



WORLD HEALTH ORGANIZATION

SIXTY-NINTH WORLD HEALTH ASSEMBLY

GENEVA, 23–28 MAY 2016

**RESOLUTIONS AND DECISIONS
ANNEXES**

GENEVA
2016

ABBREVIATIONS

Abbreviations used in WHO documentation include the following:

<p>ACHR – Advisory Committee on Health Research</p> <p>ASEAN – Association of Southeast Asian Nations</p> <p>CEB – United Nations System Chief Executives Board for Coordination</p> <p>CIOMS – Council for International Organizations of Medical Sciences</p> <p>FAO – Food and Agriculture Organization of the United Nations</p> <p>IAEA – International Atomic Energy Agency</p> <p>IARC – International Agency for Research on Cancer</p> <p>ICAO – International Civil Aviation Organization</p> <p>IFAD – International Fund for Agricultural Development</p> <p>ILO – International Labour Organization (Office)</p> <p>IMF – International Monetary Fund</p> <p>IMO – International Maritime Organization</p> <p>INCB – International Narcotics Control Board</p> <p>ITU – International Telecommunication Union</p> <p>OECD – Organisation for Economic Co-operation and Development</p>	<p>OIE – <i>Office International des Epizooties</i></p> <p>PAHO – Pan American Health Organization</p> <p>UNAIDS – Joint United Nations Programme on HIV/AIDS</p> <p>UNCTAD – United Nations Conference on Trade and Development</p> <p>UNODC – United Nations Office on Drugs and Crime</p> <p>UNDP – United Nations Development Programme</p> <p>UNEP – United Nations Environment Programme</p> <p>UNESCO – United Nations Educational, Scientific and Cultural Organization</p> <p>UNFPA – United Nations Population Fund</p> <p>UNHCR – Office of the United Nations High Commissioner for Refugees</p> <p>UNICEF – United Nations Children’s Fund</p> <p>UNIDO – United Nations Industrial Development Organization</p> <p>UNRWA – United Nations Relief and Works Agency for Palestine Refugees in the Near East</p> <p>WFP – World Food Programme</p> <p>WIPO – World Intellectual Property Organization</p> <p>WMO – World Meteorological Organization</p> <p>WTO – World Trade Organization</p>
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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-ninth World Health Assembly was held at the Palais des Nations, Geneva, from 23 to 28 May 2016, in accordance with the decision of the Executive Board at its 137th session.¹

¹ Decision EB137(6) (2015).

CONTENTS

	Page
Preface.....	iii
Agenda	ix
List of documents.....	xv
Officers of the Health Assembly and membership of its committees	xxiii

RESOLUTIONS AND DECISIONS

Resolutions

WHA69.1	Strengthening essential public health functions in support of the achievement of universal health coverage.....	3
WHA69.2	Committing to implementation of the Global Strategy for Women’s, Children’s and Adolescents’ Health.....	6
WHA69.3	Global strategy and action plan on ageing and health 2016–2020: towards a world in which everyone can live a long and healthy life	8
WHA69.4	The role of the health sector in the Strategic Approach to International Chemicals Management towards the 2020 goal and beyond	11
WHA69.5	WHO global plan of action to strengthen the role of the health system within a national multisectoral response to address interpersonal violence, in particular against women and girls, and against children.....	18
WHA69.6	Prevention and control of noncommunicable diseases: responses to specific assignments in preparation for the third High-level Meeting of the United Nations General Assembly on the Prevention and Control of Non-communicable Diseases in 2018	19
WHA69.7	Addressing the challenges of the United Nations Decade of Action for Road Safety (2011–2020): outcome of the second Global High-level Conference on Road Safety – Time for Results	20
WHA69.8	United Nations Decade of Action on Nutrition (2016–2025)	23
WHA69.9	Ending inappropriate promotion of foods for infants and young children	25
WHA69.10	Framework of Engagement with Non-State Actors	27

	Page
WHA69.11	Health in the 2030 Agenda for Sustainable Development..... 30
WHA69.12	WHO programmatic and financial report for 2014–2015, including audited financial statements for 2015..... 35
WHA69.13	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 36
WHA69.14	Scale of assessments for 2017 37
WHA69.15	Report of the External Auditor 41
WHA69.16	Salaries of staff in ungraded posts and of the Director-General..... 42
WHA69.17	Amendments to the Staff Regulations: dispute resolution..... 42
WHA69.18	Process for the election of the Director-General of the World Health Organization 43
WHA69.19	Global strategy on human resources for health: workforce 2030..... 43
WHA69.20	Promoting innovation and access to quality, safe, efficacious and affordable medicines for children 47
WHA69.21	Addressing the burden of mycetoma 50
WHA69.22	Global health sector strategies on HIV, viral hepatitis and sexually transmitted infections, for the period 2016–2021 52
WHA69.23	Follow-up of the report of the Consultative Expert Working Group on Research and Development: Financing and Coordination..... 53
WHA69.24	Strengthening integrated, people-centred health services..... 56
WHA69.25	Addressing the global shortage of medicines and vaccines, and the safety and accessibility of children’s medication..... 58
Decisions	
WHA69(1)	Composition of the Committee on Credentials..... 61
WHA69(2)	Election of officers of the Sixty-ninth World Health Assembly..... 61
WHA69(3)	Election of officers of the main committees..... 61
WHA69(4)	Establishment of the General Committee 62
WHA69(5)	Adoption of the agenda..... 62
WHA69(6)	Verification of credentials 62

	Page
WHA69(7) Election of Members entitled to designate a person to serve on the Executive Board	63
WHA69(8) Decision based on the agreed recommendations of the Open-ended Intergovernmental Meeting on Governance Reform (Geneva, 8 and 9 March 2016 and 28 and 29 April 2016).....	63
WHA69(9) Reform of WHO’s work in health emergency management: WHO Health Emergencies Programme.....	65
WHA69(10) Health conditions in the occupied Palestinian territory, including east Jerusalem, and in the occupied Syrian Golan.....	66
WHA69(11) Health and the environment: draft road map for an enhanced global response to the adverse health effects of air pollution.....	68
WHA69(12) Report of the Commission on Ending Childhood Obesity	68
WHA69(13) Strengthening synergies between the World Health Assembly and the Conference of the Parties to the WHO Framework Convention on Tobacco Control	69
WHA69(14) Implementation of the International Health Regulations (2005).....	69
WHA69(15) Public health dimension of the world drug problem, including in the context of the special session of the United Nations General Assembly on the world drug problem, held in April 2016.....	70
WHA69(16) Strategic budget space allocation	70
WHA69(17) Appointment of representatives to the WHO Staff Pension Committee	71
WHA69(18) Real estate: update of the Geneva buildings renovation strategy	71
WHA69(19) Selection of the country in which the Seventieth World Health Assembly would be held	72

ANNEXES

1. Global strategy and action plan on ageing and health 2016–2020: towards a world in which everyone can live a long and healthy life.....	75
2. WHO global plan of action to strengthen the role of the health system within a national multisectoral response to address interpersonal violence, in particular against women and girls, and against children	109
3. Brasilia Declaration	171
4. Guidance on ending the inappropriate promotion of foods for infants and young children.....	178
5. Framework of Engagement with Non-State Actors	183

	Page
6. Text of amended Staff Regulations	214
7. Global Strategy on Human Resources for Health: Workforce 2030.....	215
8. Global health sector strategies on HIV, viral hepatitis and sexually transmitted infections, for the period 2016–2021	260
9. Framework on integrated people-centred health services	390
10. WHO Health Emergencies Programme	399
11. Road map for an enhanced global response to the adverse health effects of air pollution....	406
12. Recommendations of the Commission on Ending Childhood Obesity and actions and responsibilities for their implementation.....	418
13. Recommendations contained in the Report of the Review Committee on the Role of the International Health Regulations (2005) in the Ebola Outbreak and Response	426
14. Models developed by the Working Group on Strategic Budget Space Allocation for Segment 1 of the WHO Programme budget.....	445
15. Financial and administrative implications for the Secretariat of resolutions and decisions adopted by the Health Assembly	450

AGENDA¹

PLENARY

1. Opening of the Health Assembly
 - 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 137th and 138th 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 Committee²
11. WHO reform
 - 11.1 Overview of reform implementation
 - 11.2 Member State consultative process on governance reform

¹ Adopted at the second plenary meeting.

² Including election of Vice-Chairmen and the Rapporteur.

- 11.3 Framework of engagement with non-State actors
12. Noncommunicable diseases
 - 12.1 Maternal, infant and young child nutrition
 - 12.2 Report of the Commission on Ending Childhood Obesity
 - 12.3. Draft global plan of action on violence
 - 12.4 Prevention and control of noncommunicable diseases: responses to specific assignments in preparation for the third High-level Meeting of the United Nations General Assembly on the Prevention and Control of Non-communicable Diseases in 2018
 - 12.5 Strengthening synergies between the World Health Assembly and the Conference of the Parties to the WHO Framework Convention on Tobacco Control
 - 12.6 Public health dimension of the world drug problem including in the context of the special session of the United Nations General Assembly on the world drug problem, held in April 2016
 - 12.7. Addressing the challenges of the United Nations Decade of Action for Road Safety (2011–2020): outcome of the second Global High-level Conference on Road Safety – Time for Results
13. Promoting health through the life course
 - 13.1 Monitoring of the achievement of the health-related Millennium Development Goals
 - 13.2 Health in the 2030 Agenda for Sustainable Development
 - 13.3 Operational plan to take forward the Global Strategy for Women’s, Children’s and Adolescents’ Health
 - 13.4 Multisectoral action for a life course approach to healthy ageing: draft global strategy and plan of action on ageing and health
 - 13.5 Health and the environment: draft road map for an enhanced global response to the adverse health effects of air pollution
 - 13.6 Role of the health sector in the sound management of chemicals
14. Preparedness, surveillance and response
 - 14.1 Implementation of the International Health Regulations (2005)
 - Annual report on the implementation of the International Health Regulations (2005)
 - Report of the Review Committee on the Role of the International Health Regulations (2005) in the Ebola Outbreak and Response

AGENDA

- 14.2 Pandemic influenza preparedness: sharing of influenza viruses and access to vaccines and other benefits
- 14.3 Smallpox eradication: destruction of variola virus stocks
- 14.4 Global action plan on antimicrobial resistance
- 14.5 Poliomyelitis
- 14.6 WHO response in severe, large-scale emergencies
- 14.7 Promoting the health of migrants
- 14.8 2014 Ebola virus disease outbreak
 - Update on 2014 Ebola virus disease outbreak and Secretariat response to other issues raised
[document not issued]
 - Options for strengthening information-sharing on diagnostic, preventive and therapeutic products and for enhancing WHO's capacity to facilitate access to these products, including the establishment of a global database, starting with haemorrhagic fevers
- 14.9 Reform of WHO's work in health emergency management: WHO Health Emergencies Programme
- 15. [transferred to Committee B]

COMMITTEE B

- 18. Opening of the Committee¹
- 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 WHO programmatic and financial report for 2014–2015 including audited financial statements for 2015
 - 20.2 Financing of Programme budget 2016–2017
 - Strategic budget space allocation

¹ Including election of Vice-Chairmen and Rapporteur.

- 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 Scale of assessments for 2017
- 20.6 [deleted]
- 20.7 [deleted]
- 21. Audit and oversight matters
 - 21.1 Report of the External Auditor
 - 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
 - 22.4 Appointment of representatives of the WHO Staff Pension Committee
- 23. Management and legal matters
 - 23.1 Real estate: update of the Geneva buildings renovation strategy
 - 23.2 Process for the election of the Director-General of the World Health Organization
- 24. Collaboration within the United Nations system and with other intergovernmental organizations
- 15. Communicable diseases
 - 15.1 Draft global health sector strategies
 - HIV, 2016–2021
 - Viral hepatitis, 2016–2021
 - Sexually transmitted infections, 2016–2021
 - 15.2 Global vaccine action plan
 - 15.3 Mycetoma

16. Health systems¹
- 16.1 Health workforce and services
- Draft global strategy on human resources for health: workforce 2030
 - Framework on integrated people-centred health services
- 16.2 Follow-up to the report of the Consultative Expert Working Group on Research and Development: Financing and Coordination – Report of the open-ended meeting of Member States
- 16.3 Substandard/spurious/falsely-labelled/falsified/counterfeit medical products
- 16.4 Addressing the global shortages of medicines, and the safety and accessibility of children’s medication
17. Progress reports
- Communicable diseases**
- A. Eradication of dracunculiasis (resolution WHA64.16)
- Noncommunicable diseases**
- B. Sustaining the elimination of iodine deficiency disorders (resolution WHA60.21)
- Promoting health through the life course**
- C. Strengthening of palliative care as a component of comprehensive care throughout the life course (resolution WHA67.19)
- D. Contributing to social and economic development: sustainable action across sectors to improve health and health equity [follow-up of the 8th Global Conference on Health Promotion] (resolution WHA67.12)
- E. Reproductive health: strategy to accelerate progress towards the attainment of international development goals and targets (resolution WHA57.12)
- Health systems**
- F. Health intervention and technology assessment in support of universal health coverage (resolution WHA67.23)
- G. Access to essential medicines (resolution WHA67.22)

¹ Moved from the programme of work of Committee A to that of Committee B further to decision EB138(11) (2016).

- H. Access to biotherapeutic products, including similar biotherapeutic products, and ensuring their quality, safety and efficacy (resolution WHA67.21)
- I. WHO strategy on research for health (resolution WHA63.21)

Corporate services/enabling functions

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

LIST OF DOCUMENTS

A69/1 Rev.1	Agenda ¹
A69/2	Report of the Executive Board on its 137th and 138th sessions
A69/3	Address by Dr Margaret Chan, Director-General, to the Sixty-ninth World Health Assembly
A69/4	Overview of reform implementation
A69/5	Member State consultative process on governance reform
A69/6	Framework of engagement with non-State actors ²
A69/7	Maternal, infant and young child nutrition
A69/7 Add.1	Maternal, infant and young child nutrition Guidance on ending the inappropriate promotion of foods for infants and young children ³
A69/7 Add.2	Maternal, infant and young child nutrition United Nations Decade of Action on Nutrition (2016–2025)
A69/8	Report of the Commission on Ending Childhood Obesity ⁴
A69/9	Draft global plan of action on violence ⁵
A69/10	Prevention and control of noncommunicable diseases: responses to specific assignments in preparation for the third High-level Meeting of the United Nations General Assembly on the Prevention and Control of Non-communicable Diseases in 2018
A69/11	Strengthening synergies between the World Health Assembly and the Conference of the Parties to the WHO Framework Convention on Tobacco Control
A69/11 Add.1	Financial and administrative implications for the Secretariat of resolutions proposed for adoption by the Executive Board or Health

¹ See page xi.

² See Annex 5.

³ See Annex 4.

⁴ See Annex 12.

⁵ See Annex 2.

Assembly¹

A69/12	Public health dimension of the world drug problem including in the context of the special session of the United Nations General Assembly on the world drug problem, held in April 2016
A69/13	Addressing the challenges of the United Nations Decade of Action for Road Safety (2011–2020): outcome of the second Global High-level Conference on Road Safety – Time for Results ²
A69/14	Monitoring of the achievement of the health-related Millennium Development Goals
A69/15	Health in the 2030 Agenda for Sustainable Development
A69/16	Operational plan to take forward the Global Strategy for Women’s, Children’s and Adolescents’ Health
A69/17	Multisectoral action for a life course approach to healthy ageing: draft global strategy and plan of action on ageing and health ³
A69/18	Health and the environment Draft road map for an enhanced global response to the adverse health effects of air pollution ⁴
A69/19	Role of the health sector in the sound management of chemicals
A69/20	Implementation of the International Health Regulations (2005) Annual report on the implementation of the International Health Regulations (2005)
A69/21 and A69/21 Add.1 Rev.1	Implementation of the International Health Regulations (2005) Report of the Review Committee on the Role of the International Health Regulations (2005) in the Ebola Outbreak and Response ⁵
A69/21 Add.2	Financial and administrative implications for the Secretariat of decisions proposed for adoption by the Executive Board or Health Assembly ¹
A69/22	Pandemic influenza preparedness: sharing of influenza viruses and access to vaccines and other benefits

¹ See Annex 15.

² See Annex 3.

³ See Annex 1.

⁴ See Annex 11.

⁵ See Annex 13.

LIST OF DOCUMENTS

A69/22 Add.1	Pandemic influenza preparedness: sharing of influenza viruses and access to vaccines and other benefits Report of the Special Session of the Pandemic Influenza Preparedness Framework Advisory Group
A69/22 Add.2	Pandemic influenza preparedness: sharing of influenza viruses and access to vaccines and other benefits
A69/23	Smallpox eradication: destruction of variola virus stocks
A69/24	Global action plan on antimicrobial resistance
A69/24 Add.1	Global action plan on antimicrobial resistance Options for establishing a global development and stewardship framework to support the development, control, distribution and appropriate use of new antimicrobial medicines, diagnostic tools, vaccines and other interventions
A69/25	Poliomyelitis
A69/26	WHO response in severe, large-scale emergencies
A69/27	Promoting the health of migrants
A69/28	[Document not issued]
A69/29	Options for strengthening information-sharing on diagnostic, preventive and therapeutic products and for enhancing WHO's capacity to facilitate access to these products, including the establishment of a global database, starting with haemorrhagic fevers
A69/30	Reform of WHO's work in health emergency management WHO Health Emergencies Programme ¹
A69/31	Draft global health sector strategies HIV, 2016–2021 ²
A69/32	Draft global health sector strategies Viral hepatitis, 2016–2021 ²
A69/33	Draft global health sector strategies Sexually transmitted infections, 2016–2021 ²
A69/34	Global vaccine action plan
A69/35	Mycetoma

¹ See Annex 10.

² See Annex 8.

A69/36	Health workforce: update
A69/37 and A69/37 Add.1	WHO Global Code of Practice on the International Recruitment of Health Personnel: second round of national reporting
A69/38	Health workforce and services Draft global strategy on human resources for health: workforce 2030 ¹
A69/39	Framework on integrated, people-centred health services ²
A69/40	Follow-up to the report of the Consultative Expert Working Group on Research and Development: Financing and Coordination – Report of the open-ended meeting of Member States
A69/41	Substandard/spurious/falsely-labelled/falsified/counterfeit medical products
A69/42	Addressing the global shortages of medicines, and the safety and accessibility of children’s medication
A69/43	Progress reports
A69/44	Health conditions in the occupied Palestinian territory, including east Jerusalem, and in the occupied Syrian Golan
A69/44 Add.1	Health conditions in the occupied Palestinian territory, including east Jerusalem, and in the occupied Syrian Golan Field assessment report on health conditions in the occupied Palestinian territory: summary findings
A69/45	WHO programmatic and financial report for 2014-2015 including audited financial statements for 2015
A69/46	Financing of Programme budget 2016–2017
A69/47	Financing of Programme budget 2016–2017 Strategic budget space allocation ³
A69/48	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
A69/49	Scale of assessments for 2017

¹ See Annex 7.

² See Annex 9.

³ See Annex 14.

LIST OF DOCUMENTS

A69/50	Report of the External Auditor
A69/51	Report of the Internal Auditor
A69/52	Human resources: annual report
A69/53	Report of the International Civil Service Commission
A69/54	Amendments to the Staff Regulations and Staff Rules ¹
A69/55	Appointment of representatives to the WHO Staff Pension Committee
A69/56	Real estate: update on the Geneva buildings renovation strategy
A69/57	Process for the election of the Director-General of the World Health Organization
A69/58	Collaboration within the United Nations system and with other intergovernmental organizations
A69/59	Draft resolution Global health sector strategies on HIV, viral hepatitis and sexually transmitted infections, for the period 2016–2021
A69/59 Add.1	Financial and administrative implications for the Secretariat of resolutions proposed for adoption by the Executive Board or Health Assembly ²
A69/60	Framework of engagement with non-State actors Report of the Programme, Budget and Administration Committee of the Executive Board to the Sixty-ninth World Health Assembly
A69/61	Reform of WHO's work in health emergency management Report of the Programme, Budget and Administration Committee of the Executive Board to the Sixty-ninth World Health Assembly
A69/62	WHO programmatic and financial report for 2014–2015 including audited financial statements for 2015 Report of the Programme, Budget and Administration Committee of the Executive Board to the Sixty-ninth World Health Assembly
A69/63	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 Report of the Programme, Budget and Administration Committee of

¹ See Annex 6.

² See Annex 15.

	the Executive Board to the Sixty-ninth World Health Assembly
A69/64	Report of the External Auditor and Report of the Internal Auditor and External and internal audit recommendations: progress on implementation Report of the Programme, Budget and Administration Committee of the Executive Board to the Sixty-ninth World Health Assembly
A69/65	Human Resources: annual report Report of the Programme, Budget and Administration Committee of the Executive Board to the Sixty-ninth World Health Assembly
A69/66	First report of Committee A
A69/67	Committee on Credentials
A69/68	Election of Members entitled to designate a person to serve on the Executive Board
A69/69	First report of Committee B
A69/70	Second report of Committee A
A69/71	Second report of Committee B
A69/72	Third report of Committee A
A69/73	Fourth report of Committee A
A69/74	Third report of Committee B
A69/75	Fourth report of Committee B
A69/76	Fifth report of Committee A
Information documents	
A69/INF./1	Awards
A69/INF./2	[Document not issued]
A69/INF./3	Voluntary contributions by fund and by contributor, 2015
A69/INF./4	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
A69/INF./5	Health conditions in the occupied Palestinian territory, including east Jerusalem, and in the occupied Syrian Golan Report of the Director of Health, UNRWA

LIST OF DOCUMENTS

A69/INF./6 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

A69/DIV./1 Rev.1 List of delegates and other participants

A69/DIV./2 Guide for delegates to the World Health Assembly

A69/DIV./3 Decisions and list of resolutions

A69/DIV./4 List of documents

A69/DIV./5 Instructions on using the electronic voting system for the nomination and appointment of the Director-General

A69/DIV./6 Address by Ms Christiana Figueres, Executive Secretary of the United Nations Framework Convention on Climate Change, to the Sixty-ninth World Health Assembly

OFFICERS OF THE HEALTH ASSEMBLY AND MEMBERSHIP OF ITS COMMITTEES

President

Dr Ahmed Mohammed AL-SAIDI (Oman)

Vice-Presidents

Dr Sathasivam SUBRAMANIAM
(Malaysia)

Dr Francisco TERRIENTES (Panama)

Mr Assane NGUEADOUM (Chad)

Dr Ana Isabel SOARES (Timor-Leste)

Dr Armen MURADYAN (Armenia)

Secretary

Dr Margaret CHAN, Director-General

Committee on Credentials

The Committee on Credentials was composed of delegates of the following Member States: Afghanistan, Bolivia (Plurinational State of), Georgia, Haiti, India, Kenya, Liberia, Madagascar, Poland, Republic of Korea, Spain and Tonga.

Chairman: Ms Katarzyna RUTKOWSKA
(Poland)

Vice-Chairman: Dr Bernice DAHN (Liberia)

Secretary: Ms Françoise MOURAIN-SCHUT,
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 the delegates of the following Member States: Antigua and Barbuda, Argentina, Benin, Cameroon, Central African Republic, China, Côte d'Ivoire, Cuba,

Estonia, France, Iraq, Netherlands, Russian Federation, Somalia, United Kingdom of Great Britain and Northern Ireland, United Republic of Tanzania and United States of America.

Chairman: Dr Ahmed Mohammed AL-SAIDI
(Oman)

Secretary: Dr Margaret CHAN,
Director-General

MAIN COMMITTEES

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

Committee A

Chairman: Mr Martin BOWLES (Australia)

Vice-Chairmen: Ms Taru KOIVISTO
(Finland) and Mr Nickolas STEELE
(Grenada)

Rapporteur: Ms Aishah SAMIYA (Maldives)

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

Committee B

Chairman: Dr PHUSIT PRAKONGSAI
(Thailand)

Vice-Chairmen: Dr Mahlet KIFLE (Ethiopia)
and Dr Mohsen ASADI-LARI (Islamic
Republic of Iran)

Rapporteur: Mr Abdunomon SIDIKOV
(Uzbekistan)

Secretary: Dr Clive ONDARI, Coordinator,
Safety and Vigilance

REPRESENTATIVES OF THE EXECUTIVE BOARD

Ms Precious MATSOSO (South Africa)

Dr Rubén Agustín NIETO (Argentina)

Dr Asaad HAFEEZ (Pakistan)

Dr JEON Man-bok (Republic of Korea)

RESOLUTIONS AND DECISIONS

RESOLUTIONS

WHA69.1 Strengthening essential public health functions in support of the achievement of universal health coverage¹

The Sixty-ninth World Health Assembly,

Having considered the report on health in the 2030 Agenda for Sustainable Development;²

Noting the importance of public health functions as the most cost-effective, comprehensive and sustainable ways to enhance the health of populations and individuals and to reduce the burden of disease;

Recognizing the need to strengthen public health governance and institutional and technical capacities in countries in order to contribute effectively to population health and protect people from the social and economic consequences of ill-health in a globalized world;

Acknowledging that Goal 3 of the 2030 Agenda for Sustainable Development (Ensure healthy lives and promote well-being for all at all ages) with its 13 health targets, together with the multiple other health-related targets and goals in the 2030 Agenda, will require strong intersectoral action in order to be fully implemented;

Reaffirming the commitment made in United Nations General Assembly resolution 70/1 (2015), entitled “Transforming our world: the 2030 Agenda for Sustainable Development”, especially target 3.8 (Achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all), which will contribute to ending poverty and fighting inequality and injustice;

Recalling United Nations General Assembly resolution 67/81 (2012) on global health and foreign policy, which acknowledges that universal health coverage implies that all people have access, without discrimination, to nationally determined sets of the needed promotive, preventive, curative and rehabilitative basic 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 populations in accordance with the principle of social inclusion, in order to enhance their ability to realize their right to the enjoyment of the highest attainable standard of physical and mental health;

Further recalling that United Nations General Assembly resolution 67/81 (2012) also recognizes that effective and financially sustainable implementation of universal health coverage is based on a resilient and responsive health system that provides comprehensive primary health care services, with extensive geographical coverage, including in remote and rural areas, and with a special emphasis on access to populations most in need, and that has an adequate skilled, well-trained and motivated

¹ See Annex 15 for the financial and administrative implications for the Secretariat of this resolution.

² Document A69/15.

workforce, as well as capacities for broad public health measures, health protection and addressing determinants of health through policies across sectors, including promoting the health literacy of the population;

Recalling resolution WHA62.12 (2009) on primary health care, including health system strengthening, which urges Member States to put people at the centre of health care by adopting, as appropriate, delivery models focused on the local and district levels that provide comprehensive primary health care services, including health promotion, disease prevention, curative and palliative care, and noting the importance of equitable and affordable access to services;

Recalling also resolution WHA64.9 (2011) on sustainable health financing structures and universal coverage, which recognizes that effective health systems delivering comprehensive health services, including preventive services, are of utmost importance for health, economic development and well-being and that these systems need to be based on equitable and sustainable financing;

Recalling also United Nations General Assembly resolution 68/300 (2014), the outcome document of the high-level meeting of the General Assembly on the comprehensive review and assessment of the progress achieved in the prevention and control of noncommunicable diseases that reaffirms the commitment to the prevention and control of noncommunicable diseases, which undermine social and economic development throughout the world, and that commits to the implementation of effective multisectoral public policies to promote health, and to the strengthening and orienting of health systems to address prevention and control of noncommunicable diseases and underlying social determinants through people-centred primary health care and universal health coverage throughout the life cycle;

Further recalling regional resolutions EUR/RC61/R2 (2011) on strengthening public health capacities and services in Europe: a framework for action, CD42.R14 (2000) on essential public health functions and CD53.R14 (2014) on the Strategy for Universal Access to Health and Universal Health Coverage, WPR/RC53.R7 (2002) on essential public health functions, as well as the briefing to the sixty-second session of the WHO Regional Committee for the Eastern Mediterranean on assessing essential public health functions in the Eastern Mediterranean Region, encouraging Member States to strengthen essential public health functions as a basis for improving public health practice and as a means of achieving resilient health systems moving towards universal health coverage;

Recognizing that essential public health functions are the responsibility of Member States; that they support the achievement of the objectives of universal health coverage, and facilitate the financial feasibility thereof by reducing health risks and threats, and the burden of noncommunicable and communicable diseases; and that they contribute to the achievement of other health-related Sustainable Development Goals and targets;

Noting that essential public health functions that span multiple non-health sectors and address, among other things, economic, environmental and social determinants of health, benefit the health of the entire population and could be undersupplied without government intervention;

Recognizing that successful implementation of essential public health functions requires strengthening of governance and public health capacities, which may include, inter alia, building the knowledge and evidence base for policy options and strategies; ensuring sustainable and adequate resources, agency support and skilled and dedicated staff; assessing health and health-related gender impacts of different policy options; understanding the political agendas of other sectors and creating intersectoral platforms for dialogue and addressing challenges, including with social participation; and evaluating the effectiveness of intersectoral work and integrated policy-making and working with other sectors of government to advance health and well-being;

Recalling resolution WHA58.3 (2005) on revision of the International Health Regulations, which urges Member States to strengthen and maintain public health capacities to detect, report, assess and respond to public health emergencies and public health risks, as part of countries' obligations to fully implement the International Health Regulations (2005); and resolution EBSS3.R1 (2015) of the Special Session of the Executive Board on Ebola, which recognizes the importance of addressing long-term systemic gaps in capacity to prevent and detect health threats and to respond to them effectively with the aim of improving health security at national, regional and global levels, and noting that this equally requires intersectoral action;

Underscoring the integrated, cross-cutting nature of the Sustainable Development Goals, which call for multisectoral action and provide new legitimacy for addressing wider determinants of health,

1. URGES Member States:¹

- (1) to show leadership and ownership in establishing effective health governance by national and subnational health authorities, including cross-sectoral health policies and integrated strategies aiming to improve population health to achieve Sustainable Development Goal 3, target 3.8 on universal health coverage and other health-related Sustainable Development Goals, in accordance with nationally set priorities, accelerating their achievement, as appropriate, through establishing and enhancing monitoring, evaluation and accountability mechanisms and capacities;
- (2) to enhance international cooperation to achieve universal health coverage, including financial risk protection, access to quality essential health care services and access to safe, effective, quality and affordable essential medicines and vaccines for all;
- (3) to invest adequate sustainable resources for health system strengthening in support of universal health coverage, including needs-based allocation among socioeconomic groups in favour of the most vulnerable and deprived populations within national contexts in order to reduce the burden of disease, financial risks, inequality and injustice;
- (4) to enhance institutional and operational capacity and infrastructure for public health, including scientific and operational competence of public health institutions, as appropriate to national circumstances, as well as a cross-sectoral infrastructure for delivering essential public health functions, including the capacity to tackle existing and emerging health threats and risks;
- (5) to invest in the education, recruitment and retention of a fit-for-purpose and responsive public health workforce that is effectively and equitably deployed to contribute to effective and efficient delivery of essential public health functions, based on population needs;
- (6) to ensure coordination, collaboration, communication and synergies across sectors, programmes and, as appropriate, other relevant stakeholders, with a view to improving health, protecting people from the financial risk of ill-health, and promoting a comprehensive approach to public health in support of the achievement of universal health coverage throughout the life cycle;
- (7) to foster approaches that systematically tackle social, environmental and economic determinants of health and health inequity, taking into account gender impacts;

¹ And, where applicable, regional economic integration organizations.

(8) to monitor, evaluate, analyse and improve health outcomes – including through the establishment of comprehensive and effective civil registration and vital statistics systems and effective delivery of essential public health functions, and equitable access to quality health care services – and the level of financial risk protection;

2. REQUESTS the Director-General:

(1) to develop and disseminate technical guidance on the application of essential public health functions, taking into account WHO regional definitions, in the strengthening of health systems and for the achievement of universal health coverage;

(2) to facilitate international cooperation and to continue and enhance support to Member States, upon request, in their efforts to build the necessary institutional, administrative and scientific capacity, providing technical support in relation to essential public health functions, for health system strengthening, including to prevent, detect, assess and respond to public health events, and for integrated and multisectoral approaches towards universal health coverage; and to develop facilitating tools in this regard;

(3) to take the leading role, facilitate international cooperation and foster coordination in global health at all levels, particularly in relation to health system strengthening, including essential public health functions, supportive of the achievement of the health-related Sustainable Development Goals and targets;

(4) to report to the Health Assembly on the implementation of this resolution as a contribution to the achievement of the health-related targets in the 2030 Agenda for Sustainable Development.

(Seventh plenary meeting, 27 May 2016 –
Committee A, first report)

**WHA69.2 Committing to implementation of the Global Strategy for Women’s,
Children’s and Adolescents’ Health¹**

The Sixty-ninth World Health Assembly,

Having considered the report on the operational plan to take forward the Global Strategy for Women’s, Children’s and Adolescents’ Health;²

Welcoming the launch by the United Nations Secretary-General of the new Global Strategy for Women’s, Children’s and Adolescents’ Health (2016–2030) that envisions a world in which every woman, child and adolescent in every setting realizes their rights to physical and mental health and well-being, has social and economic opportunities, and is able to participate fully in shaping prosperous and sustainable societies;

¹ See Annex 15 for the financial and administrative implications for the Secretariat of this resolution.

² Document A69/16.

Recognizing that the Global Strategy for Women's, Children's and Adolescents' Health (2016–2030) provides a road map for attaining these ambitious objectives, and that it will contribute to the implementation of the Sustainable Development Goals related to women's, children's and adolescents' health;

Acknowledging the importance of country actions and leadership, and the need to prioritize the updating of national health and financing policies, strategies and plans to reflect the 17 targets included in the Global Strategy for Women's, Children's and Adolescents' Health (2016–2030), in order to advance the health and well-being of women, children and adolescents;

Recognizing the need for an equity-driven, gender-responsive life course approach, and for multistakeholder and multisector partnerships including the private sector and civil society, such as the Every Woman Every Child movement, in implementing the Global Strategy for Women's, Children's and Adolescents' Health (2016–2030);

Emphasizing the crucial role of accountability at all levels, including the important role of data and information systems, and noting the work of the Independent Accountability Panel to synthesize an annual global report on the state of women's, children's and adolescents' health,

1. INVITES Member States:

(1) to commit, in accordance with their national plans and priorities, to implementing the Global Strategy for Women's, Children's and Adolescents' Health (2016–2030), to end the preventable deaths of women, children and adolescents, to improve overall health and well-being and to promote enabling environments in a sustained and effective manner, supported by high-level commitment and adequate financing, including, as relevant, actions identified under the nine areas as proposed by the Global Strategy for Women's, Children's and Adolescents' Health (2016–2030) and its operational framework;

(2) to strengthen accountability and follow-up at all levels, including through monitoring national progress and increasing capacity building for good-quality data collection and analysis, as appropriate;

2. INVITES relevant stakeholders, as appropriate, to support the effective implementation of national plans and contribute to the accomplishment of the Global Strategy for Women's, Children's and Adolescents' Health (2016–2030) and its milestones;

3. REQUESTS the Director General:

(1) to provide adequate technical support to Member States in updating and implementing national plans and relevant elements of the Global Strategy for Women's, Children's and Adolescents' Health (2016–2030), including good-quality data collection and analysis;

(2) to continue to collaborate with other United Nations agencies, funds and programmes,¹ and other relevant funds, partners and stakeholders, to advocate and leverage assistance for aligned and effective implementation of national plans;

(3) to report regularly on progress towards women's, children's and adolescents' health to the Health Assembly.

(Ninth plenary meeting, 28 May 2016 –
Committee A, third report)

WHA69.3 Global strategy and action plan on ageing and health 2016–2020: towards a world in which everyone can live a long and healthy life²

The Sixty-ninth World Health Assembly,

Having considered the report on multisectoral action for a life course approach to healthy ageing: draft global strategy and plan of action on ageing and health;³

Recalling resolution WHA52.7 (1999) on active ageing and resolution WHA58.16 (2005) on strengthening active and healthy ageing, both of which encouraged Member States to take measures that ensure the highest attainable standard of health and well-being for the rapidly growing numbers of older persons;

Recalling further United Nations General Assembly resolution 57/167 (2002), which endorsed the Madrid International Plan of Action on Ageing, 2002, as well as other relevant resolutions and other international commitments related to ageing;

Recalling resolution WHA65.3 (2012) on strengthening noncommunicable disease policies to promote active ageing, which notes that as noncommunicable diseases become more prevalent among older persons there is an urgent need to prevent disabilities related to such diseases and to plan for long-term care;

Recalling also resolution WHA67.19 (2014) on strengthening of palliative care as a component of comprehensive care throughout the life course;

Recalling further resolution WHA64.9 (2011) on sustainable health financing structures and universal coverage, which calls for investing in and strengthening health systems, in particular primary health care and services, including preventive services, adequate human resources for health and health information systems, in order to ensure that all citizens have equitable access to health care and services;

¹ The Global Health Partnership H6: UNAIDS, the United Nations Entity for Gender Equality and the Empowerment of Women (UN WOMEN), UNFPA, UNICEF, the World Bank and WHO.

² See Annex 15 for the financial and administrative implications for the Secretariat of this resolution.

³ Document A69/17.

Welcoming the 2030 Agenda for Sustainable Development,¹ which includes an integrated, indivisible set of global goals for sustainable development that offer the platform to deal with the challenges and opportunities of population ageing and its consequences in a comprehensive manner, pledging that no one will be left behind;

Noting that populations around the world, at all income levels, are rapidly ageing; yet, that the extent of the opportunities that arise from older populations, their increasing longevity and active ageing will be heavily dependent on good health;

Noting also that healthy ageing is significantly influenced by social determinants of health, with people from socioeconomically disadvantaged groups experiencing markedly poorer health in older age and shorter life expectancy;

Further noting the importance of healthy, accessible and supportive environments, which can enable people to age in a place that is right for them and to do the things they value;

Recognizing that older populations make diverse and valuable contributions to society and should experience equal rights and opportunities, and live free from age-based discrimination;

Welcoming WHO's first Ministerial Conference on Global Action Against Dementia (Geneva, 16 and 17 March 2015), taking note of its outcome, and welcoming with appreciation all other international and regional initiatives aimed at ensuring healthy life for older persons;

Welcoming also the *World report on ageing and health*,² that articulates a new paradigm of Healthy Ageing and outlines a public health framework for action to foster it;

Recognizing the concept of Healthy Ageing, defined as the process of developing and maintaining the functional ability³ that enables well-being in older age;

Having considered the draft global strategy and action plan on ageing and health in response to decision WHA67(13) (2014), which builds on and extends WHO's regional strategies and frameworks⁴ in this area,

1. ADOPTS the Global strategy and action plan on ageing and health;⁵

¹ United Nations General Assembly resolution 70/1 (2015), "Transforming our world: the 2030 Agenda for Sustainable Development". See http://www.un.org/ga/search/view_doc.asp?symbol=A/RES/70/1 (accessed 23 May 2016).

² World report on ageing and health. Geneva: World Health Organization; 2015.

³ This functional ability is determined by the intrinsic capacity of individuals, the environments they inhabit and the interaction between them. Moreover, Healthy Ageing is a process that spans the entire life course and that can be relevant to everyone, not just those who are currently free of disease.

⁴ Region of the Americas: Plan of Action on the Health of Older Persons, Including Active and Healthy Aging (resolution CD49.R15 (2009)); South-East Asia Region: Regional strategy for healthy ageing (2013–2018); European Region: Strategy and action plan for healthy ageing in Europe, 2012–2020 (resolution EUR/RC62/R6 (2012)); Eastern Mediterranean Region: The strategy for active, healthy ageing and old age care in the Eastern Mediterranean Region 2006–2015; Western Pacific Region: Regional framework for action on ageing and health in the Western Pacific (2014–2019). A regional strategy is in preparation in the African Region.

⁵ See Annex 1.

2. CALLS ON partners, including international, intergovernmental and nongovernmental organizations, as well as self-help and other relevant organizations:

- (1) to support and contribute to the accomplishment of the Global strategy and action plan on ageing and health and in doing so, to work jointly with Member States and with the WHO Secretariat, where appropriate;
- (2) to improve and support the well-being of older persons and their caregivers through adequate and equitable provision of services and assistance;
- (3) to support research and innovation and gather evidence on what can be done to foster healthy ageing in diverse contexts, including increased awareness of the social determinants of health and their impact on ageing;
- (4) to support the exchange of knowledge and innovative experiences, including through North–South, South–South and triangular cooperation, and regional and global networks;
- (5) to actively work on advocacy for healthy ageing over the life course and combat age-based discrimination;

3. URGES Member States:

- (1) to implement the proposed actions in the Global strategy and action plan on ageing and health through a multisectoral approach, including establishing national plans or mainstreaming those actions across government sectors, adapted to national priorities and specific contexts;
- (2) to establish a focal point and area of work on ageing and health, and to strengthen the capacity of relevant government sectors to deal with the healthy ageing dimension in their activities through leadership, partnerships, advocacy and coordination;
- (3) to support and contribute to the exchange between Member States at global and regional levels of lessons learned and innovative experiences, including actions to improve measurement, monitoring and research of healthy ageing at all levels;
- (4) to contribute to the development of age-friendly environments, raising awareness about the autonomy and engagement of older people through a multisectoral approach;

4. REQUESTS the Director-General:

- (1) to provide technical support to Member States to establish national plans for healthy ageing; to develop health and long-term care systems that can deliver good-quality integrated care; to implement evidence-based interventions that deal with key determinants of healthy ageing; and to strengthen systems to collect, analyse, use and interpret data on healthy ageing over time;
- (2) to implement the proposed actions for the Secretariat in the Global strategy and action plan on ageing and health in collaboration with other bodies of the United Nations system;
- (3) to leverage the experience and lessons learned from the implementation of the Global strategy and action plan on ageing and health in order to better develop a proposal for a Decade of Healthy Ageing 2020–2030 with Member States and with inputs from partners, including United Nations agencies, other international organizations, and nongovernmental organizations;

- (4) to prepare a global status report on healthy ageing for submission to the Seventy-third World Health Assembly, reflecting agreed standards and metrics and new evidence on what can be done in each strategic theme, to inform and provide baseline data for a Decade of Healthy Ageing 2020–2030;
- (5) to convene a forum to raise awareness of Healthy Ageing and strengthen international cooperation on actions outlined in the Global strategy and action plan on ageing and health;
- (6) to develop, in cooperation with other partners, a global campaign to combat ageism in order to add value to local initiatives, achieve the ultimate goal of enhancing the day-to-day experience of older people and optimize policy responses;
- (7) to continue to develop the WHO Global Network of Age-friendly Cities and Communities as a mechanism to support local multisectoral action on healthy ageing;
- (8) to support research and innovation to foster healthy ageing, including developing:
(i) evidence-based tools to assess and support clinical, community, and population-based efforts to enhance intrinsic capacity and functional ability; and (ii) cost-effective interventions to enhance functional ability of people with impaired intrinsic capacity;
- (9) to report on mid-term progress on implementation of the Global strategy and action plan on ageing and health, reflecting agreed quantifiable indicators, standards and metrics, and new evidence on what can be done in each strategic objective, to the Seventy-first World Health Assembly.

(Eighth plenary meeting, 28 May 2016 –
Committee A, third report)

WHA69.4 The role of the health sector in the Strategic Approach to International Chemicals Management towards the 2020 goal and beyond¹

The Sixty-ninth World Health Assembly,

Having considered the report on the role of the health sector in the sound management of chemicals;²

Recalling resolution WHA59.15 (2006), in which the Health Assembly welcomed the Strategic Approach to International Chemicals Management adopted by the International Conference on Chemicals Management (Dubai, United Arab Emirates, 4–6 February 2006) with its overall objective to achieve “the sound management of chemicals throughout their life cycle so that, by 2020, chemicals are used and produced in ways that lead to the minimization of significant adverse effects on human health and the environment”, as inspired by paragraph 23 of the Johannesburg Plan of Implementation of the World Summit on Sustainable Development (Johannesburg, South Africa, 26 August–4 September 2002);

¹ See Annex 15 for the financial and administrative implications for the Secretariat of this resolution.

² Document A69/19.

Reaffirming its commitment to the outcome document of the 2012 United Nations Conference on Sustainable Development (Rio+20), entitled “The future we want”;¹

Further recalling paragraph 213 of the outcome document “The future we want”, which states that “[w]e reaffirm our aim to achieve, by 2020, the sound management of chemicals throughout their life cycle and of hazardous waste in ways that lead to minimization of significant adverse effects on human health and the environment, as set out in the Johannesburg Plan of Implementation”;

Recalling also, paragraph 214 of “The future we want”, which calls for “the effective implementation and strengthening of the Strategic Approach to International Chemicals Management as part of a robust, coherent, effective and efficient system for the sound management of chemicals throughout their life cycle”;

Noting the limited time remaining to make progress toward the 2020 goal, and the urgent need for practical action and technical cooperation within the health sector, as well as with other sectors;

Acknowledging that chemicals contribute significantly to the global economy, living standards and health but that unsound management of chemicals throughout their life cycle contributes significantly to the global burden of disease, and that much of this burden is borne by developing countries;

Noting that annually 12.6 million deaths (22.7% of all deaths) and 596 million disability-adjusted life years (21.8% of all disease burden in disability-adjusted life years) are thought to be linked to modifiable environmental factors, including chemical exposures, and that in 2012 1.3 million deaths (2.3% of all deaths) and 43 million disability-adjusted life years (1.6% of all disease burden in disability-adjusted life years) were attributable to exposures to a number of selected chemicals;² noting also that, among these, addressing lead exposure would prevent 9.8% of intellectual disability, 4% of ischaemic heart disease and 4.6% of stroke in the population; and that unintentional poisonings killed an estimated 193 000 people in 2012, 85% in developing countries where such poisonings are strongly associated with excessive exposure to, and inappropriate use of, toxic chemicals; and recognizing that due to the complex nature of the issue, disease burden information is only available for a very small number of chemical exposures and that people are exposed to many more chemicals in their daily lives;

Concerned about acute, chronic and combined adverse effects that can result from exposure to chemicals and waste, and that the risks are often unequally distributed and can be more significant for some vulnerable populations, especially women, children, and, through them, future generations;

Underlining the need to address the social, economic, and environmental determinants of health to improve health outcomes and achieve sustainable development;

Underscoring the importance of protecting health and reducing health inequities, including by the reduction of adverse health impacts from chemicals and waste, by adopting health-in-all policies and whole-of-government approaches, as appropriate;

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

² Prüss-Ustün A, et al. Preventing disease through healthy environments: a global assessment of the environmental burden of disease. Geneva: World Health Organization; 2016 (http://www.who.int/quantifying_ehimpacts/publications/preventing-disease/en/, accessed 19 May 2016).

Recalling WHO's longstanding recognition of the importance of sound chemicals management for human health, the key role of WHO in providing leadership on the human health aspects of the sound management of chemicals throughout their life cycle, and the necessity of health sector participation in, and contribution to, these efforts as set out in resolution WHA59.15 (2006) on the Strategic Approach to International Chemicals Management; resolution WHA63.25 (2010) on improvement of health through safe and environmentally sound waste management; resolution WHA63.26 on improvement of health through sound management of obsolete pesticides and other obsolete chemicals; resolution WHA67.11 (2014) on public health impacts of exposure to mercury and mercury compounds; and resolution WHA68.8 (2015) on health and the environment: addressing the health impact of air pollution;

Recalling further the health-related outcomes of the second, third and fourth sessions of the International Conference on Chemicals Management, which drew attention to the need for greater involvement of the health sector and resulted in the adoption of a strategy for strengthening engagement of the health sector in the implementation of the Strategic Approach,¹ which details the key roles and responsibilities of the health sector in sound chemicals management;

Recalling also paragraph 1 of International Conference on Chemicals Management resolution IV/1, adopted by the fourth session of the International Conference on Chemicals Management, which endorsed the overall orientation and guidance for achieving the 2020 goal as a voluntary tool that will assist in the prioritization of efforts for the sound management of chemicals and waste as a contribution to the overall implementation of the Strategic Approach, and mindful of the invitation in paragraph 5 to "the organizations of the Inter-Organization Programme for the Sound Management of Chemicals and of the United Nations Environment Management Group that have not already done so to issue, where possible by 1 July 2016, a declaration signalling their commitment to promote the importance of the sound management of chemicals and waste both within and outside their organizations, including the actions planned within their own mandates to meet the 2020 goal";

Acknowledging with appreciation WHO's extensive activities in this regard, including, but not limited to, supporting countries to implement the International Health Regulations (2005) in relation to chemical incidents, the establishment in 2013 of the WHO Chemical Risk Assessment Network, participation in the development of the Inter-Organization Programme for the Sound Management of Chemicals Toolbox for Decision Making in Chemicals Management, joint leadership of the Global Alliance to Eliminate Lead Paint, and engagement with relevant chemicals- and waste-related multilateral environmental agreements;

Also acknowledging initiatives undertaken at the national and regional levels, and through other bodies of the United Nations system and other relevant stakeholders, and the important contribution that these initiatives make to protecting health from hazardous chemicals and waste;

Recalling the relevant chemicals- and waste-related multilateral agreements, including, inter alia, the Stockholm Convention on Persistent Organic Pollutants (2004), the Rotterdam Convention on the Prior Informed Consent Procedure for Certain Hazardous Chemicals and Pesticides in International Trade (2004, revised 2008), the Basel Convention on the Control of the Transboundary Movements of Hazardous Wastes and their Disposal (1989) and the Minamata Convention on Mercury (2013);

¹ See document SAICM/ICCM.3/24, Annex V for the strategy, and Annex I for resolution SAICM/ICCM.3/III/4.

Concerned that, despite these efforts, more progress has to be made towards minimizing the significant adverse effects on human health that may be associated with chemicals and waste, and recognizing that there is an urgent need to address existing gaps between the capacities of different countries;

Recognizing the need for enhanced cooperation aimed at strengthening the capacities of developing countries for the sound management of chemicals and hazardous wastes and promoting adequate transfer of cleaner and safer technology to those countries;

Emphasizing the importance of bringing into force the Minamata Convention on Mercury as soon as possible;

Welcoming the outcome of WHO's survey of the priorities of the health sector towards achievement of the 2020 goal of sound chemicals management,¹ which builds on the Strategy for strengthening the engagement of the health sector in the implementation of the Strategic Approach;

Recognizing paragraph 1 of the Dubai Declaration on International Chemicals Management (2006), which states that "the sound management of chemicals is essential if we are to achieve sustainable development, including the eradication of poverty and disease, the improvement of human health and the environment and the elevation and maintenance of the standard of living in countries at all levels of development";

Welcoming the 2030 Agenda for Sustainable Development, in particular Sustainable Development Goal 3, target 3.9 (to substantially reduce the number of deaths and illnesses from hazardous chemicals and air, water and soil pollution and contamination by 2030), and further recognizing Goal 12, target 12.4 (to achieve, by 2020, the environmentally sound management of chemicals and all wastes throughout their life cycle, in accordance with agreed international frameworks), as well as other goals and targets relevant to health aspects of chemicals and waste management, such as Goal 6, target 6.3, on the improvement of water quality;

Convinced that the achievement of sound management of chemicals and waste throughout their life cycle requires a multisectoral approach within which the health sector has a critical role in achieving the 2020 goal and in setting priorities for chemicals and waste for the post-2020 period;

Stressing the responsibility of industry to make available to stakeholders such data and information on health and environmental effects of chemicals as are needed safely to use chemicals and the products made from them;

Welcoming the integrated approach to financing the sound management of chemicals and wastes developed by UNEP,² which is applicable to the Strategic Approach and underscores that the three components of an integrated approach, namely mainstreaming, industry involvement and dedicated external financing, are mutually reinforcing and are all important for the financing of the sound management of chemicals and waste at all levels;

¹ Document SAICM/ICCM.4/INF/11.

² Sound management of chemicals: UNEP's contribution to the achievement of the 2020 goal (<http://www.unep.org/chemicalsandwaste/Portals/9/Mainstreaming/Sound%20Management%20of%20Chemicals/SoundManagementofChemicals.pdf>, accessed 19 May 2016).

Aware that strengthening of health systems and appropriately trained health workforce is a key factor for facilitating the health sector to more effectively contribute to the sound management of chemicals and waste;

Aware also of the need to strengthen the role of the health sector so as to ensure its contribution to multisectoral efforts to meet the 2020 goal and beyond, and that this would be facilitated by the development of a road map outlining concrete actions for the health sector,

1. URGES Member States:¹

- (1) to engage proactively, including by strengthening the role of the health sector, in actions to soundly manage chemicals and waste at the national, regional and international levels in order to minimize the risk of adverse health impacts of chemicals throughout their life cycle;
- (2) to develop and strengthen, as appropriate, multisectoral cooperation at the national, regional and international levels in order to minimize and prevent significant adverse impacts of chemicals and waste on health, including within the health sector itself;
- (3) to take account of the Strategic Approach's overall orientation and guidance towards the 2020 goal, including the health sector priorities, as well as the strategy for strengthening engagement of the health sector, and consider Emerging Policy Issues and Other Issues of Concern,² and to take immediate action where possible and where appropriate to accelerate progress towards the 2020 goal;
- (4) to encourage all relevant stakeholders of the health sector to participate in the Strategic Approach and to ensure appropriate linkages with their national and regional Strategic Approach focal points, and to participate in the reports on progress for the Strategic Approach;
- (5) to strengthen individual, institutional and networking capacities at the national and regional levels to ensure successful implementation of the Strategic Approach;
- (6) to encourage health sector participation in the intersessional process established through the fourth session of the International Conference on Chemicals Management to prepare recommendations regarding the Strategic Approach and the sound management of chemicals and waste beyond 2020, including in the third meeting of the Open Ended Working Group;
- (7) to continue and, where feasible, increase support, including financial or in-kind scientific and logistic support to the WHO Secretariat's regional and global efforts on chemicals safety and waste management, as appropriate;
- (8) to pursue additional initiatives aimed at mobilizing national and, as appropriate, international resources, including for the health sector, for the sound management of chemicals and waste;

¹And, where applicable, regional economic integration organizations.

² **Emerging policy issues:** lead in paint, chemicals in products, hazardous substances within the life cycle of electrical and electronic products, nanotechnologies and manufactured nanomaterials, endocrine-disrupting chemicals, and environmentally persistent pharmaceutical pollutants; **Other issues of concern:** Perfluorinated chemicals and the transition to safer alternatives, and highly hazardous pesticides (http://www.saicm.org/index.php?option=com_content&view=article&id=452&Itemid=685, accessed 20 May 2016).

(9) to strengthen international cooperation to address health impacts of chemicals and waste, including through facilitating transfer of expertise, technologies and scientific data to implement the Strategic Approach, as well as exchanging good practices;

2. REQUESTS the Director-General:

(1) to develop, in consultation with Member States,¹ bodies of the United Nations system, and other relevant stakeholders, a road map for the health sector at the national, regional and international levels towards achieving the 2020 goal and contributing to relevant targets of the 2030 Agenda for Sustainable Development, taking into account the overall orientation and guidance of the Strategic Approach to International Chemicals Management, and the intersessional process to prepare recommendations regarding the Strategic Approach and the sound management of chemicals and waste beyond 2020 established through the fourth session of the International Conference on Chemicals Management, and building on WHO's existing relevant work, as well as the strategy for strengthening the engagement of the health sector in the implementation of the Strategic Approach, and with particular emphasis on the following areas:

(a) health sector participation in and support for the establishment and strengthening of relevant national legislative and regulatory frameworks;

(b) supporting the establishment or strengthening of national, regional or international coordinating mechanisms, as appropriate for multisectoral cooperation, and in particular enhancing engagement of all relevant health sector stakeholders;

(c) strengthening communication and access to relevant, understandable and up-to-date information to increase interest in and awareness of the importance to health of the sound management of chemicals and waste, particularly for vulnerable populations, especially women, children, and through them, future generations;

(d) participating in bilateral, regional or international efforts to share knowledge and best practices for the sound management of chemicals, including the WHO Chemicals Risk Assessment Network;

(e) participating actively in ongoing work on the Strategic Approach's Emerging Policy Issues and Other Issues of Concern, as well as the intersessional process established through the fourth session of the International Conference on Chemicals Management to prepare recommendations regarding the Strategic Approach and the sound management of chemicals and waste beyond 2020;

(f) encouraging implementation of the strategy for strengthening the engagement of the health sector in the implementation of the Strategic Approach, including the review of the health sector's own role to the extent that it is a user of chemicals and a producer of hazardous waste;

(g) mainstreaming gender as a component in all policies, strategies and plans for the sound management of chemicals and waste, considering gender differences in exposure to and health effects of toxic chemicals, while ensuring participation of women as agents of change in policy and decision making; and

(h) strengthening efforts on implementation of the updated health sector priorities;

¹And, where applicable, regional economic integration organizations.

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- (2) to build on and enhance implementation of actions pursuant to resolution WHA63.25 on improvement of health through safe and environmentally sound waste management, and to develop a report on the impacts of waste on health, the current work of WHO in this area, and possible further actions that the health sector, including WHO, could take to protect health;
- (3) to continue to exercise and enhance the leading role of WHO in the Strategic Approach to foster the sound management of chemicals throughout their life cycle with the objective of minimizing and, where possible, preventing significant adverse effects on health;
- (4) to support the strengthening of capacities at all levels for the production, availability and analysis of quality, accessible, timely, reliable and appropriately disaggregated data for the adequate measurement of progress towards Goal 3, target 3.9, of the 2030 Agenda for Sustainable Development and to improve, where appropriate, evidence-based data;
- (5) to continue current efforts to engage the health sector in chemicals management and make progress in chemical safety in particular in the implementation of the International Health Regulations (2005);
- (6) to support Member States by providing technical support, including at the regional and country levels, for strengthening the role of the health sector towards meeting the 2020 goal, including by enhancing capacities at individual, institutional and networking levels and by dissemination of evidence-based best practices;
- (7) to support Member States to strengthen coordination for the health sector in responding to existing international efforts and, in so doing, avoid duplication;
- (8) to set aside adequate resources and personnel for the work of the Secretariat, in line with the Programme budget 2016–2017 and the Twelfth General Programme of Work, 2014–2019, and taking into account the recent call at the fourth session of the International Conference on Chemicals Management and the invitation conveyed at the first session of the United Nations Environment Assembly on support for the Strategic Approach; and to work in collaboration with the secretariat of the Strategic Approach to find means to increase that secretariat's capacity to support activities related to the health sector;
- (9) to present to the Seventieth World Health Assembly:
- (a) a road map outlining concrete actions to enhance health sector engagement towards meeting the 2020 goal and contributing to relevant targets of the 2030 Agenda for Sustainable Development, as requested in operative subparagraph 2(1) above; and
 - (b) a progress report on the preparation of the report requested in operative subparagraph 2(2) above;
- (10) to update the road map according to the outcome of the intersessional process to prepare recommendations regarding the Strategic Approach and the sound management of chemicals and waste beyond 2020.

(Eighth plenary meeting, 28 May 2016 –
Committee A, fourth report)

WHA69.5 WHO global plan of action to strengthen the role of the health system within a national multisectoral response to address interpersonal violence, in particular against women and girls, and against children¹

The Sixty-ninth World Health Assembly,

Having considered the report on the draft global plan of action on violence,²

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

Recognizing that this draft WHO global plan of action to strengthen the role of the health system within a national multisectoral response to address interpersonal violence, in particular against women and girls, and against children is a technical document informed by evidence, best practices and existing WHO technical guidance and that it offers a set of practical actions that Member States may take to strengthen their health systems to address interpersonal violence, in particular against women and girls, and against children,

1. ENDORSES the WHO global plan of action to strengthen the role of the health system within a national multisectoral response to address interpersonal violence, in particular against women and girls, and against children;³
2. ENCOURAGES Member States to adapt at national level the WHO global plan of action to strengthen the role of the health system within a national multisectoral response to address interpersonal violence, in particular against women and girls, and against children, in line with the international commitments that Member States have already made, including to the Goals of the 2030 Agenda for Sustainable Development, while taking into account region-specific situations and in accordance with national legislation, capacities, priorities and specific national circumstances;
3. URGES Member States to implement the proposed actions, as appropriate, for Member States in the WHO global plan of action to strengthen the role of the health system within a national multisectoral response to address interpersonal violence, in particular against women and girls, and against children;
4. INVITES international, regional and national partners to implement the necessary actions to contribute to the accomplishment of the four strategic directions of the WHO global plan of action to strengthen the role of the health system within a national multisectoral response to address interpersonal violence, in particular against women and girls, and against children;
5. REQUESTS the Director-General:
 - (1) to implement the proposed actions for the Secretariat in the WHO global plan of action to strengthen the role of the health system within a national multisectoral response to address interpersonal violence, in particular against women and girls, and against children;

¹ See Annex 15 for the financial and administrative implications for the Secretariat of this resolution.

² Document A69/9.

³ See Annex 2.

(2) to submit an interim report on the progress achieved in implementing the WHO global plan of action to strengthen the role of the health system within a national multisectoral response to address interpersonal violence, in particular against women and girls, and against children to the Seventy-first World Health Assembly, and a full report to the Seventy-fourth World Health Assembly.

(Eighth plenary meeting, 28 May 2016 –
Committee A, fourth report)

WHA69.6 Prevention and control of noncommunicable diseases: responses to specific assignments in preparation for the third High-level Meeting of the United Nations General Assembly on the Prevention and Control of Non-communicable Diseases in 2018¹

The Sixty-ninth World Health Assembly,

Having considered the report on prevention and control of noncommunicable diseases: responses to specific assignments in preparation for the third High-level Meeting of the United Nations General Assembly on the Prevention and Control of Non-communicable Diseases in 2018;²

Recalling resolution WHA66.10 (2013), United Nations General Assembly resolutions 66/2 (2011), 68/300 (2014), 69/313 (2015) and 70/1 (2015), and United Nations Economic and Social Council resolutions 2013/12, 2014/10 and 2015/8,

1. NOTES the process to update, in 2016, Appendix 3 of the global action plan for the prevention and control of noncommunicable diseases 2013–2020;
2. ENDORSES the process to further develop, in 2016, an approach that can be used to register and publish contributions of non-State actors to the achievement of the nine voluntary global targets for noncommunicable diseases;
3. URGES Member States to continue to implement the road map of national commitments included in United Nations General Assembly resolutions 66/2 and 68/300, including the four time-bound national commitments for 2015 and 2016, and other key commitments such as developing or strengthening surveillance systems to track social disparities in respect of noncommunicable diseases and their risk factors and pursuing and promoting gender-based approaches for the prevention of noncommunicable diseases in preparation for a third High-level Meeting of the United Nations General Assembly on the Prevention and Control of Non-communicable Diseases in 2018, taking into account the technical note published by WHO on 1 May 2015, which sets out the progress indicators that the Director-General will use to report to the United Nations General Assembly in 2017 on the progress achieved in the implementation of national commitments;
4. NOTES that the Director-General has received two reports of the working groups of the WHO global coordination mechanism on the prevention and control of noncommunicable diseases that recommend ways and means of encouraging Member States to realize the commitments included in

¹ See Annex 15 for the financial and administrative implications for the Secretariat of this resolution.

² Document A69/10.

paragraphs 44 and 45(d) of the 2011 Political Declaration of the High-level Meeting of the United Nations General Assembly on the Prevention and Control of Non-communicable Diseases;¹

5. REQUESTS the Director-General:

(1) to submit a draft updated Appendix 3 of the global action plan for the prevention and control of noncommunicable diseases 2013–2020, through the Executive Board, to the Seventieth World Health Assembly in 2017, in accordance with the timeline contained in Annex 2 of document A69/10;

(2) to submit a report setting out an approach that can be used to register and publish contributions of non-State actors to the achievement of the nine voluntary global targets for noncommunicable diseases, through the Executive Board, to the Seventieth World Health Assembly in 2017, in accordance with the timeline contained in Annex 4 of document A69/10;

(3) to continue to provide, upon request, technical support to Member States to strengthen their efforts to implement national noncommunicable disease responses, including in the areas covered by the two reports of the working groups of the WHO global coordination mechanism on the prevention and control of noncommunicable diseases, within the parameters set out in the Programme budget.

(Eighth plenary meeting, 28 May 2016 –
Committee A, fourth report)

WHA69.7 Addressing the challenges of the United Nations Decade of Action for Road Safety (2011–2020): outcome of the second Global High-level Conference on Road Safety – Time for Results²

The Sixty-ninth World Health Assembly,

Having considered the report on addressing the challenges of the United Nations Decade of Action for Road Safety (2011–2020): outcome of the second Global High-level Conference on Road Safety – Time for Results;³

Recognizing that road traffic injuries constitute a public health problem and are a leading cause of death and injury around the world, with significant health and socioeconomic costs;

Recalling resolution WHA57.10 (2004) on road safety and health, which accepted the invitation of the United Nations General Assembly for WHO to act as a coordinator on road safety issues within the United Nations system, and resolution WHA60.22 (2007) on health systems: emergency care systems;

Welcoming the proclamation of the Decade of Action for Road Safety (2011–2020), in United Nations General Assembly resolution 64/255 (2010) on improving global road safety, and the reiteration of the General Assembly's invitation to United Nations Member States to play a leading role in implementing the activities of the Decade of Action in resolution 68/269 (2014);

¹ See document A69/10, Annex 5: action 3.1, footnote 4; action 5.1, footnote 5.

² See Annex 15 for the financial and administrative implications for the Secretariat of this resolution.

³ Document A69/13.

Commending the work of WHO in coordinating global road safety initiatives through the United Nations Road Safety Collaboration, in providing secretariat support to the Decade of Action for Road Safety (2011–2020), and in leading efforts to raise awareness, increase capacity and provide technical support to Member States;

Recognizing that a multisectoral and intersectoral approach is needed to reduce the burden of road traffic deaths and injuries, and that evidence-based interventions exist; that the health sector has a significant role to play in improving road user behaviour, promotion of health, communication and education regarding preventive measures, data collection and post-crash responses; and that a “safe system approach” involves several other sectors for vehicle safety regulations, enforcement, road infrastructure, and road safety education and management;

Reaffirming that providing basic conditions and services to address road safety is primarily a responsibility of governments, while recognizing nonetheless that there is a shared responsibility to move towards a world free from road traffic fatalities and serious injuries, and that addressing road safety demands multistakeholder collaboration among the public and private sectors, academia, professional organizations, nongovernmental organizations and the media;

Welcoming the large number of activities since 2004 that have contributed to reducing the number of deaths and serious injuries due to road traffic crashes, in particular: the publication of several manuals for decision-makers and practitioners; the periodic publication of global status reports on road safety; the proclamation of the Decade of Action for Road Safety (2011–2020); the holding of three global United Nations road safety weeks; the outcome of the first Global Ministerial Conference on Road Safety (Moscow, 2009); the inclusion of relevant targets in the 2030 Agenda for Sustainable Development;¹ and the outcome of the second Global High-level Conference on Road Safety (Brasília, 18–19 November 2015),

1. ENDORSES the Brasília Declaration on Road Safety, the outcome document of the second Global High-level Conference on Road Safety;²

2. CONSIDERS that all sectors, including the public health sector, should intensify their efforts to meet the international road safety targets set by the Decade of Action for Road Safety (2011–2020) and the 2030 Agenda for Sustainable Development and accelerate their activities, including the collection of appropriate data on road traffic deaths and injuries by Member States within existing structures, for use in prevention and education, the strengthening of emergency care systems and response infrastructure (including pre-hospital and facility-based trauma care), as well as comprehensive support to victims and their families and rehabilitation support services for those injured in road traffic crashes;

3. URGES Member States:³

(1) to implement the Brasília Declaration on Road Safety;

(2) to renew their commitment to the Decade of Action for Road Safety (2011–2020) and to implement the Global Plan for the Decade of Action for Road Safety (2011–2020);

¹ Targets 3.6 and 11.2.

² See Annex 3.

³ And, where applicable, regional economic integration organizations.

(3) to act upon the results, conclusions and recommendations of WHO's global status reports on road safety;

(4) to develop and implement, if they have not already done so, a national strategy and appropriate action plans that pay particular attention to vulnerable road users with a special focus on children, youth, older persons and persons with disabilities, and for which commensurate resources are available;

(5) to adopt and enforce laws on the key risk factors, including speeding, drinking alcohol and driving, and failure to use motorcycle helmets, seat-belts and child restraints, and to consider implementing appropriate, effective and evidence-based legislation on other risk factors related to distracted or impaired driving;

(6) to improve the quality of road safety data by strengthening efforts to collect appropriate, reliable, and comparable data on road traffic injury prevention and management, including the impact of road traffic crashes on health and development, as well as the economic impacts and cost-effectiveness of interventions;

(7) to implement a single emergency national access number and improve prevention and emergency medicine training programmes for health sector professionals in respect of road traffic crashes and trauma;

4. REQUESTS the Director-General:

(1) to continue to facilitate, with the full participation of Member States and in collaboration with organizations in the United Nations system (including the United Nations Regional Commissions), through the existing mechanisms (including the United Nations Road Safety Collaboration), a transparent, sustainable and participatory process with all stakeholders, in order to assist interested countries in developing voluntary global performance targets on key risk factors and service delivery mechanisms to reduce road traffic fatalities and injuries, in the context of the process leading to the definition and use of indicators for the road safety-related targets in the 2030 Agenda for Sustainable Development and the Global Plan for the Decade of Action for Road Safety (2011–2020);

(2) to provide support to Member States in implementing evidence-based policies and practices to improve road safety and to mitigate and reduce road traffic injuries in line with the Global Plan for the Decade of Action for Road Safety (2011–2020) and the 2030 Agenda for Sustainable Development;

(3) to provide technical support for the strengthening of pre-hospital care, including emergency health services and the immediate post-crash response, hospital and ambulatory guidelines for trauma care, and rehabilitation services, capacity building and improvement of timely access to integral health care;

(4) to maintain and strengthen evidence-based approaches to raising awareness for the prevention and mitigation of road traffic injuries and to facilitate such work globally, regionally and nationally;

(5) to continue, in collaboration with the United Nations regional commissions, as well as other relevant United Nations agencies, the activities aimed at supporting the implementation of the objectives and goals of the Decade of Action for Road Safety (2011–2020) and the road safety-related targets in the 2030 Agenda for Sustainable Development, while ensuring system-wide coherence;

- (6) to continue to monitor, through its global status reports, progress towards the achievement of the goals of the Decade of Action for Road Safety (2011–2020);
- (7) to facilitate, in collaboration with the United Nations Regional Commissions, the organization of activities during 2017 for the fourth United Nations Global Road Safety Week;
- (8) to report on progress made in implementing this resolution to the Seventieth World Health Assembly.

(Eighth plenary meeting, 28 May 2016 –
Committee A, fifth report)

WHA69.8 United Nations Decade of Action on Nutrition (2016–2025)¹

The Sixty-ninth World Health Assembly,

Having considered the reports on maternal, infant and young child nutrition;²

Recalling resolution WHA68.19 (2015) on the outcome of the Second International Conference on Nutrition (Rome, 19–21 November 2014), endorsing the Rome Declaration on Nutrition as well as the Framework for Action;

Reaffirming the commitments to implement relevant international targets and action plans, including WHO's global nutrition targets for 2025 and the WHO's global action plan for the prevention and control of noncommunicable diseases 2013–2020;

Recalling resolution WHA65.6 (2012) in which the Health Assembly endorsed the comprehensive implementation plan on maternal, infant and young child nutrition and requested the Director-General, *inter alia*, to report on progress in the implementation of the plan;

Recalling United Nations General Assembly resolution 70/1 (2015), entitled "Transforming our world: the 2030 Agenda for Sustainable Development", acknowledging the integrated dimension of the goals and recognizing that to end all forms of malnutrition and address nutritional needs throughout the life course, it is necessary to give universal access to safe and nutritious food that is sustainably produced, and to ensure universal coverage of essential nutrition actions;

Recalling that the Sustainable Development Goals and targets are integrated and indivisible and balance the three dimensions of sustainable development, and acknowledging the importance of reaching Sustainable Development Goal 2, which aims to end hunger, achieve food security and improved nutrition and promote sustainable agriculture, as well as the interlinked targets of other Goals;

Welcoming United Nations General Assembly resolution 70/259 (2016), entitled "United Nations Decade of Action on Nutrition (2016–2025)"; which calls upon FAO and WHO to lead the implementation of the United Nations Decade of Action on Nutrition (2016–2025), in collaboration with the WFP, IFAD and UNICEF, and to identify and develop a work programme based on the Rome Declaration on Nutrition and its Framework for Action, along with its means of implementation for 2016–2025, using coordination mechanisms such as the Standing Committee on Nutrition and

¹ See Annex 15 for the financial and administrative implications for the Secretariat of this resolution.

² Documents A69/7, A69/7 Add.1 and A69/7 Add.2.

multistakeholder platforms such as the Committee on World Food Security, in line with its mandate, and in consultation with other international and regional organizations, platforms and movements such as the Scaling up Nutrition;

Reaffirming the commitment to eradicate hunger and prevent all forms of malnutrition worldwide, particularly undernourishment, stunting, wasting, underweight and overweight in children under 5 years of age and anaemia in women and children, among other micronutrient deficiencies; as well as to halt the rising trends in overweight and obesity and reduce the burden of diet-related noncommunicable diseases in all age groups;

Expressing concern that nearly two in every three infants under 6 months are not exclusively breastfed; that fewer than one in five infants are breastfed for 12 months in high-income countries; and that only two in every three children between 6 months and 2 years of age receive any breast-milk in low- and middle-income countries;

Expressing concern that only 49% of countries have adequate nutrition data to assess progress towards the global nutrition targets,

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

(1) to work collectively across sectors and constituencies to guide, support, and implement nutrition policies, programmes, and plans under the umbrella of the United Nations Decade of Action on Nutrition (2016–2025);

(2) to support mechanisms for monitoring and reporting of the commitments;

2. URGES Member States:

(1) to develop and/or implement strategies on maternal, infant and young child nutrition that comprehensively respond to nutrition challenges, span different sectors and include robust and disaggregated monitoring and evaluation;

(2) to consider developing, when appropriate, policies and financial commitments that are specific, measurable, achievable, relevant and time-bound (SMART) in respect of the Rome Declaration on Nutrition and the voluntary options contained in the Framework for Action of the Second International Conference on Nutrition as well as the Comprehensive Implementation Plan on Maternal, Infant and Young Child Nutrition;

(3) to consider the definition of national targets based on global targets adapted to national priorities and specific parameters;

(4) to consider allocating adequate funding taking into account the local context;

(5) to provide information on a voluntary basis on their efforts to implement the commitments of the Rome Declaration on nutrition through a set of voluntary policy options within the Framework for Action including their policy and investments for effective interventions to improve people's diets and nutrition, including in emergency situations;

3. REQUESTS the Director-General:

(1) to work with the Director-General of FAO:

(a) to support Member States, upon request, in developing, strengthening and implementing their policies, programmes and plans to address the multiple challenges of malnutrition, and convene periodic meetings of inclusive nature to share best practices, including consideration of commitments that are specific, measurable, achievable, relevant and time-bound (SMART) within the framework of the Decade of Action on Nutrition (2016–2025);

(b) to maintain an open access database of commitments for public accountability and include an analysis of the commitments made in the biennial reports on implementation of the outcome document of the Second International Conference on Nutrition and the Framework for Action;

(2) to continue to provide technical support to Member States for the implementation of the United Nations Decade of Action on Nutrition (2016–2025) and of the Comprehensive Implementation Plan on Maternal, Infant and Young Child Nutrition;

(3) to continue supporting the Breastfeeding Advocacy Initiative to increase political commitment to and investment in breastfeeding as the cornerstone of child nutrition, health and development;

(4) to support Member States in strengthening the nutrition component of national information systems, including data collection and analysis for evidence-informed policy decision-making.

(Eighth plenary meeting, 28 May 2016 –
Committee A, fifth report)

WHA69.9 Ending inappropriate promotion of foods for infants and young children¹

The Sixty-ninth World Health Assembly,

Having considered the reports on maternal, infant and young child nutrition;²

Recalling resolutions WHA33.32 (1980), WHA34.22 (1981), WHA35.26 (1982), WHA37.30 (1984), WHA39.28 (1986), WHA41.11 (1988), WHA43.3 (1990), WHA45.34 (1992), WHA46.7 (1993), WHA47.5 (1994), WHA49.15 (1996), WHA54.2 (2001), WHA55.25 (2002), WHA58.32 (2005), WHA59.21 (2006), WHA61.20 (2008) and WHA63.23 (2010) on infant and young child nutrition, appropriate feeding practices and related questions;

Further recalling resolution WHA65.6 (2012) on maternal, infant and young child nutrition, in which the Health Assembly requested the Director-General to provide guidance on the inappropriate promotion of foods for infants and young children cited in resolution WHA63.23 (2010);

¹ See Annex 15 for the financial and administrative implications for the Secretariat of this resolution.

² Documents A69/7 and A69/7 Add.1.

Convinced that guidance on ending the inappropriate promotion of foods for infants and young children is needed for Member States, the private sector, health systems, civil society and international organizations;

Reaffirming the need to promote exclusive breastfeeding practices in the first 6 months of life, and the continuation of breastfeeding up to 2 years and beyond, and recognizing the need to promote optimal complementary feeding practices for children from ages 6–36 months based on WHO¹ and FAO dietary guidelines and in accordance with national dietary guidelines;

Recognizing that the Codex Alimentarius Commission is an intergovernmental body which is the principal organ of the joint FAO/WHO food standards programme and that it is the appropriate body for establishing international standards on food products, and that reviews of Codex standards and guidelines should give full consideration to WHO guidelines and recommendations, including the International Code of Marketing of Breast-milk Substitutes and relevant Health Assembly resolutions,

1. WELCOMES with appreciation the technical guidance on ending the inappropriate promotion of foods for infants and young children;²
2. URGES Member States^{3,4,5} in accordance with national context;
 - (1) to take all necessary measures in the interest of public health to end the inappropriate promotion of foods for infants and young children, including, in particular, implementation of the guidance recommendations while taking into account existing legislation and policies, as well as international obligations;
 - (2) to establish a system for monitoring and evaluation of the implementation of the guidance recommendations;
 - (3) to end inappropriate promotion of food for infants and young children, and to promote policy, social and economic environments that enable parents and caregivers to make well informed infant and young child feeding decisions, and further support appropriate feeding practices by improving health and nutrition literacy;
 - (4) to continue to implement the International Code of Marketing of Breast-milk Substitutes and WHO recommendations on the marketing of foods and non-alcoholic beverages to children;
3. CALLS UPON manufacturers and distributors of foods for infants and young children to end all forms of inappropriate promotion, as set forth in the guidance recommendations;
4. CALLS UPON health care professionals to fulfil their essential role in providing parents and other caregivers with information and support on optimal infant and young child feeding practices and to implement the guidance recommendations;

¹ Pan American Health Organization, World Health Organization. Guiding principles for complementary feeding of the breastfed child. Washington (DC): Pan American Health Organization; 2003; Guiding principles for feeding non-breastfed children 6–24 months of age. Geneva: World Health Organization; 2005.

² See Annex 4.

³ And, where applicable, regional economic integration organizations.

⁴ Taking into account the context of federated States.

⁵ Member States could take additional actions to end inappropriate promotion of foods for infants and young children.

5. URGES the media and creative industries to ensure that their activities across all communication channels and media outlets, in all settings and using all marketing techniques, are carried out in accordance with the guidance recommendations on ending the inappropriate promotion of foods for infants and young children;
6. CALLS UPON civil society to support ending inappropriate promotion of foods for infants and young children, including activities to advocate for, and monitor, Member States' progress towards the guidance's aim;
7. REQUESTS the Director-General:
- (1) to provide technical support to Member States in implementing the guidance recommendations on ending the inappropriate promotion of foods for infants and young children and in monitoring and evaluating their implementation;
 - (2) to review national experiences with implementing the guidance recommendations in order to build the evidence on their effectiveness and consider changes, if required;
 - (3) to strengthen international cooperation with relevant United Nations funds, programmes and specialized agencies and other international organizations, in promoting national action to end the inappropriate promotion of foods for infants and young children, taking into consideration the WHO guidance recommendations;
 - (4) to report on implementation of the guidance recommendations on ending the inappropriate promotion of foods for infants and young children as part of the report on progress in implementing the comprehensive implementation plan on maternal, infant and young child nutrition to the Seventy-first and Seventy-third World Health Assemblies in 2018 and 2020, respectively.

(Eighth plenary meeting, 28 May 2016 –
Committee A, fifth report)

WHA69.10 Framework of Engagement with Non-State Actors¹

The Sixty-ninth World Health Assembly,

Having considered the report on the framework of engagement with non-State actors and the revised draft framework of engagement with non-State actors;²

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

Recalling resolution WHA64.2 (2011) and decision WHA65(9) (2012) on WHO reform, and decisions WHA67(14) (2014), EB136(3) (2015), EB138(3) (2016) and resolution WHA68.9 (2015) on a framework of engagement with non-State actors;

¹ See Annex 15 for the financial and administrative implications for the Secretariat of this resolution.

² Document A69/6.

³ Document A69/60.

Recalling also United Nations General Assembly resolution 70/1 “Transforming our world: the 2030 Agenda for Sustainable Development”, and the equally important Goals, targets and means of implementation contained therein, which calls, *inter alia*, for a revitalized global partnership for sustainable development, based on the spirit of strengthened global solidarity, focused in particular on the needs of the poorest and most vulnerable and with participation of all countries, all stakeholders and all people;

Recalling also United Nations General Assembly resolution 69/313 on the Addis Ababa Action agenda of the Third International Conference on Financing for Development (Addis Ababa, 13–16 July 2015), which is an integral part of the 2030 Agenda for Sustainable Development;

Recalling further the Rome Declaration on Nutrition and the Framework for Action on Nutrition adopted by the Second International Conference on Nutrition (Rome, 19–21 November 2014);

Underscoring the full political commitment of all Member States towards the consistent and coherent implementation of the framework of engagement with non-State actors across the three levels of the Organization,

1. ADOPTS the Framework of Engagement with Non-State Actors;^{1,2}
2. DECIDES that the Framework of Engagement with Non-State Actors shall replace the Principles governing relations between the World Health Organization and nongovernmental organizations³ and Guidelines on interaction with commercial enterprises to achieve health outcomes;⁴
3. REQUESTS the Director General:
 - (1) to immediately start implementation of the Framework of Engagement with Non-State Actors;
 - (2) to take all necessary measures, working with Regional Directors, to fully implement the Framework of Engagement with Non-State Actors in a coherent and consistent manner across all three levels of the Organization, with a view to achieving full operationalization within a two-year timeframe;
 - (3) to expedite the full establishment of the register of non-State actors in time for the Seventieth World Health Assembly;
 - (4) to report on the implementation of the Framework of Engagement with Non-State Actors to the Executive Board at each of its January sessions under a standing agenda item, through the Programme Budget and Administration Committee;
 - (5) to include in the report on the implementation of the Framework of Engagement with Non-State Actors, when deemed necessary, any matter or types of engagement with non-State actors that would benefit from further consideration by the Executive Board, through its

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

² See Annex 5.

³ Adopted in resolution WHA40.25 (1987). See Basic documents, 48th ed. Geneva: World Health Organization; 2014.

⁴ Document EB107/20, Annex.

Programme Budget and Administration Committee, due to their unique characteristics and relevance;

(6) to conduct an initial evaluation in 2019 of the implementation of the Framework of Engagement with Non-State Actors and its impact on the work of WHO with a view to submitting the results, together with any proposals for revisions of the Framework, to the Executive Board in January 2020, through its Programme Budget and Administration Committee;

(7) to include in the guide to staff, measures that pertain to application of the relevant provisions contained in the existing WHO policies on conflict of interest, with a view to facilitating the implementation of the Framework of Engagement with Non-State Actors;

(8) to develop, in consultation with Member States, a set of criteria and principles for secondments from nongovernmental organizations, philanthropic foundations and academic institutions and to submit the criteria and principles for the consideration of and establishment by, as appropriate, the Seventieth World Health Assembly, through the Executive Board, taking into account, amongst others, the following identified issues:

(a) specific technical expertise needed and excluding managerial and/or sensitive positions;

(b) the promotion of equitable geographical distribution;

(c) transparency and clarity regarding positions sought, including public announcements;

(d) secondments are temporary in nature not exceeding two years;

(9) to make reference to secondments from non-State actors in the annual report on engagement with non-State actors to be submitted, including justification behind secondments;

4. REQUESTS the Independent Expert Oversight Advisory Committee, in accordance with its current terms of reference, to include a section on the implementation of the Framework of Engagement with Non-State Actors in its report to the Programme, Budget and Administration Committee of the Executive Board at each January session;

5. REQUESTS the Seventieth World Health Assembly to review progress on the implementation at the three levels of the Organization, with a view to taking any decisions necessary to enable the full, coherent and consistent implementation of the Framework of Engagement with Non-State Actors.

(Eighth plenary meeting, 28 May 2016 –
Committee A, fifth report)

WHA69.11 Health in the 2030 Agenda for Sustainable Development¹

The Sixty-ninth World Health Assembly,

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 United Nations General Assembly resolution 70/1 (2015), entitled “Transforming our world: the 2030 Agenda for Sustainable Development”, in which the General Assembly adopted the outcome document of the United Nations summit for the adoption of the post-2015 development agenda, recognizing that eradicating poverty in all its forms and dimensions, including extreme poverty, is the greatest global challenge and an indispensable requirement for sustainable development, and envisaging a world free of poverty, hunger, disease and want, a world of universal respect for human rights and human dignity that includes equitable and universal access to health care and social protection, and where physical, mental and social well-being are assured;

Reaffirming United Nations General Assembly resolution 69/313 (2015) on the Addis Ababa Action Agenda of the Third International Conference on Financing for Development, which is an integral part of the 2030 Agenda for Sustainable Development, supports and complements it, helps to contextualize its means of implementing targets with concrete policies and actions, and reaffirms the strong political commitment to addressing the challenge of financing and creating an enabling environment at all levels for sustainable development in the spirit of global partnership and solidarity;

Recognizing the achievements of the Millennium Development Goals in galvanizing collective action at global level for better health outcomes, in particular in meeting global targets for HIV, tuberculosis, and malaria, and in reducing child mortality by 53% and maternal mortality by 44%, reductions which are cause for celebration, despite being short of the targets of the Goals;

Recalling resolutions WHA66.11 (2013) and WHA67.14 (2014) on health in the post-2015 development agenda which point to the importance of health in meeting broader sustainable development goals and the need for accelerated progress towards the unfinished business of the Millennium Development Goals;

Recognizing the importance of the numerous WHO strategies and action plans relating to health, health systems, and public health as useful tools in taking forward the work on the 2030 Agenda for Sustainable Development, and stressing that the Organization’s support to countries in implementing these strategies should be provided in a coherent way, aligned to national needs, contexts and priorities, and in efficient coordination with other United Nations agencies;

Recognizing also the opportunity provided by the 2030 Agenda for Sustainable Development for adopting a more integrated and multisectoral approach to health, health promotion and well-being that acknowledges health systems as a coherent entity made up of functions and services rather than a series of discrete disease- or subject-specific initiatives;

Recognizing further 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 and vaccines, while ensuring that the use of these services does not expose the users to

¹ See Annex 15 for the financial and administrative implications for the Secretariat of this resolution.

financial hardship, with a special emphasis on the poor, vulnerable, and marginalized segments of the population;¹

Recognizing that health workers and the public health workforce are integral to building strong and resilient health systems that contribute to the achievement of the Sustainable Development Goals;

Recalling resolution EBSS3.R1 (2015) on Ebola, in which the Executive Board recognized the urgency for all countries of having strong, resilient and integrated health systems capable of fully implementing the International Health Regulations (2005), and of having the capacity for health-related emergency preparedness and progress towards universal health coverage that promotes universal, equitable access to health services and ensures affordable, good-quality service delivery;

Recognizing the importance of strengthening health systems and building capacities for broad public health measures, health protection and promotion and work to tackle social, economic, and environmental determinants of health, in support of ensuring healthy lives and promoting well-being for all at all ages;

Recalling further the importance of fostering alignment and coordination of global health interventions in the area of health systems strengthening, including at the primary health care level, and recognizing the important role WHO should play in this regard;

Taking note of the significant infrastructure, assets and human resources of the global polio eradication initiative, and the ongoing legacy process across countries as appropriate;

Emphasizing the need for community engagement to focus attention on more rational and forward-looking integration of health workers at community level into functional health systems aligned with country objectives and actions, and on recognizing them as key players to extend and deliver basic health services directly to communities to achieve the Goals of the 2030 Agenda for Sustainable Development;

Goals

Reaffirming that the Goals and targets of the 2030 Agenda for Sustainable Development are integrated and indivisible, balance the three dimensions of sustainable development (the economic, social, and environmental), seek to achieve gender equality and the empowerment of women and girls, are global in nature and universally applicable, taking into account different national realities, capacities and levels of development and respecting national policy space and priorities;

Welcoming the 2030 Agenda for Sustainable Development, including inter alia Sustainable Development Goal 3, “Ensure healthy lives and promote well-being for all at all ages”, and reaffirming its specific and interlinked targets as well as other health-related Goals and targets and emphasizing the importance of health systems strengthening as it is critical to the achievement of all targets;

Reaffirming also the specific commitments to promoting physical and mental health and well-being, and to extending life expectancy for all, contained in the 2030 Agenda for Sustainable Development, including: achievement of universal health coverage and access to quality health care; ensuring that no one is left behind; acceleration of the progress made to date in reducing newborn, child and maternal mortality by ending all such preventable deaths before 2030; universal access to

¹ See resolution WHA67.14 (2014).

sexual and reproductive health-care services, including for family planning, information and education; ending the epidemics of HIV/AIDS, tuberculosis and malaria as well as acceleration of the fight against hepatitis, Ebola and other communicable diseases and epidemics, including by addressing growing antimicrobial resistance and the problem of neglected tropical diseases affecting developing countries; and prevention and treatment of noncommunicable diseases, including behavioural, developmental and neurological disorders, which constitute a major challenge for sustainable development;

Asserting that health is not just an end in itself, but is a means of reaching other targets under the Goals of the 2030 Agenda for Sustainable Development, and noting that investments in health contribute to sustainable, inclusive economic growth, social development, environmental protection, and the eradication of poverty and hunger, and to reducing inequality, and also acknowledging the reciprocal benefits between the attainment of the health Goal and the achievement of all other Goals;

Reaffirming the Global strategy and plan of action on public health, innovation and intellectual property;¹

Means of implementation

Recognizing also that the 2030 Agenda for Sustainable Development, including the Sustainable Development Goals, can be met within the framework of a revitalized global partnership for sustainable development, supported by the concrete policies and actions outlined in the Addis Ababa Action Agenda, which is an integral part of the 2030 Agenda for Sustainable Development, and which supports, complements and helps contextualize the 2030 Agenda's means of implementing targets, including its Technology Facilitation Mechanism, and which relates to domestic public resources, domestic and international private business and finance, international development cooperation, international trade as an engine for development, debt and debt sustainability, addressing systemic issues and science, technology, innovation and capacity building, and data, monitoring and follow-up;

Reiterating that the means of implementation of the targets under Sustainable Development Goal 17 and under the other Sustainable Development Goals are key to realizing the Agenda and are of equal importance with the other Goals and targets, and also reaffirming targets 3a, 3b, 3c and 3d, as well as other interlinked targets essential to achieving the 2030 Agenda for Sustainable Development;

Reaffirming that the scale and ambition of the 2030 Agenda for Sustainable Development requires a revitalized global partnership for sustainable development to mobilize the necessary means to ensure its implementation, noting that this partnership will work in a spirit of global solidarity, in particular solidarity with the poorest and with people in vulnerable situations, and that it will facilitate an intensive global engagement in support of implementation of all the Goals and targets, bringing together governments, the private sector, civil society, the United Nations system and other actors and mobilizing all available financial and non-financial resources;

Follow-up and review

Recalling paragraph 48 of United Nations General Assembly resolution 70/1, to assist governments in their follow-up and review of the Goals and targets, including the means of implementation, and affirming the health sector's commitment to contributing to and supporting that process, in particular the commitment to strengthening statistical capacities in developing countries;

¹ Adopted in resolutions WHA61.21 (2008) and WHA62.16 (2009).

Recognizing that the High-level Political Forum under the auspices of the General Assembly and the Economic and Social Council will have the central role in overseeing, follow-up and review at the global level,

1. URGES Member States:¹

(1) to scale up comprehensive action at the national, regional and global levels, to achieve the Goals and targets of the 2030 Agenda for Sustainable Development relating to health by 2030;

(2) to prioritize health system strengthening, including ensuring an adequately skilled and compensated health workforce, in order to achieve and sustain universal health coverage, defined as universal access to quality promotion, prevention, treatment, rehabilitation and palliation services, including access to safe, effective, quality and affordable essential medicines and vaccines for all, ensuring financial protection from out-of-pocket expenditure on health for all with a special emphasis on the poor, vulnerable, and marginalized segments of the population² as fundamental to the achievement of the 2030 Agenda for Sustainable Development;

(3) to emphasize the need for cooperative action at the national, regional, and global levels across and within all government sectors to tackle social, environmental and economic determinants of health, to reduce health inequities, in particular through the empowerment of women and girls, and contribute to sustainable development, including “Health in All Policies” as appropriate;

(4) to appropriately prioritize investments in health and strengthen the mobilization and effective use of domestic and international resources for health in accordance with the broad multisectoral impact that health investments can have on economies and communities;

(5) to support the research and development of vaccines and medicines for the communicable and noncommunicable diseases that primarily affect developing countries, to provide access to affordable essential medicines and vaccines, in accordance with the Doha Declaration on the TRIPS Agreement and Public Health, which affirms the right of developing countries to use to the full the provisions in the Agreement on Trade Related Aspects of Intellectual Property Rights regarding flexibilities to protect public health, and, in particular, to provide access to medicines for all;³

(6) to strengthen the dialogue between the medical, veterinary and environmental communities with special attention to emerging and re-emerging diseases, along with the emergence of antimicrobial resistant pathogens, in a way that fosters strengthened and improved surveillance, research, preventive measures and training to ensure or to build capacities to address and manage these global health challenges;

¹ And, where applicable, regional economic integration organizations.

² See resolution WHA67.14 (2014).

³ See Sustainable Development Goal 3, target 3b.

(7) to develop, on the basis of existing mechanisms wherever possible, quality, inclusive, transparent national accountability processes, consistent with national policies, plans and priorities, for regular monitoring and review of progress towards the Goals and targets of the 2030 Agenda for Sustainable Development, which should form the basis for global and regional progress assessment;

2. REQUESTS the Director-General:

(1) to promote a multisectoral approach and the active engagement of WHO at all levels to coordinated implementation of the Goals of the 2030 Agenda for Sustainable Development with regard to health, pursuant to the principle that the Goals of the 2030 Agenda for Sustainable Development are integrated and indivisible, including through alignment and improved collaboration across WHO programmes;

(2) to engage, in the context of United Nations system-wide strategic planning, implementation and reporting, in order to ensure coherent and integrated support to implementation of the 2030 Agenda for Sustainable Development;

(3) to take a proactive role in supporting integrated implementation of the 2030 Agenda for Sustainable Development at the national, regional and global levels and, in consultation with Member States, develop a long-term plan for maximizing the impact of the contributions of WHO at all levels towards the achievement of the 2030 Agenda for Sustainable Development;

(4) to work with the Inter-Agency and Expert Group on Sustainable Development Goal Indicators, as appropriate, for the further development and finalization of the health-related Sustainable Development Goal indicators;

(5) to take steps to ensure that needed capacities and resources, at all levels of the Organization, are developed and maintained for the successful achievement of the 2030 Agenda for Sustainable Development, particularly to support comprehensive and integrated national plans for health as part of the implementation of the 2030 Agenda for Sustainable Development, recognizing that needed competencies include the ability to work with multiple sectors, responding to a broader set of health priorities, including supporting progress towards universal health coverage, and providing capacity building or technical support;

(6) to support Member States in strengthening research and development of new technologies and tools, as well as health technology assessment, paying special attention to the health research and development needs of developing countries, building on relevant strategies, action plans and programmes, in particular on the basis of the Global strategy and plan of action on public health, innovation and intellectual property and its follow-up processes for achievement of the 2030 Agenda for Sustainable Development, in particular for achieving access for all to quality, safe, effective and affordable vaccines and medicines, and diagnostics for communicable and noncommunicable diseases;

(7) to support Member States to undertake health systems research to develop more effective approaches to ensuring and delivering universal access to health services, paying special attention to the needs of developing countries;

(8) to facilitate enhanced North–South, South–South and triangular regional and international cooperation on and access to health-related science, technology and innovation, and enhance knowledge sharing on mutually agreed terms, including through improved coordination among existing mechanisms, in particular at the United Nations level, and through a global technology facilitation mechanism;

(9) to work with Member States to ensure that WHO shall effectively contribute to the follow-up to the 2030 Agenda for Sustainable Development, within its existing mandate, by supporting the thematic reviews of progress on the Sustainable Development Goals, including cross-cutting issues, where possible, feeding into and being aligned with the cycle of the High-level Political Forum, according to the modalities to be established by the General Assembly and the Economic and Social Council in the context of the High-level Political Forum;

(10) to report to Member States on a regular basis, at least every two years, on global and regional progress towards achieving the health Goal as a whole and its interlinked targets, as well as other health-related Goals and targets of the 2030 Agenda for Sustainable Development, including a focus on universal health coverage and equity;

(11) to support Member States in strengthening national statistical capacity at all levels, in particular in developing countries, in order to ensure high-quality, accessible, timely, reliable, and disaggregated health data, including through, where appropriate, the Health Data Collaborative;

(12) to support Member States to strengthen reporting on the 2030 Agenda on Sustainable Development, in particular the health Goal and its interlinked targets;

(13) to take the 2030 Agenda for Sustainable Development into consideration in the development of the Programme budget and the General Programme of Work, as appropriate;

(14) to report on progress in implementing this resolution to the Seventieth World Health Assembly, reporting to future Health Assemblies at least once every two years thereafter.

(Eighth plenary meeting, 28 May 2016 –
Committee A, fifth report)

WHA69.12 WHO programmatic and financial report for 2014–2015, including audited financial statements for 2015

The Sixty-ninth World Health Assembly,

Having considered the WHO programmatic and financial report for 2014–2015, including audited financial statements for 2015;¹

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

ACCEPTS the WHO programmatic and financial report for 2014–2015, including audited financial statements for 2015.

(Eighth plenary meeting, 28 May 2016 –
Committee B, second report)

¹ Document A69/45.

² Document A69/62.

WHA69.13 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-ninth World Health Assembly,

Having considered the report on the status of collection of assessed contributions, including Member States in arrears in the payment of their contributions to an extent that would justify invoking Article 7 of the Constitution, and special arrangements for settlement of arrears;¹

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

Noting that, at the time of opening of the Sixty-ninth World Health Assembly, the voting rights of Central African Republic, Comoros, Guinea, Guinea-Bissau, Somalia, Ukraine and Yemen were suspended, such suspension to continue until the arrears of the Member States 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 also that Burundi, El Salvador, Solomon Islands and Venezuela (Bolivarian Republic of) were in arrears at the time of the opening of the Sixty-ninth 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 four countries should be suspended at the opening of the Seventieth World Health Assembly,

DECIDES:

- (1) that, in accordance with the statement of principles set out in resolution WHA41.7 (1988), if, by the time of the opening of the Seventieth World Health Assembly, Burundi, El Salvador, Solomon Islands and Venezuela (Bolivarian Republic of) 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;
- (2) that any suspension that takes effect as set out in paragraph (1) above shall continue at the Seventieth World Health Assembly and subsequent Health Assemblies until the arrears of Burundi, El Salvador, Solomon Islands and Venezuela (Bolivarian Republic of) 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, 28 May 2016 –
Committee B, second report)

¹ Document A69/48.

² Document A69/63.

WHA69.14 Scale of assessments for 2017

The Sixty-ninth World Health Assembly,

Having considered the report of the Director-General,

ADOPTS the scale of assessments of Members and Associate Members for the year 2017 as set out below.

Members and Associate Members	WHO scale for 2017 %
Afghanistan	0.0060
Albania	0.0080
Algeria	0.1610
Andorra	0.0060
Angola	0.0100
Antigua and Barbuda	0.0020
Argentina	0.8920
Armenia	0.0060
Australia	2.3371
Austria	0.7201
Azerbaijan	0.0600
Bahamas	0.0140
Bahrain	0.0440
Bangladesh	0.0100
Barbados	0.0070
Belarus	0.0560
Belgium	0.8851
Belize	0.0010
Benin	0.0030
Bhutan	0.0010
Bolivia (Plurinational State of)	0.0120
Bosnia and Herzegovina	0.0130
Botswana	0.0140
Brazil	3.8232
Brunei Darussalam	0.0290
Bulgaria	0.0450
Burkina Faso	0.0040
Burundi	0.0010
Cabo Verde	0.0010
Cambodia	0.0040
Cameroon	0.0100
Canada	2.9211
Central African Republic	0.0010
Chad	0.0050
Chile	0.3990
China	7.9212
Colombia	0.3220
Comoros	0.0010

Members and Associate Members	WHO scale for 2017 %
Congo	0.0060
Cook Islands	0.0010
Costa Rica	0.0470
Côte d'Ivoire	0.0090
Croatia	0.0990
Cuba	0.0650
Cyprus	0.0430
Czech Republic	0.3440
Democratic People's Republic of Korea	0.0050
Democratic Republic of the Congo	0.0080
Denmark	0.5840
Djibouti	0.0010
Dominica	0.0010
Dominican Republic	0.0460
Ecuador	0.0670
Egypt	0.1520
El Salvador	0.0140
Equatorial Guinea	0.0100
Eritrea	0.0010
Estonia	0.0380
Ethiopia	0.0100
Fiji	0.0030
Finland	0.4560
France	4.8592
Gabon	0.0170
Gambia	0.0010
Georgia	0.0080
Germany	6.3892
Ghana	0.0160
Greece	0.4710
Grenada	0.0010
Guatemala	0.0280
Guinea	0.0020
Guinea-Bissau	0.0010
Guyana	0.0020
Haiti	0.0030
Honduras	0.0080
Hungary	0.1610
Iceland	0.0230
India	0.7370
Indonesia	0.5040
Iran (Islamic Republic of)	0.4710
Iraq	0.1290
Ireland	0.3350
Israel	0.4300
Italy	3.7482

Members and Associate Members	WHO scale for 2017 %
Jamaica	0.0090
Japan	9.6802
Jordan	0.0200
Kazakhstan	0.1910
Kenya	0.0180
Kiribati	0.0010
Kuwait	0.2850
Kyrgyzstan	0.0020
Lao People's Democratic Republic	0.0030
Latvia	0.0500
Lebanon	0.0460
Lesotho	0.0010
Liberia	0.0010
Libya	0.1250
Lithuania	0.0720
Luxembourg	0.0640
Madagascar	0.0030
Malawi	0.0020
Malaysia	0.3220
Maldives	0.0020
Mali	0.0030
Malta	0.0160
Marshall Islands	0.0010
Mauritania	0.0020
Mauritius	0.0120
Mexico	1.4351
Micronesia (Federated States of)	0.0010
Monaco	0.0100
Mongolia	0.0050
Montenegro	0.0040
Morocco	0.0540
Mozambique	0.0040
Myanmar	0.0100
Namibia	0.0100
Nauru	0.0010
Nepal	0.0060
Netherlands	1.4821
New Zealand	0.2680
Nicaragua	0.0040
Niger	0.0020
Nigeria	0.2090
Niue	0.0010
Norway	0.8491
Oman	0.1130
Pakistan	0.0930
Palau	0.0010

Members and Associate Members	WHO scale for 2017 %
Panama	0.0340
Papua New Guinea	0.0040
Paraguay	0.0140
Peru	0.1360
Philippines	0.1650
Poland	0.8411
Portugal	0.3920
Puerto Rico	0.0010
Qatar	0.2690
Republic of Korea	2.0391
Republic of Moldova	0.0040
Romania	0.1840
Russian Federation	3.0882
Rwanda	0.0020
Saint Kitts and Nevis	0.0010
Saint Lucia	0.0010
Saint Vincent and the Grenadines	0.0010
Samoa	0.0010
San Marino	0.0030
Sao Tome and Principe	0.0010
Saudi Arabia	1.1461
Senegal	0.0050
Serbia	0.0320
Seychelles	0.0010
Sierra Leone	0.0010
Singapore	0.4470
Slovakia	0.1600
Slovenia	0.0840
Solomon Islands	0.0010
Somalia	0.0010
South Africa	0.3640
South Sudan	0.0030
Spain	2.4431
Sri Lanka	0.0310
Sudan	0.0100
Suriname	0.0060
Swaziland	0.0020
Sweden	0.9561
Switzerland	1.1401
Syrian Arab Republic	0.0240
Tajikistan	0.0040
Thailand	0.2910
The former Yugoslav Republic of Macedonia	0.0070
Timor-Leste	0.0030
Togo	0.0010

Members and Associate Members	WHO scale for 2017 %
Tokelau	0.0010
Tonga	0.0010
Trinidad and Tobago	0.0340
Tunisia	0.0280
Turkey	1.0181
Turkmenistan	0.0260
Tuvalu	0.0010
Uganda	0.0090
Ukraine	0.1030
United Arab Emirates	0.6040
United Kingdom of Great Britain and Northern Ireland	4.4632
United Republic of Tanzania	0.0100
United States of America	22.0000
Uruguay	0.0790
Uzbekistan	0.0230
Vanuatu	0.0010
Venezuela (Bolivarian Republic of)	0.5710
Viet Nam	0.0580
Yemen	0.0100
Zambia	0.0070
Zimbabwe	0.0040
Total	100.0000

(Eighth plenary meeting, 28 May 2016 –
Committee B, second report)

WHA69.15 Report of the External Auditor

The Sixty-ninth World Health Assembly,

Having considered the report of the External Auditor to the Health Assembly;¹

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

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

(Eighth plenary meeting, 28 May 2016 –
Committee B, second report)

¹ Document A69/50.

² Document A69/64.

WHA69.16 Salaries of staff in ungraded posts and of the Director-General

The Sixty-ninth World Health Assembly,

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

1. ESTABLISHES the salaries of Assistant Directors-General and Regional Directors at US\$ 176 463 gross per annum, with a corresponding net salary of US\$ 137 024 (dependency rate) or US\$ 124 080 (single rate);
2. ESTABLISHES the salary of the Deputy Director-General at US\$ 194 136 gross per annum, with a corresponding net salary of US\$ 149 395 (dependency rate) or US\$ 134 449 (single rate);
3. ESTABLISHES the salary of the Director-General at US\$ 238 644 gross per annum, with a corresponding net salary of US\$ 180 551 (dependency rate) or US\$ 160 566 (single rate);
4. DECIDES that those adjustments in remuneration shall take effect on 1 January 2016.

(Eighth plenary meeting, 28 May 2016 –
Committee B, second report)

WHA69.17 Amendments to the Staff Regulations: dispute resolution²

The Sixty-ninth World Health Assembly,

Noting the recommendations of the Executive Board with regard to dispute resolution,¹

1. ADOPTS the proposed amendment to the title of Article XI of the Staff Regulations;³
2. ADOPTS the proposed amendment to Staff Regulation 11.2;
3. DECIDES that these amendments shall take effect from the entry into force of the Organization's internal justice reform policies.

(Eighth plenary meeting, 28 May 2016 –
Committee B, second report)

¹ See document A69/54.

² See Annex 15 for the financial and administrative implications for the Secretariat of this resolution.

³ See Annex 6.

WHA69.18 Process for the election of the Director-General of the World Health Organization

The Sixty-ninth World Health Assembly,

Having considered the report on the process for the election of the Director-General of the World Health Organization,¹

DECIDES that candidates nominated by the Executive Board for the post of Director-General of the World Health Organization shall address the Health Assembly before the vote for appointment of the Director-General, on the understanding that:

- (a) statements shall be limited to a maximum of 15 minutes;
- (b) the order of statements shall be decided by lot;
- (c) there shall be no questions and answers after statements;
- (d) statements shall be webcast on the WHO website in all official languages.

(Eighth plenary meeting, 28 May 2016 –
Committee B, second report)

WHA69.19 Global strategy on human resources for health: workforce 2030²

The Sixty-ninth World Health Assembly,

Having considered the report on the draft global strategy on human resources for health: workforce 2030;³

Reaffirming the continuing importance of the application of the WHO Global Code of Practice on the International Recruitment of Health Personnel (hereinafter “WHO Global Code”);⁴

Recalling previous Health Assembly resolutions aimed at strengthening the health workforce;⁵

Recalling also the United Nations General Assembly resolutions in 2014 and 2015 that, respectively: call on Member States, in cooperation, as appropriate, with relevant international organizations and relevant non-State actors, to develop effective preventive measures to enhance and

¹ Document A69/57.

² See Annex 15 for the financial and administrative implications for the Secretariat of this resolution.

³ Document A69/38.

⁴ Adopted in resolution WHA63.16 (2010).

⁵ Resolutions WHA64.6 (2011) on health workforce strengthening, WHA64.7 (2011) on strengthening nursing and midwifery, WHA65.20 (2012) on WHO’s response, and role as the health cluster lead, in meeting the growing demands of health in humanitarian emergencies, WHA66.23 (2013) on transforming health workforce education in support of universal health coverage, WHA67.19 (2014) on strengthening of palliative care as a component of comprehensive care throughout the life course, WHA67.24 (2014) on follow-up of the Recife Political Declaration on Human Resources for Health: renewed commitments towards universal health coverage, and WHA68.15 (2015) on strengthening emergency and essential surgical care and anaesthesia as a component of universal health coverage.

promote the safety and protection of medical and health personnel, as well as respect for their respective professional codes of ethics;¹ and underline the importance of adequate country capacity to respond to public health threats through strong and resilient health systems, benefiting from the availability of motivated, well-trained and appropriately equipped health workers;²

Inspired by the ambition of the 2030 Agenda for Sustainable Development, including its strong multisectoral dimension and call to achieve universal health coverage;

Guided by the call in Sustainable Development Goal 3, target 3.c to substantially increase health financing and the recruitment, development, training and retention of the health workforce in developing countries, especially in least developed countries and small island developing States;

Recognizing that health workers are integral to building strong and resilient health systems that contribute to the achievement of the Sustainable Development Goals and targets related to nutrition, health, education, gender, employment, and the reduction of inequalities;³

Recognizing further that Sustainable Development Goal 3 (“Ensure healthy lives and promote well-being for all at all ages”) and its targets will only be attained through substantive and strategic investments in the global health workforce, as well as a substantial shift in health workforce-related planning, education, deployment, retention, management and remuneration;

Recognizing also that the domestic health workforce is the primary responder in all countries, including those with fragile health systems, and is key to building resilient health systems;⁴

Taking note of the significant infrastructure, assets and human resources of the global polio eradication initiative, and the ongoing legacy process across countries, as appropriate;

Deeply concerned by the rising global health workforce deficit and the mismatch between the supply, demand and population needs for health workers, now and in the future, which are major barriers to achieving universal health coverage as committed to in Sustainable Development Goal 3, target 3.8;

Taking note of the renewed focus on health system strengthening and the need to mobilize and effectively manage domestic, international and other forms of health financing in support of such strengthening;⁵

Encouraged by the emerging political consensus on the contribution of health workers to improved health outcomes, to economic growth, to implementation of the International Health Regulations (2005) and to global health security;

¹ United Nations General Assembly resolution 69/132 (2014) on global health and foreign policy.

² United Nations General Assembly resolution 70/183 (2015) on global health and foreign policy: strengthening the management of international health crises.

³ See Sustainable Development goals and targets at <https://sustainabledevelopment.un.org/?menu=1300> (accessed 25 January 2016).

⁴ See resolution WHA64.10 (2011) on strengthening national health emergency and disaster management capacities and the resilience of health systems, and document A68/27 on global health emergency workforce.

⁵ See, for example, the “Healthy Systems – Healthy Lives” initiative, and resolutions WHA62.12 (2009) on primary health care, including health system strengthening, WHA62.13 (2009) on traditional medicine, WHA64.8 (2011) on strengthening national policy dialogue to build more robust health policies, strategies and plans, and WHA64.9 (2011) on sustainable health financing structures and universal coverage.

Recognizing that investing in new health workforce employment opportunities may also add broader socioeconomic value to the economy and contribute to the implementation of the Sustainable Development Goals,

1. ADOPTS the Global Strategy on Human Resources for Health: Workforce 2030 (hereinafter “Global Strategy”), including: its vision of accelerating progress towards universal health coverage and the Sustainable Development Goals by ensuring universal access to health workers; its principles; its four strategic objectives; and its milestones for 2020 and 2030;¹
2. URGES all Member States,^{2,3} as integral to health systems strengthening:
 - (1) to adapt the Global Strategy’s four strategic objectives within national health, education and employment strategies, and broader socioeconomic development contexts, in line with national priorities and specificities;
 - (2) to engage relevant sectors and ensure intersectoral mechanisms at the national and subnational levels as required for efficient investment in and effective implementation of health workforce policies;
 - (3) to implement policy options as proposed for Member States by the Global Strategy, supported by high-level commitment and adequate financing, including through the implementation of the WHO Global Code, in particular towards:
 - (a) strengthening capacities to optimize the existing health workforce to enable it to contribute to the achievement of universal health coverage;
 - (b) actively forecasting and closing gaps between health workforce needs, demands, and supply, including by geographical distribution, as well as gaps in the distribution of the health workforce between public and private sectors, and through intersectoral collaboration;
 - (c) building the institutional capacity at the subnational and national levels for effective governance and leadership of human resources for health, which will form, for example, an essential component in the building of comprehensive national health systems to provide a long-term solution to managing disease outbreaks in their initial phases;
 - (d) consolidating a core set of human resources for health data with annual reporting to the Global Health Observatory, as well as progressive implementation of national health workforce accounts, to support national policy and planning and the Global Strategy’s monitoring and accountability framework;
3. INVITES international, regional, national and local partners and stakeholders from within the health sector and beyond to engage in, and support, the implementation of the Global Strategy and achieve its milestones for 2020 and 2030, in alignment with national institutional mechanisms in order to coordinate an intersectoral health workforce agenda, specifically calling for:

¹ See Annex 7.

² And, where applicable, regional economic integration organizations.

³ Taking into account the context of federated States where health is a shared responsibility between national and subnational authorities.

- (1) educational institutions to adapt their institutional set-up and modalities of instruction so that they are aligned with national accreditation systems and population health needs; to train health workers in sufficient quantity, quality and with relevant skills, while also promoting gender equality in admissions and teaching; and to maintain quality and enhance performance through continuing professional development programmes, including for faculty members and the existing health workforce;
- (2) professional councils, associations, and regulatory bodies to adopt regulations to optimize workforce competencies, and to support interprofessional collaboration for a skills mix responsive to population needs;
- (3) the International Monetary Fund, the World Bank, regional development banks and other financing and lending institutions to adapt their macroeconomic policies and investment criteria in the light of mounting evidence that investments in health workforce planning, and the training, development, recruitment and retention of health workers are conducive to economic and social development and achievement of the Sustainable Development Goals;
- (4) development partners, including bilateral partners and multilateral aid mechanisms, to augment, coordinate and align their investments in education, employment, health, gender and labour in support of domestic financing aimed at addressing national health workforce priorities;
- (5) global health initiatives to ensure that all grants include an assessment of health workforce implications, leverage national coordination and leadership, and contribute to efficient investment in and effective implementation of national health workforce policies;

4. REQUESTS the Director-General:

- (1) to provide support to Member States, upon request, on the implementation and monitoring of the Global Strategy, including to:
 - (a) strengthen and optimize their existing health workforces and to anticipate and respond to future health workforce needs;
 - (b) strengthen governance and leadership of human resources for health, through the development of normative guidance, the provision of technical cooperation and the fostering of effective transnational coordination, alignment and accountability;
 - (c) develop and maintain a framework for health workforce information systems, including the consolidation of a core set of health workforce data with annual reporting to the Global Health Observatory, as well as the progressive implementation of national health workforce accounts, in order to strengthen the availability, quality, and completeness of health workforce data;
 - (d) strengthen implementation of previous Health Assembly resolutions related to the health workforce, including resolution WHA66.23 (2013) on transforming health workforce education in support of universal health coverage, and to the retention of the health workforce, and support Member States upon request;
- (2) to develop capacity to support Member States, including through the promotion of research, and, upon request, through technical cooperation and other means, to develop appropriate preventive measures to enhance and promote the safety and protection of medical

and health personnel, their means of transport and installations, to improve the resilience of health systems and to promote the effective implementation of universal health coverage;

(3) to include an assessment of the health workforce implications of technical resolutions brought before the Health Assembly and the WHO regional committees;

(4) to facilitate the exchange of information and good practice on human resources for health and collaboration among Member States and relevant stakeholders, continuing the practices outlined in the WHO Global Code;

(5) to submit a regular report to the Health Assembly on progress made towards the milestones established by the Global Strategy, aligned with reporting on the WHO Global Code.

(Eighth plenary meeting, 28 May 2016 –
Committee B, third report)

WHA69.20 Promoting innovation and access to quality, safe, efficacious and affordable medicines for children¹

The Sixty-ninth World Health Assembly,

Having considered the report on addressing the global shortages of medicines, and the safety and accessibility of children's medication;²

Recalling resolutions WHA60.20 (2007) on better medicines for children and WHA67.22 (2014) on access to essential medicines, which identified actions for Member States and the Director-General in support of better access for children to essential medicines;

Recalling also resolution WHA67.20 (2014) on regulatory system strengthening for medical products, and its relevance for promoting the safety, accessibility and affordability of medicines for children;

Concerned about the lack of access to quality, safe, effective and affordable medicines for children in appropriate dosage forms, and problems with rational use of children's medicines in many countries, and that, globally, children aged under five years still do not have secure access to medicines that treat pneumonia, tuberculosis, diarrhoeal diseases, HIV infection, AIDS and malaria, as well as medicines for many other infectious diseases, noncommunicable diseases and rare diseases;

Concerned also about the lack of research and development on age-appropriate dosage forms most suitable for children, as well as on new medicines for diseases that affect children, that are appropriate for use in all environments, including areas lacking access to clean water;

Aware that an important factor linked to morbidity and mortality of children is the lack of safe, effective, affordable and quality-assured medicines for children, and in some circumstances, lack of packaging in child-proof containers;

¹ See Annex 15 for the financial and administrative implications for the Secretariat of this resolution.

² Document A69/42.

Noting that despite sustained efforts over a number of decades by Member States, the Secretariat and partners, many countries are still facing multiple challenges in ensuring the availability, affordability, quality assurance and rational use of children's medicines;

Acknowledging Goal 3 of the 2030 Agenda for Sustainable Development, "Ensure healthy lives and promote well-being for all at all ages", and particularly noting the targets related to access to medicines and its interlinked goals and targets;

Noting that *The World Health Report 2010* identified the promotion of generic medicines as a key action that could be taken to improve access by making medicines more affordable, and recognizing the importance of accelerating generic availability and uptake following the expiration of patents;

Recalling the Convention on the Rights of the Child in which States Parties recognize the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illnesses and rehabilitation of health,

1. URGES Member States:¹

(1) to accelerate implementation of the actions laid out in resolution WHA60.20 on better medicines for children and WHA67.20 on regulatory system strengthening for medical products;²

(2) to learn from successful experiences with medicines policies for children in other countries and formulate and implement appropriate national measures including legislation, as appropriate, and pharmaceutical policies in support of access to quality, safe, effective and affordable medicines for children;

(3) to take all necessary measures, including legislation, as appropriate, for the establishment of national plans and organizational structures and capacity to enhance such measures in the framework of national pharmaceutical policies, as appropriate, to improve children's health;

(4) to ensure that national health policies and plans incorporate consideration of the needs of children based on the national situation, with clear objectives for increasing access to children's medicines;

(5) to establish transparent and evidence-based processes for the design and updating of their national essential medicines list or its equivalent to include medicines for children, according to each country's health needs and priorities, taking into account the WHO Model List of Essential Medicines, including the WHO Model List of Essential Medicines for Children, and its transparent and evidence-based process, which considers public health relevance, evidence on efficacy and safety and comparative cost-effectiveness;

(6) to implement actions, with a focus on children, as agreed under Sustainable Development Goal 3, target 3b, which states: "Support the research and development of vaccines and medicines for the communicable and non-communicable diseases that primarily affect developing countries, provide access to affordable essential medicines and vaccines, in accordance with the Doha Declaration on the TRIPS Agreement and Public Health, which

¹ And, where applicable, regional economic integration organizations.

² Taking into account the context of federated States.

affirms the right of developing countries to use to the full the provisions in the Agreement on Trade-Related Aspects of Intellectual Property Rights regarding flexibilities to protect public health, and, in particular, provide access to medicines for all”;

(7) to undertake analysis of their pharmaceutical supply systems, including through the use of the WHO standardized surveys, to identify inefficiencies in the cost and pricing structures of medicines and sources of mark-ups on the prices of medicines, and to seek to reduce the price of children’s medicines by promoting greater availability and use of generics, and identifying strategies to reduce prices including mark-ups on medicines, in order to increase the availability and affordability of medicines for children;

(8) to strengthen research and development on appropriate medicines for diseases that affect children, to ensure that high-quality clinical trials for these medicines are conducted in an ethical manner and to collaborate in order to facilitate innovative research and development on, formulation of, and timely regulatory approval of, provision of adequate and prompt information on, and rational use of, medicines for children, including generic medicines;

(9) to facilitate clinical trials of medicines for children based on sound ethics, needs and principles of patient protection, and to promote clinical trial registration in any registry¹ that provides data to the WHO International Clinical Trials Registry Platform and to make information on those trials publically available, including publication of summary and complete data of completed trials in accordance with national and regional legislative frameworks, as appropriate;

(10) to strengthen national regulatory systems including pharmacovigilance and post-market surveillance and to promote quality, ethical clinical trials of medicines for children and the accessibility and availability of quality, safe, effective and affordable medicines for children;

(11) to enhance the education and training of the health workforce in the rational use of medicines for children, including generic medicines, and to enhance the health education of the public, to ensure acceptance and understanding of the rational use of medicines for children;

2. REQUESTS the Director-General:

(1) to accelerate implementation of the actions laid out in resolutions WHA60.20 on better medicines for children, WHA67.22 on access to essential medicines and WHA67.20 on regulatory system strengthening for medical products;

(2) to further develop and maintain, within the Model List of Essential Medicines, the Model List of Essential Medicines for Children, using evidence-based clinical guidelines in coordination with all relevant WHO programmes;

(3) to consider appropriate representation of paediatric experts on the WHO Expert Committee on the Selection and Use of Essential Medicines;

¹ Including internationally-recognized open registries such as “clinicaltrials.gov”, among others, and national registries.

- (4) to support Member States in taking appropriate measures through the provision of training and strengthening of regulatory capacity according to national and regional circumstances, and in promoting communication and coordination between countries on paediatric clinical trial design, ethical approval and product formulation, including through regulatory networks;
- (5) to continue to collaborate with governments,¹ other organizations of the United Nations system, including WTO and WIPO, donor agencies, nongovernmental organizations and the pharmaceutical industry, in order to encourage fair trade in safe and effective medicines for children and adequate financing for securing better access to medicines for children;
- (6) to support Member States in implementing, as appropriate, upon request, standards for ethical and appropriate clinical trials of medicines in children, and to facilitate communication and coordination among Member States¹ to promote the sharing of paediatric clinical trial information;
- (7) to support analysis and better understanding of the costs of research and development for medicines for children, including for rare diseases in children;
- (8) to support countries in implementing relevant policies in line with the 2030 Agenda for Sustainable Development, including Goal 3 and related access to medicine targets, and to provide the necessary technical assistance in this regard, upon request;
- (9) to report to the Seventy-first World Health Assembly on progress in the implementation of this resolution.

(Eighth plenary meeting, 28 May 2016 –
Committee B, third report)

WHA69.21 Addressing the burden of mycetoma²

The Sixty-ninth World Health Assembly,

Having considered the report on mycetoma,³

Deeply concerned about the impact of mycetoma, especially among children and young adults of working age, and the public health and socioeconomic burdens that the disease places on poor, rural communities;

Aware that early detection and treatment minimize the adverse consequences of mycetoma;

Noting with satisfaction the progress made by some Member States with regard to research into mycetoma and management of cases of the disease;

Concerned that several factors, including late detection of cases of mycetoma and inadequacy of available tools for diagnosis, treatment and prevention of the disease, impede further progress;

¹ And, where applicable, regional economic integration organizations.

² See Annex 15 for the financial and administrative implications for the Secretariat of this resolution.

³ Document A69/35.

Mindful that achievement of the United Nations Millennium Development Goals and the Goals of the 2030 Agenda for Sustainable Development,¹ particularly those concerning poverty, hunger, health and education, may be hampered by the negative impact of neglected diseases of the poor, including mycetoma,

1. CALLS UPON the international community and all stakeholders including, inter alia, international organizations, bodies of the United Nations system, donors, nongovernmental organizations, foundations and research institutions:

(1) to cooperate directly with countries in which mycetoma is endemic, upon the request of such countries, in order to strengthen control activities;

(2) to develop partnerships and foster collaboration with organizations and programmes involved in health system development in order to ensure that effective interventions can reach all those in need;

(3) to support institutions working on research into mycetoma;

2. ENCOURAGES Member States in which mycetoma is, or threatens to become, endemic:

(1) to assess the burden of mycetoma and, where necessary, establish a control programme;

(2) to accelerate efforts for early detection and treatment of mycetoma cases;

(3) to integrate, where feasible, efforts to control mycetoma with other relevant disease-control activities;

(4) within the context of health-system development, to establish and sustain partnerships for control of mycetoma at country and regional levels;

(5) to meet control needs, including in respect of improved access to treatment and rehabilitation services, by mobilizing national resources;

(6) to provide training to relevant health workers on the management of mycetoma;

(7) to intensify research in order to develop new tools to diagnose, treat and prevent mycetoma;

(8) to promote community awareness of disease symptoms in support of early detection and prevention of mycetoma, and to intensify community participation in control efforts;

3. REQUESTS the Director-General:

(1) to include mycetoma among the diseases termed “neglected tropical diseases”;

(2) to continue to offer technical support to institutions working on research into mycetoma, including WHO collaborating centres, in support of improved, evidence-based disease control efforts;

¹ United Nations General Assembly resolution 70/1 (2015) – Transforming our world: the 2030 Agenda for Sustainable Development, see http://www.un.org/ga/search/view_doc.asp?symbol=A/RES/70/1.

- (3) to support Member States in which mycetoma is endemic to strengthen capacities for improving early detection and access to treatment;
- (4) to foster technical cooperation among countries as a means of strengthening mycetoma surveillance, control and rehabilitation services;
- (5) through the UNICEF/UNDP/World Bank/WHO Special Programme for Research and Training in Tropical Diseases, to support the strengthening of research capacity in order to meet the need for better diagnostics, treatments and preventive tools for mycetoma;
- (6) through the Strategic and Technical Advisory Group for Neglected Tropical Diseases, to define a systematic, technically-driven process for evaluation and potential inclusion of additional diseases among the “neglected tropical diseases”;
- (7) to report on progress in implementing this resolution to the Seventy-second World Health Assembly.

(Eighth plenary meeting, 28 May 2016 –
Committee B, fourth report)

WHA69.22 Global health sector strategies on HIV, viral hepatitis and sexually transmitted infections, for the period 2016–2021¹

The Sixty-ninth World Health Assembly,

Having considered the reports by the Secretariat on the draft global health sector strategies on, respectively, HIV, viral hepatitis and sexually transmitted infections, for the period 2016–2021;²

Recalling resolution WHA64.14 (2011) on a global health sector strategy on HIV/AIDS, 2011–2015, resolutions WHA63.18 (2010) and WHA67.6 (2014) on viral hepatitis, and resolution WHA59.19 (2006) on the prevention and control of sexually transmitted infections;

Noting the targets identified in Transforming our world: the 2030 Agenda for Sustainable Development³ on HIV, viral hepatitis, sexual and reproductive health and universal health coverage,

1. ADOPTS the global health sector strategies on, respectively, HIV, viral hepatitis and sexually transmitted infections, for the period 2016–2021;⁴
2. URGES Member States to implement the proposed actions for Member States as outlined in the global health sector strategies on, respectively, HIV, viral hepatitis and sexually transmitted infections, for the period 2016–2021, adapted to national priorities, legislation and specific contexts;

¹ See Annex 15 for the financial and administrative implications for the Secretariat of this resolution.

² Documents A69/31, A69/32 and A69/33.

³ Adopted by the United Nations General Assembly in resolution 70/1 in 2015, see http://www.un.org/en/ga/search/view_doc.asp?symbol=A/RES/70/1 (accessed 19 May 2016).

⁴ See Annex 8.

3. INVITES international, regional and national partners to implement the necessary actions to contribute to meeting the targets of the global health sector strategies on, respectively, HIV, viral hepatitis and sexually transmitted infections, for the period 2016–2021;
4. REQUESTS the Director-General:
 - (1) to implement the actions for the Secretariat as outlined in the global health sector strategies on, respectively, HIV, viral hepatitis and sexually transmitted infections, for the period 2016–2021;
 - (2) to submit reports on the progress achieved in implementing the global health sector strategies on, respectively, HIV, viral hepatitis and sexually transmitted infections, for the period 2016–2021, to the Seventy-first World Health Assembly in 2018 and the Seventy-fourth World Health Assembly in 2021.

(Eighth plenary meeting, 28 May 2016 –
Committee B, fourth report)

WHA69.23 Follow-up of the report of the Consultative Expert Working Group on Research and Development: Financing and Coordination¹

The Sixty-ninth World Health Assembly,

Having considered the report on follow-up to the report of the Consultative Expert Working Group on Research and Development: Financing and Coordination – report of the open-ended meeting of Member States;²

Recalling WHA66.22 (2013) and subsequent Health Assembly decisions on the follow-up of the report of the Consultative Expert Working Group on Research and Development: Financing and Coordination, and noting progress made in the implementation of the strategic workplan endorsed in resolution WHA66.22;

Acknowledging that the 2030 Agenda for Sustainable Development includes the commitment to support the research and development of vaccines and medicines for the communicable and noncommunicable diseases that primarily affect developing countries, provide access to affordable medicines and vaccines, in accordance with the Doha Declaration on the TRIPS Agreement and Public Health, which affirms the right of developing countries to use to the full the provisions in the Agreement on Trade-Related Aspects of Intellectual Property Rights regarding flexibilities to protect public health, and, in particular, provide access to medicines for all;

Recalling the global strategy and plan of action on public health, innovation and intellectual property and its aims to promote innovation, build capacity, improve access and mobilize resources to address diseases that disproportionately affect developing countries;

¹ See Annex 15 for the financial and administrative implications for the Secretariat of this resolution.

² Document A69/40.

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;

Noting the establishment of the High-Level Panel on Access to Medicines convened by the United Nations Secretary-General;

Underscoring that health research and development should be needs-driven and evidence-based and be guided by the following core principles: affordability, effectiveness, efficiency, and equity; and that it should be considered a shared responsibility;

Acknowledging the central role of the Global Observatory on Health Research and Development to consolidate, monitor and analyze relevant information on health research and development activities related to Type II and Type III diseases and on the specific research and development needs of developing countries in relation to Type I diseases, as well as needs for information on potential areas where market failures exist, and also on antimicrobial resistance and emerging infectious diseases likely to cause major epidemics, building on national and regional observatories (or equivalent functions) and existing data collection mechanisms, with a view to contributing to the identification and the definition of gaps and opportunities for health research and development priorities, and supporting coordinated actions on health research and development;

Expressing concern at the significant gap in funding the strategic workplan endorsed in resolution WHA66.22, including the six selected demonstration projects,

1. URGES Member States:¹

(1) to make concerted efforts, including through adequate and sustainable funding, to fully implement the strategic workplan endorsed in resolution WHA66.22;

(2) to create, operationalize and strengthen, as appropriate, national health research and development observatories, or equivalent functions for tracking and monitoring of relevant information on health research and development, and to provide regular information on relevant health research and development activities to the Global Observatory on Health Research and Development or to other existing data collection mechanisms that provide regular reports to the Global Observatory on Health Research and Development;

(3) to provide support to the Director-General for the development of sustainable financing mechanisms for the full implementation of the strategic workplan endorsed in resolution WHA66.22;

2. REQUESTS the Director-General:

(1) to expedite the full implementation of the strategic workplan endorsed in resolution WHA66.22;

(2) to expedite the further development of a fully functional Global Observatory on Health Research and Development;

¹ And, where applicable, regional economic integration organizations.

- (3) to submit terms of reference and a costed workplan of the Global Observatory on Health Research and Development to the Seventieth World Health Assembly, through the Executive Board at its 140th session, under the agenda item on the Consultative Expert Working Group on Research and Development: Financing and Coordination;
- (4) to expedite, as part of the development of the Global Observatory on Health Research and Development, the development of norms and standards for classification of health research and development, including common reporting formats, building on existing sources, in consultation with Member State experts and relevant stakeholders in order to collect and collate information systematically;
- (5) to promote the Global Observatory on Health Research and Development among all stakeholders, including through regular open-access publications and outreach activities, and encourage all stakeholders to regularly share relevant information on health research and development with the Global Observatory on Health Research and Development;
- (6) to support Member States in their endeavours to establish or strengthen health research and development capacities, including the monitoring of relevant information on health research and development;
- (7) to establish a WHO Expert Committee on Health Research and Development to provide technical advice on the prioritization of health research and development for Type II and Type III diseases and specific research and development needs of developing countries in relation to Type I diseases, as well as for potential areas where market failure exists based, inter alia, on the analyses provided by the Global Observatory on Health Research and Development, with the Expert Committee consulting, as needed, with all relevant stakeholders in carrying out its work as specified in its terms of reference, which will be formulated and submitted for consideration by the Executive Board at its 140th session;
- (8) to take into account the study conducted by the UNICEF/UNDP/World Bank/WHO Special Programme for Research and Training in Tropical Diseases and, on the basis of the report of the Consultative Expert Working Group on Research and Development: Financing and Coordination, present a proposal with goals and an operational plan for a voluntary pooled fund to support research and development for Type III and Type II diseases and specific research and development needs of developing countries in relation to Type I diseases, to be submitted to the Seventieth World Health Assembly, through the Executive Board at its 140th session;
- (9) to ensure that the operational plan describes how the WHO Global Observatory on Health Research and Development, the WHO Expert Committee on Health Research and Development and the Scientific Working Group of a pooled fund will work together, with specific disease examples, and in line with the core principles of affordability, effectiveness, efficiency, equity and the principle of delinkage; and that the plan provides options for sustainable funding;
- (10) to promote and advocate for sustainable and innovative financing for all aspects of the strategic workplan endorsed in resolution WHA66.22 and to include, as appropriate, the strategic workplan in WHO financing dialogues for mobilizing sufficient resources to meet the objectives of resolution WHA66.22;
- (11) to promote policy coherence within WHO on its research and development-related activities, such as those in relation to the Research and Development Blueprint for Emerging Pathogens and the Global Action Plan on Antimicrobial Resistance in terms of application of the core principles of affordability, effectiveness, efficiency and equity and the objective of delinkage identified in resolution WHA66.22;

(12) to report to the Seventieth World Health Assembly on the implementation of this resolution, and request the Seventieth World Health Assembly to consider convening another open-ended meeting of Member States in order to assess progress and continue discussions on the remaining issues in relation to monitoring, coordination and financing for health research and development, taking into account relevant analyses and reports.

