



WORLD HEALTH ORGANIZATION

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# **SEVENTY-FIFTH WORLD HEALTH ASSEMBLY**

**GENEVA, 22–28 MAY 2022**

**RESOLUTIONS AND DECISIONS  
ANNEXES**

GENEVA  
2022

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## ABBREVIATIONS

Abbreviations used in WHO documentation include the following:

ASEAN	– Association of Southeast Asian Nations	UNCTAD	– United Nations Conference on Trade and Development
FAO	– Food and Agriculture Organization of the United Nations	UNDP	– United Nations Development Programme
IAEA	– International Atomic Energy Agency	UNEP	– United Nations Environment Programme
IARC	– International Agency for Research on Cancer	UNESCO	– United Nations Educational, Scientific and Cultural Organization
ICAO	– International Civil Aviation Organization	UNFPA	– United Nations Population Fund
IFAD	– International Fund for Agricultural Development	UNHCR	– Office of the United Nations High Commissioner for Refugees
ILO	– International Labour Organization (Office)	UNICEF	– United Nations Children’s Fund
IMF	– International Monetary Fund	UNIDO	– United Nations Industrial Development Organization
IMO	– International Maritime Organization	UNODC	– United Nations Office on Drugs and Crime
INCB	– International Narcotics Control Board	UNRWA	– United Nations Relief and Works Agency for Palestine Refugees in the Near East
IOM	– International Organization for Migration	WFP	– World Food Programme
ITU	– International Telecommunication Union	WIPO	– World Intellectual Property Organization
OECD	– Organisation for Economic Co-operation and Development	WMO	– World Meteorological Organization
PAHO	– Pan American Health Organization	WOAH	– World Organisation for Animal Health
UNAIDS	– Joint United Nations Programme on HIV/AIDS	WTO	– World Trade Organization

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

## **PREFACE**

The Seventy-fifth World Health Assembly was held at the Palais des Nations, Geneva, from 22 to 28 May 2022, in accordance with the decision of the Executive Board at its 149th session.<sup>1</sup>

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<sup>1</sup> Decision EB149(10) (2021).





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# **AGENDA<sup>1</sup>**

## **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 Chairs 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 149th and 150th sessions
3. Address by Dr Tedros Adhanom Ghebreyesus, Director-General
4. Post of Director-General
  - 4.1 [deleted]
  - 4.2 Appointment of the Director-General
  - 4.3 Contract of the Director-General
5. [Deleted]
6. [Deleted]
7. Executive Board: election
8. Awards
9. Reports of the main committees
10. Closure of the Health Assembly

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

## COMMITTEE A

### 11. Opening of the Committee<sup>1</sup>

Pillar 4: More effective and efficient WHO providing better support to countries

### 12. Programme budget 2022–2023: revision

- General Programme of Work results framework

### 13. Sustainable financing: report of the Working Group

Pillar 1: One billion more people benefiting from universal health coverage

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

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

- Draft implementation road map 2023–2030 for the global action plan for the prevention and control of noncommunicable diseases 2013–2030
- Draft recommendations to strengthen and monitor diabetes responses within national noncommunicable disease programmes, including potential targets
- Draft global strategy on oral health
- Draft recommendations on how to strengthen the design and implementation of policies, including those for resilient health systems and health services and infrastructure, to treat people living with noncommunicable diseases and to prevent and control their risk factors in humanitarian emergencies
- Progress in the implementation of the global strategy to accelerate the elimination of cervical cancer as a public health problem and its associated goals and targets for the period 2020–2030
- Progress achieved in the prevention and control of noncommunicable diseases and the promotion of mental health
- Draft intersectoral global action plan on epilepsy and other neurological disorders in support of universal health coverage
- Draft action plan (2022–2030) to effectively implement the global strategy to reduce the harmful use of alcohol as a public health priority

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

## AGENDA

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- (i) Draft recommendations for the prevention and management of obesity over the life course, including potential targets
  - (j) Draft workplan for the global coordination mechanism on the prevention and control of noncommunicable diseases
  - Strengthening synergies between the World Health Assembly and the Conference of the Parties to the WHO Framework Convention on Tobacco Control
- 14.2 The global health sector strategies on, respectively, HIV, viral hepatitis and sexually transmitted infections
- 14.3 Global strategy for tuberculosis research and innovation
- 14.4 Road map for neglected tropical diseases 2021–2030
- 14.5 Immunization Agenda 2030
- 14.6 Infection prevention and control
- 14.7 Global road map on defeating meningitis by 2030
- 14.8 Standardization of medical devices nomenclature
15. Human resources for health
- Working for Health: draft 2022–2030 action plan
  - Global health and care worker compact
  - WHO Global Code of Practice on the International Recruitment of Health Personnel
  - Global Strategy on Human Resources for Health: Workforce 2030
- Pillar 2: One billion more people better protected from health emergencies
16. Public health emergencies: preparedness and response
- 16.1 The Independent Oversight and Advisory Committee for the WHO Health Emergencies Programme
- 16.2 Strengthening WHO preparedness for and response to health emergencies
- 16.3 WHO's work in health emergencies
- 16.4 Implementation of the International Health Regulations (2005)

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

17.1 Influenza preparedness

17.2 Global Health for Peace Initiative

17.3 Poliomyelitis

- Poliomyelitis eradication
- Polio transition planning and polio post-certification

Pillar 3: One billion more people enjoying better health and well-being

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

18.1 Maternal, infant and young child nutrition

18.2 WHO Implementation Framework for Billion 3

- WHO global strategy for food safety

22.2 Special arrangements for settlement of arrears

## COMMITTEE B

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

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

Pillar 4: More effective and efficient WHO providing better support to countries

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

Financial matters

21.1 Financing and implementation of the Programme budget 2022–2023

21.2 Scale of assessments 2022–2023

21.3 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

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

## AGENDA

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### Governance matters

21.4 Prevention of sexual exploitation, abuse and harassment

21.5 WHO reform

- Written statements: guidelines for Member States

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

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

### Staffing matters

21.7 Human resources: annual report

21.8 Amendments to the Staff Regulations and Staff Rules

21.9 Report of the International Civil Service Commission

22. Budget and financial matters

22.1 WHO programmatic and financial reports for 2020–2021, including audited financial statements for 2021

22.2 [transferred to Committee A]

22.3 [deleted]

22.4 [deleted]

23. Agreement with intergovernmental organizations

24. Audit and oversight matters

24.1 Report of the External Auditor

24.2 Report of the Internal Auditor

24.3 External and internal audit recommendations: progress on implementation

25. Appointment of representatives to the WHO Staff Pension Committee

26. Collaboration within the United Nations system and with other intergovernmental organizations

- 27. Updates and future reporting
  - 27.1 Availability, safety and quality of blood products
  - 27.2 Human organ and tissue transplantation
  - 27.3 Traditional medicine
  - 27.4 Public health dimension of the world drug problem

- 28. Matters for information
  - 28.1 Progress reports

Pillar 1: One billion more people benefiting from universal health coverage

- A. Preparation for the high-level meeting of the United Nations General Assembly on universal health coverage (resolution WHA72.4 (2019))
- B. Primary health care (resolution WHA72.2 (2019))
- C. Strengthening integrated people-centred health services (resolution WHA69.24 (2016))
- D. Improving access to assistive technology (resolution WHA71.8 (2018))
- E. Reproductive health: strategy to accelerate progress towards the attainment of international development goals and targets (resolution WHA57.12 (2004))
- F. Eradication of dracunculiasis (resolution WHA64.16 (2011))
- G. Global vector control response: an integrated approach for the control of vector-borne diseases (resolution WHA70.16 (2017))
- H. WHO strategy on research for health (resolution WHA63.21 (2010))

Pillar 2: One billion more people better protected from health emergencies

- I. Smallpox eradication (resolution WHA60.1 (2007))

Pillar 4: More effective and efficient WHO providing better support to countries

- J. Strategy for integrating gender analysis and actions into the work of WHO (resolution WHA60.25 (2007))

## List of documents

A75/1 Rev.2	Agenda <sup>1</sup>
A75/1 Add.1	Proposal for supplementary agenda item
A75/2	Report of the Executive Board on its 149th and 150th sessions
A75/3	Address by Dr Tedros Adhanom Ghebreyesus, Director-General
A75/5	Post of Director-General Contract of the Director-General <sup>2</sup>
A75/6	Proposed revision to the Programme budget 2022–2023
A75/7	Reporting on operational efficiencies
A75/8	Programme budget 2022–2023: revision Extending the Thirteenth General Programme of Work, 2019–2023 to 2025
A75/8 Add.1	Financial and administrative implications for the Secretariat of resolutions proposed for adoption by the Health Assembly <sup>3</sup>
A75/9	Sustainable financing: report of the Working Group <sup>4</sup>
A75/9 Add.1	Financial and administrative implications for the Secretariat of decisions proposed for adoption by the Health Assembly <sup>3</sup>
A75/10 Rev.1	Consolidated report by the Director-General <sup>5</sup>
A75/10 Rev.1 Add.1	Financial and administrative implications for the Secretariat of decisions proposed for adoption by the Health Assembly <sup>3</sup>
A75/10 Rev.1 Add.2	Financial and administrative implications for the Secretariat of decisions proposed for adoption by the Health Assembly <sup>3</sup>

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

<sup>2</sup> See Annex 1.

<sup>3</sup> See Annex 18.

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

<sup>5</sup> See Annexes 9, 13–15.

- A75/10 Add.1 Follow-up to the political declaration of the third high-level meeting of the General Assembly on the prevention and control of non-communicable disease  
Annex 3 – Draft global strategy on oral health<sup>1</sup>
- A75/10 Add.2 Follow-up to the political declaration of the third high-level meeting of the General Assembly on the prevention and control of non-communicable disease  
Annex 4 – Recommendations on how to strengthen the design and implementation of policies, including those for resilient health systems and health services and infrastructure, to treat people living with noncommunicable diseases and to prevent and control their risk factors in humanitarian emergencies<sup>2</sup>
- A75/10 Add.3 and  
A75/10 Add.3 Corr.1 Follow-up to the political declaration of the third high-level meeting of the General Assembly on the prevention and control of non-communicable diseases.  
Annex 5 – Progress in the implementation of the global strategy to accelerate the elimination of cervical cancer as a public health problem and its associated goals and targets for the period 2020–2030<sup>3</sup>
- A75/10 Add.4 Follow-up to the political declaration of the third high-level meeting of the General Assembly on the prevention and control of non-communicable disease  
Annex 7 – Draft intersectoral global action plan on epilepsy and other neurological disorders 2022–2031<sup>4</sup>
- A75/10 Add.5 Follow-up to the political declaration of the third high-level meeting of the General Assembly on the prevention and control of non-communicable disease  
Annex 11 – Preparatory process leading to the fourth high-level meeting of the General Assembly on the prevention and control of non-communicable diseases in 2025<sup>5</sup>
- A75/10 Add.6 Follow-up to the political declaration of the third high-level meeting of the General Assembly on the prevention and control of non-communicable disease  
Annex 12 – Acceleration plan to support Member States in implementing the recommendations for the prevention and management of obesity over the life course<sup>6</sup>

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<sup>1</sup> See Annex 10.

<sup>2</sup> See Annex 11.

<sup>3</sup> See Annex 5.

<sup>4</sup> See Annex 12.

<sup>5</sup> See Annex 6.

<sup>6</sup> See Annex 7.



## LIST OF DOCUMENTS

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A75/10 Add.7	Maternal, infant and young child nutrition Sustaining the elimination of iodine deficiency disorders
A75/10 Add.8	Follow-up to the political declaration of the third high-level meeting of the General Assembly on the prevention and control of non-communicable disease Annex 1 – Draft implementation road map 2023–2030 for the global action plan for the prevention and control of non-communicable diseases 2013–2030 <sup>1</sup>
A75/11	Standardization of medical devices nomenclature International classification, coding and nomenclature of medical devices
A75/11 Add.1	Standardization of medical devices nomenclature International classification, coding and nomenclature of medical devices
A75/12	Human resources for health Working for Health: draft 2022–2030 action plan
A75/13	Human resources for health Global health and care worker compact
A75/14	Human resources for health WHO Global Code of Practice on the International Recruitment of Health Personnel: fourth round of national reporting
A75/15	Human resources for health Global strategy on human resources for health: workforce 2030
A75/16	Public health emergencies: preparedness and response The Independent Oversight and Advisory Committee for the WHO Health Emergencies Programme
A75/17	Strengthening WHO preparedness for and response to health emergencies
A75/17 Add.1	Financial and administrative implications for the Secretariat of decisions proposed for adoption by the Health Assembly <sup>2</sup>
A75/18	Strengthening WHO preparedness for and response to health emergencies Proposal for amendments to the International Health Regulations (2005) <sup>3</sup>

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<sup>1</sup> See Annex 8.

<sup>2</sup> See Annex 18.

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

A75/19	Strengthening WHO preparedness for and response to health emergencies Strengthening collaboration on One Health
A75/20	Strengthening the global architecture for health emergency preparedness, response and resilience
A75/21	Strengthening WHO preparedness for and response to health emergencies Universal Health and Preparedness Review: concept note
A75/22	Implementation of the International Health Regulations (2005)
A75/23	Poliomyelitis Poliomyelitis eradication
A75/24	Poliomyelitis Polio transition planning and polio post-certification
A75/25	Behavioural sciences for better health initiative
A75/26	Health conditions in the occupied Palestinian territory, including east Jerusalem, and in the occupied Syrian Golan
A75/27	Financing and implementation of the Programme budget 2022–2023
A75/28	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
A75/29	Prevention of sexual exploitation, abuse and harassment
A75/30	WHO reform Written statements: guidelines for Member States <sup>1</sup>
A75/31	Human resources: annual report
A75/32	WHO Results Report: Programme budget 2020–2021
A75/33	Audited Financial Statements for the year ended 31 December 2021
A75/34	Agreements with intergovernmental organizations Agreement between the World Health Organization and the International Development Law Organization <sup>2</sup>

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<sup>1</sup> See Annex 16.

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

## LIST OF DOCUMENTS

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A75/35	Report of the External Auditor
A75/36	Report of the Internal Auditor
A75/37	External and internal audit recommendations: progress on implementation
A75/38	Appointment of representatives to the WHO Staff Pension Committee
A75/39	Collaboration within the United Nations system and with other intergovernmental organizations
A75/40	Availability, safety and quality of blood products
A75/40 Add.1	Financial and administrative implications for the Secretariat of decisions proposed for adoption by the Health Assembly <sup>1</sup>
A75/41	Human organ and tissue transplantation
A75/41 Add.1	Financial and administrative implications for the Secretariat of decisions proposed for adoption by the Health Assembly <sup>1</sup>
A75/42	Updates and future reporting Traditional medicine
A75/42 Add.1	Financial and administrative implications for the Secretariat of decisions proposed for adoption by the Health Assembly <sup>1</sup>
A75/43	Public health dimension of the world drug problem
A75/43 Add.1	Financial and administrative implications for the Secretariat of decisions proposed for adoption by the Health Assembly <sup>1</sup>
A75/44	Progress reports
A75/44 Add.1	Progress reports
A75/45 <sup>2</sup>	Special procedures
A75/46	Draft resolution: Revision of the Programme budget 2022–2023
A75/47	Health situation update in Ukraine

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<sup>1</sup> See Annex 18.

<sup>2</sup> Based on the format chosen for this session of the Health Assembly, it was decided to delete this document.

- A75/48 Special arrangements for settlement of arrears  
Islamic Republic of Iran
- A75/49 Special arrangements for settlement of arrears  
Republic of the Sudan
- A75/50 Prevention of sexual exploitation, abuse and harassment  
Report of the Programme, Budget and Administration Committee  
of the Executive Board to the Seventy-fifth World Health Assembly
- A75/51 WHO programmatic and financial reports for 2020–2021, including  
audited financial statements for 2021  
Report of the Programme, Budget and Administration Committee  
of the Executive Board to the Seventy-fifth World Health Assembly
- A75/52 Financing and implementation of the Programme budget  
2022–2023  
Reporting on operational efficiencies  
Report of the Programme, Budget and Administration Committee  
of the Executive Board to the Seventy-fifth World Health Assembly
- A75/53 Programme budget 2022–2023: revision  
Extending the Thirteenth General Programme of Work, 2019–2023  
to 2025  
Report of the Programme, Budget and Administration Committee  
of the Executive Board to the Seventy-fifth World Health Assembly
- A75/54 Sustainable financing: report of the Working Group  
Report of the Programme, Budget and Administration Committee  
of the Executive Board to the Seventy-fifth World Health Assembly
- A75/55 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 the Executive Board to the Seventy-fifth World Health Assembly
- A75/56 Report of the External Auditor  
Report of the Internal Auditor  
External and internal audit recommendations: progress on  
implementation  
Report of the Programme, Budget and Administration Committee  
of the Executive Board to the Seventy-fifth World Health Assembly
- A75/57 Human resources: annual report  
Report of the Programme, Budget and Administration Committee  
of the Executive Board to the Seventy-fifth World Health Assembly
- A75/58 First report of Committee A (Draft)

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A75/59	Committee on Credentials Report
A75/60	Second report of Committee A (Draft)
A75/61	Third report of Committee A (Draft)
A75/62	First report of Committee B (Draft)
A75/63	Election of Members entitled to designate a person to serve on the Executive Board
A75/64	Second report of Committee B (Draft)
A75/65	Fourth report of Committee A (Draft)
A75/66	Third report of Committee B (Draft)
A75/67	Fifth report of Committee A (Draft)
A75/68	Fourth report of Committee B (Draft)
A75/69	Sixth report of Committee A (Draft)
A75/70	Seventh report of Committee A (Draft)

### **Information documents**

A75/INF./1	Post of Director-General Appointment of the Director-General
A75/INF./2	Practical arrangements for the conduct of the secret ballot vote for the nomination of the candidate for the post of Director-General
A75/INF./3	Awards <sup>1</sup>
A75/INF./4	Follow-up to the political declaration of the third high-level meeting of the General Assembly on the prevention and control of non-communicable diseases Strengthening synergies between the World Health Assembly and the Conference of the Parties to the WHO Framework Convention on Tobacco Control
A75/INF./5	Voluntary contributions by fund and by contributor, 2021

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<sup>1</sup> See Annex 17.

A75/INF./6 <sup>1</sup>	Decision-making
A75/INF./7	Mid-term evaluation of the implementation of the Strategic Action Plan on Polio Transition (2018–2023)
A75/INF./8	Follow-up to the political declaration of the third high-level meeting of the General Assembly on the prevention and control of non-communicable diseases

**Diverse documents**

A75/DIV./1 Rev.1	List of delegates and other participants
A75/DIV./2	Guide for delegates to the World Health Assembly
A75/DIV./3	List of decisions and resolutions
A75/DIV./4	List of documents

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<sup>1</sup> Based on the format chosen for this session of the Health Assembly, it was decided to delete this document.

# OFFICERS OF THE HEALTH ASSEMBLY AND MEMBERSHIP OF ITS COMMITTEES<sup>1</sup>

## **President**

H.E. Dr Ahmed Robleh ABDILLEH  
(Djibouti)

## **Vice-Presidents**

Dr Maria Endang SUMIWI (Indonesia)  
Professor Asena SERBEZOVA (Bulgaria)  
Mr Colin MCIFF (United States of America)  
Mr Khairy JAMALUDDIN (Malaysia)  
Professor Moustafa MIJIYAWA (Togo)

## **Secretary**

Dr Tedros Adhanom GHEBREYESUS,  
Director-General

### **Committee on Credentials**

The Seventy-fifth World Health Assembly appointed a Committee on Credentials consisting of delegates of the following 12 Member States: Australia, Azerbaijan, Bolivia (Plurinational State of), Chad, Croatia, Eswatini, Ireland, Nepal, Nicaragua, Sierra Leone, Singapore, Sudan.

**Chair:** Mr Jeff ROACH (Australia)

**Vice-Chair:** Ms María René Castro  
CUSICANQUI (Plurinational State of  
Bolivia)

**Secretary:** Mr Xavier DANNEY, Senior  
Legal Officer

### **General Committee**

The Seventy-fifth World Health Assembly elected the delegates of the following 17 countries as members of the General Committee: Angola, Armenia, Benin, Burkina Faso, Cameroon, China, Congo, Cuba, Czechia,

Dominica, El Salvador, France, Saudi Arabia, Somalia, Turkey, United Kingdom of Great Britain and Northern Ireland, Uruguay.

**Chair:** H.E. Dr Ahmed Robleh ABDILLEH  
(Djibouti)

**Secretary:** Dr Tedros Adhanom  
GHEBREYESUS, Director-General

## **MAIN COMMITTEES**

Under Rule 34 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**

**Chair:** Dr Hiroki NAKATANI (Japan)

**Vice-Chairs:** Dr Tamar GABUNIA (Georgia)  
Dr Maryam ABDOOL-RICHARDS  
(Trinidad and Tobago)

**Rapporteur:** Dr Walaiporn  
PATCHARANARUMOL (Thailand)

**Secretary:** Mr Ian ROBERTS, Coordinator,  
Library and Information Networks for  
Knowledge

### **Committee B**

**Chair:** Mr Rajesh BHUSHAN (India)

**Vice-Chairs:** Dr Firass ABIAD (Lebanon)  
Dr Emmanuel Osagie EHANIRE (Nigeria)

**Rapporteur:** Dr Grzegorz JUSZCZYK (Poland)

**Secretary:** Mrs Ivana MILOVANOVIC, Senior  
Policy Lead, Office of the Director-  
General's Envoy for Multilateral Affairs

## **REPRESENTATIVES OF THE EXECUTIVE BOARD**

Dr Patrick AMOTH (Kenya)  
Mrs Carla MORETTI (Argentina)  
Dr Wahid MAJROOH (Afghanistan)  
Dr Clemens Martin AUER (Austria)

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<sup>1</sup> In addition, the list of delegates and other participants is contained in document A75/DIV./1 Rev.1.





## **RESOLUTIONS AND DECISIONS**



## RESOLUTIONS

### **WHA75.1 Special arrangements for settlement of arrears: Islamic Republic of Iran**

The Seventy-fifth World Health Assembly,

Having considered the request of the Islamic Republic of Iran in respect of its outstanding contributions up to and including 2022 of US\$ 10 222 277 to reschedule payment of this balance over the period 2022–2031;<sup>1</sup>

Noting that this request did not comply fully with the requirements of resolution WHA54.6 (2001) on special arrangements for settlement of arrears, as to timing and procedure,

1. DECIDES to restore the voting privileges of the Islamic Republic of Iran at the Seventy-fifth World Health Assembly on the following conditions:

The Islamic Republic of Iran shall pay its outstanding arrears of assessed contributions, totalling US\$ 10 222 277 over 10 years from 2022 to 2031, as set out below, in addition to payment of its annual assessment from 2023;

<b>Year</b>	<b>US\$</b>
2022	1 022 227
2023	1 022 227
2024	1 022 227
2025	1 022 227
2026	1 022 227
2027	1 022 227
2028	1 022 227
2029	1 022 227
2030	1 022 227
2031	1 022 234
<b>Total</b>	<b>10 222 277</b>

2. FURTHER DECIDES that, in accordance with Article 7 of the Constitution of the World Health Organization, voting privileges shall be automatically suspended if the Islamic Republic of Iran does not meet the requirements laid down in paragraph 1 above;

3. REQUESTS the Director-General to report to future Health Assemblies as appropriate on the prevailing situation;

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<sup>1</sup> See document A75/48.

4. FURTHER REQUESTS the Director-General to communicate this resolution to the Government of the Islamic Republic of Iran.

(Fourth plenary meeting, 24 May 2022  
Committee A, first report)

### **WHA75.2 Special arrangements for settlement of arrears: Sudan**

The Seventy-fifth World Health Assembly,

Having considered the request of Sudan in respect of its outstanding contributions up to and including 2022 of US\$ 239 220 to reschedule payment of this balance over the period 2023–2025;<sup>1</sup>

Noting that this request did not comply fully with the requirements of resolution WHA54.6 (2001) on special arrangements for settlement of arrears, as to timing and procedure,

1. DECIDES to restore Sudan's voting privileges at the Seventy-fifth World Health Assembly on the following conditions:

Sudan shall pay its outstanding arrears of assessed contributions, totalling US\$ 239 220 over three years from 2023 to 2025, as set out below, in addition to payment of its annual assessment from 2023;

<b>Year</b>	<b>US\$</b>
2023	95 690
2024	95 690
2025	47 840
<b>Total</b>	<b>239 220</b>

2. FURTHER DECIDES that, in accordance with Article 7 of the Constitution of the World Health Organization, voting privileges shall be automatically suspended if Sudan does not meet the requirements laid down in paragraph 1 above;

3. REQUESTS the Director-General to report to future Health Assemblies as appropriate on the prevailing situation;

4. FURTHER REQUESTS the Director-General to communicate this resolution to the Government of Sudan.

(Fourth plenary meeting, 24 May 2022  
Committee A, first report)

<sup>1</sup> See document A75/49.

**WHA75.3 Appointment of the Director-General**

The Seventy-fifth World Health Assembly,

On the nomination of the Executive Board,<sup>1</sup>

APPOINTS Dr Tedros Adhanom Ghebreyesus as Director-General of the World Health Organization.

(Fifth plenary meeting, 24 May 2022)

**WHA75.4 Contract of the Director-General**

The Seventy-fifth World Health Assembly,

**I**

Pursuant to Article 31 of the Constitution and Rule 109 of the Rules of Procedure of the World Health Assembly,

APPROVES the contract establishing the terms and conditions of appointment, salary and other emoluments for the post of Director-General, as amended;<sup>2</sup>

**II**

Pursuant to Rule 112 of the Rules of Procedure of the World Health Assembly,

AUTHORIZES the President of the Seventy-fifth World Health Assembly to sign this contract in the name of the Organization.

(Fifth plenary meeting, 24 May 2022)

**WHA75.5 Revision of the Programme budget 2022–2023**

The Seventy-fifth World Health Assembly,

Having considered the proposed revision to the Programme budget 2022–2023;<sup>3</sup> and having noted the report of the Programme, Budget and Administration Committee of the Executive Board to the Seventy-fifth World Health Assembly;<sup>4</sup>

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<sup>1</sup> Resolution EB150.R1 (2022).

<sup>2</sup> Annex 1.

<sup>3</sup> Document A75/6.

<sup>4</sup> Document A75/53.

Noting that in response to the coronavirus disease (COVID-19) pandemic, the proposed revision incorporates new lessons learned and takes account of emerging issues needing to be tackled that were not yet known at the time of approval of the Programme budget 2022–2023;

Recalling resolution WHA74.3 (2021) on the Programme budget 2022–2023 in which the Director-General was requested to submit, as deemed necessary, a revised Programme budget 2022–2023, including its revised appropriation resolution, to the Seventy-fifth World Health Assembly to reflect the rapidly changing health situation of the world brought about by the COVID-19 pandemic, in the light of the findings of the independent reviews presented to the Seventy-fourth World Health Assembly;

Considering that the proposed revision is also fully aligned with resolution WHA74.7 (2021) on strengthening WHO preparedness for and response to health emergencies;

Noting also that the proposed revision includes resource requirements to strengthen leadership, accountability, compliance and risk management with a special focus on the Organization's capacity to prevent and respond to sexual exploitation, abuse and harassment,

1. APPROVES the revised programme budget for 2022–2023 with the additional elements as set out in the proposed revision to the Programme budget 2022–2023;
2. FURTHER APPROVES the increase contained in the revised programme budget for 2022–2023 of US\$ 604.4 million in the base budget segment, which brings the level of the approved Programme budget 2022–2023 base segment to US\$ 4968.4 million;
3. ALLOCATES the revised programme budget increase for the financial period 2022–2023 to the following strategic priorities:
  - (1) One billion more people benefiting from universal health coverage, increase of US\$ 89.7 million giving a new total approved budget of US\$ 1929.6 million;
  - (2) One billion more people better protected from health emergencies, increase of US\$ 404.6 million giving a new total approved budget of US\$ 1250.5 million;
  - (3) One billion more people enjoying better health and well-being, increase of US\$ 30.4 million giving a new total approved budget of US\$ 455.2 million;
  - (4) More effective and efficient WHO providing better support to countries, increase of US\$ 79.7 million giving a new total approved budget of US\$ 1333.1 million;<sup>1</sup>
4. AUTHORIZES the Director-General to use the assessed contributions together with the voluntary contributions, subject to the availability of resources, to finance the entire, revised Programme budget 2022–2023 as allocated in paragraph 3 (including its footnote) up to the amounts approved;
5. FURTHER AUTHORIZES the Director-General, where necessary, to make budget transfers among the revised levels of the four strategic priorities, up to an amount not exceeding 5% of the budget

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<sup>1</sup> Other areas remain unchanged: polio eradication (US\$ 558.3 million) and special programmes (US\$ 199.3 million) totalling US\$ 757.6 million; and emergency operations and appeals (US\$ 1000.0 million), which, being subject to the event-driven nature of the activities concerned, is an estimated budget requirement that can be subject to increase as necessary.

allocated to the strategic priority from which the transfer is made. Any such transfer will be reported in the statutory reports to the respective governing bodies;

6. REQUESTS the Director-General to uphold all provisions of paragraph 11 of resolution WHA74.3 (2021) on the Programme budget 2022–2023 with regard to regular reporting, monitoring and performance assessment of the approved revised Programme budget 2022–2023.

(Seventh plenary meeting, 27 May 2022  
Committee A, second report)

### **WHA75.6      Extension of the Thirteenth General Programme of Work, 2019–2023 to 2025<sup>1</sup>**

The Seventy-fifth World Health Assembly,

Having considered the report of the Director-General;<sup>2</sup> and having noted the report of the Programme, Budget and Administration Committee of the Executive Board to the Seventy-fifth World Health Assembly;<sup>3</sup>

Considering also the request in respect of the Thirteenth General Programme of Work, 2019–2023, made to the Director-General in resolution WHA74.3 (2021) on the Programme budget 2022–2023,

1. APPROVES the extension of the period of the Thirteenth General Programme of Work from 2023 to 2025;

2. REQUESTS the Director-General:

(1) to consult with Member States on the report of the Director-General on extending the Thirteenth General Programme of Work, 2019–2023 to 2025<sup>2</sup> and to submit the outcome of the consultation process to the Executive Board at its 152nd session in January 2023, for its consideration and adoption, through the Programme, Budget and Administration Committee of the Executive Board;

(2) to continue working on the development of the Proposed programme budget 2024–2025, based on the Thirteenth General Programme of Work, as extended, with this development work to have regard to the priorities set out in the Director-General's report<sup>2</sup> and the Member States' consultation thereon.

(Seventh plenary meeting, 27 May 2022  
Committee A, second report)

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<sup>1</sup> See Annex 18 for the financial and administrative implications for the Secretariat of this resolution.

<sup>2</sup> Document A75/8.

<sup>3</sup> Document A75/53.

## **WHA75.7      Strengthening health emergency preparedness and response in cities and urban settings<sup>1</sup>**

The Seventy-fifth World Health Assembly,

Recalling Member States' commitments to the Sustainable Development Goals, including to strengthen the capacity of all countries, in particular developing countries, for early warning, risk reduction and management of national and global health risks;

Recalling also the Thirteenth General Programme of Work, 2019–2025, and its strategic priority of one billion more people better protected from health emergencies by 2025;

Further recalling resolution WHA73.1 (2020) on COVID-19 response, in which the Seventy-third World Health Assembly requested the Director-General, *inter alia*, to continue to build and strengthen the capacities of WHO at all levels to fully and effectively perform the functions entrusted to it under the International Health Regulations (2005);

Also recalling resolution WHA73.8 (2020) on strengthening preparedness for health emergencies: implementation of the International Health Regulations (2005), which recognizes that urban settings are especially vulnerable to infectious disease outbreaks and epidemics and that urban planning is a key element of preparedness and response;

Reaffirming resolution WHA74.7 (2021) on strengthening WHO preparedness for and response to health emergencies, which underlines that preparing for and responding to health emergencies is primarily the responsibility and crucial role of governments;

Recognizing the important role that cities and local authorities have in preventing, preparing for and responding to health emergencies;

Acknowledging the High-level Conference on Preparedness for Public Health Emergencies: Challenges and Opportunities in Urban Areas held in Lyon, France, on 3 and 4 December 2018, which acknowledged that urbanization leads to new challenges for global health and that multisectoral coordination, including that at local level, and engagement of local authorities and local communities, as well as urban leaders, play an important role in emergency preparedness and response;

Recognizing the work of the technical working group on advancing health emergency preparedness in cities and urban settings in COVID-19 and beyond,<sup>2</sup> which led to the development of the framework for strengthening health emergency preparedness in cities and urban settings<sup>3</sup> and the operational guidance for national and local authorities,<sup>4</sup> and encouraging broader engagement of Member States in the discussions within this technical working group;

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<sup>1</sup> See Annex 18 for the financial and administrative implications for the Secretariat of this resolution.

<sup>2</sup> WHO and the Government of Singapore co-hosted the virtual technical working group from February to April 2021 to advance the topic.

<sup>3</sup> Framework for strengthening health emergency preparedness in cities and urban settings. Geneva: World Health Organization; 2021 (<https://apps.who.int/iris/handle/10665/348351>, accessed 12 May 2022).

<sup>4</sup> Strengthening health emergency preparedness in cities and urban settings: guidance for national and local authorities. Geneva: World Health Organization; 2022 (<https://apps.who.int/iris/handle/10665/351721>, accessed 12 May 2022).



Noting with concern that the COVID-19 pandemic has revealed serious shortcomings in preparedness – especially at the city and urban levels – for timely and effective prevention and detection of, as well as response to, potential health emergencies, including in the capacity and resilience of health systems, indicating the need to better prepare for future health emergencies;

Stressing the key roles of coordination between the national, regional and local levels, as well as of effective community engagement, in preparedness for and response to health emergencies;

Highlighting the disruptions caused by the COVID-19 pandemic and public health measures taken in response to the pandemic in cities and urban settings, as well as associated informal settlements;

Highlighting also the concern regarding lack of adequate resources for health emergency preparedness and response, particularly at the subnational level, and that resources available are predominantly at the national level,

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

- (1) to sustain political commitment at the highest level and to give due attention to preparedness for and response to health emergencies in cities and urban settings, recognizing their unique vulnerabilities;
- (2) to provide adequate resources and to strengthen capacities and capabilities in urban health emergency preparedness and response;
- (3) to strengthen multisectoral, multilevel and multistakeholder collaboration in national health emergency preparedness and response policies;
- (4) to develop, strengthen and implement health emergency preparedness and response plans, recognizing that such plans should be context-specific, given the heterogeneity of cities and urban settings;
- (5) to consider conducting simulation exercises and intra- and after-action reviews through adopting a multisectoral, multilevel and multistakeholder approach;
- (6) to collaborate and support learning and sharing of good practices with international partners including national public health institutes, the WHO Global Strategic Preparedness Network, and other relevant national and international organizations working on all aspects of the urban health emergency preparedness agenda;

2. REQUESTS the Director-General:

- (1) to provide technical support to Member States,<sup>1</sup> upon request, to strengthen capacities and capabilities in urban health emergency preparedness and response;
- (2) to take appropriate measures for securing adequate financial and human resources at all levels of WHO for providing this support, in line with the priorities of the Thirteenth General Programme of Work, 2019–2025;

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

(3) to provide support to Member States,<sup>1</sup> upon request, in the implementation of the framework for strengthening health emergency preparedness in cities and urban settings;

(4) to submit a progress report on the implementation of this resolution to the Seventy-seventh World Health Assembly in 2024.

(Seventh plenary meeting, 27 May 2022  
Committee A, third report)

### **WHA75.8      Strengthening clinical trials<sup>1</sup> to provide high-quality evidence on health interventions and to improve research quality and coordination<sup>2</sup>**

The Seventy-fifth World Health Assembly,

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

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

Recognizing that well-designed<sup>3</sup> and well-implemented clinical trials are indispensable for assessing the safety and efficacy of health interventions;

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

<sup>2</sup> See Annex 18 for the financial and administrative implications for the Secretariat of this resolution.

