challenge of noncommunicable diseases and the essential need for the efforts and engagement of all sectors, rather than by making changes in health sector policy alone, as well as the important role of the international community and international cooperation in assisting Member States in these efforts;

Noting that the health sector has a key role in working with other sectors in ensuring drinking water quality, sanitation, food and nutritional safety, and air quality and in limiting exposure to health-damaging chemicals and radiation levels, as recognized in Health Assembly resolutions;<sup>5</sup>

Recognizing that a number of mental disorders can be prevented and that mental health can be promoted in the health sector and in sectors outside health and that global support is necessary for national and local work on mental health and development, for instance through WHO’s comprehensive mental health action plan 2013–2020 and the WHO MiNDbank;

Noting further the relevance of the WHO Framework Convention on Tobacco Control for many sectors, underscoring the importance of addressing common risk factors for noncommunicable diseases across sectors and the cooperation needs under the International Health Regulations (2005),

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<sup>1</sup> United Nations General Assembly resolution 66/288, Annex.

<sup>2</sup> Ottawa, 1986; Adelaide, Australia, 1988; Sundsvall, Sweden, 1991; Jakarta, 1997; Mexico City, 2000; Bangkok, 2005; Nairobi, 2009.

<sup>3</sup> United Nations General Assembly resolution 66/2, Annex.

<sup>4</sup> Resolutions WHA53.17 and WHA66.10.

<sup>5</sup> Resolutions WHA59.15, WHA61.19, WHA63.25, WHA63.26, WHA64.15, WHA64.24.

including among the organizations in the United Nations system, and between and within Member States;

Acknowledging the final report of the Commission on Social Determinants of Health<sup>1</sup> as a source of evidence, as well as the Rio Political Declaration on Social Determinants of Health and its call for the development and implementation of robust, evidence-based, reliable measures of societal well-being, and recognizing the important advocacy role of health ministries in this regard;

Recognizing that “health in all policies” refers to taking the health implications of decisions systemically into account in public policies across sectors, seeking synergies and avoiding harmful health impacts, in order to improve population health and health equity through assessing the consequences of public policies on the determinants of health and well-being and on health systems;

Concerned about gaps in taking into account across government, at various levels of governance, the impacts of policies on health, health equity and the functioning of the health system,

1. NOTES with appreciation the Helsinki Statement on Health in All Policies, endorsed by the 8th Global Conference on Health Promotion (Helsinki, 10–14 June 2013), and notes the ongoing work on the Health in All Policies Framework for Country Action;

2. URGES Member States:<sup>2</sup>

(1) to champion health and the promotion of health equity as a priority and take efficient action on social, economic and environmental determinants of health, consistent with resolution WHA65.8, including on noncommunicable disease prevention;

(2) to take steps, including, where appropriate, effective legislation, cross-sectoral structures, processes, methods and resources such as the Urban Health Equity Assessment and Response Tool, that enable societal policies which take into account and address their impacts on health determinants, health protection, health equity and health systems functioning, and which measure and track social determinants and disparities in health;

(3) to develop, as appropriate, sustainable institutional capacity with adequate knowledge and skills in assessing health impacts of policy initiatives in all sectors, identifying solutions and negotiating policies across sectors, including within health authorities and relevant research and development institutes such as national public health institutes, to achieve improved outcomes from the perspective of health, health equity and health systems functioning;

(4) to take action to enhance health and safeguard public health interests from undue influence by any form of real, perceived or potential conflict of interest, through managing risk, strengthening due diligence and accountability, and increasing the transparency of decision-making and engagement;

(5) to include, as appropriate, relevant stakeholders such as local communities and civil society actors in the development, implementation and monitoring of policies across sectors;

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<sup>1</sup> World Health Organization, Commission on Social Determinants of Health. Closing the gap in a generation: health equity through action on the social determinants of health. Geneva: World Health Organization; 2008.

<sup>2</sup> And, where applicable, regional economic integration organizations.

(6) to contribute to the development of the post-2015 development agenda by emphasizing that policies in sectors other than health have a significant impact on health outcomes, and by identifying synergies between health and other sector policy objectives;

3. REQUESTS the Director-General:

(1) to prepare, for the consideration of the Sixty-eighth World Health Assembly, in consultation with Member States,<sup>1</sup> organizations of the United Nations system and other relevant stakeholders as appropriate, and within existing resources, a Framework for Country Action, for adaptation to different contexts, taking into account the Helsinki Statement on Health in All Policies, aimed at supporting national efforts to improve health, and ensure health protection, health equity and health systems functioning, including through action across sectors on determinants of health and risk factors of noncommunicable diseases, based on best available knowledge and evidence;

(2) to provide guidance and technical assistance, upon request, to Member States in their efforts to build the necessary capacities, structures, mechanisms and processes in order to integrate health perspectives in non-health sector policies, including, where appropriate, through implementation of “health in all policies”, and for measuring and tracking social determinants and disparities in health;

(3) to strengthen WHO’s role, capacities and knowledge resources, including by compiling and analysing good practices by Member States, to give guidance and technical assistance for implementation of policies across sectors at the various levels of governance, and to ensure coherence and collaboration across programmes and initiatives within WHO;

(4) to continue to work with and provide leadership for the organizations in the United Nations system, development banks, other international organizations and foundations in order to encourage them to take health considerations into account in major strategic initiatives and their monitoring, including the post-2015 development agenda, and to achieve coherence and synergy with commitments and obligations related to health and health determinants, including social determinants of health, in their work with Member States;

(5) to report on the progress made in implementing this resolution to the Sixty-ninth World Health Assembly through the Executive Board.

(Ninth plenary meeting, 24 May 2014 –  
Committee A, sixth report)

## **WHA67.13 Implementation of the International Health Regulations (2005)<sup>2</sup>**

The Sixty-seventh World Health Assembly,

Having considered the report on implementation of the International Health Regulations (2005);<sup>3</sup>

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

<sup>2</sup> See Annex 6 for the financial and administrative implications for the Secretariat of this resolution.

<sup>3</sup> Document A67/35.



Recalling the recent meeting and report of the Strategic Advisory Group of Experts on immunization,<sup>1</sup> which completed its scientific review and analysis of evidence on issues concerning vaccination against yellow fever and concluded that a single dose of yellow fever vaccine is sufficient to confer sustained immunity and life-long protection against yellow fever disease, and that a booster dose of yellow fever vaccine is not needed;

Noting that in its report the Strategic Advisory Group of Experts on immunization recommended that WHO should revisit the provisions in the International Health Regulations (2005) relating to the period of validity for international certificates for vaccination against yellow fever,

ADOPTS, in accordance with paragraph 3 of Article 55 of the International Health Regulations (2005), the updated Annex 7 of the International Health Regulations (2005).<sup>2</sup>

(Ninth plenary meeting, 24 May 2014 –  
Committee A, sixth report)

#### **WHA67.14 Health in the post-2015 development agenda<sup>1</sup>**

The Sixty-seventh World Health Assembly,

Having considered the report on monitoring the achievement of the health-related Millennium Development Goals: health in the post-2015 development agenda;<sup>3</sup>

Reaffirming the Constitution of the World Health Organization, which states that the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition;

Reaffirming also the principles of the United Nations Millennium Declaration adopted by the United Nations General Assembly in resolution 55/2, including human dignity, equality and equity, and stressing the need for their reflection in the post-2015 development agenda;

Recalling United Nations General Assembly resolution 66/288 “The future we want”, the Annex to which recognized that health is a precondition for and an outcome and indicator of all dimensions of sustainable development;

Stressing also that concerns related to health equity and rights should be addressed in efforts to achieve the Millennium Development Goals;

Recalling resolution WHA66.11 on health in the post-2015 development agenda, which urged Member States to ensure that health is central to the post-2015 development agenda;

Reaffirming the need to sustain current achievements and intensify efforts in those countries where accelerated progress is needed towards achievement of the health-related Millennium Development Goals, especially maternal, newborn and child health;

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<sup>1</sup> Meeting of the Strategic Advisory Group of Experts on immunization, April 2013 – conclusions and recommendations. Weekly epidemiological record. 2013;88(20):201–216.

<sup>2</sup> See Annex 5.

<sup>3</sup> Document A67/20.

Cognizant of the burden of maternal, newborn and child morbidity and mortality, communicable diseases, including HIV/AIDS, tuberculosis, malaria and neglected tropical diseases, emerging diseases and the rising burden of noncommunicable diseases and injuries;

Acknowledging that universal health coverage implies that all people have access, without discrimination, to nationally determined sets of the needed promotive, preventive, curative, palliative and rehabilitative essential health services and essential, safe, affordable, effective and quality medicines, while ensuring that the use of these services does not expose the users to financial hardship with a special emphasis on the poor, vulnerable and marginalized segments of the population;

Recognizing the importance of implementing relevant internationally agreed commitments, including the Beijing Platform for Action, the Programme of Action of the International Conference on Population and Development and the review conferences to date, the Political Declaration of the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases, the Political Declaration on HIV and AIDS, and United Nations General Assembly resolution 67/81 on global health and foreign policy in achieving provision of universal health coverage and improved health outcomes;

Recognizing the importance of strengthening health systems and building capacities for broad public health measures, health protection and addressing determinants of health towards attaining equitable universal coverage;

Emphasizing that policies and actions in sectors other than health have a significant impact on health outcomes and vice versa, hence the need to identify synergies between policy objectives in the health sector and other sectors through a whole-of-government, whole-of-society and “health in all policies” approach to the post-2015 development agenda;

Reiterating its determination to take action on social determinants of health as collectively agreed in resolution WHA62.14;

Recognizing the importance of strengthened international cooperation and honouring commitments towards national and international health financing, and ensuring that international development cooperation in health is effective and aligned with national health priorities;

Recognizing that the monitoring of health improvement should include measuring health system performance as well as health outcomes that capture healthy life expectancy, mortality, morbidity and disability;

Recognizing the importance of the health workforce and its essential contribution to health systems functioning and the need for continued commitment to relevant Health Assembly resolutions, in particular resolution WHA63.16 on the WHO Global Code of Practice on the International Recruitment of Health Personnel,

1. URGES Member States,<sup>1</sup> in the context of health in the post-2015 development agenda:
  - (1) to engage actively in discussions on the post-2015 development agenda, respecting the process established by the United Nations General Assembly;
  - (2) to ensure that health is central to the post-2015 development agenda;

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

(3) to ensure that the post-2015 development agenda will accelerate and sustain progress towards the achievement of health-related Millennium Development Goals, including child, maternal, sexual and reproductive health, nutrition, HIV/AIDS, tuberculosis and malaria;

(4) to recognize that additional attention needs to be paid to newborn health and neglected tropical diseases;

(5) to incorporate into the post-2015 development agenda the need for action to reduce the preventable and avoidable burden of mortality, morbidity and disability related to noncommunicable diseases and injuries while also promoting mental health;

(6) to promote universal health coverage, defined as universal access to quality prevention, promotion, treatment, rehabilitation and palliation services and financial risk protection as fundamental to the health component in the post-2015 development agenda;

(7) to emphasize the need for multisectoral actions to address social, environmental and economic determinants of health, to reduce health inequities and contribute to sustainable development, including “health in all policies” as appropriate;

(8) to call for the full realization of the right to the enjoyment of the highest attainable standard of physical and mental health and to consider that this right is fundamental to equitable and inclusive sustainable development;

(9) to recognize the importance of accountability through regular assessment of progress by strengthening of civil registration and vital statistics and health information systems with disaggregated data to monitor health equity;

(10) to include health-related indicators for measuring progress in all relevant dimensions of sustainable development;

(11) to emphasize the importance of strengthening health systems, including the six building blocks of a health system (service delivery; health workforce; information; medical products, vaccines and technologies; financing; and governance and leadership), in order to progress towards and sustain universal health coverage and improved health outcomes;

## 2. REQUESTS the Director-General:

(1) to continue active engagement with ongoing discussions on the post-2015 development agenda, working with the United Nations Secretary-General, in order to ensure the centrality of health in all relevant processes;

(2) to continue to inform Member States and provide support, upon request, on issues and processes concerning the positioning of health in the post-2015 development agenda;

(Ninth plenary meeting, 24 May 2014 –  
Committee A, sixth report)

**WHA67.15      Strengthening the role of the health system in addressing violence, in particular against women and girls, and against children<sup>1</sup>**

The Sixty-seventh World Health Assembly,

Having considered the report on addressing the global challenge of violence, in particular against women and girls, and against children;<sup>2</sup>

Recalling resolution WHA49.25 which declared violence a leading worldwide public health problem, resolution WHA56.24 on implementing the recommendations of the *World report on violence and health*,<sup>3</sup> and resolution WHA61.16 on female genital mutilation;

Cognizant of the many efforts across the United Nations system to address the challenge of violence, in particular against women and girls, and against children, including the International Conference on Population and Development, the Beijing Declaration and Platform for Action, and all relevant United Nations General Assembly and Human Rights Council resolutions, as well as all relevant agreed conclusions of the Commission on the Status of Women;

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

Noting also that interpersonal violence, distinguished from self-inflicted violence and collective violence, is divided into family and partner violence and community violence, and includes forms of violence throughout the life course, such as child abuse, partner violence, abuse of the elderly, violence between family members, youth violence, random acts of violence, rape or sexual assault and violence in institutional settings such as schools, workplaces, prisons and nursing homes;<sup>3</sup>

Recalling the definition of violence against women as stated in the 1993 Declaration on the Elimination of Violence against Women;<sup>4</sup>

Concerned that the health and well-being of millions of individuals and families is adversely affected by violence and that many cases go unreported;

Further concerned that violence has health-related consequences including death, disability and physical injuries, mental health impacts and sexual and reproductive health consequences, as well as social consequences;

Recognizing that health systems often are not adequately addressing the problem of violence and contributing to a comprehensive multisectoral response;

Deeply concerned that globally, one in three women experiences physical and/or sexual violence, including by their spouses, at least once in their lives;<sup>1</sup>

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<sup>1</sup> See Annex 6 for the financial and administrative implications for the Secretariat of this resolution.

<sup>2</sup> Document A67/22.

<sup>3</sup> World report on violence and health. Geneva: World Health Organization; 2002.

<sup>4</sup> United Nations General Assembly resolution 48/104.

Concerned that violence, in particular against women and girls, is often exacerbated in situations of humanitarian emergencies and post-conflict settings, and recognizing that national health systems have an important role to play in responding to its consequences;

Noting that preventing interpersonal violence against children – boys and girls – can contribute significantly to preventing interpersonal violence against women and girls, and children, that being abused and neglected during infancy and childhood makes it more likely that people will grow up to perpetrate violence against women, maltreat their own children, and engage in youth violence, and underscoring that there is good evidence for the effectiveness of parenting-support programmes in preventing child abuse and neglect in order to halt the intergenerational perpetuation of interpersonal violence;

Noting also that violence against girls needs specific attention because they are subjected to forms of violence related to gender inequality that too often remain hidden and unrecognized by society, including by health providers, and although child abuse (physical and emotional) and neglect affects boys and girls equally, girls suffer more sexual violence;

Deeply concerned that violence against women during pregnancy has grave consequences for both the health of the woman and the pregnancy, such as miscarriage and premature labour, and for the baby, such as low birth weight, as well as recognizing the opportunity that antenatal care provides for early identification and prevention of the recurrence of such violence;

Concerned that children, particularly in child-headed households, are vulnerable to violence, including physical, sexual and emotional violence, such as bullying, and reaffirming the need to take action across sectors to promote the safety, support, protection, health care and empowerment of children, especially girls in child-headed households;

Recognizing that boys and young men are among those most affected by interpersonal violence, which contributes greatly to the global burden of premature death, injury and disability, particularly for young men, and has a serious and long-lasting impact on a person's psychological and social functioning;

Deeply concerned that interpersonal violence, in particular against women and girls, and children, persists in every country in the world as a major global challenge to public health, and is a pervasive violation of the right of everyone to the enjoyment of the highest attainable standard of physical and mental health and a major impediment to achieving gender equality, and has negative socioeconomic consequences;

Recognizing that violence against women and girls is a form of discrimination, that power imbalances and structural inequality between men and women are among its root causes, and that effectively addressing violence against women and girls requires action at all levels of government, including by the health system, as well as the engagement of civil society, the involvement of men and boys and the adoption and implementation of multifaceted and comprehensive approaches that promote gender equality and empowerment of women and girls and that change harmful attitudes, customs, practices and stereotypes;

Aware that the process under way for the post-2015 development agenda may, in principle, contribute to addressing, from a health perspective, the health consequences of violence, in particular against women and girls, and children, through a comprehensive and multisectoral response;

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<sup>1</sup> World Health Organization, London School of Hygiene and Tropical Medicine, South African Medical Research Council. Global and regional estimates of violence against women: prevalence and health effects of intimate partner violence and non-partner sexual violence. Geneva: World Health Organization; 2013.

Acknowledging also the many regional, subregional and national efforts aimed at coordinating prevention and response by health systems to violence, in particular against women and girls, and against children;

Noting with great appreciation the leading role WHO has played in establishing the evidence base on the magnitude, risk and protective factors,<sup>1</sup> consequences, prevention of and response to violence,<sup>2</sup> in particular against women and girls,<sup>3</sup> and against children, in the development of norms and standards, in advocacy and in supporting efforts to strengthen research, prevention programmes and services for those affected by violence;<sup>4</sup>

Also noting that addressing violence, in particular against women and girls, and against children is included within the leadership priorities of WHO's Twelfth General Programme of Work, 2014–2019, in particular to address the social, economic and environmental determinants of health;

Recognizing the need to scale up interpersonal violence prevention policies and programmes to which the health system contributes and that although some evidence-based guidance exists on effective interventions, more research and evaluation of these and other interventions is required;

Stressing the importance of preventing interpersonal violence before it begins or reoccurs, and noting that the role of the health system in the prevention of violence, in particular against women and girls, and against children, includes supporting efforts to: reduce child maltreatment, such as through parenting support programmes; address substance abuse, including the harmful use of alcohol; prevent the reoccurrence of violence by providing health and psychosocial care and/or rehabilitation for victims and perpetrators and to those who have witnessed violence; and collect and disseminate evidence on the effectiveness of prevention and response interventions;

Affirming the health system's role in advocating, as an element of prevention, for interventions to combat the social acceptability and tolerance of interpersonal violence, in particular against women and girls, and against children, emphasizing the role such advocacy can play in promoting societal transformation;

Recognizing that interpersonal violence, in particular against women and girls, and against children, can occur within the health system itself, which can negatively impact the health workforce and the quality of health care provided and lead to disrespect and abuse of patients, and discrimination to access of services provided;

Affirming the important and specific role that national health systems must play in identifying and documenting incidents of violence, and providing clinical care and appropriate referrals for those

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<sup>1</sup> Protective factors are those that decrease or buffer against the risk and impact of violence. Although much of the research on violence against women and violence against children has focused on risk factors, it is important for prevention also to understand protective factors. Prevention strategies and programmes aim to decrease risk factors and/or to enhance protective factors.

<sup>2</sup> Including the World report on violence and health (2002).

<sup>3</sup> Including the WHO multi-country study on women's health and domestic violence against women: initial results on prevalence, health outcomes and women's responses (2005); Global and regional estimates of violence against women: prevalence and health effects of intimate partner violence and non-partner sexual violence (2013); and Responding to intimate partner violence and sexual violence against women: WHO clinical and policy guidelines (2013).

<sup>4</sup> This work is carried out mainly by the Department of Violence and Injury Prevention and Disability, the Department of Reproductive Health and Research, the Department for Mental Health and Substance Abuse and the Department for Emergency Risk Management and Humanitarian Response, in close collaboration with regional and country offices.

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affected by such incidents, particularly women and girls, and children, as well as contributing to prevention and advocating within governments and among all stakeholders for an effective, comprehensive, multisectoral response to violence,

1. URGES Member States:<sup>1</sup>

(1) to strengthen the role of their health systems in addressing violence, in particular against women and girls, and against children, to ensure that all people at risk and/or affected by violence have timely, effective and affordable access to health services, including health promotion and curative, rehabilitation and support services, that are free of abuse, disrespect and discrimination, to strengthen their contribution to prevention programmes and to support WHO's work related to this resolution;

(2) to ensure health system engagement with other sectors, such as education, justice, social services, women's affairs and child development, in order to promote and develop an effective, comprehensive, national multisectoral response to interpersonal violence, in particular against women and girls, and against children, by, inter alia, adequately addressing violence in health and development plans and establishing and adequately financing national multisectoral strategies on violence prevention and response, including protection, as well as promoting inclusive participation of relevant stakeholders;

(3) to strengthen their health system's contribution to ending the acceptability and tolerance of all forms of violence against women and girls, including through advocacy, counselling and data collection, while promoting the age-appropriate engagement of men and boys alongside women and girls as agents of change in their family and community, so as to promote gender equality and the empowerment of women and girls;

(4) to strengthen the national response, in particular the national health system response, by improving the collection and, as appropriate, dissemination of comparable data disaggregated for sex, age and other relevant factors on the magnitude, risk and protective factors, types and health consequences of violence, in particular against women and girls, and against children, as well as information on best practices, including the quality of care and effective prevention and response strategies;

(5) to continue to strengthen the role of their health systems so as to contribute to the multisectoral efforts in addressing interpersonal violence, in particular against women and girls, and against children, including by the promotion and protection of human rights, as they relate to health outcomes;

(6) to provide access to health services, as appropriate, including in the area of sexual and reproductive health;

(7) to seek to prevent reoccurrence and break the cycle of interpersonal violence by strengthening, as appropriate, the timely access for victims, perpetrators and those affected by interpersonal violence to effective health, social and psychological services and to evaluate such programmes to assess their effectiveness in reducing the reoccurrence of interpersonal violence;

(8) to enhance capacities, including through appropriate continuous training of all public and private professionals from health and non-health sectors, as well as caregivers and community health workers, to provide care and support, as well as other related preventive and health

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

promotion services, to victims and those affected by violence, in particular women and girls, and children;

(9) to promote, establish, support and strengthen standard operating procedures targeted to identify violence against women and girls, and against children, taking into account the important role of the health system in providing care and making referrals to support services;

2. REQUESTS the Director-General:

(1) to develop, with the full participation of Member States,<sup>1</sup> and in consultation with organizations of the United Nations system and other relevant stakeholders focusing on the role of the health system, as appropriate, a draft global plan of action to strengthen the role of the health system within a national multisectoral response to address interpersonal violence, in particular against women and girls, and against children, building on WHO's existing relevant work;

(2) to continue to strengthen WHO's efforts to develop the scientific evidence on the magnitude, trends, health consequences and risk and protective factors for violence, in particular against women and girls, and against children, and update the data on a regular basis, taking into account Member States' input, and to collect information on best practices, including the quality of care and effective prevention and response strategies in order to develop effective national health systems prevention and response;

(3) to continue to support Member States, upon their request, by providing technical assistance for strengthening the role of the health system, including in sexual and reproductive health, in addressing violence, in particular against women and girls, and against children;

(4) to report to the Executive Board at its 136th session on progress in implementing this resolution, and on the finalization in 2014 of a global status report on violence and health which is being developed in cooperation with UNDP and the United Nations Office on Drugs and Crime and which reflects national violence prevention efforts, and to report also to the Executive Board at its 138th session on progress in implementing this resolution, including presentation of the draft global plan of action, for consideration by the Sixty-ninth World Health Assembly.

(Ninth plenary meeting, 24 May 2014 –  
Committee A, sixth report)

### **WHA67.16 Report of the External Auditor**

The Sixty-seventh World Health Assembly,

Having considered the report of the External Auditor to the Health Assembly;<sup>2</sup>

Having noted the related report of the Programme, Budget and Administration Committee of the Executive Board to the Sixty-seventh World Health Assembly,<sup>3</sup>

ACCEPTS the report of the External Auditor to the Health Assembly.

(Ninth plenary meeting, 24 May 2014 –  
Committee B, second report)

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

<sup>2</sup> Document A67/45.

<sup>3</sup> Document A67/58.



**WHA67.17 Salaries of staff in ungraded posts and of the Director-General<sup>1</sup>**

The Sixty-seventh World Health Assembly,

Noting the recommendations of the Executive Board with regard to the remuneration of staff in ungraded posts and of the Director-General,<sup>2</sup>

1. ESTABLISHES the salaries of assistant directors-general and regional directors at US\$ 172 436 gross per annum with a corresponding net salary of US\$ 134 205 (dependency rate) or US\$ 121 527 (single rate);
2. ESTABLISHES the salary of the Deputy Director-General at US\$ 189 744 gross per annum with a corresponding net salary of US\$ 146 321 (dependency rate) or US\$ 131 682 (single rate);
3. ESTABLISHES the salary of the Director-General at US\$ 252 055 gross per annum with a corresponding net salary of US\$ 176 836 (dependency rate) or US\$ 157 262 (single rate);
4. DECIDES that the adjustments in remuneration shall take effect on 1 January 2014.

(Ninth plenary meeting, 24 May 2014 –  
Committee B, second report)

**WHA67.18 Traditional medicine<sup>3</sup>**

The Sixty-seventh World Health Assembly,

Having considered the report on traditional medicine,<sup>3</sup>

Recalling resolutions WHA22.54, WHA29.72, WHA30.49, WHA31.33, WHA40.33, WHA41.19, WHA42.43, WHA44.34, WHA54.11, WHA56.31, WHA61.21, and in particular WHA62.13 on traditional medicine, in which the Health Assembly requested the Director-General, *inter alia*, to update the WHO traditional medicine strategy 2002–2005, based on countries' progress and current new challenges in the field of traditional medicine;

Affirming the growing importance and value of traditional medicine in the provision of health care nationally and globally, and that such medicines are no longer limited exclusively to any particular regions or communities;

Noting the heightened level of interest in aspects of traditional and complementary medicine practices and in their practitioners, and related demand from consumers and governments that consideration be given to integration of those elements into health service delivery with the aim of supporting healthy living;

Noting also that the major challenges to the area of traditional and complementary medicine include deficiencies in: knowledge-based management and policy; appropriate regulation of practices and practitioners; monitoring and implementation of regulation on products; and appropriate

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<sup>1</sup> See Annex 6 for the financial and administrative implications for the Secretariat of this resolution.

<sup>2</sup> Document A67/49.

<sup>3</sup> Document A67/26.

integration of traditional and complementary medicine services into health care service delivery and self-health care,

1. TAKES NOTE of the WHO traditional medicine strategy: 2014–2023, its three objectives, and the relevant strategic directions and strategic actions that guide the traditional medicine sector in its further development and the importance of key performance indicators in guiding the evaluation of the implementation of the strategy over the next decade;

2. URGES Member States, in accordance with national capacities, priorities, relevant legislation and circumstances:

(1) to adapt, adopt and implement, where appropriate, the WHO traditional medicine strategy: 2014–2023 as a basis for national traditional and complementary medicine programmes or work plans;

(2) to develop and implement, as appropriate, working plans to integrate traditional medicine into health services, particularly primary health care services;

(3) to report to WHO, as appropriate, on progress in implementing the WHO traditional medicine strategy: 2014–2023;

3. REQUESTS the Director-General:

(1) to facilitate, upon request, Member States' implementation of the WHO traditional medicine strategy: 2014–2023, supporting their formulation of related knowledge-based national policies, standards and regulations, and strengthening national capacity-building accordingly through information sharing, networks and training workshops;

(2) to continue to provide policy guidance to Member States on how to integrate traditional and complementary medicine services within their national and/or subnational health care system(s), as well as the technical guidance that would ensure the safety, quality and effectiveness of such traditional and complementary medicine services with emphasis on quality assurance;

(3) to continue to promote international cooperation and collaboration in the area of traditional and complementary medicine in order to share evidence-based information, taking into account the traditions and customs of indigenous peoples and communities;

(4) to monitor and allocate appropriate funds in accordance with the WHO programme budget towards the implementation of the WHO traditional medicine strategy: 2014–2023;

(5) to report to the Health Assembly periodically, as appropriate, on progress made in implementing this resolution.

(Ninth plenary meeting, 24 May 2014 –  
Committee B, third report)

**WHA67.19      Strengthening of palliative care as a component of comprehensive care throughout the life course<sup>1</sup>**

The Sixty-seventh World Health Assembly,

Having considered the report on strengthening of palliative care as a component of integrated treatment throughout the life course;<sup>2</sup>

Recalling resolution WHA58.22 on cancer prevention and control, especially as it relates to palliative care;

Taking into account the United Nations Economic and Social Council's Commission on Narcotic Drugs' resolutions 53/4 and 54/6 respectively on promoting adequate availability of internationally controlled licit drugs for medical and scientific purposes while preventing their diversion and abuse, and on promoting adequate availability of internationally controlled narcotic drugs and psychotropic substances for medical and scientific purposes while preventing their diversion and abuse;

Acknowledging the special report of the International Narcotics Control Board on the availability of internationally controlled drugs: ensuring adequate access for medical and scientific purposes,<sup>3</sup> and the WHO guidance on ensuring balance in national policies on controlled substances: guidance for availability and accessibility of controlled medicines;<sup>4</sup>

Also taking into account United Nations Economic and Social Council resolution 2005/25 on treatment of pain using opioid analgesics;

Bearing in mind that palliative care is an approach that improves the quality of life of patients (adults and children) and their families who are facing the problems associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and correct assessment and treatment of pain and other problems, whether physical, psychosocial or spiritual;

Recognizing that palliative care, when indicated, is fundamental to improving the quality of life, well-being, comfort and human dignity for individuals, being an effective person-centred health service that values patients' need to receive adequate, personally and culturally sensitive information on their health status, and their central role in making decisions about the treatment received;

Affirming that access to palliative care and to essential medicines for medical and scientific purposes manufactured from controlled substances, including opioid analgesics such as morphine, in line with the three United Nations international drug control conventions,<sup>5</sup> contributes to the realization of the right to the enjoyment of the highest attainable standard of health and well-being;

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<sup>1</sup> See Annex 6 for the financial and administrative implications for the Secretariat of this resolution.

<sup>2</sup> Document A67/31.

<sup>3</sup> Document E/INCB/2010/1/Supp.1.

<sup>4</sup> Ensuring balance in national policies on controlled substances: guidance for availability and accessibility of controlled medicines. Geneva: World Health Organization; 2011.

<sup>5</sup> United Nations Single Convention on Narcotic Drugs, 1961, as amended by the 1972 Protocol; United Nations Convention on Psychotropic Substances, 1971; United Nations Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances, 1988.

Acknowledging that palliative care is an ethical responsibility of health systems, and that it is the ethical duty of health care professionals to alleviate pain and suffering, whether physical, psychosocial or spiritual, irrespective of whether the disease or condition can be cured, and that end-of-life care for individuals is among the critical components of palliative care;

Recognizing that more than 40 million people currently require palliative care every year, foreseeing the increased need for palliative care with ageing populations and the rise of noncommunicable and other chronic diseases worldwide, considering the importance of palliative care for children, and, in respect of this, acknowledging that Member States should have estimates of the quantities of the internationally controlled medicines needed, including medicines in paediatric formulations;

Realizing the urgent need to include palliation across the continuum of care, especially at the primary care level, recognizing that inadequate integration of palliative care into health and social care systems is a major contributing factor to the lack of equitable access to such care;

Noting that the availability and appropriate use of internationally controlled medicines for medical and scientific purposes, particularly for the relief of pain and suffering, remains insufficient in many countries, and highlighting the need for Member States, with the support of the WHO Secretariat, the United Nations Office on Drugs and Crime and the International Narcotics Control Board, to ensure that efforts to prevent the diversion of narcotic drugs and psychotropic substances under international control pursuant to the United Nations international drug control conventions do not result in inappropriate regulatory barriers to medical access to such medicines;

Taking into account that the avoidable suffering of treatable symptoms is perpetuated by the lack of knowledge of palliative care, and highlighting the need for continuing education and adequate training for all hospital- and community-based health care providers and other caregivers, including nongovernmental organization workers and family members;

Recognizing the existence of diverse cost-effective and efficient palliative care models, acknowledging that palliative care uses an interdisciplinary approach to address the needs of patients and their families, and noting that the delivery of quality palliative care is most likely to be realized where strong networks exist between professional palliative care providers, support care providers (including spiritual support and counselling, as needed), volunteers and affected families, as well as between the community and providers of care for acute illness and the elderly;

Recognizing also the need for palliative care across disease groups (noncommunicable diseases, and infectious diseases, including HIV/AIDS and multidrug-resistant tuberculosis), and across all age groups;

Welcoming the inclusion of palliative care in the definition of universal health coverage and emphasizing the need for health services to provide integrated palliative care in an equitable manner in order to address the needs of patients in the context of universal health coverage;

Recognizing the need for adequate funding mechanisms for palliative care programmes, including for medicines and medical products, especially in developing countries;

Welcoming the inclusion of palliative care actions and indicators in the WHO comprehensive global monitoring framework for the prevention and control of noncommunicable diseases and in the WHO global action plan for the prevention and control of noncommunicable diseases 2013–2020;

Noting with appreciation the inclusion of medicines needed for pain and symptom control in palliative care settings in the 18th WHO Model List of Essential Medicines and the 4th WHO Model

List of Essential Medicines for Children, and commending the efforts of WHO collaborating centres on pain and palliative care to improve access to palliative care;

Noting with appreciation the efforts of nongovernmental organizations and civil society in continuing to highlight the importance of palliative care, including adequate availability and appropriate use of internationally controlled substances for medical and scientific purposes, as set out in the United Nations international drug control conventions;

Recognizing the limited availability of palliative care services in much of the world and the great avoidable suffering for millions of patients and their families, and emphasizing the need to create or strengthen, as appropriate, health systems that include palliative care as an integral component of the treatment of people within the continuum of care,

1. URGES Member States:<sup>1</sup>

(1) to develop, strengthen and implement, where appropriate, palliative care policies to support the comprehensive strengthening of health systems to integrate evidence-based, cost-effective and equitable palliative care services in the continuum of care, across all levels, with emphasis on primary care, community and home-based care, and universal coverage schemes;

(2) to ensure adequate domestic funding and allocation of human resources, as appropriate, for palliative care initiatives, including development and implementation of palliative care policies, education and training, and quality improvement initiatives, and supporting the availability and appropriate use of essential medicines, including controlled medicines for symptom management;

(3) to provide basic support, including through multisectoral partnerships, to families, community volunteers and other individuals acting as caregivers, under the supervision of trained professionals, as appropriate;

(4) to aim to include palliative care as an integral component of the ongoing education and training offered to care providers, in accordance with their roles and responsibilities, according to the following principles:

(a) basic training and continuing education on palliative care should be integrated as a routine element of all undergraduate medical and nursing professional education, and as part of in-service training of caregivers at the primary care level, including health care workers, caregivers addressing patients' spiritual needs and social workers;

(b) intermediate training should be offered to all health care workers who routinely work with patients with life-threatening illnesses, including those working in oncology, infectious diseases, paediatrics, geriatrics and internal medicine;

(c) specialist palliative care training should be available to prepare health care professionals who will manage integrated care for patients with more than routine symptom management needs;

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

(5) to assess domestic palliative care needs, including pain management medication requirements, and promote collaborative action to ensure adequate supply of essential medicines in palliative care, avoiding shortages;

(6) to review and, where appropriate, revise national and local legislation and policies for controlled medicines, with reference to WHO policy guidance,<sup>1</sup> on improving access to and rational use of pain management medicines, in line with the United Nations international drug control conventions;

(7) to update, as appropriate, national essential medicines lists in the light of the recent addition of sections on pain and palliative care medicines to the WHO Model List of Essential Medicines and the WHO Model List of Essential Medicines for Children;

(8) to foster partnerships between governments and civil society, including patients' organizations, to support, as appropriate, the provision of services for patients requiring palliative care;

(9) to implement and monitor palliative care actions included in the WHO global action plan for the prevention and control of noncommunicable diseases 2013–2020;

2. REQUESTS the Director-General:

(1) to ensure that palliative care is an integral component of all relevant global disease control and health system plans, including those relating to noncommunicable diseases and universal health coverage, as well as being included in country and regional cooperation plans;

(2) to update or develop, as appropriate, evidence-based guidelines and tools on palliation, including pain management options, in adults and children, including the development of WHO guidelines for the pharmacological treatment of pain, and ensure their adequate dissemination;

(3) to develop and strengthen, where appropriate, evidence-based guidelines on the integration of palliative care into national health systems, across disease groups and levels of care, that adequately address ethical issues related to the provision of comprehensive palliative care, such as equitable access, person-centred and respectful care, and community involvement, and to inform education in pain and symptom management and psychosocial support;

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

(5) to explore ways to increase the availability and accessibility of medicines used in palliative care through consultation with Member States, relevant networks and civil society, as well as other international stakeholders, as appropriate;

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<sup>1</sup> Ensuring balance in national policies on controlled substances: guidance for availability and accessibility of controlled medicines. Geneva: World Health Organization; 2011.

- (6) to work with the International Narcotics Control Board, the United Nations Office on Drugs and Crime, health ministries and other relevant authorities in order to promote the availability and balanced control of controlled medicines for pain and symptom management;
- (7) to further cooperate with the International Narcotics Control Board to support Member States in establishing accurate estimates in order to enable the availability of medicines for pain relief and palliative care, including through better implementation of the guidance on estimating requirements for substances under international control;<sup>1</sup>
- (8) to collaborate with UNICEF and other relevant partners in the promotion and implementation of palliative care for children;
- (9) to monitor the global situation of palliative care, evaluating the progress made in different initiatives and programmes in collaboration with Member States and international partners;
- (10) to work with Member States to encourage adequate funding and improved cooperation for palliative care programmes and research initiatives, in particular in resource-poor countries, in line with the Programme budget 2014–2015, which addresses palliative care;
- (11) to encourage research on models of palliative care that are effective in low- and middle-income countries, taking into consideration good practices;
- (12) to report back in 2016 to the Sixty-ninth World Health Assembly on progress in the implementation of this resolution.

(Ninth plenary meeting, 24 May 2014 –  
Committee B, third report)

## **WHA67.20      Regulatory system strengthening for medical products<sup>2</sup>**

The Sixty-seventh World Health Assembly,

Having considered the report on regulatory system strengthening;<sup>3</sup>

Welcoming the efforts of the Director-General, and recognizing the pivotal role that WHO plays in supporting countries in strengthening their regulatory systems of medical products for human use,<sup>4</sup> and in promoting equitable access to quality, safe, efficacious and affordable medical products;

Recalling the Constitution of the World Health Organization, which affirms that the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition;

Recalling also United Nations General Assembly resolution 67/81 on global health and foreign policy, which, inter alia, recognized the importance of universal coverage in national health systems,

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<sup>1</sup> International Narcotics Control Board, World Health Organization. Guide on estimating requirements for substances under international control. New York: United Nations; 2012.

<sup>2</sup> See Annex 6 for the financial and administrative implications for the Secretariat of this resolution.

<sup>3</sup> Document A67/32.

<sup>4</sup> For the purpose of this resolution, medical products include medicines, vaccines, diagnostics and medical devices.

especially through primary health care and social protection mechanisms, in the provision of access to health services for all, in particular for the poorest segments of the population;

Recalling further resolutions WHA45.17, WHA47.17, WHA52.19, WHA54.11, WHA59.24, WHA63.12 and WHA65.19, all of which encompass aspects of the need to promote the quality, safety, efficacy and affordability of medicines, including blood products;

Reaffirming resolution WHA65.19 on substandard/spurious/false-labelled/falsified/counterfeit medical products, which establishes a new Member State mechanism for international collaboration, from a public health perspective, excluding trade and intellectual property considerations, to prevent and control substandard/spurious/false-labelled/falsified/counterfeit medical products and to promote access to affordable, safe and quality medical products;

Recognizing that effective regulatory systems are an essential component of health system strengthening and contribute to better public health outcomes, that regulators are an essential part of the health workforce, and that inefficient regulatory systems themselves can be a barrier to access to safe, effective and quality medical products;

Recognizing also that effective regulatory systems are necessary for implementing universal health coverage, responding to the dual burden of infectious and noncommunicable diseases, and achieving Millennium Development Goal 4 (Reduce child mortality), Goal 5 (Improve maternal health) and Goal 6 (Combat HIV/AIDS, malaria and other diseases);

Aware that health systems need to promote access to essential medical products and that, in order to ensure universal access to health care, rational use of medicines and the sustainability of health systems, urgent action is needed by the international community, Member States and relevant actors in health systems;

Very concerned by the impact on patients of medical products of compromised quality, safety and efficacy, in terms of poisoning, inadequate or no treatment, contributions to drug resistance, the related economic burden, and erosion of public trust in the health system;

Aware of the regulatory challenges presented by the ever-increasing complexities of medical product supply chains and welcoming the work plan of the Member State mechanism on substandard/spurious/false-labelled/falsified/counterfeit medical products;

Emphasizing WHO's role in strengthening regulatory systems for medical products from a public health perspective, and in supporting national drug regulatory authorities and relevant regional bodies in this area, and in particular in developing countries;

Recalling the WHO global strategy and plan of action on public health, innovation and intellectual property, in particular element three, which calls for establishing and strengthening regulatory capacity in developing countries as one effective policy for building and improving innovative capacity, and element six, which promotes establishing and strengthening mechanisms to improve ethical review and regulate the quality, safety and efficacy of health products and medical devices;

Noting with appreciation the many existing national and regional efforts to strengthen regulatory capacity (including through a variety of models), improve regulatory coherence and convergence among regulatory authorities, and enhance good governance, including transparency in decision-making, leading to the improved availability of quality, safe, efficacious and affordable medical products, such as the European Union regulatory framework for medical products, work under way in PAHO following the adoption by its Directing Council in 2010 of resolution CD50.R9 on



strengthening national regulatory authorities for medicines and biologicals, the African Medicines Regulatory Harmonization Initiative, and the regulatory harmonization and cooperation work in ASEAN;

Noting the ongoing collaboration between national and regional regulatory authorities in promoting cooperation among regulatory authorities at the regional and global levels;

Recognizing the significant investments made in the procurement of medicines through national health budgets and global health initiatives;

Also recognizing the essential role of WHO's prequalification programme in facilitating procurement of medical products with assured quality, safety and efficacy;

Stressing that the strengthening of regulatory systems should complement the efforts of the Secretariat and Member States to promote access to affordable medical products with assured quality, safety and efficacy;

Recalling the WHO good clinical practices that focus on the protection of human research subjects;

Recalling also WHO's ongoing reform agenda and welcoming in this regard the establishment in November 2012 of the Health Systems and Innovation cluster,

1. URGES Member States:<sup>1</sup>

- (1) to strengthen national regulatory systems, including – as appropriate and voluntarily – by:
  - (a) undergoing self-evaluations, including with WHO's support, to identify the strengths and opportunities for improvement in regulatory system functions, as a first step towards formulating plans for regulatory system strengthening, including through WHO-coordinated institutional development plans;
  - (b) collecting data on regulatory system performance to enable analysis and benchmarking for improved systems in the future;
  - (c) developing strong legal foundations and political leadership to underpin a regulatory system with a clear focus on patient safety and transparency in decision-making;
  - (d) identifying and developing a core set of regulatory functions to meet country and/or regional needs, such as market control and postmarket surveillance;
  - (e) developing needed competencies as an integral part of, although not limited to, the health workforce, and encouraging the development of the regulatory field as a profession;
  - (f) facilitating the use of relevant guidance and science-based outputs of WHO expert committees and good regulatory practices at the national, regional and international levels;

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

(g) devising and implementing strategies to address the increasing complexities of supply chains;

(2) to engage in global, regional and subregional networks of national regulatory authorities, as appropriate, recognizing the importance of collaboration to pool regulatory capacities to promote greater access to quality, safe, efficacious and affordable medical products;

(3) to promote international cooperation, as appropriate, for collaboration and information sharing, including through electronic platforms;

(4) to support regulatory systems for medical products with appropriate funding as an essential component of the health system;

(5) to support regulatory system strengthening as an essential component of the development or expansion of local or regional production of quality, safe and efficacious medical products;

(6) to achieve access to and rational use of quality, safe, efficacious and affordable essential medicines, noting the growing emergence of resistance, and as a foundation for achieving broader access to quality, safe, efficacious and affordable medical products;

(7) to support WHO's institutional capacity relating to promoting access to and rational use of quality, safe, efficacious and affordable medical products in the context of universal health coverage;

(8) to strengthen the national and regional initiatives of regulatory authorities to improve regulatory capacities for review of medical products, promoting WHO's long-term objective of supporting the strengthening of national regulatory authority capacity among Member States;

(9) to support WHO's prequalification programme, including exploring modalities in consultation with Member States<sup>1</sup> for improved sustainability of this critical programme;

(10) to identify the need to strengthen regulatory system capacity, collaboration and cooperation in the technically complex areas where substantial gaps may still exist, such as the regulation of biotherapeutic products, blood products, and in vitro diagnostics;

## 2. REQUESTS the Director-General:

(1) to continue to support Member States, upon their request, in the area of regulatory system strengthening, including, as appropriate, by continuing to:

(a) evaluate national regulatory systems;

(b) apply WHO evaluation tools;

(c) generate and analyse evidence of regulatory system performance;

(d) facilitate the formulation and implementation of institutional development plans;

(e) provide technical support to national regulatory authorities and governments;

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

- (2) to continue to develop appropriate norms, standards and guidelines, taking into account national, regional and international needs and initiatives, in accordance with WHO principles;
- (3) to ensure that all relevant parts of the Organization, at all levels, are actively engaged and coordinated in the carrying out of WHO's mandate pertaining to regulatory system strengthening as an integrated part of health system development, recognizing that WHO's support in this critical area, particularly for developing countries, may be required, as appropriate, well into the future;
- (4) to prioritize support for establishing and strengthening regional and subregional networks of regulatory authorities, as appropriate, including strengthening areas of regulation of health products that are the least developed, such as regulation of medical devices, including diagnostics;
- (5) to promote the greater participation of Member States in existing international and regional initiatives for collaboration and cooperation in accordance with WHO principles and guidelines;
- (6) to strengthen WHO's prequalification programme, including its integration and coherence, taking into account the needs and capacities of national and regional regulatory systems to assist in ensuring a supply of quality, safe, efficacious and affordable medical products;
- (7) to support the building-up of effective national and regional regulatory bodies and networks;
- (8) to increase support for and recognition of the significant role of the International Conference of Drug Regulatory Authorities in promoting the exchange of information and collaborative approaches among drug regulatory authorities, and as a resource to facilitate further development of regulatory cooperation and coherence;
- (9) to raise awareness of the importance of effective regulatory systems within the health system context;
- (10) to increase support and guidance for strengthening the capacity to regulate increasingly complex biological products, with the focus on biotherapeutic products, blood products and associated in vitro diagnostics, and, where appropriate, on new medicines for human use based on gene therapy, somatic-cell therapy and tissue engineering;
- (11) to ensure that any activity carried out under this resolution does not duplicate or circumvent the work plan and mandate of the Member State mechanism on substandard/spurious/false-labelled/falsified/counterfeit medical products;
- (12) to report to the Seventieth and Seventy-second World Health Assemblies on progress in the implementation of this resolution.