(Eighth plenary meeting, 28 May 2016 –
Committee B, fourth report)

WHA69.24 Strengthening integrated, people-centred health services¹

The Sixty-ninth World Health Assembly,

Having considered the follow-up of the report on the framework on integrated, people-centred health services;²

Acknowledging Sustainable Development Goal 3 (Ensure healthy lives and promote well-being for all at all ages) including target 3.8, which addresses achieving universal health coverage, including financial risk protection, access to quality essential health care services, and access to safe, effective, quality and affordable essential medicines and vaccines for all;

Recalling resolution WHA64.9 (2011) on sustainable health financing structures and universal coverage, which urged Member States to continue investing in and strengthening health-delivery systems, in particular primary health care and services, and adequate human resources for health and health information systems, in order to ensure that all citizens have equitable access to health care and services;

Reaffirming resolution WHA62.12 (2009) on primary health care, including health system strengthening, which requested the Director-General to prepare implementation plans for four broad policy directions, including putting people at the centre of service delivery, and also reaffirming the need to continue to prioritize progress on the implementation plans on the other three broad policy directions included in resolution WHA62.12: (1) dealing with inequalities by moving towards universal coverage; (2) multisectoral action and health in all policies; and (3) inclusive leadership and effective governors for health;

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

Recalling also resolution WHA64.7 (2011) on strengthening nursing and midwifery, which emphasized the implementation of strategies for enhancement of interprofessional education and collaborative practice as part of people-centred care, and resolution WHA66.23 (2013) on transforming health workforce education in support of universal health coverage;

Reaffirming resolution WHA60.27 (2007) on strengthening health information systems, which acknowledged that sound information is critical in framing evidence-based health policy and making

¹ See Annex 15 for the financial and administrative implications for the Secretariat of this resolution.

² Document A69/39.

decisions, and fundamental for monitoring progress towards internationally agreed health-related development goals;

Recalling resolution WHA67.20 (2014) on regulatory system strengthening for medical products, resolution WHA67.21 (2014) on access to biotherapeutic products, including similar biotherapeutic products, and ensuring their quality, safety and efficacy, resolution WHA67.22 (2014) on access to essential medicines, resolution WHA67.23 (2014) on health intervention and technology assessment in support of universal health coverage and resolution WHA67.18 (2014) on traditional medicine,

1. ADOPTS the framework on integrated, people-centred health services;¹
2. URGES Member States:
 - (1) to implement, as appropriate, the framework on integrated, people-centred health services at regional and country levels, in accordance with national contexts and priorities;
 - (2) to implement proposed policy options and interventions for Member States in the framework on integrated, people-centred health services in accordance with nationally set priorities towards achieving and sustaining universal health coverage, including with regard to primary health care as part of health system strengthening;
 - (3) to make health care systems more responsive to people's needs, while recognizing their rights and responsibilities with regard to their own health, and engage stakeholders in policy development and implementation;
 - (4) to promote coordination of health services within the health sector and intersectoral collaboration in order to address the broader social determinants of health, and to ensure a holistic approach to services, including health promotion, disease prevention, diagnosis, treatment, disease-management, rehabilitation and palliative care services;
 - (5) to integrate, where appropriate, traditional and complementary medicine into health services, based on national context and knowledge-based policies, while assuring the safety, quality and effectiveness of health services and taking into account a holistic approach to health;
3. INVITES international, regional and national partners to take note of the framework on integrated, people-centred health services;
4. REQUESTS the Director-General:
 - (1) to provide technical support and guidance to Member States for the implementation, national adaptation and operationalization of the framework on integrated, people-centred health services, paying special attention to primary health services as part of health system strengthening;
 - (2) to ensure that all relevant parts of the Organization, at headquarters, regional and country levels, are aligned, actively engaged and coordinated in promoting and implementing the framework on integrated, people-centred health services;

¹ See Annex 9.

(3) to perform research and development on indicators to trace global progress on integrated people-centred health services;

(4) to report on progress on the implementation of the framework on integrated people-centred health services to the Seventy-first and Seventy-third World Health Assemblies and at regular intervals thereafter.

(Eighth plenary meeting, 28 May 2016 –
Committee B, fourth report)

WHA69.25 Addressing the global shortage of medicines and vaccines, and the safety and accessibility of children's medication¹

The Sixty-ninth World Health Assembly,

Having considered the report on addressing the global shortages of medicines, and the safety and accessibility of children's medication;²

Recalling the Health Assembly resolutions WHA67.22 (2014) on access to essential medicines, WHA60.20 (2007) on better medicines for children, WHA67.20 (2014) on regulatory system strengthening, WHA67.21 (2014) access to biotherapeutic products, including similar biotherapeutic products, and ensuring their quality, safety and efficacy, WHA61.21 (2008) on global strategy and plan of action on public health, innovation and intellectual property, WHA65.19 (2012) on substandard/spurious/false-labelled/falsified/counterfeit medical products, WHA65.17 (2012) on the global vaccine action plan, WHA68.7 (2015) on the global action plan on antimicrobial resistance, WHA67.25 (2014) on antimicrobial resistance, WHA64.9 (2011) on sustainable health financing structures and universal coverage, and Human Rights Council resolution RES/12/24 (2009) on access to medicine in the context of the right of everyone to the enjoyment of the highest attainable standard of physical and mental health;

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;

Recognizing that the continuous supply of quality, safe, effective and affordable medicines is one of the building blocks of every well-functioning health system, which requires a reliable supply chain; and noting reports of global medicines shortages and stockouts that also infringe upon the right to the enjoyment of the highest attainable standard of health as envisaged by the WHO Constitution, that undermine the attainment of public health prevention and treatment goals and that threaten governments' ability to scale up services towards achieving universal health coverage as well as their ability to adequately respond to outbreaks and health emergencies;

Recalling Goal 3, target 3.8 of the Agenda 2030 for Sustainable Development, which includes the commitment to achieve universal health coverage, financial risk protection, access to quality essential health care services and access to safe, effective, quality and affordable medicines and vaccines for all;

¹ See Annex 15 for the financial and administrative implications for the Secretariat of this resolution.

² Document A69/42.

Acknowledging that the Agenda 2030 for Sustainable Development supports the research and development of vaccines and medicines for the communicable and noncommunicable diseases that primarily affect developing countries, to provide access to affordable essential medicines and vaccines, in accordance with the Doha Declaration on the TRIPS Agreement and Public Health, which affirms the right of developing countries to use to the full the provisions in the Agreement on Trade-Related Aspects of Intellectual Property Rights regarding flexibilities to protect public health, and, in particular, provide access to medicines for all;¹

Noting that the challenges related to medicines shortages affect access to medicines; that they are complex and widespread, and increasing in frequency; that they affect citizens, procurement agencies and countries at every level of development; and that there is insufficient information to determine the magnitude and specific characteristics of the problem;

Noting also that the implications of these shortages in the case of infectious diseases impact public health, as a shortage/stockout of antibiotics, antituberculosis drugs, antiretrovirals, antimalarials, antiparasitic drugs and medicines for neglected tropical diseases and vaccines may result in the spread of infection beyond the individual patient;

Considering that there is a need for improved international collaboration on the management of shortages of medicines,

1. URGES Member States² to develop strategies that may be used to forecast, avert or reduce shortages/stockouts, in accordance with national priorities and contexts, including:

- (1) to implement effective notification systems that allow remedial measures to avoid medicines and vaccines shortages;
- (2) to ensure that best practices for medicines and vaccines procurement, distribution and contract management processes are in place to mitigate the risk of shortages;
- (3) to develop and/or strengthen systems that are capable of monitoring medicine and vaccine supply, demand, availability and of alerting procurement departments to possible medicine and vaccine availability problems;
- (4) to strengthen institutional capacity to ensure sound financial management of procurement systems, to prevent funding shortfalls for medicines;
- (5) to prioritize, in the case of shortages, the health needs of the most affected groups and to ensure these groups have timely access to medicines;
- (6) to advance, gradually, regional and international cooperation in support of national notification systems including, but not limited to, sharing of best practices, training for human capacity building through regional and subregional structures where necessary;

2. CALLS upon manufacturers, wholesalers, global, and regional procurement agencies and other relevant stakeholders to contribute to global efforts to address the challenges of medicines and vaccines shortages, including through participation in notification systems;

¹ United Nations General Assembly resolution 70/1 (2015) (Goal 3, target 3.b).

² And, where applicable, regional economic integration organizations.

3. REQUESTS the Director-General:

- (1) to develop technical definitions, as needed, for medicines and vaccines shortages and stockouts, taking due account of access and affordability in consultation with Member State experts in keeping with WHO-established processes, and to submit a report on the definitions to the Seventieth World Health Assembly, through the Executive Board;
- (2) to develop an assessment of the magnitude and nature of the problem of shortages of medicines and vaccines;
- (3) to support Member States in addressing the global challenges of medicines and vaccines shortages by developing a global medicine shortage notification system that would include information to better detect and understand the causes of medicines shortages;
- (4) to report on progress on, and outcomes of, the implementation of this resolution to the Seventy-first World Health Assembly.

(Eighth plenary meeting, 28 May 2016 –
Committee B, fourth report)

DECISIONS

WHA69(1) Composition of the Committee on Credentials

The Sixty-ninth World Health Assembly appointed a Committee on Credentials consisting of delegates of the following Member States: Afghanistan, Bolivia (Plurinational State of), Georgia, Haiti, India, Kenya, Liberia, Madagascar, Poland, Republic of Korea, Spain and Tonga.

(First plenary meeting, 23 May 2016)

WHA69(2) Election of officers of the Sixty-ninth World Health Assembly

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

President: Dr Ahmed Mohammed Al-Saidi (Oman)

Vice-Presidents: Dr Sathasivam Subramaniam (Malaysia)
Dr Francisco Terrientes (Panama)
Mr Assane Nguéadougou (Chad)
Dr Ana Isabel Soares (Timor-Leste)
Dr Armen Muradyan (Armenia)

(First plenary meeting, 23 May 2016)

WHA69(3) Election of officers of the main committees

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

Committee A: Chairman Mr Martin Bowles (Australia)
Committee B: Chairman Dr Phusit Prakongsai (Thailand)

(First plenary meeting, 23 May 2016)

The main committees subsequently elected the following officers:

Committee A: Vice-Chairmen Ms Taru Koivisto (Finland)
Mr Nickolas Steele (Grenada)
Rapporteur Ms Aishah Samiya (Maldives)

Committee B: Vice-Chairmen Dr Mahlet Kifle (Ethiopia)
Dr Asadi-Lari (Islamic Republic of Iran)
Rapporteur Mr Abdunomon Sidikov (Uzbekistan)

(First meetings of Committees A and B,
23 and 25 May 2016, respectively)

WHA69(4) Establishment of the General Committee

The Sixty-ninth World Health Assembly elected the delegates of the following 17 countries as members of the General Committee: Antigua and Barbuda, Argentina, Benin, Cameroon, Central African Republic, China, Côte d'Ivoire, Cuba, Estonia, France, Iraq, Netherlands, Russian Federation, Somalia, United Kingdom of Great Britain and Northern Ireland, United Republic of Tanzania and United States of America.

(First plenary meeting, 23 May 2016)

WHA69(5) Adoption of the agenda

The Sixty-ninth World Health Assembly adopted the provisional agenda prepared by the Executive Board at its 138th session, with the deletion of four items and the transfer of items 16 and 17 from Committee A to Committee B.

(Second plenary meeting, 23 May 2016)

WHA69(6) Verification of credentials

The Sixty-ninth World Health Assembly recognized the validity of the credentials of the following delegations: Afghanistan; Albania; Algeria; Andorra; Angola; Antigua and Barbuda; Argentina; Armenia; Australia; Austria; Azerbaijan; Bahamas; Bahrain; Bangladesh; Barbados; Belarus; Belgium; Bhutan; Bolivia (Plurinational State of); Bosnia and Herzegovina; Brazil; Brunei Darussalam; Bulgaria; Burkina Faso; Burundi; Cabo Verde; Cambodia; Cameroon; Canada; 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; Dominican Republic; Ecuador; Egypt; El Salvador; Equatorial Guinea; Eritrea; Estonia; Ethiopia; Fiji; Finland; France; Gabon; Georgia; Germany; Ghana; Greece; Grenada; Guatemala; Guinea; Haiti; Honduras; Hungary; Iceland; India; Indonesia; Iran (Islamic Republic of); Iraq; Ireland; Israel; Italy; Jamaica; Japan; Kazakhstan; Kenya; Kiribati; Kuwait; Lao People's Democratic Republic; Latvia; Lebanon; Lesotho; Liberia; Lithuania; Luxembourg; Madagascar; Malawi; Malaysia; Maldives; Mali; Malta; Marshall Islands; Mauritania; Mauritius; Mexico; Micronesia (Federated States of); Monaco; Mongolia; Montenegro; Morocco; Mozambique; Myanmar; Namibia; Nepal; Netherlands; New Zealand; Nicaragua; Niger; Nigeria; Norway; Oman; Pakistan; Palau; Panama; Papua New Guinea; Paraguay; Peru; Philippines; Poland; Portugal; Qatar; Republic of Korea; Republic of Moldova; Romania; Russian Federation; Rwanda; Saint Kitts and Nevis; Saint Vincent and the Grenadines; 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; Suriname; Swaziland; Sweden; Switzerland; Syrian Arab Republic; Tajikistan; Thailand; the former Yugoslav Republic of Macedonia; Timor-Leste; Togo; Tonga; Tunisia; Turkey; Turkmenistan; Tuvalu; Uganda; Ukraine; United Arab Emirates; United Kingdom of Great Britain and Northern Ireland; United Republic of Tanzania; United States of America; Uruguay; Uzbekistan; Vanuatu; Venezuela (Bolivarian Republic of); Viet Nam; Yemen; Zambia; Zimbabwe.

(Seventh plenary meeting, 27 May 2016)

WHA69(7) Election of Members entitled to designate a person to serve on the Executive Board

The Sixty-ninth 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: Algeria, Bahrain, Bhutan, Burundi, Colombia, Fiji, Jamaica, Libya, Mexico, Netherlands, Turkey and Viet Nam.

(Seventh plenary meeting, 27 May 2016)

WHA69(8) Decision based on the agreed recommendations of the Open-ended Intergovernmental Meeting on Governance Reform (Geneva, 8 and 9 March 2016 and 28 and 29 April 2016)¹

The Sixty-ninth World Health Assembly, having considered the report on the Member State consultative process on governance reform,² decided:

Forward looking schedule for the agenda of the Executive Board and Health Assembly

(1) to request that the Director General develop a six-year, forward-looking planning schedule of expected agenda items for the Executive Board, including its standing committees, and the Health Assembly, based on standing items, requirements established by decisions and resolutions of the governing bodies, as well those required by the Constitution, regulations and rules of the Organization – especially taking into account the General Programme of Work, and without prejudice to additional, supplementary and urgent agenda items that might be added to the governing body agendas;

(2) to request the Director General to submit the above-mentioned forward-looking planning schedule, as an information document, to the Executive Board at its 140th session, and to update the schedule regularly, as needed;

Agenda management

(3) to request the Bureau of the Executive Board, taking into account inputs from Member States,³ to review the criteria currently applied in considering items for inclusion on the provisional agenda of the Board,⁴ and to develop proposals for new and/or revised criteria for the consideration of the 140th session of the Executive Board;

(4) to request the Director General, in consultation with Member States and taking into account previous Member State discussions,⁵ to develop by the end of October 2016, proposals to improve the level of correspondence between the number of items on the provisional agendas of the governing bodies and the number, length and timing of their sessions, including the

¹ See Annex 15 for the financial and administrative implications for the Secretariat of the adoption of the decision.

² Document A69/5.

³ Available at <http://apps.who.int/gb/mscp/mscp.html> (accessed 9 May 2016).

⁴ See decision WHA65(9) (2012) and resolution EB121.R1 (2007).

⁵ See document EB136/2015/REC/2, summary records of the fourth meeting; document EB134/2014/REC/2, summary records of the fifth meeting and twelfth meeting, section 4; and document EB132/2013/REC/2, summary records of the fifth meeting and sixth meeting.

financial implications of proposed options, for consideration by the Seventieth World Health Assembly through the 140th session of the Executive Board;

Rules of additional, supplementary and urgent agenda items

(5) to request the Director-General to prepare an analysis of the current Rules of Procedure of the Executive Board and Rules of Procedure of the World Health Assembly in order to identify interpretational ambiguities and gaps in the processes for the inclusion of additional, supplementary and urgent agenda items and to make recommendations on the further improvement of those processes; and to report to the Seventy-first World Health Assembly through the Executive Board;

Improvement of information technology tools for better access

(6) to request the Director-General to continue strengthening, and making more user-friendly, the use of existing and new information technology tools in order to improve timely and cost-effective access to governing body meetings and documentation, both pre- and post-session, and to continue making arrangements for access to the webcasts post-session of public governing body meetings;

Senior management coordination

(7) to recognize the Global Policy Group¹ as an advisory mechanism to the Director-General and encourage the Director-General, in accordance with the WHO Constitution, to continue to strengthen senior management coordination for the coherent implementation of decisions, policies and strategies of the Organization across all levels;

Improving transparency and accountability

(8) to request the Director-General and Regional Directors to make the delegations of authority and letters of representation publicly available on an electronic platform² in order to improve transparency and accountability;

Increasing harmonization across the regional committees in relation to the nomination of Regional Directors

(9) in accordance with decision WHA65(9) (2012), to invite each Regional Committee to consider measures to improve the process of nomination of Regional Directors, taking into consideration best practices from the six regions;

Improving transparency of the process for the selection of Assistant Directors-General

(10) to request the Director-General to improve transparency of the process for the selection of Assistant Directors-General, including through timely advertisement of the Assistant Director-General positions in all official languages;

¹ It is noted that the Global Policy Group currently comprises the Director-General, Deputy Director-General and the Regional Directors.

² For example the governance reform section of the WHO website.

Strengthening planning mechanisms

(11) to encourage the Director-General and Regional Directors, working with Heads of WHO Country Offices, to strengthen the implementation of planning mechanisms¹ that improve alignment across the three levels of the Organization;

Enhancing alignment

(12) to request the Director-General, working with the Regional Directors, to assess and report on the implementation of operative paragraph 4 of decision WHA65(9) in the context of reporting on WHO reform, with the aim of enhancing alignment between the Regional Committees and the Executive Board, in relation to each subparagraph;

Strengthening oversight functions

(13) to invite Regional Committees to consider reviewing their current practices, including those of their standing committees and subcommittees, where applicable, with a view to strengthening their oversight functions; and request the Director-General, working with Regional Directors, to develop and maintain a platform² for sharing the outcome of the reviews to assist in identifying best practices in the oversight functions and to report at the appropriate time to the Executive Board;

Strengthening WHO cooperation with countries

(14) to invite the Regional Committees to improve oversight of the work of regional and country offices, including through identifying best practices and establishing a set of requirements on the reporting of regional and country office management, financial information and programme results to Regional Committees;

(15) to request the Director-General and the Regional Directors to provide the biennial WHO country presence report for review by the Regional Committees, and as an information document for the Health Assembly, through the Executive Board and its Programme, Budget and Administration Committee.

(Seventh plenary meeting, 27 May 2016)

WHA69(9) Reform of WHO's work in health emergency management: WHO Health Emergencies Programme

The Sixty-ninth World Health Assembly, having considered the reports on the reform of WHO's work in health emergency management,³ decided:

(1) to welcome the progress made in the development of the new WHO Health Emergencies Programme,⁴ the elaboration of an implementation plan and timeline for the new Programme, and the establishment of the Emergencies Oversight and Advisory Committee;

¹ For example category networks and the results chain.

² For example, the governance reform homepage on the WHO website.

³ Documents A69/30 and A69/61.

⁴ See Annex 10.

(2) to encourage ongoing collaboration with the United Nations Office for the Coordination of Humanitarian Affairs to enhance humanitarian system-wide coordination of the response to large-scale infectious hazards in the future;

(3) to note that the overall budget for the WHO Health Emergencies Programme and its new operational capacities will be US\$ 494 million for the biennium 2016–2017, representing a US\$ 160 million increase over the current budget for WHO's primarily normative and technical work in health emergency management;

(4) to approve an increase of US\$ 160 million for the Programme budget 2016–2017 to initiate the implementation plan for the new WHO Health Emergencies Programme, and to authorize the Director-General to mobilize additional voluntary contributions to meet this financial need for the biennium 2016–2017;

(5) to request the Director-General to report to the Seventieth World Health Assembly, through the Executive Board, on progress made and experience gained in establishing and operationalizing the WHO Health Emergencies Programme.

(Seventh plenary meeting, 27 May 2016)

WHA69(10) Health conditions in the occupied Palestinian territory, including east Jerusalem, and in the occupied Syrian Golan¹

The Sixty-ninth World Health Assembly, mindful of the basic principle established in the Constitution of the World Health Organization, which affirms that the health of all peoples is fundamental to the attainment of peace and security, and stressing that unimpeded access to health care is a crucial component of the right to health; also taking note of the report by the Secretariat on health conditions in the occupied Palestinian territory, including east Jerusalem, and in the occupied Syrian Golan,² and noting also the field assessment report on health conditions in the occupied Palestinian territory: summary findings,³ requested the Director-General:

(1) to report and make practical recommendations on the health conditions in the occupied Palestinian territory, including east Jerusalem, and in the occupied Syrian Golan, to the Seventieth World Health Assembly, through a field assessment conducted by WHO, with special focus on:

(a) physical and procedural barriers to health access in the occupied Palestinian territory, including as a result of movement restrictions and territorial fragmentation, as well as progress made in the implementation of the recommendations contained in WHO's 2014 report, *Right to health: crossing barriers to access health in the occupied Palestinian territory, 2013*;⁴

¹ See Annex 15 for the financial and administrative implications for the Secretariat of the adoption of the decision.

² Document A69/44.

³ Document A69/44 Add.1.

⁴ Right to health: crossing barriers to access health in the occupied Palestinian territory, 2013. Geneva: World Health Organization; 2014 (http://www.emro.who.int/images/stories/palestine/documents/WHO_-_RTH_crossing_barriers_to_access_health.pdf?ua=1, accessed 6 June 2016).

- (b) incidents of delay or denial of ambulance service, and the harmful effects of the “back-to-back” procedure for the ambulance transfer of patients across checkpoints;
 - (c) physical injuries and disabilities, and damage to and destruction of medical infrastructure and facilities, as well as impediments to the reconstruction, development and equipment of these health facilities and to the safety of health care workers;
 - (d) access to adequate health services on the part of Palestinian prisoners, including the possibility of access to medical staff who can operate independently of the custodial authorities, and the health consequences of the military detention system on prisoners and detainees, especially child detainees, as well as progress made in the implementation of the recommendations contained in WHO’s 2012 Right to Health advocacy project;
 - (e) the impact of prolonged occupation and human rights violations on mental, physical and environmental health and on the development of a sustainable health system in the occupied Palestinian territory, including the health consequences of insecure living conditions, notably as a result of displacement, home demolitions and the denial of medical services;
 - (f) the effect of impeded access to water and sanitation, and food insecurity, on health conditions in the occupied Palestinian territory, particularly in the Gaza Strip, as well as the effect of Israeli actions harming the environment, including the dumping of waste materials that pose a health threat to the civilian population, and progress made in the implementation of the recommendations contained in the Gaza Strip Joint Health Sector Assessment Report of September 2014;¹
 - (g) the provision of financial and technical assistance and support by the international donor community, including through UNRWA, and its contribution to improving health conditions in the occupied Palestinian territory;
- (2) to provide support to the Palestinian health services, including through capacity-building programmes and the development of strategic plans for investments in specific treatment and diagnostic capacities locally;
 - (3) to provide health-related technical assistance to the Syrian population in the occupied Syrian Golan;
 - (4) to continue providing the 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 propose measures to improve the health of prisoners and ex-prisoners and the reintegration of ex-prisoners into the community, and to provide information to prisoners on how to cope with and report illness;

¹ Available at http://www.emro.who.int/images/stories/palestine/documents/Joint_Health_Sector_Assessment_Report_Gaza_Sept_2014-final.pdf, accessed 6 June 2016).

(6) to provide support to the Palestinian health sector in preparing for emergency situations and scaling up emergency preparedness and response capacities and in reducing shortages in life-saving drugs and medical disposables and equipment;

(7) to support the development of the health system in the occupied Palestinian territory, including development of human resources, with a particular focus on strengthening primary care and integrating mental health services provision into primary care services, as well as on health prevention and integrated disease management, and to advise donors on how to best support these activities;

(8) to ensure the allocation of human and financial resources to deliver on these objectives.

(Seventh plenary meeting, 27 May 2016)

WHA69(11) Health and the environment: road map for an enhanced global response to the adverse health effects of air pollution¹

The Sixty-ninth World Health Assembly, having considered the report of the Secretariat on health and the environment: draft road map for an enhanced global response to the adverse health effects of air pollution,² decided:

(1) to welcome the road map for an enhanced global response to the adverse health effects of air pollution;³ and

(2) to request the Director-General to report the progress towards an enhanced global response to the adverse health effects of air pollution to the Seventy-first Health Assembly and its achievements to the Seventy-third Health Assembly.

(Eighth plenary meeting, 28 May 2016)

WHA69(12) Report of the Commission on Ending Childhood Obesity

The Sixty-ninth World Health Assembly, having considered the report of the Commission on Ending Childhood Obesity,⁴ decided:

(1) to welcome the report of the Commission on Ending Childhood Obesity;⁵

(2) to invite all relevant stakeholders, including international organizations, nongovernmental organizations, philanthropic foundations, academic institutions and the private sector, to work towards implementation of the actions recommended in the report of the Commission on Ending Childhood Obesity, as appropriate, according to context, with a view to strengthening their valuable contribution to ending childhood and adolescent obesity;

¹ See Annex 15 for the financial and administrative implications for the Secretariat of the adoption of the decision.

² Document A69/18.

³ See Annex 11.

⁴ Document A69/8.

⁵ See Annex 12.

(3) to recommend that Member States develop national responses to end childhood obesity and adolescent obesity, taking into account the recommendations included in the report of the Commission on Ending Childhood Obesity and adapting them to their national context;

(4) to request the Director-General to develop, in consultation with Member States¹ and relevant stakeholders, an implementation plan guiding further action on the recommendations included in the Report of the Commission on Ending Childhood Obesity to be submitted, through the Executive Board at its 140th session, for consideration by the Seventieth World Health Assembly.

(Eighth plenary meeting, 28 May 2016)

WHA69(13) Strengthening synergies between the World Health Assembly and the Conference of the Parties to the WHO Framework Convention on Tobacco Control²

The Sixty-ninth World Health Assembly, having considered the report on strengthening synergies between the World Health Assembly and the Conference of the Parties to the WHO Framework Convention on Tobacco Control,³ decided:

(1) to invite the Conference of the Parties to the WHO Framework Convention on Tobacco Control to consider the provision to the Health Assembly of a report for information on the outcomes of the Conference of the Parties to the WHO Framework Convention on Tobacco Control, as well as the modalities relating to the presentation of such a report;

(2) to invite the Conference of the Parties to the WHO Framework Convention on Tobacco Control to consider inviting the Health Assembly to provide a report for information to the Conference of Parties to the WHO Framework Convention on Tobacco Control on resolutions and decisions of the Health Assembly relevant for tobacco-related actions;

(3) to include a follow-up item in the provisional agenda of the Seventieth World Health Assembly.

(Eighth plenary meeting, 28 May 2016)

WHA69(14) Implementation of the International Health Regulations (2005)²

The Sixty-ninth World Health Assembly, having considered the report of the Review Committee on the Role of the International Health Regulations (2005) in the Ebola Outbreak and Response,⁴ and acknowledging the leadership role of WHO, decided:

(1) to commend the successful conclusion of the work of the Review Committee on the Role of the International Health Regulations (2005) in the Ebola Outbreak and Response, the leadership of its Chair, the dedication of its distinguished members, and the submission of its report to the Director-General for transmittal to the Sixty-ninth World Health Assembly;

¹ And, where applicable, regional economic integration organizations.

² See Annex 15 for the financial and administrative implications for the Secretariat of the adoption of the decision.

³ Document A69/11

⁴ Document A69/21.

(2) to request the Director-General to develop for the consideration of the Regional Committees in 2016 a draft global implementation plan for the recommendations of the Review Committee¹ that includes immediate planning to improve delivery of the International Health Regulations (2005) by reinforcing existing approaches, and that indicates a way forward for dealing with new proposals that require further Member State technical discussions;

(3) to request the Director-General to submit a final version of the draft global implementation plan for the consideration of the Executive Board at its 140th session.

(Eighth plenary meeting, 28 May 2016)

WHA69(15) Public health dimension of the world drug problem, including in the context of the special session of the United Nations General Assembly on the world drug problem, held in April 2016²

The Sixty-ninth World Health Assembly, having considered the report on the public health dimension of the world drug problem including in the context of the special session of the United Nations General Assembly on the world drug problem, held in April 2016,³ decided that this item will be included on the agenda of the Executive Board at its 140th session in January 2017.

(Eighth plenary meeting, 28 May 2016)

WHA69(16) Strategic budget space allocation²

The Sixty-ninth World Health Assembly, having considered the report on financing of Programme budget 2016–2017: strategic budget space allocation,⁴ decided the following:

(1) to welcome the report of the Working Group on Strategic Budget Space Allocation and express its appreciation to the members of the Working Group for their thoroughness in reviewing the previous work and for developing a revised model in an objective and timely manner;⁵

(2) to endorse the proposed model recommended by the Working Group on Strategic Budget Space Allocation;

(3) to request the Director-General, with respect to the endorsed model:

(a) to implement the recommended model, over a period of three to four bienniums, and to minimize any negative budgetary impact at regional and country levels, particularly in the countries with the greatest need, in consultation with the Regional Directors, using the current allocation for technical cooperation at country level as the starting point;

¹ See Annex 13.

² See Annex 15 for the financial and administrative implications for the Secretariat of the adoption of the decision.

³ Document A69/12.

⁴ Document A69/47.

⁵ See Annex 14 for the models proposed by the Working Group on Strategic Budget Space Allocation.

- (b) to report every biennium on the implementation of the new model, as part of the programme budget reports, to the Executive Board through its Programme, Budget and Administration Committee;
- (c) to conduct reviews at least every six years in order to assess the relevance of the model to country needs and its impact on the regional budget envelopes;
- (4) to further request the Director-General to work with Regional Directors to strive towards the use of WHO country budgets and the Organization's social and intellectual capital to leverage additional resources in order to implement and sustain national priority programmes effectively.

(Eighth plenary meeting, 28 May 2016)

WHA69(17) Appointment of representatives to the WHO Staff Pension Committee

The Sixty-ninth World Health Assembly nominated Dr Palitha Gunarathna Mahipala of the delegation of Sri Lanka, as a member of the WHO Staff Pension Committee for a three-year term until May 2019.

The Health Assembly nominated Dr Naoko Yamamoto of the delegation of Japan and Dr Gerardo Lubin Burgos Bernal of the delegation of Colombia as alternate members of the WHO Staff Pension Committee for three-year terms until May 2019.

(Eighth plenary meeting, 28 May 2016)

WHA69(18) Real estate: update of the Geneva buildings renovation strategy

The Sixty-ninth World Health Assembly, having considered the report of the Director-General on real estate: update on the Geneva buildings renovation strategy,¹ decided:

- (1) to reiterate its appreciation to the Swiss Confederation and to the Republic and Canton of Geneva for the continued expression of their hospitality;
- (2) to adopt the Geneva buildings renovation strategy, as described in the report on real estate: update on the Geneva buildings renovation strategy;
- (3) to authorize the Director-General to proceed with the renovation of the main building (110 million Swiss francs) and the construction of a new building (140 million Swiss francs) at WHO headquarters in Geneva with a total cost of 250 million Swiss francs, on the understanding that if during the evolution of the design period, the likely total cost of the project was to increase by more than 10%, further authority would be sought from the Health Assembly;
- (4) to authorize the Director-General to accept the full 50-year, interest-free loan of 140 million Swiss francs from the Swiss federal authorities, subject to their final approval in December 2016;

¹ Document A69/56.

- (5) to approve the use of the Real Estate Fund for the cost of renovations and the repayment over a 50-year period of the interest-free loan, if provided by the Swiss authorities, with effect from the first year of the completion of the building; and
- (6) to request the Director-General:
 - (a) to ensure the allocation of US\$ 25 million per biennium to the Real Estate Fund; and
 - (b) to report at least every two years to the Executive Board and the Health Assembly on progress in the construction of the new accommodation and on related construction costs.

(Eighth plenary meeting, 28 May 2016)

WHA69(19) Selection of the country in which the Seventieth World Health Assembly would be held

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

(Eighth plenary meeting, 28 May 2016)

ANNEXES

ANNEX 1

Global strategy and action plan on ageing and health 2016–2020: towards a world in which everyone can live a long and healthy life¹

[A69/17 – 22 April 2016]

PURPOSE

1. In 2014, the Sixty-seventh World Health Assembly 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”.²

2. This global strategy and action plan on ageing and health also responds to the recently endorsed Sustainable Development Goals, an integrated, indivisible set of global priorities for sustainable development. Ageing is an issue that is relevant to 15 of the 17 Goals, in particular:

- Goal 1. End poverty in all its forms everywhere – for all men and women;
- Goal 2. End hunger, achieve food security and improved nutrition and promote sustainable agriculture including for older persons;
- Goal 3. Ensure healthy lives and promote well-being for all at all ages through universal health coverage including financial risk protection;
- Goal 4. Ensure inclusive and equitable quality education and promote lifelong learning opportunities for all;
- Goal 5. Achieve gender equality and empower all women and girls;
- Goal 8. Promote sustained, inclusive and sustainable economic growth, full and productive employment and decent work for all;
- Goal 10. Reduce inequality within and among countries, by promoting the social, political and economic inclusion of all, irrespective of age;
- Goal 11. Make cities and human settlements inclusive, safe, resilient and sustainable by providing universal access to safe, inclusive and accessible green and public spaces, in particular for older persons;

¹ See resolution WHA69.3 (2016).

² Decision WHA67(13) (2014).

- Goal 16. Promote peaceful and inclusive societies for sustainable development, provide access to justice for all and build effective, accountable and inclusive institutions at all levels.

3. Achieving these ambitious Goals will require concerted action both to harness the many contributions that older people can make to sustainable development and to ensure they are not left behind. The strategy frames how this can be achieved through a focus on the functional ability of older people. This approach can be applied to each Goal, to ensure that the needs and rights of older people are adequately addressed. For Goal 3, this represents a significant shift from previous global health priorities, where the emphasis was often on reducing mortality at younger ages. Instead, the focus of the strategy is on the quality of the extra years that these interventions now allow us to enjoy.

4. The strategy builds on two international policy instruments that have guided action on ageing and health since 2002 – the Madrid international plan of action on ageing¹ and WHO's policy framework on active ageing.² Both refer to the right to health and its international legal framework, highlight the skills and experience of older people and their potential contributions, regardless of physical and cognitive limitations, and map a broad range of areas where policy action can enable these contributions and ensure security in older age.

5. However, progress to improve the health of older people since 2002 has been uneven and generally inadequate. Renewed commitment and more coordinated responses are required. This strategy therefore expands on these previous instruments to address in detail the actions that are needed to achieve this. In doing so, it maintains their rights-based approach and looks to tackle the legal, social and structural barriers that limit health in older age, and to ensure the legal obligations of State and non-State actors to respect, protect and fulfil these rights are met.

6. The strategy outlines a framework for action that can be taken by all relevant stakeholders across the 15-year period of the Sustainable Development Goals. It also outlines concrete actions that can be taken within this framework during the five-year period 2016–2020.

RELATION TO EXISTING STRATEGIES AND PLANS

7. The strategy also draws on five WHO regional strategies and action plans addressing the health of older people that reflect extensive consultation with Member States and other stakeholders. It adds value by providing an overall vision and a public health framework for coordinated global action, and by underlining the importance of healthy ageing as a public health priority and the need for Member States to commit to a sustainable and evidence-informed public health response. The strategy also reflects, and is complementary to, existing commitments, approaches and platforms such as universal health coverage, social determinants of health, combatting noncommunicable diseases, disability, violence and injury prevention, age-friendly cities and communities, strengthening human resources for health, developing person-centred and integrated care, tackling dementia and ensuring the provision of palliative care.

¹ Political declaration and Madrid international plan of action on ageing. New York: United Nations; 2002 (http://www.un.org/en/events/pastevents/pdfs/Madrid_plan.pdf, accessed 3 March 2016).

² Active ageing: a policy framework. Geneva: World Health Organization; 2002 (WHO/NMH/NPH/02.8; http://apps.who.int/iris/bitstream/10665/67215/1/WHO_NMH_NPH_02.8.pdf, accessed 4 December 2015).

8. The strategy builds on the *World report on ageing and health*.¹ This articulates a conceptual model for healthy ageing and outlines a public health framework for action to foster it. This framework was used as the starting point for the extensive consultations that led to the final draft strategy.

GLOBAL SITUATION

9. Today, for the first time in history, most people can expect to live into their sixties and beyond. This reflects our successes in dealing with fatal childhood disease, maternal mortality and, more recently, mortality in older ages. When combined with marked falls in fertility rates, these increases in life expectancy are leading to equally significant changes in population structure – population ageing.

10. Longer lives are an incredibly valuable resource, both for each of us as individuals and for society more broadly. Older people participate in, and contribute to, society in many ways, including as mentors, caregivers, artists, consumers, innovators, entrepreneurs and members of the workforce. This social engagement may in turn reinforce the health and well-being of older people themselves.

11. Yet the extent of the opportunities that arise from increasing longevity will be heavily dependent on one key factor – the health of these older populations. If people are experiencing these extra years in good health and live in a supportive environment, their ability to do the things they value will have few limits. However, if these added years are dominated by rapid declines in physical and mental capacity, the implications for older people and for society as a whole are much more negative. Ensuring the best possible health in older age is therefore crucial if we are to achieve sustainable development.

12. Unfortunately, there is little evidence to suggest that older people today are experiencing better health than their parents did at the same age. Furthermore, good health in older age is not equally distributed, either between or within populations. For example, between countries there is a range of 38 years for life expectancy at birth, 37 years for healthy life expectancy at birth, and 13 years for life expectancy at age 60 years. Furthermore, over the past two decades the gap in life expectancy at age 60 years between high-income countries and low- and middle-income countries, has grown. Moreover, levels of capacity within a given population are generally distributed across a social gradient that reflects the cumulative impact of various social and economic determinants of health experienced throughout an individual's life course. One crucial consequence is that in older age the people with the greatest health needs tend to also be those with the least access to the resources that might help to meet them. This association has major implications for policy, which will need to be crafted in ways that overcome, rather than reinforce, these inequities.

13. The failure to ensure that extra years of life are enjoyed in the best possible health is avoidable. Most of the health problems of older age are linked to chronic conditions, particularly noncommunicable diseases. Many of these can be prevented or delayed by healthy behaviours and by the environments that support them. Even if chronic diseases do emerge, their consequences can be limited through integrated care to strengthen and maintain capacity or reverse declines. And for people with significant declines in capacity, supportive environments can promote dignity, autonomy, functioning and continued personal growth. Yet the world is very far from this ideal, particularly for poor older people and those from disadvantaged social groups.

¹ World report on ageing and health. Geneva: World Health Organization; 2015
(http://apps.who.int/iris/bitstream/10665/186463/1/9789240694811_eng.pdf, accessed 4 December 2015).

14. A comprehensive response to foster healthy ageing is urgently needed.

Healthy ageing

15. The changes that constitute and influence ageing are complex. At a biological level, the gradual accumulation of a wide variety of molecular and cellular damage leads to a gradual decrease in physiological reserves, an increased risk of many diseases and a general decline in capacity. But these changes are neither linear nor consistent, and they are only loosely associated with age in years. Thus, while some 70-year-olds may enjoy good physical and mental capacity, others may be frail and require significant support to meet their basic needs.

16. Beyond these biological losses, older age frequently involves other significant changes, including shifts in roles and social positions. Although some of these changes may be driven by adaptation to loss, others reflect ongoing psychological growth in older age that may be associated with the development of new viewpoints and social contexts. In developing a public health response to ageing, it is therefore important to consider strategies that reinforce resilience and psychosocial growth. Since cultural norms that cast older age as an inevitable period of decline can operate against these efforts, it will also be important to challenge many of the stereotypes that currently define what it is to be “old”.

17. This strategy frames this response through the concept of healthy ageing, which is described in detail in the *World report on ageing and health*. This is defined as “the process of developing and maintaining the functional ability that enables well-being in older age.” This functional ability is determined by the intrinsic capacity of the individual (i.e. the combination of all the individual’s physical and mental – including psychosocial – capacities), the environments he or she inhabits (understood in the broadest sense and including physical, social and policy environments), and the interaction between these.

18. Healthy ageing is a process that spans the entire life course and that can be relevant to everyone, not just those who are currently free of disease. Intrinsic capacity at any point in time is determined by many factors, including underlying physiological and psychological changes, health-related behaviours and the presence or absence of disease. These in turn are strongly influenced by the environments in which people have lived throughout their lives. Since the relationship that a person has with these environments is itself strongly influenced by factors such as his or her gender and race, these personal characteristics are also strongly associated with capacity at any point in time.

19. But intrinsic capacity is only one of the dimensions of older people’s functioning. The environments they inhabit and their interaction with them are also major determinants of what older people with a given level of capacity can do. These environments provide a range of resources or barriers that will ultimately decide whether older people can engage in activities that matter to them. Thus, while older people with severe osteoarthritis may have limited intrinsic capacity, they may still be able to do the shopping if they have access to an assistive device (such as a walking stick, wheelchair or scooter) and live close to affordable and accessible transport.

20. This conceptualization of healthy ageing reflects an individual’s accumulation of strengths or deficits across the life course. Actions to improve trajectories of healthy ageing can thus take place at any age and will be needed at multiple levels and in multiple sectors. Since much of the work of WHO addresses what can be done at younger ages, this strategy focuses on what can be done for people in the second half of their lives.

21. In doing so, it pays particular attention to the significant influence of gender norms, both on older people's healthy ageing trajectories and on the impact their ageing may have on their families and communities. For example, gender is a powerful influence on many health-related behaviours and exposures across the life course. As a consequence, women tend to live longer than men but generally experience poorer health throughout their lives and have higher rates of poverty. Moreover, when an older person experiences significant losses of capacity, the family often plays a key role in providing the care and support that are required. These unpaid and often under-respected caregiving roles are frequently filled by women and can limit their participation in the workforce or in education. This can be at a significant cost to their own well-being in older age, since it can limit the building of pension entitlements and access to health insurance and increase the risk of poverty and other insecurity.

GUIDING PRINCIPLES

22. The strategy starts from an assumption that ageing is a valuable, if often challenging, process. It considers that it is good to get old and that society is better off for having older populations. At the same time, it acknowledges that many older people will experience very significant losses, whether of physical or cognitive capacity or of family, friends and the roles they had earlier in life. Some of these losses can be avoided, and we should do what we can to prevent them. But others will be inevitable. Societal responses to ageing should not deny these challenges but seek to foster recovery, adaptation and dignity.

23. This will require transformative approaches that recognize the rights of older people and enable them to thrive in the complex, changing and unpredictable environment they are likely to live in now and in the future. However, rather than being prescriptively designed around what older people should do, the strategy aims to foster the ability of older people themselves to invent the future in ways that we, and previous generations, might never have imagined.

24. These approaches must foster the ability of older people to make multiple contributions in an environment that respects their dignity and human rights, free from gender- and age-based discrimination. Principles that underpin the strategy therefore include:

- human rights, including the right that older people have to the best possible health and its accountable, progressive realization;
- gender equality;
- equality and non-discrimination, particularly on the basis of age;
- equity (equal opportunity to the determinants of healthy ageing that does not reflect social or economic status, place of birth or residence or other social determinants);
- intergenerational solidarity (enabling social cohesion between generations).

VISION, GOALS AND STRATEGIC OBJECTIVES

25. The strategy's vision is a world in which **everyone can live a long and healthy life**. This world will be a place where functional ability is fostered across the life course and where older people experience equal rights and opportunities and can live lives free from age-based discrimination.

VISION

A world in which everyone can live a long and healthy life

STRATEGIC OBJECTIVES

1. Commitment to action on healthy ageing in every country
2. Developing age-friendly environments
3. Aligning health systems to the needs of older populations
4. Developing sustainable and equitable systems for providing long-term care (home, communities and institutions)
5. Improving measurement, monitoring and research on healthy ageing

ACTION PLAN 2016–2020

GOALS

1. Five years of evidence-based action to maximize functional ability that reaches every person.
2. By 2020, establish evidence and partnerships necessary to support a Decade of Healthy Ageing from 2020 to 2030

26. Five strategic objectives are identified. The first two, Commitment to action on healthy ageing in every country and Developing age-friendly environments, reflect the multiple and intersectoral influences that impact on healthy ageing. They also shape the broader context in which more focused action can be taken by the health and social care sectors. This action is addressed in strategic objectives 3 and 4, Aligning health systems to the needs of older populations, and Developing systems for providing long-term care (home, communities and institutions). Even though the strategy identifies these two objectives separately, in order to facilitate specific sectoral actions, they need to be considered as part of an integrated continuum of care. The final strategic objective, Improving measurement, monitoring and research on healthy ageing, addresses the actions that are needed to help build the evidence base, which can ensure that all actions have the intended impacts, are equity-oriented and cost-effective. Together the five strategic objectives are interlinked, interdependent and mutually supportive, and they are aligned to this vision for healthy ageing. Each of the five strategic objectives comprises three priority areas for action.

27. The proposed contributions that Member States, the Secretariat and other partners can make towards this vision and these strategic objectives during the period 2016–2020 are outlined in the Appendix. They are framed under two goals. While there are many significant gaps in our understanding of the factors that can foster healthy ageing, in many fields there is sufficient evidence to identify action that can be taken now to help achieve this vision. The first goal, “Five years of evidence-based action to maximize functional ability that reaches every person”, is therefore framed around ensuring that this action is taken as widely as possible and in ways which ensure that particular attention is paid to those with the least access to the resources they need to maintain their functional ability.

28. However, the *World report on ageing and health* acknowledges the lack of evidence and infrastructure in many crucial areas. The second goal, “By 2020, establish evidence and partnerships

necessary to support a Decade of Healthy Ageing from 2020 to 2030”, seeks to use the five-year period 2016–2020 to fill these gaps and ensure that Member States and other stakeholders are positioned to undertake a decade of evidence-informed, concerted action from 2020 to 2030.

STRATEGIC OBJECTIVE 1: COMMITMENT TO ACTION ON HEALTHY AGEING IN EVERY COUNTRY

29. Fostering healthy ageing requires leadership and commitment. Investment in the well-being of older people will have significant economic and social returns. In some cases, the return on these investments is direct. For example, investment in health systems that are better aligned to the needs of older people will result in them experiencing greater intrinsic capacity, which, in turn, will enable them to participate and contribute more actively. Other returns may be less obvious but are no less important. For example, investing in long-term care helps older people with a significant loss of capacity to maintain lives of dignity and continued personal growth, but it can also protect families from impoverishment, allow women to remain in the workforce and foster social cohesion through the sharing of risk across a community. Much of the investment in infrastructure or policy to foster healthy ageing will also have direct benefits for other sections of the population. For example, improved access to transportation, public buildings and spaces, or assistive, information and communication technologies can facilitate inclusion and participation of all people, including those with disabilities and parents with young children. More integrated and person-centred health systems will benefit everyone.

30. Enabling all people to live a long and healthy life requires a multisectoral approach with strong engagement from diverse sectors and different levels of government. Collaboration is also needed between government and nongovernmental actors, including service providers, product developers, academics and older people themselves. A key step to fostering action must therefore be to build the coalitions and shared understanding that can enable this multisectoral commitment.

31. However, this strategy does not propose that action on healthy ageing is necessarily undertaken as an independent programme of work. In many cases, the most effective approach will be to integrate evidence-based actions within the work of other health programmes and partnerships, or within other sectors’ policies and laws, for example those dealing with housing, transportation, social protection, education and employment. But action on healthy ageing will not happen by itself. It requires leadership, coordination and a far greater understanding of the aspirations, potential and needs of an increasingly large segment of all populations. This commitment can establish the broad political and operational platform that enables, and gives legitimacy to, effective multidimensional action. A central responsibility of this leadership and commitment will be to ensure that older people and their representative organizations are informed, consulted and actively involved in formulating, implementing and monitoring policies and laws that affect them.

32. The strategy does however propose that a fundamental step in fostering healthy ageing is to combat ageism. Some of the most important barriers to action and effective public health policy on healthy ageing are pervasive misconceptions, negative attitudes and assumptions about ageing and older people. These can influence individual behaviour (including that of older people themselves), social values and norms. They can also sway the focus of research and policy on ageing and health by shaping the conceptualization of problems and potential solutions, and the way in which institutions develop and implement rules and procedures. Unless ageism is tackled and these fundamental beliefs and processes are changed, our capacity to seize innovative opportunities to foster healthy ageing will be limited. This will require diverse actions including legislation, interventions to shift social norms, and education.

33. This strategic objective therefore focuses on creating national and regional frameworks for action, enabling Member States to access and use existing evidence and making concrete efforts to tackle ageism as an essential step in fostering healthy ageing.

Strategic objective 1.1: Establish national frameworks for action on healthy ageing

34. Governance is not just about government but extends to its relationship with the private sector, nongovernmental organizations and civil society. However, as the ultimate guardian of ensuring that people live long and healthy lives, governments, across their various administrative levels, have the responsibility to put in place appropriate policies, financial arrangements and accountability mechanisms. This needs to occur across all sectors and at different level of government.

35. Clear and evidence-informed national and regional strategies or policies that address ageing and health are needed. Effective governance of healthy ageing also requires the development of legislation, evidence-based policies and plans, whether as independent documents or integrated across health and other sectors, that pay explicit attention to equity and the inherent dignity and human rights of older people. These must adopt a rights-based approach to development and systematically incorporate the views of older people. As such, these plans need to be linked to effective coordination and accountability mechanisms, to ensure their implementation. They can be reinforced by a strong civil society, particularly associations of older people and families and carers, which can help to create more effective and accountable policies, laws and services for healthy ageing. Action will also benefit from the evaluation and sharing of experiences to support healthy ageing across countries.

Strategic objective 1.2: Strengthen national capacities to formulate evidence-based policy

36. Although there are major knowledge gaps, we have sufficient evidence to act now, and there is something that every country can do irrespective of its current situation or level of development. To ensure that action is informed by evidence, policy-makers need to be aware of key research findings and be empowered to include them in policy development. This will require more effective mechanisms to bridge the divide between how knowledge is generated and how it is used. These mechanisms include: considering the policy context, such as the role of institutions, political will, ideas, interests; facilitating evidence and knowledge creation that is relevant and timely, and conducting relevant research on ageing and health for use in that policy context, including cost-effective health system interventions applicable to the local setting; communicating better and making research findings accessible to decision-makers, by synthesizing and packaging the evidence in a way that policy-makers can use; and empowering decision-makers to use this information through a culture that values evidence and its uptake.

37. One mechanism for fostering this translation of knowledge into policy and practice is policy dialogues that draw together existing evidence and assess its relevance to national priorities. It will be important to involve civil society, representing diverse age groups and interests, in these processes, to shape policy development and implementation in line with social expectations.

Strategic objective 1.3: Combat ageism and transform understanding of ageing and health

38. Combating ageism must lie at the core of any public health response to population ageing. While this will be challenging, experience of dealing with other widespread forms of discrimination such as sexism and racism shows that attitudes and norms can be changed. Combating ageism requires, at the institutional level, the adoption of laws to protect against age-based discrimination, the modification or repeal of laws, customs or practices that discriminate directly or indirectly, as well as

the establishment of other appropriate administrative measures where needed. A key feature will be to break down arbitrary age-based categorizations (such as labelling those over a certain age as old). These overlook the great diversity of ability at any given age and can lead to simplistic responses based on stereotypes of what that age implies. Removing these restrictive social constructs can reinforce the view that, while older age will often entail losses, it can also be a period of personal growth, creativity and productivity.

39. Combating ageism also requires a new way of understanding ageing and health that moves away both from the conceptualization of older people as a burden and from unrealistic assumptions that older people today have somehow avoided the health challenges of their parents and grandparents. More accurate portrayals of ageing and health will adopt a life course perspective and seek to increase trust and break down barriers between generations, while providing a sense of common identity and respect for differences. Core strategies include communication campaigns that directly challenge ageism and concerted efforts in the media and entertainment to present a balanced view of ageing.

40. Another key step in challenging ageism will be to consolidate evidence on the current roles and needs of older people. New economic models are required that comprehensively assess the total contributions of older people; the cost of care provision (not just to public services but to the informal carers who often provide it); and the benefits of interventions to foster healthy ageing on older people's functioning, on their contributions and on society more broadly (for example on the need for care). The evidence generated will provide an ongoing reference for subsequent public discourse.

STRATEGIC OBJECTIVE 2: DEVELOPING AGE-FRIENDLY ENVIRONMENTS

41. Environments are the contexts in which people live their lives. Environments that are age-friendly help to foster healthy ageing in two ways: by supporting the building and maintenance of intrinsic capacity across the life course, and by enabling greater functional ability so that people with varying levels of capacity can do the things they value.

42. Actions to create age-friendly environments can target different contexts (the home or community, for example) or specific environmental factors (such as transport, housing, social protection, streets and parks, social facilities, health and long-term care, social attitudes and values), and they can be influenced at different levels of government (national, regional or local). When actions also take into consideration social exclusion and barriers to opportunity, these efforts to build and maintain functional ability can also serve to overcome inequities between groups of older adults.

43. The WHO global network of age-friendly cities and communities provides a good example of how age-friendly environments can be successfully implemented at local level. The network brings together municipalities from across the world that, through multisectoral action, are making their environments better places for older people to live. By taking the needs and preferences of older people as a starting point for shaping age-friendly environments, rather than looking only at a service or adopting a supply-side perspective, they ensure that specific approaches are relevant to local populations.

44. When age-friendly actions are coordinated across multiple sectors and levels, they can enhance a range of domains of functional ability, including the "abilities" to meet basic needs; to be mobile; to continue to learn, grow and make decisions; to build and maintain relationships; and to contribute. When multiple sectors and stakeholders share a common goal of fostering functional ability and shape development in ways that foster these specific abilities, this can help ensure that older people age safely in a place that is right for them, are free from poverty, can continue to develop personally and

can contribute to their communities while retaining autonomy and health. This approach is equally relevant in emergency situations.

45. However, while population-level interventions such as accessible transportation may provide a resource for all older people, some will not be able to benefit fully without individually tailored supports that foster their autonomy and engagement. For example an older woman's ability to be mobile may be determined by her desire to get out and about, and the availability of specific mobility devices which correlate to her need (walker, wheelchair, etc.), as well as the level of accessibility and safety of footpaths, buildings, lighting, and the kindness of the bus driver or other passengers to help her get on or off the bus.

46. This strategic objective outlines approaches to maximize older people's participation, with a focus on fostering autonomy and enabling their engagement. Because multisectoral action is required to achieve these, the third approach suggests how sectors can efficiently work together for the greatest impact.

Strategic objective 2.1: Foster older people's autonomy

47. Autonomy has been repeatedly identified by older adults as a core component of their well-being and has a powerful influence on their dignity, integrity, freedom and independence. Older adults have the right to make choices and take control over a range of issues, including where they live, the relationships they have, what they wear, how they spend their time, and whether they embark on a treatment. Nevertheless, many older adults – particularly women – do not yet enjoy these opportunities across the life course. These fundamental rights and freedoms must exist regardless of age, sex or level of intrinsic capacity, including in emergency situations and institutional care, and need to be enshrined in law (addressed in strategic objective 1).

48. Autonomy is shaped by many factors, including the capacity of older people; the environments they inhabit; the personal resources (such as relationships with children and other family members, friends, neighbours and broader social networks) and financial resources they can draw on; and the opportunities available to them. Autonomy is heavily dependent both on an older person's basic needs being met and on access to a range of services, such as transport and lifelong learning (addressed in strategic objective 2.3). Older people's autonomy can be particularly compromised in emergency situations, if appropriate action is not taken.

49. Enhancing autonomy regardless of an older person's level of capacity can be achieved through a range of mechanisms, including advanced care planning, supported decision-making and access to appropriate assistive devices. When adapted to the individual and his or her environments, both of which may change over time, these mechanisms can enable older people to retain the maximum level of control over their lives. Other actions that impact directly on older peoples' autonomy include protecting and ensuring their human rights through awareness-raising, legislation and mechanisms to address breaches of these rights.

50. As outlined in the *World report on ageing and health*, one key threat to autonomy is elder abuse, which currently affects 1 in 10 older people living in the community and an even higher proportion living in institutions. Another threat to autonomy is falls. Some 30% of people older than age 65, and 50% of people older than age 85, living in the community will fall at least once each year. Specific actions are therefore required to protect older people's rights to freedom from injury, violence and abuse.

Strategic objective 2.2: Enable older people's engagement

51. Engaging older people in development processes can help to build societies that are cohesive, peaceful, equitable and secure. Excluding them from these processes not only undermines their well-being and contributions, it can also impact heavily on the well-being and productivity of other generations. For example, older people make numerous social and economic contributions to their families, communities and society such as assisting friends and neighbours, mentoring peers and younger people, caring for family members and the wider community, and as consumers, workers and volunteers. Enabling the participation of older people must therefore be a central goal of socioeconomic development, and ensuring that they can engage in and benefit from these processes is essential.

52. Investing in older people through community groups, organizations of older people and self-help groups, for example, can facilitate older people's engagement. When these organizations are suitably developed and funded, they can also play an important role in service delivery, including in emergency situations, by for instance identifying older people at risk of isolation and loneliness, providing information, peer support and long-term care, and ensuring that older people have the opportunity to continually build and maintain the skills they need to navigate, benefit from and influence a changing world.

Strategic objective 2.3: Promote multisectoral action

53. Most policies, systems or services have a direct impact on older people's ability to experience healthy ageing. The way in which these are delivered is also likely to have differential impacts on older people and their families.

54. No sector alone can foster the functional ability of older people. The ability to be mobile, for instance, is influenced directly by sectors responsible for transportation, urban planning, housing, information, health and social welfare. Working together can have important efficiency gains, as action in one arena may reduce the need for others. Making housing modifications or providing assistive technologies, for example, may reduce the need for long-term care.

55. National or regional strategies and action plans on healthy ageing, as outlined in strategic objective 1, can provide a framework for action by relevant stakeholders. However, concrete and concerted actions need to be taken within and across sectors, if these frameworks are to have a positive impact on the functional ability of older people. Furthermore, these efforts need to encompass the diverse multisectoral programmes and initiatives that are required to foster functional ability, including developing and sustaining social protection systems, improving access to adequate housing, enabling lifelong learning, delivering effective health and long-term care, and fostering older people's contributions in the labour force, through volunteering and other social roles. Implementation of these programmes and initiatives will naturally vary from setting to setting, between levels of government and depending on the situation (for example, in contexts affected by disasters or not).

56. Collecting and using age- and socioeconomic-disaggregated information on older people's functional abilities is important to document inequalities and address inequities, and to assess the effectiveness of and gaps in existing policies, systems, and services in meeting the needs and rights of all older people. Having access to information and good practice are also important for governments and other key stakeholders to support the implementation of action plans, advocate for action and generate political and technical support for implementation.

STRATEGIC OBJECTIVE 3: ALIGNING HEALTH SYSTEMS TO THE NEEDS OF OLDER POPULATIONS

57. As people age, their health needs tend to become more chronic and complex. Health systems and services that address these multidimensional needs in an integrated way have been shown to be more effective than services that simply react to specific diseases independently. Yet many existing systems are better designed to cure acute conditions, continue to manage health issues in disconnected and fragmented ways, and lack coordination across care providers, settings and time. This results in health care and other services that not only fail to adequately meet the needs of older people but also lead to significant and avoidable costs, both for older people and for the health system. Where services do exist, there are frequently barriers that limit older people's access to them, such as lack of transport, unaffordability and ageism in health care delivery.

58. Problems that matter for older people, such as pressure ulcers, chronic pain and difficulties with hearing, seeing, walking or performing daily or social activities, are often overlooked by health professionals. In primary health care, the clinical focus still generally remains on detection and treatment of diseases; because these problems are not framed as diseases, health care providers may not be aware how to deal with them, and frequently lack guidance or training in recognizing and managing impairments and geriatric syndromes. This leads to older people disengaging from services, not adhering to treatment or not admitting themselves to primary health care clinics, based on the belief that there is no treatment available for their problems. Further early markers of functional decline, such as decreases in gait speed or muscle strength, are often not identified, treated or monitored, which is crucial for delaying and reversing declines in capacity. New approaches and clinical intervention models need to be introduced at primary health care level, if the aim is to prevent care dependence and maintain intrinsic capacity.

59. A transformation is needed in the way that health systems are designed, to ensure affordable access to integrated services that are centred on the needs and rights of older people. These systems will need to respond to the diverse needs of older people, including those who are experiencing high and stable levels of intrinsic capacity, those in whom capacity is declining, and those whose capacity has fallen to the point where they require the care and support of others.

60. This can be achieved through the common goal of helping older people to build and maintain the best possible functional ability at all stages of life. It will require coordination between a wide range of services, including health promotion and disease prevention; screening, early detection and acute care; ongoing management of chronic conditions; rehabilitation and palliative care. Coordination between different service levels and between health and social services will be crucial. Where an older person's capacity has fallen, provision of assistive technologies is also likely to be important.

61. As a first step, services will need to be designed around older people's needs and preferences. This can best be achieved by involving older people themselves in service planning. Many practical issues will need to be considered, including the difficulty that older people may have waiting in a queue or standing for prolonged periods, as well as the need for adequate toilets. Furthermore, services and staff need to treat older people with the respect they deserve, and this will include communicating in ways that are effective and that take account of common visual and hearing impairments.

Strategic objective 3.1: Orient health systems around intrinsic capacity and functional ability

62. Building systems that enable the best possible trajectories of functional ability across the life course will require the fundamental drivers of systems to be aligned to this shared goal. This will require significant changes to the collection, recording and linkage of health and administrative information, which is currently often condition- or intervention-based. Information on trajectories of functioning can be readily drawn from the assessments of ability and capacity that are the starting point for older person-centred and integrated care and should be routinely collected at each encounter with the system. Mechanisms are needed to automate the storage of this information, to allow trends in functioning over time to be routinely determined. This can benefit clinical practice, but in the future it could also form the basis for performance management and financing mechanisms. For example, the remuneration of and incentives for care providers could be oriented towards enabling the best possible trajectories of functioning, rather than the provision of specific interventions.

63. In many settings, other fundamental building blocks of services will also need to be reviewed, to ensure that older people have access to the care they need. For example, the medical products and assistive devices that are necessary to optimize older people's intrinsic capacities and functional ability will need to be identified and made accessible. While intraocular lenses that are used in surgery for cataracts may seem a luxury in low-resource settings, surgery can be completed in a few minutes under local anaesthetic and can make the difference between older people retaining their autonomy or becoming dependent on the care of others.

64. Harnessing technological innovations (including assistive technologies and information and communication technologies) may be particularly useful, and this is true in clinical, home and community settings. Technological innovation, or the convergence of existing technologies, may also help lower-resource countries to develop service models that "leapfrog" models delivered in other settings.

65. Since many of the disorders of older age are preventable, and many of their determinants begin earlier in life, systems will need to include effective strategies for the prevention of disease and declines in capacity. At younger ages, and when capacity is high, the priority will be on preventing the common noncommunicable diseases by enabling physical activity and good nutrition, avoiding tobacco and fostering the responsible use of alcohol. These factors remain important throughout life, but if capacity starts to decline, other approaches that help older people to avoid or delay care dependence begin to emerge. New models of health promotion and disease prevention in older age are needed, to ensure these strategies are evidence-based. Much of the resulting action will be situated in the environments that an older person inhabits.

Strategic objective 3.2: Develop and ensure affordable access to quality older person-centred and integrated clinical care

66. The entry point to older person-centred and integrated care is a strong case management system, in which individual needs are assessed and a comprehensive personalized care plan is developed around the single goal of maintaining functional ability. These plans should be designed to consider the older person's preferences and objectives, how they can best be addressed and how progress will be followed up. A key aim will be to foster self-management by providing peer support, training, information and advice, both to older people and to their caregivers.

67. Mechanisms to ensure that older people can access services without financial burden will be crucial. Sustainable financing models are urgently needed to underpin the comprehensive and integrated services that older people require. These should consider the need to minimize out-of-pocket spending and fragmentation within the health system.

68. Integration and a focus on ability do not mean that services and interventions for the key conditions of older age should be neglected. These include musculoskeletal and sensory impairments; cardiovascular disease and risk factors such as hypertension and diabetes; mental disorders, dementia and cognitive declines; cancer, oral health and geriatric syndromes such as frailty, urinary incontinence, delirium and falls. Continued research is needed to improve the treatments available for each of these conditions, and processes should be established to ensure that research findings are translated into practice. But the management of each of these conditions will need to be coordinated around the functional ability of the older person. It will also need to take account of the comorbidities common in older age, the associated risk of polypharmacy, and the combined impacts that they have on functioning. This may require the development of new clinical guidelines on how to optimize trajectories of intrinsic capacity, or the updating of existing guidelines on specific conditions to consider their impact on capacity. Services that enable recovery from declines in capacity will also be important, as will ensuring that all older people who need it have access to palliative care.

69. Furthermore, not all the health challenges experienced in older age are chronic. Older people can suffer rapid deteriorations in health as a result of a minor acute illness or exacerbation of an existing condition. Frail older people in particular thus require timely access to acute and specialist geriatric care. Moreover, older people in general retain the need for mental health and sexual health services, including the prevention and treatment of sexually transmitted infections, and as part of wider efforts to ensure and promote and protect rights and freedoms for all.

70. To enable older people to age in a place that is right for them, services should be situated as close as possible to where they live, including delivering services in their homes and providing community-based care.

Strategic objective 3.3: Ensure a sustainable and appropriately trained, deployed and managed health workforce

71. All service providers require the competencies appropriate to addressing older people's needs. These include gerontological and geriatric skills, as well as the more general competencies that are needed to provide integrated care, such as the ability to share information using information and communication technologies, combat ageism and provide self-management support. By its nature, the clinical care of older people requires the involvement of multidisciplinary teams, and competencies in working in this environment will also be essential, whether providers work in hospital or community settings.

72. Ensuring an adequately trained workforce will first require the nature, quantity and characteristics of these competencies to be defined. They should then be included in the curricula of all health professionals. Existing service providers are likely to require professional development to achieve them.

73. Ensuring that the supply of geriatricians meets population needs and encouraging the development of specialized units for the management of complex cases will also be important. This can ensure the appropriate treatment of more complex cases and can be a vehicle for research to identify better models of care.

74. New workforce cadres (such as care coordinators and self-management counsellors) and career paths will also need to be considered, as will options for extending the roles of existing health workers, whether paid or unpaid, working in institutions or in communities. In many countries, one challenge that will need to be faced will be the ageing of the health workforce. Employment models that foster retention of these skilled workers will need to be explored.

STRATEGIC OBJECTIVE 4: DEVELOPING SUSTAINABLE AND EQUITABLE SYSTEMS FOR LONG-TERM CARE

75. In many people's lives there will come a stage when they experience a significant loss of capacity. This is particularly true in older age. As part of the right to health, older people with, or at high risk of, a loss of capacity have a right to receive care and support that maintains the best possible level of functional ability and that is consistent with their human rights, fundamental freedoms and human dignity.

76. Worldwide, the number of older people requiring care and support is increasing rapidly. At the same time, the proportion of younger people who might be able to provide this care is falling, and women, the traditional caregivers within many families, are already filling, or aspiring to, other social and economic roles. As a result, the assumption that families alone can meet the needs of older people with significant losses of capacity is outdated and neither sustainable nor equitable.

77. In the 21st century, therefore, every country needs to have a comprehensive system for long-term care that can be provided at home, in communities or within institutions. These systems have many benefits beyond enabling care-dependent older people to continue to do what they value and to live lives of dignity. These include freeing women to pursue what they value, reducing inappropriate use of acute health services and helping families avoid poverty and catastrophic care expenditures. By sharing the risks and costs associated with care dependence across generations, long-term care systems can thus help foster social cohesion.

78. In framing how this can be achieved, the strategy adopts the definition of long-term care used in the *World report on ageing and health* – “The activities undertaken by others to ensure that people with or at risk of a significant ongoing loss of intrinsic capacity can maintain a level of functional ability consistent with their basic rights, fundamental freedoms and human dignity”.

79. Two key principles underpin this definition. First, even in circumstances of significant loss of functioning, older people still “have a life”. They have the right and deserve the freedom to realize their continuing aspirations to well-being, meaning, and respect. Second, as with other phases of life, intrinsic capacity during this period is not static. Rather, declines in capacity are part of a continuum and in some cases may be preventable or reversible. Fully meeting the needs of someone at this stage of life therefore demands that efforts be made to optimize these trajectories of capacity, thus reducing the deficits that will need to be compensated for through other mechanisms of care.

80. Each country needs to develop a system that takes account of its economic and cultural context, and which can take advantage of existing health and social care delivery systems in ways that foster intergenerational equity. There is no single system of long-term care that can be applied in every setting, nor even in countries with similar resource constraints. Long-term care systems should be based on an explicit partnership between older people, families, communities, other care providers, and both the public and private sectors.

81. A key role of government is to steward these partnerships and to build a consensus on the system that is most appropriate. Furthermore, governments in all settings also have a role to play in ensuring that the numerous components of the system are in place, including a sound regulatory framework, training and support for caregivers, coordination and integration across various sectors (including with the health system), and mechanisms such as accreditation and monitoring to ensure quality. In many countries, the public sector will also directly provide services, particularly to those most in need (either because of their loss of capacity, their socioeconomic status or marginalization).

Strategic objective 4.1: Establish and continually improve a sustainable and equitable long-term-care system

82. Establishing a sustainable system requires a governance structure that can guide and oversee development and assign responsibility for making progress. This can help define the key services and roles, their expected benefits and who should deliver them, as well as the barriers that may exist to their being fulfilled. A key focus would be on developing the system in ways that help older people to age in a place that is right for them and to maintain connection with their community and social networks, and that are aligned to people's needs through the provision of person-centred, integrated care (including with the health system). As a part of universal health coverage, ensuring access to this care without the risk of financial hardship for the older person, caregiver or family, will require resourcing and a commitment to prioritize support for those with the greatest health and financial needs.

83. A number of actions may help in achieving these aims. A clear recognition that long-term care is an important public health priority will be central. This can be linked to acknowledging the right of older people with significant losses of capacity to appropriate care and support, and anchoring this in national legislation to ensure access to quality services, with special attention to poor and marginalized older people. It will also be crucial to identify responsibility for system development and to initiate or review planning, defining the roles of government and other stakeholders and identifying the approaches that will be necessary to fulfil these roles, such as regulation, incentives and monitoring. Finally, sustainable and equitable mechanisms for resourcing and support will need to underpin any system, and these will need to be identified and developed.

Strategic objective 4.2: Build workforce capacity and support caregivers

84. A comprehensive long-term care system will require all who contribute to it to be adequately skilled and appropriately supported. Many of the actions outlined under strategic objective 3.5 will be relevant for training providers of long-term care services. However, because the field of long-term care is undervalued in most countries, a crucial action will be to ensure that paid caregivers are accorded the status and recognition that their contribution deserves. Furthermore, unlike in the health system, the majority of caregivers in the long-term care system are currently family members, volunteers, members of community organizations, or paid but often untrained workers. Many of them are, themselves, older people and most are women. Special efforts will be needed to ensure that all these caregivers have access to the resources, information and/or training they need to perform their role. This will ensure that older people receive the best possible care and relieve caregivers of the stress that arises from being insufficiently informed and skilled in how to deal with challenging situations. Other mechanisms that can ease the load on caregivers include the provision of respite care and of flexible working arrangements or leaves of absence for members of the workforce.

85. Extending the current workforce will also be important. An adequately skilled and appropriately supported workforce will help retain care workers. One important possibility lies in the greater

engagement of men and younger people, as well as of non-family members such as peers. Another is to draw on older volunteers who have been empowered through older people's associations. Good examples exist in many low- and middle-income countries, and these concepts and good practices may be transferrable across countries and settings.

Strategic objective 4.3: Ensure the quality of person-centred and integrated long-term care

86. Long-term care services need to be oriented around the functional ability and well-being of older people. This requires systems and caregivers to provide care in a way that both supports the best attainable trajectory of intrinsic capacity and compensates for loss of capacity through support, care and environmental action to maintain functional ability at a level that ensures well-being and allows an older person to age in a place that is right for them. This can be achieved through care that is integrated across many professions and settings, as well as condition- and care-specific services (dementia and palliative care, for example). Using innovative assistive health technologies or drawing on existing technologies in innovative ways for coordination, support and monitoring may be particularly important.

87. Ensuring the quality and effectiveness of this care requires appropriate guidelines, protocols and standards. It will also need mechanisms to accredit care providers (both institutional and professional), protect the rights of recipients, and monitor and evaluate the impact of long-term care provision on recipients' functional ability and well-being.

88. A key step will be to identify models of long-term care in different settings that have the greatest impact on healthy ageing trajectories. Coordination across and between services (including between long-term care and health care services) can be facilitated through case management. Quality management systems that identify critical care points, with a focus on optimizing functional ability and well-being, will also be required. These will need to be underpinned by mechanisms to protect the rights and autonomy of care recipients.

STRATEGIC OBJECTIVE 5: IMPROVING MEASUREMENT, MONITORING AND RESEARCH FOR HEALTHY AGEING

89. Progress on healthy ageing will require more research and evidence on age-related issues, trends and distributions, and on what can be done to promote healthy ageing across the life course. Many basic questions remain to be answered. These include:

What are older people's needs and preferences? How diverse are these? What are the healthy ageing outcomes that people value and want societies to contribute to?

What are current patterns of healthy ageing? Is increasing life expectancy associated with added years of health?

What are the determinants of a long and healthy life, including structural, biological, social, individual or systems-related determinants? For example, what environmental features make a difference for healthy ageing outcomes? What biological or cellular advances can be made accessible and relevant to the widest range of people, particularly those with least resources?

What are the current needs of older people for health care and long-term care, and are they being appropriately met? How do we know whether someone has retained their autonomy?

How should differences in healthy ageing be measured, especially differences that are relevant for policy and action?

Are inequalities increasing or narrowing? For each context, what inequalities are inequities?

Which interventions improve trajectories of healthy ageing, and in which contexts and population subgroups do they work?

Are the availability, effectiveness and coverage of these interventions improving?

What is the appropriate timing and sequencing of these interventions in diverse contexts?

How can clinical research approaches be improved to generate information on the effectiveness and cost-effectiveness of therapies in older people or people with comorbidities?

What are the attributes of an age-friendly environment? Which interventions work to create more age-friendly environments?

What are the economic and other contributions of older people? What are the total costs of losses of functional ability in older age on the individual older person, his or her family and community? What is the return on investments in health services, social care and other forms of social protection for older people?

What are the best and most sustainable investments to foster healthy ageing across the life course?

90. Addressing these and other questions requires research in a range of disciplines that will be relevant to multiple sectors, with evidence produced in a way that can inform policy choices. It will require thorough evaluations of policies and interventions that are put in place. One fundamental step will be to understand the needs, rights and expectations of older people and their families. Another will be to better understand the interactions that older men and women have with their communities, social networks, the health and social sectors, and the broader environment. This will require qualitative and quantitative studies that document how these differ by socioeconomic or other characteristics, including gender and place of residence, and how these relationships have changed over time.

91. Historically, many data collection efforts have excluded older people or aggregated data above a certain age, for example 60 or 65 years. National statistics and surveillance approaches will need to become inclusive of older people, to the oldest age groups, and in sufficient numbers to document their experiences and diverse contexts. Information resources will need to be disaggregated by age, sex and other characteristics, including civil status. This must be integrated in the design, collection and reporting of vital statistics and general population surveys, and approaches will be needed to link and analyse data across sectors. At present, when data on older people and functioning are collected, the instruments used are limited to identifying only those with disease or advanced losses of capacity. New methods and instruments are needed that can capture trajectories of healthy ageing and their determinants, outcomes and distributions across the life course, and these will need to be incorporated in routine data collection and other periodic population surveys.

92. To gauge the degree to which health and social systems are aligned to the needs of older adults, studies will need to consider not just the presence or absence of chronic and acute diseases, but also the presence of comorbidities and the impact that they have on older people's capacity and functional

ability. This must be supplemented by better information on how the needs arising from these conditions are being met, either by services spanning health promotion, disease prevention, treatment, rehabilitation and palliative care, or broader social systems. Research will also be needed to consider to what extent the full range of services that older people require are available, effective and do not impose a financial burden on individuals or their families. The involvement and contribution of older people in setting priorities and developing methods, as study respondents and as stakeholders in reviewing results, are likely to lead to more relevant and more innovative study designs and interventions, whether in terms of policies, services, devices or products.

93. Multicountry and multidisciplinary studies that are representative of population diversity and the distinct contexts of older men and women will also be important. These can help identify what works in different contexts and among diverse populations. Global and local mechanisms will also be needed to ensure synthesis and rapid translation of knowledge and evidence into policy and practice. This will include the communication of information to decision-makers in forms that are most relevant to them, such as “best practices” or “best buys” in health promotion and clinical practice, population-based health interventions, age-friendly homes and communities, and health in all policies. But it will also require researchers to be engaged in processes that allow them to better understand the knowledge gaps that limit policy development and to be encouraged to fill these.

94. As evidence builds, accountability frameworks and mechanisms will be needed to monitor progress. These should incorporate the values enshrined in this strategy, spanning global targets, universal periodic reviews of human rights, health system performance evaluations, and commitments to age-friendly cities and communities, among others.

Strategic objective 5.1: Agree on ways to measure, analyse, describe and monitor healthy ageing

95. The current metrics and methods used in the field of ageing are limited, preventing a comprehensive understanding of the health issues experienced by older people and the usefulness of interventions to address them. Transparent discussions on values and priorities are needed, involving older people and other stakeholders, to inform how operational definitions and metrics on a long and healthy life can be constructed and implemented within monitoring, surveillance and research. Consensus should be reached on common terminology and on which metrics, biological or other markers, data collection measures and reporting approaches are most appropriate. Improvements will draw on a range of disciplines and fields, and should meet clear criteria.

96. Among other priorities, these new approaches will need to measure and analyse trajectories of intrinsic capacity and functional ability across the life course, distinguish between the capacity of the individual and the impact of the broader environment, take account of the different physiology of older people and the high prevalence of multimorbidity when assessing the impact of clinical interventions, and capture the unique views of older people on what constitutes health and well-being. New analytical approaches are also needed to obtain more robust and comprehensive economic assessments of the impact of poor health on older people and the benefits of population-wide and clinical interventions.

Strategic objective 5.2: Strengthen research capacities and incentives for innovation

97. For all countries, fostering healthy ageing also requires promoting innovation, voluntary knowledge exchange and technology transfer, and attracting resources (people, institutions and financing) to address the major challenges faced. Development of innovations (in areas ranging from assistive technologies and pharmaceuticals to care models and forecasting of scenarios) must be inclusive of older people well into the oldest age groups, in terms of design and evaluation that recognize the different physiology of older men and women. This will require significant strengthening of capacity at system, institutional and individual levels. It will also need greater collaboration across organizations, disciplines and countries.

98. Multidisciplinary research, incorporating gender-sensitive and equity-oriented analyses involving older people at every stage, is needed to produce evidence that can inform new policies and evaluate existing ones. Ethical guidelines are needed to guide governments and stakeholders at all levels, to address competing demands for resources, and to develop more inclusive approaches that optimize the functional ability of every person.

99. Much innovation relevant to older people will occur in disciplines other than gerontology and geriatrics. Yet outdated stereotypes of older age often limit the capacity of researchers in many fields to consider and identify opportunities for intervention. Even in health disciplines, ageist attitudes can limit research progress.

100. Global research priorities that enable a better understanding of population ageing and health in the 21st century are needed, to address the determinants of healthy ageing and evaluate interventions to improve them. Researchers and other knowledge producers should be well informed and equipped. Resources will also need to be shifted to emerging areas or to address fundamental gaps, and findings must be easily accessible worldwide.

Strategic objective 5.3: Research and synthesize evidence on healthy ageing

101. In order to mount an effective and sustainable public health response to population ageing, much better information is required on the needs and preferences of older people; whether these are currently being met; what influences trajectories of healthy ageing; what works to improve them; and the cost-effectiveness of these interventions. Research and evaluation studies should identify what can be done to enable every person to reach relatively high and stable capacity, to support those with declining capacity, and to support those with significant losses of capacity.

102. As a start, population-based studies of older people at home, in communities and in institutions can identify the levels and distribution of intrinsic capacity and functional ability, how these are changing over time, and to what extent older people's needs for and expectations of health services and care are being met. This information should be collected in ways that allow valid and reliable comparison between settings and over time.

103. More evidence is also required on how to shape underlying political, social, biological and environmental conditions and determinants, as these contribute to and differentially affect healthy ageing trajectories across the life course within a given society and across countries. Another priority will be to determine ways to regulate, select and integrate medical, health and social services to best support older adults at home, in the community or in institutions. This would need to include consideration of their governance and organization, access and financing, and their delivery by health professionals and informal caregivers, as well as assessment of system performance. Research is also urgently needed on ways to improve the broader environmental context and multisectoral mechanisms that influence healthy ageing and to identify action that might be taken in the household, community, workplace or other locations to improve these impacts.

104. Increasing recognition that many of the determinants of healthy ageing lie earlier in life has prompted interest in how life course approaches might be used to identify critical periods for action. This analysis should include how inequities and vulnerabilities (or strengths and resilience) are accumulated and determined. Greater use of longitudinal cohort studies can clarify cause-and-effect relationships and consider what development processes shape initial and lasting differences in health. Such studies, combined with natural experiments and evaluations, may also clarify the sequencing and effectiveness of interventions that can mitigate and overcome vulnerabilities, or further support desired outcomes.

105. Finally, better clinical research is urgently needed on the etiology of, and treatments for, the key health conditions of older age, including musculoskeletal and sensory impairments, cardiovascular disease and risk factors such as hypertension and diabetes, mental disorders, dementia and cognitive declines, cancer, and geriatric syndromes such as frailty. This must include much better consideration of the specific physiological differences of older men and women and the high likelihood that they will be experiencing multimorbidities. This could also be extended to include possible interventions to modify the underlying physiological and psychological changes associated with ageing.

RESOURCES

106. Multiple actors and agents will need to align, collaborate and coproduce healthy ageing. These include formal tiers of government, individuals in communities and as patients and caregivers, and a wide spectrum of networks, associations, businesses and organizations in diverse sectors. The Programme budget 2016–2017 describes the financial resources required by the Secretariat for work to meet the Organization-wide strategic objective on ageing and health; however, the resources allocated to the area of Ageing and health are less than adequate to meet expectations. For future biennia, additional resources will be required, given the pace of population ageing and the increasing opportunities to foster healthy ageing. Further progress towards healthy ageing, regionally and nationally is dependent on the amount of additional resources available and allocated to this area, and on effective, joined-up actions across all programmes, departments and levels of the Organization. All partners – including intergovernmental and nongovernmental organizations, academic and research institutions and the private sector – will need to do more to mobilize resources at all levels.

MILESTONES 2016–2020

107. Working together to implement the global strategy requires a whole-of-government and whole-of-society response. Moreover, the specific actions identified in the Appendix for the period 2016–2020 require a timetable and milestones to which Member States and key stakeholders and development partners can commit themselves. This is part of the process of accountability for and commitment to collaboration across governments, nongovernmental organizations, countries and other stakeholders. One of the first milestones identified for this five-year period is therefore the development of a set of core quantifiable process indicators related to the action plan's objectives by the end of December 2016. These will be used to measure subsequent progress and contribute to accountability. They would mostly focus on action taken by Member States and by the Secretariat, with an investment case for this work, also prepared. Together, they will help monitor whether overall implementation is on track, whether resources and collaborations are in place, and whether course correction is required, towards the vision of healthy ageing. The indicators will also be used to gauge the extent to which preparations have advanced towards planning for a Decade of Healthy Ageing during 2020–2030, including establishing baseline values for health and other outcome indicators of interest.

2016
May: Adoption of finalized global strategy and action plan on ageing and health by the World Health Assembly
December: Identification of quantifiable progress indicators for each strategic objective in strategy
2017
February: Contribution to 15-year review of Madrid International Plan of Action on Ageing
June: Agreement on metrics and methods to assess healthy ageing – whether existing or new
2018
June: Mid-term report on implementation of strategy, including progress on evidence synthesis on key themes, monitoring, norms and “best buys”. Refine direction of strategy based on learning to date.
2019
May – September: Proposal for Decade of Healthy Ageing discussed in open consultation with Member States, entities representing older people, bodies of United Nations system and other key partners and stakeholders
2020
January: Proposal for Decade of Healthy Ageing, extending the action plan from 2020 to 2030, discussed at WHO Executive Board
October: Final report on review of strategy, with baseline for Decade on Healthy Ageing

Appendix

ACTION PLAN 2016–2020

The following table outlines the contributions to each strategic objective that can be made by Member States, the Secretariat of WHO and other bodies of the United Nations system, and national and international partners. Each country will vary in its preparedness to take the actions identified. What needs to be done, and in what order, will depend very much on the national context and priorities.

Strategic objective 1: Commitment to action on healthy ageing in every country

	Member States	Secretariat (WHO and other bodies of the United Nations system)	National and international partners
1.1 Establish national frameworks for action on healthy ageing	<p>Identify government focal points for healthy ageing</p> <p>Systematically involve older people in the development, implementation monitoring and evaluation of all laws, policies and plans on ageing and health</p> <p>Develop, in collaboration with all relevant stakeholders national and regional plans to foster healthy ageing, establishing clear lines of responsibility and mechanisms for coordination, accountability, monitoring and reporting across all relevant sectors</p> <p>Allocate adequate resources to implement action plans while ensuring that public resources are effectively managed to facilitate healthy ageing</p> <p>Revise mainstream and ageing-specific laws and policies to foster healthy ageing, and revise compliance and enforcement mechanisms</p>	<p>Support policy dialogues on the <i>World report on ageing and health</i> and the global strategy and action plan</p> <p>Develop an investment case and budget to resource the overall action plan in this area</p> <p>Strengthen intersectoral collaboration on healthy ageing</p> <p>Conduct a situation analysis of existing frameworks and share globally</p> <p>Include healthy ageing throughout the life course in the agendas of governing body meetings at all levels and in other social, health and economic fora</p> <p>Engage older people in policy-making at international, regional and national levels within WHO's own structures</p>	<p>Include healthy ageing in all dialogues and policies on health, human rights and development</p> <p>Exchange information, coordinate actions and share lessons learnt to support the development of policies and plans to foster healthy ageing</p> <p>Support the participation of older people and their representative organizations in revising and developing laws, policies and plans that impact on healthy ageing</p>

	Member States	Secretariat (WHO and other bodies of the United Nations system)	National and international partners
1.2 Strengthen national capacities to formulate evidence-based policy	<p>Create a decision making culture that values evidence and its uptake</p> <p>Create formal structures and make available opportunities, capacity and activities for translation of research and evidence, to inform policy-making</p> <p>Identify research gaps and encourage research in these areas</p> <p>Create mechanisms to enable effective communication flows between researchers and decision-makers</p>	<p>Provide technical support towards knowledge translation activities that enable evidence-based policy development on healthy ageing</p> <p>Facilitate exchanges across countries addressing innovations and good practices</p>	<p>Ensure that evidence is communicated in ways that are accessible to and useable by policy-makers</p> <p>Carry out research in areas where there are identified gaps for policy and practice</p> <p>Facilitate relationships among researchers, knowledge users, funders, older people, families and caregivers, and professional bodies in support of healthy ageing policy-making, including creating regional forums and peer-to-peer exchanges of information, good practice and tools</p>
1.3 Combat ageism and transform understanding of ageing and health	<p>Support the collection and dissemination of evidence-based and age and sex-disaggregated information about ageing and health and the contribution of older people</p> <p>Adopt legislation against age-based discrimination and put in place related enforcement mechanisms</p> <p>Modify or repeal existing laws, policies or programmes, in particular on health, employment and life-long learning, that discriminate directly or indirectly and prevent older people's participation in and access to benefits that would address their needs and rights</p> <p>Undertake communication campaigns, based on research into attitudes, beliefs and implications of ageism, to increase</p>	<p>Synthesize current evidence and provide guidance on understanding and acting on ageism for better policy</p> <p>Develop improved economic models for assessing the contributions of older people, and the costs and benefits of investments in healthy ageing</p> <p>Ensure WHO policies, guidance and communication are free from age-based and gender-based discrimination</p>	<p>Collect and disseminate evidence about ageing, the role and contribution of older people and the social and economic implications of ageism</p> <p>Ensure that a balanced view of ageing is presented in the media and entertainment, for example by minimizing sensationalist reporting of crimes against older people, and including older adults as role models</p>

Member States	Secretariat (WHO and other bodies of the United Nations system)	National and international partners
public knowledge and understanding of healthy ageing		

Strategic objective 2: Developing age-friendly environments

	Member States	Secretariat (WHO and other bodies of the United Nations system)	National and international partners
2.1 Foster older people's autonomy	<p>Raise awareness about the rights of older people and create mechanisms to address breaches of their rights, including in long-term care and emergency situations</p> <p>Provide mechanisms for advanced care planning (including long-term care provision), appropriate assistive technologies and supported decision-making that enable older people to retain the maximum level of control over their lives despite significant loss of capacity</p> <p>Provide information in formats such as large print, "easy read" and pictures that meet the needs of older people to make free and informed decisions</p> <p>Implement evidence-based falls prevention and elder abuse prevention and response programmes</p>	<p>Promote awareness and understanding of the rights of older people</p> <p>Develop technical guidance on maximizing autonomy covering a range of key issues such as food security, preventing and responding to elder abuse and preventing falls</p> <p>Provide a database of available evidence on prevalence, risk factors, consequences and interventions in elder abuse, including violence against older women</p> <p>Provide a list of essential assistive devices</p>	<p>Raise older people's awareness of their human rights</p> <p>Support the provision of assistive technologies</p> <p>Provide technical and financial support to implement policies and programmes that enhance older people's autonomy</p> <p>Create and support platforms for sharing information about what works in fostering older people's autonomy</p>
2.2 Enable older people's engagement	<p>Ensure formal participation of older people in decision-making on policies, programmes and services that concern them</p> <p>Support the development of older people's organizations</p>	<p>Promote awareness and understanding of the contributions of older people and the value of working with different generations</p> <p>Provide technical guidance and support to enable older people's engagement in development</p> <p>Engage older people in decision-making within WHO's own processes and on issues that concern them</p>	<p>Build the capacity of organizations of older people to participate effectively in policy development and planning</p> <p>Develop the capacity of older people's organizations to provide information, training, peer support and long-term care</p> <p>Support and create platforms for sharing the diverse voices of older people</p>

	Member States	Secretariat (WHO and other bodies of the United Nations system)	National and international partners
2.3 Promote multisectoral action	<p>Tailor advocacy messages to particular sectors about how they can contribute to healthy ageing</p> <p>Encourage and support municipalities to take action to become more age-friendly</p> <p>Take action at all levels and in all sectors to foster functional ability, including to:</p> <ul style="list-style-type: none"> – protect older people from poverty, ensuring that older women who are most commonly affected are supported – expand housing options and assist with home modifications that enable older people to age in a place that is right for them without financial burden – develop and ensure compliance with accessibility standards in buildings, transport, information and communication technologies and other assistive technologies – provide community places where older people can meet, such as seniors' centres and public parks – provide social opportunities as well as accessible information on leisure and social activities – deliver older people's health literacy programmes – provide opportunities for lifelong learning – promote collaboration, age diversity and inclusion in working environments <p>Ensure effective coordination of implementation and monitoring, for example through task forces (linked with the overall coordination mechanisms outlined in strategic objective 1)</p>	<p>Expand and develop the WHO global network of age-friendly cities and communities to connect cities and communities worldwide</p> <p>Provide an interactive platform to facilitate learning and exchange of information and experience on creating age-friendly environments that foster healthy ageing</p> <p>Provide technical support to countries to support the development of age-friendly environments</p> <p>Document, support and disseminate evaluations of existing age-friendly initiatives, to identify evidence of what works in different contexts</p> <p>Suggest indicators that can inform policy-makers on progress on age-friendly environments</p> <p>Provide technical guidance and support on addressing the needs and rights of older people in emergencies</p>	<p>Promote the concept of age-friendly environments</p> <p>Support the development of age-friendly cities, communities and countries by connecting actors, facilitating information exchange and sharing good practice</p> <p>Provide technical and financial assistance to Member States in order to ensure that public services enable functional ability</p> <p>Provide guidance to Member States on a range of issues, such as establishing and maintaining nationally defined social protection floors; ensuring decent work for all ages and providing adequate housing</p> <p>Support older people and their organizations to access information on mainstream programmes</p>

Strategic objective 3: Aligning health systems to the needs of older populations

	Member States	Secretariat (WHO and other bodies of the United Nations system)	National and international partners
3.1 Orient health systems around intrinsic capacity and functional ability	<p>Assess national health system responses to ageing populations and develop plans for realignment</p> <p>Sustainably finance the programmes, services and systems realignment necessary to foster healthy ageing</p> <p>Adapt information systems to collect, analyse and report data on intrinsic capacity and trends in capacity</p> <p>Ensure availability of medical products, vaccines and technologies that are necessary to optimize older people's intrinsic capacities and functional abilities</p> <p>Ensure collaboration between sectors, most importantly between health and social services, to address the needs of older people including those arising from mental disorders, dementia and cognitive declines and geriatric syndromes such as frailty, urinary incontinence, delirium and falls</p>	<p>Provide technical assistance and guidance on integrating health system responses to ageing populations into national healthy ageing policies and plans</p> <p>Provide technical advice and develop standardized approaches to enable regional and national assessments of health system alignment to needs of older people</p> <p>Provide technical assistance to enable health system change, including with regard to the health workforce, health information systems, medical products and technologies</p> <p>Document best practices and develop evidence-based service delivery models for integrated care in high, medium, and less resourced health care settings, and share models of care that have been shown to be effective in supporting intrinsic capacity</p>	<p>Advocate and support older people, their families and communities to participate in policy and planning decisions</p> <p>Support older people's engagement with health systems</p> <p>Promote older people's sexual health and rights</p> <p>Contribute with evidence and research on health system change for the older population</p>
3.2 Develop and ensure affordable access to quality older person centred and integrated clinical care	<p>Ensure that older people are provided with comprehensive assessments at the time of their engagement with the health system and periodically thereafter</p> <p>Design systems to foster the self-management of older people</p> <p>Identify and implement evidence-based models of integrated care</p> <p>Establish age-friendly infrastructure, service designs and processes</p> <p>Develop services as close as possible to where older people live</p>	<p>Provide technical support on the development of integrated services, including strategies to ensure service coverage and to reduce catastrophic health expenditure</p> <p>Develop evidence-based recommendations and clinical guidelines on prevention and management of functional decline and</p>	<p>Participate in advocacy campaigns and partner in existing initiatives to encourage the adoption of integrated care models</p> <p>Build awareness of the health needs of ageing populations and older people, and support self-management and engagement of older people, family and communities</p>

	Member States	Secretariat (WHO and other bodies of the United Nations system)	National and international partners
	<p>Implement universal health coverage</p> <p>Strategies to reduce out-of-pocket payments, wherever possible by extending population coverage, and widening the package of services that older people often need</p> <p>Deliver community-based interventions to prevent functional decline and care dependency</p> <p>Adopt and implement WHO guidelines on integrated care for older people</p> <p>Ensure the continuum of care, including linkages with sexual health programmes, and availability of acute care, rehabilitation and palliative care</p>	<p>care dependence in older age, and disseminate and pilot these guidelines at country level</p> <p>Produce evidence and guidance on clinical management of specific conditions relevant to older people, including musculoskeletal and sensory impairments, multimorbidities, cardiovascular disease and risk factors such as hypertension and diabetes, mental health illness and dementia, and cancer</p> <p>Develop tools and guidance to facilitate implementation of case management</p>	
3.3 Ensure a sustainable and appropriately trained, deployed and managed health workforce	<p>Ensure competencies on ageing and health are included in the curricula of all health professionals</p> <p>Ensure competencies in ageing (including those required for comprehensive healthy ageing assessments and integrated management of complex health care needs) of existing health professionals through pre- and in-service training</p> <p>Ensure capacity of training institutions to establish/expand geriatric education</p> <p>Ensure balanced distribution of workforce within countries and development of workforce to match demand for services</p> <p>Promote new workforce cadres (such as care coordinators, case managers, and community care workers)</p> <p>Provide opportunities for extending the roles of existing staff for delivering care for older people</p>	<p>Provide technical support and guidance on competencies required to meet the needs of older populations</p> <p>Report on the impact of population ageing on the health workforce and on the adequacy of the current workforce to meet the needs of older populations</p> <p>Provide technical assistance to countries to develop evidence-informed strategies on the health workforce</p> <p>Support the development of guidance and training programmes to improve the skills and knowledge of health professionals in low- and middle-income countries</p>	<p>Support teaching institutions in revising their curricula to address ageing and health issues</p> <p>Provide technical support and expertise to conduct training, especially in countries where there is shortage of health care professionals working in the field of ageing</p> <p>Become familiar with, and help to implement, WHO's norms and guidelines on integrated care for older people</p>

Strategic Objective 4: Developing sustainable and equitable systems for providing long-term care (home, communities, institutions)

	Member States	Secretariat (WHO and other bodies of the United Nations system)	National and international partners
4.1 Establish and continually improve a sustainable and equitable long-term care system	<p>Identify access to long-term care as a public health priority and a human right</p> <p>Steward development of the infrastructure and support needed to ensure that long-term care is addressed under universal health coverage</p> <p>Define appropriate systems of care to improve the functional ability and well-being of older people with, or at risk of, a loss of capacity</p> <p>Identify and put in place sustainable mechanisms for resourcing long-term care</p> <p>Convene relevant stakeholders, including older people and caregivers, and plan for sustainable and equitable long-term care, including provision, resourcing, regulation and monitoring, and define roles and responsibilities (linked with strategic objective 1)</p> <p>Foster collaboration between key stakeholders, including care-dependent people and their caregivers, nongovernmental organizations, and the public and private sectors, to provide long-term care</p>	<p>Provide guidance on appropriate and sustainable systems of long-term care relevant to different resource settings</p> <p>Provide technical support to Member States to identify sustainable mechanisms for resourcing long-term care</p> <p>Provide technical support for national situation analysis and the development, implementation and monitoring of legislation, services, policies and plans on long-term care</p>	<p>Contribute evidence to develop and implement appropriate systems and sustainable mechanisms for resourcing long-term care in diverse resource settings</p> <p>Contribute to the development and implementation of an integrated, sustainable, equitable, and ability-oriented, system of long-term care</p>
4.2 Build workforce capacity and support caregivers	<p>Develop and implement strategies for the provision of information, training and respite care for unpaid caregivers, and flexible working arrangements or leaves of absence for those who (want to) participate in the workforce</p> <p>Produce national standards for training of professional caregivers</p>	<p>Provide guidance on training and task-shifting for long-term care provision</p> <p>Provide online resources on long-term care provision for unpaid caregivers</p>	<p>Contribute to the development and implementation of training, continuing education and supervision for the long-term care workforce</p> <p>Ensure pay, benefits and working conditions for care workers</p> <p>Provide flexible working arrangements or leaves of absence for unpaid caregivers</p>

	Member States	Secretariat (WHO and other bodies of the United Nations system)	National and international partners
	<p>Develop – through training and task-shifting – the long-term care workforce (also including men, younger people and non-family members such as older volunteers and peers)</p> <p>Improve working conditions, remuneration and career opportunities in order to attract and retain paid caregivers</p> <p>Provide continuing education, supervision and other support for existing paid caregivers</p>		<p>Create and support platforms for the development and evaluation of cost-effective interventions to support the long-term care workforce</p> <p>Contribute with research and evidence to the development and evaluation of cost-effective interventions to support the long-term care workforce</p>
4.3 Ensure the quality of person-centred and integrated long-term care	<p>Ensure the development and implementation of national care standards, guidelines, protocols and accreditation mechanisms for ability-oriented, person-centred integrated long-term care provision</p> <p>Ensure the establishment of formal mechanisms for ability-oriented, person-centred integrated long-term care, for example through case management, advance care planning and collaboration between paid and unpaid caregivers</p> <p>Ensure the appropriate use of and affordable access to innovative assistive health technologies to improve the functional ability and well-being of people in need of long-term care</p> <p>Ensure that long-term care services are age-friendly, ethical and promote the rights of older people and their caregivers</p> <p>Ensure the monitoring of long-term care in terms of functional ability and well-being, and the continuous improvement of long-term care based on the outcomes</p>	<p>Provide technical support to Member States on ability-oriented, person-centred integrated long-term care provision</p> <p>Develop guidance on specific approaches to ensure the quality and appropriateness of long-term care in different resource settings</p>	<p>Follow national care standards, guidelines, protocols, accreditation and monitoring mechanisms</p> <p>Provide quality long-term care services in line with national care standards, guidelines and protocols in an age-friendly and equitable way promoting the rights of older people</p> <p>Provide mechanisms for care providers to share and learn from experiences</p> <p>Develop and implement innovative long-term care services, including through the use of technology for coordination, care, support and monitoring</p>

Strategic objective 5: Improving measurement, monitoring and research on healthy ageing

	Member States	Secretariat (WHO and other bodies of the United Nations system)	National and international partners
5.1 Agree on ways to measure, analyse, describe and monitor healthy ageing	<p>Ensure national vital registration and statistics are disaggregated by age and sex throughout the life course, and by important social and economic characteristics</p> <p>Encourage monitoring, surveillance and reporting in line with agreed global metrics</p> <p>Encourage data-sharing and linkages across sectors (such as health, social welfare, labour, education, environment, transportation)</p> <p>Conduct periodic, population-based monitoring of older people, including those in long-term care institutions</p> <p>Link the monitoring of healthy ageing metrics to the evaluation of national sectoral, intersectoral and multisectoral policies and programmes, and link to other international efforts (such as the Sustainable Development Goals)</p>	<p>Convene and liaise across specialized agencies of the United Nations system and other development partners to foster a consensus on metrics and methods</p> <p>Review existing data sources, methods and indicators and promote the sharing of data and methods for global, regional, national and community-based monitoring and surveillance of healthy ageing</p> <p>Develop norms, metrics and new analytical approaches to describe and monitor healthy ageing, including levels and distributions, and ways to combine and report information on intrinsic capacity, functional ability and length of life</p> <p>Develop resources, including standardized survey modules, data and biomarker collection instruments and analysis programmes</p> <p>Prepare a global situation report on healthy ageing by 2020 reflecting metrics, data availability and distribution within and across countries, and new evidence on what can be done to support healthy ageing</p>	<p>Empower older people to participate and share best practices to experience healthy ageing</p> <p>Provide qualitative and quantitative information to track progress towards healthy ageing and advocate for accountability by all stakeholders</p> <p>Work with partners to improve measuring, monitoring and reporting systems, including enabling age- and gender-sensitive analysis</p> <p>Support policy development by reporting on trends and emerging issues</p>

	Member States	Secretariat (WHO and other bodies of the United Nations system)	National and international partners
5.2 Strengthen research capacities and incentives for innovation	<p>Incorporate older people in all stages of research and innovation, including their needs and preferences</p> <p>Ensure older people are meaningfully and statistically represented in population-based studies with sufficient power to analyse data, and included in clinical trials</p> <p>Strengthen research funding, capacities and collaborations to address healthy ageing</p> <p>Create incentives and support innovation that meet the needs of different age groups, including older people, through multisectoral and intersectoral actions, including technological and social innovations for home- and community-based services for older populations</p> <p>Support voluntary and mutually agreed technology transfer that includes services, innovations, knowledge and best practices</p> <p>Guide research and innovation to ensure public and private sector developers and providers (including health and care services, devices, and drugs) meet the specific needs of all older people, including those with limited resources</p> <p>Build national capacity to synthesize research, as inputs to knowledge translation and evidence based policies (link to SO 1)</p>	<p>Advocate for strengthened research funding, capacities, methods and collaboration to foster healthy ageing and combat ageism, including through a network of WHO collaborating centres on ageing and health, pilot countries from all WHO regions, and civil society organizations</p> <p>Support international cooperation to foster technological innovation, including by facilitating the transfer of expertise and technologies such as assistive devices, information and communication technology and scientific data, and the exchange of good practices</p> <p>Develop ethical frameworks to identify health and social services that respond to the needs and rights of older people and to prioritize what is included within national benefit packages and universal health coverage</p> <p>Contribute to development and sharing of new methods and approaches to:</p> <ul style="list-style-type: none"> – deliver integrated person-centred health care and long-term care services – shape clinical research to be more relevant to older people – finance health services and long-term care within universal schemes – meet older peoples’ 	<p>Encourage older people to participate in research and identify research questions and the need for innovation, including developing study designs</p> <p>Support training and capacity development efforts, including networks of academics, researchers and trainers that incorporate low- and middle-income countries</p> <p>Ensure that older people participate in clinical trials and evaluation of new technologies that take account of the different physiology and needs of older men and women</p> <p>Support small- and large-scale innovations</p> <p>Encourage the participation of older people in the development, design and evaluation of services, technologies or products</p> <p>Promote innovation to accelerate the development of new and improved assistive technologies and interventions to support older people</p> <p>Collaborate to shape the global research and innovation agenda on healthy ageing, and advocate and support funding and capacity strengthening</p>

Member States	Secretariat (WHO and other bodies of the United Nations system)	National and international partners
	<p>needs and expectations in communities, cities and rural areas that facilitate ageing in place, with regard to issues such as health, land use, housing, transportation and broadband</p> <ul style="list-style-type: none"> – establish the prevalence and prevention of elder abuse – quantify the contributions of older people and the investments required to provide services they need – combine multiple disciplines and qualitative and quantitative data to communicate older peoples' diverse needs and expectations <p>Convene and work with partners to develop and communicate a global research agenda on healthy ageing</p>	
<p>5.3 Research and synthesize evidence on healthy ageing</p> <p>Establish regular longitudinal population surveys, measuring health status and related needs of older people and to what extent needs are being met</p> <p>Reflecting older peoples' needs and expectations, shape, fund and implement national research and innovation priorities on healthy ageing</p> <p>Promote and support research to identify the determinants of healthy ageing and to evaluate interventions that can foster functional ability</p>	<p>Organize and participate in international forums to raise awareness of research priorities for healthy ageing</p> <p>Coordinate priority multicountry research and evaluation efforts, for example building on the WHO study on global ageing and adult health or extending other existing efforts</p> <p>Collaborate with stakeholders to identify the range and potentially common trajectories of intrinsic capacity and functional ability, and their broader social, economic and environmental</p>	<p>Collaborate and participate in research design and implementation, including evaluation of what works in different settings</p> <p>Contribute learning gained from associations and organizations addressing risk factor-, disease- or condition-specific issues, that are inclusive of older people (including dementia, elder abuse and self-help approaches)</p> <p>Develop and test innovative approaches to strengthening institution-, community- and home-based care to implement the most appropriate interventions and increase access to essential medicines for older</p>

Member States	Secretariat (WHO and other bodies of the United Nations system)	National and international partners
<p>Promote and support multisectoral and intersectoral collaboration with diverse stakeholders to design and evaluate actions to foster functional ability</p> <p>Provide forums for the exchange of experiences, good practices and lessons learned</p> <p>Promote research into innovations that contribute to age-friendly environments, including at the workplace</p> <p>Synthesize research and disseminate evidence on healthy ageing that addresses important policy questions and older people's expectations</p>	<p>determinants in different populations and contexts</p> <p>Advocate for and enable research to scale up interventions and strengthen national health systems, including health workers, informal caregivers and long-term care (home-, community- and institution-based) towards meeting the needs of older people</p> <p>Review and share models of care that have been shown to be effective in supporting intrinsic capacity</p>	<p>people, including pain relief medicines such as opioids</p> <p>Support research and dissemination of evidence on the impact of health services, long-term care and environmental interventions on trajectories of healthy ageing</p> <p>Engage in dialogue within communities and the media, and use effective communication techniques to convey messages about healthy ageing</p>
<p>Reflecting global evidence on what works in diverse contexts and basic standards, encourage testing of approaches to further develop systems of long-term care (home-, community- or institution-based)</p>	<p>Develop and identify evidence-based approaches to intersectoral action to maximize functional ability, particularly in resource-poor settings</p> <p>Document health inequalities and inequities, and their impacts across the life course on healthy ageing, and report how these can be mitigated by health and social interventions and by multisectoral and intersectoral actions</p>	

ANNEX 2

WHO global plan of action to strengthen the role of the health system within a national multisectoral response to address interpersonal violence, in particular against women and girls, and against children¹

[A69/9, Annex 2 – 11 March 2016]

SECTION 1. INTRODUCTION

Scope

1. In May 2014, the Sixty-seventh World Health Assembly adopted resolution WHA67.15 on Strengthening the role of the health system in addressing violence, in particular against women and girls, and against children. It requests the Director-General “to develop, with the full participation of Member States, and in consultation with United Nations organizations, 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 existing relevant WHO work”.

2. The scope of the WHO global plan of action is guided by resolution WHA67.15. The plan focuses on violence against women and girls, and against children, while also addressing common actions relevant to all types of interpersonal violence. It also addresses interpersonal violence against women and girls, and against children, in situations of humanitarian emergencies and post-conflict settings, recognizing that such violence is exacerbated in these settings.

3. All forms of interpersonal violence lead to negative health outcomes and should be addressed by the health system. However, there are compelling reasons for a particular focus on violence against women and girls, and against children. Women and girls bear an enormous burden of specific types of violence that are rooted in socially accepted gender inequality and discrimination and are thus sanctioned, despite constituting a violation of their human rights. Because of this, women and girls experience shame and stigma, and the violence often remains hidden. All too often, health and other institutions are slow to recognize and address this violence, and services are not available or have limited capacity. Until recently, violence against women and girls was largely invisible within national and international statistics and surveillance systems. Globally, there is a strong political momentum for addressing violence against women and girls in health and development agendas, which offers an opportunity to strengthen awareness of and response to it within the health system (1).²

¹ See resolution WHA69.5 (2016).

² This is reflected in the 20-year review of the Programme of Action of the International Conference on Population and Development (2014), where 90% of the 176 Member States who participated in the review highlighted violence against women as a priority issue for them.

4. Violence against children (aged 0–18 years), including adolescents, is widespread and constitutes a violation of their human rights. It has lifelong negative consequences, including ill-health, health risk behaviours, and experiencing and perpetrating subsequent violence. In many countries, violence is often considered an acceptable way of disciplining children. Violence against children is often invisible, and few children who experience abuse have access to the programmes and services they need. Increasing attention is now being paid to violence against children, making it an opportune time to raise awareness and strengthen the response of the health system.

5. Responsibility for addressing interpersonal violence rests clearly with national and subnational governments. Addressing such violence requires a multisectoral response, where the health and other sectors need to work together. As the lead agency for health within the United Nations system, WHO has developed this global action plan for Member States in particular, and for national and international partners, using a public health approach and focusing specifically on the role of the health system.

6. Health services and programmes are an appropriate entry point for addressing interpersonal violence, in particular against women and girls, and against children. Women who experience violence are more likely to use health services than those who do not, although they rarely explicitly disclose violence as the underlying reason (2). Health care providers are often the first point of professional contact for survivors/victims of violence, and yet the underlying violence is often invisible to them. Children who are suffering violence also frequently come to health services without the violence being identified by health workers. The plan of action purposefully focuses on what the health system can do, in collaboration with other sectors and without detriment to the importance of a multisectoral response.

7. The WHO global plan of action is a technical document informed by evidence, best practices and existing WHO technical guidance. It offers a set of practical actions that Member States can take to strengthen their health systems to address interpersonal violence, in particular against women and girls, and against children.

8. The past two decades have seen an increase in the evidence concerning the prevalence of some types of violence against women and girls. More recently, there has also been accumulating evidence concerning the prevalence of violence against children. However, there is still a lack of evidence on many aspects of different forms of violence, and the science and programming to address them are still in their initial stages. In addition, policies and programming to address both violence against women and girls, and violence against children, have developed as separate fields. At the level of the health system, injury management, trauma care and mental health services are relevant for all forms of violence, but the sexual and reproductive health consequences of violence against women and girls require particular interventions. The hidden nature of violence against women and girls, and against children, requires specific training of providers in how to identify these problems. Therefore, the nature of guidance that the WHO global plan of action provides is different across these forms of violence.

9. The WHO global plan of action is linked to several other World Health Assembly resolutions, global action plans and strategies, as well as to other work of WHO (see Appendices 2–5). It builds on and links with the numerous other efforts across the United Nations system to address violence, in particular against women and girls, and against children (see Appendix 5). This includes the Programme of Action of the International Conference on Population and Development, the Beijing Declaration and Platform for Action and the outcome documents of their review conferences, and all relevant treaties and conventions, resolutions and declarations by the United Nations General Assembly and the Human Rights Council, as well as the relevant Commission on the Status of Women Agreed Conclusions, among others (see Appendix 2). The WHO global plan of action is also aligned with several of the goals and targets proposed for the Sustainable Development Goals and the 2030 Agenda for Sustainable Development (see Appendix 6).

10. The WHO global plan of action is not intended to be a comprehensive multisectoral or United Nations-wide plan. Rather, this plan addresses the specific mandate of WHO and focuses on the health system component of a multisectoral response. In doing so, the plan takes cognizance of the roles and mandates of the different United Nations organizations in coordinating and leading wider multisectoral efforts to address violence, in particular against women and girls, and against children.

Adaptation of the WHO global plan of action to regional and national contexts

11. The WHO global plan of action needs to be adapted at the regional and national levels, in line with the international commitments that Member States have already made, including to the Sustainable Development Goals, while taking into account region-specific situations and in accordance with national legislation, capacities, priorities and specific national circumstances. There is no single formulation of a global plan of action that fits all Member States, as they are at different points in their progress in strengthening the role of the health system within a national multisectoral response to address interpersonal violence, in particular against women and girls, and against children, and at different levels of socioeconomic development. However, all Member States can benefit from the comprehensive approach 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, presented in this global plan of action.

12. There are evidence-based approaches which, if implemented to scale, would enable all Member States to make significant progress in addressing interpersonal violence, in particular against women and girls, and against children. The exact manner in which the actions in this plan can be undertaken varies by country, and is affected by: the availability of data and knowledge; the magnitude and health burden of different forms of interpersonal violence, in particular against women and girls, and against children; existing initiatives for addressing the different types of such violence; and the readiness or capacity of the health system to address such violence.

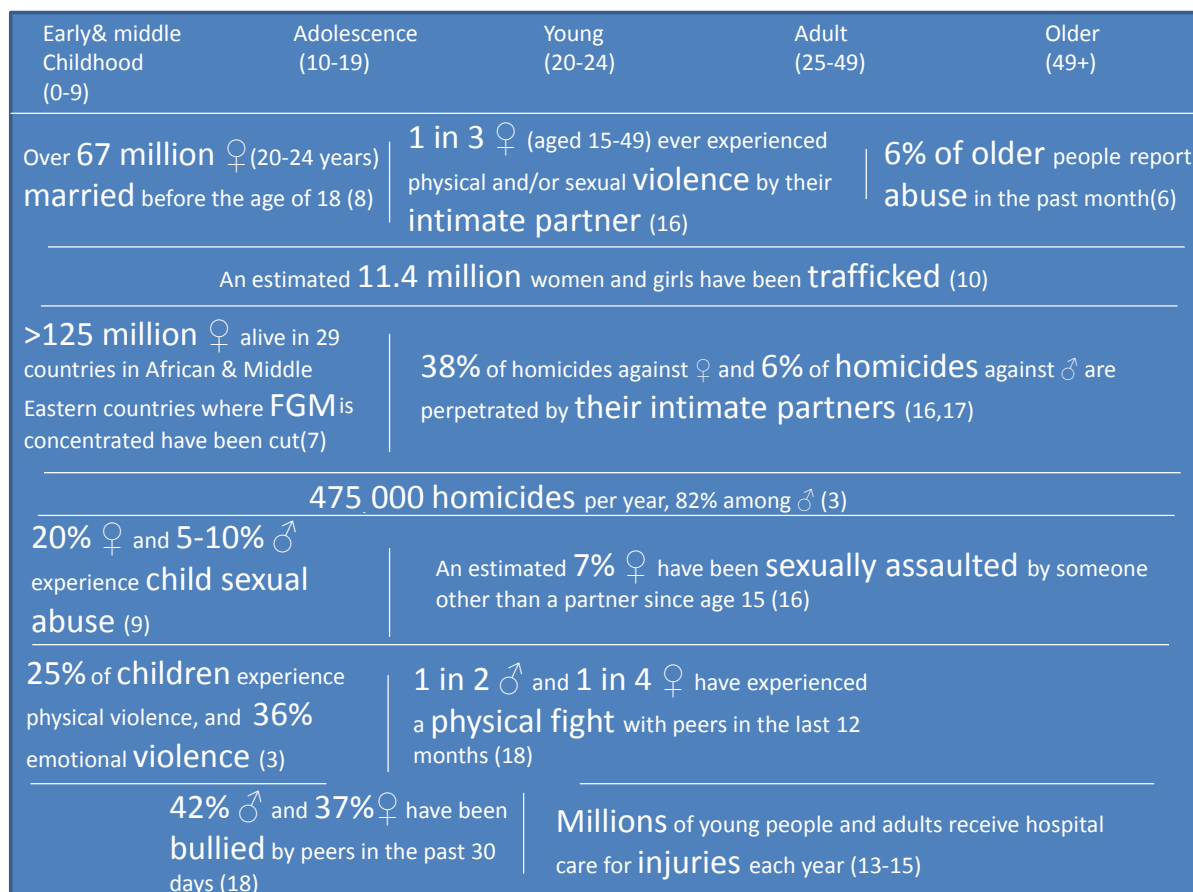
13. Member States will need to consider implementing the actions in the plan in an incremental manner over time and adequately resourcing these efforts.

Overview of the global situation (see also Appendices 7 and 8)

Magnitude

14. *Violence* affects the lives of millions of people and when not fatal can have long-lasting consequences. Deaths are only a fraction of the health and social burden arising from interpersonal violence. Women, children and elderly people bear a higher burden of non-fatal physical, sexual and psychological consequences of abuse (3). Figure 1 summarizes data on the magnitude of some of the common types of interpersonal violence, across the life course.

Figure 1. Magnitude of interpersonal violence, in particular violence against women and girls, and against children, across the life course (3, 6–10, 13–18)



15. *Violence against women.* Women are affected by different forms of gender-based violence (i.e. violence that is rooted in gender inequality) at different stages of their lives. This includes, but is not limited to:¹

- violence by intimate partners and by family members (4);
- sexual violence (including rape) by non-partners (e.g. acquaintances, friends, teachers and strangers);
- trafficking, including for sexual and economic exploitation;
- femicide, including intimate partner femicide (i.e. murder of a woman by a current or former partner), murders in the name of honour or because of dowry, murders specifically targeting women but by someone other than their partner, or murders involving sexual violence (5);
- acid throwing;

¹ See, in particular, Articles 1 and 2 of the Declaration on the Elimination of Violence against Women (United Nations General Assembly resolution 48/104 (1994)).

- sexual harassment in schools, workplaces and public places, and increasingly also online through internet or social media.

16. Intimate partner violence and sexual violence are prevalent in all settings and are also the most common forms of violence experienced by women globally. Older women also experience intimate partner violence and sexual violence, as well as specific forms of elder abuse. However, data on prevalence of elder abuse, particularly from low- and middle-income countries, are very limited (6).

17. *Violence against girls.* Girls, including adolescent girls, face all the forms of child maltreatment covered in the points below on violence against children, as well as specific forms of gender-based violence and harmful practices that are rooted in gender inequality and discrimination. These include:

- female genital mutilation, which is concentrated in about 29 countries in Africa and the Middle East but also occurs elsewhere, including in countries with diaspora communities (7);
- child, early and forced marriage, which has a higher prevalence and rates of increase in some regions (e.g. South and Central Asia, parts of sub-Saharan Africa) (8);
- girls being more likely to experience sexual abuse or be trafficked for sex than boys (9, 10);
- adolescent girls, especially those who are married or are in dating relationships, also being more likely to experience intimate partner violence (4).

18. *Violence against children.* This affects boys and girls, including adolescents, aged 0–18 years and includes:

- child maltreatment perpetrated by adults in positions of trust and authority, which can involve physical abuse (including corporal punishment), sexual abuse (including incest), and psychological/emotional abuse and neglect;
- early forms of youth violence¹ that occur largely among peers in adolescence, such as bullying, physical fighting, sexual abuse, and relationship/dating violence.

19. Families with safe and nurturing relationships between parents, caregivers and children are a protective environment for children. However, there is maltreatment of children in some families, which implies the need for the support and strengthening of such families.

20. *Intersections and linkages across different forms of interpersonal violence.* Child maltreatment and intimate partner violence against women can occur in the same household. Child maltreatment increases the risk of subsequently experiencing or perpetrating intimate partner violence and sexual violence against women, as well as bullying and fighting among children and adolescents. Efforts to address violence against women and against children need to take into account the intersections of the different forms of violence. Child maltreatment and peer violence among children and adolescents are precursors to some forms of youth violence and other forms of violence later in life.

¹ WHO defines youth violence as violence occurring outside the home among children, adolescents and young men, covering 10 to 29 years. For the purposes of this global plan, youth violence is addressed under violence against children, including youth up to the age of 18 years.

21. *Disproportionate vulnerability in certain settings.* Interpersonal violence against women and girls, and against children is exacerbated during situations of humanitarian emergencies and post-conflict settings, and in situations of displacement.

22. *Disproportionate vulnerability in certain institutions.* Violence is also exacerbated in institutions such as prisons, juvenile detention centres and institutions for persons with mental illness and other disabilities, and for the elderly. The perpetration of violence against women can also occur within the health system, particularly in settings providing sexual and reproductive health services (e.g. mistreatment and abuse of women during childbirth, forced sterilization) (11, 12). Health workers themselves may be subjected to violence in their homes, communities and in the workplace.

23. *Disproportionate vulnerability of certain populations.* Certain groups are more likely to be exposed to, or experience, different types of violence because of social exclusion, marginalization, stigma and multiple forms of discrimination.

Health consequences

24. Millions of women, girls, children and young people who are exposed to, or experience violence suffer a range of short- and long-term consequences (13–15). These include, but are not limited to, physical injuries – for which millions of people around the world receive hospital emergency care – mental health problems such as depression, anxiety and post-traumatic stress disorder, suicide, disabilities and a higher risk of noncommunicable diseases, including hypertensive disorders and cardiovascular disease.

25. In addition, women and girls exposed to violence experience sexual and reproductive health problems, including unwanted pregnancies, adverse maternal and newborn health outcomes, sexually transmitted infections and HIV infection, and gynaecological problems. Intimate partner violence against women often persists or starts during pregnancy, leading to miscarriage, stillbirths, premature birth and low birth-weight babies (16).

26. Exposure to violence, as a victim or a witness, particularly in early childhood, has significant detrimental effects on the development of a child's brain that can lead to social, emotional, and behavioural problems. Individuals, especially children, who experience violence are also more likely to engage in health-harming behaviours such as smoking, alcohol and drug abuse and unsafe sex, with lifelong consequences for health, and are more likely to perpetrate or be victims of interpersonal as well as self-directed violence in later life. Violence impacts productivity and entails substantial human and economic costs for the survivors/victims, their families and society as a whole. (See Appendix 7 for more information.)

Risk and protective factors and determinants

27. No single factor explains the increased risk of victimization or perpetration of the different forms of violence, or why violence is more prevalent in some countries and communities than others. Rather, there are multiple risk factors associated with both perpetration and victimization at the individual, relationship, community and societal levels. Violence against women and girls, and against children, both have unique risk factors that require specific attention. These are further summarized in Appendix 8. In addition, there are several risk factors/determinants that cut across all forms of interpersonal violence. These common underlying risk factors/determinants include: gender inequality, unemployment, harmful norms on masculinity, poverty and economic inequality, high rates of crime in the community, firearm availability, ease of access to alcohol, drug dealing, and inadequate enforcement of laws. Addressing these common risk factors/determinants can strengthen stand-alone programmes for each type of violence, and synergies and efficiencies can be made by combining programming where appropriate.

Progress in countries and gaps

28. Countries are at different stages of implementing health system actions to address violence in terms of their readiness and capacity.

29. Laws are in place to address some forms of violence, but their enforcement is weak. Most of the 133 countries which reported for the global status report on violence prevention (3) have laws in place that penalize at least some forms of violence, including some forms of violence against women and girls (such as domestic violence and rape), and against children. However, in many countries legislation continues to be inadequate to cover a number of specific forms of violence. Few countries are fully enforcing their laws against these and other forms of violence (3).

30. *National plans and policies for addressing violence are not adequately resourced.* A majority of countries report having national multisectoral plans to address violence against women and some forms of violence against children (child maltreatment) (3). Funding to address violence against women is absent from most national budgets (20).

31. *Intersectoral coordination is weak.* Intersectoral coordination for addressing the different forms of violence is weak, as is coordination within the health system across different programmes and services. In many countries, ministries of health are minimally engaged in intersectoral coordination mechanisms for addressing different types of violence (3).

32. *Few women and children access services in case of violence.* Evidence highlights the fact that a majority (55–95%) of women survivors of violence do not disclose or seek any type of health, legal or police services (4). Similarly, in high-income countries only a small fraction (0.3–10%) of victims of child maltreatment come to the attention of child protection services (21, 22).

33. *Coverage and quality of services needed by survivors/victims are limited and uneven.* Only half of all countries report having services in place to protect and support survivors/victims of violence. While two thirds of the countries report having medico-legal services for sexual violence, these are usually concentrated in a few cities and there are gaps in terms of the quality of services and access for women and girls (3). Available services are often fragmented, dispersed and poorly resourced. They are not integrated into the health system. Women and girls often have to navigate different agencies for services and hence bear huge costs and experience long waits (20). While a majority of countries report having in place child protection services and systems for identification and referral of child maltreatment cases, few have specific protocols. Similarly, pre-hospital and emergency medical services to treat the severe injuries often associated with youth violence (e.g. due to gunshots, stabbings, beatings and burns) are poorly developed in most low- and middle-income countries. Few countries (less than half) report having mental health services for survivors/victims of violence (3).

34. *There is limited availability of trained and sensitized personnel in the health workforce.* In most countries, there is a lack of skilled health workers to address violence (such as sexual assault nurses or forensic specialists), or health care providers lack the skills or training to respond appropriately to violence against women and girls, and against children (20, 23). Surveys worldwide have documented that attitudes condoning the acceptability of violence against women and girls are widespread and that health workers often share the prevailing social norms, values and attitudes towards violence (4, 19). Studies have documented disrespect and abuse of women seeking reproductive health services (11, 12). Health workers do not always respect the autonomy, safety and confidentiality of survivors/victims. Neither violence against women nor violence against children are included systematically in the educational curricula of nursing, medical and other health care professionals (20).

35. Coverage of large-scale prevention programmes is limited. Few countries are systematically implementing large-scale programmes to prevent different types of violence (3).

36. *Civil society plays a critical role.* The global political momentum for addressing violence against women and girls is a result of strong civil society advocacy, particularly from women's organizations (24). They have often partnered with ministries of health, local health authorities and social services to provide services and implement prevention programmes.

37. *There is limited availability of data and information.* While there are nearly 100 countries with population-based survey data on intimate partner violence against women, fewer countries have data on sexual and other forms of violence against women and girls, or on men's perpetration of such violence. In particular, there is a lack of data from humanitarian settings or on violence faced by older women (16) and vulnerable groups (24). Similarly, fewer countries report having population-based data on child maltreatment or other forms of violence against children, although their numbers are growing. Promising interventions also need to be more rigorously tested through monitoring and evaluation (3).

Process and road map of the plan

38. The WHO global plan of action incorporates the inputs from consultations with Member States in all six WHO regions, civil society organizations, entities of the United Nations system and other international partners, as well as two global consultations with Member States in June and November 2015 (see Appendix 9 for details of the process).

39. This document is organized as follows:

- Section 1 introduces and describes the scope of the plan.
- Section 2 sets out the vision, goals, objectives, strategic directions and guiding principles of the plan.
- Section 3 outlines the actions to be taken by Member States, national and international partners, and WHO: This section is further subdivided into three sections:
 - Section 3.A focuses on violence against women and girls. Specific forms of violence that are particular to or disproportionately affect girls are covered in this section, whereas forms of violence that are common to both boys and girls are covered in section 3.B.
 - Section 3.B focuses on violence against children. It includes child maltreatment and peer violence among adolescents, both boys and girls, which are precursors to some forms of violence later in life.
 - Section 3.C focuses on all forms of interpersonal violence: cross-cutting actions. These include actions that are common across the forms of violence covered in sections 3.A and 3.B, as well as other forms of interpersonal violence across the life course, such as youth violence and elder abuse. This section complements and reinforces sections 3.A and 3.B.
- Section 4 describes the monitoring and accountability framework, including mechanisms for reporting and suggestions for global-level indicators and targets.
- Appendices include a glossary of terms, links to relevant resolutions and consensus documents, and details of the Secretariat's work.

SECTION 2. VISION, GOAL, OBJECTIVES, STRATEGIC DIRECTIONS AND GUIDING PRINCIPLES

This section articulates the vision, goal, objectives, strategic directions and guiding principles of the WHO global plan of action in the context of the role that the health system plays in a national multisectoral response. It also highlights the roles of the different stakeholders in relation to the implementation of the plan.

Box 1: The role of the health system within a multisectoral response

The health system can play a role in both preventing and responding to all forms of interpersonal violence, in particular against women and girls, and against children, given the hidden nature of such violence. The role of the health system is to:

- advocate for a public health perspective;
- identify those who are experiencing violence and provide them with comprehensive health services at all levels of health service delivery (i.e. primary health care and referral levels);
- develop, implement and evaluate violence prevention programmes as part of its population-level prevention and health promotion activities;
- document the magnitude of the problem, its causes and its health and other consequences, as well as effective interventions.

However, the health system alone cannot adequately prevent and respond to interpersonal violence, in particular against women and girls, and against children. Many of the risk factors and determinants of violence lie outside the health system, requiring a holistic, integrated and coordinated response across different sectors, professional disciplines, and governmental, private and nongovernmental institutions. Therefore, in line with the “health in all policies” approach (25), governments should enable the health system to interact and coordinate its own response with a number of other sectors, including police and justice, social services, education, housing/shelter, child protection, labour and employment, and gender equality or women’s empowerment. As part of a comprehensive multisectoral prevention effort, the health system can:

- advocate with other sectors to address the risk factors and determinants of violence;
- facilitate the access of survivors/victims of violence to multisectoral services, including through strong referral mechanisms;
- inform multisectoral violence prevention policies and programmes;
- support the testing and evaluation of interventions in other sectors.

Vision

1. A world in which all people are free from all forms of violence and discrimination, their health and well-being are protected and promoted, their human rights and fundamental freedoms are fully achieved, and gender equality and the empowerment of women and girls are the norm.

Goal

2. To strengthen the role of the health system in all settings and within a national multisectoral response to develop and implement policies and programmes and provide services that promote and protect the health and well-being of everyone, and in particular of women, girls and children who are subjected to, affected by or at risk of interpersonal violence.

Objectives

3. The objectives are:

- to address the health and other negative consequences of interpersonal violence, in particular against women and girls, and against children, by providing quality comprehensive health services and programming, and by facilitating access to multisectoral services;
- to prevent interpersonal violence, in particular against women and girls, and against children.

Strategic directions

4. In order to achieve the objectives, four strategic directions are proposed that address both the health system mandate of the plan and the public health approach to addressing interpersonal violence, in particular against women and girls, and against children. These are:

Strengthen health system leadership and governance

- This strategic direction covers actions related to: advocacy within the health system and across sectors; setting and implementing policies; financing, including budget allocations; regulation; oversight and accountability for policy and programme implementation; and strengthening coordination of efforts with other sectors.

Strengthen health service delivery and health workers'/providers' capacity to respond

- This strategic direction covers actions related to: improving service infrastructure, referrals, accessibility, affordability, acceptability, availability and quality of care; integrating services; ensuring access to quality, safe, efficacious and affordable medical products and vaccines; and training and supervision of the health workforce.

Strengthen programming to prevent interpersonal violence

- This strategic direction covers actions to prevent violence that the health system can directly implement, including identifying people at risk and carrying out health promotion activities, as well as those to which it can contribute through multisectoral actions (see Box 1).

Improve information and evidence

- This strategic direction includes actions related to: epidemiological, social science and intervention research; improved surveillance, including through health information systems; and programme monitoring and evaluation.

Guiding principles

5. The plan is guided by 10 guiding principles, set out in Table 1.

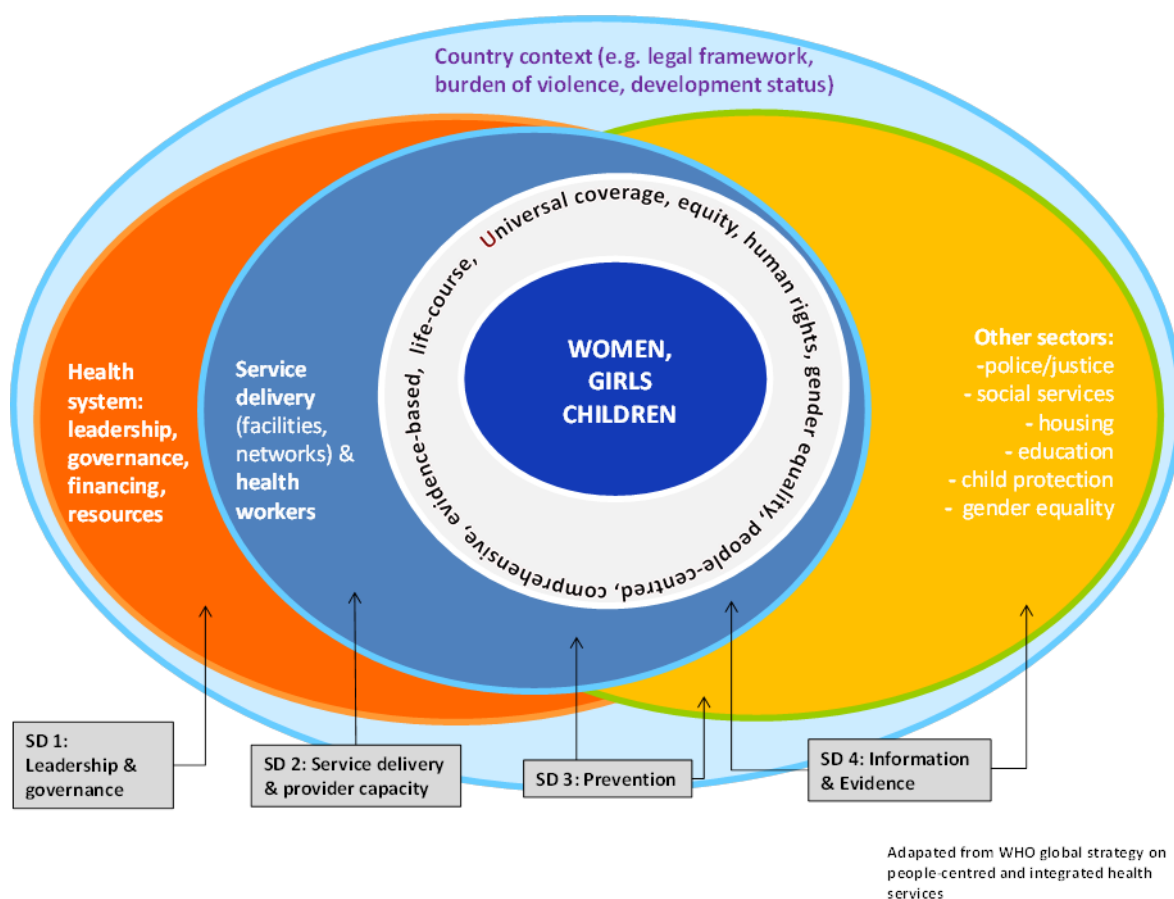
Table 1: Summary of guiding principles to inform the implementation of this plan

Guiding principles		
1.	Life course perspective	Address the risk factors and determinants of violence and the health and social needs of survivors/victims at the early stage of the life course, focusing on children, as well as at all other stages of the life course (adolescence, adulthood and older ages)
2.	Evidence-based approach	Be informed by the best available scientific evidence while tailoring interventions to each context
3.	Human rights	Respect, protect and fulfil human rights, including those of women, girls and children, in line with international human rights norms and standards, including the right to the highest attainable standard of health
4.	Gender equality	Advocate for addressing gender inequality and gender-based discrimination as key underlying determinants of violence, in particular against women and girls, by: (a) challenging unequal power relations between women and men and sociocultural norms that emphasize male dominance and female subordination; and (b) strengthening the engagement of men and boys in prevention, alongside efforts to empower women and girls
5.	Ecological approach	Address the risk factors and determinants that occur at multiple levels of the ecological framework (individual, relationship, community and societal)
6.	Universal health coverage	Ensuring that all people and all communities receive the quality services they need and are protected from health threats, while not suffering from financial hardship
7.	Health equity	In addition to universal health coverage, pay particular attention to the needs of groups that are marginalized, face multiple forms of discrimination and are more vulnerable to violence and barriers in access to services
8.	People-centred care	Provide victim/survivor-centred care and services that: respect their autonomy to make full, free and informed decisions regarding the care they receive; respect their dignity by reinforcing their value as persons, not blaming, discriminating or stigmatizing them for their experience of violence; empower them by providing information and counselling that enable them to make informed decisions; and promote their safety by ensuring privacy and confidentiality in provision of care
9.	Community participation	Listen to the needs of communities, and in particular: encourage the voices of women and adolescents to be heard; support and ensure their full and equal participation; use participatory approaches to build community ownership; form partnerships with civil society, especially women's and youth organizations; and strengthen capacities for identifying sustainable solutions
10.	Comprehensive multisectoral response	Build and strengthen partnerships and coordination between the health and other sectors, and between the public and private sectors, including for profit and non-profit service providers, civil society, professional associations and other relevant stakeholders, as appropriate to each country's situation

6. Fig. 2 summarizes how the health system role fits within the larger multisectoral response to interpersonal violence, in particular against women, girls and children (26). It depicts the guiding principles, as well as how the four strategic directions correspond to the health system and multisectoral response. Actions related to health system leadership and governance (strategic direction 1) and provision of health services and health worker capacity (strategic direction 2) are core health system actions that require an interface with other sectors (such as police, justice, social services, child protection, education, gender equality). Prevention (strategic direction 3) requires

multisectoral actions with a strong contribution from the health system. The generation of information and evidence through research, monitoring and evaluation (strategic direction 4) also requires multisectoral actions with a strong contribution, and often the lead, from the health system.