<sup>3</sup> Throughout this resolution, the phrase "well-designed trials" refers to trials that are scientifically and ethically appropriate. For submission to medical product regulatory authorities, trials should adhere to the guidelines of the International Council for Harmonisation of Technical Requirements for Pharmaceuticals for Human Use and some Member States may consider the guidelines of the International Coalition of Medicines Regulatory Authorities. In order to generate evidence that is sufficiently robust to support decision-making, such as widespread use of therapeutics or preventives, trials should be designed, conducted, analysed and reported appropriately. A well-designed trial must also be practically feasible to conduct.

Noting the role of clinical trials in the development of safe and efficacious new health interventions, and in informing associated comparative cost–effectiveness evaluations with reference to existing interventions in order to promote the affordability of health products;

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

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

Recognizing also the essential contribution of participants in clinical trials;

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

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

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

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

(1) to prioritize the development and strengthening of national clinical trial capabilities that comply with international standards of trial design and conduct and human subject protections as well as strengthening and developing national regulatory and quality-control frameworks and authorities;

(2) to increase clinical trial capabilities, and strengthen clinical trials policy frameworks, particularly in developing countries, to enable a greater number of sites that can conduct well-designed and well-implemented clinical trials, and to ensure readiness for coordination of trials through existing, new or expanded clinical trials networks that meet relevant regulations and internationally harmonized standards, promoting sharing of information and best practices of efficient and ethical clinical trial design and delivery, and in designing, preparing and conducting clinical trials;

(3) to coordinate clinical trials research priorities based on public health needs of Member States including collaborative and, as appropriate, multicountry and multiregional clinical trials when mutually beneficial, while avoiding unnecessary duplication of work, taking into account that aligning clinical trials across countries will require preparatory work, including the coordination, as appropriate, in national regulatory practices and funding frameworks;

(4) to collaborate with private-sector funders and academic institutions, while actively preventing and managing conflicts of interest, to encourage the targeting of clinical trials towards the development of health interventions that address public health priorities and concerns of global, regional and national importance, including communicable and noncommunicable diseases, with a focus on the health needs of developing countries, and that evaluate the safety and efficacy of health interventions, including having special regard to common diseases in low- and middle-income countries, unmet medical needs, rare diseases and neglected tropical diseases;

(5) to note and, as appropriate, benefit from the potential role of regional organizations in coordinating clinical trials and recruiting participants;

(6) to encourage research funding agencies to prioritize and fund clinical trials that are well-designed and well-implemented, conducted in diverse settings and include all major population groups that the intervention is intended to benefit, and have adequate statistical power, relevant control groups and interventions in order to generate the scientifically robust and actionable evidence needed to inform public health policy, regulatory decisions and medical practice while preventing underpowered, poorly-designed clinical trials and avoiding the exposure of participants in clinical trials to unjustified and unnecessary risk, in normal times as well as in public health emergencies of international concern, by means including:

(a) encouraging investment in well-designed clinical trials, including use of clinical trials networks that are developed in collaboration with affected communities, with a view to addressing their public health needs and with the potential for trials to contribute to

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<sup>1</sup> Throughout this resolution, reference to Member States includes, where applicable, regional economic integration organizations.

clinical trial capabilities, including strengthening the core competencies of research personnel, particularly in developing countries;

(b) introducing grant conditions for funding clinical trials to encourage the use of standardized data protocols where available and appropriate and to mandate registration in a publicly available clinical trial registry within the WHO International Clinical Trials Registry Platform or any other registry that meets its standards;

(c) promoting, as appropriate, measures to facilitate the timely reporting of both positive and negative interpretable clinical trial results in alignment with the joint statement on public disclosure of results from clinical trials<sup>1</sup> and the joint statement on transparency and data integrity of the International Coalition of Medicines Regulatory Authorities and WHO,<sup>2</sup> including registering the results on a publicly available clinical trial registry within the WHO International Clinical Trials Registry Platform and encouraging timely publication of the trial results, preferably in an open-access publication;

(d) promoting transparent translation of results, including comparison with existing treatments and data on effectiveness, based on thorough assessment, into clinical guidelines where appropriate;

(e) exploring measures during public health emergencies of international concern to encourage researchers to share interpretable results of clinical trials, including negative results, rapidly and responsibly with national regulatory bodies or other appropriate authorities, including WHO, for clinical guideline development and emergency use listing, to support rapid regulatory decision-making and emergency adaptation of clinical and public health guidelines as appropriate, by means including pre-print publication;

(7) to support ethics committees and regulatory authorities to enable efficient governance processes to focus on the fundamental scientific and ethical principles that underpin randomized controlled trials, maintaining patient and other trial participant protections, including personal data protection, and acting proportionately to risk, to best support well-designed and well-implemented clinical trials and facilitate the development of preparedness for clinical trials including, when appropriate, multicountry trials during public health emergencies of international concern, where scientifically appropriate, while embracing flexibility and innovation;

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

(a) safe, ethical, well-designed clinical trials can be approved and progress quickly;

(b) data from clinical trials can be assessed rapidly, for example through the WHO Emergency Use Listing procedure, and health interventions deemed safe and effective can be swiftly authorized;

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

<sup>2</sup> International Coalition of Medicines Regulatory Authorities and WHO. Joint statement on transparency and data integrity, 7 May 2021 ([https://www.who.int/news/item/07-05-2021-joint-statement-on-transparency-and-data-integrityinternational-coalition-of-medicines-regulatory-authorities-\(icmra\)-and-who](https://www.who.int/news/item/07-05-2021-joint-statement-on-transparency-and-data-integrityinternational-coalition-of-medicines-regulatory-authorities-(icmra)-and-who), accessed 25 May 2022).

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

(a) their assessments of clinical trial protocols to enable the implementation of rigorous protocols in practice;

(b) assessment reports on health interventions with potential significance and public health importance in order to inform, when possible, decision-making processes in other countries, including for potential regulatory assessments and decisions related to the inclusion of health interventions in their national health systems, as well as for safety monitoring;

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

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

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

3. REQUESTS the Director-General:

(1) to organize, in a transparent manner, stakeholder consultations, in line with the Framework of Engagement with Non-State Actors, with Member States, nongovernmental organizations including patient groups, private-sector entities including international business associations, philanthropic foundations and academic institutions, as appropriate, on the respective roles of the WHO Secretariat, Member States and non-State actors, and to identify and propose to Member States, for consideration by the governing bodies, best practices and other measures to strengthen the global clinical trial ecosystem, taking into account relevant initiatives where appropriate;

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

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

- (b) guidance on best practices for non-State actors in the design and conduct of clinical trials and in strengthening the global clinical trial ecosystem to meet the needs of major population groups that the intervention is intended to benefit, with a particular focus on under-represented populations, developed in consultation with Member States and relevant non-State actors;
- (3) to provide to Member States, on their request, guidance, taking into account relevant initiatives and guidelines, as appropriate, on best practices for developing the legislation, infrastructure and capabilities required for clinical trials, taking into account national and regional contexts;
- (4) to engage with, as appropriate, relevant non-State actors in line with the Framework of Engagement with Non-State Actors to strengthen clinical trial capabilities, particularly in developing countries, on innovations that meet the needs of major population groups that the intervention is intended to benefit, with a particular focus on under-represented populations;
- (5) to present a substantive report outlining progress in the activities requested of the Director-General in this resolution for consideration by the Seventy-sixth World Health Assembly in 2023 through the Executive Board at its 152nd session.

(Seventh plenary meeting, 27 May 2022  
Committee A, third report)

## **WHA75.9      Scale of assessments 2022–2023**

The Seventy-fifth World Health Assembly,

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

ADOPTS the scale of assessments of Members and Associate Members for 2023 as set out below.

<b>Members and Associate Members</b>	<b>WHO scale for 2023 %</b>
Afghanistan	0.0060
Albania	0.0080
Algeria	0.1090
Andorra	0.0050
Angola	0.0100
Antigua and Barbuda	0.0020
Argentina	0.7190
Armenia	0.0070
Australia	2.1111
Austria	0.6790
Azerbaijan	0.0300
Bahamas	0.0190
Bahrain	0.0540
Bangladesh	0.0100
Barbados	0.0080

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

<b>Members and Associate Members</b>	<b>WHO scale for 2023 %</b>
Belarus	0.0410
Belgium	0.8281
Belize	0.0010
Benin	0.0050
Bhutan	0.0010
Bolivia (Plurinational State of)	0.0190
Bosnia and Herzegovina	0.0120
Botswana	0.0150
Brazil	2.0131
Brunei Darussalam	0.0210
Bulgaria	0.0560
Burkina Faso	0.0040
Burundi	0.0010
Cabo Verde	0.0010
Cambodia	0.0070
Cameroon	0.0130
Canada	2.6282
Central African Republic	0.0010
Chad	0.0030
Chile	0.4200
China	15.2550
Colombia	0.2460
Comoros	0.0010
Congo	0.0050
Cook Islands (not a member of the United Nations)	0.0010
Costa Rica	0.0690
Côte d'Ivoire	0.0220
Croatia	0.0910
Cuba	0.0950
Cyprus	0.0360
Czechia	0.3400
Democratic People's Republic of Korea	0.0050
Democratic Republic of the Congo	0.0100
Denmark	0.5530
Djibouti	0.0010
Dominica	0.0010
Dominican Republic	0.0670
Ecuador	0.0770
Egypt	0.1390
El Salvador	0.0130
Equatorial Guinea	0.0120
Eritrea	0.0010
Estonia	0.0440
Eswatini	0.0020
Ethiopia	0.0100
Faroe Islands (Associate Member)	0.0010
Fiji	0.0040
Finland	0.4170
France	4.3183



<b>Members and Associate Members</b>	<b>WHO scale for 2023 %</b>
Gabon	0.0130
Gambia	0.0010
Georgia	0.0080
Germany	6.1114
Ghana	0.0240
Greece	0.3250
Grenada	0.0010
Guatemala	0.0410
Guinea	0.0030
Guinea-Bissau	0.0010
Guyana	0.0040
Haiti	0.0060
Honduras	0.0090
Hungary	0.2280
Iceland	0.0360
India	1.0441
Indonesia	0.5490
Iran (Islamic Republic of)	0.3710
Iraq	0.1280
Ireland	0.4390
Israel	0.5610
Italy	3.1892
Jamaica	0.0080
Japan	8.0335
Jordan	0.0220
Kazakhstan	0.1330
Kenya	0.0300
Kiribati	0.0010
Kuwait	0.2340
Kyrgyzstan	0.0020
Lao People's Democratic Republic	0.0070
Latvia	0.0500
Lebanon	0.0360
Lesotho	0.0010
Liberia	0.0010
Libya	0.0180
Lithuania	0.0770
Luxembourg	0.0680
Madagascar	0.0040
Malawi	0.0020
Malaysia	0.3480
Maldives	0.0040
Mali	0.0050
Malta	0.0190
Marshall Islands	0.0010
Mauritania	0.0020
Mauritius	0.0190
Mexico	1.2211
Micronesia (Federated States of)	0.0010

<b>Members and Associate Members</b>	<b>WHO scale for 2023 %</b>
Monaco	0.0110
Mongolia	0.0040
Montenegro	0.0040
Morocco	0.0550
Mozambique	0.0040
Myanmar	0.0100
Namibia	0.0090
Nauru	0.0010
Nepal	0.0100
Netherlands	1.3771
New Zealand	0.3090
Nicaragua	0.0050
Niger	0.0030
Nigeria	0.1820
Niue (not a member of the United Nations)	0.0010
North Macedonia	0.0070
Norway	0.6790
Oman	0.1110
Pakistan	0.1140
Palau	0.0010
Panama	0.0900
Papua New Guinea	0.0100
Paraguay	0.0260
Peru	0.1630
Philippines	0.2120
Poland	0.8371
Portugal	0.3530
Puerto Rico (Associate Member)	0.0010
Qatar	0.2690
Republic of Korea	2.5742
Republic of Moldova	0.0050
Romania	0.3120
Russian Federation	1.8661
Rwanda	0.0030
Saint Kitts and Nevis	0.0020
Saint Lucia	0.0020
Saint Vincent and the Grenadines	0.0010
Samoa	0.0010
San Marino	0.0020
Sao Tome and Principe	0.0010
Saudi Arabia	1.1841
Senegal	0.0070
Serbia	0.0320
Seychelles	0.0020
Sierra Leone	0.0010
Singapore	0.5040
Slovakia	0.1550
Slovenia	0.0790
Solomon Islands	0.0010

<b>Members and Associate Members</b>	<b>WHO scale for 2023 %</b>
Somalia	0.0010
South Africa	0.2440
South Sudan	0.0020
Spain	2.1341
Sri Lanka	0.0450
Sudan	0.0100
Suriname	0.0030
Sweden	0.8711
Switzerland	1.1341
Syrian Arab Republic	0.0090
Tajikistan	0.0030
Thailand	0.3680
Timor-Leste	0.0010
Togo	0.0020
Tokelau (Associate Member)	0.0010
Tonga	0.0010
Trinidad and Tobago	0.0370
Tunisia	0.0190
Turkey	0.8451
Turkmenistan	0.0340
Tuvalu	0.0010
Uganda	0.0100
Ukraine	0.0560
United Arab Emirates	0.6350
United Kingdom of Great Britain and Northern Ireland	4.3753
United Republic of Tanzania	0.0100
United States of America	22.0000
Uruguay	0.0920
Uzbekistan	0.0270
Vanuatu	0.0010
Venezuela (Bolivarian Republic of)	0.1750
Viet Nam	0.0930
Yemen	0.0080
Zambia	0.0080
Zimbabwe	0.0070
<b>TOTAL</b>	<b>100.0000</b>

(Seventh plenary meeting, 27 May 2022  
Committee B, first report)

**WHA75.10      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 of the World Health Organization**

The Seventy-fifth World Health Assembly,

Having considered the report by the Director-General;<sup>1</sup> and having noted the report of the Programme, Budget and Administration Committee of the Executive Board to the Seventy-fifth World Health Assembly;<sup>2</sup>

Noting that, at the time of opening of the Seventy-fifth World Health Assembly, the voting rights of Afghanistan, Comoros, Equatorial Guinea, the Gambia, Iran (Islamic Republic of), Somalia, South Sudan, Sudan, Venezuela (Bolivarian Republic of) and Yemen were suspended, such suspension shall 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 of the World Health Organization;

Noting that Cameroon, Chile, Dominica, Lebanon, Lesotho, Libya, North Macedonia and Solomon Islands were in arrears at the time of the opening of the Seventy-fifth 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 of the World Health Organization, whether the voting privileges of those countries should be suspended at the opening of the Seventy-sixth World Health Assembly in 2023,

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 Seventy-sixth World Health Assembly, Cameroon, Chile, Dominica, Lebanon, Lesotho, Libya, North Macedonia and Solomon Islands are still in arrears in the payment of their contributions to an extent that would justify invoking Article 7 of the Constitution of the World Health Organization, 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 Seventy-sixth World Health Assembly and subsequent Health Assemblies, until the arrears have been reduced to a level below the amount that would justify invoking Article 7 of the Constitution of the World Health Organization;
- (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 of the World Health Organization.

(Seventh plenary meeting, 27 May 2022  
Committee B, first report)

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<sup>1</sup> Document A75/28.

<sup>2</sup> Document A75/55.

**WHA75.11 Health emergency in Ukraine and refugee-receiving and -hosting countries, stemming from the Russian Federation's aggression<sup>1</sup>**

The Seventy-fifth World Health Assembly,

Having considered the report by the Director-General;<sup>2</sup>

Recalling United Nations General Assembly resolution ES-11/1 of 2 March 2022 on aggression against Ukraine; United Nations General Assembly resolution ES-11/2 of 24 March 2022 on the humanitarian consequences of the aggression against Ukraine; as well as United Nations Human Rights Council resolution 49/1 of 4 March 2022 on the situation of human rights in Ukraine stemming from the Russian aggression;

Recalling also United Nations Security Council resolution 2286 (2016) on protection of the wounded and sick, medical personnel and humanitarian personnel in armed conflict; United Nations General Assembly resolution 46/182 (1991) on strengthening of the coordination of humanitarian emergency assistance of the United Nations, and all relevant subsequent resolutions; 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; and decision WHA69(9) (2016) on reform of WHO's work in health emergency management: WHO Health Emergencies Programme;

Welcoming the legally binding provisional measures order by the International Court of Justice of 16 March 2022, ordering the Russian Federation to immediately suspend the military operations that it commenced on 24 February 2022 in the territory of Ukraine;

Noting the adoption by the WHO Regional Committee for Europe, during its special session held on 10 May 2022, of a resolution on WHA75: health emergency in Ukraine and neighbouring countries, stemming from the Russian Federation's aggression,<sup>3</sup> calling upon the WHO Regional Director for Europe to consider temporarily suspending all regional meetings in the Russian Federation, including technical meetings and meetings of experts, as well as conferences and seminars whose composition is set by the WHO Regional Office for Europe, until peaceful resolution of the conflict between the Russian Federation and Ukraine is implemented and the Russian Federation withdraws its military forces from the territory of Ukraine within its internationally recognized borders;

Recalling the Constitution of the World Health Organization and its references to the Charter of the United Nations; the obligation of all Members under Article 2 of the Charter of the United Nations to refrain in their international relations from the threat or use of force against the territorial integrity or political independence of any state, or in any other manner inconsistent with the purposes of the United Nations, and to settle their international disputes by peaceful means; and the obligation under Article 2 of the Charter of the United Nations, that all Members, in order to ensure the rights and benefits resulting from membership, shall fulfil in good faith the obligations assumed by them in accordance with the Charter;

Recalling also that health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity;

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<sup>1</sup> See Annex 18 for the financial and administrative implications for the Secretariat of this resolution.

<sup>2</sup> Document A75/47.

<sup>3</sup> Resolution EUR/RCSS/R1.

Reaffirming 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, and that peace and security are critical to the attainment of this human right;

Recalling the functions of WHO, which include, inter alia, furnishing appropriate technical assistance and, in emergencies, necessary aid;

Recognizing the grave concern over the Russian Federation's aggression against Ukraine in statements by, inter alia, the United Nations Secretary-General<sup>1</sup> and the WHO Director-General;<sup>2,3</sup>

Expressing grave concerns over the continuing health emergency in Ukraine and refugee-receiving and -hosting countries, triggered by the Russian Federation's aggression against Ukraine, resulting in conflict-related trauma and injuries as well as increased risks of illness and death from noncommunicable diseases, of emergence and spread of infectious diseases, of deterioration of mental health and psychosocial health, of human trafficking, of gender-based violence, and deterioration of sexual and reproductive health, including maternal and child health;

Alarmed in particular by the disproportionate impact of disrupted health services on vulnerable groups, such as women and children, internally displaced persons, elderly people and persons with disabilities;

Further alarmed by the health impacts of the Russian Federation's aggression, which have regional and wider-than-regional significance, including, inter alia: significant numbers of refugees fleeing Ukraine; the risks of radiological, biological and chemical events and hazards; and the exacerbation of an already significant global food security crisis;

Recalling the emergency appeal launched by WHO for Ukraine and refugee-receiving and -hosting countries on 3 March 2022,

1. CONDEMNS IN THE STRONGEST TERMS the Russian Federation's military aggression against Ukraine, including attacks on health care facilities documented through the WHO Surveillance System for Attacks on Health Care;
2. DRAWS ATTENTION to the fact that the Russian Federation's aggression against Ukraine constitutes exceptional circumstances, causing a serious impediment to the health of the population of Ukraine, as well as having regional and wider-than-regional health impacts;
3. URGES the Russian Federation to immediately cease any attacks on hospitals and other health care facilities;

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<sup>1</sup> United Nations Secretary-General's remarks at a press conference with the President of Ukraine on 28 April 2022 (<https://www.un.org/sg/en/content/sg/press-encounter/2022-04-28/secretary-generals-remarks-press-conference-president-volodymyr-zelenskyy-of-ukraine>).

<sup>2</sup> WHO Director-General's opening remarks at a WHO press conference on 13 April 2022 (<https://www.who.int/director-general/speeches/detail/who-director-general-s-opening-remarks-at-the-who-press-conference-13-April-2022>).

<sup>3</sup> WHO Director-General's remarks at the special session of the WHO Regional Committee for Europe on 10 May 2022 (<https://www.who.int/director-general/speeches/detail/WHO-Director-Generals-remarks-at-Special-Session-of-the-WHO-Regional-Committee-for-Europe-10-May-2022>).

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4. ALSO URGES the Russian Federation to fully respect and protect all medical personnel and humanitarian personnel exclusively engaged in medical duties, and their means of transport and equipment;
  5. FURTHER URGES respect for and protection of the sick and wounded, including civilians, health and humanitarian aid workers, and health care systems consistent with the Geneva Conventions and their Additional Protocols, and with broader international humanitarian law;
  6. DECIDES that continued action by the Russian Federation to the detriment of the health situation in Ukraine, at regional and global levels, would necessitate that the Health Assembly should consider the application of relevant articles of the Constitution of the World Health Organization;
  7. URGES the relevant Member States:
    - (1) to adhere to international humanitarian law, international human rights law and WHO's norms and standards;
    - (2) to allow and facilitate safe, rapid and unhindered access to populations in need of assistance by staff deployed by WHO on the ground, and by all other medical and humanitarian personnel;
    - (3) to ensure the free flow of essential medicines, medical equipment and other health technologies in all conflict and non-conflict areas;
  8. ENCOURAGES all Member States:
    - (1) to increase contributions to the WHO emergency appeal for Ukraine and refugee-receiving and -hosting countries, to the WHO Contingency Fund for Emergencies, and to WHO's work in other health emergencies, many of which have been exacerbated by the Russian Federation's military aggression against Ukraine;
    - (2) to maintain or increase support for the United Nations-led response to address the health and other urgent needs of the people of Ukraine and mitigate the negative health impact of the conflict, as well as other critical relief efforts around the globe;
  9. REQUESTS the Director-General:
    - (1) to make available the staffing, financial resources and leadership support needed across all three levels of the Organization for an effective and accountable humanitarian and emergency health response, including critical health cluster functions, under the leadership of the WHO Health Emergencies Programme, and in line with relevant Health Assembly resolutions;
    - (2) to ensure that the health response under WHO's leadership on the ground adheres to the best standards on prevention of and response to sexual exploitation, abuse and harassment and, in collaboration with other agencies, provides adequate health care and support to the victims, and documents cases of sexual abuse, including by the military;
    - (3) to continue supporting the health sectors of Ukraine and refugee-receiving and -hosting countries using a health system approach, which includes capacity-building programmes in preparedness for and response to trauma care and mass casualties as well as in maintenance of basic health services and the promotion of access thereto in a context of conflict;

- (4) to support the sustainable procurement of essential medicines, medical equipment and other health technologies;
- (5) to pursue the monitoring, collection, documentation and dissemination of data on attacks on health care facilities, health workers, health transports and patients in Ukraine;
- (6) to assess, in full cooperation with health cluster partners and other relevant entities of the United Nations system, the extent and nature of psychiatric morbidity and other forms of mental health problems, resulting from the protracted situation in Ukraine and refugee-receiving and -hosting countries;
- (7) to ensure the allocation of adequate human and financial resources in order to achieve the objectives set out in the foregoing subparagraphs;
- (8) to submit to the Seventy-sixth World Health Assembly in 2023, through the Executive Board at its 152nd session, a report on the implementation of the present resolution, including an assessment of the direct and indirect impact of the Russian Federation's aggression against Ukraine on the health of the population of Ukraine, as well as regional and wider-than-regional health impacts.

(Eighth plenary meeting, 28 May 2022  
Committee A, fourth report)

## **WHA75.12      Amendments to the International Health Regulations (2005)<sup>1</sup>**

The Seventy-fifth World Health Assembly,

Having considered the proposal for amendments to the International Health Regulations (2005),<sup>2</sup> which includes in its Annex proposed amendments submitted by the United States of America in accordance with paragraph 1 of Article 55 of the International Health Regulations (2005);

Recalling decision EB150(3) (2022) on strengthening the International Health Regulations (2005): a process for their revision through potential amendment, which noted the discussions of the Member States Working Group on Strengthening WHO Preparedness and Response to Health Emergencies related to strengthening the International Health Regulations (2005), including through implementation, compliance and potential amendments, and urged Member States to take all appropriate measures to consider potential amendments to the International Health Regulations (2005), with the understanding that this would not lead to reopening the entire instrument for renegotiation;

Expressing appreciation for the work of the Member States Working Group on Strengthening WHO Preparedness and Response to Health Emergencies in developing an inclusive Member State-led process for considering amendments to the International Health Regulations (2005);

Welcoming decision WHA75(9) (2022) on strengthening WHO preparedness for and response to health emergencies, in which Member States decided to commence a Member State-led process to

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<sup>1</sup> See Annex 18 for the financial and administrative implications for the Secretariat of this resolution.

<sup>2</sup> Document A75/18.



consider proposed amendments<sup>1</sup> to the International Health Regulations (2005) beyond those adopted in Annex 2;

Recalling that Member States decided to establish the Working Group on Amendments to the International Health Regulations (2005) through the Member States Working Group on Strengthening WHO Preparedness and Response to Health Emergencies, to discuss targeted amendments to address specific and clearly identified issues, challenges, including equity, technological or other developments, or gaps that could not effectively be addressed otherwise but are critical to supporting effective implementation of and compliance with the International Health Regulations (2005), and their universal application for the protection of all people of the world from the international spread of disease in an equitable manner;

Noting States Parties' right to notify the Director-General of rejections or reservations, pursuant to Articles 61 and 62, of the amendments in Annex 2 of the International Health Regulations (2005),

1. ADOPTS, in accordance with paragraph 3 of Article 55 of the International Health Regulations (2005), the amendments to Article 59, and the consequent necessary updates to Articles 55, 61, 62 and 63 of the International Health Regulations (2005) set out in Annex 2;

2. URGES States Parties, consistent with Article 44 of the International Health Regulations (2005), to collaborate with each other in the provision or facilitation of technical cooperation and logistical support, particularly in the development, strengthening and maintenance of the public health capacities required under the International Health Regulations (2005).

(Eighth plenary meeting, 28 May 2022  
Committee A, fifth report)

### **WHA75.13 Global strategy on infection prevention and control<sup>2</sup>**

The Seventy-fifth World Health Assembly,

Having considered the consolidated report by the Director-General;<sup>3</sup>

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

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<sup>1</sup> Including the other proposed amendments set out in the Annex to document A75/18, as well as other amendments which have or may be submitted by other States Parties to the International Health Regulations (2005) or the Director-General, including through the above-mentioned Member State-led process.

<sup>2</sup> See Annex 18 for the financial and administrative implications for the Secretariat of this resolution.

<sup>3</sup> Document A75/10 Rev.1.

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

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

Recognizing the critical importance of infection prevention and control in the human and animal health sectors and that the subject is a clinical and public health discipline based on a scientific approach, providing proactive, responsive and practical preventive and control measures grounded in infectious diseases, epidemiology, social, engineering and implementation science, and health systems strengthening that requires a dedicated specialist health work force;

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

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

Noting that that in addition to outbreaks, WHO has estimated that hundreds of millions of patients are affected by health care-associated infections leading to deaths in one in 10 infected patients every year, and noting further that in acute-care hospitals, of every 100 patients, seven in high-income countries and 15 in low- and middle-income countries will acquire at least one health care-associated infection during their hospital stay, and that up to 30% of patients in intensive care are affected by health care-associated infections, with an incidence that is two to 20 times higher in low- and middle-income countries than in high-income countries;

Recognizing that one quarter of health care facilities lacked basic water services in 2019, exposing 1.8 billion people, including health care workers and patients, to greater risk of infection, highlighting the major gaps in water, sanitation and hygiene services in health care facilities, which play a critical role in infection prevention and control, and noting the modest costs for achieving minimal water, sanitation and hygiene safety, which range from US\$ 6.5 billion to US\$ 9.6 billion in the 46 least developed countries, which represent 4–6% of these countries' recurrent health spending;

Noting that the added costs of health care-associated infections, which may vary from US\$ 1000 to US\$ 12 000 on average per episode depending on the country, result in a significant economic burden on health systems and out-of-pocket expenses for patients and families; and that the mortality among

patients affected by health care-associated sepsis was 24.4%, increasing up to 52.3% among patients treated in an intensive care unit and at least two to three times higher among those infected with antimicrobial-resistant organisms, in neonates and in low- and middle-income countries;

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

Noting further that a recent systematic analysis and predictive statistical models by antimicrobial resistance researchers showed that in 2019 the estimated number of deaths associated with bacterial antimicrobial resistance was 4.95 million globally, including 1.27 million deaths attributable to bacterial antimicrobial resistance and reflect the burden of antimicrobial resistance as a leading cause of death globally, with a high impact in low-resource settings;

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

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

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

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

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

- (1) to take steps to support and/or to ensure that infection prevention and control is one of the key components of global health preparedness, prevention and response;
- (2) to acknowledge that clean, high-quality, safe, affordable care should be universally available and that nobody should be unnecessarily exposed to infection due to suboptimal infection prevention and control practices;
- (3) to take steps to support and/or to ensure that science-based functional infection prevention and control programmes exist – for both community-acquired and health care-associated infections, taking into account the One Health approach – are implemented, monitored and

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

updated at national, subnational, and/or facility levels, as appropriate to national contexts and in line with WHO's core components of such programmes;<sup>1</sup>

(4) to take steps to support relevant authorities and/or ensure that at least the minimum requirements for infection prevention and control programmes at the national, subnational and health care facility levels are implemented and monitored, inclusive of environmentally conscious and appropriate waste management to reduce further impact on human, animal and environmental health;

(5) to support and ensure that transmission-based precautions for infection prevention and control are implemented with fidelity and quality at national and facility levels, and functional administrative, environmental and personal protection measures are in place to prevent and/or halt further transmission;

(6) to take steps to support and/or to ensure that sustainable infrastructures and resources for infection prevention and control and water, sanitation and hygiene are in place and utilized across all health care facilities, including in primary health care, home and community-based settings, and long-term care settings as appropriate to the national context;

(7) to take steps to recognize the value of having infection prevention and control professionals across a variety of settings, with appropriate competencies, skills, career pathways and empowerment with a clear mandate and authority, while being held accountable, and who work within the clinical governance framework of their organizations for implementation and reporting the impact of infection prevention and control programmes as appropriate to the national context;

(8) to take steps toward creating and implementing accredited infection prevention and control curricula within pre-graduate, post-graduate and in-service continuous education, where and as appropriate in national contexts, for all health care workers and all relevant disciplines;

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

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

(11) to introduce guidance, regulations and/or legal frameworks to enforce infection prevention and control requirements, policies and implementation of best practices through

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

systems for accrediting health facilities and other mechanisms, as appropriate and guided by domestic context;

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

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

2. REQUESTS the Director-General:

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

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

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

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

(Eighth plenary meeting, 28 May 2022  
Committee A, sixth report)

**WHA75.14 Global strategy and plan of action on public health, innovation and intellectual property<sup>1</sup>**

The Seventy-fifth World Health Assembly,

Having considered the consolidated report by the Director-General;<sup>2</sup>

Recalling resolutions WHA61.21 (2008), WHA62.16 (2009), WHA68.18 (2015) and WHA72.8 (2019) and decisions WHA71(9) (2018) and WHA73(11) (2020) on the global strategy and plan of action on public health, innovation and intellectual property that aims to promote new thinking on innovation and access to medicines and other health products;

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<sup>1</sup> See Annex 18 for the financial and administrative implications for the Secretariat of this resolution.

<sup>2</sup> Document A75/10 Rev.1.

Reiterating the essential role that the global strategy and plan of action on public health, innovation and intellectual property plays in directing and coordinating WHO's policies and programme on this interface, including the WHO–WIPO–WTO trilateral cooperation;

Stressing that the relationship, including the balance, between public health, innovation and intellectual property is a critical component of sustainable and resilient health systems, as well as but not limited to the prevention of, preparedness for and response to health emergencies, including the continuing pandemic of coronavirus disease (COVID-19) and future pandemics;

Acknowledging the continued value of the principles and elements of work enshrined in the global strategy and plan of action on public health, innovation and intellectual property, which guide and frame the work of WHO on access to medicines and other health products;

Reaffirming the goals and objectives of the global strategy and plan of action on public health, innovation and intellectual property, and recognizing the important contribution and prioritization effort made by the overall programme review of the global strategy and plan of action on public health, innovation and intellectual property;<sup>1</sup>

Renewing the expression of Member States' shared concern about the pace of implementation of the global strategy and plan of action on public health, innovation and intellectual property by stakeholders, which was further hindered by the challenges posed by the COVID-19 pandemic;

Noting the contribution that several activities within the plan of action on public health, innovation and intellectual property might have in helping to meet targets set in the Sustainable Development Goals,

1. DECIDES to extend the time frame of the plan of action on public health, innovation and intellectual property from 2022 to 2030;
2. URGES Member States:
  - (1) to reinforce the implementation, as appropriate and taking into account national contexts, of the recommendations of the overall programme review of the global strategy and plan of action on public health, innovation and intellectual property that are addressed to Member States to the extent they are consistent with the global strategy and plan of action on public health, innovation and intellectual property;
  - (2) to identify and share, through informal consultations to be convened by the Director-General at least every two years, best practices related to the implementation of actions within the global strategy and plan of action on public health, innovation and intellectual property;
3. REITERATES to the Director-General the importance of allocating the necessary resources to implement the recommendations of the overall programme review of the global strategy and plan of action on public health, innovation and intellectual property<sup>1</sup> addressed to the Secretariat as prioritized by the review panel, to the extent they are consistent with the global strategy and plan of action on public health, innovation and intellectual property;

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<sup>1</sup> Overall programme review of the global strategy and plan of action on public health, innovation and intellectual property. Report of the review panel. November 2017 ([https://cdn.who.int/media/docs/default-source/essential-medicines/intellectual-property/gspa/gspa-phi3011rev.pdf?sfvrsn=c66f768b\\_5](https://cdn.who.int/media/docs/default-source/essential-medicines/intellectual-property/gspa/gspa-phi3011rev.pdf?sfvrsn=c66f768b_5), accessed 6 April 2022).

4. REQUESTS the Director-General:

(1) to continue to provide technical assistance and share knowledge that could enable countries to implement actions consistent with the global strategy and plan of action on public health, innovation and intellectual property;

(2) to promote collaboration and coordination within and among countries and with relevant stakeholders, for the implementation of actions consistent with the global strategy and plan of action on public health, innovation and intellectual property;

(3) to identify potential synergies in and challenges to ongoing work within the Secretariat for the implementation of actions consistent with the global strategy and plan of action on public health, innovation and intellectual property;

(4) to conduct, in 2023, a review of the indicators included in the overall programme review of the global strategy and plan of action on public health, innovation and intellectual property<sup>1</sup> in consultation with Member States,<sup>2</sup> and to develop proposed revisions to align indicators with the new term of validity of the plan of action;

(5) to report to the Health Assembly in 2024, 2026 and 2028 on progress in the implementation of the global strategy and plan of action on public health, innovation and intellectual property and the present resolution;

5. ENCOURAGES non-State actors in official relations with WHO to engage with countries in the implementation of actions consistent with the global strategy and plan of action on public health, innovation and intellectual property.

(Eighth plenary meeting, 28 May 2022  
Committee B, second report)

**WHA75.15 Salaries of staff in ungraded positions and of the Director-General**

The Seventy-fifth World Health Assembly,

Having considered the consolidated report by the Director-General;<sup>3</sup>

Noting the recommendations of the Executive Board with regard to remuneration of staff in ungraded posts and of the Director-General,<sup>4</sup>

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<sup>1</sup> Overall programme review of the global strategy and plan of action on public health, innovation and intellectual property. Report of the review panel. November 2017 ([https://cdn.who.int/media/docs/default-source/essential-medicines/intellectual-property/gspa/gspa-phi3011rev.pdf?sfvrsn=c66f768b\\_5](https://cdn.who.int/media/docs/default-source/essential-medicines/intellectual-property/gspa/gspa-phi3011rev.pdf?sfvrsn=c66f768b_5), accessed 6 April 2022).

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

<sup>3</sup> Document A75/10 Rev.1.

<sup>4</sup> See document EB150/46 Rev.1; see also the summary records of the Executive Board at its 150th session, twelfth meeting, section 2.

1. ESTABLISHES the salary of each Assistant Director-General and Regional Director<sup>1</sup> at US\$ 188 253 gross per annum with a corresponding net salary of US\$ 139 747;
2. ESTABLISHES the salary of the Deputy Director-General<sup>2</sup> at US\$ 207 368 gross per annum with a corresponding net salary of US\$ 152 363;
3. ESTABLISHES the salary of the Director-General at US\$ 259 553 gross per annum with a corresponding net salary of US\$ 195 187;
4. DECIDES that those adjustments in remuneration shall take effect from 1 January 2022.