(Ninth plenary meeting, 24 May 2014 –  
Committee B, fourth report)

**WHA67.21 Access to biotherapeutic products, including similar biotherapeutic products,<sup>1</sup> and ensuring their quality, safety and efficacy<sup>2</sup>**

The Sixty-seventh World Health Assembly,

Having considered the report on regulatory system strengthening;<sup>3</sup>

Recalling the Constitution of the World Health Organization, which affirms 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;

Noting with particular concern that for millions of people, the right to the enjoyment of the highest attainable standard of physical and mental health, including access to medicines, remains a distant goal; that especially for children and those living in poverty, the likelihood of achieving this goal is becoming increasingly remote; that millions of people are driven below the poverty line each year because of catastrophic out-of-pocket payments for health care; and that excessive out-of-pocket payments can discourage the impoverished from seeking or continuing care;

Recalling resolution WHA55.14 on ensuring accessibility of essential medicines, which recognizes the responsibility of Member States to support solid scientific evidence, excluding any biased information or external pressures that may be detrimental to public health;

Further recalling that in resolution WHA55.14 the Health Assembly urged Member States, inter alia, to reaffirm their commitment to increasing access to medicines, and to translate such commitment into specific regulation within countries, especially enactment of national drug policies and establishment of lists of essential medicines based on evidence and with reference to WHO's Model List, and into actions designed to promote policy for, access to, and quality and rational use of, medicines within national health systems;

Considering that one of the objectives of pharmaceutical regulation is the assurance of the quality, safety and efficacy of pharmaceutical products through the regulatory processes of authorization, vigilance and monitoring;

Considering also that national pharmaceutical regulation should contribute to the performance and sustainability of health systems and the general welfare of society;

Considering further that an update of the norms and standards applicable to medicines is required in the light of advances made in biotechnology, and the new generation of medicines introduced as a result, in order to ensure the entry into the market of medicines that are affordable, safe, efficacious, of quality and accessible in a timely and adequate fashion;

Recognizing that the use of such medicines has a positive impact on morbidity and mortality rates and that, while there are multiple barriers to access, the high cost of such medicines affects the sustainability of health systems and could in many cases affect access to them;

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<sup>1</sup> Acknowledging that national authorities may use different terminologies when referring to similar biotherapeutic products.

<sup>2</sup> See Annex 6 for the financial and administrative implications for the Secretariat of this resolution.

<sup>3</sup> Document A67/32.

Noting the importance of, and using as appropriate, WHO's Expert Committee on Biological Standardization's guidelines on evaluation of similar biotherapeutic products (2009), and recognizing the need to update them, particularly in terms of technological advances and characterization, in order to promote more efficient regulatory frameworks from a public health perspective that ensure the efficacy, quality and safety of these products at the national and regional levels;

Conscious that similar biotherapeutic products could be more affordable and offer better access to treatments of biological origin, while ensuring quality, safety and efficacy,

1. URGES Member States:<sup>1</sup>

(1) to develop or strengthen, as appropriate, national regulatory assessment and authorization frameworks, with a view to meeting the public health needs for biotherapeutic products, including similar biotherapeutic products;

(2) to develop the necessary scientific expertise to facilitate development of solid, scientifically-based regulatory frameworks that promote access to products that are affordable, safe, efficacious and of quality, taking note of the relevant WHO guidelines that may be adapted to the national context and capacity;

(3) to work to ensure that the introduction of new national regulations, where appropriate, does not constitute a barrier to access to quality, safe, efficacious and affordable biotherapeutic products, including similar biotherapeutic products;

2. REQUESTS the Director-General:

(1) to support Member States in strengthening their capacity in the area of the health regulation of biotherapeutic products, including similar biotherapeutic products;

(2) to support, as appropriate, the development of national regulatory frameworks that promote access to quality, safe, efficacious and affordable biotherapeutic products, including similar biotherapeutic products;

(3) to encourage and promote cooperation and exchange of information, as appropriate, among Member States in relation to biotherapeutic products, including similar biotherapeutic products;

(4) to convene WHO's Expert Committee on Biological Standardization to update the 2009 guidelines, taking into account the technological advances for the characterization of biotherapeutic products and considering national regulatory needs and capacities and to report on the update to the Executive Board;

(5) to report to the Sixty-ninth World Health Assembly on progress in the implementation of this resolution.

(Ninth plenary meeting, 24 May 2014 –  
Committee B, fourth report)

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

**WHA67.22 Access to essential medicines<sup>1</sup>**

The Sixty-seventh World Health Assembly,

Having considered the report on access to essential medicines;<sup>2</sup>

Noting that WHO's definition of an essential medicine<sup>3</sup> contains the following elements: "Essential medicines are those that satisfy the priority health care needs of the population" and "Essential medicines are selected with due regard to their public health relevance, evidence of efficacy and safety, and comparative cost-effectiveness";

Recalling resolution WHA28.66 on prophylactic and therapeutic substances, which relates to the formulation and implementation of medicines policies and pharmaceutical strategies; the Declaration of Alma-Ata in 1978, which recognized the provision of essential medicines as one of the pillars of primary health care, and subsequent resolutions in relation to essential medicines, such as resolution WHA54.11 on the WHO medicines strategy, WHA58.27 on improving the containment of antimicrobial resistance, WHA60.16 on progress in the rational use of medicines, WHA60.20 on better medicines for children, WHA60.29 on health technologies, WHA61.21 on the global strategy and plan of action on public health, innovation and intellectual property, and WHA64.9 on sustainable health financing structures and universal coverage, as well as WHA66.10 in which the Health Assembly endorsed the WHO global action plan for the prevention and control of noncommunicable diseases 2013–2020, and which includes target (9) on the availability of essential medicines required to treat noncommunicable diseases;

Bearing in mind that the WHO medicines strategy, as set out in the Twelfth General Programme of Work, 2014–2019, is based on the principles of evidence-based selection of a limited range of medicines, efficient procurement and distribution systems, affordable prices, and the rational use of medicines in order to promote better management and greater availability of medicines, more cost-effective use of health resources, and higher quality health care;

Considering that the effective implementation of the above principles is of critical importance to improving people's health, progressing towards universal health coverage and achieving the health-related Millennium Development Goals;

Welcoming WHO's regional actions in support of greater access to – and availability, affordability and rational use of – safe, effective and quality-assured essential medicines, including development of the Regional Office for the Western Pacific's regional framework for action on access to essential medicines (2011–2016);

Acknowledging the complexity of the medicines supply chain and the challenges that countries encounter in this regard, the importance of good governance for medicines programmes,<sup>4</sup> and the

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<sup>1</sup> See Annex 6 for the financial and administrative implications for the Secretariat of this resolution.

<sup>2</sup> Document A67/30.

<sup>3</sup> WHO Technical Report Series, No. 985.

<sup>4</sup> In WHO's assessment instrument for measuring transparency in the public pharmaceutical sector (document WHO/EMP/MAR/2009.4), "good governance" refers to the formulation and implementation of appropriate policies and procedures that ensure the effective, efficient and ethical management of pharmaceutical systems, in particular medicine regulatory systems and medicine supply systems, in a manner that is transparent, accountable, follows the rule of law and minimizes corruption.

consequences of the high costs of medicines, which are among the factors that make accessing care and treatment unaffordable;

Aware that shortages of essential medicines are a global problem that has an impact on the care of patients, the causes and implications of which vary from one country to another, and that there is insufficient information to determine the magnitude and specific characteristics of the problem;

Realizing the role of evidence-based clinical treatment guidelines to guide cost-effective treatment practices, the need for reliable and unbiased information to support rational prescribing, and the importance of increased health literacy to support patients and consumers to use medicines wisely;

Noting with concern that despite sustained efforts over a number of decades by Member States, the Secretariat and partners, most low-income countries are still facing a multitude of challenges in improving the availability, affordability and rational use of essential medicines;

Noting that the goal of Member States is to increase access to affordable, safe, effective and quality-assured essential medicines, including, as appropriate, through the full use of the flexibilities in the Agreement on Trade-Related Aspects of Intellectual Property Rights in line with the WHO global strategy and plan of action on public health, innovation and intellectual property;

Noting that support for research and development is important for the sustainable supply of future essential medicines, to address public health needs,

1. URGES Member States:<sup>1</sup>

(1) to provide adequate resources, as required, for the development and implementation of comprehensive national medicine policies, as appropriate, to strengthen good governance of pharmaceutical systems – including regulatory, procurement and distribution systems – and to coordinate responses to address the complex and interrelated activities that affect access to essential medicines, in order to improve their availability, affordability, quality and rational use;

(2) to improve national policies for selection of essential medicines that should include medicines critical to their priority public health needs, particularly by using transparent, rigorous and evidence-based processes based on the methods of health technology assessment in selecting medicines for inclusion in the national essential medicines lists according to each country's health needs and priorities;

(3) to encourage and support research on health systems regarding the procurement, supply and rational use of essential medicines;

(4) to promote collaboration and strengthen the exchange of information on best practices in the development, implementation and evaluation of medicine policies and strategies that enhance access to affordable, safe, effective and quality-assured essential medicines;

(5) to place greater emphasis on medicines for children and to promote the availability, affordability, quality and safety of essential medicines for children through the development and manufacture of appropriate paediatric formulations and to facilitate market access to these medicines;

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

(6) to improve the education and training of health care professionals in order to support the implementation of national policies and strategies in relation to essential medicines, and to develop and implement evidence-based clinical practice guidelines and other interventions for the rational use of essential medicines;

(7) to strengthen the engagement with the general public and civil society to increase awareness and knowledge of essential medicines and public involvement, as appropriate, and through transparent mechanisms and structures, in enhancing access to and the rational use of these medicines;

(8) to identify key barriers to access to essential medicines and to develop strategies to address these barriers, making use of WHO's tools<sup>1</sup> and guidance as appropriate;

(9) to establish or strengthen, as appropriate, systems to monitor the availability, using effective inventory management systems, affordability and utilization of safe, effective and quality-assured essential medicines in public and private health facilities;

(10) to systematize information collection and strengthen monitoring mechanisms, in order to better detect and understand the causes of essential medicines shortages, and to develop strategies to prevent and mitigate the associated problems and risk caused by shortages;

(11) to consider, as appropriate, adapting national legislation in order to make full use of the provisions contained in the Agreement on Trade-Related Aspects of Intellectual Property Rights, including the flexibilities recognized by the Doha Ministerial Declaration on the TRIPS Agreement and Public Health and other WTO instruments related to that agreement, in order to promote access to essential medicines, in line with the global strategy and plan of action on public health, innovation and intellectual property;

## 2. REQUESTS the Director-General:

(1) to urge Member States to recognize the importance of effective national medicines policies, and their implementation under good governance, in order to ensure equity of access to affordable, safe, effective and quality-assured essential medicines and their rational use in practice;

(2) to facilitate and support the exchange of information and collaboration among Member States on best practices in the development and implementation of medicines policies;

(3) to support Member States in sharing best practices in the selection of essential medicines, and in developing processes for the selection of medicines for national essential medicines lists consistent with the evidence-based methods used for updating the WHO Model List of Essential Medicines;

(4) to support Member States in building capacity for the evidence-based selection of essential medicines, the development and dissemination of, and adherence to, clinical practice

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<sup>1</sup> Including but not limited to: pharmaceutical sector country profiles, the assessment instrument for measuring transparency in the public pharmaceutical sector, the WHO/Health Action International tool for measuring medicine prices, availability, affordability and price components, and WHO guidance documents on how to investigate the use of medicines in health facilities.



guidelines and the promotion of other strategies for the rational use of affordable, safe, effective and quality-assured essential medicines by health care professionals and the public;

(5) to support Member States in developing and implementing their national medicines policies and supply systems, especially with regard to regulation, financing, selection, procurement, distribution, pricing, reimbursement and use, in order to increase their efficiency and ensure access to safe, effective and quality-assured essential medicines, including high price essential medicines;

(6) to support Member States in systematizing information collection and strengthening monitoring mechanisms, in order to better detect and understand the causes of essential medicines shortages, and in developing strategies to prevent and mitigate the associated problems and risk caused by shortages;

(7) to urge Member States to expedite progress towards the achievement of the Millennium Development Goals and universal health coverage by, inter alia, implementing national medicines policies for improving access to affordable, safe, effective and quality-assured essential medicines;

(8) to provide, as appropriate, upon request, in collaboration with other competent international organizations, technical support, including, where appropriate, to policy processes to Member States that intend to make use of the provisions contained in the Agreement on Trade-Related Aspects of Intellectual Property Rights, including the flexibilities recognized by the Doha Ministerial Declaration on the TRIPS Agreement and Public Health and other WTO instruments related to that Agreement, in order to promote access to essential medicines, in accordance with the global strategy and plan of action on public health, innovation and intellectual property;

(9) to report to the Sixty-ninth World Health Assembly on progress in the implementation of this resolution.

(Ninth plenary meeting, 24 May 2014 –  
Committee B, fourth report)

### **WHA67.23 Health intervention and technology assessment in support of universal health coverage<sup>1</sup>**

The Sixty-seventh World Health Assembly,

Having considered the report on health intervention and technology assessment in support of universal health coverage;<sup>2</sup>

Recalling resolutions WHA52.19 on the revised drug strategy, WHA58.33 on sustainable health financing, universal coverage and social health insurance, WHA60.16 on progress in the rational use of medicines, WHA60.29 on health technologies, WHA63.21 on WHO's role and responsibilities in health research, and WHA64.9 on sustainable health financing structures and universal coverage;

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<sup>1</sup> See Annex 6 for the financial and administrative implications for the Secretariat of this resolution.

<sup>2</sup> Document A67/33.

Recognizing the importance of evidence-based policy development and decision-making in health systems, including decisions on resource allocation, service system designs and translation of policies into practice, as well as reaffirming WHO's roles and responsibilities in provision of support to strengthen information systems and health research capacity, and their utilization in Member States;

Noting that the efficient use of resources is a crucial factor in the sustainability of health systems' performance, especially when significant increases in access to essential medicines, including generic medicines, to medical devices and procedures, and to other health care interventions for promotion, prevention, diagnosis and treatment, rehabilitation and palliative care are pursued by Member States, as they move towards universal health coverage;

Noting that *The world health report 2010*<sup>1</sup> indicates that as much as 40% of spending on health is being wasted and that there is, therefore, an urgent need for systematic, effective solutions to reduce such inefficiencies and to enhance the rational use of health technology;

Acknowledging the critical role of independent health intervention and technology assessment, as multidisciplinary policy research, in generating evidence to inform prioritization, selection, introduction, distribution, and management of interventions for health promotion, disease prevention, diagnosis and treatment, and rehabilitation and palliation;

Emphasizing that with rigorous and structured research methodology and transparent and inclusive processes, assessment of medicines, vaccines, medical devices and equipment, and health procedures, including preventive intervention, could help to address the demand for reliable information on the safety, efficacy, quality, appropriateness, cost-effectiveness and efficiency dimensions of such technologies to determine if and when they are integrated into particular health interventions and systems;

Concerned that the capacity to assess, research and document the public health, economic, organizational, social, legal and ethical implications of health interventions and technologies is inadequate in most developing countries, resulting in inadequate information to guide rational policy, and professional decisions and practices;

Recognizing the importance of strengthened national capacity, regional and international networking, and collaboration on health intervention and technology assessment to promote evidence-based health policy,

1. URGES Member States:<sup>2</sup>

(1) to consider establishing national systems of health intervention and technology assessment, encouraging the systematic utilization of independent health intervention and technology assessment in support of universal health coverage to inform policy decisions, including priority-setting, selection, procurement supply system management and use of health interventions and/or technologies, as well as the formulation of sustainable financing benefit packages, medicines, benefits management including pharmaceutical formularies, clinical practice guidelines and protocols for public health programmes;

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<sup>1</sup> The world health report 2010. Health systems financing: the path to universal coverage. Geneva: World Health Organization; 2010.

<sup>2</sup> And, where applicable, regional economic integration organizations.

- (2) to strengthen the link between health technology assessment and regulation and management, as appropriate;
- (3) to consider, in addition to the use of established and widely agreed methods, developing, as appropriate, national methodological and process guidelines and monitoring systems for health intervention and technology assessment in order to ensure the transparency, quality and policy relevance of related assessments and research;
- (4) to further consolidate and promote health intervention and technology assessment within national frameworks, such as those for health system research, health professional education, health system strengthening and universal health coverage;
- (5) to consider strengthening national capacity for regional and international networking, developing national know-how, avoiding duplication of efforts and achieving better use of resources;
- (6) to consider also collaborating with other Member States' health organizations, academic institutions, professional associations and other key stakeholders in the country or region in order to collect and share information and lessons learnt so as to formulate and implement national strategic plans concerning capacity-building for and introduction of health intervention and technology assessment, and summarizing best practices in transparent and evidence-informed health policy and decision-making;
- (7) to identify gaps with regard to promoting and implementing evidence-based health policy, as well as improving related information systems and research capacity, and considering seeking technical support, and exchanging information and sharing experiences with other Member States, regional networks and international entities, including WHO;
- (8) to develop and improve the collection of data on health intervention and technology assessment, training relevant professionals, as appropriate, so as to improve assessment capacity;

2. REQUESTS the Director-General:

- (1) to assess the status of health intervention and technology assessment in Member States in terms of methodology, human resources and institutional capacity, governance, linkage between health intervention and technology assessment units and/or networks with policy authorities, utilization of assessment results, and interest in and impediments to strengthening capacity;
- (2) to raise awareness, foster knowledge and encourage the practice of health intervention and technology assessment and its uses in evidence-based decision-making among national policy-makers and other stakeholders, by drawing best practices from the operation, performance and contribution of competent research institutes and health intervention and technology assessment agencies and programmes, and sharing such experiences with Member States through appropriate channels and activities, including global and regional networks and academic institutions;
- (3) to integrate health intervention and technology assessment concepts and principles into the relevant strategies and areas of work of WHO, including, but not limited to, those on universal health coverage, including health financing, access to and rational use of quality-assured medicines, vaccines and other health technologies, the prevention and management of noncommunicable and communicable diseases, mother and child care, and the formulation of evidence-based health policy;

- (4) to provide technical support to Member States, especially low-income countries, relevant intergovernmental organizations and global health partners, in order to strengthen capacity for health intervention and technology assessment, including, when appropriate, the development and use of global guidance on methods and processes based on internationally agreed practices;
- (5) to ensure adequate capacity at all levels of WHO, utilizing its networks of experts and collaborating centres, as well as other regional and international networks, in order to address the demand for support to facilitate evidence-based policy decisions in Member States;
- (6) to support the exchange of information, sharing of experiences and capacity-building in health intervention and technology assessment through collaborative mechanisms and networks at global, regional and country levels, as well as ensuring that these partnerships are active, effective and sustainable;
- (7) to report on progress in the implementation of this resolution to the Sixty-ninth World Health Assembly.

(Ninth plenary meeting, 24 May 2014 –  
Committee B, fourth report)

#### **WHA67.24 Follow-up of the Recife Political Declaration on Human Resources for Health: renewed commitments towards universal health coverage<sup>1</sup>**

The Sixty-seventh World Health Assembly,

Having considered the report on the follow-up of the Recife Political Declaration on Human Resources for Health: renewed commitments towards universal health coverage,<sup>2</sup> and the outcome document of the Third Global Forum on Human Resources for Health (Recife, Brazil, 10–13 November 2013);<sup>3</sup>

Recognizing the leadership role of WHO in human resources for health, and the mandate given in this regard by resolution WHA63.16 on the WHO Global Code of Practice on the International Recruitment of Health Personnel, WHA66.23 on transforming health workforce education in support of universal health coverage, WHO's global policy recommendations on increasing access to health workers in remote and rural areas through improved retention (2010)<sup>4</sup> and WHO's guidelines on transforming and scaling up health professionals' education and training (2013);<sup>5</sup>

Recalling the commitment to attain universal health coverage and the need for an improved health workforce to achieve it;

Reaffirming the importance of the Kampala Declaration and Agenda for Global Action (2008), as well as the WHO Global Code of Practice on the International Recruitment of Health Personnel,

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<sup>1</sup> See Annex 6 for the financial and administrative implications for the Secretariat of this resolution.

<sup>2</sup> Document A67/34.

<sup>3</sup> Document A67/34, Annex.

<sup>4</sup> Increasing access to health workers in remote and rural areas through improved retention: global policy recommendations. Geneva: World Health Organization; 2010.

<sup>5</sup> Transforming and scaling up health professionals' education and training: World Health Organization guidelines 2013. Geneva: World Health Organization; 2013.

and recognizing the need to renew these commitments and take them forward in light of new developments with a view to progressing towards universal health coverage,

1. ENDORSES the call to action in the Recife Political Declaration on Human Resources for Health: renewed commitments towards universal health coverage;
2. WELCOMES the commitments made by Member States in the Recife Political Declaration on Human Resources for Health: renewed commitments towards universal health coverage;
3. URGES Member States<sup>1</sup> to implement, as appropriate, and in accordance with national and subnational responsibilities, the commitments made in the Recife Political Declaration on Human Resources for Health: renewed commitments towards universal health coverage;
4. REQUESTS the Director-General:
  - (1) to take into consideration the Recife Political Declaration on Human Resources for Health: renewed commitments towards universal health coverage in the future work of WHO;
  - (2) to develop and submit a new global strategy for human resources for health for consideration by the Sixty-ninth World Health Assembly.

(Ninth plenary meeting, 24 May 2014 –  
Committee B, fourth report)

## **WHA67.25      Antimicrobial resistance<sup>2</sup>**

The Sixty-seventh World Health Assembly,

Having considered the report on antimicrobial drug resistance;<sup>3</sup>

Recognizing WHO's leadership role in the containment of antimicrobial resistance;

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

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

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

<sup>2</sup> See Annex 6 for the financial and administrative implications for the Secretariat of this resolution.

<sup>3</sup> Document A67/39.

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

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

Noting that awareness of the broad scope and urgency of the threat posed has been limited and that previous resolutions of the Health Assembly and WHO’s strategies for the containment of antimicrobial resistance have not yet been widely implemented;

Recognizing that antimicrobial resistance involves a wide range of pathogens including bacteria, viruses and parasites but that the development of resistance among some pathogens, particularly antibiotic-resistant bacteria, is of particular urgency and most in need of immediate attention;

Welcoming the establishment of the WHO global task force on antimicrobial resistance and the tripartite collaboration between FAO, OIE and WHO,

1. URGES Member States:<sup>1</sup>

- (1) to increase political awareness, engagement and leadership in order to accelerate efforts to secure access to effective antimicrobials and to use them responsibly;
- (2) to take urgent action at national, regional and local levels to strengthen infection prevention and control, by means that include application of basic hygiene measures;
- (3) to develop or strengthen national plans and strategies and international collaboration for the containment of antimicrobial resistance;
- (4) to mobilize human and financial resources in order to implement plans and strategies to strengthen the containment of antimicrobial resistance;
- (5) to strengthen overall pharmaceutical management systems, including regulatory systems and supply chain mechanisms, and, where appropriate, laboratory infrastructure, with a view to ensuring access to and availability of effective antimicrobial agents, taking into account financial and other incentives that might have a negative impact on policies for prescribing and dispensing;
- (6) to monitor the extent of antimicrobial resistance including regular monitoring of the use of antibiotics in all relevant sectors, in particular health and agriculture, including animal husbandry, sharing such information so that national, regional and global trends can be detected and monitored;
- (7) to improve, among all relevant care providers, the public and other sectors and stakeholders, awareness of: (i) the threat posed by antimicrobial resistance, (ii) the need for responsible use of antibiotics and (iii) the importance of infection prevention and control measures;

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

(8) to encourage and support research and development, including by academia and through new collaborative and financial models, to combat antimicrobial resistance and promote responsible use of antimicrobial medicines, develop practical and feasible approaches for extending the lifespan of antimicrobial medicines and encourage the development of novel diagnostics and antimicrobial medicines;

(9) to collaborate with the Secretariat in developing and implementing a draft global action plan to combat antimicrobial resistance, including antibiotic resistance, which is based on all available evidence and best practices;

(10) to develop antimicrobial resistance surveillance systems in three separate sectors: (i) inpatients in hospitals, (ii) outpatients in all other health care settings and the community and (iii) animals and non-human usage of antimicrobials;

2. REQUESTS the Director-General:

(1) to ensure that all relevant parts of the Organization, at headquarters, regional and country levels, are actively engaged and coordinated in promoting work on containing antimicrobial resistance, including through the tracking of resource flows for research and development on antimicrobial resistance in the new global health research and development observatory;

(2) to set aside adequate resources for the work of the Secretariat, in line with the Programme budget 2014–2015 and the Twelfth General Programme of Work, 2014–2019;

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

(4) to explore with the United Nations Secretary-General options for a high-level initiative, including a high-level meeting, to increase political awareness, engagement and leadership on antimicrobial resistance;

(5) to develop a draft global action plan to combat antimicrobial resistance, including antibiotic resistance, which addresses the need to ensure that all countries, especially low- and middle-income countries, have the capacity to combat antimicrobial resistance and which takes into account existing action plans and all available evidence and best practice as well as the recommendations of WHO’s Strategic Technical Advisory Group on antimicrobial resistance and the WHO policy package to combat antimicrobial resistance, which asks Member States:

(a) to commit to a comprehensive, financed national plan with accountability and civil society engagement;

(b) to strengthen surveillance and laboratory capacity;

(c) to ensure uninterrupted access to essential medicines of assured quality;

(d) to regulate and promote rational use of medicines, including in animal husbandry, and ensure proper patient care;

(e) to enhance infection prevention and control;

(f) to foster innovation and research and development for new tools;

(6) to apply a multisectoral approach to inform the drafting of the global action plan, by consulting Member States<sup>1</sup> as well as other relevant stakeholders, especially other multilateral stakeholders, such as FAO and OIE, taking into account the need to manage potential conflicts of interest;

(7) to submit to the Sixty-eighth World Health Assembly, through the Executive Board at its 136th session, a draft global action plan to combat antimicrobial resistance, including antibiotic resistance, together with a summary report on progress made in implementing the other aspects of this resolution.

(Ninth plenary meeting, 24 May 2014 –  
Committee B, fourth report)

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



## DECISIONS

### **WHA67(1)      Composition of the Committee on Credentials**

The Sixty-seventh World Health Assembly appointed a Committee on Credentials consisting of delegates of the following Member States: Chile, Democratic People's Republic of Korea, Dominican Republic, Ethiopia, Iceland, Iraq, Japan, Malaysia, Monaco, Mozambique, Portugal, Zambia.

(First plenary meeting, 19 May 2014)

### **WHA67(2)      Election of officers of the Sixty-seventh World Health Assembly**

The Sixty-seventh World Health Assembly elected the following officers:

**President:**                      Dr Roberto Morales Ojeda (Cuba)

**Vice-Presidents:**            Dr Neil Sharma (Fiji)  
Mr François Ibovi (Congo)  
Mr Maithripala Yapa Sirisena (Sri Lanka)  
Dr Vytenis Povilas Andriukaitis (Lithuania)  
Mr Sadiq bin Abdul Karim Al-Shehabi (Bahrain)

(First plenary meeting, 19 May 2014)

### **WHA67(3)      Establishment of the General Committee**

The Sixty-seventh World Health Assembly elected the delegates of the following 17 countries as members of the General Committee: Afghanistan, Angola, Benin, Cabo Verde, China, Costa Rica, Equatorial Guinea, France, Greece, Guyana, Republic of Korea, Russian Federation, Timor-Leste, Tunisia, United Kingdom of Great Britain and Northern Ireland, United States of America, Uruguay.

(First plenary meeting, 19 May 2014)

### **WHA67(4)      Adoption of the agenda**

The Sixty-seventh World Health Assembly adopted the provisional agenda prepared by the Executive Board at its 134th session, with the deletion of four items.

(Second plenary meeting, 19 May 2014)

**WHA67(5) Election of officers of the main committees**

The Sixty-seventh World Health Assembly elected the following officers of the main committees:

<b>Committee A:</b>	<b>Chairman</b>	Dr Pamela Rendi-Wagner (Austria)
<b>Committee B:</b>	<b>Chairman</b>	Dr Ruhakana Rugunda (Uganda)

(First plenary meeting, 19 May 2014)

The main committees subsequently elected the following officers:

<b>Committee A:</b>	<b>Vice-Chairmen</b>	Professor Pe Thet Khin (Myanmar) Dr Jorge Villavicencio (Guatemala)
	<b>Rapporteur</b>	Dr Helen Mbugua (Kenya)
<b>Committee B:</b>	<b>Vice-Chairmen</b>	Dr Mohsen Asadi-Lari (Islamic Republic of Iran) Dr Siale Akauola (Tonga)
	<b>Rapporteur</b>	Dr Dipendra Raman Singh (Nepal)

(First meetings of Committees A and B,  
19 and 21 May 2014, respectively)

**WHA67(6) Verification of credentials**

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

United States of America; Uruguay; Uzbekistan; Venezuela (Bolivarian Republic of); Viet Nam; Yemen; Zambia; Zimbabwe.

(Sixth plenary meeting, 21 May 2014)

**WHA67(7) Election of Members entitled to designate a person to serve on the Executive Board**

The Sixty-seventh World Health Assembly, after considering the recommendations of the General Committee, elected the following as Members entitled to designate a person to serve on the Executive Board: China, Democratic Republic of the Congo, Eritrea, Gambia, Kuwait, Liberia, Nepal, Russian Federation, United Kingdom of Great Britain and Northern Ireland, United States of America.

(Eighth plenary meeting, 23 May 2014)

**WHA67(8) Consideration of the financial and administrative implications for the Secretariat of resolutions adopted by the Health Assembly**

The Sixty-seventh World Health Assembly, having recalled the approval by the Sixty-sixth World Health Assembly of the Programme budget 2014–2015 in its entirety, and the financing dialogue, including a coordinated Organization-wide resource mobilization, that was established in order to ensure the full financing of the programme budget,

(1) decided that resolutions adopted by the Sixty-seventh World Health Assembly will be implemented to the extent that their funding is included in the Programme budget 2014–2015, with the exception of activities that fall under the emergency component of the Programme budget,<sup>1</sup> or as otherwise specifically decided by the Health Assembly;

(2) decided further that where resolutions adopted by the Sixty-seventh World Health Assembly have cost implications that exceed the financial provisions of the Programme budget 2014–2015, the Director-General shall present a report to the Programme, Budget and Administration Committee of the Executive Board at its twenty-first meeting in January 2015 containing a proposal for handling the related costs, including an analysis of the financial and programmatic implications, and considering all available options;

(3) requested the Programme, Budget and Administration Committee to make recommendations to the Executive Board at its 136th session and to the Sixty-eighth World Health Assembly, based on the report referred to in paragraph (2) above, for consideration in conjunction with the information requested in document A66/48, paragraph 28;<sup>2</sup>

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<sup>1</sup> Activities that fall under the emergency component of the programme budget do not have a budget ceiling. In resolution WHA66.2, paragraph 9, the Health Assembly “FURTHER AUTHORIZES the Director-General, where necessary, to incur expenditures in the emergencies component of the budget beyond the amount allocated for this component, subject to availability of resources ...”.

<sup>2</sup> Namely: “... The governing bodies will be invited to provide guidance on the Director-General’s proposals relating to any reprogramming of resources or activities deemed necessary, in view of the progress towards programme budget implementation, new mandates received and World Health Assembly resolutions with associated financial implications or emerging public health needs”.

(4) requested the Director-General, in consultation with Member States, to report to the Programme, Budget and Administration Committee in January 2015 on options to ensure alignment of resolutions with the general programme of work and the related programme budgets, including how to strengthen the link between programme budgets and resolutions, reports on financial implications of resolutions and decisions adopted by the Health Assembly as well as progress reports, and provide information on the proportion of future programme budgets resulting from resolutions and decisions adopted by the governing bodies.

(Eighth plenary meeting, 23 May 2014)

### **WHA67(9)<sup>1</sup> Maternal, infant and young child nutrition**

The Sixty-seventh World Health Assembly, having considered the reports of the Secretariat on maternal, infant and young child nutrition,<sup>2</sup>

(1) endorsed the seven indicators to monitor progress towards the achievement of the global targets as part of the core set of indicators of the global monitoring framework on maternal, infant and young child nutrition;<sup>3</sup>

(2) requested the Director-General to establish a working group composed of representatives and experts appointed by Member States and United Nations bodies in order to complete the work, before the end of 2014, on the development of the core set of indicators to monitor the comprehensive implementation plan on maternal, infant and young child nutrition, building on “tracer” indicators for policy and programme implementation in health and other sectors that are relevant to the achievement of the global nutrition targets, as well as developing an extended set of indicators in order to track processes that have an impact on the global targets in specific country settings, for consideration by Member States at the Sixty-eighth World Health Assembly;

(3) also requested the Director-General to convene informal consultations with Member States<sup>4</sup> to complete the work, before the end of 2015, on risk assessment and management tools for conflicts of interest in nutrition, for consideration by Member States at the Sixty-ninth World Health Assembly;

(4) noted the work carried out by the Secretariat in response to resolution WHA65.6 on the comprehensive implementation plan on maternal, infant and young child nutrition, in which the Director-General was requested to provide clarification and guidance on the “inappropriate promotion of foods for infants and young children” cited in resolution WHA63.23 on infant and young child nutrition, taking into consideration the ongoing work of the Codex Alimentarius Commission; further recalling resolution WHA63.23, in which Member States were urged to end inappropriate promotion of food for infants and young children; and further requesting the Director-General to complete the work, before the end of 2015, for consideration by Member States at the Sixty-ninth World Health Assembly.

(Eighth plenary meeting, 23 May 2014)

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<sup>1</sup> See Annex 6 for the financial and administrative implications for the Secretariat of the adoption of the decision.

<sup>2</sup> Documents A67/15 and A67/15 Add.1.

<sup>3</sup> See document A67/15, Annex 1.

<sup>4</sup> And, where applicable, regional economic integration organizations.

**WHA67(10)<sup>1</sup> Health conditions in the occupied Palestinian territory, including east Jerusalem, and in the occupied Syrian Golan**

The Sixty-seventh World Health Assembly, mindful of the basic principle established in the Constitution of the World Health Organization, which affirms that the health of all peoples is fundamental to the attainment of peace and security, and stressing that unimpeded access to health care is a crucial component of the right to health, requested the Director-General:

- (1) to report on the health conditions in the occupied Palestinian territory, including east Jerusalem, and in the occupied Syrian Golan, to the Sixty-eighth World Health Assembly, based on a field assessment, with special focus on:
  - (a) barriers to health access in the occupied Palestinian territory, as well as progress made in the implementation of the recommendations contained in the World Health Organization 2013 report *Right to health: barriers to health access in the occupied Palestinian territory, 2011 and 2012*;<sup>1</sup>
  - (b) access to adequate health services on the part of Palestinian prisoners;
  - (c) the effect of prolonged occupation and human rights violations on mental health, particularly the mental consequences of the Israeli military detention system on child detainees;
  - (d) the effect of impeded access to water and sanitation, as well as food insecurity, on health conditions in the occupied Palestinian territory, particularly in the Gaza Strip;
  - (e) the provision of financial and technical assistance and support by the international donor community, and its contribution to improving health conditions in the occupied Palestinian territory;
- (2) to provide support to the Palestinian health services, including capacity-building programmes;
- (3) to provide health-related technical assistance to the Syrian population in the occupied Syrian Golan;
- (4) to continue providing necessary technical assistance in order to meet the health needs of the Palestinian people, including prisoners and detainees, in cooperation with the efforts of the International Committee of the Red Cross, as well as the health needs of handicapped and injured people;
- (5) to provide support to the Palestinian health sector in preparing for emergency situations and scaling up emergency preparedness and response capacities;
- (6) to support the development of the health system in the occupied Palestinian territory, including development of human resources.

(Eighth plenary meeting, 23 May 2014)

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<sup>1</sup> Right to health: barriers to health access in the occupied Palestinian territory, 2011 and 2012. Geneva: World Health Organization; 2013 (document WHO-EM/OPT/004/E).

**WHA67(11) Appointment of representatives to the WHO Staff Pension Committee**

(1) The Sixty-seventh World Health Assembly nominated Dr Ebenezer Appiah-Denkyira of the delegation of Ghana as a member for a three-year term until May 2017 and the most senior alternate member, Dr Michel Tailhades of the delegation of Switzerland, as a member for the remainder of his term of office until May 2015.

(2) The Sixty-seventh World Health Assembly also nominated Dr Darren Hunt of the delegation of New Zealand and Dr Mariam A. Al-Jalahma of the delegation of Bahrain as alternate members of the WHO Staff Pension Committee for a three-year term until May 2017.

(Ninth plenary meeting, 24 May 2014)

**WHA67(12) Real estate: update on the Geneva buildings renovation strategy**

The Sixty-seventh World Health Assembly, having considered the report on real estate: update on the Geneva buildings renovation strategy,<sup>1</sup> and having noted the report of the Programme, Budget and Administration Committee of the Executive Board to the Sixty-seventh World Health Assembly,<sup>2</sup>

- (1) noted the updated Geneva buildings renovation strategy;
- (2) authorized the Director-General to proceed with the initial planning phase, including the organization of an architectural competition;
- (3) expressed its appreciation to the Government of Switzerland for its offer to provide an initial interest-free loan of 14 million Swiss francs for planning purposes;
- (4) requested the Director-General:
  - (a) to accept the initial loan subject to the conditions described in paragraphs 10–12 of the report on real estate: update on the Geneva buildings renovation strategy,<sup>1</sup> continuing to plan the site-wide renovation project;
  - (b) to present to the Sixty-eighth World Health Assembly the selected design for the new building with an outline of the building specifications and a detailed financial update of the entire renovation strategy, with the expectation that a final decision will be taken by the Sixty-ninth World Health Assembly regarding approval of the final project and acceptance of the full loan for the construction of the new building and initiation of construction work, subject to the Swiss federal authorities' final approval of the full loan in December 2016.

(Ninth plenary meeting, 24 May 2014)

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<sup>1</sup> Document A67/52.

<sup>2</sup> Document A67/61.

**WHA67(13) Multisectoral action for a life course approach to healthy ageing**

The Sixty-seventh World Health Assembly, having considered the report on multisectoral action for a life course approach to healthy ageing,<sup>1</sup> recognizing that the proportion of older people in the population is increasing in almost every country, and that there are growing challenges for health systems associated with population ageing, requested the Director-General to develop, in consultation with Member States and other stakeholders and in coordination with the regional offices, and within existing resources, a comprehensive global strategy and plan of action on ageing and health, for consideration by the Executive Board in January 2016 and by the Sixty-ninth World Health Assembly in May 2016.

(Ninth plenary meeting, 24 May 2014)

**WHA67(14) Framework of engagement with non-State actors**

The Sixty-seventh World Health Assembly, having considered the report on the framework of engagement with non-State actors;<sup>2</sup> welcoming the progress made on the draft framework of engagement with non-State actors by the Sixty-seventh World Health Assembly; underlining the importance of an appropriate framework for engagement with non-State actors for the role and work of WHO; and recognizing that further consultations and discussions are needed on issues including conflict of interest and relations with the private sector,

- (1) decided that Member States should submit their specific follow-up comments and questions to the Director-General by 17 June 2014;
- (2) decided also that the regional committees in 2014 should discuss this matter, with reference to the draft framework of engagement with non-State actors and the report referred to in subparagraph (4)(a) below;
- (3) requested that the regional committees submit a report on their deliberations to the Sixty-eighth World Health Assembly, through the Executive Board;
- (4) requested the Director-General:
  - (a) to prepare a comprehensive report of the comments made by Member States during the Sixty-seventh World Health Assembly and the follow-up comments and questions raised, including clarification and response thereon from the Secretariat, by the end of July 2014;
  - (b) to submit a paper to the Executive Board at its 136th session, in January 2015, ensuring that Member States receive it by mid-December 2014 in order to allow them sufficient time to study the content and to be better prepared for discussion and deliberation.

(Ninth plenary meeting, 24 May 2014)

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<sup>1</sup> Document A67/23.

<sup>2</sup> Document A67/6.

**WHA67(15) Follow-up of the report of the Consultative Expert Working Group on Research and Development: Financing and Coordination**

The Sixty-seventh World Health Assembly, having considered the reports on the follow-up of the report of the Consultative Expert Working Group on Research and Development: Financing and Coordination,<sup>1</sup>

- (1) noted the progress made in implementation of resolution WHA66.22 and decision EB134(5);
- (2) recognized the indicators to measure success in implementing the health research and development demonstration projects, and requested the addition of an analysis of the extent of innovative components being implemented by the projects, including financing, the use of open access models, multisectoral research platforms and delinkage, among other criteria;
- (3) requested the Director-General to expedite the process in respect of the remaining four projects, in addition to the four already agreed, and to report on progress to the Executive Board at its 136th session;
- (4) noted, without prejudice to future discussions in the context of recommendations of the Consultative Expert Working Group on Research and Development: Financing and Coordination and actions on other sustainable mechanisms for financing health research and development, the assessment made by the Secretariat and the possibility of using an existing mechanism to host a pooled fund for voluntary contributions towards research and development for type III and type II diseases and the specific research and development needs of developing countries in relation to type I diseases;
- (5) requested the Director-General to further explore the option referred to in paragraph (4) above with the UNICEF/UNDP/World Bank/WHO Special Programme for Research and Training in Tropical Diseases, recognizing the following:
  - (a) that the scope of the diseases should not be limited to type III diseases but should be in line with the mandate of the global strategy and plan of action on public health, innovation and intellectual property;
  - (b) the need for a sustainable financial mechanism for health research and development;
  - (c) the role of Member States in the governance of the coordination mechanism;
- (6) requested the Director-General to report to the Sixty-eighth World Health Assembly, through the Executive Board at its 136th session, with reference to this decision.

(Ninth plenary meeting, 24 May 2014)

**WHA67(16) Selection of the country in which the Sixty-eighth World Health Assembly would be held**

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

(Ninth plenary meeting, 24 May 2014)

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<sup>1</sup> Documents A67/27, A67/28 and A67/28 Add.1.



## **ANNEXES**



## ANNEX 1

### **Global strategy and targets for tuberculosis prevention, care and control after 2015<sup>1</sup>**

[A67/11 – 14 March 2014]

1. WHO's declaration of tuberculosis as a global public health emergency in 1993 ended a period of prolonged global neglect. Together, the subsequent launch of the directly observed treatment, short course (DOTS) strategy; inclusion of tuberculosis-related indicators in the Millennium Development Goals; development and implementation of the Stop TB Strategy that underpins the Global Plan to Stop TB 2006–2015; and adoption of resolution WHA62.15 on the prevention and control of multidrug-resistant tuberculosis and extensively drug-resistant tuberculosis by the Sixty-second World Health Assembly have all helped to accelerate the global expansion of tuberculosis care and control.

2. In May 2012, Member States at the Sixty-fifth World Health Assembly requested the Director-General to submit a comprehensive review of the global tuberculosis situation to date, and to present new multisectoral strategic approaches and new international targets for the post-2015 period to the Sixty-seventh World Health Assembly in May 2014, through the Executive Board.<sup>2</sup> The work to prepare this has involved a wide range of partners providing substantive input into the development of the new strategy, including high-level representatives of Member States, national tuberculosis programmes, technical and scientific institutions, financial partners and development agencies, civil society, nongovernmental organizations, and the private sector.

3. ***The process.*** WHO's Strategic and Technical Advisory Group for Tuberculosis approved the broad, inclusive scope of the consultative process for the development of the strategy. It began with a web-based consultation to seek ways in which to strengthen the current strategy and introduce any new components. During 2012, as part of the annual meetings of national tuberculosis programmes, each regional office organized consultations on the proposed new strategic framework and targets with health ministry officials, national tuberculosis programme managers and partners. Officials of countries with a high tuberculosis burden then deliberated on the draft strategic framework at a special consultation organized just before the 43rd Union World Conference (Kuala Lumpur, 13–17 November 2013). Following this, the framework was presented and discussed on the opening day of the Conference at the global tuberculosis symposium, which was attended by over 700 stakeholders. In 2013, three special consultations including senior officials of Member States, technical experts and civil society were organized in order to discuss (i) formulation of the post-2015 tuberculosis targets; (ii) approaches to building on the opportunities presented by expansion of universal health coverage and social protection to strengthen tuberculosis care and prevention; and (iii) research and innovation for

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<sup>1</sup> See resolution WHA67.1.

<sup>2</sup> See document WHA65/2012/REC/3, summary record of the sixth meeting of Committee B, section 3.

improved tuberculosis care, control and elimination. In June 2013, the Strategic and Technical Advisory Group for Tuberculosis endorsed the draft, including the global targets and their rationale.<sup>1</sup>

4. The framework of the post-2015 global tuberculosis strategy is presented in Figure 1.

**Figure 1. POST-2015 GLOBAL TUBERCULOSIS STRATEGY FRAMEWORK**

<b>VISION</b>	A world free of tuberculosis – zero deaths, disease and suffering due to tuberculosis
<b>GOAL</b>	End the global tuberculosis epidemic
<b>MILESTONES FOR 2025</b>	75% reduction in tuberculosis deaths (compared with 2015) 50% reduction in tuberculosis incidence rate (less than 55 tuberculosis cases per 100 000 population) – No affected families facing catastrophic costs due to tuberculosis
<b>TARGETS FOR 2035</b>	95% reduction in tuberculosis deaths (compared with 2015) 90% reduction in tuberculosis incidence rate (less than 10 tuberculosis cases per 100 000 population) – No affected families facing catastrophic costs due to tuberculosis
<b>PRINCIPLES</b>	
<ol style="list-style-type: none"> <li>1. Government stewardship and accountability, with monitoring and evaluation</li> <li>2. Strong coalition with civil society organizations and communities</li> <li>3. Protection and promotion of human rights, ethics and equity</li> <li>4. Adaptation of the strategy and targets at country level, with global collaboration</li> </ol>	
<b>PILLARS AND COMPONENTS</b>	
<b>1. INTEGRATED, PATIENT-CENTRED CARE AND PREVENTION</b>	
<ol style="list-style-type: none"> <li>A. Early diagnosis of tuberculosis including universal drug-susceptibility testing, and systematic screening of contacts and high-risk groups</li> <li>B. Treatment of all people with tuberculosis including drug-resistant tuberculosis, and patient support</li> <li>C. Collaborative tuberculosis/HIV activities, and management of comorbidities</li> <li>D. Preventive treatment of persons at high risk, and vaccination against tuberculosis</li> </ol>	
<b>2. BOLD POLICIES AND SUPPORTIVE SYSTEMS</b>	
<ol style="list-style-type: none"> <li>A. Political commitment with adequate resources for tuberculosis care and prevention</li> <li>B. Engagement of communities, civil society organizations, and public and private care providers</li> <li>C. Universal health coverage policy, and regulatory frameworks for case notification, vital registration, quality and rational use of medicines, and infection control</li> <li>D. Social protection, poverty alleviation and actions on other determinants of tuberculosis</li> </ol>	
<b>3. INTENSIFIED RESEARCH AND INNOVATION</b>	
<ol style="list-style-type: none"> <li>A. Discovery, development and rapid uptake of new tools, interventions and strategies</li> <li>B. Research to optimize implementation and impact, and promote innovations</li> </ol>	

<sup>1</sup> Strategic and Technical Advisory Group for Tuberculosis: report of 13th meeting, 11–12 June 2013 (document WHO/HTM/TB/2013.9).

## APPROACHES

5. ***Expanding care, strengthening prevention, and intensifying research.*** Addressing the above challenges will require innovative, multisectoral, and integrated approaches. The DOTS strategy strengthened public sector tuberculosis programmes to help to tackle a large burden of drug-susceptible disease. The Stop TB Strategy,<sup>1</sup> built on DOTS, helped to begin addressing drug-resistant tuberculosis and HIV-associated tuberculosis while promoting research to develop new tools. It also helped to expand partnerships with all care providers, civil society organizations and communities, in the context of strengthening health systems. Ending the tuberculosis epidemic will require further expansion of the scope and reach of interventions for tuberculosis care and prevention; institution of systems and policies to create an enabling environment and share responsibilities; and aggressive pursuit of research and innovation to promote development and use of new tools for tuberculosis care and prevention. It will also require a provision for revisiting and adjusting the new strategy based on progress and the extent to which agreed milestones and targets are being met.