Figure 2. The health system's role within a multisectoral response in relation to the strategic directions of the WHO global plan of action (26)



Time frame

7. The time frame for this global plan of action is 15 years or until 2030, which is in line with the period of implementation of the Sustainable Development Goals. In many countries, the public health approach to violence, in particular violence against women and girls, and against children, is beginning to be understood and applied. Ministries of health are beginning to play a greater role in providing services to survivors/victims and promoting prevention. However, strengthening the role, engagement and capacity of the health system to address violence within a national multisectoral response is a long-term process, as preventing and responding to violence requires transformational change in societies.

The role of Member States, national and international partners

8. The actions elaborated in the next section (Section 3) are the primary responsibility of Member States, and in particular of national and subnational¹ governments. Health ministries working in close collaboration with other relevant ministries will need to assume leadership in operationalizing the plan. The implementation of the plan will require political commitment at the highest levels of the government.

9. National and international partners are expected to play a key role in supporting the implementation of this plan by Member States, as stakeholders who work in partnership with or alongside public sector health programmes and services. These include: private sector (for profit and non-profit) services; civil society (for example, women's organizations, youth organizations, community and faith-based organizations, and international nongovernmental organizations); parliamentarians; professional health and medical associations; bodies of the United Nations system and multilateral organizations; bilateral agencies; and academic and research institutions. They also include international and national institutions, agencies and organizations involved in humanitarian response work.

10. The roles of Member States and of national and international partners often overlap and can include multiple actions across the areas of: leadership and governance; health services delivery and capacity-strengthening of health workers; prevention; and generation of information and evidence. For example, in many countries, the health system includes a large private sector that is implementing preventive programmes and providing health services. Similarly, professional health and medical associations can be instrumental in capacity-strengthening, advocacy and policy development. Civil society organizations are crucial partners in conducting advocacy, raising awareness, mobilizing communities, and supporting the government in policy development, capacity-strengthening and service delivery. A number of organizations of the United Nations system are involved in setting norms and standards and in supporting the implementation of programmes and initiatives that are relevant for this global plan of action (see Appendix 6). The roles, responsibilities and division of labour of the different partners will need to be assessed and clarified as part of the implementation of the plan at national level.

The role of the WHO Secretariat

11. The Secretariat has been active for the past 20 years in addressing the prevention of interpersonal violence and the prevention of, and response to, violence against women and against children, in particular. Building on the progress made in addressing the different forms of violence and in accordance with WHO's mandate, the Secretariat will continue to generate evidence, develop guidelines and other normative tools, and advocate in support of implementation of the WHO global plan of action. The Secretariat will also continue to work with Member States to raise awareness about prevention of and responses to interpersonal violence, in particular against women and girls, and against children, and to assist them in the implementation of WHO's tools and guidelines in order to strengthen their policies and programmes (see Appendices 4 and 5 for a description of WHO's efforts and tools and guidelines in addressing violence). The Secretariat participates in a number of United Nations and other interagency partnerships and initiatives on violence that are relevant for the plan (see Appendix 6).

¹ In many countries with a federal or decentralized system of government, regions or states may have responsibility for the design and implementation of health- and health system-related laws, policies, programmes and services to address interpersonal violence.

SECTION 3. ACTIONS FOR MEMBER STATES, NATIONAL AND INTERNATIONAL PARTNERS, AND THE WHO SECRETARIAT

This section describes broad evidence-based actions that can be taken by Member States, national and international partners and the WHO Secretariat focusing on violence against women and girls (section 3.A) and violence against children (section 3.B), as well as cross-cutting actions that contribute to addressing all forms of interpersonal violence (section 3.C).

3.A. Violence against women and girls

This section covers health system actions to respond to and prevent gender-based violence against women and girls (VAWG). These include:

- *creating an enabling legal and health policy environment that promotes gender equality and human rights and empowers women and girls;*
- *provision of comprehensive and quality health care services, particularly for sexual and reproductive health;*
- *evidence-informed prevention programmes promoting egalitarian and non-violent gender norms and relationships;*
- *improving evidence through collection of data on the many forms of VAWG and harmful practices that are often invisible in regular surveillance, health and crime statistics.*

All forms of violence against women and girls need to be addressed. Member States should prioritize specific forms that are the most relevant for their setting, based on evidence of prevalence and burden. This plan prioritizes actions to address intimate partner violence and sexual violence as the forms of violence that are prevalent in all settings and most commonly experienced by women globally. Specific forms of violence or harmful practices that disproportionately affect girls owing to gender inequality (such as sexual violence) or that are particular to girls, and that are high on the global health and development agenda (child, early and forced marriage and female genital mutilation), are also prioritized and covered in this section. Forms of violence during childhood that are common to boys and girls are covered in section 3.B.

Strategic direction 1: Strengthen health system leadership and governance

Member States	National and international partners	WHO Secretariat
<p>1. Strengthen political will by publicly committing to address and challenge the acceptability of all forms of VAWG throughout the life course, advocate to eliminate all forms of VAWG and end all harmful practices against women and girls (including female genital mutilation and its medicalization and child, early and forced marriage), and promote gender equality.</p> <p>2. Allocate appropriate budget /resources for the prevention of and response to violence against women and girls and include VAWG services in universal health coverage.</p> <p>3. Advocate for the adoption and reform of laws, policies and regulations, their alignment with international human rights standards and their</p>	<p>1. Strengthen political will by publicly committing to address and challenge the acceptability of all forms of VAWG throughout the life course, advocate to eliminate all forms of VAWG and end all harmful practices against women and girls (including female genital mutilation and its medicalization and child, early and forced marriage), and promote gender equality.</p> <p>2. Advocate for the adoption and reform of laws, policies and regulations, their alignment with international human rights standards and their enforcement, that, inter alia: criminalize VAWG; end all harmful practices and discrimination against women and girls; promote and protect their sexual and reproductive health and reproductive rights; and</p>	<p>1. Strengthen WHO leadership, political will, resource allocation and integration of responses to VAWG in relevant global health programmes (such as maternal and child health, sexual and reproductive health, adolescent health, noncommunicable diseases, ageing, mental health, humanitarian emergencies) and in universal health coverage.</p> <p>2. Raise awareness and understanding of VAWG through evidence-based advocacy among senior policy-makers about its nature, health and other consequences, risk and causal factors, and the need for it to be integrated within health policies, plans and programmes and within health responses to humanitarian emergencies, including health clusters.</p>

<p>enforcement, that, inter alia: criminalize VAWG; end all harmful practices and discrimination against women and girls; promote and protect their sexual and reproductive health and reproductive rights in accordance with the Programme of Action of the International Conference on Population and Development and the Beijing Platform for Action and the outcome documents of their review conferences; and promote gender equality and women's empowerment, including in relation to inheritance and family laws.</p> <p>4. Establish a unit or designate a focal point in ministries of health at all administrative levels to address violence against women and girls, in order to strengthen the health system's contribution to a multisectoral response.</p> <p>5. Ensure that the response to VAWG and harmful practices is clearly articulated in health policies, regulations, plans, programmes and budgets¹ (27, 28), in particular those related to sexual and reproductive health, HIV, maternal and child health, adolescent health, mental health, healthy ageing and health responses in humanitarian emergencies. Women's organizations and survivors must be involved in planning, policy development, implementation, and monitoring and accountability; their leadership must be encouraged and supported; and particular attention must be paid to the life course needs of women and girls, including those who face multiple forms of discrimination and marginalization.</p> <p>6. Strengthen coordination within the health system with other sectors for a strong multisectoral response to VAWG, including: police and justice; housing and social services; women's affairs and child protection.</p>	<p>promote gender equality and women's empowerment, including in relation to inheritance and family laws.</p>	<p>3. Advocate with ministries of health and other relevant health system stakeholders for strengthening the allocation of human and financial resources for programming and services to address VAWG and for their inclusion in universal health coverage.</p> <p>4. Provide technical support and build capacity for the integration of interventions addressing VAWG within all relevant health programmes, plans and policies, such as those for maternal and child health, sexual and reproductive health, HIV, mental health and emergency response.</p> <p>5. Develop and support the dissemination of tools for policy-makers and managers for designing and managing programmes and services to respond to VAWG.</p> <p>6. Support and facilitate efforts to coordinate the health system's response to VAWG within the United Nations system at global and national levels, including by participating in relevant joint United Nations initiatives on VAWG (see Appendix 6).</p>
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Aligning with commitments in the Abuja Declaration and the Busan Partnership for Effective Development Co-operation, including for tracking allocations for gender equality and women's empowerment.

<p>7. Strengthen the accountability of the health system in preventing and responding to VAWG by:</p> <ul style="list-style-type: none"> • providing quality services and programmes and establishing oversight mechanisms; • addressing the mistreatment and abuse of women and girls by health workers, especially in sexual and reproductive health services, by establishing codes of conduct for health workers, and confidential feedback mechanisms and grievance procedures to address mistreatment and abuse of women and girls by health workers; • preventing and responding to violence experienced by health workers in the workplace, including by establishing policies. 	
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Strategic direction 2: Strengthen health service delivery and health workers'/providers' capacity to respond		
Member States	National and international partners	WHO Secretariat
<p>8. Develop or update and implement guidelines, protocols and/or standard operating procedures for the identification, clinical care, support and referrals for violence against women (VAW) survivors, building on WHO guidelines and tools (29-33).</p> <p>9. Provide comprehensive health care services to all women and girls who have experienced violence, including in humanitarian settings. These should include: first-line support, care for injuries, sexual and reproductive health and mental health, services for post-rape care including emergency contraception, provision of safe abortion in accordance with national laws, prophylaxis against sexually transmitted infections and HIV, and complications among women and girls who have undergone female genital mutilation; and community awareness about availability of and need for timely access to health care services,</p>	<p>3. Provide comprehensive health care services to all women and girls who have experienced violence, including in humanitarian settings. These should include: first-line support, care for injuries, sexual and reproductive health and mental health, services for post-rape care including emergency contraception, provision of safe abortion in accordance with national laws, sexually transmitted infections and HIV prophylaxis and hepatitis B vaccination (29-31); services to manage the health complications among women and girls who have undergone female genital mutilation; and community awareness about availability of and need for timely access to health care services, particularly for post-rape care.</p>	<p>7. Provide technical cooperation to ministries of health and other partners in developing or updating guidelines/protocols/standard operating procedures to address VAWG, building on or adapting WHO guidelines and tools (29-33).</p> <p>8. Develop or update and disseminate evidence-based guidelines and tools including those related to addressing sexual violence, including in conflict settings, and management of health complications of female genital mutilation.</p> <p>9. Include health services to address VAWG as part of universal health coverage for sexual and reproductive health, maternal, child and adolescent health, and mental health, including in humanitarian settings.</p>

<p>particularly for post-rape care.</p> <p>10. Improve access to quality health care services by integrating identification of and care for women experiencing intimate partner violence including during pregnancy and sexual violence into existing programmes and services addressing: sexual and reproductive health; HIV, maternal and child health, adolescent health; mental health; routine checks and health services for the elderly; and health responses to humanitarian emergencies. Facilitate access to multisectoral services (police, justice, housing, social, child protection, and livelihood and employment, etc.) including through provision of medicolegal care, building on WHO guidelines and tools (29, 33). Ensure health care services are sensitive, accessible and affordable to all, and especially to those facing multiple forms of discrimination.</p> <p>11. Improve accountability of services and quality of care by: eliminating discrimination and violence in the health workplace; promoting women-centered care; providing gender-sensitive services that respect and promote women's human rights; and addressing the mistreatment and abuse of women and girls by health workers, especially in sexual and reproductive health services.</p> <p>12. Integrate content about the identification of, and response to VAWG and harmful practices into pre-service and in-service training curricula for health workers/providers (medical, nursing and midwifery), including those working in humanitarian emergencies, building on WHO guidelines and tools (29-33).</p>	<p>4. Improve access to quality health care services by integrating identification of and care for women experiencing intimate partner violence including during pregnancy and sexual violence into existing programmes and services addressing: sexual and reproductive health; HIV, maternal and child health, adolescent health; mental health; routine checks and health services for the elderly; and health responses to humanitarian emergencies. Facilitate access to multisectoral services (police, justice, housing, social, child protection, livelihood and employment, etc.) including through provision of medicolegal care, building on WHO guidelines and tools (29, 33). Ensure health care services are sensitive, accessible and affordable to all, and especially to those facing multiple forms of discrimination.</p> <p>5. Improve accountability of services and quality of care by: eliminating discrimination and violence in the health workplace; promoting women-centered care; providing gender-sensitive services that respect and promote women's human rights; and addressing the mistreatment and abuse of women and girls by health workers, especially in sexual and reproductive health services.</p>	<p>10. Develop and support the implementation of tools to monitor and evaluate the quality of health care services addressing VAWG.</p> <p>11. Develop and disseminate a model curriculum for both pre- and in-service training of health workers/providers in responding to VAWG.</p> <p>12. Identify a pool of experts who can support Member States to develop and implement training of health workers/providers in responding to VAWG.</p>
Strategic direction 3: Strengthen programming to prevent interpersonal violence		
Member States	National and international partners	WHO Secretariat
<p>13. Develop, test and implement/scale-up programmes to prevent and reduce VAWG that can be delivered through the health system.</p> <ul style="list-style-type: none"> Support programmes addressing intimate partner violence to meet the needs of children exposed to such violence, strengthening linkages with child and adolescent health programmes. 	<p>6. Develop, test and implement/scale-up programmes to prevent and reduce VAWG that can be delivered through the health system including</p> <ul style="list-style-type: none"> Support programmes addressing intimate partner violence to meet the needs of 	<p>13. Develop or identify, evaluate and disseminate evidence-based interventions to prevent VAWG, including those that promote egalitarian gender norms and challenge harmful practices and those that can be implemented by the health system through maternal, sexual and reproductive health,</p>

<ul style="list-style-type: none"> • Address risk factors associated with intimate partner violence such as harmful alcohol and substance use and maternal depression. • Integrate education/messages on egalitarian and non-violent gender norms, and consensual and respectful sexual relations, in behavior change communication campaigns and health promotion activities by community health workers. <p>14. Support or collaborate in the development, testing and implementation of VAWG prevention programmes that challenge harmful gender norms (i.e. those that perpetuate male dominance and female subordination, stigmatize survivors, condone or normalize VAWG; or perpetuate discrimination and harmful practices against women and girls), including by engaging men and boys to address gender inequality and abusive sexual relations, alongside women and girls as agents of change.</p> <p>15. Inform policies and programmes in other sectors and those implemented by civil society about evidence-based prevention interventions, including through advocacy with the education sector to implement comprehensive sexuality education programmes, and promotion of economic and livelihood interventions for women.</p>	<p>children exposed to such violence, strengthening linkages with child and adolescent health programmes;</p> <ul style="list-style-type: none"> • Address risk factors associated with intimate partner violence such as harmful alcohol and substance use and maternal depression; and • Integrate education/messages on egalitarian and non-violent gender norms, and consensual and respectful sexual relations, in behavior change communication campaigns and health promotion activities by community health workers. <p>7. Support or collaborate in the development, testing and implementation of VAWG prevention programmes that challenge harmful gender norms (i.e. those that perpetuate male dominance and female sub-ordination, stigmatize survivors, condone or normalize VAWG; or perpetuate discrimination and harmful practices against women and girls), including by engaging men and boys to address gender inequality and abusive sexual relations, alongside women and girls as agents of change.</p> <p>8. Inform policies and programmes in other sectors and those implemented by civil society about evidence-based prevention interventions, including through advocacy with the education sector to implement comprehensive sexuality education programmes, and promotion of economic and livelihood interventions for women.</p>	<p>mental health, HIV and adolescent health programmes and services.</p> <p>14. Develop recommendations on how to provide support to children of women identified as experiencing intimate partner violence.</p> <p>15. Support efforts of Member States and in collaboration with organizations of the United Nations system and other partners to develop or strengthen existing prevention interventions that address the risk factors and determinants of VAWG, particularly those that promote gender equality and address gender norms.</p>
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Strategic direction 4: Improve information and evidence		
Member States	National and international partners	WHO Secretariat
<p>16. Strengthen routine reporting of VAWG statistics across all ages and monitoring of progress in implementing the health system's response by including indicators and collection of data on VAWG in health information and surveillance systems, prioritizing those programmes and services reaching women and girls.</p> <p>17. In line with proposed VAWG indicators for the Sustainable Development Goals,¹ support the establishment of baselines for the prevalence of VAW throughout the life course including against adolescent girls and older women, and of harmful practices through recent (i.e. in the past five years) population-based surveys.</p> <p>18. Integrate modules to regularly collect data on VAWG across all ages in demographic and health or other population-based health surveys implemented at regular intervals.</p> <p>19. Conduct or support analysis and use of data on VAWG and harmful practices and disaggregate them by age, ethnicity, socioeconomic status and education, among other factors.</p> <p>20. Conduct or support research to develop, pilot, evaluate and implement/scale up VAWG prevention and response interventions that can be implemented by the health system.</p> <p>21. Facilitate efforts by nongovernmental organizations, researchers and others to conduct research on key knowledge gaps on VAWG and harmful practices, and to develop, pilot and evaluate interventions to address VAWG.</p>	<p>9. Integrate modules to regularly collect data on VAWG across all ages in demographic and health or other population-based health surveys implemented at regular intervals.</p> <p>10. Conduct or support analysis and use of data on VAWG and harmful practices and disaggregate them by age, ethnicity, socioeconomic status and education, among other factors.</p> <p>11. Conduct or support research to develop, pilot, evaluate and implement/scale up VAWG prevention and response interventions that can be implemented by the health system.</p> <p>12. Facilitate efforts by nongovernmental organizations, researchers and other sectors to: conduct research into key knowledge gaps on VAWG and harmful practices; and to develop, pilot and evaluate interventions to address VAWG.</p>	<p>16. Develop and disseminate harmonized indicators and measurement tools to support Member States in collecting standardized information on VAWG and monitoring progress in implementing a health systems response to VAWG in a confidential and safe manner through routine health information and surveillance systems.</p> <p>17. Encourage Member States to implement population-based surveys on VAW and provide technical cooperation to Member States wanting to implement these surveys, in particular those using the WHO methodology (4).</p> <p>18. Engage in technical cooperation with Member States and support partners to build capacity in analysis of data, including data that are disaggregated (by age, ethnicity, socioeconomic status, education, etc.) on VAWG and harmful practices, and their use to inform policies, programmes and plans.</p> <p>19. Regularly update estimates of prevalence of VAW.</p> <p>20. Support Member States in piloting and evaluating health system interventions to address VAWG.</p> <p>21. Conduct and support research efforts to improve understanding of mistreatment and abuse of women within the health system.</p>

¹ Includes indicators for targets 5.2 and 5.3.

<p>22. Conduct evidence synthesis and disseminate information on what works, including best practices to prevent and respond to VAWG.</p> <p>23. Strengthen the capacity of civil society, including women's organizations, research institutions and programme implementers, to conduct research on VAWG, including on ethical and safety aspects and the application of more rigorous evaluation.</p>		
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3.B. Violence against children

This section addresses violence against and among children and adolescents up to the age of 18 years. For infants and younger children, such violence mainly involves child maltreatment (i.e. physical, sexual and psychological/emotional abuse and neglect) at the hands of parents and other authority figures; as they grow older, peer violence, in addition to child maltreatment, becomes highly prevalent. Violence perpetrated against children in institutions is also addressed in this section.

Being a victim of child maltreatment increases the likelihood of being involved in adolescent peer violence, which in turn predicts subsequent perpetration and victimization in adulthood. Although limited to childhood and adolescence, many of the actions included here are relevant for the prevention of subsequent violence in adulthood.

Strategic direction 1: Strengthen health system leadership and governance		
Member States	National and international partners	WHO Secretariat
<p>1. Integrate strategies to address child maltreatment into early childhood development and maternal and child health programmes, and strategies to address peer violence into child and adolescent health and school health programmes, educational settings, youth development schemes, workplaces, and juvenile justice systems.</p> <p>2. Advocate for the adoption or reform of laws and policies, ensure their alignment with international human rights standards (34), and enforce existing laws and policies to prevent violence against children and adolescents, including corporal punishment, in all settings and in particular in the home, schools, communities, and residential care and detention facilities.</p> <p>3. Strengthen policy-maker and public knowledge about and capacity to address the lifelong health consequences of child maltreatment, its roles as a risk factor for involvement in other forms of violence, such as youth violence and intimate partner violence, and the high prevalence of homicide and non-fatal violence-related injuries due to peer violence among adolescents.</p> <p>4. Develop and adapt sex- and age-specific performance and accountability measures to monitor how well the health system is addressing violence against children and adolescents.</p>	<p>1. Advocate for the adoption or reform of laws and policies, ensure their alignment with international human rights standards (34), and enforce existing laws and policies to prevent violence against children and adolescents, including corporal punishment, in all settings and in particular in the home, schools, communities, and residential care and detention facilities.</p> <p>2. Strengthen policy-maker and public knowledge about and capacity to address the lifelong health consequences of child maltreatment, its roles as a risk factor for involvement in other forms of violence, such as youth violence and intimate partner violence, and the high prevalence of homicide and non-fatal violence-related injuries due to peer violence among adolescents.</p>	<p>1. Raise awareness among senior policy-makers and decision-makers about the health, social and financial consequences of child maltreatment and peer violence, the need for these to receive greater attention within the health sector and other sectors, and the importance of prevention and response.</p> <p>2. Provide technical assistance to develop and implement national plans of action for addressing violence against children and adolescents.</p> <p>3. Provide technical support and build capacity within health ministries to respond to child maltreatment and peer violence.</p> <p>4. Support global efforts to coordinate health systems involvement in prevention of and response to violence against children, within the United Nations system and at national level by participating in relevant joint United Nations and multistakeholder initiatives.</p>

<p>5. Ensure appropriate allocation of budget/resources for the prevention of and response to violence against children and adolescents in relevant health plans and policies.</p> <p>6. Create a unit or focal point within ministries of health to address violence against children and to liaise with other ministries, departments and agencies to prevent and respond to violence against children.</p>		
<p>Strategic direction 2: Strengthen health service delivery and health workers'/providers' capacity to respond</p>		
<p>Member States</p> <p>7. Integrate identification and gender-sensitive case management procedures for survivors/victims of child maltreatment and peer violence into the provision of routine health services for mothers and infants, children and adolescents. Services should be gender-sensitive and keyed to the child's developmental stage, and take into account the child's evolving capacities and preferences.</p> <p>8. Train health care providers in recognizing child and adolescent conditions that may lead to the perpetration of future violence, such as behavioural problems, conduct disorders, and early alcohol and substance abuse, and treating these conditions and their underlying causes. Equally, behaviour problems in children and adolescents, which may have developed as a way to cope with past victimization, may be wrongly diagnosed as attention deficit hyperactivity, oppositional defiant, and conduct disorders, and health care providers must be alerted to these possibilities.</p> <p>9. Strengthen individual and institutional capacities to respond to child and adolescent survivors/victims of violence in relevant health system institutions and allied sectors (such as police, education, social services), and ensure that health workers and other professionals are adults who children and young people can trust and confide in.</p> <p>10. Integrate content on identifying and caring for child maltreatment and peer violence survivors/victims into national curricula for the basic training and continuing education of all</p>	<p>National and international partners</p> <p>3. Train health care providers in recognizing child and adolescent conditions that may lead to the perpetration of future violence, such as behavioural problems, conduct disorders, and early alcohol and substance abuse, and treating these conditions and their underlying causes. Equally, behaviour problems in children and adolescents, which may have developed as a way to cope with past victimization, may be wrongly diagnosed as attention deficit hyperactivity, oppositional defiant, and conduct disorders, and health care providers must be alerted to these possibilities.</p>	<p>WHO Secretariat</p> <p>5. Develop and disseminate evidence-based clinical and policy guidelines and standard operating procedures for survivors/victims of child maltreatment and peer violence that are child friendly and gender-sensitive.</p> <p>6. Engage in technical cooperation with ministries of health and/or other relevant ministries in adapting WHO normative guidance on services for survivors/victims of child maltreatment and peer violence to specific country contexts.</p> <p>7. Develop and disseminate model curricula for both pre- and in-service training of health care providers on responding to violence against children.</p>

<p>health professionals, and develop quality standards and regulations for practitioners.</p> <p>11. Ensure that national guidelines and protocols are aligned with WHO and other evidence-based guidelines on services for survivors/victims of child maltreatment and peer violence.</p>		
Strategic direction 3: Strengthen programming to prevent interpersonal violence		
<p>Member States</p> <p>12. Strengthen individual and institutional capacities to prevent child maltreatment and peer violence in relevant health system institutions and allied sectors (such as police, education, social services).</p> <p>13. Implement evidence-based interventions to prevent child maltreatment, in particular programmes that can be delivered through the health system, such as home visiting and parenting support programmes, that aim to strengthen safe and nurturing relationships within families and between parents, caregivers and children, and ensure that such programmes meet the prevention needs of marginalized groups.</p> <p>14. Advocate for and support the development and implementation by other sectors of programmes to help children and adolescents develop life and social skills, and maintain positive relationships in order to prevent peer violence.</p> <p>15. Integrate interventions to prevent child maltreatment into early child development programmes, and peer violence interventions into youth development programmes, mental health programmes and school health services, and monitor their effectiveness.</p> <p>16. Promote the participation of children and adolescents in the development of policies and programmes to prevent violence against children.</p>	<p>National and international partners</p> <p>4. Implement evidence-based interventions to prevent child maltreatment, in particular programmes that can be delivered through the health system, such as home visiting and parenting support programmes, that aim to strengthen safe and nurturing relationships within families and between parents, caregivers and children, and ensure that such programmes meet the prevention needs of marginalized groups.</p> <p>5. Advocate for and support the development and implementation by other sectors of programmes to help children and adolescents develop life and social skills, and maintain positive relationships in order to prevent peer violence.</p>	<p>WHO Secretariat</p> <p>8. Synthesize and disseminate information on what works to prevent child maltreatment and peer violence.</p> <p>9. Engage in technical cooperation with Member States in strengthening their capacities to design, implement and evaluate policies and programmes to prevent child maltreatment and peer violence, including by assessing the readiness of a country to implement and scale up prevention efforts.</p> <p>10. Develop, test and disseminate affordable programmes to prevent child maltreatment and peer violence.</p>

Strategic direction 4: Improve information and evidence		
Member States	National and international partners	WHO Secretariat
<p>17. Conduct population-based surveys of violence against children, and strengthen routine reporting of statistics on violence against children by including relevant indicators in health information and surveillance systems, and by prioritizing programmes and services that reach children and adolescents.</p> <p>18. Conduct studies on the effectiveness of programmes to prevent child maltreatment and peer violence, and on victim services.</p> <p>19. Strengthen national capacities for research on all aspects of violence against children and adolescents, including on the magnitude, consequences and economic costs of such violence, and the economic savings from prevention, and on effective prevention and response interventions.</p> <p>20. Conduct and support research, including for health system interventions and services, in order to scale up effective interventions to address child maltreatment and peer violence.</p>	<p>6. Conduct studies on the effectiveness of programmes to prevent child maltreatment and peer violence, and on victim services.</p> <p>7. Strengthen national capacities for research on all aspects of violence against children and adolescents, including on the magnitude, consequences and economic costs of such violence, and the economic savings from prevention, and on effective prevention and response interventions.</p> <p>8. Conduct and support research, including for health system interventions and services, in order to scale up effective interventions to address child maltreatment and peer violence.</p>	<p>11. Develop standardized definitions of peer violence and harmonized methods for establishing the prevalence rates of child maltreatment and peer violence, and advocate for their use.</p> <p>12. Engage in technical cooperation with Member States to evaluate health and multisectoral interventions to prevent and respond to violence against children and adolescents.</p> <p>13. Engage in technical cooperation with Member States to strengthen their capacities to conduct research on all aspects of violence against children and adolescents, and to integrate indicators of violence against children and adolescents into routine surveillance systems.</p> <p>14. Develop guidance on safe and ethical collection of data on violence against children and adolescents.</p> <p>15. Develop a research agenda to address violence against children and adolescents.</p>

3.C. All forms of interpersonal violence: cross-cutting actions

This section addresses actions that are common to or cross-cutting across all forms of interpersonal violence. As such, they are complementary to the ones in sections 3.A and 3.B on violence against women and girls and violence against children; they address the linkages between the two, and they serve to foster synergies and strengthen responses to the different types of interpersonal violence across the life course, including youth violence and elder abuse. These actions include strengthening:

- *services common to all forms of interpersonal violence;*
- *programmes to prevent all forms of interpersonal violence by addressing shared risk factors; and*
- *data collection mechanisms.*

Strategic direction 1: Strengthen health system leadership and governance		
Member States	National and international partners	WHO Secretariat
<p>1. Strengthen policy-maker and public knowledge about the need for: (a) a public health approach to preventing and responding to violence; (b) addressing violence at the different stages of the life course; (c) addressing risk factors and determinants that are common to the different forms of interpersonal violence; and (d) strengthening the capacity of health care services to provide effective care for survivors/victims.</p> <p>2. Advocate for the adoption and reform of laws, policies and regulations, their alignment with international human rights standards and their enforcement, so as to address common risk or causal factors and determinants for several types of violence, such as those that: promote gender equality; prevent harmful alcohol and substance use; reduce firearm availability; ensure access to education and keep adolescent boys and girls in secondary schooling; reduce concentrated poverty.</p> <p>3. Integrate violence prevention and response in health policies, programmes, plans and budgets, and strengthen the health system's role within national multisectoral plans of action for all forms of interpersonal violence.</p>	<p>1. Strengthen policy-maker and public knowledge about the need for: (a) a public health approach to preventing and responding to violence; (b) addressing violence at the different stages of the life course; (c) addressing risk factors and determinants that are common to the different forms of interpersonal violence; and (d) strengthening the capacity of health care services to provide effective care for survivors/victims.</p> <p>2. Advocate for the adoption and reform of laws, policies and regulations, their alignment with international human rights standards and their enforcement, so as to address common risk or causal factors and determinants for several types of violence, such as those that: promote gender equality; prevent harmful alcohol and substance use; reduce firearm availability; ensure access to education and keep adolescent boys and girls in secondary schooling; reduce concentrated poverty.</p>	<p>1. Continue to develop guidance on comprehensive policies addressing violence and injuries across the life course.</p> <p>2. Support advocacy efforts of Member States and other relevant partners by disseminating evidence on the shared risk factors for the different types of violence.</p> <p>3. Continue to monitor efforts to address violence across Member States, including through regular updates of global and regional estimates of violence against women, and global status reports on violence.</p> <p>4. Engage in technical cooperation with ministries of health and other relevant ministries (such as those responsible for gender equality/women's empowerment, child protection, education, criminal justice, and social welfare), to strengthen the links between the health system and other sectors responsible for formulating and implementing multisectoral violence prevention action plans and policies.</p>

<p>4. Ensure active participation of the focal points of national and subnational ministries of health in multisectoral coordination mechanisms for addressing violence and strengthen coordination between health and other sectors, especially sectors working on gender equality/women's empowerment, child protection, education, social welfare and criminal justice.</p> <p>5. Develop and implement performance and accountability measures to monitor how well the health system is addressing violence.</p>		<p>5. Strengthen the linkages between those working on violence and cross-cutting issues, in particular mental health.</p>
<p>Strategic direction 2: Strengthen health service delivery and health workers'/providers' capacity to respond</p>		
<p>Member States</p>	<p>National and international partners</p>	<p>WHO Secretariat</p>
<p>6. Strengthen health services, and in particular pre-hospital services and emergency medical care, and ensure that all survivors/victims of violence have access to quality, affordable care.</p> <p>7. Strengthen mental health care in social services and in general health care services, including by increasing the workforce and their capacities to deliver these services in order to address the wide range of psychological and mental health consequences of violence, building on WHO mhGAP guidelines and tools (35).</p> <p>8. Address the intersections between different forms of violence. For example, assess the situation of children of women who are identified as experiencing intimate partner violence, and the situation of the mothers and siblings of children who are identified as experiencing child maltreatment, and provide psychological and other necessary support and referrals.</p> <p>9. Sensitize health workers about the interactions between violence and other health risk behaviours and problems such as alcohol and substance use, smoking and unsafe sex.</p>	<p>3. Strengthen health services, and in particular pre-hospital services and emergency medical care, and ensure that all survivors/victims of violence have access to quality, affordable care.</p> <p>4. Strengthen mental health care in social services and in general health care services, including by increasing the work force and their capacities to deliver these services in order to address the wide range of psychological and mental health consequences of violence, building on WHO mhGAP guidelines and tools (35).</p> <p>5. Address the intersections between different forms of violence. For example, assess the situation of children of women who are identified as experiencing intimate partner violence, and the situation of the mothers and siblings of children who are identified as experiencing child maltreatment, and provide psychological and other necessary support and referrals.</p> <p>6. Sensitize health workers about the interactions between violence and other health risk behaviours</p>	<p>6. Engage in technical cooperation with Member States to strengthen their health system response to violence, including through the dissemination of existing WHO guidelines and tools, and the development of further guidance addressing the common risk factors and other cross-cutting issues, as required.</p> <p>7. Support implementation of curricula for health workers and policy-makers (health care providers and managers) on understanding and addressing the intersections and cross-cutting issues related to different types of violence.</p>

<p>10. Strengthen the engagement of and partnerships with civil society organizations and community leaders in raising awareness of communities about the health consequences of violence, available services and the importance of seeking health services promptly.</p> <p>11. Identify and address the barriers in access to services for survivors of violence, including as part of universal health coverage, improve the quality of services and monitor and evaluate progress in providing quality health services to survivors.</p>	<p>and problems such as alcohol and substance use, smoking and unsafe sex.</p> <p>7. Strengthen the engagement of and partnerships with civil society organizations and community leaders in raising awareness of communities about the health consequences of violence, available services and the importance of seeking health services promptly.</p> <p>8. Identify and address the barriers in access to services for survivors of violence, including as part of universal health coverage, improve the quality of services and monitor and evaluate progress in providing quality health services to survivors.</p>	
Strategic direction 3: Strengthen programming to prevent interpersonal violence		
<p>Member States</p> <p>12. Increase knowledge among health workers/providers, policy-makers, personnel in other sectors and members of the public about the health burden of violence, its long-term consequences and costs to society, and the importance of preventing violence before it begins.</p> <p>13. Intensify advocacy to strengthen investments in evidence-based violence prevention programmes within the health system and with other sectors in order to address common risk factors such as gender inequality, poverty and economic inequality, high rates of crime in the community, firearm availability, ease of access to alcohol, drug dealing, and inadequate enforcement of laws.</p> <p>14. Increase human and institutional capacity to design, implement and evaluate evidence-based violence prevention programmes that focus on addressing risk factors common to different forms of violence.</p> <p>15. Implement and monitor prevention interventions within the health system that address common risk</p>	<p>National and international partners</p> <p>9. Increase knowledge among health workers/providers, policy-makers, personnel in other sectors and members of the public about the health burden of violence, its long-term consequences and costs to society, and the importance of preventing violence before it begins.</p> <p>10. Intensify advocacy to strengthen investments in evidence-based violence prevention programmes within the health system and with other sectors in order to address common risk factors such as gender inequality, unemployment, norms concerning masculinity, poverty and economic inequality, high rates of crime in the community, firearm availability, ease of access to alcohol, drug dealing, and inadequate enforcement of laws.</p> <p>11. Increase human and institutional capacity to design, implement and evaluate evidence-based violence prevention programmes that focus on addressing risk factors common to different forms of violence.</p>	<p>WHO Secretariat</p> <p>8. Collect and disseminate data on effective violence prevention policies and programmes, including by maintaining a global database of information about effective programmes to prevent different types of violence.</p> <p>9. Engage in technical cooperation with Member States to help strengthen human and institutional capacity to design, implement and evaluate policies and programmes that address common risk factors to prevent violence.</p> <p>10. Collaborate with organizations of the United Nations system and other partners in the development, dissemination and implementation of policies and programmes that can prevent different forms of interpersonal violence.</p>

<p>factors, such as those that reduce harmful use of alcohol and substance use and promote mental health.</p>	<p>12. Implement and monitor prevention interventions within the health system that address common risk factors, such as those that reduce harmful use of alcohol and substance use and promote mental health.</p>	
<p>Strategic direction 4: Improve information and evidence</p>		
<p>Member States</p>		
<p>16. Improve the ability of vital registration, health information, and routine injury and surveillance systems to document and compile standardized statistics on homicide and violence-related conditions presented to health workers using the relevant International Classification of Disease (ICD) codes and ensure that these data are disaggregated by sex and age and include information on the relationship between the perpetrator and victim.</p> <p>17. Strengthen the capacity of researchers, particularly in low- and middle-income Member States, to conduct research on all forms of interpersonal violence and their intersections, on their costs to society, and on less researched types of violence that are largely neglected, such as elder abuse.</p> <p>18. Support research on and expand the evidence base on risk factors associated with the perpetration of different forms of violence.</p>	<p>National and international partners</p> <p>13. Strengthen the capacity of researchers, particularly in low- and middle-income Member States, to conduct research on all forms of interpersonal violence and their intersections, on their costs to society, and on less researched types of violence that are largely neglected, such as elder abuse.</p> <p>14. Support research on and expand the evidence base on risk factors associated with the perpetration of different forms of violence.</p>	<p>WHO Secretariat</p> <p>11. Support research on and expand the evidence base on all aspects of violence, including prevention and response, inter alia by producing regular updates on research findings.</p> <p>12. Develop and disseminate standardized tools and indicators to facilitate the collection and compilation of statistics on the different forms of violence.</p>

SECTION 4. ACCOUNTABILITY AND MONITORING FRAMEWORK

This section outlines a monitoring and accountability framework for implementing the WHO global plan of action. It presents indicators for monitoring progress in implementing the plan of action at global level over a 15-year period (to 2030).

12. The framework is in line with the targets and outcome indicators proposed for the Sustainable Development Goals (see Appendix 6). Given the health system mandate of this plan, the proposed indicators specify the contributions of the health system, while recognizing that achievement of the targets and outcome indicators requires multisectoral efforts.

13. The monitoring and accountability framework is in line with the due diligence obligations of the State to prevent, investigate and, in accordance with national legislation, punish acts of violence against individuals. These include obligations in terms of provision of health care services, legal assistance, shelters, and counselling support (36-38).

14. The proposed indicators are designed to facilitate global-level reporting on the implementation of this plan of action. They are a small subset of the monitoring and information needs that Member States will have to meet in order to monitor, at national level, their health system's response to violence, in particular violence against women and girls, and against children. As such, they reflect the contribution of the health system to attainment of the targets in the Sustainable Development Goals, as well as the actions set out in this plan. Member States may need to develop or update their national indicators, building on their existing plans, policies and programmes and in line with how they adapt the actions proposed under this plan.

15. The proposed indicators and targets are voluntary and global. Given that Member States are at different levels of readiness in their health system response to violence, in particular against women and girls, and against children, the indicators will be monitored at the aggregate level. Member States will need to adapt their plans and set incremental benchmarks for implementation and monitoring, tailored to their national and local legislation and capacities and starting points, while maintaining the highest levels of ambition to achieve the goals and targets.

16. In order to assess progress towards the global targets, it is proposed that reporting be through the World Health Assembly every five years. Reporting on progress will also serve to identify gaps and challenges, and to exchange best practices and countries' experiences in implementing the plan. The aim is to build on existing reporting systems (such as the outcome and output indicators in WHO's programme budgets), not to create new or parallel systems.

17. The role of the Secretariat will be to: (a) provide support to Member States in identifying and developing indicators for national-level monitoring; (b) develop baseline measures for global targets and propose interim milestones in collaboration with Member States; (c) develop standardized tools for collecting and analysing the data for monitoring progress at global level; (d) prepare regular global progress reports, based on national data and in collaboration with Member States, in order to benchmark the progress made, identify gaps and challenges, and share best practices and country experiences; and (e) offer guidance, technical support and training to Member States, upon request, in strengthening their national information systems for capturing the data related to the proposed indicators.

Table 2: Summary of indicators and global targets

	Indicator	Baseline (2016)	Target (2030)	Comments/assumptions
A. Violence against women and girls				
<i>SD 1: Strengthen health system leadership and governance. Outcome: An enabling policy environment to address violence against women and girls.</i>	Relevant targets in the Sustainable Development Goals (SDGs) (see Appendix 6): 3.7 – By 2030, ensure universal access to sexual and reproductive health care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes; 3.8 – Achieve universal health coverage, including access to quality essential health care services; 5.2 – Eliminate all forms of violence against women and girls; 5.3 – Eliminate all harmful practices; 5.6 – Ensure universal access to sexual and reproductive health and reproductive rights in accordance with the Programme of Action of the International Conference on Population and Development and the Beijing Platform for Action and the outcome documents of their review conferences.			
<i>A 1.1</i>	Number of Member States that have included health care services to address intimate partner violence and comprehensive post-rape care in line with WHO guidelines (29) in their national health or sexual and reproductive health plans or policies.	To be defined (TBD)	(TBD)	Member States have included health care services to address intimate partner violence and comprehensive post-rape care in line with WHO guidelines (29) in their health or sexual and reproductive health plans or policies (yes/no). Violence against women and girls is included in the package of services for the Global Strategy for Women's, Children' and Adolescents' Health (2016–2030). Means of verification: baseline and means of verification will need to be established.
<i>SD 2: Strengthen health service delivery and health workers/providers capacity to respond. Outcome: Comprehensive and quality health services delivered and health workers with skills to be responsive to the needs of women and girls subjected to violence.</i>	Relevant SDG targets: 3.3 – End the epidemic of AIDS; 3.4 – Reduce premature mortality from noncommunicable diseases and promote mental health; 3.5 – Strengthen the prevention and treatment of substance abuse, including narcotic drug abuse and harmful use of alcohol; 3.7 – By 2030, ensure universal access to sexual and reproductive health care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes; 3.8 – Achieve universal health coverage, including access to quality essential health care services; 5.2 – Eliminate all forms of violence against women and girls; 5.6 – Ensure universal access to sexual and reproductive health and reproductive rights in accordance with the Programme of Action of the International Conference on Population and Development, and the Beijing Platform for Action and the outcome documents of their review conferences.			
<i>A 2.1</i>	Number of Member States that have developed or updated their national guidelines or protocols or standard operating procedures (SOPs) for the health system response to women experiencing intimate partner violence and/or sexual violence, consistent with international human rights standards and WHO guidelines (29).	(TBD)	(TBD)	Member States have a national guideline or protocol or SOP that specifies the health system response to intimate partner violence and/or sexual violence aligned with WHO guidelines (29) and international human rights standards (yes/no). Means of verification: content review of national guidelines, protocols or SOPs. At a minimum, the protocols/guidelines for the health system response should address: identification of intimate partner violence; first-line support; provision of comprehensive post-rape care; provision (either direct or through referrals) of mental health care; and referrals to other services needed by women.

	Indicator	Baseline (2016)	Target (2030)	Comments/assumptions
A 2.2.	Number of Member States that provide comprehensive post-rape care in a medical facility (department) in every territorial and/or administrative unit, consistent with WHO guidelines (29).	(TBD)	(TBD)	<p>Member States are providing comprehensive post-rape care in at least half of all their emergency health care facilities (yes/no).</p> <p>Means of verification: provision of comprehensive post-rape care is included in WHO's HIV health sector response progress reporting. In line with WHO guidelines (29), post-rape care will include: first-line support, emergency contraception, provision of safe abortion in accordance with national laws, post-exposure prophylaxis of sexually transmitted infections and/or HIV as per applicable protocols, and hepatitis B vaccination.</p>
<p><i>SD 3: Strengthen programming to prevent interpersonal violence. Outcome: evidence-informed programming to prevent violence against women and girls being implemented.</i></p> <p>Relevant SDG targets: 5.2 – Eliminate all forms of violence against women and girls; 5.3 – Eliminate all harmful practices; 16.1 – Significantly reduce all forms of violence and related deaths everywhere; and 16.2 – End abuse, exploitation, trafficking and all forms of violence against and torture of children.</p>				
A 3.1	Number of Member States that have a national multisectoral plan addressing violence against women and girls (that includes the health system) which proposes at least one strategy to prevent violence against women and girls.	(TBD)	(TBD)	<p>Member States that have a national multisectoral plan addressing violence against women and girls that includes the health system and which proposes at least one prevention strategy/intervention (yes/no).</p> <p>Means of verification: review of national multisectoral plans of action on violence against women and girls. Prevention strategies can include one or more interventions that propose to: promote early identification of women experiencing partner violence or children exposed to violence and provide psychological support and appropriate referrals to reduce future violence; address gender/patriarchal social norms that perpetuate violence against women and girls and which condone or normalize such violence; promote social and emotional learning skills among children and adolescents related to respectful and non-violent relationships; approaches to empower and build self-efficacy among women and girls; legal and policy approaches (e.g. promoting gender equality, reducing harmful use of alcohol).</p>

	Indicator	Baseline (2016)	Target (2030)	Comments/assumptions
<p>SD 4: Improve information and evidence. <i>Outcome: Evidence base to inform policies, programmes and plans to address violence against women and girls strengthened.</i></p> <p>Relevant SDG targets: 5.2 – Eliminate all forms of violence against women and girls; 5.3 – Eliminate all harmful practices; 16.1 – Significantly reduce all forms of violence and related deaths everywhere; and 16.2 – End abuse, exploitation, trafficking and all forms of violence against and torture of children.</p>				
<p>A 4.1.</p>	<p>Number of Member States that have carried out a population-based, nationally representative study/survey on violence against women or that have included a module on violence against women in other population-based demographic or health surveys within the past five years, disaggregated by age, ethnicity, socioeconomic status etc.</p>	<p>100</p>	<p>(TBD)</p>	<p>Member States have a nationally representative survey on violence against women or have included a module on violence against women in a population-based demographic, health or other type of survey within the past five years (yes/no)</p> <p>Means of verification: as part of its efforts to produce estimates of the prevalence of violence against women, WHO has a database on prevalence of intimate partner violence and non-partner sexual violence from population-based surveys conducted in countries, which it regularly updates. While WHO's 2013 global and regional estimates of violence against women were based on surveys from 80+ countries, since then an additional 20+ population-based surveys have been conducted. It remains to be assessed how many Member States have conducted surveys in the last five years.</p>
<p>B. Violence against children</p>				
<p>SD 1: Strengthen health system leadership and governance. <i>Outcome: An enabling policy to address violence against children.</i></p> <p>Relevant SDG targets: 3.5 – Strengthen the prevention and treatment of substance abuse, including narcotic drug abuse and harmful use of alcohol; 4.2 – By 2030, ensure that all girls and boys have access to quality early childhood development, care and pre-primary education; 4a – Build and upgrade education facilities that are non-violent and inclusive learning environments; 5.3 – Eliminate all harmful practices; 16.2 – End abuse, exploitation, trafficking and all forms of violence against and torture of children.</p>				
<p>B 1.1.</p>	<p>Number of Member States that have included actions to address violence against children in their national health plans and/or policies.</p>	<p>(TBD)</p>	<p>(TBD)</p>	<p>Violence against children is not only mentioned in the goals or objectives, but there are specific actions in the country's operational plans (yes/no)</p> <p>Means of verification: This will be verified by a review of the most recent/current national health policies and plans available in the WHO database on health plans and policies.</p> <p>For Member States with a federal system, this will need to include the plans of the majority of states/provinces within the country. Plans or policies can include general health plans or specific plans for child and adolescent health and mental health.</p>

	Indicator	Baseline (2016)	Target (2030)	Comments/assumptions
<p><i>SD2: Strengthen health service delivery and health workers' capacity to respond. Outcome: Comprehensive and quality health services delivered, and health workers with the skills to be responsive to the needs of children and adolescents subjected to violence.</i></p> <p>Relevant SDG targets: 3.4 – Reduce premature mortality from noncommunicable disease and promote mental health; 3.5 – Strengthen the prevention and treatment of substance abuse, including narcotic drug abuse and harmful use of alcohol; 3.8 – Achieve universal health coverage, including access to quality essential health care services; 16.2 – End abuse, exploitation, trafficking and all forms of violence against and torture of children.</p>	<p>Number of Member States that have developed or updated their national guidelines, protocols or SOPs for the health system's response to survivors/victims of child maltreatment, consistent with international human rights standards.</p>	(TBD)	(TBD)	<p>Member States have a national guideline, protocol or SOP that specifies the health system's response to survivors/victims of child maltreatment aligned with international human rights standards (yes/no).</p> <p>Means of verification will be a content review of national guidelines, protocols or SOPs (in line with WHO guidelines on child maltreatment under development).</p>
<p><i>SD 3: Strengthen programming to prevent interpersonal violence. Outcome: Evidence-informed programming to prevent violence against children being implemented</i></p> <p>Relevant SDG targets: 16.1 – Significantly reduce all forms of violence and related death rates everywhere; 16.2 – End abuse, exploitation, trafficking and all forms of violence against and torture of children.</p>	<p>Number of Member States that report large-scale implementation of at least four out of eight evidence-based interventions to prevent violence against children.</p>	(TBD)	(TBD)	<p>Member States report large-scale implementation of at least four out of the eight evidenced-based interventions to prevent violence against children: (i) home visiting; (ii) parenting education; (iii) child sexual abuse prevention; (iv) pre-school enrichment; (v) life skills/social development programmes; (vi) bullying prevention; (vii) mentoring, and (viii) after-school programmes.</p> <p>Means of verification: Methodology as used to compile WHO's Global status report on violence prevention 2014 (3).</p>
<p><i>SD 4: Improve information and evidence. Outcome: Evidence-base to inform and monitor policies, programmes, and plans to address violence against children strengthened.</i></p> <p>Relevant SDG targets: 16.1 – Significantly reduce all forms of violence and related death rates everywhere; 16.2 – End abuse, exploitation, trafficking and all forms of violence against and torture of children.</p>	<p>Number of Member States that have conducted a nationally representative survey or included questions on child maltreatment in other household surveys (such as multiple indicator cluster surveys) within the past eight years</p>	(TBD)	(TBD)	<p>Member States reporting having conducted a population-based survey on child maltreatment (violence against children) or included questions on child maltreatment in other household surveys (such as multiple indicator cluster surveys) within the past eight years (yes/no).</p> <p>Means of verification: WHO's Global status report on violence prevention 2014 (3). In 2014, of the 133 countries who responded, 41% reported having conducted a survey; however, the proportion of countries in which surveys have been conducted in the past eight years was not assessed.</p>

	Indicator	Baseline (2016)	Target (2030)	Comments/assumptions
C. All forms of interpersonal violence: cross-cutting actions				
<i>SD 4: Improve information and evidence.</i>				
Relevant SDG targets: 5.2 – Eliminate all forms of violence against women and girls; 16.1 – Significantly reduce all forms of violence and related death rates everywhere; 16.2 – End abuse, exploitation, trafficking and all forms of violence against and torture of children.				
C 4.1	Number of Member States that have usable data on homicide from vital registration sources.	(TBD)	(TBD)	Using information from the WHO mortality database, WHO's Global status report on violence prevention 2014 ascertained that fully 60% of countries do not have usable data on homicide from vital registration sources (3). To count as usable, vital registration data had to be at least 70% complete, no more than 30% of injuries could be classified as "intent undetermined", and homicides had to be defined according to ICD 10 codes X85-Y09; Y87.1 or ICD9 codes E960-E969. Data should be disaggregated by age and sex and document the relationship between victim and perpetrator. Means of verification: WHO mortality database, count of Member States with usable homicide data.

APPENDICES

Appendix 1

Glossary of key terms

This glossary provides definitions of the key terms used in the WHO global plan of action and by the Secretariat in its work. The definitions have been derived from technical documents of WHO and other relevant bodies of the United Nations system.

(in alphabetical order)

Adolescence is defined by the United Nations as individuals aged 10–19 years. A difference can be made between early adolescence (10–14 years) and late adolescence (15–19 years).¹

Child, early and forced marriage is “marriage in which at least one of the parties is a child” – a person below the age of 18. It also “refers to marriages involving a person aged below 18 in countries where the age of majority is attained earlier or upon marriage. Early marriage can also refer to marriages where both spouses are 18 or older but other factors make them unready to consent to marriage, such as their level of physical, emotional, sexual and psychosocial development, or a lack of information regarding the person’s life options”. Furthermore it is “any marriage which occurs without the full and free consent of one or both of the parties and/or where one or both of the parties is/are unable to end or leave the marriage, including as a result of duress or intense social or family pressure”.²

Child maltreatment is defined as “the abuse and neglect of children under 18 years of age. It includes all types of physical and/or emotional ill treatment, sexual abuse, neglect, negligence and commercial or other exploitation, which results in actual or potential harm to the child’s health, survival, development or dignity in the context of a relationship of responsibility, trust or power”.³

Child sexual abuse “is defined as the involvement of a child in sexual activity that he or she does not fully comprehend, is unable to give informed consent to, or for which the child is not developmentally prepared, or else that violates the laws or social taboos of society. Children can be sexually abused by both adults and other children who are – by virtue of their age or stage of development – in a position of responsibility, trust or power over the victim.”⁴

¹ UNICEF. Adolescence, an age of opportunity: The State of the World’s Children 2011, February 2011, ISBN: 978-92-806-4555-2 (http://www.unicef.org/sowc2011/pdfs/SOWC-2011-Main-Report_EN_02092011.pdf accessed 6 August 2015).

² United Nations General Assembly. Preventing and eliminating child, early and forced marriage. Report of the Office of the United Nations High Commissioner for Human Rights. 2014. A/HRC/26/22 (http://www.ohchr.org/EN/HRBodies/HRC/RegularSessions/Session26/Documents/A-HRC-26-22_en.doc accessed 13 August 2015).

³ WHO. Global status report on violence prevention 2014, Geneva: World Health Organization, 2014 (http://apps.who.int/iris/bitstream/10665/145086/1/9789241564793_eng.pdf?ua=1&ua=1).

⁴ WHO and International Society for the Prevention of Child Abuse and Neglect. Preventing Child Maltreatment: a guide to taking action and generating evidence. Geneva: World Health Organization, 2006. (http://apps.who.int/iris/bitstream/10665/43499/1/9241594365_eng.pdf).

Comprehensive health services are “health services that are managed so as to ensure that people receive a continuum of health promotion, disease prevention, diagnosis, treatment and management, rehabilitation and palliative care services, through the different levels and sites of care within the health system, and according to their needs throughout the life course.”¹

Comprehensive sexuality education is “an age-appropriate, culturally relevant approach to teaching about sex and relationships by providing scientifically accurate, realistic, non-judgmental information. It provides opportunities to explore one’s own values and attitudes and to build decision-making, communication and risk reduction skills about many aspects of sexuality.”²

Corporal punishment is “any punishment in which physical force is used and intended to cause some degree of pain or discomfort, however light. Most involves hitting (“smacking”, “slapping”, “spanking”) children, with the hand or with an implement – a whip, stick, belt, shoe, wooden spoon, and so on. But it can also involve, for example, kicking, shaking or throwing children, scratching, pinching, biting, pulling hair or boxing ears, forcing children to stay in uncomfortable positions, burning, scalding or forced ingestion (for example, washing children’s mouths out with soap or forcing them to swallow hot spices).”³

Ecological model for understanding violence includes risk factors at the level of (a) the individual (for example, individual characteristics and life histories); (b) interpersonal relationships (for example, family dynamics and household characteristics); (c) the community (for example, community norms, levels of poverty and crime); and (d) the society (for example, societal norms, existence of laws, policies and their enforcement).⁴

Ecological model for understanding violence



Elder abuse is “a single or repeated act, or lack of appropriate action, occurring within any relationship where there is an expectation of trust that causes harm or distress to an older person. Elder abuse includes physical, sexual, psychological, emotional, financial and material abuse; abandonment; neglect; and serious loss of dignity and respect”.⁵

¹ Health systems strengthening glossary. World Health Organization. (http://www.who.int/entity/healthsystems/Glossary_January2011.pdf).

² International technical guidance on sexuality education: an evidence-informed approach for schools, teachers and health educators. Paris: UNESCO. 2009. (<http://unesdoc.unesco.org/images/0018/001832/183281e.pdf> accessed 9 November 2015).

³ Convention on the rights of the child. General comment no. 8. 2006. CRC/C/GC/8 (https://srsg.violenceagainstchildren.org/sites/default/files/documents/docs/GRC-C-GC-8_EN.pdf, accessed 13 August 2015).

⁴ World report on violence and health. Geneva: World Health Organization; 2002 (http://whqlibdoc.who.int/publications/2002/9241545615_eng.pdf).

⁵ Elder Abuse. Factsheet No. 357, 2014, reviewed 2016 (<http://www.who.int/mediacentre/factsheets/fs357/en/>, accessed 8 November 2016).

Femicide “is generally understood to involve intentional murder of women because they are women.” It “is usually perpetrated by men, but sometimes female family members may be involved. Femicide differs from male homicide in specific ways. For example, most cases of femicide are committed by partners or ex-partners, and involve ongoing abuse in the home, threats or intimidation, sexual violence or situations where women have less power or fewer resources than their partner”.¹

Gender-based violence against women is “violence that is directed against a woman because she is a woman or that affects women disproportionately. It includes acts that inflict physical, mental or sexual harm or suffering, threats of such acts, coercion and other deprivations of liberty”.²

Gender inequality and discrimination is “any distinction, exclusion or restriction made on the basis of sex which has the effect or purpose of impairing or nullifying the recognition, enjoyment or exercise by women, irrespective of their marital status, on a basis of equality of men and women, of human rights and fundamental freedoms in the political, economic, social, cultural, civil or any other field”.³

Gender equality “refers to the equal rights, responsibilities and opportunities of women and men and girls and boys. Equality does not mean that women and men will become the same but that women’s and men’s rights, responsibilities and opportunities will not depend on whether they are born male or female. Gender equality implies that the interests, needs and priorities of both women and men are taken into consideration – recognizing the diversity of different groups of women and men. Gender equality is not a “women’s issue” but should concern and fully engage men as well as women. Equality between women and men is seen both as a human rights issue and as a precondition for, and indicator of, sustainable people-centred development”.⁴ Gender inequality therefore refers to the absence of such rights, responsibilities and opportunities.

Harmful practices “are persistent practices and forms of behaviour that are grounded in discrimination on the basis of, among other things, sex, gender and age, in addition to multiple and/or intersecting forms of discrimination that often involve violence and cause physical and/or psychological harm or suffering. The harm that such practices cause to the victims surpasses the immediate physical and mental consequences and often has the purpose or effect of impairing the recognition, enjoyment and exercise of the human rights and fundamental freedoms of women and children. There is also a negative impact on their dignity, physical, psychosocial and moral integrity and development, participation, health, education and economic and social status”.⁵

¹ Understanding and addressing violence against women: Femicide. Geneva: World Health Organization, 2012 (http://apps.who.int/iris/bitstream/10665/77421/1/WHO_RHR_12.38_eng.pdf).

² Convention on the Elimination of All Forms of Discrimination against Women. General recommendation no. 19 (1992) (<http://www.un.org/womenwatch/daw/cedaw/recommendations/recomm.htm#recom19>).

³ Convention on the Elimination of All Forms of Discrimination against Women. Article 1. 1979. (<http://www.un.org/womenwatch/daw/cedaw/text/econvention.htm#article1>).

⁴ Office of the Special Adviser to the Secretary-General on Gender Issues and Advancement of Women (OSAGI). Gender Mainstreaming: Strategy For Promoting Gender Equality. 2001. (<http://www.un.org/womenwatch/osagi/pdf/factsheet1.pdf>).

⁵ CEDAW, CRC. Joint general recommendation No. 31 of the Committee on the Elimination of Discrimination against women/general comment No. 18 of the Committee on the Rights of the Child on harmful practices. 2014. CEDAW/C/GC/31-CRC/C/GC/18 (http://tbinternet.ohchr.org/_layouts/treatybodyexternal/Download.aspx?symbolno=CEDAW%2fC%2fGC%2f31%2fCRC%2fC%2fGC%2f18&Lang=en accessed 10 November 2015).

Health sector “consists of organized public and private health services (including health promotion, disease prevention, diagnostic, treatment and care services), the policies and activities of health departments and ministries, health related nongovernment organizations and community groups, and professional associations”.¹

Health system refers to “(i) all the activities whose primary purpose is to promote, restore and/or maintain health; (ii) the people, institutions and resources, arranged together in accordance with established policies, to improve the health of the population they serve, while responding to people’s legitimate expectations and protecting them against the cost of ill-health through a variety of activities whose primary intent is to improve health”.²

Health workers “all people engaged in actions whose primary intent is to enhance health”.³

Interpersonal violence as 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, intimate partner violence, abuse of the elderly, family members, youth violence, random acts of violence, rape or sexual assault and violence in institutional settings such as schools, workplaces, prisons and nursing homes.⁴

Intimate partner violence “refers to behaviour by an intimate partner or ex-partner that causes physical, sexual or psychological harm, including physical aggression, sexual coercion, psychological abuse and controlling behaviours”.⁵

Intimate partner refers to a husband, cohabiting partner, boyfriend or lover, ex-husband, ex-partner, ex-boyfriend or ex-lover. The definition of intimate partner varies between settings and studies and includes formal partnerships, such as marriage, as well as informal partnerships, including cohabiting, dating relationships and unmarried sexual relationships. In some settings, intimate partners tend to be married, while in others more informal partnerships are more common.⁶

A life course approach is “based upon understanding how influences early in life can act as risk factors for health-related behaviours or health problems at later stages”. “Taking a life-course

¹ WHO. Health promotion glossary. Geneva: World Health Organization, 1998. WHO/HPR/HEP/98.1 (<http://www.who.int/entity/healthpromotion/about/HPR%20Glossary%201998.pdf?ua=1>).

² WHO. Health systems strengthening glossary, Geneva: World Health Organization, 2011. (http://www.who.int/entity/healthsystems/Glossary_January2011.pdf accessed 19 August 2015).

³ The world health report 2006 – working together for health. Geneva: World Health Organization, (<http://www.who.int/entity/whr/2006/chapter1/en/index.html>).

⁴ Krug EG, Dahlberg LL, Mercy JA, Zwi AB, Lozano R, eds. World report on violence and health. Geneva: World Health Organization; 2002 (http://whqlibdoc.who.int/publications/2002/9241545615_eng.pdf).

⁵ WHO. Violence against women. Intimate partner and sexual violence against women. Geneva: World Health Organization, 2014. (http://apps.who.int/iris/bitstream/10665/112325/1/WHO_RHR_14.11_eng.pdf?ua=1).

⁶ Responding to intimate partner violence and sexual violence against women: WHO clinical and policy guidelines. Geneva: World Health Organization; 2013 (http://apps.who.int/iris/bitstream/10665/85240/1/9789241548595_eng.pdf, accessed 19 February 2015).

perspective helps to identify early risk factors for violence and the best times to implement a primary prevention approach”.¹

Multisectoral response “entails the coordination of resources and initiatives across sectors, involving both government institutions and civil society.” “A coordinated framework provides for the delivery of a diverse range of health care, protection and justice services that survivors need which cannot be provided by a single sector or intervention. Integrated approaches strengthen advocacy efforts; establish long-term collaboration across sectors; improve the efficiency and reach of services and prevention efforts; and maximize the available technical expertise, resources and investments on the issue”.²

Primary health care “is essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination. It forms an integral part both of the country’s health system, of which it is the central function and main focus, and of the overall social and economic development of the community. It is the first level of contact of individuals, the family and the community with the national health system bringing health care as close as possible to where people live and work, and constituted the first element of a continuing health care process”.³

Public health approach to violence prevention refers to four steps: defining and monitoring the problem; identifying risk and protective factors; developing and testing prevention and response strategies; and supporting widespread adoption.⁴

Sexual violence “is any sexual act, attempt to obtain a sexual act, or other act directed against a person’s sexuality using coercion, by any person regardless of their relationship to the victim, in any setting. It includes rape, defined as the physically forced or otherwise coerced penetration of the vulva or anus with a penis, other body part or object”.⁵

Survivor/victim refers to people who have experienced/are affected by violence. The term survivor is usually preferred by those working on violence against women to emphasize that women affected by violence have agency and are not merely passive ‘victims’ in the face of violence. The term victim is however used in criminal justice. For the purposes of this document they are used interchangeably.

Vulnerable groups are groups who are disproportionately likely to be exposed to or experience different types of violence because of social exclusion, marginalization, stigma and multiple forms of discrimination.

¹ Preventing intimate partner and sexual violence against women. Taking action and generating evidence. Geneva: World Health Organization, 2010. (http://whqlibdoc.who.int/publications/2010/9789241564007_eng.pdf).

² Ensuring holistic multisectoral policies and national plans of actions. UN Women virtual knowledge centre to end violence against women and girls (<http://www.endvawnow.org/en/articles/316-ensuring-holistic-multisectoral-policies-and-national-plans-of-actions-.html>).

³ Declaration of Alma-Ata. International Conference on Primary Health Care, Alma-Ata, USSR, 6–12 September 1978. Geneva: World Health Organization, 1978. (www.who.int/publications/almaata_declaration_en.pdf).

⁴ Krug EG, Dahlberg LL, Mercy JA, Zwi AB, Lozano R, editors. World report on violence and health. Geneva: World Health Organization; 2002 (http://whqlibdoc.who.int/publications/2002/9241545615_eng.pdf).

⁵ WHO. Violence against women. Intimate partner and sexual violence against women. Geneva: World Health Organization, 2014. (http://apps.who.int/iris/bitstream/10665/112325/1/WHO_RHR_14.11_eng.pdf?ua=1).

Violence against children is defined as: any violence against a boy or girl under 18 years of age. It therefore includes child maltreatment and overlaps with youth violence. The most frequent forms it takes are child maltreatment and youth violence.

Violence against women (VAW) is defined as: “any act of gender-based violence that results in, or is likely to result in, physical, sexual, or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or private life”. It encompasses, but is not limited to: “physical, sexual and psychological violence occurring in the family, including battering, sexual abuse of female children in the household, dowry-related violence, marital rape, female genital mutilation and other traditional practices harmful to women, non-spousal violence and violence related to exploitation; physical, sexual and psychological violence occurring within the general community, including rape, sexual abuse, sexual harassment and intimidation at work, in educational institutions and elsewhere; trafficking in women and forced prostitution; and physical, sexual and psychological violence perpetrated or condoned by the state, wherever it occurs”.¹

Violence against women and girls (VAWG) refers to violence against women as defined above, and includes also forms of violence against girls, because they are girls and that are rooted in gender inequality (for example, harmful practices, early, child and forced marriage). It emphasizes the heightened risk of women and girls to violence throughout the life course because of gender inequality and discrimination against them.

Youth violence is “violence occurring between people aged 10–29 years of age.”² It includes all types of physical and/or emotional ill treatment, and generally takes place outside of the home. It includes harmful behaviours that may start early and continue into adulthood. Some violent acts – such as assault – can lead to serious injury or death. Others, such as bullying, slapping or hitting, may result more in emotional than physical harm.

¹ United Nations General Assembly resolution 48/104, Declaration on the Elimination of Violence Against Women. 1993 (<http://www.un.org/documents/ga/res/48/a48r104.htm> accessed 6 August 2015).

² WHO. Global status report on violence prevention 2014. Geneva: World Health Organization, 2014 (http://www.who.int/violence_injury_prevention/violence/status_report/2014/en/).

Appendix 2

Relevant resolutions, agreed conclusions, general comments and articles**World Health Assembly and Executive Board resolutions:**

- WHA49.25 (1996), which declared violence a leading worldwide public health problem;¹
- WHA50.19 (1997), about the development of a plan of action for a public health approach to violence prevention based on scientific data;²
- EB95.R17 (1995) on emergency and humanitarian action, which requests the Director-General to include management of health effects in situations of collective violence;³
- WHA56.24 (2003) on implementing the recommendations of WHO's *World report on violence and health*, published in 2002;⁴
- WHA57.12 (2004) on the reproductive health strategy, which highlighted violence against women as one of the key forms of gender inequality that needs to be addressed to achieve sexual and reproductive health;⁵
- WHA60.25 (2007) on Strategy for integrating gender analysis and actions into the work of WHO;⁶
- WHA61.16 (2008) on female genital mutilation, which urges Member States to accelerate actions towards its elimination, to improve health, including sexual and reproductive health, to assist women and girls who are subjected to this violence;⁷
- WHA63.13 (2010) on the global strategy to reduce the harmful use of alcohol;⁸
- WHA66.8 (2013) on the comprehensive mental health action plan 2013–2020;⁹
- WHA66.9 (2013) on disability, including a request to the Director-General to develop a comprehensive WHO action plan – the WHO global disability action plan 2014–2021: Better health for all people with disability.^{10,11}

¹ Available at http://apps.who.int/iris/bitstream/10665/179463/1/WHA49_R25_eng.pdf.

² Available at http://apps.who.int/iris/bitstream/10665/179742/1/WHA50_R19_eng.pdf.

³ Available at http://apps.who.int/iris/bitstream/10665/172480/1/EB95_R17_eng.pdf.

⁴ Available at <http://apps.who.int/iris/bitstream/10665/78325/1/ea56r24.pdf>.

⁵ Available at http://apps.who.int/gb/ebwha/pdf_files/WHA57/A57_R12.en.pdf.

⁶ Available at http://apps.who.int/gb/ebwha/pdf_files/WHASSA_WHA60-Rec1/E/reso-60-en.pdf.

⁷ Available at http://apps.who.int/iris/bitstream/10665/23532/1/A61_R16-en.pdf.

⁸ Available at http://apps.who.int/gb/ebwha/pdf_files/WHA63/A63_R13-en.pdf.

⁹ Available at http://apps.who.int/gb/ebwha/pdf_files/WHA66/A66_R8-en.pdf.

¹⁰ Available at http://apps.who.int/gb/ebwha/pdf_files/WHA66/A66_R9-en.pdf.

¹¹ Available at http://apps.who.int/gb/ebwha/pdf_files/WHA67/A67_16-en.pdf.

Consensus resolutions and documents

- United Nations General Assembly work on violence against women;¹
 - Resolution 67/144 (2012) Intensification of efforts to eliminate all forms of violence against women;²
 - Resolution 69/147 (2014) Intensification of efforts to eliminate all forms of violence against women and girls;³
- Commission on the Status of Women
 - 57 agreed conclusions (2013);⁴
 - 51 agreed conclusions (2011);⁵
 - 42 agreed conclusions (1998);⁶
- Programme of Action of the International Conference on Population and Development (1994) and all the outcomes of its review as follows;⁷
 - Key actions for further implementation of the Programme of Action of the International Conference on Population and Development (2014);⁸
 - Resolution 2000/1, Population, gender and development (2000);⁹
 - Resolution 2005/2, Contribution of the implementation of the Programme of Action of the International Conference on Population and Development, in all its aspects, to the achievement of the internationally agreed development goals, including those contained in the United Nations Millennium Declaration (2005);¹⁰
 - Resolution 2006/2, International migration and development (2006);¹¹
 - Resolution 2009/1, The contribution of the Programme of Action of the International Conference on Population and Development to the internationally agreed development goals, including the Millennium Development Goals (2009);¹

¹ Available at <http://www.un.org/womenwatch/daw/vaw/v-work-ga.htm>.

² Available at http://www.un.org/ga/search/view_doc.asp?symbol=A/RES/67/144&Lang=E.

³ Available at http://www.un.org/en/ga/search/view_doc.asp?symbol=A/RES/69/147.

⁴ Available at <http://www.unwomen.org/~media/headquarters/attachments/sections/csw/57/csw57-agreedconclusions-a4-en.pdf>.

⁵ Available at http://www.unwomen.org/~media/headquarters/attachments/sections/csw/51/csw51_e_final.pdf.

⁶ Available at http://www.unwomen.org/~media/headquarters/attachments/sections/csw/42/csw42_i_e_final.pdf.

⁷ Available at <http://www.unfpa.org/publications/international-conference-population-and-development-programme-action>.

⁸ Available at <http://www.unfpa.org/publications/international-conference-population-and-development-programme-action>.

⁹ Available at http://www.un.org/en/development/desa/population/commission/pdf/33/CPD33_Res2000-1.pdf.

¹⁰ Available at http://www.un.org/en/development/desa/population/commission/pdf/38/CPD38_Res2005-2.pdf.

¹¹ Available at http://www.un.org/en/development/desa/population/commission/pdf/39/CPD39_Res2006-2.pdf.

- Resolution 2010/1, Health, morbidity, mortality and development (2010);²
- Resolution 2011/1, Fertility, reproductive health and development (2011);³
- Resolution 2012/1, Adolescents and youth (2012);⁴
- Resolution 2014/1, Assessment of the status of implementation of the Programme of Action of the International Conference on Population and Development (2014);⁵
- United Nations General Assembly resolution 65/277 (2011), Political declaration on HIV and AIDS: Intensifying our efforts to eliminate HIV and AIDS;⁶
- Beijing Declaration and Platform for Action (1995);⁷
- Human Rights Council resolution 7/24, Elimination of violence against women (2008);⁸
- Human Rights Council resolution 23/25, Accelerating efforts to eliminate all forms of violence against women: preventing and responding to rape and other forms of sexual violence (2013)⁹

United Nations conventions, documents and instruments:

- Universal Declaration of Human Rights (1948);¹⁰
- International Covenant on Civil and Political Rights (1966);¹¹
- International Covenant on Economic, Social and Cultural Rights (1966);¹²

¹ Available at http://www.un.org/en/development/desa/population/commission/pdf/42/CPD42_Res2009-1.pdf.

² Available at http://www.un.org/en/development/desa/population/commission/pdf/43/CPD43_Res2010-1.pdf.

³ Available at http://www.un.org/en/development/desa/population/pdf/commission/2011/documents/CPD44_Res2011-1b.pdf.

⁴ Available at http://www.un.org/en/development/desa/population/pdf/commission/2012/country/Agenda%20item%208/Decisions%20and%20resolution/Resolution%202012_1_Adolescents%20and%20Youth.pdf.

⁵ Available at http://www.un.org/en/development/desa/population/pdf/commission/2014/documents/CPD47_Resolution_2014_1.pdf.

⁶ Available at http://www.unaids.org/sites/default/files/sub_landing/files/20110610_UN_A-RES-65-277_en.pdf.

⁷ Available at <http://www.un.org/womenwatch/daw/beijing/pdf/BDPfA%20E.pdf>.

⁸ Available at http://ap.ohchr.org/Documents/E/HRC/resolutions/A_HRC_RES_7_24.pdf.

⁹ Available at http://ap.ohchr.org/documents/dpage_e.aspx?si=A/HRC/23/L.28.

¹⁰ Available at <http://www.ohchr.org/EN/UDHR/Pages/Introduction.aspx>.

¹¹ Available at <http://www.ohchr.org/EN/ProfessionalInterest/Pages/CCPR.aspx>.

¹² Available at <http://www.ohchr.org/EN/ProfessionalInterest/Pages/CESCR.aspx>.

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- Convention on Consent to Marriage, Minimum Age for Marriage and Registration of Marriages (1962);¹
 - Convention on the Elimination of All Forms of Discrimination against Women (1979);²
 - Optional Protocol to the Convention on the Elimination of Discrimination against Violence (1999);³
 - Declaration on the Protection of Women and Children in Emergency and Armed Conflict (1974);⁴
 - Protocol to Prevent, Suppress and Punish Trafficking in Persons Especially Women and Children, supplementing the United Nations Convention against Transnational Organized Crime (2000);⁵
 - Recommended Principles and Guidelines on Human Rights and Human Trafficking (2002);⁶
 - Convention for the Suppression of the Traffic in Persons and of the Exploitation of the Prostitution of Others (1949);⁷
 - Declaration on the Elimination of Violence Against Women (A/RES/48/104, 1993);⁸
 - Geneva Convention relative to the Protection of Civilian Persons in Time of War (1949);⁹
 - Protocol Additional to the Geneva Conventions of 12 August 1949, and relating to the Protection of Victims of Non-International Armed Conflicts (Protocol II) (1977);¹⁰
 - Convention on the Rights of the Child (1989):¹¹
 - Article 19: The right of the child to freedom from all forms of violence (CRC/C/GC/13, 2011) refers to the right of boys and girls up to the age of 18 to be protected from all types of violence.
 - Article 24: The right of the child to the enjoyment of the highest attainable standard of health (CRC/C/GC/15, 2013) explicitly refers to freedom from violence.

¹ Available at <http://www.ohchr.org/EN/ProfessionalInterest/Pages/MinimumAgeForMarriage.aspx>.

² Available at <http://www.ohchr.org/EN/ProfessionalInterest/Pages/CEDAW.aspx>.

³ Available at <http://www.ohchr.org/EN/ProfessionalInterest/Pages/OPCEDAW.aspx>.

⁴ Available at <http://www.ohchr.org/EN/ProfessionalInterest/Pages/ProtectionOfWomenAndChildren.aspx>.

⁵ Available at <http://www.ohchr.org/EN/ProfessionalInterest/Pages/ProtocolTraffickingInPersons.aspx>.

⁶ Available at <http://daccess-ods.un.org/access.nsf/Get?Open&DS=E/2002/68/Add.1&Lang=E>.

⁷ Available at <http://www.ohchr.org/EN/ProfessionalInterest/Pages/TrafficInPersons.aspx>.

⁸ Available at <http://www.ohchr.org/EN/ProfessionalInterest/Pages/ViolenceAgainstWomen.aspx>.

⁹ Available at <http://www.ohchr.org/EN/ProfessionalInterest/Pages/ProtectionOfCivilianPersons.aspx>.

¹⁰ Available at <http://www.ohchr.org/EN/ProfessionalInterest/Pages/ProtocolII.aspx>.

¹¹ Available at <http://www.ohchr.org/EN/ProfessionalInterest/Pages/CRC.aspx>.

United Nations general comments and recommendations:

- Convention on the Elimination of All Forms of Discrimination against Women (1979);¹
 - General recommendation no. 12 (1989);²
 - General recommendation no. 19 (1992);²
 - General recommendation no. 24 (1999);²
- Convention on the Rights of the Child;
 - General comment no. 13 (2011);³
- Committee on Economic, Social and Cultural Rights;
 - Article 12, General comment no. 14 (2000)⁴

Regional instruments:

- Council of Europe Convention on preventing and combating violence against women and domestic violence (Istanbul Convention) (2011);⁵
- Council of Europe Convention on the Protection of Children against Sexual Exploitation and Sexual Abuse (Lanzarote Convention) (2007);⁶
- Protocol to the African Charter on Human and Peoples' rights on the rights of women in Africa (2003);⁷
- Inter-American Convention on the prevention, punishment and eradication of violence against women "Convention of Belém do Pará" (1994);⁸
- Declaration on the elimination of violence against women in the ASEAN region (2004);⁹
- Arab Strategy for Combating Violence Against Women 2011–2020 (2011).¹⁰

¹ Available at <http://www.ohchr.org/EN/ProfessionalInterest/Pages/CEDAW.aspx>.

² Available at <http://www.un.org/womenwatch/daw/cedaw/recommendations/recomm.htm>.

³ Available at http://tbinternet.ohchr.org/_layouts/treatybodyexternal/Download.aspx?symbolno=CRC%2fC%2fGC%2f13&Lang=en.

⁴ Available at [http://www.unhcr.ch/tbs/doc.nsf/\(symbol\)/E.C.12.2000.4.En](http://www.unhcr.ch/tbs/doc.nsf/(symbol)/E.C.12.2000.4.En).

⁵ Available at <http://www.coe.int/t/dghl/standardsetting/convention-violence/convention/Convention%20210%20English.pdf>.

⁶ Available at <http://rm.coe.int/CoERMPublicCommonSearchServices/DisplayDCTMContent?documentId=0900001680084822>

⁷ Available at http://www.achpr.org/files/instruments/women-protocol/achpr_instr_proto_women_eng.pdf.

⁸ Available at <http://www.oas.org/juridico/english/treaties/a-61.html>.

⁹

Available at http://www.ohchr.org/Documents/Issues/Women/WG/ASEANdeclarationVaW_violenceagainstchildren.pdf.

¹⁰ Available at <http://www.arabwomen.org/Content/Publications/VAWENG.pdf>.

Appendix 3

Details of relevant work by the WHO Secretariat

1. The Secretariat has developed several guidance documents and tools including training curricula and several documents summarizing the evidence for addressing interpersonal violence. See Appendix 4 for a complete listing.
2. The Secretariat is responding to the gaps identified in the health systems response to **violence against women and girls** in a number of ways. To support Member States that want to undertake national surveys on violence against women, the Secretariat has developed and made available the survey tools and methodology for the WHO Multi-country Study on Women's Health and Domestic Violence against Women, considered to be the gold standard for measuring the magnitude of violence against women (4). The Secretariat has also compiled and published global and regional estimates of violence against women based on prevalence data for intimate partner violence and sexual violence from approximately 80 countries (3). These data are available on the WHO Global Health Observatory,¹ and will be regularly updated. The Secretariat has published several guidelines and tools to identify effective prevention interventions and guide Member States to strengthen their health systems' responses to violence against women, including for addressing sexual violence and providing mental health care to survivors in humanitarian settings (see Appendix 4). The Secretariat is supporting ministries of health with capacity strengthening for a public health approach to prevention and response to violence against women, and is assisting Member States to develop and/or update their national health sector protocols/guidelines for addressing violence against women and girls. For humanitarian settings, the Secretariat is supporting the implementation of tools through its role as Global Health Cluster Lead Agency in the humanitarian systems response.
3. The Secretariat collects data on **child maltreatment**, has summarized information on effective interventions to prevent child maltreatment, and disseminates this evidence widely. WHO published Preventing Child Maltreatment: a Guide to Taking Action and Generating Evidence in 2006,² and this has become a key reference for policy makers and practitioners. WHO has also developed and implemented an international questionnaire to measure adverse childhood experiences, including child maltreatment, in a dozen countries. The Secretariat is testing a suite of low-cost parenting programmes aimed at preventing child maltreatment. It has developed a short course on child maltreatment prevention, which has been used to train policy-makers and practitioners in various countries. It also supports Member States in developing policies and effective interventions to prevent child maltreatment, including by helping them assess their level of readiness to develop and scale up prevention programmes.
4. In partnership with UNESCO, the Secretariat has published guidance on how to address violence within a health-promoting school. In partnership with the United States Centers for Disease Control and Prevention, it coordinates the Global school-based student health survey.³ The Secretariat has worked with selected low- and middle-income Member States to build a comprehensive policy response to interpersonal violence, focusing mainly on **youth violence**. It is currently developing an overview of the evidence on what works to prevent youth violence.

¹ Available at <http://apps.who.int/gho/data/node.main.SEXVIOLENCE>.

² Available at http://apps.who.int/iris/bitstream/10665/43499/1/9241594365_eng.pdf.

³ Available at <http://www.who.int/chp/gshs/en/>.

5. WHO's work to address the problem of **elder abuse** promotes the use of evidence-based approaches to better understand the magnitude, causes and consequences, and what works to prevent such violence, and to mitigate the harm suffered by survivors/victims.
6. The Secretariat has established or participates in various partnerships and initiatives, including the Sexual Violence Research Initiative, Together for Girls, United Nations Action against Sexual Violence in Conflict, and the Violence Prevention Alliance (see Appendix 5).

Appendix 4

List of relevant WHO Secretariat publications**Violence against women and girls**

- Health care for women subjected to intimate partner violence or sexual violence (2014)¹
- Global and regional estimates of violence against women: prevalence and health effects of intimate partner violence and non-partner sexual violence (2013)²
- WHO clinical and policy guidelines for responding to intimate partner violence and sexual violence against women (2013)³
- Violence against women in Latin America and the Caribbean: a comparative analysis of population-based data from 12 countries (PAHO, 2013)⁴
- Three 2012 publications on provision of mental health and psychosocial support to survivors of sexual violence (2012)⁵
- Preventing intimate partner violence and sexual violence against women: taking action and generating evidence (WHO and the London School of Hygiene and Tropical Medicine, 2010)⁶
- WHO Multi-country Study on Women's Health and Domestic Violence against Women: Results report (2005)⁷
- Clinical management of rape survivors (2004)⁸
- Guidelines for medico-legal care for victims of sexual violence (2003)⁹
- E-learning programme: Clinical management of rape survivors in humanitarian settings (WHO, UNFPA and UNHCR, 2009)¹⁰
- Violence and injury prevention short course: Preventing intimate partner and sexual violence against women¹¹

¹ Available at http://apps.who.int/iris/bitstream/10665/136101/1/WHO_RHR_14.26_eng.pdf.

² Available at http://apps.who.int/iris/bitstream/10665/85239/1/9789241564625_eng.pdf.

³ Available at http://apps.who.int/iris/bitstream/10665/85240/1/9789241548595_eng.pdf.

⁴ Available at http://www.paho.org/hq/index.php?option=com_content&view=article&id=8175&Itemid=1519&lang=en.

⁵ Available at http://apps.who.int/iris/bitstream/10665/75175/1/WHO_RHR_HRP_12.16_eng.pdf;
http://apps.who.int/iris/bitstream/10665/75177/1/WHO_RHR_HRP_12.17_eng.pdf;
http://apps.who.int/iris/bitstream/10665/75179/1/WHO_RHR_HRP_12.18_eng.pdf.

⁶ Available at http://whqlibdoc.who.int/publications/2010/9789241564007_eng.pdf.

⁷ Available at http://www.who.int/gender/violence/who_multicountry_study/en/.

⁸ Available at http://www.who.int/hac/network/interagency/news/manual_rape_survivors/en/.

⁹ Available at <http://whqlibdoc.who.int/publications/2004/924154628X.pdf>.

¹⁰ Available at <http://www.who.int/reproductivehealth/publications/emergencies/9789241598576/en/>.

¹¹ Available at http://www.who.int/violence_injury_prevention/capacitybuilding/courses/intimate_partner_violence/en/.

Child maltreatment

- European report on preventing child maltreatment (WHO Regional Office for Europe, 2013)¹
- Preventing child maltreatment: a guide to taking action and generating evidence (WHO and International Society for Prevention of Child Abuse and Neglect, 2006)²
- Violence and injury prevention short course: Child maltreatment prevention³

Interpersonal violence

- Global status report on violence prevention (2014)⁴
- Violence prevention: the evidence (2010)⁵
- Preventing injuries and violence: a guide for ministries of health (2007)⁶
- Developing policies to prevent injuries and violence (2006)⁷
- Guidelines for conducting community surveys on injuries and violence (2004)⁸
- Guidelines for essential trauma care (2004)⁹
- Preventing violence: a guide to implementing the recommendations of the World report on violence and health (2004)¹⁰
- World report on violence and health (2002)¹¹

Youth violence

- Preventing youth violence: an overview of the evidence¹²
- European report on preventing violence and knife crime among young people (WHO Regional Office for Europe, 2010)¹³

¹ Available at http://www.euro.who.int/__data/assets/pdf_file/0019/217018/European-Report-on-Preventing-Child-Maltreatment.pdf.

² Available at http://www.who.int/violence_injury_prevention/publications/violence/child_maltreatment/en/.

³ Available at http://www.who.int/violence_injury_prevention/capacitybuilding/courses/child_maltreatment/en/.

⁴ Available at http://www.who.int/violence_injury_prevention/violence/status_report/2014/en/.

⁵ Available at http://apps.who.int/iris/bitstream/10665/77936/1/9789241500845_eng.pdf.

⁶ Available at http://whqlibdoc.who.int/publications/2007/9789241595254_eng.pdf.

⁷ Available at http://www.who.int/violence_injury_prevention/publications/39919_oms_br_2.pdf.

⁸ Available at <http://whqlibdoc.who.int/publications/2004/9241546484.pdf>.

⁹ Available at <http://whqlibdoc.who.int/publications/2004/9241546409.pdf>.

¹⁰ Available at <http://whqlibdoc.who.int/publications/2004/9241592079.pdf>.

¹¹ Available at http://www.who.int/violence_injury_prevention/violence/world_report/en/.

¹² As of 22 September 2015, available at http://apps.who.int/iris/bitstream/10665/181008/1/9789241509251_eng.pdf?ua=1.

¹³ Available at http://www.euro.who.int/__data/assets/pdf_file/0012/121314/E94277.pdf.

Elder abuse

- European report on preventing elder maltreatment¹
- A global response to elder abuse and neglect. Building primary health care capacity (2008)²
- Missing voices: views of older persons on elder abuse. A study from eight countries: Argentina, Austria, Brazil, Canada, India, Kenya, Lebanon and Sweden.³

¹ Available at http://www.euro.who.int/__data/assets/pdf_file/0010/144676/e95110.pdf.

² Available at http://www.who.int/ageing/publications/ELDER_DocAugust08.pdf.

³ Available at http://www.who.int/ageing/publications/missing_voices/en/.

Appendix 5

WHO Secretariat involvement in violence-related partnerships and initiatives

Essential Services Package for Women and Girls Subject to Violence is a joint United Nations initiative managed by UN-Women and UNFPA with WHO, UNDP and UNODC as partners in different aspects of the initiative. WHO is a partner in the health component of the initiative. It has contributed its guidelines and tools on the health response to violence against women that will be implemented through this initiative.

The **Sexual Violence Research Initiative** is a network dedicated to bringing visibility to sexual violence as a public health problem and to developing, supporting and building capacity for research in this area. WHO was a founding member of this initiative and hosted the Secretariat for the first 3 years. The Secretariat was then transferred to the South African Medical Research Council following a bid for proposals. WHO has remained a member of the coordinating group and currently is co-chair.

Together for Girls is a global public–private partnership dedicated to ending violence against children, with a focus on sexual violence against girls. The partnership includes five United Nations entities (UNICEF, UNAIDS, UNFPA, UN-Women and WHO), the Governments of Canada and the United States of America, and private sector partners. The partnership has supported population-based Violence Against Children Surveys in several countries, and compiled comprehensive data on the magnitude and consequences of violence to inform future country policies.

United Nations Action against Sexual Violence in Conflict brings together 13 United Nations entities to strengthen and provide a more coherent response to sexual violence in conflict. WHO leads the knowledge pillar of United Nations Action and contributes to this effort through the generation of evidence and normative guidance.

The **Violence Prevention Alliance** is a network of WHO Member States, international agencies and civil society organizations working to prevent interpersonal violence. Participants share an evidence-based public health approach that targets the risk factors leading to violence and promotes multisectoral cooperation.

Appendix 6

Linking the WHO global plan of action to the Sustainable Development Goals and targets

Sustainable Development Goals	Description	Links to the plan of action
Goal 3: Ensure healthy lives and promote well-being for all at all ages		
Target 3.4	By 2030 reduce by one-third premature mortality from noncommunicable diseases through prevention and treatment, and promote mental health and well-being.	Promotion of mental health and well-being and provision of mental health care is recognized as essential for both prevention and response to the different forms of interpersonal violence, in particular against women and girls, and against children.
Target 3.5	Strengthen the prevention and treatment of substance abuse, including narcotic drug abuse and harmful use of alcohol.	Harmful use of alcohol is a risk factor for involvement in most forms of interpersonal violence, and its prevention will therefore contribute to preventing violence. Exposure to intimate partner violence and sexual violence against women, child maltreatment and youth violence increases the likelihood of drug abuse and harmful use of alcohol, so preventing such violence can reduce drug abuse and harmful use of alcohol.
Target 3.7	By 2030 ensure universal access to sexual and reproductive health care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes.	Recognizing the sexual and reproductive health consequences of violence against women and girls, the plan proposes sexual and reproductive health services as key entry points for integrating violence against women services and the inclusion of violence against women as part of national reproductive health strategies and programmes.
Target 3.8	Achieve universal health coverage, including financial risk protection, access to quality essential health care services, and access to safe, effective, quality, and affordable essential medicines and vaccines for all.	The principle of universal health coverage is a key guiding principle for provision of health services to survivors/victims of interpersonal violence, in particular against women and girls, highlighting the need for financial protection, and provision of quality essential services for managing the health consequences of such violence.

Sustainable Development Goals	Description	Links to the plan of action
Goal 4: Ensure inclusive and equitable quality education and promote lifelong learning opportunities for all		
Target 4.2	By 2030, ensure that all boys and girls have access to quality early childhood development, care and pre-primary education so that they are ready for primary education.	Quality early childhood development, care and pre-primary education are protective against subsequent involvement in violence when boys and girls become older.
Target 4.7	By 2030 ensure that all learners acquire knowledge and skills needed to promote sustainable development including, among others, through education for sustainable development and sustainable lifestyles, human rights, gender equality, promotion of culture of peace and non-violence, global citizenship and appreciation of cultural diversity and of culture's contribution to sustainable development.	The plan recognizes the need for the health system to advocate with the education sector and to support it in implementing comprehensive sexuality education, life and social skills with an emphasis on non-abusive, respectful and egalitarian relations that maintain positive relationships and prevent all forms of violence later in life.
Target 4a	Build and upgrade education facilities that are child, disability and gender sensitive and provide safe, non-violent inclusive learning environments for all.	Boys and girls are subject to peer violence such as fighting and bullying in education facilities, and in some instances teaching staff use violent means of discipline and control.
Goal 5: Achieve gender equality and empower all women and girls		
Target 5.2	Eliminate all forms of violence against all women and girls in public and private spheres, including trafficking and sexual and other types of exploitation.	The plan recognizes the need for the health system to work in tandem with other sectors in applying a public health approach to addressing violence against women and girls. It includes evidence-based actions that contribute to prevention and response within the health system and across sectors.
Target 5.3	Eliminate all harmful practices, such as child, early and forced marriage and female genital mutilations.	The plan includes child, early and forced marriage and female genital mutilation as priority harmful practices against women and girls that need to be addressed by the health system in terms of response and prevention.

Sustainable Development Goals	Description	Links to the plan of action
Target 5.6	Ensure universal access to sexual and reproductive health and reproductive rights as agreed in accordance with the Programme of Action of the International Conference on Population and Development and the Beijing Platform for Action and the outcome documents of their review conferences.	The plan recognizes the promotion of all human rights including those related to sexual and reproductive health as key to preventing and responding to violence against women and girls and builds on the actions specified in the Programme of Action of the International Conference on Population and Development and the Beijing Platform for Action, chapter on violence against women.
Goal 11: Make cities and human settlements inclusive, safe, resilient and sustainable		
Target 11.7	By 2030, provide universal access to safe, inclusive and accessible, green and public spaces, particularly for women and children, older persons and persons with disabilities.	The plan recognizes the risk of exposure to violence including sexual harassment in public spaces, particularly for women and girls
Goal 16: Promote peaceful and inclusive societies for sustainable development, provide access to justice for all and build effective, accountable and inclusive institutions at all levels		
Target 16.1	Significantly reduce all forms of violence and related death rates everywhere.	The plan aims to strengthen the critical role of the health system in reducing interpersonal violence and to mitigate the health and other negative consequences of such violence, focusing on women and girls and children as population groups that are disproportionately affected by such violence.
Target 16.2	End abuse, exploitation, trafficking and all forms of violence and torture against children.	The plan prioritizes violence against children as another major form of violence in addition to violence against women. The plan recognizes that girls face particular vulnerabilities to certain forms of violence including trafficking for sexual exploitation.
Target 16.3	Promote the rule of law at the national and international levels, and ensure equal access to justice for all.	The plan includes actions to strengthen interface between the health and police/justice sectors, particularly through medico-legal evidence as a key element of supporting access to justice for survivors of violence, particularly women and girls.

Appendix 7

Summary of health consequences of violence

Population group exposed to violence and type of violence	Health and socioeconomic consequences
1. All groups subjected to violence	<ul style="list-style-type: none"> • Physical injuries • Mental health problems (e.g. depression, anxiety, post-traumatic stress disorders) • ↑ suicide • ↑ risk of noncommunicable diseases • Health-harming behaviours (e.g. alcohol and drug use, smoking, self-harm and risky sexual behaviour) • ↓ productivity • Human and economic costs for survivors, families and society
2. Women and girls¹ (a) Intimate partner violence	<p><i>In addition to 1 above, sexual and reproductive health problems (3) including unwanted pregnancies, sexually transmitted infections and HIV, pregnancy loss including miscarriages and induced abortions, low-birth weight babies, pre-term births, traumatic gynaecological fistula, chronic pain syndrome</i></p> <ul style="list-style-type: none"> • 2x ↑ induced abortion • 1.5x ↑ sexually transmitted infections and HIV • 41% ↑ pre-term birth • 16% ↑ low-birth weight babies • ↑ infant mortality • Children with developmental and behavioural problems
(b) Female genital mutilation	<ul style="list-style-type: none"> • ↑ obstructed labour and perinatal mortality • Infections • Cysts and abscesses • Fistula • Psychological and mental health problems • Sexual dysfunction
(c) Early marriage	<ul style="list-style-type: none"> • Early pregnancy and ↑ risk of perinatal and maternal mortality and morbidity • ↓ girls' access to education, livelihood skills • Social isolation
3. Children including adolescents	<ul style="list-style-type: none"> • ↑ health harming behaviours • ↑ mental and other health problems • ↓ educational attainment and future employment prospects • Intergenerational perpetuation of cycle of violence – i.e. <ul style="list-style-type: none"> • ↑ likelihood of girls later being subjected to intimate partner violence or sexual exploitation and trafficking • ↑ likelihood of boys becoming perpetrators or being subjected to violence later in life. • Youth violence ↑ involvement over time in other forms of violence as victims and perpetrators.

¹ World Health Organization (WHO), 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.

Appendix 8

**Summary of risk factors¹ and determinants of victimization and
perpetration of different types of interpersonal violence²**

Population group and type of violence	Risk factors for victimization	Risk factors for perpetration
1. Common community and societal level factors across different types of interpersonal violence (These factors may be exacerbated in settings of humanitarian crises, including conflicts)	<ul style="list-style-type: none"> • Gender inequality (e.g. harmful masculine norms) • High rates of violence and crime in community • Poverty • Unemployment • Availability of drugs, alcohol (e.g. high density of alcohol outlets) and weapons (e.g. firearms, knives) • Low levels of enforcement of laws against violence 	
2. Women and girls	Gender inequality and discrimination causal factor across all types of violence against women and girls	
Intimate partner violence	<ul style="list-style-type: none"> • History of childhood abuse³ • Exposure (witnessing) to intimate partner violence in childhood • Less than secondary education • Mental disorders and other disabilities • Partner's harmful use of alcohol • Male control/authority over women • Acceptability of violence to discipline women who violate prevailing gender norms • Women's lack of employment • Discriminatory laws (e.g. ownership of land and property, marriage, divorce, children's custody) 	<ul style="list-style-type: none"> • History of childhood abuse or neglect • Exposure (witnessing) to intimate partner violence in childhood • Low levels of school education • Depression • Alcohol abuse • Controlling behaviours • Low gender equitable attitudes • Frequent quarrelling with partner • Sexual entitlement (e.g. history of transactional sex and multiple sexual partners) • Involvement in violence outside the home
3. Children including adolescents		
Child maltreatment	<ul style="list-style-type: none"> • Young age of children • Higher work load for caregivers associated with children with special needs 	<ul style="list-style-type: none"> • Young age of parent • Parents have large numbers of children • Lack of understanding of child development • Lack of parenting skills

¹ Protective factors are not highlighted separately, but would be the converse of or opposite to the risk factors highlighted in this table.

² Heise LL, Kotsadam A. Cross-national and multilevel correlates of partner violence: an analysis of data from population-based surveys. *Lancet Global Health*. 2015; 3(6):e332-e340.

³ The factors highlighted in bold are ones that are either statistically significant or make the biggest contribution to explaining different rates of partner violence across different geographical settings.

		<ul style="list-style-type: none">• Attitudes supporting harsh disciplinary measures• Parents history of childhood abuse• Presence of non-biological caregiver in the home• Alcohol or drug misuse• Mental illness of caregivers• Poor parent-child relationships (e.g. poor family bonding and chaotic family life)• Intimate partner violence in same household
Peer violence among adolescents (i.e. bullying and fighting)		<ul style="list-style-type: none">• Some similar risk factors for perpetration of child maltreatment.• Behavioural problems• Antisocial peers• Alcohol and drug misuse• History of involvement in violence

Appendix 9

Timeline and process for developing the WHO global plan of action

The process for developing the WHO global plan of action was as follows:

1. The Secretariat constituted an internal core working group to lead, coordinate and develop various drafts of the WHO global plan of action and to facilitate the consultative process.
2. A first discussion paper – the basis of draft zero of the WHO global plan of action – was issued in March 2015 and included input from members of the core working group, representatives of other concerned WHO departments and regional advisers from all six WHO regions.
3. Draft zero was presented for consultation and received inputs from Member States (health ministries and other relevant line ministries such as those responsible for gender, justice and child development), civil society groups, professional associations, United Nations partners and other bilateral and multilateral institutions. The consultation process involved the following:
 - a. *Regional consultations with Member States*: Region of the Americas (February 2015); Western Pacific and South-East Asia Regions (April 2015); Eastern Mediterranean Region (April 2015); European Region (May 2015); and African Region (July 2015). Participants were: in the majority Member States (i.e. health ministries and other relevant line ministries); nongovernmental organizations; a few experts; and organizations in the United Nations system;
 - b. *Web consultation* (April – 4 June 2015) – 48 inputs were received including from nine Member States;
 - c. *Informal consultation* with nongovernmental organizations, academic experts, United Nations partners and other multilateral institutions (3 June 2015) – included 40 participants;
 - d. *Informal briefing of Member States*: Geneva-based Permanent Mission representatives (4 June 2015).
4. Based on feedback received from these consultations, draft zero was revised and the second discussion paper containing draft 1 of the WHO global plan of action was issued on 31 August 2015.
5. Additionally, an annotated outline of draft 1 was circulated in advance of discussions at the Regional Committees between September and October 2015.
6. Draft 1 was posted for web consultation (1 September–23 October 2015), and 40 inputs were received, including from 10 Member States. It was presented for a final agreement from Member States at a formal Member State meeting from 2 to 4 November 2015.
7. Based on feedback received from the formal Member State meeting in November 2015, a revised draft (i.e. draft 2) of the WHO global plan of action was prepared for submission to the Executive Board at its 138th session in January 2016 and for further endorsement and approval by the Sixty-ninth World Health Assembly in May 2016.

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ANNEX 3

Brasilia Declaration^{1,2}

Second Global High-level Conference on Road Safety: Time for Results Brasilia, 18 and 19 November 2015

PP1. We, Ministers and heads of delegations gathered in Brasilia, Brazil, on November 18 and 19, 2015, for the Second Global High-level Conference on Road Safety, in coordination with representatives of international, regional and sub-regional organizations and non-governmental organizations, academic institutions and the private sector, including philanthropic and corporate donors;

PP2. *Acknowledging* the leadership of the Government of the Federative Republic of Brazil in preparing and hosting this Second Global High-level Conference on Road Safety and the leadership of the Governments of the Russian Federation and the Sultanate of Oman in leading the process for adoption of related United Nations General Assembly resolutions;

PP3. *Concerned* that, in light of the World Health Organization's (WHO's) *Global status report on road safety 2015*, road traffic continues to represent a major development issue, public health problem and leading cause of death and injury around the world, as crashes kill more than 1.25 million people and injure as many as 50 million a year, with 90% of these casualties occurring in developing countries;³

PP4. Underlining the important role of public health in terms of reducing road traffic fatalities and injuries and improving health outcomes, as well as the role of health systems, including through universal health coverage;

PP5. *Also concerned* that road crashes are the leading cause of death around the world for children and youth aged 15-29 years and noting that more than two thirds of the road traffic victims are males;⁴

PP6. *Recognizing* that human suffering, combined with global costs estimated at USD 1,850 billion⁵ a year, turns reducing road traffic deaths and injuries into an urgent development priority, and that investment in road safety has a positive impact on public health and economy;

PP7. *Recalling* the Moscow Declaration recommendations, adopted at the First Global Ministerial Conference on Road Safety in 2009;

¹ Editor's note: This document has not been subject to editing by the Department of Governing Bodies.

² See resolution WHA69.7 (2016).

³ WHO, *Global status report on road safety 2015*.

⁴ WHO, *Global status report on road safety 2015*.

⁵ iRAP, *The Global Cost of Road Crashes*, 2013.

PP8. *Convinced* that appropriate multisectoral international cooperation and multisectoral national action are necessary to realize the objective of the Decade of Action for Road Safety 2011-2020 to “stabilize and then reduce the forecast level of road traffic fatalities around the world”;

PP9. *Welcoming* the inclusion of a target, within Sustainable Development Goal (SDG) 3 of the 2030 Agenda for Sustainable Development, to “by 2020, halve the number of global deaths and injuries from road traffic accidents” and *affirming* our willingness to intensify both national action and international cooperation with a view to meeting this target;

PP10. Recognizing the need for countries to introduce, or improve and strengthen, arrangements for monitoring serious injuries from road traffic accidents to facilitate action to meet, by 2020, the target to halve the number of global deaths and injuries from road traffic accidents;

PP11. *Welcoming as well* the inclusion of a target to “provide access to safe, affordable, accessible and sustainable transport systems for all, improving road safety, notably by expanding public transport, with special attention to the needs of those in vulnerable situations, women, children, persons with disabilities, and older persons” by 2030, within SDG 11 as an integral part of the 2030 Agenda for Sustainable Development;

PP12. *Noting* that the overwhelming majority of road traffic deaths and injuries are predictable and preventable and that at the mid-point of the Decade of Action much remains to be done, despite some progress and improvements in many countries, including in developing countries;

PP13. Recognizing that to only focus on road users as a cause of crashes is inappropriate and insufficient, as crashes result from multiple causes, many of which are linked to social determinants and risk factors;

PP14. *Welcoming* the recognition by the 2012 United Nations Conference on Sustainable Development (Rio+20) that improving road safety can contribute to the achievement of wider international development objectives, and that transport and mobility are central to sustainable development;

PP15. *Reaffirming* that providing basic conditions and services to address road safety is primarily a responsibility of Governments;

PP16. *Recognizing* nonetheless that there is a shared responsibility to move towards a world free from road traffic fatalities and serious injuries, and that addressing road safety demands multi- stakeholder collaboration;

PP17. *Taking into account* the important contribution of passive safety to the progress made to prevent road traffic fatalities and injuries, and encouraging the vehicle and safety equipment industries to further develop their efforts to increase the existing passive safety levels globally;

PP18. *Taking into account* that road traffic deaths and injuries are also a social equity issue, as the poor and the vulnerable are most frequently also vulnerable road users (pedestrians, cyclists, users of motorized two-and-three wheeled vehicles and passengers of unsafe public transport), who are disproportionately affected and exposed to risks and road crashes, which can lead to a cycle of poverty exacerbated by income loss; and *recalling* that the aim of road safety policies should be to guarantee protection to all users;

PP19. Recognizing that road safety requires addressing broader issues of equitable access to mobility, and that the promotion of sustainable modes of transport, in particular safe public transport and safe walking and cycling, is a key element for road safety;

PP20. *Stressing* the importance of giving due attention to the issues of sustainable urban mobility and enhanced accessibility to destinations, activities, services and goods in drafting the New Urban Agenda, to be adopted at the United Nations Conference on Sustainable Urban Development and Housing (Habitat III), to be held in Quito, Ecuador, in October 2016;

PP21. *Reaffirming* the role and importance of the United Nations legal instruments on road safety, such as the 1949 and 1968 Conventions on Road Traffic, the 1968 Convention on Road Signs and Signals, the 1958 and 1998 agreements on technical vehicle regulations, the 1997 Agreement on Periodic Technical Inspection of Vehicles, and the 1957 Agreement on Transport of Dangerous Goods;

PP22. *Commending* States that have adopted comprehensive legislation on key risk factors, including the non-use of seat belts, child restraints and helmets, drinking alcohol and driving, speeding, and *drawing attention* to other risk factors such as medical conditions and medicines which affect safe driving, fatigue, the use of narcotic, psychotropic drugs and psychoactive substances, cell phones and other electronic and texting devices;

PP23. *Considering* the crucial importance of traffic law enforcement actions supported by intelligent risk monitoring practices, and the role of awareness-raising campaigns for the prevention of road traffic crashes, and to minimize the injuries and damage they cause;

PP24. *Recognizing* the commitment of States and civil society to road safety by observing the annual World Day of Remembrance for Road Traffic Victims as well as United Nations Road Safety Weeks;

PP25. *Recognizing* the progress made by some countries in providing universal access to health and integral care in the pre-hospital, hospital, post-hospital and reintegration phases to road traffic crash victims, including strengthening mass casualty management;

PP26. *Acknowledging* the work of the United Nations system, in particular the leadership of WHO as coordinator, working in close cooperation with UN regional commissions, in particular the United Nations Economic Commission for Europe (UNECE), in establishing a Global Plan for the Decade of Action for Road Safety 2011–2020, the commitment of the United Nations Human Settlements Programme (UN-Habitat), the United Nations Environment Programme (UNEP), the United Nations Children’s Fund (UNICEF), and the International Labour Organization (ILO) among other agencies, to supporting these efforts as well as that of the World Bank and regional development banks towards implementing road safety projects and programmes, in particular in developing countries;

PP27. Emphasizing the role of the UN Safety Road Safety Collaboration as a consultative mechanism to facilitate international road safety cooperation;

PP28. Welcoming the establishment of the High-level Advisory Group on Sustainable Transport, and noting the appointment of the UN Secretary-General’s Special Envoy for Road Safety as efficient tools for fostering international action in reducing the number of global deaths and injuries related to road traffic crashes;

PP29. Inviting Governments and all relevant stakeholders to collaborate with the United Nations Secretary General’s High-Level Advisory Group on Sustainable Transport and give due consideration to its recommendations related to road safety;

PP30. *Taking into account* the importance of strengthening capacity and continuing international cooperation, including fostering South-South and triangular cooperation, including between countries that share roads across borders, to further support efforts to improve road safety, particularly in developing countries, and providing, as appropriate, financial and technical support to meet the goals of the Decade of Action and those of the 2030 Agenda for Sustainable Development;

PP31. *Determined* to learn from past experiences and build on achievements made;

Hereby renew their commitment to the Decade of Action for Road Safety 2011–2020 and to the full and timely implementation of the Global Plan for the Decade of Action, and decide to:

Recommended actions for strengthening road safety management and improving legislation and enforcement

OP1. Encourage States that have not yet done so to designate and/or strengthen funded lead agencies and related coordination mechanisms at national or sub-national level as well as to strengthen the collaboration between governments, including parliamentary bodies, civil society, academia, private sector and philanthropic foundations in that realm;

OP2. Encourage civil society, academia, private sector and philanthropic foundations to strengthen their commitments to accelerate the implementation of the Global Plan for the Decade of Action for Road Safety 2011–2020;

OP3. Invite States that have not yet done so to redouble efforts to develop and implement national road safety plans and to adopt and enforce comprehensive legislation, in line with the Global Plan for the Decade of Action for Road Safety 2011–2020, with a view to meeting the target of increasing the percentage of countries with comprehensive legislation on key risk factors, including the non-use of seatbelts, child restraints and helmets, drinking alcohol and driving, and speeding, from 15% to at least 50% by 2020, as agreed in United Nations General Assembly resolution 64/255 of 2010;

OP4. Identify other risk factors which lead to distracted or impaired driving, such as medical conditions and medicines which affect safe driving, fatigue, the use of narcotic, psychotropic drugs and psychoactive substances, road environment visual distraction, cell phones and other electronic and texting devices and adopt, as appropriate, effective and evidence-based legislation;

OP5. Enhance road policing strategies and traffic enforcement measures, with a view to reducing road traffic crashes, including by means of promoting integration among traffic enforcement agencies in policing and inspection, as well as collecting road infrastructure and road traffic crashes data;

OP6. Improve the quality of systematic and consolidated data collection on the occurrence of road traffic crashes, including information from different sources, as well as on mortality and morbidity and disabilities, comprising disaggregated data; in order to address matters of data reliability and underreporting, data collection should be conducted by the appropriate authorities, including traffic police and health services, in line with international standards and definitions;

OP7. Invites the WHO to further standardize definitions, indicators and reporting practices, including on road traffic fatalities, injuries, and risk factors with a view to producing comparable information; and building on existing best practices in this area;

OP8. Encourage researching and result-sharing to support evidence-based approaches to prevent road traffic crashes, deaths and injuries and to mitigate their consequences;

OP9. Encourage States to introduce new technologies in traffic management and intelligent transport systems to mitigate road traffic crash risk and maximize response efficiency;

OP10. Encourage States that have not yet done so to consider acceding to or ratifying the UN legal instruments on road safety, as well as to engage in the activities of specialized UN transport fora;

Recommended actions to promote safer roads and the use sustainable modes of transportation

OP11. Promote environmentally sound, safe, accessible and affordable quality modes of transport, particularly public and non-motorized transport, as well as safe intermodal integration, as a means to improving road safety, social equity, public health, urban planning, including the resilience of cities and urban-rural linkages, and in this regard take into account road safety and mobility as part of the effort to achieve sustainable development;

OP12. Adopt, implement and enforce policies and measures to actively protect and promote pedestrian safety and cycling mobility, such as pedestrian walkways and bicycle lanes and/or tracks, adequate lighting, speed cameras, road signs and road marking, with a view to also improving road safety and broader health outcomes, particularly the prevention of injuries and non-communicable diseases;

OP13. Establish and enforce adequate safe speed limits supported by appropriate safety measures such as road signs, speed cameras, and other speed restricting mechanisms, in particular around schools and residential areas, to ensure the safety of all road users;

OP14. Encourage efforts to ensure the safety and protection for all road users through safer road infrastructure, especially on highest risk roads with high rates of crashes, involving both motorized and non-motorized modes of transport, through a combination of proper planning and safety assessment, design, building and maintenance of roads taking into consideration the country's geography;

OP15. Encourage the United Nations Conference on Sustainable Urban Development and Housing (Habitat III), taking into account that the majority of road deaths and injuries take place in urban areas, to give appropriate consideration to road safety and access to safe public transport and non-motorized modes of transport in the future New Urban Agenda;

Recommended actions to protect vulnerable road users

OP16. Urge States to promote, adapt and implement road safety policies for the protection of vulnerable people among road users, in particular children, youth, older persons and persons with disabilities, in line with relevant UN legal instruments, including the Convention on the Rights of the Child and the Convention on the Rights of Persons with Disabilities;

OP17. Take appropriate measures to ensure persons with disabilities and other users with reduced mobility, on an equal basis, access to the physical environment of roads and surrounding areas and to transportation, both in urban and in rural areas;

OP18. Fully integrate a gender perspective into all policy-making and policy implementation related to mobility and road safety, especially in roads and surrounding areas and public transport;

OP19. Encourage States to develop and implement comprehensive legislation and policies on motorcycles, including training, driver licensing, vehicle registration, work conditions, and the use of helmets and personal protection equipment by motorcyclists, given the disproportionately high and increasing numbers of motorcycle deaths and injuries globally, particularly in developing countries;

Recommended actions to develop and promote the use of safer vehicles

OP20. Promote the adoption of policies and measures to implement United Nations vehicle safety regulations or equivalent national standards to ensure that all new motor vehicles, meet applicable minimum regulations for occupant and other road users protection, with seat belts, air bags and active safety systems such as anti-lock braking system (ABS) and electronic stability control (ESC) fitted as standard;

OP21. Encourage national action and international cooperation to ensure that issues of road safety, air quality, and vehicle disposal for both individual and public transportation, are addressed with respect to second hand vehicles;

Recommended actions to increase awareness and build capacity of road users

OP22. Develop public policies to decrease work-related road traffic crashes, with the participation of employers and workers, in order to enforce international standards on safety and health at work, road safety and adequate road and vehicle conditions, giving particular attention to the issue of professional drivers' work conditions;

OP23. Increase awareness of road safety risk factors, protection and prevention measures and implement multi-stakeholder advocacy actions and social marketing campaigns, that emphasize the importance of the interrelation between road safety and a healthy lifestyle;

OP24. Develop and implement comprehensive, inclusive and evidence-based educational and training programmes, on a life-long learning and testing basis, to stimulate responsible behavior of all road users with a view to creating a peaceful road and social environment, as well as awareness of risk factors;

Recommended actions to improve post-crash response and rehabilitation services

OP25. Strengthen pre-hospital care, including emergency health services and the immediate post-crash response, hospital and ambulatory guidelines for trauma care, and rehabilitation services, through the implementation of appropriate legislation, capacity-building and improvement of timely access to integral health care, and request WHO to support Member States in their national endeavors;

OP26. Provide early rehabilitation and social reintegration, including in the world of work, to injured people and persons with disabilities caused by traffic crashes and comprehensive support to victims of road traffic crashes and their families;

Recommended actions to strengthen cooperation and coordination towards global road safety

OP27. Invite governments and road safety agencies to continue and enhance their activities of international cooperation in order to share best practices, and lessons learned, transfer knowledge, promote access to innovative and sustainable technologies and build capacity, in line with the Global Plan for the Decade of Action for Road Safety 2011–2020 and the 2030 Agenda for Sustainable Development;

OP28. Invite all relevant stakeholders and especially the donor community to scale up funding for road safety and to explore innovative funding modalities to support global, regional, national and local-level research and policy implementation;

OP29. Encourage the WHO, in collaboration with other United Nations agencies and United Nations regional commissions, to facilitate, through the existing mechanisms, a transparent, sustainable and participatory process with all stakeholders to develop national, regional and global targets to reduce road traffic crashes and fatalities, and to engage in the process that will lead to the definition and use of indicators for the road safety-related Sustainable Development Goal (SDG) targets;

OP30. Invite the United Nations General Assembly to endorse the content of this declaration.

ANNEX 4

Guidance on ending the inappropriate promotion of foods for infants and young children¹

[A69/7 Add.1 – 13 May 2016]

PURPOSE

1. The purpose of this document is to provide guidance on ending the inappropriate promotion of foods for infants and young children, with the aim of promoting, protecting and supporting breastfeeding, preventing obesity and noncommunicable diseases, promoting healthy diets, and ensuring that caregivers receive clear and accurate information on feeding.

SCOPE

2. The term “foods” is used in this guidance to refer to both foods and beverages (including complementary foods). Guidance on the inappropriate promotion of breast-milk substitutes is contained in the International Code of Marketing of Breast-milk Substitutes and subsequent relevant Health Assembly resolutions. The present document does not replace any provisions in the Code but clarifies the inclusion of certain products that should be covered by the Code and subsequent resolutions.

3. This guidance applies to all commercially produced foods that are marketed as being suitable for infants and young children from 6 to 36 months of age. Products are considered to be marketed as being suitable for this age group if they (a) are labelled with the words “baby”, “infant,” “toddler” or “young child”; (b) are recommended for introduction at an age of less than 3 years; (c) have a label with an image of a child who appears to be younger than 3 years of age or feeding with a bottle; or (d) are in any other way presented as being suitable for children under 3 years of age. This approach is in line with the relevant Codex guidelines and standards on foods for infants and young children that refer to young children up to 3 years of age.²

4. This guidance is not applicable to vitamin and mineral food supplements and home-fortification products such as micronutrient powders and small-quantity lipid-based nutrient supplements. Although such supplements and products are often classified as foods for regulatory purposes, they are not foods per se, but fortification products. Many of the principles contained in this guidance, including those concerning adherence to national and global standards for nutrient levels, safety and quality and to prohibitions on any messages indicating their use for infants under 6 months of age, should nevertheless be applied to such products.

¹ See resolution WHA69.9 (2016).

² Codex guidelines on formulated complementary foods for older infants and young children (CAC/GL-8-1991, revised in 2013); Codex standard for processed cereal-based foods for infants and young children (Codex/STAN 074-1981, revised in 2006); Codex standard for canned baby foods (CODEX STAN 73-1981); and Codex standard for follow-up formula (CODEX STAN 156-1987).

5. The promotion of foods for infants and young children occurs through government programmes, non-profit organizations and private enterprises. This guidance is applicable in all these settings, as the principles it contains are important regardless of who is responsible for the promotion.

DEFINITIONS

6. Foods for infants and young children are defined as commercially produced food or beverage products that are specifically marketed as suitable for feeding children up to 36 months of age.

7. Marketing means product promotion, distribution, selling, advertising, product public relations and information services.

8. Promotion is broadly interpreted to include the communication of messages that are designed to persuade or encourage the purchase or consumption of a product or raise awareness of a brand. Promotional messages may be communicated through traditional mass communication channels, the Internet and other marketing media using a variety of promotional methods. In addition to promotional techniques aimed directly at consumers, measures to promote products to health workers or to consumers through other intermediaries are included. There does not have to be a reference to a brand name of a product for the activity to be considered as advertising or promotion.

9. Cross-promotion (also called brand crossover promotion or brand stretching) is a form of marketing promotion where customers of one product or service are targeted with promotion of a related product. This can include the packaging, branding and labelling of a product to closely resemble that of another (brand extension). In this context, it can also refer to the use of particular promotional activities for one product or the promotion of that product in particular settings to promote another product.

RECOMMENDATIONS

10. **Recommendation 1.** Optimal infant and young child feeding should be promoted based on the Guiding principles for complementary feeding of the breastfed child¹ and the Guiding principles for feeding non-breastfed children 6–24 months of age.² Emphasis should be placed on the use of suitable, nutrient-rich, home-prepared and locally available foods that are prepared and fed safely.³

11. **Recommendation 2.** Products that function as breast-milk substitutes should not be promoted. A breast-milk substitute should be understood to include any milks (or products that could be used to replace milk, such as fortified soy milk), in either liquid or powdered form, that are specifically marketed for feeding infants and young children up to 3 years of age (including follow-up formula and growing-up milks). It should be clear that the implementation of the International Code of Marketing of Breast-milk Substitutes and subsequent relevant Health Assembly resolutions covers all these products.

¹ PAHO and WHO. Guiding principles for complementary feeding of the breastfed child. 2003. http://www.who.int/maternal_child_adolescent/documents/a85622/en/ (accessed 25 November 2015).

² WHO. Guiding principles for feeding non-breastfed children 6–24 months of age. 2005. http://www.who.int/maternal_child_adolescent/documents/9241593431/en/ (accessed 25 November 2015).

³ See WHO/UNICEF. Global strategy for infant and young child feeding, Geneva. 2003. <http://apps.who.int/iris/bitstream/10665/42590/1/9241562218.pdf?ua=1&ua=1> (accessed 25 November 2015).

12. **Recommendation 3.** Foods for infants and young children that are not products that function as breast-milk substitutes should be promoted only if they meet all the relevant national, regional and global standards for composition, safety, quality and nutrient levels and are in line with national dietary guidelines. Nutrient profile models should be developed and used to guide decisions on which foods are inappropriate for promotion. The relevant Codex standards and guidelines¹ should be updated and additional guidelines developed in line with WHO's guidance to ensure that products are appropriate for infants and young children, with a particular focus on avoiding the addition of free sugars and salt.

13. **Recommendation 4.** The messages used to promote foods for infants and young children should support optimal feeding and inappropriate messages should not be included. Messages about commercial products are conveyed in multiple forms, through advertisements, promotion and sponsorship, including brochures, online information and package labels. Irrespective of the form, messages should always:

- include a statement on the importance of continued breastfeeding for up to two years or beyond and the importance of not introducing complementary feeding before 6 months of age;
- include the appropriate age of introduction of the food (this must not be less than 6 months);
- be easily understood by parents and other caregivers, with all required label information being visible and legible.

14. Messages should not:

- include any image, text or other representation that might suggest use for infants under 6 months of age (including references to milestones and stages);
- include any image, text or other representation that is likely to undermine or discourage breastfeeding, that makes a comparison to breast-milk, or that suggests that the product is nearly equivalent or superior to breast-milk;
- recommend or promote bottle feeding;
- convey an endorsement or anything that may be construed as an endorsement by a professional or other body, unless this has been specifically approved by relevant national, regional or international regulatory authorities.

15. **Recommendation 5.** There should be no cross-promotion to promote breast-milk substitutes indirectly via the promotion of foods for infants and young children.

- The packaging design, labelling and materials used for the promotion of complementary foods must be different from those used for breast-milk substitutes so that they cannot be used

¹ Codex Guidelines on formulated complementary foods for older infants and young children (CAC/GL-8-1991, revised in 2013); Codex standard for processed cereal-based foods for infants and young children (Codex/STAN 074-1981, revised in 2006); Codex standard for canned baby foods (Codex/STAN 73-1981, revised in 1989); Codex advisory list of vitamin components for use in foods for infants and children (CAC/GL 10-1979, revised in 2009).

in a way that also promotes breast-milk substitutes (for example, different colour schemes, designs, names, slogans and mascots other than company name and logo should be used).

- Companies that market breast-milk substitutes should refrain from engaging in the direct or indirect promotion of their other food products for infants and young children by establishing relationships with parents and other caregivers (for example through baby clubs, social media groups, childcare classes and contests).

16. **Recommendation 6.** Companies that market foods for infants and young children should not create conflicts of interest in health facilities or throughout health systems. Health workers, health systems, health professional associations and nongovernmental organizations should likewise avoid such conflicts of interest. Such companies, or their representatives, should not:

- provide free products, samples or reduced-price foods for infants or young children to families through health workers or health facilities, except:
 - as supplies distributed through officially sanctioned health programmes. Products distributed in such programmes should not display company brands;
- donate or distribute equipment or services to health facilities;
- give gifts or incentives to health care staff;
- use health facilities to host events, contests or campaigns;
- give any gifts or coupons to parents, caregivers and families;
- directly or indirectly provide education to parents and other caregivers on infant and young child feeding in health facilities;
- provide any information for health workers other than that which is scientific and factual;
- sponsor meetings of health professionals and scientific meetings.

17. Likewise, health workers, health systems, health professional associations and nongovernmental organizations should not:

- accept free products, samples or reduced-price foods for infants or young children from companies, except:
 - as supplies distributed through officially sanctioned health programmes. Products distributed in such programmes should not display company brands;
- accept equipment or services from companies that market foods for infants and young children;
- accept gifts or incentives from such companies;
- allow health facilities to be used for commercial events, contests or campaigns;

- allow companies that market foods for infants and young children to distribute any gifts or coupons to parents, caregivers and families through health facilities;
- allow such companies to directly or indirectly provide education in health facilities to parents and other caregivers;
- allow such companies to sponsor meetings of health professionals and scientific meetings.

18. **Recommendation 7.** The WHO set of recommendations on the marketing of foods and non-alcoholic beverages to children¹ should be fully implemented, with particular attention being given to ensuring that settings where infants and young children gather are free from all forms of marketing of foods high in saturated fats,² *trans*-fats, free sugars or salt. While foods marketed to children may not be specifically intended for infants and young children, they may, nevertheless, be consumed by them. A range of strategies should be implemented to limit the consumption by infants and young children of foods that are unsuitable for them.

¹ WHO. Set of recommendations on the marketing of foods and non-alcoholic beverages to children. Geneva: World Health Organization; 2010.

² While diets for young children should have an adequate fat content, a 2008 joint FAO/WHO expert consultation proposed that no more than 35% of total energy should come from fat.

ANNEX 5

Framework of Engagement with Non-State Actors¹

[A69/6, Annex, Appendix, Attachment – 18 May 2016]

OVERARCHING FRAMEWORK OF ENGAGEMENT WITH NON-STATE ACTORS

INTRODUCTION

1. The overarching framework of engagement with non-State actors and the WHO policy and operational procedures on management of engagement with non-State actors apply to all engagements with non-State actors at all levels of the Organization,² whereas the four specific policies and operational procedures on engagement are limited in application to, respectively, nongovernmental organizations, private sector entities, philanthropic foundations and academic institutions.

ENGAGEMENT: RATIONALE, PRINCIPLES, BENEFITS AND RISKS

Rationale

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

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

¹ See resolution WHA69.10 (2016).

² Headquarters, regional offices and country offices, entities established under WHO, as well as hosted partnerships. For hosted partnerships the Framework of Engagement with Non-State Actors will apply, subject to the policy on WHO's engagement with global health partnerships and hosting arrangements (resolution WHA63.10). Hosted, as well as external partnerships are explained in paragraph 49.

³ WHO Constitution, Articles 18, 33, 41 and 71.

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

Principles

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

Any engagement must:

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

Benefits of engagement

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

- (a) the contribution of non-State actors to the work of WHO

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

² As set out in paragraphs 22–26.

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

Risks of engagement

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

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

NON-STATE ACTORS

8. For the purpose of this framework, non-State actors are nongovernmental organizations, private sector entities, philanthropic foundations and academic institutions.

9. **Nongovernmental organizations** are non-profit entities that operate independently of governments. They are usually membership-based, with non-profit entities or individuals as members exercising voting rights in relation to the policies of the nongovernmental organization, or are otherwise constituted with non-profit, public-interest goals. They are free from concerns which are primarily of a private, commercial or profit-making nature. They could include, for example,

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

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

grassroots community organizations, civil society groups and networks, faith-based organizations, professional groups, disease-specific groups, and patient groups.

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

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

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

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

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

TYPES OF INTERACTION

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

Participation

15. Non-State actors may attend various types of meetings organized by WHO. The nature of their participation depends on the type of meeting concerned. The format, modalities, and the participation

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

² This can include think tanks which are policy-oriented institutions, as long as they primarily perform research; international associations of academic institutions are considered as nongovernmental organizations, subject to paragraph 13.

of non-State actors in consultations, hearings, and other meetings is decided on a case-by-case basis by the WHO governing bodies or by the Secretariat.

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

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

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

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

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

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

Resources

17. Resources are financial or in-kind contributions. In-kind contributions include donations of medicines and other goods and free provision of services² on a contractual basis.

Evidence

18. For the purposes of this framework, evidence refers to inputs based on up-to-date information, knowledge on technical issues, and consideration of scientific facts, independently analysed by WHO. Evidence generation by WHO includes information gathering, analysis, generation of information and

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

² With the exception of secondments, which are covered in paragraph 47.

the management of knowledge and research. Non-State actors may provide their up-to-date information and knowledge on technical issues, and share their experience with WHO, as appropriate, subject to the provisions of this framework, its four specific policies and operational procedures, and other applicable WHO rules, policies and procedures. Such contribution should be made publicly available, as appropriate, wherever possible. Scientific evidence generated should be made publicly available.

Advocacy

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

Technical collaboration

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

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

MANAGEMENT OF CONFLICT OF INTEREST AND OTHER RISKS OF ENGAGEMENT

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

- WHO needs to know the non-State actors that it engages with. Therefore each non-State actor is required to provide all relevant² information about itself and its activities, following which WHO conducts the necessary due diligence.
- WHO conducts a risk assessment in order to identify the specific risks of engagement associated with each engagement with a non-State actor.
- Risks of engagement need to be managed and communicated coherently in each of the three levels of the Organization and throughout the Organization. To that end, WHO manages engagement through a single, Organization-wide electronic tool.¹

¹ The framework is designed to regulate institutional engagements; its implementation is closely coordinated with the implementation of other organizational policies regulating conflict of interest in respect of individuals (see paragraph 49).

² As defined in paragraph 39.

- Member States exercise oversight over WHO's engagement with non-State actors in accordance with the provisions in paragraphs 67 and 68.

Conflict of interest

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

23. Individual conflicts of interests within WHO are those involving experts, regardless of their status, and staff members; these are addressed in accordance with the policies listed under paragraph 49 of the present framework.

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

25. In actively managing institutional conflict of interest and the other risks of engagement mentioned in paragraph 7 above, WHO aims to avoid allowing the conflicting interests of a non-State actor to exert, or be reasonably perceived to exert, undue influence over the Organization's decision-making process or to prevail over its interests.

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

Due diligence and risk assessment

27. When the possibility of entering into an engagement is being considered, the relevant technical unit in the Secretariat conducts an initial examination in order to establish whether such an engagement would be in the interest of the Organization and in line with the principles of WHO's engagement with non-State actors in paragraph 5 and the priorities defined in the General Programme of Work and Programme budget. If this seems to be the case, the technical unit consults the WHO Register on non-State actors and as needed asks the non-State actor to provide its basic information. Using the Organization-wide electronic tool, the unit then complements this information with a description of the proposed engagement and its own assessment of the benefits and risks involved, as needed.

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

28. The technical unit makes an initial assessment. If the engagement is of low risk, for example because of its repetitive nature¹ or because it does not involve policies, norms and standard setting, a simplified due diligence and risk assessment modulating the procedures in paragraphs 29–36 as well as 39 can be performed by the technical unit and the risk management decision taken, taking such steps as are necessary to ensure full compliance with paragraphs 5–7.² For all other engagements full procedures apply.

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

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

31. The core functions of due diligence are to:

- clarify the nature and purpose of the entity proposed to engage with WHO;
- clarify the interest and objectives of the entity in engaging with WHO and what it expects in return;
- determine the entity's legal status, area of activities, membership, governance, sources of funding, constitution, statutes, and by-laws and affiliation;
- define the main elements of the history and activities of the entity in terms of the following: health, human and labour issues; environmental, ethical and business issues; reputation and image; and financial stability;
- identify if paragraph 44 or 45 should be applied.

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

33. Risks are the expression of the likelihood and potential impact of an event that would affect the Organization's ability to achieve its objectives. A **risk assessment** on a proposed engagement is conducted in addition to due diligence. This involves the assessment of risks associated with an engagement with a non-State actor, in particular the risks described in paragraph 7 and is to be conducted without prejudice to the type of non-State actor.

¹ Provided that due diligence and risk assessment have already been carried out and the nature of engagement has remained unchanged.

² The simplified due diligence and risk assessment, and information to be provided by non-State actors as well as the criteria of low risk engagements are described in the guide for staff.

Risk management

34. **Risk management** concerns the process leading to a management decision whereby the Secretariat decides explicitly and justifiably on entry into engagement,¹ continuation of engagement, engagement with measures to mitigate risks, non-engagement or disengagement from an existing or planned engagement with non-State actors. It is a management decision usually taken by the unit engaging with the non-State actor based on a recommendation of the specialized unit responsible for performing due diligence and risk assessment.