(Eighth plenary meeting, 28 May 2022  
Committee B, second report)

**WHA75.16 Agreement between the World Health Organization and the International Development Law Organization**

The Seventy-fifth World Health Assembly,

Having considered the report on the proposed agreement between the World Health Organization and the International Development Law Organization;<sup>3</sup>

Considering also Article 70 of the Constitution of the World Health Organization,

APPROVES the agreement between the World Health Organization and the International Development Law Organization.<sup>4</sup>

(Eighth plenary meeting, 28 May 2022)

**WHA75.17 Human resources for health<sup>5</sup>**

The Seventy-fifth World Health Assembly,

Having considered the report by the Director-General;<sup>6</sup>

Recalling resolution WHA74.14 (2021) on protecting, safeguarding and investing in the health and care workforce and previous related resolutions, and reaffirming the provisions in that resolution;

Noting the continuing disruption to essential health services and the delivery of services related to coronavirus disease (COVID-19), including: (a) all medical countermeasures such as personal protective equipment, vaccines, diagnostics and therapeutics; and (b) treatment when sick, including in

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<sup>1</sup> Salary category UG1.

<sup>2</sup> Salary category UG2.

<sup>3</sup> See document A75/34.

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

<sup>5</sup> See Annex 18 for the financial and administrative implications for the Secretariat of this resolution.

<sup>6</sup> Document A75/12.



an intensive care unit, due inter alia to inequitable access to quality, safe, effective and affordable health products within and among countries and to insufficient workforce availability in most countries;

Concerned that the progress being made in addressing the global shortage of health workers is unequal, highlighting the variation across regions, particularly in those countries on the WHO Health Workforce Support and Safeguards List, 2020;

Alarmed at the increasing challenges to the health, well-being, lives and safety of health and care workers, including attacks on the health workforce and health facilities from the beginning of the COVID-19 pandemic and including those in conflict and other settings in recent years and especially in recent months, and the reported increases in psychological distress and mental health conditions experienced by health and care workers exacerbated by the onset of the COVID-19 pandemic, influencing reduced productivity and performance and impacting workforce retention;

Recognizing United Nations Security Council resolution 2286 (2016) on protection of the wounded and sick, medical personnel and humanitarian personnel in armed conflict, and acknowledging resolution WHA70.6 (2017) on human resources for health and implementation of the outcomes of the United Nations' High-Level Commission on Health Employment and Economic Growth, which recognized the need to substantially increase the protection and security of health and social workers and health facilities in all settings, including acute and protracted public health emergencies and humanitarian settings;

Further recalling resolution WHA63.16 (2010) on the WHO Global Code of Practice on the International Recruitment of Health Personnel, in which the Health Assembly adopted the Global Code, and the Global Code's recognition that an adequate and accessible health workforce is fundamental to an integrated and effective health system and to the provision of health services, bearing in mind the necessity of mitigating the potentially negative effects of health personnel migration on health systems, particularly those of developing countries;

Bearing in mind the recommendations of the report of the WHO Expert Advisory Group on the Relevance and Effectiveness of the WHO Global Code of Practice on the International Recruitment of Health Personnel on the need for full implementation of the Global Code as well as health workforce- and health systems-related support and safeguards through strengthened international cooperation, particularly to countries facing the greatest challenges;

Noting the mismatch between global and regional workforce needs to achieve universal health coverage, COVID-19 recovery and future emergency preparedness and response versus the inadequate investment in health and care workforce education, decent employment, continuous training and retention;

Recognizing the need to further advance equity for women in the health and care sector and emphasizing the critical role that women, who represent almost 70% of health workers, play in the health and care sector,

1. ADOPTS the Working for Health 2022–2030 Action Plan as a platform and implementation mechanism for accelerating investments in health and care worker education, skills, jobs, safeguarding and protection;
2. CALLS ON Member States, in accordance with national contexts and priorities:
  - (1) to implement the Working for Health 2022–2030 Action Plan and integrate, as appropriate, its objectives and actions for workforce planning and financing, education and employment, and protection and performance within their health and care workforce strategies, investment plans

and programmes at national and subnational levels, in line with resolution WHA74.14 (2021) on protecting, safeguarding and investing in the health and care workforce;

(2) to implement and monitor policy options and actions, supported by multisectoral partnership, coordination and financing:

(a) to enhance protection and safeguarding, as well as to optimize the distribution, deployment and utilization of the health and care workforce, with a focus on the employment, inclusion and participation of women at all levels and youths;

(b) to consider regional and global approaches to building multidisciplinary health and care worker capacity to address and respond to population needs, with particular emphasis on the most vulnerable groups, and to enable the functioning of efficient health systems and service delivery, with specific attention to equity, accessibility, diversity and social inclusion;

(c) to maximize the health, social and economic benefits of investment in the health and care workforce, with a view to achieving universal health coverage;

(3) to utilize, where relevant, the global health and care worker compact as guidance to inform national review, action and implementation on how to protect and support health and care workers;

(4) to engage at the national, regional and global levels to undertake and accelerate work on building a health and care workforce through training programmes and using best available educational and training facilities, online platforms and hybrid learning opportunities; and to increase the absorption of trained staff into health and care systems through sustainable employment practices;

3. INVITES international, regional, national and local partners and stakeholders from across the health sector and other relevant sectors, as appropriate, to engage in and support implementation of the Working for Health 2022–2030 Action Plan:

(1) to implement, as appropriate, national, regional and global employment initiatives to promote decent jobs, for instance for youth and women in the health and care sector;

(2) to invite Member States and regional bodies to undertake educational investment and create educational training opportunities in person and through hybrid learning or other technological platforms to allow greater access to learning tools, for instance through the WHO Academy;

(3) to support the Working for Health Multi-Partner Trust Fund and encourage direct funding to Member States for the implementation of the Working for Health 2022–2030 Action Plan in collaboration with national stakeholders, entities of the United Nations system and implementing partners;

4. REQUESTS the Director-General:

(1) to support implementation of the Working for Health 2022–2030 Action Plan by Member States through technical support, and mobilize catalytic funding and expertise, especially for those countries on the WHO Health Workforce Support and Safeguards List, 2020, taking advantage of WHO's existing training platforms, such as the WHO Academy, as a key resource for global health professionals, political leaders, business leaders and representatives of civil society;

(2) to provide support to Member States in finding ways to protect health and care workers and safeguard their rights, and to promote and ensure decent work, free from racial and all other forms

of discrimination, and a safe and enabling practice environment, for example by taking into account, as appropriate, the global health and care worker compact;

(3) to report on the progress of the implementation of this resolution to the Seventy-eighth and Eighty-first World Health Assembly (in 2025 and 2028, respectively), aligned with reporting on the Global Strategy on Human Resources for Health: Workforce 2030 and the WHO Global Code of Practice on the International Recruitment of Health Personnel; and also report to the Eighty-third World Health Assembly in 2030, in advance of the end-point of the Working for Health 2022–2030 Action Plan.

(Eighth plenary meeting, 28 May 2022  
Committee B, third report)

### **WHA75.18 Outcome of the SIDS Summit for Health: For a Healthy and Resilient Future in Small Island Developing States**

The Seventy-fifth World Health Assembly,

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

Noting that climate change, a persisting crisis, threatens the health of the people of all Member States, but that the populations of the small island developing States are among the first and hardest hit;

Recognizing that small island developing States are disproportionately impacted by climate change, which undermines the progress towards their achievement of the 2030 Agenda for Sustainable Development, including Sustainable Development Goal 3 on good health and well-being;

Noting also that, besides climate change, small island developing States share grave health and sustainable development challenges posed by the impacts of natural and man-made hazards, environmental degradation, health emergencies, loss of biodiversity, the pandemic of coronavirus disease (COVID-19), external economic shocks, malnutrition, noncommunicable diseases and mental health conditions;

Further recognizing that the vulnerabilities of small island developing States to extreme weather events, including natural and man-made hazards, and other external economic shocks, underscore the importance of strong and resilient health systems, underpinned by universal health coverage, that focus on equitable access, quality, as well as financial protection and financing for development in the era of COVID-19 and beyond;

Recalling United Nations General Assembly resolution 69/15 (2014), which set forth the SIDS Accelerated Modalities of Action (SAMOA) Pathway for an accelerated development plan in small island developing States, and General Assembly resolution 70/1 (2015), which adopted the 2030 Agenda for Sustainable Development with the collective aim to take the transformative steps for a sustainable and resilient path in ensuring that no one is left behind, and noting the correlation between high levels of vulnerability and impacts on progress towards achieving the Sustainable Development Goals;

Recalling also WHO's Memorandum of Understanding with the United Nations Framework Convention on Climate Change in the margins of the twenty-third session of the Conference of the Parties to the Convention, and the launch of the special initiative to protect people living in small island

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<sup>1</sup> Document A75/10 Rev.1 (item 18.2, WHO's implementation framework for Billion 3).

developing States and the report by the Director-General submitted to the Seventy-second World Health Assembly in May 2019 on the draft plan of action on climate change and health in small island developing States;<sup>1</sup>

Welcoming the initiative of the Director-General to host the first SIDS Summit for Health: For a Healthy and Resilient Future in Small Island Developing States on 28 and 29 June 2021;

Noting with appreciation the outcome statement of the SIDS Summit for Health<sup>2</sup> agreed upon by the small island developing States that are Member States of WHO;

Noting the actions proposed in the SIDS Summit for Health outcome statement for all partners of small island developing States to guide them in pursuing key actions needed to prevent and respond to the urgent threats faced by small island developing States;

Acknowledging the commitments made by the Director-General to pursue the actions requested of the Secretariat in response to the SIDS Summit for Health outcome statement, including those on the establishment of a SIDS Leaders Group for Health and organizing a second SIDS Summit for Health in 2023;

Taking note of the SIDS Summit for Health outcome statement, which emphasizes the urgent health challenges and needs of small island developing States with the aim of amplifying small island developing States' voice, promoting collaborative action and strengthening health and development partnerships and financing,

1. URGES Member States<sup>3</sup> to strengthen their collaboration and partnership in support and recognition of the unique vulnerabilities of small island developing States in addressing the various health needs and priorities as highlighted in the SIDS Summit for Health outcome statement and assisting the small island developing States' response to address persistent health, climate change and development challenges that they encounter by means that include the implementation of the SIDS Accelerated Modalities of Action (SAMOA) Pathway;
2. CALLS UPON all international, regional and national partners, from within and beyond the health sector, to pursue the actions called for in the SIDS Summit for Health outcome statement and to promote the needs and required actions needed for small island developing States;
3. DECIDES to propose a Voluntary Health Trust Fund for small island developing States with the terms of reference to be tabled, in conjunction with a report from the Secretariat on current practices for funding participation of Member States in WHO's meetings, at the Seventy-sixth World Health Assembly in 2023, with a view to, inter alia, facilitating the participation of small island developing States in WHO's meetings and supporting the provision of technical assistance and capacity-building in their favour on issues of direct relevance to their situation and encouraging all States and partners to make voluntary contributions to the Voluntary Health Trust Fund for small island developing States;
4. REQUESTS the Director-General:

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<sup>1</sup> Document A72/16.

<sup>2</sup> SIDS Summit for Health outcome statement: For a Healthy and Resilient Future in Small Island Developing States ([https://cdn.who.int/media/docs/default-source/sids-summit/sids-summit-for-health---final-outcome-statement.pdf?sfvrsn=7a5db89f\\_5](https://cdn.who.int/media/docs/default-source/sids-summit/sids-summit-for-health---final-outcome-statement.pdf?sfvrsn=7a5db89f_5), accessed 13 May 2022).

<sup>3</sup> And, where applicable, regional economic integration organizations.

- (1) to continue to pursue the commitments made before and at the SIDS Summit for Health, including:
- (a) provision of support for the SIDS Leaders Group for Health for high-level advocacy and driving further attention globally to the health challenges and initiatives of the small island developing States and collaboration across Member States and partners;
  - (b) provision of support for the leveraging of improved multisectoral and innovative financing for small island developing States and strengthening platforms to better support small island developing States on urgent health challenges;
  - (c) facilitating greater collaboration for cooperation frameworks with other entities of the United Nations system, Member States<sup>1</sup> and partners;
- (2) to report to the Seventy-seventh World Health Assembly in 2024 on the progress made in implementing this resolution as well as the outcomes of the second SIDS Summit for Health.

(Eighth plenary meeting, 28 May 2022  
Committee B, third report)

### **WHA75.19 Well-being and health promotion<sup>1</sup>**

The Seventy-fifth World Health Assembly,

Having considered the consolidated report by the Director-General;<sup>2</sup>

Considering the vast implications that current economic, environmental and social conditions have on the health of societies, communities and people and the potential that health promotion, health protection and disease prevention have on enhancing the capacities of people to protect and improve their health and well-being, in addition to health and social measures by governments;

Reaffirming that health is a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity;

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

Further reaffirming that the objective of WHO shall be the attainment by all peoples of the highest possible level of health;

Reaffirming that governments have a responsibility for the health of their peoples, which can be fulfilled only by the provision of adequate health and social measures;

Recalling United Nations General Assembly resolution 70/1 (2015) on transforming our world: the 2030 Agenda for Sustainable Development, which identified as part of the new Agenda that to promote physical and mental health and well-being, and to extend life expectancy for all, we must

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<sup>1</sup> See Annex 18 for the financial and administrative implications for the Secretariat of this resolution.

<sup>2</sup> Document A75/10 Rev.1 (item 18.2, WHO's implementation framework for Billion 3).

achieve universal health coverage and access to quality health care, and affirmed that no one must be left behind;

Recalling also United Nations General Assembly resolution 67/81 (2012), which recognized that effective and financially sustainable implementation of universal health coverage is based on a resilient and responsive health system that provides comprehensive primary health care services, with extensive geographical coverage, including remote and rural areas, and with a special emphasis on access to populations most in need, and has an adequate skilled, well-trained and motivated workforce, as well as capacities for broad public health measures, health protection and addressing determinants of health through policies across sectors, including promoting the health literacy of the population;

Further recalling the 2008 report of the Commission on Social Determinants of Health and the three overarching recommendations of the Commission: to improve daily living conditions, to tackle the inequitable distribution of power, money and resources; and to measure and understand the problem and assess the impact of action;

Recalling also the Thirteenth General Programme of Work, 2019–2025 and the target of one billion people enjoying better health and well-being by 2025;

Building on the legacy of the Ottawa Charter for Health Promotion, 1986 and noting the outcomes of other previous global conferences on health promotion;

Acknowledging that the health and well-being of the population is associated with peace, security, stability, improved productivity and economic growth and that socially and economically unfair and largely avoidable inequities within and between countries may have a reverse impact;

Noting that health is produced and that it can be endangered in all environments of society, which is why promoting health and well-being requires environmentally and financially sustainable action and investment by multiple sectors of government and input from wider society, including multisectoral engagement with social and economic actors, and from individuals, communities, nongovernmental organizations and the private sector;

Acknowledging that successful promotion of health and well-being builds on complementary and essential approaches, including: a Health in All Policies approach, emphasizing that public policies and decisions made in policy areas other than health affect citizens' health and its determinants; a whole-of-government approach, referring to the joint activities performed by diverse ministries, public administrations and public agencies in order to provide common solutions; as well as a whole-of-society approach, stressing the role of participatory governance and partnerships with different non-State actors at all levels, including the private sector, nongovernmental organizations, communities and individuals;

Acknowledging also that the promotion of health and well-being can address determinants of health and/or risk factors at population, community, specific group or individual levels and in different contexts, taking into account the specific needs of people in vulnerable situations, including the removal of attitudinal, institutional and environmental barriers encountered by persons with disabilities;

Noting the increasing impact on premature mortality from noncommunicable diseases and the continued burden caused by communicable diseases as well as the new demands they both put on governments in the protection and promotion of health in order to achieve health equity and ensuring universal health coverage;

Emphasizing that in order to have capacity for health-informed decisions and health-seeking behaviours individuals must have achieved an appropriate level of health literacy;

Stressing that the development of interventions at population, community and individual levels to further increase health literacy and improve health outcomes must be guided by evidence, in particular from social and behavioural science, with consideration given to using innovative approaches, communication channels and technologies;

Noting that many persons with disabilities, particularly girls and women, face barriers in accessing information and education, including those with regard to the sexual and reproductive health and reproductive rights agreed in accordance with the Programme of Action of the International Conference on Population and Development and the Beijing Platform for Action and the outcome documents of their review conferences as adopted by the United Nations General Assembly;

Recalling that multisectoral action on social, environmental and economic determinants of health, for the entire population and proportionate to the level of disadvantage of people in vulnerable situations, is essential to create inclusive, equitable, economically productive, resilient and healthy societies with healthy environments that make healthy options the easy options to choose;

Acknowledging the importance of national, international and global cooperation and solidarity for the equitable benefit of all people and the important role that relevant multilateral organizations, under the leadership of WHO, have in articulating and promoting norms and guidelines and identifying and sharing good practices for supporting actions on social, environmental and economic determinants of health;

Considering that positioning human health and well-being as one of the key features of what constitutes a successful, inclusive and fair society in the 21st century is consistent with our commitment to human rights at national, regional and international levels,

1. URGES Member States:

- (1) to strengthen health promotion and disease prevention through high-impact public policies, based on scientific evidence and best available knowledge, across sectors, developed through participatory processes; to strengthen health systems and to address health determinants and reduce risk factors, including through appropriate regulation; and to use health and health equity impact assessments in the development of those policies in order to achieve equitable outcomes;
- (2) to strengthen the health system and empower the health workforce, for example by basic and continuous training, in the provision of health promotion, disease prevention and health communication at all levels of health services, including the use of innovative approaches, communication channels and technologies, ensuring that people in vulnerable situations have access to information;
- (3) to develop enabling environments conducive to health by addressing determinants of health across sectors and by reducing risk factors and thus make it easier for individuals to make healthy choices to support the realization of healthy, safe and resilient communities;
- (4) to accelerate efforts to ensure healthy lives and promote well-being and universal health coverage by 2030 for all throughout the life course, and in this regard re-emphasize our resolve to cover one billion additional people by 2025 with quality essential health and mental health services, quality, safe and effective essential medicines, vaccines, diagnostics and health technologies, and essential and quality health information, with a view to cover all people by 2030;

(5) to ensure the implementation of country- and context-specific essential public health functions to protect and promote health and to prevent diseases;

(6) to ensure universal access to sexual and reproductive health care services, including those for family planning, information and education and the integration of reproductive health into national strategies and programmes;

(7) to consider taking steps to include basic health knowledge in curricula to ensure that everybody has an appropriate level of health literacy and to implement effective, high-impact, quality-assured, people-centred, gender-, disability- and health literacy-responsive, equity-oriented and evidence-based interventions, mindful of cultural contexts to meet the health needs of all throughout the life course and in particular of persons with disabilities and people in vulnerable situations, ensuring universal access to nationally determined sets of integrated quality health services at all levels of care for health promotion, disease prevention, diagnosis, treatment and care, and rehabilitation in a timely manner, including promoting return-to-work programmes;

(8) to support establishment, as appropriate, of mechanisms for generating, gathering and sharing evidence for the development of high-impact policies to promote and protect people's physical, mental and social well-being and to comprehensively address structural, social, economic, environmental and other determinants of health by working across all sectors through a whole-of-government, whole-of-society and Health in All Policies approach;

(9) to consider, as appropriate, establishing governmental, regional, subregional and local structures responsible for population-level health promotion, with sustainable financing, and continuous reporting; and to strengthen implementation of population-based health promotion and ensure its resilience;

(10) to promote health and well-being through coordinated and multisectoral action throughout the life course and by providing conditions for people to access and enjoy clean and safe water, healthy food from sustainable food systems, clean air, tobacco-free environments and social participation, free from all forms of discrimination and inequalities and where all people are able and empowered to take responsibility for their own health and well-being;

(11) to design and orient public systems and infrastructures, including health systems that serve people's needs, that are accessible and affordable to all in order to ensure health equity contributing to sustainable and resilient economic development;

2. REQUESTS the Director-General:

(1) to develop, within the mandate of WHO, a framework for achieving well-being, building on the 2030 Agenda for Sustainable Development with its 17 Sustainable Development Goals and identify the role that health promotion plays within this, in consultation with Member States, for consideration by the Seventy-sixth World Health Assembly in 2023, through the Executive Board at its 152nd session;

(2) to develop as part of the framework requested in paragraph 2(1) an implementation and monitoring plan that includes identifying and supporting the translation into practice of innovative approaches for well-being using health promotion tools, new technologies and approaches to contribute to WHO's General Programme of Work;



(3) to provide technical support to Member States in strengthening their governance, financing, human resources, evidence generation, data disaggregation and research structures for well-being and health promotion;

(4) to promote and recommend scientifically-sound interdisciplinary research to develop the evidence base for interventions for the promotion of health and well-being at population, community and individual levels, including the use of big data, building on the measurement systems of the Sustainable Development Goals;

(5) to report on the implementation of this resolution to the Seventy-seventh World Health Assembly in 2024, the Seventy-ninth World Health Assembly in 2026 and the Eighty-fourth World Health Assembly in 2031, through the relevant sessions of the Executive Board.

(Eighth plenary meeting, 28 May 2022  
Committee B, third report)

**WHA75.20      The global health sector strategies on, respectively, HIV, viral hepatitis and sexually transmitted infections<sup>1</sup>**

The Seventy-fifth World Health Assembly,

Having considered the consolidated report by the Director-General,<sup>2</sup>

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

(Ninth plenary meeting, 28 May 2022  
Committee A, seventh report)

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<sup>1</sup> See Annex 18 for the financial and administrative implications for the Secretariat of this resolution.

<sup>2</sup> Document A75/10 Rev.1.

## DECISIONS

### WHA75(1)      **Composition of the Committee on Credentials**

The Seventy-fifth World Health Assembly appointed a Committee on Credentials consisting of delegates of the following 12 Member States: Australia, Azerbaijan, Bolivia (Plurinational State of), Chad, Croatia, Eswatini, Ireland, Nepal, Nicaragua, Sierra Leone, Singapore, Sudan.

(First plenary meeting, 22 May 2022)

### WHA75(2)      **Election of officers of the Seventy-fifth World Health Assembly**

The Seventy-fifth World Health Assembly elected the following officers:

**President:**                      H.E. Dr Ahmed Robleh Abdilleh (Djibouti)

**Vice-Presidents:**            Dr Maria Endang Sumiwi (Indonesia)  
Professor Asena Serbezova (Bulgaria)  
Mr Colin McIff (United States of America)  
Mr Khairy Jamaluddin (Malaysia)  
Professor Moustafa Mijiyawa (Togo)

(First plenary meeting, 22 May 2022)

### WHA75(3)      **Election of officers of the main committees**

The Seventy-fifth World Health Assembly elected the following officers of the main committees:

**Committee A:      Chair**      Dr Hiroki Nakatani (Japan)  
**Committee B:      Chair**      Mr Rajesh Bhushan (India)

(First plenary meeting, 22 May 2022)

The main committees subsequently elected the following officers:

**Committee A:      Vice-Chair**      Dr Tamar Gabunia (Georgia)  
Dr Maryam Abdool-Richards (Trinidad and Tobago)

**Rapporteur**                      Dr Walaiporn Patcharanarumol (Thailand)

**Committee B:      Vice-Chair**      Dr Firass Abiad (Lebanon)  
Dr Emmanuel Osagie Ehanire (Nigeria)

**Rapporteur**                      Dr Grzegorz Juszczyk (Poland)

(First meetings of Committees A and B,  
23 and 25 May 2022, respectively)

**WHA75(4) Establishment of the General Committee**

The Seventy-fifth World Health Assembly elected the delegates of the following 17 countries as members of the General Committee: Angola, Armenia, Benin, Burkina Faso, Cameroon, China, Congo, Cuba, Czechia, Dominica, El Salvador, France, Saudi Arabia, Somalia, Turkey, United Kingdom of Great Britain and Northern Ireland, Uruguay.

(First plenary meeting, 22 May 2022)

**WHA75(5) Adoption of the agenda**

The Seventy-fifth World Health Assembly adopted the provisional agenda prepared by the Executive Board at its 150th session, with the deletion of two items and three subitems, as well as the exclusion of one supplementary item, and the transfer of one item from Committee B to Committee A.

(Second plenary meeting, 23 May 2022)

**WHA75(6) Verification of credentials**

The Seventy-fifth World Health Assembly approved the report of the Committee on Credentials<sup>1</sup> and accepted the credentials presented by the following 190 Member States as being in conformity with the Rules of Procedure of the World Health Assembly: Afghanistan; Albania; Algeria; Andorra; Angola; Antigua and Barbuda; Argentina; Armenia; Australia; Austria; Azerbaijan; Bahamas; Bahrain; Bangladesh; Barbados; Belarus; Belgium; Belize; Benin; Bhutan; Bolivia (Plurinational State of); Bosnia and Herzegovina; Botswana; Brazil; Brunei Darussalam; Bulgaria; Burkina Faso; Burundi; Cabo Verde; Cambodia; Cameroon; Canada; Central African Republic; Chad; Chile; China; Colombia; Congo; Cook Islands; Costa Rica; Côte d'Ivoire; Croatia; Cuba; Cyprus; Czechia; Democratic People's Republic of Korea; Democratic Republic of the Congo; Denmark; Djibouti; Dominica; Dominican Republic; Ecuador; Egypt; El Salvador; Equatorial Guinea; Eritrea; Estonia; Eswatini; Ethiopia; Fiji; Finland; France; Gabon; Gambia; Georgia; Germany; Ghana; Greece; Grenada; Guatemala; Guinea; Guinea-Bissau; Guyana; Haiti; Honduras; Hungary; Iceland; India; Indonesia; Iran (Islamic Republic of); Iraq; Ireland; Israel; Italy; Jamaica; Japan; Jordan; Kazakhstan; Kenya; Kiribati; Kuwait; Kyrgyzstan; Lao People's Democratic Republic; Latvia; Lebanon; Lesotho; Liberia; Libya; Lithuania; Luxembourg; Madagascar; Malawi; Malaysia; Maldives; Mali; Malta; Marshall Islands; Mauritania; Mauritius; Mexico; Micronesia (Federated States of); Monaco; Mongolia; Montenegro; Morocco; Mozambique; Namibia; Nauru; Nepal; Netherlands; New Zealand; Nicaragua; Niger; Nigeria; North Macedonia; 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 Lucia; Saint Vincent and the Grenadines; Samoa; San Marino; Sao Tome and Principe; Saudi Arabia; Senegal; Serbia; Seychelles; Sierra Leone; Singapore; Slovakia; Slovenia; Somalia; South Africa; South Sudan; Spain; Sri Lanka; Sudan; Suriname; Sweden; Switzerland; Syrian Arab Republic; Tajikistan; Thailand; Timor-Leste; Togo; Tonga; Trinidad and Tobago; Tunisia; Turkey; Turkmenistan; Tuvalu; Uganda; Ukraine; United Arab Emirates; United Kingdom of Great Britain and Northern Ireland; United Republic of Tanzania; United States of America; Uruguay; Uzbekistan; Vanuatu; Venezuela (Bolivarian Republic of); Viet Nam; Yemen; Zambia; Zimbabwe.

Fourth plenary meeting, 24 May 2022

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<sup>1</sup> Document A75/59.

**WHA75(7) Election of Members entitled to designate a person to serve on the Executive Board**

The Seventy-fifth World Health Assembly, after considering the recommendations of the General Committee, elected the delegates of the following as Members entitled to designate a person to serve on the Executive Board: Brazil, Canada, China, Ethiopia, Maldives, Micronesia (Federated States of), Morocco, Republic of Moldova, Senegal, Slovakia, United States of America, Yemen.

(Seventh plenary meeting, 27 May 2022)

**WHA75(8) Sustainable financing<sup>1</sup>**

The Seventy-fifth World Health Assembly, having considered the report of the Working Group on Sustainable Financing, including its associated recommendations,<sup>2</sup>

Decided:

- (1) to adopt the recommendations of the Working Group on Sustainable Financing, contained in Annex 4;
- (2) to request the Director-General to put in place measures to ensure the implementation of those recommendations.

(Seventh plenary meeting, 27 May 2022 –  
Committee A, third report)

**WHA75(9) Strengthening WHO preparedness for and response to health emergencies<sup>1</sup>**

The Seventy-fifth World Health Assembly, having considered the report of the Member States Working Group on Strengthening WHO Preparedness and Response to Health Emergencies,<sup>3</sup>

Decided:

- (1) to welcome the report;
- (2) with respect to targeted amendments to the International Health Regulations (2005):
  - (a) to continue the Working Group on Strengthening WHO Preparedness and Response to Health Emergencies, with a revised mandate including, as appropriate and if agreed within each region the rotation of the Bureau, and name (the “Working Group on Amendments to the International Health Regulations (2005)”) to work exclusively on consideration of proposed targeted amendments to the International Health Regulations (2005), consistent with decision EB150(3) (2022) on Strengthening the International Health Regulations (2005): a process for their revision through potential amendment, for consideration by the Seventy-seventh World Health Assembly in 2024;

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<sup>1</sup> See Annex 18 for the financial and administrative implications for the Secretariat of this decision.

<sup>2</sup> Document A75/9.

<sup>3</sup> Document A75/17.

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- (b) to request the Director-General to convene a Review Committee on the International Health Regulations (2005) (IHR Review Committee), as early as possible but no later than 1 October 2022, in accordance with Part IX, Chapter III, of the International Health Regulations (2005), in particular Article 50, paragraphs 1(a) and 6, with particular attention to be paid to the fulfilment of the letter and spirit of Article 51, paragraph 2, to make technical recommendations on the proposed amendments referred to in subparagraph (c) below, with a view to informing the work of the Working Group on Amendments to the International Health Regulations (2005);
- (c) to invite proposed amendments to be submitted by 30 September 2022, with all such proposed amendments being communicated by the Director-General to all States Parties without delay;
- (d) to request the Working Group on Amendments to the International Health Regulations (2005) to convene its organizational meeting no later than 15 November 2022, and to coordinate with the process of the Intergovernmental Negotiating Body to draft and negotiate a WHO convention, agreement or other international instrument on pandemic prevention, preparedness and response, by means that include regular coordination between the two respective Bureaux and alignment of meeting schedules and workplans, as both the International Health Regulations (2005) and the new instrument are expected to play central roles in pandemic prevention, preparedness and response in the future;
- (e) to request that the IHR Review Committee submit its report to the Director-General no later than 15 January 2023, with the Director-General communicating it without delay to the Working Group on Amendments to the International Health Regulations (2005);
- (f) to request the Working Group on Amendments to the International Health Regulations (2005) to establish a programme of work, consistent with decision EB150(3), and taking into consideration the report of the IHR Review Committee, to propose a package of targeted amendments, for consideration by the Seventy-seventh World Health Assembly, in accordance with Article 55 of the International Health Regulations (2005);
- (3) to encourage Member States to continue to review and consider the possible actions contained in Appendix 3 of document A75/17, in relation to health emergency prevention, preparedness and response, for instance through relevant ongoing processes of WHO's governing bodies, while noting that those possible actions are complementary and additional to existing mandates already under implementation by the Secretariat;
- (4) to request the Director-General:
- (a) to submit a report to the Seventy-sixth World Health Assembly, under a substantive agenda item, on:
- (i) the Secretariat's progress to implement actions that have been previously mandated by WHO's governing bodies and that are related to the activities mentioned in paragraph 3, in accordance with existing reporting requirements;
- (ii) as appropriate, views from the WHO Secretariat on possible modalities for carrying forward the activities mentioned in paragraph 3 that are not presently under implementation;

(b) to provide support to the Working Group on Amendments to the International Health Regulations (2005), by:

- (i) convening its first meeting no later than 15 November 2022, and subsequent meetings at the request of the co-chairs as frequently as necessary;
- (ii) providing the Working Group on Amendments to the International Health Regulations (2005) with the necessary services and facilities for the performance of its work, and complete, relevant and timely information and advice.

(Seventh plenary meeting, 27 May 2022 –  
Committee A, third report)

**WHA75(10) Health conditions in the occupied Palestinian territory, including east Jerusalem, and in the occupied Syrian Golan<sup>1</sup>**

The Seventy-fifth World Health Assembly, taking note of the report by the Director-General<sup>2</sup> requested in decision WHA74(9) (2021),

Decided to request the Director-General:

- (1) to report, based on field monitoring and assessment conducted by WHO, on progress in the implementation of the recommendations contained in the report on the health conditions in the occupied Palestinian territory, including east Jerusalem, and in the occupied Syrian Golan by the Director-General to the Seventy-sixth World Health Assembly in 2023, bearing in mind the legal obligation of the occupying power;
- (2) to provide support to the Palestinian health sector, using a health system strengthening approach, including capacity-building programmes, improving basic infrastructure, human and technical resources and the provision of health facilities, ensuring the accessibility, affordability and quality of health care services required to address and deal with structural problems emanating from the prolonged occupation, and developing strategic plans for investment in specific treatment and diagnostic capacities locally;
- (3) to ensure sustainable procurement of WHO prequalified vaccines, medicine and medical equipment for the occupied Palestinian territory in compliance with international humanitarian law and WHO norms and standards;
- (4) to ensure non-discriminatory, affordable and equitable access to vaccines against coronavirus disease (COVID-19) for the protected occupied population in the occupied Palestinian territory, including east Jerusalem, and in the occupied Syrian Golan, in compliance with international law;
- (5) to ensure respect for and protection of the wounded and injured population, health and humanitarian aid workers, the health care system, and all medical and humanitarian personnel exclusively engaged in medical duties, their means of transport and equipment, as well as hospitals and other medical facilities in compliance with the Geneva Conventions and their Additional Protocols;

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<sup>1</sup> See Annex 18 for the financial and administrative implications for the Secretariat of this decision.

<sup>2</sup> Document A75/26.

- (6) to assess, in full cooperation with UNICEF and other relevant United Nations entities and the WHO Regional Office for the Eastern Mediterranean and the WHO country office in the occupied Palestinian territory, including east Jerusalem, the extent and nature of psychiatric morbidity and other forms of mental health problems resulting from protracted aerial and other forms of bombing among the population, particularly children and adolescents, of the occupied Palestinian territory, including east Jerusalem;
- (7) to continue strengthening partnership with other United Nations entities and partners in the occupied Palestinian territory, including east Jerusalem, and in the occupied Syrian Golan, to enhance humanitarian health response capacities by delivering aid and protection in an inclusive and sustained manner during the COVID-19 pandemic and after the pandemic crisis;
- (8) to report, based on field assessments conducted by WHO, on the health conditions of the Syrian population in the occupied Syrian Golan, including prisoners and detainees, and ensure their adequate access to mental, physical and environmental health services, and to report on ways and means to provide them with health-related technical assistance;
- (9) 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;
- (10) to support the development of the health system in the occupied Palestinian territory, including east Jerusalem, by focusing on the development of human resources, in order to localize health services, decreasing referrals, reducing cost, strengthening provision of mental health services and maintaining strong primary health care with integrated complete appropriate health services;
- (11) to ensure the allocation of human and financial resources in order to achieve these objectives.

(Seventh plenary meeting, 27 May 2022 –  
Committee B, first report)

**WHA75(11) Follow-up to the political declaration of the third high-level meeting of the General Assembly on the prevention and control of non-communicable diseases<sup>1</sup>**

The Seventy-fifth World Health Assembly, having considered the consolidated report by the Director-General,<sup>2</sup>

Decided:

- (1) to note the consolidated report by the Director-General and its annexes;<sup>3,4,5</sup>

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<sup>1</sup> See Annex 18 for the financial and administrative implications for the Secretariat of this decision.

<sup>2</sup> Document A75/10 Rev.1.

<sup>3</sup> Documents A75/10 Add.3 (Annex 5) and A75/10 Add.3 Corr.1.

<sup>4</sup> Document A75/10 Add.5 (Annex 11).

<sup>5</sup> Document A75/10 Add.6 (Annex 12).