6. ***Eliciting systemic support and engaging stakeholders.*** In practical terms, continuing progress beyond 2015 will require intensified actions by and beyond tuberculosis programmes within and outside the health sector. The new strategy envisages concrete actions from three levels of governance in close collaboration with all stakeholders and with the engagement of communities. At the core are national tuberculosis programmes or the equivalent structures that are responsible for coordination of all activities related to delivery of tuberculosis care and prevention. Above them are the national health ministries that provide critical systemic support, enforce regulatory mechanisms, and coordinate integrated approaches through interministerial and intersectoral collaboration. Above all, the national governments have to provide the overall stewardship to keep tuberculosis elimination high on the development agenda through political commitment, investments and oversight, while making rapid progress towards universal health coverage and social protection.

7. ***Elevating leadership and widening ownership.*** Tuberculosis care and control need to be strengthened further and expanded to include prevention of tuberculosis. For this purpose, in-country leadership for tuberculosis control ought to be elevated to higher levels within health ministries. This is essential in order to effect coordinated action on multiple fronts and to accomplish three clear objectives: (1) achieving universal access to early detection and proper treatment of all patients with tuberculosis; (2) putting supportive health and social sector policies and systems in place to enable effective delivery of tuberculosis care and prevention; and (3) intensifying research to develop and apply new technologies, tools and approaches to enable eventual tuberculosis elimination. The three pillars of the global tuberculosis strategy are designed to address these objectives.

## VISION, GOAL, MILESTONES AND TARGETS

8. The vision for the post-2015 tuberculosis strategy is “a world free of tuberculosis”, also expressed as “zero deaths, disease and suffering due to tuberculosis”. The goal is to end the global tuberculosis epidemic.

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<sup>1</sup> The six components of the Stop TB Strategy are: (i) pursue high-quality DOTS expansion and enhancement; (ii) address TB/HIV, MDR-TB and other special challenges; (iii) contribute to health system strengthening; (iv) engage all care providers; (v) empower people with tuberculosis, and communities; and (vi) enable and promote research.

9. The Millennium Development Goal target “to halt and begin to reverse the incidence of tuberculosis by 2015” has already been achieved. The related Stop TB Partnership targets of reducing tuberculosis prevalence and death rates by 50% relative to 1990 are on track to be achieved by 2015. Under this strategy, new, ambitious yet feasible global targets are proposed for 2035. These include achieving a 95% decline in deaths due to tuberculosis compared with 2015, and reaching an equivalent 90% reduction in tuberculosis incidence rate from a projected 110 cases/100 000 in 2015 to 10 cases/100 000 or less by 2035. These targets are equivalent to the current levels in some low-incidence countries of North America, western Europe and the Western Pacific. An additional target proposed to ascertain progress of universal health coverage and social protection is that by 2020, no tuberculosis-affected person or family should face catastrophic costs due to tuberculosis care.

10. Milestones that will need to be reached before 2035 are also proposed for 2020, 2025, and 2030. Table 1 presents key global indicators, milestones and targets for the post-2015 strategy.

11. A key milestone is a 75% reduction in tuberculosis deaths by 2025, compared with 2015. This will require two achievements. First, the annual decline in global tuberculosis incidence rates must accelerate from an average of 2% per year in 2015 to 10% per year by 2025. A 10% per year decline in tuberculosis incidence is ambitious yet feasible; it has been projected on the basis of the fastest rate documented at national level, which occurred in the context of universal access to health care and rapid socioeconomic development in Western Europe and North America during the second half of the past century. Secondly, the proportion of incident cases dying from tuberculosis (the case-fatality ratio) needs to decline from a projected 15% in 2015 to 6.5% by 2025. It has been modelled that rapid progress towards universal access to existing tools combined with socioeconomic development can lead to a 75% reduction in tuberculosis deaths. Furthermore, improved tools, such as a rapid point-of-care test and improved tuberculosis treatment regimens are likely to emerge soon from the research and development pipeline thus facilitating achievement of the milestones.

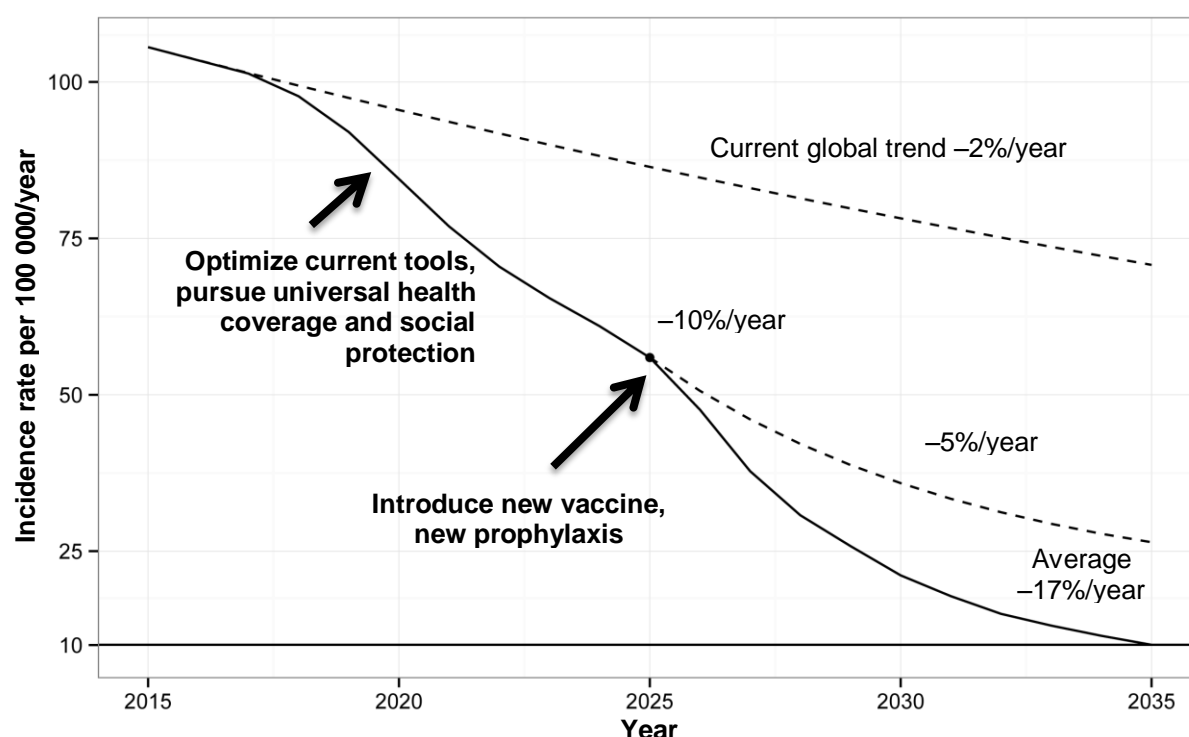
**Table 1. Key global indicators, milestones and targets for the post-2015 tuberculosis strategy**

Indicators with baseline values for 2015	Milestones			Targets
	2020	2025	2030	2035
<i>Percentage reduction in deaths due to tuberculosis</i> (projected 2015 baseline: 1.3 million deaths)	35%	75%	90%	95%
<i>Percentage and absolute reduction in tuberculosis incidence rate</i> (projected 2015 baseline 110/100 000)	20% (<85/100 000)	50% (<55/100 000)	80% (<20/100 000)	90% (<10/100 000)
<i>Percentage of affected families facing catastrophic costs due to tuberculosis</i> (projected 2015 baseline: not yet available)	Zero	Zero	Zero	Zero

12. In order to sustain progress beyond 2025 and achieve by 2035 a reduction in tuberculosis deaths of 95% and a 90% reduction in the incidence rate from 110 cases/100 000 to less than 10 cases per 100 000, there must be additional tools available by 2025. In particular, a new vaccine that is effective pre- and post-exposure, and better diagnostics, as well as safer and easier treatment for latent tuberculosis infection, will be needed. Achievements with existing tools complemented by universal health coverage and social protection would be remarkable, but would not be sufficient to maintain the

rate of progress required to achieve the 2035 targets. For new tools to be available for introduction by 2025, greatly enhanced and immediate investments in research and development will be required. Figure 2 shows the projected acceleration of the decline in global tuberculosis incidence rates with optimization of current tools combined with progress towards universal health coverage and social protection from 2015, and the additional impact of new tools by 2025.

**Figure 2. Projected acceleration in the decline of global tuberculosis incidence rates to target levels**



13. The milestone that no families affected by tuberculosis face catastrophic costs implies minimizing direct medical costs, such as fees for consultations, hospitalization, tests and medicines as well as direct non-medical costs such as those for transport and any loss of income while under care. It requires that tuberculosis patients and tuberculosis-affected households have access to appropriate social protection schemes that cover or compensate for direct non-medical costs and income losses. With sufficient political commitment, tuberculosis-related costs could be rapidly reduced in all countries, and therefore many countries may be able to reach the target by 2020.

## THE PRINCIPLES OF THE STRATEGY

### Government stewardship and accountability, with monitoring and evaluation

14. Activities under the tuberculosis strategy span the health and social sectors and beyond, including finance, labour, trade and development. Stewardship responsibilities should be shared by all levels of the government – local, provincial, and central. The central government should remain the “steward of stewards” for tuberculosis care and prevention, working with all stakeholders.

15. The success of the post-2015 global tuberculosis strategy will depend on effective execution of key stewardship responsibilities by governments in close collaboration with all stakeholders: providing the vision and direction through the national tuberculosis programme and the health system; collecting and using data for progressive improvements in tuberculosis care and prevention; and exerting influence through regulation and other means to achieve the stated goals and objectives of the strategy.

16. To ensure accountability, regular monitoring and evaluation need to be built into strategy implementation. Progress will need to be measured against ambitious national targets and indicators. Table 2<sup>1</sup> presents an illustrative list of key global indicators that should be adopted and adapted for national use and for which country-specific targets should be set. These indicators should be supplemented by others considered necessary to capture progress in the implementation of all essential activities. Examples of targets that could apply in all countries include a treatment success rate of at least 85%, and testing of 100% of tuberculosis patients for drug susceptibility and HIV.

### **Strong coalition with civil society organizations and communities**

17. The affected communities must also be a prominent part of proposed solutions. Community representatives and civil society must be enabled to engage more actively in programme planning and design, service delivery, and monitoring, as well as in information, education, support to patients and their families, research, and advocacy. To this end, a strong coalition that includes all stakeholders needs to be built. Such a coalition of partners can assist people in both accessing high-quality care and in demanding high-quality services. A national coalition can also help drive greater action on the determinants of the tuberculosis epidemic.

### **Protection and promotion of human rights, ethics and equity**

18. Policies and strategies for the design of the overall national tuberculosis response, and the delivery of tuberculosis care and prevention, have to explicitly address human rights, ethics and equity. Access to high-quality tuberculosis care is an important element of the right to health. This strategy is built on a rights-based approach that ensures protection of human rights and promotion of rights-enhancing policies and interventions. These include engagement of affected persons and communities in facilitating implementation of all pillars and components of the strategy with special attention to key affected populations.

19. Tuberculosis care and prevention pose ethical dilemmas. National tuberculosis programmes should acknowledge and address these with due respect to relevant ethical values. These may include, for example, the conflict between the public interest in preventing disease transmission and patients' rights to demand a supportive care environment or refuse treatment; the response to the stigmatization attached to the disease and the discrimination against those affected; the lengthy treatment and the challenges of adherence to treatment; ensuring patient-centred service provision and balancing the risk of infection to health care workers; the care to be offered when there are not effective treatment options; and setting of priorities for research and for delivery of interventions. Ways to address these dilemmas should be guided by globally recognized principles and values, should be sensitive to local values and traditions, and should be informed by debates among all stakeholders.

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<sup>1</sup> See page 87.



20. The strategy aims to promote equity through identification of the risks, needs and demands of those affected, to enable equal opportunities to prevent disease transmission, equal access to diagnosis and treatment services, and equal access to means to prevent associated social impacts and catastrophic economic costs. The process through which to meet the targets, and achieve the goals, of the strategy will be better served by applying a rights-based approach, developing and maintaining the highest ethical standards in every action taken, and ensuring that inequities are progressively reduced and eliminated.

### **Adaptation of the strategy and targets at country level, with global collaboration**

21. No global strategy can apply similarly to all settings across or within countries. The tuberculosis strategy will have to be adapted to diverse country settings, based on a comprehensive national strategic plan. Prioritization of interventions should be undertaken based on local contexts, needs and capacities. A sound knowledge of country-specific disease epidemiology will be essential, including mapping of people at a greater risk, understanding of socioeconomic contexts of vulnerable populations, and a grasp of health system context including underserved areas. Adoption of the global strategy should be immediately followed by its national adaptation and development of clear guidance on how the different components of the strategy could be implemented, based on local evidence when possible.

22. In a globalized world, diseases like tuberculosis can spread far and wide via international travel and trade. Tackling tuberculosis effectively requires close collaboration among countries. Effective intercountry collaboration also requires global coordination and support to enable adherence to the International Health Regulations (2005) and ensure health security. Countries within a region can benefit from regional collaboration. Migration within and between countries poses challenges and addressing them will require in-country coordination and cross-border collaboration. Global coordination is also essential for mobilizing resources for tuberculosis care and prevention from diverse multilateral, bilateral and domestic sources. WHO's global tuberculosis report, which annually provides an overview of the status of the tuberculosis epidemic and implementation of global strategies, demonstrates and symbolizes the benefits of close collaboration and global coordination.

### **PILLAR ONE: INTEGRATED, PATIENT-CENTRED CARE AND PREVENTION**

23. *Strengthening and expansion of core functions of tuberculosis programmes.* Pillar one comprises patient-centred interventions required for tuberculosis care and prevention. The national tuberculosis programme, or equivalent, needs to engage and coordinate closely with other public health programmes, social support programmes, public and private health care providers, nongovernmental and civil society organizations, communities and patient associations in order to help ensure provision of high-quality, integrated, patient-centred tuberculosis care and prevention across the health system. Pillar one is meant to help countries to progress from previous strategies and to embrace new strategies and technologies for providing universal access to drug susceptibility testing; to expand services to manage tuberculosis among children; to provide additional outreach services to underserved and vulnerable populations; and to embark on systematic screening and preventive treatment of relevant high-risk groups – all in partnership with relevant stakeholders. Use of innovative information and communication technologies for health (eHealth and mHealth) could particularly help to improve tuberculosis care provision including logistics and surveillance.

### **Early diagnosis of tuberculosis including universal drug susceptibility testing, and systematic screening of contacts and high-risk groups**

24. **Ensure early detection of tuberculosis.** Currently an estimated two thirds of global incident tuberculosis cases are notified to national tuberculosis control programmes and reported to WHO. Ensuring universal access to early and accurate diagnosis of tuberculosis will require the strengthening and expansion of a network of diagnostic facilities with easy access to new molecular tests; information and education to prompt people with symptoms of tuberculosis to seek care; engagement of all care providers in service delivery; the abolition of barriers that people encounter in seeking care; and systematic screening in selected high-risk groups. Although the current most frequently used test for tuberculosis – sputum-smear microscopy – is a low-cost option providing specific diagnosis, it significantly lacks sensitivity. As a result, health services miss many tuberculosis patients or identify them only at advanced stages of the disease. Screening for symptoms alone may not suffice; additional screening tools such as a chest radiograph may facilitate referral for diagnosis of bacteriologically negative tuberculosis, extrapulmonary tuberculosis and tuberculosis in children.

25. **Detect all cases of drug-resistant tuberculosis.** Diagnosis of drug resistance remains a particular challenge for laboratory systems in many low- and middle-income countries. Capacity to diagnose drug-resistant tuberculosis is limited in most places where it is sorely needed. Only a fraction of the estimated cases of multidrug-resistant tuberculosis receive a laboratory test to confirm the disease. Adequate capacity to diagnose all cases of drug-resistant tuberculosis is essential to make further progress in global tuberculosis care and control.

26. **Scale up introduction of new diagnostics.** Wide introduction of new molecular diagnostic testing platforms will allow early and accurate diagnosis of tuberculosis and drug resistance. It could help to diagnose less advanced forms of tuberculosis and facilitate early treatment, contributing potentially to decreased disease transmission, reduced case fatality, and prevention of adverse sequelae of the disease. Introduction of the new molecular diagnostics will require change of diagnostic policies and training at all levels. More sensitive and rapid diagnostics will increase the number of reliably diagnosed patients. The new realities of the additional workload will mean lining up additional human and financial resources.

27. **Implement systematic screening for tuberculosis among selected high-risk groups.** The burden of undetected tuberculosis is large in many settings, especially in high-risk groups. There can be long delays in diagnosing tuberculosis and initiating the appropriate treatment among people with poor access to health services. Many people with active tuberculosis do not experience typical symptoms in the early stages of the disease. These individuals may not seek care early enough and may not be identified for testing for tuberculosis if they do. Mapping of high-risk groups and carefully planned systematic screening for active disease among them may improve early case detection. Early detection helps to reduce the risks of tuberculosis transmission, poor treatment outcomes, undesirable health sequelae, and adverse social and economic consequences of the disease. Contacts of people with tuberculosis, especially children aged five years or less, people living with HIV, and workers exposed to silica dust should always be screened for active tuberculosis. Other risk-groups should be identified and prioritized for possible screening based on national and local tuberculosis epidemiology, health system capacity, resource availability, and the feasibility of reaching the identified risk-groups. A screening strategy should be monitored and assessed continuously, to inform a re-prioritization of risk groups, re-adaptation of screening approaches, and discontinuation of screening if indicated. Screening strategies should follow established ethical principles for infectious disease screening, should protect human rights, and should minimize the risk of discomfort, pain, stigmatization and discrimination.

## **Treatment of all people with tuberculosis including drug-resistant tuberculosis, and patient support**

28. ***Treat all forms of drug-susceptible tuberculosis.*** The new tuberculosis strategy will aim to ensure provision of services for early diagnosis and proper treatment of all forms of tuberculosis affecting people of all ages. New policies incorporating molecular diagnostics will help to strengthen management of smear-negative pulmonary tuberculosis and extrapulmonary tuberculosis as well as tuberculosis among children. Key affected populations and risk groups with suboptimal treatment uptake or treatment success will need to be given priority attention in order to accelerate the decline in case fatality required in order to reach the ambitious targets for reductions in tuberculosis mortality.

29. ***Treat all cases of drug-resistant tuberculosis.*** Resistance to medicines poses a major threat to global progress in tuberculosis care and prevention. Globally, about 4% of new tuberculosis patients and about 20% of patients receiving retreatment have multidrug-resistant tuberculosis. Providing universal access to services for drug-resistant tuberculosis will require a rapid scale up of laboratory services and programmatic management. New models of delivering patient-centred treatment will need to be devised and customized to diverse settings and contexts. Ambulatory services should be given preference over hospitalization, which should be limited to severe cases. Expansion of services for management of drug-resistant tuberculosis will require bold policies and investments to abolish health system bottlenecks that impede progress.

30. ***Strengthen capacity to manage drug-resistant cases.*** The proportion of drug-resistant tuberculosis patients successfully completing treatment varies substantially between countries and averaged 48% globally in 2012. Currently available treatment regimens for drug-resistant tuberculosis remain unsatisfactory in terms of duration, safety, effectiveness and cost. New safer, affordable and more effective medicines allowing treatment regimens that are shorter in duration and easier to administer are key to improving treatment outcomes. Linkages with existing pharmacovigilance mechanisms will contribute to promoting safer use and management of medicines. Interventions to improve quality of life for patients while enabling adherence to treatment include management of adverse drug reactions and events; access to comprehensive palliative and end-of-life care; measures to alleviate stigmatization and discrimination; and social support and protection. Importantly, all care providers managing drug-resistant tuberculosis should have access to continued training and education, enabling them to align their practices with international standards.

31. ***Address tuberculosis among children.*** With an estimated 500 000 cases and 74 000 deaths occurring annually, tuberculosis is an important cause of morbidity and mortality among children. In countries with a high prevalence of tuberculosis, women of childbearing age also carry a heavy burden of the disease. Maternal tuberculosis associated with HIV is a risk factor for transmission of tuberculosis to the infant and is associated with premature delivery, low birth-weight of neonates, and higher maternal and infant mortality. National tuberculosis programmes need to address systematically the challenges of caring for children with tuberculosis, and child contacts of adult tuberculosis patients. These may include, for instance, developing and using child-friendly formulation of medicines, and family-centred mechanisms for enabling adherence to treatment.

32. ***Integrate tuberculosis care within maternal and child health services.*** Proper management of tuberculosis among children will require the development of affordable and sensitive diagnostic tests that are not based on sputum specimens. Tuberculosis care should be integrated within maternal and child health services to enable provision of comprehensive care at the community level. An integrated family-based approach to tuberculosis care would help to remove access barriers, reduce delays in diagnosis and improve management of tuberculosis in women and children.

33. ***Build patient-centred support into the management of tuberculosis.*** Patient-centred care and support, sensitive and responsive to patients' educational, emotional and material needs, is fundamental to the new global tuberculosis strategy. Supportive treatment supervision by treatment partners is essential: it helps patients to take their medication regularly and to complete treatment, thus facilitating their cure and preventing the development of drug resistance. Supervision must be carried out in a context-specific and patient-sensitive manner. Patient-centred supervision and support must also help to identify and address factors that may lead to treatment interruption. It must help to alleviate stigmatization and discrimination. Patient support needs to extend beyond health facilities to patients' homes, families, workplaces and communities. Treatment and support must also extend beyond cure to address any sequelae associated with tuberculosis. Examples of patient-centred support include providing treatment partners trained by health services and acceptable to the patient; access to social protection; use of information and communication technology for providing information, education and incentives to patients; and the setting up of mechanisms for patient and peer groups to exchange information and experiences.

### **Collaborative tuberculosis/HIV activities, and management of comorbidities**

34. ***Expand collaboration with HIV programmes.*** The overall goal of collaborative tuberculosis/HIV activities is to decrease the burden of tuberculosis and HIV infection in people at risk of or affected by both diseases. HIV-associated tuberculosis accounts for about one quarter of all tuberculosis deaths and a quarter of all deaths due to AIDS. The vast majority of these cases and deaths are in the African and South-East Asia regions. All tuberculosis patients living with HIV should receive antiretroviral treatment. Integrated tuberculosis and HIV service delivery has been shown to increase the likelihood that a tuberculosis patient will receive antiretroviral treatment, shorten the time to treatment initiation, and reduce mortality by almost 40%.

35. ***Integrate tuberculosis and HIV services.*** Although there has been an encouraging global scale-up of collaborative tuberculosis/HIV activities, the overall coverage of services remains low. Further, the level and rate of progress vary substantially among countries. There remains a mismatch between the coverage of HIV testing for tuberculosis patients and that of antiretroviral treatment, co-trimoxazole preventive treatment, and HIV prevention. Reducing delays in diagnosis, using new diagnostic tools and instituting prompt treatment can improve health outcomes among people living with HIV. Tuberculosis and HIV care should be further integrated with services for maternal and child health and prevention of mother-to-child transmission of HIV in high-burden settings.

36. ***Co-manage tuberculosis comorbidities and noncommunicable diseases.*** Several noncommunicable diseases and other health conditions including diabetes mellitus, undernutrition, silicosis, as well as smoking, harmful alcohol and drug use, and a range of immune-compromising disorders and treatments are risk factors for tuberculosis. Presence of comorbidities may complicate tuberculosis management and result in poor treatment outcomes. Conversely, tuberculosis may worsen or complicate management of other diseases. Therefore, as a part of basic and coordinated clinical management, people diagnosed with tuberculosis should be routinely assessed for relevant comorbidities. WHO's *Practical Approach to Lung Health*<sup>1</sup> is an example of promoting tuberculosis care as an integral part of management of respiratory illnesses. The local situation should determine which comorbidities should be systematically screened for among people with active tuberculosis. A national collaborative framework can help integrated management of noncommunicable diseases and communicable diseases including tuberculosis.

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<sup>1</sup> Document WHO/HTM/TB/2008.410; document WHO/NMH/CHP/CPM/08.02.

## **Preventive treatment of persons at high risk, and vaccination against tuberculosis**

37. ***Expand preventive treatment of people with a high risk of tuberculosis.*** Latent tuberculosis infection is diagnosed by a tuberculin skin test or interferon- $\gamma$  release assay. However, these tests cannot predict which persons will develop active tuberculosis disease. Isoniazid preventive therapy is currently recommended for the treatment of latent tuberculosis infection among people living with HIV and children under five years of age who are contacts of patients with tuberculosis. It has a proven preventive effect but severe side effects can occur, especially among the elderly. Although regimens with similar efficacy and shorter duration have been studied, more evidence on efficacy and safety are needed. More studies are also required to assess the effectiveness and feasibility of undertaking preventive treatment among other high-risk groups such as, for example, people in congregate settings like prisons and workplaces, health care workers, recent converters of a test of infection, and miners exposed to silica dust. Management of latent tuberculosis infection in people with a high risk of developing active tuberculosis could be an essential component of tuberculosis elimination, particularly in low tuberculosis-incidence countries.

38. ***Continue BCG vaccination in high-prevalence countries.*** BCG vaccination prevents disseminated disease including tuberculous meningitis and military tuberculosis, which are associated with high mortality in infants and young children. However, its preventive efficacy against pulmonary tuberculosis, which varies among populations, is only about 50%. Until new and more effective vaccines become available, BCG vaccination soon after birth should continue for all infants except for those persons with HIV living in high tuberculosis prevalence settings.

## **PILLAR TWO: BOLD POLICIES AND SUPPORTIVE SYSTEMS**

39. ***Sharing of responsibilities.*** The second pillar encompasses strategic actions that will enable implementation of the components under pillar one through sharing of responsibilities. These include actions by and beyond national tuberculosis programmes, across ministries and departments. Such actions address medical and non-medical needs of those ill with tuberculosis and also help to prevent tuberculosis. This will require a well-resourced, organized and coordinated health system with government stewardship backed up by supportive health policies and regulations as well as broader social and development policies. National tuberculosis programmes, their partners and those overseeing the programmes need to engage actively in the setting of a broader social and economic development agenda. Similarly, leaders in development must recognize tuberculosis as being among the social concerns that deserve priority attention.

40. ***Social determinants of tuberculosis.*** Pillar two further includes actions beyond the health sector that can help to prevent tuberculosis by addressing underlying social determinants. Proposed interventions include reducing poverty, ensuring food security, and improving living and working conditions as well as interventions to address direct risk factors such as tobacco control, reduction of harmful alcohol use, and diabetes care and prevention. Tuberculosis prevention will also require actions on the part of governments in order to help to reduce vulnerabilities and risks among people most susceptible to the disease.

41. ***Multidisciplinary and multisectoral approach.*** The implementation of pillar two components demands a multidisciplinary and multisectoral approach. Accountability for pillar two will rest not only with health ministries, but also other ministries including finance, labour, social welfare, housing, mining and agriculture. Eliciting actions from across diverse ministries will require commitment and stewardship from the highest levels of government. This should translate into ensuring adequate resources and accountability for optimal and integrated clinical care; protection from catastrophic

economic burden due to the disease; social interventions aimed at reducing vulnerability to the disease; and protection and promotion of human rights.

### **Political commitment with adequate resources for tuberculosis care and prevention**

42. *Develop ambitious national strategic plans.* Scaling up and sustaining interventions for tuberculosis care and prevention will require high-level political commitment along with adequate financial and human resources. Continuous training and supervision of personnel are fundamental to sustain significantly expanded activities for tuberculosis care and prevention. Central coordination under government stewardship is essential. This must lead to, as a first step, development of a national strategic plan embedded in a national health sector plan, taking into account tuberculosis epidemiology, health system structure and functions including procurement and supply systems, resource availability, regulatory policies, links with social services, migrant populations and cross-border collaboration, the role of communities, civil society organizations and the private sector, and coordination with all stakeholders. A national strategic plan should be ambitious and comprehensive, and incorporate five distinct sub-plans: a core plan, a budget plan, a monitoring and evaluation plan, an operational plan and a technical assistance plan.

43. *Mobilize adequate resources.* The expansion of tuberculosis care and prevention across and beyond the health sector will be possible only if adequate funding is secured. The national strategic plan should be properly budgeted with clear identification of gaps in finances. A well-budgeted plan should facilitate resource mobilization from diverse international and national sources for full implementation of the plan. In most low- and middle-income countries, the currently available resources are inadequate or sufficient only for modestly ambitious plans. Coordinated efforts are required to mobilize additional resources to fund truly ambitious national strategic plans with a progressive increase in domestic funding.

### **Engagement of communities, civil society organizations, and all public and private care providers**

44. *Engage communities and civil society.* A robust response to end the tuberculosis epidemic will require the establishment of lasting partnerships across the health and social sectors and between the health sector and communities. Informed community members can identify people with suspected tuberculosis, refer them for diagnosis, provide support during treatment and help to alleviate stigmatization and discrimination. Civil society organizations have specific capacities and tuberculosis programmes can benefit from harnessing them. Their competencies include reaching out to vulnerable groups, mobilizing communities, channelling information, helping to create demand for care, framing effective delivery models and addressing determinants of the tuberculosis epidemic. National tuberculosis programmes should reach out to civil society organizations not currently engaged in tuberculosis care, encourage them to integrate community-based tuberculosis care into their work, and widen the network of facilities engaged in tuberculosis care and prevention. Civil society should also be engaged in policy development and planning as well as periodic monitoring of programme implementation.

45. *Scale up public–private mix approaches and promote International Standards for Tuberculosis Care.* In many countries, tuberculosis care is delivered by diverse private care providers. These providers include pharmacists, formal and informal practitioners and nongovernmental and faith-based organizations, as well as corporate health facilities. Several public sector providers outside the purview of national tuberculosis programmes also provide tuberculosis care. These include, inter alia, large public hospitals, social security organizations, prison health services and military health

services. Leaving a large proportion of care providers out of an organized response to tuberculosis control has contributed to stagnating case notification, inappropriate tuberculosis management, and irrational use of tuberculosis medicines leading to the spread of drug-resistant tuberculosis. National tuberculosis programmes will have to scale up country-specific public–private mix approaches already working well in many countries. To this effect, close collaboration with health professionals’ associations will be essential. The *International Standards for Tuberculosis Care*, other tools and guidelines developed by WHO as well as modern information and communication technology platforms can be used effectively for this purpose.

### **Universal health coverage policy, and regulatory frameworks for case notification, vital registration, quality and rational use of medicines, and infection control**

46. ***Move with urgency to universal health coverage.*** Universal health coverage, defined as, “the situation where all people are able to use the quality health services that they need and do not suffer financial hardship paying for them” is fundamental for effective tuberculosis care and prevention. Universal health coverage is achieved through adequate, fair and sustainable prepayment financing of health care with full geographical coverage, combined with effective service quality assurance and monitoring and evaluation. For tuberculosis specifically, this implies: (a) expanding access to the full range of high-quality services recommended in this strategy, as part of general health services; (b) expanding coverage, including costs of consultations and testing, medicines, follow-up tests and all expenditures associated with staying in complete curative or preventive treatment; and (c) expanding access to services for all in need, especially vulnerable groups faced with the most barriers and worst outcomes.

47. ***Strengthen regulatory frameworks.*** National policy and regulatory frameworks for health care financing and access, quality-assured production and use of medicines and diagnostics, quality-assured health services, infection control, vital registration and disease surveillance systems are powerful levers that are essential for effective tuberculosis care and prevention. In countries with a high tuberculosis burden, these frameworks need to be urgently strengthened and enforced. The strategy calls for improvements in several areas outlined below.

48. ***Enforce mandatory notification of tuberculosis cases.*** Many tuberculosis cases are not notified, especially those managed by private care providers that are not linked to national tuberculosis programmes. Under-notification of cases hampers disease surveillance, contact investigation, outbreak management, and infection control. An effectively enforced infectious disease law, or equivalent, that includes compulsory notification of tuberculosis cases by all health care providers, is essential.

49. ***Ensure recording of tuberculosis deaths within vital registration.*** Most countries with a high burden of tuberculosis do not have comprehensive vital registration systems and the quality of information about the number of deaths due to tuberculosis is often inadequate. An effective vital registration system has to be in place to ensure that each death due to tuberculosis is properly recorded.

50. ***Regulate the production, quality and use of tuberculosis diagnostics and medicines.*** Poor quality tuberculosis medicines put patients at great risk. Irrational prescription of treatment regimens leads to poor treatment outcomes and may cause drug resistance. Use of inappropriate diagnostics such as serological tests leads to inaccurate diagnosis. Regulation and adequate resources for enforcement are required for the registration, importation and manufacturing of medical products. There should be regulation of how medical products are subsidized and a determination of which types of health professional are authorized to prescribe or dispense tuberculosis medicines.

51. ***Undertake comprehensive infection control measures.*** Appropriate regulation is required to ensure effective infection control in health care services and other settings where the risk of disease transmission is high. Managerial, administrative, environmental and personal measures for infection control should be part of infectious disease legislation, and regulations related to the construction and organization of health faculties.

### **Social protection, poverty alleviation and actions on other determinants of tuberculosis**

52. ***Relieve the economic burden related with tuberculosis.*** A large proportion of people with tuberculosis face a catastrophic economic burden related to the direct and indirect costs of illness and health care. Adverse social consequences may include stigmatization and social isolation, interruption of studies, loss of employment, or divorce. The negative consequences often extend to the family of the persons ill with tuberculosis. Even when tuberculosis diagnosis and treatment are offered free of charge, social protection measures are needed to alleviate the burden of income loss and non-medical costs of seeking and staying in care.

53. ***Expand coverage of social protection.*** Social protection should cover the needs associated with tuberculosis such as: (a) schemes for compensating the financial burden associated with illness, such as sickness insurance, disability pension, social welfare payments, other cash transfers, vouchers or food packages; (b) legislation to protect people with tuberculosis from discrimination such as expulsion from workplaces, educational or health institutions, transport systems or housing; and (c) instruments to protect and promote human rights, including addressing stigma and discrimination, with special attention to gender, ethnicity, and protection of vulnerable groups. These instruments should include capacity-building to enable affected communities to express their needs and protect their rights, and to call to account those who impinge on human rights, as well as those who are responsible for protecting those rights.

54. ***Address poverty and related risk factors.*** Poverty is a powerful determinant of tuberculosis. Crowded and poorly ventilated living and working environments often associated with poverty constitute direct risk factors for tuberculosis transmission. Undernutrition is an important risk factor for developing active disease. Poverty is also associated with poor general health knowledge and a lack of empowerment to act on health knowledge, which leads to risk of exposure to several tuberculosis risk factors. Poverty alleviation reduces the risk of tuberculosis transmission and the risk of progression from infection to disease. It also helps to improve access to health services and adherence to recommended treatment.

55. ***Pursue “health-in-all-policies” approaches.*** Actions on the determinants of ill health through “health-in-all-policies” approaches will immensely benefit tuberculosis care and prevention. Such actions include, for example: (a) pursuing overarching poverty reduction strategies and expanding social protection; (b) improving living and working conditions and reducing food insecurity; (c) addressing the health issues of migrants and strengthening cross-border collaboration; (d) involving diverse stakeholders, including tuberculosis affected communities, in mapping the likely local social determinants of tuberculosis; and (e) preventing direct risk factors for tuberculosis, including smoking and harmful use of alcohol and drugs, and promoting healthy diets, as well as proper clinical care for medical conditions that increase the risk of tuberculosis, such as diabetes.

### **PILLAR THREE: INTENSIFIED RESEARCH AND INNOVATION**

56. ***Enhancing investments in research.*** Progress in global tuberculosis control is constrained not only by the lack of new tools to better detect, treat or prevent tuberculosis but also by the weaknesses



of health systems in delivering optimal diagnosis and treatment with existing tools. Ending the tuberculosis epidemic will require substantial investments in the development of novel diagnostic, treatment and prevention tools, and for ensuring their accessibility and optimal uptake in countries alongside better and wider use of existing technologies. This will be possible only through increased investments and effective engagement of partners, the research community and country tuberculosis programmes.

57. ***Embarking on research for tuberculosis elimination.*** Revolutionary new technology and service delivery models are needed to achieve tuberculosis elimination. This will require an intensification of research, from fundamental research to drive innovations for improved diagnostics, medicines and vaccines, to operational and health systems research to improve current programmatic performance and introduce novel strategies and interventions based on new tools. To highlight the need for reinvigorated tuberculosis research and catalyse further efforts, an International Roadmap for Tuberculosis Research has been developed. The Roadmap outlines priority areas for future scientific investment across the research continuum. It provides a framework for outcome-oriented research. A mapping of the efforts carried out in the various research areas will also be necessary, so as to follow up on progress made. Embarking on research for tuberculosis elimination will require a multi-dimensional approach informed by stakeholders including scientists, public health experts, tuberculosis programme managers, financial partners, policy-makers and civil society representatives. Guided by clinical and programmatic needs, such an approach should not only help undertake public health oriented research for the development of new tools and strategies but also facilitate their seamless integration into ongoing programmes. It is important that tuberculosis becomes a key domain of investigation within national health research agendas.

### **Discovery, development and rapid uptake of new tools, interventions and strategies**

58. ***Develop a point-of-care rapid diagnostic test for tuberculosis.*** Since 2007, several new tests and diagnostic approaches have been endorsed by WHO, including: liquid culture with rapid speciation as the reference standard for bacteriological confirmation; molecular line probe assays for rapid diagnosis of multidrug-resistant tuberculosis; non-commercial culture and drug-susceptibility testing methods; light-emitting diode fluorescence microscopes; and a nucleic acid amplification test for rapid and simultaneous diagnosis of tuberculosis and rifampicin-resistant tuberculosis. However, an accurate and rapid point-of-care test that is usable in field conditions is still missing. This requires greater investments in biomarker research, and the overcoming of difficulties in transforming sophisticated laboratory technologies into robust, accurate and affordable point-of-care platforms.

59. ***Develop new drugs and regimens for the treatment of all forms of tuberculosis.*** The pipeline of new drugs has expanded substantially over the last decade. There are nearly a dozen new or repurposed tuberculosis drugs under clinical investigation. Bedaquiline, the first new tuberculosis drug for decades, was approved in 2013 by WHO for the treatment of multidrug-resistant tuberculosis. A second new drug, delamanid, also for the treatment of multidrug-resistant tuberculosis, is in the process of review by WHO. Novel regimens, including new or repurposed medicines and adjuvant and supportive therapies, are being investigated and early results appear promising. In order for further progress to be made, investments are required in both research and capacity-building to implement trials in accordance with international standards, and to identify means of shortening the duration of tuberculosis medicines trials.

60. ***Enhance research to detect and treat latent infection.*** Globally, more than 2000 million people are estimated to be infected with *Mycobacterium tuberculosis*, but only 5% to 15% of those infected will develop active disease during their lifetime. Ending the tuberculosis epidemic will require the elimination of this pool of infection. Research is needed to develop new diagnostic tests to identify

people with latent tuberculosis infection who are likely to develop tuberculosis disease. Further, treatment strategies that could be safely used to prevent development of tuberculosis in latently infected persons will also need to be identified. These strategies should include new medicines or combinations as well as interventions to identify and mitigate risk factors for progression. Further research will be required to investigate the impact and safety of targeted and mass preventive strategies.

61. ***Aim for an effective vaccine against tuberculosis.*** The century-old BCG vaccine is useful to protect against severe forms of tuberculosis in infants and young children but has limited efficacy against other forms of tuberculosis. Much progress has been made in the development of new vaccines; currently there are 12 vaccine candidates in clinical trials. More research and investments are required to address a series of major scientific challenges and identify priorities for future tuberculosis vaccine research. A post-exposure vaccine that prevents the disease in latently infected individuals will be essential to eliminating tuberculosis in the foreseeable future.

### **Research to optimize implementation and impact, and promote innovations**

62. ***Invest in applied research.*** Investments in fundamental research need to be complemented with those for applied research that supports rapid adoption, adaptation, and implementation of evidence-based policies. Research aimed at improving understanding of the challenges and developing interventions that result in improved policies, better design and implementation of health systems and more efficient methods of service delivery is critical to produce evidence for improving current strategies and introducing new tools. Research is also needed to identify and address bottlenecks to implementation of existing and new policies, and to provide evidence from the perspective of patients as well as from health systems.

63. ***Use research to inform and improve implementation.*** Most innovations cannot be translated into effective local action without careful planning and adaptation, and partnership with stakeholders. In addition to routine surveillance, well-planned and well-conducted research is required to assess national and local epidemiological and health system situations, socio-behavioural aspects of health care seeking, adherence to treatment, stigmatization and discrimination, and to evaluate different implementation models.

64. ***Create a research-enabling environment.*** Fostering better and more relevant operational, health system and social science research will help implementation and contribute to the development of national and global policies. For this purpose, good systems for research prioritization, planning and implementation need to be in place at country level. Indicators to measure progress should include investments in outcomes as well as in the impact of research activities. A broad-based, concerted effort is needed to develop research capacity, allocate appropriate resources, and encourage stakeholders to work together. An enabling environment for performing programme-based research and translating results into policy and practice is necessary to achieving the full potential of tuberculosis programmes.

## **ADAPTING AND IMPLEMENTING THE STRATEGY**

### **Initiating and sustaining strategic dialogue**

65. ***Engage all stakeholders in strategy adoption and adaptation.*** A first step in adapting and implementing the strategy would be for Member States to hold inclusive national consultations with a wide range of stakeholders, including communities most affected by tuberculosis, in order to consider, adopt and prepare for adaptation of the strategy. Blanket application of a global strategy could be

inappropriate if it does not adequately respond to an assessment of local needs that is derived from the nature of the tuberculosis epidemic, the health system context, the social and economic development agenda and the expressed demands of the populations at risk. Furthermore, it must build on the capacities of health systems and those of partners.

66. ***Use a multidisciplinary approach.*** A meaningful implementation of this strategy will demand the involvement of many actors and their sharing of responsibilities. The scope of existing tuberculosis advisory panels will need to be expanded beyond clinical, epidemiological and public health expertise. It will need to include a wider range of capacities from civil society and from the fields of finance and development policy, human rights, social protection, regulation, health technology assessment, the social sciences, and communications. The work to adapt the new global tuberculosis strategy to national contexts may be an adjunct to overall national health strategic planning, but will need a significant and specific effort.

67. ***Prepare to develop new strategic plans.*** Countries follow different development planning cycles. Existing strategic and operational plans may need to be modified, building on any new approaches. Detailed national strategic plans are also essential to mobilize funding from domestic and international sources. Development of new national strategic plans or modifications to existing ones should take into consideration the recommended framework of the new strategy.

### **Epidemiological and health systems mapping**

68. ***Undertake a detailed epidemiological and health system context assessment.*** A prerequisite for adoption of the strategy and preparation for its adaptation will be a detailed assessment of the national epidemiological and health system situation. Proper mapping should provide important information, such as population groups most affected by the disease and most at risk of developing it; age and sex characteristics and trends; prevalence of different forms of tuberculosis and dominant comorbidities, including HIV, undernutrition, diabetes, tobacco use, and alcohol misuse; important subnational and urban–rural variations; distribution and types of care providers; available social protection schemes and their current and potential linkages for the benefit of tuberculosis care and prevention.

69. ***Collect and use data to improve systems mapping.*** Some of the information for context assessment can be derived from routine reporting and, in some countries, from national or regional tuberculosis prevalence survey results. Other required information may have to be obtained from the review of periodic national programme evaluations, field assessments and local quantitative and qualitative studies. For this purpose, countries need to build capacities in order to establish an information system that monitors the characteristics of the tuberculosis epidemic, and make appropriate use of the data generated from the system at all levels.

### **MEASURING PROGRESS AND IMPACT**

70. Target setting and monitoring of progress in implementing each component of the global strategy are essential. Monitoring should be done routinely using standardized methods based on data with documented quality. Table 2 below provides examples of the indicators that can be used to monitor progress in implementing different components and subcomponents of this strategy. The main indicators of disease burden are incidence, prevalence and mortality. Given the overarching 2035 targets of the strategy, particular attention to measurement of trends in mortality and incidence is required.

71. Mortality data are critical in order to enable prioritization of public health interventions and the measurement of progress made in disease control and the overall health of the population, including health inequalities. A robust national vital registration system that includes recording of data on causes of death is essential for measurement of trends in mortality due to tuberculosis. Vital registration data can also be used to identify subgroups of the population that have higher mortality over case-notification ratios, thereby allowing targeting of interventions. The quality of these data is documented globally by WHO<sup>1</sup> and statistical methods can be used to account for incomplete coverage or miscoding. Countries that already have vital registration systems need to ensure that data are of sufficient quality. Those without such systems need to introduce them. An interim solution being adopted by an increasing number of countries is the introduction of a sample vital registration system.

72. Globally, incidence is estimated to be declining slowly, at a rate of about 2% per year. The 2025 and 2035 targets mean that, in the post-2015 period, great attention will need to be given to measuring how fast incidence is falling. In high-income countries with high-performance tuberculosis surveillance and health systems, case notification systems capture all, or almost all, incident cases. However, in other countries, routine case notifications provide biased data due to under-diagnosis (cases not diagnosed) and under-reporting (cases diagnosed by health practitioners but not reported to public health authorities). In such settings, inventory studies and capture–recapture modelling may be used to estimate tuberculosis incidence.

73. Accurate measurement of trends in tuberculosis incidence requires the performance of tuberculosis surveillance systems to be strengthened so that they cover all providers of health care and minimize the level of under-reporting. WHO has developed a tuberculosis surveillance checklist, the “standards and benchmarks for tuberculosis surveillance and vital registration systems”, to assess a national surveillance system’s ability to measure tuberculosis cases accurately. The checklist defines 10 surveillance standards that must be met in order for notification and vital registration data to be considered as a direct measurement of tuberculosis incidence and tuberculosis mortality, respectively. Countries that meet all standards can be certified as having an appropriate surveillance system. The WHO checklist should be used to improve tuberculosis surveillance progressively towards the ultimate goal of measuring trends in tuberculosis cases directly from notification data in all countries.

74. Prevalence is a very useful indicator of the tuberculosis disease burden. It is directly measurable through population-based surveys.<sup>2</sup> Prevalence surveys also provide information that is useful for policy improvements, in particular those related to access to health and to tuberculosis diagnosis. Measurement of tuberculosis prevalence using nationwide surveys is not feasible everywhere. Nationwide prevalence surveys are important for high-burden settings and will be especially relevant and useful for direct measurement of impact in countries that implemented a repeat or baseline survey around 2015. The WHO Global Task Force on TB Impact Measurement has set criteria for prioritization of prevalence surveys at country level and works with countries and other partners to support implementation and analysis of surveys. The Task Force closely monitors the implementation of all surveys to ensure international comparability through the use of WHO-recommended methods and standards. The Task Force also assesses progress towards prevalence reduction targets.

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<sup>1</sup> Mathers CD, Fat DM, Inoue M, Rao C, Lopez AD. Counting the dead and what they died from: an assessment of the global status of cause of death data. *Bull World Health Organ.* 2005;83(3):171–7.