35. A dedicated secretariat mechanism reviews proposals of engagement referred to it and recommends engagement, continuation of engagement, engagement with measures to mitigate risks, non-engagement or disengagement from an existing or planned engagement with non-State actors. The Director-General, working with the Regional Directors, ensures coherence and consistency in implementation and interpretation of this Framework across all levels of the Organization.

36. WHO takes a risk-management approach to engagement, only entering into an engagement with a non-State actor when the benefits in terms of direct or indirect contributions to public health and the fulfilment of the Organization's mandate as mentioned in paragraph 6 outweigh any residual risks of engagement as mentioned in paragraph 7, as well as the time and expense involved in establishing and maintaining the engagement.

Transparency

37. WHO's interaction with non-State actors is managed transparently. WHO provides an annual report to the governing bodies on its engagement with non-State actors, including summary information on due diligence, risk assessment and risk management undertaken by the Secretariat. WHO also makes publicly available appropriate information on its engagement with non-State actors.

38. The **WHO register of non-State actors** is an Internet-based, publicly available electronic tool used by the Secretariat² to document and coordinate engagement with non-State actors. It contains the main standard information provided by non-State actors³ and high-level descriptions of the engagement that WHO has with these actors.⁴

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

40. When the Secretariat decides on an engagement with a non-State actor, a summary of the information submitted by that entity and held in the WHO register of non-State actors is made public. The accuracy of the information provided by the non-State actor and published in the register is the

¹ Other than decisions related to official relations as set out in paragraphs 50–57.

² The register of non-State actors is the first level of a tool used by the Secretariat containing four levels of information: a publicly available level, a level made available to Member States, a working level for the Secretariat, and a level of confidential and sensitive information accessible to a limited number of individuals within the Secretariat.

³ Information on financial contributions received from non-State actors is documented in this register and in the Programme Budget web portal.

⁴ The register covers all three levels of the Organization – global, regional and country – and includes hosted partnerships and joint programmes.

responsibility of the non-State actor concerned and does not constitute any form of endorsement by WHO.

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

42. In addition to the publicly available information, Member States have electronic access to a summary report on due diligence of each non-State actor and their respective risk assessment and risk management on engagement. Member States also have access, on demand, to the associated full report through a remote secure access platform.

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

SPECIFIC PROVISIONS

44. WHO does not engage with the tobacco industry or non-State actors that work to further the interests of the tobacco industry. WHO also does not engage with the arms industry.

Engagement where particular caution should be exercised

45. WHO will exercise particular caution, especially while conducting due diligence, risk assessment and risk management, when engaging with private sector entities and other non-State actors whose policies or activities are negatively affecting human health and are not in line with WHO’s policies, norms and standards, in particular those related to noncommunicable diseases and their determinants.

Association with WHO’s name and emblem

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

Secondments

47. WHO does not accept secondments from private sector entities.

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

RELATION OF THE FRAMEWORK TO WHO'S OTHER POLICIES

48. This framework replaces the Principles governing relations between the World Health Organization and nongovernmental organizations¹ and the Guidelines on interaction with commercial enterprises to achieve health outcomes (noted by the Executive Board).²

49. The implementation of the policies listed below as they relate to WHO's engagement with non-State actors will be coordinated and aligned with the Framework of Engagement with Non-State Actors. In the event that a conflict is identified, it will be brought to the attention of the Executive Board through its Programme, Budget and Administration Committee.

(a) Policy on WHO's engagement with global health partnerships and hosting arrangements.³

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

(ii) WHO's involvement in external partnerships is regulated by the policy on WHO's engagement with global health partnerships and hosting arrangements. The Framework of Engagement with Non-State Actors also applies to WHO's engagement in these partnerships.⁴

(b) Regulations for Expert Advisory Panels and Committees and the Guidelines for Declaration of Interests (WHO Experts). The management of WHO's relations with individual experts is regulated by the Regulations for Expert Advisory Panels and Committees⁵ and the Guidelines for Declaration of Interests (WHO Experts).

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

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

¹ Basic documents, 48th ed. Geneva: World Health Organization; 2014: pp.97–102.

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

³ Endorsed by the Health Assembly in resolution WHA63.10 (2010) on partnerships and its Annex 1.

⁴ The Codex Alimentarius Commission is an intergovernmental body which is the principal organ of the joint FAO/WHO food standards programme for which the administration is not solely provided by WHO. The Commission is supported by subsidiary bodies including Codex committees, regional coordinating committees and task forces. Meetings of the Commission, Committees, including independent expert committees, and Task Forces are regulated by the Rules of Procedure and other decisions adopted by the Codex Alimentarius Commission.

⁵ See Basic documents, 48th ed. Geneva: World Health Organization; 2014: pp.121–130.

Study and Scientific Groups, Collaborating Institutions and other Mechanisms of Collaboration.¹

(e) Financial Regulations and Financial Rules.

(i) The procurement of goods and services is regulated by the Financial Regulations and Financial Rules;² it is not covered by the Framework of Engagement with Non-State Actors, although pro-bono contributions from non-State actors are covered.

(ii) Like any other financing of WHO, financing from non-State actors is regulated by the Financial Regulations and Financial Rules and the decision on accepting such financial contributions is also regulated by this framework.

OFFICIAL RELATIONS

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

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

52. Official relations shall be based on a plan for collaboration between WHO and the entity with agreed objectives and outlining activities for the coming three-year period structured in accordance with the General Programme of Work and Programme budget and consistent with this framework. This plan shall also be published in the WHO register of non-State actors. These organizations shall provide annually a short report on the progress made in implementing the plan of collaboration and other related activities which will also be published in the WHO register. These plans shall be free from concerns which are primarily of a commercial or profit-making nature.

53. For nongovernmental organizations working on global health issues, sustained and systematic engagement could include research and active advocacy around WHO meetings and WHO’s policies, norms and standards. Official relations may be considered for such nongovernmental organizations based on at least three years of their activities and future work plan on research and advocacy on global public health issues.

54. The Executive Board shall be responsible for deciding on the admission of organizations into official relations with WHO and shall review this status every three years. The Director-General may

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

² Basic documents, 48th ed. Geneva: World Health Organization; 2014: pp.103–113.

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

propose international nongovernmental organizations, philanthropic foundations and international business associations for admission. The Director-General can also propose an earlier review based on the experience in the collaboration with the organization concerned.

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

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

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

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

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

57. Regional committees may also decide on a procedure granting accreditation to their meetings to other international, regional, and national¹ non-State actors not in official relations with WHO as long as the procedure is managed in accordance with this framework.

Procedure for admitting and reviewing organizations in official relations

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

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

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

¹ In accordance with the Constitution of the World Health Organization, Article 71.

engagement and a framework for future collaborative activities, the Committee may recommend postponement of consideration or rejection of an application.

61. The Board, after considering the recommendations of the Committee, shall decide whether an organization is to be admitted into official relations with WHO. A reapplication from a non-State actor shall not normally be considered until two years have elapsed since the Board's decision on the previous application.

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

63. The entities in official relations and the Secretariat should name focal points for collaboration who are responsible for informing each other and their organizations of any developments in the implementation of the plan for collaboration and who are the first points of contact for any changes or problems.

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

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

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

OVERSIGHT OF ENGAGEMENT

67. The Executive Board, through its Programme, Budget and Administration Committee, oversees the implementation of WHO's Framework of Engagement with Non-State Actors, proposes revisions to the framework and can grant the privileges of official relations to international nongovernmental organizations, philanthropic foundations and international business associations.

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

- (a) oversight of WHO's implementation of the Framework of Engagement with Non-State Actors including:

- (i) consideration of the annual report on engagement with non-State actors submitted by the Director-General
- (ii) any other matter on engagement referred to the Committee by the Board
- (b) entities in official relations with WHO, including:
 - (i) proposals for admitting non-State actors into official relations
 - (ii) review of renewals of entities in official relations
- (c) any proposal, when needed, for revisions of the Framework of Engagement with Non-State Actors.

NON-COMPLIANCE WITH THIS FRAMEWORK

69. Non-compliance can include inter alia the following: significant delays in the provision of information to the WHO register of non-State actors; provision of wrong information; use of the engagement with WHO for purposes other than protecting and promoting public health, such as for commercial, promotional, marketing and advertisement purposes; misuse of WHO's name and emblem; attempt at undue influence; and abuse of the privileges conferred by official relations.

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

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

IMPLEMENTATION

72. Consistent with the principles identified in paragraph 5, this framework will be implemented in its entirety in a manner that manages and strengthens WHO's engagement with non-State actors towards the attainment of public health objectives, including through multistakeholder partnerships, whilst protecting and preserving WHO's integrity, independence, credibility and reputation;

73. The Director-General, in the application of this framework, when responding to acute public health events described in the International Health Regulations (2005) or other emergencies with health consequences, will act according to the WHO Constitution¹ and the principles identified in this framework. In doing so, the Director-General may exercise flexibility as might be needed in the application of the procedures of this framework in those responses, when he/she deems necessary, in accordance with WHO's responsibilities as health cluster lead, and the need to engage quickly and

¹ Including Article 2(d) of the Constitution of the World Health Organization.

broadly with non-State actors for coordination, scale up and service delivery¹. The Director-General will inform Member States through appropriate means,² including in particular written communication, without undue delay when such a response requires exercise of flexibility, and include summary information with justification on the use of such flexibility in the annual report on engagement with non-State actors.

MONITORING AND EVALUATION OF THE FRAMEWORK

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

75. Furthermore, the implementation of the framework should be periodically evaluated. The results of such evaluation, together with any proposals for revisions of the framework, shall also be submitted to the Executive Board through its Programme, Budget and Administration Committee.

WHO POLICY AND OPERATIONAL PROCEDURES ON ENGAGEMENT WITH NONGOVERNMENTAL ORGANIZATIONS

1. This policy regulates specifically WHO's engagement with nongovernmental organizations by type of interaction.³ The provisions of the overarching framework also apply to all engagements with nongovernmental organizations.

PARTICIPATION

Participation by nongovernmental organizations in WHO meetings⁴

2. WHO can invite nongovernmental organizations to participate in consultations, hearings or other meetings in accordance with paragraph 15 of the overarching framework. Consultations and hearings can be electronic or in person.

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

¹ Taking into account resolution WHA65.20 (2012) on WHO's response, and role as the health cluster lead, in meeting the growing demands of health in humanitarian emergencies.

² Including as described in United Nations General Assembly resolution 46/182 (Strengthening of the coordination of humanitarian assistance of the United Nations), which establishes the Secretary-General's emergency relief coordinator, and the International Health Regulations (2005).

³ See paragraphs 14–20 of the overarching framework for the five types of interaction.

⁴ Other than sessions of the governing bodies, which are regulated by the policy on management of engagement.

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

Involvement of the Secretariat in meetings organized by nongovernmental organizations

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

Specific policies and operational procedures

6. The participation of WHO in meetings organized by nongovernmental organizations as co-organizers, cosponsors, panellists or speakers shall be managed according to the provisions of this Framework.

RESOURCES

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

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

- (a) the acceptance of a contribution does not constitute an endorsement by WHO of the nongovernmental organization;
- (b) the acceptance of a contribution does not confer on the contributor any privilege or advantage;
- (c) the acceptance of a contribution as such does not offer the contributor any possibility for advising, influencing, participating in, or being in command of the management or implementation of operational activities;
- (d) WHO keeps its discretionary right to decline a contribution, without any further explanation.

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

Specific policies and operational procedures

10. Any acceptance of resources from a nongovernmental organization is handled in accordance with the provisions of this framework and relevant other WHO rules and guidelines such as the Staff Regulations and Staff Rules, the Financial Regulations and Financial Rules and policies governing procurement, as well as WHO's guidelines for medicine donations and WHO's guidelines for health care equipment donations;
11. For reasons of transparency, contributions from nongovernmental organizations must be publicly acknowledged by WHO in accordance with its policies and practices.
12. Acknowledgements shall usually be worded along the following lines: "The World Health Organization gratefully acknowledges the financial contribution of [Nongovernmental organization] towards [description of the outcome or activity]".
13. Contributions received from nongovernmental organizations are listed in the financial report and audited financial statements of WHO as well as the Programme budget web portal and the WHO register of non-State actors.
14. Nongovernmental organizations may not use the fact that they have made a contribution in their materials used for commercial, promotional, marketing and advertisement purposes.¹ However, they may make reference to the contribution in their annual reports or similar documents. In addition, they may mention the contribution on their websites, and in special non-promotional publications, provided that the content and context have been agreed with WHO.

EVIDENCE

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

ADVOCACY

16. WHO collaborates with nongovernmental organizations on advocacy for health and increasing awareness of health issues; for changing behaviours in the interest of public health; and for fostering collaboration and greater coherence between non-State actors where joint action is required.
17. Nongovernmental organizations are encouraged to disseminate WHO's policies, guidelines, norms and standards and other tools through their networks.
18. WHO encourages nongovernmental organizations to implement and advocate for the implementation of WHO's policies, norms and standards. WHO engages in dialogue with

¹ In accordance with paragraph 46 of the overarching framework.

nongovernmental organizations in order to promote the implementation of WHO's policies, norms and standards.¹

19. Nongovernmental organizations can only collaborate with WHO in advocacy for the implementation of WHO policies norms or standards if they commit themselves to implement these policies, norms or standards in their entirety. No partial or selective implementation is acceptable.

TECHNICAL COLLABORATION

20. WHO may engage with the nongovernmental organizations for technical collaboration as defined in the overarching framework paragraph 20. Technical collaboration with nongovernmental organizations is encouraged. This collaboration must be in the interest of WHO, and managed in accordance with the overarching framework and this policy to protect WHO, and in particular, its normative work, from any undue influence or conflict of interest and to ensure there is no interference with WHO's advisory function to Member States.

WHO POLICY AND OPERATIONAL PROCEDURES ON ENGAGEMENT WITH PRIVATE SECTOR ENTITIES

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

2. When engaging with private sector entities, it should be borne in mind that WHO's activities affect the commercial sector in broader ways, through, among others, its public health guidance, its recommendations on normative standards, or other work that might indirectly or directly influence product costs, market demand, or profitability of specific goods and services.

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

PARTICIPATION

Participation by private sector entities in WHO meetings³

4. WHO can invite private sector entities to participate in consultations, hearings or other meetings in accordance with paragraph 15 of the overarching framework. Consultations and hearings can be electronic or in person.

¹ Nongovernmental organizations working with WHO will be expected to conform to WHO's public health policies in areas such as food safety, chemical safety, ethical promotion of medicinal drug products, tobacco control, noncommunicable diseases, as well as health and safety at work.

² See paragraphs 14–20 of the overarching framework for the five types of interaction.

³ Other than sessions of the governing bodies, which are regulated by the policy on management of engagement.

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

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

Involvement of the Secretariat in meetings organized by private sector entities

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

Specific policies and operational procedures

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

9. WHO does not cosponsor meetings organized wholly or partly by private sector entities. It may, however, cosponsor a meeting for which the scientific initiators have hired a commercial conference organizer to deal with the logistical aspects, provided that the commercial organizer makes no contribution to the scientific content of the meeting.

10. WHO does not cosponsor meetings organized by other actors where one or more health-related private sector entities are also cosponsors. Other instances of cosponsorship of meetings organized by other actors where non health-related private sector entities are also cosponsors should be reviewed on a case-by-case basis and are subject to the provisions of this framework.

11. There shall be no commercial exhibitions on WHO premises and at WHO's meetings.

12. WHO does not cosponsor commercial exhibitions, whether as part of meetings organized by private sector entities or as part of meetings organized by other actors.

RESOURCES

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

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

(b) Financial contributions may not be sought or accepted from private sector entities that have, themselves or through their affiliated companies, a direct commercial interest in the outcome of the project toward which they would be contributing, unless approved in conformity with the provisions for clinical trials or product development (see paragraph 36 below).

(c) The provisions set out in paragraph 13(b) shall be without prejudice to specific mechanisms, such as the Pandemic Influenza Preparedness Framework (“PIP Framework”), set up by the Health Assembly that involve the receipt and pooling of resources.¹

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

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

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

15. Any acceptance of resources from private sector entities is handled in accordance with the provisions of this framework and relevant other WHO rules and guidelines such as the Staff Regulations and Staff Rules, the Financial Regulations and Financial Rules and policies governing

¹ In accordance with paragraph 17 of the overarching framework.

procurement, as well as WHO's guidelines for medicine donations and WHO's guidelines for health care equipment donations;

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

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

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

19. Private sector entities may not use the fact that they have made a contribution in their materials used for commercial, promotional, marketing and advertisement purposes.¹ However, they may make reference to the contribution in their annual reports or similar documents. In addition, they may mention the contribution on their websites, and in special non-promotional publications, provided that the content and context have been agreed with WHO.

Donations of medicines and other health technologies²

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

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

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

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

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

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

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

¹ In accordance with paragraph 46 of the overarching framework.

² Such donations shall be in line with interagency guidelines: World Health Organization, Ecumenical Pharmaceutical Network, International Pharmaceutical Federation, International Federation of Red Cross and Red Crescent Societies, International Health Partners, The Partnership for Quality Medical Donations, et al. Guidelines for medicine donations – revised 2010. Geneva: World Health Organization; 2011.

- (g) A phase-out plan for the donation has been agreed upon with recipient countries.
- (h) A system for monitoring adverse reactions to the product has been set up with the participation of the donating company.

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

Financial contributions for clinical trials

22. Except as provided in paragraph 36 below on product development, financial contributions from a private sector entity for a clinical trial arranged by WHO on that company's proprietary product are considered on a case-by-case basis. In this connection, it should be ensured that:

- (a) the research or development activity is of public health importance;
- (b) the research is conducted at WHO's request and potential conflicts of interest are managed;
- (c) WHO only accepts such financial contributions, if the research would not take place without WHO's involvement or if WHO's involvement is necessary in order to ensure that the research is undertaken in conformity with internationally accepted technical and ethical standards and guidelines.

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

Contributions for WHO meetings

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

25. Contributions may be accepted to support the overall costs of a meeting.

26. WHO receptions and similar functions shall not be paid for by private sector entities.

Contributions for WHO staff participating in external meetings

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

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

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

Contributions for publications

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

Cost recovery

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

EVIDENCE

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

ADVOCACY

31. WHO encourages private sector entities to implement and advocate for the implementation of WHO's policies, norms and standards. WHO engages in dialogue with private sector entities in order to promote the implementation of WHO's policies, norms and standards.¹

32. Private sector entities can only collaborate with WHO in advocacy for the implementation of WHO policies norms or standards if they commit themselves to implement these policies, norms or standards in their entirety. No partial or selective implementation is acceptable.

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

TECHNICAL COLLABORATION

34. WHO may engage with the private sector for technical collaboration as defined in the overarching framework paragraph 20. Technical collaboration with private sector entities is encouraged. This collaboration must be in the interest of WHO, and managed in accordance with the overarching framework and this policy to protect WHO, and in particular, its normative work, from

¹ Private sector entities working with WHO will be expected to conform to WHO's public health policies in areas such as food safety, chemical safety, ethical promotion of medicinal drug products, tobacco control, noncommunicable diseases, as well as health and safety at work.

any undue influence or conflict of interest and to ensure there is no interference with WHO's advisory function to Member States.

Specific policies and operational procedures

35. If WHO has drawn up official specifications for a product, it may provide technical advice to manufacturers for development of their product in accordance with these specifications, provided that all private sector entities known to have an interest in such a product are given the opportunity to collaborate with WHO in the same way.

36. WHO may collaborate with private sector entities in the research and development of health related technologies that contribute to increasing access to quality, safe, efficacious and affordable medical products. Collaborative research and development should, as a general rule, be undertaken only if WHO and the private sector entity have concluded an agreement which ensures that the final product will ultimately be widely available, including to the public sector of developing countries at a preferential price. If such an agreement is concluded, financing may be accepted from the private sector entity for a trial arranged by WHO on the product in question, on the basis that contractual commitments obtained from the private sector entity outweigh any potential conflict of interest in accepting such financing.

WHO POLICY AND OPERATIONAL PROCEDURES ON ENGAGEMENT WITH PHILANTHROPIC FOUNDATIONS

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

PARTICIPATION

Participation by philanthropic foundations in WHO meetings²

2. WHO can invite philanthropic foundations to participate in consultations, hearings or other meetings in accordance with paragraph 15 of the overarching framework. Consultations and hearings can be electronic or in person.

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

4. The nature of participation of philanthropic foundations depends on the type of meeting concerned. The format, modalities, and the participation of philanthropic foundations in consultations, hearings, and other meetings is decided on a case-by-case basis by the WHO governing bodies or by the Secretariat. Participation and inputs received from philanthropic foundations shall be made

¹ See paragraphs 14–20 of the overarching framework for the five types of interaction.

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

publicly available, wherever possible. Philanthropic foundations do not take part in any decision making process of the Organization.

Involvement of the Secretariat in meetings organized by philanthropic foundations

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

Specific policies and operational procedures

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

RESOURCES

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

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

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

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

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

- (a) the acceptance of a contribution does not constitute an endorsement by WHO of the philanthropic foundation;
- (b) the acceptance of a contribution does not confer on the contributor any privilege or advantage;
- (c) the acceptance of a contribution as such does not offer the contributor any possibility for advising, influencing, participating in, or being in command of the management or implementation of operational activities;
- (d) WHO keeps its discretionary right to decline a contribution, without any further explanation.

Specific policies and operational procedures

12. Any acceptance of resources from a philanthropic foundation is handled in accordance with the provisions of this framework and relevant other WHO rules and guidelines such as the Staff Regulations and Staff Rules, the Financial Regulations and Financial Rules and policies governing procurement, as well as WHO's guidelines for medicine donations and WHO's guidelines for health care equipment donations.
13. For reasons of transparency, contributions from philanthropic foundations must be publicly acknowledged by WHO in accordance with its policies and practices.
14. Acknowledgements shall usually be worded along the following lines: "The World Health Organization gratefully acknowledges the financial contribution of [Philanthropic foundation] towards [description of the outcome or activity]".
15. Contributions received from philanthropic foundations are listed in the financial report and audited financial statements of WHO as well as the Programme budget web portal and the WHO register of non-State actors.
16. Philanthropic foundations may not use the fact that they have made a contribution in their materials used for commercial, promotional, marketing and advertisement purposes.¹ However, they may make reference to the contribution in their annual reports or similar documents. In addition, they may mention the contribution on their websites, and in special non-promotional publications, provided that the content and context have been agreed with WHO.

EVIDENCE

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

ADVOCACY

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

¹ In accordance with paragraph 46 of the overarching framework.

19. WHO encourages philanthropic foundations to implement and advocate for the implementation of WHO's policies, norms and standards. WHO engages in dialogue with Philanthropic foundations in order to promote the implementation of WHO's policies, norms and standards.¹

20. Philanthropic foundations can only collaborate with WHO in advocacy for the implementation of WHO policies norms or standards if they commit themselves to implement these policies, norms or standards in their entirety. No partial or selective implementation is acceptable.

TECHNICAL COLLABORATION

21. WHO may engage with the philanthropic foundations for technical collaboration as defined in the overarching framework paragraph 20. Technical collaboration with philanthropic foundations is encouraged. This collaboration must be in the interest of WHO, and managed in accordance with the overarching framework and this policy to protect WHO, and in particular, its normative work, from any undue influence or conflict of interest and to ensure there is no interference with WHO's advisory function to Member States).

WHO POLICY AND OPERATIONAL PROCEDURES ON ENGAGEMENT WITH ACADEMIC INSTITUTIONS

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

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

PARTICIPATION

Participation by academic institutions in WHO meetings

3. WHO can invite academic institutions to participate in consultations, hearings or other meetings in accordance with paragraph 15 of the overarching framework. Consultations and hearings can be electronic or in person.

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

5. The nature of participation of academic institution depends on the type of meeting concerned. The format, modalities, and the participation of academic institution in consultations, hearings, and

¹ Philanthropic foundations working with WHO will be expected to conform to WHO's public health policies in areas such as food safety, chemical safety, ethical promotion of medicinal drug products, tobacco control, noncommunicable diseases, as well as health and safety at work.

² See paragraphs 14–20 of the overarching framework for the five types of interaction.

other meetings is decided on a case-by-case basis by the WHO governing bodies or by the Secretariat. Participation and inputs received from academic institutions shall be made publicly available, wherever possible. Academic institutions do not take part in any decision-making process of the Organization.

Involvement of the Secretariat in meetings organized by academic institutions

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

Specific policies and operational procedures

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

RESOURCES

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

9. WHO can provide resources to an academic institution for implementation of particular work (such as research, a clinical trial, laboratory work and preparation of a document), in accordance with the Financial Regulations and Financial Rules and other applicable rules and policies. This can be either for a project of the institution which WHO considers merits support, based on a clear public health interest, and is consistent with WHO's General Programme of Work, or for a project organized or coordinated by WHO. The former constitutes a grant, the latter a service.

Specific policies and operational procedures

10. Any acceptance of resources from an academic institution is handled in accordance with the provisions of this framework and relevant other WHO rules and guidelines such as the Staff Regulations and Staff Rules, the Financial Regulations and Financial Rules and policies governing procurement, as well as WHO's guidelines for medicine donations and WHO's guidelines for health care equipment donations;

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

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

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

14. Academic institutions may not use the fact that they have made a contribution in their materials used for commercial, promotional, marketing and advertisement purposes.¹ However, they may make reference to the contribution in their annual reports or similar documents. In addition, they may mention the contribution on their websites, and in special non-promotional publications, provided that the content and context have been agreed with WHO.

EVIDENCE

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

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

ADVOCACY

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

18. WHO encourages academic institutions to implement and advocate for the implementation of WHO's policies, norms and standards. WHO engages in dialogue with academic institutions in order to promote the implementation of WHO's policies, norms and standards.²

19. Academic institutions can only collaborate with WHO in advocacy for the implementation of WHO policies norms or standards if they commit themselves to implement these policies, norms or standards in their entirety. No partial or selective implementation is acceptable.

TECHNICAL COLLABORATION

20. WHO may engage with academic institutions for technical collaboration as defined in the overarching framework paragraph 20. Technical collaboration with academic institutions is encouraged. This collaboration must be in the interest of WHO, and managed in accordance with the overarching framework and this policy to protect WHO, and in particular, its normative work, from any undue influence or conflict of interest and to ensure there is no interference with WHO's advisory function to Member States.

¹ In accordance with paragraph 46 of the overarching framework.

² Academic institutions working with WHO will be expected to conform to WHO's public health policies in areas such as food safety, chemical safety, ethical promotion of medicinal drug products, tobacco control, noncommunicable diseases, as well as health and safety at work.

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

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

(Eighth plenary meeting, 28 May 2016 –
Committee A, fifth report)

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

ANNEX 6

Text of amended Staff Regulations¹

[A69/54 – 15 April 2016]

XI. DISPUTE RESOLUTION

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11.2 Any dispute which cannot be resolved internally, arising between the Organization and a member of the staff regarding the fulfilment of the contract of the said member, shall be referred for final decision to the Administrative Tribunal of the International Labour Organization.

¹ Text amended in accordance with resolution WHA69.17 (2016).

ANNEX 7

Global Strategy on Human Resources for Health: Workforce 2030^{1,2}

INTRODUCTION

1. In May 2014, the Sixty-seventh World Health Assembly adopted resolution WHA67.24 on Follow-up of the Recife Political Declaration on Human Resources for Health: renewed commitments towards universal health coverage. In paragraph 4(2) of that resolution, Member States requested the Director-General of the World Health Organization (WHO) to develop and submit a new global strategy for human resources for health (HRH) for consideration by the Sixty-ninth World Health Assembly.
2. Development of the Global Strategy was informed by a process launched in late 2013 by Member States and constituencies represented on the Board of the Global Health Workforce Alliance, a hosted partnership within WHO. Over 200 experts from all WHO regions contributed to consolidating the evidence around a comprehensive health labour market framework for universal health coverage (UHC). A synthesis paper was published in February 2015³ and informed the initial version of the Global Strategy.
3. An extensive consultation process on the draft version was launched in March 2015. This resulted in inputs from Member States and relevant constituencies such as civil society and health-care professional associations. The process also benefited from discussions in the WHO regional committees, technical consultations, online forums, a briefing session to Member States' permanent missions to the United Nations (UN) in Geneva, exchanges during the 138th Executive Board and a final round of written comments in March 2016. Feedback and guidance from the consultation process were reflected in the current version of the Global Strategy, which was also aligned with, and informed by the WHO Framework on integrated people-centred health services.⁴
4. The Global Strategy on Human Resources for Health: Workforce 2030 is primarily aimed at planners and policy-makers of Member States, but its contents are of value to all relevant stakeholders in the health workforce area, including public and private sector employers, professional associations, education and training institutions, labour unions, bilateral and multilateral development partners, international organizations, and civil society.
5. Throughout this document, it is recognized that the concept of universal health coverage may have different connotations in countries and regions of the world. In particular, in the WHO Regional Office for the Americas, universal health coverage is part of the broader concept of universal access to health care.

¹ See resolution WHA69.19 (2016).

² Editor's note: This document has not been subject to editing by the Department of Governing Bodies.

³ Global Health Workforce Alliance. Health workforce 2030 – towards a global strategy on human resources for health [Synthesis paper]. Geneva: World Health Organization; 2015 (http://www.who.int/hrh/documents/synthesis_paper_them2015/en/, accessed 5 June 2015).

⁴ WHO Global Strategy on People-Centred and Integrated Health Services – interim report. Geneva: World Health Organization; 2015 (WHO/HIS/SDS/2015.6; <http://www.who.int/servicedeliverysafety/areas/people-centred-care/en/>, accessed 5 June 2015).

Global strategy on human resources for health: Workforce 2030 – Summary

Vision	Accelerate progress towards universal health coverage and the UN Sustainable Development Goals by ensuring equitable access to health workers within strengthened health systems			
Overall goal	To improve health, social and economic development outcomes by ensuring universal availability, accessibility, acceptability, coverage and quality of the health workforce through adequate investments to strengthen health systems, and the implementation of effective policies at national, ¹ regional and global levels			
Principles	<ul style="list-style-type: none"> • Promote the right to the enjoyment of the highest attainable standard of health • Provide integrated, people-centred health services devoid of stigma and discrimination • Foster empowered and engaged communities • Uphold the personal, employment and professional rights of all health workers, including safe and decent working environments and freedom from all kinds of discrimination, coercion and violence • Eliminate gender-based violence, discrimination and harassment • Promote international collaboration and solidarity in alignment with national priorities • Ensure ethical recruitment practices in conformity with the provisions of the WHO Global Code of Practice on the International Recruitment of Health Personnel • Mobilize and sustain political and financial commitment and foster inclusiveness and collaboration across sectors and constituencies • Promote innovation and the use of evidence 			
Objectives	1. To optimize performance, quality and impact of the health workforce through evidence-informed policies on human resources for health, contributing to healthy lives and well-being, effective universal health coverage, resilience and strengthened health systems at all levels.	2. To align investment in human resources for health with the current and future needs of the population and of health systems, taking account of labour market dynamics and education policies; to address shortages and improve distribution of health workers, so as to enable maximum improvements in health outcomes, social welfare, employment creation and economic growth.	3. To build the capacity of institutions at sub-national, national, regional and global levels for effective public policy stewardship, leadership and governance of actions on human resources for health.	4. To strengthen data on human resources for health, for monitoring and ensuring accountability for the implementation of national and regional strategies, and the Global Strategy.

¹ Policy and actions at “country” or “national” level should be understood as relevant in each country in accordance with subnational and national responsibilities.

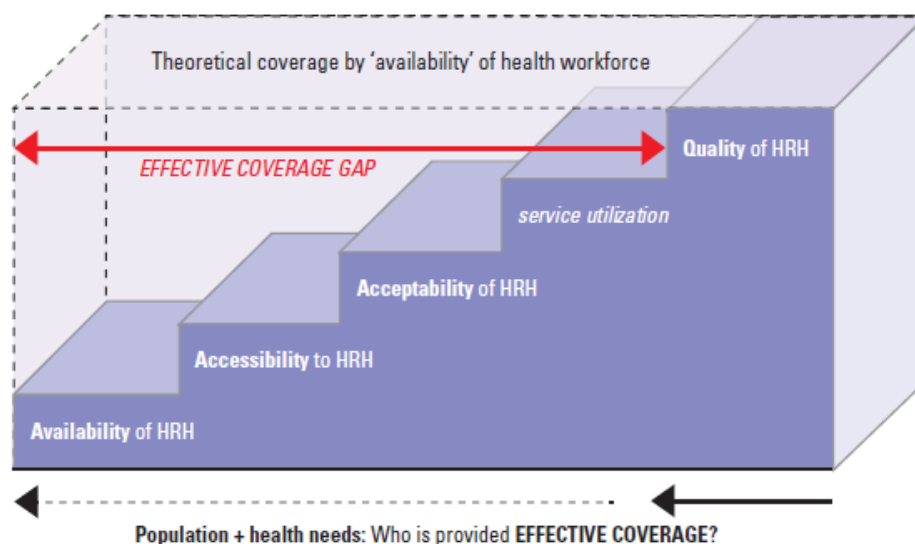
Global milestones (by 2020)	<ul style="list-style-type: none"> All countries have inclusive institutional mechanisms in place to coordinate an intersectoral health workforce agenda. All countries have a human resources for health unit with responsibility for development and monitoring of policies and plans. All countries have regulatory mechanisms to promote patient safety and adequate oversight of the private sector. All countries have established accreditation mechanisms for health training institutions. All countries are making progress on health workforce registries to track health workforce stock, education, distribution, flows, demand, capacity and remuneration. All countries are making progress on sharing data on human resources for health through national health workforce accounts and submit core indicators to the WHO Secretariat annually. All bilateral and multilateral agencies are strengthening health workforce assessment and information exchange. 				
Global milestones (by 2030)	<ul style="list-style-type: none"> All countries are making progress towards halving inequalities in access to a health worker. All countries are making progress towards improving the course completion rates in medical, nursing and allied health professionals training institutions. All countries are making progress towards halving their dependency on foreign-trained health professionals, implementing the WHO Global Code of Practice. All bilateral and multilateral agencies are increasing synergies in official development assistance for education, employment, gender and health, in support of national health employment and economic growth priorities. As partners in the United Nations Sustainable Development Goals, to reduce barriers in access to health services by working to create, fill and sustain at least 10 million additional full-time jobs in health and social care sectors to address the needs of underserved populations. As partners in the United Nations Sustainable Development Goals, to make progress on Goal 3c to increase health financing and the recruitment, development, training and retention of the health workforce. 				
Core WHO Secretariat activities in support of implementation of the Global Strategy	<table border="1"> <tr> <td data-bbox="959 1391 991 1839">Develop normative guidance; set the agenda for operations research to identify evidence-based policy options; facilitate the sharing of best practices; and provide technical cooperation on – health workforce education, optimizing the scope of practice of different cadres, evidence-based deployment and retention strategies, gender mainstreaming, availability, accessibility,</td> <td data-bbox="991 1391 1023 1839">Provide normative guidance and technical cooperation, and facilitate the sharing of best practices on health workforce planning and projections, health system needs, education policies, health labour market analyses, and costing of national strategies on human resources for health. Strengthen evidence on, and the adoption of, macroeconomic and</td> <td data-bbox="1023 1391 1054 1839">Provide technical cooperation and capacity-building to develop core competency in policy, planning and management of human resources for health focused on health system needs. Foster effective coordination, alignment and accountability of the global agenda on human resources for health by facilitating a network of international stakeholders.</td> <td data-bbox="1054 1391 1086 1839">Review the utility of, and support the development, strengthening and update of tools, guidelines and databases relating to data and evidence on human resources for health for routine and emergency settings. Facilitate yearly reporting by countries to the WHO Secretariat on a minimum set of core indicators of human resources for</td> </tr> </table>	Develop normative guidance; set the agenda for operations research to identify evidence-based policy options; facilitate the sharing of best practices; and provide technical cooperation on – health workforce education, optimizing the scope of practice of different cadres, evidence-based deployment and retention strategies, gender mainstreaming, availability, accessibility,	Provide normative guidance and technical cooperation, and facilitate the sharing of best practices on health workforce planning and projections, health system needs, education policies, health labour market analyses, and costing of national strategies on human resources for health. Strengthen evidence on, and the adoption of, macroeconomic and	Provide technical cooperation and capacity-building to develop core competency in policy, planning and management of human resources for health focused on health system needs. Foster effective coordination, alignment and accountability of the global agenda on human resources for health by facilitating a network of international stakeholders.	Review the utility of, and support the development, strengthening and update of tools, guidelines and databases relating to data and evidence on human resources for health for routine and emergency settings. Facilitate yearly reporting by countries to the WHO Secretariat on a minimum set of core indicators of human resources for
Develop normative guidance; set the agenda for operations research to identify evidence-based policy options; facilitate the sharing of best practices; and provide technical cooperation on – health workforce education, optimizing the scope of practice of different cadres, evidence-based deployment and retention strategies, gender mainstreaming, availability, accessibility,	Provide normative guidance and technical cooperation, and facilitate the sharing of best practices on health workforce planning and projections, health system needs, education policies, health labour market analyses, and costing of national strategies on human resources for health. Strengthen evidence on, and the adoption of, macroeconomic and	Provide technical cooperation and capacity-building to develop core competency in policy, planning and management of human resources for health focused on health system needs. Foster effective coordination, alignment and accountability of the global agenda on human resources for health by facilitating a network of international stakeholders.	Review the utility of, and support the development, strengthening and update of tools, guidelines and databases relating to data and evidence on human resources for health for routine and emergency settings. Facilitate yearly reporting by countries to the WHO Secretariat on a minimum set of core indicators of human resources for		

	<p>acceptability, coverage, quality control and performance enhancement approaches, including the strengthening of public regulation.</p>	<p>funding policies conducive to greater and more strategically targeted investments in human resources for health.</p>	<p>Systematically assess the health workforce implications resulting from technical or policy recommendations presented at the World Health Assembly and regional committees.</p> <p>Provide technical cooperation to develop health system capacities and workforce competency, including to manage the risks of emergencies and disasters.</p>	<p>health, for monitoring and accountability for the Global Strategy.</p> <p>Support countries to establish and strengthen a standard for the quality and completeness of national health workforce data.</p> <p>Streamline and integrate all requirements for reporting on human resources for health by WHO Member States.</p> <p>Adapt, integrate and link the monitoring of targets in the Global Strategy to the emerging accountability framework of the UN Sustainable Development Goals.</p> <p>Develop mechanisms to enable collection of data to prepare and submit a report on the protection of health workers, which compiles and analyses the experiences of Member States and presents recommendations for action to be taken by relevant stakeholders, including appropriate preventive measures.</p>
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Background: the 21st century context for a progressive health workforce agenda

6. **Health systems can only function with health workers; improving health service coverage and realizing the right to the enjoyment of the highest attainable standard of health is dependent on their availability, accessibility, acceptability and quality.**¹ Mere availability of health workers is not sufficient: only when they are equitably distributed and accessible by the population, when they possess the required competency, and are motivated and empowered to deliver quality care that is appropriate and acceptable to the sociocultural expectations of the population, and when they are adequately supported by the health system, can theoretical coverage translate into effective service coverage (Figure 1). However, countries at all levels of socioeconomic development face, to varying degrees, difficulties in the education, deployment, retention, and performance of their workforce. Health priorities of the post-2015 agenda for sustainable development – such as ending AIDS, tuberculosis and malaria; achieving drastic reductions in maternal mortality; expanding access to essential surgical services; ending preventable deaths of newborns and children under-5; reducing premature mortality from noncommunicable diseases; promoting mental health; addressing chronic diseases and guaranteeing UHC – will remain aspirational unless accompanied by strategies involving transformational efforts on health workforce capability. Countries in, or emerging from, armed conflict, natural or man-made disasters, those hosting refugees, and those with climate change vulnerability, present specific health workforce challenges that should be taken into account and addressed. Further, every Member State should have the ability to implement effective disaster risk reduction and preparedness measures, and fulfil their obligations envisaged in the International Health Regulations (2005).² This requires a skilled, trained and supported health workforce.³

Figure 1. Human resources for health: availability, accessibility, acceptability, quality and effective coverage



Source: Campbell et al., 2013.

¹ Global Health Workforce Alliance. A universal truth: no health without a workforce. Report of Third Global Forum on Human Resources for Health, Recife, Brazil. Geneva: World Health Organization; 2014 (<http://www.who.int/workforcealliance/knowledge/resources/hrhreport2013/en/>, accessed 13 February 2015).

² International health regulations (2005), 2nd ed. Geneva: World Health Organization; 2008 (<http://www.who.int/ihr/publications/9789241596664/en/>, accessed 13 February 2015).

³ The world health report 2007 – a safer future: global public health security in the 21st century. Geneva: World Health Organization; 2007 (<http://www.who.int/whr/2007/en/>, accessed 13 February 2015).

7. **The health workforce has a vital role in building the resilience of communities and health systems to respond to disasters caused by natural or man-made hazards, as well as related environmental, technological and biological hazards and risks.** The health consequences of these events are often devastating, including high numbers of deaths, injuries, illnesses and disabilities. Such events can interfere with health service delivery through loss of health staff, damage to health facilities, interruption of health programmes, and overburdening of clinical services. Investment in the health workforce, in improving health service coverage and in emergency and disaster risk management not only builds health resilience and health security, it also reduces health vulnerability and provides the human resources required to prevent, prepare for, respond to, and recover from emergencies. Greater focus is required on the various roles of the entire health workforce in emergencies, for example in planning for staffing requirements (including surge capacity for emergency response¹), training and protection, involving them in preparedness and response, and measures for adaptation to climate change in the health sector.

8. **Despite significant progress, there is a need to boost political will and mobilize resources for the workforce agenda** as part of broader efforts to strengthen and adequately finance health systems. Past efforts in health workforce development have yielded significant results: examples abound of countries that, by addressing their health workforce challenges, have improved health outcomes.^{2,3} In addition, at the aggregate level, health workforce availability is improving for the majority of countries for which data are available, although often not rapidly enough to keep pace with population growth.³ Overall, progress has not been fast enough or deep enough. Shortages, skill-mix imbalances, maldistribution, barriers to inter-professional collaboration, inefficient use of resources, poor working conditions, a skewed gender distribution, limited availability of health workforce data – all these persist, with an ageing workforce further complicating the picture in many cases. Reviewing past efforts in implementing national, regional and global strategies and frameworks, the key challenge is how to mobilize political will and financial resources for the health system and its critical HRH component in the longer term.^{4,5}

9. **The health workforce will be critical to achieve health and wider development objectives in the next decades.** The United Nations General Assembly (UNGA) has adopted a new set of Sustainable Development Goals (SDGs) for 2016–2030. The SDGs follow the Millennium Development Goals of the period 2000–2015, with a call to action to people and leaders across the world to ensure a life of dignity for all.⁶ The health workforce underpins the proposed health goal, with a target (3c) to “substantially increase health financing, and the recruitment, development and

¹ Planning for surge capacity includes through global, regional and national emergency workforces, in line with the provisions envisaged in WHA68(10), 2014 Ebola virus disease outbreak and follow-up to the Special Session of the Executive Board on the Ebola Emergency (http://apps.who.int/gb/ebwha/pdf_files/WHA68-REC1/A68_R1_REC1-en.pdf#page=27).

² Campbell J, Buchan J, Cometto G, David B, Dussault G, Fogstad H et al. Human resources for health and universal health coverage: fostering equity and effective coverage. *Bull World Health Organ.* 2013; 91(11):853–63.

³ Van Lerberghe W, Matthews Z, Achadi E, Ancona C, Campbell J, Channon A et al. Country experience with strengthening of health systems and deployment of midwives in countries with high maternal mortality. *Lancet.* 2014; 384(9949):1215–25.

⁴ DeLuca MA, Soucat A, editors. *Transforming the global health workforce.* New York: New York University College of Nursing; 2013.

⁵ Cometto G, Boerma T, Campbell J, Dare L, Evans T. The third Global Forum: framing the health workforce agenda for universal health coverage. *Lancet Glob Health.* 2013; (6):e324–5.

⁶ The road to dignity by 2030: ending poverty, transforming all lives and protecting the planet. Synthesis report of the Secretary-General on the post-2015 agenda. New York: United Nations; 2014 (http://www.un.org/disabilities/documents/reports/SG_Synthesis_Report_Road_to_Dignity_by_2030.pdf, accessed 13 February 2015).

training and retention of the health workforce in developing countries, especially in least developed countries and small island developing States". In 2014, the World Health Assembly recognized that the health goal and its 13 health targets – including a renewed focus on equity and UHC – would only be attained through substantive and strategic investment in the global health workforce. In resolution WHA67.24, Member States requested the WHO Director-General to develop a global strategy on HRH and submit this to the Sixty-ninth World Health Assembly in May 2016.¹

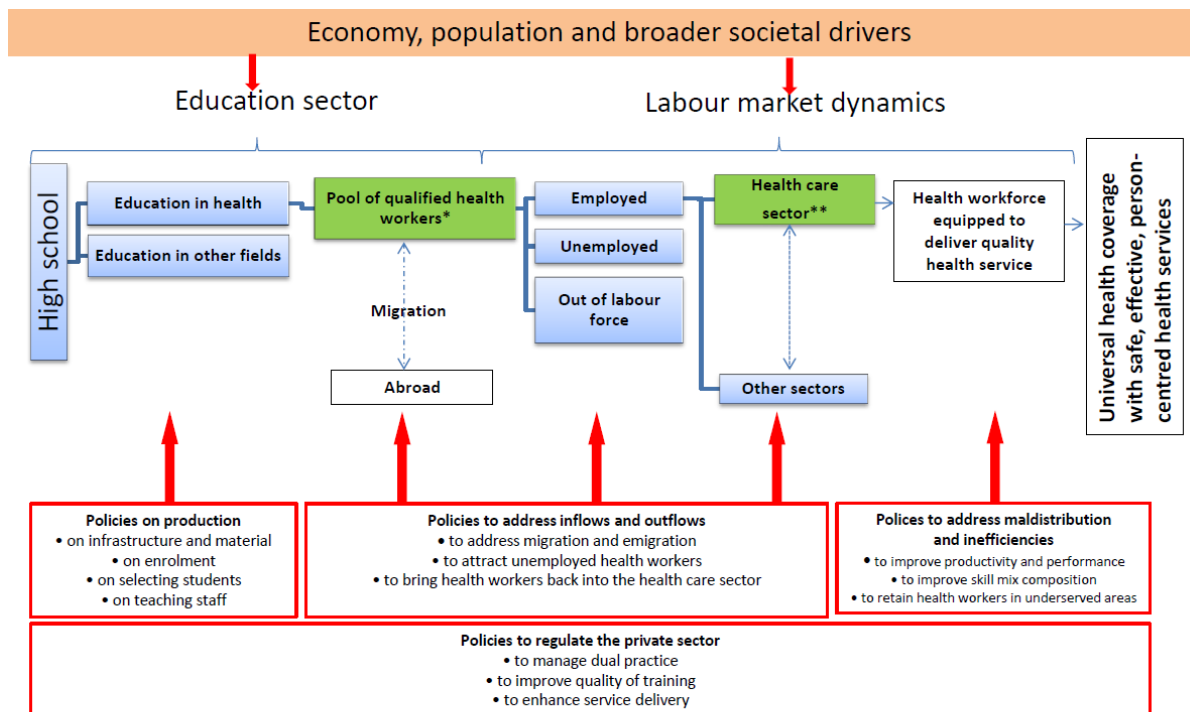
10. Globally, investment in the health workforce is lower than is often assumed,² reducing the sustainability of the workforce and health systems. The chronic under-investment in education and training of health workers in some countries and the mismatch between education strategies in relation to health systems and population needs are resulting in continuous shortages. These are compounded by difficulties in deploying health workers to rural, remote and underserved areas. Shortages and distribution challenges contribute to global labour mobility and the international recruitment of health workers from low-resource settings. In some countries, in addition to major under-investment in education, particularly in underserved areas, imbalances between supply capacity and the market-based demand determined by fiscal space, and between demand and population needs, result in challenges in universal access to health workers within strengthened health systems, and even the paradox of health worker unemployment co-existing with major unmet health needs.

11. The foundation for a strong and effective health workforce, able to respond to the 21st century priorities, requires matching effectively the supply and skills of health workers to population needs, now and in the future. The health workforce also has an important role in contributing to the preparedness and response to emergencies and disasters, in particular through participation in national health emergency management systems, local leadership and the provision of health services. Evolving epidemiologic profiles and population structures are increasing the burden of noncommunicable diseases and chronic conditions on health systems throughout the world.³ This is accompanied by a progressive shift in the demand for patient-centred care, community-based health services, and personalized long-term care.² Demand for the global health workforce is therefore expected to grow substantially. At the same time, emerging economies are undergoing an economic transition that will increase their health resource envelope, and a demographic transition that will see hundreds of millions of potential new entrants into the active workforce. Attaining the necessary quantity, quality and relevance of the health workforce will require that policy and funding decisions on both the education and health labour market are aligned with these evolving needs (Figure 2).

¹ Resolution WHA67.24. Follow-up of the Recife Political Declaration on Human Resources for Health: renewed commitments towards universal health coverage. In: Sixty-seventh World Health Assembly, Geneva, 19–24 May 2014. Resolutions and decisions, annexes. Geneva: World Health Organization; 2014 (WHA67/2014/REC/1; (http://apps.who.int/gb/ebwha/pdf_files/WHA67/A67_R24-en.pdf?ua=1, accessed 5 June 2015).

² Hernandez P, Poullier J, Van Mosseveld C, Van de Maele N, Cherilova V, Indikadahena C et al. Health worker remuneration in WHO Member States. *Bull World Health Organ.* 2013; 91(11):808–15.

³ GBD 2013 Mortality and Causes of Death Collaborators. Global, regional, and national age-sex specific all-cause and cause-specific mortality for 240 causes of death, 1990–2013: a systematic analysis for the Global Burden of Disease Study 2013. *Lancet.* 2015; 385(9963):117–71.

Figure 2. Policy levers to shape health labour markets

*Supply of health workers= pool of qualified health workers willing to work in the health-care sector.

**Demand of health workers= public and private institutions that constitute the health-care sector.

Source: Sousa A, Scheffler M R, Nyoni J, Boerma T "A comprehensive health labour market framework for universal health coverage" Bull World Health Organ 2013;91:892– 894

Source: adapted from Sousa et al., 2013.

12. **Persistent health workforce challenges, combined with these broader macro-trends, require the global community to reappraise the effectiveness of past strategies and adopt a paradigm shift in how to plan, educate, deploy, manage and reward health workers.** Transformative advances alongside a more effective use of existing health workers are both needed and possible through: the adoption of inclusive models of care encompassing promotive, preventive, curative, rehabilitative and palliative services; by reorienting health systems towards a collaborative primary care approach built on team-based care; and by fully harnessing the potential of technological innovation. In parallel, much-needed investment and reform in the health workforce can be leveraged to create qualified employment opportunities, in particular for women and youth. These prospects represent an unprecedented occasion to design and implement health workforce strategies that address the equity and coverage gaps faced by health systems, while also unlocking economic growth potential. Realizing this potential hinges on the mobilization of political will and building institutional and human capacity for the effective implementation of this agenda.

13. **The vision that by 2030 all communities have universal access to health workers, without stigma and discrimination, requires combining the adoption of effective policies at national, regional and global levels with adequate investment to address unmet needs.** Realistically, the scale-up required in the coming decades to meet increasing demand, address existing gaps and counter expected turnover is greater than all previous estimates. Projections developed by WHO and the World Bank (Appendix 1) point to the creation of approximately 40 million new health and social care

jobs globally to 2030,¹ and to the need for 18 million additional health workers, primarily in low-resource settings, to attain high and effective coverage of the broad range of health services necessary to ensure healthy lives for all.

14. It has long been known *what* needs to be done to address critical health workforce bottlenecks; now there is better evidence than ever on *how* to do it. The global strategy on human resources for health: Workforce 2030 considers new evidence and best practices on what works in health workforce development for different aspects. These range from assessment, planning and education, across management, retention, incentives and productivity; several WHO tools and guidelines can support policy development, implementation and evaluation in these areas (Appendix 2). The Global Strategy addresses all these aspects in an integrated way in order to inspire and inform more incisive action by all relevant sectors of government and all key stakeholders, at national level by planners and policy-makers, and at regional and global level by the international community. Given the intersectoral nature and potential impacts of health workforce development, the Global Strategy aims to stimulate not only the development of national health and HRH strategies, but also the broader socioeconomic development frameworks that countries adopt.

15. As human resources for health represent an enabler to many service delivery priorities, this Strategy complements and reinforces a range of related strategies developed by WHO and the United Nations. The Strategy reaffirms in particular the importance of the WHO Global Code of Practice on the International Recruitment of Health Personnel,² which calls upon countries to strive to use their own HRH to meet their needs, to collaborate towards more ethical and fair international recruitment practices, and to respect the rights of migrant health workers; it builds upon related regional strategies and frameworks such as the Toronto Call to Action³ and the African Roadmap on Human Resources for Health;⁴ and it provides a foundation for the work of the High-Level Commission on Health Employment and Economic Growth,⁵ established by the United Nations Secretary-General following UNGA Resolution 70/183.⁶ The Strategy also supports, among others, the goals and principles of the UN Global Strategy for Women's, Children's and Adolescents'

¹ Economic, demographic, and epidemiological transitions and the future of health labour markets. [Technical Working Group 1 synthesis paper for the Global Strategy on Human Resources for Health, 28 September 2014]. Global Health Workforce Alliance; 2014 (http://www.who.int/workforcealliance/media/news/2014/WG1_SynthesisSept282014.pdf?ua=1, accessed 14 February 2015).

² Resolution WHA63.16. WHO Global Code of Practice on the International Recruitment of Health Personnel. In: Sixty-third World Health Assembly, Geneva, 17–21 May 2010. Resolutions and decisions, annexes. Geneva: World Health Organization; 2010 (WHA63/2010/REC/1; (http://apps.who.int/gb/ebwha/pdf_files/WHA63/A63_R16-en.pdf, accessed 13 February 2015).

³ Pan American Health Organization, Health Canada, and the Ontario Ministry of Health and Long-Term Care. Toronto call to action: towards a decade of human resources for health in the Americas. Washington DC: Pan American Health Organization; 2005 (http://www.bvsde.paho.org/bvsdeescuelas/fulltext/CallAction_eng1.pdf, accessed 30 December 2015).

⁴ Road map for scaling up the human resources for health: for improved health service delivery in the African Region 2012–2025. Brazzaville: WHO Regional Office for Africa; 2012 (http://www.hrh-observatory.afro.who.int/images/4th_HRHConsultation/Road-map-HRH_EN.pdf, accessed 25 October 2015).

⁵ United Nations High-Level Commission on Health Employment and Economic Growth, 2 March 2016 (<http://www.who.int/hrh/com-heeg/en/>, accessed 14 March 2016).

⁶ Global health and foreign policy: strengthening the management of international health crises. New York: United Nations, 2016 (Resolution A/RES/70/183, http://www.un.org/en/ga/search/view_doc.asp?symbol=A/RES/70/183, accessed 14 March 2016).

Health,¹ the WHO framework on integrated people-centred health services,² the Every Newborn Action Plan,² the Family Planning 2020 objectives,³ the Global Plan towards the Elimination of New HIV Infections,⁴ the emerging UNAIDS 2016–2021 strategy,⁵ the Global Action Plan for the Prevention and Control of Noncommunicable Diseases,⁶ the WHO Disability Action Plan,⁷ UNGA Resolution 69/132 on Global health and foreign policy⁸ and the Sendai Framework for Disaster Risk Reduction 2015–2030.⁹

16. **This is a cross-cutting agenda that represents the critical pathway to attain coverage targets across all service delivery priorities.** It affects not only the better known cadres of midwives, nurses and physicians, but all health workers, from community to specialist levels, including but not limited to: community-based and mid-level practitioners, dentists and oral health professionals, hearing care and eye care workers, laboratory technicians, biomedical engineers, pharmacists, physical therapists and chiropractors, public health professionals and health managers, supply chain managers, and other allied health professions and support workers. The Strategy recognizes that diversity in the health workforce is an opportunity to be harnessed through strengthened collaborative approaches to social accountability, inter-professional education and practice, and closer integration of the health and social services workforces to improve long-term care for ageing populations.

17. **The Global strategy on human resources for health outlines policy options for WHO Member States, responsibilities of the WHO Secretariat and recommendations for other stakeholders** on how to:

- optimize the health workforce to accelerate progress towards UHC and the SDG (objective 1);
- understand and prepare for future needs of health systems, harnessing the rising demand in health labour markets to maximize job creation and economic growth (objective 2);
- build the institutional capacity to implement this agenda (objective 3); and

¹ United Nations Secretary General's Global Strategy for Women's, Children's and Adolescents' Health – zero draft for consultation, 5 May 2015 (http://www.who.int/life-course/partners/global-strategy/global-strategy_zero-draft.pdf, accessed 5 June 2015).

² World Health Organization and United Nations Children's Fund. Every newborn: an action plan to end preventable deaths. Geneva: World Health Organization; 2014 (http://apps.who.int/iris/bitstream/10665/127938/1/9789241507448_eng.pdf, accessed 14 February 2015).

³ Family Planning 2020 (<http://www.familyplanning2020.org/>).

⁴ 90-90-90: an ambitious treatment target to help end the AIDS epidemic. Geneva: Joint United Nations Programme on HIV/AIDS; 2014 (http://www.unaids.org/sites/default/files/media_asset/90-90-90_en_0.pdf, accessed 14 February 2015).

⁵ Timeline: Developing the UNAIDS 2016-21 Strategy. Geneva: Joint United Nations Programme on HIV/AIDS; 2015 (http://www.unaids.org/en/resources/campaigns/20150301_strategy_consultation/timeline, accessed 5 June 2015).

⁶ Global action plan for the prevention and control of noncommunicable diseases 2013–2020. Geneva: World Health Organization; 2013 (http://apps.who.int/iris/bitstream/10665/94384/1/9789241506236_eng.pdf?ua=1, accessed 14 February 2015).

⁷ WHO global disability action plan 2014–2021: Better health for all people with disability. Geneva: World Health Organization; 2015 (<http://www.who.int/disabilities/actionplan/en/>, accessed 19 October 2015).

⁸ Global health and foreign policy. United Nations General Assembly Resolution 69/132, 11 December 2014. New York: United Nations; 2015 (http://www.un.org/en/ga/search/view_doc.asp?symbol=A/RES/69/132, accessed 30 December 2015).

⁹ Sendai Framework for Disaster Risk Reduction 2015–2030. New York: United Nations; 2015 (http://www.unisdr.org/files/43291_sendaiframeworkfordrren.pdf, accessed 25 October 2015).

- strengthen data on HRH for monitoring and ensuring accountability of implementation of both national strategies and the Global Strategy itself (objective 4).

Each objective is described in detail in the following sections.

Objective 1: Optimize performance, quality and impact of the health workforce through evidence-informed policies on human resources for health, contributing to healthy lives and well-being, effective universal health coverage, resilience and strengthened health systems at all levels

Milestones:

- **1.1 By 2020, all countries will have established accreditation mechanisms for health training institutions.**
- **1.2 By 2030, all countries will have made progress towards halving inequalities in access to a health worker.**
- **1.3 By 2030, all countries will have made progress towards improving the course completion rates in medical, nursing and allied health professionals training institutions.**

18. **Addressing population needs for the SDGs and UHC requires making the best possible use of limited resources, and ensuring they are employed strategically through adoption and implementation of evidence-based health workforce policies tailored to the national health system context at all levels.** The ongoing challenges of health workforce deficits and imbalances, combined with ageing populations and epidemiologic transformations, require a new, contemporary agenda with an unprecedented level of ambition. Better alignment to population needs, while improving cost-effectiveness, depends on recognition that integrated and people-centred health-care services can benefit from team-based care at the primary level.^{1,2} This approach exploits the potential contribution of different typologies of health worker, operating in closer collaboration and according to a more rational scope of practice, which entails health workers operating within the full scope of their profession while avoiding under-utilization of skills. For example, the nursing scope of practice has been shown to be adaptable to population and patient health needs, and has been particularly successful in delivering services to the most vulnerable and hard-to-reach populations.³ Similarly, the midwifery scope of practice has the potential to provide 87% of the essential care needed for sexual, reproductive, maternal and newborn health services.⁴ Realizing this agenda requires the following: adoption of more effective and efficient strategies and appropriate regulation for health workforce education; a more sustainable and responsive skills mix, harnessing opportunities from the education

¹ Milani RV, Lavie CJ. Health care 2020: reengineering health care delivery to combat chronic disease. *Am J Med.* 2015; 128(4):337–43.

² Resolution WHA62.12. Primary health care, including health system strengthening. In: Sixty-second World Health Assembly, Geneva, 18–22 May 2009. Resolutions and decisions, annexes. Geneva: World Health Organization; 2009 (WHA62/2009/REC/1; <http://apps.who.int/medicinedocs/documents/s17694en/s17694en.pdf>, accessed 19 October 2015).

³ Nursing and midwifery services – Strategic directions 2011–2015. Geneva: World Health Organization; 2010 (<http://www.who.int/hrh/resources/nmsd/en/>, accessed 22 February 2016).

⁴ The state of the world's midwifery 2014. New York: United Nations Population Fund; 2014 (<http://www.unfpa.org/sowmy>, accessed 13 February 2015).

and deployment of community-based and mid-level health workers; improved deployment strategies and working conditions; incentive systems; enhanced social accountability; inter-professional collaboration; and continuous professional development opportunities and career pathways tailored to gender-specific needs in order to enhance both capacity and motivation for improved performance.

19. Dramatic improvement in efficiency can be attained by strengthening the ability of national institutions to devise and implement more effective strategies and appropriate regulation for the health workforce. There are major opportunities to ensure a more effective and efficient use of resources and a better alignment with community needs. This can be achieved by adopting a person-centred health-care delivery model and a diverse, sustainable skills mix geared to primary health care and supported by effective referral and links through all levels of care to the social services workforce. Similarly, major gains are possible in performance and productivity by improving management systems and working conditions¹ for HRH, and by using the support of, and collaboration with the private for-profit, voluntary and independent sectors. These sectors should be regulated, and incentives elaborated for closer alignment of their operations and service delivery profiles with public sector health goals. Realizing these efficiency gains requires institutional capacity to implement, assess and improve HRH planning, education, regulation and management policies.

Policy options for WHO Member States

20. Most of the proposed policy options in this and subsequent sections are of general relevance and may be considered by countries at all levels of socioeconomic development. Policy options that may be particularly relevant in some countries are explicitly indicated. This distinction is not rigid, given that the situation of countries can change over time, and that the broader socioeconomic conditions of a country do not necessarily and directly correspond to the status of health workforce policies. Furthermore, similar health workforce and health system challenges may apply in different settings, albeit with context-specific implications on funding, employment and labour market dynamics. Ultimately the relevance and applicability of policy options must be determined and tailored to the specific reality of each WHO Member State, in relation to the needs of the population, education policies and health system requirements, including during emergencies. Similarly, the responsibilities of the WHO Secretariat are understood to be in relation to demand for support expressed by Member States.

Policy options to be considered in all countries

21. **Strengthen the content and implementation of HRH plans as part of long-term national health and broader development strategies to strengthen health systems,** ensuring consistency between health, education, employment, gender, migration, development cooperation and fiscal policies. This will benefit from intersectoral dialogue and alignment among relevant ministries (health, labour, education, finance, etc.), professional associations, labour unions, civil society, employers, the private sector, local government authorities, and other constituencies. Planning should take into account workforce needs as a whole, rather than treating each profession separately. Such an integrated approach has to consider population and health system needs, adjusting investment volumes, education policies on the intake of trainees, and incentive mechanisms as needed. This is required to redress prevalent labour market failures – such as shortages, maldistribution and unemployment of

¹ C149 – Nursing Personnel Convention, 1977 (No. 149). Convention concerning Employment and Conditions of Work and Life of Nursing Personnel. Geneva: International Labour Office; 1977 (http://www.ilo.org/dyn/normlex/en/f?p=NORMLEXPUB:12100:0::NO::P12100_INSTRUMENT_ID:312294, accessed 11 February 2016).

health workers co-existing with unmet health needs. HRH development is a continuous process that requires regular appraisal of results and feedback loops to inform and adjust priorities.

22. Promote decent working conditions in all settings.¹ Ministries of health, civil service commissions and employers should adopt gender-sensitive employment conditions, remuneration and non-financial incentives. They should cooperate to ensure occupational health and safety, fair terms for health workers, merit-based career development opportunities and a positive practice environment to enable their effective deployment, retention and adequate motivation to deliver quality care and build a positive relationship with patients. Gender-based discrimination, violence and harassment during training, recruitment/employment and in the workplace should be eliminated. It is particularly important to ensure that public sector rules and practices are conducive to adequate incentive mechanisms, working conditions and career structures for health workers, with appropriate levels of flexibility and autonomy.

23. Ensure the effective use of available resources. Globally, 20–40% of all health spending is wasted,² with health workforce inefficiencies and weaknesses in governance and oversight responsible for a significant proportion of that. Accountability systems should be put in place to improve efficiency of health and HRH spending. In addition to measures such as improving pre-service training completion rates and removing ghost workers from the payroll,³ it is critical to adopt appropriate, cost-effective and equitable population health approaches to provide community-based, person-centred, continuous and integrated care. This entails implementing health-care delivery models with an appropriate and sustainable skills mix in order to meet population health needs equitably. Health systems should thus align market forces and population expectations with primary health care needs, universal access to health care and people-centred integrated service delivery, supported by effective referral to secondary and specialized care, while avoiding over-medicalization and unnecessary interventions. There is a need to modify and correct the configuration and supply of specialists and generalists, advanced practitioners, the nursing and midwifery workforce, and other mid-level and community-based cadres. Enabling public policy stewardship and regulation are needed to formally recognize all these positions and allow them to practice to their full scope. Appropriate planning and education strategies and incentives, adequate investment in the health-care workforce, including general practice and family medicine, are required to provide community-based, person-centred, continuous, equitable and integrated care.

24. Adopt transformative strategies in the scale-up of health worker education. Public and private sector investments in health personnel education should be linked with population needs and health system demands. Education strategies should focus investment in trainers, for which there is good evidence of a high social rate of return. Priority should also focus on orienting curricula to balance the pressure to train for international markets, and on producing professionals capable of

¹ The notion of decent work entails opportunities for work that is productive and delivers a fair income, security in the workplace and social protection for families, better prospects for personal development and social integration, freedom for people to express their concerns, organize and participate in the decisions that affect their lives, and equality of opportunity and treatment for all women and men (<http://www.ilo.org/global/topics/decent-work/lang--en/index.htm>).

² The world health report 2010 – health systems financing: the path to universal health coverage. Geneva: World Health Organization; 2010 (<http://www.who.int/whr/2010/en/>, accessed 15 February 2015).

³ Dominican Republic's health sector reinvests savings from ghost workers to improve care. Intrahealth International; 2010 (<http://www.intrahealth.org/page/dominican-republics-health-sector-reinvests-savings-from-ghost-workers-to-improve-care>, accessed 15 February 2015).

meeting local needs,¹ promoting technical, vocational education and social accountability approaches that improve the geographic distribution of health workers. A coordinated approach is needed to link HRH planning and education (including an adequate and gender-balanced pipeline of qualified trainees from rural and remote areas), and encourage inter-professional education and collaborative practice. Education standards and funding should be established and monitored in national policies: radical improvements in the quality of the workforce are possible if the higher education and health sector collaborate by implementing a transformative education agenda² grounded in competency-based learning. This approach should equip health workers with skills to work collaboratively in inter-professional teams, with knowledge to intervene effectively on social determinants of health and expertise in public health. This must include epidemic preparedness and response to advance the implementation of the International Health Regulations (2005). The social mission of health education institutions represents an opportunity to nurture in health workers the public service ethics, professional values and social accountability attitudes requisite to deliver respectful care that responds to local needs and population expectations. Particular account should be taken of the needs of vulnerable groups such as children, adolescents and people with disabilities; ethnic or linguistic minorities and indigenous populations; as well as the need to eliminate discrimination related to gender, ageing, mental health, sexual and reproductive health, and HIV and AIDS among others. Opportunities should be considered for North–South and South–South collaboration, as well as public–private partnerships on training and investment, maximizing opportunities for skills transfer and mutual benefit, and minimizing negative consequences of international mobility of health personnel. This includes advances in e-learning and putting in place mechanisms to track and manage education investments in individual health workers and their continuing professional development.

25. Optimize health worker motivation, satisfaction, retention, equitable distribution and performance. While urbanization trends and the potential of telemedicine may, in some contexts, reduce the acute challenge of geographical maldistribution, in the majority of settings access to health workers remains inequitable. The “decent employment” agenda entails strategies to improve both performance and equitable distribution of health workers. Such an integrated package of gender-sensitive attraction and retention policies includes: job security, a manageable workload, supportive supervision and organizational management, continuing education and professional development opportunities, enhanced career development pathways (including rotation schemes where appropriate), family and lifestyle incentives, hardship allowances, housing and education allowances and grants, adequate facilities and working tools, and measures to improve occupational health and safety, including a working environment free from any type of violence, discrimination and harassment. The adoption of specific measures in a given country context has to be determined in relation to cost-effectiveness and sustainability considerations, and may be aided by employee satisfaction surveys to adapt working conditions to health worker feedback. Critical to ensuring equitable deployment of health workers are the selection of trainees from, and delivery of training in, rural and underserved areas, financial and non-financial incentives, and regulatory measures or service delivery reorganization.³

¹ McPake B, Squires A, Mahat A, Araujo EC, editors. The economics of health professional education and careers: insights from a literature review. Washington DC: World Bank; 2015.

² Frenk J, Chen L, Bhutta ZA, Cohen J, Crisp N, Evans T et al. Health professionals for a new century: transforming education to strengthen health systems in an interdependent world. *Lancet*. 2010; 376(9756):1923–58.

³ Buchan J, Couper ID, Tangcharoensathien V, Thepannyaet K, Jaskiewicz W, Perfilieva, Dolea C. Early implementation of WHO recommendations for the retention of health workers in remote and rural areas. *Bull World Health Organ*. 2013; 91(11):834–40.

26. **Harness – where feasible and cost-effective – information and communication technology (ICT) opportunities.** New ICT tools can be of particular relevance in relation to e-learning, electronic health records, telemedicine, clinical decision-making tools, links among professionals and between professionals and patients, supply chain management, performance management and feedback loops, patient safety,¹ service quality control, and the promotion of patient autonomy.² New professional qualifications, skills and competency are needed to harness the potential of ICT solutions to health-care delivery.³ Standards, accreditation procedures and evaluation activities should be established to certify and ensure the quality of training delivered through blended approaches that include e-learning; appropriate regulations should also be established for the provision of mobile health (m-health) services, and for handling workforce data that respects confidentiality requirements.⁴

27. **Build greater resilience and self-reliance in communities.** Engage them in shared decisions and choice through better patient-provider relations. Invest in health literacy, and empower patients and their families with knowledge and skills; this will encourage them to become key stakeholders and assets to a health system, and to collaborate actively in the production and quality assurance of care, rather than being passive recipients of services. Health workers should be equipped with the sociocultural skills to serve as an effective bridge between more empowered communities and more responsive health systems.

28. **Strengthen capacities of the domestic health workforce in emergency and disaster risk management for greater resilience and health-care response capacity.** Prepare health systems to develop and draw upon the capacities of the national health workforce in risk assessments, prevention, preparedness, response and recovery. Provide resources, training and equipment for the health workforce and include them in policy and implementation of operations for emergencies at local, national and international levels. Preparedness work should include efforts to build the capacity of national authorities at all levels in managing post-disaster and post-conflict recovery, in synergy with the longer-term health system strengthening and reform strategies.

29. **Enhance and promote the safety and protection of medical and health personnel.** Through UNGA Resolution 69/132, Member States, in cooperation as appropriate with relevant international organizations and non-State actors, have undertaken to develop effective preventive measures to enhance and promote the safety and protection of medical and health personnel, as well as respect for their respective professional codes of ethics, including but not restricted to:

- a. Clear and universally recognized definitions and norms for the identification and marking of medical and health personnel, their means of transport and installations;

¹ Bates D, Gawande AA. Improving safety with information. *N Engl J Med*. 2003; 348:2526–34.

² Information technology (IT) in the new global strategy on human resources for health. Breakout session at the GETHealth Summit, Dublin, Republic of Ireland, 14 November 2014 (http://www.who.int/workforcealliance/media/news/2014/4HSE_GlobalHealthProgrammeIreland.pdf?ua=1, accessed 15 February 2015).

³ Gregório J, Cavaco A, Lapão LV. A scenario-planning approach to human resources for health: the case of community pharmacists in Portugal. *Human Resources for Health*. 2014; 12:58.

⁴ Bollinger R, Chang L, Jafari R, O’Callaghan T, Ngatia P, Settle D et al. Leveraging information technology to bridge the health workforce gap. *Bull World Health Organ*. 2013; 91(11):890–1.

- b. Specific and appropriate educational measures for medical and health personnel, State employees and the general population;
- c. Appropriate measures for the physical protection of medical and health personnel, their means of transport and installations;
- d. Other appropriate measures, such as national legal frameworks where warranted, to effectively address violence against medical and health personnel;
- e. Collection of data on obstruction, threats and physical attacks on health workers.

Policy options to be considered in some countries, depending on context

30. **Strengthen the capacity and quality of educational institutions and their faculty through accreditation of training schools and certification of diplomas awarded to health workers.** This should meet current and future education requirements to respond to population health needs and changing clinical practice. In some contexts, this may entail redesigning health workforce intake approaches through joint education and health planning mechanisms. In some countries, there is a particular need to collaborate with the Ministry of Education and renew focus on primary and secondary education to enhance science teaching. This renewed focus should also ensure an adequate and gender-balanced pool of eligible high-school graduates, reflective of the population's underlying demographic characteristics and distribution, to enter health training programmes, in order to improve health workforce distribution and enhance a person-centred approach. The faculty of health training institutions represents a priority investment area, both in terms of adequate numbers and in relation to building and updating their competency to teach using updated curricula and training methodologies, and to lead research activities independently.

31. **Ensure that the foreseen expansion of the health resource envelope leads to cost-effective resource allocation.** Specifically, prioritize the deployment of inter-professional primary care teams of health workers with broad-based skills, avoiding the pitfalls and cost-escalation of overreliance on specialist and tertiary care. This requires adopting a diverse, sustainable skills mix, and harnessing the potential of community-based and mid-level health workers in inter-professional primary care teams.^{1,2} In many settings, developing a national policy to integrate, where they exist, community-based health workers in the health system can enable these cadres to benefit from adequate system support and to operate more effectively within integrated primary care teams,^{3,4} a trend already emerging in some countries. Support from national and international partners targeting an expansion of these cadres should align with national policies, regulations and systems.⁵ In some contexts,

¹ Lewin S, Munabi-Babigumira S, Glenton C, Daniels K, Bosch-Capblanch X, van Wyk BE et al. Lay health workers in primary and community health care for maternal and child health and the management of infectious diseases. *Cochrane Database Syst Rev.* 2010; 3.

² Lassi Z, Cometto G, Huicho L, Bhutta ZA. Quality of care provided by mid-level health workers: systematic review and meta-analysis. *Bull World Health Organ.* 2013; 91(11):824–33.

³ McCord GC, Liu A, Singh P. Deployment of community health workers across rural sub-Saharan Africa: financial considerations and operational assumptions. *Bull World Health Organ.* 2013; 91:244–53B.

⁴ Tulenko K, Møgedal S, Afzal MM, Frymus D, Oshin A, Pate M et al. Community health workers for universal health-care coverage: from fragmentation to synergy. *Bull World Health Organ.* 2013; 91:847–52.

⁵ Møgedal S, Wynd S, Afzal M. Community health workers and universal health coverage: a framework for partners' harmonised support [e-book]. Geneva: Global Health Workforce Alliance; 2013 (http://www.who.int/workforcealliance/knowledge/resources/frame_partner_support/en/, accessed 5 June 2015).

primary health care teams need to identify strategies to collaborate effectively with traditional healers and practitioners.

32. Optimize health workforce performance through a fair and formalized employment package, within an enabling and gender-sensitive working environment. This includes providing health workers with clear roles and expectations, guidelines, adequate work processes, gender-balanced opportunities to correct competency gaps, supportive feedback, group problem-solving, and a suitable work environment and incentives.¹ In addition – and crucially – the package should comprise a fair wage appropriate to skills and contributions, with timely and regular payment as a basic principle, meritocratic reward systems and opportunities for career advancement.

33. Governments to collaborate with professional councils and other regulatory authorities to adopt regulation² that takes into account transparency, accountability, proportionality, consistency, and that is targeted to the population's needs. Advancing this agenda requires strengthening the capacity of regulatory and accreditation authorities. Regulatory bodies should play a central role in ensuring that public and private sector professionals are competent, sufficiently experienced and adhere to agreed standards relative to the scope of practice and competency enshrined in regulation and legislative norms; countries should be supported in establishing or strengthening them to provide continuous updates to accreditation and credentialing. Regulatory bodies should also be actively engaged in policy-setting processes to improve the development and enforcement of standards and regulations, and in introducing competency-based national licensing and relicensing assessments for graduates from both public and private institutions. To avoid potential conflicts of interest, governments, professional councils and associations should create appropriate mechanisms to separate their role as guarantor of the quality of practice for the benefit of public health objectives from that of representing the interests of their members, where there are no clear boundaries between these functions.³

Responsibilities of the WHO Secretariat

34. Develop normative guidance, support operations research to identify evidence-based policy options, and facilitate technical cooperation when requested by Member States and relevant stakeholders. These responsibilities may cover: health workforce education; preventive measures for the safety and protection of health workers; optimizing the scope of practice of different cadres; evidence-based deployment and retention strategies; gender mainstreaming; and availability, accessibility, acceptability, quality control and performance enhancement approaches, including the strengthening of public regulation.

¹ Rowe A et al. Health care provider performance review. Near final results of a systematic review presented at a World Bank workshop, September 2014 (<http://www.worldbank.org/content/dam/Worldbank/Event/SIEF/20140905-quality-of-health-care-services-products/01-Health-care-provider-performance-review-Alexander-Rowe.pdf>, accessed 4 January 2016).

² “*Right-touch regulation* means always asking what risks we are trying to address, being proportionate and targeted in regulating that risk or finding ways other than regulation to address it. It is the minimum regulatory force required to achieve the desired result.” United Kingdom Professional Standards Authority.

Recommendations to other stakeholders and international partners

35. **Education institutions to adapt their institutional set-up and modalities of instruction to respond to transformative educational needs.** These should be aligned with country accreditation systems, standards and needs, and promote social accountability, inter-professional education and collaborative practice. Reflecting the growth in private education establishments, it is critical that quality standards are aligned across public and private training institutes. Both public and private education institutions need to overcome gender discrimination in admissions and teaching, and more generally to contribute to national education and student recruitment objectives.

36. **Professional councils to collaborate with governments to implement effective regulations for improved workforce competency, quality and efficiency.** Regulators should assume the following key roles: keep a live register of the health workforce; oversee accreditation of pre-service education programmes; implement mechanisms to assure continuing competence, including accreditation of post-licensure education providers; operate fair and transparent processes that support practitioner mobility and simultaneously protect the public; and facilitate a range of conduct and competence approaches that are proportionate to risk, and are efficient and effective to operate.¹ Governments, professional councils and associations should work together to develop appropriate task-sharing models and inter-professional collaboration, and ensure that all cadres with a clinical role, beyond dentists, midwives, nurses, pharmacists and physicians, also benefit in a systematic manner from accreditation and regulation processes. The sharing of experience among regulatory authorities across countries could facilitate the dissemination of best practices.

Objective 2: Align investment in human resources for health with the current and future needs of the population and health systems, taking account of labour market dynamics and education policies, to address shortages and improve distribution of health workers, so as to enable maximum improvements in health outcomes, social welfare, employment creation and economic growth

Milestones:

- **2.1 By 2030, all countries will have made progress towards halving their dependency on foreign-trained health professionals, implementing the WHO Global Code of Practice on the International Recruitment of Health Personnel.**
- **2.2 By 2030, all bilateral and multilateral agencies will have increased synergies in official development assistance for education, employment, gender and health, in support of national health employment and economic growth priorities.**
- **2.3 By 2030, partners in the Sustainable Development Goals will have made progress to reduce barriers in access to health services by working to create, fill and sustain at least 10 million additional full-time jobs in health- and social-care sectors to address the needs of underserved populations.**

¹ University Research Co., LLC. Improving health worker performance. Bethesda MD: United States Agency for International Development; 2014 (https://www.usaidassist.org/sites/assist/files/improving_health_worker_performance_feb2014.pdf, accessed 15 February 2015).

- **2.4 By 2030, partners in the UN Sustainable Development Goals will have made progress on Goal 3c to increase health financing and the recruitment, development, training and retention of health workforce.**

37. **The demand for and size of the global health workforce are forecasted to grow substantially in the next decades as a consequence of population and economic growth, combined with demographic and epidemiologic transitions.** Health-care provision will also change in nature in order to cover a growing range of patient services such as community care. There are, however, significant mismatches in the needs of, demand for and supply of health workers nationally, subnationally and globally, leading to inequitable distribution and deployment of health workers. The objective to achieve universal access to health care at all levels requires an adequate and equitable distribution of health workers across and within countries. Efforts to scale up essential actions and programmes to achieve the health-related targets of the SDGs might be compromised by a massive needs-based shortage of health workers in some countries (Appendix 1). This shortage is, in turn, also leading to an overreliance and burden on mid-level and community-based health workers. In parallel, many countries struggle to match supply and demand of health workers under affordability and sustainability constraints, experiencing periodic swings between shortage and over-supply. These trends, sometimes exacerbated by ageing populations, often result in underproduction and/or maldistribution of health workers, and disproportionate recruitment of foreign-trained health personnel.¹ In order to overcome these challenges, socially responsible measures need to be developed and implemented towards strengthening in an integrated manner all aspects of health workforce planning, financing, education, regulation and management.

38. **Public sector intervention is needed to recast the insufficient provision of health workers, their inequitable deployment and/or poor motivation and performance.** Implementing an HRH agenda conducive to attaining health goals in the post-2015 period will require greater availability and more efficient use of resources. Domestic spending on HRH averages 33.6% of total government expenditure on health in countries with available data¹² in many countries, greater efforts to mobilize domestic resources are both necessary and possible, and should be supported by appropriate macroeconomic policies at national and global levels. Funding levels should reflect the value of effective HRH to the country's economy by factoring the potential for improved worker productivity in other sectors.² However, some countries will require overseas development assistance for a few more decades to ensure both adequate fiscal space and strengthened governance of health systems in order for the HRH investments required to meet population needs and guarantee universal access to care. In this context, a high-level policy dialogue is warranted to explore how to make international mechanisms for development assistance (across education, employment, gender and health) fit-for-purpose, and allow these mechanisms to provide sustained investment in both capital and recurrent costs for HRH.

¹ Tankwanchi A, Ozden C, Vermund S. Physician emigration from sub-Saharan Africa to the United States: analysis of the 2011 AMA Physician Masterfile. *PLoS Medicine*. 2013; 10(12).

² Scheil-Adlung X, Wiskow C. ILO comments on draft papers of TWGs 1, 3, 7 & 8 [submission to the public consultation process on the Global Strategy on Human Resources for Health]. Global Health Workforce Alliance; 2014 (http://www.who.int/workforcealliance/media/news/2014/GHWA-consultation_ILO-comments.pdf?ua=1, accessed 14 February 2015).

39. **Evidence is starting to emerge on the broader socioeconomic impacts of health workforce investment.** Health-care employment has a significant growth-inducing effect on other sectors:¹ this, together with the expected growth in health labour markets, means that investing in health-care education and employment will increasingly represent a strategy for countries at all levels of socioeconomic development to create qualified jobs in the formal sector.² This should take place in the context of guaranteeing rights to all health workers, including a safe and decent work environment and freedom from all kind of discrimination, coercion and violence. This opportunity is likely to be harnessed in particular by women due to the trend of feminization of the health workforce. To exploit these opportunities fully, it will be critical to remove broader societal barriers that prevent women from joining the health workforce or confine them to its lower tiers. Such barriers include higher illiteracy levels, violence and sexual harassment in the workplace, traditional customs that require women to have permission from a male family member to work or be trained in a different location than their habitual residence, traditional social role expectations that translate in a greater burden of family responsibilities, and limited provisions for life course events such as maternity and paternity leave.

Policy options for WHO Member States

All countries

40. **Build planning capacity to develop or improve HRH policy and strategies that quantify health workforce needs, demands and supply** under different future scenarios. This should be carried out in order to manage health workforce labour markets and devise effective and efficient policies that respond to today's population needs while anticipating tomorrow's expectations. HRH needs should be quantified in terms of predicted workloads rather than by population or facility-based norms. HRH plans should be costed, financed, implemented and continually refined to address:

- a. the estimated number, category and qualification of health workers required to meet public health goals and population health needs;
- b. the capacity to produce sufficient and adequately distributed qualified workers (education and effective regulation policies); and
- c. the government and labour market capacity to recruit, deploy and retain health workers (economic and fiscal capacity, and workforce deployment, remuneration and retention through financial and non-financial strategies).

Estimates should be based on full-time equivalents – rather than simple head counts – to reflect flexibility (job sharing, part-time engagements) in work arrangements; this is particularly important to plan for equality of opportunities for male and female health workers.

41. **Catalyse multisectoral action on health workforce** issues to generate the required support from ministries of finance, education and labour (or equivalent), collaborating with and facilitated by the health sector. This will also ensure alignment of different sectors, constituencies and stakeholders with the national health workforce strategies and plans, harnessing benefits for job creation, economic growth, social welfare and gender empowerment, in addition to health system strengthening.

¹ Arcand, JL, Araujo EC, Menkulasic G, Weber M. Health sector employment, health care expenditure and economic growth: what are the associations? Washington DC: World Bank (in press).

² World Development Report 2013: Jobs. Washington DC: World Bank; 2012 (<http://issuu.com/world.bank.publications/docs/9780821395752>, accessed 30 December 2015).

42. **Invest in decent conditions of employment through long-term (10–15 years) public policy stewardship and strategies.** Such strategies should respect the rights of male and female workers,¹ promote better working environments, stimulate personal growth and fulfilment and include at the very least provision of a living wage (including for community-based health workers) and incentives for equitable deployment and retention, in line with the SDG Goal on Decent Work and Economic Growth. This should also develop and promote the elimination of stigma and discrimination by and towards health workers.

Policy options to be considered in some countries, depending on context

43. **Invest in the education and training, recruitment, deployment and retention of health workers to meet national and subnational needs through domestically trained health workers.** Educational investment strategies should match current and anticipated needs of the health system and health labour market, and take into account the implications of challenges related to an ageing workforce on the planning and education strategies. Strategies for destination countries to decrease reliance on foreign-trained health workers and mitigate the negative effects of health personnel migration on the health systems of developing countries may include:

- increasing investment in domestic health professional education;
- aligning government educational spending with employment opportunities;
- adopting innovative financing mechanisms, allowing local and private entities to provide complementary funding to government subsidies to health worker training;
- not hiring directly from countries with the lowest health care worker-to-population ratios;
- encouraging more cost-effective ways to educate health professionals to respond to population needs;
- planning a more diversified skills mix for health teams; and
- better harnessing the complementarity of different cadres, including mid-level providers.²

44. **Consider opportunities to strengthen the skills and employment agenda within countries.** This may include re-skilling workers from declining sectors and industries of the economy (e.g. manufacturing, agriculture) to be redeployed in the health and social care sectors, particularly in jobs and roles where the duration of training is short, and entry barriers are relatively low, without compromising the quality of education and care. Actions should also assist newly qualified students to enter the employment market, particularly during times of recession.

¹ Labour Relations (Public Service) Convention, 1978 (No. 151). Convention concerning protection of the right to organise and procedures for determining conditions of employment in the public service. Geneva: International Labour Organization; 1978 (http://www.ilo.org/dyn/normlex/en/f?p=NORMLEXPUB:12100:0::NO::P12100_INSTRUMENT_ID:312296, accessed 14 February 2015).

² Cometto G, Tulenko K, Muula AS, Krech R. Health Workforce Brain Drain: From Denouncing the Challenge to Solving the Problem. *PLoS Med.* 2013; 10(9).

45. **Increase investments to boost market-based demand and supply of the health workforce, and align them more closely with population health needs.** This includes appropriate strategies and incentives to deploy health workers in underserved areas. In many countries, this will entail increasing the capacity to supply health workers to cope with rising domestic demand fuelled by economic growth, while containing cost escalation.¹⁴ The potential mutual benefits of international migration of health personnel for health systems of source and destination countries is acknowledged. However, education and retention strategies should aim to retain health workers in their country of origin and to attain an adequate geographic distribution. This should be done respecting the right to mobility of individuals, and in alignment with the principles of the WHO Global Code of Practice on the International Recruitment of Health Personnel.

46. **Mobilize resources for HRH from both traditional and innovative sources.** These comprise the general budget, progressive taxation, social health insurance, dedicated earmarked funds and innovative mechanisms of financing.¹ Such allocation of adequate resources to the health sector should be consistent with and aligned to the broader national health and social protection agenda.²

47. During complex humanitarian emergencies and in the post-conflict recovery phase, there is a need to **develop capacity to absorb and utilize effectively and transparently both domestic and international resources.** HRH support from development partners in these settings should be predictable and long-term.

48. **Countries with small or sparse populations, such as small island developing states, require creative strategies to overcome the challenges posed by their population or geographic structure.** These strategies should promote the strengthening of institutional capacities in all involved sectors and may include: long-term partnerships with other countries to pool health workforce education, accreditation and regulation needs (given the high capital investment and recurrent costs to establish and run domestic health training institutions and/or regulatory authorities); tailored staffing profiles for health-care units responsible for service delivery at the peripheral level; harnessing the potential of telemedicine to complement the services offer by primary health care teams; and enhancing the functionality of referral systems.

Responsibilities of the WHO Secretariat

49. **Provide normative guidance and facilitate technical cooperation when requested by Member States and relevant stakeholders.** WHO support under this objective covers health workforce planning and projections, education policies, health system needs (taking into account evolving population needs linked to epidemiological transition), health labour market analysis, costing of national HRH strategies, and tracking of national and international financing for HRH. Acknowledging the continued need for external assistance in some countries, WHO will also provide estimates of HRH requirements (and the socioeconomic impact of their education and employment) to global and regional financial institutions, development partners and global health initiatives. This should inform the adoption of macroeconomic and funding policies conducive to greater and more strategically targeted investments in HRH. To facilitate a progressive transition towards national

¹ Leadership and governance for enhanced HRH contributions to health systems strengthening: insights, imperatives, investments [Technical Working Group 5 synthesis paper for the Global Strategy on Human Resources for Health, 31 August 2014]. Global Health Workforce Alliance; 2014 (http://www.who.int/workforcealliance/media/news/2014/TWG5_LeadershipandGovernance.pdf?ua=1, accessed 14 February 2015).

² Social Protection Floors Recommendation, 2012 (No. 202). Recommendation concerning national floors of social protection. Geneva: International Labour Organization; 2012 (http://www.ilo.org/secsoc/areas-of-work/legal-advice/WCMS_205341/lang--en/index.htm, accessed 14 February 2015).

ownership and financing of HRH policies and strategies, WHO will also provide technical assistance to Member States to identify approaches to mobilize sufficient domestic resources and to allocate them efficiently.

Recommendations to other stakeholders and international partners

50. The International Monetary Fund, World Bank, regional development banks and others to recognize investment in the health workforce as a productive sector. Investment in the health sector has the potential to create millions of new jobs and spur economic growth and broader socioeconomic development. These institutions could harness this opportunity to adapt their macroeconomic policies to allow greater investment in social services.

51. Global health initiatives to establish governance mechanisms to ensure that all grants and loans include an assessment of health workforce implications. This involves a deliberate strategy and accountability mechanisms on how specific programming contributes to HRH capacity-building efforts at institutional, organizational and individual levels, beyond disease-specific in-service training and incentives. Emphasis should be given to increasing sustainable investment and support for HRH. The recruitment of general service staff by disease-specific programmes weakens health systems, and should be avoided through integration of disease-specific programmes into primary health care strategies.

52. Development partners to align their investments for HRH with coordinated, long-term national needs as expressed in national sector plans. Investments should adhere to the principles of aid effectiveness, the International Health Partnership and related initiatives, and the Third International Conference on Financing for Development.¹ This support should align education, employment, gender and health with national human resource development and health system strengthening strategies. In addition, global health initiatives should realign their support to strengthen HRH in a sustainable way, including the possibility for investment in capital and recurrent expenditure (including salaries) for general service staff, and overcoming the current preferential focus on short-term, disease-specific, in-service training.^{2,3} In this respect, development partners might consider establishing a multilateral funding facility to support international investment in health systems⁴ as a means to support the realization of human rights and the SDG Goals. While continuing to advocate for an increase in allocation of domestic resources to HRH, development partners should also support countries to strengthen – where needed – their capacity for tax collection.

53. Relevant institutions should be encouraged to establish mechanisms to track the proportion of development assistance for health allocated to HRH. The Organisation for Economic Co-operation and Development and the Humanitarian Financial Tracking System, for example, should establish mechanisms to determine the proportion of development assistance for

¹ Report of the third International Conference on Financing for Development, Addis Ababa, 13–16 July 2015. New York: United Nations; 2015 (A/CONF.227/20, <http://www.un.org/esa/ffd/ffd3/>, accessed 19 October 2015).

² Vujcic M, Weber S, Nikolic I, Atun R, Kumar R. An analysis of GAVI, the Global Fund and World Bank support for human resources for health in developing countries. *Health Policy Plan.* 2012; 27(8):649–57.

³ Bowser D, Sparkes SP, Mitchell A, Bossert TJ, Bärnighausen T, Gedik G, Atun R. Global Fund investments in human resources for health: innovation and missed opportunities for health systems strengthening. *Health Policy Plan.* 2014; 29(8):986–97.

⁴ Gostin L. Ebola: towards an international health systems fund. *Lancet.* 2014; 384(9951):e49–51.

health that is allocated to HRH, as current processes and data requirements for tracking international aid flows to health do not allow a reliable and consistent capture of health workforce investments.¹

54. Regional or subregional bodies can bolster political and financial commitment to implementing this agenda. Entities such as the African Union, European Union, Arab League, Union of South American Nations, and Association of Southeast Asian Nations play an important role in facilitating policy dialogue and peer review among countries with a comparable socioeconomic structure or cultural background. They also help to generate and sustain the political will that underpins supportive investment and policy decisions.

Objective 3: Build the capacity of institutions at subnational, national, regional and global levels for effective public policy stewardship, leadership and governance of actions on human resources for health

Milestones:

- **3.1 By 2020, all countries will have inclusive institutional mechanisms in place to coordinate an intersectoral health workforce agenda.**
- **3.2 By 2020, all countries will have an HRH unit with responsibility to develop and monitor policies and plans.**
- **3.3 By 2020, all countries will have regulatory mechanisms to promote patient safety and adequate oversight of the private sector.**

55. Effective governance and strengthening of institutional capacities are required for the implementation of a comprehensive health workforce agenda in countries. Despite considerable advances in the last decades, progress in the HRH area has not been fast enough, nor deep enough. Health workforce development is partly a technical process, requiring expertise in planning, education and management, and the capacity to root this in long-term vision for the health system. But it is also a political process, depending on the will and power of different sectors and constituencies in society, and different levels of government to coordinate efforts.² Key challenges are, simultaneously, to ensure effective intersectoral governance and collaboration among stakeholders; strengthen technical capacity; and mobilize financial resources for the contemporary HRH agenda.³ This requires the political will – and accountability – of heads of government.

56. Technical and management capacities are needed to translate political will and decisions into effective implementation. Public health workforce planning and management – from the national to local level – must be professionalized, ensuring equal opportunities across gender, race and linguistic/ethnic groups. Just as capable health professionals are needed, so are capable professional health managers, HRH scientists, planners and policy-makers. This capability, backed up by strengthened evidence and information, is essential to provide political leaders with solid evidence and technical advice, and to guarantee effective implementation and oversight of policies, norms and

¹ Campbell J, Jones I, Whyms D. “More money for health – more health for the money”: a human resources for health perspective. *Human Resources for Health*. 2011; 9:18.

² Sales M, Kieny MP, Krech R, Etienne C. Human resources for universal health coverage: from evidence to policy and action. *Bull World Health Organ*. 2013; 91(11):798–8A.

³ Padilha A, Kasonde J, Mukti G, Crisp N, Takemi K, Buch E. Human resources for universal health coverage: leadership needed. *Bull World Health Organ*. 2013; 91(11):800–0A.

guidelines.¹ Crucially, this capacity needs to be built alongside accountability mechanisms and be available at the appropriate administrative level. In federal countries, or those with a decentralized health workforce administration, competency, human capital and institutional mechanisms need to be built at the subnational and local levels, including the training of personnel in management positions.

57. Appropriate global health governance mechanisms can support the implementation of national HRH agendas. Political commitment and action at the country level are the foundations of any effective response to health workforce challenges. However, some HRH issues are transnational and require a global approach underpinned by a commitment to international solidarity. These include the creation and sharing of global public goods and evidence; the provision or mobilization of technical and financial assistance when requested; the ethical management of health labour mobility and mitigating its negative effects; and the assessment of HRH implications of global health goals and resolutions.

Policy options for WHO Member States

All countries

58. Ensure that all countries have an HRH unit or department reporting to a senior level within the Ministry of Health (Director General or Permanent Secretary). Such a unit should have the capacity, responsibility, financing and accountability for a standard set of core functions of HRH policy, planning and governance, data management and reporting. These functions are, at a minimum, to: advocate HRH development; mobilize and use resources effectively and accountably; champion better working conditions, reward systems and career structures for health workers; set policies on regulation, service provision and education of health workers; lead short- and long-term health workforce planning and development; identify suitable strategies to engage in a collaborative manner with the private sector; analyse workforce data and labour economics; effectively track international mobility of health workers, managing migratory flows to maximize benefits for source countries; monitor and evaluate HRH interventions and trends; and build alliances with data producers and users.

59. Establish the national case for investment in HRH as a vital component of the SDGs, UHC and universal access to health care. The national case should be used as a basis for plans and budgets to mobilize adequate resources, supported by necessary regulations and mechanisms for policy coordination and oversight. The effective implementation of a national workforce agenda requires support from ministries of finance, education and labour, civil service commissions, local government and the private sector, including through sound health-care economics and social welfare arguments. Countries should establish national mechanisms for HRH governance and policy dialogue.² These mechanisms should collaborate with civil society, citizens, health workers, health professionals and their unions or associations, regulatory bodies, employer associations, and insurance funds so as to broaden ownership and institutional sustainability of HRH policies and strategies.

¹ Nurse J. What are the health workforce and service implications of the Global Framework for Public Health? [Discussion paper for the Global Strategy on Human Resources for Health, 29 August 2014]. Global Health Workforce Alliance; 2014 (http://www.who.int/workforcealliance/media/news/2014/RefA_PublicHealthpaper.pdf?ua=1, accessed 20 January 2015).

² Kingue S, Roskam E, Bela AC, Adjidja A, Codjia L. Strengthening human resources for health through multisectoral approaches and leadership: the case of Cameroon. *Bull World Health Organ.* 2013; 91(11):864–7.

60. **Strengthen technical and management capacity in ministries of health and other relevant sectors and institutions to develop and implement effective HRH policies, norms and guidelines.** This will encourage innovative processes, technologies, service organization and training delivery modalities, and a more effective use of resources.

61. **Ensure that the public health workforce aligns development efforts with the social services workforce** and wider social determinants of health. This includes access to housing, food, education, employment and local environmental conditions. The clinical health workforce should be educated on the social determinants of health and promote this agenda in their practice.

Policy options to be considered in some countries, depending on context

62. **Align incentives for health workforce education and health-care provision with public health goals and population needs.** This includes balancing the growing needs of the ageing population and new and ever more expensive health technologies with a realistic forecast of the available resource envelope; and adopting new interventions when cost-effective in the local context.

63. **Strengthen the institutional environment for health workforce education, deployment, retention and performance management.** In some countries, this entails building the human and institutional public capacity to design, develop and deliver pre-service and in-service education of health workers; develop health-care professional associations to support effective relationships with health workers; design effective performance management and incentive systems; and to develop collaboration with regulators of private sector educational institutions and health providers. In decentralized contexts, where these functions may be carried out at the subnational or peripheral level, the capacities will need to be built or strengthened at the relevant administrative level.

64. **Flexible approaches to HRH development must be tailored to the specific reality of each country.** HRH development is unequivocally an aspect of health system development and governance, which is the responsibility of the state. The exercise of this responsibility involves multi-stakeholder partnerships with a broad range of actors, including local authorities, international institutions, businesses, civil society organizations, the private sector, foundations, philanthropists and social impact investors, scientists, academics and individuals. In order to be efficient, health workforce interventions must take due account of the specific circumstances of each country.

Responsibilities of the WHO Secretariat

65. **Provide technical support and capacity-building to develop core public competency in HRH policy, planning, projections, resource mobilization and management, as requested by Member States and relevant stakeholders.** Capacity-building efforts may be facilitated by the development of an internationally recognized, postgraduate professional programme on HRH policy and planning, with international mentoring and a professional network to support the implementation of workforce science.

66. **Strengthen global capacity to implement the transnational HRH agenda.** This can be achieved by fostering effective coordination, alignment and accountability through a network of international HRH stakeholders and actors. Building on the experience and achievements of the Global Health Workforce Alliance over its 10 years of existence (2006–2016), WHO will support at all levels of the Organization the establishment of a global network for HRH collaboration, consistent with the principles and policies that govern WHO's engagement with non-state actors. This mechanism aims to: maintain high-level political commitment; facilitate the alignment of global health initiatives to the HRH investment priorities outlined in this Strategy; promote inter-sectoral and multilateral policy dialogue; encourage collaboration with the private sector for cost-effective, socially responsible and

people-centred interventions; and foster global coordination and mutual accountability, effectively linked with UN system processes for monitoring the Sustainable Development Goals.

67. Provide technical support to develop health system capacities and workforce competency to manage the risks of emergencies and disasters, as requested by Member States and relevant stakeholders. This support will facilitate: assessment of HRH availability before, during and after emergencies; integration of emergency risk management into relevant policies, technical programmes and associated workforce development, education and training; and support to coordination mechanisms for planning and deployment of personnel for emergencies.

Recommendations to other stakeholders and international partners

68. Parliaments and civil society to contribute to sustained momentum of the HRH agenda. This can be achieved through oversight of government activities and accountability mechanisms to monitor performance, and by advocating the improvement of both public and private sector educational institutions and employers. Social accountability mechanisms should be encouraged.

69. The international community, development partners, and global health initiatives to examine systematically the health workforce implications of any health goals that are considered and adopted. As part of this, the WHO Secretariat should also cooperate with the mechanisms of its governing bodies to create the conditions whereby all future resolutions presented to the World Health Assembly and regional committees include an assessment of health workforce implications resulting from technical or policy recommendations.¹

70. The international community, development partners, and global health initiatives to work closely with states to strengthen national and subnational public institutions and governance in a post-emergency or post-conflict recovery phase, when donor funding and opportunity for reform is greatest.² A coordinated mechanism will enable a common understanding of context and interventions, bring all stakeholders together and, with the state in a coordinating role, target interventions with an explicit capacity-building objective. In these settings, interventions to strengthen the domestic health workforce may be more effective if they target a decentralized level or are effected through non-state actors, where results and lessons for scale-up can be seen more quickly.

Objective 4: Strengthen data on human resources for health for monitoring and accountability of national and regional strategies, and the Global Strategy

Milestones:

- **4.1 By 2020, all countries will have made progress to establish registries to track health workforce stock, education, distribution, flows, demand, capacity and remuneration.**

¹ Data and measurement of HRH availability, accessibility, acceptability, and quality. [Technical Working Group 3 background paper for the Global Strategy on Human Resources for Health]. Global Health Workforce Alliance; 2014 (http://www.who.int/workforcealliance/media/news/2014/TWG3_Paper_07Dec14.pdf?ua=1, accessed 14 February 2015).

² Pavignani E. Human resources for health through conflict and recovery: lessons from African countries. *Disasters*. 2011; 35(4):661–79.

- **4.2 By 2020, all countries will have made progress on sharing HRH data through national health workforce accounts and submitting core indicators to the WHO Secretariat annually.**
- **4.3 By 2020, all bilateral and multilateral agencies will have strengthened health workforce assessment and information exchange.**

71. **Better HRH data and evidence are required as a critical enabler to enhance advocacy, planning, policy-making, governance and accountability at national, regional and global levels.** The evidence-to-policy feedback loop is an essential feature of resilient health systems, defined as those with the capacity to learn from experience and adapt according to changing needs. Projections of future workforce requirements should be informed by reliable and updated health workforce information, taking into account population needs, labour market analyses, and scanning of scenarios. Projections can support the development, implementation, monitoring, impact assessment and continuous updating of workforce plans and strategies. The evidence-to-policy field has potential for major improvements in the coming decade. Specific opportunities stem from technological innovation, connectedness, the Internet and the beginning of a “big data” era, characterized by dramatic growth in the types and quantity of data collected by systems, patients and health workers. These can represent a tool to improve the quality of data and exchange of information to strengthen national health systems.

72. **The post-2015 development objectives require aligning the public policy agenda on governance, accountability, availability, accessibility, acceptability, quality and equity with strategic intelligence on the national, regional and global health labour market.** Demand for, and proactive use of health workforce data in international public policy, need to be stimulated, and global discourse encouraged on assessing the health workforce implications of any public health objective. This, in turn, will trigger demand for, and analysis of workforce data, particularly on global health initiatives and programming linked to the health targets of the SDGs. Improvements in HRH information architecture and interoperability can generate core indicators in support of these processes. Data collected should include a comprehensive overview of workforce characteristics (public and private practice); remuneration patterns (multiple sources, not only public sector payroll); worker competency (e.g. the role of health workers disaggregated across cadres and between different levels of care); performance (systematic data collection on productivity and quality of care); absence, absenteeism and their root causes; labour dynamics of mobility (rural vs urban, public vs private, international mobility); attacks against health workers; and the performance of the HRH management system itself (the average time it takes to fill a vacancy, the attrition rate during education and employment, the outcomes of accreditation programmes, etc.).

73. **The Strategy includes an accountability framework to assess progress on its recommendations.** At the country level, policy options identified as most relevant to individual Member States should be embedded in national health and development strategies and plans. Specific HRH targets and indicators should be included in these national policies, strategies and development frameworks, and multisectoral and multiconstituency mechanisms strengthened to reflect the key HRH interventions and accountability points from inputs to impact. Existing processes and mechanisms for health sector review at country level should include a regular assessment of progress in the health workforce agenda in the national context. Global accountability will include a progressive agenda to implement national health workforce accounts,¹ with annual reporting by countries on core HRH indicators against the milestones identified under the four objectives of this Strategy (Appendix 3).

¹ National health workforce accounts: the knowledge-base for health workforce development towards universal health coverage – policy brief. Geneva: World Health Organization; 2015 (http://www.who.int/hrh/documents/brief_nhwfa/en/, accessed 19 October 2015).

Reporting requirements for Member States will be streamlined by progressive improvement in HRH data, effectively linking monitoring of the Strategy with that of the WHO Global Code of Practice on the International Recruitment of Health Personnel, other HRH-focused Health Assembly resolutions, and strategic documents and resolutions adopted at the regional level. Global monitoring will also be linked and synchronized with the accountability framework of the SDGs.

Policy options for WHO Member States

All countries

74. Invest in the analytical capacity of countries for HRH and health system data. This should be based on policies and guidelines for standardization and interoperability of HRH data, such as those given in the WHO Minimum Data Set¹ and national health workforce accounts. National or regional workforce observatories and similar or related mechanisms can be a useful implementation mechanism for this agenda and serve as a platform to share and advocate best practices. Opportunities for greater efficiency can be exploited by harnessing technological advances, connectedness and the Internet, and the rise in new approaches for health workforce futures in the design of systems for HRH data collection, gathering and use.²

75. Establish national health workforce registries of the competent and practising, rather than those that have simply completed a training programme. The registries should progressively extend the minimum data set to a comprehensive set of key performance indicators on health worker stock, distribution, flow, demand, supply capacity and remuneration, in both the public and private sector. Data should be disaggregated by age, sex, ethnic or linguistic group, and place of employment, as a prerequisite to understand health labour markets and the design of effective policy solutions. In some contexts, the establishment of a register of practising workforce linked to the payroll can also facilitate excising ghost workers. Systems should also be put in place to enable the systematic collection of data on attacks on health workers.

76. Put in place incentives and policies to collect, report, analyse and use reliable and impartial workforce data to inform transparency and accountability, and enable public access to different levels of decision-making. In particular, countries should facilitate national and subnational collection and reporting of health workforce data through standardized, annual reporting to the WHO Global Health Observatory. Countries should invest resources to ensure they have the capacity to analyse and use the data for local decision-making. All workforce data (respecting personal confidentiality and relevant data protection laws) should be treated as a global public good to be shared in the public domain for the benefit of different branches of government, health-care professional associations and relevant stakeholders.

77. Embed in national health or HRH strategies the relevant policy options included in this Strategy, and the corresponding monitoring and accountability requirements. Accountability for HRH at the national level should be accompanied by mechanisms for accountability of HRH at the grassroots level, harnessing the voice and capacity of communities and service users to provide

¹ Human resources for health information system: minimum data set for health workforce registry. Geneva: World Health Organization; 2015 (http://www.who.int/hrh/statistics/minimum_data_set/en/, accessed 5 June 2015).

² Horizon 2035: health and care workforce futures – progress update. Centre for Workforce Intelligence; 2014 (<http://www.cfwf.org.uk/publications/horizon-2035-progress-update-july-2014>, accessed 14 February 2015).

feedback to improve the quality of care and patient safety. The development of social accountability mechanisms should be nurtured through an enabling environment. Similarly, at the global level countries should request the UN Secretary-General's Office to ensure that the SDG accountability framework includes health workforce targets and indicators.

78. Strengthen HRH information systems and build the human capital required to operate them in alignment with broader health management information systems, including the ability to utilize such systems during emergencies and disasters. The capacity to use data effectively for dialogue with policy-makers and civil society should also be strengthened.

Policy options to be considered in some countries, depending on context

79. Strengthen health systems by applying “big data” approaches to gain a better understanding of the health workforce, including its size, characteristics and performance to generate insights into gaps and possibilities for health workforce strengthening. This should be done in compliance with national norms and legislative frameworks regulating the collection and use of personal data that will guarantee absolute confidentiality and anonymity of individual health workers.

80. Exploit “leapfrogging” opportunities through the adoption of ICT solutions for HRH data collation and storage, avoiding the capital-heavy infrastructure needed in the past.

Responsibilities of the WHO Secretariat

81. Support the development and strengthening, review the utility of and update and maintain tools, guidelines and databases relating to data and evidence on HRH for routine and emergency settings.

82. Facilitate the progressive implementation of national health workforce accounts to support countries to strengthen and establish a standard for the quality and completeness of their health workforce data. Improved HRH evidence will contribute to a global digital reporting system for countries to report on a yearly basis on a minimum set of core HRH indicators. This will include information on health workforce production, recruitment, availability, composition, distribution, costing and migratory flows,⁶⁷ disaggregated by sex, age and place of employment.

83. Streamline and integrate all requirements for reporting on HRH by WHO Member States. In their annual report on HRH, Member States would thus integrate progress on implementing the WHO Global Code of Practice on the International Recruitment of Health Personnel; other HRH-focused Health Assembly resolutions; and the Global strategy on human resources for health.

84. Adapt, integrate and link the monitoring of targets in the Global Strategy to the emerging accountability framework of the SDGs and other resolutions adopted by the United Nations General Assembly. For instance, WHO should develop mechanisms to enable collection of data to prepare and submit a report on the protection of health workers, which compiles and analyses the experiences of Member States and presents recommendations for action to be taken by relevant stakeholders, including appropriate preventive measures, as called for by UNGA Resolution 69/132 on Global health and foreign policy.

Recommendations to other stakeholders and international partners

85. **The International Labour Organization (ILO) to revise the International Standard Classification of Occupations** for greater clarity on delineation of health workers and health professions.¹ This will entail a move towards definitions that reflect worker competency together with the tasks they perform. Of particular urgency is the need to streamline and rationalize the categorization and nomenclature of community health workers and other types of community-based practitioners.

86. **Research and academic institutions to address priority evidence gaps.** Examples of areas where further research is required are approaches to regulate effectively dual practice, strategies to optimize quality and performance, and the optimal institutional and regulatory context for task sharing and skills delegation.² Further, there is a need to leverage strengthened HRH data and measurement for impact evaluations and research on cost-effectiveness and return on investment of health workforce interventions.³ The early involvement of decision-makers and stakeholders in the setting of research priorities can be instrumental in scaling up and utilizing research results.⁴

87. **Professional associations and civil society to collaborate with the research community to facilitate the uptake and utilization of evidence in the policy-making process.** The advocacy, communications and accountability functions of these constituencies can play a major role in bridging the evidence-to-policy gap.

88. **Development partners to support national HRH data collection, analysis and use for improved planning and accountability,** in alignment with the national health workforce accounts framework. Further, bilateral and multilateral agencies should routinely make available in the public domain the health workforce information and evidence collected as part of the initiatives they support.

Appendix 1

HEALTH WORKFORCE REQUIREMENTS FOR IMPLEMENTATION OF THE GLOBAL STRATEGY ON HUMAN RESOURCES FOR HEALTH

WHO has been facilitating since April 2015 a coordinated inter-agency, multi-constituency effort to estimate health workforce requirements and projections to 2030. Appendix 1 provides selected

¹ Benton DC. Technical Working Group consultation papers 1 to 8: input of the International Confederation of Nurses to the public consultation process on the Global Strategy on Health Resources for Health. Global Health Workforce Alliance; 2014 (<http://www.who.int/workforcealliance/media/news/2014/6ICN.pdf?ua=1>, accessed 14 February 2015).

² Ranson MK, Chopra M, Atkins S, Dal Poz MR, Bennett S. Priorities for research into human resources for health in low- and middle-income countries. *Bull World Health Organ.* 2010; 88(6):435–43.

³ Foster AA. Recommendations for HRH global strategy papers: input of Intrahealth International to the public consultation process on the Global Strategy on Health Resources for Health, November 2014. Global Health Workforce Alliance; 2015 (<http://www.who.int/workforcealliance/media/news/2014/8IntraHealthInternational.pdf?ua=1>, accessed 14 February 2015).

⁴ Getting research into policy and practice. London: Department for International Development; 2011 (<http://www.dfid.gov.uk/What-we-do/Research-and-evidence/news/research-news/2011/Getting-research-into-policy-and-practice/>, accessed 19 October 2015).

elements of this ongoing analysis. The final paper will be published on the WHO website (<http://www.who.int/hrh/en/>) once the analysis is completed.

Data on current stock and density of health workers for 193 countries were extracted from the WHO Global Health Observatory, which includes data provided by WHO Member States. Future simulations of supply, need and demand on the other hand represent modelled estimates. The modelling has significant margins of uncertainty related to both the assumptions made and the variability in quality and completeness of the underlying data.

Simulating future supply of health workers

The supply of physicians and nurses/midwives was projected to 2030 based on historical data on the increase in physician and nurse/midwife densities in each country. To forecast supply, a linear growth rate model was adopted, which assumes that the historical growth rate of physicians and nurses/midwives per capita for each country will continue into the future at the same rate each year.

Data points that represented obvious outliers due to misreporting were removed and replaced with missing data. Missing data points for physicians and nurses/midwives per 1000 population between any two real data points were linearly interpolated. The following equations were then estimated for each country from time $t = \{1990, \dots, 2013\}$:

(Eq 1) Physicians per 1000 population $_t = \alpha_0 + \alpha_1 * \text{year}_t + \varepsilon_t$

(Eq 2) Nurses/midwives per 1000 population $_t = \beta_0 + \beta_1 * \text{year}_t + \varepsilon_t$

where ε_t is the random disturbance term and α_0 , β_0 , α_1 and β_1 are unknown parameters, with the last two parameters representing the linear growth rates to be estimated from the model.

The following rules were applied to predict future (2014–2030) values of worker densities:

- Where at least two data points were available, the estimated linear trend was extended into the future until 2030 using the estimated coefficients for α and β .
- If the estimated linear growth was found to be too large or too small, the country's growth rate was replaced with aggregate medians, and then the median growth rate was applied to the last available observation for that country (i.e. most recent year).
- For physicians: if a given country's linear growth rate was larger or smaller than 1 standard deviation from the mean growth rate for all countries, the median growth rate of a comparable group of countries was substituted.
- For nurses/midwives: for nurses and midwives, there was large over-dispersion of the linear growth rate distribution. Consequently, if a country's linear growth rate was larger than 80% or smaller than 20% of the growth rate distribution, then the median growth rate of a comparable group of countries was substituted.
- For both physicians and nurse/midwives: if the predicted density in 2030 resulted in a negative number, the country's growth rate was also replaced with the corresponding median aggregate value in a comparable group of countries.
- If there was just one point for a country (and thus linear growth rate could not be estimated), the same median substitution for the growth rate as described above was applied.

- When no observations were available before 2013 (i.e. no empirical data for both physicians and nurses/midwives), neither the physician nor nurse/midwife supply was projected. Instead, the mean 2030 predicted supply density across a comparable group of countries was substituted.

The estimates thus derived (Table A1.1) indicate that in 2013 (latest available data) the global health workforce was over 43 million. This includes 9.8 million physicians, 20.7 million nurses/midwives, and approximately 13 million other health workers. The global nurse/midwife to physician ratio was 2.1.

The supply projections, based on current trends and under the assumptions made in the model, point to a significant growth (55%) leading to an aggregate number by 2030 of 67.3 million health workers. This comprises approximately 13.8 million physicians, 32.3 million nurses/midwives and 21.2 million other health workers.

Table A1.1. Stock of health workers (in millions), 2013^a and 2030^b

WHO Region	Physicians		Nurses/ midwives		All other cadres ^c		Total health workers		
	2013	2030	2013	2030	2013	2030	2013	2030	% Change
	N	N	N	N	N	N	N	N	
Africa	0.2	0.5	1.0	1.5	0.6	1.0	1.9	3.1	63%
Americas	2.0	2.4	4.7	8.2	2.6	3.4	9.4	14.0	50%
Eastern Mediterranean	0.8	1.3	1.3	1.8	1.0	2.2	3.1	5.3	72%
Europe	2.9	3.5	6.2	8.5	3.6	4.8	12.7	16.8	32%
South-East Asia	1.1	1.9	2.9	5.2	2.2	3.7	6.2	10.9	75%
Western Pacific	2.7	4.2	4.6	7.0	3.0	6.1	10.3	17.3	68%
Grand total	9.8	13.8	20.7	32.3	13.0	21.2	43.5	67.3	55%

a WHO Global Health Observatory

b Forecast

c Refers to the seven other broad categories of the health workforce as defined by the WHO Global Health Workforce Statistics Database, i.e. dentistry, pharmacy, laboratory, environment and public health, community and traditional health, health management and support, and all other health workforce categories. A multiplier for “all other cadres” was developed based on the values of countries with available data.

NB: Since absolute values are rounded to the nearest 100 000, totals may not precisely add up.

An updated, needs-based “SDG index” of minimum density of doctors, nurses and midwives

The 2006 World Health Report broke new ground by developing an evidence-based model for health worker need, based on achieving 80% coverage of assisted deliveries. The threshold of 2.3 skilled health workers per 1000 population has enabled advocacy and inter-country comparability. However, the model is clearly limited to one single health service (delivery by a skilled birth attendant). In considering a new health workforce threshold, the focus must shift to reflect the broader range of services that are targeted by UHC and the SDGs.

Tracers of indicators for UHC were selected to reflect noncommunicable diseases, maternal, newborn and child health, and infectious disease priorities. Table A1.2 lists the 12 indicators and their primary classification (5 indicators for infectious diseases, 3 for maternal, newborn and child health, and 4 for noncommunicable diseases). Coverage data for all countries available for the 12 indicators were combined in an aggregate coverage indicator (SDG index), which weighted the importance of specific indicators based on the contribution of the diseases they track to the global burden of diseases.

Table A1.2. SDG tracer indicators

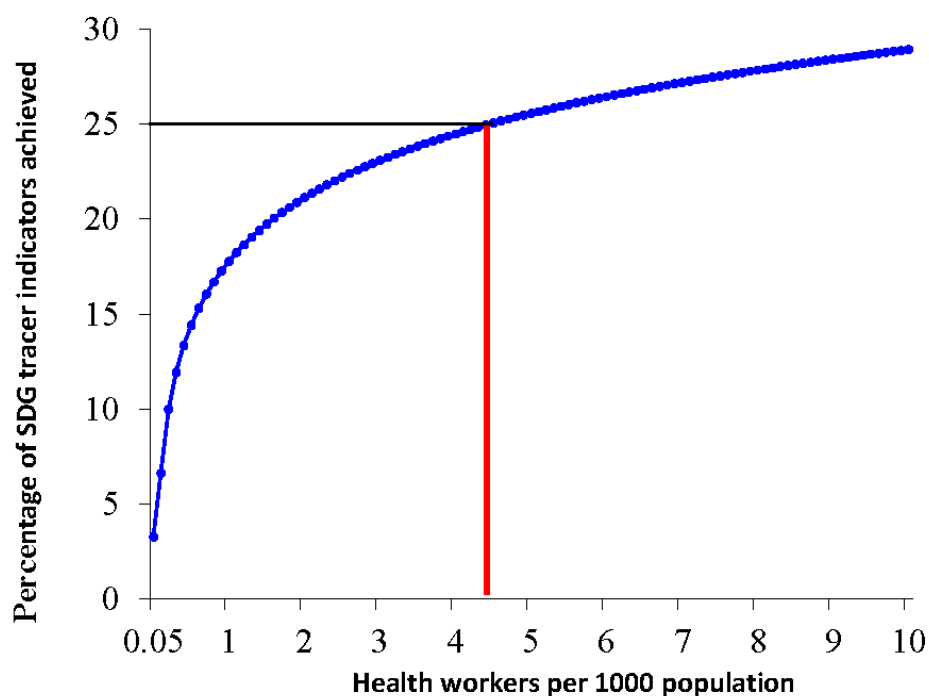
Indicator	Classification
Antenatal care	MNCH
Antiretroviral therapy	ID
Cataract	NCD
Diabetes	NCD
DTP3 immunization	ID
Family planning	MNCH
Hypertension	NCD
Potable water	ID
Sanitation	ID
Skilled birth attendance	MNCH
Tobacco smoking	NCD
Tuberculosis	ID

DTP3, third dose of diphtheria-tetanus-pertussis vaccine; ID, infectious diseases; MNCH, maternal, newborn and child health; NCD, noncommunicable diseases.

The coverage of this composite SDG index was analysed across countries, and a regression analysis performed to identify the aggregate density of doctors, nurses and midwives corresponding to the 50th percentile (median) rank of attainment. It was not possible to factor into the analysis other health worker cadres (such as community-based and mid-level health workers, and other allied health professionals) due to extensive limitations in data availability for these other cadres. On the basis of the analysis conducted according to the SDG index methodology described above, an indicative threshold of an aggregate density of 4.45 physicians, nurses and midwives per 1000 population was identified, as it corresponds to the median score of SDG tracer indicator attainment (25%). This value has been used for the needs-based estimates in this analysis.

Other thresholds have been developed in the past, and alternative methods are possible to estimate a threshold of minimum requirements for health workforce availability. It should be emphasized that this figure does not represent a planning target for countries, as it does not reflect the heterogeneity of countries in terms of baseline conditions, health system needs, optimal workforce composition and skills mix. Further, it is acknowledged that this threshold reflects only physicians, nurses and midwives, an inherent limitation caused by the paucity of data on other cadres. Planning targets for countries should rather be set based on national level policy dialogue, taking into account the context-specific needs of the health system, service delivery profile, and labour market conditions. They should reflect a more diverse skills mix, going beyond the cadres of doctors, nurses and midwives to harness the potential contribution of all health workers for a more responsive and cost-effective composition of health-care teams.

Figure A1.1. SDG index composite method: percentage of 12 SDG tracer indicators achieved as a function of aggregate density of doctors, nurses and midwives per 1000 population



Estimating health workforce requirements and needs-based shortages to 2030 in countries with a lower HRH density than the SDG index threshold

The index of 4.45 physicians, nurses and midwives per 1000 population was used to estimate the health workforce needs and needs-based shortages by 2030 (i.e. the additional number of health workers that would be needed to attain this threshold of health worker density, over and above the projected supply in 2030).

Table A1.3 examines the needs-based shortage of health-care workers in 2013 and 2030 by cadre and by WHO region. Needs-based shortages were calculated by subtracting the current/projected supply of health-care workers from the current/projected needs (as defined by the SDG index threshold of 4.45 physicians, nurses and midwives) in countries facing a shortage.

Table A1.3. Estimates of health worker needs-based shortages (in millions)* in countries below the SDG index threshold by region, 2013 and 2030

Region	2013				2030				% change
	Physicians	Nurses/ midwives	Other cadres	Total	Physicians	Nurses/ midwives	Other cadres	Total	
Africa	0.9	1.8	1.5	4.2	1.1	2.8	2.2	6.1	45%
Americas	0.0	0.5	0.2	0.8	0.1	0.5	0.1	0.6	-17%
Eastern Mediterranean	0.2	0.9	0.6	1.7	0.2	1.2	0.3	1.7	-1%
Europe	0.0	0.1	0.0	0.1	0.0	0.0	0.0	0.1	-33%
South-East Asia	1.3	3.2	2.5	6.9	1.0	1.9	1.9	4.7	-32%
Western Pacific	0.1	2.6	1.1	3.7	0.0	1.2	0.1	1.4	-64%
Grand Total	2.6	9.0	5.9	17.4	2.3	7.6	4.6	14.5	-17%

* Since all values are rounded to the nearest 100 000, totals may not precisely add up.

Globally, the needs-based shortage of health-care workers in 2013 is estimated to be about 17.4 million, of which almost 2.6 million are doctors, over 9 million are nurses and midwives, and the remainder represent all other health worker cadres. The largest needs-based shortages of health workers are in South-East Asia at 6.9 million and Africa at 4.2 million. The shortage in absolute terms is highest in South-East Asia due to the large populations of countries in this Region, but in relative terms (i.e. taking into account population size) the most severe challenges are in the African Region. The global needs-based shortage of health-care workers is projected to be still more than 14 million in 2030 (a decline of only 17%). Hence, current trends of health worker production and employment will not have sufficient impact on reducing the needs-based shortage of health-care workers by 2030, particularly in some countries: in the African Region the needs-based shortage is actually forecast to worsen between 2013 and 2030, while it will remain broadly stable in the Eastern Mediterranean Region.

Assessing health workforce needs in relation to service requirements in countries of the Organisation for Economic Co-operation and Development (OECD)

All countries in the OECD have a density of health workers above the SDG index threshold of 4.45 physicians, nurses and midwives per 1000 population. Their health systems, however, have a service delivery profile that goes beyond the provision of essential health services such as those to which the UHC tracer indicators refer. In the context of a global health labour market characterized by high mobility of physicians, nurses and midwives, it is necessary to consider also the health workforce implications of the service requirements in OECD countries to gain a more comprehensive overview of the global imbalances and deficits of the health workforce. A model was therefore developed to produce estimates of possible scenarios of health workforce trends in these contexts. The model is based on an approach that determines HRH requirements in relation to health system objectives and health services requirements.¹ A stock-and-flow approach was used to simulate future HRH supply in terms of headcounts. Projections factored expected inflows (e.g. new graduates) and outflows (e.g. due to retirement) of each country's current stock. These were then adjusted according to levels of

¹ Tomblin-Murphy G et al. A synthesis of recent high-income OECD country analyses of HRH requirements and labor market dynamics (in press).

participation (providing direct patient care) and activity (proportion of full-time hours spent providing direct patient care) for different types of health workers.

The model considers as parameters a number of policy variables, including health workforce education, participation, productivity and attrition. It also factors in other variables that go beyond the health workforce per se, such as demographic trends and changes in the health status of the population.

These simulations in the baseline scenarios sum to aggregate shortfalls against service requirements of about 50 000 midwives, 1.1 million nurses, and 750 000 physicians across the 31 included countries for 2030. These estimates are, however, highly sensitive to the assumptions on the parameters of the model: sensitivity analysis shows that by 2030 the shortfall against service requirements could be in excess of 4 million health workers (over 70 000 midwives, 3.2 million nurses and 1.2 million physicians).

Assessing market-based demand for health workers in 2030

Understanding health labour market trends also requires assessing demand for health workers as a function of countries' capacity to create funded positions (whether in the public or private sector) for them. The demand for health workers was modelled using supply projections, per capita gross domestic product (GDP), per capita out-of-pocket health expenditures, and population aged 65+. Estimates could be produced only for 165 countries with sufficient data to model demand. The result of these simulations (Table A1.4) indicates a growing demand for health workers.

Table A1.4. Estimated health worker^a demand (in millions^b) in 165 countries, by Region

WHO Region	2013	2030
Africa	1.1	2.4
Americas	8.8	15.3
Eastern Mediterranean	3.1	6.2
Europe	14.2	18.2
South-East Asia	6.0	12.2
Western Pacific	15.1	25.9
World	48.3	80.2

^a Health worker refers to physicians, nurses/midwives, and other health workers.

^b Since all values are rounded to the nearest 100 000, totals may not precisely add up.

Source: World Bank, Washington DC (forthcoming).

In the aggregate, the model to project demand forecasts that by 2030 there will be a global aggregate demand for some 80 million health workers in the 165 countries with sufficient data to produce estimates, with the potential for the creation of approximately 40 million additional jobs (the current stock is estimated at approximately 43 million in 193 WHO Member States – see Table A1.1). The additional jobs, however, will not necessarily be created in the regions and countries where they are most needed to address unmet population needs.

Interpretation

In contextualizing and correctly interpreting the findings of these analyses, it is necessary to acknowledge important limitations.

- The development of global estimates of needs has to rely on some level of standardization of the model specifications and its underlying assumptions. It is assumed, for instance, that different countries have similar health-care production functions, or that cadres of health workers that have the same or a similar classification have overlapping roles and tasks. The actual picture may be more varied.
- Similarly, needs have been estimated to be the same across all countries with a density below the SDG index threshold. However, national patterns of burden of disease, as well as their demographic structure, are known determinants of variance in health services use (and, indirectly, of health workforce requirements).
- The model assumes that the ratios between numbers of physicians, nurses/midwives, and other health workers will follow recent trends. A renewed focus on a more diverse skills mix and a greater role for community health workers in some settings¹ may conversely result in an increase of these relative to the number of nurses/midwives and physicians in future.
- While efforts were made to collect the best available evidence to inform the analysis, it was not possible to find a strong empirical basis for many key variables in the modelling strategy adopted. Therefore a number of assumptions had to be made.

Even in the case of OECD countries, data limitations make it imperative to consider these simulations with caution. Therefore the results should not be interpreted as precise predictions; instead they serve as compass bearings, showing the directions in which the HRH situation is heading, and may continue if the current trends continue.

Notwithstanding, by including coverage of noncommunicable diseases in the SDG index, this analysis represents a step forward in terms of identifying health workforce requirements for UHC and the SDGs. The identification of a higher threshold of minimum health workforce availability requirements resulted in greater needs (and needs-based shortages) than all previous estimates. The difference is particularly stark if the new threshold is compared with past analyses based on requirements for skilled assistance at birth, which resulted in the identification of a much lower requirement of 2.3 skilled health workers (physicians and nurses/midwives) per 1000 population. The SDG index threshold of 4.45 physicians, nurses and midwives per 1000 population represents almost a doubling of the recommended density of skilled health workers to meet health needs. This increase reflects the staffing needed to deliver a more comprehensive range of health services^{2,3} and it is not dissimilar to other benchmarks of HRH density developed in relation to the UHC goal (such as the 4.11 physicians, nurses and midwives per 1000 population threshold developed in the past by the ILO).

¹ Office of the UN Secretary-General's Special Envoy for Health in Agenda 2030 and for Malaria. New report highlights benefits from investments in CHW programs (<http://www.mdghealthenvoy.org/new-report-highlights-benefits-from-investments-in-chw-programs/>).

² Transforming our world: the 2030 agenda for sustainable development. New York: United Nations Department of Economic and Social Affairs (<https://sustainabledevelopment.un.org/post2015/transformingourworld>).

³ Marten R, McIntyre D, Travassos C, Shishkin S, Longde W, Reddy S et al. An assessment of progress towards universal health coverage in Brazil, Russia, India, China and South Africa (BRICS). *Lancet*. 384(9960):2164–71.

Considering jointly the needs-based shortage of over 14 million health workers in countries currently below the threshold of 4.45 physicians, nurses and midwives per 1000 population – and the shortfall against service requirements in selected OECD countries (possibly in excess of 4 million) – the aggregate projected global deficit of health workers against needs (defined differently in different contexts) could exceed 18 million (range: 16–19) by 2030.

However, global aggregate projections and trends mask important disparities: the estimates of the current and projected future supply of health workers show that, despite increased production, population growth in some contexts is outstripping the increase in health workers, resulting in lower densities. While needs-based shortages are forecast to reduce significantly in most regions of the world, on current trends they might remain unchanged in the Eastern Mediterranean Region, and worsen in the African Region. On current trends, by 2030 some parts of the world would face a substantial and widening mismatch between the number of health workers needed to provide essential services (need), the availability of health professionals (supply) and the countries' capacity to employ them (demand): in the African Region, where many countries are confronted with fiscal space challenges, a modest growth in the capacity to employ workers is likely to lead to a shortage based on economic demand, with the overall supply of health workers remaining constrained. Both demand and supply will, however, fall short of population needs. Greater investments will be required in these contexts to boost market-based demand and supply, and to align them more closely with population health needs. By contrast, emerging economies might see a narrowing gap between the supply of health workers and the numbers needed to provide essential health services. However, economic growth and demographic trends in these countries will likely boost the demand for health care beyond the essential services. The current pace of health worker production will need to be significantly accelerated to meet the demand. This tight labour market condition could potentially raise the cost of health workers, possibly stimulating labour movements across borders and fuelling cost escalation in the health sector in these countries.¹⁴ These dynamics, together with a growing demand for health workers in advanced economies with an ageing population, and a persisting divergence in working and living conditions in different countries, point to growing international migration of health workers in the coming decades.

These projections and simulations should therefore be understood as a note of caution against complacency. Maintaining the status quo in health worker production and employment is expected to result in too slow a progress (or even a worsening gap, especially in countries that are already lagging behind in their health outcomes) and continuing global imbalances.

Appendix 2

ANNOTATED LIST OF SELECTED WHO TOOLS AND GUIDELINES FOR HUMAN RESOURCES FOR HEALTH

The planning, design and implementation of the policy options described in this Strategy can be informed and supported by a number of tools, guidelines and other normative documents. The following is a list of selected products developed by WHO on human resources for health. It is envisaged that during the lifetime of the Strategy (2016–2030) this list will evolve dynamically and be updated to reflect new evidence and emerging priorities and opportunities. For more information and updated tools and guidelines please refer to <http://www.who.int/hrh/tools/en/>.

Workload indicators for staff need

The Workload Indicators for Staff Need (WISN) use business and industry planning principles for the health sector. This tool provides guidance for health managers on how to analyse and calculate the health workers' workload to derive health worker requirements in health-care facilities. The program software is simple to run and is supported by an easy-to-follow instruction manual and WISN case studies.

http://www.who.int/hrh/resources/wisn_user_manual/en/.

Task shifting for HIV and optimizing health workers' roles for maternal and newborn health

The guidelines for task sharing and delegation provide countries with guidance on how to use a more diverse skills mix, most efficiently and rationally, for the delivery of essential HIV/AIDS and reproductive, maternal, newborn, child health services. The guidelines highlight evidence-based, effective and cost-effective interventions to delegate service delivery tasks to other cadres of health workers.