(2) to adopt:

- the implementation road map 2023–2030 for the global action plan for the prevention and control of noncommunicable diseases 2013–2030;<sup>1</sup>
- the recommendations to strengthen and monitor diabetes responses within national noncommunicable disease programmes, including targets;<sup>2</sup>
- the global strategy on oral health;<sup>3</sup>
- the recommendations on how to strengthen the design and implementation of policies, including those for resilient health systems and health services and infrastructure, to treat people living with noncommunicable diseases and to prevent and control their risk factors in humanitarian emergencies;<sup>4</sup>
- the intersectoral global action plan on epilepsy and other neurological disorders 2022–2031;<sup>5</sup>
- the action plan (2022–2030) to effectively implement the global strategy to reduce the harmful use of alcohol as a public health priority;<sup>6,7</sup>
- the recommendations for the prevention and management of obesity over the life course, including considering the development of targets in this regard;<sup>8</sup>
- the workplan for the global coordination mechanism on the prevention and control of noncommunicable diseases 2022–2025;<sup>9</sup>

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

(Eighth plenary meeting, 28 May 2022 –  
Committee A, fifth report)

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<sup>1</sup> See Annex 8.

<sup>2</sup> See Annex 9.

<sup>3</sup> See Annex 10.

<sup>4</sup> See Annex 11.

<sup>5</sup> See Annex 12.

<sup>6</sup> See Annex 13.

<sup>7</sup> Published under the title *Global alcohol action plan 2022–2030*.

<sup>8</sup> See Annex 14.

<sup>9</sup> See Annex 15.



**WHA75(12) Written statements: guidelines for Member States**

The Seventy-fifth World Health Assembly, having considered the report on WHO reform – written statements: guidelines for Member States,<sup>1</sup>

Decided that the guidelines contained in Annex 16 shall henceforth be applied to written statements relating to sessions of the Health Assembly submitted by Member States.

(Eighth plenary meeting, 28 May 2022 –  
Committee B, second report)

**WHA75(13) Human resources: annual report**

The Seventy-fifth World Health Assembly, having considered the report by the Director-General;<sup>2</sup> and having considered the report of the Programme, Budget and Administration Committee of the Executive Board to the Seventy-fifth World Health Assembly<sup>3</sup> with the proposed application of a housing allowance for the Director-General presented in the Annex to document A75/31, and the corresponding amendment proposed to the draft contract of the Director-General, contained in document A75/5,

Decided:

(1) to defer a decision on the proposed application of a housing allowance for the Director-General as presented in the Annex to document A75/31 to the Seventy-sixth World Health Assembly in 2023, through the 152nd session of the Executive Board and the thirty-seventh meeting of the Programme, Budget and Administration Committee of the Executive Board;

(2) to grant an interim allowance of US\$ 5000 per month for the Director-General given the exceptional circumstances.

(Eighth plenary meeting, 28 May 2022 –  
Committee B, second report)

**WHA75(14) WHO programmatic and financial reports for 2020–2021, including audited financial statements for 2021**

The Seventy-fifth World Health Assembly, having considered the WHO Results Report for the Programme budget 2020–2021<sup>4</sup> and the audited financial statements for the year ended 31 December 2021;<sup>5</sup> and having noted the report of the Programme, Budget and Administration Committee of the Executive Board to the Seventy-fifth World Health Assembly,<sup>6</sup>

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<sup>1</sup> Document A75/30.

<sup>2</sup> Document A75/31.

<sup>3</sup> Document A75/57.

<sup>4</sup> Document A75/32.

<sup>5</sup> Document A75/33.

<sup>6</sup> Document A75/51.

Decided to accept the WHO Results Report for the Programme budget 2020–2021 and the audited financial statements for the year ended 31 December 2021.

(Eighth plenary meeting, 28 May 2022 –  
Committee B, second report)

### **WHA75(15) Appointment of representatives to the WHO Staff Pension Committee**

The Seventy-fifth World Health Assembly,

Decided:

- (1) to appoint Dr Sebastien Klappert of the delegation of Germany as an alternate member of the WHO Staff Pension Committee for the remainder of the term of office of Dr Kai Zaehle until the closure of the Seventy-seventh World Health Assembly in May 2024;
- (2) to appoint Dr Theophile Dushime of the delegation of Rwanda as an alternate member of the WHO Staff Pension Committee for a three-year term until the closure of the Seventy-eighth World Health Assembly in May 2025;
- (3) to appoint Mr Gerald Anderson of the delegation of the United States of America as an alternate member of the WHO Staff Pension Committee for a three-year term until the closure of the Seventy-eighth World Health Assembly in May 2025;
- (4) to appoint Dr Ahmed Shadoul of the delegation of Sudan, the most senior alternate member, as a member of the WHO Staff Pension Committee for the remainder of his term of office until the closure of the Seventy-sixth World Health Assembly in May 2023;
- (5) to appoint Ms Yanjmaa Binderiya of the delegation of Mongolia, the second most senior alternate member, as a member of the WHO Staff Pension Committee for the remainder of her term of office until the closure of the Seventy-seventh World Health Assembly in May 2024.

(Eighth plenary meeting, 28 May 2022 –  
Committee B, second report)

### **WHA75(16) Report of the External Auditor**

The Seventy-fifth World Health Assembly, having considered the report of the External Auditor to the Health Assembly;<sup>1</sup> and having noted the report of the Programme, Budget and Administration Committee of the Executive Board to the Seventy-fifth World Health Assembly,<sup>2</sup>

Decided to accept the report of the External Auditor to the Health Assembly.

(Eighth plenary meeting, 28 May 2022 –  
Committee B, second report)

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<sup>1</sup> Document A75/35.

<sup>2</sup> Document A75/56.

**WHA75(17) Availability, safety and quality of blood products<sup>1</sup>**

The Seventy-fifth World Health Assembly, having considered the report by the Director-General,<sup>2</sup>

Decided to request the Director-General to continue to report to the Health Assembly every two years until 2030 on progress made in the implementation of resolution WHA63.12 (2010) on availability, safety and quality of blood products.

(Eighth plenary meeting, 28 May 2022 –  
Committee B, second report)

**WHA75(18) Human organ and tissue transplantation<sup>1</sup>**

The Seventy-fifth World Health Assembly, having considered the report by the Director-General,<sup>3</sup>

Decided to request the Director-General to continue to report to the Health Assembly every two years until 2030 on progress made in the implementation of resolution WHA63.22 (2010) on human organ and tissue transplantation.

(Eighth plenary meeting, 28 May 2022 –  
Committee B, second report)

**WHA75(19) Traditional medicine<sup>1</sup>**

The Seventy-fifth World Health Assembly, having considered the report by the Director-General,<sup>4</sup>

Decided to request the Director-General to submit a final report on progress made in the implementation of resolution WHA67.18 (2014) on traditional medicine to the Seventy-sixth World Health Assembly in 2023, through the Executive Board at its 152nd session, by means of a consolidated document that responds also to the request made in decision WHA73(15) (2020) in respect of global strategies or action plans that are scheduled to expire within one year.

(Eighth plenary meeting, 28 May 2022 –  
Committee B, second report)

**WHA75(20) Public health dimension of the world drug problem<sup>1</sup>**

The Seventy-fifth World Health Assembly, having considered the report by the Director-General,<sup>5</sup>

Decided to request the Director-General to continue to report to the Health Assembly every two years until 2030 on WHO's activities to address the public health dimensions of the world drug problem and progress made in the implementation of decision WHA70(18) (2017) on the public health dimension of the world drug problem.

(Eighth plenary meeting, 28 May 2022 –  
Committee B, second report)

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<sup>1</sup> See Annex 18 for the financial and administrative implications for the Secretariat of this decision.

<sup>2</sup> Document A75/40.

<sup>3</sup> Document A75/41.

<sup>4</sup> Document A75/42.

<sup>5</sup> Document A75/43.

**WHA75(21) Maternal, infant and young child nutrition<sup>1</sup>**

The Seventy-fifth World Health Assembly, having considered the consolidated report by the Director-General,<sup>2</sup>

Decided to request the Director-General:

- (1) to develop guidance for Member States on regulatory measures aimed at restricting the digital marketing of breast-milk substitutes, so as to ensure that existing and new regulations designed to implement the International Code of Marketing Breast-milk Substitutes and subsequent relevant Health Assembly resolutions adequately address digital marketing practices;
- (2) to report on the performance of the task described in paragraph (1) to the Seventy-seventh World Health Assembly in 2024.

(Eighth plenary meeting, 28 May 2022 –  
Committee B, third report)

**WHA75(22) WHO global strategy for food safety<sup>1</sup>**

The Seventy-fifth World Health Assembly, having considered the consolidated report by the Director-General,<sup>2</sup>

Decided:

- (1) to adopt the updated WHO global strategy for food safety;
- (2) to call on Member States to develop national implementation road maps or reflect actions to implement the strategy within existing food safety policies and programmes and to make appropriate financial resources available to support such work;
- (3) to request the Director-General to report on progress in the implementation of the updated WHO global strategy for food safety to the Seventy-seventh World Health Assembly in 2024 and thereafter every two years until 2030.

(Eighth plenary meeting, 28 May 2022 –  
Committee B, third report)

**WHA75(23) Reducing public health risks associated with the sale of live wild animals of mammalian species in traditional food markets – infection prevention and control<sup>1</sup>**

The Seventy-fifth World Health Assembly, having considered the consolidated report by the Director-General,<sup>2</sup>

Decided to request the Director-General:

- (1) to update the interim guidance on reducing public health risks associated with the sale of live wild animals of mammalian species in traditional food markets in order to answer questions

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<sup>1</sup> See Annex 18 for the financial and administrative implications for the Secretariat of this decision.

<sup>2</sup> Document A75/10 Rev.1.

on the scope of the guidance, including the species that the guidance covers (mammalian species or mammalian species plus other species) and farmed or wild live animals;

(2) to develop plans to support country implementation of the interim guidance on reducing public health risks associated with the sale of live wild animals of mammalian species in traditional food markets – infection prevention and control;

(3) to report on progress made in updating the interim guidance on reducing public health risks associated with the sale of live wild animals of mammalian species in traditional food markets – infection prevention and control and the country support plans to the Seventy-seventh World Health Assembly in 2024 and thereafter every two years until 2030, in parallel with reporting on the progress in implementing the WHO global strategy for food safety.

(Eighth plenary meeting, 28 May 2022 –  
Committee B, third report)

#### **WHA75(24) Global Health for Peace Initiative<sup>1</sup>**

The Seventy-fifth World Health Assembly, having considered the consolidated report by the Director General,<sup>2</sup>

Recalling that the WHO Constitution recognizes that the health of all peoples is fundamental to the attainment of peace and security, and recalling resolution WHA34.38 (1981), which recognized the role of physicians and other health workers in the preservation and promotion of peace as the most significant factor for the attainment of health for all;

Reiterating the commitment of Member States to the 2030 Agenda for Sustainable Development, which emphasized, inter alia, that there can be no sustainable development without peace and no peace without sustainable development; and emphasizing the importance of ensuring healthy lives, promoting well-being for all at all ages, and promoting just, peaceful and inclusive societies;

Noting the role of WHO within its mandate as the directing and coordinating authority on international health matters,

Decided:

(1) to note the report;

(2) to request the Director-General to consult with Member States<sup>3</sup> and Observers<sup>4</sup> on the implementation of the proposed ways forward contained in document EB150/20 on the Global Health for Peace Initiative, and to then develop – in full consultation with Member States<sup>3</sup> and Observers,<sup>4</sup> and in full collaboration with other organizations of the United Nations system and relevant non-State actors in official relations with WHO – a road map, if any, for the Initiative, for consideration by the Seventy-sixth World Health Assembly in 2023 through the Executive Board at its 152nd session.

(Eighth plenary meeting, 28 May 2022 –  
Committee B, third report)

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<sup>1</sup> See Annex 18 for the financial and administrative implications for the Secretariat of this decision.

<sup>2</sup> Document A75/10 Rev.1.

<sup>3</sup> And, where applicable, regional economic integration organizations.

<sup>4</sup> As described in paragraph 3 of document EB146/43.

**WHA75(25) Standardization of medical devices nomenclature<sup>1</sup>**

The Seventy-fifth World Health Assembly, having considered the reports by the Director-General,<sup>2,3</sup> and re-affirming WHO's role in the development, in a transparent and evidence-based way, of norms, standards and a standardized glossary of definitions relating to medical devices, as requested in resolution WHA60.29 (2007) on health technologies,

Decided to request the Director General:

(1) to integrate available information related to medical devices, including terms, codes and definitions, in the web-based database and clearinghouse established in line with resolution WHA60.29 (2007) and now available as the Priority Medical Devices Information System (MEDEVIS);<sup>4</sup> and to link this to other WHO platforms, such as the International Classification of Diseases (ICD-11),<sup>5</sup> to serve as a reference to stakeholders and Member States;

(2) to submit a substantive report on progress made in implementing this decision to the Executive Board at its 152nd session in January 2023 and its 156th session in January 2025.

(Eighth plenary meeting, 28 May 2022 –  
Committee B, fourth report)

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<sup>1</sup> See Annex 18 for the financial and administrative implications for the Secretariat of this decision.

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

<sup>3</sup> Document A75/11 Add.1.

<sup>4</sup> MeDevIS is available at <https://medevis.who-healthtechnologies.org/> (accessed 13 May 2022).

<sup>5</sup> ICD-11 is available at <https://www.who.int/standards/classifications/classification-of-diseases> (accessed 13 May 2022).

## **ANNEXES**





## ANNEX 1

### **Contract of the Director-General**

THIS CONTRACT is made this twenty-fourth day of May of the year two thousand and twenty-two between the World Health Organization (hereinafter called the Organization) of the one part and Dr Tedros Adhanom Ghebreyesus (hereinafter called the Director-General) of the other part.

#### WHEREAS

(1) It is provided by Article 31 of the Constitution of the Organization that the Director-General of the Organization shall be appointed by the World Health Assembly (hereinafter called the Health Assembly) on the nomination of the Executive Board (hereinafter called the Board) on such terms as the Health Assembly may decide; and

(2) The Director-General has been duly appointed by the Health Assembly at its meeting held on the twenty-fourth day of May of the year two thousand and twenty-two for a period of five years.

NOW THIS CONTRACT WITNESSETH and it is hereby agreed as follows,

I. (1) The Director-General shall serve from the sixteenth day of August of the year two thousand and twenty-two until the fifteenth day of August of the year two thousand and twenty-seven, on which date the appointment and this Contract shall terminate.

(2) Subject to the authority of the Board, the Director-General shall exercise the functions of chief technical and administrative officer of the Organization and shall perform such duties as may be specified in the Constitution and in the rules of the Organization and/or as may be assigned to him by the Health Assembly or the Board.

(3) The Director-General fully commits to the responsible management and appropriate stewardship of WHO's resources, including financial resources, human resources and physical resources, in an efficient and effective manner to achieve the Organization's objectives; an ethical culture, so that all Secretariat decisions and actions are informed by accountability, transparency, integrity, and respect; equitable geographical representation and gender balance in staff appointments and in accordance with Article 35 of the Constitution of the World Health Organization; follow-up of recommendations from the Organization's internal and external audits, and timeliness and transparency of official documentation.

(4) The Director-General shall be subject to the Staff Regulations of the Organization in so far as they may be applicable to him. In particular he shall not hold any other administrative post, and shall not receive emoluments from any outside sources in respect of activities relating to the Organization. He shall not engage in business or in any employment or activity that would interfere with his duties in the Organization.

(5) The Director-General, during the term of this appointment, shall enjoy all the privileges and immunities in keeping with the office by virtue of the Constitution of the Organization and any relevant arrangements already in force or to be concluded in the future.

(6) The Director-General may at any time give six months' notice of resignation in writing to the Board, which is authorized to accept such resignation on behalf of the Health Assembly; in which case, upon the expiration of the said period of notice, the Director-General shall cease to hold the appointment and this Contract shall terminate.

(7) The Health Assembly shall have the right, on the proposal of the Board and after hearing the Director-General and subject to at least six months' notice in writing, to terminate this Contract for reasons of exceptional gravity likely to prejudice the interests of the Organization.

II. (1) As from the sixteenth day of August of the year two thousand and twenty-two the Director-General shall receive from the Organization an annual salary of two hundred and fifty-nine thousand, five hundred and fifty-three United States dollars, before staff assessment, resulting in a net salary (to be paid monthly) of one hundred and ninety-five thousand, one hundred and eighty-seven United States dollars per annum or its equivalent in such other currency as may be mutually agreed between the parties to this Contract.

(2) In addition to the normal adjustments and allowances authorized to staff members under the Staff Rules, the Director-General shall receive an annual representation allowance of twenty-one thousand United States dollars or its equivalent in such other currency as may be mutually agreed between the parties to this Contract, to be paid monthly commencing on the sixteenth day of August of the year two thousand and twenty-two. The representation allowance shall be used at his discretion entirely in respect of representation in connection with his official duties. He shall be entitled to such reimbursable allowances as travel allowances and removal costs on appointment, on subsequent change of official station, on termination of appointment, or on official travel and home leave travel.

(3) The Director-General shall participate in and contribute to the United Nations Joint Staff Pension Fund in accordance with the Regulations and Rules of the United Nations Joint Staff Pension Fund for the term of his appointment.

III. The terms of the present Contract relating to rates of salary and representation allowance are subject to review and adjustment by the Health Assembly, on the proposal of the Board and after consultation with the Director-General, in order to bring them into conformity with any provision regarding the conditions of employment of staff members which the Health Assembly may decide to apply to staff members already in the service.

IV. If any question of interpretation or any dispute arises concerning this Contract that is not settled by negotiation or agreement, the matter shall be referred for final decision to the competent tribunal provided for in the Staff Rules.

WHEREUNTO we have set our hands the day and year first above written.

.....  
Director-General

.....  
President of the Seventieth-Fifth

World Health Assembly

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## ANNEX 2

### **Amendments to the International Health Regulations (2005)<sup>1</sup>**

#### *Article 59 Entry into force; period for rejection or reservations*

1. The period provided in execution of Article 22 of the Constitution of the World Health Organization for rejection of, or reservation to, these Regulations shall be 18 months from the date of the notification by the Director-General of the adoption of these Regulations by the Health Assembly. Any rejection or reservation received by the Director-General after the expiry of that period shall have no effect.

1bis. The period provided in execution of Article 22 of the Constitution of the World Health Organization for rejection of, or reservation to, an amendment to these Regulations shall be 10 months from the date of the notification by the Director-General of the adoption of an amendment to these Regulations by the Health Assembly. Any rejection or reservation received by the Director-General after the expiry of that period shall have no effect.

2. These Regulations shall enter into force 24 months after the date of notification referred to in paragraph 1 of this Article, and amendments to these Regulations shall enter into force 12 months after the date of notification referred to in paragraph 1bis of this Article, except for:

- (a) a State that has rejected these Regulations or an amendment thereto in accordance with Article 61;
- (b) a State that has made a reservation, for which these Regulations or an amendment thereto shall enter into force as provided in Article 62;
- (c) a State that becomes a Member of WHO after the date of the notification by the Director-General referred to in paragraph 1 of this Article, and which is not already a party to these Regulations, for which these Regulations shall enter into force as provided in Article 60; and
- (d) a State not a Member of WHO that accepts these Regulations, for which they shall enter into force in accordance with paragraph 1 of Article 64.

3. If a State is not able to adjust its domestic legislative and administrative arrangements fully with these Regulations or an amendment thereto within the period set out in paragraph 2 of this Article, as applicable, that State shall submit within the applicable period specified in paragraph 1 or 1bis of this Article a declaration to the Director-General regarding the outstanding adjustments and achieve them no later than 12 months after the entry into force of these Regulations or an amendment thereto for that State Party.

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<sup>1</sup> See resolution WHA75.12.

*Article 55 Amendments*

1. Amendments to these Regulations may be proposed by any State Party or by the Director-General. Such proposals for amendments shall be submitted to the Health Assembly for its consideration.
2. The text of any proposed amendment shall be communicated to all States Parties by the Director-General at least four months before the Health Assembly at which it is proposed for consideration.
3. Amendments to these Regulations adopted by the Health Assembly pursuant to this Article shall come into force for all States Parties on the same terms, and subject to the same rights and obligations, as provided for in Article 22 of the Constitution of the World Health Organization and Articles 59 to 64 of these Regulations, subject to the periods provided for in those Articles with respect to amendments to these Regulations.

*Article 61 Rejection*

If a State notifies the Director-General of its rejection of these Regulations or of an amendment thereto within the applicable period provided in paragraph 1 or 1bis of Article 59, these Regulations or the amendment concerned shall not enter into force with respect to that State. Any international sanitary agreement or regulations listed in Article 58 to which such State is already a party shall remain in force as far as such State is concerned.

*Article 62 Reservations*

1. States may make reservations to these Regulations or an amendment thereto in accordance with this Article. Such reservations shall not be incompatible with the object and purpose of these Regulations.
2. Reservations to these Regulations or an amendment thereto shall be notified to the Director-General in accordance with paragraphs 1 and 1bis of Article 59 and Article 60, paragraph 1 of Article 63 or paragraph 1 of Article 64, as the case may be. A State not a Member of WHO shall notify the Director-General of any reservation with its notification of acceptance of these Regulations. States formulating reservations should provide the Director-General with reasons for the reservations.
3. A rejection in part of these Regulations or an amendment thereto shall be considered as a reservation.
4. The Director-General shall, in accordance with paragraph 2 of Article 65, issue notification of each reservation received pursuant to paragraph 2 of this Article. The Director-General shall:
  - (a) if the reservation was made before the entry into force of these Regulations, request those Member States that have not rejected these Regulations to notify him or her within six months of any objection to the reservation; or
  - (b) if the reservation was made after the entry into force of these Regulations, request States Parties to notify him or her within six months of any objection to the reservation; or
  - (c) if the reservation was made to an amendment to these Regulations, request States Parties to notify him or her within three months of any objection to the reservation.

States Parties objecting to a reservation to an amendment to these Regulations should provide the Director-General with reasons for the objection.

5. After this period, the Director-General shall notify all States Parties of the objections he or she has received with regard to reservations. In the case of a reservation made to these Regulations, unless by the end of six months from the date of the notification referred to in paragraph 4 of this Article a reservation has been objected to by one third of the States referred to in paragraph 4 of this Article, it shall be deemed to be accepted and these Regulations shall enter into force for the reserving State, subject to the reservation. In the case of a reservation made to an amendment to these Regulations, unless by the end of three months from the date of the notification referred to in paragraph 4 of this Article, a reservation has been objected to by one third of the States referred to in paragraph 4 of this Article, it shall be deemed to be accepted and the amendment shall enter into force for the reserving State, subject to the reservation.

6. If at least one third of the States referred to in paragraph 4 of this Article object to the reservation to these Regulations by the end of six months from the date of the notification referred to in paragraph 4 of this Article or, in the case of a reservation to an amendment to these Regulations, by the end of three months from the date of the notification referred to in paragraph 4 of this Article, the Director-General shall notify the reserving State with a view to its considering withdrawing the reservation within three months from the date of the notification by the Director-General.

7. The reserving State shall continue to fulfil any obligations corresponding to the subject matter of the reservation, which the State has accepted under any of the international sanitary agreements or regulations listed in Article 58.

8. If the reserving State does not withdraw the reservation within three months from the date of the notification by the Director-General referred to in paragraph 6 of this Article, the Director-General shall seek the view of the Review Committee if the reserving State so requests. The Review Committee shall advise the Director-General as soon as possible and in accordance with Article 50 on the practical impact of the reservation on the operation of these Regulations.

9. The Director-General shall submit the reservation, and the views of the Review Committee if applicable, to the Health Assembly for its consideration. If the Health Assembly, by a majority vote, objects to the reservation on the ground that it is incompatible with the object and purpose of these Regulations, the reservation shall not be accepted and these Regulations or an amendment thereto shall enter into force for the reserving State only after it withdraws its reservation pursuant to Article 63. If the Health Assembly accepts the reservation, these Regulations or an amendment thereto shall enter into force for the reserving State, subject to its reservation.

#### *Article 63 Withdrawal of rejection and reservation*

1. A rejection made under Article 61 may at any time be withdrawn by a State by notifying the Director-General. In such cases, these Regulations or an amendment thereto, as applicable, shall enter into force with regard to that State upon receipt by the Director-General of the notification, except where the State makes a reservation when withdrawing its rejection, in which case these Regulations or an amendment thereto, as applicable, shall enter into force as provided in Article 62. In no case shall these Regulations enter into force in respect to that State earlier than 24 months after the date of notification referred to in paragraph 1 of Article 59 and in no case shall an amendment to these Regulations enter into force in respect to that State earlier than 12 months after the date of notification referred to in paragraph 1bis of Article 59.

2. The whole or part of any reservation may at any time be withdrawn by the State Party concerned by notifying the Director-General. In such cases, the withdrawal will be effective from the date of receipt by the Director-General of the notification.

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## ANNEX 3

### **Agreement between the World Health Organization and the International Development Law Organization**

The World Health Organization (hereafter “WHO”); and

The International Development Law Organization (hereafter “IDLO”);

Hereafter individually and collectively termed “the Party” and “the Parties”;

Considering that the objective of WHO is the attainment by all peoples of the highest possible level of health, and to this end WHO is the directing and coordinating authority for health-related work with an international dimension;

Considering that IDLO is the only global intergovernmental organization exclusively devoted to promoting the rule of law to advance peace and sustainable development, IDLO works to enable governments and empower people to reform laws and strengthen institutions to promote peace, justice, sustainable development and economic opportunity;

Recalling that WHO and IDLO concluded a Memorandum of Understanding on 19 May 2019 recognizing the need for cooperation between each other in matters of mutual interest, sharing the view that law is central to assuring the highest attainable standards of physical and mental health, and social well-being, and to expand their commitment to a strategic partnership between IDLO and WHO;

Desiring to coordinate their efforts within their respective mandates and in accordance with the Constitution of WHO and the Agreement for the Establishment of the International Development Law Organization;

Acknowledging that the law is an important tool to promote the right to health of populations through legislations and regulations governing such matters and that many States do not have the legislative frameworks required to effectively advance and ensure public health;

Wishing to strengthen their cooperation on the basis of regular consultations;

Have agreed as follows:

#### Article 1

##### Object and areas of cooperation

1. The object of this Agreement is to facilitate and reinforce cooperation and collaboration between the Parties, where appropriate, in the area(s) of public health and law that relate to the activities of the Parties.
2. Within the scope of their respective mandates and programmes of work, the Parties agree to a general strengthening of their cooperation, specifically as regards the areas of cooperation noted in the

aforementioned Memorandum of Understanding, as well as other areas where cooperation would contribute to achievement of the objectives of each organization.

#### Article 2

##### Financial aspects and joint resource mobilization

1. This Agreement defines in general terms the basis for cooperation but does not constitute a financial obligation to serve as a basis for expenditures.
2. To the extent that any activity may give rise to a legal or financial obligation, a separate agreement shall be concluded subject to the respective financial regulations and rules of IDLO and WHO, prior to such activity being undertaken.

#### Article 3

##### Reciprocal representation

1. On the basis of reciprocity, IDLO is invited to represent itself at sessions of the World Health Assembly and the Executive Board in accordance with the rules and decisions adopted by these bodies and, as appropriate, any other meetings held under the auspices of WHO in the deliberations of which IDLO could participate, without the right to vote, on agenda items of concern to it.
2. On the basis of reciprocity, WHO is invited to represent itself at sessions of the IDLO Assembly of Parties in accordance with the rules and decisions adopted by that body and, as appropriate, any other meetings held under the auspices of IDLO in the deliberations of which WHO could participate, without the right to vote, on agenda items of concern to it.

#### Article 4

##### Sharing of information

The Parties agree to exchange, by whatever means, information concerning their activities which they deem appropriate, subject to their existing policies, respect for the sovereign rights of their Member States and Governments, confidentiality obligations and the protection of commercial, contractual or other secrets.

#### Article 5

##### Privileges and immunities

No provision of this Agreement shall be interpreted or considered as a renunciation, limitation, waiver or modification of the privileges and immunities enjoyed by the Parties under international agreements and national laws applicable to them.



## Article 6

## Entry into force, amendment and denunciation

1. This Agreement is valid from the date of its signature by the Director-General of WHO and the Director-General of IDLO, subject to approval by the World Health Assembly.
2. This Agreement may be amended at any time by mutual written consent of the Parties.
3. Either Party may denounce this Agreement at any time by serving written notice on the other Party of its intent to do so six (6) months in advance. The denunciation of the Agreement shall not prejudice any activities being conducted under the terms of the Agreement at the time of said denunciation.

## Article 7

## Settlement of differences

Any difference, dispute or litigation arising from the interpretation or application of this Agreement shall be settled amicably through negotiation between the Parties. If attempted negotiation yields no result, either Party may request that the difference be submitted for arbitration in accordance with the currently applicable Arbitration Rules of the United Nations Commission on International Trade Law.

IN WITNESS WHEREOF, this Agreement is done and signed at Geneva on [.....], in two copies, in the English language.

For the International Development Law  
Organization

For the World Health Organization

Director-General  
Jan Beagle

Director-General  
Tedros Adhanom Ghebreyesus

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## ANNEX 4

### **Recommendations of the Working Group on Sustainable Financing to the Seventy-fifth World Health Assembly<sup>1</sup>**

[A75/9, Appendix 2 – 13 May 2022]

38. The Working Group on Sustainable Financing:
- (a) Recognized that now more than ever, in the context of coronavirus disease (COVID-19), the current funding model including the budgeting process for WHO is unsustainable and limits the Organization's ability to make an impact where it is most needed, at the country and regional levels, and the status quo is unacceptable;
  - (b) Considered the recommendations of various independent review panels and committees with regard to the financing of WHO, including, inter-alia, those of the Independent Panel for Pandemic Preparedness and Response, the Global Preparedness Monitoring Board, the Independent Expert Oversight Advisory Committee, the Independent Oversight and Advisory Committee for the WHO Health Emergencies Programme and the Review Committee on the Functioning of the International Health Regulations (2005) during the COVID-19 Response;
  - (c) Noted the mutual reliance on WHO for the ongoing delivery of normative global health policy and technical advice, and that all Member States have an interest in seeing a WHO that benefits from sustainable, flexible and predictable funding;
  - (d) Stressed that Member States as a collective must match their willingness to fund the Organization with the demands that they place on it;
  - (e) Stressed that any increase in Member States' assessed contributions needs to be accompanied by appropriate governance reforms, to be agreed by Member States, together with the further strengthening of transparency, efficiency, accountability and compliance within the Organization;
  - (f) Acknowledged that many Member States face severe financial challenges, including those accentuated by the COVID-19 pandemic, which may hinder their capacity to fulfil their financial obligations, sometimes despite existing mechanisms;
  - (g) Highlighted the need for coordination between the Working Group on Sustainable Financing and the Working Group on Strengthening WHO Preparedness and Response to Health Emergencies; and
  - (h) Recognized that initiatives are currently under way to expand funding for the global health architecture, and emphasized the importance of linking these efforts to the critical need to enhancing WHO financing.

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<sup>1</sup> See decision WHA75(8).

39. Based on the above-mentioned premises, the Working Group developed the following recommendations:

- (a) that governance, transparency, accountability, efficiency and compliance be strengthened through a number of initiatives including, but not necessarily limited to:
  - (i) mechanisms to be put in place for robust oversight with sufficient time by the World Health Assembly, the Executive Board and the Programme, Budget and Administration Committee of the Executive Board of all initiatives in terms of results, potential overlaps with existing initiatives, a time frame for implementation, and associated costs, financing and reporting, particularly where presented in the form of resolutions or decisions for approval;
  - (ii) a more transparent presentation from the Secretariat of programme budget priority-setting through all three levels of the Organization to assist Member States with the preparation, evaluation and approval of the programme budget and budgeting for specific initiatives, including discipline within the Secretariat and Member States in committing to new activities. Budgeting processes should be better linked with governance processes;
  - (iii) strengthening the role of the Programme, Budget and Administration Committee, to make it more effective, robust and transparent, and more engaged with the Secretariat during the budgeting process and potentially through additional deliberations;
  - (iv) specific reforms that may be undertaken by the Secretariat, that are within its remit, and would enable Member States to exercise enhanced visibility and oversight across the Organization.
- (b) that the base segment of the programme budget should be fully flexibly funded;
- (c) that the Health Assembly request Member States and other donors to strive to provide WHO with fully unearmarked voluntary contributions for the financing of WHO's base programme segment, in accordance with the Framework of Engagement with Non-State Actors, as appropriate, as a prerequisite for securing WHO's financial independence and increasing efficiency of the Organization;
- (d) that the Secretariat and Member States continue their efforts to boost funding for WHO which:
  - (i) is fully flexible or at least thematic in nature, as well as sustainable and predictable;
  - (ii) encompasses increased support from donors in developed and developing countries;
  - (iii) is able to consolidate support from multiple sizes of donors;
  - (iv) explores new, agile and underutilized sources of funding, such as those from the private sector, in accordance with the Framework of Engagement with Non-State Actors.
- (e) that the Seventy-fifth World Health Assembly, recognizing the important role of assessed contributions in sustainably financing the Organization, request the Secretariat to develop budget proposals, through the regular budget cycle, for an increase of assessed contributions to contribute

to financial sustainability of WHO and with its aspiration to reach a level of 50% of the 2022–2023 base budget<sup>1</sup> by the biennium 2030–2031, while aiming to achieve this by the biennium 2028–2029:

(i) further requests the Secretariat to develop, and, in the light of the principle in paragraph 38(e), submit concurrently with the first proposed increase in assessed contributions to the Seventy-sixth World Health Assembly through the thirty-seventh meeting of the Programme, Budget and Administration Committee, the 152nd session of the Executive Board and the thirty-eighth meeting of Programme, Budget and Administration Committee, an implementation plan on reform. This implementation plan should include progress to date on reforms as well as a preliminary timeline and required resources for implementation for additional reforms, including but not limited to budgetary, programmatic, finance, governance and accountability reforms within the remit of the Secretariat. The Secretariat commits to enact these reforms as soon as possible; to identify a clear set of deliverables for the biennium 2024–2025; and to report on these regularly. The Executive Board at its 152nd session, through the thirty-seventh meeting of the Programme, Budget and Administration Committee, will endorse the implementation plan, which may be informed by discussions in the Member State task group recommended in paragraph 40;

(ii) requests the Secretariat to develop a budget proposal with a targeted first increase of 20%<sup>2</sup> of the assessed contributions assessment for the biennium 2022–2023, which would be presented to Member States for consideration as part of the Proposed programme budget 2024–2025, submitted for approval to the Seventy-sixth World Health Assembly, through the thirty-seventh meeting of the Programme, Budget and Administration Committee, the 152nd session of the Executive Board and the thirty-eighth meeting of Programme, Budget and Administration Committee;

(iii) in considering further proposals for increases in assessed contributions, Member States will assess progress towards the implementation of, inter alia, budgetary, programmatic, finance, governance and accountability deliverables within the remit of the Secretariat, which would take place as per programme budget cycles with the corresponding programme budget resolutions. These discussions would take into account, as appropriate, the progress of other global health financial mechanisms.

<sup>1</sup> The baseline will be fixed to the base segment of the approved Programme budget 2022–2023 (resolution WHA74.3 (2021)) in order to provide certainty to Member States. This is without prejudice to the adoption of subsequent scales of assessment by the Health Assembly.

<sup>2</sup> This increase will bring the level of assessed contributions to 26% of the base segment of the approved Programme budget 2022–2023.

The Table below provides increases over three bienniums for illustrative purposes, based on the Bureau proposal.

Biennium	Total assessed contributions	Increase over current level of assessment	% of base budget 2022–2023
2022–2023	956.9	baseline	22%
2024–2025	1 148.3	20%	26%
2026–2027	1 550.2	35%	36%
2028–2029	2182	40%	50%

(f) that the Health Assembly request the Secretariat to explore the feasibility of a replenishment mechanism to broaden further the financing base, in consultation with Member States and taking into consideration the Framework of Engagement with Non-State Actors; and to present a report that includes relevant options for Member States to consider, to the Seventy-sixth World Health Assembly, through the 152nd session of Executive Board and the thirty-seventh meeting of the Programme, Budget and Administration Committee in January 2023. The replenishment mechanism, with relevant rules of procedure, would be based on the following principles:

- (i) is Member State-driven and approved by the Health Assembly and open to all donors that comply with the Framework of Engagement with Non-State Actors;
- (ii) addresses both WHO needs for flexibility and donor needs to show accountability for results to their own constituents;
- (iii) ensures efficiency and no competition between different parts of WHO;
- (iv) aligns with the defined needs of WHO as approved by its governing bodies and is oriented to prioritize the financing needs of the base budget in all its components;
- (v) aligns with the global health architecture avoiding competition with other global actors;
- (vi) aligns with resolutions and decisions of the Health Assembly.