<sup>2</sup> World Health Organization. *Tuberculosis prevalence surveys: a handbook.* Geneva 2011.  
[http://www.who.int/tb/advisory\\_bodies/impact\\_measurement\\_taskforce/resources\\_documents/thelimebook/en/index.html](http://www.who.int/tb/advisory_bodies/impact_measurement_taskforce/resources_documents/thelimebook/en/index.html).

**Table 2. Illustrative list of key global indicators for the post-2015 global tuberculosis strategy**

<b>COMPONENT</b>	<b>ILLUSTRATIVE INDICATORS</b>
<b>PILLAR ONE: INTEGRATED, PATIENT-CENTRED CARE AND PREVENTION</b>	
<b>A. Early diagnosis</b>	Percentage of people with suspected tuberculosis tested using WHO recommended rapid diagnostics Percentage of all tuberculosis patients for whom results of drug susceptibility testing were available Percentage of eligible index cases of tuberculosis for which contact investigations were undertaken
<b>B. Treatment</b>	Tuberculosis treatment success rate Percentage of patients with drug-resistant tuberculosis enrolled on second-line treatment
<b>C. Tuberculosis/HIV and comorbidities</b>	Percentage of tuberculosis patients screened for HIV Percentage of HIV-positive tuberculosis patients on antiretroviral therapy
<b>D. Preventive treatment</b>	Percentage of eligible people living with HIV and children aged under-five who are contacts of tuberculosis patients being treated for latent tuberculosis infection
<b>PILLAR TWO: BOLD POLICIES AND SUPPORTIVE SYSTEMS</b>	
<b>A. Government commitment</b>	Percentage of annual budget defined in tuberculosis national strategic plans that is funded
<b>B. Engagement of communities and providers</b>	Percentage of diagnosed tuberculosis cases that were notified
<b>C. Universal health coverage and regulatory frameworks</b>	Percentage of population without catastrophic health expenditures Percentage of countries with a certified tuberculosis surveillance system
<b>D. Social protection, social determinants</b>	Percentage of affected families facing catastrophic costs due to tuberculosis Percentage of population without undernutrition
<b>PILLAR THREE: INTENSIFIED RESEARCH AND INNOVATION</b>	
<b>A. Discovery</b>	Percentage of desirable number of candidates in the pipelines of new diagnostics, drugs and vaccines for tuberculosis
<b>B. Implementation</b>	Percentage of countries introducing and scaling-up new diagnostics, drugs or vaccines

## **THE ROLE OF THE SECRETARIAT**

75. The Secretariat, at all levels of the Organization, will provide support to Member States in reviewing, adopting, adapting and implementing their post-2015 tuberculosis strategies, building on the framework provided in the strategy. WHO will draw on its comparative advantages in areas of the core functions outlined below and use its Strategic and Technical Advisory Group for Tuberculosis and regional advisory bodies, as well as the Organization's governing bodies, in order to guide, support and evaluate its work.

76. WHO will continue its policy and norms-setting work, building on a range of available and future guidance documents on tuberculosis. The Secretariat will provide the strategic guidance and tools needed for adaptation and implementation of the strategy in diverse country settings. These tools will need to be iterated as further evidence on effective approaches and best practices becomes available. Periodic guidance will be needed on the use of new tuberculosis diagnostics, medicines susceptibility testing methods and new treatment regimens as they become available. WHO will work with partners to stimulate further evidence generation and policy recommendations on how national tuberculosis programmes can engage in the development agenda to address social determinants of tuberculosis.

77. To enable this strategy to have a rapid impact and to support Member States, the Secretariat will pursue its core function of technical support coordination. It will continue to stimulate contributions from partners, at global, national and local levels. The tuberculosis technical assistance mechanism (TBTEAM) managed by WHO helps to facilitate and mobilize financing for technical assistance by partnering with major development agencies. The gaps in technical expertise among supporting agencies will need to be filled by collaborating with experts working in global health disciplines beyond tuberculosis, and by drawing more young collaborators into the field.

78. WHO will continue to strengthen its stewardship role in generating global demand for research, prioritizing among tuberculosis research needs, and supporting with partners the effective conduct of research to inform global and national strategy and policy design and implementation. This will entail further work with basic scientists, epidemiologists, social scientists and innovators in the public, private and academic communities, as well as affected populations. It will also mean that national tuberculosis programmes need to work with academic partners and associated research institutions, research-focused public partnerships and public-private partnerships.

79. WHO will foster effective partnerships to support the work proposed under the three pillars of the new strategy. This work in partnership aims to support Member States in achieving universal access to tuberculosis care and prevention and in reaching out to vulnerable populations and communities most affected by the tuberculosis epidemic worldwide. WHO will work with the Stop TB Partnership, and will seek out new partnerships that can leverage effective commitment and innovation in the non-health sector driven elements of the strategy.

80. The launch of the Stop TB Strategy 2006–2015 by WHO led to its swift translation into a comprehensive, costed global plan of action by the Stop TB Partnership. Similarly for the post-2015 global tuberculosis strategy, WHO will actively support the development of a global investment plan by the Stop TB Partnership, outlining activities and defining financing requirements to meet the ambitious targets while achieving the stated milestones on the way. WHO will work closely with the Stop TB Partnership and will contribute to preparing the global action and investment plan to guide post-2015 efforts for tuberculosis care and prevention by providing the required strategic, scientific and technical input.

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## ANNEX 2

### **Text of amended Rules of Procedure of the World Health Assembly<sup>1</sup>**

[A67/5 – 7 May 2014]

#### CONDUCT OF BUSINESS AT PLENARY MEETINGS

##### *Rule 48*

Formal proposals relating to items of the agenda may be introduced until the first day of a regular session of the Health Assembly and no later than two days before the opening of a special session. All such proposals shall be referred to the committee to which the item of the agenda has been allocated, except if the item is considered directly in a plenary meeting.

*[Rule 49 deleted]*

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<sup>1</sup> See resolution WHA67.2.

## ANNEX 3

### **WHO global disability action plan 2014–2021: better health for all people with disability<sup>1,2</sup>**

[A67/16 – 4 April 2014]

1. In May 2013, the Sixty-sixth World Health Assembly in resolution WHA66.9 on disability endorsed the recommendations of the *World report on disability*.<sup>3</sup> The Health Assembly requested the Director-General to prepare, in consultation with Member States<sup>4</sup> and organizations of the United Nations system, a comprehensive WHO action plan based on the evidence in the *World report on disability*, and in line with the Convention on the Rights of Persons with Disabilities (adopted by the United Nations General Assembly in resolution 61/106) and the outcome document of the high-level meeting of the United Nations General Assembly on the realization of the Millennium Development Goals and other internationally agreed development goals for persons with disabilities: the way forward, a disability-inclusive development agenda towards 2015 and beyond.

2. Disability is universal. Everybody is likely to experience disability directly or to have a family member who experiences difficulties in functioning at some point in his or her life, particularly when they grow older. Following the International Classification of Functioning, Disability and Health and its derivative version for children and youth, this action plan uses “disability” as an umbrella term for impairments, activity limitations and participation restrictions, denoting the negative aspects of the interaction between an individual (with a health condition) and that individual’s contextual (environmental and personal) factors. Disability is neither simply a biological nor a social phenomenon.

3. WHO recognizes disability as a global public health issue, a human rights issue and a development priority. Disability is a global public health issue because people with disability, throughout the life course, face widespread barriers in accessing health and related services, such as rehabilitation, and have worse health outcomes than people without disability. Some health conditions may also be a risk factor for other health problems, which are often poorly managed, such as a higher incidence of obesity in people with Down syndrome and higher prevalence of diabetes or bowel cancer in people with schizophrenia. Disability is also a human rights issue because adults, adolescents and children with disability experience stigmatization, discrimination and inequalities; they are subject to multiple violations of their rights including their dignity, for instance through acts of violence, abuse, prejudice and disrespect because of their disability, and they are denied autonomy. Disability is a development priority because of its higher prevalence in lower-income countries and because

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<sup>1</sup> See resolution WHA67.7.

<sup>2</sup> The terms “people” and “persons” with disabilities are used interchangeably throughout this action plan and include children and youth. Consistent with the Convention on the Rights of Persons with Disabilities (adopted by the United Nations General Assembly in resolution 61/106), “persons with disabilities” is used whenever the plan refers to rights and entitlements. In most other instances “people with disabilities” is used.

<sup>3</sup> World Health Organization, World Bank. *World report on disability*. Geneva: World Health Organization; 2011.

<sup>4</sup> And, where applicable, regional economic integration organizations.



disability and poverty reinforce and perpetuate one another. Poverty increases the likelihood of impairments through malnutrition, poor health care, and dangerous living, working and travelling conditions. Disability may lead to a lower standard of living and poverty through lack of access to education and employment, and through increased expenditure related to disability.

4. The action plan will be relevant to and should benefit all people with disability from birth to old age. Persons with disability include people who are traditionally understood as disabled, such as children born with cerebral palsy, wheelchair users, persons who are blind or deaf or people with intellectual impairments or mental health conditions, and also the wider group of persons who experience difficulties in functioning due to a wide range of conditions such as noncommunicable diseases, infectious diseases, neurological disorders, injuries, and conditions that result from the ageing process. Article 1 of the Convention on the Rights of Persons with Disabilities indicates that persons with disabilities include those who have long-term physical, mental, intellectual or sensory impairments which, in interaction with various barriers, may hinder their full and effective participation in society on an equal basis with others.

5. Much of WHO's mission is dedicated to the prevention of health conditions that may result in death, morbidity or disability. This action plan, however, is directed at improving the health, functioning and well-being of people with disability. It therefore considers prevention only in so far as persons with disabilities require the same access to preventive services and programmes as others. Prevention includes a wide range of measures aimed at reducing risks or threats to health: promotion of healthy lifestyles, such as guidance on good nutrition, the importance of regular physical exercise and avoiding tobacco use; protection of people from developing a health condition in the first place, such as immunization against infectious diseases or safe birthing practices; detection of a secondary or co-morbid health condition at an early stage, such as screening for diabetes or depression; and reduction of the impact of an established health condition, by means such as pain management, rehabilitation programmes, patient support groups or removal of barriers to access. Improving access to preventive services and programmes for persons with disabilities is important for achieving better health outcomes and is covered by Objectives 1 and 2 of this plan.

## **OVERVIEW OF THE GLOBAL SITUATION**

6. There are more than 1000 million people with disability globally, that is about 15% of the world's population or one in seven people. Of this number, between 110 million and 190 million adults experience significant difficulties in functioning. It is estimated that some 93 million children – or one in 20 of those under 15 years of age – live with a moderate or severe disability. The number of people who experience disability will continue to increase as populations age, with the global increase in chronic health conditions. National patterns of disability are influenced by trends in health conditions and environmental and other factors, such as road traffic crashes, falls, violence, humanitarian emergencies including natural disasters and conflict, unhealthy diet and substance abuse.

7. Disability disproportionately affects women, older people, and poor people. Children from poorer households, indigenous populations and those in ethnic minority groups are also at significantly higher risk of experiencing disability. Women and girls with disability are likely to experience “double discrimination”, which includes gender-based violence, abuse and marginalization. As a result, women with disability often face additional disadvantages when compared with men with disability and women without disability. Indigenous persons, internally displaced or stateless persons, refugees, migrants and prisoners with disability also face particular challenges in accessing services. The prevalence of disability is greater in lower-income countries than higher-income countries. In its outcome document of the high-level meeting on disability and development in 2013, the United Nations General Assembly noted that an estimated 80% of people with disability live in developing

countries and stressed the need to ensure that persons with disabilities are included in all aspects of development, including the post-2015 development agenda.

8. People with disability face widespread barriers in accessing services, such as those for health care (including medical care, therapy and assistive technologies), education, employment, and social services, including housing and transport. The origin of these barriers lies in, for example, inadequate legislation, policies and strategies; the lack of service provision; problems with the delivery of services; a lack of awareness and understanding about disability; negative attitudes and discrimination; lack of accessibility; inadequate funding; and lack of participation in decisions that directly affect their lives. Specific barriers also exist in relation to persons with disabilities being able to express their opinions and seek, receive and impart information and ideas on an equal basis with others and through their chosen means of communication.

9. These barriers contribute to the disadvantages experienced by people with disability. Particularly in developing countries, people with disability experience poorer health than people without disability, as well as higher rates of poverty, lower rates of educational achievement and employment, reduced independence and restricted participation. Many of the barriers they face are avoidable and the disadvantage associated with disability can be overcome. The *World report on disability* synthesizes the best available evidence on how to overcome the barriers that persons with disability face in accessing health, rehabilitation, support and assistance services, their environments (such as buildings and transport), education and employment.

## **VISION, GOAL, OBJECTIVES, GUIDING PRINCIPLES AND APPROACHES**

10. The vision of the action plan is a world in which all persons with disabilities and their families live in dignity, with equal rights and opportunities, and are able to achieve their full potential.

11. The overall goal is to contribute to achieving optimal health, functioning, well-being and human rights for all persons with disabilities.

12. The action plan has the following three objectives:

- (1) to remove barriers and improve access to health services and programmes;
- (2) to strengthen and extend rehabilitation, habilitation, assistive technology, assistance and support services, and community-based rehabilitation; and
- (3) to strengthen collection of relevant and internationally comparable data on disability and support research on disability and related services.

13. This action plan supports the implementation of measures that are designed to meet the rights of persons with disabilities, as enshrined in the Convention on the Rights of Persons with Disabilities, in particular Articles 9 (Accessibility), 11 (Situations of risk and humanitarian emergencies), 12 (Equal recognition before the law), 19 (Living independently and being included in the community), 20 (Personal mobility), 25 (Health), 26 (Habilitation and rehabilitation), 28 (Adequate standard of living and social protection), 31 (Statistics and data collection), 32 (International cooperation) and 33 (National implementation and monitoring). It also supports Articles 4 (General obligations), 5 (Equality and non-discrimination), 6 (Women with disabilities), 7 (Children with disabilities) and 21 (Freedom of expression and opinion, and access to information). It proposes actions to support the commitments made in the outcome document adopted by the United Nations General Assembly at its high-level meeting on disability and development (New York, 23 September 2013) to ensure access for persons with disabilities to health care services, including rehabilitation, habilitation and assistive

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devices, and to improve disability data collection, analysis and monitoring and promote knowledge, social awareness and understanding of disability.

14. The action plan supports the Organization's continuing work towards mainstreaming disability in its programmes, in line with recent United Nations General Assembly resolutions.<sup>1</sup> It is aligned with the Twelfth General Programme of Work, 2014–2019, in particular reflecting the new political, economic, social and environmental realities and evolving health agenda. It complements and supports the implementation of other plans and strategies of the Organization, such as those on healthy ageing, reproductive, maternal and child health, emergencies and disasters, mental health, avoidable blindness and visual impairment, and noncommunicable diseases.

15. The design of the action plan is guided by the following principles, most of which are reflected in the Convention on the Rights of Persons with Disabilities:

- respect for the inherent dignity, individual autonomy, including the freedom to make one's own choices, and independence of persons;
- non-discrimination;
- full and effective participation and inclusion in society;
- respect for difference and acceptance of persons with disabilities as part of human diversity and humanity;
- equality of opportunity;
- accessibility;
- equality between men and women;
- respect for the evolving capacities of children with disability and respect of the right of children with disability to preserve their identities;
- respect for the continued dignity and value of persons with disabilities as they grow older.

16. People with disability have unique insights about their disability and situation but have been excluded from the decision-making process about issues that directly affect their lives. In line with Article 4 of the Convention on the Rights of Persons with Disabilities, persons with disabilities through their representative organizations should be fully consulted and actively involved in all stages of formulating and implementing policies, laws, and services that relate to them.

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<sup>1</sup> Resolutions 66/288 (The future we want), 66/229 (Convention on the Rights of Persons with Disabilities and the Optional Protocol thereto), 66/124 (High-level Meeting of the General Assembly on the realization of the Millennium Development Goals and other internationally agreed development goals for persons with disabilities), 65/186 (Realizing the Millennium Development Goals for persons with disabilities towards 2015 and beyond), 68/3 (Outcome document of the high-level meeting of the United Nations General Assembly on the realization of the Millennium Development Goals and other internationally agreed development goals for persons with disabilities: the way forward, a disability-inclusive development agenda towards 2015 and beyond) and 64/131 (Realizing the Millennium Development Goals for persons with disabilities).

17. The design and implementation of the action plan are based on and guided by the following approaches:

- a human rights-based approach, including empowerment of persons with disabilities
- a life-course approach, including the continuum of care
- universal health coverage
- a culturally-appropriate person-centred approach
- multisectoral/community-based rehabilitation<sup>1</sup>
- universal design (see paragraph 29 below).

### **PROPOSED ACTIONS FOR MEMBER STATES, INTERNATIONAL AND NATIONAL PARTNERS, AND THE SECRETARIAT**

18. Specific actions, detailing what can be done to achieve the plan's three objectives, are proposed for Member States, international and national partners, and the Secretariat. Options for how to implement the actions are proposed as inputs from various parties. The actions and inputs are based on the evidence of successful ways of overcoming barriers to accessing services outlined in the *World report on disability* and build on the Secretariat's technical work to enhance the quality of life of people with disability. It is essential that countries tailor their actions to their specific contexts.

19. As disability cuts across all sectors and involves diverse actors, implementation of the action plan will need the strong commitment of, provision of resources by and action from a wide range of international, regional and national partners and the development and strengthening of regional and global networks. National and local governments play the most significant roles, but other actors also have important parts to play, including organizations of the United Nations system, development organizations, organizations of persons with disabilities; service providers, including those in civil society and faith-based organizations; academic institutions; the private sector; communities; and people with disability and their families. The plan also recognizes the important contribution of formal and informal caregivers to the support of persons with disabilities and the particular support requirements they need to fulfil this role.

20. The success of the plan will depend on an effective multisectoral approach, with practical mechanisms for coordination and implementation between relevant ministries and departments responsible for the provision of health, rehabilitation and associated services for persons with disabilities. Relevant areas of government include health, disability services, social protection, welfare and community services, finance, infrastructure, transport, communications, labour and education. Effective coordination is essential, but each ministry, department and agency is primarily responsible for ensuring that its main areas of activity are accessible to, and respond to the requirements of, persons with disabilities.

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<sup>1</sup> Community-based rehabilitation offers an operational methodology to realize human rights and development objectives at the community level, based on a comprehensive multisectoral approach, which can empower persons with disabilities and their families.

21. One way to facilitate multisectoral collaboration is through community-based rehabilitation. This activity has evolved to become a multisectoral strategy that offers practical guidance on how to link between, and strengthen the capacity of, mainstream services to ensure that persons with disabilities and their families have access to and benefit from education, employment, and health and social services. It is implemented through the combined efforts of persons with disabilities, their families, organizations and communities, and relevant government and nongovernmental health, education, vocational, social and other services. The approach is currently applied in more than 90 countries for rehabilitation, equalization of opportunities, poverty reduction, and social inclusion of persons with disabilities.

22. The action plan recognizes the considerable variation in contexts and starting points of countries and regions in their efforts to ensure access to health services and provide specific programmes and support for persons with disabilities. The plan is intended to provide structure and guidance but cannot be a “one-size-fits-all” solution. Actions towards achieving the plan’s objectives need to be aligned with existing regional and national obligations, policies, plans and targets.

## **MONITORING PROGRESS TOWARDS THE ACHIEVEMENT OF THE OBJECTIVES OF THE ACTION PLAN**

23. The indicators of success set for each objective can be used to help to monitor and measure progress towards attainment of the plan’s goal. Baseline data and targets will be decided upon once the plan is approved. Given that the targets will be voluntary and global, each Member State is not expected to reach all the specific targets but can contribute to varying degrees towards their achievement. As indicated in the actions for Objective 3, the Secretariat will provide guidance, training and technical support to Member States, upon request, for improving disability data analysis and use in an efficient and cost-effective manner. Monitoring and reporting to the governing bodies on progress in implementing this action plan are recommended at the midway point (2017) and during its final year (2021).

## **OBJECTIVE 1: TO REMOVE BARRIERS AND IMPROVE ACCESS TO HEALTH SERVICES AND PROGRAMMES**

24. Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity. WHO’s Constitution enshrines the enjoyment of the highest attainable standard of health as a fundamental right of every human being. The right to health includes access to timely, acceptable and affordable health care of appropriate quality. Promoting the right to health also requires Member States to generate conditions in which: (i) each person can enjoy the highest attainable standard of health; and (ii) health services are provided on the basis of free and informed consent.

25. Disability is extremely diverse. Even though some health conditions associated with disability result in extensive health care needs and others do not, all people with disability have the same general health care needs as everybody else and therefore require access to mainstream health care services. People with disability may experience greater vulnerability to preventable secondary conditions, comorbidities and age-related conditions, and may require specialist health care services. Sometimes they are subjected to treatment or other protective measures without consent. Some studies have also indicated that certain groups of people with disabilities exhibit higher rates of risky behaviour such as smoking, poor diet and physical inactivity. They are also at greater risk of experiencing violence than those without disability, and have a higher risk of injury from road traffic crashes, burns or falls. For example, children with disability are three to four times more likely to experience violence. Children with mental health conditions or intellectual impairments appear to be among the most vulnerable, with a 4.6 times higher risk of experiencing sexual violence than their non-disabled peers.

26. As well as causing disability, emergencies can also increase the vulnerability of persons with disabilities, whose basic and specific needs are frequently ignored or overlooked in emergency risk management. Those needs are often not identified and addressed before, during and after an emergency. Persons with disabilities are rarely consulted or represented in the design of emergency risk management policies and programmes.

27. Good health enables participation in a wide range of activities, including education and employment. However, evidence shows that people with disability, throughout the life course, have unequal access to health care services, have greater unmet health care needs and experience poorer levels of health compared with the general population. Health systems frequently fail to respond adequately to both the general and specific health care needs of people with disability. People with disability encounter a range of attitudinal, physical and systemic barriers when they attempt to access health care. Analysis of the World Health Survey shows that, compared with people without disability, men and women with disabilities are twice as likely to find that health care facilities and providers' skills are inadequate, three times more likely to be denied health care and four times more likely to be treated badly in the health care system. Of all persons with disabilities, half cannot afford required health care; people with disabilities are also 50% more likely than those without disability to suffer catastrophic health expenditures.<sup>1</sup>

28. Barriers to accessing health services include: physical barriers related to the architectural design of health facilities, medical equipment or transport; health providers' lack of adequate knowledge and skills; misconceptions about the health of persons with disabilities, leading to assumptions that persons with disabilities do not require access to health promotion and disease prevention services and programmes; lack of respect or negative attitudes and behaviour towards persons with disabilities; informational barriers and communication difficulties; and inadequate information for persons with disabilities about their right to access health care services. Although both men and women face barriers to health care, men are less likely than women to consider that they or their children are sick enough to require health care services and to know where to access those services. Men also report more difficulties in accessing health care financing.

29. Article 25 of the Convention on the Rights of Persons with Disabilities reinforces the rights of persons with disabilities to enjoy the highest standard of health without discrimination on the basis of disability. Article 9 (Accessibility) outlines the measures to be taken to ensure that persons with disabilities have access, on an equal basis with others, to the physical environment, transport, information and communications (including information and communications technologies and systems), and other facilities and services open or provided to the public by both State and non-State actors and in both urban and rural areas. These measures include the identification and elimination of obstacles and barriers to accessibility in relation to buildings, roads, transportation and other indoor and outdoor facilities (including medical facilities), and information, communications and other services (including electronic and emergency services). Because of the diversity of health service users, a universal design approach is important in ensuring that products, environments, programmes and services are designed to be usable by all people, to the greatest extent possible, without the need for adaptation or specialized design.

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<sup>1</sup> When people have to pay fees or co-payments for health care, the amount can be so high in relation to income that it results in "financial catastrophe" for the individual or the household. WHO has proposed that health expenditure be viewed as catastrophic whenever it is greater than or equal to 40% of a household's non-subsistence income, i.e. income available after basic needs have been met.

30. Health disparities will be reduced by making existing health care systems more inclusive at all levels and making public health programmes (including those for a healthy lifestyle, promoting improved diets and encouraging physical activity) accessible to persons with disabilities throughout the life course. Given that multiple factors limit access to health care for people with disability, actions are needed in all components of health care systems, including improving governance and increasing levels of awareness, knowledge and data in health and related ministries so that they may better consider disability and increase access to services. Maintaining nationally-defined social protection floors<sup>1</sup> containing basic social security guarantees that ensure universal access to essential health care and income security at least at a nationally defined minimum level is recommended. National health care policies need to acknowledge formally that some groups of people with disability experience health inequalities; that acknowledgement will be an essential step towards reducing health disparities, and towards making a commitment to collaboration and a coordinated approach among health care providers. Community-based rehabilitation is an important means of ensuring and improving coordination of and access to health services, particularly in rural and remote areas.

31. Successful removal of barriers and improvement in access to health services require input from persons with disabilities, who are most familiar with and affected by such barriers. Ensuring that health-related information is issued in an appropriately accessible format, and that modes of communication meet the requirements of persons with disabilities (such as sign language) is important. Some persons with disabilities may also require support to assert their right to health and equal access to health services.

<b>OBJECTIVE 1: TO REMOVE BARRIERS AND IMPROVE ACCESS TO HEALTH SERVICES AND PROGRAMMES</b>		
<b>Indicators of success</b>	<b>Means of verification</b>	<b>Evidence of success</b>
<p><b>1.1</b> X% of countries have national health policies that explicitly mention that persons with disabilities have the right to the enjoyment of the highest attainable standard of health</p> <p><b>1.2</b> X% of countries prohibit health insurers from discriminating against pre-existing disability</p> <p><b>1.3</b> Proportion of persons with disabilities who have access to the health services that they need</p> <p><b>1.4</b> X% of households with persons with disabilities incur catastrophic out-of-pocket expenditures on health services</p>	<p>Data to be collected through surveys of key informants in health ministries and civil society/organizations of persons with disabilities, administered by the Secretariat at baseline and after 5 and 10 years</p> <p>The model disability survey (see Objective 3) and other national disability and health surveys carried out as part of the monitoring framework and measurement approach to universal health coverage</p>	<p>Existence of health policy in line with the Convention on the Rights of Persons with Disabilities</p> <p>Universal health coverage inclusive of persons with disabilities</p>

<sup>1</sup> International Labour Organization Social Protection Floors Recommendation, 2012 (No. 202): recommendation concerning national floors of social protection, adopted 14 June 2012.

<b>ACTIONS FOR OBJECTIVE 1</b>	<b>Proposed inputs for Member States</b>	<b>Inputs for the Secretariat</b>	<b>Proposed inputs for international and national partners</b>
<p><b>1.1</b> Develop and/or reform health and disability laws, policies, strategies and plans for consistency with the principles of the Convention on the Rights of Persons with Disabilities</p>	<ul style="list-style-type: none"> <li>• Review and revise existing policies by eliminating discriminatory provisions to help to ensure better access for and inclusion of persons with disabilities in health and other sectors</li> <li>• Mobilize the health sector to contribute to the development of a multisectoral national disability strategy and action plan that ensures clear lines of responsibility and mechanisms for coordination, monitoring and reporting</li> <li>• Provide health sector support for monitoring and evaluating the implementation of health policies to ensure compliance with the provisions of the Convention on the Rights of Persons with Disabilities</li> <li>• Promote people-centred health services and the active involvement of men, women, boys and girls with disability and organizations of persons with disabilities throughout the process</li> </ul>	<ul style="list-style-type: none"> <li>• Provide technical support; develop guidelines on disability-inclusive health systems strengthening to help to achieve universal coverage</li> <li>• Provide technical support and build capacity within health ministries and other relevant sectors for the development, implementation and monitoring of laws, policies, strategies and plans</li> </ul>	<ul style="list-style-type: none"> <li>• Support opportunities for exchange on effective policies to promote the health of people with disability</li> <li>• Participation of relevant national bodies, including organizations of persons with disabilities and other civil society entities, in reforming health and disability laws, policies, strategies and plans</li> </ul>



<b>ACTIONS FOR OBJECTIVE 1</b>	<b>Proposed inputs for Member States</b>	<b>Inputs for the Secretariat</b>	<b>Proposed inputs for international and national partners</b>
<p><b>1.2</b> Develop leadership and governance for disability-inclusive health</p>	<ul style="list-style-type: none"> <li>• Identify focal points for disability within health ministries and formulate internal action plans that support inclusion and access to mainstream health care services</li> <li>• Ensure participation of the health sector in national coordinating bodies on disability</li> <li>• Ensure participation of organizations of persons with disabilities in health policy-making and quality assurance processes</li> </ul>	<ul style="list-style-type: none"> <li>• Provide support to Member States to build their leadership capacity; develop and implement a training package on disability inclusion in the health sector</li> <li>• Host regional workshops, integrated with ongoing/related initiatives, for health ministry staff, policy-makers and representatives of organizations of persons with disabilities on universal health coverage and equity, drawing on country experience</li> </ul>	<ul style="list-style-type: none"> <li>• Provide support to health ministries to build their leadership capacity for ensuring disability-inclusive health services (Article 32 of the Convention on the Rights of Persons with Disabilities)</li> <li>• Capacity-building for organizations of persons with disabilities to participate effectively in health service governance</li> </ul>
<p><b>1.3</b> Remove barriers to financing and affordability through options and measures to ensure that people with disability can afford and receive the health care they need without extreme out-of-pocket and catastrophic expenditures</p>	<ul style="list-style-type: none"> <li>• Allocate adequate resources to ensure implementation of the health components of the national disability strategy and plan of action</li> <li>• Ensure that financing schemes for national health care include minimum packages and poverty- and social-protection measures that target and meet the health care needs of people with disability and that information about the schemes reach persons with disabilities</li> <li>• Reduce or remove out-of-pocket payments for people with disability who have no means of financing health care</li> <li>• Promote multisectoral approaches to meeting the indirect costs related to accessing health care (e.g. transport)</li> </ul>	<ul style="list-style-type: none"> <li>• Provide technical support to countries for development of health financing measures that increase access and affordability</li> </ul>	<ul style="list-style-type: none"> <li>• Provide technical and financial support to Member States in order to ensure that persons with disabilities can access mainstream health care services</li> <li>• Provide guidance to Member States in establishing and maintaining nationally-defined social protection floors</li> <li>• Support people with disability in accessing information on health care financing options</li> </ul>

ACTIONS FOR OBJECTIVE 1	Proposed inputs for Member States	Inputs for the Secretariat	Proposed inputs for international and national partners
	<ul style="list-style-type: none"> <li>• Where private health insurance exists, ensure that it is affordable and accessible for persons with disabilities</li> </ul>		
<p><b>1.4</b> Remove barriers to service delivery (including impediments to physical access, information and communication, and coordination) across all health care programmes, including those on sexual and reproductive health, health promotion and other population-based public health initiatives</p>	<ul style="list-style-type: none"> <li>• Adopt national accessibility standards (in line with universal design principles) and ensure compliance with them within mainstream health settings</li> <li>• Provide a broad range of reasonable accommodation measures to overcome barriers to accessing mainstream health services, including structural modifications to facilities, equipment with universal design features, adjustments to appointment systems, alternative models of service delivery, and communication of information in appropriate formats such as sign language, Braille, large print, Easy Read and pictorial information</li> <li>• Support mechanisms to improve the continuum of care experienced by people with disability across the life course, including: discharge planning, multidisciplinary team work, development of referral pathways and service directories</li> <li>• Promote and facilitate access to mainstream national and local public health initiatives that promote and protect health</li> </ul>	<ul style="list-style-type: none"> <li>• Support identification of barriers to particular services through technical support for collecting disability-disaggregated data on use of services</li> <li>• Develop resource on accessibility issues for health care facilities</li> <li>• Provide technical guidance to support the inclusion of people with disability in public health policies, strategies and programmes</li> <li>• Promote capacity-building of community-based rehabilitation programmes, especially in the areas related to health</li> </ul>	<ul style="list-style-type: none"> <li>• Support user groups to audit accessibility in order to identify barriers that may prevent persons with disabilities from accessing health services</li> <li>• Finance pilot programmes that aim to demonstrate the benefits of including people with disability</li> <li>• Empower people with disability to optimize their health by providing information, training and peer support</li> <li>• Support development of community-based rehabilitation programmes</li> </ul>

ACTIONS FOR OBJECTIVE 1	Proposed inputs for Member States	Inputs for the Secretariat	Proposed inputs for international and national partners
	<ul style="list-style-type: none"> <li>• Support inclusion by community-based rehabilitation programmes of health care referral within their activities</li> </ul>		
<p><b>1.5</b> Overcome specific challenges to the quality of health care experienced by persons with disabilities, including health workers' knowledge, attitudes and practices as well as participation of persons with disabilities in decisions that directly affect them</p>	<ul style="list-style-type: none"> <li>• Promote increased understanding, knowledge and positive perceptions of people with disability through targeted communication and social media campaigns, developed in conjunction with organizations of persons with disabilities</li> <li>• Support education and training by promoting and encouraging the integration of disability into relevant undergraduate curricula and continuing education for service providers</li> </ul>	<ul style="list-style-type: none"> <li>• Build understanding and promote importance of the inclusion of disability issues (including rights) in the curricula of schools of medicine and nursing, and other health-related institutions</li> <li>• Design model curricula on disability for personnel working in health care, rehabilitation and habilitation</li> <li>• Provide technical support to Member States seeking to implement model curricula on disability and health</li> </ul>	<ul style="list-style-type: none"> <li>• Integrate education on the health and human rights of persons with disabilities into undergraduate and continuing education for all health care workers</li> <li>• Ensure people with disability are involved as providers of education and training where relevant</li> <li>• Provide training and support for community workers and informal caregivers who assist persons with disabilities to access health services</li> <li>• Provide opportunities for persons with disabilities to develop self-advocacy skills to effectively address specific challenges in accessing health services</li> </ul>
<p><b>1.6</b> Meet the specific needs of persons with disabilities in all aspects of health emergency risk management, including emergency prevention, preparedness, response and recovery</p>	<ul style="list-style-type: none"> <li>• Integrate disability in health emergency risk management policies, assessments, plans and programmes</li> <li>• Include actions on emergency risk management in disability policies, services and programmes</li> </ul>	<ul style="list-style-type: none"> <li>• Provide technical guidance and support to strengthen capacities for dealing with disability in emergency risk management for health</li> </ul>	<ul style="list-style-type: none"> <li>• Integrate disability across emergency risk management in global, regional and national multisectoral and health policy frameworks and forums</li> <li>• Include disability in risk assessments and make provision for disability in health services in emergency response and recovery</li> </ul>

**OBJECTIVE 2: TO STRENGTHEN AND EXTEND REHABILITATION, HABILITATION, ASSISTIVE TECHNOLOGY, ASSISTANCE AND SUPPORT SERVICES, AND COMMUNITY-BASED REHABILITATION**

32. Not all persons with disabilities require habilitation, rehabilitation, assistive technology, assistance and support services and community-based rehabilitation, but many do. Access to various services and technologies is often a prerequisite for people with disability to be able to go to work, participate in community life, and access health care, and for children and adolescents with disability to attend school. Enabling the individual to participate and be included in the community is the focus of such services.

33. Article 26 (Habilitation and rehabilitation) of the Convention on the Rights of Persons with Disabilities outlines the need for States Parties to undertake appropriate measures to organize, strengthen and extend habilitation and rehabilitation services and programmes in the areas of health, employment, education and social services. Article 26 also stipulates that States Parties shall promote the availability, knowledge and use of assistive devices and technologies, designed for persons with disabilities, as they relate to habilitation and rehabilitation. In addition, Article 4 (General obligations), Article 20 (Personal mobility), and Article 32 (International cooperation) require Member States and the international community to invest in facilitating access to good-quality assistive technology, for instance by making them available at affordable cost.

34. Habilitation and rehabilitation can reduce the impact of a broad range of health conditions (such as diseases and injuries). These two actions are defined in the *World report on disability* as sets of measures that assist individuals who experience, or are likely to experience, disability to achieve and maintain optimal functioning in interaction with their environments. Encompassing medical care, therapy and assistive technologies, such measures should begin as early as possible and be made available as close as possible to where people with disability live.

35. Assistive technologies are evolving quickly and include any item, piece of equipment or product, whether it is acquired commercially, modified or customized, that is used to increase, maintain or improve the functional capabilities of individuals with disability. Assistive technologies include low vision devices, hearing aids, augmentative and alternative communication, walking frames, wheelchairs, and prostheses such as artificial legs. The field also covers information and communications technologies such as computers, screen-reading software and customized telephones. Assistive technologies play a significant role in enabling people with disability to function and participate.

36. Assistance and support services enable individuals with disability to undertake activities of daily life and participate in their community. These services, commonly provided through family members and social networks as well as through formal provision, include personal assistance, independent living services, respite services, sign language interpretation, employment and education support, and information and advice.

37. Community-based rehabilitation programmes can provide rehabilitation, assistive technologies and support services in countries with limited resources, and empower persons with disabilities and their families. WHO's guidelines on the subject offer practical suggestions on how to build links with and strengthen the capacity of mainstream services and facilitate access to specific services.<sup>1</sup>

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<sup>1</sup> Community-based rehabilitation: CBR guidelines. Geneva: World Health Organization; 2010.

38. Investments in habilitation and rehabilitation and provision of assistive technologies are beneficial because they build human capacity and can be instrumental in enabling people with limitations in functioning to remain in or return to their home or community, live independently, and participate in education, the labour market and civic life. In addition, such investments can reduce the need for formal support services as well as reducing the call on caregivers' time and the physical burden imposed on them.

39. Global data on the need for habilitation, rehabilitation, assistive technologies and support and assistance services, the type and quality of measures provided, and estimates of unmet need do not exist. However, national-level data reveal large gaps in the provision of and access to services in many low- and middle-income countries. Data from four southern African countries, for example, revealed that only 26%–55% of people received the medical rehabilitation they needed. Hearing aid production currently meets less than 10% of global need, and less than 3% of hearing aid needs in developing countries are met annually. The need for services may be increased by environmental factors such as disasters and conflict.

40. Significant barriers exist to the provision of habilitation, rehabilitation, assistive technology and assistance and support services, including the lack of prioritization; the lack of policies and plans; high costs and nonexistent or inadequate funding mechanisms; insufficient numbers of appropriately trained professionals; absence of facilities and equipment; and ineffective service models and lack of integration and decentralization of services (for example, rehabilitation and habilitation service provision within primary and secondary health care settings). Major rehabilitation and habilitation centres are usually located in urban areas; in rural areas, even basic therapeutic services are often not available. Travelling to secondary or tertiary rehabilitation and habilitation services can be costly and time-consuming, and public transport is often not adapted for people with mobility difficulties. Women may experience additional difficulties in travelling to health care services. Lack of research and data on needs, unmet needs, type and quality of services provided, costs, and benefits also constrains the development of effective rehabilitation and habilitation services. Furthermore, there is insufficient consultation with and involvement of persons with disabilities in the provision of rehabilitation and habilitation services.

41. Habilitation and rehabilitation are cross-sectoral activities and may be provided by health professionals in conjunction with specialists in education, employment, social welfare and other fields. In resource-constrained settings these services may be provided by non-specialist workers, such as community-based rehabilitation workers, in addition to family, friends and community groups. Although health ministries will play a central role in ensuring access to appropriate, timely, affordable and high-quality services, it is important to recognize and articulate the linkages with other ministries, for example social welfare (which may provide assistive devices or subsidies for services and equipment), labour (for the provision of vocational rehabilitation), and education (for training of personnel). Nongovernmental entities, including faith-based organizations and private companies, often contribute significantly to the provision of rehabilitation and habilitation services. Governments play an important role in determining the mechanism through which these services can be coordinated and regulated across sectors and partners.

42. Habilitation and rehabilitation are voluntary activities yet some individuals may require support in making decisions about treatment choices. In all cases habilitation, rehabilitation, assistance and support services and community-based rehabilitation should empower persons with disabilities and their family members. The active participation and decision-making of persons with disabilities and the families of children with disabilities are integral to the success of habilitation, rehabilitation and assistance and support services.

<b>OBJECTIVE 2: TO STRENGTHEN AND EXTEND REHABILITATION, HABILITATION, ASSISTIVE TECHNOLOGY, ASSISTANCE AND SUPPORT SERVICES, AND COMMUNITY-BASED REHABILITATION</b>		
<b>Indicators of success</b>	<b>Means of verification</b>	<b>Evidence of success</b>
<b>2.1</b> X% of countries have national policies on habilitation, rehabilitation and community services or programmes related to persons with disabilities	Use of the International Standard Classification of Occupations, and surveys by professional organizations	Existence of rehabilitation, habilitation and community services legislation, policy and regulation compatible with the principles of the Convention on the Rights of Persons with Disabilities
<b>2.2</b> Number of graduates from educational institutions per 10 000 population – by level and field of education (for example, physical rehabilitation medicine, physical therapy, occupational therapy, and prosthetics and orthotics)	Data to be collected through surveys of key informants in health ministries and civil society/ organizations of persons with disabilities, administered by the Secretariat at baseline and after 5 and 10 years (indicator 2.3)	
<b>2.3</b> Proportion of the population covered by community-based rehabilitation or other community services	Use of disability surveys such as WHO's model disability survey (indicator 2.4)	
<b>2.4</b> Proportion of persons with disabilities that receive the assistive technologies that they need (for example hearing aids, low vision devices, prosthetics and/or orthotics)		

ACTIONS FOR OBJECTIVE 2	Proposed inputs for Member States	Inputs for the Secretariat	Proposed inputs for international and national partners
<p><b>2.1</b> Provide leadership and governance for developing and strengthening policies, strategies and plans on habilitation, rehabilitation, assistive technology, support and assistance services, community-based rehabilitation and related strategies</p>	<ul style="list-style-type: none"> <li>• Develop or revise legislation, policies, standards and regulatory mechanisms for habilitation, rehabilitation, assistive technology, community support and assistance services, community-based rehabilitation, and related strategies</li> <li>• Undertake situation analysis to inform policies and planning</li> <li>• Raise awareness about rehabilitation and habilitation and devise mechanisms for national sector planning, coordination and financing</li> </ul>	<ul style="list-style-type: none"> <li>• Provide technical guidance; finalize and disseminate evidence-based guidelines on health-related rehabilitation</li> <li>• Provide technical guidance and support to build capacity within health ministries and other relevant sectors for the development, implementation and monitoring of legislation, policies, strategies and plans</li> <li>• Host regional events on developing and/or strengthening regional action plans on rehabilitation</li> <li>• Provide support for national and regional situation analyses whose results can be used in the design of plans to strengthen service delivery</li> </ul>	<ul style="list-style-type: none"> <li>• Participate directly in the development of policies, strategies and plans</li> <li>• Provide technical inputs and support to countries that are introducing and expanding rehabilitation and habilitation services</li> </ul>
<p><b>2.2</b> Provide adequate financial resources to ensure the provision of appropriate habilitation and rehabilitation services and assistive technologies</p>	<ul style="list-style-type: none"> <li>• Develop or promote funding mechanisms to increase coverage and access to affordable habilitation, rehabilitation and assistive technology services.</li> <li>• Depending on each country's specific circumstances, these could include a mix of: <ul style="list-style-type: none"> <li>• public funding targeted at people with disability, with priority given to essential elements of rehabilitation and habilitation including assistive technology, and at those who cannot afford to pay</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• Provide in collaboration with other relevant agencies evidence-based guidance for health ministries, other relevant sectors and stakeholders on appropriate funding mechanisms for rehabilitation</li> </ul>	<ul style="list-style-type: none"> <li>• Advocate national leadership for increased resource allocation for rehabilitation</li> <li>• Provide financial support through international cooperation including in humanitarian crises</li> </ul>

ACTIONS FOR OBJECTIVE 2	Proposed inputs for Member States	Inputs for the Secretariat	Proposed inputs for international and national partners
	<ul style="list-style-type: none"> <li>• promoting equitable access to rehabilitation through health and social insurance coverage</li> <li>• reallocation and redistribution of existing resources</li> <li>• provision of support through international cooperation, for instance in humanitarian crises</li> </ul>		
<p><b>2.3</b> Develop and maintain a sustainable workforce for rehabilitation and habilitation as part of a broader health strategy</p>	<ul style="list-style-type: none"> <li>• Formulate and implement national health, rehabilitation and habilitation plans to increase the numbers and capacity of human resources – both men and women – for rehabilitation</li> <li>• Improve working conditions, remuneration and career opportunities in order to attract and retain rehabilitation and habilitation personnel</li> <li>• Produce national standards in training for different types and levels of rehabilitation and habilitation personnel that can enable career development and continuing education across levels</li> <li>• Train health personnel for early identification, assessment and referral of people that can benefit from rehabilitation, habilitation, support and assistance services</li> </ul>	<ul style="list-style-type: none"> <li>• Provide evidence-based guidance for health ministries, other relevant sectors and stakeholders on the recruitment, training and retention of rehabilitation personnel</li> <li>• Provide technical support for supporting health ministries, other relevant sectors and stakeholders to build the capacity of training providers, and develop standards for training</li> <li>• Design an online training package on community-based rehabilitation in order to strengthen the workforce, particularly at the community level</li> </ul>	<ul style="list-style-type: none"> <li>• Produce training standards for different types and levels of specialist rehabilitation personnel</li> <li>• Build training capacity in accordance with national health, rehabilitation and habilitation plans</li> <li>• Implement measures to improve recruitment and retention of specialist rehabilitation and habilitation personnel, particularly in rural and remote areas</li> <li>• Train non-specialist health personnel on disability and rehabilitation and habilitation relevant to their roles and responsibilities</li> </ul>



<b>ACTIONS FOR OBJECTIVE 2</b>	<b>Proposed inputs for Member States</b>	<b>Inputs for the Secretariat</b>	<b>Proposed inputs for international and national partners</b>
<p><b>2.4</b> Expand and strengthen rehabilitation and habilitation services ensuring integration, across the continuum of care, into primary (including community), secondary and tertiary levels of the health care system, and equitable access, including timely early intervention services for children with disabilities</p>	<ul style="list-style-type: none"> <li>• Review existing rehabilitation and habilitation programmes and services and make necessary changes to improve coverage, effectiveness and efficiency</li> <li>• Integrate rehabilitation and habilitation services within existing health, social and educational infrastructure</li> <li>• Use community-based rehabilitation as a strategy to complement and strengthen existing rehabilitation and habilitation service provision, particularly in countries where few services are available</li> <li>• Establish mechanisms for effective coordination between different rehabilitation and habilitation service providers and levels of the health care system</li> <li>• Work with a range of stakeholders to ensure services for children with disability are available and coordinated between the responsible agencies</li> </ul>	<ul style="list-style-type: none"> <li>• Support countries in integrating rehabilitation and habilitation services into the health system with a focus on decentralization of services at the primary/community level</li> <li>• Develop relevant tools and training packages to develop and strengthen habilitation and rehabilitation services including for children</li> <li>• Provide technical guidance for countries that want to develop or strengthen community-based rehabilitation programmes</li> <li>• Support the creation of a global database on community-based rehabilitation to indicate where programmes are being implemented and establish a related global network to provide information, training and support to programmes included in the database</li> </ul>	<ul style="list-style-type: none"> <li>• Work with health ministries to expand and strengthen the provision of rehabilitation and habilitation services in line with national plans</li> <li>• Promote community-based rehabilitation as an effective strategy to support persons with disabilities and facilitate their access to rehabilitation services</li> <li>• Provide technical and financial support to ensure the delivery of high-quality community-based rehabilitation programmes, and to maintain existing networks at the global, regional and country levels</li> <li>• Work with relevant stakeholders to establish and streamline referral systems in order to ensure that persons with disabilities, throughout the life course, have access to the modes of service delivery they require at each level of the health system</li> </ul>

ACTIONS FOR OBJECTIVE 2	Proposed inputs for Member States	Inputs for the Secretariat	Proposed inputs for international and national partners
<p><b>2.5</b> Make available appropriate assistive technologies that are safe, of good quality and affordable</p>	<ul style="list-style-type: none"> <li>• Include the provision of assistive technologies in health, rehabilitation, habilitation and other relevant sectoral policies, strategies and plans, with accompanying necessary budgetary support</li> <li>• Design a range of financing mechanisms and programmes, such as rental systems</li> <li>• Define standards for assistive technology provision</li> </ul>	<ul style="list-style-type: none"> <li>• Prepare and disseminate evidence-based guidance on the provision and use of assistive technologies</li> <li>• Provide technical support to Member States to build capacity to develop and strengthen provision and use of assistive technologies</li> </ul>	<ul style="list-style-type: none"> <li>• Provide technical and financial support to Member States to build capacity to develop and strengthen provision of assistive technologies</li> </ul>
<p><b>2.6</b> Promote access to a range of assistance and support services and support independent living and full inclusion in the community</p>	<ul style="list-style-type: none"> <li>• Contribute to the development of plans that strengthen community-based assistance and support services, including sufficient human resources and funding when institutions are being closed</li> <li>• Strengthen referral mechanisms between rehabilitation and habilitation services and assistance and support services</li> </ul>	<ul style="list-style-type: none"> <li>• Advocate and provide technical guidance on designing and implementing appropriate policy frameworks</li> </ul>	<ul style="list-style-type: none"> <li>• Advocate the development of policy frameworks to ensure the effective provision of assistance and support services</li> <li>• Support national leadership in identifying and securing the technical and financial resources required for assistance and support services</li> <li>• Provide technical inputs/support to ensure that persons with disabilities and their family members and/or informal caregivers have access to community support</li> </ul>

ACTIONS FOR OBJECTIVE 2	Proposed inputs for Member States	Inputs for the Secretariat	Proposed inputs for international and national partners
<p>2.7 Engage, support and build the capacity of persons with disabilities and their family members and/or informal caregivers in order to support independent living and full inclusion in the community</p>	<ul style="list-style-type: none"> <li>• Include persons with disabilities and their family members and/or informal caregivers in all aspects of developing and strengthening rehabilitation, habilitation, support and assistance services</li> <li>• Collaborate with other sectors besides the health sector in order to ensure appropriate support is provided for informal caregivers, the majority of whom are women</li> </ul>	<ul style="list-style-type: none"> <li>• Promote awareness and understanding of the rights of persons with disabilities and the role of families and/or informal caregivers</li> <li>• Maintain and strengthen partnerships with organizations and associations representing persons with disabilities and their family members and/or caregivers</li> </ul>	<ul style="list-style-type: none"> <li>• Advocate the inclusion of persons with disabilities and their family members and/or caregivers in all aspects of developing and strengthening rehabilitation and habilitation services</li> <li>• Advocate the importance of informal caregivers in the lives of people with disability, and the importance of promoting their health and well-being</li> </ul>

### **OBJECTIVE 3: TO STRENGTHEN COLLECTION OF RELEVANT AND INTERNATIONALLY COMPARABLE DATA ON DISABILITY AND SUPPORT RESEARCH ON DISABILITY AND RELATED SERVICES**

43. Good-quality data and research on disability are essential for providing the basis for policy and programmes and for efficient allocation of resources. They are also important for deepening understanding of disability issues and successful ways to remove barriers and for ensuring that persons with disabilities can participate in and contribute to society on an equal basis.