<http://www.who.int/healthsystems/TTR-TaskShifting.pdf> and <http://www.optimizemnh.org/>.

Transforming and scaling up health professionals' education and training

These guidelines set out a vision of transforming education for health professions, and offer recommendations on how best to achieve the goal of producing graduates that are responsive to the health needs of the populations they serve. The guidelines encourage educational and training institutions to foster institutional and instructional reforms, and to enhance the interaction and planning between education, health and other sectors.

<http://www.who.int/hrh/education/en/> and <http://whoeducationguidelines.org./content/guidelines-order-and-download>.

Increasing access to health workers in remote and rural areas through improved retention

These policy recommendations examine the evidence base and outline policy options for maximizing retention of health workers in rural and underserved areas. They can be used in conjunction with other WHO resources, such as the WHO Global Code of Practice on the International Recruitment of Health Personnel. To ensure better health worker retention outcomes in countries, the best results will be achieved by choosing and implementing a bundle of contextually relevant recommendations, encompassing interventions on education, regulation, financial incentives, and personal and professional support.

<http://www.who.int/hrh/retention/guidelines/en/>.

WHO Global code of practice on the international recruitment of health personnel

In May 2010, the Sixty-third World Health Assembly (WHA63.16) endorsed the Code aiming to establish and promote a comprehensive framework that promotes principles and practices for the ethical management of international migration of health personnel. It also outlines strategies to facilitate the strengthening of the health workforce within national health systems, and the evidence and data requirements for tracking and reporting on international mobility of health personnel. The Code was designed by Member States to serve as a continuous and dynamic framework for global dialogue and cooperation.

<http://www.who.int/hrh/migration/code/practice/en/> and

http://www.who.int/hrh/migration/code/code_en.pdf?ua=1.

National health workforce accounts

The purpose of a national health workforce account (NHWA) is to standardize the health workforce information architecture and interoperability as well as track HRH policy performance towards universal health coverage. The implementation of NHWAs facilitates a harmonized, integrated approach for regular collection, analysis and use of standardized health workforce information to inform evidence-based policy decisions.

http://www.who.int/hrh/documents/15376_WHOBrief_NHWFA_0605.pdf.

Minimum data set for health workforce registry

This tool provides guidance on the minimum information fields required to develop or modify an electronic system for health workers at national or subnational levels. The minimum data set for health workforce registry (MDS) provided in this document can be used by ministries of health to support the development of standardized health workforce information systems.

http://www.who.int/hrh/statistics/minimum_data_set/en/.

Monitoring and evaluation of human resources for health with special applications for low- and middle-income countries

The handbook offers health managers, researchers and policy-makers a comprehensive, standardized and user-friendly reference for monitoring and evaluating human resources for health, including approaches to strengthen relevant technical capacities. It brings together an analytical framework with strategy options for improving the health workforce information and evidence base, as well as country experiences that highlight successful approaches.

<http://www.who.int/workforcealliance/knowledge/toolkit/25/en/>.

Analysing disrupted health sectors

This modular manual supports policy-makers in settings characterized by complex humanitarian emergencies to analyse and plan for their health systems. Module 10 of the tool reviews aspects to be considered in the study of a health workforce in these settings. In these irregular contexts, tailored strategies for planning, education, deployment, retention and staff performance management are required.

http://www.who.int/hac/techguidance/tools/disrupted_sectors/en/ and Module 10 – Analysing human resources for health: http://www.who.int/hac/techguidance/tools/disrupted_sectors/adhsm_mod10_en.pdf?ua=1.

Appendix 3

MONITORING AND ACCOUNTABILITY FRAMEWORK

The monitoring and accountability framework of the Global Strategy entails a regular process to assess progress on its milestones. At the national level, countries should consider reflecting relevant actions contributing to the milestones in national policies, strategies and frameworks, as relevant to context. Existing processes and mechanisms for health sector review should include a regular assessment of progress in the health workforce agenda in the national context. Global accountability will include a

progressive agenda to implement national health workforce accounts (see objective 4), with annual reporting by countries on core HRH indicators to the WHO Secretariat. Reporting requirements for Member States will be streamlined by effectively linking monitoring of the Strategy with that of the WHO Global Code of Practice on the International Recruitment of Health Personnel, other HRH-focused Health Assembly resolutions, and strategic documents and resolutions adopted at regional level. Global monitoring will also be complemented by specific analyses – to be conducted by WHO in collaboration with OECD and other relevant institutions – on aspects relating to official development assistance for health and international mobility of health personnel.

Table A3.1. Monitoring and accountability framework to assess progress on the Global Strategy milestones

Global milestones (by 2020)	Baseline indicator (2016)	Numerator	Denominator	Periodicity of data collection	Source
1. All countries have inclusive institutional mechanisms in place to coordinate an intersectoral health workforce agenda.	The percentage of countries with institutional mechanisms in place to coordinate an intersectoral health workforce agenda.	Number of countries with an HRH unit or function that negotiate inter-sectoral relationships with other line ministries and stakeholders.	Total number of countries	Annual	NHWA
2. All countries have a human resources for health unit with responsibility for development and monitoring of policies and plans.	The percentage of countries with a human resources for health unit or functions, responsible for developing and monitoring policies and plans on human resources for health.	Number of countries with a human resources for health unit or functions, responsible for developing and monitoring policies and plans on human resources for health.	Total number of countries	Annual	NHWA
3. All countries have regulatory mechanisms to promote patient safety and adequate oversight of the private sector.	The percentage of countries with a national mechanism to promote patient safety and adequate oversight of the private sector.	Number of countries with a national mechanism to promote patient safety and adequate oversight of the private sector.	Total number of countries	Annual	NHWA

Global milestones (by 2020)	Baseline indicator (2016)	Numerator	Denominator	Periodicity of data collection	Source
4. All countries have established accreditation mechanisms for health training institutions.	The percentage of countries with accreditation mechanisms for health training institutions.	Number of countries with accreditation mechanisms for health training institutions.	Total number of countries	Annual	NHWA
5. All countries are making progress on health workforce registries to track health workforce stock, distribution, flows, demand, supply, capacity and remuneration.	The percentage of countries with a health workforce registry to track health workforce stock, distribution, flows, demand, supply, capacity and remuneration.	Number of countries with a health workforce registry to track health workforce stock, distribution, flows, demand, supply, capacity and remuneration.	Total number of countries	Annual	NHWA
6. All countries are making progress on sharing data on human resources for health through national health workforce accounts, and submit core indicators to the WHO Secretariat annually.	The percentage of countries with established national health workforce accounts and that submit core indicators to the WHO Secretariat annually.	Number of countries with established national health workforce accounts and that submit core indicators to the WHO Secretariat annually.	Total number of countries	Annual	NHWA
7. All bilateral and multilateral agencies have participated in efforts to strengthen health workforce assessments and information exchange in countries.	The percentage of bilateral and multilateral agencies that have integrated health workforce assessments and information exchange.	Number of bilateral and multilateral agencies that have integrated health workforce assessments and information exchange.	Number of bilateral and multilateral agencies reporting via OECD's Creditor Reporting System	3 years	WHO survey

Global milestones (by 2030)	Baseline indicator (2016)	Numerator	Denominator	Periodicity of data collection	Source
1. All countries are making progress towards halving inequalities in access to a health worker.	Density of health workers (dentist, midwife, nurse, pharmacist, physician) per 1000 population by subnational (district) level distribution.	Number of health workers (dentist, midwife, nurse, pharmacist, physician) by subnational (district) x 1000.	Total population by subnational (district) x 1000	Annual	NHWA
2. All countries are making progress towards improving the course completion rates in medical, nursing and allied health professional training institutions.	Percentage of countries that have achieved at least an 80% student graduation rate across medical, nursing and allied health professional training institutions.	Number of countries that have achieved at least an 80% student graduation rate across medical, nursing and allied health professional training institutions.	Total number of countries	Annual	NHWA
3. All countries are making progress towards halving their dependency on foreign-trained health professionals, implementing the WHO Global Code of Practice.	Share of foreign-trained health workers (physician and nurse).	Number of foreign-trained health workers (physician and nurse).	Number of health workers	Annual	NHWA; OECD
4. All bilateral and multilateral agencies are increasing synergies in official development assistance for education, employment, gender and health, in support of national health employment and economic growth priorities.	Percentage of bilateral and multilateral agencies where official development assistance (e.g. education, employment, gender and health) supports the attainment of SDG 3c.	Number of bilateral and multilateral agencies where official development assistance (e.g. education, employment, gender and health) supports the attainment of SDG 3c.	Number of bilateral and multilateral agencies in OECD Creditor Reporting System	3 years	WHO survey
5. As partners in the UN Sustainable Development Goals, to reduce barriers in access	Number of health workers (all reported cadres).	Number of health workers (all reported cadres).	Not applicable	Annual	NHWA

Global milestones (by 2030)	Baseline indicator (2016)	Numerator	Denominator	Periodicity of data collection	Source
to health services by working to create, fill and sustain at least 10 million additional full-time jobs in health and social care sectors to address the needs of underserved populations.					
6. As partners in the UN Sustainable Development Goals, to make progress on Goal 3c to increase health financing and the recruitment, development, training and retention of the health workforce.	WHO will collaborate with Member States, the Health Data Collaborative and relevant stakeholders to strengthen capacity to monitor the health-related Sustainable Development Goals.				WHO and partners

NHWA: national health workforce account; OECD: Organisation for Economic Co-operation and Development; SDG: Sustainable Development Goal; UN: United Nations; WHO: World Health Organization.

ANNEX 8

Global health sector strategies on HIV, viral hepatitis and sexually transmitted infections, for the period 2016–2021¹

The draft global health sector strategies were presented for consideration by the Sixty-ninth World Health Assembly in separate reports.² The Health Assembly then adopted resolution WHA69.22, in which the three strategies were adopted together. For ease of reference, the strategies are set out separately below in Appendices 1–3.

Appendix 1

Global health sector strategy on HIV, 2016–2021

[A69/31 – 22 April 2016]

INTRODUCTION AND CONTEXT

1. The international community has committed to ending the AIDS epidemic as a public health threat by 2030 – an ambitious target of the 2030 Agenda for Sustainable Development adopted by the United Nations General Assembly in September 2015.³ Interim targets have been established for 2020. This strategy describes the health sector contribution towards the achievement of these targets. It outlines both what countries need to do and what WHO will do. If implemented, these fast-track actions by countries and by WHO will accelerate and intensify the HIV response in order for the “end of AIDS” to become a reality.

2. The strategy builds on the extraordinary public health achievements made in the global HIV response since WHO launched the Special Programme on AIDS in 1986.⁴ It continues the momentum generated by the Millennium Development Goals and the universal access commitments.⁵ Recently, the Global health sector strategy on HIV/AIDS 2011–2015⁶ has galvanized global and country action that has helped halt and reverse the AIDS epidemic. During that period, HIV treatment coverage was

¹ See resolution WHA69.22 (2016).

² Documents A69/31, A69/32 and A69/33.

³ United Nations General Assembly resolution 70/1 – Transforming our world: The 2030 Agenda for Sustainable Development, see http://www.un.org/ga/search/view_doc.asp?symbol=A/RES/70/1&Lang=E (accessed 15 March 2016).

⁴ In March 1987, WHO published the “Special Programme on AIDS: strategies and structure projected needs”, which is available at: http://apps.who.int/iris/bitstream/10665/62299/1/WHO_SPA_GEN_87.1.pdf (accessed 15 March 2016).

In addition, the Global Programme on AIDS 1987–1995 published its “Final Report with Emphasis on 1994–1995 Biennium”, available at: http://apps.who.int/iris/bitstream/10665/65955/1/WHO_ASD_97.1.pdf (accessed 15 March 2016).

⁵ United Nations General Assembly resolution 65/277 — Political Declaration on HIV and AIDS: Intensifying Our Efforts to Eliminate HIV and AIDS http://www.unaids.org/sites/default/files/sub_landing/files/20110610_UN_A-RES-65-277_en.pdf (accessed 15 March 2016).

⁶ The global health sector strategy on HIV/AIDS 2011–2015 is available at: http://apps.who.int/iris/bitstream/10665/44606/1/9789241501651_eng.pdf (accessed 15 March 2016).

expanded rapidly with well over 17 million people living with HIV on antiretroviral therapy by the end of 2015; new HIV infections and deaths declined; dozens of countries moved towards the elimination of mother-to-child transmission of HIV; and HIV responses have been embedded in broader health and development programmes. However, there is no room for complacency. Much has changed since 2011, with new opportunities to exploit and many new challenges to overcome. Ending the AIDS epidemic will require rapid acceleration of the response over the next five years and then sustained action through to 2030 and beyond. This can only be achieved through renewed political commitment, additional resources, and technical and programmatic innovations.

3. The strategy positions the health sector response to HIV as being critical to the achievement of universal health coverage – one of the key health targets of the Sustainable Development Goals. The strategy promotes a people-centred approach, grounded in principles of human rights and health equity. It will contribute to a radical decline in new HIV infections and HIV-related deaths, while also improving the health and well-being of all people living with HIV. It will guide efforts to accelerate and focus HIV prevention, enable people to know their HIV status, provide antiretroviral therapy and comprehensive long-term care to all people living with HIV, and challenge pervasive HIV-related stigmatization and discrimination.

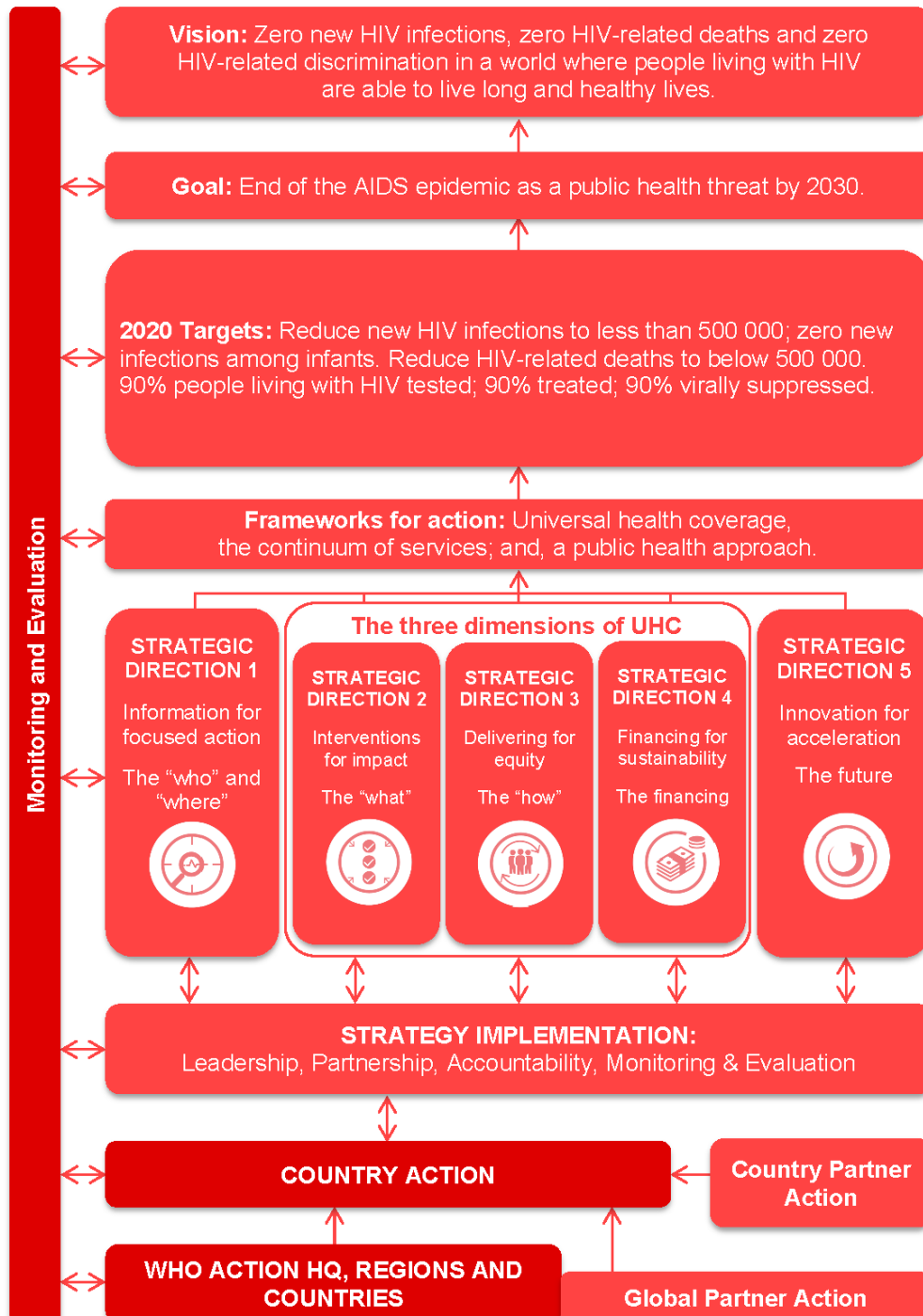
4. Broad partnerships and strong linkages with other health and development issues must be emphasized in the next phase of the response. This strategy is fully aligned with the post-2015 health and development agenda and targets. It provides the health sector contribution to a broader multisectoral response as outlined in the UNAIDS strategy for 2016–2021.¹ It is also aligned with other relevant global health strategies and plans, including those for sexually transmitted infections, tuberculosis, viral hepatitis, sexual and reproductive health, maternal and child health, blood safety, mental health, noncommunicable diseases and integrated people-centred health services. It has been informed by the extraordinary efforts of many countries, recognizing that countries and communities are central to the response. It takes into consideration the HIV and broader health strategies of key development partners, including the Global Fund to fight AIDS, Tuberculosis and Malaria, and the United States President’s Emergency Plan for AIDS Relief.² Full implementation of the strategy will contribute to the achievement of other Sustainable Development Goals – it will prevent and relieve poverty, reduce inequities, promote gender equality, enhance productivity and tackle exclusion, stigmatization and discrimination.

5. The strategy outlines a vision, goals and actions for the global health sector response, including five strategic directions: strengthening and focusing national HIV programmes and plans through sound strategic information and good governance; defining a package of essential HIV services and high-impact interventions along the HIV services continuum; adapting and delivering the HIV services continuum for different populations and locations to maximize quality and achieve equitable coverage; implementing systems to fully fund the continuum of HIV services and to minimize the risk of financial hardship for those requiring the services; and embracing innovation to drive rapid progress (see Figure 1).

¹ UNAIDS Strategy 2016–2021, see http://www.unaids.org/en/resources/documents/2015/UNAIDS_PCB37_15-18 (accessed 15 March 2016).

² For more information on the United States President’s Emergency Plan for AIDS Relief, see <http://www.pepfar.gov/about/strategy/> (accessed 15 March 2016).

Figure 1. Outline of the global health sector strategy on HIV, 2016-2021



OUTLINE OF THE STRATEGY

6. The strategy has five major components:
1. **Setting the scene** – reviews the current status of HIV epidemics and responses, identifies opportunities and challenges for the future, and argues the case for adequate investment in the health sector response to HIV;
 2. **Framing the strategy** – describes the three organizing frameworks for the strategy (universal health coverage, the continuum of HIV services and the public health approach);
 3. **Presenting a global vision and setting global goals and targets** – presents a set of impact and service coverage targets for 2020 and 2030 to drive the response;
 4. **Recommending priority actions** – recommends fast-track actions to be taken by both countries and WHO under each of **five strategic directions**;
 5. **Guiding implementation** – outlines key elements of **strategy implementation**, including strategic partnerships, monitoring and evaluation, and costing.

1. WHY THE WORLD MUST STEP UP THE HIV RESPONSE QUICKLY

7. The enormous investments in the HIV response over the past 15 years are paying off. Large declines in HIV-related deaths in the past decade attest to the commitment, resources and innovations that have already been directed at the global HIV epidemic. Fewer people are dying of HIV-related causes, with an estimated 1.1 million (range of 940 000–1.3 million) deaths in 2015, down 43% from 2003, largely the result of increased access to antiretroviral therapy. In 2015, new HIV infections were estimated at 2.1 million (range of 1.8 million–2.4 million).^{1,2}

1.1 The challenges

8. Despite major progress in the response, HIV epidemics continue to pose serious public health threats in all regions. Shadowing the gains are important challenges.

9. **Not enough and not fast enough.** Current coverage of services is inadequate and the rate of expansion is too slow to achieve global targets. The full benefits of effective HIV interventions and services are not being realized. Globally, 17 million of the 37 million people living with HIV at the end of 2014 did not know their HIV status and 22 million were not accessing antiretroviral therapy.²

10. **Major inequities persist and populations are being left behind.** Success in the global HIV response is distributed unevenly and inequitably. While HIV incidence is declining overall, it is increasing in some countries and regions. Adolescent girls and young women in sub-Saharan Africa are being infected at twice the rate as that of boys and men of the same age. Progress is not sufficient or quick enough, and is not reaching many of the populations most at risk for HIV infection. In addition, there are substantial disparities in access to treatment and care, with boys and men lagging behind in many countries. Human rights violations, along with widespread gender-based violence and

¹ Most data presented in the strategy are drawn from routine country reports, World Health Organization and Joint United Nations Programme on HIV/AIDS reporting systems, such as the Global AIDS Response Reporting (GARPR) system.

² Global AIDS Update 2016, UNAIDS <http://www.unaids.org/en/resources/documents/2016/Global-AIDS-update-2016> (accessed 23 June 2016)

stigmatization and discrimination, continue to hinder access to health services, particularly for children, adolescents, young women and key populations.¹

11. **Middle-income countries require specific focus.** An estimated 70% of people living with HIV worldwide are in middle-income countries and global success will also be determined by whether efforts in these countries accelerate or stall. With changing donor priorities, expanding equitable and sustainable health financing systems is particularly critical for middle-income countries. At the same time, low-income countries will continue to rely on external development assistance to ensure that essential HIV services are funded adequately.

12. **Fragile communities and mobile populations.** The world is facing an increasingly complex series of challenges. Conflict, natural disasters, economic crises and climate change can trigger humanitarian emergencies, which destroy local health systems, displace communities and force increasing numbers of people into migration with interrupted or poor access to health services.

13. **Insufficiently targeted interventions and services.** National HIV responses often fail to focus interventions on the populations and locations most in need, thereby increasing inefficiencies and undermining their impact.

14. **Ensuring and maintaining quality.** Rapid expansion of HIV programmes without ensuring the quality of services risks undermining programme effectiveness, wasting precious resources and contributing to negative public health outcomes, such as the emergence of drug resistant strains of HIV. Assuring the quality of prevention, diagnostic and treatment commodities is essential as demand and use increases.

15. **Increasing burden of coinfections and other comorbidities.** AIDS deaths are declining with expanding access to antiretroviral therapy, however, investments in treatment are being challenged by increasing morbidity and mortality associated with coinfections, such as hepatitis B and hepatitis C, and other comorbidities, including cancers, cardiovascular disease, diabetes and other noncommunicable diseases, and mental health and substance use disorders. Despite a scale-up in antiretroviral therapy, and improvements in the prevention and management of HIV and tuberculosis coinfection, tuberculosis is still the leading cause of hospitalization of adults and children living with HIV, and remains the leading cause of HIV-related deaths.

16. **Doing more of the same is not enough.** The global epidemic has reached a point where a steady-state response – that is, maintaining coverage at current levels or gradual expansion – will soon see a rebound in new HIV infections and HIV-related deaths. Proceeding at the current pace will not be enough to end an epidemic that is constantly evolving. New HIV infections will increase and more people will require HIV treatment and care. The costs of prevention, care and treatment will continue to expand. By the end of 2015, the number of people living with HIV had reached an estimated 36.7 million (range of 34.0 million–39.8 million) worldwide.

17. The world is faced with a dilemma: “business as usual” will see the HIV response lose steam and slide back. The actions outlined in this strategy will avoid that outcome. They involve accelerating

¹ The present strategy on HIV uses the definition of “key populations” presented in the UNAIDS Strategy 2016–2021, available at http://www.unaids.org/en/resources/documents/2015/UNAIDS_PCB37_15-18 (accessed 15 March 2016): “Key populations, or key populations at higher risk, are groups of people who are more likely to be exposed to HIV or to transmit it and whose engagement is critical to a successful HIV response. In all countries, key populations include people living with HIV. In most settings, men who have sex with men, transgender people, people who inject drugs, sex workers and their clients [and prisoners] are at higher risk of exposure to HIV than other groups. However, each country should define the specific populations that are key to their epidemic and response based on the epidemiological and social context.”

the development and implementation of comprehensive, high-impact HIV prevention and treatment interventions, using rights-based and people-centred approaches, identifying sustainable financing for HIV programmes into the future and ensuring progressive integration of the HIV response into broader health programmes and services.

1.2 Ready for a major leap forward

18. There are enormous opportunities for capitalizing on the progress made over the past 15 years, to catapult the response to a new trajectory towards the elimination of the AIDS epidemic. The health sector must show leadership as the response moves forward.

1.2.1 Critical areas for fast-track action

19. We must build on the existing momentum of the HIV response, to benefit from the solid base of comprehensive national programmes and to exploit renewed political commitment. More, however, is required. There are six areas where new commitments, resources and intensified efforts will be essential for the attainment of the 2020 and 2030 targets.

20. **Bolstering combination prevention with new tools.** The HIV prevention effects of antiretroviral medicines, including antiretroviral therapy are well recognized. The game-changing potential of pre-exposure prophylaxis – using antiretroviral medicines to prevent HIV infection – has been confirmed. Strategically combining antiretroviral therapy with pre-exposure prophylaxis, as part of combination HIV prevention, could almost eliminate HIV transmission to HIV-negative sexual and drug-using partners.

21. There is great scope to capitalize further on the preventive power of voluntary medical male circumcision. Innovations that close in on the 80% coverage target for voluntary medical male circumcision in designated “priority” countries would dramatically curtail new infections in some of the world’s largest HIV epidemics.

22. Male and female condoms, in combination with lubricants, must continue to be the mainstay of prevention programmes. However, the full benefits of consistent condom use are yet to be realized. Innovations in condom programming could catapult the HIV response forward. The development of an effective topical microbicide and HIV vaccine would be powerful additions to an increasingly robust HIV prevention intervention portfolio.

23. **Ensuring all people living with HIV know their status.** New HIV testing approaches, including self- and community-based testing, and new quality-assured testing technologies, promise to identify and link greater numbers of people living with HIV to early treatment and care, maximizing HIV prevention potential and treatment effectiveness. The strategic focusing of HIV testing services will be critical in reaching those most at risk and diagnosing people early.

24. **Expanding quality treatment for all people living with HIV.** Filling the treatment gap, expanding from 17 million people to all people who are living with HIV, must be a priority and will massively curtail new infections and deaths. However, the initiation of antiretroviral therapy for everyone living with HIV will require an unprecedented effort from countries and partners. Specific attention must be given to addressing the greatest inequities in access to treatment – to reach those left behind: infants, children, adolescent girls and boys, men and key populations. The quality of medicines and services must be assured. Strategies to maximize treatment adherence and retention in care will be essential to fully realize the potential of treatment.

25. **Keeping people healthy and alive through person-centred and holistic care.** The broad health needs of the millions of people living with HIV, including those on lifelong antiretroviral therapy, must be addressed. Linkages between HIV services and those for tuberculosis, viral hepatitis and other major health issues are significantly reducing morbidity and mortality. Strengthening those linkages, including with noncommunicable disease services, will ensure holistic and integrated person-centred care, boosting the overall impact of programmes. Joint HIV and tuberculosis programming in countries with the highest burden of tuberculosis and HIV coinfection further strengthens integration, enhancing access to life-saving interventions, while maximizing efficient use of resources. Using a chronic care model for HIV treatment and care offers opportunities for addressing broader health needs, particularly noncommunicable diseases, and mental health and substance use disorders. Palliative care remains a critical component of a comprehensive health sector response, helping to ensure dignity and comfort for people in managing their pain and other symptoms.

26. **Reaching and protecting those most vulnerable and at risk.** The HIV response can no longer ignore those populations most affected and left behind. Effective HIV prevention and empowerment interventions must reach girls and young women – a group which continues to be the most vulnerable and affected in many communities, particularly in the high-burden epidemics of sub-Saharan Africa. Major new and focused investments will be required to strengthen community-based services to: provide appropriate interventions for adolescents; tackle effectively gender-based violence, also related to harmful alcohol use; reduce the vulnerability of girls and young women; bring men and boys into treatment; reach key populations (notably men who have sex with men, people who inject drugs, sex workers, transgender people and prisoners); expand harm reduction programmes for people who use drugs; and deliver services to mobile and displaced populations. More has to be done to overturn laws and change policies that marginalize and stigmatize populations, promote risk behaviours, create access barriers to effective services and perpetuate these inequities and inequalities.

27. **Reducing costs and improving efficiencies.** In a resource-constrained environment with competing development priorities, an unprecedented scale-up in HIV services by 2020 can only be achieved by making radical savings through reduced prices of key medicines and other commodities and increased efficiencies in service delivery, along with a more rational allocation of resources.

1.2.2 Huge benefits foreseen

28. An immediate, fast-tracked global response that achieves the targets set out in this strategy will effectively end the epidemic as a global public health threat (see Figures 2 and 3). Modelling undertaken by UNAIDS shows that, in combination with high-impact prevention packages and a strengthened commitment to protect human rights, an accelerated testing and treatment effort would:¹

- reduce new adult HIV infections from 2.1 million in 2010 to 500 000 in 2020
- avert 28 million HIV infections between 2015 and 2030
- avert almost 6 million infections in children by 2030
- avert 21 million AIDS-related deaths between 2015 and 2030
- avoid US\$ 24 000 million of additional costs for HIV treatment
- enable countries to reap a 15-fold return on their HIV investments.

¹ Understanding fast-track: accelerating action to end the AIDS epidemic by 2030, see http://www.unaids.org/sites/default/files/media_asset/201506_JC2743_Understanding_FastTrack_en.pdf (accessed 15 March 2016).

29. Further investments in HIV responses have the potential to significantly impact on other health targets of the Sustainable Development Goal 3 on health, including those related to maternal and child health, tuberculosis, viral hepatitis, noncommunicable diseases and mental health, substance use disorders, sexual and reproductive health, and universal health coverage.

Figure 2. Projections for decline in new HIV infections

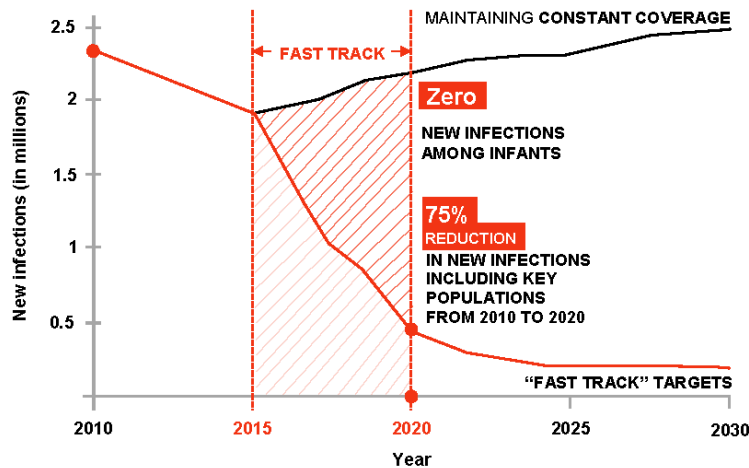
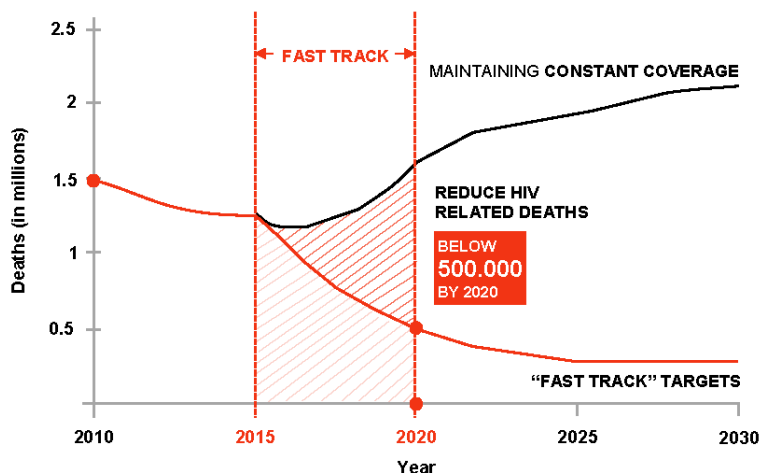


Figure 3. Projections for decline in HIV-related deaths



Source: UNAIDS, 2016-2021 Strategy, see: http://www.unaids.org/sites/default/files/media_asset/20151027_UNAIDS_PCB37_15_18_EN_rev1.pdf (accessed 15 March 2016).

1.2.3 Building an investment case

30. Most of the tools required to reach the fast-track targets are in hand, and several potentially vital upgrades and innovations are imminent. Using them to full effect, however, will require a rapid augmentation of existing investments in the HIV response, and focusing resources on both the most effective services and interventions, and on the populations and geographical locations where HIV

transmission and burden are greatest. Resources mobilized from all sources for HIV programmes in low- and middle-income countries increased by an additional US\$ 250 million from 2012 to reach US\$ 19 100 million in 2013 and then increased again to an estimated US\$ 21 007 million in 2015. The rising trend was due mainly to greater domestic investments, which comprised about 57% of the total in 2014. Nevertheless, investments in HIV will need to grow to US\$ 31 900 million in 2020 and US\$ 29 300 million in 2030 if long-term control of the epidemic is to be achieved.

31. Many countries have gained significant experience and expertise in designing and implementing high coverage, high-quality and comprehensive HIV services that have had a major impact on HIV vulnerability, incidence, morbidity and mortality, and the quality of lives of people living with HIV. There are many opportunities for countries to “leap-frog” their own HIV responses, learning from other countries so that they can rapidly adapt and implement the most effective policies, services and interventions.

32. With limited available resources, countries need to plan carefully, setting ambitious but realistic country targets, and develop strong investment cases. The investment case should provide justification for an adequate allocation of domestic resources, facilitate the mobilization of external resources and help identify global partners who would support efforts. Investment cases need to:

- define and provide a budget for the packages of interventions and services required, based on the country context
- argue for the most cost-effective interventions
- identify the populations and locations most affected and where resources should be focused
- define the most efficient and equitable models of service delivery
- outline the most appropriate allocation of resources across the different levels of the health system; and
- identify potential and reliable sources of funding.

33. Refocused actions, innovations that can boost impact and a renewed commitment to investment are required throughout the six years of this strategy.

34. The strategy builds a case for such investment: it identifies five strategic directions to focus the actions of country programmes and WHO, and outlines the priority interventions and innovations that can achieve the greatest impact.

2. FRAMING THE STRATEGY

35. The HIV strategy is one of a series of three, related health sector strategies for the period 2016–2020, which include a strategy to end the epidemic of viral hepatitis and one to end the epidemic of sexually transmitted infections. The strategies use a common structure, drawing on three organizing frameworks: universal health coverage; the continuum of health services; and the public health approach. All three strategies are designed to contribute to the attainment of the Sustainable Development Goal 3 (Ensure healthy lives and promote well-being for all at all ages). The HIV strategy describes how the health sector response to HIV can contribute to the achievement of the “ending the epidemic of AIDS” target, universal health coverage, and other key health and development targets. The HIV strategy is also aligned with other relevant health strategies, notably the

End TB Strategy,¹ the UNAIDS strategy (mentioned previously), and other HIV strategies (those of key partners, and those that are sectoral and multisectoral in nature).

2.1 The Sustainable Development Goals – providing direction

36. The Sustainable Development Goals provide an ambitious and far-reaching development agenda for the period 2016–2030. Health is a major goal in this post-2015 agenda, reflecting its central role in alleviating poverty and facilitating development. The health-related Sustainable Development Goal 3 addresses a range of health challenges critical for development, notably target 3.3 on communicable diseases, which includes ending the AIDS epidemic.² Efforts to end AIDS will also impact on other health targets, including those on reducing maternal mortality (target 3.1), preventing deaths of newborns and children under the age of 5 years (target 3.2), reducing mortality from noncommunicable diseases and promoting mental health (target 3.4), preventing and treating substance use disorders (target 3.5), sexual and reproductive health (target 3.7), achieving universal health coverage (target 3.8), access to affordable medicines and vaccines (target 3.b) and health financing and health workforce (target 3.c). In addition to its impact on Goal 3, ending the AIDS epidemic will contribute to ending poverty (Goal 1), ending hunger (Goal 2), achieving gender equality and empowering women and girls (Goal 5), reducing inequality in access to services and commodities (Goal 10), promoting inclusive societies that promote non-discrimination (Goal 16), and financing and capacity building for implementation (Goal 17).

2.2 Universal health coverage – an overarching framework

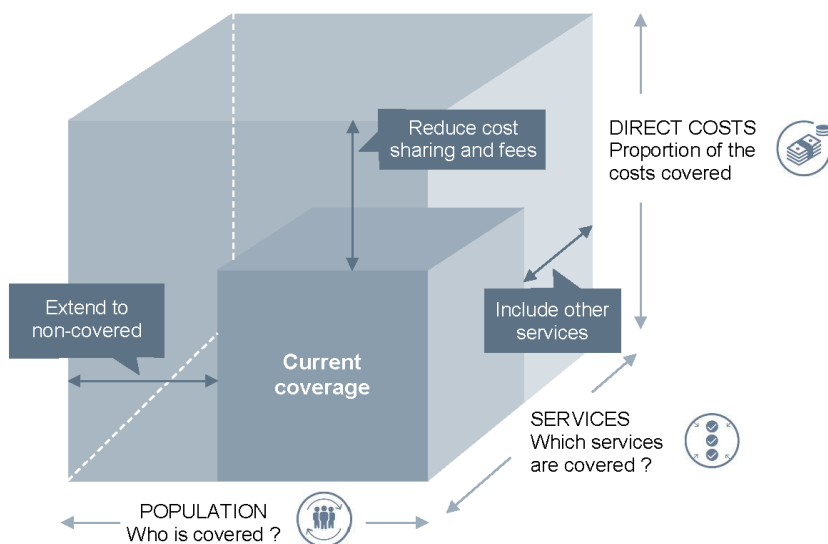
37. At the global level, 150 million people experience financial catastrophe and 100 million people suffer impoverishment every year as a result of out-of-pocket health expenses. The Sustainable Development Goals focus on the importance of ensuring financial security and health equity and universal health coverage provides a framework for addressing them. Universal health coverage (see Figure 4) is achieved when all people receive the health services required, which are of sufficient quality to make a difference, without those people incurring financial hardship. It comprises three major, interlinked objectives: improving the range, quality and availability of essential health services (covering the range of services needed); improving the equitable and optimal uptake of services in relation to need (covering the populations in need of services); and reducing costs and providing financial protection for those who need the services (covering the costs of services).

¹ End TB Strategy, see <http://www.who.int/tb/strategy/en/> (accessed 15 March 2016).

² United Nations General Assembly resolution 70/1 – Transforming our world: the 2030 Agenda for Sustainable Development, see http://www.un.org/ga/search/view_doc.asp?symbol=A/RES/70/1&Lang=E (accessed 15 March 2016).

38. As resources, efficiencies and capacities increase, the range of services provided can be expanded, the quality can be improved, and more populations can be covered with less direct costs to those who need the services – a progressive realization of universal health coverage.

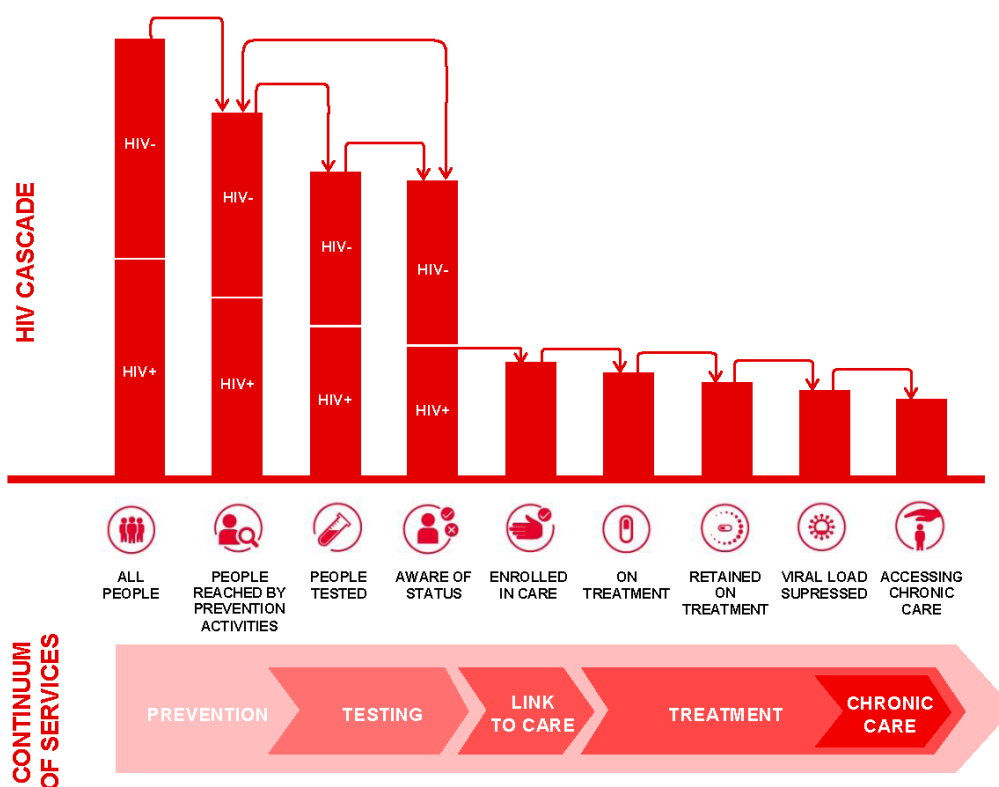
Figure 4. The three dimensions of universal health coverage



2.3 The continuum of HIV services – an organizing framework

39. Universal health coverage provides an overarching framework for the strategy while the continuum, or cascade, of HIV services provides an organizing framework for implementation. Countries need to implement high impact, evidence-based interventions along the entirety of the continuum of services for HIV vulnerability and risk reduction, prevention, diagnosis, treatment and chronic care (see Figure 5), focusing on populations and geographical locations where most HIV transmission is occurring and which are experiencing the greatest HIV burden. The continuum of services will need to be adapted and monitored for different populations, settings and epidemic types, while ensuring that common comorbidities such as tuberculosis and viral hepatitis are also well addressed. The strategy defines the essential services and interventions along the continuum, and it recommends ways for assuring and improving the quality of services and programmes. As people move along the HIV services continuum, there is a loss to follow up, with this “leakage” creating a retention cascade (see Figure 5). The objective is to engage individuals as early as possible along the continuum, retain them in care, and minimize any leakages along the cascade.

Figure 5. The continuum of HIV services and retention cascade



2.4 A public health approach

40. The strategy is rooted in a public health approach that is concerned with preventing disease, promoting health, and prolonging life among the population as a whole. It aims to ensure the widest possible access to high-quality services at the population level, based on simplified and standardized interventions and services that can readily be taken to scale, including in resource-limited settings. A public health approach aims to achieve health equity and promote gender equality, to engage communities and to leverage public and private sectors in the response. It promotes the principle of Health in All Policies through, where necessary, legal, regulatory and policy reforms. It aims to strengthen integration and linkages between HIV and other services, improving both impact and efficiency.

41. The strategy builds on the many ways in which HIV responses have helped to strengthen health systems in many countries, leading to better quality services. Those responses have pioneered financing models and strategies for reducing the prices of commodities and the financial risks to individuals and communities. HIV responses have catalysed breakthroughs in science and technology and proven that it is feasible to rapidly scale-up clinical and public health programmes in challenging settings. They have driven transformations in the way health services are delivered, through decentralized and linked services, task shifting, and stronger intersectoral collaboration. Benefits are also apparent in enhanced systems for the provision of chronic care and for strengthening adherence to and retention on lifelong treatments, as well as improved systems concerned with monitoring and evaluation, and procurement and distribution. Crucially, they have capitalized on the advantages of engaging communities in designing, implementing and monitoring HIV programmes, and have highlighted their roles in strengthening governance and accountability.

3. VISION, GOAL AND TARGETS

42. The strategy outlines a global vision, a global goal and a set of global targets, all of which are fully aligned with the vision, goal and targets of the multisectoral UNAIDS strategy and the Sustainable Development Goals.

3.1 The vision

43. *The vision:* Zero new HIV infections, zero HIV-related deaths and zero HIV-related discrimination in a world where people living with HIV are able to live long and healthy lives.

3.2 The goal

44. *The goal:* To end the AIDS epidemic as a public health threat by 2030, within the context of ensuring healthy lives and promoting well-being for all at all ages.

3.3 The global targets for 2020

45. *Global targets:* Countries have an opportunity to take a decisive leap towards ending their AIDS epidemics – if they act swiftly and with enough resolve to reach ambitious targets for 2020. These targets apply to everyone: children, adolescents and adults; rich and poor; women and men; and all key populations. Tracking new HIV infections is the leading indicator to measure progress towards the overall goal of ending the AIDS epidemic as a public health threat by 2030.

HIV-related deaths:

- reduce global HIV-related deaths to below 500 000
- reduce tuberculosis deaths among people living with HIV by 75%
- reduce hepatitis B and C deaths among people coinfected with HIV by 10%, in line with mortality targets for all people with chronic hepatitis B and C virus infection.

Testing and treatment:

- ensure that 90% of people living with HIV know their HIV status
- ensure that 90% of people diagnosed with HIV receive antiretroviral therapy
- ensure that 90% of people living with HIV, and who are on treatment, achieve viral load suppression.

Prevention:

- reduce new HIV infections to below 500 000
- zero new infections among infants.

Discrimination:

- zero HIV-related discriminatory laws, regulations and policies, and zero HIV-related discrimination in all settings, especially health settings
- 90% of people living with HIV and key populations report no discrimination in the health sector.

Financial sustainability:

- overall financial investments for the AIDS response in low- and middle-income countries reach at least US\$ 26 000 million, with a continued increase from the current levels of domestic public sources
- ensure that all countries have integrated essential HIV services into national health financing arrangements.

Innovation:

- increase research into and development of HIV-related vaccines and medicines for use in treatment and prevention
- provision of access by 90% of countries to integrated health services covering HIV, tuberculosis, hepatitis B and C, reproductive health and sexually transmitted infections.

3.4 Country targets for 2020

46. Countries should develop, as soon as practicable, ambitious national goals and targets for 2020 and beyond, which ideally would be guided by global goals and targets. Such goals and targets should take into consideration the country context, including the nature and dynamics of country HIV epidemics, populations affected, structure and capacity of the health care and community systems, and resources that can be mobilized. Targets should be feasible and based on the best possible data available on the HIV situation, trends and responses, and monitored through a set of standard and measurable indicators. The targets should apply to everyone.

4. STRATEGIC DIRECTIONS AND PRIORITY ACTIONS

47. To achieve the 2020 and 2030 targets, action is required in five areas, referred to as “strategic directions”. Under each of the strategic directions, specific actions need to be taken by countries, WHO and partners. This strategy outlines the priority actions to be taken by countries and WHO. The proposed actions are intended to guide country efforts, with countries selecting and implementing those actions that are most appropriate to their HIV epidemics and country contexts, considering national jurisdictions and legislation. It aims to maximize the synergies between HIV and other health areas, and to align the health sector response with other global health and development strategies, plans and targets.

48. The five strategic directions that guide priority actions by countries and by WHO are presented below:

Strategic direction 1: Information for focused action (know your epidemic and response).

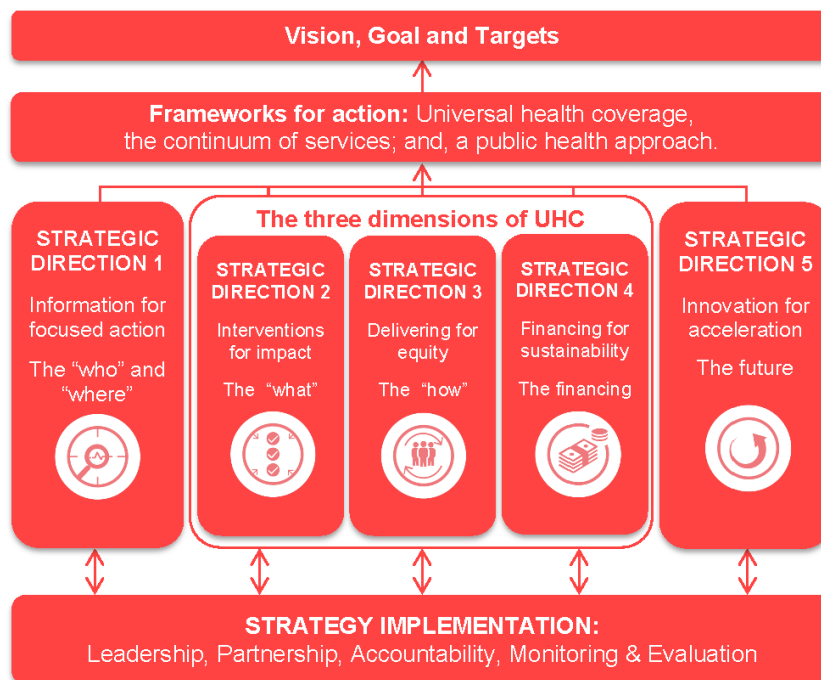
Strategic direction 2: Interventions for impact (covering the range of services needed).

Strategic direction 3: Delivering for equity (covering the populations in need of services).

Strategic direction 4: Financing for sustainability (covering the costs of services).

Strategic direction 5: Innovation for acceleration (looking towards the future).

Figure 6. The five strategic directions of the global health sector strategy on HIV, 2016–2021



49. Each of the strategic directions addresses a specific set of questions:

Strategic direction 1 – What is the situation? – focuses on the need to understand the HIV epidemic and response as a basis for advocacy, political commitment, national planning, resource mobilization and allocation, implementation, and programme improvement.

Strategic direction 2 – What services should be delivered? – addresses the first dimension of universal health coverage by describing the essential package of high-impact interventions that need to be delivered along the continuum of HIV services to reach country and global targets, and which should be considered for inclusion in national health benefit packages.

Strategic direction 3 – How can these services be delivered? – addresses the second dimension of universal health coverage by identifying the best methods and approaches for delivering the continuum of HIV services to different populations and in different locations, so as to achieve equity, maximize impact and ensure quality.

Strategic direction 4 – How can the costs of delivering the package of services be covered? – addresses the third dimension of universal health coverage by identifying sustainable and innovative models for financing HIV responses, approaches for reducing costs and financial protection systems so that people can access the services they need without incurring financial hardship.

Strategic direction 5 – How can the trajectory of the response be changed? – identifies those areas where there are major gaps in knowledge and technologies, where innovation is required to shift the trajectory of the HIV response so that actions can be accelerated and the 2020 and 2030 targets achieved.

4.1 STRATEGIC DIRECTION 1: Information for focused action

Knowing your HIV epidemic and response in order to implement a tailored response

50. The global HIV response has matured over the past 30 years, supported by unprecedented financial investments and public health and technical innovations. Nevertheless, major service gaps exist, inequities in access persist and resource constraints are becoming more pressing. The success of the next phase of the response will depend on more efficient, tailored and sustained action informed by country realities and quality data.

51. High-quality “granular” data – disaggregated by sex, age and other population characteristics, across the different levels of the health care system – make it possible to focus HIV services more precisely and effectively, and to deploy or adapt services to reach greater numbers of people in need. Greater community and stakeholder involvement in collecting and analysing the data has the potential to improve the quality and effective use of the information. The rigorous application of ethical standards in gathering and using data is important so as not to compromise the confidentiality and safety of individuals and communities. With limited resources available, countries need to use these data to build strong investment cases, to argue for fair allocation of domestic resources and to mobilize external resources.

4.1.1 Understanding the epidemic and the response – data for decisions

52. A robust and flexible strategic information system is the cornerstone for advocacy, national strategic planning, and ensuring accountability for the best and fairest use of resources. Such HIV information systems must be integrated within the broader national health information system.

Understanding the epidemic – the “who” and the “where”

53. HIV information systems must be capable of: identifying the locations where and among whom new HIV infections are occurring; determining the major modes of HIV transmission and risk behaviours; estimating the size of populations at risk and affected; monitoring the health consequences of HIV epidemics, including common HIV coinfections and other comorbidities; and ascertaining the social, legal and economic conditions that increase the vulnerability of populations.

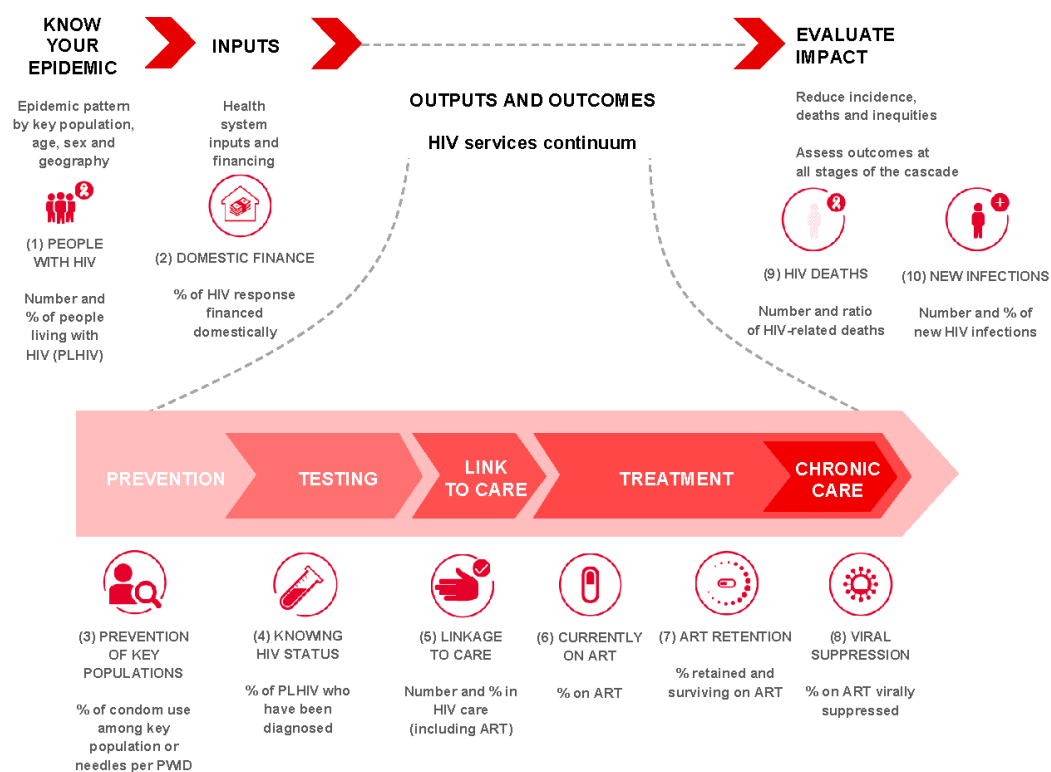
54. In the most affected region, sub-Saharan Africa, adolescent girls and young women continue to experience the greatest burden of HIV, with HIV incidence and prevalence among young women more than twice as high as among young men. Those disproportionately affected by HIV epidemics in all regions, including in high-burden settings, have been identified as: men who have sex with men, people who inject drugs, sex workers, transgender people and prisoners. They are also the ones more likely to have limited access to critical HIV services. In many settings, some populations fall outside

the routine HIV surveillance system, often because they are less likely to access health services. These include adolescents, men and mobile populations. Migration and population movements within and between countries can significantly influence the dynamics of local HIV epidemics, highlighting the importance of including mobile populations in national HIV strategies, plans, efforts and activities.

Monitoring and understanding the response

55. Monitoring and understanding the HIV response at country and global levels are critical for informing more strategic investments in HIV programmes, and for maximizing their effectiveness, responsiveness and cost-effectiveness. Quality data are required to measure service access, service uptake, populations covered, quality and acceptability along the entire continuum of HIV services. This ensures that gaps and deficiencies are identified, which in turn ensures that remedial actions can be implemented. With the aim of gauging the health sector response along the continuum of HIV services, WHO guidelines recommends for countries to consider the adoption of 50 national indicators where appropriate, of which 10 are identified for global monitoring (see Figure 7).

Figure 7. Key indicators for monitoring the HIV response across the continuum of HIV services and including the HIV care cascade



"ART" refers to antiretroviral therapy – "PWD" refers to people who inject drugs

Fast-track actions for countries

- **Build a comprehensive strategic information system** to provide quality and timely data, using standardized indicators and methodologies, guided by WHO and UNAIDS guidelines.
- **Increase the “granularity” of data**, appropriately disaggregated to the district, community and facility levels by age, sex, population and location to better understand subnational epidemics, assess performance along the continuum of HIV services and guide more focused investments and services.
- **Link and integrate HIV strategic information systems with broader health information systems** and identify opportunities for integrated strategic information platforms.

Fast-track actions for WHO

- **Provide global leadership**, in cooperation with UNAIDS, in HIV surveillance and monitoring the health sector response.
- **Set standards and provide updated guidance and operational tools** for data collection, analysis and reporting, including the WHO and UNAIDS guidelines for second-generation HIV surveillance and the WHO consolidated strategic information guidelines.
- **Provide technical support to countries** for the adaptation and implementation of WHO and UNAIDS HIV strategic information guidelines and tools for strengthening national, district and facility data systems. Support the analysis of health services cascades in key countries to guide quality improvement.
- **Report** annually on the health sector response to HIV and progress towards the 2020 and 2030 HIV targets.

4.1.2 Governance, national strategic planning and accountability

56. National HIV governing structures, such as national HIV programmes, HIV commissions and country coordination mechanisms, play a critical role in advocating for an effective response, national strategic planning and resource allocation, promoting policy coherence, coordinating roles and actions across different stakeholders, aligning the HIV response with broader health programmes and ensuring that an enabling environment is in place. National government leadership is essential for achieving coherence and coordination, although the importance of decentralized decision-making, where appropriate, should also be recognized.

57. Data generated from the national HIV strategic information system are critical for informing the national HIV strategy and implementation plan and other HIV-related efforts and activities. The strategy should define national targets that are aligned with global targets and actions required to reach these targets. The strategy should outline critical policy, legal and structural measures that need to be taken to enable and enhance the HIV response.

58. The linkages need to be clearly shown between the HIV health strategy and other related strategies, including: sectoral HIV strategies; other relevant strategies specific to diseases and risk factors, such as those for tuberculosis and sexual and reproductive health; and broader national health and development strategies.

Fast-track actions for countries

- **Review and, where necessary, reform national HIV governance structures** to ensure that HIV is “taken out of isolation” by promoting appropriate linkages and integration of HIV services within the broader national health programme and coordinating the HIV response across relevant sectors.
- **Set national targets and milestones** for 2020 and 2030, based on global targets for eliminating AIDS as a public health threat.
- **Review and update the national HIV strategy** to reflect the new national HIV targets and priorities and develop a costed implementation plan to operationalize the strategy.
- **Strengthen programme accountability** by regularly reporting on national HIV programme implementation, financing, performance and impact, including progress towards the 2020 and 2030 targets.

Fast-track actions for WHO

- **Develop and update guidance** on national HIV strategic planning, prioritization and costing, with a focus on achieving 2020 and 2030 targets.
- **Provide technical support to countries** to undertake regular HIV programme and impact reviews to monitor progress towards national and global HIV targets and to improve country implementation.

4.2 STRATEGIC DIRECTION 2: Interventions for impact*People should receive the full range of HIV services they need*

59. Achievement of the prevention, testing and treatment targets for 2020 requires a robust health system that is able to engage and retain people along the entire continuum of HIV prevention and care services. It must ensure that people: can access effective HIV prevention services; are tested, receive and understand their HIV diagnosis; are referred to appropriate HIV prevention services or enrolled in care; are initiated early on antiretroviral therapy if diagnosed HIV positive; are retained on effective treatment to achieve sustained viral suppression; are moved to alternative antiretroviral regimens if treatment fails; and can access chronic and palliative care, including prevention and management of major coinfections and other comorbidities.

4.2.1 Defining an essential benefit package for HIV

60. Each country should review its package of essential HIV services in light of changing epidemics, new knowledge and innovations, and define a set of essential HIV interventions, services, medicines and commodities to be included in its national health benefit package. The benefit package should be covered in whole, or in part, through public funding so as to minimize out-of-pocket payments, ensure access to services for all who need them and cover the entire continuum of HIV services. Selection of essential interventions and services should be through a transparent process, involving key stakeholders, considering the following criteria: effectiveness, cost, cost-effectiveness, acceptability, feasibility, relevance, demand and ethics. The package should be regularly reviewed to ensure that the selected interventions reflect changes in the country epidemic and context, advances in technologies and service delivery approaches and evidence of impact or harm. Combinations of interventions

should be specifically considered, recognizing that some interventions will only be effective, or achieve maximum impact, if they are delivered in combination with other interventions.

61. WHO guidelines make recommendations on the selection and use of interventions along the full continuum of HIV services, summarize the evidence of effectiveness of different interventions and services, and provide guidance on how such interventions might be applied in different contexts.

4.2.2 Reducing HIV vulnerability and HIV transmission and acquisition

62. Reducing new HIV infections by 75% by the end of 2020 as compared with 2010 will require major reductions in vulnerability and risk behaviour, new approaches to delivering effective prevention interventions to those who need them, and new prevention technologies.

63. Some populations are particularly vulnerable to HIV infection because of their high exposure to HIV and/or their inability to avoid risks or to use effective HIV prevention interventions. As mentioned, factors that increase HIV vulnerability in certain locations and populations, notably among girls and young women in sub-Saharan Africa, include gender inequality, gender-based and sexual violence, and stigmatization and discrimination. For other populations, vulnerability may be associated with their living conditions, such as men living in remote mining communities and in detention or with their inability to access services, such as migrants and displaced populations.

64. Evidence-based and comprehensive prevention frameworks are most effective when there is a strategic combination of behavioural, biomedical and structural approaches that includes primary prevention methods that reach HIV-negative people and a focus on working with people living with HIV as important partners in prevention by placing an emphasis on positive health, dignity and prevention. The HIV prevention landscape is changing dramatically and rapidly with the introduction of new technologies and approaches, most notably the use of antiretroviral drugs to prevent HIV transmission and acquisition. Combination HIV prevention will continue to rely on long-standing and highly effective interventions, including male and female condoms, behaviour change communication, harm reduction for people who use drugs and universal precautions in health care settings. However, even if these interventions were widely accepted and taken to scale, the world would still fall short of the 2020 target. The strategic use of antiretroviral medicines and the expansion of voluntary medical male circumcision for HIV prevention have the potential to change the course of the HIV response. To achieve the prevention target HIV prevention programmes will require a focused and combination approach, using high-impact interventions to reduce vulnerability and prevent sexual transmission, transmission through injecting drug use, transmission in health care settings, and mother-to-child transmission.

65. The following high-impact interventions should be included in a comprehensive HIV prevention package.

66. **Male and female condoms and lubricants.** Despite their effectiveness and their central role in the prevention of HIV and other sexually transmitted infections, the acceptability and uptake of these interventions remain low. Opportunities to realize the potential of such critical interventions include: reducing the cost of female condoms; revitalizing condom marketing approaches; and expanding distribution through diverse services and marketing outlets.

67. **Harm reduction for people who inject drugs.** The comprehensive package of harm reduction interventions is defined in WHO's *Consolidated guidelines on HIV prevention, diagnosis, treatment and care for key populations*.^{1,2} Sterile needle and syringe programmes, opioid substitution therapy for opioid users, and risk reduction communication are high-impact interventions within this broader harm reduction package. Needle and syringe programmes substantially and cost-effectively reduce HIV transmission among people who inject drugs. Opioid substitution therapy is highly effective in reducing injecting behaviours that put opioid-dependent people at risk of HIV infection. These services need to reach high coverage to have a public health impact. Special attention is required for cocaine and amphetamine-type stimulant users, for which opioid substitution therapy is not effective, and for non-injecting drug users where sexual transmission risk may be high.

68. **Antiretroviral-based prevention.** Antiretroviral medicines have great potential to prevent HIV transmission and acquisition, including through pre-exposure prophylaxis and post-exposure prophylaxis, by preventing mother-to-child transmission of HIV, and through antiretroviral therapy that achieves viral suppression. Pre-exposure prophylaxis should be considered as an additional, powerful HIV prevention tool for individuals who are at high risk of HIV acquisition; post-exposure prophylaxis should be made available for people who have had a significant exposure to HIV. Guidance on the use of pre-exposure prophylaxis, post-exposure prophylaxis and antiretroviral therapy for HIV prevention is provided in WHO's *Consolidated guidelines on the use of antiretroviral therapy for treating and preventing HIV infection*.³ Countries should establish appropriate criteria for risk assessment, develop models of service delivery and decide on the most strategic combination of antiretroviral and other prevention approaches based on their country context. Particular attention should be given to testing for HIV before people start pre-exposure prophylaxis in order to minimize the risk of the emergence of HIV drug resistance. HIV drug-resistance surveillance should be extended to cover pre-exposure prophylaxis services if they are introduced.

69. **Prevention of HIV infection in infants.** In 2014, only 62% of the estimated 1.5 million pregnant women living with HIV received antiretroviral therapy through "Option B+". Although elimination of mother-to-child transmission is feasible, HIV transmission rates remain unacceptably high – in excess of 10% in many countries. Since 2011, the *Global Plan: towards the elimination of new HIV infections among children by 2015 and keeping their mothers alive*⁴ has helped to accelerate elimination efforts. Similarly, countries are increasingly active in working towards the elimination of congenital syphilis in infants. Despite gains, achievement of the dual elimination target for 2020 will require intensified efforts for many countries. Critical elements of this elimination strategy are lifelong antiretroviral therapy for all pregnant and breastfeeding women living with HIV; early infant diagnosis; and infant prophylaxis and treatment.

¹Consolidated guidelines on HIV prevention, diagnosis, treatment and care for key populations, see <http://www.who.int/hiv/pub/guidelines/keypopulations/en/> (accessed 18 March 2016).

²WHO's comprehensive package for the prevention, treatment and care of HIV among people who inject drugs includes the following interventions: 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; and prevention and management of overdose.

³Consolidated guidelines on the use of antiretroviral therapy for treating and preventing HIV infection, see <http://www.who.int/hiv/pub/guidelines/en/> (accessed 18 March 2016).

⁴Global Plan: towards the elimination of new HIV infections among children and keeping their mothers alive, see http://www.unaids.org/en/resources/documents/2011/20110609_JC2137_Global-Plan-Elimination-HIV-Children_en.pdf (accessed 22 March 2016).

70. **Voluntary medical male circumcision.** It is estimated that, in high HIV-prevalence countries in sub-Saharan Africa, circumcising 80% of men aged 15–49 years who have not already been circumcised would prevent 3.3 million HIV infections by 2025, generating savings of US\$ 16 500 million. To achieve this coverage, accelerated scale-up is needed through innovative approaches, such as the use of safe male circumcision devices that enable the procedure to be performed by mid-level health care workers, and targeted campaigns to increase demand for circumcision among populations with low circumcision rates and significant exposure to HIV.

71. **Injection and blood safety.** Although reliable data are lacking, it is likely that unsafe medical injections and blood transfusions account for significant numbers of new HIV infections. Safe medical injections and blood supplies, along with universal precautions, are central to a well-functioning health system. The launch of the WHO injection safety policy in 2015 has focused greater attention on the issue and promotes a transition to the use of safety-engineered injection devices for therapeutic injections and vaccinations that prevent reuse and sharps injuries.

72. **Behaviour change interventions.** A range of behavioural interventions can provide information and skills that support primary prevention and risk reduction, address factors that increase risk behaviours, promote transitions to less risky behaviours, prevent HIV transmission, and increase the uptake of effective prevention services. Behavioural change messages and communication approaches can have the desired impact if they are targeted, specific to particular population groups and settings, and linked to increased access to prevention commodities, such as condoms and sterile injecting equipment. Adolescent girls and young women in sub-Saharan Africa require specific attention, given their vulnerability and the very high HIV incidence witnessed in some communities.

73. **Prevention and management of gender-based and sexual violence.** It is widely recognized that women and girls are particularly vulnerable to gender-based and sexual violence; however, boys, men and transgender people are also vulnerable. Structural interventions, such as addressing gender inequities and antisocial behaviour, harmful use of alcohol and other major risk factors, are required to prevent violence. The health sector also has an important role in providing care to those who have experienced such violence, including post-rape care and provision of post-exposure prophylaxis.

Fast-track actions for countries

- **Prioritize high-impact prevention interventions**, including for male and female condom programming, injection and blood safety, and behaviour change communication.
- **Maximize the prevention benefits of antiretroviral drugs** by scaling up antiretroviral therapy coverage for all people living with HIV and implementing a strategic combination of pre-exposure prophylaxis and post-exposure prophylaxis with other prevention interventions.
- **Eliminate HIV and congenital syphilis in infants** by setting national targets and providing lifelong antiretroviral therapy for pregnant and breastfeeding women, expanding early infant diagnosis and providing immediate antiretroviral therapy for all infants diagnosed with HIV.
- **Implement, to scale, a comprehensive package of harm reduction interventions** tailored to and appropriate for the local drug-using patterns and country context. Priority should be given to the high-impact interventions, where appropriate, including the provision of sterile injecting equipment, opioid substitution therapy, risk reduction information and drug dependence treatment.
- **Prioritize combination HIV prevention to adolescents, girls and young women**, and male sexual partners, particularly in high-burden settings in sub-Saharan Africa, using interventions that aim to reduce both vulnerability and risk behaviours, including gender-based and sexual violence and sexual risk behaviour associated with alcohol and other drug use.

Fast-track actions for WHO

- **Advocate and support expansion of new prevention technologies** and approaches in the context of combination prevention, including implementation of early antiretroviral therapy, pre-exposure prophylaxis and post-exposure prophylaxis, and, in priority countries, voluntary medical male circumcision.
- **Provide guidance on combination HIV prevention**, rapidly integrating new, evidence-based health sector interventions into HIV prevention packages for different epidemic contexts, with particular attention to female and male adolescents, girls, women and key populations (including young key populations).
- **Support increased commitment, resources and actions to eliminate HIV infections in children**, working in cooperation with UNICEF. Validate the elimination of mother-to-child transmission of HIV and syphilis in countries.
- **Reinforce country implementation of WHO standards and policies on existing prevention interventions**, including quality male and female condom and lubricant programmes, and injection and blood safety.

4.2.3 Expanding HIV testing

74. Achieving the target of 90% of people with HIV knowing their HIV status by 2020 will demand wider use of effective and new HIV testing approaches, strategies and technologies, while ensuring the quality of testing and ethical testing practices. Testing services need to target those populations, settings and locations where HIV risk and transmission is highest. Testing should be consensual, confidential and accompanied by appropriate information and counselling.

75. HIV testing is the first step in enabling people with HIV to know their HIV status and to be linked to HIV prevention, treatment and care services. Late diagnosis can compromise efforts to ensure long-term effectiveness of treatment and lessen the potential impact on prevention. It is estimated that, globally, about half of people living with HIV currently do not know their HIV status. HIV testing also offers an opportunity, in parallel, to screen for other infections and health conditions, including sexually transmitted infections, tuberculosis and viral hepatitis, which is likely to contribute significantly to reducing comorbidity and mortality. Early diagnosis of HIV in infants born to women living with HIV is critical to ensure the timely initiation of life-saving antiretroviral therapy, and yet, in 2013, fewer than 50% of exposed infants were tested.

76. Selection of the most appropriate combination of HIV testing approaches and strategies will depend on HIV epidemic dynamics, the populations affected and the local health system. New and targeted approaches provide opportunities to rapidly expand the coverage, quality and yield of testing services, for example, the routine offer of testing to all key populations in primary care and clinical settings including tuberculosis services, couples testing, community-based testing, self-testing and the use of lay testers, along with testing technologies that may be used at point-of-care. When resources are limited, testing should be targeted where yields will be greatest while maintaining equity. Expanding testing coverage requires specific attention to ensuring the quality of the diagnostics and testing services to minimize the risk of misdiagnosis of HIV status. Comprehensive guidance on HIV testing approaches and strategies is presented in WHO's *Consolidated guidelines on HIV testing services*.

Fast-track actions for countries

- **Diversify testing approaches and services** by combining provider-initiated and community-based testing, promoting decentralization of services and utilizing HIV testing services to test for other infections and health conditions.
- **Focus testing services to reach populations and settings** where the HIV burden is greatest and to achieve equity.
- **Prioritize the expanded coverage of early infant diagnosis technologies.**
- **Ensure that HIV testing services meet ethical and quality standards.**

Fast-track actions for WHO

- **Regularly update consolidated guidance on HIV testing and testing for common coinfections**, rapidly integrating guidance on new testing approaches, strategies and diagnostics.
- **Support countries to implement quality assurance programmes for testing**, guided by data on misdiagnosis and misclassification.
- **Support expansion of paediatric HIV testing** through updated guidance and technical support to countries, including early infant diagnosis and testing in low-prevalence settings.

4.2.4 Expanding antiretroviral therapy, managing comorbidities and providing chronic care

77. The target of having 90% of people with HIV on antiretroviral therapy by 2020 will require acceleration in the scale-up of antiretroviral therapy and improved retention in care. Achievement of the target of viral suppression of 90% of people on antiretroviral therapy will require major improvements in treatment adherence, robust and well-tolerated antiretroviral therapy regimens and effective HIV drug-resistance surveillance and toxicity monitoring systems to minimize treatment failure. WHO guidelines on the use of antiretroviral medicines provide a means of achieving the 90% coverage target and help simplify treatment initiation protocols by recommending that anyone diagnosed with HIV should begin antiretroviral therapy as soon as possible following diagnosis. Countries should develop national treatment plans that provide a road map for expanding access to antiretroviral therapy through differentiated care that ensures rapid and equitable access to treatment, particularly for people at an advanced stage of HIV-related disease.

78. The global target of having 15 million people on treatment was exceeded in 2015. Nevertheless, this represents only about 40% of people living with HIV, all of whom should have access to treatment. The situation is particularly poor for children living with HIV, only 32% of whom were receiving antiretroviral therapy in 2014. Similarly, people from key populations tend to have very poor access to antiretroviral therapy. In addition, as more asymptomatic people are treated with antiretroviral drugs, viral load testing to assess treatment effectiveness and prevent the emergence of HIV drug resistance will be important. Surveillance of HIV drug resistance at the population level is essential for monitoring the quality of treatment programmes and the selection of treatment regimens. Access to second- and third-line antiretroviral therapy regimens continues to be severely limited in most low- and middle-income countries, highlighting the importance of preventing first-line treatment failure.

79. As coverage of antiretroviral therapy expands, people living with HIV are also experiencing a broad range of other health issues, including those related to HIV infection and HIV treatment, non-HIV-related coinfections and comorbidities, and ageing – all of which require comprehensive care and management.

80. **Expand antiretroviral therapy coverage.** Safe, simple, affordable and well-tolerated first-line antiretroviral regimens, using one tablet a day fixed-dose combinations, enable rapid and sustainable scale-up of antiretroviral therapy for adults. Continuous assessment of evidence on treatment efficacy and toxicity, with regular updates of WHO's consolidated antiretroviral guidelines will ensure that the latest scientific evidence, new medicines and technologies, and country experiences in treatment scale-up can inform national treatment guidelines and protocols. The lack of early infant diagnosis, fixed-dose antiretroviral combinations and palatable antiretroviral formulations pose particular barriers to paediatric treatment scale-up. To maximize treatment outcomes, antiretroviral therapy should be started as early as possible for both adults and children, highlighting the need for early diagnosis and effective linkages to treatment for those testing HIV positive.

81. **Prevent and manage HIV and tuberculosis coinfection.** Effective tuberculosis and HIV co-management has resulted in a decline in the number of people dying from HIV-associated tuberculosis by a third between 2004 and 2014. However, tuberculosis continues to be the major cause of morbidity among people living with HIV and is estimated to account for around a third of HIV-related deaths. More than half of the cases of HIV-associated tuberculosis are undetected, undermining access to life-saving antiretroviral therapy. Intensified implementation and uptake of key interventions, including systematic tuberculosis screening among people living with HIV, isoniazid preventive therapy, as well as HIV testing of all people with diagnosed or presumed tuberculosis, timely initiation of antiretroviral therapy, and co-trimoxazole prophylaxis, will be required to further reduce tuberculosis-related morbidity and mortality.

82. **Prevent and manage HIV and viral hepatitis coinfection.** Chronic hepatitis B virus infection and chronic hepatitis C virus infection are growing causes of morbidity and mortality among people living with HIV in a range of countries. HIV and hepatitis C virus coinfection rates are highest among people who inject drugs, affecting all regions. HIV has a profound impact on hepatitis B virus and hepatitis C virus infection, resulting in higher rates of chronic hepatitis, accelerated fibrosis progression with increased risk of cirrhosis and hepatocellular carcinoma, and higher liver-related mortality. Integrated management of HIV and viral hepatitis infection should be provided, with early diagnosis and treatment of both HIV infection and viral hepatitis infection based on WHO's guidelines on HIV, hepatitis B and hepatitis C treatment.

83. **Address other HIV coinfections.** The prevalence and impact of other coinfections, both opportunistic and non-opportunistic, among people living with HIV varies by country and population, requiring tailored responses. If not addressed, they have the potential to compromise gains made through the expansion of antiretroviral therapy. Prevention, early detection and treatment of common coinfections, such as candidiasis, cryptococcosis, human papillomavirus and other sexually transmitted infections, malaria and *Pneumocystis pneumonia* require specific attention.

84. **Prevent and manage HIV drug resistance.** Preventing and managing the emergence of HIV drug resistance will be crucial as the world moves towards wider and earlier use of HIV medicines for both HIV treatment and prevention. Addressing HIV drug resistance is critical for achieving viral suppression, dealing with treatment failure, and preventing the need to move to more expensive and toxic second- and third-line antiretroviral therapy regimens. HIV drug-resistance surveillance and monitoring of early warning indicators should be integrated into national HIV treatment services, quality improvement efforts and broader health information systems, including those for antimicrobial resistance.

85. **Provide person-centred chronic care for people living with HIV.** Simple and effective care interventions can improve the general health and well-being of people living with HIV, including factors such as adequate nutrition, access to safe water and sanitation, and palliative care. People living with HIV are at increased risk of developing a range of noncommunicable diseases as a consequence of their HIV infection or related to side-effects of their treatment or ageing, including cardiovascular disease, diabetes, chronic lung disease and various cancers. Common mental health comorbidities include depression, anxiety, dementia and other cognitive disorders. Chronic HIV care services should include interventions across the continuum of care, including screening for, monitoring and managing the most common health risks and comorbidities experienced by people living with HIV. The increasing burden of cervical cancer among women living with HIV, associated with human papillomavirus infection, requires specific attention, particularly given the availability of effective human papillomavirus vaccine, screening and treatment. Effective pain management, palliative care and end-of-life care are also essential interventions to be included in HIV services.

Fast-track actions for countries

- **Regularly review and update national HIV treatment and care guidelines** and protocols, including guidance on the prevention and management of common comorbidities.
- **Develop and update treatment plans** to ensure continuity of treatment, differentiated care, as well as timely transitioning from old to new treatment regimens and approaches.
- **Implement strategies to minimize HIV drug resistance** and use the data to inform national antiretroviral policies and guidelines.
- **Provide general and chronic care services**, make available the WHO Package of essential noncommunicable disease interventions for primary care,¹ provide community and home-based care, and ensure access to opioid medicines for the management of pain and end-of-life care.

Fast-track actions for WHO

- **Review and report on the major causes of, and trends in, morbidity and mortality** among people living with HIV, disaggregated by geographic region, population and gender.
- **Provide updated consolidated guidelines on the use of antiretroviral drugs for HIV treatment and prevention** and the prevention and management of common comorbidities that will guide rapid and sustainable treatment scale-up to all people living with HIV. Provide guidance on differentiated care for people presenting at different stages of HIV infection and disease.
- **Provide assistance to countries to develop and implement national HIV treatment guidelines, plans and protocols** based on the WHO global guidelines.
- **Provide guidance on HIV drug resistance surveillance, prevention and management** and regularly report on global HIV drug-resistance prevalence and trends.

4.3 STRATEGIC DIRECTION 3: Delivering for equity

All people should receive the services they need, which are of sufficient quality to have an impact

86. Achievement of the 2020 HIV targets will require a robust and flexible health system that includes: a strong health information system; efficient service delivery models; a sufficient and well-trained workforce; reliable access to essential medical products and technologies; adequate health financing; and strong leadership and governance. HIV interventions are most effective when they occur in appropriate social, legal, policy and institutional environments that encourage and enable people to access and use services, which, in themselves, are free of stigmatization and discrimination. Such interventions therefore need to be grounded in an enabling environment that promotes health equity and human rights, and that features well-supported health and community systems.

¹ Package of essential noncommunicable (PEN) disease interventions for primary health care in low-resource settings, see http://www.who.int/cardiovascular_diseases/publications/pen2010/en/.

87. HIV is an area of public health in which major inequities exist in terms of vulnerability and risk, service access, and health and social outcomes. Countries need to strike a balance between focusing their HIV responses for maximum impact and ensuring that no one is left behind, particularly children and adolescents, girls and women, key populations, and people living in remote areas. Priority should be given to reaching populations and locations in greatest need and overcoming major inequities.

4.3.1 Adapting the HIV services continuum for different populations and locations

88. HIV interventions and the continuum of HIV services need to be adapted for different populations and locations, to reach those most affected and to ensure that no one is left behind. WHO guidelines, and implementation tools developed with partners, define essential packages of HIV interventions and service delivery models for different populations and settings, including specific packages for adolescents, women and girls, people who use drugs, sex workers, men who have sex with men, transgender people and prisoners.

89. **Decentralization.** Different levels of the health system have different roles to play in delivering HIV and related services. The strategic decentralization, integration and linking of services provide opportunities to increase access, coverage, acceptability and quality. Decentralizing services can strengthen community engagement and may improve access to services, care-seeking behaviour and retention in care.

90. **Differentiated care.** As national guidelines evolve towards providing antiretroviral therapy to all people with HIV regardless of clinical and immunological status, HIV services will be challenged to manage an increasing number of patients on treatment and an increasingly diverse set of patient needs. Differentiated care involves the provision of different care packages to patients on antiretroviral therapy based on the stage of their HIV disease, their stability on treatment and their specific care needs. Patients who are stable on treatment, for example, may be moved to community-based care, enabling overburdened clinical care settings to focus on patients who are unwell either because they are unstable on antiretroviral therapy or because they present to the clinic with an advanced stage of HIV disease or major comorbidities.

91. **Person-centred and integrated care.** People living with HIV and affected communities experience a broad range of health risks and problems; therefore, HIV and related services need to identify and deliver appropriate interventions in order to address commonly occurring conditions. With the effectiveness of antiretroviral therapy and ageing populations of people living with HIV, HIV services will need to evolve to provide comprehensive chronic care that includes the management of noncommunicable diseases. Greater integration, linking and coordination of HIV services with those for other relevant health areas (including services for sexually transmitted infections, broader sexual and reproductive health, substance use disorders, viral hepatitis, tuberculosis, blood safety, noncommunicable diseases and gender-based violence) has the potential to reduce costs, improve efficiencies and lead to better outcomes. Appropriate models of integration and linkage will depend on the country context and health system, and should be informed by operational research. Joint planning should occur for cross-cutting areas such as health information systems and monitoring and evaluation, laboratory and diagnostic services, human resource planning and capacity building, procurement and supply chain management, and resource mobilization.

92. **Linking HIV and tuberculosis services.** The strategic linking and integration of HIV and tuberculosis services and programmes provide a good model for integration. WHO's guidelines for national programmes on collaborative tuberculosis and HIV activities identify 12 collaborative activities for implementation to integrate tuberculosis and HIV services. Uptake of indicators from the WHO's publication, *A guide to monitoring and evaluation for collaborative TB/ HIV activities* (2015 revision),¹ helps countries to identify and reduce weak linkages within the care cascade. The introduction of electronic reporting and web-based systems with unique patient identifiers to be used by both programmes can facilitate smooth interoperability and enhanced patient follow-up.

93. **Community engagement and community-based services.** The meaningful involvement of the community, particularly people living with HIV, is essential for the delivery of effective HIV and broader health services, especially in settings and among populations affected by stigmatization, discrimination and marginalization. Engagement of communities at all levels bolsters advocacy efforts, policy coherence and programme coordination, strengthens accountability and can address factors that affect access, uptake, performance and outcomes of HIV responses. Community organizations and networks play a key role in delivering services to people who are not reached by government services, generating strategic information that might not be available through national HIV information systems and promoting and protecting human rights. Developing community capacities through adequate training and supervision helps improve the quality of community-based services and programmes. National HIV programmes should facilitate predictable funding of community organizations and adequate remuneration for services provided.

94. **Addressing the needs of special settings.** There are specific settings where HIV vulnerability and risk are high and where access to basic HIV services might be severely compromised, such as in prisons and detention centres, refugee camps and settings of humanitarian concern. Services provided to individuals in such settings should be equivalent to those available to the broader community. Particular challenges exist for mobile and displaced populations, including those affected by conflict, natural disasters and economic migration. Members of such population groups are dislocated from their communities, support networks and regular health services, the effect of which may be interruptions in the continuity of their prevention, treatment and care. For example, they may not be able to access or utilize local HIV and other health services because of lack of necessary documentation or high costs of the services with no form of financial protection, such as health insurance.

95. **Ensuring the quality of interventions and services.** Rapid expansion of programmes to improve coverage should neither compromise the quality of services nor contribute to inequities in access to services and health outcomes. Countries should monitor the integrity of their continuum of HIV services to determine where improvements can be made. Services should be organized to minimize "leakages" and maximize retention and adherence. Major challenges include: acceptability and uptake of effective prevention interventions; targeting HIV testing and counselling to achieve greatest yield; ensuring quality of testing to minimize incorrect diagnosis; linking people diagnosed to appropriate prevention and treatment services as early as possible; ensuring adherence to and continuity of treatment; providing chronic care to prevent and manage comorbidities, including tuberculosis and viral hepatitis; and monitoring treatment outcomes, including antiretroviral toxicity and viral suppression in order to ensure timely switching to second- and third-line treatment and to prevent the emergence of HIV drug resistance.

¹ A guide to monitoring and evaluation for collaborative TB/HIV activities: 2015 revision, see <http://www.who.int/publications/monitoring-evaluation-collaborative-tb-hiv/en/> (accessed 22 March 2016).

96. Quality of care can be optimized by ensuring that HIV services, including testing and laboratory services adhere to national and international norms and standards, are continuously monitored and improved, and are made more acceptable and accessible to patients' needs and preferences. Indicators and mechanisms for monitoring the quality of services should address such issues as waiting lists, facility waiting times, frequency of visits, and competencies and supervision of health care workers. Ultimately, the quality of HIV interventions must be measured by their ability to improve people's health and well-being.

Fast-track actions for countries

- **Set national norms and standards** across the HIV service continuum based on international guidelines and other standards and monitor their implementation.
- **Define and implement tailored HIV intervention packages** for specific populations and locations, ensuring services are relevant, acceptable and accessible to populations most affected.
- **Provide differentiated care** by providing tailored intervention packages to individuals at different stages of HIV disease and with different treatment needs.
- **Adapt service delivery models to strengthen integration and linkages with other health areas and to achieve equity**, with a particular focus on reaching adolescents, young women, men and key populations.
- **Enable effective engagement of and capacity building of communities** and ensure that legal and regulatory frameworks facilitate stronger collaboration and partnerships with community groups and between the public and private sectors.
- **Integrate HIV into national emergency plans** to ensure the continuity of essential HIV services during emergencies and in settings of humanitarian concern, with a particular focus on preventing treatment interruptions. Provide training to essential emergency and health service staff based on the Inter-Agency Standing Committee Task Force on HIV/AIDS in Emergency Setting's Guidelines for HIV/AIDS interventions in emergency settings.¹
- **Provide equitable services in closed settings**, including implementing the comprehensive package of HIV interventions for prisoners and prison settings as developed by WHO and the United Nations Office on Drugs and Crime.

¹ Guidelines for HIV/AIDS interventions in emergency settings, see http://www.who.int/3by5/publications/documents/en/iasc_guidelines.pdf (accessed 22 March 2016).

Fast-track actions for WHO

- **Provide updated guidance on essential HIV packages, differentiated care and service delivery models for specific populations and specific settings**, including for adolescents, mobile populations, populations in humanitarian settings (WHO in cooperation with UNHCR). Prisoners (WHO in cooperation with the United Nations Office on Drugs and Crime) and key populations.
- **Support countries in their effort to adapt their HIV services continuum**, based on an analysis of their situation, with a particular focus on improving treatment adherence and retention in care.
- **Provide technical support to countries for implementing the WHO policy on collaborative TB/HIV activities**¹ and *A guide to monitoring and evaluation for collaborative TB/HIV activities*.²
- **Provide guidance on community-based services and community engagement** and involve civil society in the development and implementation of WHO's policies and guidance.
- **Provide technical assistance to countries and partners** to undertake timely health needs assessments in settings of humanitarian concern and among fragile communities.

4.3.2 Strengthening human resources for health

97. The expansion of HIV services to achieve the HIV targets for 2020 and 2030 will place unprecedented demands on the health workforce. Different cadres of health care workers will be required to perform different roles across the full continuum of HIV services. New models of service delivery for meeting more ambitious targets will require strengthening the health workforce, reviewing the roles and tasks of health workers and their deployment across different services. In addition to the provision of routine HIV services, there will be an increasing need for health workers to be competent in delivering services to specific populations, including key populations, and in providing chronic care for people living with HIV. A comprehensive national health workforce plan should address the needs of the overall health system, along with what is required to deliver the full HIV service continuum.

98. Task-shifting is increasingly being used as part of broader human resources reforms to improve service accessibility, efficiency and quality. Such approaches have already enabled rapid scale-up of HIV testing, treatment and other services in low-resource settings and will play an increasingly important role in expanding the capacity of health care systems. Within the context of task-shifting and task-sharing, supportive mechanisms need to be put in place, including mentoring and supervision, to ensure the quality of services. Peer-support workers can provide valuable services and can help link the community and health services, and in turn should receive regular training, mentoring, supervision and appropriate compensation for their work.

¹ WHO policy on collaborative TB/HIV activities: guidelines for national programmes and other stakeholders, see http://apps.who.int/iris/bitstream/10665/44789/1/9789241503006_eng.pdf?ua=1 (accessed 22 March 2016).

² A guide to monitoring and evaluation for collaborative TB/HIV activities, see http://www.unaids.org/sites/default/files/media_asset/2015_guide_monitoring_evaluation_collaborative_TB-HIV_activities_en.pdf (accessed 22 March 2016).

99. Given the risk of HIV transmission in health care settings, health workers should be protected by comprehensive occupational health and safety programmes, which promote universal precautions, access to prevention commodities such as condoms, post-exposure prophylaxis following significant exposure to HIV, confidential HIV testing, and treatment and care for health workers living with HIV.

Fast-track actions for countries

- **Develop, monitor implementation and regularly update a national HIV health workforce plan** that is part of a broader health workforce plan, and aligned with the national health plan and priorities.
- **Develop the capacity of the health workforce** by defining core competencies for different roles in the provision of comprehensive HIV services, providing relevant training and introducing appropriate accreditation and certification processes.
- **Identify opportunities for task-shifting** to extend the capacity of the health workforce, and apply an appropriate training system and regulatory framework including for community health workers.
- **Promote the retention of health workers** through appropriate incentives, in particular ensuring adequate wages for all health workers, including for community health and lay workers.

Fast-track actions for WHO

- **Advocate for training of health workers** to focus on the delivery of people-centred care that addresses discrimination in the health sector, including discrimination against key populations.
- **Provide guidance on task-shifting** across the full continuum of HIV services, including on the use of lay providers for the delivery of specific services, such as HIV testing, support for pre-exposure prophylaxis and antiretroviral therapy delivery, and prevention and management of common comorbidities.

4.3.3 Securing the supply of good quality and affordable medicines, diagnostics and commodities

100. The rapid expansion in coverage of HIV prevention, diagnosis and treatment interventions is dependent on the availability and secure supply of affordable and high-quality HIV medicines, diagnostics and other commodities. Inferior quality and interrupted supplies of essential HIV commodities, whether it be condoms, injecting equipment, male circumcision devices, diagnostics, medicines or other commodities, impede programme expansion and risk prevention and treatment failure, including the emergence of HIV drug resistance.

101. The accurate forecasting of country and global needs of all HIV commodities is required to inform the readiness and capacity of manufacturers to meet expected needs and to ensure the continuity of supplies. Local manufacturing capacity should be considered, with the potential to reduce prices, guarantee supply and promote national ownership. National HIV and broader health plans and budgets should address procurement and supply chain management needs. Medicines, diagnostics and other commodities constitute a major component of national HIV programme costs. Selecting the right products of sufficient quality is critical for achieving the best outcomes at an affordable price. WHO offers a range of guidance for countries to facilitate the selection process, including guidelines on the use of antiretroviral medicines for HIV treatment and prevention, the

WHO Model List of Essential Medicines, testing strategies, and the WHO List of Prequalified Products.

102. To ensure their long-term secure supply, the procurement and supply management of HIV commodities should be integrated into the broader national procurement and supply management system. The demand for affordable HIV treatment has resulted in comprehensive price reduction strategies for HIV medicines that may be applied to other medicines, diagnostics and health commodities. Strategies include fostering generic competition, including through, where appropriate, voluntary licences that include pro-access terms and conditions such as those negotiated by the Medicines Patent Pool, and applying, as appropriate, the use of the provisions in the Agreement on Trade-Related Aspects of Intellectual Property Rights regarding flexibilities to protect public health, and in accordance with the Global Strategy and Plan of Action on Public Health, Innovation and Intellectual Property, including compulsory licences and filing patent oppositions, differential pricing and direct price negotiations with manufacturers, as well as local manufacturing. WHO maintains databases on the prices of HIV medicines and diagnostics, and collaborates with the Medicines Patent Pool,¹ which maintains a database on patent status to help countries to achieve the best possible prices for these commodities.

103. There are also many opportunities to spend less on the procurement of HIV medicines, diagnostics and commodities, and improve efficiencies in supply management, such as bulk procurement with staggered deliveries for short shelf-life commodities, advance purchasing and improved forecasting in order to avoid wastage through expired products.

Fast-track actions for countries

- **Strengthen the national HIV procurement and supply management structures and processes** by ensuring that they are integrated into the broader national procurement and supply management system.
- **Ensure the procurement of quality-assured HIV medicines, diagnostics, condoms, male circumcision devices and other HIV-related commodities**, including through the use of WHO prequalification.
- **Plan and implement an HIV medicines and commodities access strategy** to reduce prices of HIV medicines, diagnostics and other commodities, including through the use of the provisions in the Agreement on Trade-Related Aspects of Intellectual Property Rights regarding flexibilities to protect public health.
- **Safeguard and expand availability of WHO-prequalified generic products** through the expansion of licence agreements and expedition of registration at national level.

¹ The Medicines Patent Pool is a public-health oriented voluntary licensing mechanism, see <http://www.medicinespatentpool.org/> (accessed 22 March 2016).

Fast-track actions for WHO

- **Forecast demand** for, access to and uptake of medicines, diagnostics and other commodities for HIV and major comorbidities, and use this information to advocate for adequate manufacturing capacity of producers, including, where appropriate, in suitable low- and middle-income settings.
- **Promote WHO's Prequalification Programme** to allow fast-track registration of priority medicines and commodities, and to safeguard and expand availability of quality-assured medicines and diagnostics.
- **Provide guidance on HIV product selection** by national programmes, donors and implementing agencies through the generation and dissemination of strategic information on prices and manufacturers of HIV medicines, diagnostics and other commodities.
- **Provide technical support to countries** to forecast the need for essential HIV commodities, include them in their national procurement and supply management plans and develop a strategy for negotiating price reductions with manufacturers.
- **Support regulatory authorities** in pre-market assessment and registration of new HIV medicines and diagnostics, with post-market surveillance.
- **Provide technical support to countries** to develop comprehensive price reduction strategies in order to ensure access to essential HIV medicines, diagnostics and commodities.

4.3.4 Creating and sustaining an enabling environment

104. An effective HIV response requires a supportive social, legal and policy environment that encourages and enables people to access and use services. Reaching diverse populations in many different settings requires strong, well-supported health and community systems and an enabling environment that promotes health equity, gender equality and human rights.

105. **Policies, laws and regulations.** The health sector has a major obligation to ensure that policies, laws and regulations, including those in other sectors, are pro-health and support national HIV responses. When properly enforced, laws and policies that eliminate gender inequality and protect and promote human rights can reduce vulnerability to and risk of HIV infection, expand access to health services and enhance their reach, quality and effectiveness – especially for key populations.

106. An array of barriers, nevertheless, continues to prevent certain populations from accessing and using effective interventions and services, such as age of consent laws for adolescents, lack of social protection for migrants and displaced populations, and the criminalization of some populations and behaviours (such as drug use, sex work and sex between men). HIV programmes have an important role in monitoring policies, laws and regulations in other sectors to determine their possible implications for the HIV and broader health response, and where barriers exist to advocate for appropriate reviews and reforms to ensure pro-health outcomes.

Fast-track actions for countries

- **Reform policies, laws and regulations** that hinder equitable access to HIV-related services, especially for key populations and other vulnerable groups.
- **End policies and practices that reinforce stigmatization and discrimination** (especially in health care settings), particularly for people living with HIV and key populations.
- **Create institutional and community environments** that make it safe for people to access HIV services without fear of discrimination, involving communities in the planning and delivery of services to improve their reach, quality and effectiveness.
- **Address gender inequality** by integrating evidence-based interventions into national HIV plans and strategies.

Fast-track actions for WHO

- **Advocate for the use of public health evidence** to shape pro-health laws and actions based on medical ethics, human rights and public health principles.
- **Develop and promote WHO policies and guidelines** that explicitly address gender inequality, gender-based violence, stigmatization and discrimination, human rights, key populations, and public health alternatives to criminalization.
- **Develop, update and implement guidance and implementation tools** on the prevention and management of gender-based violence and the inclusion of structural barriers to accessing essential HIV services for different populations, including children, adolescents and key populations.

4.4 STRATEGIC DIRECTION 4: Financing for sustainability*All people should receive the services they need without experiencing financial hardship*

107. Implementing fast-track actions to end the AIDS epidemic by 2030 will require major new global investments, increasing from US\$ 21 700 million in 2015 to US\$ 32 000 million in 2020. By front-loading investments, the full continuum of HIV interventions and services can be rapidly taken to scale.

108. Financing for a sustainable HIV response requires action in three areas:

Revenue raising to pay for HIV interventions and services, with an emphasis on improving domestic tax collection (including both general revenues and compulsory health insurance contributions) supplemented by external sources, such as donor grants and private revenues;

Financial risk protection and pooling, including establishing equitable mechanisms to pool funds across the health system to ensure adequate coverage of the continuum of HIV services that reduces financial barriers to services while providing financial risk protection;

Improving efficiency in the use of health system resources to enable greater effective coverage of HIV services, including by reducing the costs of HIV medicines, diagnostics and other commodities and by reducing duplication of underlying subsystems with other programmes and the wider health system, such as strategic information, human resources, and procurement and supply management. Systematic use of cost studies and programme and financial data should inform programmatic priorities.

109. The national health financing system should address HIV along with all other national priority health needs, avoiding fragmented funding channels and aiming to achieve health equity.

4.4.1 Increasing investments through innovative financing and new funding approaches

110. Existing international and domestic funding commitments are not enough to achieve the 2020 and 2030 targets outlined in this strategy. New sources of funding will be required, not only to fund a sustainable scale-up of HIV-related interventions and services, but also to fill funding gaps resulting from shifting donor priorities. The HIV response has already stimulated innovation in health system financing, at global and country levels, such as the use of levies on airline tickets and mobile telephones, and through income taxes. Further innovation will be required to generate the resources required for a sustained response.

111. Increasing HIV funding needs to be part of the broader efforts in place to increase overall investments in health, in order to ensure that all priority health services can be scaled up towards universal health coverage. Public, domestic funding is central to funding essential and sustainable health services, including those for HIV. UNAIDS has set 2020 targets for domestic funding of HIV programmes, including 12% domestic funding for programmes in low-income countries, 45% for lower-middle income countries and 95% for upper middle-income countries. Public spending on health can be increased either by raising more tax revenues (increasing the government's fiscal capacity) or by allocating a greater share of overall government funds to health (giving health a greater priority in the public budget). Health ministries need to actively engage with ministries of finance on issues related to budgets, public financial management systems, and fiscal space concerns. HIV investment cases should be used to advocate for and negotiate a fair allocation of public resources for HIV.

112. Most low-income and lower middle-income countries will continue to rely on external and private sector funding for their HIV services and interventions through to 2020 and beyond. It is important that revenue flows from such sources are fully aligned with national HIV priorities, programmes and plans that are in turn embedded in a coherent national health plan. Stability and predictability of these flows are essential in order to minimize the risk of service interruption.

4.4.2 Addressing financial barriers to access and provide financial risk protection

113. Health financing systems that minimize out-of-pocket payments for all essential health services increase access to these services and prevent impoverishment. To minimize catastrophic health payments, out-of-pocket spending should be limited to less than 15–20% of total health spending.

114. Essential HIV interventions, across the continuum of HIV services, should be included in the national health benefit package and be provided free of charge. In addition, the provision of supportive arrangements (such as decentralizing services or offering transport vouchers) to minimize the indirect costs for people using services can improve service uptake and impact. User fees result in inequities in access to HIV treatment, undermine service use, contribute to poor treatment adherence, increase risks of treatment failure, and constitute unnecessary financial burdens on households.

115. Financial risk protection and access to needed services for people living with HIV and other affected populations will depend on a broader robust and fair national health financing system. Public financing systems for health, involving predominant reliance on revenues raised from general taxation and/or payroll taxes for compulsory health insurance are the most equitable and efficient systems. Such prepayment mechanisms should be based on ability to pay, with broad pooling of the revenues to enable benefits to be provided to those in need, including those who cannot afford to contribute to the system.

4.4.3 Reducing prices and costs and improving efficiencies

116. Fiscal pressures require that countries select the most effective HIV interventions and approaches, target those activities according to the populations and settings where they will have greatest impact, reduce the prices of medicines and other health commodities, and increase the efficiency of services. Programmes that can demonstrate “value for money” and efficiency gains are better positioned to argue for fair allocation of resources and external financial support. There are various opportunities to improve efficiencies and reduce costs.

117. **Good programme management** can improve the efficient flow, allocation and utilization of resources from national budgets or external sources to service delivery. This includes better coordination of donor funding and alignment with national plans and the broader health system, pooling of resources, performance-based funding and increased accountability at all levels and across all stakeholders, including implementers and funders.

118. **Improved selection, procurement and supply of affordable medicines diagnostics and other health commodities** can reduce the cost of services and eliminate waste. These approaches are described under Strategic direction 3.

119. **More efficient and high-quality service delivery** can result in major savings and improved health outcomes. Strategic direction 3 already considers opportunities for improving service delivery models, including through service integration and linkages, decentralization, task-shifting and the use of lay health providers and community systems strengthening. Assuring the quality of services is essential for improving efficiencies – good quality services will result in greater health gains for every dollar spent. Good treatment adherence and retention in care, for example, will minimize treatment failure, reduce hospitalization, and lessen the need to switch to more expensive second- and third-line treatments. The coordination of HIV interventions and services with other health programmes and the overall health system will reduce inefficiencies, and, as a result, will maximize intended results.

Fast-track actions for countries

- **Develop a robust HIV investment case** to advocate for adequate allocation of domestic resources and to mobilize external funding support.
- **Estimate national HIV resource needs** and, where necessary, develop plans to transition from external to public domestic funding of HIV services, with a particular focus on protecting essential services most reliant on external funding in order to avoid service interruption.
- **Reduce financial barriers**, including phasing out direct, out-of-pocket payments for accessing HIV and other health services.
- **Provide universal protection against health-related financial risk**, covering all populations, and identify the most appropriate way for achieving such protection, including public compulsory health financing systems.
- **Monitor health expenditures and costs and cost-effectiveness of HIV services** through the national monitoring and evaluation system in order to identify opportunities for cost reduction and saving.
- **Strengthen coordination with other health programmes** including identifying opportunities to consolidate underlying health systems, such as those for strategic information, human resources, and procurement and supply management.

Fast-track actions for WHO

- **Estimate and regularly review resource needs** (in cooperation with UNAIDS) to achieve the 2020 and 2030 targets.
- **Advocate for full funding of the HIV response** by building political commitment for sustained national financing and by promoting strategic financing partnerships, including with the Global Fund to Fight AIDS, Tuberculosis and Malaria, UNITAID, the United States President's Emergency Plan for AIDS Relief, the Bill & Melinda Gates Foundation and others.
- **Support countries to develop national HIV investment cases** and financial transition plans to move from external to domestic HIV funding.
- **Provide guidance and tools for assessing and monitoring health service costs** and cost-effectiveness and support countries to adopt WHO's Health Accounts Country Platform.¹
- **Advocate for countries** to include essential HIV intervention and services into national health benefit packages and remove financial barriers to accessing HIV services and commodities.

¹ For more information on WHO's health accounts country platform approach, see http://www.who.int/health-accounts/platform_approach/en/ (accessed 22 March 2016).

4.5 STRATEGIC DIRECTION 5: Innovation for acceleration

Changing the trajectory of the response to achieve ambitious targets

120. Research and innovation provide the tools and knowledge that can change the trajectory of the HIV response, improve efficiency and quality, achieve equity and maximize impact. It is unlikely that the HIV targets set for 2020 and 2030 will be achieved if countries rely only on existing HIV knowledge, technologies and service delivery approaches.

121. Innovation is not only required to develop new technologies and approaches, but also to use existing tools more efficiently and to adapt them for different populations, settings or purposes. Interventions that have been developed and established in one region may require “re-engineering” to be effective elsewhere, such as the concept of task-shifting developed in high prevalence settings of southern Africa being adapted as a novel approach in eastern Europe or Asia. Harm reduction programmes developed for opioid users will require innovative approaches to make them relevant for cocaine users. The rapid transfer of knowledge can help countries to “leapfrog” their HIV responses, learning from the experiences of others to quickly identify and adapt the most promising interventions and approaches. Operational research can guide HIV service improvements to ensure investments are maximized.

122. WHO supports HIV research in four main areas: building capacity of health research systems; convening partners around priority-setting for research; setting norms and standards for good research practice; and facilitating the translation of evidence into affordable health technologies and evidence-informed policy. While having a very limited direct role in research and product development, WHO works closely with research and development partners and manufacturers to ensure that essential new HIV technologies are available and affordable to countries as soon as possible.

123. Given the critical role of partners in innovation, this strategic direction describes key areas for innovation that will require joint effort by countries, WHO and other partners. Given the 15-year time horizon for achieving the 2030 targets, short-, medium- and long-term research priorities should be considered. This strategy focuses on the short- and medium-term priorities.

4.5.1 Optimizing HIV prevention

124. Recent innovations in prevention technologies have dramatically strengthened the HIV prevention portfolio, including the use of antiretroviral agents for preventing HIV transmission and acquisition, and the expansion of medical male circumcision for prevention of HIV acquisition. More extensive use of these opportunities and further innovations – some already in the pipeline – will increase impact.

125. To realize fully the potential of pre-exposure prophylaxis of HIV infection will require improved formulations, delivery systems and service delivery models, including topical and long-acting injectable formulations. Innovations in male and female condom design and medical male circumcision devices should aim to improve acceptability and uptake. HIV vaccine research and efforts to find a functional cure in people living with HIV will continue to be a key component of the HIV research agenda. New information and communication technologies should be exploited to deliver effective prevention interventions through eHealth, using web-based and mobile-based applications.

4.5.2 Optimizing HIV testing and diagnostics

126. New and improved diagnostics technologies and testing approaches will lead to earlier and more accurate HIV diagnosis, and strengthened patient monitoring. There are several opportunities for innovation. New developments in HIV self-testing have the potential to expand HIV testing dramatically, but will need to ensure quality and adequate linkages to confirmatory testing and broader HIV services. Simple, affordable and reliable point-of care diagnostics for HIV diagnosis, including early infant diagnosis, and patient monitoring, particularly for viral load measurement, will enable HIV testing and patient monitoring to be taken to communities and remote areas. The development of polyvalent or integrated diagnostic platforms for the combined diagnosis of HIV and coinfections, such as tuberculosis, viral hepatitis and syphilis, has the potential to increase service efficiencies and improve patient care.

4.5.3 Optimizing HIV medicines and treatment regimens

127. Despite major advances in the safety, potency and acceptability of antiretroviral medicines and regimens, there are still areas where innovations and improvements are required. Whereas much progress has been made in the development of simple and effective first-line antiretroviral therapy regimens and formulations, innovation is required to develop simple and robust fixed-dose second-line and third-line regimens. Research on optimal doses of antiretroviral medicines should aim to inform effective regimens while minimizing toxicity and drug–drug interactions and reducing costs. Much innovation is still required on developing suitable antiretroviral formulations and harmonized regimens, including simple and palatable formulations for infants and children, regimens for adolescents to improve acceptability and adherence, and long-acting oral and injectable formulations to improve adherence and viral suppression. At the same time, there is the need to develop more effective medicines and regimens for the prevention and management of major coinfections and other comorbidities.

4.5.4 Optimizing service delivery

128. Much of the success of a rapid scale-up of antiretroviral therapy can be attributed to the adoption of a public health approach to HIV treatment and care, which promotes the use of simplified and standardized regimens, protocols and approaches, makes efficient use of the different levels of health services and engages fully with communities. Similarly, many of the HIV prevention successes can be attributed to innovations in health services and the strengthening of community systems, so that those populations most vulnerable and at risk can be reached with effective interventions.

129. However, as HIV programmes mature, they need to be adapted to meet new challenges, expand their reach and impact, and enhance equity. A careful balance is required, whereby services are tailored to specific settings and populations, while at the same time maintaining a certain level of simplicity and standardization to allow for large-scale, efficient and sustainable expansion. Experience from a scale-up of antiretroviral therapy has highlighted the need to consider differentiated HIV treatment and care to respond to the different treatment needs of people living with HIV (depending on their age, the stage of HIV disease, their response to treatment, the presence of comorbidities and other health conditions, and local contexts).

130. Particular focus needs to be given to the development of innovative services to reach, engage and retain in care a number of populations and to deliver specific packages of interventions. Innovative combination prevention packages are urgently needed to tackle the high HIV incidence in some populations of adolescent girls and young women particularly in sub-Saharan Africa, and to increase the engagement of boys and men in both prevention and treatment services. Poor treatment adherence, low rates of retention in care and increasing mortality among adolescents living with HIV require priority attention. Low coverage of voluntary medical male circumcision in adolescent boys and older men needs to be addressed.

5. STRATEGY IMPLEMENTATION: PARTNERSHIPS, ACCOUNTABILITY, MONITORING AND EVALUATION, AND COSTING

131. Effective implementation of the strategy depends on concerted action from all stakeholders in the health sector response to HIV. Success requires strong partnerships to ensure policy and programme coherence. Within the health sector, linkages across different disease-specific and cross-cutting programmes need to be established and strengthened.

5.1 Collaboration with partners

132. WHO has an important convening role in bringing together different constituencies, sectors and organizations in support of a coordinated and coherent health sector response to HIV. In addition to working with the health ministries of Member States, the WHO Secretariat works closely with other key partners, including the following.

133. **Multilateral and bilateral donor and development agencies, funds and foundations.** WHO has developed joint HIV workplans and other collaborative arrangements with a range of major HIV donor agencies, including the Global Fund to Fight AIDS, Tuberculosis and Malaria; UNITAID; and the United States President's Emergency Plan for AIDS Relief.

134. **Civil society.** WHO has established a Civil Society Reference Group on HIV, which brings together representatives from a broad range of HIV-related civil society constituencies and networks. The Reference Group advises WHO on its HIV policies and programme of work, and facilitates dissemination and implementation of WHO policies and guidance. Civil society is represented in all WHO technical working groups, including those involved in the development of WHO's policies, guidelines and tools. A range of civil society organizations have official relations with WHO, enabling them to attend as observers sessions of various WHO governing bodies, including the World Health Assembly.

135. **UNAIDS and partner United Nations agencies.** WHO, as a cosponsor of UNAIDS, depends on the broader United Nations system to provide a comprehensive multisectoral HIV response. The 10 other cosponsors, along with the UNAIDS secretariat, contribute to the health sector response to HIV, guided by the UNAIDS "division of labour" which outlines key areas of responsibilities across the UNAIDS family.

136. **Technical partners.** WHO has established a Strategic and Technical Advisory Committee on HIV, which comprises a range of technical experts from national HIV programmes, implementing organizations, research institutes and civil society to advise the Director-General on the Organization's HIV policies and programme of work. Technical partners play a critical role in WHO working groups that are responsible for developing WHO policies and guidelines.

5.2 Global and country accountability

137. Accountability mechanisms that function well and are transparent and that have strong civil society participation are vital, given the range of partners and stakeholders that is needed for an effective HIV response. Important building blocks include nurturing strong leadership and governance and involve: full engagement with all relevant stakeholders; setting clear national targets that reflect, where appropriate, the Sustainable Development Goals, including the goals and targets of this strategy, and other global commitments; using appropriate indicators on the availability, coverage, quality and impact of interventions to track progress; and establishing transparent and inclusive assessment and reporting processes. Several instruments already exist for measuring progress (including for creating an enabling environment). Consistent monitoring and regular reporting on progress at country and global levels are vital for strengthening accountability.

5.3 Monitoring, evaluating and reporting

138. Implementation of the strategy will be monitored at four levels, using existing mechanisms:

- monitoring and reporting progress towards global goals and targets
- monitoring and evaluating the response at regional and country levels
- applying WHO's framework for results-based management
- applying the UNAIDS accountability framework.

5.3.1 *Monitoring and reporting progress towards global goals and targets*

139. At the global level, regular reviews will assess progress on the various commitments and targets. These reviews will build on data received from countries through various existing monitoring and evaluation mechanisms and procedures, such as the Global AIDS Progress Reporting and complemented by additional data where necessary. WHO has identified a set of ten **core global** indicators, which are organized along the continuum of HIV services, and which should be used for monitoring and reporting on the progress of the health sector response to HIV (see Figure 7).

140. Progress at global and regional levels in moving towards the targets set out in this strategy will be regularly assessed. Benchmarking – or comparisons between and within countries – will also be used to assess performance in reaching targets. The strategy is designed to be sufficiently flexible to incorporate additional priorities or fill gaps in the health sector response to HIV that may be identified. To that end, WHO will continue to work with its partners to provide support to countries for the harmonized and standardized collection of core indicators, based on WHO's *Consolidated strategic information guidelines for HIV in the health sector*,¹ and in the preparation of global and regional reports. Regular reporting of the data is proposed.

¹ Consolidated strategic information guidelines for HIV in the health sector, see <http://who.int/hiv/pub/guidelines/strategic-information-guidelines/en/> (accessed 22 March 2016).

141. WHO will implement a monitoring and accountability framework for the strategy in consultation with stakeholders. It will also monitor and share data on the uptake of its guidelines on HIV, as well as on progress in implementation of the strategy, to highlight barriers and promote best practices.

5.3.2 Monitoring and evaluating the response at country level

142. Progress in implementing the health sector response to HIV should be assessed with indicators on availability, coverage outcome and impact, taking into consideration other relevant recommendations for monitoring implementation. WHO's *Consolidated Strategic Information Guidelines* recommends a standardized core set of 50 **national indicators** that countries may use to monitor and report on their national HIV programmes and overall national HIV responses. Progress towards the HIV-related Sustainable Development Goals will be tracked and reported.

143. Indicators for monitoring the strengthening of health systems derive from a common platform for monitoring and evaluating national health strategies coordinated by WHO. Instruments are also available for measuring progress in implementing policy, legal and structural measures for enhancing the HIV response.

5.3.3 WHO's framework for results-based management

144. WHO's Twelfth General Programme of Work 2014–2019¹ provides the high-level strategic vision for the work of WHO, and outlines six areas of work. Most activities related to HIV fall under Category 1 on communicable diseases. However, other important HIV-related activities fall under other categories, notably, Category 2 on noncommunicable diseases (including substance use, mental health and chronic care), Category 3 on promoting health through the life course (including maternal, adolescent and child health, and sexual and reproductive health) and Category 4 (including access to medicines and diagnostics, integrated service delivery, strategic information and human resources). Under Category 1, HIV and viral hepatitis have their own area of work for which biennial workplans are developed along with a set of agreed outcomes and budget.

145. This strategy covers three bienniums (2016–2017, 2018–2019 and 2020–2021). Workplan implementation is monitored through progress reports at the end of each biennium. Mid-term biennium reviews will be undertaken to facilitate implementation.

¹ Twelfth General Programme of Work 2014–2019: not merely the absence of disease, see http://www.who.int/about/resources_planning/twelfth-gpw/en/ (accessed 22 March 2016).

5.3.4 *The UNAIDS accountability framework*

146. WHO's HIV work is reflected in the budget and workplan of the UNAIDS unified budget, results and accountability framework,¹ which entails a single framework for 2016–2021 that promotes joint planning and budgeting across the 11 cosponsors and the UNAIDS secretariat. Detailed workplans and budgets are developed for two-year periods, for the period of this strategy starting with 2016–2017. Each cosponsor is responsible for implementing a set of broad activities related to their organizational mandate and the UNAIDS Technical Support Division of Labour. The UNAIDS Unified Budget, Results and Accountability Framework is accompanied by a performance-monitoring framework, which defines indicators against which progress in implementation of the budget and work plan is measured. Annual progress reports are submitted to the UNAIDS Programme Coordinating Board.

5.4 **Cost of implementing the strategy**

147. The Global health sector strategy on HIV, 2016–2021, describes the health sector contribution to the goal of ending AIDS as a public health threat by 2030. The costing of implementation of the strategy has been undertaken based on the costing of the UNAIDS 2016–2021 Strategy, which used specific targets and unit costs for the interventions included in the strategy.

148. Data for the costing are drawn from demographic estimates prepared by the United Nations Population Division, national household surveys (Demographic and Health Surveys and AIDS Indicator Survey),² UNAIDS estimates of the burden of HIV by country, and country reports through the Global AIDS Response Progress Reporting system.³ The costs are calculated for 120 low- and middle-income countries across the six WHO regions.

149. Unit costs are based on reviews of costing studies and have been reviewed by experts from a range of countries. An expert panel provided estimates of future costs of antiretroviral therapy. Those estimates assume some continued decline in antiretroviral prices and reductions in both laboratory costs (as testing regimens are simplified) and in service delivery costs, as some patients are transferred to community care. Future coverage targets are from the UNAIDS 2016–2021 Strategy.

150. The total costs of the present strategy are estimated to rise from about US\$ 20 000 million in 2016 to almost US\$ 22 000 million in 2020 and to US\$ 21 000 million in 2021 (see Figure 8). Antiretroviral therapy requires the largest amount of resources, about 47% of the total; programme enablers represent the next largest component at 13%; HIV testing services are next at 9%; followed by condom programmes at 8%.

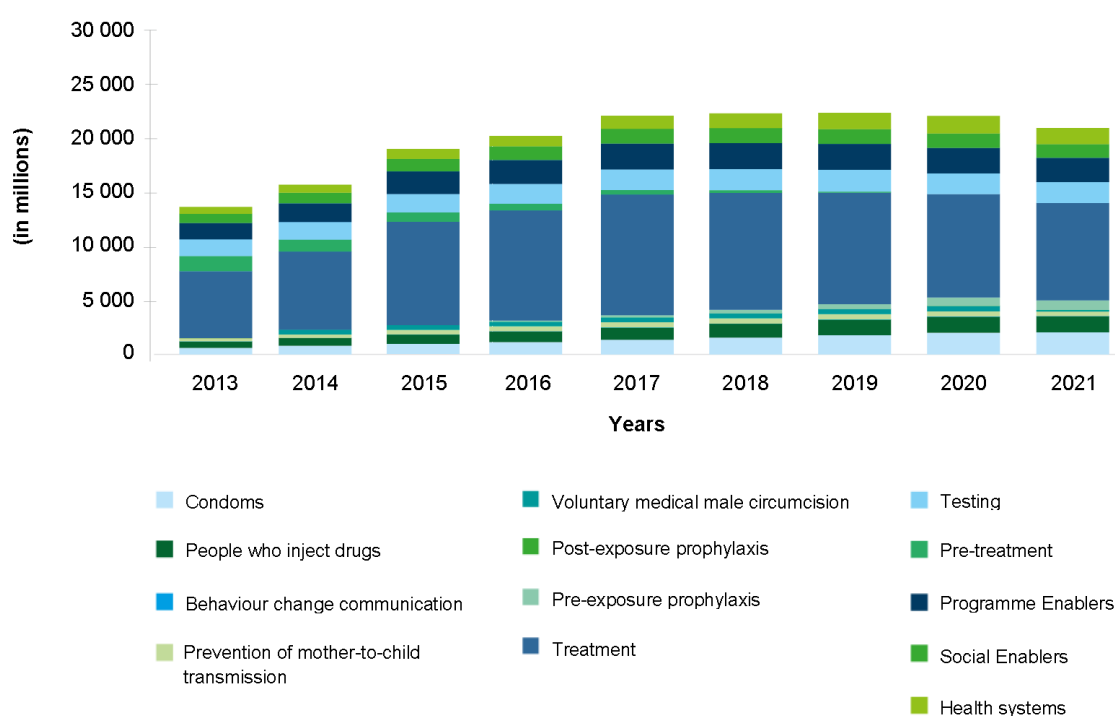
¹ At the 37th meeting of the UNAIDS Programme Coordinating Board (Geneva, 26–28 October 2015), the framework was presented, entitled: UNAIDS unified budget, results and accountability framework 2016–2021, see http://www.unaids.org/sites/default/files/media_asset/20151103_UNAIDS_UBRAF_PCB37_15-19_EN.pdf (accessed 22 March 2016).

² The DHS Program: demographic and health surveys, see <http://dhsprogram.com/What-We-Do/Survey-Types/DHS.cfm> (accessed 22 March 2016).

³ Global AIDS Response Progress Reporting, see <http://www.unaids.org/en/dataanalysis/knowyourresponse/globalaidsprogressreporting> (accessed 22 March 2016).

151. More than one third of all resources are required for four countries (in order of burden): South Africa, Nigeria, Brazil and China. More than half of all resources required for low- and middle-income countries are needed in the African Region (55%).¹ The next largest regions are the Americas Region at 16%, the Western Pacific Region at 13% and the South-East Asia Region at 8%. In the European Region, 5% of resources are needed, and 4% are needed in the Eastern Mediterranean Region. About one quarter of resources are needed in low-income countries, about one quarter in lower middle-income countries, and just under one half in upper middle-income countries.

Figure 8. Costs by intervention and year (in US\$)



¹ The regions refer to the six WHO regions, with data covering 120 low- and middle-income countries.

Appendix 2

[A69/32 – 22 April 2016]

**Global health sector strategy on viral hepatitis,
2016–2021 – towards ending viral hepatitis**

1. Viral hepatitis is an international public health challenge, comparable to other major communicable diseases, including HIV, tuberculosis and malaria. Despite the significant burden it places on communities across all global regions, hepatitis has been largely ignored as a health and development priority until recently. It will no longer remain hidden, however, with the adoption of the resolution on the 2030 Agenda for Sustainable Development.¹ Target 3.3 is of particular relevance: it calls for specific action to combat viral hepatitis.²

2. This is the first global health sector strategy on viral hepatitis, a strategy that contributes to the achievement of the 2030 Agenda for Sustainable Development. It covers the first six years of the post-2015 health agenda, 2016–2021, building on WHO's framework for global action for the prevention and control of viral hepatitis³ and two resolutions on viral hepatitis adopted by the World Health Assembly in 2010 and in 2014.⁴ The strategy addresses all five hepatitis viruses (hepatitis A, B, C, D and E), with a particular focus on hepatitis B and C, owing to the relative public health burden they represent.

3. The strategy describes the contribution of the health sector to combating viral hepatitis, towards its elimination as a public health threat. It promotes synergies between viral hepatitis and other health issues, and aligns the hepatitis response with other global health and development strategies, plans and targets. It positions the response to viral hepatitis within the context of universal health coverage – an overarching health target of the 2030 Agenda for Sustainable Development. The strategy outlines a way ahead, and provides:

- a vision of a world where viral hepatitis transmission is halted and everyone living with viral hepatitis has access to safe, affordable and effective care and treatment
- a goal of eliminating viral hepatitis as a major public health threat by 2030
- targets that seek to reduce the incidence of chronic hepatitis infection from the current 6–10 million cases of chronic infection to 0.9 million infections by 2030, and to reduce the annual deaths from chronic hepatitis from 1.4 million to less than 0.5 million by 2030. Achieving these targets will require a radical change in the hepatitis response, and will mean that hepatitis is elevated to a higher priority in public health responses.

¹ United Nations General Assembly resolution 70/1 (2015) – Transforming our world: the 2030 Agenda for Sustainable Development, see http://www.un.org/ga/search/view_doc.asp?symbol=A/RES/70/1&Lang=E (accessed 2 April 2016).

² Sustainable Development Goal 3, target 3.3: “By 2030, end the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases and combat hepatitis, water-borne diseases and other communicable diseases.”

³ *Prevention and Control of Viral Hepatitis Infection: Framework for Global Action*, see <http://www.who.int/hiv/pub/hepatitis/Framework/en/> (accessed 3 April 2016).

⁴ Resolutions WHA63.18 (2010) and WHA67.6 (2014).

4. The strategy must exploit new opportunities, including: increasing public awareness; advances in hepatitis medicines, diagnostics and other technologies; and strengthening commitment to achieve health equity. The strategy defines a set of priority actions for countries to undertake, and counterbalances this with a set of priority actions for WHO to undertake, in support of countries.

5. Priority actions are organized under five strategic directions, which are:

Strategic direction 1 – Information for focused action: developing a strong strategic information system to understand viral hepatitis epidemics and focus the response;

Strategic direction 2 – Interventions for impact: defining essential, high-impact interventions on the continuum of hepatitis services that should be included in health benefit packages;

Strategic direction 3 – Delivering for equity: strengthening health and community systems to deliver high-quality services to achieve equitable coverage and maximum impact;

Strategic direction 4 – Financing for sustainability: proposing strategies to reduce costs, improve efficiencies and minimize the risk of financial hardship for those requiring the services;

Strategic direction 5 – Innovation for acceleration: promoting and embracing innovation to drive rapid progress.

OUTLINE OF THE STRATEGY

6. The strategy has five major components:

1. **Towards eliminating viral hepatitis** – reviews the current status of viral hepatitis epidemics and responses, identifies opportunities and challenges for the future, and argues the case for adequate investment in the health sector response to viral hepatitis;

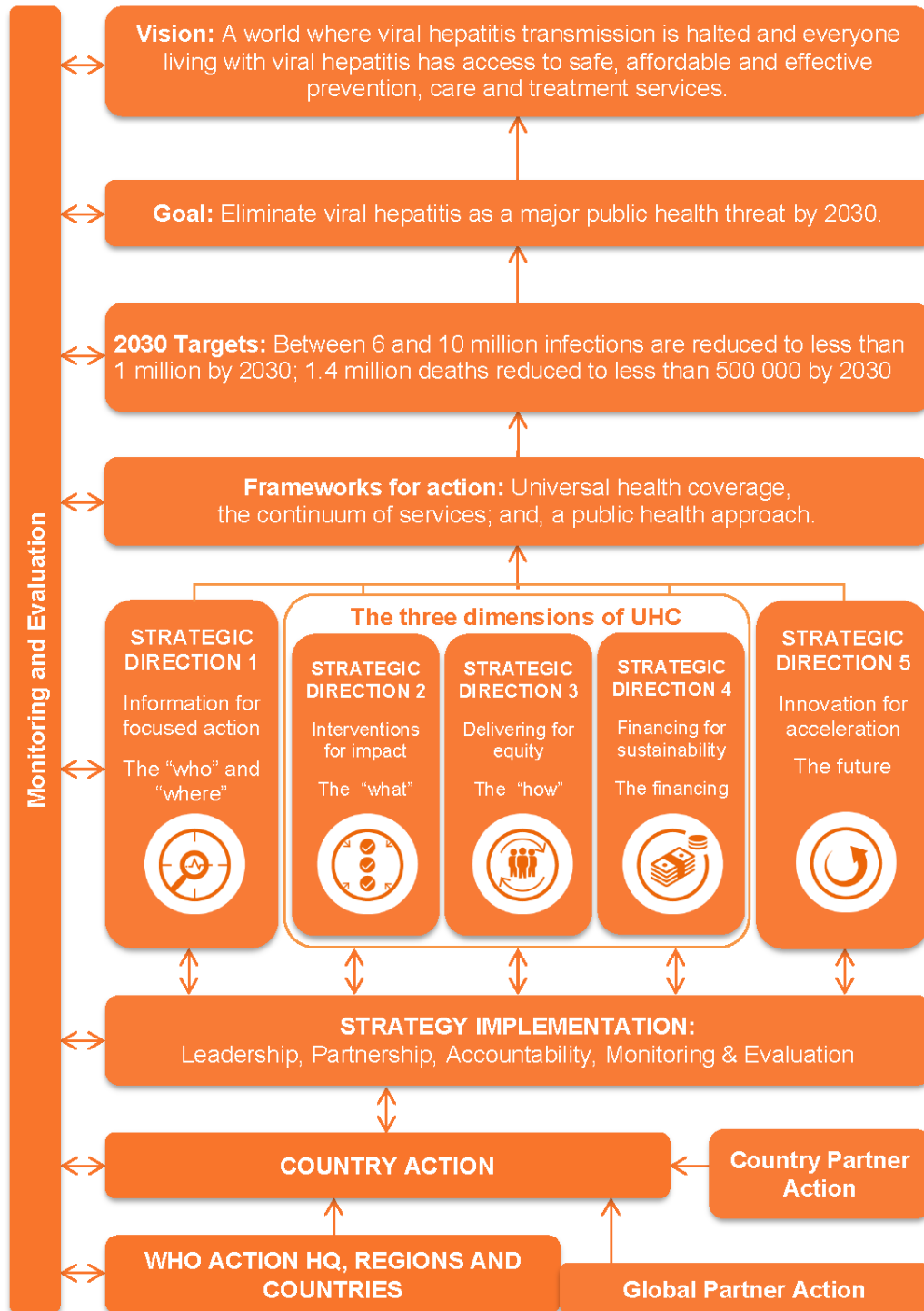
2. **Framing the strategy** – describes the three organizing frameworks for the strategy (universal health coverage, the continuum of hepatitis services and the public health approach);

3. **Vision, goal, targets and guiding principles** – presents a set of impact and service coverage targets for 2020 and 2030 to drive the response;

4. **Strategic directions and priority actions** – recommends actions to be taken by both countries and WHO under each of **five strategic directions**; and

5. **Strategy implementation: leadership, partnerships, accountability, monitoring and evaluation** – outlines key elements of strategy implementation, including strategic partnerships, monitoring and evaluation and costing.

Figure 1. Framework for the global health sector strategy on viral hepatitis, 2016-2021



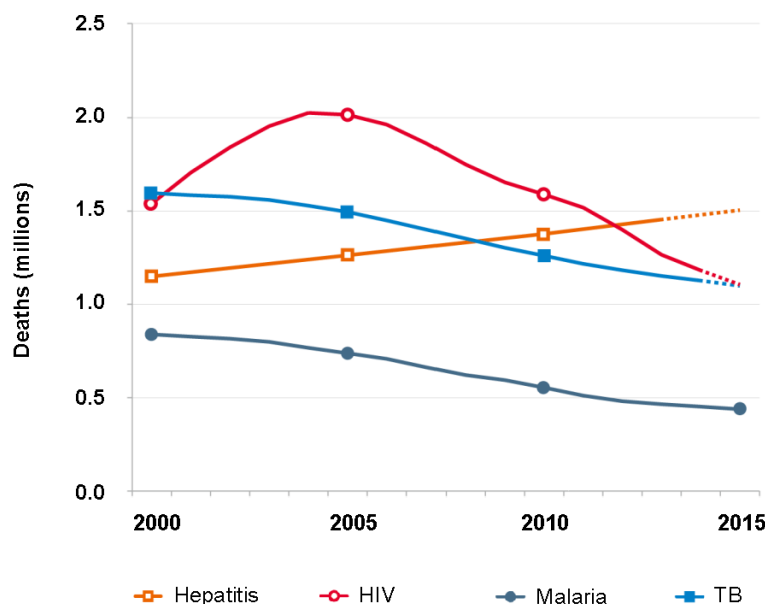
1. TOWARDS ELIMINATING VIRAL HEPATITIS

7. The need for a global health sector strategy on viral hepatitis stems from the scale and complexity of the hepatitis pandemic, along with growing recognition of its massive public health burden and the huge opportunities for action. To date, few countries have seized these opportunities; action has tended to be fragmented and inadequate. The time has come for a coherent public health response that prioritizes effective interventions, promotes service delivery approaches that ensure quality and equity, takes programmes to scale to achieve sustained impact at the population level, and establishes clear stakeholder responsibility and accountability.

1.1 A major public health burden

8. The viral hepatitis pandemic takes a heavy toll on lives, communities and health systems. In 2013, viral hepatitis was the seventh highest cause of mortality globally. It is responsible for an estimated 1.4 million deaths per year from acute infection and hepatitis-related liver cancer and cirrhosis – a toll comparable to that of HIV and tuberculosis (Figure 2). Of those deaths, about 47% are attributable to hepatitis B virus, 48% to hepatitis C virus and the remainder to hepatitis A virus and hepatitis E virus. Viral hepatitis is also a growing cause of mortality among people living with HIV. About 2.9 million people living with HIV are co-infected with hepatitis C virus and 2.6 million with hepatitis B virus.¹

Figure 2. Estimated global number of deaths due to viral hepatitis, HIV, malaria and tuberculosis, 2000–2015



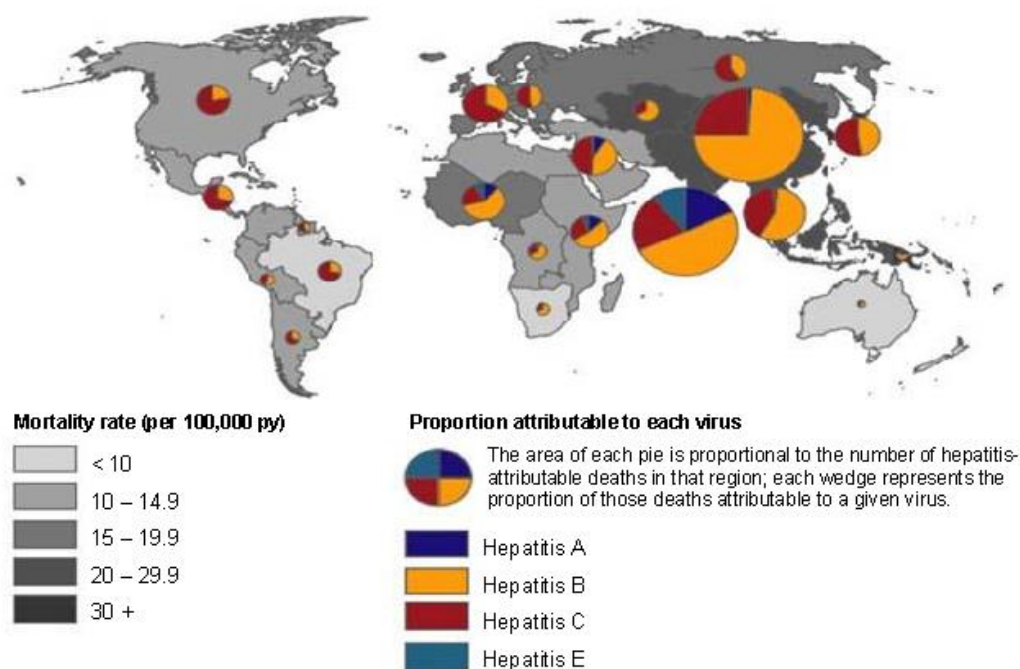
Source: Global Burden of Disease and WHO/UNAIDS estimates, see <http://ihmeuw.org/3pms>, <http://ihmeuw.org/3pmt> (accessed 2 April 2016).