(g) that the Secretariat improve the mechanism for the fair and equitable allocation and reallocation of resources to fully fund all programme budget outcomes across all major offices and across the three levels of the Organization in order to address the chronically underfunded areas; and that it inform Member States regularly about its progress through the Programme, Budget and Administration Committee;

40. The Working Group on Sustainable Financing also recommends the establishment of an agile Member States task group on strengthening WHO's budgetary, programmatic and financing governance<sup>1</sup> to analyse challenges in governance for transparency, efficiency, accountability and compliance, and come up with recommendations, which would report to the Seventy-sixth World Health Assembly, through the 152nd session of the Executive Board and the thirty-seventh meeting of the Programme, Budget and Administration Committee in January 2023, to recommend long-term improvements. The establishment of the task group, open to all Member States,<sup>2</sup> should be taken up during the 151st session of the Executive Board.

41. The Working Group further recommends that the Health Assembly request the Secretariat to explore possible revision and adjustments in the recovery of programme support costs with a view to

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<sup>1</sup> The following were identified as possible elements for the task group: including, but not limited to, the role of governing bodies to prioritize topics for inclusion on the provisional agenda of the Health Assembly; enhancing transparency, improving the budgeting process for WHO based on best practices used in the United Nations system, including how the budget is presented; the costing of resolutions and decisions and other initiatives using a results-based approach; the use of guidelines and thresholds for earmarking and deadlines for achieving the thresholds; exploring inclusion of non-State contributors in accordance with the Framework of Engagement with Non-State Actors; efficiency gains; guidelines for ensuring equity in resource allocation to all levels and departments of WHO; and standardizing reporting procedures for small donors.

<sup>2</sup> And regional economic integration organizations, as appropriate.

covering the full cost of the activities undertaken within programmes financed through voluntary contributions, building upon the review<sup>1</sup> of WHO's programme support costs that was conducted in 2013.

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<sup>1</sup> See document EBPBAC18/3.

## ANNEX 5

### **Progress in the implementation of the global strategy to accelerate the elimination of cervical cancer as a public health problem and its associated goals and targets for the period 2020–2030<sup>1</sup>**

[A75/10 Add.3, Annex 5 – 25 April 2022]

1. This Annex sets out the progress achieved in the implementation of resolution WHA73.2 on the global strategy to accelerate the elimination of cervical cancer as a public health problem and its associated goals and targets for the period 2020–2030.

#### **Context**

2. The Secretariat launched the global strategy to accelerate the elimination of cervical cancer as a public health problem on 17 November 2020. Campaigns, health care worker training events and advocacy events were organized by governments, civil society and partners in countries across all regions, ushering in the global strategy with actions that advanced its implementation.

3. The global strategy outlines three key steps: vaccination, screening and treatment. Successful implementation of these steps could reduce more than 40% of new cases of the disease and 5 million related deaths by 2050. Data for 2020 show that age-standardized cervical cancer incidence rates varied from 84 per 100 000 women in the highest-risk countries to less than 10 per 100 000 women in the lowest-risk countries.<sup>2</sup>

4. To eliminate cervical cancer, all countries must reach and maintain an incidence rate of below four per 100 000 women. In particular:

- (a) achieving that goal rests on three key pillars and their corresponding targets:
  - (i) vaccination: 90% of girls fully vaccinated with the HPV vaccine by the age of 15;
  - (ii) screening: 70% of women screened using a high-performance test by the age of 35 and again by the age of 45; and
  - (iii) treatment: 90% of women with pre-cancer treated and 90% of women with invasive cancer managed; and
- (b) each country should meet the 90–70–90 targets by 2030 to get on the path to eliminate cervical cancer within the next century.

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<sup>1</sup> See decision WHA75(11).

<sup>2</sup> See Global Cancer Observatory. World Health Organization/International Agency for Research on Cancer (<http://gco.iarc.fr/>, accessed 1 December 2021).

5. Despite the disruptions caused by the pandemic of coronavirus disease (COVID-19), WHO continues to respond to requests for support and technical assistance from Member States that prioritize cervical cancer elimination.

### **WHO guidance and tools**

6. WHO has published various normative products to support countries in the implementation of the interventions recommended in the global strategy.

7. **Human papillomavirus (HPV) vaccination.** The introduction of HPV vaccine in national immunization schedules had progressed to 117 countries by January 2022 and is expected to reach 120 countries end-2022, 40 countries also offer the vaccine to boys. Suboptimal levels of HPV coverage remain a concern, with few countries reaching the 90% target. Due to the COVID-19 pandemic, for the first time the global coverage for HPV vaccination declined – from 15% in 2019 to 13% in 2020. The decline was in particular attributed to reduced coverage in low- and middle-income countries. Countries started efforts by end-2020 for catch-up vaccinations of missed girls and will need to sustain those efforts to improve their coverage. A fourth HPV vaccine has been prequalified by WHO.<sup>1</sup>

8. The Secretariat published a guide to help monitor HPV vaccination coverage at the country level.<sup>2</sup> WHO also published an updated WHO HPV Vaccine Global Market Study<sup>3</sup> and has taken steps to further alleviate supply constraints.

9. **Screening and treating precancerous lesions.** The second edition of the WHO guideline for screening and treatment of cervical pre-cancer lesions was launched in July 2021. It addresses the needs of the general population of eligible women, and includes new and updated recommendations and good practice statements for women living with HIV. It also emphasizes the need for countries to transition to the use of high-performance screening test, such as HPV molecular tests.<sup>4</sup> WHO also published a new guidance on introducing and scaling up testing for HPV as part of a comprehensive programme for the prevention and control of cervical cancer.<sup>5</sup> To support countries to implement the guideline, WHO published a paper on the importance of implementation research for the introduction of new, evidence-based interventions.

10. **Women living with HIV.** WHO's initial estimates<sup>6</sup> of the contribution of HIV to the global cervical cancer burden showed that women living with HIV have a sixfold greater risk of cervical cancer compared to women without HIV. The Secretariat developed a policy brief to support countries to scale up access to and uptake of cervical cancer screening and treatment among women living with HIV, using

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<sup>1</sup> See WHO – Prequalification of Medical Products (IVDs, Medicines, Vaccines and Immunization Devices, Vector Control). World Health Organization (<https://extranet.who.int/pqweb/content/cecolin%C2%AE>, accessed 7 April 2022).

<sup>2</sup> WHO. Human papillomavirus (HPV) vaccine coverage monitoring manual. Geneva: World Health Organization; 2020.

<sup>3</sup> Global market study. HPV vaccines. Geneva: World Health Organization; 2019.

<sup>4</sup> WHO guideline for screening and treatment of cervical pre-cancer lesions for cervical cancer prevention, 2nd ed. Geneva: World Health Organization; 2021.

<sup>5</sup> Introducing and scaling up testing for human papillomavirus as part of a comprehensive programme for prevention and control of cervical cancer: a step-by-step guide. Geneva: World Health Organization; 2020

<sup>6</sup> Stelzle D, Tanaka LF, Lee KK, Khalil AI, Baussano J, Shah ASV, et al. Estimates of the global burden of cervical cancer associated with HIV. *Lancet Glob Health*. 2021; 9: e161–69. doi: 10.1016/S2214-109X(20)30459-9.



quality modern technologies.<sup>1</sup> In addition, WHO published updated consolidated guidelines on HIV prevention, testing, treatment, service delivery and monitoring, including a chapter dedicated to the prevention of cervical cancer for women living with HIV.<sup>2</sup> New indicators to measure progress in screening and treatment for cervical pre-cancer and cancer will be included in the annual Global AIDS Monitoring reporting system.

11. **Invasive cancer treatment and palliative care.** The WHO Framework for strengthening and scaling-up services for the management of invasive cervical cancer<sup>3</sup> was developed to underpin the third pillar of the global strategy and to assist countries to reach the target of treating 90% of women diagnosed with invasive cancer. In collaboration with the International Atomic Energy Agency, WHO released an interagency guidance<sup>4</sup> to enable the effective procurement of equipment utilized in cervical cancer treatment. The WHO Model List of Essential Medicines was updated for medicines used for the treatment of invasive cervical cancer.

12. WHO-commissioned research demonstrated that physical, psychological, spiritual and social suffering is highly prevalent and often severe and multifaceted among women with cervical cancer. Essential augmented packages for palliative care for women with cervical cancer were proposed.<sup>5,6,7</sup>

13. **Post-market surveillance of medical devices.** To support the safe operation of devices used in cervical cancer programmes as these programmes scale up, WHO published a policy brief on the implementation of post-market surveillance in cervical cancer programmes.<sup>8</sup>

14. **Costing national cervical cancer programme.** WHO supported several Member States to estimate the costs of the implementation of their national plans for cervical cancer elimination. The costing plans were published for the benefit of other Member States' planning processes.<sup>9</sup>

15. **Surveillance, monitoring and evaluation.** In collaboration with the International Agency for Research on Cancer (IARC), WHO has developed a draft framework for monitoring the global strategy implementation. Furthermore, in order to establish a baseline for subsequent monitoring, WHO is developing a first set of estimates of global, regional and country cervical cancer screening coverage.

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<sup>1</sup> New WHO recommendations on screening and treatment to prevent cervical cancer among women living with HIV: policy brief. Geneva: World Health Organization; 2021.

<sup>2</sup> Consolidated guidelines on HIV prevention, testing, treatment, service delivery and monitoring: recommendations for a public health approach. Geneva: World Health Organization; 2021.

<sup>3</sup> WHO framework for strengthening and scaling-up of services for the management of invasive cervical cancer. Geneva: World Health Organization; 2020.

<sup>4</sup> Technical specifications of radiotherapy equipment for cancer treatment. Geneva: World Health Organization; 2021.

<sup>5</sup> Krakauer EL, Kwete X, Kane K., Afshan G, Bazzett-Matabel L, Bien-Aimé, et al. Cervical Cancer-Associated Suffering: Estimating the Palliative Care Needs of a Highly Vulnerable Population. *JCO Glob Oncol.* 2021;7:862–872. doi: 10.1200/GO.21.00025.

<sup>6</sup> Krakauer EL, Kane K, Kwete X, Afshan G, Bazzett-Matabele L, Ruthnie Bien-Aimé D, et al. Essential Package of Palliative Care for Women With Cervical Cancer: Responding to the Suffering of a Highly Vulnerable Population. *JCO Glob Oncol.* 2021;7:873-885. doi: 10.1200/GO.21.00025.

<sup>7</sup> Krakauer EL, Kane K, Kwete X, Afshan G, Bazzett-Matabele L, Ruthnie Bien-Aimé D, et al. Augmented Package of Palliative Care for Women With Cervical Cancer: Responding to Refractory Suffering. *JCO Glob Oncol.* 2021;7:886-895. doi: 10.1200/GO.21.00027.

<sup>8</sup> Implementation of post-market surveillance in cervical cancer programmes: policy brief for manufacturers of medical devices, including in vitro diagnostic medical devices. Geneva: World Health Organization; 2021.

<sup>9</sup> Costing the National Strategic Plan on Prevention and Control of Cervical Cancer. Geneva: World Health Organization; 2020.

Another tool – cervical cancer country profiles<sup>1</sup> – provides a snapshot of the status of countries’ national cervical cancer control plans and link cervical cancer-specific indicators with global strategy priority interventions. A portal has been launched to provide access to WHO data on HPV vaccine introductions in countries and the trends in vaccination coverage in HPV programmes to monitor progress towards achieving the 2030 targets.<sup>2</sup>

16. **Research and innovation.** WHO has developed a framework of evidence generation for artificial intelligence-based medical devices, training, validation and evaluation, which includes specific chapters on cervical cancer screening as a top-priority use case for the application of artificial intelligence.<sup>3</sup>

17. **Knowledge repository.** A web-based tool has been developed to facilitate access to guidance and tools published across WHO and other partners, which are relevant for the implementation of the global strategy.<sup>4</sup>

### **Support for Member States, giving priority to high-burden countries**

18. All WHO regions took actions to provide support to Member States in implementing cervical cancer interventions. This report highlights examples of progress in WHO regions but does not necessarily provide a complete list of all achievements.

19. **African Region.** The African Region includes 19 of 20 Member States with the highest burden of cervical cancer. In 2020, it accounted for 21% of global cervical cancer mortality. To respond to the challenge, the Regional Office for Africa has been strengthening the regional capacity to provide support and integrated assistance to countries. The 71st session of the Regional Committee for Africa adopted a regional framework for the implementation of the global strategy.<sup>5</sup>

20. Support for scaling up cervical cancer programmes and technical support has been provided to Guinea, Kenya, Malawi, Nigeria, Rwanda, Togo, Uganda and Zambia to update their cervical cancer guidelines and strategies. In other countries, the national cancer control plans were reviewed and adapted to global strategy targets and priority interventions. As of 2020, WHO provided technical and financial support for HPV vaccination in Cabo Verde, Cameroon and Mauritania, with the result that a total of 19 countries have nationally introduced HPV vaccination. A total of 11 Member States (Burkina Faso, Côte d’Ivoire, Kenya, Malawi, Nigeria, Rwanda, Senegal, South Africa, Uganda, Zimbabwe and Zambia) are also being supported in the uptake of the high-performance screening technology.

21. **Region of the Americas.** A comprehensive cervical cancer virtual training programme and a basic course on palliative care continue to be rolled out through the Pan American Health Organization/WHO Regional Office for the Americas (PAHO/AMRO) virtual public health campus for health care providers. A virtual tele-mentoring programme on cervical cancer elimination was established, creating a community of practice and sharing of experiences on cervical cancer prevention.

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<sup>1</sup> Cervical Cancer Country Profiles. Geneva: World Health Organization; 2021. (<https://www.who.int/teams/noncommunicable-diseases/surveillance/data/cervical-cancer-profiles>, accessed 7 April 2022).

<sup>2</sup> See [https://www.who.int/teams/immunization-vaccines-and-biologicals/diseases/human-papillomavirus-vaccines-\(HPV\)/hpv-clearing-house](https://www.who.int/teams/immunization-vaccines-and-biologicals/diseases/human-papillomavirus-vaccines-(HPV)/hpv-clearing-house) (accessed 7 April 2022).

<sup>3</sup> Generating evidence for artificial intelligence-based medical devices: a framework for training, validation and evaluation. Geneva: World Health Organization; 2021.

<sup>4</sup> See <https://cceirepository.who.int/> (accessed 10 December 2021).

<sup>5</sup> See document AFR/RC71/9.

On palliative care, monthly virtual tele-mentoring sessions have separately been developed, with several sessions devoted to issues specific to women with cervical cancer.

22. Country-specific national elimination plans have been elaborated in Chile, Honduras, Jamaica, Paraguay and Suriname. In El Salvador, HPV testing has been expanded and HPV vaccines have begun to be introduced. Guatemala has begun to introduce HPV testing with support from Unitaïd and with the engagement of WHO regional and country offices. Chile has instituted an awareness-raising campaign to encourage women to seek cervical cancer screening. Paraguay is updating its guideline and developing a national training programme to reinforce capacity for screening and pre-cancer treatment.

23. **Eastern Mediterranean Region.** The Regional Office for the Eastern Mediterranean conducted a regional situation analysis to determine the current burden and capacity to achieve the global targets; in partnership with IARC, it also provided technical assistance for most countries to strengthen their cancer registries.

24. Only three countries have introduced the HPV vaccine, while nine countries provide cervical cancer screening services. The Regional Office supported Morocco's training of health care workers to facilitate HPV vaccine introduction. It also mobilized targeted support to develop national cervical cancer screening programmes in Iran (Islamic Republic of), Iraq, Jordan, Morocco, Saudi Arabia and Sudan. Morocco, Saudi Arabia and Sudan received technical and financial support to respond to cervical cancer national assessment and treatment needs. Regional advocacy efforts to facilitate introduction of the HPV vaccine are planned in countries eligible for support from Gavi, the Vaccine Alliance – Afghanistan, Djibouti and Sudan.

25. **European Region.** The Regional Office for Europe is developing a regional road map on cervical cancer elimination. Technical support for cervical cancer screening and early diagnosis has continued in Belarus, Georgia, Kyrgyzstan, Romania and Uzbekistan, including capacity-building and policy dialogues. The Regional Office has provided intensive technical assistance and training to Uzbekistan to support the implementation of all three pillars of the global strategy.

26. In May 2021, Kyrgyzstan made a decision to introduce HPV vaccine for routine immunization of 11-year-old girls as of September 2022 and to conduct catch-up vaccinations of girls up to the age of 14. In October 2021, Uzbekistan launched catch-up HPV vaccinations of girls aged 11–14 and reached high (>90%) coverage with the first dose. The second dose will be administered to the catch-up cohort in June 2022. With the help of WHO and the United Nations Population Fund (UNFPA), Uzbekistan launched a cervical cancer screening pilot in June 2021 to screen 56 000 women with HPV tests in two administrative regions.

27. **South-East Asia Region.** The Regional Office for South-East Asia launched an implementation framework for the elimination of cervical cancer as a public health problem for 2021–2030 at the 74th session of the Regional Committee for South-East Asia. Training in cervical cancer screening and the management of precancerous lesions based on the regional training package<sup>1</sup> as well as training in colposcopy<sup>2</sup> have been provided to Member States. An advocacy and educational video was launched in 2021 to promote the efforts to eliminate cervical cancer in the region.

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<sup>1</sup> See Cervical cancer screening and management of cervical pre-cancers. WHO Regional Office for South-East Asia (<https://www.who.int/southeastasia/activities/cervical-cancer-screening-and-management-of-cervical-pre-cancer>, accessed 1 December 2021).

<sup>2</sup> See IFPC/IARC Training course in colposcopy and the prevention of cervical cancer. World Health Organization/International Agency for Research on Cancer (<https://screening.iarc.fr/elearningifpc.php>, accessed 1 December 2021).

28. The Regional Office is reviewing the existing national guideline on screening and management of precancerous lesions to facilitate its alignment with WHO recommendations. Seven countries have introduced HPV vaccination into national immunization plans, while five countries (Bhutan, the Maldives, Myanmar, Sri Lanka and Thailand) have introduced it in nationwide programmes and two countries (India and Indonesia) have introduced it at subnational levels and WHO provided support to Myanmar in 2020. HPV testing is used in Thailand as a primary screening test and Myanmar completed a pilot project to introduce this high-performance screening test.

29. **Western Pacific Region.** Mongolia has been introducing HPV testing. The Regional Office for the Western Pacific provided support to Vanuatu, with an emphasis on cervical cancer prevention, including screening, diagnosing and treatment of women with early-stage cancers. To further support demand generation for services, advocacy and communication material on cervical cancer are being developed with the Federated States of Micronesia. WHO is also providing the Solomon Islands with vital equipment for the treatment of precancers. Tuvalu introduced HPV vaccination in September 2021.

### **Collaboration with partners**

30. WHO collaborated with the Joint United Nations Programme on HIV/AIDS (UNAIDS) at the 47th session of the UNAIDS Programme Coordinating Board (15–18 December 2020), at which a thematic session focused on cervical cancer and HIV infection.

31. To support HPV vaccination introduction, WHO continues to collaborate with Gavi and technical partners, including through global-level HPV vaccine access dialogues, in order to facilitate the equitable distribution of HPV vaccines. Additional ongoing collaboration, with a multipartner effort coordinated by Unitaid and with procurement support from UNICEF, aims to expand access to secondary prevention services, including efforts to lay the foundation on which to scale up national services and to improve access to innovative technologies.

32. Other high-level engagements involved the Commonwealth Secretariat and the African Union Commission, including the awareness-raising efforts at the level of Commonwealth health ministers to advocate for Member States to commit to the global strategy implementation.

33. United Nations agencies, including UNAIDS, UNFPA and UNICEF, are aligning their strategies with the inclusion of cervical cancer elimination targets.

### **The way forward**

34. **Support countries to accelerate the implementation of the global strategy.** The Secretariat will work with governments and other partners to accelerate the implementation of the global strategy to achieve the targets set for 2030. WHO will also support countries to strengthen the integration of cervical cancer prevention and care in primary health care, sexual and reproductive health services and HIV and other service points and outreach programmes. Global and national partnerships, including with advocacy groups and women who have survived cervical cancer, will be promoted to advance cervical cancer elimination.

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## ANNEX 6

### **Preparatory process leading to the fourth high-level meeting of the General Assembly on the prevention and control of non-communicable diseases in 2025<sup>1</sup>**

[A75/10 Add.5, Annex 11 – 27 April 2022]

#### **Mandate**

1. Paragraph 50 of the political declaration of the third high-level meeting of the General Assembly on the prevention and control of non-communicable diseases requests “the United Nations Secretary-General in consultation with Member States, and in collaboration with the World Health Organization and relevant funds, programmes and specialized agencies of the United Nations system, to submit to the General Assembly, by the end of 2024, for consideration by Member States, a report on the progress achieved in the implementation of the present political declaration, in preparation for a high-level meeting on a comprehensive review, in 2025, of the progress achieved in the prevention and control of non-communicable diseases and the promotion of mental health and well-being”.<sup>2</sup>
2. The preparatory process leading to the fourth high-level meeting of the General Assembly on the prevention and control of non-communicable diseases was first set out in paragraph 44 of document A74/10 Rev.1, which was noted by Member States at the Seventy-fourth World Health Assembly.
3. The purpose of this Annex is to provide an update on that preparatory process.

#### **Scope, purpose and modalities**

4. Premature deaths caused by noncommunicable diseases (NCDs) can be prevented when countries take legislative and regulatory measures and implement policies to respond to the needs of people living with or at risk of cardiovascular diseases, cancers, diabetes, chronic respiratory diseases or mental health conditions, including preventive, curative, palliative and specialized care. Some 85% of all premature deaths occurs in low- and middle-income countries. A large proportion of the global population live in low- and middle-income countries where the social, economic and physical environments afford lower levels of protection from the risks of NCDs, such as tobacco use, the harmful use of alcohol, unhealthy diets, physical inactivity and air pollution. In addition, during the pandemic of coronavirus disease (COVID-19), NCDs and mental health services have been the most commonly disrupted among all essential health services.
5. Many countries are still lacking the capacity to fulfil the commitment, as set out in paragraph 17 of United Nations General Assembly resolution 73/2, to provide strategic leadership for the prevention and control of NCDs by promoting greater policy coherence and coordination through

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<sup>1</sup> See decision WHA75(11).

<sup>2</sup> United Nations General Assembly resolution 73/2.

whole-of-government and Health in All Policies approaches and by engaging stakeholders in appropriate, coordinated, comprehensive, integrated and bold whole-of-society action and response.

6. Engagement between governments and non-State actors for the prevention and control of NCDs has proven to be challenging in the context of non-State actor compliance with public health policies and regulations, particularly in finding common ground to optimize the complementary expertise and resources of the private sector<sup>1</sup> while giving due regard to managing risks, including conflicts of interest and undue influence.

7. The fourth high-level meeting of the General Assembly on the prevention and control of non-communicable diseases in 2025 will be a time to reflect on the tragic premature death toll from NCDs of 15 million people each year since 2015 – and which is projected to reach a total of more than 150 million over the previous decade by 2025. It will also provide an opportunity to adopt a new, ambitious and achievable political declaration on NCDs based on evidence and grounded in human rights that will serve as an important framework to accelerate the global NCD response from 2025, including achieving the SDGs before 2030, and place countries on a sustainable path into the next decades.

8. The President of the United Nations General Assembly will convene the fourth high-level meeting of the General Assembly on the prevention and control of non-communicable diseases in 2025. The scope, modalities, format, organization and date of the fourth high-level meeting will be agreed upon by Member States through a separate “modalities” resolution to be adopted at the United Nations General Assembly. The resolution will be negotiated by Member States under the auspices of two co-facilitators, to be appointed by the President of the United Nations General Assembly closer to the meeting. Similarly, the outcome document to be adopted at the fourth high-level meeting will be negotiated by Member States under the auspices of the same two co-facilitators.

### **Preparatory process leading to the fourth high-level meeting in 2025**

9. The preparatory process leading to the fourth high-level meeting includes meetings and consultations co-sponsored by WHO and relevant partners, which may serve as input into the negotiations among Member States on the “modalities” resolution and the outcome document.

10. The preparatory process may also contribute to the development of recommendations that may be included in the 2024 progress report of the United Nations Secretary-General to the United Nations General Assembly on the prevention and control of NCDs.

11. A list of meetings related to the prevention and control of NCDs will be regularly updated on the WHO website.<sup>2</sup>

- **Meetings held in 2021**

- WHO Small Island Developing States Summit for Health
- Global Diabetes Summit
- United Nations Food Systems Summit
- Nutrition for Growth Summit

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<sup>1</sup> Document A71/14.

<sup>2</sup> <https://www.who.int/teams/noncommunicable-diseases/on-the-road-to-2025>, accessed 15 March 2022.

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- Ninth session of the Conference of the Parties to the WHO Framework Convention on Tobacco Control
  - Second session of the Meeting of the Parties to the Protocol to Eliminate Illicit Trade in Tobacco Products
  - Twenty-sixth session of the Conference of the Parties to the United Nations Framework Convention on Climate Change
  - Tenth Global Conference on Health Promotion
  - **Meetings scheduled for 2022**
    - International Strategic Dialogue on NCDs and SDGs
    - High-level technical meeting of national NCD Directors and Programme Managers from Small Island Developing States
  - **Meetings scheduled for 2023**
    - First WHO Ministerial Conference for Small Island Development States on the Prevention and Control of NCDs
    - Second WHO global dialogue on financing national NCDs responses
    - Second high-level meeting of the United Nations General Assembly on universal health coverage
    - Tenth session of the Conference of the Parties to the WHO Framework Convention on Tobacco Control
    - Third session of the Meeting of the Parties to the Protocol to Eliminate Illicit Trade in Tobacco Products
    - Third WHO global meeting of national NCD Directors and Programme Managers
    - Informal consultations with Member States on the recommendations to be included in the report of the United Nations Secretary-General regional preparatory meetings
  - **Meetings scheduled for 2024**
    - Global Conference on People Living with NCDs and Mental Health Conditions
    - Third WHO Global Ministerial Conference on the Prevention and Control of NCDs

12. Activities in the areas of air pollution, mental health conditions (including mental, neurological and substance use disorders), climate change and social determinants of health, including regional meetings and decisions, may also contribute to the development of recommendations that may be included in the 2024 progress report of the United Nations Secretary-General to the United Nations General Assembly on the prevention and control of NCDs.

13. Taking into consideration WHO's leadership and coordination role in promoting and monitoring global action against NCDs, including in relation to the work of other relevant United Nations agencies, development banks, and other regional and international organizations in addressing NCDs in a coordinated manner, the WHO Director-General will prepare the 2024 progress report, in consultation

with Member States, on behalf of the Secretary-General. The format of the report in 2024 will be similar to the format used for the four previous reports.<sup>1,2,3,4</sup>

14. In 2025, Member States will consider the progress report of the United Nations Secretary-General at the United Nations General Assembly. The President of the United Nations General Assembly will appoint two co-facilitators who will preside over the negotiations among the Member States of a “modalities” resolution setting out the scope, modalities, format and organization of the fourth high-level meeting. The co-facilitators will also preside over the negotiations among the Member States on the 2025 outcome document.

15. The fourth high-level meeting will be convened under the auspices of the President of the United Nations General Assembly to consider adopting the outcome document. The high-level meeting will also provide an opportunity for Member States to deliver statements and for Member States, nongovernmental organizations and private sector entities to engage in roundtable discussions.

16. In the run-up to the fourth high-level meeting, WHO will continue to encourage and support all Member States to implement the commitments made at the three high-level meetings of the General Assembly on the prevention and control of non-communicable diseases in 2011,<sup>5</sup> 2014<sup>6</sup> and 2018.<sup>7</sup> To accelerate technical support and impact at the country level all donors need to scale up much-needed financial and technical contributions for the prevention and control of NCDs through bilateral and multilateral channels, including WHO’s programme on NCDs and the United Nations Multi-Partner Trust Fund to Catalyze Country Action for Non-communicable Diseases and Mental Health. WHO also urges relevant non-State actors and people living with NCDs to support local and global efforts to achieve the set of nine voluntary targets set by the World Health Assembly in 2013<sup>8</sup> for 2025 and Sustainable Development Goal target 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).

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<sup>1</sup> Note by the Secretary-General transmitting the report by the Director-General of the World Health Organization on the global status of non-communicable diseases, with a particular focus on the development challenges faced by developing countries (A/65/362) (<https://undocs.org/en/A/65/362>, accessed 3 March 2022).

<sup>2</sup> Prevention and control of non-communicable diseases. Report of the Secretary-General (A/66/83) (<https://undocs.org/en/A/66/83>, accessed 3 March 2022).

<sup>3</sup> Note by the Secretary-General transmitting the report of the Director-General of the World Health Organization on the prevention and control of non-communicable diseases (A/68/650) (<https://undocs.org/A/68/650>, accessed 3 March 2022).

<sup>4</sup> Progress on the prevention and control of non-communicable diseases. Report of the Secretary-General (A/72/662) (<https://undocs.org/en/A/72/662>, accessed 3 March 2022).

<sup>5</sup> <https://www.un.org/en/ga/ncdmeeting2011/>, accessed 3 March 2022.

<sup>6</sup> <https://www.un.org/press/en/2014/ga11530.doc.htm>, accessed 3 March 2022.

<sup>7</sup> <https://digitallibrary.un.org/record/1648984?ln=en>, accessed 3 March 2022.

<sup>8</sup> Resolution WHA66.10 (2013).



## ANNEX 7

### **Acceleration plan to support Member States in implementing the recommendations for the prevention and management of obesity over the life course<sup>1</sup>**

[A75/10 Add.6. Annex 12 – 27 April 2022]

#### **BACKGROUND**

1. In 2021, the Seventy-fourth World Health Assembly adopted resolution WHA74.4, in which it requested the Director-General to develop recommendations for the prevention and management of obesity over the life course, including considering the potential development of targets in this regard.
2. The Secretariat drafted the requested recommendations and targets and included them in Annex 9 to the report by the Director-General on the political declaration of the third high-level meeting of the General Assembly on the prevention and control of non-communicable diseases, which was submitted to the Executive Board at its 150th session.<sup>2</sup>
3. The Executive Board through decision EB150 (4) (2022) decided to recommend that the Seventy-fifth World Health Assembly note the report and its annexes, and adopt the recommendations for the prevention and management of obesity over the life course and the related targets. During the discussions,<sup>3</sup> Member States requested that the recommendations on obesity should be complemented by an acceleration plan clarifying how the Secretariat would support Member States in implementing the recommendations based on individual country needs and priorities, including reporting mechanisms.

#### **SCOPE AND PURPOSE OF THE ACCELERATION PLAN**

4. The acceleration plan aims to consolidate, prioritize and accelerate country-level action against the obesity epidemic through coherent and harmonized efforts across the three levels of the Organization and within the broader ecosystem of support, including other United Nations organizations and multilateral entities, existing coalitions, and non-State actors, i.e. nongovernmental organizations, private sector entities (including international business associations), philanthropic foundations and academic institutions, as well as people living with obesity and their families and communities.
5. Pursuant to WHO's transformation agenda aimed at creating measurable impact at the country level, the acceleration plan focuses on establishing and implementing a data-driven incremental strategy to support an initial subset of countries to tackle and reverse obesity trends, with a view to extending the strategy to other countries at a later date.
6. The acceleration plan sets out an achievable scenario for global action that addresses the multiple drivers of obesity and aims to bring about a change in obesity prevalence and trends over time until

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<sup>1</sup> See decision WHA75(11).

<sup>2</sup> Document EB150/7.

<sup>3</sup> See the summary records of the Executive Board at its 150th session, seventh meeting.

global targets are reached. By plotting a path between present and future global targets, this acceleration scenario can help countries to track progress, correct course where necessary and focus on the ambitious objectives. Acceleration efforts will progressively result in: (i) an increased number of countries implementing effective policies to address prevention and management of obesity; (ii) improved policy efficiency and coverage and expanded access to obesity prevention and management services; and (iii) an improved trend in obesity rates across the life course.

7. In 2019, obesity accounted for approximately 5 million deaths<sup>1</sup> from noncommunicable diseases (cardiovascular disease, diabetes, cancer, neurological disorders, chronic respiratory diseases and digestive disorders), which corresponded to 12% of all deaths from noncommunicable diseases. Reaching the target of zero growth in obesity and diabetes is critical to achieving Sustainable Development Goal target 3.4 of reducing by one-third premature mortality from noncommunicable diseases by 2030. The acceleration plan has therefore been designed to align with the recommendations to strengthen and monitor diabetes responses within national noncommunicable disease programmes, and its timeline matches that of the implementation road map 2023–2030 for the global action plan for the prevention and control of noncommunicable diseases 2013–2030. The acceleration plan has also been drafted to align with broader global nutrition targets and priorities since obesity forms part of the double burden of malnutrition.

8. The acceleration plan will be used to guide the actions of the Secretariat. Its success, however, will rely on country leadership, political commitment and the adoption of a whole-of-society approach where everyone, including people living with obesity and their families and communities, plays a part in tackling obesity.

## **WORKSTREAMS OF THE ACCELERATION PLAN**

9. The acceleration plan will be implemented through five workstreams.

<b>Workstream 1: Identify priority actions for greater impact on the prevention and management of obesity throughout the life course</b>
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10. The Secretariat will continue to provide guidance that enables Member States to design and implement priority actions, including modelling and operational tools to support the rationale for the prioritization and scaling up of interventions.

11. This workstream will include the following elements.

- **Package of prioritized interventions addressing healthy diet and physical activity across multiple settings.** The development of obesity is the result of individual susceptibility (biology, genetic risk and other conditions) coupled with an obesogenic environment. This is influenced by food systems and food environment; urban and built environments; information systems and digital environments; and education, sport, social protection and health systems – and is further impacted by upstream social, commercial and economic determinants. While a comprehensive whole-of-society transformation is needed, there are core interventions that can effectively change the obesogenic environment and support the population at large to prevent and manage obesity. They include: regulations on the harmful marketing of food and beverages to protect children; fiscal and pricing policies to promote

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<sup>1</sup> <https://www.who.int/news-room/facts-in-pictures/detail/6-facts-on-obesity> (accessed 29 March 2022).

healthy diets; nutrition labelling policies; school food and nutrition policies (including initiatives to regulate the sales of products high in fats, sugars and salt in proximity of schools); actions to support the early food environment (such as breastfeeding promotion, protection and support); public education and awareness campaigns; standards and regulations on active travel and physical activity in schools; and integration of obesity prevention and management services into primary health care with associated guidance for secondary and tertiary health care. These prioritized interventions are based on the decisions of the World Health Assembly and WHO recommendations and guidelines, complemented by various implementation tools such as policy briefs, model policies, implementation guides, nutrient profiling systems and nutrient benchmarks.

- **Impact analysis and modelling tool.** This simple, easy-to-use tool calculates the impact of WHO recommended actions on child and adult obesity outcomes and process indicators, with a view to informing policy decision-making on the prioritization and allocation of resources required to implement selected interventions.
- **Obesity prevention and management service delivery framework.** This tool aims to promote expanded access to obesity prevention and management services for all populations across the life course, including people with and at risk of obesity. It facilitates the inclusion of obesity prevention and management as a critical component of universal health coverage. It is based on the principles of primary health care, follows a chronic care approach, and is supported by the integration of obesity prevention and management into existing service delivery frameworks across the health care system, including communities and homes. It also supports the planning of required resources for the scaling up and sustainability of services. The framework is accompanied by an operational guide for country use that enables adaptation across high-, medium- and low-income countries.

## Workstream 2: Support implementation of country actions

12. The Secretariat will provide support that enables Member States to act proactively throughout the obesity policy cycle, from the design of country strategies and action plans to the setting up and implementation of specific policy measures or services. Support will be provided to those countries showing a firm commitment to act. The Secretariat envisages that expressions of interest will be triggered by a group of front-runner countries whose leadership will fuel the global movement to accelerate efforts towards the reduction of obesity.