44. There are, however, insufficient rigorous and comparable data and research related to disability and health care systems nationally and globally. Data are collected on mortality, but policy-relevant data on functioning and disability are lacking. National data collection systems, which may include censuses, population surveys and administrative data registries, do not often collect data on disability. People with disability are often excluded from trials that seek scientific evidence for the outcomes of a health intervention. The lack of evidence is a significant barrier for decision-making and in turn impacts on access to mainstream health care and specialized services for people with disability.

45. Data needed to strengthen health care systems include: number of people and health status of people with disability; social and environmental barriers, including discrimination; responsiveness of health care systems to persons with disabilities; use of health care services by people with disability; and the extent of the need, both met and unmet, for care.

46. Internationally, methodologies for collecting data on disability need to be developed, tested cross-culturally, and applied consistently. Tools are required for disaggregating data relating to people with disability. Data need to be standardized and internationally comparable in order to be able to benchmark and monitor national and international progress on disability policies and on the implementation of the principles of the Convention on the Rights of Persons with Disabilities. Nationally, disability should be included in data collection and the data analysed and used for policy and planning. Definitions of disability, based on the International Classification of Functioning, Disability and Health, including the Children and Youth Version, can allow for the generation of internationally comparable data. The

inclusion of a disability module in existing sample surveys can be a cost-effective and efficient approach to generate data on people with disability. Dedicated surveys, such as the model disability survey being prepared by the Secretariat, should provide comprehensive information on disability characteristics that is relevant for policy formulation, such as prevalence, health conditions associated with disability, use of and need for services, quality of life, opportunities, and rehabilitation and habilitation needs. Disaggregating these data further by sex, age, income or occupation is important for uncovering patterns, trends and other information about “subgroups” of people with disability. Collecting administrative data can provide specific information on users, types, quantity and cost of services.

47. Priority areas for health-related research should be selected on the basis of country contexts and may include measurement of disability and its determinants; identification of barriers to health care, rehabilitation, habilitation and assistive technology provision and strategies for overcoming them; success factors for health promotion interventions for people with disability; prevention of secondary conditions; early detection and referral of health problems through primary health care; the link between rehabilitation and habilitation needs, receipt of services, health outcomes (functioning and quality of life), and costs; models of service provision, approaches to human resource development and financing modalities; and cost-effectiveness of rehabilitation measures, including community-based rehabilitation programmes. Research on disability should be inclusive of persons with disabilities, and research agendas should be drafted with the active participation of persons with disabilities or their representative organizations.

<b>OBJECTIVE 3: TO STRENGTHEN COLLECTION OF RELEVANT AND INTERNATIONALLY COMPARABLE DATA ON DISABILITY AND SUPPORT RESEARCH ON DISABILITY AND RELATED SERVICES</b>		
<b>Indicators of success</b>	<b>Means of verification</b>	<b>Evidence of success</b>
<b>3.1</b> X% of countries that have collected comprehensive <sup>1</sup> information on disability	Governmental responses	Number of countries with a valid, reliable monitoring tool providing internationally comparable data on the health and social situation of persons with disabilities
<b>3.2</b> X% of countries that provide research grants for disability research	National reporting from health and education ministries, national centres of excellence or academic bodies	Frequency of data collection broken down as having been done within the past five years or not within the past five years  Research funding programmes, where they exist, that provide resources for research on disability

<sup>1</sup> Defined as all domains of functioning (impairments in body function and structure, activities and participation), related health conditions and environmental factors. Note that most efforts to collect data on disability since 2000 do not consider environmental factors; 55 countries have collected data on all other domains. Another option would be to develop an index (for example, one point for every domain of functioning, health conditions and environmental factors to a maximum of five points).

<b>ACTIONS FOR OBJECTIVE 3</b>	<b>Proposed inputs for Member States</b>	<b>Inputs for the Secretariat</b>	<b>Proposed inputs for international and national partners</b>
<p><b>3.1</b> Improve disability data collection through the development and application of a standardized model disability survey</p>	<ul style="list-style-type: none"> <li>• Implement valid and reliable tools, consistent with the International Classification of Functioning, Disability and Health, in order to enable and improve the collection of data on disability</li> </ul>	<ul style="list-style-type: none"> <li>• Develop evidence-based tools to assist and strengthen collection of data on disability, including a model disability survey</li> <li>• Develop guidance on involving persons with disabilities in collection, analysis and use of data on disability</li> <li>• Provide technical support to Member States to build capacity for disability-related data collection, analysis and use through development and implementation of training</li> </ul>	<ul style="list-style-type: none"> <li>• Provide technical and financial support to the Secretariat to assist with the development of tools for the collection of data on disability</li> <li>• Provide technical and financial support to Member States to improve their capacity to collect data on disability</li> </ul>
<p><b>3.2</b> Reform national data collection systems, including health information systems, to routinely include gender- and age-disaggregated disability data based on the International Classification of Functioning, Disability and Health</p>	<ul style="list-style-type: none"> <li>• Include disability in national data collection systems and provide sex- and age-disaggregated data</li> <li>• Strengthen administrative and service data on disability, including recordkeeping within health systems that is age- and sex-disaggregated</li> </ul>	<ul style="list-style-type: none"> <li>• Provide technical guidance to support Member States in developing and/or reforming national data collection systems, including health information systems, in order to strengthen the disability component</li> </ul>	<ul style="list-style-type: none"> <li>• Provide technical and financial support to Member States developing and/or reforming national data collection systems in order to strengthen the disability component</li> </ul>
<p><b>3.3</b> Strengthen research on priority issues in disability, with a particular focus on the key objectives of this action plan</p>	<ul style="list-style-type: none"> <li>• Work with research funding agencies to promote disability as a priority issue</li> <li>• Support research on priority disability issues (e.g. needs and unmet needs for services, barriers to service delivery, and health and rehabilitation outcomes), with dissemination of findings and application in policy-making and planning</li> </ul>	<ul style="list-style-type: none"> <li>• Prepare, publish and disseminate evidence-based guidelines for Member States and partners on priority disability issues (such as monitoring and evaluating community-based rehabilitation)</li> <li>• Collaborate with research partners as steward for research on priority disability issues (such as noncommunicable disease-related disability)</li> </ul>	<ul style="list-style-type: none"> <li>• Support Member States and the Secretariat to conduct research on priority disability issues</li> </ul>

<b>ACTIONS FOR OBJECTIVE 3</b>	<b>Proposed inputs for Member States</b>	<b>Inputs for the Secretariat</b>	<b>Proposed inputs for international and national partners</b>
<p><b>3.4</b> Strengthen and build human resource capacity in the area of disability research in a range of disciplines</p>	<ul style="list-style-type: none"> <li>• Develop and implement a strategy for strengthening and building human resource capacity (including persons with disabilities) in the area of disability research</li> <li>• Collaborate with key education and training institutions (both national and international) to strengthen and build human resource capacity in the area of disability research</li> <li>• Ensure that persons with disabilities have access to the training they need to influence research agendas and become researchers</li> </ul>	<ul style="list-style-type: none"> <li>• Collaborate with Member States and key national and international partners to develop strategies to strengthen and build human resource capacity in the area of disability research</li> </ul>	<ul style="list-style-type: none"> <li>• Provide technical and financial support to Member States and civil society for developing and implementing strategies to strengthen and build human resource capacity in the area of disability research</li> <li>• Provide learning and research opportunities by linking universities in low-income countries with those in high- and middle-income countries</li> </ul>

## ANNEX 4

### **Newborn health action plan**

#### **Every newborn: an action plan to end preventable deaths<sup>1</sup>**

[A67/21 and A67/21 Corr.1 – 2 May and 13 May 2014]

1. Although remarkable progress has been made in recent decades to reduce the number of child deaths worldwide, the neonatal mortality rate globally has declined at a slower pace despite a large proportion of newborn deaths being preventable. Opportunities for improving newborn health are unprecedented as, today, much more is known about effective interventions and service delivery channels, and approaches to accelerating coverage and raising quality of care. Recently, renewed commitments to saving the lives of newborn infants have been made by many governments and partners, in response to the United Nations Secretary-General's Global Strategy for Women's and Children's Health and its accompanying Every Woman, Every Child initiative and to recommendations made by the Commission on Information and Accountability for Women's and Children's Health<sup>2</sup> and the United Nations Commission on Life-Saving Commodities for Women and Children.<sup>3</sup> This response has triggered an initiative by multiple stakeholders to propose to the global health community the development of a global action plan.

#### **PREPARATION OF THE ACTION PLAN**

2. The preparation of the Every Newborn action plan was guided by the advice of experts and partners, led by WHO and UNICEF, and by the outcome of several multistakeholder consultations at different global and regional forums.

3. A further consultative process with Member States followed, in particular regarding the goals and actions being proposed for the five strategic directions of the action plan and their related targets, through one global and two regional meetings of stakeholders. In addition, a draft of the action plan was posted on the WHO website in December 2013 for consultation by Member States and other stakeholders before the 134th session of the Executive Board. At that session, the Board noted the proposed process for the further development of the draft action plan.<sup>4</sup>

4. The subsequent web-based consultation was conducted, as outlined in document EB134/17 Add.1. A Note Verbale was sent to Member States on 4 February 2014, describing the process and inviting feedback. In addition, information about the web consultation was widely disseminated through social

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<sup>1</sup> See resolution WHA67.10. Referred to hereinafter as the Every Newborn action plan.

<sup>2</sup> Commission on Information and Accountability for Women's and Children's Health. Keeping promises, measuring results. Geneva: World Health Organization; 2011.

<sup>3</sup> United Nations Commission on Life-Saving Commodities for Women and Children. Commissioners' report: September 2012. New York: United Nations; 2012.

<sup>4</sup> See the summary records of the Executive Board at its 134th session, fourth meeting, section 4, and seventh meeting (document EB134/2014/REC/2).

media and networks on reproductive, maternal, newborn and child health to encourage as broad a response as possible.

5. By the deadline of 28 February 2014, more than 300 comments had been received, including responses from 43 State actors, 23 professional associations, 102 nongovernmental organizations, and many individuals. The Secretariat took these comments into account in revising the draft action plan.

6. The Every Newborn action plan provides clear objectives and actions for Member States and other stakeholders. It also proposes indicators that can be used to evaluate both progress in implementation and the impact of the action plan.

## **BACKGROUND**

7. The number of child deaths worldwide has declined markedly in recent decades, largely through interventions to lower mortality after the first month of life. The mortality rate among children under 5 years of age has fallen globally by almost 50% (from 90 deaths per 1000 live births in 1990 to 48 deaths per 1000 live births in 2012), but the neonatal mortality rate has decreased by only 37% (from 33 deaths per 1000 live births to 21 deaths per 1000 live births) over the same period and represented, in 2012, 44% of the total child mortality.<sup>1</sup>

8. Many newborn deaths are preventable and can be avoided if the actions in this plan are implemented and its goals and targets achieved. The action plan is based on evidence of what works. It recognizes that survival of a newborn is a sensitive marker of a health system's response to its most vulnerable citizens and calls upon all stakeholders to improve access to, and quality of, health care for women and newborns within the continuum of care that spans pre-conception, pregnancy, childhood and adolescence.

9. The action plan sets out a vision of a world in which there are no preventable deaths of newborns or stillbirths, where every pregnancy is wanted, every birth celebrated, and women, babies and children survive, thrive and reach their full potential. To realize this vision, the plan proposes strategic objectives, mortality-related goals, and coverage and quality of care targets by 2035, with intermediate goals for 2020, 2025 and 2030. Mortality goals are related to targeted coverage of quality care for women and babies around the time of birth, care of sick and small newborns, and postnatal care. The action plan includes an impact framework, milestones (Appendix 1) and indicators to measure progress (Appendix 2).

10. Developed within the framework for the Every Woman, Every Child initiative, the plan aims to enhance and support coordinated, comprehensive planning and implementation of newborn-specific actions within the context of national reproductive, maternal, newborn, child and adolescent health strategies and action plans. The goal is to achieve equitable and high-quality coverage of essential, referral and emergency care for women and newborns in every country through: links with other global and national plans; and measurement and accountability.

11. The focus is primarily on newborn survival and health and the prevention of stillbirths. These targets were not included in the Millennium Development Goal framework and consequently received less attention and investment, resulting in slower reductions in mortality.

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<sup>1</sup> UNICEF, WHO, The World Bank, United Nations. Levels and trends in child mortality: report 2013. Estimates developed by the UN Inter-agency Group for Child Mortality Estimation. New York: United Nations Children's Fund; 2013.



12. Stillbirths, newborn survival and health are intrinsically linked with the survival, health and nutrition of women before conception and during and between pregnancies. The periods of greatest risk for morbidity and mortality for woman and child are the hours that precede and the hours and days that follow birth. The action plan therefore emphasizes the need to reach every woman and newborn baby when they are most vulnerable – in labour, during birth and in the first days of life. Intervention in this critical time period provides the greatest potential for ending preventable neonatal deaths, stillbirths and maternal deaths, and would result in a triple return on investment. The plan is part of the broader initiative to end preventable maternal and newborn deaths; a comprehensive maternal action plan is also needed to provide guidance on care before conception and during pregnancy.

13. The action plan was drafted in close consultation with stakeholders; the draft version uploaded on the WHO website in February 2014 elicited more than 300 formal comments. The plan takes into account all inputs, the findings from an analysis of obstacles to scaling up effective interventions to improve newborn health, a comprehensive epidemiological analysis and a review of the evidence of the effectiveness of the proposed interventions.

## EXISTING COMMITMENTS

14. Putting the action plan into practice will strengthen existing commitments, such as the pledge made in the Family Planning 2020 initiative “Committing to Child Survival: A promise Renewed”<sup>1</sup> (which calls for an end to preventable child deaths) and strong regional and global undertakings to end preventable maternal deaths. Given the large proportion of deaths of children under 5 years of age that occur in the neonatal period and the close link between maternal and neonatal mortality, these commitments will not be fulfilled without specific efforts to reduce neonatal mortality and stillbirths. The plan builds on, and links to, other global action plans, such as those on nutrition, vaccines, malaria, pneumonia, diarrhoea, water and sanitation, and elimination of mother-to-child transmission of HIV, syphilis and neonatal tetanus, and takes into consideration multiple timeframes for the achievement of these existing commitments’ targets and goals.

15. Many governments and partners have renewed their commitments to saving the lives of women and newborns in response to the United Nations Secretary-General’s Global Strategy for Women’s and Children’s Health (launched in 2010) and accompanying initiative Every Woman, Every Child, and to the recommendations from the Commission on Information and Accountability for Women’s and Children’s Health<sup>2</sup> and the United Nations Commission on Life-Saving Commodities for Women and Children.<sup>3</sup> Recognizing that progress in newborn health has lagged behind advances in maternal and child health, the action plan takes forward the Global Strategy’s mission, supporting the call by the Health Assembly in resolution WHA58.31 on working towards universal coverage of maternal, newborn and child health interventions, to commit resources and to accelerate national action to build a seamless continuum of care for reproductive, maternal, newborn and child health. These initiatives also affirm women’s and children’s health as matters of fundamental human rights.

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<sup>1</sup> See *Committing to child survival: a promise renewed – progress report 2013*. New York: United Nations Children’s Fund; 2013.

<sup>2</sup> Commission on Information and Accountability for Women’s and Children’s Health. *Keeping promises, measuring results*. Geneva: World Health Organization; 2011.

<sup>3</sup> United Nations Commission on Life-Saving Commodities for Women and Children. *Commissioners’ report*: September 2012. New York: United Nations; 2012.

16. The Global Investment Framework for Women's and Children's Health<sup>1</sup> estimates that an additional investment of US\$ 5 per person per year on reproductive, maternal, newborn and child health across the continuum of care would produce a nine-fold return on investment in social and economic benefits in the highest-burden countries.

17. In 2011, the Health Assembly, in resolution WHA64.12 on WHO's role in the follow-up to the United Nations High-level Plenary Meeting of the General Assembly on the Millennium Development Goals (New York, September 2010), expressed deep concern at the slow and uneven progress in achieving Millennium Development Goals 4 and 5. In resolution WHA64.13 on working towards the reduction of perinatal and neonatal mortality, the Health Assembly observed that movement towards reducing perinatal and neonatal mortality had stagnated, and requested the Director-General to promote targeted plans to increase access to high-quality and safe health services that prevent and treat perinatal and neonatal conditions. The action plan responds to that request and also reflects the Health Assembly's decisions in resolution WHA64.9 on sustainable health financing structures and universal coverage.

## **RIGHTS**

18. Under Articles 6 and 24 of the Convention on the Rights of the Child, every newborn child has the inherent right to life, survival and development, the highest attainable standard of health and access to health care services for treatment and rehabilitation. The notion of legal obligations is reinforced in General Comment No. 15 by the Committee on the Rights of the Child on the right of the child to the enjoyment of the highest attainable standard of health,<sup>2</sup> which specifies that States have an obligation to reduce child mortality and that particular attention should be paid to neonatal mortality.

19. In September 2012, the United Nations Human Rights Council welcomed the technical guidance on the application of a human rights-based approach to the implementation of policies and programmes to reduce preventable maternal mortality and morbidity,<sup>3</sup> reinforcing women's rights to access quality, appropriate and affordable services and support across the continuum of care. The Council's resolution 22/32 on the right of the child to the enjoyment of the highest attainable standard of health affirmed the importance of applying a human rights-based approach to eliminating preventable maternal and child mortality and morbidity, and requested States to renew their political commitment and take action to address the main causes of maternal and child mortality.

## **CURRENT SITUATION**

20. In addition to 2.9 million babies who die in the first month of life, it is estimated that 2.6 million babies are stillborn (die in the last three months of pregnancy or during childbirth) and some 287 000 women die each year from complications of pregnancy and childbirth. The global annual

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<sup>1</sup> Stenberg K, Axelson H, Sheehan P, Anderson I, Gülmezoglu AM, Temmerman M et al. Advancing social and economic development by investing in women's and children's health: a new Global Investment Framework. *Lancet*. 2013;383:1333–54. doi:10.1016/S0140-6736(13)62231-X.

<sup>2</sup> Convention on the Rights of the Child, document CRC/C/GC/15.

<sup>3</sup> United Nations Human Rights Council resolution 21/6.

average rate of reduction in neonatal mortality since 1990 has been 2.0%, lower than that of maternal mortality (3.1%) and under-5-year-old mortality (2.9%).<sup>1</sup>

21. Most newborn deaths occur in low- and middle-income countries. Two thirds of all neonatal mortality is reported from 12 countries,<sup>2</sup> six of which are in sub-Saharan Africa. Countries with a rate of 30 or more deaths per 1000 live births account for 60% of all newborn deaths.<sup>3</sup>

22. Many countries with a high burden of newborn deaths have experienced recent conflict or humanitarian emergencies. Other countries have weak health systems with limited infrastructure and low density of skilled health workers, and their populations face high out-of-pocket expenditures. Inequitable access to quality health services for women and children results in stark disparities in mortality rates and intervention coverage between and within countries. Nevertheless, 11 low- and lower-middle-income countries have reduced their neonatal mortality rate by more than 40% since 2000,<sup>4</sup> showing that it is possible to make rapid progress.

23. Three causes accounted for more than 80% of neonatal mortality in 2012 (Figure 1): complications of prematurity, intrapartum-related neonatal deaths (including birth asphyxia) and neonatal infections. Complications of prematurity are also the second leading cause of all deaths of children aged under 5 years. Annually, 15 million babies are born prematurely and 32.4 million with a weight below the tenth percentile for their gestational age; 10 million do not breathe at birth, of whom six million require basic neonatal resuscitation (bag and mask ventilation).

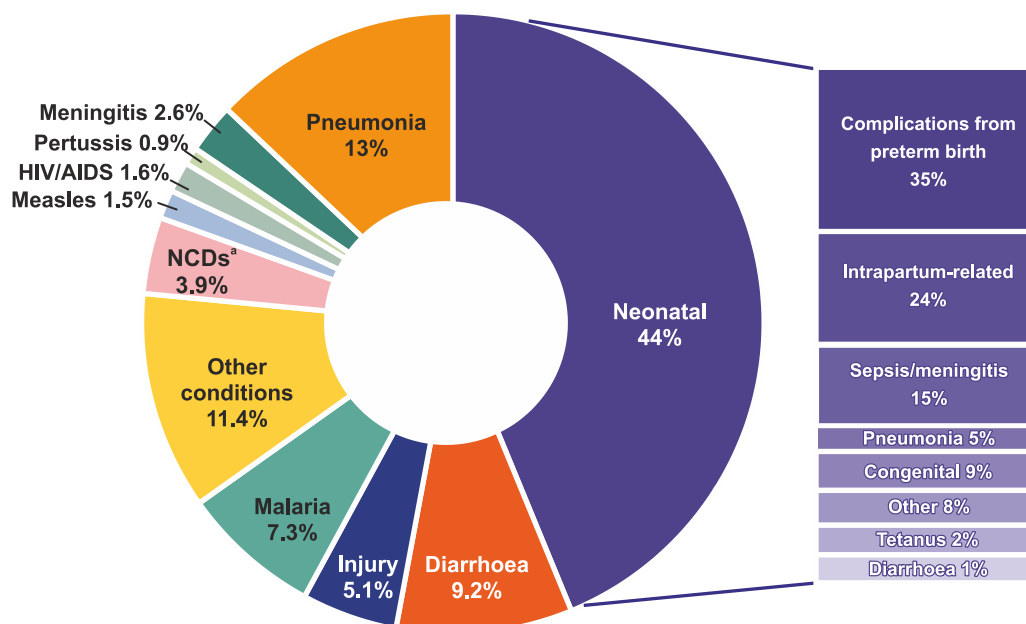
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<sup>1</sup> WHO, UNICEF, UNFPA, World Bank. Trends in maternal mortality: 1990 to 2010. Geneva: World Health Organization; 2012, and UNICEF, WHO, World Bank, United Nations Population Division. Levels and trends in child mortality: report 2013. New York: United Nations Children's Fund; 2013, respectively.

<sup>2</sup> In descending order of annual number of newborn deaths: India, Nigeria, Pakistan, China, Democratic Republic of the Congo, Ethiopia, Bangladesh, Indonesia, Angola, Kenya, United Republic of Tanzania and Afghanistan.

<sup>3</sup> Afghanistan, Angola, Burundi, Central African Republic, Chad, Comoros, Congo, Côte d'Ivoire, Democratic Republic of the Congo, Djibouti, Equatorial Guinea, Ethiopia, Guinea, Guinea-Bissau, India, Lesotho, Mali, Mauritania, Mozambique, Nigeria, Pakistan, Sierra Leone, Somalia, South Sudan, Swaziland, Togo and Zimbabwe.

<sup>4</sup> Bangladesh, Cambodia, Democratic People's Republic of Korea, Egypt, El Salvador, Malawi, Mongolia, Rwanda, Senegal, Sri Lanka and United Republic of Tanzania.

**Figure 1. Causes of deaths in children under 5 years of age, 2012**

**More than 80% of newborn deaths are in small babies (preterm or small for gestational age) in the highest burden settings.**

<sup>a</sup>NCDs = noncommunicable diseases.  
Source: WHO Global Health Observatory, 2014.

24. The highest risks of death in utero, in the neonatal period and throughout infancy and early childhood are faced by small and low-birth-weight babies, that is, those who are born preterm or small for gestational age, or both. More than 80% of all newborn deaths occur among small babies in southern Asia and sub-Saharan Africa.

25. Disabilities remain an important issue. Many could be prevented by adequate care during labour and childbirth and in the neonatal period. Preterm babies who survive the first month of life face higher risks of post-neonatal mortality, long-term neurodevelopmental impairment, stunting and noncommunicable diseases. Babies who are small for gestational age face risks of stunting and adult-onset metabolic conditions. Four million term or near-term neonates have other life-threatening conditions, including intrapartum-related brain injury, severe bacterial infection and pathological jaundice, which result in life-long impairments. More than one million neonates survive each year with long-term neurodevelopmental impairment. It is therefore important to look beyond survival and provide appropriate follow-up care for children affected by these conditions to ensure early detection and appropriate care and rehabilitation. As Article 23 of the Convention on the Rights of the Child stresses, it is also important to meet the needs of mentally or physically disabled children.

26. Some 10% of the entire global burden of disease is related to neonatal and congenital conditions. As the Health Assembly recognized in resolution WHA63.17 on birth defects, factors leading to birth defects and congenital abnormalities can affect health outcomes for babies who survive the neonatal period, as do many of the diverse causes and determinants of congenital disorders. Prevention of birth defects and provision of care for affected children need to be integrated into existing maternal, reproductive and child health services, with social welfare provision for all who need it.

27. Social determinants are an important factor in the health of women and newborns. Poverty, inequality and societal unrest undermine maternal and newborn care in numerous ways, such as poor nutritional status of girls and women (including during pregnancy) and inadequate housing and sanitation. Complex humanitarian emergencies cause dramatic movements of people (including pregnant women and newborns) and compromise access to functional health systems. Low education levels, gender discrimination and a lack of empowerment prevent women from seeking health care and making the best choices for their own and their children's health, resulting in perilous delays and unnecessary deaths. This action plan acknowledges the inherent links between contextual factors and maternal and newborn health and focuses primarily on health system solutions.

#### **EFFECTIVE INTERVENTIONS FOR IMPROVING THE HEALTH OF NEWBORNS ACROSS THE CONTINUUM OF CARE**

28. Unprecedented opportunities for improving newborn health now exist after decades of analysis and research that have generated information on the burden and causes of neonatal mortality, demonstrated effective interventions and service delivery channels, and identified ways to accelerate progress in extending the coverage of interventions to reduce mortality.<sup>1</sup>

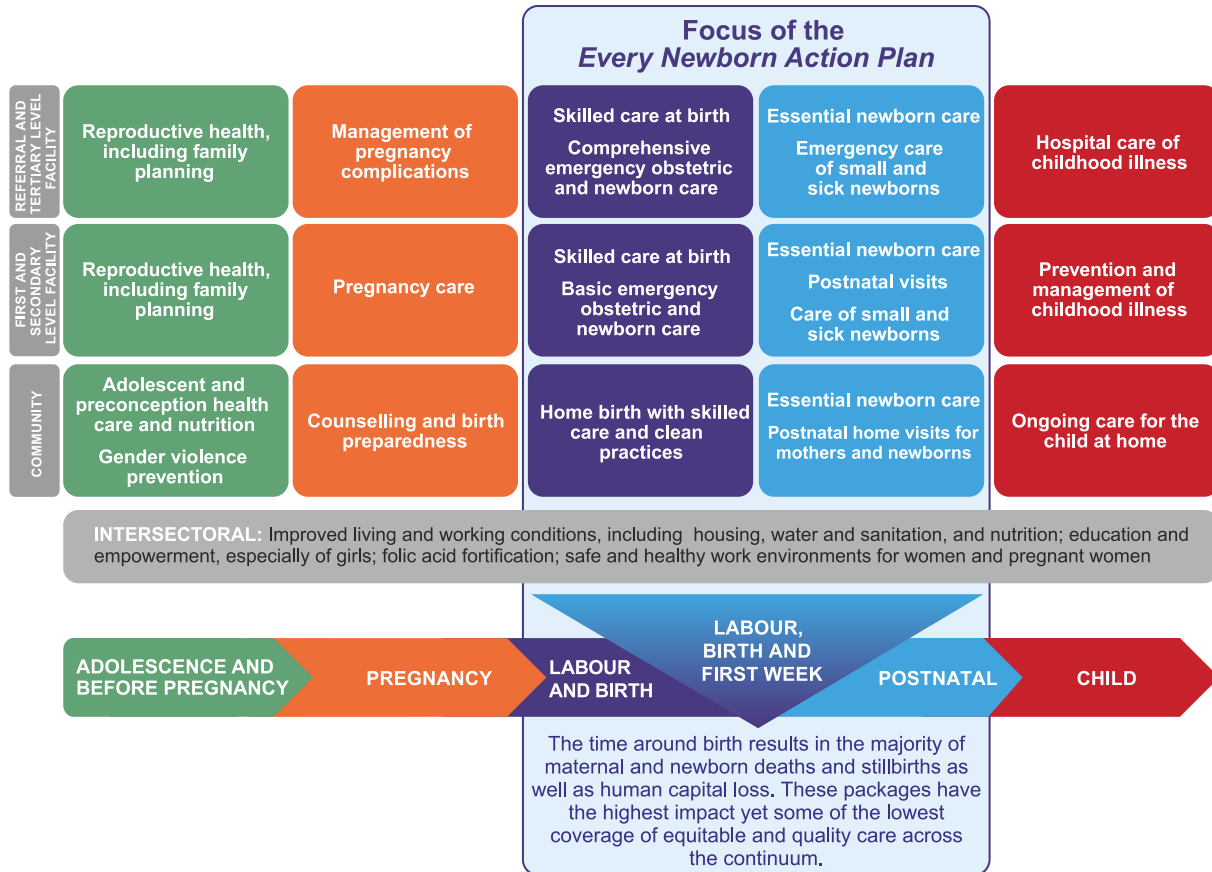
29. Effective interventions for improving survival and health of newborns form one component of integrated health services for reproductive, maternal, newborn, and child and adolescent health (Figure 2). These are well documented across the life course and have been packaged for levels of service delivery.<sup>2</sup> Many are delivered from common platforms for health care delivery; integrated planning and delivery can ensure efficient and effective health services for women and children.

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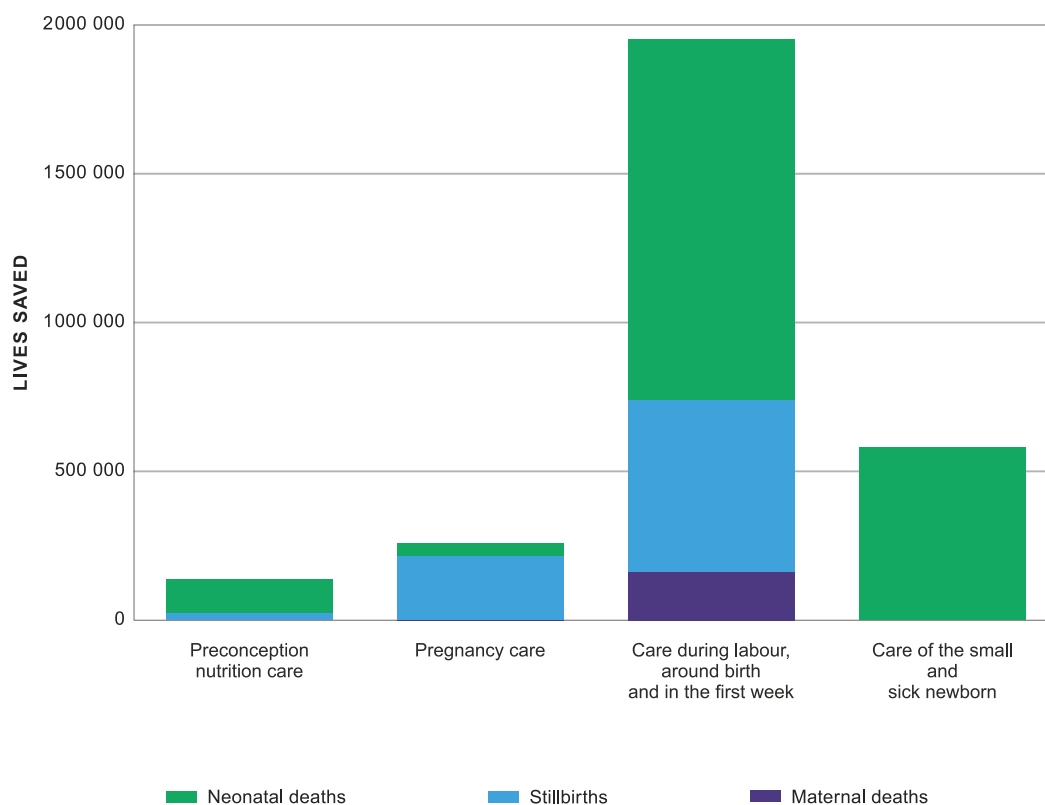
<sup>1</sup> Compilation of WHO recommendations on maternal, newborn, child and adolescent health ([http://www.who.int/maternal\\_child\\_adolescent/documents/mnca-recommendations/en/](http://www.who.int/maternal_child_adolescent/documents/mnca-recommendations/en/), accessed 27 March 2014).

<sup>2</sup> A global review of the key interventions related to reproductive, maternal, newborn and child health. Geneva: The Partnership for Maternal, Newborn and Child Health; 2011.

**Figure 2. Packages in the continuum of care**



30. The packages of care with greatest impact on ending preventable neonatal deaths and stillbirths include: care during labour, childbirth and the first week of life; and care for the small and sick newborn. Figure 3 outlines preliminary results of the estimated impact of these interventions if universal coverage of care was to be achieved by 2025. Since these packages would save the most newborn lives as well as prevent maternal deaths and stillbirths, these are the focus of the Every Newborn action plan.

**Figure 3. Lives that could be saved by 2025 with universal coverage of care (preliminary results)**

Source: Special analysis detailed in *The Lancet* Every Newborn series.<sup>1</sup>

31. Interventions in the package of “care during labour, around childbirth and in the first week after birth” include (but are not limited to) skilled care at birth, basic and comprehensive obstetric care, management of preterm births (including the use of antenatal corticosteroids), and essential newborn care (hygienic care, thermal control, support for breastfeeding and, if required, newborn resuscitation). It is important that the interventions for mother and newborn are seen as a functional unit delivered in a narrow time window by the same health care provider (or team) and in the same place, with referral for management of complications including mother and baby together.

32. The package of “care of small and sick newborns” comprises interventions to deal with complications arising from preterm birth and/or babies who are small for gestational age, and neonatal infections (sepsis, meningitis, pneumonia and those causing diarrhoea). Appropriate management of small and sick newborns includes extra thermal care and support for feeding for small or preterm babies, including kangaroo mother care, antibiotic treatment for infections and full supportive facility care. The last encapsulates additional feeding support (including cup and nasogastric tube feeding and intravenous fluids), infection prevention and management, safe oxygen therapy, case management of jaundice and possibly surfactant and respiratory support.

<sup>1</sup> Bhutta Z, Das J, Bahl R, Lawn J, Salam R, Paul V et al. Can available interventions end preventable deaths in mothers, newborn babies, and stillbirths, and at what cost? *Lancet*. 2014;384: 347–370. doi:10.1016/S0140-6736(14)60792-3.

33. Postnatal care provides the delivery platform for care of the normal newborn, including the promotion of healthy practices and detection of problems requiring additional care. It is provided in a different time window, often by different providers in different places. Care of the normal newborn includes early initiation of (exclusive) breastfeeding, prevention of hypothermia, clean postnatal care practices and appropriate cord care. Close observation for 24 hours and at least three additional postnatal contacts (on day 3 (48–72 hours), between days 7 and 14, and at six weeks after birth) is recommended for all mothers and newborns to establish good care-giving practices and detect any life-threatening conditions.<sup>1</sup>

34. Other interventions across the continuum of care are also vital for the survival and health of women and their babies. For example, antenatal care provides an opportunity for integrated service delivery for pregnant women, including obstetric services, but also covers infections, such as preventing, detecting and treating malaria and syphilis in pregnancy, caring for women with tuberculosis and HIV infection, preventing mother-to-child transmission of HIV and reducing harmful lifestyle practices such as smoking and alcohol use. According to WHO's *World health statistics 2013*, the coverage rate of some interventions, such as vaccination with tetanus toxoid, is already high in many settings (82% of all newborns are now protected at birth against neonatal tetanus); there is therefore less potential for averting deaths (see Figure 3), but coverage rates must remain high. Some 81% of women receive antenatal care at least once during pregnancy, but only 55% receive the recommended minimum of four visits or more, and the quality of care is often suboptimal.

35. Care before and between pregnancies affects the survival and health of women and their babies. Family planning is a vital contributor through delaying, spacing and limiting births, all of which can reduce newborn mortality and boost the health of mothers, their babies and their other children. Access to family planning and the right to control if, when and how frequently to become pregnant empower women and girls and improve babies' health and survival. Investments in family planning will contribute significantly to an overall reduction in maternal and neonatal mortality: reducing the number of unintended pregnancies could avert 60% of maternal and 57% of child deaths.

36. Additional components of care before and between pregnancy that affect newborn health include life-skills education, nutrition, prevention and management of harmful practices (including smoking and alcohol use), identification and treatment of conditions such as sexually transmitted infections and mental illness, and tackling intimate partner violence. The nutritional status of women is of particular importance, as a woman undernourished before pregnancy is more likely to give birth to babies who are preterm or small for gestational age at birth, or both. This risk is determined partly by undernutrition of a woman in her own first 1000 days and during her adolescence. It is essential to break the intergenerational cycle of ill health and undernutrition, especially given increasing evidence about links between low birth weight and undernutrition in the first 1000 days of life and the rise of noncommunicable diseases in adulthood.

37. Preventing early unintended pregnancy in adolescent girls is a major component of efforts to improve newborn health.<sup>2</sup> Very young mothers and their babies face greater risks from pregnancy and

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<sup>1</sup> WHO recommendations on postnatal care of the mother and newborn. Geneva: World Health Organization; 2013.

<sup>2</sup> WHO guidelines on preventing early pregnancy and poor reproductive outcomes among adolescents in developing countries. Geneva: World Health Organization; 2011.



birth.<sup>1</sup> Delaying pregnancy in adolescent girls is a powerful means of saving maternal and newborn lives and empowering girls to finish their education.

38. Care for women before and during pregnancy, childbirth and the postnatal period and between pregnancies<sup>2</sup> and for the newborn is best provided by a dedicated health professional qualified in midwifery. Care should be respectful and should optimize normal biological processes. In most cases, the person providing care will be a professional midwife, who will need support from a team composed of other health professionals, such as nurses, obstetricians and paediatricians, when complications arise. The team could provide all aspects of care in settings where there are no professional midwives: for these settings, the term “midwifery personnel” is used.

39. Community health workers, especially in rural areas, can play an important role in bridging the gap between health services and families, and home visits made by them during pregnancy and in the first week after childbirth have been shown to have a positive impact on newborn care practices and neonatal mortality rates. They are also effective in detecting and referring mothers with postpartum complications and offering family-planning counselling. Other community agents, such as traditional leaders, influential family members and traditional birth attendants, also influence the demand for, and access to, skilled care.

40. The provision of a continuum of care throughout the life course requires seamless, functional coordination between levels of health services and the public and private sectors. Delivering health care to women and newborns requires coordination between technical programmes and initiatives and collaboration among all concerned stakeholders: governments, professional associations, civil society, academic and research institutions, the business community, development partners and families.

## **ACTION PLAN: VISION AND GOALS**

41. The **vision** of the Every Newborn action plan is of a world in which there are no preventable deaths of newborns or stillbirths, where every pregnancy is wanted, every birth celebrated, and women, babies and children survive, thrive and reach their full potential.

42. **Goal 1 – ending preventable newborn deaths:**<sup>3</sup> all countries will reach the target neonatal mortality rate of 10 or fewer newborn deaths per 1000 live births by 2035 and continue to reduce death and disability, ensuring that no newborn is left behind. Achievement of this goal will result in an average global neonatal mortality rate of 7 deaths per 1000 live births, a figure that is consistent with, and necessary to the achievement of, the goal set in *Committing to child survival: a promise renewed*<sup>4</sup> of ending preventable child deaths. By 2030, all countries will reach the rate of 12 or fewer newborn deaths per 1000 live births, resulting in an average global neonatal mortality rate of 9 deaths per 1000 live births (other interim goals are shown in Figure 4). It is intended that these target rates will also link to forthcoming proposed goals for ending preventable maternal deaths. All countries should

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<sup>1</sup> Motherhood in childhood. Facing the challenge of adolescent pregnancy. The state of world population 2013. New York: United Nations Population Fund; 2013.

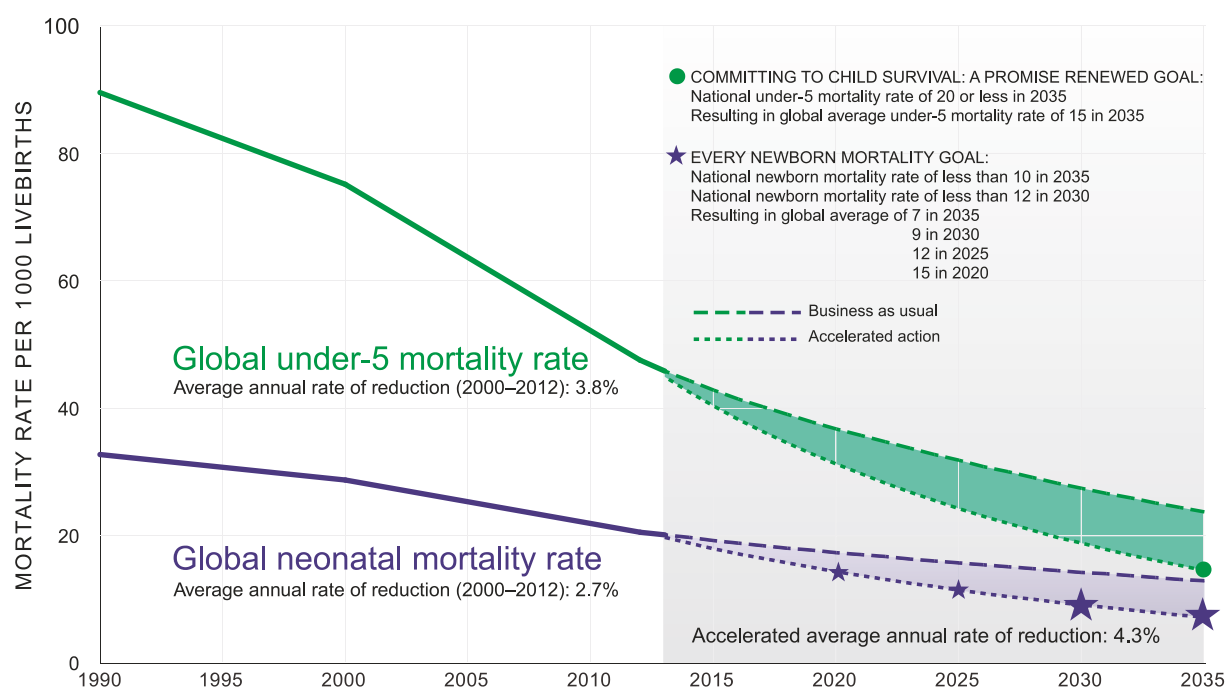
<sup>2</sup> The term postnatal care is used to denote care for mothers and babies during the six-week period after birth, in line with WHO recommendations on postnatal care of the mother and newborn (Geneva: World Health Organization; 2013).

<sup>3</sup> A newborn death is defined as the death within 28 days of birth of any live-born baby regardless of weight or gestational age.

<sup>4</sup> *Committing to child survival: a promise renewed – progress report 2013*. New York: United Nations Children’s Fund; 2013.

ensure this goal is also achieved for underserved populations, maximizing human capital. The goal may be considered a continuation of Millennium Development Goal 4 (Reduce child mortality) to cover the unfinished business of reducing newborn deaths.