¹ Global Burden of Disease and WHO/UNAIDS estimates.

9. Worldwide, about 240 million people have chronic hepatitis B virus infection and 130–150 million have chronic hepatitis C virus infection. Without an expanded and accelerated response, the number of people living with hepatitis B virus is projected to remain at the current, high levels for the next 40–50 years, with a cumulative 20 million deaths occurring between 2015 and 2030. The number of people living with hepatitis C virus is actually increasing, despite the existence of an effective cure. A stepped-up global response can no longer be delayed.

10. The five hepatitis viruses (A, B, C, D and E) are very different, with different modes of transmission, affecting different populations and resulting in different health outcomes. An effective response requires a range of common actions, while at the same time delivering tailored interventions for each of the viruses (see Figure 3).

Figure 3. Regional distribution of viral hepatitis deaths



Source: Stanaway and Cooke (personal communication).

11. Viral hepatitis B and C are blood-borne infections, with significant transmission occurring in early life and through unsafe injections and medical procedures, and less commonly through sexual contact. Hepatitis B virus prevalence is highest in sub-Saharan Africa and east Asia, where between 5–10% of the adult population is chronically infected. Mother-to-child transmission of hepatitis B virus is a major mode of transmission in high prevalence settings. High rates of chronic infections are also found in the Amazon region of South America and the southern parts of eastern and central Europe. In the Middle East and the Indian subcontinent, an estimated 2–5% of the general population is chronically infected. Immunization is the most effective strategy for prevention of hepatitis B virus infection.

12. Hepatitis C is found worldwide. The most affected regions are central and east Asia and north and west Africa, where most infections are caused by unsafe medical injections and other medical procedures. Hepatitis C virus epidemics related to injecting drug use occur in all regions, with an estimated 67% of people who inject drugs having been infected with hepatitis C virus. Comprehensive prevention strategies for both hepatitis B virus and hepatitis C virus should include assurance of safe blood products, safe injection practices, harm reduction services for people who inject drugs and promotion of safer sex.

13. Hepatitis D is transmitted through contact with infected blood. It only occurs in people who are already infected with hepatitis B virus and can therefore be prevented through hepatitis B virus vaccination and other prevention efforts.

14. Viral hepatitis A and E are food- and water-borne infections that can result in acute outbreaks in communities with unsafe water and poor sanitation. They do not result in chronic infection or chronic liver disease and there is no specific treatment. Prevention is through improved sanitation, food safety and vaccination.

1.2 There are unprecedented opportunities to act

15. Ending hepatitis epidemics as a major public health threat is feasible with the tools and approaches currently available and in the pipeline. Opportunities exist for enhancing and expanding the response by investing in **five core intervention areas**:

Vaccines – Effective vaccines are available for preventing viral hepatitis A, B and E infections, with a range of countries already implementing large-scale and inexpensive hepatitis B virus childhood vaccination programmes;

Prevention of mother-to-child transmission of hepatitis B virus – Timely hepatitis B virus birth-dose vaccination is a key intervention for preventing the transmission of the virus from mother to infant at birth, which could be enhanced through antenatal testing and the use of antiviral drugs;

Injection, blood and surgical safety – Transmission of viral hepatitis B and C in health care settings can be stopped through the rigorous application of universal precautions for all invasive medical interventions, promotion of injection safety measures and securing the safe supply of blood products;

Harm reduction for people who inject drugs – Ensuring access to sterile injecting equipment and effective drug dependence treatment can prevent and control epidemics of viral hepatitis B and C among people who inject drugs, as part of a comprehensive package of interventions for the prevention, treatment and care of HIV, viral hepatitis and other blood-borne infections among people who inject drugs;¹

¹ WHO's comprehensive package for the prevention, treatment and care of HIV and viral hepatitis among people who inject drugs includes the following interventions: needle and syringe programmes; opioid substitution therapy and other drug dependence treatment; HIV testing and counselling; antiretroviral therapy for people with HIV; 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, and prevention and management of drug overdose.

Treatment – New oral, well-tolerated medicines and treatment regimens for people with chronic hepatitis C virus infection can achieve cure rates of more than 90%. Effective treatment is also available for people with chronic hepatitis B virus infection, although for most people such treatment needs to be lifelong.

16. To have greatest impact, effective interventions should be combined and tailored for the specific population, location and setting. For example, for hepatitis B virus epidemics, in certain countries with high prevalence of this virus, the most significant public health benefits are likely to be achieved by focusing efforts on reducing deaths by the prevention of early-life infection through birth-dose and childhood vaccination, and the treatment of people with chronic hepatitis infection.

1.3 Clearing a path for success

17. New opportunities provide hope for the elimination of viral hepatitis as a public health threat. Some very significant barriers need to be addressed, however, in order to realize this goal:

Leadership and commitment is uneven. – Exceptional leadership in the hepatitis response is emerging from a range of countries. Civil society, too, has mobilized a global hepatitis movement. As a consequence viral hepatitis has been elevated to a public health priority. However many countries – and the international community as a whole – are yet to act with the determination and urgency required to eliminate hepatitis epidemics. Few countries have national viral hepatitis strategies or plans, and even fewer have designated units and budgets within their health ministries to lead, guide and coordinate their hepatitis responses and to be held accountable by its citizens.

Data are inadequate. – The true public health dimensions and impact of hepatitis epidemics are poorly understood in many countries. National and subnational data are often lacking or inadequate and hepatitis surveillance programmes are weak, making it difficult to plan for focused action and prioritize the allocation of resources.

Coverage of prevention programmes is limited. – Prevention programmes, particularly for specific populations that are most affected and at risk, are often of limited scope and coverage. Between 2000 and 2010, there was a reduction of 91% in hepatitis B virus infections and a reduction of 83% in infections of hepatitis C virus due to unsafe injections. However, medical injections still account for an estimated 1.7 million new hepatitis B virus infections annually and between 157 000 and 315 000 new hepatitis C virus infections annually. Global coverage of harm reduction programmes for people who inject drugs, including needle and syringe programmes, is less than 10%. By 2014, global childhood hepatitis B virus vaccination coverage had increased to over 82%, however, coverage of hepatitis B virus birth-dose lagged behind at just 38%.

Most people do not know their hepatitis status. – Simple and effective hepatitis testing strategies and tools are lacking, with less than 5% of people with chronic hepatitis infection knowing their status. For this reason, diagnosis often occurs late and appropriate tests to assess liver disease and guide treatment decisions, including when to start treatment, are seldom available.

Few have access to treatment and care services. – Of those people with chronic viral hepatitis infection, it is estimated that less than 1% have accessed effective antiviral therapy. Those with complications of chronic hepatitis infection, including end-stage cirrhosis and hepatocellular carcinoma, may not be able to access basic care, notably palliative and end-of-life care.

Medicines and diagnostics are unaffordable for most. – The development of highly effective treatment regimens, including direct-acting antiviral medicines, has revolutionized the treatment of chronic hepatitis C virus infection, and there is a long development “pipeline” of additional promising options. The high prices of new medicines are a major barrier to access in most countries. Treatment for chronic hepatitis B virus infection is lifelong for most people. The challenges will be to ensure that such medicines are affordable and that those people in need of treatment have access to those medicines without experiencing financial hardship.

A public health approach to hepatitis is lacking. – A reorientation of hepatitis programmes towards a comprehensive public health approach will be critical if hepatitis elimination is to be achieved. This will require people-centred health services that can reach those populations most affected, well-functioning laboratories to ensure high-quality testing and treatment monitoring, a secure supply of affordable medicines and diagnostics, an appropriately trained health workforce, adequate public funding for essential interventions and services and active involvement of affected communities.

Structural barriers increase vulnerability and prevent equitable access to services. – Human rights violations, along with widespread stigmatization and discrimination, continue to hinder access to health services for populations that may be criminalized and marginalized and who are at higher risk of hepatitis infection, including people who inject drugs, men who have sex with men, prisoners and sex workers.

18. Responses to hepatitis can learn from successful public health programmes in other areas, including those for HIV, tuberculosis, immunization and chronic care. Innovative HIV service delivery approaches can be adapted to reach specific populations (see text box). Quality improvement and price-reduction strategies that have enabled rapid expansion of HIV treatment coverage provide lessons for increasing access to affordable hepatitis C virus treatment. Immunization programmes can demonstrate how a range of strategies can be used to reach all communities and ensure access to effective, safe and affordable vaccines.

Populations most affected and at risk

Each country should define the specific populations within their country that are most affected by viral hepatitis epidemics and the response should be based on the epidemiological and social context. In many countries, much transmission of hepatitis B virus and hepatitis C occurs in health care settings and therefore specific populations for focused attention include people who have been exposed to viral hepatitis through unsafe blood supplies and unsafe medical injections and procedures. In settings with high hepatitis B prevalence, mother-to-child transmission of hepatitis B is likely to be a major mode of transmission, along with early childhood infection among those who have not been vaccinated. Populations exposed through sexual transmission may include young people and adolescents, men who have sex with men, sex workers, transgender people and prisoners. People who inject drugs are at high risk of hepatitis C infection and hepatitis B infection because of the shared use of contaminated injecting equipment and blood. Mobile populations, and people affected by conflict and civil unrest may be at particular risk of all forms of viral hepatitis infection because of their living conditions, lack of access to clean water and safe food and medical services that cannot maintain effective infection control measures.

People who will require specific attention include those with coinfections such as: hepatitis B and C combined; viral hepatitis and tuberculosis; and HIV and viral hepatitis.

19. The challenges described above are holding back country responses; however, the fact that so much room for improvement exists marks a significant opportunity for countries. Increasingly, people with chronic hepatitis infection and affected communities are demanding action. There is a clear imperative to act now. Many of the actions required are comparatively simple to undertake and will profoundly impact on hepatitis epidemics and other health and development priorities.

2. FRAMING THE STRATEGY

20. The viral hepatitis strategy is designed to contribute to the attainment of the 2030 Agenda for Sustainable Development, and specifically to health-related Goal 3 (target 3.3). The strategy describes priority actions required to achieve the global hepatitis targets and how the hepatitis response can contribute to the achievement of universal health coverage, other health targets and the broader 2030 Agenda. It is aligned with other relevant health strategies and plans, including those for HIV, sexually transmitted infections, safe injections, blood safety, vaccines, tuberculosis and noncommunicable diseases, and responds to the requirements of Health Assembly resolutions on viral hepatitis that were adopted in 2010 and 2014.¹

21. The strategy draws on three organizing frameworks: universal health coverage; the continuum of hepatitis services; and the public health approach.

2.1 2030 Agenda for Sustainable Development – providing direction

22. The 2030 Agenda for Sustainable Development is ambitious and far-reaching. Health is a major goal in this post-2015 agenda, reflecting its central role in alleviating poverty and facilitating development. The health-related Goal 3 addresses a range of health challenges that are critical for development, notably, target 3.3 on communicable diseases, which includes combating viral hepatitis epidemics. Effectively combating such epidemics will also impact on other health targets, including those on reducing maternal mortality (target 3.1), reducing mortality from noncommunicable diseases (target 3.4), preventing and treating substance use disorders (target 3.5), achieving universal health coverage (target 3.8), access to affordable medicines and vaccines (target 3.b) and health financing and health workforce (target 3.c). In addition to its impact on health-related Goal 3, combating viral

¹ Resolutions WHA63.18 (2010) and WHA67.6 (2014).

hepatitis epidemics will contribute to ending poverty (Goal 1), ending hunger (Goal 2), managing water and sanitation (Goal 6), reducing inequality in access to services and commodities (Goal 10), promoting inclusive societies that promote non-discrimination (Goal 16), and financing and capacity building for implementation (Goal 17).

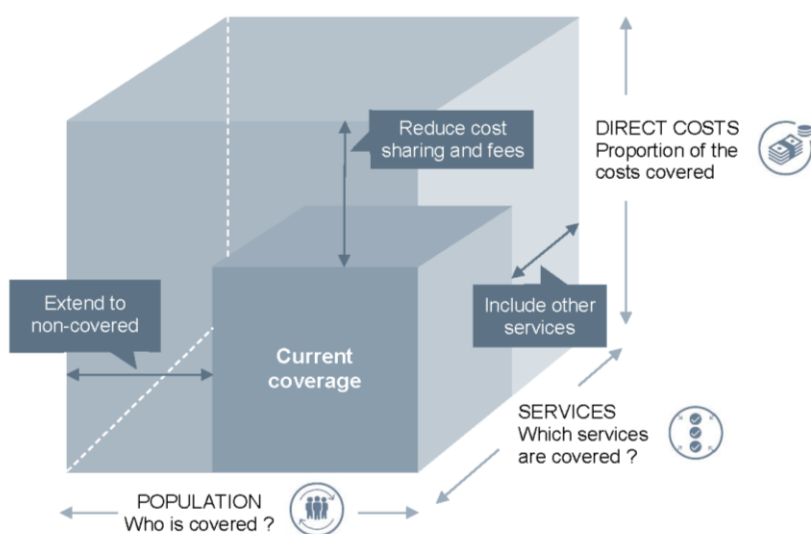
2.2 Universal health coverage – an overarching framework

23. At the global level, 150 million people experience financial catastrophe and 100 million people suffer impoverishment every year as a result of out-of-pocket health expenses. Ensuring financial security and health equity are key concerns in the 2030 Agenda for Sustainable Development, and universal health coverage provides a framework for addressing them. Universal health coverage (see Figure 4) is achieved when all people receive the health services they need, which are of sufficient quality to make a difference, without those people incurring financial hardship. Universal health coverage comprises three major, interlinked objectives:

- (1) expanding the range of services provided – improving the range, quality and availability of essential health services that are needed;
- (2) covering the populations in need of services – improving the equitable and optimal uptake of services in relation to need;
- (3) reducing the direct costs of services – providing financial protection for those who need the services.

24. As resources, efficiencies and capacities increase, the range of services provided can be expanded, the quality can be improved, and more populations can be covered with less direct costs to those who need the services – a progressive realization of universal health coverage.

Figure 4. The three dimensions of universal health coverage



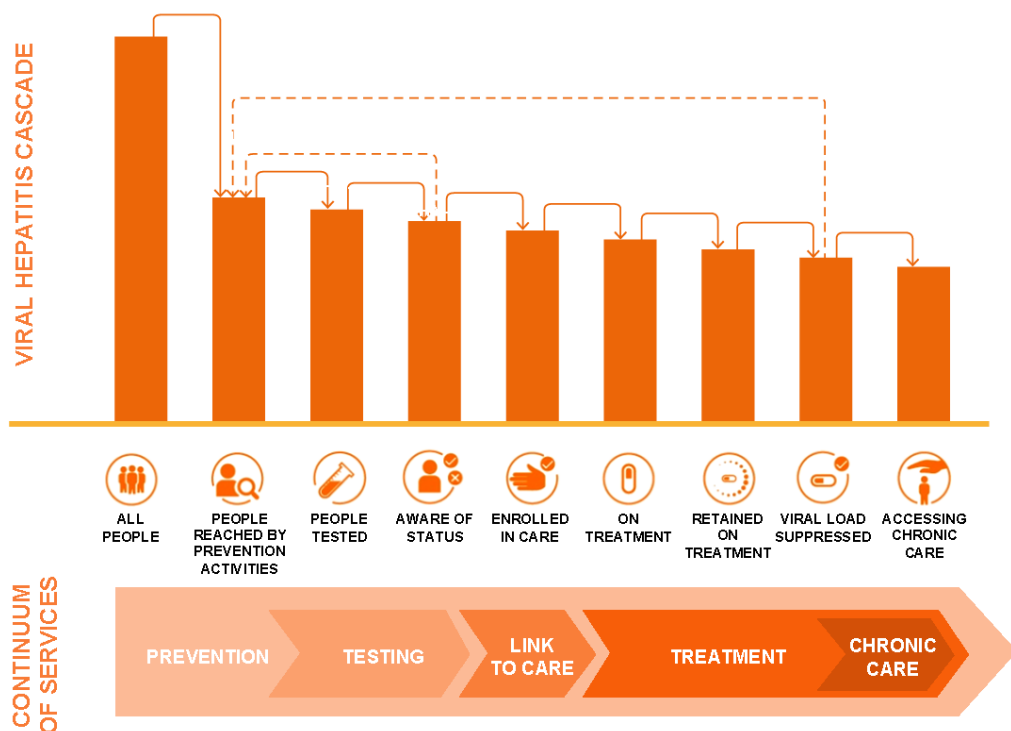
2.3 The continuum of hepatitis services – an organizing framework

25. While the concept of universal health coverage frames the strategy overall, the continuum of hepatitis services that are needed to curb the epidemic provides the organizing framework for the specific actions to be taken (see Figure 5). That continuum spans the entire range of interventions that is needed to achieve the strategy's targets – from reducing vulnerability, preventing and diagnosing infection, linking people to health services, through to providing treatment and chronic care. The strategy defines the essential services and interventions that need to be delivered along this continuum and the strategic information that is needed to focus interventions for maximum impact.

2.4 A public health approach

26. The strategy is based on a public health approach that is concerned with preventing infection and disease, promoting health, and prolonging life among the population as a whole. It aims to ensure the widest possible access to high-quality services at the population level, based on simplified and standardized interventions and services that can readily be taken to scale and decentralized, including in resource-limited settings. A public health approach aims to achieve health equity and promote gender equality, engage communities, and leverage public and private sectors in the response.

Figure 5. The continuum of viral hepatitis services and the retention cascade



3. GLOBAL VISION, GOAL AND TARGETS

27. The strategy outlines a global vision, a global goal, and a set of global targets that are aligned with the 2030 Agenda for Sustainable Development and relevant Health Assembly resolutions.

3.1 Global vision

28. A world where viral hepatitis transmission is halted and everyone living with viral hepatitis has access to safe, affordable and effective prevention, care and treatment services.

3.2 Goal

29. Eliminate viral hepatitis as a major public health threat by 2030.¹

3.3 Targets for 2020 and 2030

30. Countries can contribute to the elimination of viral hepatitis as a major global public health threat if they act with enough resolve to achieve a set of ambitious targets for 2020 and 2030. These targets (see Table 1) apply to everyone at risk of viral hepatitis infection: children, adolescents and adults; rich and poor; women and men; and all populations affected and at risk.

¹ Goal 3 of the 2030 Agenda for Sustainable Development calls for combating hepatitis and in 2014, the World Health Assembly in resolution WHA67.6 requested that the Director-General examine the feasibility of viral hepatitis elimination. WHO's modelling and analysis suggest that the effort to combat viral hepatitis could secure elimination as a public health threat when five synergistic service coverage targets in prevention and treatment are reached (see Table 1). WHO has defined the elimination of viral hepatitis as a public health threat as achieving a 90% reduction in new chronic infections and a 65% reduction in mortality.

Table 1. Global hepatitis strategy targets at a glance

TARGET AREA	BASELINE 2015	2020 TARGETS	2030 TARGETS
Impact targets			
Incidence: New cases of chronic viral hepatitis B and C infections	Between 6 and 10 million infections are reduced to 0.9 million infections by 2030 (95% decline in hepatitis B virus infections, 80% decline in hepatitis C virus infections)	30% reduction (equivalent to 1% prevalence of HBsAg ¹ among children)	90% reduction (equivalent to 0.1% prevalence of HBsAg among children) ²
Mortality: Viral hepatitis B and C deaths	1.4 million deaths reduced to less than 500 000 by 2030 (65% for both viral hepatitis B and C)	10% reduction	65% reduction
Service coverage targets			
Hepatitis B virus vaccination: childhood vaccine coverage (third dose coverage)	82% ³ in infants	90%	90%
Prevention of hepatitis B virus mother-to-child transmission: hepatitis B virus birth-dose vaccination coverage or other approach to prevent mother-to-child transmission	38%	50%	90%
Blood safety	39 countries do not routinely test all blood donations for transfusion-transmissible infections 89% of donations screened in a quality-assured manner ⁴	95% of donations screened in a quality-assured manner	100% of donations are screened in a quality-assured manner
Safe injections: percentage of injections administered with safety-engineered devices in and out of health facilities	5%	50%	90%
Harm reduction: number of sterile needles and syringes provided per person who injects drugs per year	20	200	300
Viral hepatitis B and C diagnosis	<5% of chronic hepatitis infections diagnosed	30%	90%
Viral hepatitis B and C treatment	<1% receiving treatment	5 million people will be receiving hepatitis B virus treatment 3 million people have received hepatitis C virus treatment (Both targets are cumulative by 2020)	80% of eligible persons with chronic hepatitis B virus infection treated 80% of eligible persons with chronic hepatitis C virus infection treated

¹ The abbreviation "HBsAg" refers to hepatitis B virus surface antigen. It should be noted that some of WHO's regional committees have already endorsed region-specific targets. 1% is to be taken as the global average.

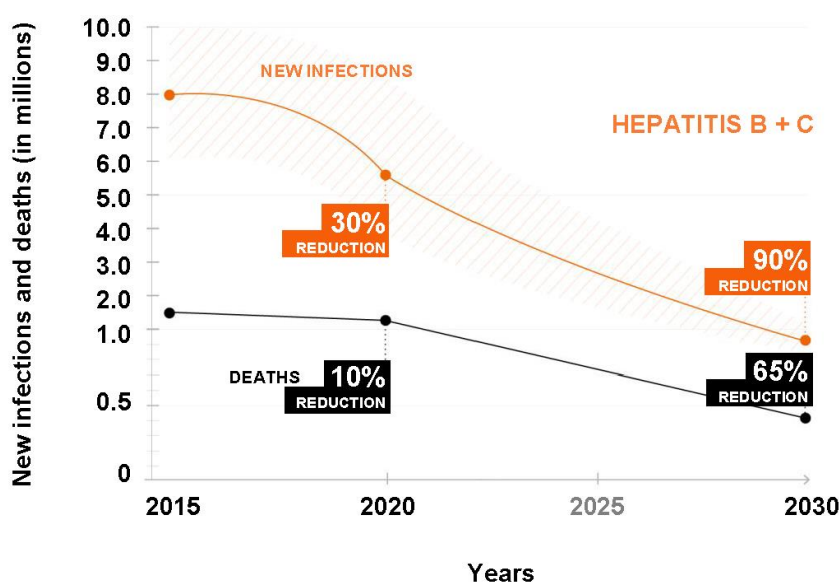
² Documentation of the 0.1% HBsAg prevalence will require development of new methods for validation that should be developed in the light of all available efforts to eliminate mother-to-child transmission of the hepatitis B virus, such as the use of the hepatitis B vaccine and antiviral medicines.

³ WHO/UNICEF coverage estimates 2013 revision, July 2014, see: http://apps.who.int/immunization_monitoring/globalsummary/timeseries/tswucoveragebcg.html (accessed 1 April 2016).

⁴ Global database on blood safety, summary report 2011, see: http://www.who.int/bloodsafety/global_database/GDBS_Summary_Report_2011.pdf?ua=1 (accessed 1 April 2016).

31. The strategy includes both impact (incidence and mortality) and service coverage targets (see Table 1). By 2020, five million people will be receiving treatment for chronic hepatitis B virus infection, three million people will have been treated for chronic hepatitis C virus infection and the number of new cases of chronic hepatitis infection would have been reduced by 30% compared with the number of new cases in 2015. By 2030, the incidence of chronic hepatitis infection will have been reduced by 90% and there will be universal access to key prevention and treatment services.

Figure 6. Targets for reducing new cases of and deaths from chronic viral hepatitis B and C infection



3.4 Country targets for 2020

32. Informed by global goals and targets, countries should develop as soon as practicable ambitious national goals and targets for 2020 and beyond, taking into consideration the country context, including the nature and dynamics of country viral hepatitis epidemics, populations affected, structure and capacity of the health care and community systems, and resources that can be mobilized. Targets should be feasible and developed based on country realities, the best possible data available on the viral hepatitis situation, trends and responses, and monitored through a set of standard and measurable indicators. The targets should apply to everyone.

4. STRATEGIC DIRECTIONS AND PRIORITY ACTIONS

33. To achieve the goals of the 2030 Agenda for Sustainable Development, action is required in five areas, referred to as “strategic directions”. Under each of the strategic directions, specific actions should be taken by countries, WHO and partners. This strategy outlines those priority actions to be taken by countries and by WHO. The proposed actions are intended to guide country efforts, with countries selecting and implementing those actions that are most appropriate to their respective

hepatitis epidemics, national priorities and country contexts, taking into consideration national policies, jurisdiction and legislation.

Strategic directions

34. The five strategic directions that guide priority actions by countries and by WHO are presented below:

Strategic direction 1: Information for focused action (know your epidemic and response).

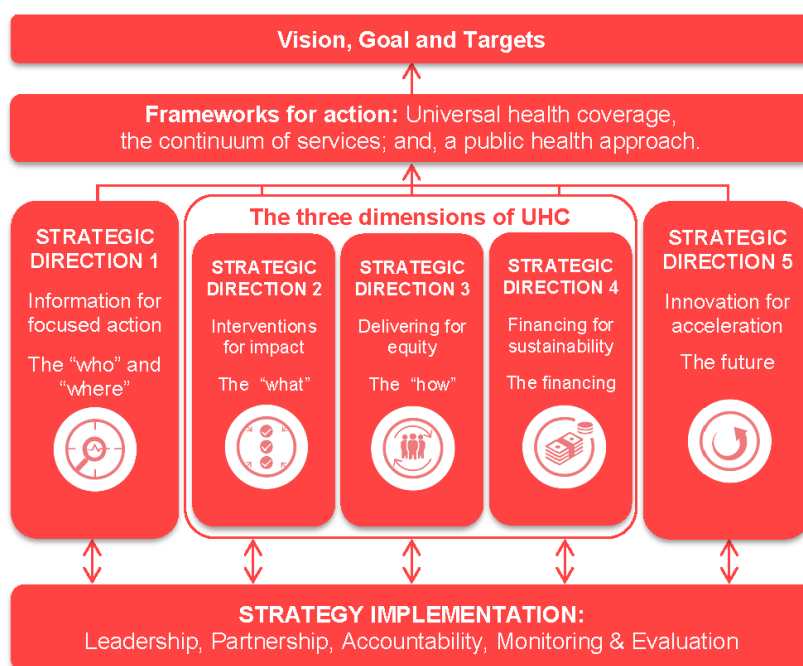
Strategic direction 2: Interventions for impact (covering the range of services needed).

Strategic direction 3: Delivering for equity (covering the populations in need of services).

Strategic direction 4: Financing for sustainability (covering the financial costs of services).

Strategic direction 5: Innovation for acceleration (looking towards the future).

Figure 7. The five strategic directions of the global health sector strategy on viral hepatitis, 2016–2021



35. Each of the strategic directions addresses a specific set of questions:

Strategic direction 1 – What is the situation? – focuses on the need to understand the viral hepatitis epidemic and response as a basis for advocacy, political commitment, national planning, resource mobilization and allocation, implementation, and programme improvement.

Strategic direction 2 – What services should be delivered? – addresses the first dimension of universal health coverage by describing the essential package of high-impact interventions that need to be delivered along the continuum of hepatitis services to reach country and global targets, and which should be considered for inclusion in national health benefit packages.

Strategic direction 3 – How can these services be delivered? – addresses the second dimension of universal health coverage by identifying the best methods and approaches for delivering the continuum of hepatitis services to different populations and in different locations, so as to achieve equity, maximize impact and ensure quality.

Strategic direction 4 – How can the costs of delivering the package of services be met? – addresses the third dimension of universal health coverage by identifying sustainable and innovative models for financing of hepatitis responses and approaches for reducing costs so that people can access the necessary services without incurring financial hardship.

Strategic direction 5 – How can the trajectory of the response be changed? – identifies where there are major gaps in knowledge and technologies, where innovation is required to shift the trajectory of the viral hepatitis response in order for those responses to be accelerated and in order for the 2020 and 2030 targets to be achieved.

4.1 STRATEGIC DIRECTION 1: Information for focused action

Know your hepatitis epidemic and response in order to implement tailored investments

36. Global leaders have recognized viral hepatitis as an international public health and development priority by explicitly including it under target 3.3 of the 2030 Agenda for Sustainable Development. However, such global recognition has not necessarily resulted in country action. Few countries have national hepatitis strategies, plans and budgets. A robust strategic information system that analyses and translates up to date data on viral hepatitis into usable information can leverage much-needed political commitment. Such a system is essential for generating the necessary data to create awareness and advocate for action and resources, to set national targets, to plan for a focused response, to implement programmes most efficiently in order to achieve greatest impact, and to monitor and improve quality and outcomes.

4.1.1 Understanding the epidemic and the response – data for decisions

37. With limited resources interventions, services and investments need to be strategically targeted to the local epidemic. Timely and reliable data, with an adequate level of “granularity”, are essential to identify “hotspots”, the main modes of transmission and risk factors, the specific populations that are vulnerable, at risk and affected, the health burden in terms of cirrhosis and hepatocellular carcinoma, and the coverage and quality of essential hepatitis services. Such data make it possible to proactively focus high-impact interventions more precisely and effectively, and to deploy or adapt services to reach greater numbers of people in need. Community and stakeholder involvement in collecting and analysing the data is important for improving the quality and relevance of the information. The rigorous application of ethical standards in gathering and using data is important so as not to

compromise the confidentiality and safety of individuals and communities. The hepatitis information system should be fully integrated into the broader national health information system to ensure standardized and coordinated reporting and to maximize efficiencies.

38. Monitoring and understanding the response to viral hepatitis is critical for informing more strategic investments in hepatitis services, and for maximizing their effectiveness, responsiveness and cost-effectiveness. The hepatitis service continuum provides a good framework for establishing a national hepatitis monitoring and evaluation system, with indicators measuring coverage and performance along each step of the “cascade”. Resources can then be directed to address any significant “leaks” in the cascade, to improve retention in care.

Priority actions for countries

- **Integrate viral hepatitis strategic information activities and indicators** within national health information systems and tools, including for outbreak surveillance, and monitoring and evaluation of the national hepatitis response.
- **Assess the national hepatitis burden**, including the numbers of persons with chronic hepatitis and hepatocellular carcinoma and cirrhosis attributable to hepatitis B virus and hepatitis C virus, assessing trends over time, using subnational and disaggregated data.
- **Monitor access to, uptake and quality of vital hepatitis services**, disaggregated by different populations and geographical locations to guide service improvement.

Priority actions for WHO

- **Develop and update normative guidance and tools** on hepatitis surveillance, and monitoring and evaluation, including surveillance of acute disease and defining a standardized set of core indicators across the continuum of hepatitis services.
- **Support countries to strengthen their health information systems and to use strategic information tools** for setting targets, planning, implementing, and monitoring and evaluating their hepatitis responses.

4.1.2 Implement evidence-based national hepatitis plans

39. The national hepatitis response should be guided by a national plan with a well-defined governance and management structure that can ensure a coordinated and efficient response and clear accountability. Strategic planning processes should enable meaningful inputs from all key stakeholders on policy development, service planning and resource allocation.

40. Informed by current data, national plans and investment cases can be used to mobilize political commitment, define and budget for tailored packages of interventions and services, define responsibilities and allocate resources across the different levels of the health system, and identify potential and reliable sources of funding. Such hepatitis plans, efforts and other activities should be fully aligned and appropriately integrated with broader national health and development strategies and plans, with the goal of achieving universal health coverage. Regular reviews of the national hepatitis response are essential in order to ensure that the national plan is current and “fit for purpose”.

41. Concerted advocacy efforts, particularly by political and community leaders, and a sound communication strategy are required to increase public and political awareness of the public health importance of viral hepatitis, to generate resources and to mobilize action. World Hepatitis Day provides an opportunity each year to raise public awareness, however, a broader and intensified

communication strategy is required to generate the interest required to elevate and accelerate the hepatitis response to reach the global targets.

Priority actions for countries

- **Establish a national governance structure and coordination mechanism** to oversee the national hepatitis response, integrated within the national health programme.
- **Develop a national plan on viral hepatitis with a budget** based on the global health sector strategy on viral hepatitis and integrate it into the broader national health programme.
- **Set national targets and define indicators** based on global targets and indicators, to monitor and evaluate, and to report on the national hepatitis response.
- **Regularly review the national hepatitis response** and revise the national plan as necessary.
- **Raise national awareness on viral hepatitis**, by promoting the national plan, celebrating World Hepatitis Day (July 28), and engaging community and political leaders advocates and “champions”.

Priority actions for WHO

- **Develop and update guidance** and tools on national strategic planning, including guidance on setting national hepatitis targets, costing, programme implementation and review, and monitoring and evaluation.
- **Provide technical assistance to countries** to set ambitious but achievable national targets and develop national plans and activities with budgets.
- **Regularly report on the global viral hepatitis situation and response**, including progress towards the achievement of 2020 and 2030 targets at the global and regional levels.
- **Increase global awareness on viral hepatitis** through such activities as World Hepatitis Day and high-level meetings, such as the Global Hepatitis Summit.

4.2 STRATEGIC DIRECTION 2: Interventions for impact

People should receive the full range of hepatitis services they need

4.2.1 Defining an essential benefit package for viral hepatitis

42. Each country needs to define a set of essential viral hepatitis interventions, services, medicines and commodities relevant to the country context, to be included in the national health benefit package. The benefit package should be covered in whole, or in part, through public funding so as to minimize out-of-pocket payments, ensure access to services for all who need them, and cover the entire continuum of hepatitis services, including prevention, diagnosis, treatment and care. Selection of essential interventions and services should be through a transparent process, which would take account of the following criteria: effectiveness, cost, cost-effectiveness, acceptability, feasibility, relevance, demand and ethics. The selection process would benefit from broad stakeholder engagement, including service providers and affected communities, and should be informed by scientific evidence and good practice. The package should be regularly reviewed to ensure that the selected interventions reflect changes in the country epidemic and context, advances in technologies and service delivery approaches, and evidence of impact or harm. Combinations of interventions should be specifically

considered, recognizing that some interventions will only be effective, or achieve maximum impact, if they are delivered in combination with other interventions.

4.2.2 *Essential interventions for viral hepatitis*

43. The essential package of viral hepatitis interventions and services should include all **five core viral hepatitis interventions**: vaccination, particularly for hepatitis B virus, and, where appropriate, hepatitis A virus; injection, blood and surgical safety and universal precautions; prevention of mother-to-child transmission of hepatitis B virus; harm reduction services for people who inject drugs; and treatment of chronic hepatitis B virus and hepatitis C virus infection. In addition, ensuring high levels of sanitation and access to safe food and water is essential for preventing and controlling epidemics of hepatitis A virus and hepatitis E virus. Interventions for prevention of sexual transmission of hepatitis B virus and hepatitis C virus are important for specific populations. Hepatitis prevention interventions also contribute to broader health outcomes, including the prevention of HIV, sexually transmitted and other blood-borne infections described below. The relative composition and balance of the interventions will vary by country, based on the country context and epidemic dynamics, including the prevalence of the various types of viral hepatitis. Particular focus should be given to interventions targeting viral hepatitis B and C infections, given their relative health burden, as compared with viral hepatitis A, D and E infections.

4.2.3 *Preventing transmission*

Using vaccines

44. Effective vaccines exist for preventing viral hepatitis A, B and E infections. Hepatitis B virus vaccination is a critical intervention for the elimination of hepatitis B virus epidemics. Wider provision of the existing, safe and effective hepatitis B virus vaccine, including through universal childhood vaccination and by delivery of birth-dose, will drastically reduce new hepatitis B infections, reducing rates of chronic illness and death. The strategy calls for an increase in routine childhood hepatitis B virus vaccination coverage from 82% in 2015 to 90% by 2020, which will require strengthening of overall childhood immunization programmes along with specific efforts to target hepatitis B virus vaccination for those people at increased risk. Depending on the country context, hepatitis A virus vaccination may be included in routine childhood immunization programmes, and may also be considered an appropriate intervention in response to outbreaks in specific communities.

Priority actions for countries

- **Implement a comprehensive hepatitis B virus immunization programme**, based on WHO's guidance: inclusion of hepatitis B virus vaccine in national childhood immunization schedules; strengthening hepatitis B virus birth-dose programmes; consideration of catch-up hepatitis B virus vaccination for children or adolescents with low coverage; and offering hepatitis B virus vaccination to people who are at increased risk of acquiring and transmitting the virus.
- **Consider the role of viral hepatitis A and E vaccination** in a comprehensive hepatitis prevention strategy and national immunization programme, based on the country context, following WHO's guidance.

Priority actions for WHO

- **Promote enhanced access to all hepatitis vaccines**, including through international agencies that procure vaccines or advocate for vaccine access.
- **Develop and update guidance on** the most effective use of all hepatitis vaccines (viral hepatitis A, B and E), improving hepatitis B virus vaccine birth-dose coverage, and vaccination for specific populations at high risk.
- **Support the evaluation of new hepatitis vaccines and vaccination approaches**, in association with the Strategic Advisory Group of Experts (SAGE) on immunization, including evaluation of products that do not require a supply cold chain.

Improving blood safety

45. The risk of transmission of viral hepatitis B and C (as well as HIV and other blood-borne infections) through the transfusion of contaminated blood and blood products is extremely high, and, despite being preventable, still occurs because of the absence, or poor quality, of screening in blood transfusion services. Ensuring the availability of safe blood and blood products is a vital public health duty for every national government. Countries should work towards self-sufficiency in safe blood and blood products, aiming for 100% of donations from regular, voluntary, and non-remunerated blood donors.

Priority actions for countries

- **Establish and implement national policies and practices on blood safety** based on WHO's guidance, which promotes the rational use of blood and blood products to prevent unnecessary blood transfusions and ensure reliable screening of blood for viral hepatitis B and C.
- **Implement quality control measures for laboratory testing of viral hepatitis B and C** to ensure a reliable supply of quality-assured screening assays.
- **Establish systems of surveillance, haemovigilance and monitoring** of the incidence and prevalence of viral hepatitis infections in blood donors and on post-transfusion hepatitis risk.

Priority actions for WHO

- **Provide updated guidance** to countries on the management of safe blood supplies and the strengthening of linkages between blood transfusion services and viral hepatitis services.
- **Support countries, with tools and technical assistance**, to establish systems of surveillance, haemovigilance and monitoring of supplies of blood and blood products.

Enhancing infection prevention and control in health care settings

46. Consistent implementation of infection control practices, including safe injection measures in health care and community settings, will reduce transmission of viral hepatitis and other infections to both users of health care services as well as health care workers. This hepatitis strategy sets a target for increasing the percentage of medical injections administered with safety-engineered injection devices from a baseline of 5% in 2015 to 50% in 2020 and 90% in 2030.

47. An estimated 15 700 million injections are administered annually in low- and middle-income countries, with many injections being unsafe and/or unnecessary. Despite a major decline since 2000, about 5.5% of injections in 2010 were still being administered with reused injecting equipment. It is estimated that more than 90% of injected medications used in primary care for therapeutic purposes can be administered orally. Reducing unnecessary injections remains a vital challenge, along with staff training in safe injections practices, and effective sharps and waste management. The WHO injection safety policy and global campaign, launched in 2015, aims to address this major public health risk.¹

Priority actions for countries

- **Strengthen and sustain routine infection prevention and control practices** in health care settings (public and private), including in laboratories.
- **Implement the WHO injection safety policy**, with the aim of reducing unnecessary injections and transitioning, where appropriate, to the exclusive use of safety-engineered injection devices.
- **Ensure access to appropriate injection equipment for people who inject drugs** that meet their needs, including low dead-space syringes.
- **Provide health workers with free immunization** against vaccine-preventable diseases, including, where appropriate, hepatitis B virus vaccine, and provide hepatitis B virus post-exposure prophylaxis as necessary.

Priority actions for WHO

- **Update normative guidance on:** standard precautions and effective disinfection and sterilization methods; safe injection practices and alternatives to injections; infection control inside and outside health care services; and for specific procedures, including endoscopy, tattooing and cosmetic procedures.
- Support countries to **fully implement WHO's injection safety policy** and global campaign, and other infection control measures, and monitor its implementation and impact.

Preventing mother-to-child transmission of viral hepatitis

48. Transmission of hepatitis B virus in highly endemic areas often occurs from infected mothers to their infants during the perinatal period. Elimination of mother-to-child transmission of hepatitis B virus will require a comprehensive approach that includes prevention of hepatitis B virus infection in young women, hepatitis B virus testing, care of pregnant women with chronic hepatitis B virus infection, delivery of hepatitis B virus vaccine to the infant within 24 hours of birth, safe delivery practices, strengthened maternal and child health services, and the development of new interventions to prevent transmission based on antiviral treatment.

49. Birth-dose vaccination is a key intervention for prevention of hepatitis B virus infection in infants. However, its delivery can be a challenge in communities where a large proportion of births occur outside of health facilities. As a result, global coverage is only around 38%. This strategy calls for the expansion of interventions to prevent mother-to-child transmission of hepatitis B virus to achieve a coverage of 50% by 2020 and 90% by 2030.

¹ For information on WHO's injection safety policy and global campaign, see http://www.who.int/injection_safety/global-campaign/en/ (accessed 3 April 2016).

Priority actions for countries

- **Provide timely administration of hepatitis B virus birth-dose vaccine** with special attention given to those births occurring outside of health care settings and in remote areas.
- **Update national policies and guidelines** on maternal and neonatal health, based on WHO's evolving guidance on elimination of mother-to-child transmission of viral hepatitis.

Priority actions for WHO

- **Advocate for** enhanced access to and uptake of hepatitis B virus birth-dose vaccination, including through international advocacy, advising on procurement policies of international agencies and providing implementation guidance on delivering vaccines in different settings.
- **Develop and update global guidance on** a comprehensive package of interventions to eliminate mother-to-child transmission of hepatitis B virus, including the possible role of perinatal use of antiviral drugs and on viral hepatitis testing for pregnant women, mothers and infants.

Providing harm reduction services

50. A package of harm reduction services for people who inject drugs can be highly effective in preventing the transmission and acquisition of viral hepatitis A, B and C, as well as HIV and other blood-borne infections. Such a package should be integrated into a comprehensive set of services for the prevention and management of substance use disorders. WHO, UNODC and UNAIDS have defined a set of interventions and services that should be included in a comprehensive package for people who inject drugs.¹ Included in the package are five intervention areas that will have greatest impact on hepatitis epidemics: sterile needle and syringe programmes, opioid substitution therapy for opioid users, risk reduction communication, hepatitis B vaccination, and treatment of chronic hepatitis infection.

51. The hepatitis C virus is more easily transmissible than HIV, therefore harm reduction services should include provision of all injecting paraphernalia, including mixing containers and solutions. This hepatitis strategy calls for a major increase in provision of sterile needles and syringes to people who inject drugs, from an estimated baseline of 20 needles and syringes per person who injects drugs per year to 200 by 2020 and 300 by 2030. Current coverage of these interventions is too low to have a significant impact on hepatitis epidemics. Ensuring sufficient coverage of other harm reduction interventions depends on overcoming legal and societal barriers.

¹ For the WHO, UNODC, UNAIDS technical guide for countries to set targets for universal access to HIV prevention, treatment and care for injecting drug users – 2012 revision, see http://www.who.int/hiv/pub/idu/targets_universal_access/en/ (accessed 1 April 2016).

Priority actions for countries

- **Implement a comprehensive package of harm reduction services, where appropriate**, based on the WHO package of evidence-based harm reduction interventions for people who inject drugs, taking into account the domestic context, legislation and jurisdictional responsibilities.
- **Address legal and institutional barriers** to the provision of harm reduction services.
- **Link hepatitis and harm reduction services** to facilitate integrated prevention, treatment and care for people who use drugs.

Priority actions for WHO

- **Develop and update policies and guidance** on evidence-based prevention and management of viral hepatitis B and C infection for people who inject drugs and for non-injecting drug users, including people who use cocaine and amphetamine-type stimulants.
- **Provide advocacy and technical support to countries to mobilize commitment** and resources for recommended harm reduction interventions.

Promoting safer sex

52. Although sexual transmission of viral hepatitis B and C plays a minor role in most hepatitis epidemics, specific attention should be given to certain populations, particularly men who have sex with men and who have not been vaccinated against hepatitis B virus, and in heterosexual persons with multiple sexual partners. Safer sex practices, including minimizing the number of sexual partners and consistently and correctly using male and female condoms, offer powerful protection against viral hepatitis B and C and HIV infection, and a range of other sexually transmitted infections. In some populations, problem alcohol and other drug use can exacerbate certain vulnerabilities and sexual risk behaviours. Such factors should be considered when designing services.

Priority actions for countries

- **Intensify condom programming** to increase demand and supply of male and female condoms and water-soluble lubricants in both traditional and non-traditional outlets, especially for populations most at risk of viral hepatitis B and/or C infection.
- **Ensure that the national hepatitis B virus vaccination policy** includes persons at increased risk of acquiring hepatitis B virus infection through sexual contact.

Priority actions for WHO

- **Advocate for** increased investments in male and female condom programmes and their integration into hepatitis prevention services.
- **Provide guidance on standards for, and procurement and supply** of quality-assured male and female condoms and lubricants.

Ensuring access to safe food and water

53. An estimated 748 million people lack access to an improved source of drinking water, and 2500 million people, more than one third of the global population, live without basic sanitation facilities. In settings with very poor sanitary conditions and hygienic practices, most children acquire hepatitis A virus at an early age and achieve immunity. Outbreaks in such settings tend to be rare. However, where sanitary conditions are variable, children are often exposed to infection as they grow older, and large outbreaks may occur. Assuring access to safe food, drinking water and sanitation systems can dramatically reduce the transmission of viral hepatitis A and E. Specifically, actions should include a focus on hygiene as a priority in all settings through alignment with efforts to address Goal 6 of the 2030 Agenda for Sustainable Development, which includes the following 2030 targets:

- achieve universal and equitable access to safe and affordable drinking water for all;
- achieve access to adequate and equitable sanitation and hygiene for all and end open defecation, paying special attention to the needs of women and girls and those in vulnerable situations;
- support and strengthen the participation of local communities in improving water and sanitation management.

Priority actions for countries

- **Work with water and sanitation departments** to ensure access to safe drinking water and sanitation systems, particularly in high-risk settings such as under-served neighbourhoods, and camps for internally displaced persons or refugees.

Priority actions for WHO

- **Update guidance** on risk assessment and management of water supplies, sanitation, hygiene and food safety, and promote and support country implementation of the guidance.

4.2.4 Diagnosing hepatitis infection

54. Early diagnosis of hepatitis infection is critical for effective treatment and care. Yet globally, less than 5% of persons with chronic viral hepatitis are aware of their status. Awareness is lacking, reliable diagnostics that are appropriate for the setting of intended use and testing services are not sufficiently available, and laboratory capacity is weak. Increasing early diagnosis requires overcoming those shortcomings, using effective testing approaches, quality-assured diagnostics, and linking the results of testing to treatment and care services. The strategy calls for a major increase in diagnosis of chronic viral B and C infection, with 30% of people infected knowing their status by 2020 and 90% by 2030.

Priority actions for countries

- **Integrate viral hepatitis testing** into national hepatitis policies and guidelines that defines, among other things, priority populations and locations for testing, testing approaches and strategies.
- **Strengthen the national laboratory system** to provide quality diagnosis of acute and chronic hepatitis with timely reporting of results and ensure the reliable supply of quality-assured (WHO prequalified) diagnostics.
- **Establish key linkages between testing and other services** to improve referral and access to quality-assured treatment and other support services.

Priority actions for WHO

- **Regularly update guidance** on hepatitis testing approaches, strategies and diagnostics, incorporating the latest innovations.
- **Support country adaptation and implementation** of WHO's policies and guidelines on viral hepatitis diagnostics, testing approaches and strategies.

4.2.5 Enhancing hepatitis treatment and chronic care

Expanding treatment

55. Effective antiviral agents against viral hepatitis B and C have the potential to dramatically reduce morbidity and mortality, including among people co-infected with HIV. Not all people with chronic hepatitis infection require, or are eligible for, treatment. Individuals need to be assessed for liver disease to determine whether treatment is indicated, and, if not eligible for treatment, regularly monitored to determine when treatment should be initiated. Direct-acting antivirals for the treatment of chronic hepatitis C virus have cure rates exceeding 95%, with pangenotypic regimens becoming available. Effective treatment is available for chronic hepatitis B virus infection, although lifelong treatment is usually required. WHO's guidelines for treatment of chronic viral hepatitis B and C infection promote a public health approach with a move towards simpler and safer oral treatment regimens.

56. According to WHO's guidelines issued in 2014, of the 130–150 million people living with chronic hepatitis C virus infection, only 26–30 million are eligible for treatment. Nevertheless, less than 1% of people with chronic hepatitis infection are receiving treatment. The strategy calls for five million people with chronic hepatitis B virus infection to be on treatment by 2020, and for three million people with chronic hepatitis C virus to have been treated by 2020. By 2030, treatment coverage for both chronic viral hepatitis B and C infections should reach 80% of eligible persons.

Providing chronic care

57. People with chronic hepatitis infection may require care for a range of health and psychosocial problems. In addition to liver cirrhosis and hepatocellular carcinoma, people with chronic hepatitis infection may experience extrahepatic manifestations of their infection, including insulin resistance and diabetes. Alcohol use, smoking and obesity may complicate chronic infection. An assessment of alcohol intake is recommended for all people with chronic viral hepatitis infection followed by the offer of a behavioural alcohol reduction intervention for those people with moderate-to-high alcohol intake.

58. Persons living with hepatitis B or hepatitis C may also have coinfections, including HIV, tuberculosis or other hepatitis viruses (hepatitis B, C and D). About three million people living with HIV are co-infected with hepatitis C and 2.6 million with hepatitis B. Treatment regimens that do not cover coinfection expose those patients to a progression of their chronic liver disease. The effective management of HIV-hepatitis B and HIV-hepatitis C virus coinfections is important to secure the health gains acquired through HIV treatment. This requires testing services that can ensure a linkage with adapted care.

59. Persons at increased risk of hepatitis C virus infection are often also at higher risk of tuberculosis, particularly people who inject drugs. Two out of three people who inject drugs and who develop tuberculosis will also be infected with hepatitis C. Dual infection with hepatitis B and hepatitis D can lead to severe chronic hepatitis. In countries where the prevalence of hepatitis D coinfection makes it a public health problem, specific approaches are needed. For all types of coinfections, co-management needs to take into consideration the side-effects and interactions of the drugs used to treat HIV, tuberculosis and viral hepatitis.

60. In addition to antiviral treatment, chronic care is required for many, including the management of decompensated liver disease and hepatocellular carcinoma. Treatment of advanced liver cirrhosis and hepatocellular carcinoma, including liver transplantation and chemotherapy, is very limited in most low- and middle-income settings, highlighting the need to provide access to good quality palliative and end-of-life care.

Priority actions for countries

- **Prioritize hepatitis treatment** by including access to antiviral treatment for people with chronic viral hepatitis B and C infection as a central component of the national hepatitis strategy and plan.
- **Establish national hepatitis treatment and care guidelines, plans and protocols** based on WHO hepatitis treatment and care guidelines.
- **Provide quality treatment that** ensures standardized care of people with chronic hepatitis infection, including appropriate disease staging, timely treatment initiation, patient and drug toxicity monitoring, management of liver cirrhosis, hepatocellular carcinoma and liver failure.
- **Address common comorbidities**, including HIV infection and risk factors that may accelerate progression of liver disease, including alcohol use and provide palliative and end-of-life care, including access to adequate analgesia.

Priority actions for WHO

- **Advocate** for adequate investments to scale up viral hepatitis B and C treatment to reach global targets.
- **Develop and regularly update consolidated guidelines** for the prevention, diagnosis, treatment and care of chronic hepatitis infection, including advanced liver disease and major comorbidities, and provide support to countries for their adaptation and implementation.
- **Provide technical support to countries** to develop costed national hepatitis treatment plans and guidelines.

4.3 STRATEGIC DIRECTION 3: Delivering for equity

All people should receive the hepatitis services they need, and such services should be of adequate quality

61. Large proportions of people at high risk of, or living with, chronic hepatitis infection do not have access to prevention services, remain undiagnosed, do not use or adhere to treatment, and cannot access chronic care services. Furthermore, existing hepatitis services seldom address critical underlying factors that can generate health inequities, such as poverty, discrimination and criminalization, drug dependence and poor mental health. Interventions and services, where they exist, are often poorly targeted and fail to reach those who are at greatest risk or who are most affected. Such factors lessen the overall impact of interventions and services. The impact of hepatitis responses is also dependent on the quality of hepatitis medicines and diagnostics, interventions and services. When hepatitis services are available, issues of affordability, accessibility and acceptability can prevent their optimal utilization.

62. An effective hepatitis response requires robust and flexible health systems that can sustainably deliver people-centred care across the full continuum of services to those populations, locations and settings in greatest need. The hallmarks of such health systems are: a strong health information system; efficient service delivery models; appropriately trained and distributed workforce in adequate numbers and with an appropriate skills mix; reliable access to essential medical products and technologies; adequate health financing; and strong leadership and governance. Hepatitis interventions are most effective when they occur in appropriate social, legal, policy and institutional environments, which encourage and enable people to access and use services. Those interventions need to be grounded in an enabling environment that promotes health equity and human rights, that features well-supported health and community systems, and that makes it possible to harness the strengths and contributions of partners, especially those in civil society.

4.3.1 Adapting viral hepatitis services

63. An efficient health system should be able to deliver essential hepatitis services to different populations and settings, reinforce strategic linkages between different health services, ensure quality of the services and actively engage communities. The roles and responsibilities of different levels of the health system in delivering hepatitis services need to be defined, from community-based and primary health services through to tertiary referral centres.

Tailoring services for different populations and locations

64. Not all hepatitis interventions and services will be required by all populations and in all locations and settings. Strategic information gathered on affected populations, risk factors and locations should help to guide the adaptation and implementation of the essential hepatitis package to specific populations, country settings and contexts. Depending on the country context and epidemiology, priority might be given to certain age groups (such as those born between certain dates), certain high prevalence groups (such as incarcerated persons, people who inject drugs, migrants, haemodialysis patients, people who undergo skin-piercing procedures including tattooing, some indigenous communities, sex workers and men who have sex with men), people at a certain stage of hepatitis disease (such as advanced liver fibrosis), or others. It is important to have strategic information systems sensitive enough to identify these groups in order to deliver services for the highest impact.

Linking and integrating hepatitis services with other health services

65. Greater integration and linking of viral hepatitis services with other relevant health services (including for sexually transmitted infections, HIV, broader sexual and reproductive health, harm reduction and drug use disorders, alcohol use disorders, blood safety, cancer prevention and management, and noncommunicable diseases) can speed up progress towards key milestones and targets, and increase efficiency, reach, acceptability and savings. Investments in hepatitis programmes may also facilitate the prevention and management of other major health conditions. Linkages at different levels of the health system are required, with the relative contributions and roles of primary health care, referral care and hospital care being defined. Appropriate models of integration and linkage will depend on the country context and health system, and should be informed by operational research. Linkages are also required with programmes in other sectors, such as correctional services, police and justice, social welfare, water and sanitation, and housing.

Strengthening community-based services

66. Community-based services provide opportunities to reach marginalized groups, improve acceptability and utilization of services, facilitate decentralization of services to provide more equitable access, enhance the quality and impact of services, improve efficiencies and reduce costs. There are considerable opportunities to support communities to expand their capacity and provide services across hepatitis prevention and care continuum. Lessons can be learnt from community-based services addressing other health issues, such as HIV and palliative care.

Involving people living with viral hepatitis

67. Actively engaging affected populations in developing strategies and programmes should result in better targeted and acceptable services. Affected populations can also act as a powerful force in addressing discrimination, criminalization and harmful socioeconomic and cultural norms that help generate health inequities.

Ensuring the quality of interventions and services

68. Rapid expansion of programmes to improve coverage should not compromise the quality of services, nor contribute to inequities in access to services and health outcomes. Quality can be optimized by ensuring that interventions and services conform to national and international norms and standards, are continuously monitored and improved, and are made more acceptable and accessible to patients' needs and preferences.

Priority actions for countries

- **Define populations and locations** that are most affected and require intensified support, and prioritize them in the national hepatitis response while minimizing the risk of stigmatization.
- **Build community capacity** to deliver quality community-based hepatitis services, supported by legal and regulatory frameworks and appropriate financial incentives.
- **Decentralize and expand hepatitis services** to include, where appropriate, services in custodial settings, refugee camps and places of humanitarian concern.
- **Identify good models of integrated and linked service delivery** through operational research, including linkages with other key health areas.
- **Improve the quality of services** by setting national norms and standards for services, integrating quality indicators into strategic information systems and promoting the adoption and implementation of WHO's guidelines.
- **Regularly undertake hepatitis “cascade analyses” for different populations and settings** to determine the quality of services, assess service utilization and acceptability, identify major weaknesses and propose possible remedial actions.

Priority actions for WHO

- **Provide guidance on implementation of models of integrated and linked service delivery**, and community-based services for the prevention and management of viral hepatitis.
- **Promote the WHO cascade monitoring and evaluation framework** as a key component of national hepatitis monitoring and evaluation systems, and provide technical assistance to countries in analysing their hepatitis prevention, treatment and care cascades.
- **Provide guidance on quality assurance and quality improvement systems**, including for hepatitis services and for hepatitis commodities.

4.3.2 Strengthening human resources for hepatitis

69. Many essential viral hepatitis interventions are integrated within broader health services and programmes, such as programmes for child vaccination, blood and injection safety, food safety, water and sanitation, harm reduction for drug users, clinical management of infectious diseases and chronic care for noncommunicable diseases. In all such settings, including primary health care, health workers should be knowledgeable about viral hepatitis risk and infection, and the package of essential hepatitis interventions. They should be competent to work with people living with chronic hepatitis infection and those most affected and at risk. Defining the core hepatitis competencies of different cadres of health workers at different levels of the health system will help define those tasks which can be shifted and to what level, along with defining training, accreditation and supervisory needs. Issues related to viral hepatitis should be included in pre-service and in-service training for health workers. Community-based and peer-support workers play an important role in reaching marginalized groups, linking people with chronic hepatitis to care, supporting treatment adherence and providing chronic care. Those workers should receive regular training, mentoring and supervision and appropriate compensation for their work. Given the risk of viral hepatitis transmission in health care settings, health workers should be protected by comprehensive occupational health and safety programmes.

Priority actions for countries

- **Ensure that the national health workforce strategy and plan** addresses the needs of hepatitis services, including integrating hepatitis content into the training of health workers and defining core competencies relevant to delivering hepatitis services at different levels of the health system.
- **Identify opportunities for task-shifting and task-sharing** to extend the capacity of the health workforce and provide community health workers with sufficient support.
- **Implement occupational health measures** that address the risk of viral hepatitis transmission within health care settings and address the needs of health workers living with viral hepatitis.

Priority actions for WHO

- **Provide policy and technical guidance** aimed at building a competent workforce that can effectively deliver a public programme for addressing viral hepatitis.
- **Provide guidance on occupational health** and safety policies relating to viral hepatitis.

4.3.3 Ensuring access to good quality and affordable hepatitis vaccines, medicines, diagnostics and other commodities

70. Effective hepatitis programmes depend on the uninterrupted supply of quality-assured vaccines, medicines, diagnostics and other commodities. Robust procurement and supply management systems are required to ensure that the right products are selected, purchased at a reasonable price and efficiently delivered to the point of care. Disruptions in supply, including stockouts, of hepatitis medicines contribute significantly to the risk of treatment failure.

71. Accurate forecasting of country and global needs of all hepatitis commodities is required to inform the readiness and capacity of manufacturers to meet expected needs. Local manufacturing capacity should be considered, where economic analysis shows there is potential to reduce prices and guarantee supply. National hepatitis and broader health plans and budgets should address procurement and supply chain management needs. Medicines, vaccines, diagnostics and other commodities will constitute an increasingly important component of national hepatitis budgets, particularly as treatment is expanded. WHO's hepatitis guidelines, the WHO Model List of Essential Medicines, WHO's hepatitis testing strategies and the WHO lists of prequalified products can guide countries in the selection of the right products which are of sufficient quality. The procurement and supply management of hepatitis commodities should be integrated into the broader national procurement and supply management system.

72. The demand for affordable treatment for viral hepatitis B and C infection requires comprehensive price reduction strategies for medicines, diagnostics and health commodities, including for those medicines and diagnostics in the development pipeline. Strategies include fostering generic competition, including through voluntary licences, and using the Agreement on Trade-Related Aspects of Intellectual Property Rights regarding flexibilities to protect public health. That would include compulsory licences and filing patent oppositions, differential pricing and direct price negotiations with manufacturers, as well as local manufacturing in accordance with the Global Strategy and Plan of Action on Public Health, Innovation and Intellectual Property, which also notes that intellectual property rights are an important incentive for the development of new health care products. Different measures may have to be taken for different medicines and different countries, noting the differences

in access barriers in low-income and lower middle-income countries as compared with upper middle-income countries.

73. There are also many opportunities to save on procurement of hepatitis commodities and improve efficiencies in supply management, such as bulk procurement with staggered deliveries for short shelf-life commodities, advanced purchasing and improved forecasting to avoid wastage through expired products.

Priority actions for countries

- **Strengthen the national hepatitis procurement and supply management structures and processes** by ensuring that they are integrated into the broader national procurement and supply management system while promoting incentives for continued innovation.
- **Ensure the procurement of quality-assured hepatitis vaccines, medicines, diagnostics, condoms, and other hepatitis-related commodities**, including through the use of WHO prequalification.
- **Plan and implement a hepatitis medicines and commodities access strategy** to reduce prices of hepatitis-related commodities, including, where appropriate, through implementation of flexibilities of the Agreement on Trade-Related Aspects of Intellectual Property Rights, in accordance with the Global Strategy and Plan of Action on Public Health, Innovation and Intellectual Property.
- **Safeguard and expand availability of WHO-prequalified generic products** through the expansion of licence agreements and timely registration at national level.

Priority actions for WHO

- **Advocate for comprehensive strategies to reduce prices** of viral hepatitis vaccines, medicines, diagnostics and other commodities.
- **Forecast demand** for, access to and uptake of commodities for hepatitis and major comorbidities and use this information to advocate for adequate manufacturing capacity of producers.
- **Promote the WHO Prequalification Programme** to allow fast-track registration of priority medicines and commodities, and to safeguard and expand availability of quality-assured medicines and diagnostic products.
- **Provide guidance on hepatitis product selection** by national programmes, donors and implementing agencies through the generation and dissemination of strategic information on prices, manufacturers, regulations and patent landscapes of hepatitis commodities.
- **Provide technical support to countries** to forecast the need for essential hepatitis commodities, include them in their national procurement and supply management plans and develop a strategy for negotiating price reductions with manufacturers.
- **Support regulatory authorities** in pre-market assessment and registration of new hepatitis medicines and diagnostics, with post-market surveillance.
- **Assess the quality and performance** of commercially available hepatitis diagnostics and issue appropriate recommendations.

4.3.4 Promoting an enabling environment

74. As with other public health programmes, the viral hepatitis response requires an enabling environment of policies, laws and regulations that support the implementation of evidence-based policies and programmes, and promote and protect human and health rights, reduce stigmatization and ensure health equity. The health sector has a compelling obligation to ensure that such an environment exists. When properly enforced, laws and policies can reduce people's vulnerability and risk for hepatitis infection, expand access to health services and enhance their reach, quality and effectiveness – especially for most-affected populations. However, legal, institutional and other barriers may prevent certain groups of people from accessing effective interventions and using health services such as adolescents, prisoners, people who use drugs, men who have sex with men, sex workers and transgender people.

75. People with viral hepatitis and those at risk may be exposed to stigmatization, discrimination and social marginalization, further impeding their access to hepatitis services. Many of these barriers can be overcome if existing models of service delivery are reviewed and adapted to meet the needs of affected populations. Others may require the reform or removal of certain laws, regulations and policies.

Priority actions for countries

- **Use public health evidence to shape pro-health laws** and actions in all relevant sectors that will enable an effective viral hepatitis response.
- **Remove legal, regulatory and policy barriers** that hinder equitable access to hepatitis services, especially for most-affected populations and other groups at risk.
- **End policies and practices that condone or encourage stigma and discrimination against people at risk for hepatitis or living with hepatitis**, especially in health care settings and places of employment.
- **Create institutional and community environments** that make it safe for people to access hepatitis services, involving communities in the planning and delivery of services to improve their reach, quality and effectiveness.
- **Address gender inequality** by integrating evidence-based interventions into national hepatitis plans and strategies.

Priority actions for WHO

- **Advocate for the use of public health evidence** to shape pro-health laws and actions based on medical ethics, human rights and public health principles.
- **Develop and promote WHO's policies and guidelines** that explicitly address gender inequality, gender-based violence, stigma and discrimination, human rights, the health of marginalized populations, and public health alternatives to criminalization.
- **Provide technical assistance to countries** to review policies and laws and develop programmes that advance gender equality, empower women and girls, and promote human rights and health equity, particularly for young people and most affected populations.

4.4 STRATEGIC DIRECTION 4: Financing for sustainability

People should receive the hepatitis services they need without experiencing financial hardship

76. Adequate investment in the full continuum of hepatitis services is necessary to achieve the targets for 2020 and 2030, and to promote universal health coverage. A sustainable response will require funding the essential hepatitis package through the national health financing system, mobilizing new and predictable funding, minimizing the financial burden for individuals and households through prepayment and pooling, achieving savings and avoiding wastage, and using available funds efficiently and equitably. Increasing access to high quality and affordable medicines and diagnostics for viral hepatitis B and C infection, coupled with standardized and simple treatment protocols, is critical.

77. Financing for a sustainable hepatitis (and broader health) response requires action in three areas:

Revenue raising to pay for viral hepatitis interventions and services, with an emphasis on improving domestic tax collection (including both general revenues and compulsory health insurance contributions) supplemented by external sources, such as donor grants, and private revenues as relevant;

Financial risk protection and pooling, including establishing equitable mechanisms to pool funds across the health system to ensure adequate coverage along the hepatitis services continuum, reducing financial barriers to services while providing financial risk protection;

Improving efficiency in the use of health system resources to enable greater effective coverage of hepatitis services, by reducing the costs of medicines, diagnostics and other commodities and by reducing duplication of underlying subsystems with other programmes and the wider health system, such as strategic information, human resources and procurement and supply management.

78. The national health financing systems should address viral hepatitis along with all other priority national health issues, avoiding fragmented funding channels while aiming to achieve health equity.

4.4.1 Increasing investments through innovative financing and new funding approaches

79. Unlike the other major communicable diseases, such as HIV, tuberculosis and malaria, there has been very little external development assistance funding for comprehensive viral hepatitis responses. Similarly, most countries do not have dedicated hepatitis budgets or programmes. Therefore, new sources of funding will be required for countries to launch, accelerate and sustain public health responses to viral hepatitis, and these resources will need to be substantial if the ambitious global targets are to be realized.

80. Strategies to increase investment in hepatitis need to be part of broader efforts to increase overall investments in health, so that all priority health services can be scaled up towards universal health coverage. Public, domestic funding will be central to funding essential viral hepatitis services in all countries and to ensure the long-term sustainability of such services. Public spending on health can be increased either by raising more tax revenues (increasing a government's fiscal capacity) or by allocating a greater share of overall government funds to health (giving health a greater priority in the public budget). Health ministries need to actively engage with ministries of finance on issues related to budgets, public financial management systems, and fiscal space concerns, with the aim of having a

minimum 5% of the gross domestic product allocated for public spending on health. Hepatitis investment cases should be developed and used to advocate for and negotiate a fair allocation of public resources for viral hepatitis.

81. Many low- and lower middle-income countries will rely on external funding to expand their hepatitis responses over the period of the strategy. Revenue flows from such sources need to be fully aligned with national hepatitis and broader health sector priorities, programmes and plans. Stability and predictability of these revenue flows are essential to minimize the risk of service interruption. The coordination of hepatitis interventions and services with other health programmes and the overall health system will reduce inefficiencies and, as a result, maximize intended results.

4.4.2 Addressing financial and other barriers to access and provide financial risk protection

82. Health financing systems that minimize out-of-pocket payments for all essential health services increase access to these services and prevent impoverishment. To minimize catastrophic health payments, out-of-pocket spending should be limited to less than 15–20% of the total health spending.

83. Treating chronic hepatitis infections, especially new treatments for hepatitis C, and care for cirrhosis and cancer are currently unaffordable for many people. Essential viral hepatitis interventions, across the continuum of hepatitis services, should be included in the national health benefit package and be provided free of charge. In addition, the provision of supportive arrangements (such as decentralizing services or offering transport vouchers) to minimize the indirect costs for people using services can improve service uptake and impact. User fees result in inequities in access to hepatitis treatment, undermine service use, contribute to poor treatment adherence, increase risks of treatment failure, and constitute unnecessary financial burdens on households.

84. Financial risk protection and access to needed services for people at risk and living with hepatitis will depend on a broader, robust and fair national health financing system. Public financing systems for health, involving predominant reliance on revenues raised from general taxation and/or payroll taxes for compulsory health insurance, are the most equitable and efficient systems. Such prepayment mechanisms should be based on an ability to pay, with broad pooling of the revenues to enable benefits to be provided to those in need, including those who cannot afford to contribute to the system.

4.4.3 Reducing prices and costs, and removing inefficiencies

85. Fiscal constraints require that countries select the most effective interventions and approaches, target those activities to the populations and settings where they will have greatest impact, reduce the prices of medicines and other health commodities, and increase the efficiency of services. Programmes that can demonstrate “value for money” and efficiency gains are better positioned to argue for fair allocation of resources and external financial support. The potential for efficiency gains across programmes needs to be explored.

86. Good programme management can improve the efficient flow, allocation and utilization of resources from national budgets or external sources to service delivery. This includes better coordination of donor funding and alignment with national plans and the broader health system, pooling of resources, performance-based funding and increased accountability at all levels and across all stakeholders, including implementers and funders.

87. Opportunities to reduce cost through improving the efficiency of services and improving the selection, procurement and supply of affordable vaccines, medicines, diagnostics and other health commodities are described under strategic direction 3.

Priority actions for countries

- **Develop a robust viral hepatitis investment case** to advocate for adequate allocation of domestic resources and to mobilize external funding support.
- **Estimate national hepatitis resource needs** and develop a plan for filling any resource gap through raising new funds and allocating adequate health resources to hepatitis.
- **Reduce financial barriers**, including phasing out direct, out-of-pocket payments for accessing hepatitis and other health services.
- **Provide universal protection against health-related financial risk**, covering all populations, and identify the most appropriate way for achieving such protection, including public compulsory health financing systems.
- **Monitor health expenditures and costs and cost-effectiveness of hepatitis services** through the national monitoring and evaluation system to identify opportunities for cost reduction and saving.
- **Strengthen coordination with other health programmes:** Identify opportunities for improving system-wide efficiencies by consolidating underlying health systems, such as those for strategic information, human resources and procurement and supply management.

Priority actions for WHO

- **Estimate and regularly review resource needs** for a comprehensive viral hepatitis response at the global level to achieve the 2020 and 2030 targets.
- **Advocate for full funding of the viral hepatitis response** by building political commitment for sustained financing and national ownership, fair allocation of government resources to hepatitis and inclusion of essential hepatitis services into national health benefit packages.
- **Support countries to develop investment cases** and funding proposals to mobilize external funding for viral hepatitis responses.
- **Provide guidance and tools for assessing and monitoring health service costs** and cost-effectiveness, and support countries to adopt the WHO Health Accounts Country Platform.¹

4.5 STRATEGIC DIRECTION 5: Innovation for acceleration

Elimination of viral hepatitis epidemics will require new technologies and approaches

88. Research and innovation provide opportunities to change the trajectory of the global hepatitis response, improve efficiency and quality of services and maximize impact. It is unlikely that the ambitious targets set for 2020 and 2030 can be achieved if we are limited to existing medicines, technologies and service delivery approaches. Innovations are required along the entire continuum of prevention, diagnosis, treatment and care services. They need to be backed with operational research and collaboration between researchers and policy-makers to ensure that research findings are translated into practice rapidly and on a scale sufficient to have the desired impact.

¹ The WHO Health Accounts Country Platform is available at: http://www.who.int/health-accounts/platform_approach/en/ (1 April 2016).

89. This strategic direction outlines areas where research and innovation will play a key role in accelerating the hepatitis response. Whereas WHO has an important role in convening partners and promoting and shaping a global research agenda, much leadership will rest with others, including research institutions and private industry. WHO also has a responsibility to monitor the development of new vaccines, medicines, diagnostics, other commodities and service delivery approaches, and, where appropriate, to rapidly integrate them into WHO guidelines. Countries have a critical role in defining priorities for innovation, facilitating research, documenting early implementation experiences and leading on operational research. Given the 15-year time horizon for achieving the 2030 targets, short-, medium- and long-term research priorities should be considered. This strategy focuses on the short- and medium-term priorities.

4.5.1 Optimizing prevention

90. In addition to the existing technologies for preventing viral hepatitis infections, there are major opportunities for improving and expanding the package of prevention interventions for viral hepatitis.

91. **Injection equipment.** Effective implementation of the WHO injection safety policy and global campaign will require innovations in safety-engineered injection equipment, that is affordable, to prevent re-use. Harm reduction programmes would benefit from new designs of needles and syringes that minimize the “dead space” where blood may remain after use.

92. **Hepatitis vaccines.** Hepatitis B virus vaccination programmes would be greatly enhanced by the development of a more heat-stable and freeze-stable vaccine and simplified delivery systems for hepatitis B virus birth-dose. The development of effective therapies for hepatitis C has paradoxically led to a reduction in efforts to find a vaccine against hepatitis C and that this trend needs to be reversed. The development of an effective hepatitis C vaccine would be a powerful addition to the hepatitis prevention intervention portfolio and would complement new advances in hepatitis C treatment.

93. **Using antiviral medicines for prevention.** The potential role of pre-exposure and post-exposure-prophylaxis for preventing viral hepatitis B and C acquisition should be considered, noting the experience from the HIV response. Similarly, more research is required on the use of antiviral drugs for preventing mother-to-child transmission of hepatitis B virus, which would be an important complement to hepatitis B virus birth-dose vaccination. The impact of expanded coverage of viral hepatitis B and C treatment on viral hepatitis B and C prevention should be assessed.

94. **Prevention benefits of treatment.** Assess the potential prevention benefits of expanded coverage of viral hepatitis B and C treatment on viral hepatitis B and C transmission.

4.5.2 Optimizing testing and diagnostics

95. There are huge opportunities to improve viral hepatitis diagnostics technologies, strategies and approaches, essential for rapidly expanding viral hepatitis testing services and ensuring accurate and reliable diagnosis, clinical assessment and patient monitoring. Simple technologies are required to ensure that testing services can reach remote areas and hard-to-reach populations. Priority should be given to the development of rapid diagnostic tests for diagnosing viral hepatitis B and C infection, point-of-care tests for monitoring hepatitis B and hepatitis C viral load (and hepatitis C virus antigen) to guide treatment decisions, and simplified methods for reliably assessing liver fibrosis and cirrhosis.

4.5.3 *Optimizing medicines and treatment regimens*

96. The development of highly effective medicines to treat chronic hepatitis C infection has been a “game-changer” in tackling hepatitis C epidemics. There is also an impressive pipeline of new medicines, combinations and candidate molecules under development that promise to offer more effective, potent, tolerable and safer oral medicines and treatment regimens. Priority should be given to the development of affordable, simple pangenotypic regimens for hepatitis C virus. Progress in the development of medicines to treat chronic hepatitis B infection has been less rewarding, with a “cure” yet to be found. Elimination of viral hepatitis B and C epidemics will require safe and effective curative treatments. The development of long-acting treatment formulations should improve treatment adherence. In addition, new medicines and other treatments are required to improve the management of complications of chronic viral hepatitis infection, including treatments for chronic liver disease, liver failure and hepatocellular carcinoma.

4.5.4 *Optimizing service delivery*

97. Few countries have public health programmes that deliver comprehensive hepatitis services, apart from childhood hepatitis B virus vaccination programmes. Various obstacles exist in the efficient delivery of hepatitis B virus vaccine at birth, a key intervention for preventing mother-to-child transmission of hepatitis B virus. Harm reduction services that have been effective in preventing HIV epidemics among people who inject drugs have been less successful in preventing hepatitis C virus epidemics, even though the key interventions are the same. Early diagnosis and staging of chronic hepatitis disease is compromised by both the lack of simple and reliable diagnostics and effective testing services that can reach those populations and locations most affected. In 2015, less than 1% of people with chronic hepatitis infection were receiving treatment, mostly through individual clinical care.

98. Gaps in the response, such as those outlined above, highlight challenges in service delivery that require careful analysis and new service delivery approaches. Large-scale treatment and care of people with chronic hepatitis will require a new public health approach to service delivery, including simplified and standardized treatment regimens and protocols, and decentralized care, including at the primary health care level and in the community. Investment in operational research is required to assess different service delivery models and opportunities for improving service delivery quality. Expanded treatment, particularly for lifelong hepatitis B treatment, will require strategies and approaches to maximize treatment adherence and retention in care, monitor patients for treatment outcomes and failure, and monitor for drug toxicity and the emergence of drug resistance.

5. STRATEGY IMPLEMENTATION: PARTNERSHIPS, ACCOUNTABILITY, MONITORING AND EVALUATION, AND COSTING

99. Effective implementation of the strategy depends on concerted action from all stakeholders in the health sector response to viral hepatitis. Success requires strong leadership and partnerships to ensure policy and programme coherence. Within the health sector, linkages across different disease-specific and cross-cutting programmes need to be established and strengthened.

5.1 Collaboration with partners

100. WHO has an important convening role: it brings together different constituencies, sectors and organizations in support of a coordinated and coherent health sector response to viral hepatitis. In addition to its Member States, the Secretariat works closely with other key partners, including the following.

Multilateral and bilateral donor and development agencies, funds and foundations. Unlike other major communicable diseases, such as HIV, tuberculosis and malaria, there are very few major donor agencies supporting viral hepatitis. The GAVI Alliance plays a critical role in supporting routine childhood immunization programmes, with hepatitis B virus vaccine included in the pentavalent vaccine. A key challenge over the coming years will be to mobilize the involvement of other major donor and development agencies in the viral hepatitis response.

Civil society. Civil society has played a lead role in getting viral hepatitis on the global health and development agendas, with strong leadership from hepatitis patient groups, treatment advocates and public health activists. WHO has established a Civil Society Reference Group on Viral Hepatitis, which brings together representatives from a broad range of hepatitis-related civil society constituencies and networks. The Reference Group advises WHO on its viral hepatitis policies and programme of work, and facilitates dissemination and implementation of WHO's policies and guidance. Civil society is represented in all WHO's technical working groups, including those for the development of WHO's policies, guidelines and tools. A range of civil society organizations have official relations with WHO, enabling them to attend as observers sessions of various WHO governing bodies.

Technical partners. WHO has established a Strategic and Technical Advisory Committee on Viral Hepatitis, which comprises a range of technical experts from national hepatitis programmes, implementing organizations, research institutes and civil society to advise the Director-General on the Organization's hepatitis policies and programme of work. Technical partners play a critical role in WHO's working groups that are responsible for developing WHO's policies and guidelines.

5.2 Monitoring, evaluating and reporting

101. Implementation of the strategy will be monitored at three levels, using existing mechanisms:

- monitoring and evaluating of progress towards global goals and targets
- monitoring and evaluating the response at country level
- WHO's framework for results-based management.

102. A number of targets will be monitored through the use of the existing Global AIDS Response Progress Reporting system and the Monitoring and Evaluation Accountability Framework that supports the implementation of the Global Vaccine Action Plan 2011–2020.

5.2.1 Monitoring and reporting progress towards global goals and targets

103. At the global level, regular reviews are planned to assess progress on the various commitments and targets. These reviews will build on the data received from countries through various existing monitoring and evaluation mechanisms.

104. Progress at global and regional levels in moving towards the targets set out in this strategy will be regularly assessed. Comparisons between and within countries – “benchmarking” – will also be used to assess performance in reaching targets. The strategy is designed to be sufficiently flexible to incorporate additional priorities or fill gaps in the health sector response to hepatitis that may be identified. WHO will continue to work with its partners to provide support to countries for the

harmonized and standardized collection of data on core indicators, and in the preparation of global and regional reports.

105. WHO will develop a monitoring and accountability framework for the strategy in consultation with key stakeholders, building on existing strategic information and reporting systems. It will also monitor and share data on the uptake of its guidelines on viral hepatitis, as well as on progress in implementation of the strategy, in order to highlight barriers and promote best practices.

5.2.2 Monitoring and evaluating the response at country level

106. Progress in implementing the health sector response to viral hepatitis should be assessed with indicators on availability, coverage outcome and impact, taking into consideration other relevant recommendations for monitoring implementation. Progress towards the goals of the 2030 Agenda for Sustainable Development, in particular the health-related goals, will be tracked and reported.

107. Indicators for monitoring the strengthening of health systems derive from a common platform for monitoring and evaluating national health strategies, known as the Country Health Systems Surveillance platform, coordinated by WHO. Instruments are also available for measuring progress in implementing policy, legal and structural measures for enhancing the hepatitis response.

5.2.3 WHO's framework for results-based management

108. WHO's Twelfth General Programme of Work, 2014–2019, provides high-level strategic vision for the work of WHO. The Programme of Work outlines six areas of work. Most activities related to viral hepatitis fall under Category 1 on *Communicable Diseases*. However, other important hepatitis-related activities fall under other categories, notably Category 2 on noncommunicable diseases (including cancer, substance use and chronic care), Category 3 on promoting health through the life course (including maternal, adolescent and child health) and Category 4 (including access to medicines and diagnostics, integrated service delivery, strategic information and human resources). Under Category 1 "HIV and viral hepatitis" has its own area of work for which biennial workplans are developed with a set of agreed outcomes and budget. This strategy covers three bienniums (2016–2017, 2018–2019 and 2020–2021). Workplan implementation is monitored through a mid-term review at the end of the first year of each biennium and progress towards the achievement of each of the outcomes is reported at the end of each biennium.

5.3 Implementing the strategy at the national level

109. The global strategy is intended to guide the development and implementation of national viral hepatitis strategies, efforts and activities. Broad buy-in through the preparation process will assist in effective implementation. In order to enable country ownership, national hepatitis strategies or plans should be aligned with existing plans such as national development plans, national health sector strategies and other disease strategies. They should also, to the extent possible, align with national planning and financial cycles.

5.4 Accountability

110. Well-functioning and transparent accountability mechanisms, with strong civil society participation, are vital, given the range of partners and stakeholders needed for an effective viral hepatitis response. Important building blocks include nurturing strong leadership and governance that involve full engagement with all relevant stakeholders, setting clear targets, using appropriate

indicators to track progress, and establishing transparent and inclusive assessment and reporting processes.

5.5 Costing estimates for implementing the strategy

111. The Global health sector strategy on viral hepatitis, 2016–2021 is expected to deliver a 30% reduction in new cases and a 10% reduction in the number of hepatitis-related deaths by 2020, and a 90% reduction in new cases and a 65% reduction in hepatitis-related deaths by 2030.

112. The main interventions are testing and treatment (for both hepatitis B virus and hepatitis C virus) (with eight million people treated by 2020, and 80% of those eligible treated by 2030), hepatitis B virus vaccination (with 90% coverage by 2020) and prevention of mother-child transmission (with 50% coverage by 2020, with birth-dose vaccination, and 90% by 2030, incorporating both birth-dose vaccination and additional interventions including peri-partum antivirals), harm reduction among people who inject drugs (providing sterile injecting equipment and opioid substitution therapy) and measures to maximize blood and injection safety.

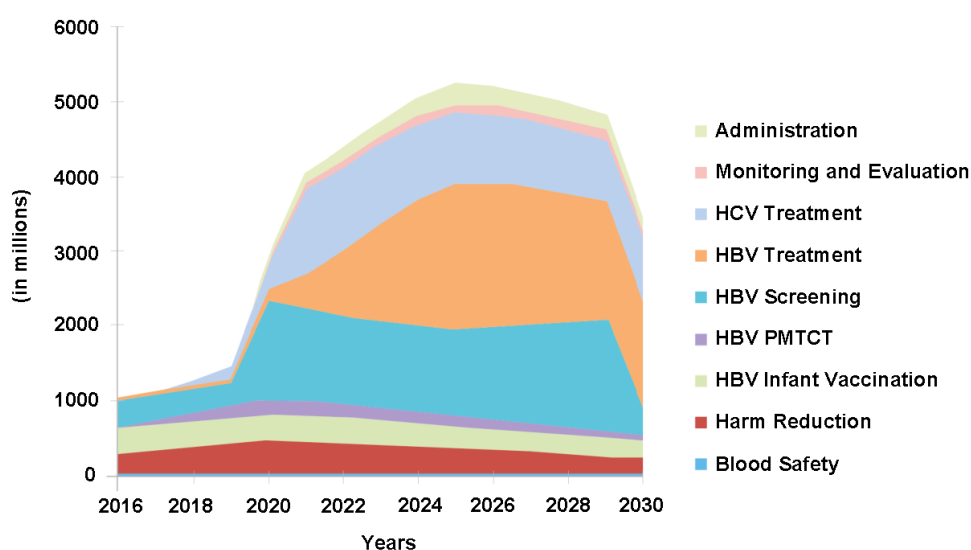
113. The costs of some interventions are assumed to be shared across different parts of the health sector: 25% of the estimated cost of outreach to people who inject drugs and opioid substitution therapy is incorporated under this strategy, as the costs are also reflected in the HIV strategy; 10% of the estimated cost of the blood and injection safety costs is incorporated; and only 10% and 50% of the expected testing costs, for Africa and elsewhere, respectively, are incorporated in the viral hepatitis strategy as costs of active testing campaigns are also incorporated in the HIV strategy.

114. In low- and lower-middle income countries, the full costs of the intervention are considered additional costs for the health sector. However, in upper-middle income and higher-income countries, intervention costs are expected to be partially or fully offset by savings made in reduced care needs for those with advanced disease or by replacing alternative less effective treatments already in use. Therefore, the costing of this strategy includes 100% of the cost for low- and lower-middle income countries and 25% of the costs of the upper-middle income countries. It does not include the cost of high-income countries.

115. The total cost of implementing this strategy for the period 2016–2021 is US\$ 11 900 million. (see Figure 8). The peak annual cost in this period is 2021, and the value is US\$ 4100 million. In the years following 2021, annual costs continue to grow and peak in 2026 at US\$ 5200 million. Costs decline to US\$ 3500 million per year in 2031. The principal drivers of cost are hepatitis B treatment, screening and hepatitis C costs. Costs decline in the future largely due to reduced need for hepatitis B virus testing and lower hepatitis B virus treatment loads (due to reduced rates of new cases, and the introduction of a cure for persons on antivirals).

116. For comparison, the cost in the period 2016–2021 across all low- and middle-income countries (full costs included for those countries but no costs for high-income countries) is US\$ 19 300 million. In this scenario, the annual cost in the strategy period peaks at US\$ 7100 million. In the years following 2021, annual costs continue to grow, peaking at US\$ 8800 million in 2025, and then declining.

Figure 8. The cost of implementing the global health sector strategy on viral hepatitis, 2016–2030 (US\$ million)



Appendix 3

[A69/33 – 16 May 2016]

Global health sector strategy on sexually transmitted infections, 2016–2021 – towards ending sexually transmitted infections

INTRODUCTION AND CONTEXT

1. The global health sector strategy on sexually transmitted infections, 2016–2021 builds on conclusions from the evaluation of the implementation of the global strategy for the prevention and control of sexually transmitted infections 2006–2015¹ and sets out a vision, goals, targets, guiding principles and priority actions for ending the sexually transmitted infections epidemic as a public health problem.

¹ Document A68/36 progress report G.

2. The 2030 Agenda for Sustainable Development¹ defines a set of ambitious global health goals and targets. Of particular interest to the proposed strategy is Goal 3 (Ensure healthy lives and promote well-being for all at all ages) (see Box 1), including its focus on health-related areas.

3. This global health sector strategy on sexually transmitted infections describes an important component of the health sector contribution towards the achievement of these targets. It outlines actions for countries and for WHO. If implemented, these actions will accelerate and intensify the sexually transmitted infections response so that progress towards ending the epidemics becomes a reality. Furthermore, the implementation of the global health sector strategy on sexually transmitted infections, once adopted, will require political commitment and resources to rapidly accelerate the response over the next five years and to sustain action through to 2030 and beyond.

4. The strategy positions the health sector response to sexually transmitted infection epidemics as critical to the achievement of universal health coverage – one of the key health targets of the Sustainable Development Goals identified in the 2030 Agenda for Sustainable Development. The strategy, once adopted, and its implementation will contribute to a radical decline in new sexually transmitted infections and in deaths related to such infections (including still births and cervical cancer), while improving individual health, men's and women's sexual health, and the well-being of all people. It will guide efforts to: accelerate and focus comprehensive prevention efforts through scaling up evidence-based combined behavioural, biomedical and structural approaches; facilitate people's access to information on their sexually transmitted infection status; improve access to treatment and comprehensive long-term care when needed; and challenge pervasive stigmatization and discrimination. The strategy promotes a people-centred approach, grounded in principles of human rights, gender equality and health equity.

Box 1. Sustainable Development Goal 3: Ensure healthy lives and promote well-being for all at all ages

Targets

- 3.1 By 2030, reduce the global maternal mortality ratio to less than 70 per 100 000 live births
- 3.2 By 2030, end preventable deaths of newborns and children under 5 years of age, with all countries aiming to reduce neonatal mortality to at least as low as 12 per 1000 live births and under-5 mortality to at least as low as 25 per 1000 live births
- 3.3 By 2030, end the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases and combat hepatitis, water-borne diseases and other communicable diseases
- 3.4 By 2030, reduce by one third premature mortality from non-communicable diseases through prevention and treatment and promote mental health and well-being
- 3.5 Strengthen the prevention and treatment of substance abuse, including narcotic drug abuse and harmful use of alcohol
- 3.6 By 2020, halve the number of global deaths and injuries from road traffic accidents
- 3.7 By 2030, ensure universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes

¹ United Nations General Assembly resolution 70/1 – Transforming our world: The 2030 Agenda for Sustainable Development, see http://www.un.org/ga/search/view_doc.asp?symbol=A/RES/70/1&Lang=E (accessed 13 April 2016).

3.8	Achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all
3.9	By 2030, substantially reduce the number of deaths and illnesses from hazardous chemicals and air, water and soil pollution and contamination
3.a	Strengthen the implementation of the World Health Organization Framework Convention on Tobacco Control in all countries, as appropriate
3.b	Support the research and development of vaccines and medicines for the communicable and non-communicable diseases that primarily affect developing countries, provide access to affordable essential medicines and vaccines, in accordance with the Doha Declaration on the TRIPS Agreement and Public Health, which affirms the right of developing countries to use to the full the provisions in the Agreement on Trade-Related Aspects of Intellectual Property Rights regarding flexibilities to protect public health, and, in particular, provide access to medicines for all
3.c	Substantially increase health financing and the recruitment, development, training and retention of the health workforce in developing countries, especially in least developed countries and small island developing States
3.d	Strengthen the capacity of all countries, in particular developing countries, for early warning, risk reduction and management of national and global health risks

5. This strategy is fully aligned with the 2030 Agenda for Sustainable Development, and the drive towards universal health coverage. It is also aligned with other key WHO global health strategies and plans, including those for sexual and reproductive health, HIV, violence against women and girls, adolescent health, maternal, newborn and child health, noncommunicable diseases, integrated people-centred health services, viral hepatitis, tuberculosis, and blood safety.¹

6. Broad partnerships and strong links with other health and development issues must be emphasized in the next phase of the sexually transmitted infection response. The strategy takes into consideration the global health strategies of key development partners, including the Global Fund to fight AIDS, Tuberculosis and Malaria; the United States President's Emergency Plan for AIDS Relief; GAVI Alliance; and the Global Strategy for Women's Children's and Adolescents' Health (2016–2030).²

7. The strategy defines the quality-assured sexually transmitted infection services that are essential for meeting people's needs and preferences, and proposes actions to address the underlying determinants of sexually transmitted infection epidemics, including stigmatization and discrimination, and inequities that put people at greater risk for infection and limit access to effective prevention and treatment services. Further, the strategy describes how to ensure equitable coverage of services and maximum impact for all people in need, which includes a focus on both the general population and specific population groups (see Box 2).

¹ Information is available on WHO's advocacy role and on online consultations, for example, Giving "voice to youth", see <http://www.who.int/reproductivehealth/en> (accessed 20 April 2016); and on the WHO Global action plan on antimicrobial resistance http://www.who.int/drugresistance/global_action_plan/en/ (accessed 24 April 2016).

² The Global Strategy for Women's, Children's and Adolescents' Health (2016–2030) is available at: <http://www.everywomaneverychild.org/global-strategy-2> (accessed 22 April 2016).

Box 2. Specific populations

Each country needs to define the specific populations that are most affected by sexually transmitted infection epidemics. The response should be based on the epidemiological and social context. Specific populations that focus on sexually transmitted infections will include populations most likely to have a high number of sex partners, such as sex workers and their clients. Other populations for consideration include men who have sex with men, transgendered people, and people with an existing sexually transmitted infection, including people living with HIV. Many of these groups overlap with groups recognized as key populations for HIV. Other groups considered to be particularly vulnerable to sexually transmitted infections include young people and adolescents, women, mobile populations, children and young people living on the street, prisoners, drug users and people affected by conflict and civil unrest.

8. The strategy also recommends approaches to minimize the risk of financial hardship for people requiring services, and embraces innovation to drive accelerated progress. Many of the priority actions highlighted draw on the strong body of evidence generated by the implementation of the 2006–2015 strategy on sexually transmitted infections¹ and responses around the world.²

OUTLINE OF THE STRATEGY

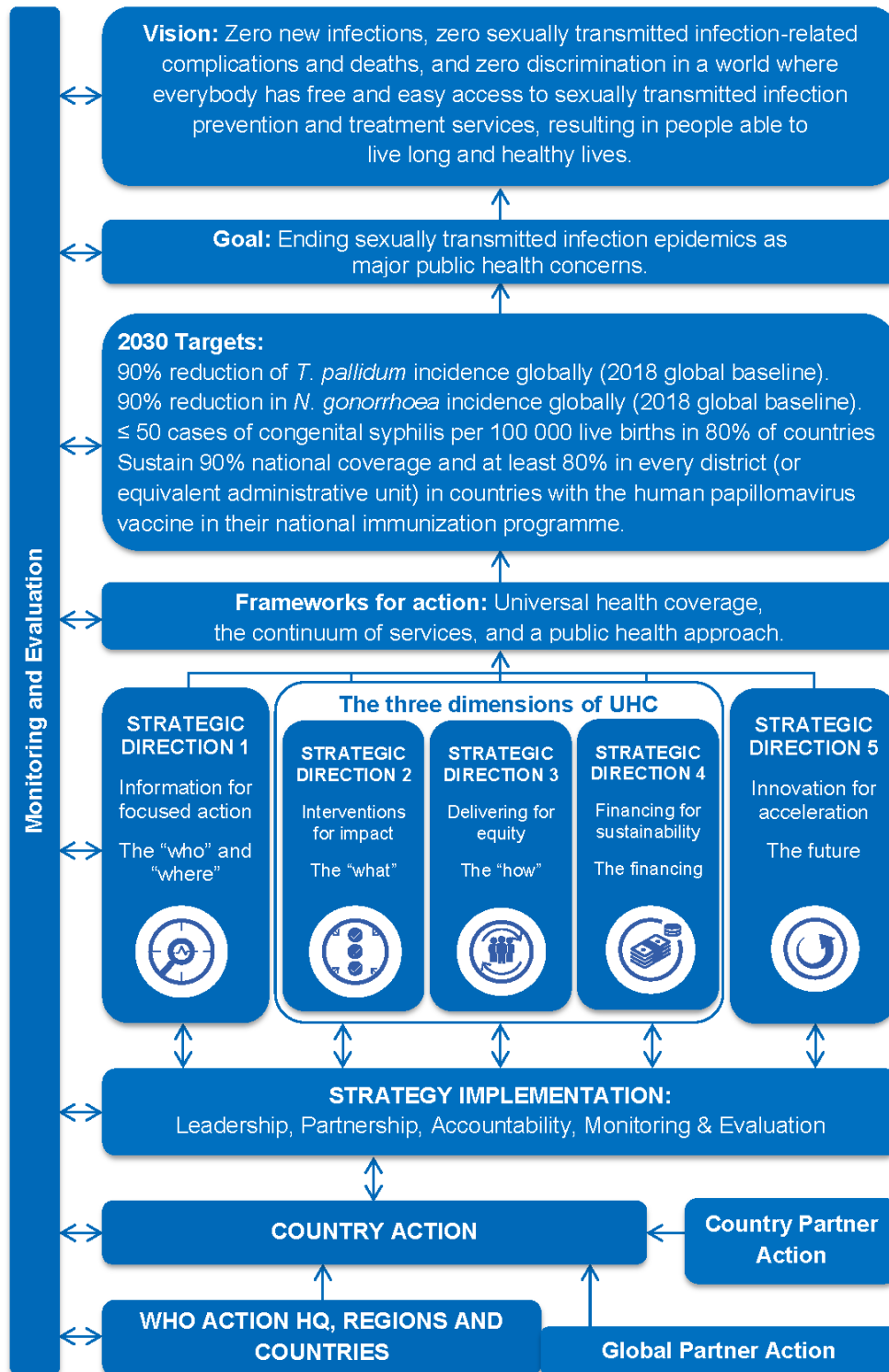
9. The following five major sections underpin this strategy (an overview of which is provided in Figure 1):

1. **Setting the scene** – reviews the current status of sexually transmitted infection epidemics and burden, identifies opportunities and challenges for the future, and argues the case for adequate investment in the health sector response to sexually transmitted infections.
2. **Framing the strategy** – describes the three organizing frameworks for the strategy (universal health coverage, continuum of sexually transmitted infection services and the public health approach) and presents the structure of the strategy.
3. **Vision, goal, targets and guiding principles** – presents a set of impact and service coverage targets for 2020 and 2030 to drive the response.
4. **Strategic directions and priority actions** – recommends actions to be taken for both countries and WHO under each of five strategic directions.
5. **Strategy implementation: leadership, partnerships, accountability, monitoring and evaluation** – outlines the key elements of implementation.

¹ Global strategy for the prevention and control of sexually transmitted infections: 2006–2015, see [http://www.who.int/hiv/pub/toolkits/stis_strategy\[1\]en.pdf](http://www.who.int/hiv/pub/toolkits/stis_strategy[1]en.pdf) (accessed 22 April 2016).

² See document A68/36 progress report G (2015).

Figure 1. Outline of the global health sector strategy on sexually transmitted infections 2016–2021



1. SETTING THE SCENE: Why the sexually transmitted infection response should be a global priority

10. The burden of morbidity and mortality worldwide resulting from sexually transmitted pathogens compromises quality of life, as well as sexual and reproductive health and newborn and child health (see Figure 2). Sexually transmitted infections also facilitate indirectly the sexual transmission of HIV and cause cellular changes that precede some cancers. Sexually transmitted infections impose a substantial strain on the budgets of both households and national health systems in middle- and low-income countries, and have an adverse effect on the overall well-being of individuals (Box 3).

Box 3. The hidden toll of sexually transmitted infections

It is estimated that annually there are 357 million new cases of four curable sexually transmitted infections among people aged 15–49 years (see Figure 2): *Chlamydia trachomatis* (131 million), *Neisseria gonorrhoeae* (78 million), syphilis (6 million), or *Trichomonas vaginalis* (142 million).^{*} The prevalence of some viral sexually transmitted infections is similarly high, with an estimated 417 million people infected with herpes simplex type 2, and approximately 291 million women harbouring the human papillomavirus. The prevalence of these sexually transmitted infections varies by region and gender. These epidemics have a profound impact on the health and lives of children, adolescents and adults worldwide:

- Fetal and neonatal deaths – syphilis in pregnancy leads to over 300 000 fetal and neonatal deaths each year, and places an additional 215 000 infants at increased risk of early death;
- Cervical cancer – the human papillomavirus infection is responsible for an estimated 530 000 cases of cervical cancer and 264 000 cervical cancer deaths each year;
- Infertility – sexually transmitted infections, such as gonorrhoea and chlamydia, are important causes of infertility worldwide;
- HIV risk – the presence of a sexually transmitted infection, such as syphilis, gonorrhoea, or herpes simplex virus infection, greatly increases the risk of acquiring or transmitting HIV infection (by two to three times, in some populations);
- The physical, psychological and social consequences of sexually transmitted infections severely compromise the quality of life of those infected.

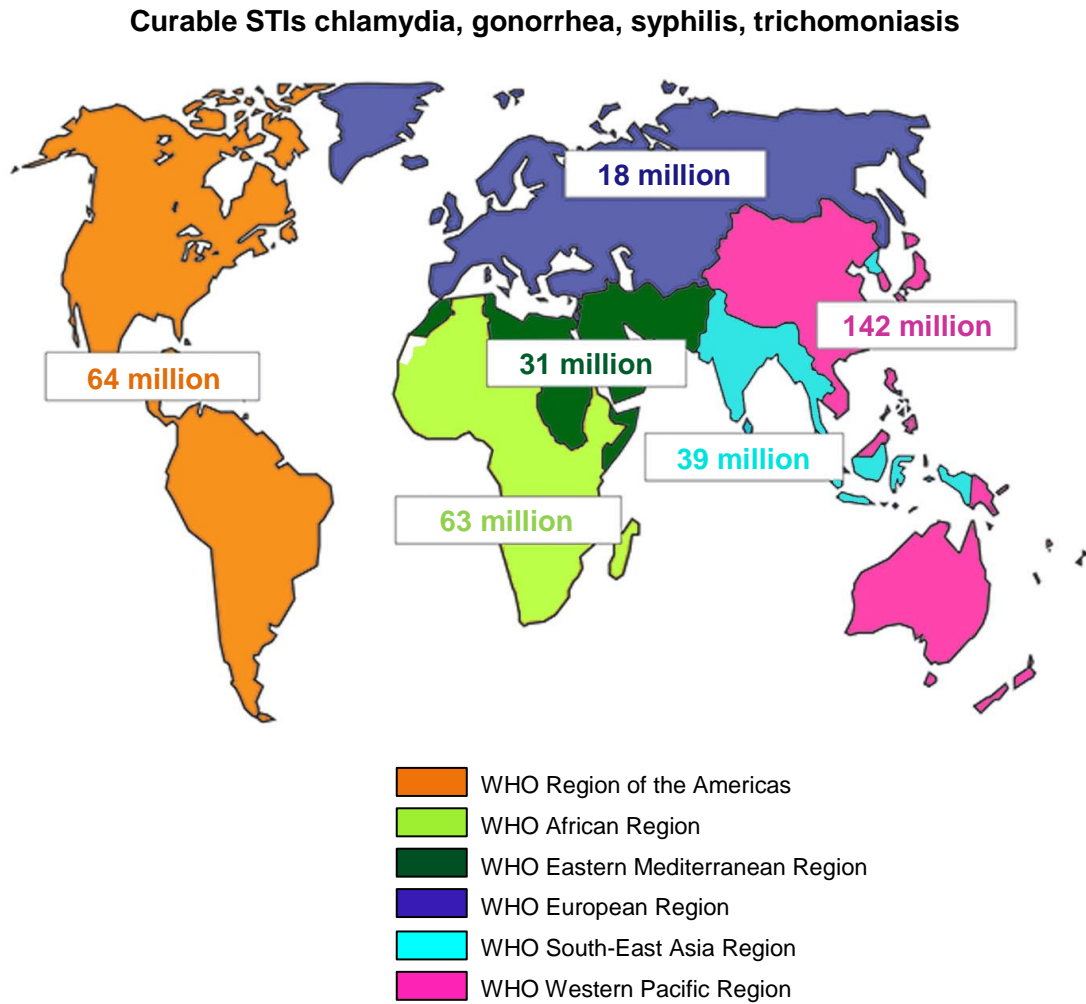
Adequate control and/or elimination of sexually transmitted infections will contribute to reducing disease and human suffering.

^{*} Most recent estimates are for 2012.

11. Complications due to sexually transmitted infections have a profound impact on sexual and reproductive health. The numbers of men and women infected with sexually transmitted infections are similar (with the exception of herpes simplex virus type 2), notwithstanding some regional differences (see Figures 3(a) and 3(b)); however, complications disproportionately affect women in several ways.

12. Limited data on sexually transmitted infections, in particular data disaggregated by sex, compromise the global response. There is inconsistent reporting between and within regions and countries. The strategy proposes a priority focus on two areas: first, on securing better data on the sexually transmitted infection burden by sex and by age group in order to measure progress towards the control of sexually transmitted infections; and secondly, on identifying priority areas for action.

Figure 2. WHO estimates: 357 million new cases of curable sexually transmitted infections in 2012



Source: Newman LM, Rowley J, Vander Hoorn S et al. Global estimates of the prevalence and incidence of four curable sexually transmitted infections in 2012, PLoSOne 2015.

Figure 3(a). Estimated incidences of four curable sexually transmitted infections, by region and sex, 2012

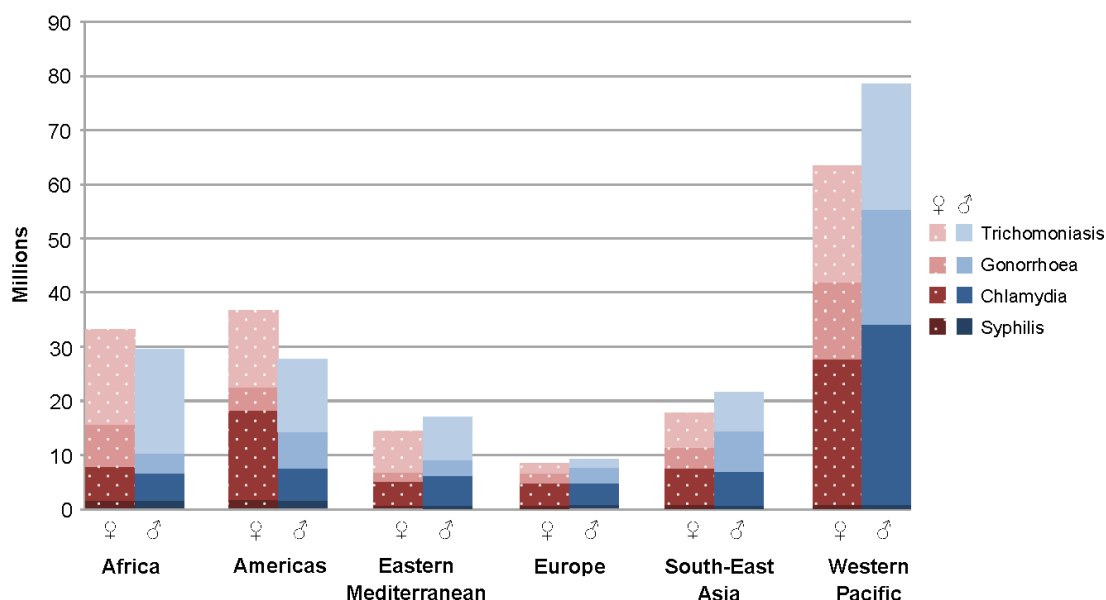
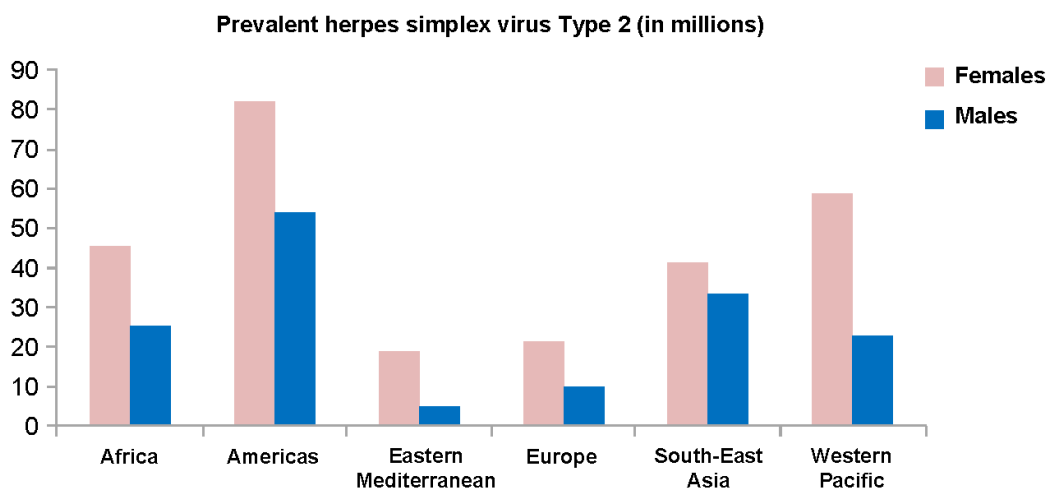


Figure 3(b). Estimated prevalence of herpes simplex virus type 2, by region and sex, 2012



13. In recent years there have been notable achievements in advancing the sexually transmitted infection response. There has been an appreciable decline, for example, in the incidence of *Haemophilus ducreyi* (chancroid) in general population syphilis rates, and in some sequelae of such infections, including neonatal conjunctivitis. An increase in the number of pregnant women screened for syphilis and HIV, with increased access to adequate treatment, has helped to underline the feasibility of dual elimination of mother-to-child transmission of HIV and syphilis. Furthermore, increased access to human papillomavirus vaccination has already been shown to reduce pre-cervical cancer lesions and

genital warts. Further acceleration of the global response will sustain and build on these achievements and trigger further successes in sexually transmitted infection management and reduction.

14. Most of the tools required for reaching ambitious 2030 targets are available. Potentially vital innovations, such as point-of-care tests for sexually transmitted infections, vaccines against such infections and multipurpose technologies are on the horizon. Using them to full effect, however, will require a rapid increase in investment in the sexually transmitted infection response, focusing resources on the most effective programmes and on the populations and geographical locations where need is greatest, and linking sexually transmitted infection interventions with other health services, to mutual benefit. These key directions are detailed in the strategy.

Prioritizing three sexually transmitted infections for strategic global focus

15. The global health sector strategy on sexually transmitted infections focuses primarily on three infections that require immediate action for control and that can be monitored:

1. *Neisseria gonorrhoeae* because of the rising risk of untreatable gonorrhoea and the risk of coinfection with other sexually transmitted infections including *Chlamydia trachomatis*;
2. *Treponema pallidum* with the elimination of congenital syphilis, which implies that strong systems are in place to ensure screening and treatment of all pregnant women and control of syphilis in specific populations;
3. *Human papillomavirus* with an emphasis on vaccination towards the elimination of cervical cancer and genital warts.

Cost-effective interventions exist for all three sexually transmitted infections.

16. WHO also recognizes the importance of *Chlamydia trachomatis* infection and the increasing rate of infection in adolescents. However, because the best strategies to control and measure chlamydia infections are still to be defined, further research and cost-effectiveness analyses are encouraged. Furthermore, WHO will catalyse the development of point-of-care testing as a critical step within the sexually transmitted infection cascade and continuum of services.

2. FRAMING THE STRATEGY

17. The proposed strategy on sexually transmitted infections is one of three related health sector strategies for 2016–2021, designed to contribute to the attainment of the 2030 Agenda for Sustainable Development, and the Goals it enshrines. Health is a major goal in this new Agenda, which reflects its central role in alleviating poverty and facilitating development.

18. The strategy positions the response to the sexually transmitted infection burden within the broader post-2015 development framework. It describes the priority actions that are required in order to achieve global targets related to sexually transmitted infections, and how the response to such infections can contribute to the achievement of universal health coverage and other key health goals.

19. This strategy draws on three overarching frameworks: universal health coverage; the continuum of services relating to sexually transmitted infections; and the public health approach.

Universal health coverage

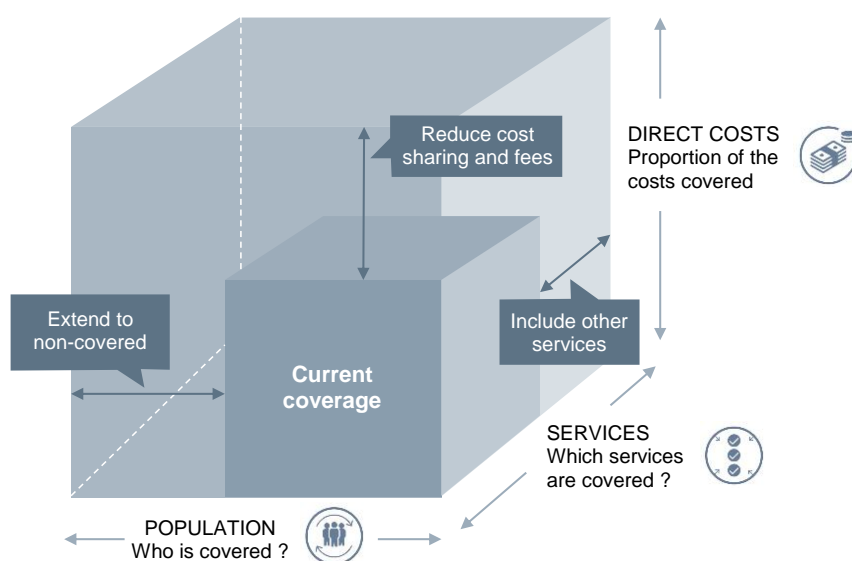
20. Universal health coverage (see Figure 4) provides an overarching framework for the strategy. It comprises three interlinked objectives:

- (1) improve the range, quality and availability of essential health interventions and services (covering the range of services needed);
- (2) improve the equitable and optimal uptake of services in relation to need (covering the populations in need of services);
- (3) reduce costs and provide financial protection for those who need the services (covering the costs of services).

21. As resources, efficiencies and capacities increase, the range of services provided can be expanded, the quality can be improved, and more populations can be covered with less direct costs to those who need the services – a progressive realization of universal health coverage. Each country will need to determine the most suitable path towards universal health coverage based on its own country context, prioritizing and making trade-offs in order to be able to move forward as rapidly as possible while ensuring programme sustainability, quality and equity.

22. Using the perspective of universal health coverage (Figure 4), the proposed strategy emphasizes the need for: strengthening health and community systems; identifying high-impact interventions; tackling the social determinants that drive the epidemic and hinder the response; and ensuring that people use the quality health services they need without suffering financial hardship or stigmatization. In particular, the strategy addresses issues related to effective and equitable service coverage, which includes overcoming barriers to care and understanding the needs of women, adolescents and specific population groups (see Box 3), including those linked to increased vulnerabilities.

Figure 4. The three dimensions of universal health coverage: all people receive the services they need of sufficient quality to make a difference without incurring financial hardship



The continuum of sexually transmitted infection services as an organizing framework for sexually transmitted infection programmes

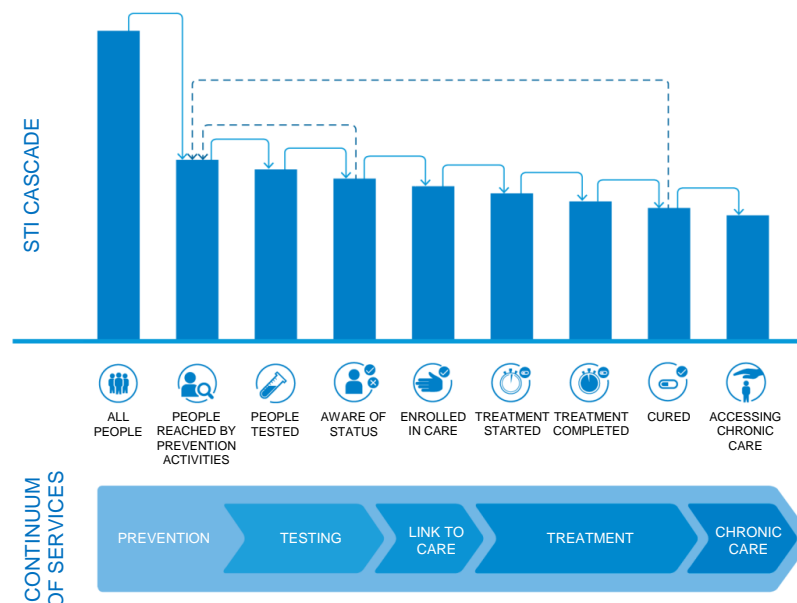
23. While the concept of universal health coverage frames the overall strategy, the continuum of services that are needed to overcome sexually transmitted infection epidemics provides a comprehensive service delivery framework for organizing strategic action (Figure 5). That continuum spans the full range of required interventions – preventing, diagnosing, treating and curing – that is needed to achieve strategic targets and includes all people: people reached by prevention activities; people tested; people aware of their status; people enrolled in care; people whose treatment has started; people whose treatment is complete; people who are cured; and people accessing chronic care.

24. The strategy describes the priority actions for enhancing the impact and equity of sexually transmitted infection responses along that entire continuum, with special attention to reaching populations that are left behind. Depending on the context, those left behind may include: women, men, adolescents, men who have sex with men, sex workers, and transgender people. It identifies ways to ensure and improve the quality of services, and proposes strategies to achieve financial sustainability and minimize the risk of financial hardship for people requiring such services.

25. As people move along the continuum of sexually transmitted infection services, there tends to be some loss to follow-up (see Figure 5). The objective is to engage individuals as early as possible, retain them in care and minimize any leakages along the cascade of service continuum.

26. The strategy also makes a strong case for expanding the provision of good quality prevention and care of sexually transmitted infections more widely into the areas of primary health care, sexual and reproductive health, and HIV services. It emphasizes opportunities to increase coverage by working collaboratively with other government sectors, and with community-based organizations and private providers.

Figure 5. The continuum of sexually transmitted infection services and the cascade



A public health approach

27. The strategy is rooted in a public health approach that is concerned with preventing disease, promoting health and ensuring quality of life among the population as a whole. It aims to ensure the widest possible access to high-quality services at the population level, based on simplified and standardized interventions and services that can readily be taken to scale, including in resource-limited settings. Through adopting a public health approach, the strategy proposes:

- standardized, simplified protocols and guidance
- integrated people-centred health services
- decentralized service delivery
- a focus on equity
- community participation
- the meaningful involvement of people most affected by sexually transmitted infections
- leveraging public and private sectors
- ensuring services are free or affordable
- moving from an individual clinical focus to population-based national plans.

28. It promotes the principle of Health in All Policies through, where necessary, legal, regulatory and policy reforms. It aims to strengthen integration and linkages between sexually transmitted infection services and other services, improving both impact and efficiency.

The structure of the global strategy

29. The strategy describes five strategic directions, under which there are priority actions that countries need to take. In addition, the support that WHO will provide in order to scale up a global response is also described. Such a response capitalizes on the opportunities provided through the frameworks emerging in response to the 2030 Agenda for Sustainable Development for ending the sexually transmitted infection epidemics as major public health concerns.

30. The five strategic directions (provided in Figure 1) in the strategy for the period 2016–2021 include:

Strategic direction 1 – Information for focused action – focuses on the need to understand the sexually transmitted infection epidemic and response as a basis for advocacy, political commitment, national planning, resource mobilization and allocation, implementation, and programme improvement.

Strategic direction 2 – Interventions for impact – addresses the first dimension of universal health coverage by describing the essential package of high-impact interventions that need to be delivered along the continuum of sexually transmitted infection services to reach country and global targets, and which should be considered for inclusion in national health benefit packages.

Strategic direction 3 – Delivering for equity – addresses the second dimension of universal health coverage by identifying the best methods and approaches for delivering the continuum of sexually transmitted infection services to different populations and in different locations, so as to achieve equity, maximize impact and ensure quality. It includes a critical focus on interventions and approaches focused on human rights, gender equality, and addressing barriers that undermine equitable access to services for different populations and in different settings and locations.

Strategic direction 4 – Financing for sustainability – addresses the third dimension of universal health coverage by identifying sustainable and innovative models for financing of sexually transmitted infection responses and approaches for reducing costs so that people can access the necessary services without incurring financial hardship.

Strategic direction 5 – Innovation for acceleration – identifies those areas where there are major gaps in knowledge and technologies, where innovation is required to shift the trajectory of the sexually transmitted infection response towards and beyond the 2020 milestones.

31. The strategy outlines a pathway towards the goal of eliminating sexually transmitted infections as a public health threat by 2030. Impact and service coverage targets are defined for 2020 and 2030 to measure progress towards the elimination goal. To achieve these targets, action is required in five areas, which are organized under five strategic directions.

32. The five strategic directions and the priority actions are informed by the evaluation of the implementation of the global strategy for prevention and control of sexually transmitted infections: 2006–2015¹ noted by the Sixty-eighth World Health Assembly in 2015.² The evaluation emphasized a need to: (1) strengthen surveillance and improve knowledge of prevalence, etiology and antimicrobial resistance; (2) scale up sexually transmitted infection interventions, in particular for specific populations through ensuring an appropriate enabling environment; (3) increase access to services by integrating the prevention and management of sexually transmitted infections into the broader agendas of HIV, sexual and reproductive health, and other key platforms; (4) strengthen financing mechanisms for relevant services and strengthening human resource capacity; and (5) accelerate access to innovations through the development of point-of-care diagnostic tests and new preventive interventions, such as vaccines, microbicides, suppressive therapy for the herpes simplex virus, and HIV prevention and health promotion methods.

3. VISION, GOAL, TARGETS AND GUIDING PRINCIPLES

33. The strategy outlines a vision, goal, targets, milestones, the broader impact, and guiding principles for the global health sector.

34. The targets and milestones were proposed during a WHO expert consultation on sexually transmitted infections in August 2014, which included country representatives and experts in this area of public health. The choice of targets was influenced by the availability of cost-effective interventions that should be urgently scaled up and the use of existing indicators and reporting frameworks to reduce

¹ See the progress report of the implementation of the global strategy for prevention and control of sexually transmitted infections: 2006–2015, at <http://www.who.int/reproductivehealth/publications/rtis/STI-progress.pdf?ua=1> (accessed 22 April 2016).

² See documents A68/36, progress report G, and WHA68/2015/REC/3, summary record of the twelfth meeting of Committee A, section 4.

the reporting burden of countries. These targets can be monitored through the existing Global AIDS Response Progress Reporting system (for *N. gonorrhoeae* and *T. pallidum*) and the Global vaccine action plan (for human papillomavirus vaccination). The proposed 70% targets were based on expert consensus and are not informed by a modelling exercise. The human papillomavirus vaccine target is consistent with the targets identified in the global vaccine action plan.¹

35. The global targets should be achieved by 2030, which aligns with the timeline established for the Sustainable Development Goals.² The report to be produced in 2021 will measure the milestones, and an evaluation will be undertaken at that time on whether targets are on track. Any adjustments that are required to achieve the 2030 global targets may also be made at that time.

The vision

36. Zero new infections, zero sexually transmitted infection-related complications and deaths, and zero discrimination in a world where everybody has free and easy access to prevention and treatment services for sexually transmitted infections, resulting in people able to live long and healthy lives.

The goal

37. Ending sexually transmitted infection epidemics as major public health concerns.³

Global targets for 2030

38. A concerted effort to rapidly scale up effective interventions and services can achieve the goal of ending sexually transmitted infection epidemics as public health concerns by 2030, by reaching this ambitious set of targets (see Figure 6):

- 90% reduction of *T. pallidum* incidence globally (2018 global baseline)
- 90% reduction in *N. gonorrhoeae* incidence globally (2018 global baseline)
- 50 or fewer cases of congenital syphilis per 100 000 live births in 80% of countries⁴
- sustain 90% national coverage and at least 80% in every district (or equivalent administrative unit) in countries with the human papillomavirus vaccine in their national immunization programme.

¹ See document WHA65/2012/REC/1, Annex 4.

² The Sustainable Development Goals and targets are identified in the United Nations General Assembly resolution 70/1 – Transforming our world: The 2030 Agenda for Sustainable Development identifies see http://www.un.org/ga/search/view_doc.asp?symbol=A/RES/70/1&Lang=E (accessed 22 April 2016).

³ Ending the sexually transmitted infection epidemics as major public health concerns is defined by the reduction in cases of *N. gonorrhoeae* and *T. pallidum*, as well as by the elimination of congenital syphilis and of pre-cervical cancer lesions through high coverage of human papillomavirus vaccines.

⁴ Aligned with the global guidance on criteria and processes for validation: elimination of mother-to-child transmission of HIV and syphilis, see http://apps.who.int/iris/bitstream/10665/112858/1/9789241505888_eng.pdf?ua=1&ua=1 (accessed 25 April 2016).

Milestones for 2020

39. Milestones for 2020 (see Figure 7) include:

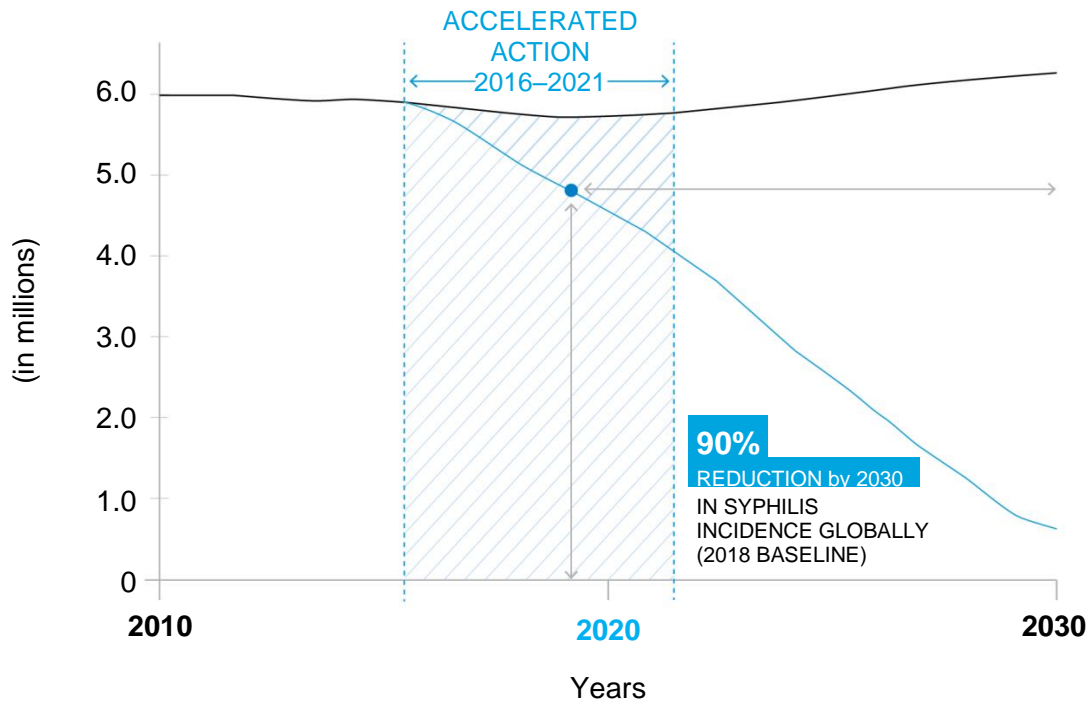
- **70% of countries have sexually transmitted infection surveillance systems in place** that are able to monitor progress towards the relevant targets
- **70% of countries have at least 95% of pregnant women screened for HIV and/or syphilis**; 95% of pregnant women screened for HIV and/or syphilis with free, prior and informed consent; 90% of HIV-positive pregnant women receiving effective treatment; and 95% of syphilis-seropositive pregnant women treated with at least one dose of intramuscular benzathine penicillin or other effective regimen
- **70% of key populations for HIV have access to a full range of services relevant to sexually transmitted infection and HIV**, including condoms
- **70% of countries provide sexually transmitted infection services** or links to such services in all primary, HIV, reproductive health, family planning, and antenatal and postnatal care services
- **70% of countries deliver human papillomavirus vaccines** through the national immunization programme
- **70% of countries report on antimicrobial resistance in *N. gonorrhoeae***
- **90% national coverage** sustained and at least 80% in every district (or equivalent administrative unit) in countries with the human papillomavirus vaccine in their national immunization programme.

Country targets for 2020

40. Informed by global goals and targets, countries should develop as soon as practicable ambitious national goals and targets for 2020 and beyond, taking into account the country context, including the nature and dynamics of country epidemics, populations affected, structure and capacity of the health care and community systems, and resources that can be mobilized. Targets should be feasible and developed based on the best possible data available on the sexually transmitted infections situation, trends and responses, and monitored through a set of standard and measurable indicators. The targets should apply to everyone.

Figure 6. Incidence targets: syphilis and gonorrhoea

Syphilis incidence



Gonorrhoea incidence

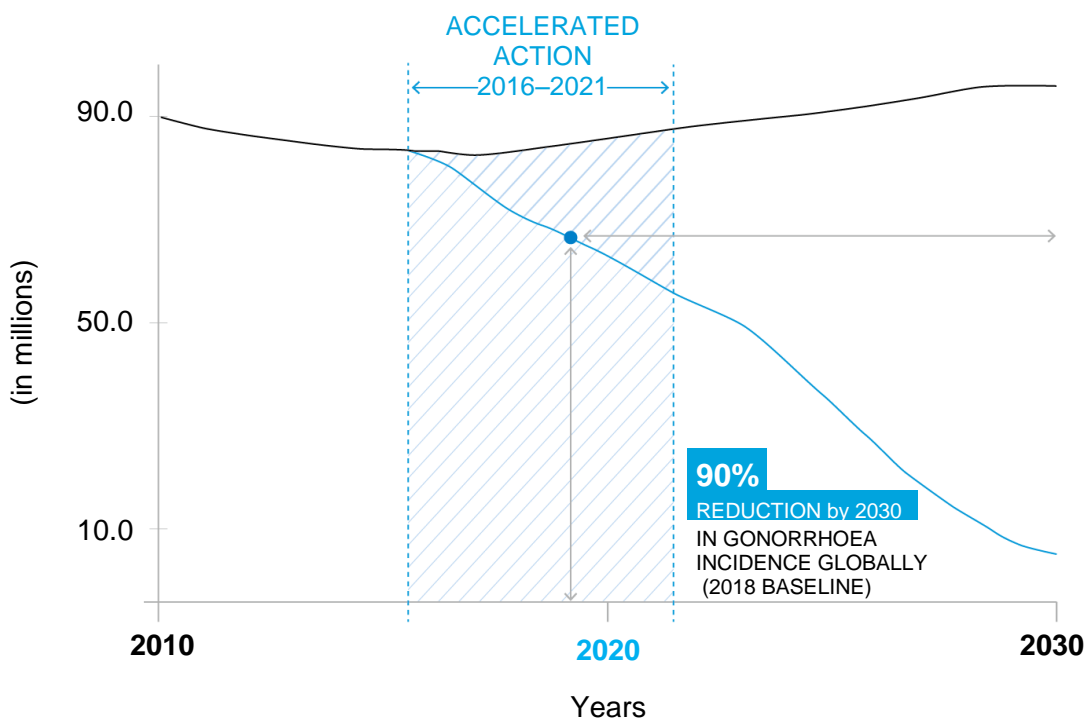
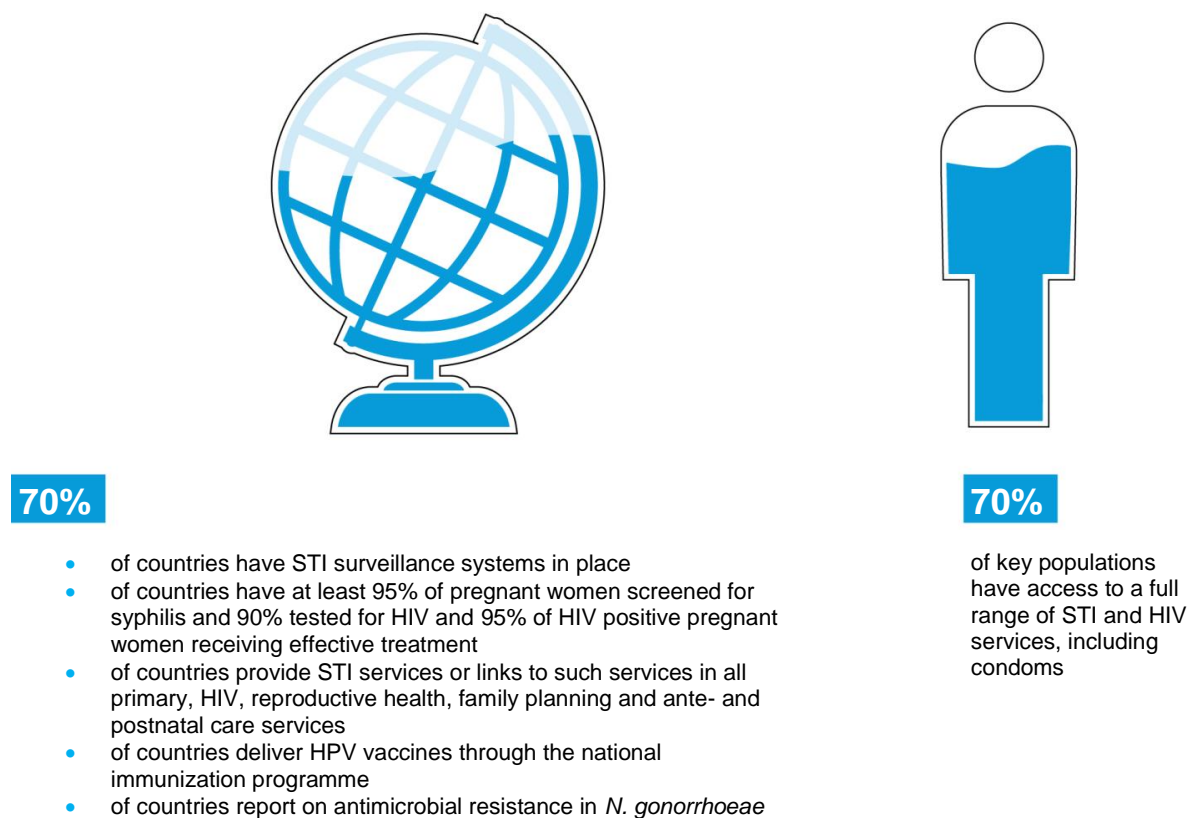


Figure 7. The strategy on sexually transmitted infections – 2020 milestones



The broader impact

41. By saving millions of lives directly and indirectly, and by improving the health and well-being of an even greater number of people, an expanded and more effective response to sexually transmitted infections will contribute significantly to reaching universal health coverage, realizing people's overall right to health, and achieving the goals of the 2030 Agenda for Sustainable Development. The impact will be multiplied if actions are underpinned by strong health and community systems, accompanied by strengthened responses in other health areas, and address the social and regulatory factors that increase the risk of sexually transmitted infections and impede access to appropriate services.

42. In the 2030 Agenda for Sustainable Development, the targets under Sustainable Development Goal 3 cover broad areas and do not include a specific mention of, or targets for, sexually transmitted infections.¹ Accelerated action to address 2020 targets related to sexually transmitted infections will enhance progress relating to a number of 2030 Sustainable Development Goals.

43. The proposed strategy will contribute to five of the 13 health-related targets by 2030:

- ending preventable deaths of mothers, newborns and children under 5 years of age

¹ United Nations General Assembly resolution 70/1 (2015) – Transforming our world: The 2030 Agenda for Sustainable Development, see http://www.un.org/ga/search/view_doc.asp?symbol=A/RES/70/1&Lang=E (accessed 22 April 2016).

- ending epidemics of AIDS, and combatting hepatitis and other communicable diseases
- reducing by one third premature mortality from noncommunicable diseases through prevention and treatment, and promoting mental health and well-being
- ensuring universal access to services for sexual and reproductive health care, family planning, information and education, and the integration of reproductive health into national strategies and programmes
- achieving universal health coverage, including financial risk protection, access to quality essential health care services and access to safe, effective, quality and affordable essential medicines and vaccines for all.

44. Effective action addressing sexually transmitted infections will help to combat antimicrobial resistance; eliminate adverse neonatal outcomes; reduce HIV transmission; prevent cancer; decrease the burden of infertility; and support the health and well-being of young people.