13. This workstream will include the following elements.

- **Intercountry dialogues.** These dialogues will be conducted with a view to gaining a better understanding of the existing policy landscape, pinpointing current needs, identifying country commitments and developing a blueprint for country action. The Secretariat will work with all Member States to review the respective epidemiological burdens in countries, study existing national strategies and policies and identify common barriers to implementation. The dialogues will also help to establish intercountry collaboration.
- **Individual country road maps.** The Secretariat will engage with Member States and other relevant stakeholders such as United Nations country teams to: review the obesity epidemiological burden and the underlying levers for obesity across different populations in each country; analyse current strategies and integration with other areas, including noncommunicable disease and universal health coverage roll-out; identify existing gaps

and bottlenecks for designing country-specific solutions; set relevant objectives, targets and indicators; determine the resources required for implementation; and develop an acceleration plan with clearly defined actions and supporting activities. It is proposed that delivery labs be convened and a series of structured workshops held in order to engage government officials and country offices in a joint process to design country road maps on obesity prevention and management. The delivery labs would represent an opportunity to: clarify national health sector objectives, including on obesity; prioritize interventions to be implemented; set targets, indicators and acceleration scenarios to track progress; define how country-level stakeholders should be engaged; and identify suitable reporting mechanisms.

- **Technical support.** The Secretariat will support Member States in the implementation of country-specific road maps according to the established timeline. This will include strengthening capacities for action across government and other partners and the establishment of health literacy programmes. It will also involve identifying possible areas of cooperation within the United Nations system, including through multi-year cooperation strategies.

<p><b>Workstream 3: Communicate rationale for action, advocate for the adoption of WHO recommendations and targets and acknowledge progress</b></p>
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14. The Secretariat will develop communication products tailored to the general public and specialized audiences, respectively, that will provide clear rationale for action, generate consensus on solutions and spread a new global narrative on obesity that destigmatizes people living with obesity and includes their views from across the life course in the design and implementation of interventions and services. Communication and advocacy efforts will also be undertaken to expand the group of front-runner countries.

15. This workstream will include the following elements.

- **Communication products on obesity.** The Secretariat will develop advocacy briefs illustrating the guiding principles for action on obesity directed at policy-makers. These briefs will highlight the importance of adopting a whole-of-government, whole-of-society approach as well as a life-course approach to obesity, and will include messages designed to build support for policy adoption. The Secretariat will also produce videos, public broadcasts, web publications, photo essays and social media packages to support the involvement in tackling the obesity epidemic of people living with obesity and raise the general public's awareness of their needs.
- **Global progress reports.** These reports will describe the global progress made towards tackling the obesity epidemic, including actions taken, bottlenecks hindering implementation and country case studies. They will also be used to acknowledge country-level progress.
- **Blueprints for country-level public information campaigns and communication plans.** These blueprints will contain public information campaigns and communication plans designed to be rolled out in a synchronized manner across regions and countries, jointly with United Nations organizations and civil society stakeholders, including the World Obesity Federation and associations representing people living with obesity. Using these blueprints, joint communication campaigns could be organized on World Obesity Day.

**Workstream 4: Promote the engagement of multiple stakeholders in support of country action**

16. The Secretariat will promote the engagement of partners in support of the acceleration plan and will assist Member States in their efforts to establish appropriate stakeholder engagement. It will also reach out to other stakeholders with similar mandates operating in the same space at the global, regional and country levels to optimize resources and amplify impact.

17. This workstream will include the following elements.

- **Stakeholder mapping and engagement.** The Secretariat will support mapping and analysis at the country, regional and global levels to assess the potential role of stakeholders in the implementation of country road maps and in the monitoring and review of county-level actions. This will include: United Nations organizations and other multilateral entities; governmental organizations; non-State actors; and associations representing people living with obesity and noncommunicable diseases. The Secretariat will support Member States in convening dialogues with all relevant stakeholders and will offer guidance on engagement strategies, including mechanisms to promote harmonization and reduce the risk of conflicts of interest.
- **Support for the establishment of an ecosystem to address obesity at the global and national levels.** The Secretariat will engage with United Nations organizations, non-State actors, existing coalitions and networks, such as the Obesity Coalition (led by WHO, the World Obesity Federation and UNICEF) and other physical activity and city networks, to mobilize support for the implementation of country road maps.

**Workstream 5: Monitor progress towards global obesity targets**

18. The Secretariat will support the establishment of monitoring and review mechanisms at the country level and will provide periodic global reports on progress made towards reducing obesity rates.

19. This workstream will include the following elements.

- **Development of monitoring tools.** The Secretariat will develop operational guidance on how to collect and analyse data and measure progress towards the global obesity targets. It will also publish a set of criteria to evaluate overall progress in implementing the priority interventions identified in paragraph 2 above. This operational guidance will similarly include a section on how to collect and evaluate data related to changes in the underlying drivers of obesity, through mechanisms streamlined with existing reporting systems. The Secretariat will further provide support for the design of review mechanisms at the country and regional levels, including the development of targets and indicators for tracking progress against global obesity targets. National stocktaking meetings and case studies will also be conducted.
- **Comprehensive reports on progress towards global obesity targets and in the implementation of policies and programmes.** The Secretariat will regularly report on the progress made towards the achievement of global obesity targets, as part of reporting requirements under the acceleration plan. These reports will be submitted to the World Health Assembly on a biannual basis, jointly with reports on noncommunicable diseases.

## ANNEX 8

### **Implementation road map 2023–2030 for the global action plan for the prevention and control of noncommunicable diseases 2013–2030<sup>1</sup>**

[A75/10 Add.8, Annex 1 – 27 April 2022]

1 [Paragraph 1 described the mandate for the development of the road map.]

#### **Scope, purpose, and modalities**

2 The global attention paid to noncommunicable diseases (NCDs) over the past two decades has been insufficient to reduce the burden of NCDs against the nine voluntary targets of the global action plan for the prevention and control of noncommunicable diseases 2013–2030 (NCD-GAP) and Sustainable Development Goal (SDG) target 3.4 (By 2030, reduce by one third premature mortality from NCDs through prevention and treatment and promote mental health and well-being) as measured by SDG indicator 3.4.1 (Mortality rate attributed to cardiovascular disease, cancer, diabetes or chronic respiratory disease). There has also not been a significant change in the trends for NCD risk factors, except for tobacco use, across the WHO regions over the past decade.<sup>2</sup> Health system capacity has not kept up with the needs of NCDs and is reflected in the lack of progress in the NCD service coverage domain of the Universal Health Coverage Global Monitoring Report.

3 The heterogeneity in the epidemiology of NCDs across countries and regions, as well as local sociocultural, economic and political contexts, implies that countries need to take divergent domestic routes towards meeting SDG target 3.4 and the NCD-GAP targets. Pathway analyses show that every country still has options for achieving the global NCD targets.<sup>3</sup> Combinations of priority interventions for risk factors and diseases specific to the in-country context, along with domestic capacity for ensuring action across government sectors, can help in the acceleration of NCD response.<sup>4,5</sup>

4 The purpose of the implementation road map is to guide and support Member States to take urgent measures, in 2023 and beyond, to accelerate progress and reorient and accelerate their domestic action plans with a view to placing themselves on a sustainable path to meeting the nine voluntary global NCD targets and SDG target 3.4.

5 The NCD-GAP with its six objectives will be the guidance for the development and strengthening of national NCD response plans. The NCD Global Monitoring Framework's nine voluntary global targets for 2025 will remain as they are, with the premature mortality target aligned to SDG target 3.4

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<sup>1</sup> See decision WHA75(11).

<sup>2</sup> World Health Statistics 2020. A visual summary. Geneva: World Health Organization; 2020.

<sup>3</sup> NCD Countdown Collaborators. NCD Countdown 2030: pathways to achieving Sustainable Development Goal target 3.4. *Lancet*. 2020; 396:918–934. doi: 10.1016/S0140-6736(20)31761-X.

<sup>4</sup> In line with United Nations General Assembly resolution 68/300, para. 30(a)(vii).

<sup>5</sup> In line with United Nations General Assembly resolution 68/300, para. 30(a)(viii).

and the target for reducing physical inactivity updated by the Health Assembly in 2021.<sup>1</sup> The target on reducing harmful use of alcohol is under revision and the outcome will be used for the road map.

6 The implementation road map, while focusing on the “4 by 4 NCD agenda” (tobacco use, the harmful use of alcohol, unhealthy diet, physical inactivity, cardiovascular diseases, cancer, diabetes and chronic respiratory diseases) as per the mandate, will have to be implemented in full alignment with the commitments to reduce air pollution and promote mental health and well-being (the “5 by 5 NCD agenda”).<sup>2</sup>

7 The development of the road map will be completed before the end of 2022 as a technical product that will integrate all WHO recommended interventions and technical packages for the prevention and control of NCDs. It will also catalyse action in other areas of work against NCDs such as eye, ear and hearing care. The road map is expected to serve as an overarching guide for regions and countries, United Nations organizations and non-State actors to accelerate ongoing national NCD responses, including by strengthening and reorienting multisectoral action plans; scaling up health system capacity for NCDs through primary health care and universal health coverage; and strengthening national capacity, leadership, governance and partnerships for the period 2023 to 2030, taking into account new developments since 2013.

### **Strategic directions for implementing the global action plan for the prevention and control of noncommunicable diseases 2013–2030**

**Strategic direction 1: Accelerate national response based on the understanding of noncommunicable disease epidemiology and risk factors and the identified barriers and enablers in countries**

#### **1.1 EVALUATE THE PROGRESS MADE IN ACHIEVING THE TARGETS ON PREVENTION AND CONTROL OF NONCOMMUNICABLE DISEASES**

8 WHO has updated the data on cause-specific mortality to characterize the risk and trends in NCD mortality in each country and has evaluated combinations of NCDs that contribute to premature mortality. Heat maps for each country have been published on WHO’s website to indicate the probability of premature death from NCDs.<sup>3</sup>

#### **1.2 Identify barriers to implementing cost-effective interventions across prevention and control of noncommunicable diseases**

9 A number of common domestic challenges to implement the best buy and other recommended interventions for the prevention and control of NCDs were identified in the report of the United Nations Secretary-General to the General Assembly in 2017.<sup>4</sup> However, countries should complement and contextualize specific barriers and enablers relevant in their national contexts.

10 Countries should systematically examine their progress using WHO guidance and tools, in introducing evidence-based national guidelines, protocols and standards for the prevention and

<sup>1</sup> See resolution WHA71.6 (2018).

<sup>2</sup> See document A72/19.

<sup>3</sup> Implementation road map 2023–2030 for the global action plan for the prevention and control of NCDs 2013–2030. Geneva: World Health Organization.

<sup>4</sup> See document A71/14.

management of NCDs, including health system strengthening in primary health care and including NCDs in universal health coverage, policies for inclusion of NCDs in emergencies in humanitarian settings<sup>1</sup> and migrants, among other vulnerable groups and policies for NCDs research. Reducing inequity is critical for achieving the desired outcomes.

11 The continuing pandemic of coronavirus disease (COVID-19) poses further challenges for creating and maintaining healthy environments and people living with NCDs are at increased risk of severe illness and death due to COVID-19. NCDs needs to be part of the national preparedness and response plans. The economic effects of the pandemic are likely to have a long-term impact on NCD prevention and control.

**Strategic direction 2: Prioritize and scale up the implementation of most impactful and feasible interventions in the national context**

## 2.1 ENGAGE

12 Countries should accelerate their capacity for multisectoral and multistakeholder collaborations at national and subnational levels, including by identifying complementary opportunities where non-State-actors can contribute to strengthening the national NCD response.

13 Heads of State and Government can provide strategic leadership for the prevention and control of NCDs by promoting policy coherence and coordination through whole-of-government and Health in All Policies approaches and by engaging stakeholders, when appropriate and taking due consideration of their potential conflict of interest with public health goals.<sup>2,3</sup>

14 The WHO's global coordination mechanism on the prevention and control of noncommunicable diseases (GCM/NCD) will facilitate the multisectoral collaboration and multistakeholder engagement for strengthening national NCD responses and sustain the meaningful involvement of people living with NCDs in support of effective, equitable and inclusive national NCD policies, programmes and services.

15 Meaningful engagement of people with lived experience of NCDs in co-creation, co-design, implementation and accountability should be a key element of delivering interventions in a people-centred manner.<sup>4</sup> Such collaborations can be fostered by civil society organizations, many of which are formed and supported by patients and their families.

16 International partners can support and strengthen research and innovation by working with academic partners and research institutions in countries.

17 Countries may consider optimizing the complementary expertise and resources of private sector actors in health care systems, the availability of medicines, service delivery and monitoring, while giving due regard to managing conflicts of interest<sup>5</sup> and ensuring that such engagements directly contribute to

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<sup>1</sup> Integrating NCD care in humanitarian settings. An operational guide. Geneva: UNHCR; 2020 (<https://www.unhcr.org/5fb537094.pdf>, accessed 1 December 2021).

<sup>2</sup> United Nations General Assembly resolution 73/2, para. 17.

<sup>3</sup> United Nations General Assembly resolution 73/2.

<sup>4</sup> Nothing for Us Without Us. Geneva: World Health Organization; 2021.

<sup>5</sup> In line with United Nations General Assembly resolution 73/2, para. 43.



the implementation of national NCD responses to reach specific health objectives.<sup>1</sup> WHO will develop a tool to support national governments in assessing the landscape and meaningfully engaging with the private sector in NCD prevention and control.

18 The United Nations Interagency Task Force on the Prevention and Control of Non-Communicable Diseases will ensure that the road map is fully supported by the United Nations system as a whole, in line with the Task Force's strategic priorities, which include: (i) supporting countries to deliver multisectoral action on meeting NCD-related SDG targets; (ii) mobilizing resources to support the development of national responses; and (iii) harmonizing action and forging partnerships. The new United Nations Multi-Partner Trust Fund to Catalyze Country Action for Non-communicable Diseases and Mental Health, which has been established by WHO, UNICEF and UNDP, will be an enabler for implementing the road map.

## 2.2 ACCELERATE

### 2.2.1 Accelerate and invest in the implementation of the most cost-effective and feasible noncommunicable disease interventions in the national context

19 WHO best buy and other recommended interventions<sup>2</sup> are a set of cost-effective and feasible interventions for implementation in all settings, especially in low-income and lower-middle-income countries. WHO will propose updates to the set of interventions to the World Health Assembly in 2023, through the Executive Board.<sup>3</sup> The updated set of cost-effective interventions for NCD prevention and management will be a guide to select locally relevant and scalable interventions.

20 At the national level, the Global Strategy to Accelerate Tobacco Control: Advancing Sustainable Development through the Implementation of the WHO Framework Convention on Tobacco Control 2019–2025,<sup>4</sup> WHO's global strategy to reduce the harmful use of alcohol and its global action plan, WHO's global action plan on physical activity 2018–2030<sup>5</sup> and WHO guidance and tools for promoting a healthy diet<sup>6</sup> should be implemented to scale, fostering coherence across sectors and also making them part of good governance in every country.

21 Countries can implement fiscal measures, as appropriate, aiming at minimizing the impact of the main risk factors for NCDs.<sup>7</sup> Countries can therefore include health taxes in their revenue programmes and link these to NCD prevention and control. Within the recommended packages for reducing the use of tobacco and the harmful use of alcohol, raising excise taxes on tobacco and alcohol products are among the most effective and cost-effective measures.

22 Countries can invest adequate, predictable and sustainable resources for the prevention and control of NCDs through domestic, bilateral, regional and multilateral channels, including traditional

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<sup>1</sup> In line with United Nations General Assembly resolution 73/2, para. 44.

<sup>2</sup> Updated Appendix 3 to the NCD–GAP. Geneva: World Health Organization; 2017.

<sup>3</sup> In line with paragraph 3(a) of decision WHA72(11) (2019).

<sup>4</sup> Geneva: World Health Organization; 2019.

<sup>5</sup> Geneva: World Health Organization; 2018.

<sup>6</sup> Healthy diet. Geneva: World Health Organization; 2020 (<https://www.who.int/news-room/fact-sheets/detail/healthy-diet>, accessed 1 December 2021).

<sup>7</sup> In line with para. 21 of United Nations General Assembly resolution 73/2.

and voluntary innovative financing mechanisms.<sup>1</sup> Addressing NCDs is an attractive investment for countries. Cost-effective, high-impact interventions exist through WHO special initiatives and technical packages but are not sufficiently implemented and scaled up in countries.

23 With the support of partners, WHO has developed special initiatives and technical packages for reducing NCD risk factors, control of the four major NCDs and rehabilitation for people experiencing disability in order to enable countries to implement evidence-based interventions. The packages include tools to support local adaptation and implementation. Detailed descriptions of the available packages and initiatives are available on the website.<sup>2</sup>

### **2.2.2 A web-based simulation tool to select a prioritized set of noncommunicable disease interventions for countries**

24 To support countries in prioritizing and scaling up interventions, a web-based simulation tool will be developed in 2022. It will use mathematical models to estimate the health impact of the recommended interventions at the national level in the period up to 2030 and beyond. A visual representation of the scale to which the intervention can be implemented and the corresponding impact on premature mortality will help countries to identify a set of key accelerators tailored to their specific epidemiological situation. The tool developed by the University of Washington for cardiovascular diseases is a prototype of the proposed tool.<sup>3</sup>

### **2.2.3 Strengthen noncommunicable disease prevention and control in primary health care for promoting equitable access and quality of care**

25 NCD prevention and control is weak in primary health care in many countries. The strengthening and scale-up of NCD interventions in primary health care will help to improve access and equitable coverage. Primary care is the first responder and gatekeeper for NCDs. Early diagnosis and good control of NCDs and their risk factors in primary care will reduce the disease complications that are leading to catastrophic health expenditures and premature deaths. The Operational Framework for Primary Health Care<sup>4</sup> provides guidance for countries to strengthen primary health care systems through intersectoral actions and by empowering individuals and communities. The WHO PEN app provides the package for primary care as an easy access digital solution.<sup>5</sup> Referral care is also critical to manage complications of NCDs.

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<sup>1</sup> See paragraph 45(d) of the political declaration of the high-level meeting of the General Assembly on the prevention and control of non-communicable diseases (A/RES/66/2) (<https://undocs.org/Home/Mobile?FinalSymbol=A%20FRES%2066%202&Language=E&DeviceType=Desktop&LangRequested=False>, accessed 7 April 2022).

<sup>2</sup> Governance of WHO's leadership and coordination role in promoting and monitoring global action against noncommunicable diseases. Geneva: World Health Organization.

<sup>3</sup> Calculating lives saved by cardiovascular health interventions. University of Washington (<https://dcp-uw.shinyapps.io/RTSL2/>, accessed 1 December 2021).

<sup>4</sup> World Health Organization and United Nations Children's Fund; 2020.

<sup>5</sup> WHO Package of Essential Noncommunicable (PEN) disease interventions for primary health care. Geneva: World Health Organization; 2020.

### **2.2.4 Ensure that universal health coverage benefit packages include prevention and control of noncommunicable diseases**

26 Progressive realization of universal health coverage can contribute to the achievement of the right to health. Consideration of the positive value of financial risk protection is particularly relevant for NCD priority-setting given the long-term cost implications for the patient and their household. The 2019 Global Monitoring Report indicates that there has been no pronounced progress for the NCD component since 2000 and this situation will have to be addressed in all countries.<sup>1</sup>

27 The WHO UHC Compendium provides a set of interventions for NCD and risk factors that can be included in national universal health coverage benefit packages. Universal health coverage is not comprehensive or universal until essential NCD packages and services are included and scaled up.

28 Countries will need to balance the demands of responding directly to the COVID-19 pandemic with preparing for other health emergencies, while maintaining strategic planning and coordinated action to maintain essential health service delivery, especially for NCDs.<sup>2</sup>

### **2.2.5 Sustainable financing**

29 Sustainable financing is required for countries to support population-level interventions and reduce the unmet need for services and financial hardship arising from out-of-pocket payments. Countries should incrementally increase the allocation for health and within that for NCDs. This also involves improving the effectiveness of catalytic funding support. Out-of-pocket expenditure can be reduced only when NCDs are well covered under financial protection schemes in countries.

### **2.2.6 Build back better with implementation research, innovation and digital solutions**

30 Meeting the objectives and targets of the NCD-GAP and SDG target 3.4 in a post-COVID-19 world requires a concerted response and integration of the NCD agenda into existing global and national efforts to rebuild resilient health systems.

31 Implementation research can identify how to implement policies and interventions in contexts in which populations and/or resources may differ from the contexts in which they were initially formulated and evaluated. It can also identify the reasons for the lack of impact in programme implementation.<sup>3</sup>

32 New technologies, including digital interventions, can be leveraged to scale up population-wide screening and early diagnosis and support self-care and management for people living with NCDs.

33 Service delivery models will have to be reviewed and repurposed to ensure that basic diagnostics, technology and medicines, along with a trained workforce in adequate numbers, are available to deliver interventions for NCDs.

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<sup>1</sup> Primary Health Care on the Road to Universal Health Care. 2019 Global Monitoring Report. Geneva: World Health Organization; 2019.

<sup>2</sup> COVID-19 Partners Platform. Pillar 9. Geneva: World Health Organization.

<sup>3</sup> A guide to implementation research in the prevention and control of noncommunicable diseases. Geneva: World Health Organization; 2016.

## 2.3 ALIGN

34 The Global Action Plan for Healthy Lives and Well-being for All<sup>1</sup> brings together stakeholders to accelerate progress towards the health-related SDGs, including NCD-related goals and targets. As countries are advancing multiple SDG targets, this alignment will help to integrate the prevention and management of NCDs within the broader SDG Agenda.

35 The NCD implementation road map recognizes that mental disorders and other mental health conditions contribute to the global NCD burden. The efforts to meet the objectives of the comprehensive mental health action plan 2013–2030 aligns with the expansion of the “4 by 4 NCD agenda” to the “5 by 5 NCD agenda” encompassing mental health and air pollution, as well as synergizing with SDG indicator 3.4.2 (Suicide mortality rate). The WHO menu of cost-effective interventions for mental health<sup>2</sup> and the WHO air quality guidelines<sup>3</sup> can be considered along with other NCD interventions, as appropriate to the local context.

36 Health promotion and health literacy are enablers for tackling NCD prevention and control, decreasing the NCD burden and ensuring sustainability of health systems. Settings-based approaches, especially healthy settings, can help to amplify NCD interventions, including actions to address socioeconomic and commercial determinants.

**Strategic direction 3: Ensure timely, reliable and sustained national data on noncommunicable disease risk factors, diseases and mortality for data driven actions and to strengthen accountability**

## 3.1 ACCOUNT

37 Investing in surveillance and monitoring is essential to obtain reliable and timely data at the national and subnational levels in order to prioritize interventions, assess implementation and learn from the impact of NCD prevention and control. Periodic NCD risk-factor surveys, country capacity assessments, disease registries, health facility-level data, as appropriate, and reliable vital registration are critical for prioritizing and selecting the most appropriate and cost-effective interventions for NCD prevention and control.

38 WHO will update the status of NCD prevention and control through a web portal to bring together data from different sources and render it comparable in order to allow the tracking of global, regional and cross-country progress. Countries should be able to track their progress across the NCD Global Monitoring Framework in the web portal. WHO will work towards reflecting NCD-related indicators in health systems performance and access to health care metrics.

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<sup>1</sup> Stronger Collaboration, Better Health. Geneva: World Health Organization; 2019.

<sup>2</sup> WHO menu of cost-effective interventions for mental health. Geneva: World Health Organization; 2021.

<sup>3</sup> WHO global air quality guidelines. Particulate matter (PM<sub>2.5</sub> and PM<sub>10</sub>), ozone, nitrogen dioxide, sulfur dioxide and carbon monoxide. Geneva: World Health Organization; 2021.

39 NCD measures should be included as integral components of the national and subnational health information systems aligned with the WHO SCORE package.<sup>1</sup>

## **RECOMMENDED ACTIONS**

### **The recommended actions for Member States to be taken in 2022 include:**

40 Assess the current status of domestic NCD responses against the nine global voluntary NCD targets and the SDG target on NCDs and identify the barriers and opportunities for scaling up the national NCD response, including:

- (a) strengthen the national capacity for the governance of multistakeholder engagement, cross-sectoral collaboration and meaningful and effective partnerships;
- (b) strengthen national monitoring and surveillance systems for NCDs and their risk factors for reliable and timely data; and
- (c) prioritize research to enhance the understanding of the epidemiology of NCDs and their risk factors, their social, economic and commercial determinants and multilevel and multisectoral governance, and invest in translational and implementation research to advance NCD prevention and control.

### **The recommended actions for international partners to be taken in 2022 include:**

41 Assist and support in the development of the implementation road map across the strategic directions and actions at the global, regional, country and local levels.

### **The recommended actions for the Secretariat to be taken in 2022 include:**

42 Complete the development of the implementation road map 2023–2030 for the NCD-GAP and publish it (as a technical product – WHO public health good), including:

- (a) develop an NCD data portal in order to provide a visual summary of all NCD indicators and to facilitate countries in tracking their progress;
- (b) develop heat maps for countries to identify specific NCDs and their contribution to the premature mortality;
- (c) propose updates focused on the prevention and management of NCDs to Appendix 3 to the NCD GAP 2013–2030,<sup>2</sup> in consultation with Member States, United Nations organizations and non-State actors, for consideration by the governing bodies;
- (d) develop a web-based simulation tool, using interventions for NCDs that are updated with the latest evidence and aligned to PHC and UHC frameworks in order to support countries in identifying priority interventions-based on their national context;

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<sup>1</sup> SCORE for Health Data Technical Package. Geneva: World Health Organization (<https://www.who.int/data/data-collection-tools/score>, accessed 1 December 2021).

<sup>2</sup> Updated Appendix 3 to the NCD-GAP. Geneva: World Health Organization; 2017.

- (e) develop guidance in order to promote policy coherence for NCDs and risk factors among all relevant government sectors and involving relevant stakeholders, by establishing or strengthening national governance mechanisms that can guide integrated, coordinated, coherent NCD responses;
  - (f) develop guidance to support Member States in making informed decisions on pursuing meaningful multistakeholder collaboration, including with the private sector and civil societies, that aligns with and further advances national NCD responses;
  - (g) use the WHO Innovation Scaling Framework to help to scale up NCD prevention and control by harnessing research, innovation and digital solutions; and
  - (h) develop guidance for the meaningful engagement of people living with NCDs and mental health conditions in order to support WHO and Member States in the co-development and co-design of NCD principles, policies, programmes and services.
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## ANNEX 9

### **Recommendations to strengthen and monitor diabetes responses within national noncommunicable disease programmes, including targets<sup>1</sup>**

[EB150/7, Annex 2 – 11 January 2022]

#### **CHALLENGES AND OPPORTUNITIES**

1. Never in the past has our knowledge been so profound and the modalities to prevent diabetes and treat all people living with diabetes so great. And yet, many people and communities in need of effective prevention, life-enhancing and life-saving treatment for diabetes do not receive them.

(a) The global age-adjusted prevalence of diabetes among adults over 18 years of age rose from 4.7% in 1980 to 8.5% in 2014.<sup>2</sup> Today, more than 420 million people are living with diabetes worldwide. This number is estimated to rise to 578 million by 2030 and to 700 million by 2045.<sup>3</sup> One in two adults with diabetes are unaware of their condition.

(b) Diabetes is a major cause of blindness, kidney failure, heart attacks, stroke and lower limb amputation, especially in people who are unaware of the condition or if it is insufficiently managed.

(c) People with type 1 diabetes need insulin to survive. Today there is a high prevalence of diabetic ketoacidosis at the point of diagnosis worldwide. Efforts to improve earlier diagnosis of diabetes is critical for type 1 diabetes and initiation of insulin treatment in order to prevent deaths.<sup>4</sup>

(d) Although the overall number of diabetes deaths increased markedly from 2000 to 2019, the proportion of diabetes deaths occurring under the age of 70 has decreased by 2%.<sup>5</sup>

(e) The increasing prevalence of type 2 diabetes is largely caused by the increasing prevalence of obesity and concurrent physical inactivity. The global prevalence of overweight and obesity among children and adolescents aged 5–19 has risen dramatically, from 4% in 1975 to more than

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<sup>1</sup> See decision WHA75(11).

<sup>2</sup> Global report on diabetes. Geneva: World Health Organization; 2016.

<sup>3</sup> Saeedi P, Petersohn I, Salpea P, Malanda B, Karuranga S, Unwin N, et al. IDF Diabetes Atlas Committee. Global and regional diabetes prevalence estimates for 2019 and projections for 2030 and 2045: Results from the International Diabetes Federation Diabetes Atlas, 9th edition. *Diabetes Res Clin Pract* 2019;157:107843. doi: 10.1016/j.diabres.2019.107843.

<sup>4</sup> Cherubini, V, Grimsman, JM, Åkesson, K, Birkebæk, NH, Cinek, O, Dovč, K, et al. Temporal trends in diabetic ketoacidosis at diagnosis of paediatric type 1 diabetes between 2006 and 2016: results from 13 countries in three continents. *Diabetologia*, 63(8), 1530–1541. doi: 10.1007/s00125-020-05152-1.

<sup>5</sup> Global Health Estimates 2019: Deaths by Cause, Age, Sex, by Country and by Region, 2000–2019. Geneva: World Health Organization; 2020.

18% in 2016.<sup>1</sup> In 2019, only 40% of countries have an operational policy that addresses overweight and obesity.<sup>2</sup> Tobacco smokers are 30–40% more likely to develop type 2 diabetes than non-smokers.<sup>3</sup>

(f) The global cost of diabetes has been estimated at US\$ 1 trillion–31 trillion or 1–8% of global gross domestic product (GDP) in 2015. While the main drivers of cost are hospital inpatient and outpatient care, indirect costs accounted for 34.7% of the total burden, mostly attributable to production losses due to labour-force dropout and premature mortality.<sup>4</sup>

(g) Some 27 % of countries do not have an operational policy, strategy or action plan for diabetes, while 20% do not have one for reducing unhealthy diets and physical inactivity.<sup>1</sup>

(h) Limited progress has been seen in preventing and treating diabetes as part of efforts to meet target 3.8 of the Sustainable Development Goals (SDGs)(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 2019 Global Monitoring Report shows that diabetes health services are conspicuous by their lack of progress as part of universal health coverage in comparison to those for communicable diseases.<sup>5</sup> Only two thirds of countries report having time-bound noncommunicable disease (NCD) targets, which may include targets of no increase in diabetes and obesity and improved access to medicines and technologies, in line with the nine voluntary global targets of the WHO Global Monitoring Framework. A recent review by the Secretariat of progress towards the target of halting the rise of diabetes against a 2010 baseline showed that only 14 countries are expected to be on track by 2025, with no additional countries achieving the target by 2030.

(i) In general, primary health care facilities in low-income countries do not have the basic technologies needed to diagnose and manage diabetes.<sup>1</sup> Globally, essential medicines for diabetes are reported to be generally available in about 80% of facilities in the public health care sector.<sup>1</sup> However, they are available in only about one half of such facilities in low-income and lower-middle-income countries.

(j) Insulin and associated health technology products remain unaffordable in many countries, particularly for patients paying out-of-pocket or for health systems in many low- and middle-income countries that are unable to provide sustained and equitable coverage for all people with diabetes due to the high prices of these products. Effective public policy-making to increase

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<sup>1</sup> Obesity and overweight. Key facts. Geneva: World Health Organization; 2021 (<https://www.who.int/news-room/fact-sheets/detail/obesity-and-overweight>, accessed 1 December 2021).

<sup>2</sup> Assessing national capacity for the prevention and control of noncommunicable diseases: report of the 2019 global survey. Geneva: World Health Organization; 2020.

<sup>3</sup> The Health Consequences of Smoking—50 Years of Progress. A Report of the Surgeon General. Executive Summary. Rockville, MD, U.S. Department of Health and Human Services; 2014 (<https://www.hhs.gov/sites/default/files/consequences-smoking-exec-summary.pdf>, accessed 1 December 2021).

<sup>4</sup> Bommer C, Heeseemann E, Sagalova E, Manne-Goehler J, Atun R, Bärnighausen T, et al. The global economic burden of diabetes in adults aged 20–79 years: a cost-of-illness study. *Lancet Diabetes Endocrinol* 2017; 5: 423–30. doi: 10.1016/S2213-8587(17)30097-9.

<sup>5</sup> Primary Health Care on the Road to Universal Health Care. 2019 Global Monitoring Report. Geneva: World Health Organization; 2019.



access to affordable medicines and health products requires the use of evidence derived from the accurate analysis of reliable and transparent data on prices and availability.<sup>1,2</sup>

(k) The COVID-19 pandemic has revealed the fragility of overstretched health care systems. A 2020 WHO survey indicated that half of the countries surveyed had partially or completely disrupted services for the diagnosis and treatment of diabetes and diabetes-related complications. One third of countries did not have diabetes in their emergency preparedness plans.<sup>3</sup>

(l) Data on diabetes derived from monitoring and surveillance systems in most countries are sparse and inadequate. Only 56% of countries have conducted a diabetes prevalence survey within the past five years. While 50% of countries, mostly high-income countries, report having diabetes registries, their predominantly hospital-based nature and limited coverage do not provide sufficient information on diabetes outcomes.<sup>4</sup> Two thirds of countries do not have civil vital registration systems to capture information on cause of death. Therefore, the reliability of information on the attributable mortality related to diabetes is doubtful.

(m) In 2019, only one third of countries report having a policy or plan for NCD research and research is among the least-funded key actions of the global action plan for the prevention and control of NCDs 2013–2030 (NCD-GAP).

2. Opportunities exist to facilitate solutions to the challenges. The main opportunities are:

(a) **Tracer for all NCDs:** The optimal management of diabetes requires coordinated inputs from a range of health professionals, access to essential medicines and technologies and a system that supports patient empowerment. This has relevance beyond diabetes and diabetes could serve as a tracer condition for general comprehensiveness and the strength of national responses to NCDs.

(b) **A solid basis for scaling up:** In 2019, 85% of countries report having staff dedicated to diabetes in their NCD unit/branch/department, while 73% of countries report having an operational policy, strategy or action plan on diabetes, an increase of 45% relative to 2010. In addition, 80 % of countries report having operational policies or strategies for reducing unhealthy diet and physical inactivity and 84% of countries report having national diabetes management guidelines that are used in at least 50% of health facilities.<sup>5</sup> While policies and programmes are reported to be in place in several countries, there are no clear monitoring framework or nationally agreed targets and indicators to assess the impact of these policies on diabetes prevention and control. Setting targets and indicators could stimulate effective implementation.

(c) **Towards universal health coverage:** The political commitments towards universal health coverage to achieve SDG target 3.8 is an opportunity to include diabetes prevention and control

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<sup>1</sup> Babar ZUD, Ramzan S, El-Dahiyat F, Tachmazidis I, Adebisi A, Hasan SS. The availability, pricing, and affordability of essential diabetes medicines in 17 low-, middle- and high-income countries. *Frontiers in pharmacology* 2019;10:1375. Doi: 10.3389/fphar.2019.01375.

<sup>2</sup> WHO guideline on country pharmaceutical pricing policies. Geneva: World Health Organization; 2015.

<sup>3</sup> The impact of the COVID-19 pandemic on noncommunicable disease resources and services: results of a rapid assessment. Geneva: World Health Organization; 2020.

<sup>4</sup> Global report on diabetes. Geneva: World Health Organization; 2016.

<sup>5</sup> Assessing national capacity for the prevention and control of noncommunicable diseases: report of the 2019 global survey.2020. World Health Organization. Geneva .

in benefit packages and address diabetes more effectively and equitably, as well as to ensure financial protection for the most vulnerable.

(d) **A new perspective on NCDs:** The COVID-19 pandemic has disproportionately affected people with diabetes and this can provide an impetus to better integrate diabetes in pandemic and other emergency preparedness and response.

(e) **Marking the 100-year anniversary of insulin:** The establishment of the Global Diabetes Compact offers an opportunity for the global diabetes community to come together to reflect on addressing barriers in accessing insulin and associated health technologies, including the promotion of convergence and the harmonization of regulatory requirements for insulin and other medicines and health products for the treatment of diabetes, as well as the assessment of the feasibility and potential value of establishing a web-based tool to share information relevant to the transparency of markets for diabetes medicines and health products.