**Figure 4. Ending preventable newborn and child deaths**

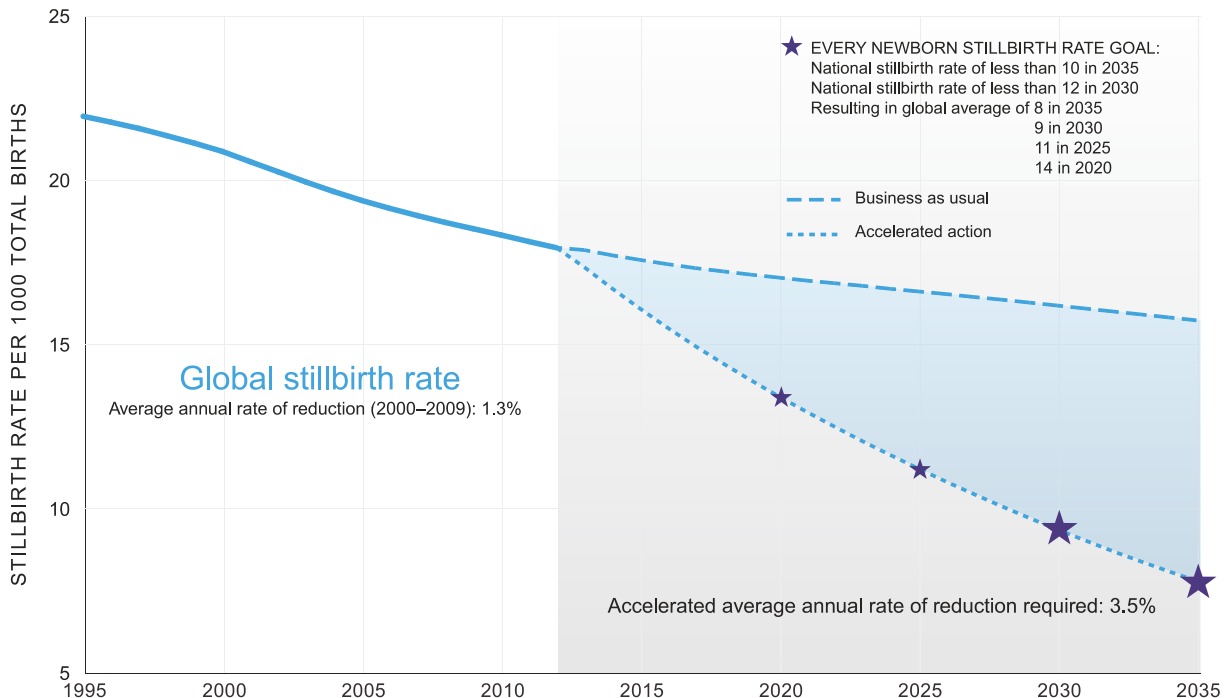


Sources: Data from *The Lancet* Every Newborn series.<sup>1</sup>

43. **Goal 2 – ending preventable stillbirths:**<sup>2</sup> all countries will reach the target stillbirth rate of 10 or fewer stillbirths per 1000 total births by 2035 and continue to close equity gaps. Achieving this goal will result in an average global stillbirth rate of 8 per 1000 total births. By 2030, all countries will reach the rate of 12 or fewer stillbirths per 1000 total births resulting in an average global stillbirth rate of 9 deaths per 1000 total births (other interim goals are shown in Figure 5). All countries should focus on addressing inequalities and use audit data to track and prevent stillbirths.

<sup>1</sup> Lawn J, Blencowe H, Oza S, You D, Lee A, Waiswa P et al. Every Newborn: progress, priorities, and potential beyond survival. *Lancet*. 2014;384:189–205. doi:10.1016/S0140-6736(14)60496-7.

<sup>2</sup> For international comparison purposes, a stillbirth is defined as a baby born with no signs of life, weighing more than 1000 g or with more than 28 completed weeks of gestation.

**Figure 5. Ending preventable stillbirths**

Sources: Data from *The Lancet* Every Newborn series.<sup>1</sup>

44. The ambitious goals proposed in this action plan of ending preventable newborn deaths and stillbirths by 2035 – with intermediate goals for 2030, 2025 and 2020 – require universal, equitable and high-quality coverage of essential, referral and emergency care for every woman and newborn in every country. This demands measurement, accountability and linkages with other global and national plans.

## ACTION PLAN STRATEGIC OBJECTIVES AND PRINCIPLES

45. To achieve the vision and mortality goals, the Every Newborn action plan proposes five strategic objectives.

**Strategic objective 1: strengthen and invest in care during labour, birth and the first day and week of life.** A large proportion of maternal and newborn deaths and stillbirths occur within this period. Many deaths and complications can be prevented by ensuring provision of high-quality essential care for every pregnant woman and baby around the time of labour, childbirth and in the first 24 hours and week after birth.

**Strategic objective 2: improve the quality of maternal and newborn care.** Substantial gaps in the quality of care exist across the continuum of care for women's and children's health. Women and newborns in many settings do not receive the care they need even when they have contact with the health system before, during or after pregnancy. Introducing high-quality care

<sup>1</sup> Lawn J, Blencowe H, Oza S, You D, Lee A, Waiswa P et al. Every Newborn: progress, priorities, and potential beyond survival. *Lancet*. 2014;384:189–205. doi:10.1016/S0140-6736(14)60496-7.

with high-impact, cost-effective interventions for mother and baby together – delivered, in most cases, by the same health providers with midwifery skills at the same time – is the key to improving the quality of care.

**Strategic objective 3: reach every woman and newborn to reduce inequities.** Having access to high-quality health care based on need without suffering financial hardship is a human right. Robust evidence of approaches for ending preventable newborn deaths that effectively accelerate the coverage of essential interventions through innovations such as task-sharing, improved access to life-saving commodities, health insurance and financing mechanisms, and use of information technology and social and knowledge networks is increasing.

**Strategic objective 4: harness the power of parents, families and communities.** Engaged community leaders, women's groups and community workers turn the tide for better health outcomes for newborns, particularly in poor rural communities. Education and information are crucial for empowering parents, families and their communities to demand quality care and to improve care practices in the home.

**Strategic objective 5: count every newborn – measurement, programme-tracking and accountability.** Measurement enables managers to improve performance and adapt actions as needed. Assessing outcomes and financial flows with standardized indicators improves accountability. There is an urgent need to improve metrics globally and nationally, especially for birth outcomes and quality of care around the time of birth. Every newborn needs to be registered, and newborn and maternal deaths and stillbirths need to be counted.

46. The action plan is based on six guiding principles.

(1) **Country leadership.** Countries have primary ownership and responsibility for establishing good governance and providing effective and good-quality reproductive, maternal and newborn health services. Communities' participation in the planning, implementation and monitoring of policies and programmes that affect them is a central feature of such leadership and is one of the most effective transformational mechanisms for action and accountability for newborn health. Development partners should align their contributions and harmonize actions.

(2) **Human rights.** Principles and standards derived from international human rights treaties should guide all planning and programming for reproductive, maternal and newborn health and all phases of the programming process. Evidence and practice show the vital importance to health and development of many human rights outcomes.

(3) **Integration.** Providing every woman and newborn with good-quality care that is available without discrimination and is accessible and acceptable requires integrated service delivery. Coordinated health system approaches involving multiple programmes, stakeholders and initiatives across the continuum of reproductive, maternal, newborn and child health and nutrition are therefore essential, without losing visibility for newborn-specific content.

(4) **Equity.** Equitable and universal coverage of high-impact interventions and a focus on reaching excluded, vulnerable and the poorest population groups are central to realizing the rights of every woman and newborn to life, survival, health and development.

(5) **Accountability.** Effective, accessible, inclusive and transparent programme-coverage and impact-monitoring mechanisms, independent review, and action by all relevant actors are prerequisites for equitable coverage, quality of care and optimal use of resources.

Accountability also includes access to processes and mechanisms for remedies, be they legal, administrative or of some other form.

(6) **Innovation.** Best practice evidence of strategies that broaden the coverage of interventions for newborns and reduce mortality has been accumulating over recent decades. Innovative thinking about ways to increase the participation of all stakeholders and reach the poorest and most underserved populations is nevertheless needed. More research and development is required to optimize the application of knowledge of which interventions and strategies are most effective.

## **ACTIONS TO ACHIEVE THE STRATEGIC OBJECTIVES**

### **Strategic objective 1: strengthen and invest in care during labour, birth and the first day and week of life**

#### **Rationale for strategic objective 1**

47. The period occurring after 28 weeks of gestation to the first month after birth is especially important not just for survival, but also for early childhood interaction and development, when the foundations for the evolution of cognitive and psychosocial skills are created. Furthermore, it is during labour, birth and the first week of life that 44% (1.2 million) of stillbirths, 73% (2 million) of newborn deaths and 61% (176 290) of maternal deaths occur.

48. Every pregnant woman should receive essential care provided by a skilled attendant who is proficient at monitoring labour and assisting the birth, able promptly to detect and manage complications competently, and capable of arranging for immediate referral when needed. Every baby should receive essential newborn care starting immediately after birth, during the first day, and continued at critical intervals in the first week of life and beyond.

49. Although globally the proportion of women giving birth with a skilled attendant (physician, nurse or midwife) has increased to 70%, great disparities in coverage and quality of care exist between and within countries. Coverage of skilled care at birth in sub-Saharan Africa reaches only half the population. Skilled care around childbirth is most efficiently provided in many countries in public or private health facilities, as immediate access to emergency obstetric and newborn services when complications occur is crucial to the survival of mother and child.

50. Packages of proven interventions should ensure the provision of basic and additional care for women and newborns to prevent or treat the main causes of mortality. Providing extra care to small (either small for gestational age and/or preterm) and sick babies is particularly important in reducing neonatal mortality. Health personnel need to be sufficiently competent and equipped to support women and these babies, many of whom do not need advanced or intensive care and can be managed in a lower-level health facility or possibly in the community. Inpatient care facilities can play a vital role for babies who need full supportive facility care (see paragraph 32). Recent research indicates that simplified antibiotic regimens for treatment of possible serious bacterial infections delivered through outreach services from primary health facilities might save additional lives in settings where referral is not possible.

51. Research is an important element of investing in care around the time of birth and an integral part of the actions proposed in this plan. Research priorities include understanding the factors that impede or facilitate extending coverage of proven interventions in low- and middle-income countries,

ways to fill existing gaps (such as the need for greater understanding of the biological basis of term and preterm labour and new ways of preventing preterm birth) and investigation of the long-term effects, later in life, of morbidities occurring before and around conception, during pregnancy and in the first month of life. Improving data collection and fostering innovation and collaboration are also essential.

### **Proposed actions**

#### **Key actions for strategic objective 1**

Governments, in collaboration with stakeholders, should:

- (a) conduct a systematic situational analysis and agree a core set of interventions and packages for the local context;
- (b) institute measures to increase the coverage of skilled care at birth in health facilities;
- (c) raise community awareness of the importance of the period around birth and the first week of life for preventing maternal and newborn deaths and stillbirths;
- (d) increase accountability of all relevant stakeholders;
- (e) develop or sharpen national plans for newborn health within the continuum of reproductive, maternal, newborn and child health and nutrition;
- (f) allocate adequate financial resources to implement the national plan.

52. Governments and all concerned stakeholders should raise awareness and foster recognition in communities that the time around childbirth and the first week of life is vital to saving maternal and newborn lives and assume accountability for creating the conditions in which every woman and newborn can realize their right to health and health care.

53. All countries are encouraged to develop or re-focus national strategies and action plans in line with the principles, goals, targets and strategic objectives of the action plan. Each government should conduct a systematic situational analysis and agree a set of core interventions and packages that match the local context, are relevant to the burden of neonatal morbidity and mortality, and fit within the continuum of care. Equitable access to high-quality care during labour, childbirth and the first week of the postnatal period should be emphasized in all relevant country action plans.

54. Comprehensive maternal and newborn health packages must be a part of core entitlements under existing and emerging universal health systems in all countries. National authorities should institute measures to increase coverage of skilled care at birth in health facilities. They should support the implementation of guidelines and policies to improve management during labour and childbirth, including the use of the partograph, a simple tool for monitoring labour and anticipating complications, and increase the number of postnatal visits to women and their babies. Where necessary, more midwives, auxiliary staff and community health workers should be trained and retained.

55. National authorities, supported by stakeholders, should cost plans and allocate sufficient funding for women's and children's health, with due emphasis on care around the time of birth and the first week of life. Governments and all concerned partners should ensure that investments in maternal and newborn health are sustained beyond 2015 and increased where needed.

## **Strategic objective 2: improve the quality of maternal and newborn care**

### **Rationale for strategic objective 2**

56. Skilled care at birth is provided by midwives, nurses and physicians in many countries, but women who give birth with a skilled attendant may receive suboptimal or poor-quality, non-respectful care. The partograph is still not commonly used, and infection prevention and newborn care practices immediately after birth are often harmful and do not adhere to the principles of the Baby-friendly Hospital Initiative, which include keeping the baby warm, keeping mother and baby together, initiating breastfeeding early and promoting exclusive breastfeeding. Creation of appropriate areas for newborn care is often overlooked. Increasing the number of births in health facilities is therefore not sufficient to reduce neonatal mortality, particularly early neonatal deaths. Quality care for mothers and newborns should be assured, even in natural calamities, disasters or emergencies.

57. It is estimated that one in three pregnant women needs some intervention during birth and between 5% and 15% require a caesarean section.<sup>1</sup> Many women and babies in higher-mortality settings will not have access to emergency obstetric or even basic neonatal care. The incidence of birth complications, intrapartum-related death and neonatal encephalopathy rises with increasing neonatal mortality, reflecting a lack of quality obstetric and neonatal emergency care. Though high caesarean section rates are not desirable, rates of less than 5% are usually a marker of unavailability of maternal and neonatal emergency and intensive care.

58. Quality and equity of care affect health outcomes in lower-mortality settings. As it is difficult to predict need for emergency obstetric services, every maternity service should be able to provide basic life-saving interventions for women and newborns and have uninterrupted access to transport for referral when serious complications arise.

59. Quality of care is particularly important for reducing risks of disabilities or impairments. For example, preterm babies are vulnerable to eye complications. Blindness from retinopathy of prematurity is preventable by improving quality of neonatal care, including safer use of oxygen, and by detecting retinopathy early. Preterm infants must be followed up and their eyes must be checked.

60. A seamless continuum between primary care and referral-level facilities saves lives. Community-based skilled birth attendants may be common in low- and intermediate-mortality settings where human resources and capacity for training exist, but about one third of births globally (mainly in higher neonatal mortality settings) occur at home without care from a health professional. Effective community-based approaches require a functioning continuum of care and effective linkages to health facilities with comprehensive emergency obstetric care.

61. There is overwhelming evidence that the standard of education of physicians, nurses and midwives is low in many countries. Midwifery curricula in some do not meet global standards, with students not acquiring the competences necessary to provide good-quality services with confidence. Limitations in regulation and professional association capacity mean that midwifery personnel have little legal protection and lack an organized voice to represent their interests. These factors, combined with staff shortages, poorly equipped facilities and low remuneration, lead to poor motivation and low quality of care.

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<sup>1</sup> WHO, UNFPA, UNICEF and Mailman School of Public Health, Columbia University. Monitoring emergency obstetric care: a handbook. Geneva: World Health Organization; 2009.

62. Health services need to deal with risk factors for poor neonatal outcomes, such as adolescent pregnancy, short birth intervals, malnutrition (underweight and obesity), chronic disease (such as diabetes), infectious diseases (like tuberculosis and HIV/AIDS), substance abuse (tobacco and alcohol use, for instance), domestic violence and poor mental health. Workplace policies are important in supporting women during pregnancy and in the postnatal period and should include regulations to protect pregnant and lactating women from doing physically demanding work.<sup>1</sup> Behavioural and community interventions to reduce exposure to potentially harmful pollutants, such as from traditional cook-stoves and second-hand tobacco smoke, are also necessary. Prevention, screening and management of sexually transmitted infections (such as HIV and syphilis), malaria and noncommunicable diseases are often implemented through specific programmes but have to be well integrated with maternal and newborn health services.

63. Existing programme platforms can provide specific links to improved newborn survival and health and will contribute to strengthening the quality of provided health services, including those for family planning, HIV infection and tuberculosis, syphilis, malaria, water and sanitation, nutrition, integrated management of childhood illness, home visits in the postnatal period, and immunization.

64. Adolescent-friendly health services offering sexual and reproductive health need to be available to young people, as data show that adolescents are not reached by health services and HIV infection is increasing among them. Prevention of early and unintended pregnancy, along with care for girls and young women during pregnancy, birth and in the postnatal period, are vital to supporting their own and their babies' mental and physical health.

65. Many health facilities, particularly those in remote areas, do not have life-saving commodities for women and newborns, as identified by the United Nations Commission on Life-Saving Commodities for Women and Children. Challenges include unregistered new formulations of medicines, major supply-chain bottlenecks, stock-outs, costs in settings where services are not free, and carers and health care providers being uneducated about commodities and their effectiveness. The private sector's considerable expertise in developing, manufacturing and distributing medicines, medical devices and technologies must be harnessed to increase availability, especially in resource-poor settings.

66. Few global indicators exist for monitoring the quality of maternal and newborn care, and mechanisms for monitoring and evaluation are non-existent in many countries. Maternal and perinatal death surveillance and response can be a powerful approach to improving care quality. Many countries have adopted legislation requiring notification of maternal deaths, which can provide an entry point for a confidential enquiry into causes leading to maternal death and planning of remedial action. A similar approach could be taken to perinatal mortality.

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<sup>1</sup> International Labour Organization. C183 – Maternity Protection Convention, 2000 (No. 183) ([http://www.ilo.org/dyn/normlex/en/f?p=1000:12100:0::NO::P12100\\_ILO\\_CODE:C183](http://www.ilo.org/dyn/normlex/en/f?p=1000:12100:0::NO::P12100_ILO_CODE:C183), accessed 27 March 2014).



## Proposed actions

### Key actions for strategic objective 2

Governments, in collaboration with stakeholders, should:

- (a) update national policies, guidelines, norms and standards for maternal and newborn care;
- (b) operationalize effective quality improvement systems for respectful, high-quality maternal and newborn care;
- (c) adopt competence-based curricula for training of health care workers, and put in place regulatory frameworks for midwifery and other health care personnel;
- (d) ensure postnatal care visits in the first week, and provision of quality extra care for small and sick newborns;
- (e) consider and evaluate innovative approaches to motivate staff and to improve access and quality of care; further investigate cost-effectiveness and associated risks of performance-based financing, as has been introduced in some countries;
- (f) ensure that all facilities are adequately staffed with multidisciplinary teams, are able to manage maternal and neonatal complications at referral-facility level, and have basic optimum infrastructure;
- (g) ensure life-saving commodities for women's and children's health are included in every national essential medicines list;
- (h) develop strategies to engage private-sector providers in increasing their advocacy for action on newborn and maternal deaths and stillbirths, and develop innovative technologies to improve newborn and maternal health outcomes;
- (i) institute maternal and perinatal death surveillance and response, including notification of maternal and perinatal deaths (preferably within 24 hours);
- (j) enhance public oversight of the quality of maternal and newborn care through raising public awareness and increasing community involvement.

67. Governments, in collaboration with professional associations, academia, training institutions and other stakeholders, should regularly update national policies and guidelines for interventions around the continuum of care for women's and children's health relative to global evidence-based guidelines and locally defined strategies. Additionally, they should operationalize effective quality improvement systems and adopt and enforce the implementation of norms and standards for respectful and high-quality maternal and newborn care.

68. Governments should adopt competency-based curricula for training of health care workers and put in place regulatory frameworks defining the scope and practice of midwifery and nursing, including specific skills of caring for small-for-gestational-age or sick newborns, lactation counselling and support training, and the minimum standards of educational requirement needed. Rectifying the shortage of specialists, such as neonatologists and breastfeeding counsellors, should also be considered, where appropriate.

69. Staffing levels for each facility providing maternal and newborn care need to be planned in such a way that services can be provided on a continuous basis, 24 hours a day, seven days a week. Team work is essential: teams in first- and second-level referral hospitals should be multidisciplinary and

include specialized obstetric, paediatric and anaesthetic staff to manage maternal and neonatal complications.

70. Maternity facilities must have appropriate infrastructure and be adequately equipped to provide the care needed by mothers and babies. The norms of infection prevention and biosafety must be respected. Electricity, water, sanitation and hand-washing facilities, clean toilets, appropriate spaces for women to give birth with privacy and dedicated areas to manage sick newborns safely must be in place.

71. After birth, women and newborns in health facilities should receive all essential services before discharge. Mother and baby should be routinely accommodated in the same room with provision made for mothers to provide kangaroo mother care comfortably. Expression and storage of breastmilk should be encouraged in health facilities that care for preterm, small-for-gestational-age and/or sick babies, complemented by milk banks in selected referral care facilities. Secondary and tertiary care facilities should have suitably equipped and staffed neonatal units and nurseries and be linked to primary care facilities through a well-functioning referral system. The required postnatal care visits in the first week after birth are necessary for counselling on health-seeking behaviours and for detection of any complications.

72. Life-saving commodities (including essential technologies) for women's and children's health should be included in every national essential medicines list and an uninterrupted supply chain to all facilities, especially the most peripheral, should be ensured.

73. Monitoring and improvement of quality of care must be instituted in all public and private maternity care services through, for example, maternal and perinatal death surveillance and response, birth and death registration (including fetal deaths or stillbirths) and periodic surveys of health facilities' availability and readiness. Information technology can assist in real-time monitoring: mobile phones, for example, are valuable in increasing communication and sharing data among health providers and communities. Community and service links aiming to improve care quality require investment; audits and accountability are also key elements of the process of improving quality of care.

74. Motivation of staff is an important determinant of the quality of care. Innovative approaches should also be applied as appropriate, such as coaching, mentoring, accreditation and continuous education to improve access to and quality of care. National authorities may consider incentives such as financial payments, bonuses and public recognition. Performance-based financing is being introduced in several countries, but further investigation of its cost-effectiveness and associated risks are needed.

75. Raising public awareness and increasing community involvement can accelerate improvements in quality of care. Parliamentarians, who represent voters, legislate, scrutinize and approve budgets and oversee government actions, are therefore seminal in determining women's and children's well-being. Civil society and local leaders, including business leaders, can strengthen political will and help to increase public awareness and community ownership of problems and solutions. A free flow of data and information is needed to enable this, with results from annual health sector reviews being made publicly available in line with recommendations made by the Commission on Information and Accountability for Women's and Children's Health.

76. Engaging the private sector through public-private partnerships can bring multiple benefits, including high-level advocacy; technology transfer to low-income countries; lower costs and increased availability of quality-certified essential medicines and medical devices; improved quality of care and the provision of evidence-based services by private practitioners; improved stewardship and regulatory

function of governments; transport provision for emergency cases; stronger employer-based health services and workplace policies and programmes that support pregnant women and new mothers; and development of innovative technologies with the potential to reduce newborn and maternal deaths and prevent stillbirths and disability.

### **Strategic objective 3: reach every woman and newborn to reduce inequities**

#### **Rationale for strategic objective 3**

77. Every woman and newborn has the right to good-quality health care in line with the principles of universal health coverage and human rights. Access to high-quality maternal and newborn care depends, among other factors, on the availability of skilled health workers who are motivated, adequately equipped and equitably distributed. In many countries, inequitable access to health professionals, particularly in rural areas, is one of the main factors behind persistently high mortality rates for women and newborns.

78. Currently, fewer than one in six countries with the highest burden of maternal and neonatal mortality reaches the minimum benchmark of 23 doctors, midwives and nurses per 10 000 population necessary to provide a basic package of care.<sup>1</sup> Severe shortages of midwives exist in at least 38 countries.<sup>2</sup> These factors, combined with poor working conditions and few incentives for staff to live and work in remote areas or among disadvantaged populations, lead to unequal distribution of health workers and great inequities in access to care for mothers and newborns in countries with a high and inequitable burden of newborn deaths.

79. Costs of health services can present an important barrier to families seeking care during pregnancy and childbirth and in the postnatal period. Direct costs, such as over-the-counter payments for medicines and fees for consultations and procedures, and indirect costs on, for example, transport and lost income have led to sharp inequities in coverage, most notably for women who give birth with a skilled attendant. Up to 11% of the population in some countries incur high costs in paying for health care, with as many as 5% forced into poverty because of health care-related expenditure, including costs associated with essential maternal and newborn care.<sup>3</sup> The goal of universal health coverage stipulates that everybody should be able to access health services and not be subject to financial hardship in doing so, but the world is falling short on both counts, particularly for women and children.

80. Special measures are necessary in health service and community settings to overcome violations of human rights where there is gender bias against the girl child.

81. The absence of information on budgets limits transparency and oversight for maternal and newborn health. Few countries have conducted national health accounts with specific sub-accounts for maternal and newborn health, and tracking of development assistance has become prominent in the public domain only recently.

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<sup>1</sup> Global atlas of the health workforce (<http://apps.who.int/globalatlas/default.asp>, accessed 27 March 2014).

<sup>2</sup> The state of the world's midwifery, report 2011: delivering health, saving lives. New York: United Nations Population Fund; 2011.

<sup>3</sup> The world health report 2010. Health systems financing: the path to universal coverage. Geneva: World Health Organization; 2010.

82. Private sector enterprises should take special measures to promote community and workplace support for mothers in relation to pregnancy and breastfeeding and feasible and affordable child-care services, in compliance with the provisions of ILO's Maternity Protection Convention, 2000 (No. 183). The private sector can and should contribute to the promotion, protection and support of early and exclusive breastfeeding by ensuring that marketing and promotional practices fully conform to the provisions of the International Code of Marketing of Breast-Milk Substitutes and subsequent relevant Health Assembly resolutions and by complying with national legal and regulatory provisions aimed at giving effect to them.

83. Reaching all women and newborns requires investment in every aspect of the health system, including leadership and governance, the workforce, infrastructure, commodities and supplies, service delivery, information systems, and financing. Different contexts require tailored approaches, with specific attention to preparedness for, and rapid response to, complex humanitarian emergencies.

### **Proposed actions**

#### **Key actions for strategic objective 3**

Governments, in collaboration with stakeholders, should:

- (a) conduct a systematic analysis of obstacles to achieving full-scale, high rates of coverage of effective intervention packages for quality care within the health system and community and take action to remove those obstacles;
- (b) ensure the integration of actions for newborn health into existing reproductive, maternal, newborn and child health initiatives and service delivery platforms so that no opportunity to reach mothers and newborns is missed;
- (c) prepare and implement a development plan for the health workforce to ensure competency and respectful behaviour, improve the density, and increase motivation and retention of relevant health worker cadres as needed;
- (d) optimize performance of available staff by considering delegation of tasks to mid-level health personnel with appropriate training and support, and the role of community health workers in bridging gaps between families and health services;
- (e) adopt and enforce laws and policies on equity of access and quality of maternal and newborn care in public and private sectors;
- (f) plan maternal and newborn health services on the basis of an evidence-based agenda, and staffing required for its delivery;
- (g) ensure elimination of barriers (social and financial) that limit access to care by mothers and newborns, including girls in some populations who are especially vulnerable;
- (h) track national health expenditures, including those for maternal and newborn health, and mobilize additional domestic resources;
- (i) develop targeted programmes in and out of school to expand adolescents' and young adults' access to, and use of, modern contraceptive methods and give pregnant adolescents the full support they need;
- (j) consider community strategies to improve demand for services, birth preparedness and essential newborn care practices, including home visits by community health workers and participatory women's groups.

84. A first proposed step for countries to move towards universal coverage of maternal and newborn care is to conduct a systematic analysis of the barriers to extending provision of the intervention packages necessary for provision of good-quality care. These can be found within the health system itself, but gaps in family and community knowledge, misperceptions and lack of resources can also contribute. Results of such analyses should be taken into consideration in the design of national newborn action plans.

85. Integration of actions on the health of newborns into existing reproductive, maternal, newborn and child health initiatives and service delivery platforms (including those for HIV, malaria and immunization) will be crucial to ensuring that no opportunities to reach mothers and newborns are missed. Countries must critically assess what services are needed, motivate health workers, improve hospitals' efficiency, eliminate waste and corruption, and optimize the use of technologies and health services.

86. Every country should have a comprehensive development plan for the health workforce that covers education and training, the distribution, motivation and retention of skilled personnel, and redresses the mismatch between available health care workers and positions through a system that tracks from pre-service training through to posting and retention. It is essential that health workers have respectful attitudes and behaviours towards women and newborns, and working conditions should allow health workers to operate in a safe and respectful environment. Plans should include actions to expand and/or more equitably redistribute the workforce and, where needed, implement immediate remedial measures, including appropriate remuneration. Provision of housing, electricity and salary supplements has been effective in motivating health workers to serve in remote and underserved areas.

87. Optimizing performance of available staff is a priority. Evidence that life-saving interventions can safely be delegated to mid-level health workers is strong, but only if they are appropriately trained. Midwifery personnel, for example, should be able to provide the full range of emergency obstetric care where referral possibilities are limited.

88. Governments should adopt and enforce laws and policies on equity of access and quality of maternal and newborn care in public and private sectors. Policies should include ensuring women's and children's universal access to health care services without enduring financial hardship; notification of maternal and perinatal deaths; context-specific approaches to HIV infection and infant feeding; ratification of ILO's Maternity Protection Convention, 2000 (No. 183); and legislation to implement the International Code of Marketing of Breast-Milk Substitutes.

89. Plans for extending maternal and newborn health services should be based on objective information and evidence. Countries need to estimate requirements for the number of pregnancies and births within a given setting and build and equip the necessary infrastructure. They need to define a standard package of maternal and newborn care for each level of health provision and determine the number of staff and constitution of teams, including midwives and midwifery personnel and, where needed, specialists such as obstetricians, neonatal nurses and paediatricians. Geographical mapping of access points has been successful in several countries in supporting decision-making on the number and location of maternity facilities to reach the greatest number of families and communities. Sound planning should inform increased investment in care quality around childbirth.

90. Targeted programmes in and out of school are needed to expand adolescents and young adults' access to, and use of, modern contraceptive methods. Measures taken to prevent early pregnancies should include legislation to prevent or lower the number of girls who marry under the age of 18 years and life-skills education (for boys and girls) to help to keep girls in school, reduce rates of coerced sex,

prevent early and unintended pregnancy before 20 years, and inculcate positive cultural norms and traditions. Young people should be able to access contraceptives and comprehensive sexual education that is empowering and that is designed to enable them to make sexual and reproductive decisions freely and responsibly. Countries should provide the enabling environment for this to happen. Youth-friendly health services should be available to give pregnant adolescents the full support they need to be well prepared for birth and parenthood, regardless of marital status.

91. Policies are needed to eliminate disparities in health care access. Such policies include subsidizing the cost of care and focusing on the most vulnerable population groups to ensure that good-quality maternal and newborn health services are available at an affordable cost at the point of use (which would mean free of charge to many people). Countries should reduce reliance on out-of-pocket payments by increasing forms of prepayment with pooling of funds to share financial risks across the population. Prepayment typically involves taxes and other government charges and/or insurance. To mobilize resources, governments must prioritize the health sector in domestic budgets, increase efficiency in collection of national revenue and adopt innovative ways of raising funds through, for instance, taxes on tobacco and alcohol.

92. Countries must track total health expenditure by financial source (and per capita) and total expenditure on reproductive, maternal, newborn and child health by financing source (and per capita). All major development partners should report their assistance for maternal and newborn health against their commitments and make covenants that would enable national authorities to establish predictable budgets and reinforce mutual accountability.

93. Community strategies to improve demand for services, birth preparedness and essential newborn care practices, including participatory women's groups and home visits supported by community health workers, volunteers or lay facilitators, have a critical role to play in reducing inequalities in mortality and access to care. Evidence suggests that participatory women's groups have the largest impacts on mortality among the poorest.

#### **Strategic objective 4: harness the power of parents, families and communities**

##### **Rationale for strategic objective 4**

94. It is vitally important to overcome barriers to accessing skilled care at birth and to harness the power of parents, families and communities, engaging them to seek care throughout pregnancy, birth and the first days and weeks of their children's lives. This is particularly important in low-income countries, where almost half of mothers do not receive skilled care during childbirth, more than 70% of babies born outside facilities receive no postnatal care<sup>1</sup> and most maternal and newborn deaths and stillbirths occur. Many newborns die at home without any care having been sought.

95. It is essential to empower women, parents, families and communities to seek health care services when needed and to ensure they can provide recommended care in the home by themselves. Health outcomes, both positive and negative, are determined by decisions made within the household, the families' ability to reach care when needed and the quality of the services received when they arrive. Unfortunately, many actors outside of health services are often not engaged in discussions and efforts to improve their health and to increase the coverage of essential interventions.

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<sup>1</sup> WHO, UNICEF. Accountability for maternal, newborn and child survival: the 2013 update. Geneva: World Health Organization; 2013.

96. Programmes that seek to strengthen health services through mobilizing community members to adopt healthy practices, shifting social norms to increase social support and addressing barriers to access have demonstrated the effects of such approaches. The resulting changes are particularly evident for maternal and newborn health. A woman's right to make decisions is crucial for her health and the health of her family.

97. Community-oriented activities can be broadly categorized in four areas: (i) increasing awareness of rights, needs, responsibilities and potential problems related to maternal and newborn health; (ii) developing capacities to stay healthy, make healthy decisions and respond to obstetric and neonatal emergencies; (iii) strengthening social support networks among women, families and communities and links with the health services; and (iv) improving quality of care through strengthening health services' interactions with women, families and communities and responses to their needs.<sup>1</sup> Investment is necessary in each of these areas, particularly in settings where maternal and neonatal mortality rates are high and access to health services is limited. Actions need to be taken collectively by multiple parties alongside efforts to improve the quality of health services. Civil society can play a catalytic role through existing and strengthened coalitions and networks.

98. Families, especially parents, are at the forefront of providing newborn care. They can and should ensure certain aspects of care for the healthy baby after birth, including keeping the baby clean and warm, initiating early and exclusive breastfeeding and performing proper cord care (including the use of chlorhexidine, if appropriate). This is particularly important for babies born at home or discharged a few hours after birth. Even though practices like breastfeeding are often considered as natural behaviours, many women require skilled support.

99. Interactions between carer and child are crucial for psychosocial and cognitive development and should start from the day of birth. Simple communication and stimulation catalyse the maturation of neurological pathways and are relevant for full-term and preterm babies. Support for early child development is an essential component of newborn care.

100. Men can play an important role in maternal and newborn health as partners, fathers and community members. Men are often key decision-makers in maternal and newborn care-seeking behaviour and need to understand the needs, risks and danger signs of pregnancy, childbirth and postnatal periods. Health programmes that are traditionally designed to interact with women need to broaden their understanding of men's needs and perspectives (without compromising women's rights), working with men and women (adolescents and adults) and positioning gender perspectives and reproductive rights as pertinent to both. Health care workers need to make it convenient for men to accompany their partners and attend births, supporting them to enhance couples' communication and decision-making.

101. In 2009, WHO and UNICEF issued a joint statement on home visits for newborn children based on research showing that visits conducted by community health workers improved newborn survival rates.<sup>2</sup> Extensive studies in Africa and Asia since then have shown that home visits during pregnancy and in the first week after birth increase the number of women seeking antenatal care and receiving skilled care during birth. Visits by community health workers also help families to take better care of

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<sup>1</sup> Working with individuals, families and communities to improve maternal and newborn health. Geneva: World Health Organization; 2003.

<sup>2</sup> WHO, UNICEF. Home visits for the newborn child: a strategy to improve survival. Geneva: World Health Organization; 2009.

the newborn and lead to improved practices, such as delayed bathing and early initiation of exclusive breastfeeding, resulting in significant reductions in neonatal mortality.

102. Community leaders, family members, traditional birth attendants and other influential people can also be positive agents for support. Depending on the context, elder family members, such as grandmothers and mothers-in-law, have a strong, culturally sanctioned power for decision-making and care, influencing, for example, the diet of pregnant women, workload and household responsibilities and use of emergency services.

103. Community mobilization through facilitated participatory learning and action with women's groups is recommended in order to improve maternal and newborn health, particularly in rural settings with low access to health services. The intervention can have a positive effect on newborn mortality, and further research may improve understanding of the effects on maternal health and care-seeking. Implementation of facilitated participatory learning and action with women's groups should focus on enabling discussions in which women can identify priority problems and advocate for local solutions for maternal and newborn health. In order to ensure quality, this intervention should be implemented with close monitoring and evaluation as well as prior adaptation to the local context.

104. Lay health workers, including traditional birth attendants, have successfully performed functions related to health care delivery for women and newborns and can be important members of the health team. They are not intended to replace a health professional in attending births, but can effectively promote maternal, newborn and reproductive health interventions such as, but not limited to, appropriate care-seeking, preparedness for birth and complications, and support for breastfeeding. Traditional birth attendants are often valued and respected community resources and finding new roles for them in areas such as providing continuous support for women during labour (in the presence of a skilled attendant) and serving as a link between communities and health services is important.<sup>1</sup>

105. In conjunction with other actions, social and mass media can be influential in imparting knowledge, changing behaviour and instilling social accountability for newborn health services. Advocacy campaigns using radio and television have contributed to increasing the number of births in health facilities, early initiation and exclusive breastfeeding, and other interventions. Multi-pronged approaches enhance the reach of messages.

106. The private sector's considerable expertise in strategic communications can be harnessed to change social norms (such as acceptance that maternal and newborn deaths are inevitable), promote optimal health behaviours and increase demand for good-quality care. Many private corporations have capacity for conducting research and mining diverse sources of data to create understanding of what motivates behaviours, an extremely valuable asset that has not yet been tapped to its full potential. Public-private partnerships are especially amenable to multimedia advocacy campaigns through existing private sector communications platforms, television, radio, social media and e-health and mobile-telephone technologies.

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<sup>1</sup> WHO recommendations: optimizing health worker roles to improve access to key maternal and newborn health interventions through task shifting. Geneva: World Health Organization; 2012; WHO, International Confederation of Midwives, International Federation of Gynecology and Obstetrics. Making pregnancy safer: the critical role of the skilled attendant: a joint statement by WHO, ICM and FIGO. Geneva: World Health Organization; 2004.



107. Civil society organizations can contribute significantly to social mobilization, creating political will and policy design, and can help to hold governments and health services accountable for implementing their programmes and plans.

108. Systematic reviews of the results of evidence-based approaches designed to harness the power of women, parents and communities are being conducted in areas such as: preparedness for birth and complications; transport schemes; maternity waiting homes; community participation in programme planning and quality improvement; alleviation of financial barriers and cash transfers; integrated case management of newborn and childhood illnesses; the use of mobile telephone technology; maternal and perinatal death audits; and results-based financing. Findings will inform future policy on these approaches.

### Proposed actions

#### Key actions for strategic objective 4

Governments, in collaboration with stakeholders, should:

- (a) promote zero tolerance for preventable maternal and newborn deaths;
- (b) maximize the power of parents' voices, civil society, mass media and social media to provide information and change norms;
- (c) conduct a systematic analysis of obstacles to accessing quality maternal and newborn services and uptake of essential home care practices by women, families and communities and actively involve communities in determining priorities and planning appropriate actions;
- (d) equip families, including men, with the knowledge and capacities to provide good home care;
- (e) strengthen links between community and health facilities through applying innovative approaches to reach remote areas;
- (f) adopt combined approaches to improving care quality within the home and from health services;
- (g) evaluate the utility of community-based organizations such as participatory women's groups to foster community mobilization, particularly among rural populations with limited access to care;
- (h) adopt evidence-based strategies to generate and sustain demand for services using community-oriented actions;
- (i) engage, enable and support in-country civil society organizations to demand transparency and oversight and improve access to, and quality of, care;
- (j) engage the private sector to support multimedia communication campaigns to change social norms, promote zero tolerance for preventable mortality and advocate for optimal behaviours.

109. Maternal and newborn deaths and stillbirths need to be recognized by communities, families and individuals as avoidable and not inevitable. To ensure zero tolerance of preventable deaths, there has to be a change in social norms and expectations surrounding childbirth and newborn survival, and parents affected by stillbirths or newborn deaths need to be given a voice. Peer-to-peer strategies of

using parents' voices to mobilize civil society, mass media and social media can be used to spread information and change norms.

110. The analysis of obstacles proposed under strategic objective 3 should also focus on factors that determine the demand for maternal and newborn health services and affect the provision of recommended self-care in the home in countries with a high burden of neonatal mortality. Understanding the motivational, cultural, structural and financial elements that support families and communities to implement good home care practices and seek appropriate care for mothers and their newborns is essential for devising an appropriate response. Programmes should include activities to give women and families a voice and allow their participation in prioritizing problems and solutions.

111. Where access to health services is inequitable or low, countries should consider investing in community health workers as a powerful resource for improving maternal and newborn care, particularly in hard-to-reach areas, and ensure their integration as an important human resource alongside health professionals for maternal and child health matters. Appropriate training, supportive supervision, deployment and compensation are necessary.

112. Consideration should be given to strengthening community-based organizations such as women's groups to foster community mobilization through dialogue-based approaches such as facilitated cycles of participatory learning and action. This is particularly relevant among rural populations for whom access to care is limited. Further evaluation of the utility of this approach in poor urban areas and with other actors, including men and grandmothers, is urgently needed.

113. Families, particularly men and fathers, also have important roles. They should be involved in individual household-level and community activities to enhance their contribution to supporting family health. Various channels can build capacity to provide good home care, such as health education, media campaigns and home visits by trained community health workers.

114. Strengthening linkages between communities and health facilities improves health outcomes for women and their babies, especially where referral services are provided. Mobile phone technology, which is now widely available and can reach remote areas in many countries, provides one approach for improving these linkages. It has been successfully used to supply health messages, establish help lines and facilitate real-time monitoring of births and deaths and can be linked with community mobilization interventions to create greater synergy.

115. Creating demand for services for underserved communities requires innovative approaches based on evidenced-based strategies. For example, conditional cash transfers to families and communities can be considered where financial circumstances impede access to health care, with careful monitoring to demonstrate cost-effectiveness.

116. The Commission on Information and Accountability for Women's and Children's Health has called for improved oversight and transparency, urging parliamentarians, community leaders, civil society and the general population to demand information and participate actively in planning and monitoring health services and the quality of care received by mothers and children. Countries should pursue these recommendations. Similarly, all concerned stakeholders should accept independent accountability for implementing this action plan at global level as part of their commitment to saving the lives of newborns.

## **Strategic objective 5: count every newborn – measurement, programme tracking and accountability**

### **Rationale for strategic objective 5**

117. Vital statistics provide indispensable information, in this case making policies more effective and responsive to the needs of women and children. In 2010, however, about one third of 135 million births globally and two thirds of deaths went unregistered. Half the countries in the WHO African and South-East Asia regions do not record cause of death in their vital statistics, and serious deficiencies are present within existing systems.<sup>1</sup> The vital registration systems in some countries do not follow global recommendations about which child to count and often function for only part of the country. In others, not all deaths are registered. Failure to collect high-quality data on registration of births and deaths, including cause of death, results in an absence of crucial information for policy-making, planning and evaluation across all development sectors, including health and health services. The United Nations Human Rights Council resolution 19/9 on birth registration and the right of everyone to recognition everywhere as a person before the law is entirely dedicated to birth registration and legal identification for all, without discrimination.

118. As governments and partners establish and expand access to interventions related to newborn health, more and better information is needed for monitoring and assessing progress towards achieving the commitments made to ending preventable newborn deaths and stillbirths.

119. Few universal indicators are available for monitoring equity of access and quality of maternal and newborn care. Some steps to improve measurement have been initiated, such as adding questions to household survey instruments on postnatal care for mothers and newborns and to facility-assessment tools about the availability of commodities specifically for newborns, including resuscitation equipment and antenatal corticosteroids. Many challenges remain, however, in gathering these data. Population-based household surveys, including demographic and health surveys and multiple indicator cluster surveys, have long collected data on indicators on family planning, antenatal care and attendance at birth. More information on postnatal contacts for newborns has recently been incorporated into these surveys and the number of countries with available data is steadily increasing. A process for generating indicators that can be considered for addition to household surveys to measure newborn care practices and the content of postnatal care is a milestone proposed in this plan.

120. Major gaps persist in the collection of data on outcomes, coverage and quality of care around the time of birth, and much more rigorous attention needs to be paid to the development and testing of indicators and their inclusion in health management information systems. Few indicators related to the health of newborns are currently included in routine health management information systems, with limited use of the data for improving quality. A set of core and additional indicators for tracking not only population-based coverage of effective interventions, but also the quality of care in health services, needs to be agreed for use in varying contexts, including complex humanitarian emergencies. Managers at all levels need to know to what degree the system can deliver essential maternal and newborn services and identify performance weaknesses that can be rectified through better planning, budgeting and service delivery. Many of the indicators can be integrated in routine health information systems, with results validated periodically through specific surveys.

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<sup>1</sup> Oomman N, Mehl G, Berg M, Silverman R. Modernising vital registration systems: why now? *Lancet*. 2013;381(9875):1336–7. doi: 10.1016/S0140-6736(13)60847-8.

121. Many countries have accepted maternal death surveillance and response as an effective means of identifying deaths, investigating their determinants and taking remedial action on preventable causes. Perinatal deaths should be considered an important component of these initiatives. A meta-analysis of the impact associated with the introduction of perinatal audits in low- and middle-income countries demonstrated a 30% reduction in mortality when solutions identified from the audit process were linked to action.<sup>1</sup> New guidance from WHO and its partners provides clear recommendations on how to implement maternal death surveillance successfully at full scale.<sup>2</sup> The guidance promotes a phased approach and suggests a focus on strengthening maternal death surveillance and response in health facilities before expanding it to communities. Auditing maternal and perinatal deaths and linking the results to a national process has the potential to strengthen capacity to avoid preventable causes of mortality. Legal protection mechanisms that would facilitate full enquiries are nevertheless inadequate in many countries, meaning the full potential of the approach often remains untapped.

### Proposed actions

#### Key actions for strategic objective 5

Governments, in collaboration with stakeholders, should:

- (a) invest in birth and death registration coverage and quality, promoting recording of every birth, live or stillbirth, and recording stillbirths and neonatal deaths;
- (b) consider the use of specific perinatal death certificates that capture additional data on stillbirths, gestational age and birth weight in addition to maternal complications;
- (c) develop a minimum perinatal dataset and ensure that all birth outcomes are collected, with consistent definitions and cross-links to databases for vital registration;
- (d) institutionalize maternal and perinatal death surveillance and response, linking this with perinatal death reviews and taking action to address avoidable factors identified through such reviews;
- (e) track morbidity and disability outcomes especially when neonatal intensive care is being expanded;
- (f) evaluate and define national indicators of service delivery for maternal and newborn health (based on the global indicators proposed in Appendix 2) and integrate them into routine data collection systems and instruments;
- (g) urge parliamentarians, community leaders, civil society and the general population to demand information and participate actively in planning and monitoring of access to quality health services received by women and children;
- (h) develop strategies to engage the private sector in improving the collection and quality of birth and death registration systems and in investing, developing and executing innovative mechanisms for gathering data.

<sup>1</sup> Pattinson R, Kerber K, Waiswa P, Day LT, Mussell F, Asiruddin SK et al. Perinatal mortality audit: counting, accountability, and overcoming challenges in scaling up in low- and middle-income countries. *International Journal of Gynecology and Obstetrics*. 2009;107 (Suppl. 1):S113–21, S121–2. doi: 10.1016/j.ijgo.2009.07.011.

<sup>2</sup> Maternal death surveillance and response: technical guidance. Information for action to prevent maternal death. Geneva: World Health Organization; 2013.

122. Countries should introduce and invest in improving birth and death registration systems and consider innovative mechanisms for gathering data, such as through community health workers and use of mobile phones. Registration of stillbirths and newborn deaths should be accompanied by programmatically-relevant categorization of the causes of deaths. Additional data (such as gestational age and birth weight) and consideration of the social determinants of mortality should be included. The quality and completeness of data need to be monitored continuously and the data should be disseminated as the basis for planning.