45. The lack of specific sexually transmitted infection targets in the 2030 Agenda for Sustainable Development can have implications for priority-setting by countries and, in particular, for the priority given to the measurement of sexually transmitted infection indicators. It is crucial, however, to understand that the fast and extensive implementation of the actions outlined in this strategy will contribute substantially to achieving the goals of the 2030 Agenda for Sustainable Development.

The guiding principles

46. The strategy is rooted in a public health approach¹ that is concerned with preventing disease, promoting health, and prolonging life in the population as a whole, and is designed to promote a long-term, sustainable response.

47. The following principles guide the strategy:

- universal health coverage
- government stewardship and accountability
- evidence-based interventions, services and policies
- protection and promotion of human rights, gender equality and health equity
- partnership, integration and linkage with relevant sectors, programmes and strategies
- meaningful engagement and empowerment of people most affected by sexually transmitted infections.

¹ The core public health functions involve assessing and monitoring the health of specific most-affected populations to identify health threats and priorities; formulating public policies to solve identified health problems and priorities; and ensuring that all populations have access to appropriate and cost-effective care, and evaluating the effectiveness of that care.

4. STRATEGIC DIRECTIONS AND PRIORITY ACTIONS

4.1. STRATEGIC DIRECTION 1: Information for focused action

Knowing your sexually transmitted infection epidemic in order to implement a tailored response

48. A robust strategic information system is a cornerstone for advocating, funding, strategically planning and implementing effective sexually transmitted infection interventions, for monitoring and improving them, and for providing evidence of their impact. It is essential for countries to know their sexually transmitted infection epidemics and to know the related responses in order that up-to-date and accurate information guides national responses.

Strategic information for advocacy and investment

49. With limited resources, countries need to build a strong, comprehensive case to justify the use of domestic resources for sexually transmitted infection prevention and care, and to mobilize external resources. A well-functioning strategic information system is essential for rallying political commitment and for building a strong case for investment. It enables countries to define and develop a budget for an effective package of interventions and services based on the country context, decide on the most appropriate allocation of resources across the different levels of the health system, and identify potential and reliable sources of funding.

Understanding the epidemics

50. Knowing the epidemics includes understanding where, how and among whom new infections are occurring, and identifying the factors that facilitate sexually transmitted infection transmission or limit access to and use of appropriate services. Prevention, treatment and care programmes can then be prioritized and focused accordingly.

51. Geographical and population mapping can help countries to design and implement the most efficient and effective responses. Strategic information systems should provide subnational and disaggregated data to monitor epidemic trends and to map the locations and core groups among which most transmission of sexually transmitted infections is occurring. This will enable resources and services to be allocated, according to where the greatest impact can be achieved.

National sexually transmitted infection surveillance

52. There are four core components of sexually transmitted infection surveillance: case reporting, prevalence assessments, assessment of the etiology of sexually transmitted infection syndromes, and monitoring of antimicrobial resistance. Currently, most relevant national surveillance systems are based on universal syndromic case reporting.

53. Over time, countries should be assisted to move from syndromic to etiologic surveillance. This will require not only strengthening of in-country laboratory capacity, but also the development and introduction of affordable point-of-care sexually transmitted infection diagnostics. National case reporting should focus on syphilis, gonorrhoea, urethral discharge and genital ulcer disease. In addition, countries should conduct routine syphilis prevalence monitoring of pregnant women and of specific populations, including men who have sex with men, and sex workers; countries should also

conduct gonorrhoea and chlamydia prevalence monitoring among the same populations and among adolescents.

54. Every few years, countries using syndromic management should conduct an etiologic assessment to inform treatment recommendations. All countries should have an ongoing system in place to conduct routine gonococcal antimicrobial resistance monitoring.

55. A strong strategic information system that focuses on sexually transmitted infection is required to generate data disaggregated by sex and age, and to triangulate and synthesize data regularly from other data collection systems covering other health-related topics, such as HIV, and maternal, reproductive and child health.

56. Robust data on sexually transmitted infections make it possible to focus related programmes more precisely and effectively, and to deploy or adapt services to reach greater numbers of people in need. Civil society is an important partner for strengthening strategic information systems, and for ensuring that data are collected and used in an ethical manner that benefits communities.

57. Surveillance data on sexually transmitted infections can also be used as the basis for estimating national prevalence and incidence of syphilis and gonorrhoea, and congenital syphilis rates. Such estimates can be used to assess progress towards the goals of this strategy.

58. The potential impact of the introduction of pre-exposure prophylaxis of HIV infection in different communities should be monitored, including through the surveillance of sexually transmitted infections, sexual behaviour and drug resistance. While there is currently no evidence from studies or early programmes for risk compensation in sexual practices, such as decreased condom use or more sexual partners, this important innovation should be monitored to ensure its effectiveness and also to ensure that any unanticipated consequences are addressed.

Priority actions for countries

- **Strengthen and integrate sexually transmitted infection surveillance into the national health information system** as a part of health system strengthening, using standardized indicators and methodologies as guided by WHO; ensure that data collection methods yield high-quality information, meet ethical standards, and do not pose risks for communities or the health care workers involved.
- **Increase the “granularity” of data** including through: enhanced sexually transmitted infection-related disaggregated data collection based on different stratifiers that include age, sex, population and location; involve affected communities and specific populations to achieve high-quality data and analysis.
- **Identify specific populations** who are most at risk for sexually transmitted infections and places where most of the transmission is occurring; establish mechanisms to promote the participation of affected communities; conduct routine case reporting and periodic prevalence assessment of core sexually transmitted infections to assess the magnitude of the sexually transmitted infection problem in target populations, including by disaggregating the data; describe the sexually transmitted infection epidemics and measure the impact in terms of sequelae and cost.
- **Include data on the risk factors and determinants of sexually transmitted infections** in order to understand and address these determinants. Include a focus on pre-exposure prophylaxis as appropriate. Use both standard and innovative participatory survey methodologies to develop accurate estimates of key population sizes and detailed understandings of subnational epidemics; integrate biological surveillance with other programmes, such as a behavioural surveillance survey, in the HIV files – include contact tracing and treatment of partners.
- **Strengthen national laboratory capacity** through quality assurance and the introduction of point-of-care diagnostics to ensure routine monitoring of sexually transmitted infections and antimicrobial resistance to *N. gonorrhoeae*.

Priority actions for WHO

- **Provide global leadership and assistance to countries** in strengthening sexually transmitted infection surveillance and in using standard methodologies for such surveillance and estimation of the burden and impact; support the development of strategic information systems and sexually transmitted infection epidemics and response mapping, including the analysis of disaggregated data for monitoring inequities; support countries in strengthening case reporting, prevalence assessment, etiologic assessment and antimicrobial resistance monitoring; strengthen global systems for collecting and sharing national surveillance data on sexually transmitted infections, including disaggregated data and analysis for monitoring equity.
- **Provide guidance on the collection and analysis of disaggregated data** based on different stratifiers and the involvement of affected communities and specific populations, including key populations for HIV, in efforts to obtain high-quality data and achieve high-quality analysis; use internationally endorsed methods for estimating the sizes of key populations for HIV and on setting programme targets for services for key populations for HIV.
- **Ensure linkages** of some components of sexually transmitted infection surveillance to existing mechanisms including HIV and antimicrobial resistance surveillance.

Tracking, monitoring and sharing evidence on the response

59. The strategic information system needs to be capable of collecting and analysing disaggregated data along the entire continuum of care: prevention, treatment and care services to identify gaps in the coverage and performance of services, and to determine areas requiring improvements. By identifying indicators for measuring progress and for monitoring and evaluating interventions, countries can assess, report and improve services relating to sexually transmitted infections, and achieve greater equity in their responses. They can determine whether services are available and being used, whether and where disparities and gaps exist, which delivery models are most effective (for instance, through health facilities, community-based services or other approaches), and which elements require improvement. Linking the sexually transmitted infection response with other health and development initiatives requires greater integration of health information systems and the alignment of reporting across health programmes.

National strategic planning, programme implementation and accountability

60. The strategic information system has to inform a national strategy and implementation plan that is based on the country context, defines national targets and is aligned with global targets. This national strategy and implementation plan guides the national health response to sexually transmitted infections.

61. The strategy should describe actions that need to be taken to achieve the national targets, including identifying specific populations and priority locations based on local epidemiology, prioritizing evidence-based and high-impact interventions and service delivery models that best suit the context, and implementing a monitoring and evaluation framework that can track progress towards the targets.

62. There should be clear linkages between this global strategy and other relevant sectoral strategies, other relevant disease-specific strategies, such as those for tuberculosis, and sexual and reproductive health, and broader national health and development strategies. Each country should have a national programme focusing on sexually transmitted infections, with the necessary resources and capacity to implement a relevant national strategy and plan, and to monitor and report on progress.

63. Countries need to track, assess and report on progress towards the agreed targets, using indicators on availability, coverage outcomes and impact of services. Benchmarking – or comparisons between and within countries – should be used to assess performances. Existing instruments should be used for measuring progress in implementing policy, legal and structural measures for enhancing the sexually transmitted infection response, including the National Composite Policy Index¹ and the People Living with HIV Stigma Index.²

Priority actions for countries

- **Strengthen the governance and accountability of programmes relating to sexually transmitted infections** and conduct regular programme reviews to help to ensure that national strategies, plans and resource allocation reflect actual country needs as they evolve.
- **Set national targets and milestones** and identify indicators for monitoring and evaluating the national sexually transmitted infection programme, as well as for monitoring equity so that countries can assess and regularly report on the status of their response, and use those assessments for further programme improvements.
- **Ensure that relevant monitoring and evaluation frameworks track the entire continuum of services** in both the public and private sectors, and are harmonized with other health information systems, and are set up to track equity through appropriate disaggregation and analysis; use subnational data collection and mapping techniques to detect deficiencies in service provision and infrastructure, and to help inform decisions made on where to place additional services; monitor access to, and uptake and quality of sexually transmitted infection services for specific populations.

Priority actions for WHO

- **Develop, update and disseminate guidance** on national strategic planning and prioritization relating to sexually transmitted infections; WHO regional and country offices to support regular reviews to assess progress towards the 2020 and 2030 global targets.
- **Provide technical support to countries** with sexually transmitted infection programmes and impact reviews to focus investments.
- **Make information available** on the status of country and regional progress towards targets and support the use of benchmarking – or comparisons between and within countries across different subgroups – to assess progress towards reaching targets.

¹ The National Composite Policy Index is Appendix 4 in the 2010 Reporting document of the United National General Assembly Special Session on HIV/AIDS, Monitoring the Declaration of Commitment on HIV/AIDS: Guidelines on construction of core indicators, see http://data.unaids.org/pub/Manual/2009/JC1676_Core_Indicators_2009_en.pdf (accessed 22 April 2016).

² For more information, see the People Living with HIV Stigma Index, at <http://www.stigmaindex.org/> (accessed 22 April 2016).

4.2. STRATEGIC DIRECTION 2: Interventions for impact

People should receive the full range of sexually transmitted infection services they need

Defining a set of core interventions: the sexually transmitted infection benefit package

64. Each country needs to define a set of essential sexually transmitted infection interventions and services. Sexually transmitted infection strategies are most effective when people have access to and benefit from a continuum of high-quality services for preventing, diagnosing and managing sexually transmitted infections. In addition to integrating relevant services into routine service delivery processes, targeted outreach to specific populations may be required.

65. Informed about their sexually transmitted infection prevalence and incidence, each country must prioritize interventions across the continuum of prevention to treatment and package these interventions in effective and acceptable ways. As resources and capacity increase, the scope of interventions and services can be expanded progressively, with the aim of further improving sexually transmitted infection and broader health outcomes. The evidence shows clearly that combination packages achieve greater impact than discrete, individual interventions.

66. When countries define their package of interventions, coinfection should be considered. Sexually transmitted infections share common risk-associated behaviours; multiple infections can be acquired at the same time and existing infection can facilitate transmission and acquisition of other sexually transmitted infections, including HIV. Diagnosis of one infection is an indicator of risk for others. Although coinfection is common, precise global estimates of coinfection rates are unavailable. Specific populations, including key populations for HIV, are at highest risk for coinfection of sexually transmitted infections. As such, special attention should be paid at all levels of the health system to symptomatic and asymptomatic coinfection in these populations, as well as in the general population.

67. Although the core interventions and services will vary by country, based on epidemic dynamics and country context, each of the following intervention areas should be covered:

- prevent sexually transmitted infection transmission and acquisition
- achieve early diagnosis of sexually transmitted infections and linkage to treatment
- manage symptomatic patients
- reach sex partners and offer them treatment
- package interventions for maximum impact: (1) eliminate mother-to-child transmission of syphilis and HIV; (2) fully utilize human papillomavirus and hepatitis B vaccines; (3) control the spread and impact of gonococcal antimicrobial resistance
- ensure quality of care for sexually transmitted infection services and interventions: (1) strengthen the continuum of prevention, diagnosis, treatment and care; (2) link and integrate services and programmes; (3) implement quality assurance and improvement programmes.

68. The core package needs to be regularly reviewed to ensure that, as new evidence emerges and new technologies and approaches are developed, innovations are rapidly integrated and opportunities harnessed. Updated guidelines for the management of sexually transmitted infections will be made available by WHO to support countries in developing and implementing their core interventions and services.

Prevent sexually transmitted infection transmission and acquisition

69. Combination prevention is the most effective approach for the prevention of sexually transmitted infections. Evidence-based comprehensive prevention frameworks work best when there is a strategic combination of behavioural, biomedical and structural approaches. Such a combination includes an understanding of sexually transmitted infections and primary prevention methods, including condoms, and a focus on working with people most affected by, and vulnerable to, sexually transmitted infections, in particular adolescents. HIV combination prevention efforts should also incorporate components focused on other sexually transmitted infections.

70. Effective prevention requires ensuring access to vital information, commodities (such as condoms) and services (such as vaccination, voluntary medical male circumcision, testing, treatment and care) within a human rights framework. Alongside that, behavioural interventions are critically important for sexually transmitted infection prevention including HIV, and include: the promotion of consistent use of male and female condoms; education including a focus on increasing awareness of sexually transmitted infections; reduction in the number of sexual partners; increased uptake of testing for sexually transmitted infections, including HIV; delayed sexual debut; as well as the promotion of sexual well-being.

71. Many such interventions have the dual advantage of preventing sexually transmitted infections, including HIV and unintended pregnancies, in particular through the use of condoms by adolescents. Focusing the interventions appropriately for specific populations (including key populations for HIV), adolescents and pregnant women is a priority. In addition, when community knowledge about sexually transmitted infections is strengthened, and stigmatization and discrimination are reduced, the use of services related to sexually transmitted infection tends to improve.

Priority actions for countries

- **Prioritize high-impact and comprehensive prevention interventions** tailored to the epidemic closely linked with HIV prevention, sexual and reproductive health, mother and child health and immunization programmes that include:
 - comprehensive health information, education and health promotion programmes for adolescents
 - male and female condom programming for dual protection against sexually transmitted infections and unintended pregnancy, in particular for adolescents, and distributed through communities and through outreach services for specific populations
 - the use of maternal and child health and family planning clinics as additional outlets for the provision of care and distribution of condoms to women who could be at risk of sexually transmitted infections
 - greater use of social marketing programmes to increase demand and supply of quality-assured, affordable sexually transmitted infection services, and condoms in traditional and non-traditional outlets
 - promoting voluntary medical male circumcision where appropriate
 - ensuring access to human papillomavirus and hepatitis B vaccination.
- **Tailor and focus risk reduction interventions** addressing sexual health from a well-being perspective to the needs of populations that are most affected; address the key factors that place people at greater risk for sexually transmitted infections and that impede access to effective and relevant services, including interventions to redress human rights violations that emerge from the criminalization of same-sex behaviours or sex work, to prevent and manage gender-based violence, as well as violence related to sexual orientation and gender identity.

Priority actions for WHO

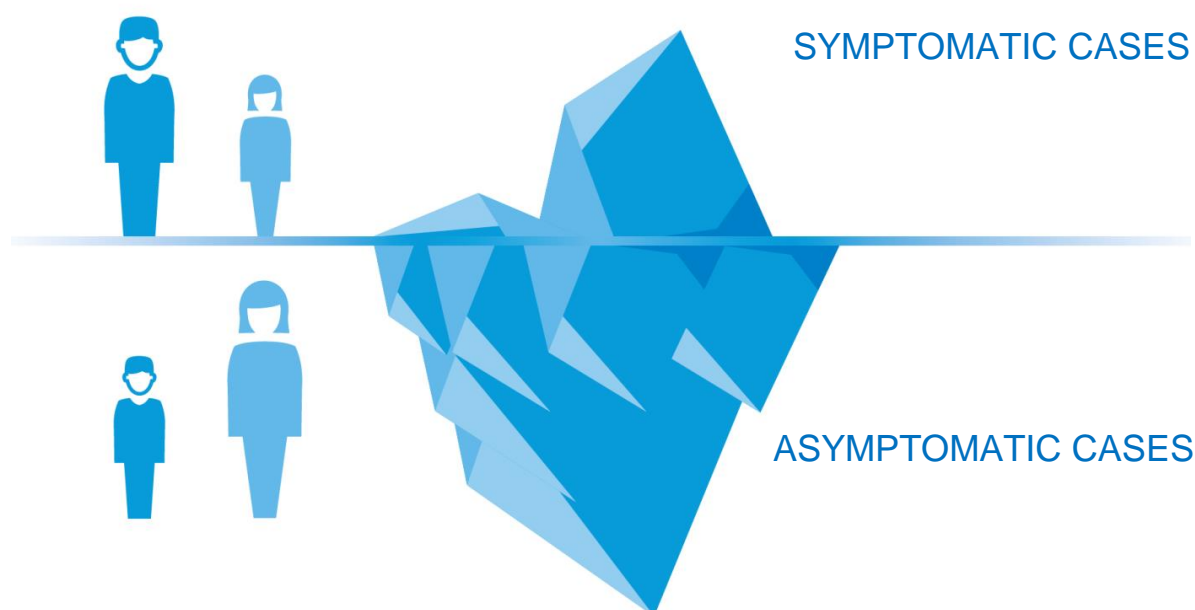
- **Update and disseminate updated guidance on sexually transmitted infection prevention** including: rapidly integrating new evidence-based health sector interventions into sexually transmitted infection prevention packages for different epidemic contexts, giving particular attention to specific and key populations, adolescents, and women; promoting effective male and female condom programmes, including setting global standards and facilitating procurement.
- **Update and disseminate guidance for targeted populations on sexually transmitted infection vulnerability and risk reduction interventions;** work with partners to promote new initiatives on reducing risk, and empowering and increasing resiliency, confidence and agency among adolescent girls and young women and among specific and key populations; provide evidence and guidance on the role of positive gender norms and attitudes that help to reduce sexually transmitted infection vulnerability and risk; advocate increased commitment, resources and actions to eliminate sexually transmitted infections in newborns.

Achieve early diagnosis of sexually transmitted infections and linkage to treatment

72. Early diagnosis of sexually transmitted infections can be achieved by: screening, that is, detecting illness due to testing based upon risk factors in an asymptomatic individual; and diagnosis, that is, discovering the underlying cause of symptoms. Early diagnosis of sexually transmitted infections, including those without symptoms, is the best opportunity for effective medical treatment and support, and for preventing further transmission. This can be challenging, given that most sexually transmitted infections are asymptomatic (see Figure 8). In the absence of affordable point-of-care tests for sexually transmitted infections, screening remains rare in resource-constrained settings.

Figure 8. Sexually transmitted infections

Women are more affected by asymptomatic sexually transmitted infections than men and men are more likely to have symptomatic sexually transmitted infections than women



73. Each country will need to select the most appropriate combination of screening and diagnostic approaches based on the nature and dynamics of its sexually transmitted infection epidemics, the

affected populations and its health system, as well as on the evidence available. Special efforts are required for the detection and management of asymptomatic sexually transmitted infections in specific populations, which include key populations for HIV, adolescents and young adults, and pregnant women, such as case-finding or screening, with enhanced interventions for reaching sexual partners. Specific attention is required in ensuring that sexually transmitted infection diagnosis is accessible, and also in ensuring the quality of diagnostic tools and services, to minimize risk of misdiagnosis. Prompt diagnosis and effective management of sexually transmitted infections breaks the chain of transmission and prevents the development of complications and long-term sequelae of such infections.

Manage symptomatic patients

74. Each primary point-of-care for persons with sexually transmitted infections should follow an up-to-date management protocol for people with symptomatic infections of that kind, and for their sexual partners, based on global guidelines. Primary point-of-care outlets are varied and include primary health care clinics, sexual and reproductive health services, including antenatal care services and services that provide care and management of persons living with HIV. Moreover, sexually transmitted infection case management for high-risk populations should be linked closely with HIV prevention services, including outreach services.

Reach sex partners and offer them treatment

75. Partner notification is integral to effective sexually transmitted infection prevention and care. Approaches for informing sex partners and offering them counselling and treatment vary according to circumstances and include patient referral (whereby patients are encouraged to contact their sex partners themselves), provider referral (the health care provider notifies the partner and arranges treatment), contractual patient–provider referral (a two-step approach that links patient and provider referral methods), and expedited partner therapy (the diagnosed patient takes the prescriptions or medication to his/her partner without prior examination of the partner). A “couples approach” for increasing counselling and partner treatment rates should be encouraged, in particular in the context of antenatal care. The selected strategy has to be rights-based and sensitive to gender inequalities, while ensuring and expediting partners’ access to treatment.

Package interventions for maximum impact

76. The overall public health impact of these core interventions can be boosted by combining them with other initiatives, specifically: the global campaign to eliminate mother-to-child transmission of HIV and syphilis; wider introduction of the vaccine against the human papillomavirus; voluntary medical male circumcision to impact on HIV and other sexually transmitted infections; and strategies to confront the emergence of gonococcal antimicrobial resistance.

Eliminate mother-to-child transmission of syphilis and HIV

77. A number of countries have committed themselves to eliminate mother-to-child transmission of HIV and syphilis (also known as “congenital syphilis”). In many countries, the elimination of mother-to-child transmission of syphilis is linked to a dual elimination campaign (elimination of mother-to-child transmission of HIV and syphilis).¹ A few countries have begun implementing a triple

¹ Global guidance on criteria and processes for validation: elimination of mother-to-child transmission of HIV and syphilis, see http://apps.who.int/iris/bitstream/10665/112858/1/9789241505888_eng.pdf?ua=1&ua=1 (accessed 21 April 2016).

elimination campaign (elimination of mother-to-child transmission of HIV, syphilis and hepatitis B). The steps required towards preparing for validation will help countries to strengthen their sexually transmitted infection programmes, and should help to reduce inequities among different populations within a country.

Fully utilize human papillomavirus and hepatitis B vaccines

78. Vaccinating against human papillomavirus can dramatically reduce cervical cancers caused by the virus; the hepatitis B vaccine is safe and effective in preventing hepatitis B infection.¹ Countries should urgently consider the further introduction or expansion of these vaccination programmes with human papillomavirus vaccines, in the context of a comprehensive framework for cervical cancer prevention and control. The take up of human papillomavirus vaccine by the population to which it is targeted should be a critical pillar of adolescent health programmes with increased health education and strategies to reach adolescents.

Priority actions for countries

- **Adapt and implement guidelines on sexually transmitted infection and HIV screening and diagnosis:** procure, introduce and expand use of WHO prequalified diagnostics; implement quality assurance and quality improvement measures to lower the risk of misdiagnosis, and reduce delays between collecting specimens, laboratory testing, sharing the results, and access to treatment.
- **Implement and scale-up evidence-based national sexually transmitted infection management guidelines** based on country data and services available:
 - implement strategies for detecting and managing asymptomatic infections in specific and key populations, pregnant women and adolescents, such as regular case testing or screening, with enhanced interventions for reaching sexual partners
 - update implementation plans for guiding effective and sustainable scale-up of symptomatic sexually transmitted infection management, based on the latest evidence
 - encourage use of single dose treatment, delivered at a health facility where feasible, to enhance adherence
 - integrate sexually transmitted infection management in specific populations, HIV prevention services and care to address major coinfections and comorbidities, notably HIV.
- **Ensure availability of effective sexually transmitted infection management commodities and medicines** when people seek care for sexually transmitted infections: ensure procurement of quality-assured medicines; work to decrease barriers on accessibility and affordability of quality sexually transmitted infection diagnostics.
- **Develop and implement strategies to strengthen sexual partner management:** adopt strategies for partner notification and evaluate the level of implementation; safeguard patient confidentiality; ensure linkage to counselling and treatment of partners.
- **Screen all pregnant women for syphilis,** and ensure that those who are seropositive receive appropriate injectable penicillin therapy: link efforts to eliminate mother-to-child transmission of syphilis with those to eliminate mother-to-child transmission of HIV; in order to attain validation standards, strive to increase coverage and reduce disparities in the delivery of interventions against mother-to-child transmission of syphilis.

¹ See Appendix 2 above.

- **Urgently consider introducing a vaccination programme against human papillomavirus** as part of a comprehensive approach to cervical cancer prevention: define a package of information, including health promotion, which targets adolescents and can be delivered in coordination with the implementation of human papillomavirus vaccination programmes.
- **Introduce hepatitis B vaccination into national infant immunization** programmes of any countries that have not yet done so – to do so urgently, and ensure timely delivery of the birth dose of hepatitis B vaccine to prevent perinatal transmission of hepatitis B infection.

Priority actions for WHO

- **Regularly update and disseminate consolidated sexually transmitted infection management guidelines** that include: clinical, operational and programmatic guidance that will guide rapid and sustainable treatment scale-up; consolidated guidance on sexually transmitted infections and HIV testing approaches, strategies and diagnostics, incorporating the latest innovations, with a particular focus on early diagnosis; regular testing and screening; support to countries in the adaptation, implementation and monitoring of guidelines; provide and update evidence-based guidelines for partner notification, communication and counselling, diagnosis and treatment.
- **Accelerate support for the elimination of mother-to-child transmission of syphilis:** provide technical guidance on how to achieve standards for the validation for the elimination of mother-to-child transmission of syphilis; identify ways to reduce barriers to diagnostics and treatment for elimination of mother-to-child transmission of syphilis; accelerate development of new technologies for improved diagnosis and treatment of syphilis in pregnant women and newborns.
- **Strengthen efforts to ensure high-quality diagnostics for sexually transmitted infections are accessible and available:** strengthen the WHO Prequalification Programme to ensure rapid access to quality sexually transmitted infection diagnostics; work to decrease barriers on accessibility and affordability of quality sexually transmitted infection diagnostics.
- **Set the research agenda and conduct research to address gaps in sexually transmitted infection management** in resource-poor settings; support research to identify effective, efficient, safe and acceptable diagnostic tests, technologies and approaches relevant to sexually transmitted infections.
- **Strengthen sexually transmitted infection immunization guidance:** assess schedules and doses for immunization policies, and advise on the most effective methods for protecting high-risk groups, as well as males; support operational research in countries for the introduction of human papillomavirus vaccine and for linking it to adolescent health programmes; support efforts to ensure that the human papillomavirus vaccine is available in countries at an affordable price; develop guidance on other health interventions that could be introduced, together with the vaccination programme.

Control the spread and impact of gonococcal antimicrobial resistance

79. Gonorrhoea is one of the most common sexually transmitted infections worldwide and it has a significant effect on morbidity and mortality. Over the past decades, *N. gonorrhoeae* has developed resistance to almost all medicines used to treat the infection, which raises the prospect of untreatable gonococcal infections. WHO has strengthened the Gonococcal Antimicrobial Surveillance Programme by establishing a network of laboratories to coordinate gonococcal antimicrobial resistance monitoring and provide data to inform treatment guidelines. Other sexually transmitted infection pathogens with potential antimicrobial resistance include *T. pallidum*, herpes simplex virus and *Haemophilus ducreyi*. These are linked to the overall global antimicrobial resistance action plan.¹

¹ See resolution WHA68.7 (2015).

Strengthen synergies and linkages for sexually transmitted infection services and interventions

- **Strengthen the continuum of prevention, diagnosis, treatment and care**

80. Services should be organized to minimize “leakages”, to maximize retention along the continuum, and adherence to prevention and care interventions. Major challenges include: acceptability and uptake of effective prevention interventions; stigmatization and discrimination in some health care settings; targeting diagnosis to maximum effect and minimizing incorrect diagnoses; linking people to appropriate prevention and treatment services as early as possible; and ensuring treatment adherence.

81. Services should be people-centred, patient-friendly, that respect people’s rights and that address their varying needs without judgement or prejudice; in addition to being more effective, people-centred services may be more efficient. The involvement of community groups and networks has also been shown to be effective, especially for reaching specific populations, including those that can be harder to reach such as those recognized as adolescents and key populations for HIV.

82. A strong continuum of services also requires strong coordination across various levels of health service delivery with an effective cross-sector referral mechanism.

- **Link and integrate services and programmes**

83. Greater integration and linking of sexually transmitted infection services and programmes with those for other relevant health areas (including for HIV, family planning, maternal and neonatal care; health promotion, including sexual health; immunization; noncommunicable diseases; and mental health), that is, comprehensive primary healthcare and other sectors (such as school health education programmes targeting adolescents, and occupational health) have the potential to reduce costs, improve efficiency and lead to better outcomes. Appropriate models of integration and linkage will depend on the country context and health system, and should be informed by operational research.

Priority actions for countries

- **Strengthen the implementation of strategies and interventions to monitor antimicrobial resistance**, including strengthening national laboratory network capacities; integrate surveillance of antimicrobial resistance of *N. gonorrhoeae* to the national antimicrobial resistance surveillance plan; adapt national treatment guidelines to resistance patterns and implement interventions to limit the spread of antimicrobial resistance; reduce the prescription and procurement of antimicrobials.
- **Strengthen links, collaboration and integration**, including between sexually transmitted infection programmes and those with responsibilities for HIV, reproductive health, mother-to-child transmitted diseases, cancer and noncommunicable disease, and adolescent health:
 - support further integration through primary health care services
 - integrate key indicators for prevention and control into national sexually transmitted infection monitoring and evaluation systems
 - ensure adequate communication and coordination between the different levels of the health system, and the public and private sectors
 - analyse the continuum of prevention and control services to determine the quality of services, identify major weaknesses and take remedial action.

Priority actions for WHO

- **Provide global leadership on tackling antimicrobial resistance:** coordinate the response on antimicrobial resistance of *N. gonorrhoeae* with the global action plan on antimicrobial resistance:¹
 - increase support for the Gonococcal Antimicrobial Surveillance Programme² and other efforts to monitor antimicrobial resistance and contain the spread of untreatable gonorrhoea
 - update treatment guidelines for gonorrhoea
 - monitor the possible emergence of antimicrobial resistance to treatments for *T. pallidum*, herpes simplex virus and *H. ducreyi*
 - invest further in research for the development of points-of-care for sexually transmitted infection including tests that will allow better identification of antimicrobial resistance.
- **Support countries to progress linkages and integration of services:**
 - propose indicators and methods for measuring effective linkage
 - document and disseminate best practices on integration and mHealth
 - promote the WHO monitoring and evaluation framework to national sexually transmitted infection monitoring and evaluation systems
 - facilitate the collection of national data on the continuum of services and report on major findings
 - identify common weaknesses in the continuum of services and propose interventions to address them
 - include learning on effective interventions and approaches in WHO's operational and programmatic guidance.

4.3 STRATEGIC DIRECTION 3: Delivering for equity

All people should receive the sexually transmitted infection services they need, which are of adequate quality

84. Reaching the targets on sexually transmitted infection requires an appropriate enabling environment for action grounded in principles of human rights and gender equality and will only be possible by focusing suitable, high-impact interventions and services for specific populations, including those who are most at risk for and vulnerable to sexually transmitted infections and in places where most transmission of sexually transmitted infections is occurring. Ensuring access to effective services should therefore be equitable and free of discrimination. This can be a challenge, as sexually transmitted infections occur with high frequency among specific populations and among adolescents, all of whom may experience challenges in accessing or remaining linked to health services and, in particular, to sexually transmitted infection services. As a result, large proportions of people at high risk for sexually transmitted infections do not use prevention methods and services effectively, remain undiagnosed, or do not use or adhere to treatment therapies.

85. Coverage of treatment services can be increased through collaboration with other health programmes, government sectors (for example, education, occupational health, prison services, migration), as well as with community-based organizations and private health care providers.

¹ For the global action plan on antimicrobial resistance, see http://www.who.int/drugresistance/global_action_plan/en/ (accessed 22 April 2016).

² For information on the Gonococcal Antimicrobial Surveillance Programme, see http://www.who.int/reproductivehealth/topics/rtis/gonococcal_resistance/en/ (accessed 22 April 2016).

Promote an enabling environment which includes policies and laws that promote human rights and gender equality

86. When properly enforced, laws and policies that protect and promote public health and human rights, including sexual and reproductive health and rights, can reduce vulnerability to and risk of sexually transmitted infection; expand access to sexually transmitted infection care and other health services; and enhance their reach, quality and effectiveness. In many countries legal, institutional and other barriers continue to deter people from using services relating to sexually transmitted infections. The health sector is obliged to ensure that policies, laws and regulations support relevant national programmes and national health responses more generally, by promoting gender equality and through protecting and promoting the human and health rights of populations that are at increased risk for sexually transmitted infections (including specific populations, as defined earlier) and for adolescents.

Reduce vulnerability and risk

87. Effective interventions for reducing sexually transmitted infection vulnerability and risk hinge on awareness building and targeted health promotion and risk reduction communication, and on increased access to and use of sexual and reproductive health services. Progress in these areas requires: effective actions to reduce stigmatization and discrimination in health care settings and the community; initiatives to prevent and provide services that address gender-based violence and violence related to sexual orientation or gender identity; and interventions that empower women and stigmatized populations. In some populations the harmful use of alcohol can exacerbate certain vulnerabilities and risk behaviours and so should be taken into account when designing services.

Reaching all populations with appropriate services

88. In addition to meeting the needs of the general population effectively, reaching specific populations with the most appropriate interventions will be critical for ending sexually transmitted infection epidemics in countries. Actions are needed to overcome or remove barriers that prevent these populations from accessing the sexually transmitted infection and broader health services they need. Depending on the population, these barriers may include age of consent laws, criminalization of behaviours such as sex work and sex between men, and institutionalized stigmatization and discrimination, as well as gender-based and other forms of violence including intimate partner violence. The sexually transmitted infection response also needs to reflect the fact that different populations may require different sets of interventions and different types of services.

Specifically address men and boys

89. Men and boys have often been overlooked as a population requiring a specific focus for sexually transmitted infection control. Increasingly, sexually transmitted infection and HIV responses are recognizing the importance of ensuring that comprehensive approaches include components focused on ensuring access to services for men and boys as well as for women and girls. Additional interventions may include targeted social and behaviour change programmes among men; promotion of voluntary medical male circumcision; programmes focused on alcohol and substance use; and a focus on specific populations including mobile populations and migrants, men who have sex with men, male sex workers and the male clients of sex workers.

Engaging and linking with communities and partners

90. Engagement with communities and other partners at all levels is vital for defining the package of interventions, improving policy coherence, programme coordination and accountability, and for

addressing the various factors that affect the design, delivery, performance and outcomes of sexually transmitted infection programmes. Partnerships should be guided by public health principles, including the need for robust government stewardship, public accountability, and the promotion of human rights, gender equality and health equity. Strong engagement with civil society, including the faith-based sector, and especially at community level, will help ensure that essential services are accessible to all populations. Structured linkages with private sector and civil society service providers would also help extend coverage while improving quality assurance.

Strengthening health systems

91. The keystone of an effective sexually transmitted infection response is a strong health system that is capable of providing reliable, effective and equitable people-centred care in both the public and private sectors. The hallmarks of such a system are: efficient service delivery models that meet patients' variable needs; an appropriately trained and distributed workforce in sufficiently adequate numbers and responsive skill mix; a robust health information system; reliable and affordable access to essential medical products and technologies; adequate health financing; and strong leadership and governance. Currently, very few health systems demonstrate all these features.

Targeting special settings

92. There are specific settings where vulnerability and risk are high and where access to basic sexually transmitted infection services might be severely compromised, such as in prisons and detention centres, refugee camps and settings of humanitarian concern. Countries should ensure that services provided to individuals in these settings are equivalent to those available to the broader community.

Priority actions for countries

- **Target sexually transmitted infection interventions and services to populations and locations where need, risk and vulnerability are highest:**
 - integrate evidence-based gender-equality interventions into national sexually transmitted infection action plans including interventions that promote positive norms, empower women and girls, and address violence
 - include comprehensive sexual health education in school curricula for adolescents
 - identify and prioritize implementation of tailored service packages to meet the needs of populations vulnerable to and most affected by sexually transmitted infections, including linking to a broader package of appropriate health services, such as mother and child health, HIV services or vaccination
 - include multisectoral actions to reduce stigmatization and discrimination in national sexually transmitted infection strategies, policies and programmes
 - involve community-based organizations and peer networks in the planning and delivery of services;
 - monitor access to, and uptake and quality of, HIV and sexually transmitted infection health services for specific populations
 - provide services appropriate for adolescents and review policies on consent to improve access
 - implement the comprehensive package of sexually transmitted infection interventions for prisoners and prison settings as developed by UNODC and WHO
 - include contingency plans for essential sexually transmitted infection services into national sexually transmitted infection plans to ensure continuity of relevant services in settings of humanitarian concern.

- **Create safe institutional and community environments** through:
 - applying public health evidence to shape health-related laws and policies that promote human rights and gender equality in line with internationally agreed norms and standards
 - remove legal, regulatory and policy barriers and practices (especially in health care settings) that condone or encourage stigmatization and, discrimination and violence
 - ensure training of health care providers on human rights and gender equality in relation to sexually transmitted infection and HIV
 - establish independent mechanisms for monitoring and accountability to ensure grievance redress for the violation of human rights.
- **Integrate sexually transmitted infection services into national programmes** through health systems and a community-based approach, and through mechanisms related to sexual and reproductive health, maternal and child health, adolescent health and HIV:
 - equip health workers with the skills and commodities to rapidly expand primary prevention, testing and treatment of sexually transmitted infections
 - use service delivery methods and approaches (including marshalling private sector providers and pharmacies into the sexually transmitted infection response) that provide equitable and effective services for all, particularly for specific populations
 - ensure that legal and regulatory frameworks facilitate stronger collaboration and partnerships with community groups and between the public and private sectors
 - provide or facilitate greater support for capacity development (for example, to strengthen participation in programme planning, service delivery, and monitoring and evaluation), and increased investment in community-based peer support and outreach programmes
 - involve community groups in monitoring sexually transmitted infection services.

Priority actions for WHO

- **Build on existing guidance to better define essential packages and service delivery models for specific populations, locations, situations and settings**, including for women and girls, adolescents and key populations:
 - provide and disseminate guidance on clinical management of rape among adolescents and children, and promote the uptake of guidance on health sector response to partner violence and sexual violence among women in sexually transmitted infection programmes and service delivery settings
 - synthesize and disseminate evidence on prevention and response to violence among specific populations at increased risk of sexually transmitted infection, including people who have same-sex sexual partners and sex workers
 - collaborate with UNESCO, UNFPA and UNICEF to design a package for preventing and managing sexually transmitted infections that meets the needs and realities of young people
 - with UNHCR update guidance on the delivery of sexually transmitted infection services in settings of humanitarian concern
 - work with UNODC to regularly update guidance on sexually transmitted infection services for prisoners and prison settings.

- **Promote an enabling technical, political and advocacy environment** within countries in support of an enabling environment that promotes human rights and gender equality:
 - support Member States to review and revise their health-related laws and policies to align them with international norms and standards
 - provide advice on addressing sexual violence, with a focus on adolescents, and children, and promote the uptake of existing guidance on health sector response to violence against women in sexually transmitted infection service or programme settings.
- **Develop and disseminate guidance and tools to strengthen sexually transmitted infection service integration within health systems:**
 - develop tools on laboratory capacity strengthening for sexually transmitted infection and HIV testing
 - develop tools to strengthen programme management and supervision through a health systems approach
 - involve partners, civil society and community representatives in the development of guidelines and tools for the provision of sexually transmitted infection services.

Ensure access to quality vaccines, diagnostics, medicines and other commodities

93. Effective programmes on sexually transmitted infections depend on the uninterrupted supply of quality-assured vaccines for human papillomavirus and medicines, diagnostics and other commodities for other sexually transmitted infections. Robust procurement and supply management systems are required to ensure that the right products are selected, purchased at a reasonable price and efficiently delivered to the point of service delivery. Quality of care can be enhanced by ensuring that quality-assured commodities are procured, and that services adhere to national and international norms and standards, are continuously monitored and improved, and are made more accessible and acceptable to patients' needs and preferences.

Priority actions for countries

- **Establish and implement national quality assurance norms and standards**, based on international guidelines and standards, monitor their implementation and apply quality improvement measures where deficiencies are identified; ensure the procurement of quality-assured medicines, vaccines, diagnostics and condoms, including through the use of the WHO's prequalification systems; establish mechanisms to continuously monitor service utilization and acceptability, and the preferences and needs of patients, communities and health care workers; strengthen national reference laboratories to monitor the quality of diagnostic tests.
- **Establish supply and demand forecast and monitoring mechanisms** to ensure a continuous supply of essential commodities and avoid stockouts:
 - include human papillomavirus vaccine, and medicines and diagnostics for the treatment of sexually transmitted infections in the national procurement and supply management plan
 - strengthen health system commodity procurement processes for quality-assured vaccines, medicines, diagnostics, condoms, and other commodities related to sexually transmitted infections.

Priority actions for WHO

- **Provide leadership and support on quality assurance:**
 - emphasize quality assurance and quality improvement principles, approaches and indicators in WHO's guidance
 - support capacity building of national regulatory authorities, quality control laboratories, and manufacturers or other private companies, to ensure the quality of medicines including generics
 - strengthen the WHO Prequalification Programme to encourage manufacturers to apply for prequalification of medicines, diagnostics and devices, and to facilitate the rapid assessment of new applications
 - regularly report on quality improvement along the continuum of sexually transmitted infection prevention, care and treatment services.
- **Assess the quality and performance of commercially available sexually transmitted infection commodities** and issue appropriate recommendations; support capacity-building of national regulatory authorities, quality control laboratories, and manufacturers to ensure the quality of medicines, including generics and diagnostics.

4.4. STRATEGIC DIRECTION 4: Financing for sustainability

People should receive the sexually transmitted infection services they need without experiencing financial hardship

94. Central to the 2030 Agenda for Sustainable Development is the eradication of poverty and the reduction of inequality. At the global level, 150 million people experience financial catastrophe and 100 million people suffer impoverishment every year as a result of out-of-pocket health expenses. Ensuring financial security and health equity, therefore, are central to the achievement of the Sustainable Development Goals, and universal health coverage provides a framework for addressing them.

95. Countries face the challenge of investing in an expanded programme to achieve the sexually transmitted infection targets for 2020 and beyond, while ensuring long-term sustainability of funding – all in a context where development priorities are shifting and external financial support is uncertain. The trend of increasing domestic funding for sexually transmitted infection programmes needs to continue although some low-income countries, especially those with a heavy burden, will need substantial external support to ensure rapid scale-up.

96. Financing for a sustainable sexually transmitted infection response requires an approach that is embedded in a wider overall national health strategy and action in three areas: raising sufficient funds to pay for sexually transmitted infection programmes, including through public and private domestic funding and external sources; establishing equitable mechanisms to pool funds for financial risk protection; and optimizing the use of resources by reducing costs and improving efficiencies. Health system financing has a major impact on programme coverage, equity and health outcomes.

97. Ensuring sustainable financing for sexually transmitted infections through a health system approach that is system-wide will help to secure greater system-wide efficiencies and synergies.

98. Financing for a sustainable response requires action in three areas:
- increasing revenue through innovative financing and new funding approaches
 - financial risk protection and pooling
 - reducing price and costs and improving efficiency.

Increasing revenue through innovative financing and new funding approaches

99. On their path to financing universal coverage, countries should be encouraged to examine a variety of specific financing issues, which include: review of funding flows and allocation mechanisms; consolidation of pooling arrangements; harmonization of purchasing mechanisms; and reviewing the potential to integrate HIV, sexually transmitted infection and hepatitis interventions into national benefit packages.

100. The existing international and domestic funding commitments are not enough to achieve the 2030 targets outlined in this strategy. Additional sources of funding will be required to fund the sustainable scale-up of programmes and fill funding gaps that result from shifting donor priorities. Countries will need to develop and implement financial transition plans as they increase domestically funded programmes. Fiscal capacity for many low- and middle-income countries is limited for a variety of structural reasons (including size of the informal sector, weak capacity of fiscal administration, and poor public financial management), which restricts their ability to effectively raise substantial domestic resources in the short- or medium-term, despite good macroeconomic performance. Countries that continue to require external support will need to adjust and enhance their strategies for mobilizing external support, and strengthen advocacy efforts.

101. Increased government resources both from domestic and external sources do not necessarily translate into more resources for the health sector. Overall government resources for health are subject to volatility and, despite political will, budget envelopes may be misaligned with government priorities in many contexts. Countries should be encouraged to think in terms of sustaining coverage of priority services and interventions, rather than programmes per se.

102. Countries should be encouraged to align with the broader financing for development agenda¹ to improve domestic tax systems and to crack down on international tax avoidance and illicit flows, while re-emphasizing the political advocacy needed for prioritization.

Financial risk protection and pooling

103. Countries should implement health financing systems that minimize out-of-pocket payments for all essential health services, with the aim of increasing access to these services and to prevent impoverishment. To minimize catastrophic health payments, out-of-pocket spending should be limited to less than 15–20% of the total health spending. Preventing and controlling sexually transmitted infections are, in principle, relatively easy and affordable in most settings. Many sexually transmitted infection services are provided free of charge, and countries increasingly also use supportive arrangements (such as decentralizing services) to minimize the indirect costs for people using services. However, in many places, user fees continue to be imposed. As with other out-of-pocket expenses

¹ Financing for development, see the United Nations Department of Economic and Social Affairs website: <http://www.un.org/esa/ffd/> (accessed 22 April 2016).

(formal and informal), such fees undermine service use, result in inequities in service access, weaken linkages to treatment and increase risks of treatment failure. Moreover, they constitute unnecessary financial burdens on households. Where possible, countries should consider reconciling benefit packages for different disease interventions. This is essential to improving financial protection, as well as for efficiency to avoid resource waste through duplication and fragmentation.

104. The WHO Health Accounts Country Platform¹ provides countries with a harmonized, integrated platform for annual and timely collection of health expenditure data, with the aim of protecting the population from catastrophic health expenditure and reducing inequities in health.

Reducing prices and costs and improving efficiencies

105. Fiscal constraints require that countries select the most effective sexually transmitted infection interventions and approaches, target those activities to the populations and settings where they will have greatest impact, reduce the prices of medicines and other health commodities, and increase the efficiency of services. Programmes that can demonstrate value for money and efficiency gains are better positioned to argue for fair allocation of resources and external financial support. The potential for efficiency gains across programmes needs to be explored.

Priority actions for countries

- **Develop a costed investment case for sexually transmitted infections to ensure adequate allocation of domestic and external resources:**
 - develop financial transition plans with a special focus on the transition needs of programmes and services most reliant on external donors (that is, external to country donors – international aid or private donations)
 - develop new funding channels, such as a health promotion fund, with a negotiated portion of the revenue earmarked for sexually transmitted infection programmes and related services
 - achieve greater health equity by consolidating existing pooled funds into larger pools, thereby avoiding fragmented health insurance systems
 - use innovative financing, such as the use of special national and local taxes to support health services.
- **Implement health financing systems, financial protection schemes and other mechanisms** (such as voucher systems) that enable people to access essential, quality-assured services without suffering financial hardship:
 - phase out out-of-pocket payments (including informal user charges) and reduce other financial barriers to accessing sexually transmitted infection and other health services; ensure that health insurance schemes cover comprehensive sexually transmitted infection services
 - ensure that people's contributions to health insurance systems reflect their abilities to pay, with subsidies (financed from government tax revenue) available for poor and vulnerable people
 - ensure that financial risk protection schemes are universal, covering all populations, including those who are criminalized and marginalized.

¹ For more information on the WHO Health Accounts Country Platform, see http://www.who.int/health-accounts/platform_approach/en/ (accessed 22 April 2016).

- **Pursue comprehensive strategies to reduce prices of sexually transmitted infection commodities**, including through, where appropriate, voluntary licences, applying as appropriate, the use of the provisions in the Agreement on Trade-Related Aspects of Intellectual Property Rights regarding flexibilities to protect public health, and in accordance with the Global Strategy and Plan of Action on Public Health, Innovation and Intellectual Property, including compulsory licences and filing patent oppositions, differential pricing and direct price negotiations with manufacturers, as well as local manufacturing.
- **Increase efficiencies through improved planning and more efficient procurement** and distribution systems; adapt models of sexually transmitted infection service delivery based on the country context and epidemic, including, where appropriate, the introduction of task-shifting.

Priority actions for WHO

- **Estimate resource needs for sexually transmitted infections and advocate for a fully funded response through domestic and external support and a focus on:**
 - reduced or subsidized cost of sexually transmitted infection diagnostics and medicines; resource mobilization through existing global financial mechanisms
 - strengthening WHO's prequalification programme to safeguard and expand availability of generic products; support countries to develop investment cases and funding proposals, and support the development of national health financing plans that incorporate sexually transmitted infection programmes
 - promote the WHO Health Accounts Country Platform and support adoption by countries; explore innovative, sustainable health-financing mechanisms; provide guidance and technical support to establish robust and fair health financing systems, including the design and implementation of national compulsory health insurance.
- **Provide strategic information on prices and manufacturers of sexually transmitted infection commodities**, including through the WHO Global Price Reporting Mechanism and the Drug Regulatory Status Database; provide support to countries to strengthen their capacity to negotiate price reductions with manufacturers and to apply, where appropriate, the use of the provisions in the Agreement on Trade-Related Aspects of Intellectual Property Rights regarding flexibilities to protect public health.

4.5. STRATEGIC DIRECTION 5: Innovation for acceleration

Changing the trajectory of the response to achieve ambitious targets

106. Research and innovation provide the tools and knowledge that can change the trajectory of the sexually transmitted infection response, improve efficiency and quality, achieve equity and maximize impact. It is unlikely that the targets set for 2020 and 2030 will be achieved if countries rely only on existing knowledge, technologies and service delivery approaches.

107. Innovation is required not only to develop new technologies and approaches, but also to use existing tools more efficiently and to adapt them for different populations, settings or purposes. For example, WHO supports HIV research in: building capacity of health research systems; convening partners around priority-setting for research; setting norms and standards for good research practice; and facilitating the translation of evidence into affordable health technologies and evidence-informed policy. While having a very limited direct role in research and product development, WHO works closely with research and development partners and manufacturers to ensure that essential new HIV technologies are available and affordable to countries as soon as possible.

108. Given the critical role of partners in innovation, this strategic direction describes key areas for innovation that will require joint effort by countries, WHO and other partners. Given the 15-year time horizon for achieving the 2030 targets, short-, medium- and long-term research priorities should be considered. This strategy focuses on the short- and medium-term priorities.

Optimize sexually transmitted infection prevention

109. The main technologies for preventing sexually transmitted infections have changed little in recent times. Although male and female condoms have been proven to be effective against unintended pregnancies and sexually transmitted infections, low acceptance and incorrect or inconsistent use mean that their potential benefits are not being realized. There are major opportunities for innovations that would boost sexually transmitted infection prevention.

Optimize sexually transmitted infection diagnostics

110. New and improved diagnostics technologies, strategies and approaches would lead to earlier and more accurate diagnosis, and strengthened patient monitoring. A major barrier to advancing sexually transmitted infection control and prevention is the lack of reliable, low-cost, point-of-care tests. There are several opportunities for innovation.

Optimize medicines and treatment regimens

111. Despite major advances in the safety, potency and acceptability of medicines and regimens, there remain areas where improvements are required and possible.

Optimize service delivery

112. Overall impact is boosted when service delivery approaches fit the realities and needs of potential beneficiaries (especially hard-to-reach priority populations), minimize inefficiencies, use simplified and standard protocols, and fully engage communities. There are opportunities for further innovation in all those respects.

Priority innovations

- **Multipurpose technologies and approaches for preventing sexually transmitted infections and unintended pregnancies, especially female-controlled technologies:** male and female condoms that employ new designs and materials to increase acceptability and reduce costs, and new marketing methods to boost their demand and use; more effective behavioural and communication approaches for adolescents, in particular adolescents boys, on dual protection (prevention of pregnancy and of sexually transmitted infections and/or HIV); an increased range of vaccines for preventing the acquisition of sexually transmitted infections, especially herpes simplex virus, *C. trachomatis* and *N. gonorrhoeae* infections.
- **Innovations in service scale-up and delivery:**
 - a major scale-up of human papillomavirus and hepatitis B vaccination programmes is required alongside strengthened operational research for the introduction of vaccines
 - decentralization and task-shifting, including for earlier, accurate diagnosis and effective linkage to treatment and care
 - community-based service delivery and more acceptable models for reaching specific populations with comprehensive services
 - enhanced research on health-seeking behaviour; user-friendly services and use of mHealth for adolescents that are better suited and more acceptable
 - service linkages and integration, including clearly identifying which services would draw mutual benefit from strategic linking or integration, plus innovative mechanisms and procedures for linkage or integration.

- **Testing innovations for sexually transmitted infections:**
 - including point-of-care tests to improve the screening strategy of target populations, case management and monitoring
 - point-of-care diagnostic tests and/or self-testing technologies that are affordable, and more rapid, reliable and simpler to use
 - development of multiplex platforms, which would enable simultaneous diagnosis of several sexually transmitted infections at the same time, in particular *C. trachomatis*, *N. gonorrhoeae*, syphilis, HIV and antimicrobial resistance, as well as antimicrobial resistance and viral load
 - improved diagnosis tools for pelvic inflammatory disease
 - operational research to guide the most effective methods for introducing rapid tests in countries, and to identify major challenges and opportunities related to them.
- **Innovations to address treatment challenges and drug resistance:** more robust regimens to reduce the risk of drug resistance; new, more effective medicines for treating syphilis, gonorrhoea and herpes simplex; reducing the number of treatment doses to reduce toxicities and costs.

Priority actions for WHO

- **Develop and support public–private partnerships** to catalyse the development of new technologies, in particular point-of-care testing, multiplex platforms and the development of effective microbicides to prevent HIV and other sexually transmitted infections acquisition; and new treatment options.
- **Validation and standardization of innovative technologies and approaches**, including: new and existing diagnostic technologies and operational research in implementing point-of-care tests for sexually transmitted infection screening; dissemination of best practices describing service delivery models; guidance to countries on creating an environment that is supportive of innovation; ensuring access to affordable point-of-care tests for sexually transmitted infections, particularly in low- and middle-income countries.

5. STRATEGY IMPLEMENTATION: LEADERSHIP, PARTNERSHIPS, ACCOUNTABILITY, MONITORING AND EVALUATION

5.1 Collaboration with partners

113. WHO has an important convening role in bringing together different constituencies, sectors and organizations in support of a coordinated and coherent health sector response to sexually transmitted infections. In addition to its Member States, the Secretariat works closely with other key partners, including bilateral donor and development agencies and initiatives, funds and foundations; civil society; technical institutions and networks; the commercial private sector; and partnership networks.

5.2 Global and country accountability

114. Given the range of partners and stakeholders that join forces in an effective response, well-functioning and transparent accountability mechanisms are vital. Those mechanisms need to feature strong civil society participation. A mutual accountability process benefits from strong leadership and governance that features genuine engagement with relevant stakeholders; clear national targets that reflect the 2030 Agenda for Sustainable Development and other pertinent global commitments; appropriate indicators on the availability, coverage, quality and impact of interventions to track progress; and transparent and inclusive assessment and reporting procedures.

115. To ensure the implementation and the monitoring of the strategy in countries five key steps are proposed:

- convening a regional workshop to introduce the global health sector strategy on sexually transmitted infections, and to ensure that regional strategies tailored to regional specificity are developed and presented to the regional committees
- developing a global workplan and regional workplans
- regional meetings should invite countries to review the global health sector strategy and the workplans to adapt them to the country context and to elaborate a timeline towards the implementation of the strategy on sexually transmitted infection
- holding joint country workshops on sexual and reproductive health, HIV and viral hepatitis to plan on where and how sexually transmitted infection services should be integrated
- strengthening the country monitoring system to permit report on progress and impact of the sexually transmitted infection strategy implementation.

5.3 Monitoring, evaluating and reporting

Monitoring and reporting of progress towards global goals and targets

116. At the global level, regular reviews are planned to assess progress on the various commitments and targets. These reviews will build on the data that countries report through various monitoring and evaluation mechanisms.

117. Progress at global and regional levels towards the targets set out in this strategy will be regularly assessed. Benchmarking – or comparisons between and within countries – will also be used to assess performance in reaching targets. The strategy is designed to be sufficiently flexible to incorporate additional priorities or fill newly identified gaps in the health sector response to sexually transmitted infection. To that end, WHO will continue to work with its partners to provide support to countries for the harmonized and standardized collection of core indicators, and in the preparation of global and regional reports. Regular reporting of the data is proposed.

118. WHO will develop a suitable monitoring and accountability framework for the strategy in consultation with key stakeholders. It will also monitor and share data on the uptake of its sexually transmitted infection guidelines, as well as on progress in implementation of the strategy, in order to highlight barriers and promote best practices.

Monitoring and evaluating the response at country level

119. Progress in implementing the health sector response to sexually transmitted infections is to be assessed with indicators on availability, coverage outcome and impact, while taking into consideration other relevant recommendations for monitoring implementation. In the context of the 2030 Agenda for Sustainable Development, progress on the health-related Sustainable Development Goals will be tracked and reported.

120. Indicators for monitoring the strengthening of health systems derive from a common platform for monitoring and evaluating national health strategies, known as the Country Health Systems Surveillance platform, coordinated by WHO. Instruments are also available for measuring progress in implementing policy, legal and structural measures for enhancing the HIV and sexually transmitted infection responses.

WHO's framework for results-based management

121. Workplan implementation is monitored through a mid-term review at the end of the first year of each biennium. Progress on the achievement of the Organization-wide expected results is reported at the end of each biennium.

5.4 Implementing the strategy at the national level

122. The global strategy is intended to guide the development and implementation of national sexually transmitted infection strategies. Broad buy-in through the preparation process will assist in effective implementation, with technical assistance provided through WHO and development partners in support of national strategy development and building the case for investment. In order to enable country ownership, national sexually transmitted infection strategies or plans should be aligned with existing plans, such as national development plans, national health sector strategies and other disease strategies. They should also, to the extent possible, align with national planning and financial cycles (see Figure 9).

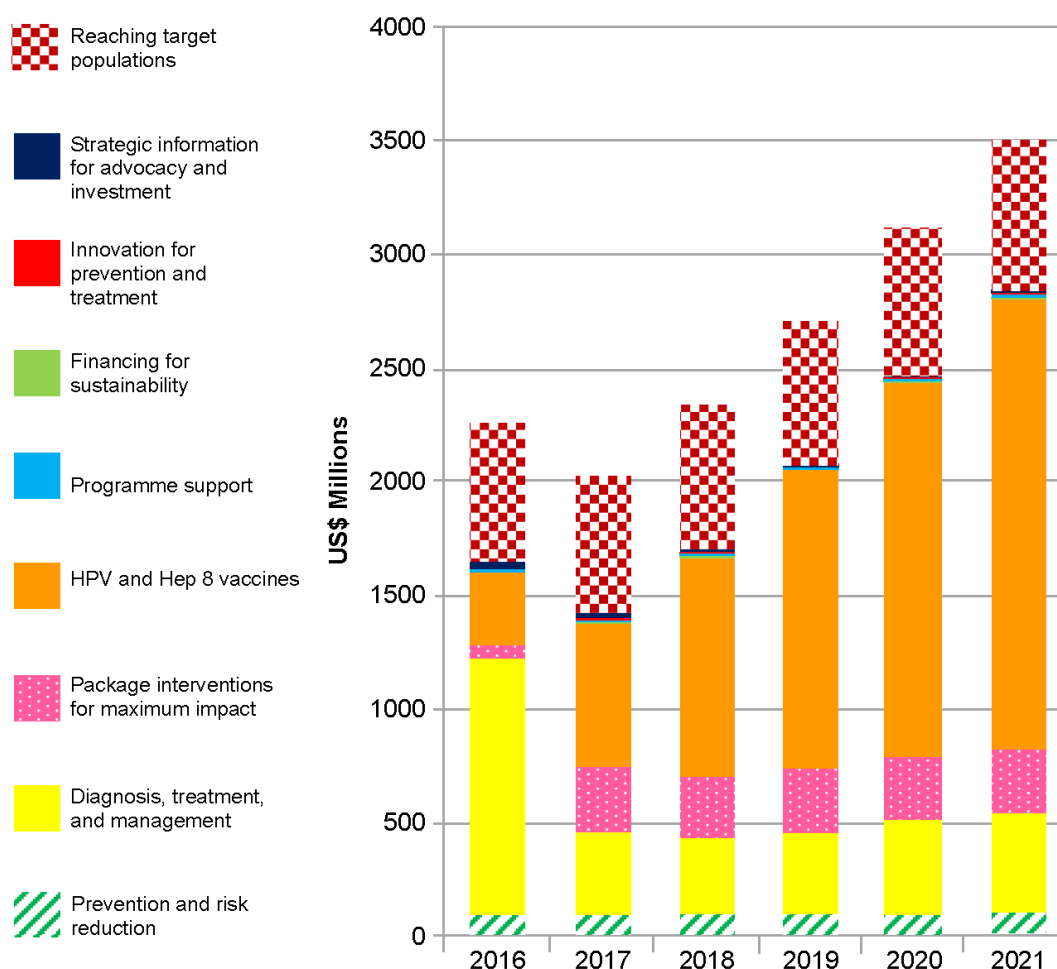
Figure 9. Planning and financial cycles

5.5 Costing estimates for implementing the strategy

123. Full achievement of the global health sector strategy on sexually transmitted infections, 2016–2021 will cost an estimated US\$ 18 200 million for the five years, of which 99.7% is for implementing priority interventions in 117 low- and middle-income countries, and almost US\$ 53 million (0.3%) is for global-level technical support, research and advocacy by WHO and partners (see Figure 10).

124. Cost drivers are sexually transmitted infection vaccination (US\$ 3260 million), sexually transmitted infection screening (US\$ 3690 million), adolescent chlamydia screening (US\$ 2540 million), and syphilis screening in antenatal care services (US\$ 1400 million). Clinical sexually transmitted infection management is costed for an overall US\$ 3000 million, of which service delivery makes up US\$ 818 million, and diagnostic testing for gonorrhoea and chlamydia US\$ 1400 million.

125. Within global-level activities prioritized, the biggest costs are for the development of point-of-care tests to improve affordable sexually transmitted infection screening, operational research, and guidance on sexually transmitted infection surveillance. Global costs increase from US\$ 2600 million in 2016 to US\$ 4000 million in 2021, driven by incremental scale-up of sexually transmitted infection vaccination and treatment (Figure 10).

Figure 10. Costing of the global health sector strategy on sexually transmitted infections, 2016–2021

126. Sub-Saharan Africa, bearing 40% of the global burden of sexually transmitted infection, covers 44% of the need for services and 30% of global control cost related to sexually transmitted infection. The Western Pacific Region, with 15% of global sexually transmitted infection burden, makes up 15% of sexually transmitted infection service needs and 26% of global control cost. The South-East Asia Region covers 20% of global sexually transmitted infection burden and 18% of global cost. Across the 117 countries, 26% of service volumes/need and 15% of costs are in low-income countries; 47% of service need and 39% of cost in lower middle-income countries, and 27% of service need and 46% of cost in upper middle-income countries.

127. These estimates build on WHO's estimates of regional burdens of disease due to *C. trachomatis*, *N. gonorrhoeae*, *Treponema pallidum* and *Trichomonas vaginalis* as of 2012, and declines in sexually transmitted infection rates assumed to start in 2018 in line with the strategy's target for 2030. Clinical management is costed for these curable sexually transmitted infections, as well as for herpes simplex virus type 2, bacterial vaginosis and *Mycoplasma genitalium*, using the strategy's recommendation to continue syndromic case management and expand etiologic testing where feasible and cost-effective.

128. Human papillomavirus vaccination of girls and screening of women of reproductive age will generate considerable health care and productivity savings in future years by preventing cervical cancers. Benefits from improving sexually transmitted infection control and reducing sexually transmitted infection rates by 90% according to the strategy's target for 2030 will further include health care savings from future sexually transmitted infection episodes averted that incur economic productivity losses, morbidity and mortality due to sexually transmitted infection-attributable infertility, pregnancy and congenital complications and psychosocial impacts.

129. The costing foresees considerable reductions in prices for human papillomavirus vaccines (across all income tiers), and chlamydia diagnostic tests, assumed to be effective from 2016. Global costs critically depend on these assumed price declines, and could be lower if further price reductions were to be achieved within the strategy horizon.

130. Investment in point-of-care test development will generate future savings by lowering sexually transmitted infection diagnostic and screening costs, and improving case management (shifting from syndromic to etiologic approach) and detection of asymptomatic sexually transmitted infection, thus contributing to lower sexually transmitted infection burdens. In addition, investment in vaccines other than against human papillomavirus could in future greatly enhance reductions in sexually transmitted infection transmission.

131. Implementation of sexually transmitted infection control is expected to be funded from country domestic resources through health systems, and human papillomavirus vaccination through national immunization programmes (with donor support for vaccine procurement, which covers around 70% of vaccination cost in countries eligible for funding through the GAVI Alliance.¹ Costing did not include activities shared with HIV programmes, such as prevention education and sexually transmitted infection screening delivered in the context of HIV prevention. In addition to leveraging HIV prevention budgets, sexually transmitted infection initiatives will need to leverage funds from maternal, child and adolescent health interventions and immunization programmes. There is a need for a more integrated response to enhance synergies across programmes. Low-income countries will need (continuation of, and increasing) international donor support, whereas upper middle-income countries could be expected to mobilize required funding internally, if national sexually transmitted infection strategies are articulated and budgeted. Political commitment, backed by the financial commitments of both resource-poor as well as donor countries, is crucial to global efforts to eliminate sexually transmitted infections.

¹ For information on the GAVI Alliance, see <http://www.gavi.org/> (accessed 22 April 2016).

ANNEX 9

[A69/39 – 15 April 2016]

Framework on integrated people-centred health services¹

[Paragraphs 1-10 set out the background and the consultative process for the development of this framework.]

11. The framework on integrated people-centred health services in brief sets forth a compelling vision in which “all people have equal access to quality health services that are co-produced² in a way that meets their life course needs, are coordinated across the continuum of care, and are comprehensive, safe, effective, timely, efficient and acceptable; and all carers are motivated, skilled and operate in a supportive environment”. The framework is based on experience and evidence gained recently in different countries and wide-ranging consultation with experts at the global, regional and national levels, informed by related global policy commitments, regional strategies and initiatives in the area of universal health coverage, health systems strengthening, social determinants of health, and the core values and principles of primary health care: the right to health, social justice, solidarity and participation.

12. Realization of integrated people-centred health services will depend on health system inputs, including the availability, accessibility and quality of health workers and the services they provide. The global strategy on human resources for health outlines the medium-term actions needed to ensure equitable access to a skilled and motivated health workforce within a fully functioning health system. As such, efforts have been made to form firm links between the framework on integrated, people-centred health services and the global strategy, including aligning human resources for health investment frameworks at national and global levels to future needs of health systems. Integrated, people-centred health services require particular health workers with relevant skills. In addition to the benefits to communities and populations, the benefits of an integrated people-centred care approach also extend to health workers, including: improved job satisfaction; more balanced workloads and fewer instances of burnout; and education and training opportunities to learn new skills, such as working in team-based health care environments.

13. For the development of this framework, four different types of country settings have been analysed: low-, middle- and high-income countries, and countries facing special circumstances, such as conflict, and fragile States, small island States and large federal States. Given that health systems are highly context-specific, the framework does not propose a single model of people-centred and integrated health services. Instead, it proposes five interdependent strategies that need to be adopted.

¹ See resolution WHA69.24 (2016).

² **Definition: co-production of health:** care that is delivered in an equal and reciprocal relationship between professionals, people using care services, their families and the communities to which they belong. It implies a long-term relationship between people, providers and health systems where information, decision-making and service delivery become shared.

STRATEGIES, POLICY OPTIONS AND INTERVENTIONS

14. The five interdependent strategies are: (1) empowering and engaging people and communities; (2) strengthening governance and accountability; (3) reorienting the model of care; (4) coordinating services within and across sectors; and (5) creating an enabling environment. Attainment of these five strategies cumulatively will help to build more effective health services; lack of progress in one area will potentially undermine progress in other areas.

15. Action towards each strategy is intended to have an influence at different levels – from the way services are delivered (to individuals, families and communities) to changes in the way organizations, care systems and policy-making operate. Strategic approaches, potential policy options and interventions are detailed in the Table for the attainment of each strategy. Some of these potential policy options and interventions are cross-cutting for several strategic approaches. This non-exhaustive list has been drafted on the basis of literature reviews, input from technical consultations and expert opinion; it does not constitute a set of evidence-based guidelines for reform, as the evidence base for some of these policies and interventions is not fully established. Moreover, the appropriate mix of policies and interventions to be used at the country level will need to be designed and developed according to the local context, values and preferences.

Table. Strategies, policy options and interventions for the framework on integrated, people-centred health services

Strategy 1: Empowering and engaging people and communities

Empowering and engaging people is about providing the opportunity, skills and resources that people need to be articulate and empowered users of health services and advocates for a reformed health system. This strategy seeks to unlock community and individual resources for action at all levels. It aims to empower individuals to make effective decisions about their own health and to enable communities to become actively engaged in co-producing healthy environments, and to provide informal carers with the necessary education to optimize their performance and support in order to continue in their role. Empowering and engaging people is also about reaching the underserved and marginalized groups of the population in order to guarantee universal access to and benefit from quality services that are co-produced according to their specific needs.	
Strategic approach	Policy options and interventions
1.1 <i>Empowering and engaging individuals and families.</i> In order to achieve better clinical outcomes through co-production of care, particularly for noncommunicable and chronic diseases, individuals and families need to be active participants. This step is fundamental because people themselves will spend the most time living with and responding to their own health needs and will be the ones making choices regarding healthy behaviours and their ability to self-care. Empowerment is also about care that is delivered in an equal and reciprocal relationship between, on the one hand, clinical and non-clinical professionals and, on the other, the individuals using care services, their families, and communities, thereby improving their care experience.	<ul style="list-style-type: none"> • health education¹ • informed consent • shared clinical decision making between individual, families, carers and providers • self-management including personal care assessment and treatment plans • knowledge of health system navigation

¹ **Definition: health education:** any combination of learning experiences designed to help individuals and communities to improve their health, by increasing their knowledge or influencing their attitudes.

<p>1.2 <i>Empowering and engaging communities.</i> This approach will enable communities to voice their needs and so influence the way in which care is funded, planned and provided. It will help to build confidence, trust, mutual respect and the creation of social networks, because people's physical and mental well-being depends on strong and enduring relationships. It strengthens the capacity of communities to organize themselves and generate changes in their living environments.</p>	<ul style="list-style-type: none"> • community delivered care • community health workers • development of civil society • strengthened social participation in health
<p>1.3 <i>Empowering and engaging informal carers.</i> Family members and other care-givers play a critical role in the provision of health care. Carers must receive adequate training in order to be able to provide high quality interventions, and to serve as advocates for the recipients of care, both within the health system and at the policy level. Additionally, carers have their own needs for personal fulfilment and require emotional support to sustain their role.</p>	<ul style="list-style-type: none"> • training for informal carers • informal carer networks • peer support and expert patient groups • caring for the carers • respite care
<p>1.4 <i>Reaching the underserved and marginalized.</i> This approach is of paramount importance for guaranteeing universal access to quality health services. It is essential for fulfilling broader societal goals such as equity, social justice and solidarity, and helps to create social cohesion. It requires actions at all levels of the health sector, and concerted action with other sectors and all segments of society, in order to address the other determinants of health and health equity.</p>	<ul style="list-style-type: none"> • integration of health equity goals into health sector objectives • provision of outreach services for the underserved including mobile units, transport systems and telemedicine • outreach programmes for disadvantaged/marginalized populations, who may not receive effective coverage owing to barriers linked to factors that include income, education, residence, gender, ethnicity, working conditions or migrant status • contracting out of services when warranted • expansion of primary care-based systems

Strategy 2: Strengthening governance and accountability

<p>Strengthening governance requires a participatory approach to policy formulation, decision-making and performance evaluation at all levels of the health system, from policy-making to the clinical intervention level. Good governance is transparent, inclusive, reduces vulnerability to corruption and makes the best use of available resources and information to ensure the best possible results. Good governance is reinforced by a robust system for mutual accountability among policy-makers, managers, providers and users and by incentives aligned with a people-centred approach. Establishing a strong policy framework and a compelling narrative for reform will be important to building a shared vision, as well as setting out how that vision will be achieved.</p>	
Strategic approach	Policy options and interventions
<p>2.1 <i>Bolstering participatory governance.</i> Robust governance mechanisms are needed in order to achieve a coherent and integrated approach in health care policy, planning and delivery at all levels of the health system. Governments need to take responsibility for protecting and enhancing the welfare of their populations and to build trust and legitimacy with citizens through effective stewardship. The stewardship role of the health ministry is essential for good governance in health, and involves the identification and participation of community stakeholders so that voices are heard and consensus is achieved. It is also needed to ensure that the different goals of donor agencies and vertical</p>	<ul style="list-style-type: none"> • community participation in policy formulation and evaluation • community representation at health care facilities' boards • national health policies, strategies and plans promoting integrated people-centred health services • strengthened health services governance and management at subnational, district and local levels

<p>programmes tackling specific diseases do not hinder the ability of health systems to focus on community health and well-being for all.</p>	<ul style="list-style-type: none"> • harmonization and alignment of donor programmes with national policies, strategies and plans • decentralization, where appropriate, to local levels • comprehensive planning across the public/private sector • strengthened stewardship role of the health ministry in respect of non-State actors • clinical governance
<p>2.2 <i>Enhancing mutual accountability.</i> Essentially, this means answerability of decision-making, and encompasses both the “rendering of the account” (that is, providing information about performance) and the “holding to account” (namely, the provision of rewards and sanctions). Strengthening accountability of health systems requires joint action at all levels to improve services organization and delivery, health policy in health and non-health sectors, public and private sectors, and people, towards a common goal.</p>	<ul style="list-style-type: none"> • health rights and entitlement • provider report cards • patient satisfaction surveys • patient reported outcomes and balanced scorecard • performance based financing and contracting • population registration with accountable care provider(s)

Strategy 3: Reorienting the model of care

<p>Reorienting the model of care means ensuring that efficient and effective health care services are designed, purchased and provided through innovative models of care that prioritize primary and community care services and the co-production of health. This encompasses the shift from inpatient to outpatient and ambulatory care and from curative to preventive care. It requires investment in holistic and comprehensive care, including health promotion and ill-health prevention strategies that support people’s health and well-being. It also respects gender and cultural preferences in the design and operation of health services.</p>	
Strategic approach	Policy options and interventions
<p>3.1 <i>Defining service priorities based on life course needs.</i> This approach means appraising the package of health services offered at different levels of the care delivery system based on the best available evidence, covering the entire life course. It uses a blend of methods to understand both the particular health needs of the population, including social preferences, and the cost-effectiveness of alternative health interventions, guiding decision making on allocation of resources to health care. It also includes health technology assessment.</p>	<ul style="list-style-type: none"> • local health needs assessment based on existing patterns of communicable and noncommunicable diseases • comprehensive packaging of services for all population groups defined by means of a participatory and transparent process • strategic purchasing • gender, cultural and age-sensitive services • health technology assessment
<p>3.2 <i>Revaluing promotion, prevention and public health.</i> This approach means placing increased emphasis and resources on promotive, preventive and public health services. Public health systems include all public, private, and voluntary entities that contribute to the delivery of essential public health functions within a defined geographical area.</p>	<ul style="list-style-type: none"> • monitoring population health status • population risk stratification • surveillance, research and control of risks and threats to public health • improved financial and human resources allocated to health promotion and disease prevention • public health regulation and enforcement
<p>3.3 <i>Building strong primary care-based systems.</i> Strong primary care services are essential for reaching the entire population and guaranteeing universal access to services. Building such services involves ensuring adequate funding, appropriate training, and connections to other services and sectors. This approach promotes coordination and continuous</p>	<ul style="list-style-type: none"> • primary care services with a family and community-based approach • multidisciplinary primary care teams • family medicine • gatekeeping to access other specialized services

care over time for people with complex health problems, facilitating intersectoral action in health. It calls for interprofessional teams to ensure the provision of comprehensive services for all. It prioritizes community and family-oriented models of care as a mainstay of practice with a focus on disease prevention and health promotion.	<ul style="list-style-type: none"> • greater proportion of health expenditure allocated to primary care
3.4 <i>Shifting towards more outpatient and ambulatory care.</i> Service substitution is the process of replacing some forms of care with those that are more efficient for the health system. The approach means finding the right balance between primary care, specialized outpatient care and hospital inpatient care, recognizing that each has an important role within the health care delivery system.	<ul style="list-style-type: none"> • home care, nursing homes and hospices • repurposing secondary and tertiary hospitals for acute complex care only • outpatient surgery • day hospitals • progressive patient care
3.5 <i>Innovating and incorporating new technologies.</i> Rapid technological change is enabling the development of increasingly innovative care models. New information and communication technologies allow new types of information integration. When used appropriately, they can assure continuity of information, track quality, facilitate patients' empowerment and reach geographically isolated communities.	<ul style="list-style-type: none"> • shared electronic medical record • telemedicine • mHealth

Strategy 4: Coordinating services within and across sectors

<p>Services should be coordinated around the needs and demands of people. This result requires integration of health care providers within and across health care settings, development of referral systems and networks among levels of care, and the creation of linkages between health and other sectors. It encompasses intersectoral action at the community level in order to address the social determinants of health and optimize use of scarce resources, including, at times, through partnerships with the private sector. Coordination does not necessarily require the merging of the different structures, services or workflows, but rather focuses on improving the delivery of care through the alignment and harmonizing of the processes and information among the different services.</p>	
Strategic approach	Policy options and interventions
4.1 <i>Coordinating care for individuals.</i> Coordination of care is not a single activity, but rather a range of strategies that can help to achieve better continuity of care and enhance the patient's experience with services, particularly during care transitions. The focus for improvement is on the delivery of care to the individual, with services coordinated around their needs and those of their families. This approach also covers improved information flows and maintenance of trustworthy relationships with providers over time.	<ul style="list-style-type: none"> • care pathways • referral and counter-referral systems • health navigators • case management • improved care transition • team-based care
4.2 <i>Coordinating health programmes and providers.</i> This approach includes bridging the administrative, informational and funding gaps between levels of care and providers. This involves sector components such as pharmaceutical and product safety regulators, information technology teams working with disease surveillance systems, allied health teams delivering treatment plans in collaboration with each other, disease-specific laboratory services linked to broader services improvement, and provider networks focused on closer relationships in patient care.	<ul style="list-style-type: none"> • regional or district-based health service delivery networks • purchasing integrated services • integrating vertical programmes into national health systems • incentives for care coordination

<p>4.3 <i>Coordinating across sectors.</i> Successful coordination in health matters involves multiple actors, both within and beyond the health sector. It encompasses sectors such as social services, finance, education, labour, housing, the private sector and law enforcement, among others. It necessitates strong leadership from the health ministry to coordinate intersectoral action, including coordination for early detection and rapid response to health crises.</p>	<ul style="list-style-type: none"> • health in all policies • intersectoral partnerships • merging of health sector with social services • working with education sector to align professional curriculum towards new skills needed • integrating traditional and complementary medicine with modern health systems • coordinating preparedness and response to health crises
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Strategy 5: Creating an enabling environment

<p>In order for the four previous strategies to become an operational reality, it is necessary to create an enabling environment that brings together all stakeholders to undertake transformational change. This complex task will involve a diverse set of processes to bring about the necessary changes in leadership and management, information systems, methods to improve quality, reorientation of the workforce, legislative frameworks, financial arrangements, and incentives.</p>	
Strategic approach	Policy options and interventions
<p>5.1 <i>Strengthening leadership and management for change.</i> New forms of collaborative leadership that help to bring together multiple stakeholders are needed for successful reform of health services. All health care professionals, and especially clinicians, need to be engaged in management and leadership for change in continuous partnership with local communities. Achieving people-centred and integrated care requires the application of complex processes and service innovations that warrant an underlying change management strategy.</p>	<ul style="list-style-type: none"> • transformational and distributed leadership • change management strategies
<p>5.2 <i>Strengthening information systems and knowledge management.</i> Development of information systems and an organizational culture that supports monitoring and evaluation, knowledge sharing and using data in decision-making is also a prerequisite for transformational change.</p>	<ul style="list-style-type: none"> • development of information systems • systems research • knowledge management
<p>5.3 <i>Striving for quality improvement and safety.</i> Institutions and providers need to strive constantly for quality improvement and safety. These efforts include both technical and perceived quality.</p>	<ul style="list-style-type: none"> • quality assurance • creating a culture of safety • continuous quality improvement
<p>5.4 <i>Reorienting the health workforce.</i> Special attention needs to be given to readying the health workforce with an appropriate skills mix in order equitably and sustainably to meet population health needs. Health workers must be organized around teams and supported with adequate processes of work, clear roles and expectations, guidelines, opportunities to correct competency gaps, supportive feedback, fair wage, and a suitable work environment and incentives.</p>	<ul style="list-style-type: none"> • tackling health workforce shortages and maldistribution • health workforce training • multi-professional teams working across organizational boundaries • improving working conditions and compensation mechanisms • provider support groups • strengthening professional associations
<p>5.5 <i>Aligning regulatory frameworks.</i> Regulation plays a key role in establishing the rules within which professionals and organizations must operate within more people-centred and integrated health systems – for example, in terms of setting new quality standards and/or paying against performance targets.</p>	<ul style="list-style-type: none"> • aligning regulatory framework

<p>5.6 <i>Improving funding and reforming payment systems.</i> Changes in the way care is funded and paid for are also needed to promote adequate levels of funding and the right mix of financial incentives in a system that supports the integration of care between providers and settings and protection of patients against undue out-of-pocket expenditures on health.</p>	<ul style="list-style-type: none"> • assuring sufficient health system financing and aligning resource allocation with reform priorities • mixed payment models based on capitation • bundled payments
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IMPLEMENTATION APPROACH

16. The lessons of history need to be acknowledged: the successful reorientation of health services will most likely be a long journey and will need sustained political commitment. Ultimately, each country or local jurisdiction needs to set its own goals for integrated and people-centred health services, and develop its own strategies for achieving these goals. The strategies must respond to the local context, existing barriers and the values held by people within the State or area, and should be achievable given the current health service delivery system and the financial and political resources available. Efforts should primarily concentrate on improving access to services for underserved and marginalized populations, on placing increased emphasis and resources on promotive, preventive and public health services and on strengthening district-level health services, among others. Given that this framework is fundamentally transformative in its implications for the future of health systems, system leaders must adopt strategies for change to ensure the effective alignment of strategies and processes that promote people-centred and integrated care. Delivering high-quality, people-centred care and integrated health services requires the creation and nurturing of collective engagement, commonly-held values, effective communication and transparency. The implementation approach, therefore, of this framework is as follows:

- (a) Country-led: strategies for pursuing integrated people-centred health services should be developed and led by countries, with external support where necessary, and should respond to local conditions and contexts.
- (b) Equity-focused: efforts to enhance equity are a necessary part of people-centred and integrated health care strategies. Efforts can target immediate factors driving inequitable service utilization, but may also address more fundamental social determinants.
- (c) Participatory: the notion of people-centred and integrated health services puts informed and empowered people at the centre of the health system. Therefore, processes to develop national strategies for such services should ensure accountability to local stakeholders and, especially, to disadvantaged populations.
- (d) Systems strengthening: service delivery depends on effective information and financing systems, and the availability of skilled and motivated health workers. Changes made to service delivery will inevitably have ramifications across the entire health system.
- (e) Evidence-based practice with iterative learning/action cycles: decisions at all levels should be based on the best available evidence. Quality improvement methodology shows that success is most likely when there are iterative learning and action cycles that track changes in the service delivery system, identify emerging problems and bring stakeholders together to solve them.
- (f) Results-oriented: a key focus should be on the ongoing monitoring of progress through specific and measurable objectives and results.

(g) Ethics-based: by making sure that care optimized the risk benefit ratio in all interventions, respects the individual's right to make informed and autonomous decisions, safeguards privacy, protects the most vulnerable, and ensures the fair distribution of resources.

(h) Sustainable: planning, managing and delivering care that is equitable, efficient, effective and that contributes to long-term development in a sustainable manner.

THE ROLE OF STAKEHOLDERS

17. The role of stakeholders in this framework is as follows:

(a) Member States: countries committed to moving towards people-centred and integrated health services should develop and communicate a clear vision, setting sound strategies and regulatory frameworks that facilitate the way towards their achievement. This process needs to be country-led and involves co-production between all government sectors, providers and the people that they serve. Governments need to secure adequate funding for reform and implementation research. This process has to be replicated at both subnational and local levels.

(b) Individuals, families and communities: they constitute the main focus of attention of the framework. Policy formulation, health services organization and co-production of health services should be developed and implemented in partnership with individuals, families and communities.

(c) Civil society organizations: as representatives of patients, families, communities and carers, these organizations have an important role to play in advocating for more people-centred and integrated health services, as well as in empowering their members to be able to better manage their own health concerns and engage with the health system.

(d) Health service providers: these constitute a fundamental component of the framework. Policy formulation, health services organization and co-production of health services should be developed and implemented in partnership with service providers, as in the case of individuals, families and communities.

(e) Academic, training and research institutions: these bodies have an important role to play in developing new professional curricula for the health workforce, training the health workforce, and conducting health systems and implementation research efforts.

(f) Professional and students associations: these organizations can play important roles in adopting and endorsing new practices, and in providing support to their members.

(g) Private sector: regulatory steps should be taken to assure that reforms to increase care integration and people-centredness apply equally to public and private service providers, including for profit, non-for-profit, and faith-based organizations. Partnerships with private sector industry, such as pharmaceutical and medical device industries, can also be pursued when appropriate.

(h) Health insurers: these entities should guarantee sufficient financing for service delivery reform and reorient payment systems and purchasing practices to incentivise more integrated, people-centred approaches to care.

- (i) Development partners: these should, except under exceptional circumstances where rapid or unique action is required, seek to integrate their support to health service delivery into countries' own health systems. They can also help to share technical knowledge about different approaches to promoting more people-centred and integrated services.
- (j) Secretariat: the role of the Secretariat will be to drive policies that can support the development of people-centred and integrated health services across the world. The adoption of integrated people-centred health services, and the five key strategies identified in this framework, will therefore require sustained advocacy and technical cooperation efforts.

PROGRESS MONITORING

18. As the framework represents a new programme of work for WHO, there are no universally utilized indicators to measure progress in establishing integrated people-centred health services. The Global Health Observatory, the monitoring and evaluation frameworks for universal health coverage and the Sustainable Development Goals, and the Global Reference List of 100 Core Health Indicators¹ – none includes measures of integration or people-centredness. Given this situation, the framework proposes performing research and development on indicators to track global progress on integrated people-centred health services. This effort will convene international partners to develop appropriate metrics for these critical, but less frequently measured domains of health care.

19. The elaboration of these indicators will facilitate the development of the medium- and long-term goals and targets that are needed to monitor progress in the implementation of the framework at the global, regional and national levels.

¹ See <http://www.who.int/healthinfo/indicators/2015/en/> (accessed 4 April 2016).

ANNEX 10

WHO Health Emergencies Programme¹

[A69/30 – 5 May 2016]

[Paragraph 1 sets out the background.]

2. The new WHO Health Emergencies Programme represents a fundamental development for the Organization, complementing WHO's traditional technical and normative role with new operational capacities and capabilities for its work in outbreaks and humanitarian emergencies. The new Programme is designed to bring speed and predictability to WHO's emergency work, using an all-hazards approach, promoting collective action, and encompassing preparedness, readiness, response and early recovery activities. The new Programme is aligned with the principles of a single programme, with one clear line of authority, one workforce, one budget, one set of rules and processes, and one set of standard performance metrics.

3. All WHO's work in emergencies is thus brought into a single programme, with a common structure across headquarters and all regional offices in order to optimize intra-agency coordination, operations and information flow. Relevant functions of the Programme are replicated at country level, as appropriate. The common structure reflects WHO's major functions in health emergency risk management, as follows:

- *Infectious hazards management*: this includes high threat pathogens, expert networks and, at headquarters, the secretariat of the Pandemic Influenza Preparedness Framework;
- *Country health emergency preparedness and the International Health Regulations (2005)*: this includes monitoring and evaluation of national preparedness capacities, planning and capacity building for critical capacities and, at headquarters, the secretariat of the International Health Regulations (2005);
- *Health emergency information and risk assessments*: this includes event detection and verification, health emergency operations monitoring, and data management and analytics;
- *Emergency operations*: this includes incident management functions, operational partnerships and readiness, and operations support and logistics;
- Emergency operations management and administration, and external relations.

4. A standing interdepartmental task force at headquarters and regional office levels enables the programme to harness the broad range of expertise across WHO's technical programmes and networks, particularly for research and development, policy, capacity building for preparedness, health systems strengthening, and protracted crises planning and programming. Those linkages are operationalized

¹ See decision WHA69(9) (2016).

through mechanisms, such as the WHO blueprint for accelerating research and development in epidemics or health emergency situations.

5. The Programme is headed by an Executive Director. The Executive Director, recruited through an international competitive process, serves at the level of Deputy Director-General and reports to the Director-General. The Director-General enlisted an executive search firm to assist in the selection process, which was completed before the Sixty-ninth World Health Assembly took place in May 2016. The Executive Director is responsible for technical oversight and standards, all strategic and operational planning, risk and performance monitoring, budget and staff planning, and interagency and partner relations. The Regional Directors are central to the success and implementation of the Programme, particularly by providing leadership in the application and enforcement of Programme standards, government and regional intergovernmental relations, interagency and partner relations at regional level, and the day-to-day management of emergency management activities in their regions. The Executive Director and Regional Directors will jointly recruit Regional Emergency Directors, who will have delegated authority for emergency activities in their regions and form part of the global management team of the new Programme.

6. Ultimate authority for WHO's work in emergencies rests with the Director-General. The day-to-day oversight and management of major outbreaks and health emergencies, including WHO Grade 3 events, Public Health Emergencies of International Concern and Level 3 emergencies under the United Nations Inter-Agency Standing Committee, is delegated to the Executive Director, to optimize the operational support of the entire Organization. The Director-General delegates oversight and management of Grade 2 crises and major protracted crises, following a rapid, accurate and objective risk assessment under the Executive Director, to either the Executive Director or the relevant Regional Director, depending on the nature of the infectious hazard or health emergency event, the capacity and capabilities of the countries concerned, and of the WHO country offices and regions, and the degree of internationally coordinated support that is required. The Director-General delegates oversight and day-to-day management of organizational readiness, Member State preparedness, long-standing protracted emergencies and Grade 1 response activities to Regional Directors. On a day-to-day basis, the Regional Emergency Directors will report to their respective Regional Directors on the implementation of these emergency management activities in their regions and to the Executive Director on issues of policy, strategy and operational planning related to such activities. In the management of graded emergencies, the reporting lines for the Regional Emergency Directors are aligned with the delegated authorities from the Director-General to the Regional Director or Executive Director. Regardless of the grade of an emergency, the Executive Director and relevant Regional Director will be kept fully apprised of the evolving risks and the performance of the response.

7. WHO Representatives and country offices have important responsibilities for implementing and facilitating the activities of the WHO Health Emergencies Programme, with their performance measured against standardized indicators. As part of their basic duties, all WHO Representatives have mandatory responsibility for ensuring organizational and partnership readiness for the initial response to acute onset emergencies and, in the context of the International Health Regulations (2005), for supporting States Parties in key functions, particularly with respect to National Focal Points, monitoring and evaluation of core capacities, and the immediate notification and/or verification of newly detected or reported events. All WHO Representatives are responsible for facilitating objective, joint external evaluations and in-country risk assessments, as needed, under the responsibility of the Executive Director. In high-vulnerability, low-capacity countries, WHO offices will have dedicated staff to support Member States with their work in all-hazards preparedness and response capacity building. In settings of protracted crises, WHO will strengthen its in-country leadership, ensuring that, over time, all WHO Representatives receive the training given to Humanitarian Coordinators. Where health clusters have been activated, priority is being given to deploying long-term, properly trained Health Cluster Coordinators with sufficient staff to fulfil core cluster functions. For large-scale

emergencies and high risk outbreaks, an Incident Manager and team will be appointed and deployed to complement the capacities of the Representative and country team.

8. A single, common results framework has been developed for the new Programme in order to standardize planning, budgeting, staffing, monitoring and feedback across all seven major offices and all 147 WHO country offices. The results framework reflects each of the major functions (and structure) of the Programme, articulates the major outcomes and outputs, and serves as the basis for a single budget and staff workplan. The development of the single budget and staff plan for the new Programme is the responsibility of the Executive Director, in consultation with Regional Directors, senior staff, and relevant WHO Representatives. The budget and staff plan will be submitted to the Director-General for decision. Day-to-day management of staff at regional and country levels is through the Regional Director. In a major outbreak or acute emergency, the Executive Director will establish and manage a budget and workforce across WHO through the Incident Management structure. For major risk assessments and responses, the Executive Director has the authority to relocate Programme staff from anywhere in the Organization within 72 hours. The Executive Director will consult with the Director-General, Regional Directors and Assistant Directors-General for the release of other WHO staff.

9. The WHO Emergency Response Framework will be revised and updated, and serve as a single, common, all-hazards set of emergency management processes for WHO's work in organizational readiness, risk assessment and response. New, standard processes have already been developed for risk assessments, grading of events, and incident management. All major infectious risks and all major emergencies with health consequences – including outbreaks – will be assessed and/or graded by WHO using those standardized processes. All these standards are closely aligned with the processes in use by the wider humanitarian and crisis management system. The Executive Director will submit the outcomes of all major risk assessments and event gradings to the Director-General within 24 hours for decisions on grade, incident management, and leadership, in consultation with Regional Directors. The single incident management system is increasingly improving the predictability and interoperability of WHO response activities. WHO country office readiness, including with local partners, will be assessed using a standardized format. Performance standards will be established or updated for each process.

10. Recognizing the special importance of rapid, accurate and objective assessments of risks that are of potentially high consequences, the Programme, under the Executive Director, will initiate an on-the-ground assessment within 72 hours, once notified of a high threat pathogen (for example, human-to-human transmission of a novel influenza virus), clusters of unexplained deaths in high-vulnerability/low-capacity settings, and other events deemed appropriate at the discretion of the Director-General. When feasible, the Programme will engage partner agencies with relevant expertise to participate in such risk assessments. The assessments will include an analysis of the capacity and capability of the countries concerned, and of the WHO country office and region. As with all risk assessments, the outcomes will be communicated to the Director-General through the Executive Director within 24 hours of completion of the assessment, together with recommendations of the WHO Health Emergencies Programme on risk mitigation, management and/or response measures, as appropriate. The outcomes of such risk assessments will be shared with Member States through their respective National Focal Points for the International Health Regulations (2005), or other channels, as appropriate to the circumstances, and to the United Nations Inter-Agency Standing Committee and WHO Emergencies Oversight and Advisory Committee.

11. WHO's work in support of Member State preparedness will be aligned with the recommendations of the Review Committee on the Role of the International Health Regulations (2005)

in the Ebola Outbreak and Response¹ and the Sendai Framework for Disaster Risk Reduction 2015–2030. It is expected that the Programme’s work in preparedness will be structured to support application by all States Parties of the new monitoring and evaluation framework for the International Health Regulations (2005) and assessments with the new joint external evaluation tool, as requested; and that support for national preparedness planning and capacity building will be prioritized to high-vulnerability, low-capacity countries, with a focus on rapidly establishing the most critical core capacities for early warning, incident management, risk communications and safe hospitals. Preparedness planning and capacity-building will be closely integrated with the Organization’s work in health systems strengthening. The work of the new Programme on preparedness and disaster risk reduction will be finalized following the Health Assembly’s consideration of the report of the Review Committee.

12. Work is progressing on a unified set of emergency business rules and systems for operating rapidly and on a “no regrets” basis in the areas of planning, human resource management, procurement and finance. Response planning is being standardized, using templates and standard procedures to enable the rapid realization of common strategic and operational plans. Emergency finances are being made available immediately, through a minimum-burden application process to the new WHO Contingency Fund for Emergencies. Rapid deployment mechanisms are being designed for staff and consultants, both rostered and non-rostered, based on new contractual modalities with appropriate insurance, duty of care and entitlements. A continuous business improvement system is being put in place to monitor, evaluate and improve core services, with systematic updating of standard operating procedures to reflect lessons learned.

13. Recognizing the important role that humanitarian actors and systems already play in outbreaks, and the need for a systematic approach to optimize that engagement in the face of large-scale, escalating outbreaks in the future, the Director-General initiated discussions on this issue with the United Nations Emergency Relief Coordinator of the United Nations Office for the Coordination of Humanitarian Affairs. The Director-General and the Coordinator concur that the mechanisms used to coordinate international support for natural disasters and conflicts could and should be extended and adapted for outbreaks, with adjustments for the particular challenges posed by infectious hazard management. This could include inviting the heads of agencies not part of the the United Nations Inter-Agency Standing Committee who have expertise in infectious diseases to participate in the deliberations of the Principals of the Inter-Agency Standing Committee concerning such events. Based on these discussions, in June 2016, the Director-General and the Emergency Relief Coordinator proposed the development of standard operating procedures to this effect to the Inter-Agency Standing Committee, which is convened by the Coordinator and brings together United Nations emergency agencies, networks of nongovernmental organizations, and humanitarian organizations (for example, the International Committee of the Red Cross and the International Federation of Red Cross and Red Crescent Societies). Progress in this regard will be among the issues reported to the global health crises task force that is established by the United Nations Secretary-General to monitor implementation of the recommendations of the High-level Panel on the Global Response to Health Crises.

Oversight of the WHO Health Emergencies Programme

14. On 29 March 2016, the Director-General established the Independent Oversight and Advisory Committee to provide oversight and monitoring of the development and performance of the WHO Health Emergencies Programme, guide the Programme’s activities and report findings through the

¹ See document A69/21.

Executive Board to the Health Assembly.¹ Reports of the Committee will be shared with the Secretary-General of the United Nations and with the Inter-Agency Standing Committee.

15. The Independent Oversight and Advisory Committee met for the first time on 5 May 2016 to plan its work for the remainder of 2016. The Committee consists of eight members who have extensive experience in a broad range of disciplines, including public health, infectious diseases, humanitarian crises, public administration, emergency management, community engagement, partnerships and development.

Implementation plan for the WHO Health Emergencies Programme

16. Having completed the design of the new Programme, the Organization initiated a transition phase, with the goal of establishing the new structure and positions across headquarters, all six regional offices and the first set of priority countries by 1 July 2016, and of completing the transition of existing staff into the new structure by 1 October 2016. Giving the new structure the capacity to perform its functions will require the recruitment of a substantial number of additional staff, with new skill sets, over a period of 24–36 months.

17. By the end of 2016, WHO seeks to have the new teams in place for health emergency information and risk assessment and for preparedness monitoring and evaluation functioning at headquarters and in all six regional offices. That date has also been set as the target for staffing the basic, essential functions of the new emergency operations teams at headquarters and in the Regional Office for Africa and the Regional Office for the Eastern Mediterranean, which currently manage the majority of WHO's protracted emergency response operations. During this period, the Secretariat will work to establish appropriately staffed emergency management teams, including Health Cluster Coordinators, in at least 10 priority countries affected by protracted crises. Staffing the remaining priority positions in headquarters, regional offices and priority countries is expected to be completed by late 2017.

18. Work has already begun to implement the new emergency management and administrative processes, through the existing structures for WHO's work in emergencies. For example, the new WHO incident management system has been applied since February 2016 to support major new emergencies, including the Zika virus-related Public Health Emergency of International Concern, the yellow fever outbreak in Angola and the El Niño phenomenon in Ethiopia. Similarly, standard operating procedures for the Contingency Fund for Emergencies have been developed, and, as at 18 April 2016, US\$ 6.89 million had been disbursed for five crises.² In all cases, funds were made available to the Incident Manager within 24 hours of approval.

19. Significant progress has also been made to strengthen the Global Health Emergency Workforce. Emergency medical teams continue to join the WHO-led quality assurance process, with 59 teams from 26 countries. In future work, WHO will give priority to establishing national emergency medical teams that can deploy locally in high-vulnerability countries, and to strengthening rapidly the Health Cluster leadership and capacity in priority countries. In parallel, WHO will strengthen the secretariat of the Global Alert and Response Network, and enhance its advocacy work, in order to enhance the capacity of partners in the Response Network to systematically support WHO and Member States in alert detection, risk assessments and rapid response activities.

¹ See http://www.who.int/about/who_reform/emergency-capacities/oversight-committee/en/ (accessed 14 October 2016).

² For more information on the Contingency Fund for Emergencies, see http://www.who.int/about/who_reform/emergency-capacities/contingency-fund/en/ (accessed 14 October 2016).

Financing the WHO Health Emergencies Programme

20. Financing the work of the new WHO Health Emergencies Programme will require a combination of the following:

- core financing of the Programme for baseline staff and activities at the three levels of the Organization;
- full financing of the Contingency Fund for Emergencies to enable it to rapidly initiate operations in acute emergencies;
- crisis-specific financing for activities in protracted crises (for example, for the health component of humanitarian response plans).

21. The Programme budget 2016–2017 includes US\$ 334 million in budget space for activities and staff that would be transitioned to the new WHO Health Emergencies Programme. This figure includes US\$ 70.6 million of the 8% increase in the Programme budget 2016–2017, which was approved by the Sixty-eighth World Health Assembly.¹

22. Implementing the new WHO Health Emergencies Programme against the planned timeline outlined in paragraphs 16 and 17 above requires an additional US\$ 160 million in core financing for the Programme during the biennium 2016–2017 (US\$ 60 million in 2016 and US\$ 100 million in 2017), as part of a total budget of US\$ 494 million for the new Programme in the period 2016–2017. The one-off, start-up costs for establishing the new Programme are US\$ 8 million (exclusive of new IT investments), thus the requirements from 2017 onwards represent fixed or recurrent costs requiring sustainable financing. Forty-four percent of these requirements are at country level, 26% at regional level and 30% at headquarters. Of these core costs, 38% are for emergency operations, 16% for risk assessment and information management activities, 16% for Member State preparedness and International Health Regulations (2005), and 12% for infectious hazard management, with the balance for core services and related functions. The core budget to fully implement the planned capacities and activities of the new Programme in the biennium 2018–2019 is US\$ 630 million.

23. As at 22 April 2016, WHO had received US\$ 140 million against the US\$ 494 million core budget that was required for the WHO Health Emergencies Programme in 2016–2017, and US\$ 26.9 million in funding and pledges against the US\$ 100 million capitalization target for the new Contingency Fund for Emergencies. Further financing is required for activities to be conducted in response to specific emergencies and events, whether acute or protracted.

24. In order to provide a sustainable solution for closing the substantial financing gap for the new WHO Health Emergencies Programme, additional voluntary contributions are required, ideally combined eventually with additional assessed contributions, in keeping with the expansion of WHO's mandate to include a substantive operational role in emergencies. Recognizing the urgency of establishing and rendering operational the WHO Health Emergencies Programme, in June 2016 the Director-General convened a meeting of existing and potential donors and interested parties for that purpose.

¹ See resolution WHA68.1 (2015).

ACTION BY THE HEALTH ASSEMBLY

[The paragraph contained the text of a draft decision that the Health Assembly adopted as decision WHA69(9).]

ANNEX 11

Road map for an enhanced global response to the adverse health effects of air pollution¹

[A69/18 – 6 May 2016]

[Paragraph 1 sets out the background to the development of the road map.]

1. The initial period covered by the proposed road map and its related actions is 2016–2019, at the end of which the road map will be updated to incorporate results from monitoring, feedback and evaluation, and submitted to the Health Assembly by the Secretariat. In addition, it will be aligned with priorities included in the thirteenth general programme of work.²
2. In response to the urgent need that had been identified for the health sector to respond to the effects on health associated with air pollution, the Health Assembly through resolution WHA68.8, *inter alia*, noted with deep concern that indoor and outdoor air pollution are both among the leading avoidable causes of disease and death globally, and the world's largest single environmental health risk; and acknowledged that 4.3 million deaths occur each year from exposure to household (indoor) air pollution and that 3.7 million deaths each year are attributable to ambient (outdoor) air pollution, at a high cost to societies. In addition, the Health Assembly, *inter alia*, underscored that the root causes of air pollution and its adverse impacts are predominantly socioeconomic in nature, and was cognizant of the need to address the social determinants of health related to development in urban and rural settings, including poverty eradication, as an indispensable element for sustainable development and for the reduction of the health impact of air pollution. Furthermore, the Health Assembly, *inter alia*, recognized that in order to contribute to national policy choices that protect health and reduce health inequities, the health sector would need to engage in cross-sectoral approaches to health, including adopting a Health in All Policies approach.
3. The two recent global developments that offer opportunities for synergies and efficiencies and that are relevant to the implementation of resolution WHA68.8 (2015) are the Paris Agreement³ adopted at the twenty-first session of the Conference of the Parties to the United Nations Framework Convention on Climate Change, and the selection of indicators for targets relating to the 2030 Agenda for Sustainable Development.⁴

¹ See decision WHA69(11) (2016).

² Following on from the Twelfth General Programme of Work, 2014–2019, the thirteenth general programme of work will commence in 2020.

³ The Paris Agreement was adopted at the twenty-first session of the Conference of the Parties to the United Nations Framework Convention on Climate Change (Paris, 11 December 2015), see http://unfccc.int/meetings/paris_nov_2015/meeting/8926.php (accessed 9 March 2016).

⁴ For details on the resolution adopted by the United Nations General Assembly on 25 September 2015, see United Nations General Assembly resolution 70/1 – Transforming our world: the 2030 Agenda for Sustainable Development, at: http://www.un.org/ga/search/view_doc.asp?symbol=A/RES/70/1 (accessed 9 March 2016).

4. The Paris Agreement¹ highlights the need to reverse drastically the current trend in the generation of climate change gases, which in turn requires the implementation of a series of policies that mitigate climate change, including clean combustion technologies and demand management mechanisms. Many of those policies also reduce health-damaging air pollutants such as particulate matter. In addition, there are pollutants, such as black carbon, that directly affect climate and human health. Reducing air pollution – and the millions of deaths every year associated with air pollution – will require the targeting of many inefficient technologies and policies that also lead to climate pollutant emissions.

5. With respect to the 2030 Agenda for Sustainable Development, agreement was reached on indicators to monitor the targets associated with the Sustainable Development Goals.² Targets and indicators for the Sustainable Development Goals in health (Goal 3), cities (Goal 11) and energy (Goal 7) are identified in resolution WHA68.8. Four of those indicators are being reported in WHO databases at the present time, and benefit from ongoing international cooperation to ensure their quality and completeness, including through the WHO-hosted Global Platform of Air Quality and Health.³

6. The road map identifies and harnesses opportunities for synergies and efficiencies linked to those policies that focus on reducing climate change and monitoring progress with the relevant Sustainable Development Goals. For example, the links with the Sustainable Development Goals provide a rationale and framework for the health sector to effectively contribute to achieving some of the “non-health” Sustainable Development Goals, and can also offer a focus for early action on air pollution prevention, as relevant to, for example, cities (Goal 11) or household energy (Goal 7). One of the beneficial impacts of climate change mitigation is that the funding associated with it can be used to improve air quality. Further, the increase in public awareness stimulates the demand for policies that reduce air pollution, prevent diseases and improve health and well-being (see paragraph 18). To obtain such efficiency gains, it is crucial to identify co-benefits from different measures that are outlined in the road map – to health and air pollution, and to climate change and sustainable development.

7. The road map is intended as a tool to enable the health sector, including health protection authorities supported by WHO, to take a leading role in raising awareness both of the impacts of air pollution on health and of opportunities for public health. Effective interactions with relevant sectors, including public and private stakeholders, will enable such sectors to be informed with respect to sustainable solutions. In turn, that will ensure that health concerns are integrated into decision-making, evaluation processes, and national, regional and local policies.

8. The vision, rationale and mechanisms for ways in which the health sector can enhance the global response to the adverse health effects of air pollution are described below. The framework for

¹ The Paris Agreement, which reflects the ambitious target of keeping global warming well below 2 °C with an aspirational target of 1.5°C, is legally binding, is flexible, and includes the monitoring and revising of each country’s commitments and actions every five years with a view to continually raising ambition, and also includes a commitment to adapt, including with regard to funding. In addition, it includes coverage of loss and damage, in recognition of the fact that the effects of climate change will have significant impacts on some vulnerable populations, despite the proposed measures and actions that are designed to mitigate such effects and to adapt to change. The Paris Agreement outlines differentiated responsibilities, recognizing the responsibilities of the richest countries, and includes actions by developing countries.

² For details on the resolution adopted by the United Nations General Assembly on 25 September 2015, see United Nations General Assembly resolution 70/1 – Transforming our world: the 2030 Agenda for Sustainable Development, at: http://www.un.org/ga/search/view_doc.asp?symbol=A/RES/70/1 (accessed 9 March 2016).

³ For more information on the Global Platform of Air Quality and Health, see: <http://public.wmo.int/en/resources/bulletin/air-quality-and-human-health-priority-joint-action> (accessed 27 April 2016).

strengthening the health sector response to air pollution health risks is provided in Appendix 1. The theory of change is summarized in Appendix 2.

9. The road map is organized into four categories:

(a) **Expanding the knowledge base.** Building and disseminating global evidence and knowledge relating to: the impacts on health of air pollution, the effectiveness (in health terms) of policies, and interventions to address air pollution and its sources that have been undertaken by different sectors. This includes identifying knowledge gaps and the promotion of innovation and research needed to address the impacts of air pollution on health.

(b) **Monitoring and reporting.** Enhancing systems, structures and processes needed to support monitoring and reporting on health trends associated with air pollution and its sources, and fulfilling the requirements of the resolution, while contributing to the monitoring of progress with respect to the Sustainable Development Goals, in particular, targets 3.9, 7.1 and 11.6.

(c) **Global leadership and coordination.** Leveraging health sector leadership and coordinated action at the global, regional, country and city levels in order to enable an appropriate and adequate response to this major public health problem, and ensuring synergies with other global processes, such as the achievement of the Sustainable Development Goals and follow-up to the Paris Agreement.

(d) **Institutional capacity strengthening.** Building the capacity of the health sector in order to analyse and influence policy and decision-making processes in support of joint action on air pollution and health, for example, to support the development of strategies and action plans to reduce household and ambient air pollution health risks, through setting relevant policies at national level or in cities, as well as to support the implementation of recommendations from WHO air quality guidelines.

10. In general terms, a level of awareness exists with respect to the impact on health of exposure to air pollution. The health sector, however, lacks access to existing evidence. In addition, there are limited assessments of health impacts from interventions in other sectors in terms of the prevention of those diseases caused by air pollution, including in specific settings, such as in the home or in urban environments. Furthermore, there are limited assessments of related costs and benefits. A programme of activities would encourage research and analyses, and enhance access to evidence, in general as well as in economic terms, concerning health risks and benefits of specific sector policies and of specific groups of society, and interventions to address air pollution,¹ Wide access to the evidence base mentioned above will be provided by a WHO public health information tool (a “one stop shop” on air pollution and health evidence using the web and other media).

11. Knowledge gaps will be identified and research strategies promoted to improve evidence, as needed, in areas including: the health impacts of sources of natural air pollution (for example, sand and dust storms); new threats such as nanomaterials, ultrafine particles, pesticides used in agriculture,

¹ The sectors referred to include transport, energy, waste, agriculture, industry and urban planning. Similarly, experiences and insights about good practices are not widely accessible or used. Therefore, activities carried out in the first programme of work under the proposed road map will focus on building relevant knowledge and evidence, and on providing wide and easy access to it, using appropriate formats and means in order to have access to a range of target audiences (including community health workers, health sector managers, civil society organizations, development partners and the media).

including the effectiveness of control measures; and links between household and ambient air pollution and high temperature.

12. Data that inform health trends associated with exposure to air pollution and its sources are currently being collected and reported using different methodologies and procedures. In order to facilitate more harmonized data collection and reporting on air pollution exposure and associated health impacts, monitoring and reporting tools are being refined and guidance will be developed in a separate programme of work. Specific consideration will be given to monitoring key sources of human exposure to air pollution. Such sources include homes and cities, and health care facilities and rural areas. The framework for data harmonization, analysis, reporting and visualization being developed under WHO's global platform on air quality and health, established in January 2014, will serve as the primary mechanism for ensuring reliable, valid and accessible estimates of human exposure to air pollution globally. This global platform will continue to draw on all relevant existing sources of data worldwide. It will work to improve the quality of the data and to extend geographical coverage, in close cooperation with relevant international and national agencies and research groups.

13. Synergies will be harnessed between the monitoring of targets related to the Sustainable Development Goals and air pollution and related health impacts. Strengthening the existing global WHO databases that focus on indoor air pollution, household energy fuels and technology, ambient air quality and air pollution in cities, for example, will contribute directly to the effective monitoring of the relevant Sustainable Development Goals.¹

14. Prevention of diseases caused by air pollution requires effective intersectoral engagement. To enable better health sector engagement and leadership, the road map includes a specific programme of work focused on strengthening the capacity of health actors to use public health evidence and arguments to contribute to and influence air pollution policy-making processes (including in the transport, agriculture, energy, industry and waste management sectors), so as to strengthen the capacity to design policies and interventions that achieve improvements in air quality and health. This will include, for example, the establishment of platforms to enable the health sector to cooperate with other sectors, to provide access to scientific information and to databases and modelling of expected impacts of policies, as well as the capacity for a health impacts assessment, cost-benefit and cost-effectiveness analysis of mitigation measures to the health sector and other relevant stakeholders. Similarly, health sector sources of air pollution should be addressed, such as the use of diesel generators to power health facilities or buildings and medical technologies that are not energy efficient.

15. The integration of air pollution mitigation strategies into wider public health prevention and health care delivery strategies, as relevant, is fundamental to an effective health sector response to air pollution. As reflected in the road map, strategies to mitigate air pollution will be linked to strategies and activities relating to the prevention of noncommunicable diseases or childhood pneumonia, as well as to relevant existing health development strategies, such as the global action plan for the prevention

¹ The relevant Sustainable Development Goals and targets referred to are: Goal 3 (Ensure healthy lives and promote well-being for all at all ages) target 3.9 (By 2030, substantially reduce the number of deaths and illnesses from hazardous chemicals and air, water, and soil pollution and contamination); Goal 7 (Ensure access to affordable, reliable, sustainable and modern energy for all) target 7.1 (By 2030, ensure universal access to affordable, reliable and modern energy services); and Goal 11 (Make cities and human settlements inclusive, safe, resilient and sustainable) target 11.6 (By 2030, reduce the adverse per capita environmental impact of cities, including by paying special attention to air quality and municipal and other waste management).

and control of noncommunicable diseases 2013–2020,¹ as well as processes and conventions (such as the WHO Framework Convention on Tobacco Control).

16. Institutional strengthening efforts will also seek to enhance the capacity of health care workers (including medical practitioners, nurses and community health workers) to provide recommendations on ways of avoiding exposure to air pollution to communities and individuals, among whom there are sensitive or vulnerable populations, including children, older people and slum dwellers. Related activities will include developing curricula and conducting training, advocacy and outreach within relevant health forums, such as international professional medical and nursing associations.

17. A broad communication strategy will be developed to raise global awareness and stimulate demand for policies that reduce air pollution, prevent diseases and improve health and well-being. There is an urgent need to communicate effectively with the public and with decision-makers about health risks associated with air pollution, and in particular the substantial health benefits expected from actions to mitigate air pollution. The communication strategy will be designed to build on relevant existing efforts, such as the partnership between WHO and the Climate and Clean Air Coalition; of particular relevance is the Breathe Life campaign.² The communications strategy will cater for the needs of different groups, communication mechanisms and opportunities available in different parts of the world.

18. Institutional capacity strengthening will focus on country implementation, including in low- and middle-income countries. In this context, examples and models of good practice will be developed and tested in cooperation with countries, for example, to roll out policies and plans that ensure clean indoor air through better access and sustained adoption of clean fuels and technologies in the homes of rural and poor populations. Support will be provided to urban stakeholders to engage and make use of untapped opportunities to promote urban policies in different sectors that prevent air pollution diseases and promote well-being. Such an approach will help to generate support for health, promoting actions and behaviours at the subnational level that enable the reduction of air pollution. Further, it will increase overall demand for compliance and enforcement of related national measures and it will contribute to the achievement of Sustainable Development Goals that focus on health, cities and energy.

19. Synergies with the Paris Agreement and with the Sustainable Development Goals will be identified and awareness raised with regard to the opportunities for efficiencies involved in the implementation of resolution WHA68.8. Knowledge synthesis includes, for example, identifying the type and extent of the interventions that reduce human exposure to air pollutants, that minimize climate change, and that contribute to the Sustainable Development Goals; or documenting those interventions with the most health co-benefits for vulnerable populations. Analyses of costs and benefits to health, health care and health systems can help to quantify and compare the impacts of interventions that focus solely on air pollution with those that have additional co-benefits to climate and Sustainable Development Goals. Such analysis will involve strengthening the evidence base, and will furthermore raise awareness among the public, the media and policy-makers concerning the public health implications of short-lived climate pollutants, a particular form of air pollution (including black carbon). A priority is to strengthen the capacity of the health sector to engage with

¹ The global action plan for the prevention and control of noncommunicable diseases 2013–2020 is available at: http://apps.who.int/iris/bitstream/10665/94384/1/9789241506236_eng.pdf (accessed 31 March 2016).

² See the website of the Climate and Clean Air Coalition, at: <http://www.unep.org/ccac/Initiatives/CCACHealth/tabid/133348/Default.aspx> (accessed 31 March 2016). Of particular interest is the recent report published in collaboration with WHO: “Reducing global health risks through mitigation of short-lived pollutants: scoping report for policymakers”, at <http://new.ccacoalition.org/en/resources/reducing-global-health-risks-through-mitigation-short-lived-climate-pollutants-scoping> (accessed 31 March 2016).

policies related to the Sustainable Development Goals and climate as the health sector is helping to analyse policy choices and supporting joint action on air pollution and health. This can include the development of relevant models, tools and training on the assessment of co-benefits (and risks), the increased recognition of risks posed by short-lived climate pollutants to air quality and climate change – as well as of the benefits of policies that promote healthy, sustainable, low-pollutant and low-carbon solutions in urban and rural settings.

20. It is envisaged that a global high-level and intergovernmental conference on air quality and health be considered, for example, in two years' time. The objective of such a conference would be to review progress, including in the context of the implementation of the Sustainable Development Goals and other relevant global policy priorities. An additional objective would be to provide an opportunity to discuss and agree on further action required in order to ensure an effective and appropriate response to address the health impacts of air pollution, including action related to monitoring, reporting, capacity building, reduction measures, policy experience and financing.

21. Regular evaluations of progress on activities related to the road map will be undertaken. Feedback will be used to make necessary adjustments and improvements. Regular reports will also be prepared on implementation of the road map, including the status of implementation of relevant policies for air pollution reduction and progress on diseases related to air pollution, such as noncommunicable diseases. In addition, reporting will focus on activities, on any revisions required, on resources available to support the implementation of the resolution, and on progress towards achieving the overall goals and objectives of the resolution. Important sources of information will be the relevant databases and related mechanisms, such as those strengthened by the implementation of the resolution.

22. An additional focus will be on supporting the country-level implementation of relevant WHO guidelines on air quality, including the new indoor air quality guidelines on household fuel combustion. The latter will be supported, for example, by the provision of technical advice and capacity building aimed at facilitating the development of national action plans on indoor air quality.

23. Within the programme of work on institutional capacity strengthening, reference is made to the need to build up WHO's internal technical and operational capacity to support this work, in view of current limits in staff and resources, including at regional and country levels. Additional technical staff will be needed in the regions, in some country offices, and at headquarters, including capacity in epidemiology, statistics/modelling, health economics, advocacy and research. This should enable the strengthening of capacity in countries and global engagement on intersectoral cooperation to mitigate air pollution health impacts, while improving health and contributing to the achievement of the Sustainable Development Goals.

24. WHO will continue to work closely with other international and national agencies and strengthen its strategic partnerships, in particular within the United Nations system, including with WMO, UNEP and the United Nations Economic Commission for Europe, in order to: support the adoption of integrated strategies to tackle air pollution; ensure health is a priority; and deliver mitigation decisions related to the Sustainable Development Goals and the Conference of the Parties, building on respective competencies, mandates, responsibilities and audiences.

25. A report on the implementation of resolution WHA68.8 and progress on mitigating the health effects of air pollution, and on other challenges to air quality was welcomed by the Sixty-ninth World Health Assembly¹. The report drew on new data on human exposure to air pollutants (such as from

¹ See decision WHA69(11) (2016).

kerosene use in the home or in cities); and described initial efforts to strengthen the capacity of the health sector to support prevention in cities and in homes, and on global health communications. The report also identified the challenges, opportunities, the vision of the road map and its scale of ambition, and clarified how the activities associated with the road map would fill gaps; and the role of Member States, the Secretariat and other stakeholders in strengthening the global response to health-related impacts of air pollution. It made the case for investment and identified the scale of investment needed to implement activities in the road map, including resources needed to enable the Secretariat to provide the required support to countries across the three levels of the Organization (describing the current limits in installed capacity). The report clarified expected deliverables in terms of the prevention of air pollution and related diseases, and country commitments to Sustainable Development Goals and to climate change mitigation.

Appendix 1

ROAD MAP FOR AN ENHANCED GLOBAL RESPONSE TO THE ADVERSE HEALTH EFFECTS OF AIR POLLUTION

The road map for the period 2016–2019 is represented in the figures below, which depict the sequence of activities. Figures 1–4 focus on the four relevant activities, which are, respectively, expanding the knowledge base, monitoring and reporting, global leadership and coordination, and institutional capacity strengthening.

Figure 1. Expanding the knowledge base



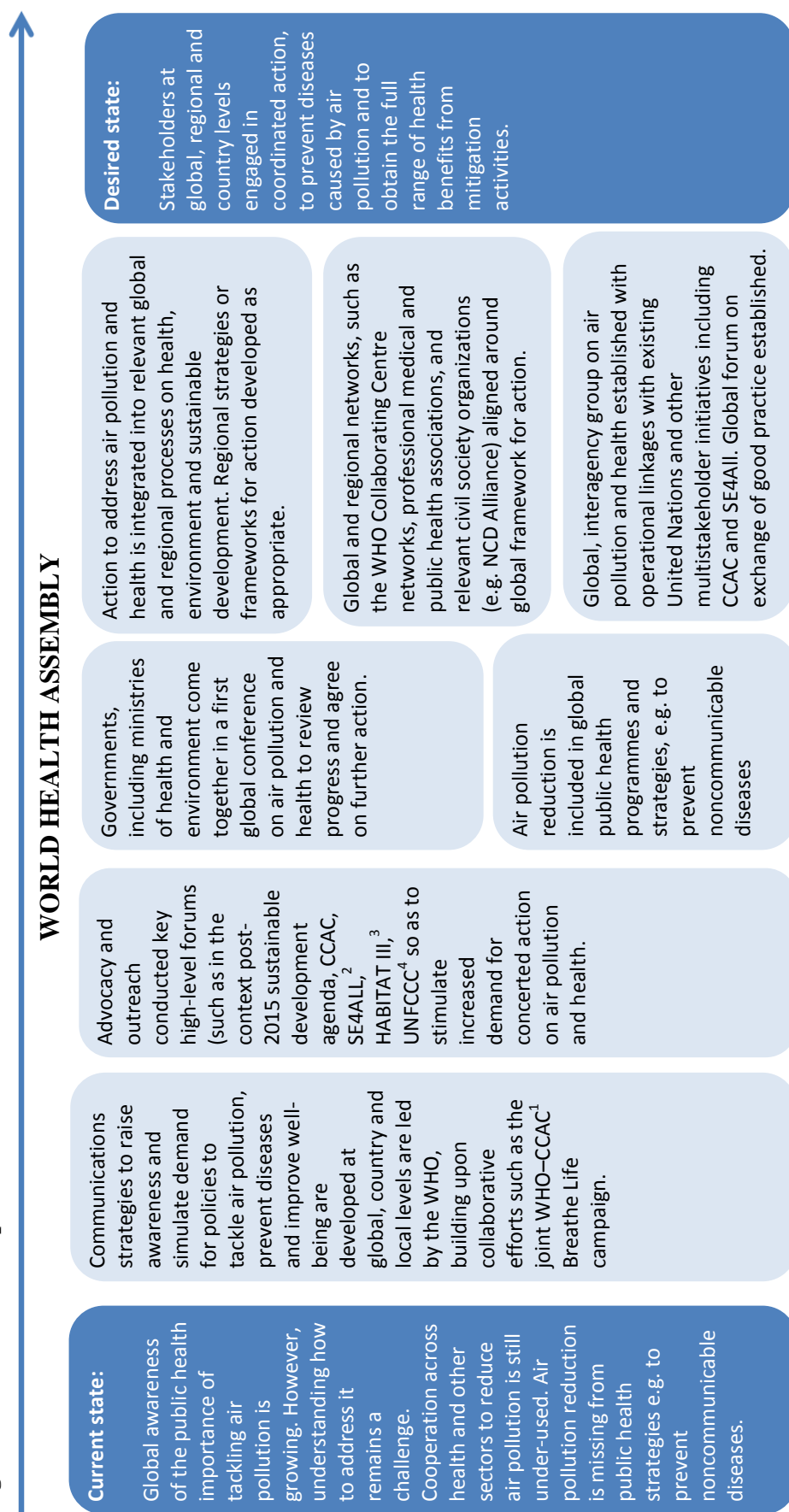
Figure 2. Monitoring and reporting



¹ LRTAP Convention refers to the United Nations Economic Convention for Europe, Convention on Long-Range Transboundary Air Pollution, see http://www.unece.org/env/lrtap/lrtap_h1.html (accessed 12 November 2015).

² For more information on the European Environmental Agency, see <http://www.eea.europa.eu/> (accessed 12 November 2015).

Figure 3. Global leadership and coordination



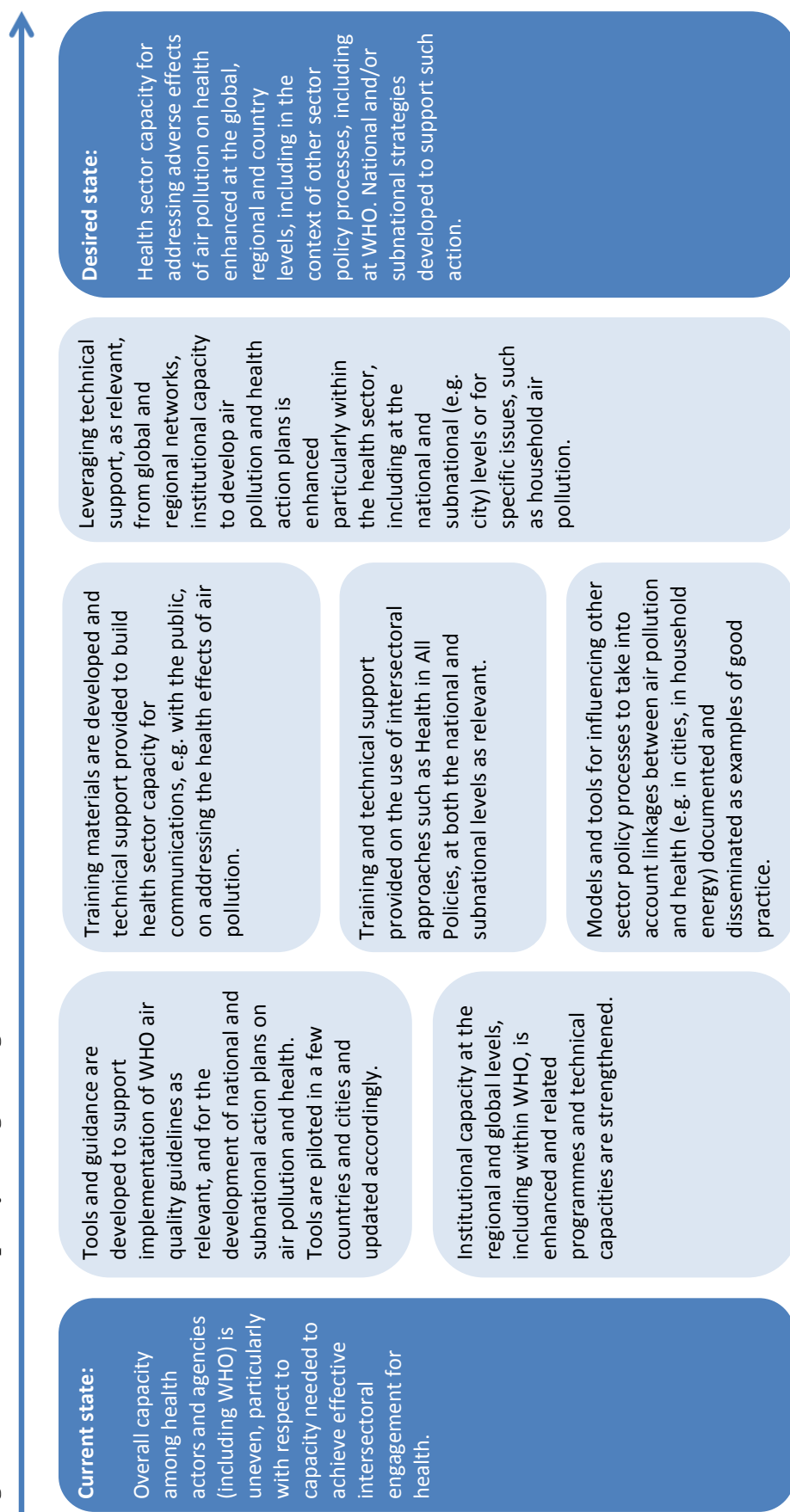
¹ CCAC refers to Climate and Clean Air Coalition.

² SE4ALL refers to Sustainable Energy for All Initiative, see <http://www.se4all.org/> (accessed 12 November 2015).

³ HABITAT III refers to the HABITAT III Conference, see <http://unhabitat.org/habitat-iii-conference/> (accessed 12 November 2015).

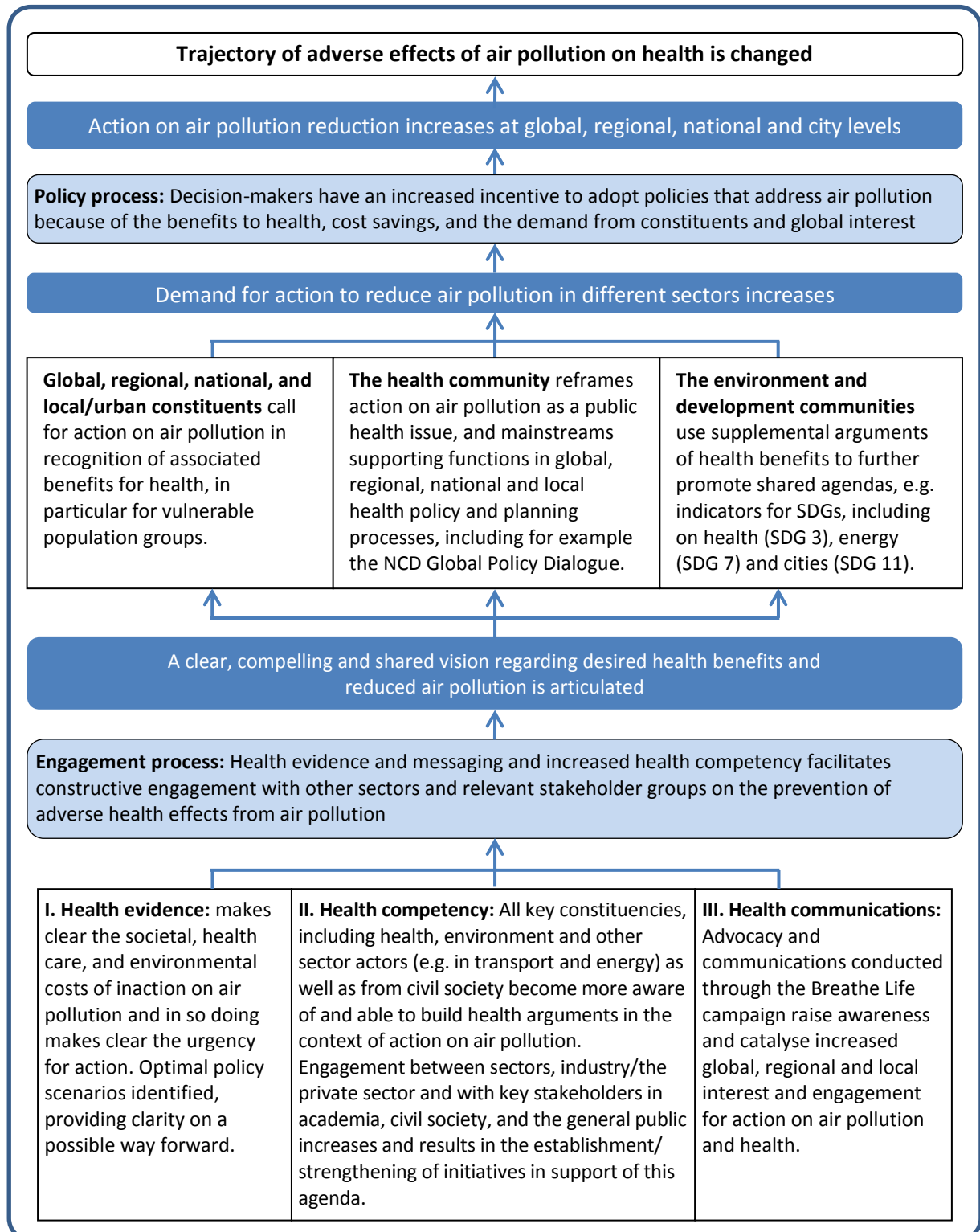
⁴ UNFCCC refers to the United Nations Framework Convention on Climate Change.

Figure 4. Institutional capacity strengthening



Appendix 2

AN ENHANCED GLOBAL RESPONSE TO THE ADVERSE EFFECTS OF AIR POLLUTION ON HEALTH – A THEORY OF CHANGE



ANNEX 12

Recommendations of the Commission on Ending Childhood Obesity and actions and responsibilities for their implementation¹

[A69/8, Annex – 24 March 2016]

[The overarching goals of the Commission on Ending Childhood Obesity are to provide policy recommendations to governments to prevent infants, children and adolescents from developing obesity, and to identify and treat pre-existing obesity in children and adolescents. The aims are to reduce the risk of morbidity and mortality due to noncommunicable diseases, lessen the negative psychosocial effects of obesity both in childhood and adulthood, and reduce the risk of the next generation developing obesity.]