(f) **Harnessing digital technologies:** Increasing the use of digital technologies and improving digital literacy could enhance patient education and self-care, improve the capacity to assess and report on risk factors, on the availability and real need of essential medicines, as well as contributing to better diabetes care and outcomes. Initiatives such as the Be Healthy Be Mobile initiative, if applied to diabetes treatment, provide guidance and resources to assist countries and governments in introducing and scaling up digital solutions for diabetes.<sup>1</sup>

(g) **Promoting inclusiveness:** The participation of people living with diabetes and their caregivers provides essential expertise to positively impact policy design and powerful narratives to raise awareness of diabetes among the public and build commitment among policymakers. The involvement and active participation of people living with diabetes in the Global Diabetes Compact provides a platform and model for their meaningful participation and co-creation of solutions.

## SETTING DIABETES COVERAGE TARGETS

3. The Secretariat, supported by an academic group, developed an approach to setting diabetes coverage targets based on a draft proposal.<sup>2</sup> The draft proposed coverage targets were subsequently discussed at a technical consultation, held on 28–29 July 2021, seeking additional expert advice on refining the methods and selection approach. The technical background paper used to develop the targets is available on WHO's website along with the current discussion paper.<sup>2</sup>

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<sup>1</sup> Be Healthy Be Mobile. A handbook on how to implement mDiabetes. Geneva: World Health Organization; 2016.

<sup>2</sup> Gregg E, Buckley J, Ali MK, Davies J, Flood D, Griffiths B, et al. Target Setting to Reduce the Global Burden of Diabetes Mellitus by 2030: (unpublished data). Geneva: World Health Organization; 2021 (<https://www.who.int/publications/m/item/improving-health-outcomes-of-people-with-diabetes-mellitus>, accessed 1 December 2021).

4. The process of selecting and prioritizing the five global diabetes coverage targets entailed the following steps:

- (a) the review and development of a taxonomy of potential target metrics organized across four domains (policy or system-level factors; processes of care; intermediate outcomes; and long-term health outcomes) and risk tiers (diagnosed diabetes; high risk; whole population);
- (b) the prioritization of a subset of metrics, based on four criteria:
  - health importance or strong evidence for prediction or benefit with respect to important health outcomes;
  - modifiable and feasible via scalable interventions across diverse settings;
  - global data availability and ease of measurement, the metric being either currently available or plausibly available through scale-up of practical surveillance approaches; and
  - international gap and disparity, with a large proportion of the population affected and large international variations in term of target achievement;
- (c) the review of the current global status of the prioritized five metrics in terms of variation, levels, trends and coverage (this assessment informed the decision to set the levels of the targets); and
- (d) the estimation of the projected health impact associated with meeting versus not meeting the coverage targets.

5. Following this process, the Secretariat recommends that five global diabetes coverage targets be established for achievement by 2030:

- 80% of people with diabetes are diagnosed;<sup>1</sup>
- 80% of people with diagnosed diabetes have good control of glycaemia;
- 80% of people with diagnosed diabetes have good control of blood pressure;
- 60% of people with diabetes of 40 years or older receive statins; and
- 100% of people with type 1 diabetes have access to affordable insulin treatment<sup>2</sup> and blood glucose self-monitoring.

6. The coverage targets do not constitute individual-level guideline treatment targets but global coverage targets that capture areas of missed opportunity (i.e. global diabetes diagnosis and treatment gaps), in which attention to goals will be both clearly measurable and have a strong impact on health

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<sup>1</sup> The term “people with diabetes” includes all types of diabetes. Due to the potentially fatal consequences of delayed diagnoses and the high prevalence of diabetic ketoacidosis at diagnosis, more efforts to establish earlier diagnoses of people with type 1 diabetes should be promoted worldwide.

<sup>2</sup> Including devices for insulin delivery, such as syringes and needles.

outcomes. The targets are ambitious but achievable and would have global health impact in many countries of the world.

7. In this regard, modelling projections have demonstrated that:

- achieving the target levels of diagnosis, treatment and control of three targets (glycaemia, blood pressure, and statin use) of at least 60% results in a gain in median disability-adjusted life years (DALYs) of 38 per 1000 persons over 10 years, whereas achieving a target of 80% results in a gain in median disability-adjusted life years of 64 per 1000 persons over 10 years;<sup>1</sup> and
- in most regions, improving treatment and control without screening reduces the number of deaths attributable to cardiovascular disease by 25–35%, while improving diagnosis, treatment and control reduces the most common cause of deaths (deaths attributable to cardiovascular disease) by more than 40%.<sup>1</sup>

8. Achieving the five global diabetes coverage targets will contribute to the achievement of SDG target 3.4. Their achievement is also aligned with the NCD-GAP; the political declaration of the third high-level meeting of the General Assembly on the prevention and control of noncommunicable diseases; and health systems strengthening for social protection and universal health coverage, as provided in United Nations General Assembly resolution 72/81.

### **Alignment with NCD Global Monitoring Framework and implications for monitoring**

9. The global coverage targets complement the NCD Global Monitoring Framework's existing target of halting the rise of diabetes, providing an additional specific and measurable set of targets related to diabetes care. The measurement of the targets is expected to be mainly conducted via population-based surveys, allowing most countries to report without creating an additional data collection burden. In this regard, three of the five targets are already captured by the tools used to report on the existing Global Monitoring Framework indicators.

10. The recommendations comprise a set of actions, which, when performed collectively by Member States and international partners, will tackle the growing public health burden imposed by diabetes and contribute to achieving the targets.

## **RECOMMENDATIONS TO STRENGTHEN AND MONITOR DIABETES RESPONSES**

11. Recommended actions for **Member States**:

**(a) Strengthen national capacity, leadership, governance, multisectoral action and partnerships to accelerate country response for the prevention and control of diabetes:**

- Strengthen the capacity of ministries of health to exercise a strategic leadership and coordination role in diabetes policy development that engages all stakeholders across government, nongovernmental organizations, civil society, people living with diabetes

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<sup>1</sup> WHO Discussion Paper: Draft recommendations to strengthen and monitor diabetes responses within national noncommunicable disease programmes, including potential targets. Geneva: World Health Organization; 2021 (<https://www.who.int/teams/noncommunicable-diseases/governance/diabetestargets>, accessed 18 August 2022).

and the private sector, ensuring that issues relating to the prevention and control of diabetes receive a coordinated, comprehensive and integrated response.

- Provide sufficient national budgetary allocation for diabetes prevention and control and identify financing mechanisms to reduce out-of-pocket expenditure.
- Strengthen the design and implementation of policies for diabetes by ensuring that existing national universal health coverage benefit packages and NCD multisectoral strategy/policy/action plans contain the necessary provisions for diabetes prevention and management.
- Consider setting national diabetes coverage targets, building on the guidance provided by WHO, in order to progressively cover more people with quality diabetes care, increase accountability and periodically assess national capacity for the prevention and control of diabetes.

**(b) Reduce modifiable risk factors for diabetes and underlying social determinants:**

- Accelerate the implementation of policies and strategies to reduce risk factors for diabetes and its complications, including by identifying synergies from the recommendations for the prevention and management of obesity.<sup>1</sup>
- Promote health literacy and strengthen the meaningful engagement of people living with diabetes in clinical decision-making, with a focus on health–professional–patient communication and education.
- Consider disproportionate diabetes burdens among subpopulations and address the underlying social determinants that expose these populations to greater risk of developing diabetes and its complications, substandard care or lack of access to essential diabetes medicines.

**(c) Strengthen and orient health systems to address the prevention and control of diabetes through people-centred primary health care and universal health coverage:**

- Expand the delivery of primary health care and prioritize it as the cornerstone of sustainable, people-centred, community-based and integrated diabetes care.
- Set minimum standards for the early detection and management of diabetes across the continuum of care, with a focus on primary health care, while strengthening referral systems between primary and other levels of care.
- Consider adopting the global coverage targets to be achieved by 2030 in order to stimulate early detection and improved management and consider the adaptation of targets to local circumstances.

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<sup>1</sup> WHO Discussion Paper: Draft recommendations for the prevention and management of obesity over the life course, including potential targets. Geneva: World Health Organization; 2016 (<https://www.who.int/publications/m/item/who-discussion-paper-draft-recommendations-for-the-prevention-and-management-of-obesity-over-the-life-course-including-potential-targets>, accessed 1 December 2021).

- Strengthen the health workforce and the institutional capacity for early detection and management of diabetes, including for the diagnosis and management of diabetes-related complications, the provision of patient education, mental health care and psychosocial support, the promotion of self-care, and the provision of palliative care and rehabilitation.
- Ensure the availability and affordability of essential medicines and priority devices by integrating medicines, insulin delivery devices and blood glucose monitoring devices in national benefit packages.
- Ensure the uninterrupted treatment of people living with diabetes during humanitarian emergencies.
- Evaluate the impact of innovative digital health solutions.
- Include people living with diabetes in decision-making processes for policies, strategies and the implementation of diabetes prevention and control.

**(d) Promote and support national capacity for high-quality research, innovation and development for the prevention and control of diabetes.**

**(e) Monitor the trends and determinants of diabetes and evaluate progress in their prevention and control:**

- Develop and strengthen surveillance and monitoring systems for diabetes and related NCD risk factors, guided by WHO NCD surveillance framework.
- Develop and strengthen monitoring systems to evaluate treatment gaps and clinical outcomes (morbidity and mortality) and health system performance (capacity and interventions) through the systematic collection of standardized routine facility-based diabetes care indicators.

12. Recommended actions for **international partners**, including the private sector:

**(a) Strengthen national capacity, leadership, governance, multisectoral action and partnerships to accelerate country response for the prevention and control of diabetes:**

- Maintain the visibility of diabetes on the global health and development agenda.
- Align international cooperation on diabetes with national plans on NCDs in order to strengthen aid effectiveness and the development impact of external resources in support of diabetes.
- Civil society to foster accountability and support countries in the regular review of progress of national diabetes road maps towards the achievement of national diabetes targets.

**(b) Reduce modifiable risk factors for diabetes and underlying social determinants:**

- Advocate for and support population-based policies, including food and nutrition policies, health promotion activities and health literacy campaigns.

- Advocate for and help implement and evaluate community-based diabetes prevention and control initiatives.

**(c) Strengthen and orient health systems to address the prevention and control of diabetes through people-centred primary health care and universal health coverage:**

- Commit to supporting activities that improve the affordability and availability of essential medicines and basic technologies for the diagnosis, management and self-care of people with diabetes.
- Support and scale up the implementation of digital health solutions based on country need assessments.
- At the same time, report and participate in the reporting mechanism that WHO will use to register and publish their contributions,<sup>1</sup> which could include existing data or mechanisms.
- Promote partnerships to accelerate ambitious action to increase access and care towards the Global Diabetes Compact vision and the contributions of the private sector.

**(d) Promote and support national capacity for high-quality research, innovation and development for the prevention and control of diabetes:**

- Invest in and support national capacity for research on diabetes prevention and control in order to inform the formulation and implementation of national policies.

**(e) Monitor the trends and determinants of diabetes and evaluate progress in their prevention and control:**

- Support the development and maintenance of surveillance systems and promote the use of information and communications technology.
- Invest in information systems that link various sources of information on management and outcomes.

13. Recommended actions for **WHO**:

**(a) Strengthen national capacity, leadership, governance, multisectoral actions and partnerships in order to accelerate country response for the prevention and control of diabetes:**

- Convene and lead partners through the Global Diabetes Compact in order to raise awareness, create synergies for action and harness the collective capacity of global, regional and national actors working to improve diabetes prevention and control.
- Support country activities for including diabetes in universal health coverage and develop recommendations for the adequate, predictable and sustained financing of

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<sup>1</sup> See United Nations General Assembly resolution 68/300.

diabetes prevention and control, including in resource-constrained settings and to address the needs of disadvantaged and marginalized populations.

- Scale up the meaningful engagement of people with diabetes in the design, implementation and evaluation of programmes and services for diabetes.

**(b) Reduce modifiable risk factors for diabetes and underlying social determinants:**

- Provide guidance on the prevention of type 2 diabetes by implementing the best buy approach, health promotion and health literacy.

**(c) Strengthen and orient health systems to address the prevention and control of diabetes through people-centred primary health care and universal health coverage:**

- Support country adaptation and the implementation of WHO diabetes management guidelines.
- Develop technical and normative products to cover the whole spectrum of diabetes care and facilitate the implementation of evidence-based digital solutions.
- Engage the private sector in strengthening commitments and contributions in order to increase access to essential medicines and health technologies for diabetes, including the prequalification of insulin, pooled procurement and the harmonization of regulatory requirements, while giving due regard to managing conflicts of interest.
- Invite the private sector to strengthen its commitment and contribution to the prevention and management of diabetes by participating in the WHO-led task force,<sup>1,2</sup> including participating in the prequalification programmes for insulin and self-monitoring devices and in international pooled-procurement mechanisms for diabetes medicines (once established) led by the United Nations and other intergovernmental organizations and international financing mechanisms, while giving due regard to managing conflicts of interest.
- Develop guidance and provide technical assistance to countries for enabling the uninterrupted treatment of diabetes during humanitarian emergencies.
- Estimate the cost of achieving the global coverage targets.

**(d) Promote and support national capacity for high-quality research, innovation and development for the prevention and control of diabetes:**

- Develop a plan for supporting national research in diabetes prevention and the control of diabetes and its complications.

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<sup>1</sup> Dialogue with the private sector on medicines and technologies for diabetes care, September 2021. Geneva: World Health Organization; 2021 (<https://www.who.int/news-room/events/detail/2021/09/01/default-calendar/dialogue-with-the-private-sector-on-medicines-and-technologies-for-diabetes-care>, accessed 1 December 2021).

<sup>2</sup> See document EB144/20.



- Support the prioritization of the research agenda for diabetes prevention and control and promote implementation research in order to assess the effectiveness of individual and population-wide interventions in preventing and controlling diabetes and obesity.
- Support countries in developing diabetes-related research policies or plans that include community-based research and an evaluation of the impact of interventions and policies.

**(e) Monitor the trends and determinants of diabetes and evaluate progress in their prevention and control:**

- Continue monitoring NCD risk-factor dynamics and country capacity to prevent and control NCDs, including diabetes.
  - Develop a monitoring framework and tool for monitoring the performance of health care systems by monitoring processes of care and outcomes at the level of health facilities.
  - Support the development and maintenance of surveillance systems and promote the use of information and communications technology.
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## ANNEX 10

### **Global strategy on oral health<sup>1</sup>**

[A75/10 Add.1, Annex 3 – 27 April 2022]

[Paragraphs 1–2 described the background to the global strategy on oral health, including the mandate for and process of its development.]

#### **GLOBAL OVERVIEW OF ORAL HEALTH**

3. Oral health is the state of the mouth, teeth and orofacial structures that enables individuals to perform essential functions, such as eating, breathing and speaking, and encompasses psychosocial dimensions, such as self-confidence, well-being and the ability to socialize and work without pain, discomfort and embarrassment. Oral health varies over the life course from early life to old age, is integral to general health and supports individuals in participating in society and achieving their potential.

#### **Oral disease burden**

4. Globally, there were estimated to be more than 3.5 billion cases of oral diseases and other oral conditions in 2017, most of which are preventable.<sup>2</sup> For the last three decades, the combined global prevalence of dental caries (tooth decay), periodontal (gum) disease and tooth loss has remained unchanged at 45%, which is higher than the prevalence of any other noncommunicable disease.

5. Cancers of the lip and oral cavity together represent the sixteenth most common cancer worldwide, with over 375 000 new cases and nearly 180 000 deaths in 2020.<sup>3</sup> Noma is a noncommunicable necrotizing disease that typically occurs in young children living in extreme poverty. Noma starts as a lesion of the gums inside the mouth and destroys the soft and hard tissues of the mouth and face; it is fatal for as many as 90% of affected children.<sup>4</sup> Orofacial clefts, the most common craniofacial birth defect, have a global prevalence of approximately 1 in 1000–1500 births with wide variation in different

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<sup>1</sup> See decision WHA75(11).

<sup>2</sup> Bernabe GE, Marcenes W, Hernandez CR, Bailey J, Abreu LG, Alipour V, et al. Global, Regional, and National Levels and Trends in Burden of Oral Conditions from 1990 to 2017: A Systematic Analysis for the Global Burden of Disease 2017 Study *J Dent Res*. 2020;99(4):362-373. doi: 10.1177/0022034520908533.

<sup>3</sup> Lip, oral cavity. International Agency for Research on Cancer fact sheet. Geneva: World Health Organization (<https://gco.iarc.fr/today/data/factsheets/cancers/1-Lip-oral-cavity-fact-sheet.pdf>, accessed 1 December 2021).

<sup>4</sup> Information brochure for early detection and management of noma. World Health Organization. Regional Office for Africa. 2017.

studies and populations.<sup>1,2</sup> Traumatic dental injury is estimated to have a global prevalence of 23% for primary teeth and 15% for permanent teeth, affecting more than 1 billion people.<sup>3</sup>

6. Oral diseases often have comorbidity with other noncommunicable diseases. Evidence has shown an association between oral diseases, particularly periodontal disease, and a range of other noncommunicable diseases, such as diabetes and cardiovascular disease.

### **Social, economic and environmental costs of poor oral health**

7. The personal consequences of untreated oral diseases and conditions – including physical symptoms, functional limitations, stigmatization and detrimental impacts on emotional, economic and social well-being – are severe and can affect families, communities and the wider health care system. For those who obtain treatment for oral diseases and conditions, the costs can be high and can lead to significant economic burdens.

8. High out-of-pocket payments and catastrophic health expenditure associated with oral health care often lead people not to seek care when needed. Worldwide, in 2015 oral diseases and conditions accounted for an estimated US\$ 357 billion in direct costs (such as treatment expenditures) and US\$ 188 billion in indirect costs (such as productivity losses due to absence from work or school), with large differences between high-, middle- and low-income countries.<sup>4</sup>

9. There is a strong and consistent association between socioeconomic status (income, occupation and educational level) and the prevalence and severity of oral diseases and conditions.<sup>5,6</sup> Across the life course, oral diseases and conditions disproportionately affect the poor and vulnerable members of societies, often including those who are on low incomes; people living with disability; older people living alone or in care homes; people who are refugees, in prison or living in remote and rural communities; and people from minority and/or other socially marginalized groups.

10. The environmental impact of the oral health care system is a great concern, as shown in the Minamata Convention on Mercury, a global treaty that obliges parties to implement measures to phase down the use of dental amalgam, which contains 50% mercury. Other environmental challenges related to oral health care include the use of natural resources, such as energy and water; the use of safe and environmentally sound dental material and oral care products; and sustainable waste management.

### **Social and commercial determinants and risk factors of oral health**

11. Oral diseases and conditions and oral health inequalities are directly influenced by social and commercial determinants. The social determinants of oral health are the structural, social, economic and

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<sup>1</sup> Birth defects surveillance. A manual for programme managers. Geneva: World Health Organization; 2020.

<sup>2</sup> Salari N, Darvishi N, Heydari M, Bokae S, Darvishi F, Mohammadi M. Global prevalence of cleft palate, cleft lip and cleft palate and lip: A comprehensive systematic review and meta-analysis. *J Stomatol Oral Maxillofac Surg.* 2021;S2468-7855(21)00118X. doi:10.1016/j.jormas.2021.05.008.

<sup>3</sup> Petti, S, Glendor U, Andersson L. World traumatic dental injury prevalence and incidence, a meta-analysis – One billion living people have had traumatic dental injuries. *Dent Traumatol.* 2018 Apr;34(2):71-86. doi: 10.1111/edt.12389.

<sup>4</sup> Righolt AJ, Jevdjevic M, Marcenis W, Listl S. Global-, Regional-, and Country-Level Economic Impacts of Dental Diseases in 2015. *J Dent Res.* 2018;97(5):501-507. doi: 10.1177/0022034517750572.

<sup>5</sup> Peres MA, Macpherson LMD, Weyant RJ, Daly D, Venturelli R, Mathur MR, et al. Oral diseases: a global public health challenge. *Lancet.* 2019;394(10194):249-260. doi: 10.1016/S0140-6736(19)31146-8.

<sup>6</sup> Matsuyama Y, Jürges H, Listl S. The Causal Effect of Education on Tooth Loss: Evidence From United Kingdom Schooling Reforms. *Am J Epidemiol.* 2019;188(1):87-95. doi: 10.1093/aje/kwy205.

political drivers of oral diseases and conditions in society. The commercial determinants of oral health are the strategies used by some actors in the private sector to promote products and choices that are detrimental to health.

12. Oral diseases and conditions share risk factors common to the leading noncommunicable diseases, that is, cardiovascular disease, cancer, chronic respiratory disease, diabetes and mental health conditions. These risk factors include both smoking and smokeless tobacco, harmful alcohol use, high sugars intake and lack of breastfeeding, as well as the human papillomavirus for oropharyngeal cancers.

13. Modifiable risk factors for cleft lip and palate include maternal active or passive tobacco smoking, while those for traumatic dental injury include alcohol use, traffic accidents and sports injuries. The aetiology of noma is unknown but its risk factors include malnutrition; coinfections; vaccine-preventable diseases; poor oral hygiene; and poor living conditions, such as deficiencies in water, sanitation and hygiene.

### **Oral health promotion and oral disease prevention**

14. Only rarely have oral health promotion and oral disease prevention efforts targeted the social and commercial determinants of oral health at the population level. Moreover, oral health promotion and oral disease prevention are not typically integrated in other noncommunicable disease programmes that share major common risk factors and social determinants. In 2015, the WHO guideline on sugars intake for adults and children made the strong recommendation to reduce the intake of free sugars throughout the life course based on the evidence of direct associations between the intake of free sugars and body weight and dental caries. Nonetheless, public health initiatives to reduce sugar consumption are rare.

15. Initiatives that address upstream determinants can be cost-effective and have a high population reach and impact. Upstream strategies to reduce the intake of free sugars and the use of tobacco and alcohol include policies, taxes and/or regulation of the price, sale and advertisement of unhealthy products. Midstream policy interventions include creating more supportive conditions in key settings, such as educational settings, schools, workplaces and care homes.

16. Millions of people do not have access to oral health promotion and oral disease prevention programmes.<sup>1</sup> The use of fluorides for the prevention of dental caries is limited. Frequently, essential prevention methods, such as fluoridation of the water supply and other community-based methods, topical fluoride applications or the use of quality, fluoride toothpaste, are not available or affordable.

### **Oral health care systems**

17. Political commitment and resources for oral health care systems often are limited at the ministry of health level. Typically, the oral health care system is inadequately funded, delivered by independent private providers, highly specialized and isolated from the broader health care system. In most countries, universal health coverage benefit packages and noncommunicable disease interventions do not include essential oral health care.

18. Essential oral health care covers a defined set of safe, cost-effective interventions at the individual and community levels to promote oral health, as well as to prevent and treat the most prevalent and/or severe oral diseases and conditions, including appropriate rehabilitative services and referral. Oral health

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<sup>1</sup> Petersen PE, Baez RJ, Ogawa H. Global application of oral disease prevention and health promotion as measured 10 years after the 2007 World Health Assembly statement on oral health. *Community Dent Oral Epidemiol.* 2020;48:338–348. doi: <https://doi.org/10.1111/cdoe.12538>.

care is not usually covered in primary care facilities and the private and/or public insurance scheme coverage of oral health is highly variable within and between countries.

19. In many countries, insufficient attention is given to planning the health workforce to address the population's oral health needs. Oral health training is rarely integrated in general health education systems. Typically, training focuses on educating highly specialized dentists rather than mid-level and community oral health workers or optimizing the roles of the wider health team.

20. The COVID-19 pandemic has had a negative impact on public health programmes and the provision of essential oral health care in most countries, leading to delays in oral health care treatment, increased use of antibiotic prescriptions and greater oral health inequalities. The pandemic should be seen as an opportunity to strengthen the integration of oral health care into general health care systems as part of universal health coverage efforts.

## **VISION, GOAL AND GUIDING PRINCIPLES**

### **Vision**

21. The vision of this strategy is universal health coverage for oral health for all individuals and communities by 2030, enabling them to enjoy the highest attainable state of oral health and contributing to healthy and productive lives.

22. universal health coverage means that all individuals and communities have access to essential, quality health services that respond to their needs and that they can use without suffering financial hardship. These services include oral health promotion and prevention, treatment and rehabilitation interventions related to oral diseases and conditions across the life course. In addition, upstream interventions are needed to strengthen the prevention of oral diseases and reduce oral health inequalities. Achieving the highest attainable standard of oral health is a fundamental right of every human being.

### **Goal**

23. The goal of the strategy is to guide Member States to: (a) develop ambitious national responses to promote oral health; (b) reduce oral diseases, other oral conditions and oral health inequalities; (c) strengthen efforts to address oral diseases and conditions as part of universal health coverage; and (d) consider the development of targets and indicators, based on national and subnational contexts, building on the guidance to be provided by WHO's global action plan on oral health, in order to prioritize efforts and assess the progress made by 2030.

### **Guiding principles**

#### **Principle 1: A public health approach to oral health**

24. A public health approach to oral health strives to provide the maximum oral health benefit for the largest number of people by targeting the most prevalent and/or severe oral diseases and conditions. To achieve this, oral health programmes should be integrated in broader and coordinated public health efforts. A public health approach to oral health requires intensified and expanded upstream actions on the social and commercial determinants of oral health, involving a broad range of stakeholders from social, economic, education, environment and other relevant sectors.

**Principle 2: Integration of oral health in primary health care**

25. Primary health care is the cornerstone of strengthening health systems because it improves the performance of health systems, resulting in better health outcomes. The integration of essential oral health care in other noncommunicable disease services in primary health care is an essential component of universal health coverage. Such integration has many potential benefits, including increased chance of prevention, early detection and control of related conditions and comorbidities, as well as more equitable access to comprehensive, quality health care.

**Principle 3: Innovative workforce models to respond to population needs for oral health**

26. Resource and workforce planning models need to better align the education and training of health workers with public health goals and population oral health needs, particularly for underserved populations. Universal health coverage can only be achieved by reforming health, education and resource planning systems to ensure the health workforce has the needed competencies to provide essential oral health care services across the continuum of care. This may require reassessing the roles and responsibilities of mid-level and community-based health workers and other relevant health professionals that include the oral health sector. The new WHO Global Competency Framework for Universal Health Coverage should guide the development of health workforce models for oral health.

**Principle 4: People-centred oral health care**

27. People-centred care for oral health consciously seeks and engages the perspectives of individuals, families and communities, including people affected by poor oral health. In this approach, people are seen as participants as well as beneficiaries of trusted health systems that respond to their needs and preferences in humane and holistic ways. People-centred care actively fosters a more holistic approach to needs assessment, shared decision-making, oral health literacy and self-management. Through this process, people develop the opportunity, skills and resources to be articulate, engaged and empowered users and stakeholders of oral health services.

**Principle 5: Tailored oral health interventions across the life course**

28. People are affected by oral diseases and conditions – and their risk factors and social and commercial determinants – from early life to old age. The effects may vary and accumulate over time and have complex consequences in later life, particularly in relation to other noncommunicable diseases. Tailored, age-appropriate oral health strategies that include essential oral health care need to be integrated in relevant health programmes across the life course, including prenatal, infant, child, adolescent, working adult and older adult programmes. These may include age-appropriate, evidence-based interventions that are focused on promoting healthier eating, tobacco cessation, alcohol reduction and self-care.

**Principle 6: Optimizing digital technologies for oral health**

29. Artificial intelligence, mobile devices and other digital technologies can be used strategically for oral health at different levels, including for improving oral health literacy, implementing oral health e-training and provider-to-provider telehealth, as well as for increasing early detection, surveillance and referral for oral diseases and conditions within primary care. In parallel, it is critical to establish and/or reinforce governance for digital health and to define norms and standards for digital oral health based on best practice and scientific evidence.

## STRATEGIC OBJECTIVES

### **Strategic objective 1: Oral health governance – Improve political and resource commitment to oral health, strengthen leadership and create win–win partnerships within and outside the health sector**

30. Strategic objective 1 seeks the recognition and integration of oral health in all relevant policies and public health programmes as part of the broader national noncommunicable disease and universal health coverage agendas. Increased political and resource commitment to oral health are vital at the national and subnational levels, as is the reform of health and education systems. Ideally, this would include a guaranteed minimum share of public health expenditure that is directed exclusively to national oral health programmes.

31. Central to this process is establishing or strengthening the capacity of a national oral health unit with professionals trained in public health. A dedicated, qualified, functional, well-resourced and accountable oral health unit should be established or reinforced within noncommunicable disease structures and other relevant public health and education services.

32. Sustainable partnerships within and outside the health sector, as well as engagement with communities, civil society and the private sector, are essential to mobilize resources, target the social and commercial determinants of oral health and implement reforms. For example, collaboration between the ministry of health and the ministry of environment is critical to address environmental sustainability within oral health care, such as the implementation of the Minamata Convention on Mercury and challenges related to the management of chemicals and waste (including mercury).

### **Strategic objective 2: Oral health promotion and oral disease prevention – Enable all people to achieve the best possible oral health and address the social and commercial determinants and risk factors of oral diseases and conditions**

33. Strategic objective 2 calls for evidence-based, cost-effective and sustainable interventions to promote oral health and prevent oral diseases and conditions. At the downstream level, oral health education supports the development of personal, social and political skills that enable all people to achieve their full potential for oral health self-care. At the upstream level, oral health promotion includes creating public policies and fostering community action to improve people's control over their oral health and to promote oral health equity.

34. Prevention efforts target key risk factors and the social and commercial determinants of oral diseases and other oral conditions. These initiatives should be fully integrated and mutually reinforcing with other relevant noncommunicable disease prevention strategies and regulatory policies related to tobacco use, harmful alcohol use and limiting free sugars intake to less than 10% of total energy and ideally to less than 5%. Prevention efforts should also include safe and cost-effective community-based methods to prevent dental caries, such as fluoridation of the water supply where appropriate, topical fluoride application and the use of quality, fluoride toothpaste.

### **Strategic objective 3: Health workforce – Develop innovative workforce models and revise and expand competency-based education to respond to population oral health needs**

35. Strategic objective 3 aims to ensure that there is an adequate number, availability and distribution of skilled health workers to deliver an essential package of oral health services to meet population needs. This requires that the planning and prioritization of oral health services be explicitly included in all costed health workforce strategies and investment plans.

36. More effective workforce models will likely involve a new mix of dentists, mid-level oral health care providers (such as dental assistants, dental nurses, dental prosthetists, dental therapists and dental hygienists), community-based health workers and other relevant health professionals who have not traditionally been involved in oral health care, such as primary care physicians and nurses. Implementing such models may require reassessing and updating national legislative and regulatory policies for the licensing and accreditation of the health workforce. Health educators will be key stakeholders in establishing competency and professionalism standards for oral health to guide and assess the education, training and practice of an innovative health workforce.

37. Curricula and training programmes need to adequately prepare health workers to manage and respond to the public health aspects of oral health and address the environmental impact of oral health services on planetary health. Professional oral health education must go beyond development of a clinical skill set to include robust training in health promotion and disease prevention and key competencies, such as evidence-informed decision-making, reflective learning about the quality of oral health care, inter-professional communication and the provision of people-centred health care. Intra- and inter-professional education and collaborative practice will also be important to allow the full integration of oral health services in health systems and at the primary care level.

#### **Strategic objective 4: Oral health care – Integrate essential oral health care and ensure related financial protection and essential supplies in primary health care**

38. Strategic objective 4 seeks to increase access by the entire population to safe, effective and affordable essential oral health care as part of the universal health coverage benefit package. Health workers who provide oral health services should be active members of the primary health care team and work collaboratively, including across other levels of care, to tackle oral diseases and conditions as well as other noncommunicable diseases, with a focus on addressing common risk factors and supporting general health consultations.

39. Financial protection through expanded private and public insurance policies and programmes, including coverage of oral health services, is one of the cornerstones of universal health coverage. Ensuring the reliable availability and distribution of essential medical consumables, generic medicines and other dental supplies is also important for the management of oral diseases and conditions in primary health care and referral services.

40. Digital health technology should be examined for its potential role in the delivery of accessible and effective essential oral health care. This might include the development of policy, legislation and infrastructure to expand the use of digital health technologies, such as mobile phones, intra-oral cameras and other digital technologies, to support remote access and consultation for early detection and referral to services for the management of oral diseases and conditions.

#### **Strategic objective 5: Oral health information systems – Enhance surveillance and health information systems to provide timely and relevant feedback on oral health to decision-makers for evidence-based policy-making**

41. Strategic objective 5 involves developing more efficient, effective and inclusive integrated health information systems that include oral health to inform planning, management and policy-making. At the national and subnational levels, strengthening information systems should include the systematic collection of data on oral health status, social and commercial determinants, risk factors, workforce, oral health services readiness and resource spending.

42. These improved systems can use routine health information systems, demographic and health surveys and promising digital technologies and should ensure protection of patient data. They should



also be established to monitor patterns and trends in oral health inequalities and track the implementation and impact of existing policies and programmes related to oral health.

43. New oral health epidemiological methods, including high-resolution video, multispectral imaging and mobile technologies, have the potential to improve the quality of population-based oral health data while reducing costs and complexity. WHO's new mobile technologies for oral health implementation guide, for example, provides guidance on using mobile technologies for population-based and health service delivery surveillance.

### **Strategic objective 6: Oral health research agendas – Create and continuously update context and needs-specific research that is focused on the public health aspects of oral health**

44. Strategic objective 6 strives to create and implement new oral health research agendas that are oriented towards public health programmes and population-based interventions. These should include research on learning health systems, implementation sciences, workforce models, digital technologies and the public health aspects of oral diseases and conditions.

45. Other research priorities include upstream interventions; primary health care interventions; mercury-free dental restorative materials; barriers to access to oral health care; oral health inequalities; oral health promotion in key settings such as schools; environmentally sustainable practices; and economic analyses to identify cost-effective interventions.

46. The translation of research findings into practice is equally important and should include the development of regionally specific, evidence-informed clinical practice guidelines. Researchers have an important role in supporting the development and evaluation of population oral health policies and evaluating and applying the evidence generated by new public health interventions.

## **ROLE OF WHO, MEMBER STATES AND PARTNERS**

### **WHO**

47. WHO will provide a leadership and coordination role in promoting and monitoring global action on oral health, including in relation to the work of other relevant United Nations agencies, development banks and other regional and international organizations. It will set the general direction and priorities for global oral health advocacy, partnerships and networking; articulate evidence-based policy options; and provide Member States with technical and strategic support.

48. WHO will continue its work with global public health partners, including WHO collaborating centres, to establish networks for building capacity in oral health care, research and training; mobilize contributions from nongovernmental organizations and civil society; and facilitate the collaborative implementation of the strategy, particularly with respect to the needs of low- and middle-income countries. WHO will also collaborate with Member States to ensure that there is uptake and accountability for the strategy at the national level, particularly in national health policies and strategic plans.

49. By 2023, WHO will translate this strategy into an action plan for public oral health, including a monitoring framework for tracking progress with clear measurable targets to be achieved by 2030. By 2024, WHO will recommend cost-effective, evidence-based oral health interventions as part of the updated Appendix 3 to the NCD-GAP and the WHO UHC Compendium.

50. WHO will continue to update technical guidance to ensure safe and uninterrupted dental care, including during and after the COVID-19 pandemic and other health emergencies. In collaboration with the United Nations Environment Programme (UNEP), WHO will develop technical guidance on environmentally sustainable oral health care, including mercury-free products and less invasive procedures. WHO will also consider the classification of noma within the road map for neglected tropical diseases 2021–2030.

51. WHO will help scale up and sustain innovations for oral health impact in accordance with the WHO innovation scaling framework, including social, service delivery, health product, business model, digital and financial innovations.

52. WHO will create an oral health data platform as part of its data repository for health-related statistics. WHO will strengthen integrated oral health information systems and surveillance activities through the development of new standardized data-gathering technologies and methods, as well as oral health indicators for population health surveys. WHO will promote and support research in priority areas in order to improve oral health programme implementation, monitoring and evaluation.

### **Member States**

53. Member States have the primary role in responding to the challenge of oral diseases and conditions in their populations. Governments are responsible for engaging all sectors of society to generate effective responses for the prevention and control of oral diseases and conditions, the promotion of oral health and the reduction of oral health inequalities. They should secure appropriate oral health budgets based on intervention costing and investment cases to achieve universal health coverage for oral health.

54. Member States should ensure that oral health is a solid, robust and integral part of national and subnational health policies and that national oral health units have sufficient capacity and resources to provide strong leadership, coordination and accountability on oral health.