123. Investment and technical support are needed in order to improve the quantity, consistency and frequency of national input data for all maternal and birth outcomes as part of a minimum perinatal dataset linked to vital registration and data derived from health facilities. Countries should strengthen mechanisms for maternal death surveillance and response and surveillance of perinatal mortality, linking this with perinatal death reviews and taking action to address avoidable factors identified through such reviews. It is also important to track disability outcomes (such as retinopathy of prematurity, deafness and cerebral palsy), particularly for countries expanding neonatal intensive care.

124. The global core indicators proposed as part of the action plan (Appendix 2) should be evaluated by stakeholders and, after assessment, integrated into national health information management systems. The set of indicators proposed will be further developed as part of the operationalization of the action plan (referred to in paragraph 135), covering the domains of service readiness, outcomes, service use, intervention coverage and quality of care.

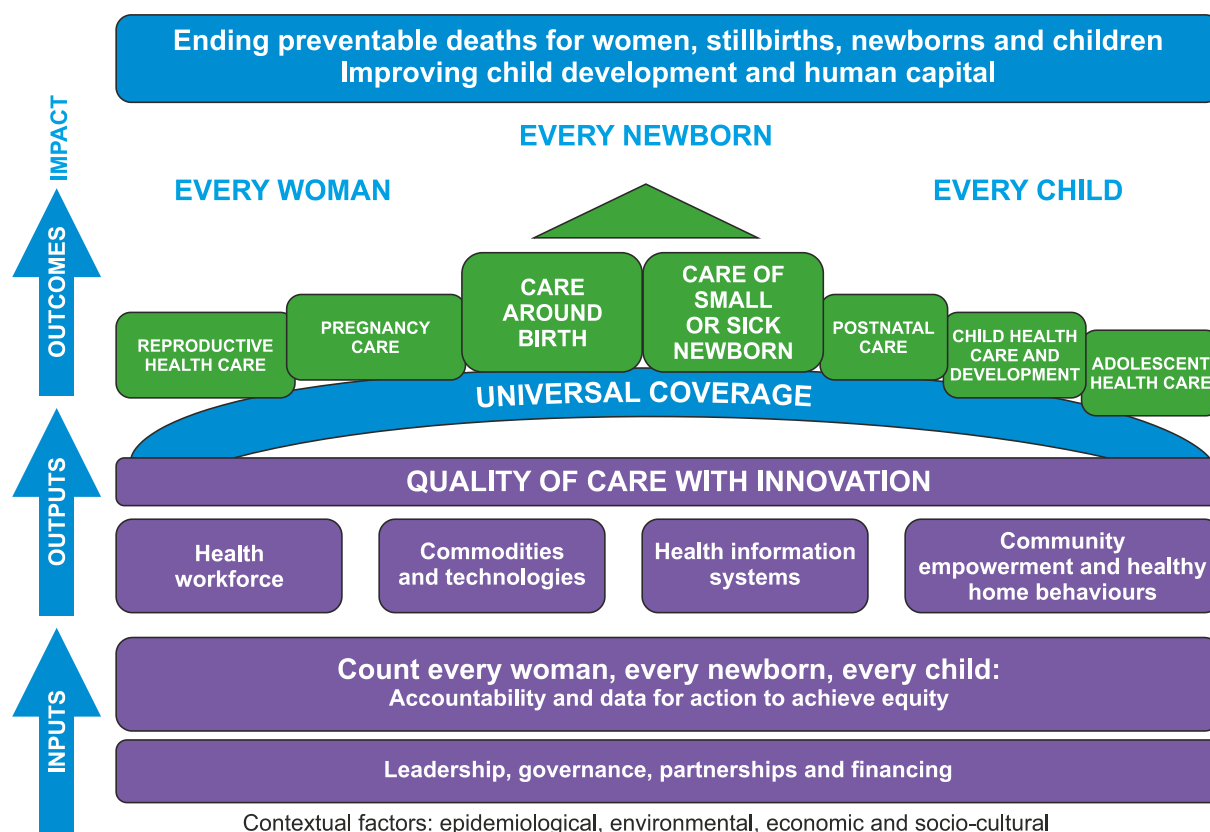
125. All stakeholders, from parliamentarians and community leaders to civil society and the general population, need to demand information and participate in planning and monitoring access to quality health services received by women and children, possibly through use of scorecards, to increase accountability for implementing this action plan.

126. While routine systems are being strengthened, countries and development partners should undertake periodic household surveys to obtain data on mortality, intervention coverage and use of services. The private sector should also be engaged in improving the collection and quality of birth and death registration systems and in investing, developing and executing innovative mechanisms for gathering data, especially through the use of mobile phones.

## **FRAMEWORK FOR SUCCESS**

127. The impact framework shown in Figure 6 inserts “every newborn” into the “Every woman, every child” concept and broadens the goals to include ending preventable deaths for women, stillbirths, newborns and children, and improving child development and human capital. The outcome level of the framework includes all packages for reproductive, maternal, newborn and child health. This places the action plan’s particular emphasis on care of women and babies in labour, birth and the first week of life but also on care of small and sick newborns, with the objective of universal health coverage for all packages. Increased coverage of quality of care requires programme change to be expanded within the health system and community. Inputs to a strengthened health system require rigorous measurement, strong programme tracking and accountability. Finally, the sociopolitical, economic, environmental, biological and legal contexts affect all levels of change.

Figure 6. Every newborn impact framework



128. Mortality targets will only be achieved through improvements in coverage and quality of care for women and babies at birth and care of small and sick newborns. Interim targets of evidence-based interventions for coverage and quality of care around birth, care for newborns at risk, home visits and participatory group support for women and newborns are therefore proposed (Appendix 1).

#### 129. Coverage targets by 2020

(a) **Coverage and quality of care around birth:** 90% of women giving birth and babies born in health facilities will receive effective, high-quality and respectful care that includes essential care during pregnancy and labour and following birth, with preventive care and appropriate management of complications for the mother and newborn. Maternal and perinatal death surveillance, timely response and regular monitoring of quality of care will be an integral part of maternal and newborn health services.

(b) **Coverage and quality of care for small and sick newborns:** at least half of babies who do not breathe spontaneously at birth after thorough drying and stimulation will be resuscitated with bag and mask ventilation; at least half of stable preterm newborns or babies weighing less than 2000 g will receive kangaroo mother care and other supportive care; and at least half of newborns with possible serious bacterial infection will receive antibiotic therapy. Country-specific targets for comprehensive neonatal intensive care will be set, including tracking of disability.

(c) **Home visits and participatory group support for women and newborns:** each country will achieve at least a 20% increase (or an increase to 90% if their baseline is above 70%) of early postnatal care for women and newborns within two days of birth to promote breastfeeding, counselling and screening for maternal and newborn complications, and postnatal family planning. Linking to community participatory approaches and parent groups is an important component of this strategy.

#### 130. Coverage targets by 2025

(a) **Coverage and quality of care around birth:** 95% of women will give birth with a skilled attendant, and every woman and her newborn will receive effective, high-quality and respectful care (see paragraph 129).

(b) **Coverage and quality of care for small and sick newborns:** at least 75% of babies who do not breathe spontaneously at birth after thorough drying and stimulation will be resuscitated with bag and mask ventilation; at least 75% of stable preterm newborns or babies weighing less than 2000 g will receive kangaroo mother care and other supportive care; and at least 75% of newborns with possible serious bacterial infection will receive antibiotic therapy.

(c) **Home visits and participatory group support for women and newborns:** 90% of women and newborns will receive early postnatal care of high quality within two days of birth. The quality of postnatal care will be tracked with improved metrics to assess content and longer-term outcomes, such as the nutrition goal of 50% exclusive breastfeeding in all countries by 2025. Linking to community participatory approaches and parent groups is an important component of this strategy.

### MEASURES OF SUCCESS

131. The Every Newborn action plan is about taking action to achieve ambitious mortality goals and coverage targets to end preventable newborn deaths and stillbirths. The pathway to impact will be marked by milestones, which are defined at global and national levels for the period 2014–2020 (Appendix 1). The milestones will form the starting point for accountability and independent oversight and the basis for monitoring progress in implementation. Monitoring and evaluation coincide with the reviews of progress towards the Millennium Development Goals in 2015 and will be ready for the prospective post-2015 sustainable development goals, linking to the new accountability mechanism.

132. A more detailed monitoring plan, with coverage and outcome metrics to track progress, is a milestone at global level. These indicators will need to be collected and used for national programme action within countries. Clearly delineating stillbirth interventions and strategies represents another milestone.

133. The real change for women and their babies will take place within countries. National milestones include (but are not limited to) ensuring that: commodities are included in national essential medicine lists and are tracked; the community voice, especially of women, is heard; national health plans are sharpened and costed so as to deal appropriately with newborn health and stillbirths; and national expenditure for reproductive, maternal, newborn and child health is tracked and reported.

134. Considering a woman and her baby together forms a core concept of the action plan, so a package of interventions is needed for both: they are distinct yet interdependent, and the interdependence is vital to both. As a complement to this action plan, WHO, UNICEF and partners

will develop a mother–baby friendly initiative that will focus on improving quality of care for mothers and newborns in facilities, linked to community actions and district health system strengthening. A set of norms and standards for quality of care around birth and the immediate postnatal period will be defined and, once established in consultation with countries and technical experts, will need to be adapted and adopted within countries.

135. Achieving the vision, mortality goals and coverage targets outlined in the plan require measurable indicators to track progress and inform health policy and programmes. The selection of the core indicators (Appendix 2) involved a grading process for direct relevance to the action plan framework, targets and goals and review of current data availability. Core indicators in some cases are agreed and tracked, but some need to be further tested and integrated into national measurement systems. Urgent work is required to improve the metrics for these and other supporting indicators and increase the number of countries routinely tracking them. The operationalization of these core indicators and a wide list of additional necessary indicators forms part of the short-term milestones listed in Appendix 1.

## **RESEARCH PRIORITIES**

136. Research into delivery, development and discovery needs to be placed at the forefront of efforts to reduce neonatal mortality. Research priorities for newborn health were identified by a global exercise for the period 2013–2025: nine out of 10 priorities related to improving delivery of known interventions.

137. The top research priorities for the delivery of interventions include: finding approaches to scale up simplified newborn resuscitation at lower levels of the health system; identifying and managing newborn infection at community level; removing barriers to the extension of exclusive breastfeeding and facility-based kangaroo mother care; evaluating the use of chlorhexidine for cord care in neonates born in health facilities; and developing strategies to improve the quality of facility-based care provided during labour and childbirth.

138. Development research priorities identified included: adapting kangaroo mother care to make it deliverable at community level; detecting early high-risk women in pregnancy and labour in the community; improving and simplifying intrapartum monitoring; evaluating appropriate oral antibiotics for treatment of neonatal sepsis; defining the role of perinatal audits in improving quality of care during labour and childbirth; and developing lower-cost surfactant and devices for use in low- and middle-income countries.

139. Discovery research priorities highlighted: science and technology in order to understand the causal pathways of preterm labour; new tocolytics to delay preterm birth; stable surfactant with easier mode of delivery; effective maternal vaccines to prevent neonatal sepsis; point-of-care diagnostics and new biological agents to improve identification and treatment of neonatal sepsis; better ways to detect fetal distress; and identification of biomarkers for intrauterine growth retardation and antepartum stillbirths.

## **COORDINATION**

140. Putting the action plan into practice will require the participation of many stakeholders, ranging from governments and policy-makers, donor countries, the United Nations and other multilateral organizations and global philanthropic institutions to civil society, health care workers and their

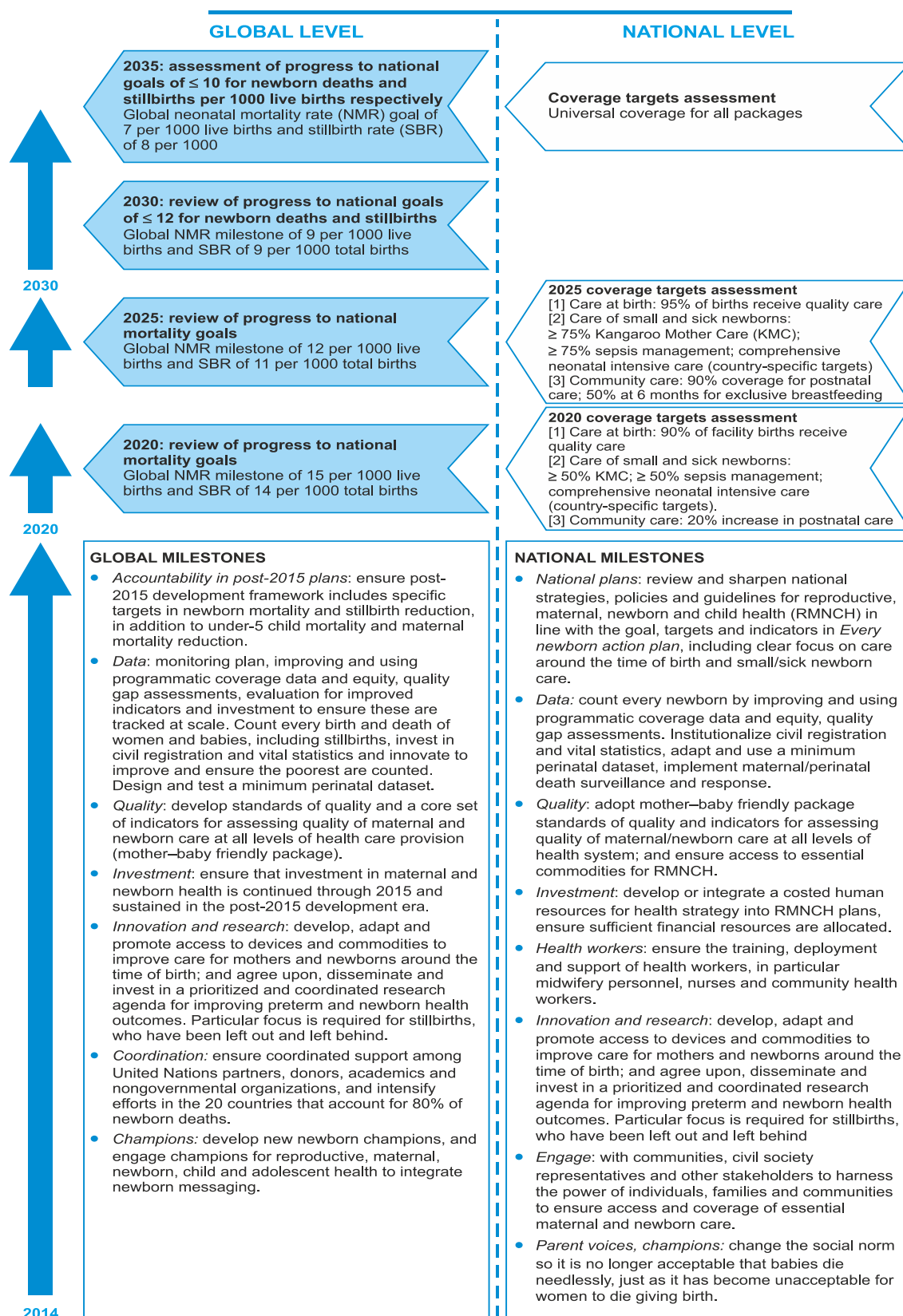


professional associations, the business community, and academic and research institutions (see Appendix 3).

141. The plan defines priority actions to provide a healthy start for every newborn within the context of integrated reproductive, maternal, newborn, child and adolescent health programmes. Maternal and child health services are an ideal platform for delivering integrated packages that include a range of interventions, including those for malaria, HIV infection, nutrition and immunization. It is vital that post-2015 development goals include the vision of healthy societies in which women and adolescent girls, newborns and children survive and thrive. Coordination for implementation of this vision will rely on a strong, secure continuum of care to reduce dramatically preventable maternal, newborn and child deaths, and which has the potential to build more equitable societies and transform human development.

## APPENDIX 1

## GLOBAL AND NATIONAL GOALS, TARGETS AND MILESTONES 2014–2035



## APPENDIX 2

**PROPOSED GLOBAL INDICATORS FOR THE EVERY NEWBORN ACTION PLAN<sup>1</sup>**

	<b>Core indicators</b>	<b>Additional indicators</b>
Impact	1. Maternal mortality ratio*	
	2. Stillbirth rate	<b>Intrapartum stillbirth rate</b>
	3. Neonatal mortality rate*	Low birth weight rate* Preterm birth rate Small for gestational age <b>Neonatal morbidity rates, such as infection</b> <b>Rates of long-term disability after neonatal conditions</b>
Coverage: care for all mothers and newborns	4. Skilled attendant at birth* 5. Early postnatal care for mothers and babies* 6. Infants exclusively breastfed for the first six months of life (%) *	Early initiation of exclusive breastfeeding
Coverage: complications and extra care	<b>7. Antenatal corticosteroid use</b> <b>8. Newborn resuscitation</b> <b>9. Kangaroo mother care and feeding support</b> <b>10. Treatment of neonatal sepsis</b>	Caesarean section rate*
Input: counting	Birth registration*	Death registration, including cause of death
<i>Input: Every newborn service delivery packages</i>	<i>Mother–baby friendly measurable norms and standards</i> <i>Care of small and sick newborn</i>	

<sup>1</sup> \* = indicator as defined and tracked in *World Health Statistics 2013*; Grey = not currently routinely tracked; **Bold** = indicator requiring additional evaluation for consistent measurement and linked to milestones in Appendix 1; *Italics* = input package requiring norms and standards to be defined and linked to milestones in Appendix 1.

All indicators are to be tracked in such a way that they can be broken down to assess equity by, for instance, urban/rural, regional or wealth quintile.

## APPENDIX 3

## ACTIONS BY CONSTITUENCY

## Everyone has a role to play

Actors	Actions
<p><b>Governments and policy-makers at national, regional and global levels</b></p>	<ul style="list-style-type: none"> <li>• <i>National plans</i>: review and revise national strategies, policies and guidelines for reproductive, maternal, newborn and child health in line with the goals, targets and indicators defined in the Every Newborn action plan, including a clear focus on care around the time of birth.</li> <li>• <i>Budgets</i>: allocate sufficient financial resources to maternal and newborn health, and ensure adequate investment to improve quality of care.</li> <li>• <i>Legislation</i>: adopt appropriate legislation on birth registration, maternal deaths notification, maternity protection and the International Code of Marketing of Breast-Milk Substitutes.</li> <li>• <i>Health workers</i>: develop or integrate a costed strategy on human resources for health into reproductive, maternal, newborn and child health plans to ensure the training, deployment and support of health workers, particularly midwifery personnel, skilled birth attendants, nurses and community health workers.</li> <li>• <i>Quality</i>: adopt standards of quality and core set of indicators for assessing quality of maternal and newborn care at all levels of health care provision.</li> <li>• <i>Commodities</i>: include essential commodities for maternal and newborn health in national essential medicines list and ensure an uninterrupted supply at all levels of the health system.</li> <li>• <i>Engage</i>: engage with communities, civil society representatives and other stakeholders to harness the power of individuals, families and communities to ensure access and coverage of essential maternal and newborn care.</li> <li>• <i>Accountability</i>: count every newborn by institutionalizing civil registration and vital statistics and maternal, perinatal and neonatal death surveillance and response.</li> </ul>

Actors	Actions
<p><b>Organizations in the United Nations system and other multilateral agencies</b></p>	<ul style="list-style-type: none"> <li>• <i>Policy</i>: ensure post-2015 development framework includes specific targets in newborn mortality reduction and stillbirth reduction, in addition to under-5-year-old child mortality and maternal mortality reduction.</li> <li>• <i>Technical assistance</i>: provide technical assistance and support to government planning, implementation and accountability efforts.</li> <li>• <i>Coordination</i>: ensure coordinated support among United Nations partners and intensify efforts in the 20 countries that account for 80% of all newborn deaths.</li> <li>• <i>Quality</i>: develop standards of quality and core set of indicators for assessing quality of maternal and newborn care at all levels of health care provision.</li> <li>• <i>Investment</i>: ensure that multilateral investment in maternal and newborn health is continued through 2015 and sustained in the post-2015 development era.</li> <li>• <i>Champions</i>: engage champions for reproductive, maternal, newborn, child and adolescent health in order to provide coherent and coordinated messages about newborn health.</li> </ul>
<p><b>Donors and foundations</b></p>	<ul style="list-style-type: none"> <li>• <i>Funding</i>: mobilize funds to fill gaps and support the implementation of costed, evidence-based, country-owned reproductive, maternal, newborn and child health plans that include a focus on birth.</li> <li>• <i>Health worker training</i>: support the training and deployment of health workers, including investing in midwifery personnel, skilled birth attendants, nurses and community health workers that can deliver quality essential interventions focused on birth.</li> <li>• <i>Commodities</i>: support access to quality commodities by investing in innovative financing, creating incentives for producers and purchasers, supporting quality assurance and regulation, and research and development efforts to improve products.</li> <li>• <i>Accountability</i>: engage in country compacts and enhance accountability around financial flows.</li> </ul>

Actors	Actions
<b>Private business</b>	<ul style="list-style-type: none"> <li>• <i>Innovation</i>: invest in developing and adapting devices and commodities to care for mothers and newborns around the time of birth; invest in social and behavioural change campaigns, including those that reach the poorest and most vulnerable.</li> <li>• <i>Implement</i>: scale up best practices and partner with the public sector to improve service delivery.</li> </ul>
<b>Nongovernmental organizations, communities and/or parent groups</b>	<ul style="list-style-type: none"> <li>• <i>Community health workers</i>: support preventive care before and after the period around birth and referrals to basic and comprehensive facilities as appropriate.</li> <li>• <i>Community leadership and accountability</i>: foster community leadership and accountability to remove barriers (in relation to, for instance, transport), hold health providers accountable for providing quality services and strengthen links between communities and facilities.</li> <li>• <i>Champions</i>: identify and support local champions, including parliamentarians, parent groups, professionals, community health volunteers and community leaders; engage and link champions for reproductive, maternal, newborn, child and adolescent health in order to provide coherent and coordinated messages about newborn health.</li> <li>• <i>Demand</i>: generate and sustain demand for services using community-owned actions (for instance incentives such as conditional cash transfers, insurance, transport, social mobilization, savings credit schemes and cooperatives).</li> <li>• <i>Adolescents</i>: give special attention to adolescent girls and implement approaches to help to prevent early and unintended pregnancies.</li> <li>• <i>Seek care</i>: use community health workers, skilled birth attendants and midwives in order to obtain essential maternal and newborn care that saves the lives of babies and women.</li> <li>• <i>Quality and accountability</i>: be a voice for change; demand quality, affordable, accessible services; report poor services through governmental and nongovernmental mechanisms.</li> </ul>

Actors	Actions
<b>Academics and research institutions</b>	<ul style="list-style-type: none"> <li>• <i>Prioritize research needs</i>: agree upon and disseminate a prioritized and coordinated research agenda for improving preterm and newborn health outcomes.</li> <li>• <i>Invest in research</i>: encourage increased budget allocation for research into innovative interventions.</li> <li>• <i>Build research capacity</i>: build capacity at research institutions, especially in low- and middle-income countries, and train professionals.</li> <li>• <i>Disseminate findings</i>: disseminate research findings and best practices.</li> <li>• <i>Build partnerships</i>: strengthen global networks of academic providers, researchers and trainers.</li> </ul>
<b>Health professionals</b>	<ul style="list-style-type: none"> <li>• <i>Essential interventions</i>: prioritize essential interventions around the time of birth and care of small and sick newborns as part of an integrated package of reproductive, maternal, newborn and child health services.</li> <li>• <i>Health workers</i>: provide quality integrated services to babies and women through accelerated training, retention and motivation approaches.</li> <li>• <i>Commodities</i>: work with local and national bodies to ensure consistent availability of commodities and supplies essential for key interventions around the period of birth.</li> <li>• <i>Quality</i>: monitor quality of care including through use of maternal and perinatal death surveillance and response.</li> </ul>

## ANNEX 5

### **Text of the updated Annex 7 of the International Health Regulations (2005)<sup>1</sup>**

[A67/35 – 2 May 2014]

#### **REQUIREMENTS CONCERNING VACCINATION OR PROPHYLAXIS FOR SPECIFIC DISEASES**

1. In addition to any recommendation concerning vaccination or prophylaxis, the following diseases are those specifically designated under these Regulations for which proof of vaccination or prophylaxis may be required for travellers as a condition of entry to a State Party:

Vaccination against yellow fever.

2. Recommendations and requirements for vaccination against yellow fever:

(a) For the purpose of this Annex:

- (i) the incubation period of yellow fever is six days;
- (ii) yellow fever vaccines approved by WHO provide protection against infection starting 10 days following the administration of the vaccine;
- (iii) this protection continues for the life of the person vaccinated; and
- (iv) the validity of a certificate of vaccination against yellow fever shall extend for the life of the person vaccinated, beginning 10 days after the date of vaccination.

(b) Vaccination against yellow fever may be required of any traveller leaving an area where the Organization has determined that a risk of yellow fever transmission is present.

(c) If a traveller is in possession of a certificate of vaccination against yellow fever which is not yet valid, the traveller may be permitted to depart, but the provisions of paragraph 2(h) of this Annex may be applied on arrival.

(d) A traveller in possession of a valid certificate of vaccination against yellow fever shall not be treated as suspect, even if coming from an area where the Organization has determined that a risk of yellow fever transmission is present.

(e) In accordance with paragraph 1 of Annex 6 the yellow fever vaccine used must be approved by the Organization.

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<sup>1</sup> See resolution WHA67.13.



(f) States Parties shall designate specific yellow fever vaccination centres within their territories in order to ensure the quality and safety of the procedures and materials employed.

(g) Every person employed at a point of entry in an area where the Organization has determined that a risk of yellow fever transmission is present, and every member of the crew of a conveyance using any such point of entry, shall be in possession of a valid certificate of vaccination against yellow fever.

(h) A State Party, in whose territory vectors of yellow fever are present, may require a traveller from an area where the Organization has determined that a risk of yellow fever transmission is present, who is unable to produce a valid certificate of vaccination against yellow fever, to be quarantined until the certificate becomes valid, or until a period of not more than six days, reckoned from the date of last possible exposure to infection, has elapsed, whichever occurs first.

(i) Travellers who possess an exemption from yellow fever vaccination, signed by an authorized medical officer or an authorized health worker, may nevertheless be allowed entry, subject to the provisions of the foregoing paragraph of this Annex and to being provided with information regarding protection from yellow fever vectors. Should the travellers not be quarantined, they may be required to report any feverish or other symptoms to the competent authority and be placed under surveillance.

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## ANNEX 6

### Financial and administrative implications for the Secretariat of resolutions and decisions adopted by the Health Assembly

<p><b>1. Resolution WHA67.1</b> Global strategy and targets for tuberculosis prevention, care and control after 2015</p>
<p><b>2. Linkage to the Programme budget 2014–2015</b> (see document A66/7 <a href="http://apps.who.int/gb/ebwha/pdf_files/WHA66/A66_7-en.pdf">http://apps.who.int/gb/ebwha/pdf_files/WHA66/A66_7-en.pdf</a>)</p> <p>Category: 1. Communicable diseases Programme area: Tuberculosis</p> <p>Outcome: 1.2 Output: 1.2.1</p> <p><b>How would this resolution contribute to the achievement of the outcome(s) of the above programme area(s)?</b></p> <p>This resolution fully adopts the global strategy for tuberculosis prevention, care and control after 2015. It therefore supports a majority of the Secretariat's tuberculosis control efforts during the biennium, including: preparing normative guidance and operational tools for implementing the strategy; and providing support to Member States to develop and adapt their national plans in line with the strategy, and build country level capacity to implement the strategy, together with related monitoring and evaluation. The resolution and strategy will inform the preparation of future biennial work plans from 2016 to 2035.</p> <p><b>Does the Programme budget already include the outputs and deliverables requested in this resolution? (Yes/no)</b></p> <p>Yes.</p>
<p><b>3. Estimated cost and staffing implications in relation to the Programme budget</b></p> <p><b>(a) Total cost</b></p> <p><b>Indicate (i) the lifespan of the resolution during which the Secretariat's activities would be required for implementation and (ii) the cost of those activities (estimated to the nearest US\$ 10 000).</b></p> <p>Costs and staffing in relation to this strategy will be included in each of the biennial budgets during the lifespan of the strategy, based on a realistic costing of outputs and deliverables related to the work planned for each of the respective programme budget periods starting with the programme budget for 2016–2017.</p> <p><b>(b) Cost for the biennium 2014–2015</b></p> <p><b>Indicate how much of the cost indicated in 3 (a) is for the biennium 2014–2015 (estimated to the nearest US\$ 10 000).</b></p> <p>A substantial amount of the work identified as deliverables in the Programme budget 2014–2015 will contribute to the development and future implementation of the post-2015 strategy, as there is continuity between the two approaches (current and new), and the transition work will start during the current biennium.</p> <p>Total: US\$ 98.5 million (staff: US\$ 52.0 million; activities: US\$ 46.5 million).</p> <p><b>Indicate at which levels of the Organization the costs would be incurred, identifying specific regions where relevant.</b></p> <p>All levels of the Organization.</p>

**Is the estimated cost fully included within the approved Programme budget 2014–2015? (Yes/no)**  
Yes.

**If “no”, indicate how much is not included.**

**(c) Staffing implications**

**Could the resolution be implemented by existing staff? (Yes/no)**  
Yes.

**If “no”, indicate how many additional staff – full-time equivalents – would be required, identifying specific regions and noting the necessary skills profile(s), where relevant.**

**4. Funding**

**Is the estimated cost for the biennium 2014–2015 indicated in 3 (b) fully funded? (Yes/no)**  
No.

**If “no”, indicate the funding gap and how the funds would be mobilized (provide details of expected source(s) of funds).**

The Secretariat is currently undertaking a thorough analysis of available funding for the work related to the implementation of this resolution in 2014–2015 and will identify funding shortfalls. This funding gap will be tackled through the Organization-wide coordinated resource mobilization plan for dealing with funding shortfalls in the Programme budget 2014–2015.

**1. Resolution WHA67.2 Improved decision-making by the governing bodies**

**2. Linkage to the Programme budget 2014–2015 (see document A66/7 [http://apps.who.int/gb/ebwha/pdf\\_files/WHA66/A66\\_7-en.pdf](http://apps.who.int/gb/ebwha/pdf_files/WHA66/A66_7-en.pdf))**  
Category: 6. Corporate services/enabling functions

Programme area: Leadership and governance	Outcome: 6.1
	Output: 6.1.3

**How would this resolution contribute to the achievement of the outcome(s) of the above programme area(s)?**

By increasing electronic access to meetings of WHO’s governing bodies, webcasting of the public meetings of the Health Assembly, as part of WHO reform in the area of governance, will contribute to greater coherence in global health and the strengthening of WHO’s governance.

**Does the Programme budget already include the outputs and deliverables requested in this resolution? (Yes/no)**  
Yes.

**3. Estimated cost and staffing implications in relation to the Programme budget**

**(a) Total cost**

**Indicate (i) the lifespan of the resolution during which the Secretariat’s activities would be required for implementation and (ii) the cost of those activities (estimated to the nearest US\$ 10 000).**

(i) The resolution is not time-bound.

(ii) Total: US\$ 320 000 per biennium, subject to annual cost increase (staff: US\$ nil; activities: US\$ 320 000).

**(b) Cost for the biennium 2014–2015**

**Indicate how much of the cost indicated in 3 (a) is for the biennium 2014–2015 (estimated to the nearest US\$ 10 000).**

Total: US\$ 200 000 in 2015 only (staff: US\$ nil; activities: US\$ 200 000).

**Indicate at which levels of the Organization the costs would be incurred, identifying specific regions where relevant.**

Headquarters.

**Is the estimated cost fully included within the approved Programme budget 2014–2015? (Yes/no)**

No.

**If “no”, indicate how much is not included.**

US\$ 200 000. The costs are currently not foreseen in the Programme budget 2014–2015; however, in view of the relatively small additional budget required for the activities, the matter will be dealt with through some minor reprogramming.

**(c) Staffing implications**

**Could the resolution be implemented by existing staff? (Yes/no)**

No.

**If “no”, indicate how many additional staff – full-time equivalents – would be required, identifying specific regions and noting the necessary skills profile(s), where relevant.**

External contracted personnel will be required.

**4. Funding**

**Is the estimated cost for the biennium 2014–2015 indicated in 3 (b) fully funded? (Yes/no)**

Yes.

**If “no”, indicate the funding gap and how the funds would be mobilized (provide details of expected source(s) of funds).**

Not applicable.

**1. Resolution WHA67.6 Viral hepatitis**

**2. Linkage to the Programme budget 2014–2015 (see document A66/7  
[http://apps.who.int/gb/ebwha/pdf\\_files/WHA66/A66\\_7-en.pdf](http://apps.who.int/gb/ebwha/pdf_files/WHA66/A66_7-en.pdf))**

Category: 1. Communicable diseases

Programme area: HIV/AIDS	Outcome: 1.1
	Output: 1.1.2

Programme area: Vaccine-preventable diseases	Outcome: 1.5
	Output: 1.5.2

Category: 4. Health systems

Programme area: Integrated, people-centred health services	Outcome: 4.2
	Output: 4.2.3

Programme area: Access to medicines and health technologies and strengthening regulatory capacity	Outcome: 4.3
	Output: 4.3.1

Category: 5. Preparedness, surveillance and response

Programme area: Alert and response capacities	Outcome: 5.1
	Output: 5.1.1

Programme area: Epidemic-prone and pandemic-prone diseases	Outcome: 5.2
	Output: 5.2.1

**How would this resolution contribute to the achievement of the outcome(s) of the above programme area(s)?**

The key actions called for in the resolution directly support attainment of outputs formulated in the programme areas mentioned above, in particular by increasing commitment and capacities for an appropriate response for the prevention, diagnosis and treatment of hepatitis.

**Does the Programme budget already include the outputs and deliverables requested in this resolution? (Yes/no)**

Yes.

**3. Estimated cost and staffing implications in relation to the Programme budget**

**(a) Total cost**

**Indicate (i) the lifespan of the resolution during which the Secretariat's activities would be required for implementation and (ii) the cost of those activities (estimated to the nearest US\$ 10 000).**

(i) The resolution is not time-bound and it is anticipated that many activities will be ongoing.

(ii) An overall costing for the full implementation of the resolution across the Organization will be completed in the process of preparation of the programme budget for 2016–2017.

The resolution includes elements that go beyond the previously agreed framework for action on hepatitis, particularly with regard to accelerating access to hepatitis treatment and the assessment of the economic impact and burden of the disease at global and regional levels.

The estimated total cost for the period 2014–2017 is US\$ 38.91 million.

An indicative costing for the biennium 2016–2017 is US\$ 33.11 million. This includes estimations for the work to be performed by (a) the secretariat of the global hepatitis programme at headquarters – US\$ 8.65 million (staff: US\$ 4.75 million; activities: US\$ 3.90 million); (b) other headquarters departments – US\$ 6.12 million; (c) regional offices – US\$ 9.80 million; and (d) country offices – US\$ 8.54 million.

**(b) Cost for the biennium 2014–2015**

**Indicate how much of the cost indicated in 3 (a) is for the biennium 2014–2015 (estimated to the nearest US\$ 10 000).**

Total: US\$ 5.8 million, including headquarters – US\$ 3.3 million (staff: US\$ 2.1 million; activities: US\$ 1.2 million); and regional and country offices – US\$ 2.5 million.

**Indicate at which levels of the Organization the costs would be incurred, identifying specific regions where relevant.**

In support of the initial implementation of the resolution, priority will be given to covering core activities at headquarters, including the elaboration of diagnostic and treatment guidelines, global and regional reporting, support to national strategy development, and the initiation of a treatment access initiative. Activities in regions and countries will focus on national strategic planning, capacity building for adaptation and implementation of policies and normative guidance, improving country-level strategic information on hepatitis, and providing technical assistance for expanding access to hepatitis diagnostics and treatment.

**Is the estimated cost fully included within the approved Programme budget 2014–2015? (Yes/no)**

Yes.

**If “no”, indicate how much is not included.**

**(c) Staffing implications**

**Could the resolution be implemented by existing staff? (Yes/no)**

No.

**If “no”, indicate how many additional staff – full-time equivalents – would be required, identifying specific regions and noting the necessary skills profile(s), where relevant.**

For the biennium 2014–2015, existing staff within the global hepatitis programme and other departments at headquarters and in the regional offices will initiate implementation of the resolution. However, this will not be sufficient and, in the medium term, additional staff will be required. It is estimated that the requirements for additional staff would include the following full-time equivalent staff: at headquarters, 10.5; in the regional offices, 17; and country offices would need to contribute national professional officers in 15 focus countries.

#### **4. Funding**

**Is the estimated cost for the biennium 2014–2015 indicated in 3 (b) fully funded? (Yes/no)**

No.

**If “no”, indicate the funding gap and how the funds would be mobilized (provide details of expected source(s) of funds).**

Funding gap: US\$ 3.7 million (headquarters: US\$ 1.7 million; regional and country offices: US\$ 2.0 million).

This funding gap will be tackled through the Organization-wide coordinated resource mobilization plan for dealing with funding shortfalls in the Programme budget 2014–2015.

#### **1. Resolution WHA67.7 WHO global disability action plan 2014–2021: better health for all people with disability**

#### **2. Linkage to the Programme budget 2014–2015 (see document A66/7 [http://apps.who.int/gb/ebwha/pdf\\_files/WHA66/A66\\_7-en.pdf](http://apps.who.int/gb/ebwha/pdf_files/WHA66/A66_7-en.pdf))**

Category: 2. Noncommunicable diseases

Programme area: Disabilities and rehabilitation

Outcome: 2.4

Output: 2.4.1

#### **How would this resolution contribute to the achievement of the outcome(s) of the above programme area(s)?**

In the resolution the Health Assembly adopts the WHO global disability action plan 2014–2021: better health for all people with disability, which specifies actions for Member States, the Secretariat and partners to support the achievement of outcome 2.4, drawing on evidence of “what works”.

#### **Does the Programme budget already include the outputs and deliverables requested in this resolution? (Yes/no)**

Yes – if current budget trends continue through to 2021.

#### **3. Estimated cost and staffing implications in relation to the Programme budget**

##### **(a) Total cost**

**Indicate (i) the lifespan of the resolution during which the Secretariat’s activities would be required for implementation and (ii) the cost of those activities (estimated to the nearest US\$ 10 000).**

(i) Eight years (covering the period 2014–2021).

(ii) Total: US\$ 39.8 million (staff: US\$ 19.9 million; activities: US\$ 19.9 million).

##### **(b) Cost for the biennium 2014–2015**

**Indicate how much of the cost indicated in 3 (a) is for the biennium 2014–2015 (estimated to the nearest US\$ 10 000).**

Total: US\$ 7.75 million (staff: US\$ 3.50 million; activities: US\$ 4.25 million).

**Indicate at which levels of the Organization the costs would be incurred, identifying specific regions where relevant.**

All levels of the Organization.

**Is the estimated cost fully included within the approved Programme budget 2014–2015? (Yes/no)**

Yes.

**If “no”, indicate how much is not included.**

**(c) Staffing implications**

**Could the resolution be implemented by existing staff? (Yes/no)**

No. Additional staff are required at headquarters and in four regional offices. Recruitment for key posts will take place in this biennium.

**If “no”, indicate how many additional staff – full-time equivalents – would be required, identifying specific regions and noting the necessary skills profile(s), where relevant.**

One full-time focal point per regional office is required in the regional offices for Africa, South-East Asia, Europe and the Eastern Mediterranean.

Three technical officers are required at headquarters, each one leading on one of the three objectives of the plan: health, rehabilitation and data.

**4. Funding**

**Is the estimated cost for the biennium 2014–2015 indicated in 3 (b) fully funded? (Yes/no)**

No – just under 50% of funds are available.

**If “no”, indicate the funding gap and how the funds would be mobilized (provide details of expected source(s) of funds).**

Funding gap: US\$ 4 million. This funding gap will be tackled through the Organization-wide coordinated resource mobilization plan for dealing with funding shortfalls in the Programme budget 2014–2015.

**1. Resolution WHA67.8** Comprehensive and coordinated efforts for the management of autism spectrum disorders

**2. Linkage to the Programme budget 2014–2015 (see document A66/7 [http://apps.who.int/gb/ebwha/pdf\\_files/WHA66/A66\\_7-en.pdf](http://apps.who.int/gb/ebwha/pdf_files/WHA66/A66_7-en.pdf))**

Category: 2. Noncommunicable diseases

Programme area: Mental health and substance abuse	Outcome: 2.2 Outputs: 2.2.1 and 2.2.2
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Programme area: Disabilities and rehabilitation	Outcome: 2.4 Output: 2.4.1
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**How would this resolution contribute to the achievement of the outcome(s) of the above programme area(s)?**

The resolution requests the Director-General, inter alia, to implement resolution WHA66.8 on the comprehensive mental health action plan 2013–2020 and resolution WHA66.9 on disability. Implementation of this resolution will therefore drive work to support increased access to services for mental health, and for people with disabilities.

**Does the Programme budget already include the outputs and deliverables requested in this resolution? (Yes/no)**  
Yes.

However, the scope of activities currently budgeted for is limited; implementation of the resolution will involve additional activities whose cost must be added to the approved Programme budget 2014–2015.

### **3. Estimated cost and staffing implications in relation to the Programme budget**

#### **(a) Total cost**

**Indicate (i) the lifespan of the resolution during which the Secretariat's activities would be required for implementation and (ii) the cost of those activities (estimated to the nearest US\$ 10 000).**

(i) Six and a half years (covering the period July 2014 – December 2020).

(ii) Total: US\$ 37 million (staff: US\$ 13 million; activities: US\$ 24 million).

#### **(b) Cost for the biennium 2014–2015**

**Indicate how much of the cost indicated in 3 (a) is for the biennium 2014–2015 (estimated to the nearest US\$ 10 000).**

Total: US\$ 2.8 million (staff: US\$ 0.4 million; activities: US\$ 2.4 million).

**Indicate at which levels of the Organization the costs would be incurred, identifying specific regions where relevant.**

Headquarters, 25%; regional offices, 21%; and country offices, 54%.

**Is the estimated cost fully included within the approved Programme budget 2014–2015? (Yes/no)**

No.

**If “no”, indicate how much is not included.**

US\$ 1.8 million will need to be added to the approved Programme budget 2014–2015.

#### **(c) Staffing implications**

**Could the resolution be implemented by existing staff? (Yes/no)**

No.

**If “no”, indicate how many additional staff – full-time equivalents – would be required, identifying specific regions and noting the necessary skills profile(s), where relevant.**

WHO collaborating centres and a network of experts and civil society stakeholders will be utilized for taking forward the activities with only a small increase in WHO staff.

##### During the biennium 2014–2015

At headquarters: one international expert in public health and developmental disorders (100% full-time equivalent) at grade P.4 and one secretary (50% full-time equivalent) at grade G.5.

##### During the biennium 2016–2017

At headquarters: two international experts in public health and developmental disorders (100% full-time equivalent) at grade P.4 and one secretary (50% full-time equivalent) at grade G.5.

In the regional offices: six international experts in public health and developmental disorders with a knowledge of the needs in their respective regions (50% full-time equivalent; grade P.4).

At the country office level: of the 60% of the budget that is available for implementation of the resolution at this level, a part will be spent on recruiting experts at grade P.4.



**4. Funding**

**Is the estimated cost for the biennium 2014–2015 indicated in 3 (b) fully funded? (Yes/no)**

No.

**If “no”, indicate the funding gap and how the funds would be mobilized (provide details of expected source(s) of funds).**

US\$ 1 million (of which US\$ 0.5 million will be for headquarters) is included in the approved Programme budget 2014–2015 and will come from a combination of assessed and voluntary contributions, generated during the financing dialogue process and the associated resource mobilization effort.

The additional US\$ 1.8 million not included in the approved Programme budget will need to be mobilized to cover implementation (limited additional staffing and the development of technical material) from July 2014 to December 2015 through the Organization-wide coordinated resource mobilization plan for dealing with funding shortfalls in the Programme budget 2014–2015.

**1. Resolution WHA67.9 Psoriasis**

**2. Linkage to the Programme budget 2014–2015 (see document A66/7  
[http://apps.who.int/gb/ebwha/pdf\\_files/WHA66/A66\\_7-en.pdf](http://apps.who.int/gb/ebwha/pdf_files/WHA66/A66_7-en.pdf))**

Category: 2. Noncommunicable diseases

Programme area: Noncommunicable diseases

Outcome 2.1

Output 2.1.1

**How would this resolution contribute to the achievement of the outcome(s) of the above programme area(s)?**

Activities in the resolution will help to raise public awareness of psoriasis and its shared risk factors, and will result in a greater understanding of it as a consequence. This will contribute to reducing disease, disability and premature death from psoriasis.

**Does the Programme budget already include the outputs and deliverables requested in this resolution? (Yes/no)**

No.

**3. Estimated cost and staffing implications in relation to the Programme budget****(a) Total cost**

**Indicate (i) the lifespan of the resolution during which the Secretariat’s activities would be required for implementation and (ii) the cost of those activities (estimated to the nearest US\$ 10 000).**

(i) Begins in the biennium 2014–2015 and continues in future bienniums.

(ii) Total: For the biennium 2014–2015, US\$ 150 000 (staff: US\$ 60 000; activities: US\$ 90 000); costs for future bienniums to be included within future programme budgets.

**(b) Cost for the biennium 2014–2015**

**Indicate how much of the cost indicated in 3 (a) is for the biennium 2014–2015 (estimated to the nearest US\$ 10 000).**

Total: US\$ 150 000.

**Indicate at which levels of the Organization the costs would be incurred, identifying specific regions where relevant.**

Headquarters for the preparation of the global report.

**Is the estimated cost fully included within the approved Programme budget 2014–2015? (Yes/no)**

No.

**If “no”, indicate how much is not included.**

The costs are not covered by the approved Programme budget 2014–2015, but the relatively small additional budget for the activities will be addressed through some minor reprogramming.

**(c) Staffing implications**

**Could the resolution be implemented by existing staff? (Yes/no)**

No.

**If “no”, indicate how many additional staff – full-time equivalents – would be required, identifying specific regions and noting the necessary skills profile(s), where relevant.**

A short-term consultant for four months.

**4. Funding**

**Is the estimated cost for the biennium 2014–2015 indicated in 3 (b) fully funded? (Yes/no)**

No.

**If “no”, indicate the funding gap and how the funds would be mobilized (provide details of expected source(s) of funds).**

Funds need to be mobilized through the Organization-wide coordinated resource mobilization plan for dealing with funding shortfalls in the Programme budget 2014–2015.

**1. Resolution WHA67.10 Newborn health action plan**

**2. Linkage to the Programme budget 2014–2015 (see document A66/7 [http://apps.who.int/gb/ebwha/pdf\\_files/WHA66/A66\\_7-en.pdf](http://apps.who.int/gb/ebwha/pdf_files/WHA66/A66_7-en.pdf))**

Category: 3. Promoting health through the life-course

Programme area: Reproductive, maternal, newborn, child and adolescent health	Outcome: 3.1 Output: 3.1.1
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**How would this resolution contribute to the achievement of the outcome(s) of the above programme area(s)?**

The resolution will support the human and financial resources required: (i) for the provision of technical support to Member States in implementing the newborn health component of national plans; (ii) for monitoring their implementation, impact and progress; and (iii) for preparing periodic progress reports to the Health Assembly.

**Does the Programme budget already include the outputs and deliverables requested in this resolution? (Yes/no)**

Yes.