1. Childhood obesity is reaching alarming proportions in many countries and poses an urgent and serious challenge. The Sustainable Development Goals, set by the United Nations in 2015, identify prevention and control of noncommunicable diseases as core priorities. Among the noncommunicable disease risk factors, obesity is particularly concerning and has the potential to negate many of the health benefits that have contributed to increased life expectancy.
2. The prevalence of infant, childhood and adolescent obesity is rising around the world. Although rates may be plateauing in some settings, in absolute numbers, there are more children who are overweight and obese in low- and middle-income countries than in high-income countries. Obesity can affect a child's immediate health, educational attainment and quality of life. Children with obesity are very likely to remain obese as adults and are at risk of chronic illness.
3. Progress in tackling childhood obesity has been slow and inconsistent. The Commission on Ending Childhood Obesity was established in 2014 to review, build upon and address gaps in existing mandates and strategies. Having consulted over 100 WHO Member States and reviewed nearly 180 online comments [...], the Commission has developed a set of recommendations to successfully tackle childhood and adolescent obesity in different contexts around the world.
4. Many children today are growing up in an obesogenic environment that encourages weight gain and obesity. Energy imbalance has resulted from the changes in food type, availability, affordability and marketing, as well as a decline in physical activity, with more time being spent on screen-based and sedentary leisure activities. The behavioural and biological responses of a child to the obesogenic environment can be shaped by processes even before birth, placing an even greater number of children on the pathway to becoming obese when faced with an unhealthy diet and low physical activity.
5. No single intervention can halt the rise of the growing obesity epidemic. Addressing childhood and adolescent obesity requires consideration of the environmental context and of three critical time periods in the life-course: preconception and pregnancy; infancy and early childhood; and older childhood and adolescence. In addition, it is important to treat children who are already obese, for their own well-being and that of their children.

¹ See decision WHA69(12) (2016).

6. Obesity prevention and treatment requires a whole-of-government approach in which policies across all sectors systematically take health into account, avoid harmful health impacts, and thus improve population health and health equity.

7. The Commission has developed a comprehensive, integrated package of recommendations to address childhood obesity. It calls for governments to take leadership and for all stakeholders to recognize their moral responsibility in acting on behalf of the child to reduce the risk of obesity. The recommendations are presented under the following areas.

Recommendation 1. Implement comprehensive programmes that promote the intake of healthy foods and reduce the intake of unhealthy foods and sugar-sweetened beverages by children and adolescents.

- 1.1 Ensure that appropriate and context-specific nutrition information and guidelines for both adults and children are developed and disseminated in a simple, understandable and accessible manner to all groups in society.
- 1.2 Implement an effective tax on sugar-sweetened beverages.
- 1.3 Implement the Set of Recommendations on the Marketing of Foods and Non-alcoholic Beverages to Children to reduce the exposure of children and adolescents to, and the power of, the marketing of unhealthy foods.
- 1.4 Develop nutrient-profiles to identify unhealthy foods and beverages.
- 1.5 Establish cooperation between Member States to reduce the impact of cross-border marketing of unhealthy foods and beverages.
- 1.6 Implement a standardized global nutrient labelling system.
- 1.7 Implement interpretive front-of-pack labelling, supported by public education of both adults and children for nutrition literacy.
- 1.8 Require settings such as schools, child-care settings, children's sports facilities and events to create healthy food environments.
- 1.9 Increase access to healthy foods in disadvantaged communities.

Recommendation 2. Implement comprehensive programmes that promote physical activity and reduce sedentary behaviours in children and adolescents.

- 2.1 Provide guidance to children and adolescents, their parents, caregivers, teachers and health professionals on healthy body size, physical activity, sleep behaviours and appropriate use of screen-based entertainment.
- 2.2 Ensure that adequate facilities are available on school premises and in public spaces for physical activity during recreational time for all children (including those with disabilities), with the provision of gender-friendly spaces, where appropriate.

Recommendation 3. Integrate and strengthen guidance for noncommunicable disease prevention with current guidance for preconception and antenatal care, to reduce the risk of childhood obesity.

- 3.1 Diagnose and manage hyperglycaemia and gestational hypertension.
- 3.2 Monitor and manage appropriate gestational weight gain.
- 3.3 Include an additional focus on appropriate nutrition in guidance and advice for both prospective mothers and fathers before conception and during pregnancy.
- 3.4 Develop clear guidance and support for the promotion of good nutrition, healthy diets and physical activity, and for avoiding the use of and exposure to tobacco, alcohol, drugs and other toxins.

Recommendation 4. Provide guidance on, and support for, healthy diet, sleep and physical activity in early childhood to ensure children grow appropriately and develop healthy habits.

- 4.1 Enforce regulatory measures such as the International Code of Marketing of Breast-milk Substitutes and subsequent World Health Assembly resolutions.
- 4.2 Ensure all maternity facilities fully practise the Ten Steps to Successful Breastfeeding.
- 4.3 Promote the benefits of breastfeeding for both mother and child through broad-based education to parents and the community at large.
- 4.4 Support mothers to breastfeed, through regulatory measures such as maternity leave, facilities and time for breastfeeding in the workplace.
- 4.5 Develop regulations on the marketing of complementary foods and beverages, in line with WHO recommendations, to limit the consumption of foods and beverages high in fat, sugar and salt by infants and young children.
- 4.6 Provide clear guidance and support to caregivers to avoid specific categories of foods (e.g. sugar-sweetened milks and fruit juices or energy-dense, nutrient-poor foods) for the prevention of excess weight gain.
- 4.7 Provide clear guidance and support to caregivers to encourage the consumption of a wide variety of healthy foods.
- 4.8 Provide guidance to caregivers on appropriate nutrition, diet and portion size for this age group.
- 4.9 Ensure only healthy foods, beverages and snacks are served in formal child-care settings or institutions.
- 4.10 Ensure food education and understanding are incorporated into the curriculum in formal child-care settings or institutions.
- 4.11 Ensure physical activity is incorporated into the daily routine and curriculum in formal child-care settings or institutions.
- 4.12 Provide guidance on appropriate sleep time, sedentary or screen time, and physical activity or active play for the 2–5 years of age group.
- 4.13 Engage whole-of-community support for caregivers and child-care settings to promote healthy lifestyles for young children.

Recommendation 5. Implement comprehensive programmes that promote healthy school environments, health and nutrition literacy and physical activity among school-age children and adolescents.

- 5.1 Establish standards for meals provided in schools, or foods and beverages sold in schools, that meet healthy nutrition guidelines.
- 5.2 Eliminate the provision or sale of unhealthy foods, such as sugar-sweetened beverages and energy-dense, nutrient-poor foods, in the school environment.
- 5.3 Ensure access to potable water in schools and sports facilities.
- 5.4 Require inclusion of nutrition and health education within the core curriculum of schools.
- 5.5 Improve the nutrition literacy and skills of parents and caregivers.
- 5.6 Make food preparation classes available to children, their parents and caregivers.
- 5.7 Include Quality Physical Education in the school curriculum and provide adequate and appropriate staffing and facilities to support this.

Recommendation 6. Provide family-based, multicomponent, lifestyle weight management services for children and young people who are obese.

- 6.1 Develop and support appropriate weight management services for children and adolescents who are overweight or obese that are family-based, multicomponent (including nutrition, physical activity and psychosocial support) and delivered by multi-professional teams with appropriate training and resources, as part of universal health coverage.

Actions and responsibilities for implementing the recommendations

Actions and responsibilities for

WHO:

- (a) Institutionalize a cross-cutting and life-course approach to ending childhood obesity across all relevant technical areas in WHO: headquarters, regional and country offices.
- (b) Develop, in consultation with Member States, a framework to implement the recommendations of the Commission.
- (c) Strengthen capacity to provide technical support for action to end childhood obesity at global, regional and national levels.
- (d) Support international agencies, national governments and relevant stakeholders in building upon existing commitments to ensure that relevant actions to end childhood obesity are implemented at global, regional and national levels.
- (e) Promote collaborative research on ending childhood obesity with a focus on the life-course approach.
- (f) Report on progress made on ending childhood obesity.

International organizations:

- (a) Cooperate to build capacity and support Member States in addressing childhood obesity.

Members States:

- (a) Take ownership, provide leadership and engage political commitment to tackle childhood obesity over the long term.
- (b) Coordinate contributions of all government sectors and institutions responsible for policies, including, but not limited to: education; food, agriculture; commerce and industry; development; finance and revenue; sport and recreation; communication; environmental and urban planning; transport and social affairs; and trade.
- (c) Ensure data collection on BMI-for-age of children – including for ages not currently monitored – and set national targets for childhood obesity.
- (d) Develop guidelines, recommendations or policy measures that appropriately engage relevant sectors – including the private sector, where applicable – to implement actions, aimed at reducing childhood obesity.

Non-State actors**Nongovernmental organizations:**

- (a) Raise the profile of childhood obesity prevention through advocacy efforts and the dissemination of information.
- (b) Motivate consumers to demand that governments support healthy lifestyles and that the food and non-alcoholic beverage industry provide healthy products, and do not market unhealthy foods and sugar-sweetened beverages to children.
- (c) Contribute to the development and implementation of a monitoring and accountability mechanism.

The private sector:

- (a) Support the production of, and facilitate access to, foods and non-alcoholic beverages that contribute to a healthy diet.
- (b) Facilitate access to, and participation in, physical activity.

Philanthropic foundations:

- (a) Recognize childhood obesity as endangering child health and educational attainment and address this important issue.
- (b) Mobilize funds to support research, capacity building and service delivery.

Academic institutions:

- (a) Raise the profile of childhood obesity prevention through the dissemination of information and incorporation into appropriate curricula.
- (b) Address knowledge gaps with evidence to support policy implementation.
- (c) Support monitoring and accountability activities.

8. The greatest obstacle to effective progress on reducing childhood obesity is a lack of political commitment and a failure of governments and other actors to take ownership, leadership and necessary actions.

9. Governments must invest in robust monitoring and accountability systems to track the prevalence of childhood obesity. Such systems are vital in providing data for policy development and in offering evidence of the impact and effectiveness of interventions.

10. The Commission endorses the importance and necessity of tackling the complex issue of childhood obesity. WHO, other international organizations and their Member States, and non-State actors have a critical role to play in harnessing momentum and ensuring that all sectors remain committed to working together to reach a positive conclusion.

...

ACTIONS AND RESPONSIBILITIES FOR IMPLEMENTING THE RECOMMENDATIONS

51. The Commission recognizes that successful implementation of the recommendations requires the committed input, focus and support of a number of agencies. Necessary actions and responsibilities would involve the following:

Action WHO:	Rationale
<p>(a) Institutionalize a cross-cutting and life-course approach to ending childhood obesity across all relevant technical areas in headquarters, regional and country offices.</p> <p>(b) Develop, in consultation with Member States, a framework to implement the recommendations of the Commission.</p> <p>(c) Strengthen capacity to provide technical support for action to end childhood obesity at global, regional and national levels.</p> <p>(d) Support international agencies, national governments and relevant stakeholders in building upon existing commitments to ensure that relevant actions to end childhood obesity are implemented at global, regional and national level.</p> <p>(e) Promote collaborative research on ending childhood obesity with a focus on the life-course approach.</p> <p>(f) Report on progress made on ending childhood obesity.</p>	<p>It is essential that momentum is maintained to address this complex and critical issue. WHO can lead and convene high-level dialogue within the United Nations system and with and between Member States, to build upon the commitments made in the Sustainable Development Goals, the Political Declaration of the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases, the Rome Declaration of the Second International Conference on Nutrition and others, to address the actions detailed in this report to end childhood obesity.¹</p> <p>Using its normative function, both globally and through its network of regional and country offices, WHO can provide technical assistance by developing or building on guidelines, tools and standards to support the recommendations of the Commission and other relevant WHO mandates at country level.</p> <p>WHO can disseminate guidance for implementation, monitoring and accountability, and monitor and report on progress to end childhood obesity.</p>
<p>International organizations:</p> <p>(a) Cooperate to build capacity and</p>	<p>Cooperation among international organizations, including other</p>

¹ See document A69/8, Annex, for full information.

support Member States in addressing childhood obesity.

Members States:

- (a) Take ownership, provide leadership and make political commitment to tackle childhood obesity over the long term.
- (b) Coordinate contributions of all government sectors and institutions responsible for policies, including, but not limited to: education; food; agriculture; commerce and industry; development; finance/revenue; sport and recreation; communication; environmental and urban planning; transport and social affairs; and trade.
- (c) Ensure data collection on BMI-for-age of children – including for ages not currently monitored – and set national targets for childhood obesity.
- (d) Develop guidelines, recommendations or policy measures that appropriately engage relevant sectors – including the private sector, where applicable – to implement actions, aimed at reducing childhood obesity, as set out in this report.

Non-State actors

Nongovernmental organizations:

- (a) Raise the profile of childhood obesity prevention through advocacy efforts and the dissemination of information.
- (b) Motivate consumers to demand that governments support healthy lifestyles and that the food and non-alcoholic beverage industry provide healthy products, and do not market unhealthy foods and sugar-sweetened beverages to children.
- (c) Contribute to the development and

United Nations agencies, can promote the establishment of global and regional partners and networks for advocacy, resource mobilization, capacity building and collaborative research. The United Nations Inter-Agency Task Force on noncommunicable diseases can support Member States in addressing childhood obesity.

Governments hold the ultimate responsibility in ensuring their citizens have a healthy start in life. Thus, taking an active role to address childhood obesity should not be interpreted as interference with individual choice, rather as the state taking ownership of the development of their human capital. It is clear that to address childhood obesity effectively, the active engagement of multiple agencies of government is needed. There is an understandable tendency to see obesity as a problem for the health sector.

However, preventing childhood obesity requires the coordinated contributions of all government sectors and institutions responsible for policies. Governments must establish appropriate whole-of-government approaches to address childhood obesity. Further, regional and local governments must understand their obligations and harness resources and efforts to ensure a coordinated and comprehensive response to the issue.

Using such data, governments can establish obesity targets and intermediate milestones, consistent with the global nutrition and noncommunicable disease targets established by the Health Assembly. They should include in their national monitoring frameworks agreed international indicators for obesity outcomes (to track progress in achieving national targets), diet and physical activity programme implementation (including coverage of interventions) and the obesity policy environment (including institutional arrangements, capacities and investments in obesity prevention and control). Monitoring should be conducted, to the fullest possible extent, through existing monitoring mechanisms.

There are many ways in which non-State actors can play an important and supportive role in addressing the challenge of childhood obesity. As this report shows, the risk of childhood obesity is greatly influenced by food, physical activity and eating behaviours, by the school and social environment, by cultural attitudes to body image, by the behaviour of adults and by the conduct of the private sector.

Although building the policy framework is undertaken by government, in some countries developing nutrition information and education campaigns, implementing programmes, and monitoring and holding actors to account for commitments made, may be tasks shared between government and civil society.

Social movements can engage members of the community and provide a platform for advocacy and action.

implementation of a monitoring and accountability mechanism.

The private sector:

- (a) Support the production of, and facilitate access to, foods and non-alcoholic beverages that contribute to a healthy diet.
- (b) Facilitate access to, and participation in, physical activity.

The private sector is not a homogeneous entity and includes the agricultural food production sector, the food and non-alcoholic beverage industry, retailers, catering companies, sporting-goods manufacturers, advertising and recreation businesses, and the media. It is, therefore, important to consider those entities whose activities are directly or indirectly related to childhood obesity either positively or negatively. Countries need to engage constructively with the private sector to encourage implementation of policies and interventions.

The Commission is aware of a number of private sector initiatives that have the potential to impact positively on childhood obesity. These need to be encouraged where they are supported by an evidence base. As many companies operate globally, international collaboration is vital. However, attention must also be given to local and regional entities and artisans. Cooperative relationships with industry have already led to some encouraging outcomes related to diet and physical activity. Initiatives by the food manufacturing industry to reduce fat, sugar and salt content, and portion sizes of processed foods, and to increase the production of innovative, healthy and nutritious choices, could accelerate health gains worldwide.

The Commission believes that real progress can be made by constructive, transparent and accountable engagement with the private sector.

Philanthropic foundations:

- (a) Recognize childhood obesity as endangering child health and educational attainment and thus address this important issue.
- (b) Mobilize funds to support research, capacity building and service delivery.

Philanthropic foundations are uniquely placed to make significant contributions to global public health and can also engage in monitoring and accountability activities.

Academic institutions:

- (a) Raise the profile of childhood obesity prevention through the dissemination of information and incorporation into appropriate curricula.
- (b) Address knowledge gaps with evidence to support policy implementation.
- (c) Support monitoring and accountability activities.

Academic institutions can contribute to addressing childhood obesity through studies on biological, behavioural and environmental risk factors and determinants, and the effectiveness of interventions in each of these.

[Paragraphs 52-61 and 62 cover monitoring and accountability, and conclusions, respectively.]

ANNEX 13

Recommendations contained in the Report of the Review Committee on the Role of the International Health Regulations (2005) in the Ebola Outbreak and Response¹

[A69/21, Annex – 13 May 2016]

[Paragraphs 1-12 contain an executive summary and paragraphs 1-150 of the main report cover introduction and background, methods of work, and the effectiveness of IHR implementation in the Ebola epidemic: the role of States Parties.]

RECOMMENDATIONS

151. If the world is serious about wanting to prepare for and respond rapidly and effectively to public health emergencies in the future, it must increase the priority given to the IHR, address the inequities in the global response to Ebola, and strengthen the role of WHO in coordinating the implementation of the IHR.

152. Our recommendations are grouped into two: (i) a strategy to ensure implementation of the IHR based on new proposals (Recommendations 1–6); (ii) improved delivery of the IHR by reinforcing existing approaches in IHR implementation (Recommendations 7–12).

...

Recommendation 1: Implement rather than amend the IHR

The Review Committee found:

154. It is the view of this Review Committee that the failures in the international response to Ebola did not result from major inadequacies in the text of the Regulations. The Review Committee considers that the IHR remain an indispensable legal framework for preventing and containing the international spread of public health risks. The overarching challenge with the IHR is poor implementation.

155. After thorough review of the IHR, the Review Committee considered that: opening the amendment process would take years at a time when implementation of the IHR is urgent; and could divert the focus from implementation to discussion about the scope, machinery or language of the IHR. While the committee recognized that there are, inevitably, provisions in the IHR where improvements could be made e.g., to simplify the process to produce standing recommendations, it nonetheless felt that the risks of undertaking amendments to the IHR far exceeded any potential benefits.

¹ See decision WHA69(14) (2016).

156. In developing the new recommendations in this report, the Review Committee determined that the IHR does not require an amendment.

The Review Committee recommends that:

There is neither the need for, nor benefit to be drawn from, opening up the amendment process for the IHR, at this time.

Recommendation 2: Develop a Global Strategic Plan to improve public health preparedness and response

The Review Committee found:

157. While WHO has developed technical guidance, regional strategies, and advises countries on implementation on an *ad hoc* basis, the lack of an overarching strategy to guide countries on how to put the IHR into practice and to monitor global progress, has contributed to the world remaining ill-prepared for major public health emergencies. Furthermore, it is clear that many less well-resourced countries will be unable to establish the core capacity requirements on their own by the final deadline of June 2016. Setting further informal deadlines without a strategy for country ownership and support will serve no purpose. Instead, a global strategy with ambitious yet achievable targets and milestones needs to be put in place.

158. The Review Committee noted the challenge of balancing the need for urgent action with the reality that less well-resourced States Parties will not achieve the required health systems strengthening in a short period. The Committee is of the opinion that a 10-year plan for continuous improvement of public health preparedness, with a prioritized focus on IHR implementation in the first 1–3 years, is the appropriate response to this challenge.

The Review Committee recommends that:

The WHO Secretariat should lead the development of a Global Strategic Plan to improve public health preparedness, in conjunction with States Parties and other key stakeholders, to ensure implementation of the IHR, especially the establishment and monitoring of core capacities. The Global Strategic Plan should inform the development of regional office and national plans.

WHO Secretariat and States Parties:

2.1 The Strategic Plan should:

2.1.1 Be developed for endorsement by the 2017 World Health Assembly and thereafter be presented to the Assembly for annual review of progress made by States Parties and development partners.

2.1.2 Set out a programme of continuous review and improvement of core capacity, using the WHO's IHR Monitoring and Evaluation Framework.

2.1.3 Have clear process and performance indicators with the aim of improving implementation of the IHR and public health preparedness and response.

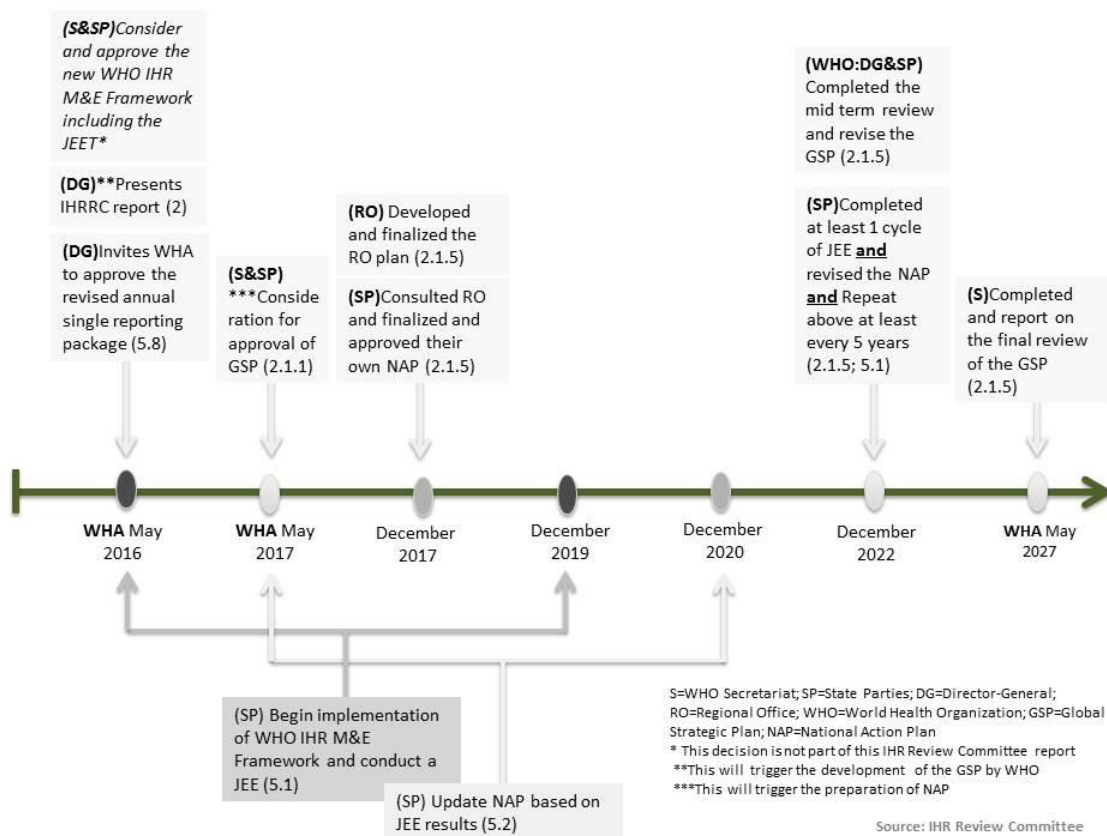
2.1.4 Include performance indicators that assess the strengths and weaknesses of global responses to both “International Public Health Alerts” (see Recommendation 6) and to Public Health Emergencies of International Concern.

2.1.5 Have the following timeline (see Fig. 7):

- By December 2017, each State Party should have a prioritized national core capacity development and maintenance plan (a “National Action Plan”), with the support of international partners as needed. This plan should be approved by respective governments in consultation with the regional office, and should have indicators and targets for reporting to WHO (see Recommendation 5).
- The National Action Plan should incorporate regular joint internal and independent external assessment of country capacity on a 5-year cyclical basis, with each assessment reported to the World Health Assembly linked to improvement or maintenance measures.
- By December 2017, all regional offices should develop costed and prioritized regional implementation plans, which will be further refined to support the National Action Plans and ensure continuous improvement at the country level.
- By 2022, each State Party should have completed at least one cycle of joint external evaluation (see Recommendation 5) and review of its National Action Plan.
- By 2022, WHO should have completed a mid-term review of the Global Strategic Plan to identify progress made and revise the plan accordingly.
- By 2027, WHO should report to the World Health Assembly on a review of the Global Strategic Plan and the IHR.

2.2 The Global Strategic Plan should include financial and technical support from WHO, development partners and the private sector, which should be linked as incentives to the achievement of predetermined milestones in the National Action Plans.

Fig. 7. Proposed timeline for implementation of Recommendations 2 and 5



Recommendation 3: Finance IHR implementation, including to support the Global Strategic Plan

The Review Committee found:

159. Many States Parties and international development partners have not given adequate attention to the funding and collaboration required to strengthen and maintain the public health capacities mandated under the IHR. Financing the implementation of core capacities in resource-constrained countries and fragile states is particularly challenging for States Parties; the Ebola epidemic highlighted that, in these settings, implementation of the IHR is impossible without significant external financial and technical support before, during and after an event. Some affected countries reported being unable to exert national ownership of resources introduced into countries by international development partners, which also indicates the need for more national coordination and capacity.

160. This Review Committee was not constituted to make a detailed financial analysis of the financing requirements for IHR implementation. Nevertheless, it noted that estimates have been made and considers that at present levels of funding, it is not possible for WHO to deliver on its global mandate of support and coordination at all levels. The Review Committee notes that the Ebola Interim Assessment Panel and the UN High Level Panel, recommend an increase in assessed contributions to the WHO budget.

The Review Committee recommends that:

WHO, States Parties and international development partners should urgently commit to providing financial support at the national, regional and international levels for the successful implementation of the Global Strategic Plan.

States Parties

3.1 Allocate appropriate resources to the development, maintenance and assessment of IHR core capacities, as a priority component of the national health system.

3.2 Starting from 2017, increase contributions to the WHO Secretariat, to allow the establishment of an effective risk assessment, risk management and risk communication programme for health emergencies at the headquarters, regional and country levels, including a WHO Contingency Fund for Emergencies, permitting WHO to support effective emergency response in countries with limited resources.

WHO Secretariat

3.3 In conjunction with international development partners, offers assistance to States Parties in developing, as part of the Global Strategic Plan, a costed National Action Plan for IHR implementation.

3.4 Facilitates partnerships between countries with limited resources and either other States Parties or international actors to ensure that priority is given for technical and financial assistance. Such assistance must be contingent on countries undertaking an independent review of core capacities and linking financial incentives to the achievement of pre-determined milestones.

3.5 Facilitates collaborations between development partners and States Parties to encourage financial incentives for core capacity compliance and also for support in an emerging public health emergency.

International development partners

161. In support of the Global Strategic Plan, regional office plans, and the National Action Plans:

3.6 Development partners such as the United Nations Development Group (UNDP), the World Bank and middle- and high-income countries should, under IHR Article 44, continue to fund and support countries that require financial and technical support, and this support should be linked as incentives to pre-determined milestones in the national plan.

3.7 The World Bank should, with WHO's support, increase access to funds, to empower States Parties to urgently strengthen IHR core capacities, focusing on the most vulnerable countries.

Recommendation 4: Increase awareness of the IHR, and reaffirm the lead role of WHO within the UN system in implementing the IHR**The Review Committee found:**

162. The IHR provide an essential multilateral framework, which, under the WHO Constitution, legally binds States Parties and the Organization to an agreement to protect the world's population from the disease threats, particularly those that may spread internationally. However, there is inadequate global understanding of IHR and of its potential role during public health emergencies, both across government and the UN system.

163. The evidence from the Ebola crisis confirmed the need for clear leadership both in a public health crisis and of the IHR. The Review Committee considered that this leadership sits within WHO's mandate. The Committee has considered the recommendation of the UN High-Level Panel to establish a high level council on global public health crises. While recognizing the importance of raising awareness of the IHR globally, the Committee is of the opinion that this structure may duplicate the mandate of WHO, and therefore cause confusion in governance during an emergency and also with regard to the remit of the World Health Assembly. The Committee stresses the importance of WHO in playing a lead role in IHR implementation.

The Review Committee recommends that:

Awareness and recognition of the IHR is improved within the UN system through the designation of an advocate. The key role of WHO in leading and governing implementation of the IHR should be reaffirmed.

UN Secretary-General

4.1 Should consider including in the remit of the UN Secretary General's Special Representative for Disaster Risk Reduction a mandate to act as an advocate for the IHR to ensure that the IHR are well-understood and positioned prominently across sectors both in governments and in international organizations, and that their ongoing implementation is closely monitored. This would serve to improve global awareness and recognition of the IHR and would be a powerful signal from outside WHO, about the importance of the IHR for country governments and not just for ministries of health.

WHO Director-General and UN Secretary-General

4.2 The central role of WHO in risk assessment, management and communication about public health emergencies should be strengthened (see Recommendation 12). The Review Committee does not support the constitution of the High Level council on global public health crisis as currently presented, and the Committee recommends that the UN Secretary General and WHO Director-General should consult before any decisions are taken on implementation of Recommendation 26 of the UN High-Level Panel report.

4.3 In line with WHO's leadership role in coordinating cross-sectoral global responses to public health emergencies, the Review Committee recommends early consultation between the WHO Director-General and the UN Secretary-General in order to facilitate effective and coordinated global response.

Recommendation 5: Introduce and promote external assessment of core capacities**The Review Committee found:**

164. Evaluation of States Parties' progress in establishing IHR core capacities has been mostly based on self-assessment. Although such assessment has had WHO engagement, self-assessment has significant weaknesses. For instance, experience in late 2014 from a WHO-supported external evaluation in the EMRO region revealed shortfalls in core capacities not identified or recognized by previous self-assessment. Thus, external evaluation appears to be a necessary complement. The Committee observed that, with the GHSA also requesting reporting on IHR implementation from participating countries, there is potential for the creation of parallel systems that could be burdensome to countries. The Committee welcomed the WHO IHR Monitoring and Evaluation Framework, which includes the development of the IHR all-hazards Joint External Evaluation Tool (JEET), in collaboration with the GHSA. The new approach of assessment will be submitted to the Sixty-ninth World Health Assembly, and the Committee encourages its endorsement. The Committee recognized other relevant evaluation frameworks and noted that other frameworks make their assessments publically available.

The Review Committee recommends that:

Self-assessment, complemented by external assessment of IHR core capacities, becomes recognized best-practice to monitor and strengthen the implementation of the IHR.

States Parties

5.1 Starting in 2016, all States Parties should urgently undertake an assessment of their core capacities¹ utilising the WHO IHR Monitoring and Evaluation Framework, including the JEET, implemented by an integrated, internal and external evaluation team appointed by WHO and endorsed by the State Party, and jointly funded, to maximize objectivity, and ensure that the findings of such assessments are forwarded promptly to WHO. Each State Party should complete its first joint external evaluation by December 2019, and repeated at least every five years.

5.2 National Action Plans (see Recommendation 2.1.5) should be updated by States Parties within one year of the JEET, with support from WHO regional and country offices as appropriate. This Plan should address identified gaps in capacity in accordance with their national and IHR public health priorities. To fill capacity gaps that cannot be addressed using national resources, States Parties should develop active partnerships with partner countries or other international development partners (see Recommendation 12).

5.3 States Parties that have not yet achieved fully the minimum core capacities, should report annually to the World Health Assembly, commencing in May 2017, including specific information on their progress and outcomes of each area of assessment using JEET and national plans. States Parties who have achieved the capacities should also report annually to WHO on their maintenance activities and status of capacities in the different areas.

5.4 Mindful of the need to not unnecessarily increase the reporting burden of States Parties, any or all of the reporting requirements may be combined into a single report to WHO.

¹ Under IHR Articles 5, 13, 19, and 20, and Annexes 1A and 1B.

WHO Secretariat

5.5 WHO should develop a guidance manual and training programme to assist countries in implementing the IHR in their specific context. This guidance and training should explain the core capacity requirements, the assessment process, the links with the development or funding partners, and the reporting to WHO.

5.6 Noting that a dual reporting system is an unnecessary burden for states that report under both IHR and GHSA, WHO should use its global coordination mandate to ensure that GHSA shares the same IHR reporting.

5.7 WHO should use a risk-based approach to prioritize its technical support for resource-constrained and fragile states at risk of emergence of new diseases or outbreaks.

5.8 The Director-General should invite the World Health Assembly to agree to the following changes in the way that States Parties and the Secretariat report annually, in a single report, to the World Health Assembly on the implementation of the Regulations:

5.8.1 WHO to report which assessment tool, including JEET, that States Parties have used, or agreed to use.

5.8.2 WHO should distribute to each World Health Assembly summaries of the findings of all assessments (including those using the JEET and otherwise) carried out in the preceding 12 months.

5.8.3 WHO should inform the World Health Assembly of each State Party to which it has provided technical or other support in assessment or development/maintenance of the core capacities, and summarize the nature of that support, including support WHO has facilitated or arranged from third parties.

5.8.4 State Parties that have prepared a National Action Plan must ensure that their annual report to the World Health Assembly on IHR implementation includes an update on status, activities and progress with the implementation based specifically on each element of their most recent assessment and national plan, the overall status of their core capacities and highest priority areas requiring further action;

5.8.5 Those States Parties which have not used the JEET should, as part of their annual reporting through WHO to the World Health Assembly, summarize their intentions for developing and maintaining their core capacities beyond 2016;

5.8.6 All States Parties with second extensions to the deadline for core capacities (i.e., June 2016) should provide to WHO (no later than December 2016, for referral to the World Health Assembly in 2017) a final progress report on implementation as organized and described in their implementation plan.

International Development Partners

5.9 Development partners and middle- and high-income countries should build on existing initiatives, including consideration of “twinning” e.g. between Ministries of Health/National Public Health Institutes, to support the implementation of IHR as part of an integrated approach to health-systems strengthening, particularly in low and middle income countries and fragile states.

Recommendation 6: Improve WHO's risk assessment and risk communication**The Review Committee found:**

165. Under the IHR, WHO and States Parties have specific but complementary responsibilities in risk assessment, risk management and risk communication; however, during the Ebola response, neither WHO nor States Parties had sufficient capacity to fulfil these responsibilities adequately. In addition, these responsibilities were poorly coordinated.

166. The Director-General's declaration of an event as a PHEIC is one of the IHR's most powerful tools for warning the world about a major health threat. Yet the criteria for calling an Emergency Committee and for determining a PHEIC are not universally understood, nor is the criteria for ending a PHEIC. If an Emergency Committee is convened by the Director-General but a PHEIC is not determined, there is similarly little guidance on what the ongoing mandate of that Committee is nor how that event should be handled. The binary nature of an event either being declared a PHEIC or not, can mean that the world is required to quickly switch from relative inaction to a state of emergency with little warning. An intermediate level of alert is needed to warn the world of potential threats – that do not meet the criteria of a PHEIC but which nevertheless require coordinated actions to limit the potential spread of disease. In addition, other than the numerous risk assessments shared with NFPs through the EIS, there is little transparency or outside review of WHO's risk assessment work. There is a need for WHO to change its procedures, to improve the effectiveness and the transparency of the Organization's assessment of public health risks of potential international concern.

167. The Committee noted dissatisfaction with WHO's information operations, and that in today's interconnected world, WHO needs to reconsider the balance between the trade-off between the timeliness and accuracy of information provided. This was exacerbated by a general lack of knowledge of the IHR and their practical implications within States Parties and amongst those organizations who were in due course required to respond to the Ebola crisis. However, when WHO did provide information it was highly regarded and influential.

The Review Committee recommends that:

WHO establishes a standing advisory committee, which would have the primary purpose of regularly reviewing WHO's risk assessment and risk communication; creates an intermediate level of alert via a new category of risk that requires specific follow-up, called an International Public Health Alert (IPHA); and develops an updated communication strategy.

WHO Secretariat

6.1 Should establish a standing advisory committee with the primary purpose of regularly reviewing and providing advice to the Director-General on risk assessment and risk communication. This Committee would increase the transparency, quality, and trust in WHO's risk assessments and risk communication. In the Committee's view, the establishment of a standing advisory committee could serve to advise WHO on when an alert is required. The creation of such a committee is aligned with WHO's mandate to give expert public health advice, and is consistent with the IHR. The indicative terms of reference and methods of work for this standing advisory committee are in Appendix IV.

6.2 Should introduce a new level of alert lower than that of a PHEIC, called an International Public Health Alert (IPHA). Issuing an IPHA would be a flexible and rapid way of achieving the intermediate alert level that several panels and States Parties have called for without amendment to the IHR. An IPHA would require specific risk assessment that, where appropriate, includes objective expert advice from the standing advisory committee. For both IPHAs and PHEICs, WHO should define, in a

publicly accessible manual, the purpose and criteria of these alerts, and the operational and financial consequences that they trigger. Factors to be considered in determining an IPHA should include but not be limited to:

- The nature of the disease
- The geographic spread
- The complexity of the coordination of the response
- The extent of political and media interest
- Whether it is a newly emerging disease
- Whether the event may lead to travel and trade restrictions
- Whether the event has the potential to become a PHEIC.

6.3 To ensure consistency of actions associated with different levels of risk and to reduce confusion, the relationships between the risk grading and response actions across the IHR, the updated ERF, and the IASC activation levels, should be clearly documented and communicated to all stakeholders.

6.4 Should develop a risk communications strategy at headquarters, regional and country office levels that allows it to:

6.4.1 Provide timely, authoritative and focused information as well as to react rapidly to misinformation and changing circumstances, using all available forms of communication.

6.4.2 Support countries through better risk communication by: publishing rapid risk assessments on public health risks of potential international concern; updating its Outbreak Communication Guidelines¹ and other material in support of States Parties' risk communication, which can be tailored to local circumstances, and seeks to inform the understanding of IHR.

6.4.3 Provide clear and consistent communication in times of emergency relevant to private sector actors (e.g. pharmaceutical, travel, trade, transport companies) so as to enable them to adjust their operations and plans accordingly and to avert unjustified actions.

6.4.4 Proactively and assertively make use of the provisions in IHR Article 11 to share information about public health risks with States Parties and the public, and engage with States Parties and other stakeholders to increase understanding of IHR and transparency.

6.4.5 Establish active communication and coordination channels with other agencies, so that information is shared on an ongoing basis, which establishes a foundation for effective communication in times of crises.

¹ WHO Outbreak Communications Guidelines. Geneva: World Health Organization; 2005 (<http://www.who.int/risk-communication/guidance/about/en/>, accessed 15 March 2016).

6.4.6 Develop within WHO a coherent overarching narrative and key topline messages that can be cascaded directly to communication practitioners so that various stakeholders can develop specific messages that are aligned. This will minimize conflicting messages and confusion.

6.4.7 Ensure greater ownership of the communication process and outcomes not just within the WHO set up (i.e. consistent internal communications) but also across its various external stakeholders (i.e. States Parties and partners).

6.4.8 Establish robust listening channels (perception surveys, public opinion polls, community feedback) to have a better handle on perception and information gaps so that they can be addressed in a timely manner to suit local conditions.

Section II: Improving delivery of the IHR by reinforcing existing approaches for IHR implementation

Recommendation 7: Enhance compliance with requirements for Additional Measures and Temporary Recommendations

The Review Committee found:

168. The Temporary Recommendations issued by the Director-General after the declaration of a PHEIC provide guidance that is based on objective, independent, expert assessment. During the Ebola emergency, many countries introduced unnecessarily restrictive and unjustified health measures that contravened Temporary Recommendations, harmed local populations and disrupted the global response effort.

169. While inappropriate State Party restrictions were a major factor in airlines ceasing operation, there were many other factors that contributed. These included, for example, lack of assured safe accommodation within affected States for airline crews, a perceived lack of safe facilities for crews if quarantine was required, issues related to aeromedical evacuation for sick crew (in part due to the inappropriate country restrictions), and an absence of timely and authoritative information required by airline decision-makers.

170. Although States Parties are not precluded from implementing measures that are not recommended by WHO, they must meet a number of requirements specified in the IHR. Many States Parties failed to comply with some or all of these requirements. On some occasions, senior WHO officials communicated directly with Ministers and Heads of Government, as well as with NFPs, to have excessive measures lifted; their efforts were often not successful.

The Review Committee recommends that:

States Parties should ensure that the public health response measures they implement comply with the IHR. To this end, WHO should increase transparency about Additional Measures adopted by States Parties, and publicity about Temporary Recommendations, and develop partnerships with international travel and trade organizations, and engage with other relevant private stakeholders.

WHO Secretariat

7.1 Should, when a PHEIC is determined, strengthen its practice of actively monitoring response measures implemented by States Parties and actions taken by non-State actors, and the impact of such measures and actions on other States Parties.

7.2 Should review the public health rationales submitted to it under Article 43 by States Parties implementing additional measures, and inform the State Party as to whether or not it considers that the measures are appropriate.

7.3 When a State Party implements additional measures that go beyond Temporary Recommendations for the event and/or which have an unreasonable adverse impact on one or more other State Parties, and either:

- (i) fails to notify WHO or provide details about such measures when requested or,
- (ii) fails to provide an adequate public health rationale or
- (iii) fails to review such measures within three months or
- (iv) fails to reconsider them when requested to do so by the WHO Secretariat, in addition to immediately posting, and regularly updating, this information on the Event Information Site (including follow-up communications from WHO and/or the State Party), the Committee recommends that after a further period of two weeks, the Secretariat should post a summary on the WHO website and bring this to the attention of the subsequent sessions of the WHO Executive Board and the World Health Assembly.

7.4 WHO should use an escalation pathway to engage with States Parties, including through linkage with the NFP, progressively higher level communication channels with States Parties, including engaging with ministers and heads of government as appropriate.

7.5 WHO should establish a task force with ICAO, IMO, the International Air Transport Association (IATA) and other relevant stakeholders to facilitate rapid information-sharing about risk assessment, risk management and risk communication for important public health events with the travel industry, to ensure that, during a crisis, essential travel (including for example ongoing aeromedical evacuation) continues.

States Parties:

7.6 Ensure that all response measures implemented regarding international traffic and trade, and matters covered by Temporary Recommendations, comply with all relevant IHR obligations.

7.7 Take all possible steps to ensure compliance of airlines and other international carriers operating within their territory to ensure consistency with the State Party's IHR obligations and Temporary Recommendations.

7.8 Ensure coordination with their national health, border, transport and other relevant ministries, and other appropriate transport sector authorities to ensure their compliance with the IHR in relevant contexts, and Temporary Recommendations, and works with commercial organizations in their countries to maintain the continuation of travel and trade with affected States Parties.

Recommendation 8: Strengthen National IHR Focal Points**The Review Committee found:**

171. In the large majority of States Parties, the NFP is located within the Ministry of Health. Under the IHR, NFPs are the essential hub of information among all relevant sectors within countries and for communications with WHO (and increasingly communications between countries). However, NFPs often lack sufficient authority within government to fulfil their mandate of soliciting and gathering relevant information from all sectors, including in outbreaks and other public health emergencies. They must also be able to communicate rapidly and effectively with key decision-makers sometimes at the most senior level. However, NFPs often also lack the required financial, human, administrative and logistical resources to carry out their most essential functions. The Review Committee observed that there was limited knowledge by high level-officials of the role of NFPs, including in communicating with civil society groups and communities. More fundamentally NFPs are often assumed to be an individual despite a clear definition in the IHR (2005) that the NFP is a Centre.

The Review Committee recommends that:

National IHR Focal Points should be centres with sufficient staff with experience, expertise and seniority, and should be supported with the required resources (administrative, logistical and financial) to carry out all of their mandatory coordination and communication functions – as well as any other functions assigned by the State Party.

States Parties

8.1 NFPs must be positioned to ensure they have sufficient authority and governmental mandates to access the most senior government officials in health and other sectors, to access information sources across the health sector (at all levels) and in the many other sectors that are critical for effective compliance by the State Party with its IHR obligations.

WHO Secretariat

8.2 Should update existing guidance from 2007¹ and 2009² that advises States in designating, establishing, legally empowering and other issues relating to the NFP; WHO should develop new guidance in collaboration with States Parties, drawing on the past decade's experience.

8.3 WHO should review the existing network of NFPs and make recommendations on how it might be strengthened, such as through training.

¹ National IHR Focal Point Guide. The designation/establishment of National IHR Focal Points. Geneva: World Health Organization; 2007. (<http://www.who.int/ihr/English2.pdf?ua=1>, accessed 15 March 2016).

² International Health Regulations (2005): Toolkit for implementation in national legislation. The National IHR Focal Point. Geneva: World Health Organization; 2009 (WHO/HSE/IHR/2009.4; http://www.who.int/ihr/NFP_Toolkit.pdf?ua=1, accessed 15 March 2016).

Recommendation 9: Prioritize support to the most vulnerable countries**The Review Committee found:**

172. Challenging situations with regard to the implementation of the IHR can be encountered in many different contexts. Countries affected by protracted crises such as conflict or natural disasters, fragile states vulnerable to public health risks because insecurity can lead to the deterioration of health systems, and some small developing island states are examples of such challenging situations. In particular, core capacities for surveillance, risk assessment, reporting and response may be weak or almost non-existent. Some of these countries have migrant populations or refugees, in whom tracking the spread of disease requires specific approaches.

The Review Committee recommends that:

WHO must prioritize support in establishing core capacities and the detection of public health risks to those countries that are either extremely low-resource, are in the midst of conflict, or those that are considered fragile.

WHO Secretariat and Partners

9.1 Should, in States Parties affected by conflict or other protracted crises, continue to implement innovative and informal arrangements as necessary to perform epidemic intelligence activities to detect acute public health events and help assess these according to Article 9 of the IHR (for example, using mass media, rumour surveillance, social media, health care personnel, nongovernmental organizations and other sources). This may also extend to innovative arrangements to provide technical and financial support for essential clinical and public health functions in conflict-affected areas.

9.2 Should, in States Parties without the appropriate capacities, offer to assess acute events, mobilize public health assistance and work with all relevant stakeholders on the ground with a view to having timely alert and response capabilities in place, for the benefit of all people affected by public health threats.

9.3 Should work with international and humanitarian IGOs and NGOs as well as CSOs, to detect, report, alert and respond in time to events of potential international concern among displaced people. In particular, WHO should coordinate with agencies such as the International Office for Migration (IOM) and the United Nations High Commission for Refugees (UNHCR) to facilitate the exchange of information on migrant populations and undertaking of appropriate actions to stem the spread of disease. The concept of “border spaces” or spaces of vulnerability can be addressed by mobilizing local core capacities at or near the border, rather than just focusing on the more narrowly defined role of points of entry, and screening capacity in such zones should be improved.

9.4 Should work with States Parties with refugees or large mobile populations to ensure that their core capacities and contingency plans include arrangements for such populations. This should include mapping population movement to identify potentially vulnerable zones and areas of high risk in the event of a public health emergency. When relevant, migrants and mobile populations need to be a part of national health emergency response plans.

States Parties

9.5 In the event of a public health risk where there is the likelihood that population movement across the border between two or more States may spread disease, the affected States Parties should establish a cross-border working group on public health coordination.

Recommendation 10: Boost IHR core capacities within health systems strengthening**The Review Committee found:**

173. The core capacities required under the IHR, such as effective surveillance and detection, and emergency response capacities, are an integral part of health systems. In practice, IHR core capacities do not exist separately from national health systems. In many countries, and as shown during the Ebola epidemic in West Africa, the weakness of IHR core capacities reflects the weakness of the health system. Similarly, the effectiveness of a country's response to a public health emergency relies both on the effective core capacities to identify threats and to mobilize resources, but also on a functioning health system, including infection prevention and control. Health-systems strengthening is receiving much-needed global support and financing, and it is important to ensure that such programmes include a focus on IHR core capacities. In addition, the adoption of the Sustainable Development Goals provides an additional argument to support strengthening of health systems as a way to establish and maintain IHR core capacities. The WHO Health Systems and Innovation Cluster is working with Germany and Japan to develop and implement a road map for strengthening health systems, which includes an IHR core capacities component. The Committee considers it critical to strengthen IHR core capacities within the context of wider health-systems strengthening.

The Review Committee recommends that:

WHO and States Parties should ensure that all programmes to strengthen health systems specifically address IHR core capacities.

States Parties

10.1 Should ensure that their legislation and domestic health systems financing plans explicitly include IHR core capacities.

10.2 Should prioritize building on existing systems relevant to IHR core capacities. For example, where there are functional surveillance systems for infectious diseases, zoonoses, antimicrobial resistance, counterfeit drugs, environmental or chemical hazards, and so on, countries should ensure that these systems share information and capabilities, and collaborate to maximize mutual benefits. States Parties should implement programmes on the reinforcement of infection prevention and control, and ensure that these programmes are connected with the implementation of IHR core capacities, and also develop emergency management structures and processes.

International Development Partners

10.3 Should consider, as part of their support for the Global Strategic Plan, how their development aid and technical assistance for health-systems strengthening, in low- and middle-income countries, can include IHR core capacity strengthening.

Recommendation 11: Improve rapid sharing of public health and scientific information and data**The Review Committee found:**

174. Information-sharing and data-sharing during public health crises are critical for an effective response, and for fostering research. It is critical that information-sharing is improved between WHO and States Parties, between States Parties themselves, and among the research community: during the Ebola epidemic, there were delays in the sharing of epidemiological information. These delays arguably slowed the international response, and have occurred in other public health emergencies including MERS and Zika. The Committee found that a number of States Parties continue to be concerned that data-sharing would not be balanced by benefit-sharing. The PIP Framework serves as an example of an agreement that facilitates sample and, potentially, gene sequence data-sharing, with benefit-sharing on an equal footing.

175. The sharing of information or data critical to research can also be hampered for various reasons. The Review Committee supports the WHO's R&D Blueprint which, among other measures to reinforce global preventive measures and preparedness of all-hazards research, aims at "the open sharing of data and the fair sharing of biological samples for research".

The Review Committee recommends that:

WHO champions the open sharing of information on public health risks, and expands guidance on global norms for sharing data¹ to biological samples and gene sequence data during public health emergencies.

WHO and States Parties should ensure that sharing of samples and sequence data is balanced with benefit-sharing on an equal footing.

WHO Secretariat

11.1 WHO should continue to strive for rapid, open-access journal publications on major public health risks. As well as supporting policies on early data-sharing, WHO should also commit to developing the capacity, in terms of technology and language, in low- and middle-income countries to share preliminary research.

States Parties

11.2 Should comply with all IHR requirements regarding the notification, verification and ongoing communication required after detection of a potential public health threat, to support WHO's ability to share information.

WHO Secretariat and States Parties

11.3 Consider using the PIP Framework or similar existing agreements as a template for creating new agreements for other infectious agents that have caused, or may potentially cause, PHEICs. These

¹ Developing global norms for sharing data and results during public health emergencies. Statement arising from a WHO Consultation held on 1–2 September 2015. Geneva: World Health Organization; 2015 (http://www.who.int/medicines/ebola-treatment/blueprint_phe_data-share-results/en/, accessed 15 March 2016).

agreements should be based on the principle of balancing the sharing of samples and data with benefit-sharing on an equal footing.

Recommendation 12: Strengthen WHO's capacity and partnerships to implement the IHR and to respond to health emergencies

The Review Committee found:

176. At the time of the Ebola epidemic, IHR implementation capacity was inadequate at the three WHO levels. Challenges during the Ebola epidemic and response were related to the erosion of human and financial resources of the WHO Secretariat at headquarters, regional office and country office levels. This loss of resources had a significant impact on the capacity of the Secretariat to undertake risk assessment and risk management. The Review Committee is encouraged by the subsequent reforms of WHO structures being implemented by the Director-General.

177. The global response to the Ebola epidemic was characterized by a lack of coordination between WHO, as the key United Nations public health agency, and United Nations humanitarian agencies such as the Office for the Coordination of Humanitarian Affairs (OCHA). This was due in part to inadequately coordinated emergency planning across the United Nations, but also because the crisis was defined as a public health emergency rather than as a humanitarian crisis. At the height of the Ebola crisis, some West African governments were frustrated by the challenges of trying to coordinate all the role-players offering financial and technical support, but it appears that WHO was unable to play an appropriate coordinating role in these instances, including being unable to coordinate with relevant United Nations and humanitarian agencies. The result was that support efforts were sometimes duplicative or out of step with other responses on the ground. In particular, efforts were not informed by other key role-players such as community stakeholders, agriculture, food security, migration and human displacement.

178. The contribution of key actors outside the public health sector to the Ebola response has been under-recognized; however, these stakeholders could be useful partners for WHO in future responses. The Review Committee observed that the role of the private commercial sector was insufficiently acknowledged during the Ebola epidemic, when it contributed usefully to the response. In addition, military medical staff had a significant role in the health response and their role in future outbreaks needs consideration.

The Review Committee recommends that:

WHO's ability to implement the IHR is strengthened through Secretariat reform and stronger partnerships, and significantly increased financial support from States Parties and other key stakeholders.

WHO Secretariat

12.1 The Director-General of WHO should put the implementation of the IHR as a top priority of the WHO Secretariat and make it visible.

12.2 A tiered emergency response structure with strong linkages to both internal and external partners should be instituted, with clear, documented structures and processes for command and control, accountability, and leadership. Such a programme to strengthen and streamline WHO's response to emergencies and to the IHR should be a continued priority, and resources should be appropriately allocated to ensure the rapid success of this new programme. This programme should balance the advantages of a strong, decisive, accountable, multilevel programme with the strengths of

the established working relationships that States Parties have with country and regional offices. There should be accountability for these reforms at WHO through regular reports to the WHO Executive Board and to the World Health Assembly.

12.3 A review of the WHO's regional and country structures for the implementation of the IHR should be completed. This review should allow for adequate staffing and funding of country and regional offices in the most vulnerable regions.

12.4 WHO should strengthen its partnerships with GOARN, and improve its partnerships with CSOs and key private sector stakeholders to enhance the Organization's capacity to perform surveillance, risk assessment and risk communication, but also to benefit from the action and assistance of such organizations in emergency situations.

12.5 WHO should develop agreements relevant to IHR implementation, when not already in place, with key UN agencies and other international bodies (see Recommendation 7.5). WHO should develop or strengthen its links with key UN agencies in the IASC.

12.6 WHO should work with States Parties and conduct joint simulation exercises with NGOs and humanitarian organizations.

12.7 WHO should collaborate with WTO and other relevant agencies, such as ICAO, IMO, OIE, the Food and Agriculture Organization of the United Nations (FAO), and the International Labour Organization (ILO) as appropriate, to develop a prototype template for Standing Recommendations, with a view to such recommendations being recognized as standards under the WTO agreements. The template should be piloted through the development of a small number of examples such as aspects of foodborne illness or yellow fever vaccination certificates. Following this process, the template should be reviewed and revised as appropriate and consideration given to the development of further Standing Recommendations.

12.8 WHO should encourage recognition of such Standing Recommendations in dispute settlement proceedings under WTO agreements, and by an interagency agreement between the WTO and WHO.

12.9 Should provide information technology (IT) systems and/or provide access, where appropriate, to WHO IT systems, to States Parties to assist them with their own public health intelligence and event management functions, and promote risk assessment capacity building at a national level and facilitate risk communication to WHO.

12.10 WHO, through a body such as OCHA's Civil-Military Coordination Section or the International Committee on Military Medicine, seek to identify military medical staff available to deploy, with the agreement of the host country, to provide medical care to civilian healthcare workers in the case of a significant infectious disease outbreak. Such military medical teams should be available within all WHO regions, and where appropriate, external assistance sought to facilitate the training of such teams. This should be linked into WHO's work on the Global Health Emergency Workforce.

12.11 The Task Force charged with examining how air travel might be continued during a future outbreak should consider the relevance to airports of the processes and procedures which successfully enabled large commercial entities to continue operating during the Ebola epidemic.

12.12 WHO should ensure that the health lessons of the commercial organizations which successfully continued operating during the Ebola outbreak, unidentified in all the major reports on Ebola, are captured and disseminated.

States Parties

12.13 Should ensure that consideration is given to how commercial entities might contribute to both surveillance and to the management of public health events, including infectious disease outbreaks.

States Parties and International Development Partners

12.14 Adequate and sustainable funding should be guaranteed for these reform processes.

ANNEX 14

Models developed by the Working Group on Strategic Budget Space Allocation¹ for Segment 1 of the WHO Programme budget

[A69/47, Annex, Appendix 2 – 15 April 2016]

Introduction

1. At its meeting of 8 and 9 April 2015, the Working Group made a number of suggestions to the Secretariat and their consultant on new models they would like them to run relating to Segment 1. The Working Group proposed that it would consider the results at a meeting on the fringes of the World Health Assembly in May 2015.

2. The previous models, based on the methods developed and approved by the World Health Assembly in 2006, had followed six steps and the Working Group suggested modifications to some of them. The original steps follow to facilitate explanation of the modifications.

- a. **Step 1:** Identify the variables (indicators) to use to determine country needs, put them in per capita terms, where appropriate, scale them from zero to one so that they can be compared in the same units, and take an arithmetic mean to get a composite score.
- b. **Step 2:** Estimate the model of per capita country needs based on this composite score.
- c. **Step 3:** Classify countries into groups so that the least needy countries would receive no allocation. In the work prepared by the Secretariat previously for consideration by the Working Group, that was done in terms of need deciles (10% of countries). The two least needy deciles (or the least needy 20% of countries) would receive zero allocation for Segment 1. Decile 8 would receive a per capita allocation of 1; each subsequent decile would receive a higher weighted need because of their greater estimated need. The first decile of countries, the most needy, would receive just over six times more per capita than those in decile 8. This weighting was taken from the 2006 model. Each country within a specific decile would receive the same per capita allocation as in 2006.
- d. **Step 4:** Decide on a method to scale up the estimated per capita needs to the size of the population. Following the 2006 approach, three methods were prepared by the Secretariat and discussed by the Working Group, all of which assume some degree of economies of scale, that is, per capita needs for funding falls as population rises:
 - i. **Square root of population** – closer to actual distribution of the population, compresses population the least so gives relatively higher allocations to large countries compared to small countries;

¹ Decision WHA69(16) (2016).

- ii. **Log of population** – more compression than the square root so gives relatively higher allocations to countries with smaller than larger populations;
 - iii. **Adjusted log population squared (ALPS)** – a compromise between log of population and square root.
- e. **Step 5:** Estimate notional country proportion of the total allocations – multiply the per capita needs index for each country by the population scaling factor and divide by the sum of all country population adjusted needs. This gives each country's share.
 - f. **Step 6:** Estimate regional proportions of the total allocations – the sum of each country's population adjusted share in the region gives the regional share of the total allocation.
3. The modifications requested by the Working Group are outlined here in order of the above steps:
- a. **Indicators of need:** Omit total disability-adjusted life years (DALYs) per capita, the proportion of deliveries in the presence of skilled birth attendants and population density. Use the following indicators and domains:
 - **Health status**
 - Life expectancy
 - Under-5 mortality
 - Noncommunicable diseases (several indicators to be explored including prevalence of tobacco use, premature death due to noncommunicable diseases (NCDs))
 - **Economic variables**
 - Gross national income (GNI) per capita in purchasing power parities (PPP)
 - Poverty headcount ratio at US\$ 1.25 a day as percentage of the population
 - **Access**
 - Health workforce density
 - Political instability (several indicators to be explored including indicators used by the World Bank)
 - DTP3 coverage¹
 - b. **Change the method of scaling indicators from 0 to 1.** Rather than using the method of 2006, adopt the method used by UNDP in the Human Development Report.
 - c. **Omit the first part of step 3** – the Working Group recommended not to divide countries into deciles and apply the same needs to all countries in each decile. It also decided not to use a separate need's index but instead to use the actual composite score (the average of the eight indicators). The Working Group recommended, however, to still cut off the

¹ [Three doses of diphtheria-tetanus-pertussis vaccine].

lowest need 20% of countries or use another way to assign 0 (“no need”) to best performing countries.

- d. **Explore and compare various population scaling factors** for their impact on the final allocation, including the three used to date as well as those used by institutions such as the United Nations Economic and Social Council and the African Development Bank.

Missingness

4. Table 1 shows the degree of missingness for each of the variables recommended by the Working Group.

5. The main issue is with the poverty indicator where 53.6% of countries do not have data from the most recent years (after 2010). If we relax the requirement that data are recent, and take any data point from 2000, the missingness is still 28.9%.

6. For all indicators, except poverty, we simply used the average of the countries in the region for which data were available to impute missing values.

7. For poverty, this approach would lead to counterintuitive results due to extremely diverse levels of economic development among countries in the same region (for example, Switzerland and Tajikistan in the European Region (EUR), United Arab Emirates and Afghanistan in the Eastern Mediterranean Region (EMR) etc.). We therefore chose to impute using the average for countries at the different income levels as denoted by the World Bank in its current classification – high income, upper-middle income, lower-middle income, low income.

Table 1: Missingness, timeliness and source of data

Domain	Indicator	% missing	Year	Source
Health				
	Life expectancy	0	2012	GHO
	Under-5 mortality rate (per 1000 live births)	1.6	2013	WDI
	Infant mortality rate (per 1000 live births)	1.6	2013	WDI
	Current smoking of any tobacco product (% of population)	29.9	2011	GHO
	Age-standardized mortality rate due to NCDs (per 100 000 population)	11.9	2012	GHO
Economic				
	GNI per capita PPP \$	7.2	Latest available between 2010–2013	WDI
	Poverty headcount ratio at \$1.25 a day (PPP) (% of population)	53.6	Latest available between 2010–2013	WDI
	Poverty headcount ratio at \$1.25 a day (PPP) (% of population)	28.9	Latest available between 2000–2014	WDI

Access				
DTP3	0.0	2013	GHO	
Combined Physicians–Nurses/Midwives per 1000 population	3.6	Latest available between 2010–2013		WDI
Political Stability and Absence of Violence/Terrorism (Government Effectiveness)	1.0	2013	WGI	

Acronyms: GHO = WHO’s Global Health Observatory; WDI is World Bank’s World Development Indicators; WGI is World Bank’s Worldwide Governance Indicators.

Population scaling

8. We estimated all models using the three population scaling methods described above, and added two more.

9. The first is used by the Asian Development Bank (population size to the power of 0.6 – the square root used above raises population size to the power of 0.5) so the ADB approach compresses population less than the original three options: log(pop), sqrt(pop), and ALPS.

10. The second was suggested by Australia in their comments on the previous methods. They suggested that even small countries need some sort of WHO presence either in country or in a subregional office, so a minimum allocation per country regardless of how small they are is warranted. Having reviewed other existing approaches to this issue, Australia had also suggested using the WB definition of small States, defined as countries with a population of 1.5 million or less. The value of ALPS for a population of 1.5 million (e.g. Gabon) is 0.47, so this factor was applied to all countries with a population of less than 1.5 million as well.

Results with the variables and methods suggested by the Working Group

11. Table 2 shows Model A which includes all the indicators suggested by the Working Group but using the percentage of adult smokers as the indicator of noncommunicable disease need. In this model, the 20% of countries with the lowest need are not given any allocation. Most of the regional allocations are a long way from current allocations, particularly for the African Region (AFR) and the European Region.

Table 2: Model A

Region	Log(pop)	SQRT	ALPS	ADB	ALPS_min
AFR	39.0	34.0	36.6	31.6	35.4
AMR	13.3	11.6	12.6	10.9	12.9
EMR	14.5	14.7	13.9	14.4	13.3
EUR	14.5	12.1	13.6	11.1	13.1
SEAR	9.6	16.2	12.5	19.2	12.1
WPR	9.1	11.3	10.9	12.8	13.2

(Indicators: life expectancy, under-5 mortality, adult smoking rate, GNI per capita PPP, Poverty head count < \$1.25, DTP3, health worker density, political stability)

12. In Table 3, Model B replicates Model A, but using age standardized mortality due to noncommunicable diseases instead of smoking. AFR would receive a larger allocation and EUR less, but AFR still receives less than 40% with all but one of the population scaling methods.

Table 3: Model B

Region	Log(pop)	SQRT	ALPS	ADB	ALPS_min
AFR	41.3	36.2	38.8	33.6	37.6
AMR	13.2	11.3	12.5	10.6	13.1
EMR	15.2	15.5	14.6	15.1	14.0
EUR	12.4	10.2	11.6	9.4	11.0
SEAR	9.5	16.4	12.5	19.5	12.1
WPR	8.3	10.4	10.0	11.9	12.1

(Indicators: life expectancy, under-5 mortality, age standardized NCD mortality rate, GNI per capita PPP, Poverty head count < \$1.25, DTP3, health worker density, political stability)¹

13. We then adapted Model B to incorporate something that China had suggested in its comments on the previous model. Model C (Table 4) slightly changes the way the country needs allocations are made. Instead of assigning zero to the best performing 20% of countries based on the composite score, China had suggested the following: for each of the indicators, a country receives zero on that indicator if it performed at the same level or above the OECD median. For example, the OECD median for life expectancy at birth is 81 years. Thus, those countries where life expectancy is 81 years or higher would get zero for this indicator in the composite score.

14. Countries could get a zero score on one indicator but a positive score on others, zero on all of them, or positive on all. The average of all indicators describes the countries overall need. Note that high income countries scoring above the OECD median on all indicators receive no budget allocation. All other steps, including scaling of variables based on the UNDP method, are as before.

15. Table 4 shows the allocations based on this model (Model C). The last column is the results to the 2014–2015 planned budget allocations to allow a comparison.

Table 4: Model C: Model based on zero need for indicators above the OECD median

Region	Log(pop)	SQRT	ALPS	ADB	ALPS_min	Planned budget for 2014–2015
AFR	47.4	41.2	44.5	38.3	43.4	42.3
AMR	11.7	9.9	11.1	9.2	11.3	8.4
EMR	15.3	15.7	14.7	15.4	14.2	14.3
EUR	6.8	5.9	6.4	5.5	6.4	4.5
SEAR	10.9	18.7	14.5	22.3	14.1	15.7
WPR	7.8	8.6	8.8	9.3	10.6	14.8

¹ Inclusion of the indicator “deliveries in the presence of skilled birth attendants (SBA)” made very little difference to the regional allocations of Models A and B.

ANNEX 15

Financial and administrative implications for the Secretariat of resolutions and decisions adopted by the Health Assembly

Resolution WHA69.1 Strengthening essential public health functions in support of the achievement of universal health coverage
A. Link to the general programme of work and the programme budget
<p>1. Please indicate to which impact and outcome in the Twelfth General Programme of Work, 2014–2019 and which output in the Programme budget 2016–2017 this draft resolution will contribute if adopted.</p> <p>Twelfth General Programme of Work, 2014–2019: Given that essential public health functions by definition touch on a wide range of health goals, the resolution will contribute to all eight impact goals: reduce under-5 child mortality; reduce maternal mortality; reduce the number of people dying from AIDS, tuberculosis and malaria; eradicate poliomyelitis; reduce dracunculiasis; reduce premature mortality from noncommunicable diseases; prevent death, illness and disability arising from emergencies; and reduce rural-urban difference in under-5 mortality.</p> <p>Programme budget 2016–2017: Outcome 3.4 Strengthened intersectoral policies and actions to increase health equity by addressing social determinants of health; Outcome 3.5 Reduced environmental threats to health; Outcome 4.3 Improved access to, and rational use of, safe, efficacious and quality medicines and other health technologies; Outcome 4.2 Policies, financing and human resources in place to increase access to integrated, people-centred health services; Outcome 4.4 All countries having well-functioning health information, eHealth, research, ethics and knowledge management systems to support national health priorities; Outcome 5.1 All obligations under the International Health Regulations (2005) met; Outcome 5.3 Countries with the capacity to manage public health risks associated with emergencies; Outcome 5.4 All countries are adequately prepared to prevent and mitigate risks to food safety; and Outcome 5.6 All countries adequately respond to threats and emergencies with public health consequences.</p>
<p>2. If there is no link to the results as indicated in the Twelfth General Programme of Work, 2014–2019 and the Programme budget 2016–2017, please provide a justification for giving consideration to the draft resolution.</p> <p>Not applicable.</p>
<p>3. What is the proposed timeline for implementation of this resolution?</p> <p>To be aligned with the 2030 Agenda for Sustainable Development.</p> <p><i>If the timeline stretches to future programme budgets, please ensure that further information is provided in the costing section.</i></p>

B. Budgetary implications of implementation of the resolution			
1. Current biennium: estimated budgetary requirements, in US\$			
<p>The areas of work highlighted in the resolution touch on: (a) awareness and advocacy; (b) coordination; (c) country support; and (d) monitoring and evaluation. The broad scope of the work currently being done across WHO in the areas of essential public health makes estimating the amounts of the current budget being devoted to these areas a complex task. An analysis is nevertheless presented below.</p> <p>The majority of the work will have to be done with the current resources and staffing.</p>			
Level	Staff	Activities	Total
Country offices	0	19 950 000	19 950 000
Regional offices	0	1 200 000	1 200 000
Headquarters	0	1 000 000	1 000 000
Total	0	22 150 000	22 150 000
1(a) Is the estimated budget requirement in respect of implementation of the resolution fully included within the current programme budget? (Yes/No)			
Yes.			
1(b) Financing implications for the budget in the current biennium:			
– How much is financed in the current biennium?			
100%			
Monitoring and evaluation implications of the resolution will be incorporated into broader efforts to monitor the health-related goals of the 2030 Agenda for Sustainable Development.			
– What are the gaps?			
None.			
– What action is proposed to close these gaps?			
Not applicable.			
2. Next biennium: estimated budgetary requirements, in US\$			
Level	Staff	Activities	Total
Country offices	0	19 950 000	19 950 000
Regional offices	0	1 200 000	1 200 000
Headquarters	0	1 000 000	1 000 000
Total	0	22 150 000	22 150 000
2(a) Financing implications for the budget in the next biennium:			
– How much is currently financed in the next biennium?			
Financing gaps may arise once the implications for WHO's work have been determined.			
– What are the financing gaps?			
Unknown at present.			
– What action is proposed to close these gaps?			
Any gaps would be addressed as part of the Organization-wide coordinated resource-mobilization plan for dealing with funding shortfalls in the programme budget for the next biennium.			

Resolution WHA69.2 Committing to implementation of the Global Strategy for Women's, Children's and Adolescents' Health			
A. Link to the general programme of work and the programme budget			
1. Please indicate to which impact and outcome in the Twelfth General Programme of Work, 2014–2019 and which output in the Programme budget 2016–2017 this draft resolution will contribute if adopted.			
From the Twelfth General Programme of Work, 2014–2019:			
Impact goal: Reduce under-five child mortality			
Outcome: Increased access to interventions for improving health of women, newborns, children and adolescents			
From the Programme budget 2016–2017:			
Outcome 3.1.			
Outputs 3.1.1, 3.1.2, 3.1.3, 3.1.4, 3.1.5 and 3.1.6.			
2. If there is no link to the results as indicated in the Twelfth General Programme of Work, 2014–2019 and the Programme budget 2016–2017, please provide a justification for giving consideration to the draft resolution.			
Not applicable.			
3. What is the proposed timeline for implementation of this resolution?			
2016–2030.			
<i>If the timeline stretches to future programme budgets, please ensure that further information is provided in the costing section.</i>			
B. Budgetary implications of implementation of the resolution			
1. Current biennium: estimated budgetary requirements: US\$ 206.1 million			
Level	Staff	Activities	Total
Country offices	33.6	77.8	111.4
Regional offices	18.4	16.8	35.2
Headquarters	35.7	23.8	59.5
Total	87.7	118.4	206.1
1(a) Is the estimated budget requirement in respect of implementation of the resolution fully included within the current programme budget? (Yes/No)			
Yes.			
1(b) Financing implications for the budget in the current biennium:			
– How much is financed in the current biennium?			
US\$ 141.5 million			
– What are the gaps?			
US\$ 64.6 million			
– What action is proposed to close these gaps?			
The gap will be addressed through the coordinated resource mobilization efforts including the financing dialogue for possible financing by voluntary contribution.			

2. Next biennium: estimated budgetary requirements, in US\$ millions			
Level	Staff	Activities	Total
Country offices	–	–	–
Regional offices	–	–	–
Headquarters	–	–	–
Total	–	–	–
<p>2(a) Financing implications for the budget in the next biennium: Information not yet available.</p> <p>– How much is currently financed in the next biennium? To be determined during the development of the programme budget for 2018–2019.</p> <p>– What are the financing gaps? US\$ millions – to be determined.</p> <p>– What action is proposed to close these gaps? Not applicable.</p>			
<p>Resolution WHA69.3 Global strategy and action plan on ageing and health 2016–2020: towards a world in which everyone can live a long and healthy life</p>			
A. Link to the general programme of work and the programme budget			
<p>1. Please indicate to which impact and outcome in the Twelfth General Programme of Work, 2014–2019 and which output in the Programme budget 2016–2017 this draft resolution will contribute if adopted.</p> <p>Category 3, Promoting health through the life course: Outcome 3.2 ageing and health, and outputs 3.2.1, 3.2.2 and 3.2.3.</p>			
<p>2. If there is no link to the results as indicated in the Twelfth General Programme of Work, 2014–2019 and the Programme budget 2016–2017, please provide a justification for giving consideration to the draft resolution.</p> <p>Not applicable.</p>			
<p>3. What is the proposed timeline for implementation of this resolution?</p> <p>2016–2020 in line with Global Strategy and Action Plan on Ageing and Health</p> <p><i>If the timeline stretches to future programme budgets, please ensure that further information is provided in the costing section.</i></p>			
B. Budgetary implications of implementation of the resolution			
1. Current biennium: estimated budgetary requirements, in US\$ million			
Level	Staff	Activities	Total
Country offices	4.00	6.00	10.00
Regional offices	2.88	4.32	7.20
Headquarters	7.68	5.12	12.80
Total	14.56	15.44	30.00

<p>1(a) Is the estimated budget requirement in respect of implementation of the resolution fully included within the current programme budget? (Yes/No)</p> <p>Yes.</p>																							
<p>1(b) Financing implications for the budget in the current biennium:</p> <p>– How much is financed in the current biennium?</p> <p>US\$ 13.5 million</p> <p>– What are the gaps?</p> <p>US\$ 16.5 million</p> <p>– What action is proposed to close these gaps?</p> <p>The gap will be addressed through coordinated resource mobilization efforts, including the financing dialogue, for possible financing by voluntary contributions.</p>																							
<p>2. Next biennium: estimated budgetary requirements, in US\$ million</p> <table border="1"> <thead> <tr> <th>Level</th> <th>Staff</th> <th>Activities</th> <th>Total</th> </tr> </thead> <tbody> <tr> <td>Country offices</td> <td>6.60</td> <td>9.90</td> <td>16.50</td> </tr> <tr> <td>Regional offices</td> <td>4.92</td> <td>7.38</td> <td>12.30</td> </tr> <tr> <td>Headquarters</td> <td>8.48</td> <td>12.72</td> <td>21.20</td> </tr> <tr> <td>Total</td> <td>20.00</td> <td>30.00</td> <td>50.00</td> </tr> </tbody> </table>				Level	Staff	Activities	Total	Country offices	6.60	9.90	16.50	Regional offices	4.92	7.38	12.30	Headquarters	8.48	12.72	21.20	Total	20.00	30.00	50.00
Level	Staff	Activities	Total																				
Country offices	6.60	9.90	16.50																				
Regional offices	4.92	7.38	12.30																				
Headquarters	8.48	12.72	21.20																				
Total	20.00	30.00	50.00																				
<p>2(a) Financing implications for the budget in the next biennium:</p> <p>– How much is currently financed in the next biennium?</p> <p>US\$ 10 million</p> <p>– What are the financing gaps?</p> <p>US\$ 40 million</p> <p>– What action is proposed to close these gaps?</p> <p>The gap will be addressed through coordinated resource mobilization efforts, including the financing dialogue, for possible financing by voluntary contributions.</p>																							

<p>Resolution WHA69.4 The role of the health sector in the Strategic Approach to International Chemicals Management towards the 2020 goal and beyond</p>	
<p>A. Link to the general programme of work and the programme budget</p>	
<p>1. Please indicate to which impact and outcome in the Twelfth General Programme of Work, 2014–2019 and which output in the Programme budget 2016–2017 this draft resolution will contribute if adopted.</p> <p>Twelfth General Programme of Work, 2014–2019: Impact goals: Reduce premature mortality from noncommunicable diseases; and Prevention of death, illness and disability arising from emergencies; and Outcome: Reduced environmental threats to health.</p> <p>Programme budget 2016–2017: Output 3.5.1 Countries enabled to assess health risks and develop and implement policies, strategies or regulations for the prevention, mitigation and management of the health impacts of environmental and occupational risks;</p> <p>Output 3.5.2 Norms and standards established and guidelines developed for environmental and occupational health risks and benefits associated with, for example, air and noise pollution, chemicals, waste, water and sanitation, radiation, nanotechnologies and climate change; and</p> <p>Output 3.5.3 Public health objectives addressed in implementation of multilateral agreements and conventions on the environment and in relation to the proposed sustainable development goals and the post-2015 development agenda.</p>	

<p>2. If there is no link to the results as indicated in the Twelfth General Programme of Work, 2014–2019 and the Programme budget 2016–2017, please provide a justification for giving consideration to the draft resolution.</p> <p>Not applicable.</p>			
<p>3. What is the proposed timeline for implementation of this resolution?</p> <p>A road map, to be developed in consultation with Member States and others, will be presented to the Seventieth World Health Assembly, in 2017, and a report on waste produced within the current biennium.</p> <p><i>If the timeline stretches to future programme budgets, please ensure that further information is provided in the costing section.</i></p>			
<p>B. Budgetary implications of implementation of the resolution</p> <p>The budgetary implications are largely driven by the process used for consultation on the road map.</p>			
<p>1. Current biennium: estimated budgetary requirements, in US\$ million</p>			
Level	Staff	Activities	Total
Country offices	n/a	n/a	n/a
Regional offices	0.18	0.60	0.78
Headquarters	0.12	0.26	0.38
Total	0.30	0.86	1.16
<p>1(a) Is the estimated budget requirement in respect of implementation of the resolution fully included within the current programme budget? (Yes/No)</p> <p>Yes.</p>			
<p>1(b) Financing implications for the budget in the current biennium:</p> <ul style="list-style-type: none"> – How much is financed in the current biennium? US\$ 0.35 million – What are the gaps? US\$ 0.81 million – What action is proposed to close these gaps? The gap will be addressed through coordinated resource mobilization efforts for possible financing by voluntary contribution. 			
<p>2. Next biennium: estimated budgetary requirements, in US\$ million</p>			
Level	Staff	Activities	Total
Country offices	n/a	n/a	n/a
Regional offices	n/a	n/a	n/a
Headquarters	n/a	n/a	n/a
Total	n/a	n/a	n/a
<p>2(a) Financing implications for the budget in the next biennium:</p> <ul style="list-style-type: none"> – How much is currently financed in the next biennium? Not applicable. – What are the financing gaps? Not applicable. – What action is proposed to close these gaps? Not applicable. 			

Resolution WHA69.5 WHO global plan of action to strengthen the role of the health system within a national multisectoral response to address interpersonal violence, in particular against women and girls, and against children			
A. Link to the general programme of work and the programme budget			
1. Please indicate to which impact and outcome in the Twelfth General Programme of Work, 2014–2019 and which output in the Programme budget 2016–2017 this draft resolution will contribute if adopted.			
Twelfth General Programme of Work, 2014–2019: Outcome 2.3 Reduced risk factors and improved coverage with interventions to prevent and manage unintentional injuries and violence;			
Outcome 3.1 Reproductive, maternal, newborn, child and adolescent health: Increased access to interventions for improving the health of women, newborns, children and adolescents; and			
Outcome 5.3 Emergency risk and crisis management: countries with capacity to manage public health risks associated with emergencies.			
Programme budget 2016–2017: Output 2.3.3 Development and implementation of policies and programmes to address violence against women, youth and children facilitated;			
Output 3.1.3 Countries enabled to implement and monitor effective interventions to cover unmet needs in sexual and reproductive health;			
Output 3.1.6 Research undertaken and research capacity strengthened for sexual and reproductive health including in family planning, maternal and perinatal health, adolescent sexual and reproductive health, sexually transmitted infections, preventing unsafe abortion, infertility, sexual health, female genital mutilation, violence against women, and sexual and reproductive health in humanitarian settings; and			
Output 5.3.1 Technical assistance to Member States for the development and maintenance of core capacities to manage risks to health associated with disasters and conflicts using an all-hazards approach.			
2. If there is no link to the results as indicated in the Twelfth General Programme of Work, 2014–2019 and the Programme budget 2016–2017, please provide a justification for giving consideration to the draft resolution.			
Not applicable.			
3. What is the proposed timeline for implementation of this resolution?			
The global plan of action covers the 15-year 2016–2030 timeline, in line with the Sustainable Development Goals.			
<i>If the timeline stretches to future programme budgets, please ensure that further information is provided in the costing section.</i>			
B. Budgetary implications of implementation of the resolution			
1. Current biennium: estimated budgetary requirements, in US\$			
Level	Staff	Activities	Total
Country offices	1 113 750	800 000	1 913 750
Regional offices	3 875 000	2 250 000	6 125 000
Headquarters	4 278 450	5 365 000	11 643 450
Total	9 267 200	8 415 000	17 682 200

<p>1(a) Is the estimated budget requirement in respect of implementation of the resolution fully included within the current programme budget? (Yes/No)</p> <p>Yes.</p>			
<p>1(b) Financing implications for the budget in the current biennium:</p> <p>– How much is financed in the current biennium?</p> <p>40%</p> <p>– What are the gaps?</p> <p>60%</p> <p>– What action is proposed to close these gaps?</p> <p>Coordinated resource mobilization through the Financing Dialogue and voluntary specified fundraising.</p>			
<p>2. Next biennium: estimated budgetary requirements, in US\$</p>			
Level	Staff	Activities	Total
Country offices	3 275 750	4 000 000	7 275 750
Regional offices	6 053 550	3 850 000	9 903 550
Headquarters	6 839 200	9 718 000	17 657 200
Total	16 168 500	17 568 000	33 736 500
<p>2(a) Financing implications for the budget in the next biennium:</p> <p>– How much is currently financed in the next biennium?</p> <p>At present there is no funding for 2018–2019.</p> <p>– What are the financing gaps?</p> <p>100%</p> <p>– What action is proposed to close these gaps?</p> <p>Actions to be determined as necessary: coordinated resource mobilization through the Financing Dialogue and voluntary specified fundraising.</p>			

<p>Resolution WHA69.6 Prevention and control of noncommunicable diseases: responses to specific assignments in preparation for the third High-level Meeting of the United Nations General Assembly on the Prevention and Control of Non-communicable Diseases in 2018</p>	
<p>A. Link to the general programme of work and the programme budget</p>	
<p>1. Please indicate to which impact and outcome in the Twelfth General Programme of Work, 2014–2019 and which output in the Programme budget 2016–2017 this draft resolution will contribute if adopted.</p> <p>Programme budget 2016–2017: Output 2.1.1 Development and/or implementation of multisectoral policies and plans to prevent and control noncommunicable diseases accelerated.</p>	
<p>2. If there is no link to the results as indicated in the Twelfth General Programme of Work, 2014–2019 and the Programme budget 2016–2017, please provide a justification for giving consideration to the draft resolution.</p> <p>Not applicable.</p>	

3. What is the proposed timeline for implementation of this resolution?			
2016 and 2017.			
<i>If the timeline stretches to future programme budgets, please ensure that further information is provided in the costing section.</i>			
B. Budgetary implications of implementation of the resolution			
1. Current biennium: estimated budgetary requirements, in US\$			
Level	Staff	Activities	Total
Country offices	0	0	0
Regional offices	0	0	0
Headquarters	1 100 000	100 000	1 200 000
Total	1 100 000	100 000	1 200 000
1(a) Is the estimated budget requirement in respect of implementation of the resolution fully included within the current programme budget? (Yes/No)			
Yes.			
1(b) Financing implications for the budget in the current biennium:			
– How much is financed in the current biennium?			
100%			
– What are the gaps?			
None.			
– What action is proposed to close these gaps?			
Not applicable.			
2. Next biennium: estimated budgetary requirements, in US\$			
Level	Staff	Activities	Total
Country offices	0	0	0
Regional offices	0	0	0
Headquarters	0	0	0
Total	0	0	0
2(a) Financing implications for the budget in the next biennium:			
– How much is currently financed in the next biennium?			
Not applicable.			
– What are the financing gaps?			
Not applicable.			
– What action is proposed to close these gaps?			
Not applicable.			

Resolution WHA69.7 Addressing the challenges of the United Nations Decade of Action for Road Safety (2011–2020): outcome of the second Global High-level Conference on Road Safety – Time for Results			
A. Link to the general programme of work and the programme budget			
1. Please indicate to which impact and outcome in the Twelfth General Programme of Work, 2014–2019 and which output in the Programme budget 2016–2017 this draft resolution will contribute if adopted.			
Impacts: reduce premature mortality from noncommunicable diseases; and prevention of death, illness and disability arising from emergencies. Outcome 2.3, output 2.3.1.			
2. If there is no link to the results as indicated in the Twelfth General Programme of Work, 2014–2019 and the Programme budget 2016–2017, please provide a justification for giving consideration to the draft resolution.			
Not applicable.			
3. What is the proposed timeline for implementation of this resolution?			
A process to set targets and indicators will be developed during the biennium 2016–2017 and other activities referred to in the resolution will be carried out during the bienniums 2016–2017 and 2018–2019.			
<i>If the timeline stretches to future programme budgets, please ensure that further information is provided in the costing section.</i>			
B. Budgetary implications of implementation of the resolution			
1. Current biennium: estimated budgetary requirements, in US\$ million			
Level	Staff	Activities	Total
Country offices	1.20	1.30	2.50
Regional offices	1.00	0.50	1.50
Headquarters	2.00	1.30	3.30
Total	4.20	3.10	7.30
1(a) Is the estimated budget requirement in respect of implementation of the resolution fully included within the current programme budget? (Yes/No) Yes			
1(b) Financing implications for the budget in the current biennium:			
– How much is financed in the current biennium? US\$ 5.84 million			
– What are the gaps? US\$ 1.46 million			
– What action is proposed to close these gaps?			
The gap will be closed through resource mobilization and voluntary contributions.			

2. Next biennium: estimated budgetary requirements, in US\$ million			
Level	Staff	Activities	Total
Country offices	1.30	1.50	2.80
Regional offices	1.10	0.75	1.85
Headquarters	2.20	1.20	3.40
Total	4.60	3.45	8.05

2(a) Financing implications for the budget in the next biennium:

- How much is currently financed in the next biennium? US\$ 1.81 million
- What are the financing gaps? US\$ 6.24 million
- What action is proposed to close these gaps?

The gap will be closed through the financing dialogue and extrabudgetary funding.

Resolution WHA69.8 United Nations Decade of Action on Nutrition (2016–2025)			
A. Link to the general programme of work and the programme budget			
1. Please indicate to which impact and outcome in the Twelfth General Programme of Work, 2014–2019 and which output in the Programme budget 2016–2017 this draft resolution will contribute if adopted.			
General Programme of Work outcome 2.5 and Programme budget output 2.5.1.			
2. If there is no link to the results as indicated in the Twelfth General Programme of Work, 2014–2019 and the Programme budget 2016–2017, please provide a justification for giving consideration to the draft resolution.			
Not applicable.			
3. What is the proposed timeline for implementation of this resolution?			
Implementing the resolution will require long-term commitment from Member States. The Secretariat can immediately implement tasks during the biennium 2016–2017 and report to the Health Assembly in 2018 and 2020.			
<i>If the timeline stretches to future programme budgets, please ensure that further information is provided in the costing section.</i>			
B. Budgetary implications of implementation of the resolution			
1. Current biennium: estimated budgetary requirements, in US\$ million			
Level	Staff	Activities	Total
Country offices	0.360	1.200	1.560
Regional offices	0.660	0.300	0.960
Headquarters	1.334	0.800	2.134
Total	2.354	2.300	4.654

<p>1(a) Is the estimated budget requirement in respect of implementation of the resolution fully included within the current programme budget? (Yes/No)</p> <p>Yes.</p>			
<p>1(b) Financing implications for the budget in the current biennium:</p> <p>– How much is financed in the current biennium? US\$ 3.014 million</p> <p>– What are the gaps? US\$ 1.640 million</p> <p>– What action is proposed to close these gaps? For staff: synergies with other programmes and discussions with regional offices and with donors at the country level. For meetings: discussions with FAO on cost-sharing and jointly approach donors.</p>			
<p>2. Next biennium: estimated budgetary requirements, in US\$ million</p>			
Level	Staff	Activities	Total
Country offices	0.360	1.200	1.560
Regional offices	0.660	0.300	0.960
Headquarters	1.334	0.200	1.534
Total	2.354	1.700	4.054
<p>2(a) Financing implications for the budget in the next biennium:</p> <p>– How much is currently financed in the next biennium? US\$ 2.514 million</p> <p>– What are the financing gaps? US\$ 1.540 million</p> <p>– What action is proposed to close these gaps? For staff: synergies with other programmes and discussions with regional offices and with donors at the country level. For meetings: discussions with FAO on cost-sharing and jointly approach donors.</p>			

<p>Resolution WHA69.9 Ending inappropriate promotion of foods for infants and young children</p>	
<p>A. Link to the general programme of work and the programme budget</p>	
<p>1. Please indicate to which impact and outcome in the Twelfth General Programme of Work, 2014–2019 and which output in the Programme budget 2016–2017 this draft resolution will contribute if adopted.</p> <p>General Programme of Work outcome 2.5 and Programme budget output 2.5.2.</p>	
<p>2. If there is no link to the results as indicated in the Twelfth General Programme of Work, 2014–2019 and the Programme budget 2016–2017, please provide a justification for giving consideration to the draft resolution.</p> <p>Not applicable.</p>	

3. What is the proposed timeline for implementation of this resolution?

Implementing the resolution will require long-term commitment from Member States. The Secretariat can immediately implement tasks during the biennium 2016-2017 and report to the Health Assembly in 2018 and 2020.

If the timeline stretches to future programme budgets, please ensure that further information is provided in the costing section.

B. Budgetary implications of implementation of the resolution**1. Current biennium: estimated budgetary requirements, in US\$ million**

Level	Staff	Activities	Total
Country offices	0.120	0.100	0.220
Regional offices	0.330	0.081	0.411
Headquarters	0.330	0.020	0.350
Total	0.780	0.201	0.981

1(a) Is the estimated budget requirement in respect of implementation of the resolution fully included within the current programme budget? (Yes/No)

Yes.

1(b) Financing implications for the budget in the current biennium:**– How much is financed in the current biennium?**

US\$ 0.89 million

– What are the gaps?

US\$ 0.09 million

– What action is proposed to close these gaps?

Synergies with other programmes and discussion with regional offices and with donors at the country level.

2. Next biennium: estimated budgetary requirements, in US\$ million

Level	Staff	Activities	Total
Country offices	0.120	0.100	0.220
Regional offices	0.330	0.081	0.411
Headquarters	0.330	0.020	0.350
Total	0.780	0.201	0.981

2(a) Financing implications for the budget in the next biennium:**– How much is currently financed in the next biennium?**

US\$ 0.89 million

– What are the financing gaps?

US\$ 0.09 million

– What action is proposed to close these gaps?

Synergies with other programmes and discussion with regional offices and with donors at the country level. It is assumed that salaries of regional programme managers will continue to be funded by WHO as in the present biennium.

Resolution WHA69.10 Framework of engagement with non-State actors			
A. Link to the general programme of work and the programme budget			
<p>1. Please indicate to which impact and outcome in the Twelfth General Programme of Work, 2014–2019 and which output in the Programme budget 2016–2017 this draft resolution will contribute if adopted.</p> <p>Twelfth General Programme of Work outcome 6. Programme budget output 6.1.2.</p>			
<p>2. If there is no link to the results as indicated in the Twelfth General Programme of Work, 2014–2019 and the Programme budget 2016–2017, please provide a justification for giving consideration to the draft resolution.</p> <p>Not applicable.</p>			
<p>3. What is the proposed timeline for implementation of this resolution?</p> <p>Implementation will begin in 2016.</p> <p><i>If the timeline stretches to future programme budgets, please ensure that further information is provided in the costing section.</i></p>			
B. Budgetary implications of implementation of the resolution			
1. Current biennium: estimated budgetary requirements, in US\$ million			
Level	Staff	Activities	Total
Country offices	2.8	0	2.8
Regional offices	2.8	0	2.8
Headquarters	7.0	1.6	8.6
Total	12.6	1.6	14.2
<p>1(a) Is the estimated budget requirement in respect of implementation of the resolution fully included within the current programme budget? (Yes/No)</p> <p>Yes. However, the resolution calls for new work that was not anticipated when the Programme budget 2016–2017 was developed and approved.</p>			
<p>1(b) Financing implications for the budget in the current biennium:</p> <ul style="list-style-type: none"> – How much is financed in the current biennium? US\$ 7.5 million – What are the gaps? US\$ 6.7 million – What action is proposed to close these gaps? The gap will be addressed through coordinated resource mobilization efforts for possible financing by voluntary contribution. 			

2. Next biennium: estimated budgetary requirements, in US\$ million			
Level	Staff	Activities	Total
Country offices	2.8	0	2.8
Regional offices	2.8	0	2.8
Headquarters	7.0	0	7.0
Total	12.6	0	12.6

2(a) Financing implications for the budget in the next biennium:

- How much is currently financed in the next biennium? 0

- What are the financing gaps?
US\$ 12.6 million
- What action is proposed to close these gaps?
The costs of implementation will be included in the Programme budget 2018–2019 and financed from flexible funds allocated to Category 6.

Resolution WHA69.11 Health in the 2030 Agenda for Sustainable Development	
A. Link to the general programme of work and the programme budget	
1. Please indicate to which impact and outcome in the Twelfth General Programme of Work, 2014–2019 and which output in the Programme budget 2016–2017 this draft resolution will contribute if adopted.	The resolution cuts across all areas of WHO work and thus all outcomes of the Twelfth General Programme of Work and outputs of the Programme budget 2016–2017.
2. If there is no link to the results as indicated in the Twelfth General Programme of Work, 2014–2019 and the Programme budget 2016–2017, please provide a justification for giving consideration to the draft resolution.	Not applicable.
3. What is the proposed timeline for implementation of this resolution?	The 15 years from 2016 to 2030, in line with the Sustainable Development Goals.
<i>If the timeline stretches to future programme budgets, please ensure that further information is provided in the costing section.</i>	

B. Budgetary implications of implementation of the resolution			
The budgetary implications of this general resolution, should any arise, would appear only after the implications of the resolution for WHO's work have crystallized.			
1. Current biennium: estimated budgetary requirements, in US\$ million			
Level	Staff	Activities	Total
Country offices	Not applicable.	Not applicable.	Not applicable.
Regional offices	Not applicable.	Not applicable.	Not applicable.
Headquarters	Not applicable.	Not applicable.	Not applicable.
Total	Not applicable.	Not applicable.	Not applicable.
1(a) Is the estimated budget requirement in respect of implementation of the resolution fully included within the current programme budget? (Yes/No)			
Not applicable.			
1(b) Financing implications for the budget in the current biennium:			
– How much is financed in the current biennium?			
Not applicable.			
– What are the gaps?			
Not applicable.			
– What action is proposed to close these gaps?			
Not applicable.			
2. Next biennium: estimated budgetary requirements, in US\$ million			
Level	Staff	Activities	Total
Country offices	Not applicable.	Not applicable.	Not applicable.
Regional offices	Not applicable.	Not applicable.	Not applicable.
Headquarters	Not applicable.	Not applicable.	Not applicable.
Total	Not applicable.	Not applicable.	Not applicable.
2(a) Financing implications for the budget in the next biennium:			
– How much is currently financed in the next biennium?			
Not applicable.			
– What are the financing gaps?			
Not applicable.			
– What action is proposed to close these gaps?			
Not applicable.			

Resolution WHA69.17 Amendments to the Staff Regulations: dispute resolution			
A. Link to the general programme of work and the programme budget			
1. Please indicate to which impact and outcome in the Twelfth General Programme of Work, 2014–2019 and which output in the Programme budget 2016–2017 this draft resolution will contribute if adopted.			
General Programme of Work, 2014–2019: Outcome 6.2 WHO operates in an accountable and transparent manner and has well-functioning risk-management and evaluation frameworks.			
Programme budget 2016–2017: Output 6.2.3 Ethical behaviour, decent conduct and fairness promoted across the Organization.			
2. If there is no link to the results as indicated in the Twelfth General Programme of Work, 2014–2019 and the Programme budget 2016–2017, please provide a justification for giving consideration to the draft resolution.			
Not applicable.			
3. What is the proposed timeline for implementation of this resolution?			
Implementation is anticipated to begin between 1 September 2016 and 1 January 2017.			
<i>If the timeline stretches to future programme budgets, please ensure that further information is provided in the costing section.</i>			
B. Budgetary implications of implementation of the resolution			
1. Current biennium: estimated budgetary requirements, in US\$			
Level	Staff	Activities	Total
Country offices			
Regional offices			
Headquarters	10 756 350	35 000	10 791 350
Total	10 756 350	35 000	10 791 350
1(a) Is the estimated budget requirement in respect of implementation of the resolution fully included within the current programme budget? (Yes/No)			
No.			
1(b) Financing implications for the budget in the current biennium:			
– How much is financed in the current biennium?			
US\$ 5 646 725			
– What are the gaps?			
US\$ 5 144 625			
– What action is proposed to close these gaps?			
The Secretariat is actively exploring ways to set up and manage the new functions across the Organization in a more cost-efficient way which could reduce the actual cost.			

2. Next biennium: estimated budgetary requirements, in US\$			
Level	Staff	Activities	Total
Country offices	n/a	n/a	n/a
Regional offices	n/a	n/a	n/a
Headquarters	n/a	n/a	n/a
Total	n/a	n/a	n/a

2(a) Financing implications for the budget in the next biennium:

- **How much is currently financed in the next biennium?**
Not applicable.
- **What are the financing gaps?**
Not applicable.
- **What action is proposed to close these gaps?**
Not applicable.

Resolution WHA69.19 Global strategy on human resources for health: workforce 2030			
A. Link to the general programme of work and the programme budget			
1. Please indicate to which impact and outcome in the Twelfth General Programme of Work, 2014–2019 and which output in the Programme budget 2016–2017 this draft resolution will contribute if adopted.	Twelfth General Programme of Work: Category 4 Health Systems; programme area 4.2 Integrated people-centred health services. Programme budget: Output 4.2.2.		
2. If there is no link to the results as indicated in the Twelfth General Programme of Work, 2014–2019 and the Programme budget 2016–2017, please provide a justification for giving consideration to the draft resolution.	Not applicable.		
3. What is the proposed timeline for implementation of this resolution?	The proposed implementation timeline spans the 15 years from 2016 to 2030. However, the current financing request is aligned with two bienniums of the Twelfth General Programme of Work, 2016–2017 and 2018–2019.		
<i>If the timeline stretches to future programme budgets, please ensure that further information is provided in the costing section.</i>			
B. Budgetary implications of implementation of the resolution			
1. Current biennium: estimated budgetary requirements, in US\$ million			
Level	Staff	Activities	Total
Country offices	7.66	13.15	20.81
Regional offices	7.19	1.89	9.08
Headquarters	7.81	3.27	11.08
Total	22.66	18.31	40.97

<p>1(a) Is the estimated budget requirement in respect of implementation of the resolution fully included within the current programme budget? (Yes/No)</p> <p>Yes.</p>																							
<p>1(b) Financing implications for the budget in the current biennium:</p> <p>– How much is financed in the current biennium?</p> <p>US\$ 17.00 million</p> <p>– What are the gaps?</p> <p>US\$ 23.97 million</p> <p>– What action is proposed to close these gaps?</p> <p>The gap will be addressed through coordinated resource mobilization efforts for possible financing by voluntary contributions.</p>																							
<p>2. Next biennium: estimated budgetary requirements, in US\$ million</p> <table border="1"> <thead> <tr> <th>Level</th> <th>Staff</th> <th>Activities</th> <th>Total</th> </tr> </thead> <tbody> <tr> <td>Country offices</td> <td>8.04</td> <td>13.81</td> <td>21.85</td> </tr> <tr> <td>Regional offices</td> <td>7.55</td> <td>1.99</td> <td>9.54</td> </tr> <tr> <td>Headquarters</td> <td>8.19</td> <td>3.43</td> <td>11.62</td> </tr> <tr> <td>Total</td> <td>23.78</td> <td>19.23</td> <td>43.01</td> </tr> </tbody> </table>				Level	Staff	Activities	Total	Country offices	8.04	13.81	21.85	Regional offices	7.55	1.99	9.54	Headquarters	8.19	3.43	11.62	Total	23.78	19.23	43.01
Level	Staff	Activities	Total																				
Country offices	8.04	13.81	21.85																				
Regional offices	7.55	1.99	9.54																				
Headquarters	8.19	3.43	11.62																				
Total	23.78	19.23	43.01																				
<p>2(a) Financing implications for the budget in the next biennium:</p> <p>– How much is currently financed in the next biennium?</p> <p>0</p> <p>– What are the financing gaps?</p> <p>US\$ 43.01 million</p> <p>– What action is proposed to close these gaps?</p> <p>The gap will be addressed through coordinated resource mobilization efforts, including the financing dialogue, for possible financing by voluntary contributions.</p>																							

<p>Resolution WHA69.20 Promoting innovation and access to quality, safe, efficacious and affordable medicines for children</p>	
<p>A. Link to the general programme of work and the programme budget</p>	
<p>1. Please indicate to which impact and outcome in the Twelfth General Programme of Work, 2014–2019 and which output in the Programme budget 2016–2017 this draft resolution will contribute if adopted.</p> <p>Twelfth General Programme of Work: outcomes 3 and 4.3.1.</p>	

<p>2. If there is no link to the results as indicated in the Twelfth General Programme of Work, 2014–2019 and the Programme budget 2016–2017, please provide a justification for giving consideration to the draft resolution.</p> <p>Not applicable.</p>			
<p>3. What is the proposed timeline for implementation of this resolution?</p> <p>From the fourth quarter of 2016 until the end of 2019.</p> <p><i>If the timeline stretches to future programme budgets, please ensure that further information is provided in the costing section.</i></p>			
<p>B. Budgetary implications of implementation of the resolution</p>			
<p>1. Current biennium: estimated budgetary requirements, in US\$ million</p>			
Level	Staff	Activities	Total
Country offices	0.83	0.13	0.96
Regional offices	0.83	0.27	1.10
Headquarters	1.12	0.98	2.10
Total	2.78	1.38	4.16
<p>1(a) Is the estimated budget requirement in respect of implementation of the resolution fully included within the current programme budget? (Yes/No)</p> <p>Yes.</p>			
<p>1(b) Financing implications for the budget in the current biennium:</p> <p>– How much is financed in the current biennium?</p> <p>– What are the gaps? US\$ 4.16 million.</p> <p>– What action is proposed to close these gaps? The gap will be addressed through the coordinated resource mobilization efforts for possible financing by voluntary contribution.</p>			
<p>2. Next biennium: estimated budgetary requirements, in US\$ million</p>			
Level	Staff	Activities	Total
Country offices	0.83	0.123	0.96
Regional offices	0.83	0.27	1.10
Headquarters	1.12	0.98	2.10
Total	2.78	1.38	4.16
<p>2(a) Financing implications for the budget in the next biennium:</p> <p>– How much is currently financed in the next biennium?</p>			

– **What are the financing gaps?**

US\$ 4.16 million.

– **What action is proposed to close these gaps?**

The gap will be addressed through the coordinated resource mobilization efforts for possible financing by voluntary contribution.

Resolution WHA69.21 Addressing the burden of mycetoma

A. Link to the general programme of work and the programme budget

1. Please indicate to which impact and outcome in the Twelfth General Programme of Work, 2014–2019 and which output in the Programme budget 2016–2017 this draft resolution will contribute if adopted.

Twelfth General Programme of Work, 2014–2019: Outcome 1.4 Increased and sustained access to essential medicines for neglected tropical diseases.

Programme budget 2016–2017: Output 1.4.2 Implementation and monitoring of neglected tropical disease control interventions facilitated by evidence-based technical guidelines and technical support; and Output 1.4.3 New knowledge, solutions and implementation strategies that respond to the health needs of disease-endemic countries.

The activities mandated by the resolution are part of the deliverables that need reinforcement specifically for the control of mycetoma. The UNICEF/UNDP/World Bank/WHO Special Programme for Research and Training in Tropical Diseases no longer engages in managing research and development for drugs and diagnostics, should such be required for mycetoma, but would assist the Secretariat in convening expert groups to analyse the situation and form research priorities. The funds required to take these priorities forward are not included in the present report.

2. If there is no link to the results as indicated in the Twelfth General Programme of Work, 2014–2019 and the Programme budget 2016–2017, please provide a justification for giving consideration to the draft resolution.

Not applicable.

3. What is the proposed timeline for implementation of this resolution?

10 years.

If the timeline stretches to future programme budgets, please ensure that further information is provided in the costing section.

B. Budgetary implications of implementation of the resolution

1. Current biennium: estimated budgetary requirements, in US\$

Level	Staff	Activities	Total
Country offices	300 000	300 000	600 000
Regional offices	200 000	200 000	400 000
Headquarters	400 000	100 000	500 000
Total	900 000	600 000	1 500 000

1(a) Is the estimated budget requirement in respect of implementation of the resolution fully included within the current programme budget? (Yes/No)

Yes.

1(b) Financing implications for the budget in the current biennium:– **How much is financed in the current biennium?**

None.

– **What are the gaps?**

US\$ 1 500 000

– **What action is proposed to close these gaps?**

Advocacy, reprioritizing, resource mobilization. A potential source of external funding may be negotiated with WHO partners through product development partnerships.

2. Next biennium: estimated budgetary requirements, in US\$

Level	Staff	Activities	Total
Country offices	400 000	400 000	800 000
Regional offices	300 000	250 000	550 000
Headquarters	500 000	150 000	650 000
Total	1 200 000	800 000	2 000 000

2(a) Financing implications for the budget in the next biennium:– **How much is currently financed in the next biennium?**

None.

– **What are the financing gaps?**

US\$ 2 000 000

– **What action is proposed to close these gaps?**

Advocacy, reprioritizing, resource mobilization. A potential source of external funding may be negotiated with WHO partners through product development partnerships.

Resolution WHA69.22 Global health sector strategies on HIV, viral hepatitis and sexually transmitted infections, for the period 2016–2021

A. Link to the general programme of work and the programme budget**1. Please indicate to which impact and outcome in the Twelfth General Programme of Work, 2014–2019 and which output in the Programme budget 2016–2017 this draft resolution will contribute if adopted.**

Outcome 1.1: outputs 1.1.1 [HIV] and 1.1.2 [Viral hepatitis]

Outcome 1.5: outputs 1.5.1 [HIV, Sexually transmitted infections] and 1.5.3 [Viral hepatitis]

Outcome 2.2: output 2.2.3 [HIV, Viral hepatitis]

Outcome 3.1: outputs 3.1.1, 3.1.2, 3.1.3 and 3.1.5 [HIV, Sexually transmitted infections] and 3.16 [Sexually transmitted infections]

Outcome 3.3: output 3.3.2 [HIV]

Outcome 3.4: output 3.3.2 [HIV]

Outcome 4.2: output 4.2.3 [HIV, Viral hepatitis and Sexually transmitted infections]

Outcome 4.3: outputs 4.3.1, 4.3.2 and 4.3.3 [HIV, Viral hepatitis and Sexually transmitted infections]

Outcome 5.1: output 5.1.1 [Viral hepatitis, Sexually transmitted infections]

Outcome 5.2: output 5.2.1 [Viral hepatitis, Sexually transmitted infections]

<p>2. If there is no link to the results as indicated in the Twelfth General Programme of Work, 2014–2019 and the Programme budget 2016–2017, please provide a justification for giving consideration to the draft resolution.</p> <p>Not applicable.</p>			
<p>3. What is the proposed timeline for implementation of this resolution?</p> <p>2016–2021</p> <p><i>If the timeline stretches to future programme budgets, please ensure that further information is provided in the costing section.</i></p>			
<p>B. Budgetary implications of implementation of the resolution</p>			
<p>1. Current biennium: estimated budgetary requirements, in US\$ million</p>			
Level	Staff	Activities	Total
Country offices	50.14	23.10	73.24
Regional offices	29.60	16.56	46.16
Headquarters	41.31	24.95	66.26
Total	121.05	64.61	185.66
<p>1(a) Is the estimated budget requirement in respect of implementation of the resolution fully included within the current programme budget? (Yes/No)</p> <p>Yes.</p>			
<p>1(b) Financing implications for the budget in the current biennium:</p> <p>How much is financed in the current biennium?</p> <p>An estimated US\$ 139.46 million.</p> <ul style="list-style-type: none"> – HIV: 2016–2017 total cost is US\$ 134.85 million, with an estimated US\$ 115.85 million available across WHO for strategy implementation. – Viral hepatitis: 2016–2017 total cost is US\$ 33.11 million, with an estimated US\$ 15.20 million available across WHO for strategy implementation. – Sexually transmitted infections: 2016–2017 total cost is US\$ 17.70 million, with an estimated US\$ 8.41 million available across WHO for strategy implementation. <p>What are the gaps?</p> <p>An estimated US\$ 46.20 million.</p> <ul style="list-style-type: none"> – HIV: An estimated additional US\$ 19.00 million is required to ensure full implementation of the activities outlined to reach the strategy targets. – Viral hepatitis: An estimated additional US\$ 17.91 million is required to ensure full implementation of the activities outlined to reach the strategy targets. – Sexually transmitted infections: The anticipated gap for strategy implementation is estimated at approximately US\$ 9.29 million. <p>What action is proposed to close these gaps?</p> <ul style="list-style-type: none"> – HIV: Additional resource mobilization through the Department of HIV and as part of the Organization-wide coordinated resource mobilization plan for dealing with funding shortfalls in the Programme budget 2016–2017. – Viral hepatitis: Resource mobilization through the Department of HIV (including the Global Hepatitis Programme) and as part of the Organization-wide coordinated resource mobilization plan for dealing with funding shortfalls in the Programme budget 2016–2017. 			

- **Sexually transmitted infections:** Additional resource mobilization through the Department of Reproductive Health and Research and as part of the Organization-wide coordinated resource mobilization plan for dealing with funding shortfalls in the Programme budget 2016–2017.

2. Next biennium: estimated budgetary requirements, in US\$ million

Level	Staff	Activities	Total
Country offices	52.54	24.20	76.74
Regional offices	30.20	16.86	47.06
Headquarters	41.60	25.60	67.20
Total	124.34	66.66	191.00

2(a) Financing implications for the budget in the next biennium:

- **How much is currently financed in the next biennium?**

At present there is no funding for the period 2018–2019.

- **What are the financing gaps?**

100%

- **What action is proposed to close these gaps?**

Actions to be determined as necessary: coordinated resource mobilization through the financing dialogue and voluntary specified fundraising.

Resolution WHA69.23 Follow-up of the report of the Consultative Expert Working Group on Research and Development: Financing and Coordination

A. Link to the general programme of work and the programme budget

- 1. Please indicate to which impact and outcome in the Twelfth General Programme of Work, 2014–2019 and which output in the Programme budget 2016–2017 this draft resolution will contribute if adopted.**

Improved access to and rational use of safe, efficacious and quality medicines and health technologies.

Outcome: 4:3

Output: 4.3.2

- 2. If there is no link to the results as indicated in the Twelfth General Programme of Work, 2014–2019 and the Programme budget 2016–2017, please provide a justification for giving consideration to the draft resolution.**

Not applicable.

- 3. What is the proposed timeline for implementation of this resolution?**

2016–2017 and 2018–2019.

If the timeline stretches to future programme budgets, please ensure that further information is provided in the costing section.

B. Budgetary implications of implementation of the resolution			
1. Current biennium: estimated budgetary requirements: US\$ 9.5 million			
Level	Staff	Activities	Total
Country offices	–	–	–
Regional offices	–	–	–
Headquarters	5	4.5	9.5
Total	5	4.5	9.5
1(a) Is the estimated budget requirement in respect of implementation of the resolution fully included within the current programme budget? (Yes/No)			
YES – for the Global Observatory on Health Research and Development and the coordination mechanism. NO – under the programme budget for the health research and development demonstration projects (US\$ 30 million).			
1(b) Financing implications for the budget in the current biennium:			
– How much is financed in the current biennium?			
US\$ 1.7 million			
– What are the gaps?			
US\$ 7.8 million for the work under the programme budget; US\$ 30 million for the demonstration projects (outside the programme budget).			
– What action is proposed to close these gaps?			
The gap will be addressed through the coordinated resource mobilization efforts including the financing dialogue for possible financing by voluntary contribution.			
2. Next biennium: estimated budgetary requirements, in US\$ millions			
Level	Staff	Activities	Total
Country offices	–	–	–
Regional offices	–	–	–
Headquarters	7	6	13
Total	7	6	13
2(a) Financing implications for the budget in the next biennium:			
– How much is currently financed in the next biennium?			
US\$ 1 million			
– What are the financing gaps?			
US\$ 12 million for activities under the programme budget and US\$ 50 million for the demonstration projects, outside the programme budget.			
– What action is proposed to close these gaps?			
The gap will be addressed through the coordinated resource mobilization efforts as mandated in operative paragraph 2(9) of the resolution.			

Resolution WHA69.24 Strengthening integrated, people-centred health services			
A. Link to the general programme of work and the programme budget			
1. Please indicate to which impact and outcome in the Twelfth General Programme of Work, 2014–2019 and which output in the Programme budget 2016–2017 this draft resolution will contribute if adopted.			
<p>Twelfth General Programme of Work, 2014–2019: Through its mapping of strategies for more integrated and effective services, expansion of services to underserved populations and support for the systems underpinning health security at the country level, the resolution will contribute to the following impacts: reducing under-5 child mortality; reducing maternal mortality; reducing premature mortality from noncommunicable diseases; preventing death, illness and disability arising from emergencies; and reducing rural-urban difference in under-5 mortality.</p> <p>Programme budget 2016–2017: Output 4.2.1 Equitable integrated, people-centred service delivery systems in place in countries and public health approaches strengthened; Output 4.2.2 Health workforce strategies oriented towards universal health coverage implemented in countries; and Output 4.2.3 Countries enabled to improve patient safety and quality of services, and patient empowerment within the context of universal health coverage.</p>			
2. If there is no link to the results as indicated in the Twelfth General Programme of Work, 2014–2019 and the Programme budget 2016–2017, please provide a justification for giving consideration to the draft resolution.			
Not applicable.			
3. What is the proposed timeline for implementation of this resolution?			
The resolution will support the implementation of the Framework on integrated people-centred health services, 2016–2026.			
<i>If the timeline stretches to future programme budgets, please ensure that further information is provided in the costing section.</i>			
B. Budgetary implications of implementation of the resolution			
1. Current biennium: estimated budgetary requirements, in US\$			
Level	Staff	Activities	Total
Country offices	0	5 000 000	5 000 000
Regional offices	550 000	400 000	950 000
Headquarters	550 000	1 015 000	1 565 000
Total	1 100 000	6 415 000	7 515 000
1(a) Is the estimated budget requirement in respect of implementation of the resolution fully included within the current programme budget? (Yes/No)			
Yes.			
1(b) Financing implications for the budget in the current biennium:			
– How much is financed in the current biennium?			
US\$ 0.94 million			
– What are the gaps?			
US\$ 6.575 million			

– **What action is proposed to close these gaps?**

The funding gap will be tackled as part of the Organization-wide coordinated resource mobilization plan for dealing with funding shortfalls in the Programme budget 2016–2017.

2. Next biennium: estimated budgetary requirements, in US\$

Level	Staff	Activities	Total
Country offices	0	4 200 000	4 200 000
Regional offices	550 000	400 000	950 000
Headquarters	550 000	1 015 000	1 565 000
Total	1 100 000	5 615 000	6 715 000

2(a) Financing implications for the budget in the next biennium:

– **How much is currently financed in the next biennium?**

0

– **What are the financing gaps?**

US\$ 6.715 million

– **What action is proposed to close these gaps?**

The funding gap will be tackled as part of the Organization-wide coordinated resource mobilization plan for dealing with funding shortfalls in the Programme budget 2018–2019.

Resolution WHA69.25 Addressing the global shortage of medicines and vaccines, and the safety and accessibility of children's medication

A. Link to the general programme of work and the programme budget

1. Please indicate to which impact and outcome in the Twelfth General Programme of Work, 2014–2019 and which output in the Programme budget 2016–2017 this draft resolution will contribute if adopted.

Twelfth General Programme of Work: Outcomes 3 and 4.3.1.

2. If there is no link to the results as indicated in the Twelfth General Programme of Work, 2014–2019 and the Programme budget 2016–2017, please provide a justification for giving consideration to the draft resolution.

Not applicable.

3. What is the proposed timeline for implementation of this resolution?

From the fourth quarter of 2016 until the end of 2019.

If the timeline stretches to future programme budgets, please ensure that further information is provided in the costing section.

B. Budgetary implications of implementation of the resolution			
1. Current biennium: estimated budgetary requirements, in US\$ million			
Level	Staff	Activities	Total
Country offices	0.20	0.46	0.66
Regional offices	0.16	0.43	0.59
Headquarters	0.55	2.51	3.06
Total	0.91	3.40	4.31
1(a) Is the estimated budget requirement in respect of implementation of the resolution fully included within the current programme budget? (Yes/No)			
Yes.			
1(b) Financing implications for the budget in the current biennium:			
– How much is financed in the current biennium? 0			
– What are the gaps?			
US\$ 4.31 million.			
– What action is proposed to close these gaps?			
The gap will be addressed through the coordinated resource mobilization efforts for possible financing by voluntary contribution.			
2. Next biennium: estimated budgetary requirements, in US\$ million			
Level	Staff	Activities	Total
Country offices	0.20	0.46	0.66
Regional offices	0.16	0.43	0.59
Headquarters	0.55	1.51	2.06
Total	0.91	2.40	3.31
2(a) Financing implications for the budget in the next biennium:			
– How much is currently financed in the next biennium?			
– What are the financing gaps?			
US\$ 3.31 million.			
– What action is proposed to close these gaps?			
The gap will be addressed through the coordinated resource mobilization efforts for possible financing by voluntary contribution.			

Decision WHA69(8) Decision based on the agreed recommendations of the Open-ended Intergovernmental Meeting on Governance Reform (Geneva, 8 and 9 March 2016 and 28 and 29 April 2016)			
A. Link to the general programme of work and the programme budget			
1. Please indicate to which impact and outcome in the Twelfth General Programme of Work, 2014–2019 and which output in the Programme budget 2016–2017 this draft decision will contribute if adopted. Outcome 6.1 and Output 6.1.3.			
2. If there is no link to the results as indicated in the Twelfth General Programme of Work, 2014–2019 and the Programme budget 2016–2017, please provide a justification for giving consideration to the draft decision. Not applicable.			
3. What is the proposed timeline for implementation of this decision? The decision will be implemented during the biennium 2016–2017. <i>If the timeline stretches to future programme budgets, please ensure that further information is provided in the costing section.</i>			
B. Budgetary implications of implementation of the decision			
1. Current biennium: estimated budgetary requirements, in US\$ million			
Level	Staff	Activities	Total
Country offices	0	0	0
Regional offices	0	0	0
Headquarters	0	0.125	0.125
Total	0	0.125	0.125
1(a) Is the estimated budget requirement in respect of implementation of the decision fully included within the current programme budget? (Yes/No) Yes.			
1(b) Financing implications for the budget in the current biennium: – How much is financed in the current biennium? US\$ 0.125 million – What are the gaps? US\$ 0 million – What action is proposed to close these gaps? Not applicable.			

2. Next biennium: estimated budgetary requirements, in US\$ million			
Level	Staff	Activities	Total
Country offices	0	0	0
Regional offices	0	0	0
Headquarters	0	0.05	0.05
Total	0	0.05	0.05
2(a) Financing implications for the budget in the next biennium:			
– How much is currently financed in the next biennium?			
US\$ 0.05 million			
– What are the financing gaps?			
US\$ 0 million			
– What action is proposed to close these gaps?			
Not applicable.			
Decision WHA69(10) Health conditions in the occupied Palestinian territory, including east Jerusalem, and in the occupied Syrian Golan			
A. Link to the general programme of work and the programme budget			
1. Please indicate to which impact and outcome in the Twelfth General Programme of Work, 2014–2019 and which output in the Programme budget 2016–2017 this draft decision will contribute if adopted.			
Impact goals: 4 and 7			
Outcomes: 1.5, 2.1, 2.2, 2.3, 3.1, 3.2, 3.3, 3.4, 4.1, 4.2, 5.1, 5.3, 6.1, 6.4			
2. If there is no link to the results as indicated in the Twelfth General Programme of Work, 2014–2019 and the Programme budget 2016–2017, please provide a justification for giving consideration to the draft decision.			
Not applicable.			
3. What is the proposed timeline for implementation of this decision?			
The remainder of the biennium 2016–2017.			
<i>If the timeline stretches to future programme budgets, please ensure that further information is provided in the costing section.</i>			
B. Budgetary implications of implementation of the decision			
1. Current biennium: estimated budgetary requirements, in US\$ million			
Level	Staff	Activities	Total
Country offices	7.0	9.3	16.4
Regional offices	0.0	0.0	0.0
Headquarters	0.0	0.0	0.0
Total	7.0	9.3	16.4

<p>1(a) Is the estimated budget requirement in respect of implementation of the decision fully included within the current programme budget? (Yes/No)</p> <p>Yes</p>																							
<p>1(b) Financing implications for the budget in the current biennium, in US\$ million</p> <p>– How much is financed in the current biennium?</p> <p>US\$ 8.9</p> <p>– What are the gaps?</p> <p>US\$ 7.5</p> <p>– What action is proposed to close these gaps?</p> <p>The gaps will be closed through coordinated resource mobilization efforts.</p>																							
<p>2. Next biennium: estimated budgetary requirements, in US\$ million</p> <table border="1"> <thead> <tr> <th>Level</th> <th>Staff</th> <th>Activities</th> <th>Total</th> </tr> </thead> <tbody> <tr> <td>Country offices</td> <td>–</td> <td>–</td> <td>–</td> </tr> <tr> <td>Regional offices</td> <td>–</td> <td>–</td> <td>–</td> </tr> <tr> <td>Headquarters</td> <td>–</td> <td>–</td> <td>–</td> </tr> <tr> <td>Total</td> <td>Nil</td> <td>Nil</td> <td>Nil</td> </tr> </tbody> </table>				Level	Staff	Activities	Total	Country offices	–	–	–	Regional offices	–	–	–	Headquarters	–	–	–	Total	Nil	Nil	Nil
Level	Staff	Activities	Total																				
Country offices	–	–	–																				
Regional offices	–	–	–																				
Headquarters	–	–	–																				
Total	Nil	Nil	Nil																				
<p>2(a) Financing implications for the budget in the next biennium:</p> <p>– How much is currently financed in the next biennium?</p> <p>Not applicable.</p> <p>– What are the financing gaps?</p> <p>Not applicable.</p> <p>– What action is proposed to close these gaps?</p> <p>Not applicable.</p>																							

<p>Decision WHA69(11) Health and the environment: road map for an enhanced global response to the adverse health effects of air pollution</p>	
<p>A. Link to the general programme of work and the programme budget</p>	
<p>1. Please indicate to which impact and outcome in the Twelfth General Programme of Work, 2014–2019 and which output in the Programme budget 2016–2017 this draft decision will contribute if adopted.</p> <p>Programme budget outcomes 2.1, 3.1 and 3.5 (outputs 3.5.1, 3.5.2 and 3.5.3.).</p> <p>General Programme of Work: decision is aligned with leadership priorities focused on addressing health-related development goals.</p>	
<p>2. If there is no link to the results as indicated in the Twelfth General Programme of Work, 2014–2019 and the Programme budget 2016–2017, please provide a justification for giving consideration to the draft decision.</p> <p>Not applicable.</p>	

3. What is the proposed timeline for implementation of this decision?

Work on air pollution and health will continue beyond 2019. A review will be undertaken in parallel with the development of the next general programme of work, which may result in some modifications to the overall budget depending on changes to broader Organizational priorities

If the timeline stretches to future programme budgets, please ensure that further information is provided in the costing section.

B. Budgetary implications of implementation of the decision**1. Current biennium: estimated budgetary requirements, in US\$ million**

Level	Staff	Activities	Total
Country offices	0.68	1.26	1.94
Regional offices	2.99	5.87	8.86
Headquarters	2.33	1.94	4.27
Total	6.00	9.07	15.07

1(a) Is the estimated budget requirement in respect of implementation of the decision fully included within the current programme budget? (Yes/No)

Yes, there could be possibility within the approved Programme budget 2016–2017 to ensure the implementation of this decision.

1(b) Financing implications for the budget in the current biennium:– **How much is financed in the current biennium?**

US\$ 3.5 million

– **What are the gaps?**

US\$ 11.6 million

– **What action is proposed to close these gaps?**

The gap will be addressed through coordinated resource mobilization efforts, including the financing dialogue, for possible financing by voluntary contributions.

2. Next biennium: estimated budgetary requirements, in US\$ million

Level	Staff	Activities	Total
Country offices	0.68	1.26	1.94
Regional offices	2.99	5.87	8.86
Headquarters	2.33	2.59	4.92
Total	6.00	9.72	15.72

2(a) Financing implications for the budget in the next biennium:– **How much is currently financed in the next biennium?**

0

– **What are the financing gaps?**

US\$ 15.7 million

– **What action is proposed to close these gaps?**

The gap will be addressed through coordinated resource mobilization efforts, including the financing dialogue, for possible financing by voluntary contributions.

Decision WHA69(12) Report of the Commission on Ending Childhood Obesity			
A. Link to the general programme of work and the programme budget			
1. Please indicate to which impact and outcome in the Twelfth General Programme of Work, 2014–2019 and which output in the Programme budget 2016–2017 this draft decision will contribute if adopted.			
General Programme of Work: Category 2 Noncommunicable diseases. Programme budget 2016–2017: outcome 2.1 and outputs 2.1.1 and 2.1.2.			
2. If there is no link to the results as indicated in the Twelfth General Programme of Work, 2014–2019 and the Programme budget 2016–2017, please provide a justification for giving consideration to the draft decision.			
Not applicable.			
3. What is the proposed timeline for implementation of this decision?			
An implementation plan will be developed through the Executive Board at its 140th session for consideration by the Seventieth World Health Assembly (2017).			
<i>If the timeline stretches to future programme budgets, please ensure that further information is provided in the costing section.</i>			
B. Budgetary implications of implementation of the decision			
1. Current biennium: estimated budgetary requirements, in US\$ million			
Level	Staff	Activities	Total
Country offices	Not applicable	0.45	0.45
Regional offices	Not applicable	0.55	0.55
Headquarters	0.70	0.30	1.00
Total	0.70	1.30	2.00
1(a) Is the estimated budget requirement in respect of implementation of the decision fully included within the current programme budget? (Yes/No)			
Yes.			
1(b) Financing implications for the budget in the current biennium:			
– How much is financed in the current biennium?			
US\$ 1 million.			
– What are the gaps?			
US\$ 1 million.			
– What action is proposed to close these gaps?			
The gap will be addressed through coordinated resource mobilization effort.			

2. Next biennium: estimated budgetary requirements, in US\$ million.			
Level	Staff	Activities	Total
Country offices	Not applicable	Not applicable	Not applicable
Regional offices	Not applicable	Not applicable	Not applicable
Headquarters	Not applicable	Not applicable	Not applicable
Total	0	0	0

2(a) Financing implications for the budget in the next biennium:

- **How much is currently financed in the next biennium?**
Not applicable.
- **What are the financing gaps?**
Not applicable.
- **What action is proposed to close these gaps?**
Not applicable

Decision WHA69(13) Strengthening synergies between the World Health Assembly and the Conference of the Parties to the WHO Framework Convention on Tobacco Control			
A. Link to the general programme of work and the programme budget			
1. Please indicate to which impact and outcome in the Twelfth General Programme of Work, 2014–2019 and which output in the Programme budget 2016–2017 this draft decision will contribute if adopted.			
Noncommunicable diseases: outcome 2.1; and outputs 2.1.1 and 2.1.2.			
2. If there is no link to the results as indicated in the Twelfth General Programme of Work, 2014–2019 and the Programme budget 2016–2017, please provide a justification for giving consideration to the draft decision.			
Not applicable.			
3. What is the proposed timeline for implementation of this decision?			
From 2016 to 2019 and beyond.			
<i>If the timeline stretches to future programme budgets, please ensure that further information is provided in the costing section.</i>			
B. Budgetary implications of implementation of the decision			
1. Current biennium: estimated budgetary requirements, in US\$ million			
Level	Staff	Activities	Total
Country offices	0.000	0.000	0.000
Regional offices	0.000	0.000	0.000
Headquarters	0.019	0.012	0.031
Total	0.019	0.012	0.031

<p>1(a) Is the estimated budget requirement in respect of implementation of the decision fully included within the current programme budget? (Yes/No)</p> <p>Yes.</p>																							
<p>1(b) Financing implications for the budget in the current biennium:</p> <p>– How much is financed in the current biennium? US\$ 0.031 million</p> <p>– What are the gaps? 0</p> <p>– What action is proposed to close these gaps? Not applicable.</p>																							
<p>2. Next biennium: estimated budgetary requirements, in US\$ million</p> <table border="1"> <thead> <tr> <th>Level</th> <th>Staff</th> <th>Activities</th> <th>Total</th> </tr> </thead> <tbody> <tr> <td>Country offices</td> <td>0.000</td> <td>0.000</td> <td>0.000</td> </tr> <tr> <td>Regional offices</td> <td>0.000</td> <td>0.000</td> <td>0.000</td> </tr> <tr> <td>Headquarters</td> <td>0.019</td> <td>0.012</td> <td>0.031</td> </tr> <tr> <td>Total</td> <td>0.019</td> <td>0.012</td> <td>0.031</td> </tr> </tbody> </table>				Level	Staff	Activities	Total	Country offices	0.000	0.000	0.000	Regional offices	0.000	0.000	0.000	Headquarters	0.019	0.012	0.031	Total	0.019	0.012	0.031
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Headquarters	0.019	0.012	0.031																				
Total	0.019	0.012	0.031																				
<p>2(a) Financing implications for the budget in the next biennium:</p> <p>– How much is currently financed in the next biennium? US\$ 0.031 million</p> <p>– What are the financing gaps? 0</p> <p>– What action is proposed to close these gaps? Not applicable.</p>																							

<p>Decision WHA69(14) Implementation of the International Health Regulations (2005)</p>	
<p>A. Link to the general programme of work and the programme budget</p>	
<p>1. Please indicate to which impact and outcome in the Twelfth General Programme of Work, 2014–2019 and which output in the Programme budget 2016–2017 this draft decision will contribute if adopted.</p> <p>Twelfth General Programme of Work, 2014–2019: implementing the provisions of the International Health Regulations (2005) is one of WHO's six leadership priorities. Programme budget 2016–2017, outcome 5.1: all obligations under the International Health Regulations (2005) met.</p>	
<p>2. If there is no link to the results as indicated in the Twelfth General Programme of Work, 2014–2019 and the Programme budget 2016–2017, please provide a justification for giving consideration to the draft decision.</p>	

<p>3. What is the proposed timeline for implementation of this decision?</p> <p>The global implementation plan must be finalized prior to the 140th session of the Executive Board in January 2017.</p> <p><i>If the timeline stretches to future programme budgets, please ensure that further information is provided in the costing section.</i></p>			
<p>B. Budgetary implications of implementation of the decision</p>			
<p>1. Current biennium: estimated budgetary requirements, in US\$ millions</p>			
Level	Staff	Activities	Total
Country offices	–	–	–
Regional offices	–	–	–
Headquarters	–	–	–
Total	Nil	Nil	Nil
<p>1(a) Is the estimated budget requirement in respect of implementation of the decision fully included within the current programme budget? (Yes/No)</p> <p>Yes.</p>			
<p>1(b) Financing implications for the budget in the current biennium in US\$ millions</p> <p>– How much is financed in the current biennium?</p> <p>Not applicable.</p> <p>– What are the gaps?</p> <p>Not applicable.</p> <p>– What action is proposed to close these gaps?</p> <p>Not applicable.</p>			
<p>2. Next biennium: estimated budgetary requirements, in US\$ millions</p>			
Level	Staff	Activities	Total
Country offices	–	–	–
Regional offices	–	–	–
Headquarters	–	–	–
Total	Nil	Nil	Nil
<p>2(a) Financing implications for the budget in the next biennium in US\$ millions</p> <p>– How much is currently financed in the next biennium?</p> <p>Not applicable.</p> <p>– What are the financing gaps?</p> <p>Not applicable.</p> <p>– What action is proposed to close these gaps?</p> <p>Not applicable.</p>			

Decision WHA69(15) Public health dimension of the world drug problem, including in the context of the special session of the United Nations General Assembly on the world drug problem, held in April 2016			
A. Link to the general programme of work and the programme budget			
1. Please indicate to which impact and outcome in the Twelfth General Programme of Work, 2014–2019 and which output in the Programme budget 2016–2017 this draft decision will contribute if adopted.			
General Programme of work – Category 2 outcome: Increased access to services for mental health and substance use disorders.			
Programme budget – Output 2.2.3 Expansion and strengthening of country strategies, systems and interventions for disorders caused by alcohol and other psychoactive substance use enabled.			
2. If there is no link to the results as indicated in the Twelfth General Programme of Work, 2014–2019 and the Programme budget 2016–2017, please provide a justification for giving consideration to the draft decision.			
Not applicable.			
3. What is the proposed timeline for implementation of this decision?			
The proposed timeline for implementation is 8 months (from June 2016 to January 2017).			
<i>If the timeline stretches to future programme budgets, please ensure that further information is provided in the costing section.</i>			
B. Budgetary implications of implementation of the decision			
1. Current biennium: estimated budgetary requirements, in US\$ million			
Level	Staff	Activities	Total
Country offices	–	–	–
Regional offices	–	–	–
Headquarters	0.3	0.05	0.35
Total	0.3	0.05	0.35
1(a) Is the estimated budget requirement in respect of implementation of the decision fully included within the current programme budget? (Yes/No)			
No.			
1(b) Financing implications for the budget in the current biennium:			
– How much is financed in the current biennium?			
US\$ nil			
– What are the gaps?			
US\$ 0.35 million			
– What action is proposed to close these gaps?			
The gaps will be tackled through coordinated resource mobilization efforts.			

2. Next biennium: estimated budgetary requirements, in US\$ million			
Level	Staff	Activities	Total
Country offices	–	–	–
Regional offices	–	–	–
Headquarters	–	–	–
Total	–	–	–
<p>2(a) Financing implications for the budget in the next biennium:</p> <ul style="list-style-type: none"> – How much is currently financed in the next biennium? Not applicable. – What are the financing gaps? US\$ nil – What action is proposed to close these gaps? Not applicable. 			
<p>1. Decision WHA69(16) Strategic budget space allocation¹</p>			
<p>2. Linkage to the Proposed programme budget 2016–2017 (see document A68/7 http://apps.who.int/gb/ebwha/pdf_files/WHA68/A68_7-en.pdf)</p> <p>Category: 6. Corporate services/enabling functions</p> <p>Programme area: Strategic planning, resources Outcome: 6.3 coordination and reporting Output: 6.3.1</p> <p>How would this decision contribute to the achievement of the outcome of the above programme area? The decision will endorse implementation of the guiding principles for strategic budget space allocation in order to improve performance and use of resources for technical cooperation at country level.</p> <p>Does the Programme budget already include the outputs and deliverables requested in this decision? (Yes/no) Yes.</p>			
<p>3. Estimated cost and staffing implications in relation to the Programme budget</p> <p>(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).</p> <p>(i) The decision is not time-bound.</p> <p>(ii) With respect to Secretariat activities, the decision would not incur any costs related to the Programme budget.</p> <p>(b) Cost for the biennium 2016–2017 Indicate how much of the cost indicated in 3(a) is for the biennium 2016–2017 (estimated to the nearest US\$ 10 000). n/a</p> <p>Indicate at which levels of the Organization the costs would be incurred, identifying specific regions where relevant. The decision relates to all three levels of the Organization, but no further costs would be incurred.</p> <p>Is the estimated cost fully included within the approved Programme budget 2016–2017? (Yes/no) There is no cost implication in relation to the Programme budget.</p> <p>If “no”, indicate how much is not included. n/a</p>			

¹ This costing originally accompanied decision EB137(7), which appears in EB137/2015/REC/1, Annex.

(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 2016-2017 indicated in 3(b) fully funded? (Yes/no)**

There is no cost implication, thus the question of full funding is not applicable.

If “no”, indicate the funding gap and how the funds would be mobilized (provide details of expected source(s) of funds).