**3. Estimated cost and staffing implications in relation to the Programme budget**

**(a) Total cost**

**Indicate (i) the lifespan of the resolution during which the Secretariat’s activities would be required for implementation and (ii) the cost of those activities (estimated to the nearest US\$ 10 000).**

(i) Four years (covering the period 2014–2017).

(ii) Total: US\$ 34.40 million (staff: US\$ 10.45 million; activities: US\$ 23.95 million).

**(b) Cost for the biennium 2014–2015**

**Indicate how much of the cost indicated in 3(a) is for the biennium 2014–2015 (estimated to the nearest US\$ 10 000).**

Total: US\$ 18.93 million (staff: US\$ 5.21 million; activities: US\$ 13.72 million).

**Indicate at which levels of the Organization the costs would be incurred, identifying specific regions where relevant.**

Implementation will take place at all levels of the Organization and across all regions.

**Is the estimated cost fully included within the approved Programme budget 2014–2015? (Yes/no)**

Yes.

**If “no”, indicate how much is not included.**

**(c) Staffing implications**

**Could the resolution be implemented by existing staff? (Yes/no)**

Yes, but funding for current staff needs to be assured.

**If “no”, indicate how many additional staff – full-time equivalents – would be required, identifying specific regions and noting the necessary skills profile(s), where relevant.**

**4. Funding**

**Is the estimated cost for the biennium 2014–2015 indicated in 3 (b) fully funded? (Yes/no)**

No.

**If “no”, indicate the funding gap and how the funds would be mobilized (provide details of expected source(s) of funds).**

US\$ 9.47 million. This funding gap will be tackled through the Organization-wide coordinated resource mobilization plan for dealing with funding shortfalls in the Programme budget 2014–2015.

**1. Resolution WHA67.11** Public health impacts of exposure to mercury and mercury compounds: the role of WHO and ministries of public health in the implementation of the Minamata Convention

**2. Linkage to the Programme budget 2014–2015 (see document A66/7 [http://apps.who.int/gb/ebwha/pdf\\_files/WHA66/A66\\_7-en.pdf](http://apps.who.int/gb/ebwha/pdf_files/WHA66/A66_7-en.pdf))**

Category: 3. Promoting health through the life-course

Programme area: Health and the environment

Outcome: 3.5

Outputs: 3.5.1, 3.5.2 and 3.5.3

Category: 2. Noncommunicable diseases

Programme area: Noncommunicable diseases

Outcome: 2.1

Output: 2.1.1

Category: 5. Preparedness, surveillance and response

Programme area: Food safety

Outcome: 5.4

Output: 5.4.3

**How would this resolution contribute to the achievement of the outcome(s) of the above programme area(s)?**

By facilitating the prevention of human exposure to mercury and mercury compounds the resolution will directly contribute to the outcomes for the programme areas listed, namely: reduced environmental threats to health; increased access to interventions to prevent and manage noncommunicable diseases and their risk factors; and all countries adequately prepared to prevent and mitigate risks to food safety.

**Does the Programme budget already include the outputs and deliverables requested in this resolution? (Yes/no)**

Yes.

**3. Estimated cost and staffing implications in relation to the Programme budget**

**(a) Total cost**

**Indicate (i) the lifespan of the resolution during which the Secretariat's activities would be required for implementation and (ii) the cost of those activities (estimated to the nearest US\$ 10 000).**

(i) A significant level of activities will be required from 2014 to 2020; activities will continue at a reduced level beyond that period (the Minamata Convention does not have an end date).

(ii) Total (2014–2020): US\$ 9.03 million (staff: US\$ 2.68 million; activities: US\$ 6.35 million).

**(b) Cost for the biennium 2014–2015**

**Indicate how much of the cost indicated in 3 (a) is for the biennium 2014–2015 (estimated to the nearest US\$ 10 000).**

Total: US\$ 2.47 million (staff: US\$ 720 000; activities: US\$ 1.75 million).

**Indicate at which levels of the Organization the costs would be incurred, identifying specific regions where relevant.**

All levels of the Organization.

**Is the estimated cost fully included within the approved Programme budget 2014–2015? (Yes/no)**

Yes.

**If “no”, indicate how much is not included.**

**(c) Staffing implications**

**Could the resolution be implemented by existing staff? (Yes/no)**

Yes.

**If “no”, indicate how many additional staff – full-time equivalents – would be required, identifying specific regions and noting the necessary skills profile(s), where relevant.**

**4. Funding**

**Is the estimated cost for the biennium 2014–2015 indicated in 3 (b) fully funded? (Yes/no)**

No.

**If “no”, indicate the funding gap and how the funds would be mobilized (provide details of expected source(s) of funds).**

The gap is estimated at US\$ 1.3 million. Potential sources of funds include: the Global Environment Facility, which is the financial mechanism for the Minamata Convention; and the Organization-wide coordinated resource mobilization plan for dealing with funding shortfalls in the Programme budget 2014–2015.

**1. Resolution WHA67.12** Contributing to social and economic development: sustainable action across sectors to improve health and health equity

**2. Linkage to the Programme budget 2014–2015 (see document A66/7 [http://apps.who.int/gb/ebwha/pdf\\_files/WHA66/A66\\_7-en.pdf](http://apps.who.int/gb/ebwha/pdf_files/WHA66/A66_7-en.pdf))**

Category: 2. Noncommunicable diseases

Programme area: Noncommunicable diseases	Outcome: 2.1 Output: 2.1.1
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Programme area: Mental health and substance abuse	Outcome: 2.2 Output: 2.2.1
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Programme area: Nutrition	Outcome: 2.5 Output: 2.5.1
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Category: 3. Promoting health through the life-course

Programme area: Social determinants of health	Outcome: 3.4 Output: 3.4.1
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Programme area: Health and the environment	Outcome: 3.5 Output: 3.5.2
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Programme area: Gender, equity and human rights mainstreaming	Outcome: 3.3 Output: 3.3.1
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**How would this resolution contribute to the achievement of the outcome(s) of the above programme area(s)?**

This resolution will contribute to improved health and health equity and social and economic development through sustained action across sectors. It will further strengthen the health sector's role in working with other sectors to tackle health issues, particularly prevention and control of noncommunicable diseases. It will strengthen collaboration both within WHO and between WHO and its partners.

**Does the Programme budget already include the outputs and deliverables requested in this resolution? (Yes/no)**

Yes.

**3. Estimated cost and staffing implications in relation to the Programme budget**

**(a) Total cost**

**Indicate (i) the lifespan of the resolution during which the Secretariat's activities would be required for implementation and (ii) the cost of those activities (estimated to the nearest US\$ 10 000).**

(i) Three years (covering the period 2014–2016).

(ii) Total: US\$ 1.45 million (staff: US\$ 790 000; activities: US\$ 660 000).

**(b) Cost for the biennium 2014–2015**

**Indicate how much of the cost indicated in 3 (a) is for the biennium 2014–2015 (estimated to the nearest US\$ 10 000).**

Total: US\$ 980 000 (staff: US\$ 530 000; activities: US\$ 450 000).

**Indicate at which levels of the Organization the costs would be incurred, identifying specific regions where relevant.**

Staffing costs will be incurred at headquarters only; activity costs will be incurred at all levels of the Organization.

**Is the estimated cost fully included within the approved Programme budget 2014–2015? (Yes/no)**

Yes.

If “no”, indicate how much is not included.

(c) **Staffing implications**

**Could the resolution be implemented by existing staff? (Yes/no)**

Yes.

**If “no”, indicate how many additional staff – full-time equivalents – would be required, identifying specific regions and noting the necessary skills profile(s), where relevant.**

**4. Funding**

**Is the estimated cost for the biennium 2014–2015 indicated in 3 (b) fully funded? (Yes/no)**

No.

**If “no”, indicate the funding gap and how the funds would be mobilized (provide details of expected source(s) of funds).**

US\$ 980 000; source(s) of funds: assessed contributions and core voluntary contributions, with resource mobilization efforts undertaken, especially through the financing dialogue.

**1. Resolution WHA67.13 Implementation of the International Health Regulations (2005)**

**2. Linkage to the Programme budget 2014–2015 (see document A66/7 [http://apps.who.int/gb/ebwha/pdf\\_files/WHA66/A66\\_7-en.pdf](http://apps.who.int/gb/ebwha/pdf_files/WHA66/A66_7-en.pdf))**

Category: 5. Preparedness, surveillance and response

Programme area: Alert and response capacities

Outcome: 5.1

Output: 5.1.1

**How would this resolution contribute to the achievement of the outcome(s) of the above programme area(s)?**

The resolution will sustain the Secretariat in its role of providing support to Member States in implementing the International Health Regulations (2005). The Strategic Advisory Group of Experts on immunization concluded that a single dose of yellow fever vaccine is sufficient to confer sustained immunity and life-long protection against yellow fever disease and that a booster dose of yellow fever vaccine is not needed. WHO has endorsed this conclusion and a number of Member States have requested guidance from the Secretariat on implementation of this advice under the International Health Regulations (2005).

**Does the Programme budget already include the outputs and deliverables requested in this resolution? (Yes/no)**

Yes.

**3. Estimated cost and staffing implications in relation to the Programme budget**

(a) **Total cost**

**Indicate (i) the lifespan of the resolution during which the Secretariat’s activities would be required for implementation and (ii) the cost of those activities (estimated to the nearest US\$ 10 000).**

(i) No Secretariat activities are required for implementation of this resolution.

(ii) Total: US\$ nil (staff: US\$ nil; activities: US\$ nil).

**(b) Cost for the biennium 2014–2015**

**Indicate how much of the cost indicated in 3 (a) is for the biennium 2014–2015 (estimated to the nearest US\$ 10 000).**

Total: US\$ nil (staff: US\$ nil; activities: US\$ nil).

**Indicate at which levels of the Organization the costs would be incurred, identifying specific regions where relevant.**

Not applicable.

**Is the estimated cost fully included within the approved Programme budget 2014–2015? (Yes/no)**

Not applicable.

**If “no”, indicate how much is not included.**

**(c) Staffing implications**

**Could the resolution be implemented by existing staff? (Yes/no)**

Not applicable.

**If “no”, indicate how many additional staff – full-time equivalents – would be required, identifying specific regions and noting the necessary skills profile(s), where relevant.**

**4. Funding**

**Is the estimated cost for the biennium 2014–2015 indicated in 3 (b) fully funded? (Yes/no)**

Not applicable.

**If “no”, indicate the funding gap and how the funds would be mobilized (provide details of expected source(s) of funds).**

Not applicable.

**1. Resolution WHA67.14 Health in the post-2015 development agenda****2. Linkage to the Programme budget 2014–2015 (see document A66/7 [http://apps.who.int/gb/ebwha/pdf\\_files/WHA66/A66\\_7-en.pdf](http://apps.who.int/gb/ebwha/pdf_files/WHA66/A66_7-en.pdf))**

Category: 4. Health systems

Additional links to:

Category: 1. Communicable diseases

Outcomes: Multiple

Category: 2. Noncommunicable diseases

Outputs: Multiple

Category: 3. Promoting health through the life-course

Programme areas: All in categories 1–4.

**How would this resolution contribute to the achievement of the outcome(s) of the above programme area(s)?**

The resolution will contribute to ensuring that people obtain the health services they need in all areas – whether for communicable or noncommunicable diseases – and across the life-course. It supports the establishment of strong health systems, by acting on all their component parts – financing, health workforce, medical products, information, governance and infrastructure – in order to support the assurance of good-quality health services of all types, not just those for treatment, with financial risk protection. It encourages Member States to support the inclusion of health, including universal health coverage, in an appropriate form in the post-2015 development agenda. It will also encourage: (i) the provision of information by the Secretariat to Member States, supporting them in developing their positions on health in the post-2015 development agenda, including by providing policy briefs and appropriate estimates; and (ii) the engagement of the Secretariat in the post-2015 process to support countries in ensuring that health is central to the agenda.

**Does the Programme budget already include the outputs and deliverables requested in this resolution? (Yes/no)**  
Yes.

### **3. Estimated cost and staffing implications in relation to the Programme budget**

#### **(a) Total cost**

**Indicate (i) the lifespan of the resolution during which the Secretariat's activities would be required for implementation and (ii) the cost of those activities (estimated to the nearest US\$ 10 000).**

(i) Two years (covering the period 2014–2015).

(ii) Total: US\$ 1.31 million (staff: US\$ 1.16 million; activities: US\$ 150 000).

#### **(b) Cost for the biennium 2014–2015**

**Indicate how much of the cost indicated in 3 (a) is for the biennium 2014–2015 (estimated to the nearest US\$ 10 000).**

Total: US\$ 1.31 million (staff: US\$ 1.16 million; activities: US\$ 150 000).

**Indicate at which levels of the Organization the costs would be incurred, identifying specific regions where relevant.**

The provision of support to countries in developing their strategies will cover all regions, with the Secretariat involved at all three levels of the Organization. The preparation of policy briefs and estimations will principally involve headquarters; there will also be some regional office involvement.

**Is the estimated cost fully included within the approved Programme budget 2014–2015? (Yes/no)**  
Yes.

**If “no”, indicate how much is not included.**

#### **(c) Staffing implications**

**Could the resolution be implemented by existing staff? (Yes/no)**

Yes.

**If “no”, indicate how many additional staff – full-time equivalents – would be required, identifying specific regions and noting the necessary skills profile(s), where relevant.**

### **4. Funding**

**Is the estimated cost for the biennium 2014–2015 indicated in 3 (b) fully funded? (Yes/no)**

Yes.

**If “no”, indicate the funding gap and how the funds would be mobilized (provide details of expected source(s) of funds).**

Not applicable.

**1. Resolution WHA67.15** Strengthening the role of the health system in addressing violence, in particular against women and girls, and against children

**2. Linkage to the Programme budget 2014–2015 (see document A66/7**  
**[http://apps.who.int/gb/ebwha/pdf\\_files/WHA66/A66\\_7-en.pdf](http://apps.who.int/gb/ebwha/pdf_files/WHA66/A66_7-en.pdf))**

Category: 2. Noncommunicable diseases

Programme area: Violence and injuries

Outcome: 2.3

Output: 2.3.3



Programme area: Mental health and substance abuse	Outcome: 2.2 Output: 2.2.2
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Category: 3. Promoting health through the life-course

Programme area: Reproductive, maternal, newborn, child and adolescent health	Outcome: 3.1 Output: 3.1.4
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Category: 5. Preparedness, surveillance and response

Programme area: Emergency risk and crisis management	Outcome: 5.3 Output: 5.3.1
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**How would this resolution contribute to the achievement of the outcome(s) of the above programme area(s)?**

The resolution will contribute to bringing increased attention to bear on violence, in particular violence against women and girls, as a public health issue, on its severe health impacts and its preventability, and on the role that the health sector plays in tackling violence. It will further strengthen the health sector's role within a multisectoral response and provide committed policy-makers in the health sector with a stronger mandate for dealing with the topic.

The resolution will also help to increase collaboration both between WHO and its external partners and within the Organization.

**Does the programme budget already include the outputs and deliverables requested in this resolution? (Yes/no)**  
Yes.

**3. Estimated cost and staffing implications in relation to the Programme budget**

**(a) Total cost**

**Indicate (i) the lifespan of the resolution during which the Secretariat's activities would be required for implementation and (ii) the cost of those activities (estimated to the nearest US\$ 10 000).**

- (i) Five years (covering the period 2014–2018).
- (ii) Total: US\$ 34.65 million (staff: US\$ 18.81 million; activities: US\$ 15.84 million).

**(b) Cost for the biennium 2014–2015**

**Indicate how much of the cost indicated in 3(a) is for the biennium 2014–2015 (estimated to the nearest US\$ 10 000).**

Total: US\$ 13.54 million (staff: US\$ 7.39 million; activities: US\$ 6.15 million).

**Indicate at which levels of the Organization the costs would be incurred, identifying specific regions where relevant.**

All levels of the Organization.

**Is the estimated cost fully included within the approved Programme budget 2014–2015? (Yes/no)**  
Yes.

**If “no”, indicate how much is not included.**

**(c) Staffing implications****Could the resolution be implemented by existing staff? (Yes/no)**

Yes, for the biennium 2014–2015.

For the biennium 2016–2017 and beyond, additional staff might be needed, in particular at regional and country levels.

**If “no”, indicate how many additional staff – full-time equivalents – would be required, identifying specific regions and noting the necessary skills profile(s), where relevant.**

The need for additional staff will depend on the development of the draft global plan of action requested in the resolution.

**4. Funding****Is the estimated cost for the biennium 2014–2015 indicated in 3 (b) fully funded? (Yes/no)**

No: approximately US\$ 5 million of the US\$ 13.54 million for the biennium have currently been secured.

**If “no”, indicate the funding gap and how the funds would be mobilized (provide details of expected source(s) of funds).**

For the biennium 2014–2015, the funding gap is approximately US\$ 8.54 million. It is envisaged that the gap will be closed through the financing dialogue process and the Organization-wide coordinated resource mobilization plan.

**1. Resolution WHA67.18 Traditional medicine****2. Linkage to the Programme budget 2014–2015 (see document A66/7 [http://apps.who.int/gb/ebwha/pdf\\_files/WHA66/A66\\_7-en.pdf](http://apps.who.int/gb/ebwha/pdf_files/WHA66/A66_7-en.pdf))**

Category: 4. Health systems

Programme area: Access to medicines and health technologies <sup>1</sup> and strengthening regulatory capacity	Outcome: 4.3 Output: 4.3.1
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**How would this resolution contribute to the achievement of the outcome(s) of the above programme area(s)?**

The objectives of the WHO traditional medicine strategy: 2014–2023 are in line with the vision and priorities set out in the Twelfth General Programme of Work, 2014–2019 and reflected in the Programme budget 2014–2015. The implementation of the traditional medicine strategy will also contribute to the achievement of the outcomes of the programme areas for integrated, people-centred health services and access to medicines and health technologies and strengthening regulatory capacity, as described in the Programme budget 2014–2015.

**Does the Programme budget already include the outputs and deliverables requested in this resolution? (Yes/no)**

Yes.

<sup>1</sup> As stated in resolution WHA60.29, the term “health technologies” refers to devices, medicines, vaccines, procedures and systems developed to solve a health problem and improve the quality of lives.

**3. Estimated cost and staffing implications in relation to the Programme budget****(a) Total cost**

Indicate (i) the lifespan of the resolution during which the Secretariat's activities would be required for implementation and (ii) the cost of those activities (estimated to the nearest US\$ 10 000).

(i) Ten years (covering the period 2014–2023).

(ii) Total: US\$ 26.11 million (staff: US\$ 20.11 million; activities: US\$ 6.00 million).

**(b) Cost for the biennium 2014–2015**

Indicate how much of the cost indicated in 3 (a) is for the biennium 2014–2015 (estimated to the nearest US\$ 10 000).

Total: US\$ 5.2 million (staff: US\$ 4.0 million; activities: US\$ 1.2 million).

Indicate at which levels of the Organization the costs would be incurred, identifying specific regions where relevant.

All levels of the Organization, including headquarters and all six regional offices, with the involvement of country offices determined region by region.

Is the estimated cost fully included within the approved Programme budget 2014–2015? (Yes/no)

Yes.

If “no”, indicate how much is not included.

**(c) Staffing implications**

Could the resolution be implemented by existing staff? (Yes/no)

Yes.

If “no”, indicate how many additional staff – full-time equivalents – would be required, identifying specific regions and noting the necessary skills profile(s), where relevant.

**4. Funding**

Is the estimated cost for the biennium 2014–2015 indicated in 3 (b) fully funded? (Yes/no)

No.

If “no”, indicate the funding gap and how the funds would be mobilized (provide details of expected source(s) of funds).

Funding gap: US\$ 1.97 million.

Expected sources of funds: US\$ 1.10 million from the Government of China, the Government of Macao Special Administrative Region (China) and the Government of India; US\$ 866 000 through fund raising efforts and the financing dialogue.

**1. Resolution WHA67.19 Strengthening of palliative care as a component of comprehensive care throughout the life course****2. Linkage to the Programme budget 2014–2015 (see document A66/7 [http://apps.who.int/gb/ebwha/pdf\\_files/WHA66/A66\\_7-en.pdf](http://apps.who.int/gb/ebwha/pdf_files/WHA66/A66_7-en.pdf))**

Category: 2. Noncommunicable diseases

Programme area: Noncommunicable diseases

Outcome: 2.1

Output: 2.1.1

**How would this resolution contribute to the achievement of the outcome(s) of the above programme area(s)?**

It will support achievement because palliative care is part of the continuum of care required for tackling noncommunicable diseases, particularly cardiovascular disease, cancer, chronic respiratory disease and diabetes. It is one of the activities included in the WHO global action plan for the prevention and control of noncommunicable diseases 2013–2020. An indicator for tracking access to palliative care is also included in the action plan's global monitoring framework.

**Does the Programme budget already include the outputs and deliverables requested in this resolution? (Yes/no)**

Yes.

**3. Estimated cost and staffing implications in relation to the Programme budget****(a) Total cost**

**Indicate (i) the lifespan of the resolution during which the Secretariat's activities would be required for implementation and (ii) the cost of those activities (estimated to the nearest US\$ 10 000).**

(i) Implementation will cover, and continue beyond, the seven remaining years of the global action plan for the prevention and control of noncommunicable diseases 2013–2020.

(ii) Total: US\$ 20 million (staff: US\$ 10 million; activities: US\$ 10 million).

**(b) Cost for the biennium 2014–2015**

**Indicate how much of the cost indicated in 3 (a) is for the biennium 2014–2015 (estimated to the nearest US\$ 10 000).**

Total: US\$ 1 million (staff: US\$ 600 000; activities: US\$ 400 000).

**Indicate at which levels of the Organization the costs would be incurred, identifying specific regions where relevant.**

All levels of the Organization.

**Is the estimated cost fully included within the approved Programme budget 2014–2015? (Yes/no)**

Yes.

**If "no", indicate how much is not included.**

**(c) Staffing implications**

**Could the resolution be implemented by existing staff? (Yes/no)**

No, but the cost of filling the necessary positions has been included in the Programme budget.

**If "no", indicate how many additional staff – full-time equivalents – would be required, identifying specific regions and noting the necessary skills profile(s), where relevant.**

In the biennium 2016–2017, at least one additional staff member at grade P.5 will be needed at headquarters together with one at grade P.4 in each of the regional offices.

**4. Funding**

**Is the estimated cost for the biennium 2014–2015 indicated in 3 (b) fully funded? (Yes/no)**

No.

**If "no", indicate the funding gap and how the funds would be mobilized (provide details of expected source(s) of funds).**

The funding gap is US\$ 640 000. It will be tackled through the Organization-wide coordinated resource mobilization plan for dealing with funding shortfalls in the Programme budget 2014–2015.

<p><b>1. Resolution WHA67.20</b> Regulatory system strengthening for medical products</p>
<p><b>2. Linkage to the Programme budget 2014–2015 (see document A66/7 <a href="http://apps.who.int/gb/ebwha/pdf_files/WHA66/A66_7-en.pdf">http://apps.who.int/gb/ebwha/pdf_files/WHA66/A66_7-en.pdf</a>)</b></p> <p>Category: 4. Health systems</p> <p>Programme area: Access to medicines and health technologies and strengthening regulatory capacity Outcome: 4.3 Output: 4.3.3</p> <p>Additional links to Categories 1, 2, 3 and 5.</p> <p><b>How would this resolution contribute to the achievement of the outcome(s) of the above programme area(s)?</b></p> <p>This resolution will enhance strengthening of regulatory capacity worldwide to ensure the quality, safety and efficacy of medicines and other health technologies, through: improving assessment tools and their implementation; providing technical support and training to regulatory bodies; providing guidance on evaluation of new product classes; supporting and fostering regional and subregional networks and convergence of regulatory requirements; and strengthening of pharmacovigilance systems. It will also strengthen WHO's prequalification programme and allow prequalification of new classes of medicines.</p> <p>Safe, effective and affordable medicines and health products are an essential element of: universal health coverage; attainment of the Millennium Development Goals; dealing with the growing burden of noncommunicable diseases; and fighting epidemics and pandemics.</p> <p><b>Does the Programme budget already include the outputs and deliverables requested in this resolution? (Yes/no)</b></p> <p>Yes.</p>
<p><b>3. Estimated cost and staffing implications in relation to the Programme budget</b></p> <p><b>(a) Total cost</b></p> <p><b>Indicate (i) the lifespan of the resolution during which the Secretariat's activities would be required for implementation and (ii) the cost of those activities (estimated to the nearest US\$ 10 000).</b></p> <p>Current estimates are for a duration of 10 years (2014–2023) for a total cost of up to US\$ 250 million. Costs and staffing in relation to this strategy will be included in each of the biennial budgets during the lifespan of the strategy, based on a realistic costing of outputs and deliverables related to the work planned for each of the respective programme budget periods starting with the programme budget for the biennium 2016–2017.</p> <p><b>(b) Cost for the biennium 2014–2015</b></p> <p><b>Indicate how much of the cost indicated in 3 (a) is for the biennium 2014–2015 (estimated to the nearest US\$ 10 000).</b></p> <p>Total: US\$ 30.0 million (staff: US\$ 11.5 million; activities: US\$ 18.5 million).</p> <p><b>Indicate at which levels of the Organization the costs would be incurred, identifying specific regions where relevant.</b></p> <p>Costs will be incurred at headquarters, all WHO regional offices and certain country offices.</p> <p><b>Is the estimated cost fully included within the approved Programme budget 2014–2015? (Yes/no)</b></p> <p>No.</p> <p><b>If "no", indicate how much is not included.</b></p> <p>US\$ 25 million will be required to implement the full scope of this resolution, taking into account, for example, the increased breadth and depth of support to be provided to regional regulatory networks and for global collaboration and information exchange, prequalification of essential new classes of medicines, and strengthening of pharmacovigilance.</p>

**(c) Staffing implications**

**Could the resolution be implemented by existing staff? (Yes/no)**

No.

**If “no”, indicate how many additional staff – full-time equivalents – would be required, identifying specific regions and noting the necessary skills profile(s), where relevant.**

A total of 18 additional full-time equivalent staff members in the professional and higher categories will be needed. At headquarters, three full-time equivalents will be required and in the regional and subregional offices, 15 full-time equivalents will be needed (two full-time equivalents per regional office, and one full-time equivalent per team in the three intercountry teams in the African Region). The staff members concerned should have a background in regulatory expertise, experience working in developing countries and some experience in working in an international environment.

**4. Funding**

**Is the estimated cost for the biennium 2014–2015 indicated in 3 (b) fully funded? (Yes/no)**

No.

**If “no”, indicate the funding gap and how the funds would be mobilized (provide details of expected source(s) of funds).**

The funding gap is currently estimated at US\$ 25 million. It will be tackled through the Organization-wide coordinated resource mobilization plan for dealing with funding shortfalls in the Programme budget 2014–2015.

**1. Resolution WHA67.21** Access to biotherapeutic products, including similar biotherapeutic products,<sup>1</sup> and ensuring their safety, quality and efficacy

**2. Linkage to the Programme budget 2014–2015 (see document A66/7 [http://apps.who.int/gb/ebwha/pdf\\_files/WHA66/A66\\_7-en.pdf](http://apps.who.int/gb/ebwha/pdf_files/WHA66/A66_7-en.pdf))**

Category: 4. Health systems

Programme area: Access to medicines and health technologies <sup>2</sup> and strengthening regulatory capacity	Outcome: 4.3 Output: 4.3.3
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Additional links to Category 2. Noncommunicable diseases.

**How would this resolution contribute to the achievement of the outcome(s) of the above programme area(s)?**

Biotherapeutic products that treat a wide range of noncommunicable diseases are currently unaffordable for the majority of the world's population. The implementation of the resolution will facilitate access to biotherapeutic products of assured quality, safety and efficacy by those who need them most, thus supporting the outcome mentioned above.

**Does the Programme budget already include the outputs and deliverables requested in this resolution? (Yes/no)**

Yes.

<sup>1</sup> Acknowledging that national authorities may use different terminologies when referring to similar biotherapeutic products.

<sup>2</sup> As stated in resolution WHA60.29, the term “health technologies” refers to devices, medicines, vaccines, procedures and systems developed to solve a health problem and improve the quality of lives.

### 3. Estimated cost and staffing implications in relation to the Programme budget

#### (a) Total cost

Indicate (i) the lifespan of the resolution during which the Secretariat's activities would be required for implementation and (ii) the cost of those activities (estimated to the nearest US\$ 10 000).

- (i) Ten years (covering the period 2014–2023).
- (ii) Total: US\$ 25.0 million (staff: US\$ 12.5 million; activities: US\$ 12.5 million).

#### (b) Cost for the biennium 2014–2015

Indicate how much of the cost indicated in 3 (a) is for the biennium 2014–2015 (estimated to the nearest US\$ 10 000).

Total: US\$ 3.0 million (staff: US\$ 1.5 million; activities: US\$ 1.5 million).

Indicate at which levels of the Organization the costs would be incurred, identifying specific regions where relevant.

Headquarters and three regional offices.

Is the estimated cost fully included within the approved Programme budget 2014–2015? (Yes/no)

Yes.

If “no”, indicate how much is not included.

#### (c) Staffing implications

Could the resolution be implemented by existing staff? (Yes/no)

No, but recruitment will take place against positions that are already included in the approved Programme budget.

If “no”, indicate how many additional staff – full-time equivalents – would be required, identifying specific regions and noting the necessary skills profile(s), where relevant.

A total of 1.5 full-time equivalent staff will be required in the professional and higher categories (full-time equivalents in individual regions: 0.5, the Americas; 0.5, South-East Asia; and 0.5, Western Pacific). Staff members will need expertise and experience in regulation of biotherapeutic products.

### 4. Funding

Is the estimated cost for the biennium 2014–2015 indicated in 3 (b) fully funded? (Yes/no)

No.

If “no”, indicate the funding gap and how the funds would be mobilized (provide details of expected source(s) of funds).

The funding gap is currently estimated at US\$ 2.5 million. It will be tackled through the Organization-wide coordinated resource mobilization plan for dealing with funding shortfalls in the Programme budget 2014–2015.

**1. Resolution WHA67.22** Access to essential medicines

**2. Linkage to the Programme budget 2014–2015 (see document A66/7  
[http://apps.who.int/gb/ebwha/pdf\\_files/WHA66/A66\\_7-en.pdf](http://apps.who.int/gb/ebwha/pdf_files/WHA66/A66_7-en.pdf))**

Category: 4. Health systems

Programme area: Access to medicines and health technologies <sup>1</sup> and strengthening regulatory capacity	Outcome: 4.3 Output: 4.3.1
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Additional links to Categories 1, 2, 3 and 5.

**How would this resolution contribute to the achievement of the outcome(s) of the above programme area(s)?**

It will support achievement of improved access to and rational use of safe, efficacious and quality medicines and health technologies through: the development and implementation of national policies and best practices; regional approaches for sharing of information and experience; and provision by the Secretariat of support and guidance to countries for increasing and monitoring access to essential medicines.

**Does the Programme budget already include the outputs and deliverables requested in this resolution? (Yes/no)**

Yes.

**3. Estimated cost and staffing implications in relation to the Programme budget**

**(a) Total cost**

**Indicate (i) the lifespan of the resolution during which the Secretariat's activities would be required for implementation and (ii) the cost of those activities (estimated to the nearest US\$ 10 000).**

- (i) Six years (covering the period 2014–2019).
- (ii) Total: US\$ 18 million (staff: US\$ 8 million; activities: US\$ 10 million).

**(b) Cost for the biennium 2014–2015**

**Indicate how much of the cost indicated in 3 (a) is for the biennium 2014–2015 (estimated to the nearest US\$ 10 000).**

Total: US\$ 8.6 million (staff: US\$ 3.6 million; activities: US\$ 5.0 million)

**Indicate at which levels of the Organization the costs would be incurred, identifying specific regions where relevant.**

Headquarters and all six regional offices.

**Is the estimated cost fully included within the approved Programme budget 2014–2015? (Yes/no)**

Yes.

**If “no”, indicate how much is not included.**

**(c) Staffing implications**

**Could the resolution be implemented by existing staff? (Yes/no)**

No, but recruitment will take place against approved positions that are included in the approved Programme budget.

<sup>1</sup> As stated in resolution WHA60.29, the term “health technologies” refers to devices, medicines, vaccines, procedures and systems developed to solve a health problem and improve the quality of lives.



**If “no”, indicate how many additional staff – full-time equivalents – would be required, identifying specific regions and noting the necessary skills profile(s), where relevant.**

Eight full-time equivalent staff will be required in the professional and higher categories (two at headquarters and six in the regional offices). The staff members concerned should have expertise in pricing, procurement and supply and rational use of medicines and health products.

#### 4. Funding

**Is the estimated cost for the biennium 2014–2015 indicated in 3 (b) fully funded? (Yes/no)**

No.

**If “no”, indicate the funding gap and how the funds would be mobilized (provide details of expected source(s) of funds).**

The funding gap is estimated at US\$ 5.6 million. It will be tackled through the Organization-wide coordinated resource mobilization plan for dealing with funding shortfalls in the Programme budget 2014–2015.

**1. Resolution WHA67.23** Health intervention and technology assessment in support of universal health coverage

**2. Linkage to the Programme budget 2014–2015 (see document A66/7 [http://apps.who.int/gb/ebwha/pdf\\_files/WHA66/A66\\_7-en.pdf](http://apps.who.int/gb/ebwha/pdf_files/WHA66/A66_7-en.pdf))**

Category: 4. Health systems

Programme area: National health policies, strategies and plans Outcome: 4.1  
Output: 4.1.2

Programme area: Access to medicines and health technologies and strengthening regulatory capacity Outcome: 4.3  
Output: 4.3.1

Additional links to Categories 1, 2, 3 and 5.

**How would this resolution contribute to the achievement of the outcome(s) of the above programme area(s)?**

The resolution will support increased capacity in countries to assess the cost–effectiveness of health interventions as well as of medicines and other health technologies, using an evidence-based and transparent approach. This will allow policy-makers to prioritize investment in health and support progress towards sustainable universal health coverage.

**Does the Programme budget already include the outputs and deliverables requested in this resolution? (Yes/no)**

Yes.

**3. Estimated cost and staffing implications in relation to the Programme budget**

**(a) Total cost**

**Indicate (i) the lifespan of the resolution during which the Secretariat’s activities would be required for implementation and (ii) the cost of those activities (estimated to the nearest US\$ 10 000).**

(i) Six years (covering the period 2014–2019).

(ii) Total: US\$ 28 million (staff: US\$ 12 million; activities: US\$ 16 million).

Costs and staffing implications in relation to implementation of the actions contained in this resolution will be included in each of the biennial budgets, based on a realistic costing of outputs and deliverables related to the work planned for each of the respective programme budget periods starting with the programme budget for the biennium 2016–2017.

**(b) Cost for the biennium 2014–2015**

**Indicate how much of the cost indicated in 3 (a) is for the biennium 2014–2015 (estimated to the nearest US\$ 10 000).**

Total: US\$ 13.6 million (staff: US\$ 6.6 million; activities: US\$ 7.0 million).

**Indicate at which levels of the Organization the costs would be incurred, identifying specific regions where relevant.**

Headquarters and all six regional offices.

**Is the estimated cost fully included within the approved Programme budget 2014–2015? (Yes/no)**

Yes.

**If “no”, indicate how much is not included.**

**(c) Staffing implications**

**Could the resolution be implemented by existing staff? (Yes/no)**

No, recruitment will take place against approved positions that are included in the approved Programme budget.

**If “no”, indicate how many additional staff – full-time equivalents – would be required, identifying specific regions and noting the necessary skills profile(s), where relevant.**

A total of eight full-time equivalent staff will be required in the professional and higher categories (two at headquarters and one at each of the regional offices). These staff should have expertise in cost-effectiveness analysis or health intervention and technology assessment.

**4. Funding**

**Is the estimated cost for the biennium 2014–2015 indicated in 3 (b) fully funded? (Yes/no)**

No.

**If “no”, indicate the funding gap and how the funds would be mobilized (provide details of expected source(s) of funds).**

The funding gap is currently estimated at US\$ 13.6 million. It will be tackled through the Organization-wide coordinated resource mobilization plan for dealing with funding shortfalls in the Programme budget 2014–2015.

**1. Resolution WHA67.24** Follow-up of the Recife Political Declaration on Human Resources for Health: renewed commitments towards universal health coverage

**2. Linkage to the Programme budget 2014–2015 (see document A66/7 [http://apps.who.int/gb/ebwha/pdf\\_files/WHA66/A66\\_7-en.pdf](http://apps.who.int/gb/ebwha/pdf_files/WHA66/A66_7-en.pdf))**

Category: 4. Health systems

Programme area: Integrated people-centred health services      Outcome: 4.2  
Output: 4.2.2

**How would this resolution contribute to the achievement of the outcome(s) of the above programme area(s)?**

It will contribute to supporting countries to plan and implement strategies in line with WHO’s global strategy on human resources for health.

**Does the Programme budget already include the outputs and deliverables requested in this resolution? (Yes/no)**

Yes.

**3. Estimated cost and staffing implications in relation to the Programme budget****(a) Total cost**

Indicate (i) the lifespan of the resolution during which the Secretariat's activities would be required for implementation and (ii) the cost of those activities (estimated to the nearest US\$ 10 000).

(i) Four years (covering the period 2014–2017).

(ii) Total: US\$ 18.8 million (staff: US\$ 13.0 million; activities: US\$ 5.8 million).

**(b) Cost for the biennium 2014–2015**

Indicate how much of the cost indicated in 3 (a) is for the biennium 2014–2015 (estimated to the nearest US\$ 10 000).

Total: US\$ 9.4 million (staff: US\$ 6.5 million; activities: US\$ 2.9 million).

Indicate at which levels of the Organization the costs would be incurred, identifying specific regions where relevant.

Country offices, 30%; regional and subregional offices, 40%; and headquarters, 30%.

Is the estimated cost fully included within the approved Programme budget 2014–2015? (Yes/no)

Yes.

If “no”, indicate how much is not included.

**(c) Staffing implications**

Could the resolution be implemented by existing staff? (Yes/no)

Yes, provided that current vacancies at headquarters and the regional offices are filled.

If “no”, indicate how many additional staff – full-time equivalents – would be required, identifying specific regions and noting the necessary skills profile(s), where relevant.

**4. Funding**

Is the estimated cost for the biennium 2014–2015 indicated in 3 (b) fully funded? (Yes/no)

No.

If “no”, indicate the funding gap and how the funds would be mobilized (provide details of expected source(s) of funds).

The funding gap is estimated at US\$ 3.8 million. It will be tackled through the Organization-wide coordinated resource mobilization plan for dealing with funding shortfalls in the Programme budget 2014–2015.

**1. Resolution WHA67.25 Antimicrobial resistance****2. Linkage to the Programme budget 2014–2015 (see document A66/7 [http://apps.who.int/gb/ebwha/pdf\\_files/WHA66/A66\\_7-en.pdf](http://apps.who.int/gb/ebwha/pdf_files/WHA66/A66_7-en.pdf))**

Category: 5. Preparedness, surveillance and response

Programme area: Epidemic-prone and pandemic-prone diseases

In addition, combating antimicrobial resistance involves, and has implications for, a broad range of categories and programme areas.

**How would this resolution contribute to the achievement of the outcome(s) of the above programme area(s)?**

The resolution is of direct relevance to the outcome “Increase the number of countries with a national antimicrobial resistance (AMR) action plan”.<sup>1</sup> The resolution will ensure global commitment by Member States and other organizations to achieve this outcome. The cross-cutting nature and health impacts of antimicrobial resistance mean that the resolution is also of direct relevance to outcomes and deliverables in other categories and programme areas.

**Does the Programme budget already include the outputs and deliverables requested in this resolution? (Yes/no)**

Yes. However, the Programme budget 2014–2015 does not cover the implementation of the draft global action plan mentioned in operative subparagraph 2(5).

**3. Estimated cost and staffing implications in relation to the Programme budget****(a) Total cost**

**Indicate (i) the lifespan of the resolution during which the Secretariat’s activities would be required for implementation and (ii) the cost of those activities (estimated to the nearest US\$ 10 000).**

(i) Two years (covering the period 2014–2015).

(ii) Total: US\$ 9.6 million (staff: US\$ 7.4 million; activities: US\$ 2.2 million).

**(b) Cost for the biennium 2014–2015**

**Indicate how much of the cost indicated in 3 (a) is for the biennium 2014–2015 (estimated to the nearest US\$ 10 000).**

Total: US\$ 9.6 million (staff: US\$ 7.4 million; activities: US\$ 2.2 million).

**Indicate at which levels of the Organization the costs would be incurred, identifying specific regions where relevant.**

At headquarters and in all six regional offices. All activity costs will be implemented through headquarters; staff costs will be US\$ 4.6 million at headquarters and US\$ 470 000 in each regional office.

**Is the estimated cost fully included within the approved Programme budget 2014–2015? (Yes/no)**

No, it is only partially included.

**If “no”, indicate how much is not included.**

Total: US\$ 7.8 million (staff: US\$ 6.6 million; activities: US\$ 1.2 million).

**(c) Staffing implications**

**Could the resolution be implemented by existing staff? (Yes/no)**

No.

**If “no”, indicate how many additional staff – full-time equivalents – would be required, identifying specific regions and noting the necessary skills profile(s), where relevant.**

Under the assumption that existing staff will continue to be assigned to the activities planned under the current Programme budget, including those on antimicrobial resistance, additional full-time equivalent staff members will be required in order to implement this resolution, comprising one full-time equivalent at each of the regional offices and four to six full-time equivalents at headquarters (staff in professional and higher category posts with expertise in health policy, communications and project management).

<sup>1</sup> As shown on WHO’s Programme budget web portal.

**4. Funding**

**Is the estimated cost for the biennium 2014–2015 indicated in 3 (b) fully funded? (Yes/no)**

No.

**If “no”, indicate the funding gap and how the funds would be mobilized (provide details of expected source(s) of funds).**

The funding gap is estimated at US\$ 8.8 million. It will be tackled through the Organization-wide coordinated resource mobilization plan for dealing with funding shortfalls in the Programme budget 2014–2015.

**1. Decision WHA67(9) Maternal, infant and young child nutrition****2. Linkage to the Programme budget 2014–2015 (see document A66/7 [http://apps.who.int/gb/ebwha/pdf\\_files/WHA66/A66\\_7-en.pdf](http://apps.who.int/gb/ebwha/pdf_files/WHA66/A66_7-en.pdf))**

Category: 2. Noncommunicable diseases

Programme area: Nutrition

Outcome: 2.5

Output: 2.5.1

**How would this decision contribute to the achievement of the outcome(s) of the above programme area(s)?**

The decision will allow the Secretariat to complete three pending tasks relating to the comprehensive implementation plan on maternal, infant and young child nutrition: developing multisectoral policies on food and nutrition (through the Second International Conference on Nutrition), providing guidance on the marketing of complementary foods, and developing an accountability framework (through work on the global monitoring framework for maternal, infant and young child nutrition).

**Does the Programme budget already include the outputs and deliverables requested in this decision? (Yes/no)**

Yes.

**3. Estimated cost and staffing implications in relation to the Programme budget****(a) Total cost**

**Indicate (i) the lifespan of the decision during which the Secretariat’s activities would be required for implementation and (ii) the cost of those activities (estimated to the nearest US\$ 10 000).**

(i) Two years (covering the period 2014–2015).

(ii) Total: US\$ 1.87 million (staff: US\$ 690 000; activities: US\$ 1.18 million).

**(b) Cost for the biennium 2014–2015**

**Indicate how much of the cost indicated in 3 (a) is for the biennium 2014–2015 (estimated to the nearest US\$ 10 000).**

Total: US\$ 1.87 million (staff: US\$ 690 000; activities: US\$ 1.18 million).

**Indicate at which levels of the Organization the costs would be incurred, identifying specific regions where relevant.**

Headquarters.

**Is the estimated cost fully included within the approved Programme budget 2014–2015? (Yes/no)**

Yes.

**If “no”, indicate how much is not included.**

**(c) Staffing implications**

**Could the decision be implemented by existing staff? (Yes/no)**

Yes.

**If “no”, indicate how many additional staff – full-time equivalents – would be required, identifying specific regions and noting the necessary skills profile(s), where relevant.**

**4. Funding**

**Is the estimated cost for the biennium 2014–2015 indicated in 3 (b) fully funded? (Yes/no)**

No.

**If “no”, indicate the funding gap and how the funds would be mobilized (provide details of expected source(s) of funds).**

The funding gap is estimated at US\$ 780 000. It will be tackled through the Organization-wide coordinated resource mobilization plan for dealing with funding shortfalls in the Programme budget 2014–2015.

**1. Decision WHA67(10) Health conditions in the occupied Palestinian territory, including east Jerusalem, and in the occupied Syrian Golan**

**2. Linkage to the Programme budget 2014–2015 (see document A66/7 [http://apps.who.int/gb/ebwha/pdf\\_files/WHA66/A66\\_7-en.pdf](http://apps.who.int/gb/ebwha/pdf_files/WHA66/A66_7-en.pdf))**

Categories: All

Programme areas: The decision links to programme areas in all the categories. Outcomes: All  
Outputs: All

**How would this decision contribute to the achievement of the outcome(s) of the above programme area(s)?**

The six actions requested in the decision and the comprehensive work of the Organization that this involves will contribute to all the programmatic outcomes.

**Does the Programme budget already include the outputs and deliverables requested in this decision? (Yes/no)**

Yes, with the exception of the field assessment and subsequent report to the Sixty-eighth World Health Assembly, which are outside the scope of the Programme budget 2014–2015.

**3. Estimated cost and staffing implications in relation to the Programme budget****(a) Total cost**

**Indicate (i) the lifespan of the decision during which the Secretariat’s activities would be required for implementation and (ii) the cost of those activities (estimated to the nearest US\$ 10 000).**

(i) One year (from May 2014 to May 2015).

(ii) Total: US\$ 4.79 million (staff: US\$ 2.83 million; activities: US\$ 1.96 million).

**(b) Cost for the biennium 2014–2015**

**Indicate how much of the cost indicated in 3 (a) is for the biennium 2014–2015 (estimated to the nearest US\$ 10 000).**

Total: US\$ 4.79 million (staff: US\$ 2.83 million; activities: US\$ 1.96 million)..

**Indicate at which levels of the Organization the costs would be incurred, identifying specific regions where relevant.**

The costs will be incurred predominately at the country level, with some technical support for the field assessment and the related report potentially provided by the Regional Office for the Eastern Mediterranean and headquarters.

**Is the estimated cost fully included within the approved Programme budget 2014–2015? (Yes/no)**

No.

**If “no”, indicate how much is not included.**

US\$ 150 000, representing the cost of the field assessment and related report. The costs are currently not foreseen in the Programme budget 2014–2015; however, in view of the relatively small additional budget for the activities, the matter will be resolved through some reprogramming at country or regional level.

**(c) Staffing implications**

**Could the decision be implemented by existing staff? (Yes/no)**

Yes.

**If “no”, indicate how many additional staff – full-time equivalents – would be required, identifying specific regions and noting the necessary skills profile(s), where relevant.**

**4. Funding**

**Is the estimated cost for the biennium 2014–2015 indicated in 3 (b) fully funded? (Yes/no)**

No.

**If “no”, indicate the funding gap and how the funds would be mobilized (provide details of expected source(s) of funds).**

The funding gap is estimated at US\$ 803 500; it will be tackled through the the Organization-wide coordinated resource mobilization plan for dealing with funding shortfalls in the Programme budget 2014–2015.