55. Member States can strengthen oral health care system capacities by integrating oral health in primary health care as a part of universal health coverage benefit packages; ensuring the affordability of essential oral health medicines and consumables, as well as other equipment or supplies for the prevention and management of oral diseases and conditions; and prioritizing environmentally sustainable and less invasive oral health care.

56. Member States should also assess and reorient the health workforce as required to meet population oral health needs by reorienting the outcomes of the education programmes to the oral health services to be provided. This requires enabling inter-professional education and collaborative practice that involves mid-level and community-based health workers. They should critically review and continuously update their oral health education content across health worker training programmes and training curricula, prioritizing a public health approach to oral health that enables health workers to develop essential competencies such as reflective problem-solving and leadership skills.

57. Member States can address the determinants of oral health and the risk factors of oral diseases and conditions by advocating for evidence-based regulatory measures that address the underlying determinants that increase or reduce risks and working with commercial entities to encourage them to reformulate products to reduce sugar levels, reduce portion sizes or shift consumer purchasing towards products with lower sugar content. Member States can also target determinants by strengthening health-promoting conditions in key settings; implementing community-based methods to prevent dental caries; supporting legislation to increase the affordability of quality, fluoride toothpaste; and advocating for its recognition as an essential health product within the national list of essential medicines.

58. Member States should improve oral health surveillance, data collection and monitoring to inform decision-making and advocacy. This includes developing and standardizing updated methods and technologies for gathering oral health epidemiological data, integrating electronic dental and medical records and strengthening the integrated surveillance of oral diseases and conditions. It also includes the analysis of oral health system and policy data, operational research and the evaluation of oral health interventions and programmes.

### **International partners**

59. UNICEF, UNEP, the International Telecommunication Union and other United Nations agencies, as well as development banks and other international partners, have valuable roles to play in achieving the goals and objectives of the strategy at global, regional and national levels. This includes taking initiative in advocacy, resource mobilization, exchange of information, sharing of lessons learned, capacity-building, research and developing targets and indicators for streamlined global collaboration.

60. Coordination is needed among international partners, including the organizations of the United Nations system, intergovernmental bodies, non-State actors, nongovernmental organizations, professional associations, youth and student organizations, patients' groups, academia and research institutions. Establishing and working efficiently as an international coalition on oral health will better support countries in their implementation of the strategy.

### **Civil society**

61. Civil society is a key stakeholder in setting priorities for oral health care services and public health. It has a role to play in encouraging governments to develop ambitious national and subnational oral health responses and contributing to their implementation. Civil society can forge multistakeholder partnerships and alliances that mobilize and share knowledge, assess progress, provide services and amplify the voices of people living with and affected by oral diseases and conditions. Actively engaging in meaningful partnership with civil and community organizations, as well as co-designing/co-producing innovative approaches to oral health care, provide an opportunity to develop more responsive and sustainable models of care.

62. Civil society can support consumers and lead grass-roots mobilization and advocacy for increased focus in the public agenda on oral health promotion and the prevention and control of oral diseases and conditions. Civil society and consumers can advocate with governments and industries to demand that the food and beverage industry provide healthy products; support governments in implementing their tobacco control programmes; and form networks and action groups to promote the availability of food and beverages that are low in free sugars and of quality, fluoride toothpaste, including through subsidization or reduced taxes.

63. National dental associations and other oral health professionals organizations have a responsibility to support the oral health of their communities. They can collaborate with and support national and subnational governments in implementing the strategy through the provision of essential oral health care, including by helping to plan and implement population-wide prevention measures and by participating in oral health data collection and surveillance.

### **Private sector**

64. The private sector can strengthen its commitment and contribution to national and subnational oral health responses by implementing occupational oral health measures, including through good corporate practices, workplace wellness programmes and health insurance plans.

65. The private sector should take concrete steps towards reducing the marketing, advertising and sale of products that cause oral diseases and conditions, such as tobacco products and food and beverages that are high in free sugars. Increased private sector transparency and accountability is a key component of such actions.

66. The private sector should strive to improve the access to and affordability of safe, effective and quality dental equipment and devices and oral hygiene products. It should accelerate research on affordable, safe and environmentally sound equipment and materials for oral health care.

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## ANNEX 11

### **Recommendations on how to strengthen the design and implementation of policies, including those for resilient health systems and health services and infrastructure, to treat people living with noncommunicable diseases and to prevent and control their risk factors in humanitarian emergencies<sup>1</sup>**

[A75/10 Add.2, Annex 4 – 27 April 2022]

1. Paragraphs 31, 46 and 48 of the NCD-GAP call for ensuring the continuity of essential noncommunicable disease services, including the availability of life-saving technologies and essential medicines, in humanitarian emergencies. Also, in paragraph 40 of United Nations General Assembly resolution 73/2 (2018), Member States reaffirmed their commitment to “strengthen the design and implementation of policies, including for resilient health systems and health services and infrastructure to treat people living with noncommunicable diseases and prevent and control their risk factors in humanitarian emergencies, including before, during and after natural disasters, with a particular focus on countries most vulnerable to the impact of climate change and extreme weather events”.
2. To provide initial guidance to Member States, the Secretariat submitted Annex 9 of document EB148/7 (2021), which describes the process the Secretariat is following to support Member States in their commitment to strengthen policies to treat people living with noncommunicable diseases and prevent and control their risk factors in humanitarian emergencies.
3. Building on this initial guidance, this annex suggests recommendations for Member States, international partners and WHO to ensure essential service provision for people living with noncommunicable diseases in humanitarian emergencies by investing in and building longer-term noncommunicable disease emergency preparedness and responses during the pandemic of coronavirus disease (COVID-19) and beyond, as part of “build back better” through a multisectoral all-hazards approach.

#### **CHALLENGES AND OPPORTUNITIES**

##### **THE COVID-19 PANDEMIC: A PERSISTING DEADLY INTERPLAY WITH THE NONCOMMUNICABLE DISEASE EPIDEMIC**

4. In December 2020, the United Nations General Assembly adopted resolution 75/130, “noting with concern that non-communicable diseases, notably cardiovascular diseases, cancers, diabetes, chronic respiratory diseases, as well as mental disorders, other mental health conditions and neurological disorders, are the leading causes of premature death and disability globally, including in low- and middle-income countries, and that people living with non-communicable diseases are more susceptible to the risk of developing severe COVID-19 symptoms and are among the most affected by the pandemic, and recognizing that necessary prevention and control efforts are hampered by, inter alia, lack of

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<sup>1</sup> See decision WHA75(11).

universal access to quality, safe, effective, affordable essential health services, medicines, diagnostics and health technologies, as well as a global shortage of qualified health workers”.

5. Lack of functioning civil registration and vital statistics systems as well as different processes to test and report COVID-19 deaths make it difficult to account for accurate, complete and timely data on causes of deaths and comorbidities, including from COVID-19 among people living with or at risk of noncommunicable diseases.

6. The virus and the pandemic affect people living with or at risk of noncommunicable diseases through different pathways, including:

- (a) a higher susceptibility to COVID-19 infection and higher severity and case fatality rates among people with noncommunicable diseases;
- (b) delays in diagnosis of noncommunicable diseases, resulting in more advanced disease stages;
- (c) delayed, incomplete or interrupted therapy of noncommunicable diseases; and
- (d) increases in behavioural risk factors for noncommunicable diseases, such as physical inactivity, increased harmful use of alcohol, tobacco use and unhealthy diets.

7. COVID-19 has disproportionately impacted people living with or at risk of noncommunicable diseases, including economically disadvantaged groups such as migrant workers, older adults, as well as forcibly displaced and refugee populations in humanitarian contexts. Therefore, the pandemic magnified and further drew attention to persistent inequalities in both health outcomes and health determinants, including noncommunicable disease risk factors, social determinants and access to health services, both within and across countries. Working long-term and recognizing how COVID-19 and noncommunicable diseases are syndemically interlocked conditions<sup>1,2</sup> may be the first step towards developing the nuanced approaches that are needed to more comprehensively protect society’s vulnerable populations.

8. Disruptions of essential noncommunicable disease health services due to COVID-19 have been widespread due to the shortage of medicines, staff, diagnostics and public transport services among other constraints. The rapid assessment survey of the impact of the COVID-19 pandemic on noncommunicable disease resources and services,<sup>3</sup> conducted by WHO’s Noncommunicable Disease Department in May 2020 and to which 163 Member States (84%) responded, reported widespread complete or partial disruptions to a range of noncommunicable disease services across countries. Some 59% of countries reported that access to outpatient essential noncommunicable disease services were restricted to some degree, while 35% reported that inpatient noncommunicable disease services were open for emergencies only. About half of countries reported complete or partial disruptions to hypertension management services (53%) or to diabetes and diabetic complication management services (49%). In terms of disruption of activities, 77% of countries reported some disruption to ministry of health noncommunicable disease activities planned for 2020, such as screening programmes, awareness

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<sup>1</sup> Horton, R. Offline: COVID-19 is not a pandemic. *Lancet*. 2020;396(10255):874. doi: 10.1016/S0140-6736(20)32000-6.

<sup>2</sup> Nassereddine, G, Habli, S, Slama, S, Sen, K, Rizk, A, Sibai, AM. COVID-19 and noncommunicable diseases in the Eastern Mediterranean Region: the need for a syndemics approach to data reporting and health care delivery. *BMJ Glob Health*. 2021;6(6):e006189. doi: 10.1136/bmjgh-2021-006189.

<sup>3</sup> The impact of the COVID-19 pandemic on noncommunicable disease resources and services: results of a rapid assessment. Geneva: World Health Organization; 2020.

campaigns, population-based surveys (STEPS)<sup>1</sup> or training courses and implementation of WHO technical packages<sup>2</sup> such as WHO/PEN<sup>3</sup> and WHO/HEARTS.<sup>4</sup>

9. The COVID-19 pandemic increased also rehabilitation needs in those who were affected by the virus with an anticipated secondary surge in needs as the pandemic settles, due to the disruption of routine health and rehabilitation services, as well as the potential long-term impacts and sequelae among people living with noncommunicable diseases and other people infected by the virus.

10. The subsequent two rounds of WHO-wide surveys assessing the continuity of essential health services during the COVID-19 pandemic (pulse surveys) revealed less severe but persistent disruption of services, including for noncommunicable diseases.<sup>5</sup> Complementing these surveys, WHO's Noncommunicable Disease Department invited countries to complete a COVID-19-related module as part of the periodic assessment of national capacity for noncommunicable disease prevention and control, between May and September 2021. This assessment confirmed enduring disruption, with 70% of Member States reporting some disruption to noncommunicable disease-related services more than one year into the pandemic. At least half of countries reported disruptions for diabetes and hypertension management services, cancer screening and treatment services as well as asthma services. Cancer screening services were most likely to be severely disrupted, with more than 10% of Member States still reporting a high level of disruption.<sup>6</sup>

11. The lack of understanding and attention given to the interplay between the virus and noncommunicable diseases in the early stages of the COVID-19 pandemic hampered the inclusion of noncommunicable diseases in country strategic preparedness and response plans. A review of 87 plans and 121 documents through a noncommunicable disease lens, which was conducted by WHO in October 2020, revealed that only 33 countries included noncommunicable diseases as part of the essential health services to be maintained during the pandemic, only 16 countries included the management of noncommunicable diseases and only 3 countries had a specific budget line for noncommunicable diseases. Deeply concerned about this blind spot, the United Nations General Assembly, in resolution 74/306 (2020), called upon Member States “to further strengthen efforts to address noncommunicable diseases as part of universal health coverage, recognizing that people living with noncommunicable diseases are at a higher risk of developing severe COVID-19 symptoms and are among the most impacted by the pandemic”. Similarly, in resolution 75/130 (2020), entitled “Global health and foreign policy: strengthening health system resilience through affordable health care for all”, adopted in December 2020, the General Assembly noted with concern the severe impact COVID-19 on people living with noncommunicable diseases, stressing the importance of monitoring the indirect impacts of the COVID-19 pandemic on integrated service delivery as well as maintaining the essential

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<sup>1</sup>STEPwise Approach to NCD Risk Factor Surveillance (STEPS). Geneva: World Health Organization (<https://www.who.int/teams/noncommunicable-diseases/surveillance/systems-tools/steps>, accessed 1 December 2021).

<sup>2</sup> Noncommunicable diseases: About us. Geneva: World Health Organization (<https://www.who.int/teams/noncommunicable-diseases/about>, accessed 1 December 2021).

<sup>3</sup> WHO package of essential noncommunicable (PEN) disease interventions for primary health care. Geneva: World Health Organization ([https://www.who.int/publications/i/item/who-package-of-essential-noncommunicable-\(pen\)-disease-interventions-for-primary-health-care](https://www.who.int/publications/i/item/who-package-of-essential-noncommunicable-(pen)-disease-interventions-for-primary-health-care), accessed 1 December 2021).

<sup>4</sup> HEARTS Technical Package. Geneva: World Health Organization (<https://www.who.int/publications/i/item/hearts-technical-package>, accessed 1 December 2021).

<sup>5</sup> Second round of the national pulse survey on continuity of essential health services during the COVID-19 pandemic January–March 2021. Geneva: World Health Organization; 2021.

<sup>6</sup> Assessment of noncommunicable diseases service disruption during the COVID-19 pandemic. Geneva: World Health Organization; 2021 (<https://cdn.who.int/media/docs/default-source/ncds/ncd-surveillance/ncd-rapid-assessment-covid-19-2021.pdf>, accessed 28 February 2022).

part of health care delivery and global supply chains, including for noncommunicable diseases, and called for governments to reaffirm their commitments made under the political declaration of the third high-level meeting of the General Assembly on the prevention and control of noncommunicable diseases to accelerate the implementation of national noncommunicable diseases responses as part of the 2030 Agenda.

12. To support countries in mitigating the disruption of essential health services, WHO released in March 2020 and subsequently updated an operational guidance on maintaining essential services during the outbreak, outlining basic principles and practical recommendations that support decision-making to ensure the continuity of selected essential health services, highlighting key actions that countries should consider, including for noncommunicable diseases. Another guidance was issued in January 2021 to support countries in analysing and using routine data to monitor the effects of COVID-19 on essential health services.<sup>1</sup>

13. WHO's Noncommunicable Disease Department contributed to this normative work through the development of scientific briefs summarizing the latest evidence for the susceptibility and/or negative impact on outcomes for COVID-19 from the presence of specific noncommunicable diseases, as well as the development of modelling studies with policy scenarios to model possible service delivery model changes, the economic parameters associated with these and the mid-term and long-term health impacts, including on meeting SDG target 3.4. The work was complemented by numerous case studies documenting how countries mitigated the disruptions to noncommunicable disease-related services, including through innovative digital health solutions (such as the use of mobile health technologies to support people living with noncommunicable diseases or the use of telemedicine to ensure continuity of care).<sup>2</sup>

14. As the world engages in a new phase of the pandemic, rolling out COVID-19 vaccines in the attempt to control the pandemic, the review of the situation of noncommunicable diseases during the pandemic has demonstrated that noncommunicable disease preparedness and response must be part of any pandemic response and preparedness at global, regional and national levels. Recovery and building back better needs to go together with action to address noncommunicable diseases. The prevention, screening, early diagnosis and treatment of hypertension, diabetes, cancer and other noncommunicable diseases cannot be postponed because the noncommunicable disease epidemic is not on hold. Addressing noncommunicable diseases and COVID-19 simultaneously and at sufficient scale requires a response stronger than any seen before to safeguard lives and livelihoods. Furthermore, the lessons learned from the COVID-19 pandemic offer opportunities for strengthening emergency preparedness and responses beyond pandemic ones.

15. Beyond the COVID-19 pandemic, WHO was, as at 8 December 2021, aware of and responding to 73 active emergencies graded according to the WHO Emergency Response Framework.

## **FROM COVID-19 TO AN ALL-HAZARDS EMERGENCY PREPAREDNESS AND RESPONSE APPROACH FOR NONCOMMUNICABLE DISEASES**

16. The number of people currently affected by humanitarian emergencies worldwide is unprecedented. The United Nations Office for the Coordination of Humanitarian Affairs has estimated that 235 million people will need humanitarian assistance and protection in 2021. Responding to these emergencies, the United Nations and partner organizations aim to assist 160 million people most in need

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<sup>1</sup> Analysing and using routine data to monitor the effects of COVID-19 on essential health services: practical guide for national and subnational decision-makers. Geneva: World Health Organization; 2021.

<sup>2</sup> The impact of the COVID-19 pandemic on noncommunicable disease resources and services: results of a rapid assessment. Geneva: World Health Organization; 2020.



across 56 countries and will require a total of US\$ 35 billion to do so.<sup>1</sup> As a result of climate change, population growth, unplanned urbanization, food insecurity and massive movements of people, emergencies have become more and more complex, protracted and interlinked.

17. While the COVID-19 pandemic has shifted the attention to pandemic emergency preparedness and responses, the nature and frequency of emergencies require the global health community to adopt a broader approach, in which all types of hazards are assessed, anticipated and better responded to. The special session of the World Health Assembly which was held later last year to consider developing a WHO convention, agreement or other international instrument on pandemic preparedness and response offered a unique opportunity to better address the need of people living with noncommunicable diseases in humanitarian emergencies and contributed to assignment under resolution WHA74.7 (2021) to strengthen country, international partners and WHO preparedness for and response to health emergencies, through a multisectoral, all-hazards approach.

## LESSONS LEARNED AND OPPORTUNITIES

18. Due to population growth and ageing, among other factors, the noncommunicable disease burden among populations affected by natural and man-made disasters is growing and will further require better inclusion of a noncommunicable disease component in emergency preparedness and responses. The decade of protracted conflicts in the Middle East, the evolving health profile and the identified needs of forcibly displaced populations from Afghanistan, the Bolivarian Republic of Venezuela, Ethiopia, Myanmar and South Sudan, as well as the unfolding humanitarian crisis in Ukraine, provide strong evidence for the need to strengthen the noncommunicable disease component of emergency preparedness and responses. The experience gained by WHO and humanitarian partners in providing technical assistance in countries in emergencies should be further analysed and capitalized on.

19. The following developments represent opportunities for the global health community to establish a better response for the people living with noncommunicable diseases as part of emergency preparedness and responses.

(a) The current pandemic triggered renewed attention to the specific considerations of planning and maintaining essential health services, including in humanitarian settings.<sup>2,3,4</sup> Managing COVID-19 epidemics in fragile states and crisis-affected populations presents a challenge for countries and humanitarian actors, with huge competing population needs and limited resources, if essential health services are unable to be safely delivered or accessed and if the pre-crisis services to be maintained, adapted or suspended are not prioritized and/or widely made available and subsidized as part of national benefit health packages.

(b) Complementing WHO interim guidance on essential health services during an outbreak, the WHO Global Health Cluster COVID-19 Taskforce developed a guidance note on how to

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<sup>1</sup> Global Humanitarian Overview 2021. United Nations Office for the Coordination of Humanitarian Affairs; 2021.

<sup>2</sup> Blanchet K, Alwan A, Antoine C, Cros MJ, Feroz, F, Guracha TA, et al. Protecting essential health services in low-income and middle-income countries and humanitarian settings while responding to the COVID-19 pandemic. *MJ Glob Health.* 2020;5(10):e003675. doi: 10.1136/bmjgh-2020-003675.

<sup>3</sup> Singh L, Singh NS, Maldonado BN, Tweed S, Blanchet K, Graham WJ. What does “leave no one behind” mean for humanitarian crises-affected populations in the COVID-19 pandemic? *BMJ Glob Health.* 2020; 5(4): e002540. doi: 10.1136/bmjgh-2020-002540.

<sup>4</sup> Garry S, Abdelmagid N, Baxter L, Roberts N, de Waroux OLP, Ismail S, et al. Considerations for planning COVID-19 treatment services in humanitarian responses. *Confl Health.* 2020;14(1):80. doi:10.1186/s13031-020-00325-6.

prioritize and plan essential health services during COVID-19 response in humanitarian settings.<sup>1</sup> More recently, efforts are under way under the Task Force and the WHO Emergency Programme to define a minimum set of evidence-based services (package of high-priority health services in humanitarian settings) that are relevant and operationally feasible for humanitarian settings for health clusters and health cluster partners to promote, use and progressively guarantee. Informed by existing reference packages from fragile and conflict-affected cluster settings, the anticipated high-priority health services package will draw on recommended interventions and actions developed under the WHO UHC Compendium.

(c) The development and deployment of the WHO noncommunicable disease kit since 2017 in more than 20 countries and humanitarian hubs worldwide, including during the COVID-19 pandemic,<sup>2</sup> contributed to addressing part of the unmet needs for noncommunicable disease essential medicines and supplies during emergencies. With more than 7500 kit modules procured since 2017, at an annual value of US\$ 3.6 million, the noncommunicable disease kit has filled a critical gap, becoming one of the most procured WHO standard emergency health kits. Recent reviews of the experience gained in using the noncommunicable disease kit informed its 2021 revision, also highlighting actions to be taken to improve its planning and distribution, as well as the support to be provided to build the capacity of humanitarian and primary care responders.

(d) Attention to noncommunicable diseases in humanitarian settings, as well as coordination among United Nations agencies, humanitarian responders and donors, is growing and improving. The Informal Interagency Working Group on NCDs in Humanitarian Settings, the WHO Global Health Cluster and the International Alliance for Diabetes Action<sup>3</sup> not only provide platforms for the exchanges of information and practices but increasingly contribute to the co-creation of solutions to improve noncommunicable disease management in practice.

(e) Crises/affected populations such as forcibly displaced people and refugees can provide critical reflections on how emergencies impact their lives and help shape the design of policies and service delivery programmes that are meant to address their needs. The Apart Together survey of refugees' and migrants' self-reported impact of COVID-19 or the series of consultations organized by regional chapters of the NCD Alliance, such as the "Voices of People Living with NCDs in Humanitarian Crises",<sup>4</sup> represent positive examples of inclusiveness, complementing the efforts of WHO and civil society partners in advocating for the meaningful engagement of people with noncommunicable diseases.

(f) Research outputs on noncommunicable diseases and COVID-19 and more broadly on noncommunicable diseases in humanitarian settings are increasing in scope and quality, providing a stronger evidence basis to inform the design of policies and programmes. Drawing on descriptive epidemiological studies reporting on the burden of noncommunicable disease among COVID-19 or other crisis-affected population, a much greater emphasis has been placed on access to noncommunicable disease services and models of care for noncommunicable disease adapted

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<sup>1</sup> Essential Health Services: A guidance note. How to prioritize and plan essential health services during COVID-19 response in humanitarian settings. Geneva: World Health Organization; 2020.

<sup>2</sup> WHO Provides NCD Kits to Timor-Leste to Prevent Risk of Comorbidity Amidst COVID-19 Pandemic. Press release. Geneva: World Health Organization (<https://www.who.int/southeastasia/news/feature-stories/detail/who-provides-ncd-kits-to-timor-leste-to-prevent-risk-to-comorbidity-amidst-covid-19-pandemic>, accessed 1 December 2021).

<sup>3</sup> See International Alliance for Diabetes Action website (<https://www.iadadiabetes.org/>).

<sup>4</sup> Amplifying voices and perspectives of people living with NCDs in the Eastern Mediterranean Region. NCD Alliance; 2020 (<https://ncdalliance.org/news-events/news/amplifying-voices-and-perspectives-of-people-living-with-ncds-in-the-eastern-mediterranean-region>, accessed 1 December 2021).

to humanitarian settings.<sup>1</sup> Several initiatives and platforms have recently been launched, complementing WHO's efforts in shaping the research agenda.<sup>2</sup>

## RECOMMENDATIONS

### 20. Recommended actions for **Member States**:

#### (a) **COVID-19 related**:

- integrate and strengthen policies, programmes and services to treat people living with noncommunicable diseases and prevent and control their risk factors into country COVID-19 response and recovery plans, in line with United Nations comprehensive plans;
- collect and use data to assess the impact of COVID-19 on people living with noncommunicable diseases and monitor the impact of the pandemic on noncommunicable disease services disruption, morbidity and mortality;
- maintain, restore and scale up prevention, early diagnosis and care for people living with or at high risk of noncommunicable diseases as soon as feasible and ensure that they are protected from exposure to COVID-19 and considered in health and social protection;
- mobilize and use COVID-19 and other emergency funding to support the provision and continuity of essential services, ensuring access to essential, safe, affordable, quality and effective noncommunicable disease medicines and supplies, including for the prevention and control of noncommunicable diseases and their modifiable risk factors;
- ensure the meaningful engagement of civil society, health professionals and people living with noncommunicable diseases in the planning, implementation and evaluation of national COVID-19 preparedness and response plans;
- prioritize people living with noncommunicable diseases in national deployment and vaccination roll-outs for COVID-19 vaccines; and
- raise awareness about the links between COVID-19 and noncommunicable diseases, how people living with noncommunicable diseases can protect themselves, their families and communities from COVID-19 and how they can access and maintain safe continuity of care for their condition;

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<sup>1</sup> Jaung MS, Willis R, Sharma P, Aebischer Perone S, Frederiksen S, Truppa C, et al. Models of care for patients with hypertension and diabetes in humanitarian crises: a systematic review. *Health Policy Plan.* 2021;36(4):509-532. doi: 10.1093/heapol/czab007.

<sup>2</sup> NCDs in Humanitarian Settings. A knowledge hub presenting the key resources around NCDs in humanitarian settings accessibly in one place. London School of Hygiene and Tropical Medicine (<https://www.lshtm.ac.uk/research/centres-projects-groups/humanitarian-ncd>, accessed 1 December 2021).

**(b) Beyond COVID-19 (all hazards):**

- work towards achieving strong and resilient health systems with universal health coverage and primary health care, as an essential foundation for effective preparedness and response to public health emergencies:
  - include policies, programmes and services for the prevention and control of noncommunicable diseases and their modifiable risk factors as part of national and subnational efforts to strengthen health systems to better prepare for, respond to and recover from health emergencies, through a multisectoral all-hazards approach;
  - meaningfully involve people living with noncommunicable diseases, affected communities and those in vulnerable situations, including forcibly displaced populations and refugees, in order to better understand their health needs, empower their individual emergency preparedness and shape noncommunicable disease health policies, programmes and services;
  - take steps to ensure that a minimum set of quality noncommunicable disease services are made available to affected populations, as part of a prioritized essential noncommunicable disease health package to be guaranteed during any health emergency, at various levels of care, considering national humanitarian and health system contexts;
  - accelerate the implementation of national noncommunicable disease road maps, ensuring that national benefit packages include a bundle of services for the prevention and control of noncommunicable diseases and their risk factors, with sufficient pre-payment mechanisms to minimize financial hardship for people with noncommunicable diseases;
  - develop strategies and tools to strengthen core public health capacities and workforces for the provision of noncommunicable disease services in humanitarian settings, including through digital health solutions;
  - ensure access to essential, safe, affordable, quality and effective noncommunicable disease medicines and supplies in emergency preparedness and response plans and as part of emergency procurements, pre-positionings and deployments, guided by WHO standard noncommunicable disease kit and other essential bulk items, with appropriate consideration for cold chain-sensitive medicines such as insulin; and
  - document countries experiences and promote research on noncommunicable disease in humanitarian settings.

**21. Recommended actions for international, humanitarian partners, civil society and the private sector:**

- advocate for the inclusion of programmes and services for the prevention and control of noncommunicable diseases and their modifiable risk factors as part of a multisectoral all-hazards approach to health emergency preparedness and responses, including in current COVID-19 country strategic preparedness and response plans;
- strengthen partnerships, global coordination and cooperation between United Nations agencies, humanitarian organizations, civil society, people living with noncommunicable diseases and the private sector to support all countries, upon their request, in implementing their

multisectoral national action plans, for strengthening their health systems response to health emergencies, including for maintaining the safe provision noncommunicable disease services during them;

- support the development, implementation and continuity of a prioritized essential noncommunicable disease health package to be guaranteed in health emergencies, at various levels of care, considering national and subnational humanitarian and health system contexts;
- support countries in building their public health and workforce capacity for integrated care in humanitarian settings, with strengthened capabilities to work across noncommunicable diseases and other diseases/conditions;
- support countries to strengthen investment in research, evidence generation, enhanced guidelines, evaluation and monitoring to support contextual implementation and ensure quality and accountability;
- support countries in the procurement and deployment of essential, safe, affordable, quality and effective noncommunicable disease medicines and supplies, including WHO standard noncommunicable disease kits or other essential bulk items, with appropriate consideration for cold chain-sensitive medicines such as insulin;
- promote and support research on noncommunicable disease in humanitarian settings; and
- support and advocate for people living with noncommunicable diseases to be meaningfully consulted and engaged in the design, implementation and evaluation of noncommunicable disease policies, programmes and services in humanitarian settings

22. Recommended actions for **WHO**:

- As part of ongoing efforts for strengthening WHO preparedness for and response to health emergencies and reinforcing its leadership and coordination of the Inter-Agency Standing Committee Health Cluster and its complementarity to other humanitarian actors:
  - review current WHO noncommunicable disease-related responses in countries in emergencies and suggest a strategic approach to improving WHO technical assistance to countries across preparedness, response and recovery, leveraging crises as an entry point to build health systems back better through development of sustainable noncommunicable disease services;
  - strengthen collaboration and communication across WHO, including with the Global Health Cluster and other humanitarian partners such as the Informal Interagency Group on NCDs in Humanitarian Settings, in order to enhance WHO leadership and normative functions and better assist countries in emergencies;
  - in collaboration with the WHO Emergency Health Programme, the Global Health Cluster and other humanitarian and academic partners, develop a prioritized essential noncommunicable disease health package to be guaranteed in health emergencies, at various levels of care, considering national humanitarian and health system contexts, drawing on the WHO UHC Compendium;
  - support countries in the prioritization, procurement and deployment of essential, safe, affordable, quality and effective noncommunicable disease medicines and supplies,

including WHO standard noncommunicable disease kits and essential bulk items, with appropriate consideration for cold chain-sensitive medicines such as insulin;

- support countries in building their public health and workforce capacity for integrated care in humanitarian settings, with strengthened capabilities to work across noncommunicable diseases and other diseases/conditions;
  - strengthen WHO’s normative role and technical capacity to develop and disseminate normative products, technical guidance, tools, data and scientific evidence in order to support countries in developing and implementing national response plans to health emergencies, with necessary provisions for treating people living with noncommunicable diseases and for preventing and controlling their risk factors in humanitarian emergencies;
  - further advocate with donors the prioritization of building bridges with a view to prioritizing noncommunicable diseases in humanitarian emergencies across the health, development and peace-building sectors;
  - strengthen global, regional and country preparedness and response capabilities and capacities for health emergencies by enhancing the meaningful engagement of people living with noncommunicable diseases in the planning, implementation and evaluation of national preparedness and response plans; and
  - engage WHO noncommunicable disease technical advisory groups and other academic partners to shape the research agenda and document country experiences in order to inform policies for strengthening noncommunicable disease emergency preparedness and responses.
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## ANNEX 12

### **Intersectoral global action plan on epilepsy and other neurological disorders 2022–2031<sup>1</sup>**

[A75/10 Add.4, Annex 7 – 27 May 2022]

[Paragraphs 1–3 described the background to the intersectoral global action plan on epilepsy and other neurological disorders 2022–2031, including the mandate for and process of its development.]

#### **OVERVIEW OF THE GLOBAL SITUATION**

4. Disorders of the nervous system are the leading cause of DALYs and the second leading cause of death globally, accounting for 9 million deaths per year. The five largest contributors of neurological DALYs in 2016 were stroke (42.2%), migraine (16.3%), dementia (10.4%), meningitis (7.9%) and epilepsy (4.9%).<sup>2</sup> Globally in 2016, 52.9 million children younger than 5 years had developmental disabilities and 95% of these children lived in low- and middle-income countries.<sup>3</sup>

5. The high burden associated with neurological disorders is compounded by profound health inequities. For example, nearly 80% of the 50 million people with epilepsy live in low- and middle-income countries, where treatment gaps exceed 75% in most low-income countries and exceed 50% in most middle-income countries.<sup>4</sup> Disabilities associated with neurological conditions inordinately affect women, older people, those living in poverty, rural or remote areas and other vulnerable populations. Women are also often disproportionately affected by neurological disorders, such as dementia, migraine and multiple sclerosis. Children from underprivileged households, indigenous populations, ethnic minorities and internally displaced or stateless persons, refugees and migrants are also at significantly higher risk of experiencing disability associated with neurological conditions.

6. Neurological disorders lead to increased costs for governments, communities, families and individuals, as well as to loss of productivity for economies. In 2010, brain disorders were estimated to cost € 798 billion in Europe alone.<sup>5</sup> In 2019, the total global societal cost of dementia was estimated at US\$ 1.3 trillion, equivalent to 1.5% of global GDP.<sup>6</sup>

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<sup>1</sup> See decision WHA75(11).

<sup>2</sup> Global, regional, and national burden of neurological disorders, 1990–2016: a systematic analysis for the Global Burden of Disease Study 2016. *Lancet Neurol.* 2019;18(5):459–480. doi: 10.1016/S1474-4422(18)30499-X. See also Global health estimates 2020: Disease burden by cause, age, sex by country and by region, 2000–2019. Geneva: World Health Organization; 2020.

<sup>3</sup> Developmental disabilities among children younger than 5 years in 195 countries and territories, 1990–2016: a systematic analysis for the Global Burden of Disease Study 2016. *Lancet.* 2018;6(10):E100–E1121. doi: 10.1016/S2214-109X(18)30309-7.

<sup>4</sup> Epilepsy: a public health imperative. Geneva: World Health Organization; 2019.

<sup>5</sup> J Olesen 1, A Gustavsson, M Svensson, H-U Wittchen, B Jönsson, CDBE2010 study group, et al. The economic cost of brain disorders in Europe. *Eur J Neurol.* 2012; 19(1):155–162. doi: 10.1111/j.1468-1331.2011.03590.x.

<sup>6</sup> Global status report on the public health response to dementia. Geneva: World Health Organization; 2021.

7. Many neurological conditions are preventable, including 25% of the global burden of epilepsy cases.<sup>1</sup> Numerous determinants, including environmental risk factors and protective factors, are known to impact brain development in early life and brain health across the life course. Protective factors for brain development in early life include components such as education, social connection and support, healthy diets, sleep and physical activity.

8. Worldwide, people living with neurological disorders and associated disabilities continue to experience discrimination and human rights violations. For this reason, the intersectoral global action plan on epilepsy and other neurological disorders 2022–2031 is underpinned by a human rights perspective that is grounded in the International Covenant on Civil and Political Rights, the International Covenant on Economic, Social and Cultural Rights, the Convention on the Rights of Persons with Disabilities, the Convention on the Rights of the Child and other relevant international and regional human rights instruments.

9. Supporting the appropriate health system building blocks is particularly important for improving the quality of life of people living with neurological disorders. The implementation of appropriate policy and legislative frameworks is crucial and should aim to promote quality care, provide financial and social protection benefits (including protection from out-of-pocket expenditures) and ensure respect and fulfilment of the rights of people with neurological disorders. Comprehensive responses aimed at tackling neurological disorders should be firmly grounded in a social and economic determinants of health approach.

10. Health systems have not yet adequately responded to the burden of neurological disorders. While approximately 70% of people with neurological disorders live in low- and middle-income countries,<sup>2</sup> their needs are poorly recognized, with only 28% of low-income countries reporting that they have a dedicated policy for neurological disorders.<sup>3</sup> Currently, the number of health workers specialized in neurological health is insufficient to tackle the treatment gaps globally. The median neurological workforce (defined as the total number of adult neurologists, neurosurgeons and child neurologists) in low-income countries is 0.1 per 100 000 people, compared to 7.1 per 100 000 people in high-income countries.<sup>3</sup>

11. The ongoing COVID-19 pandemic highlights the relevance of neurology to global public health and its significance in broader global health dialogues. Disruption of services, medication inaccessibility, interruption in vaccination programmes and increased mental health issues have added to the burden of those with neurological disorders. More directly, neurological manifestations of COVID-19 infection are present in both the acute stage and the post-COVID-19 condition. Certain underlying neurological conditions represent a risk factor for hospitalization and death due to COVID-19, especially for older adults.<sup>4</sup> The intersectoral global action plan on epilepsy and other neurological disorders 2022–2031 represents an unprecedented opportunity to address the impact of neurological disorders through a comprehensive response throughout and following the pandemic.

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<sup>1</sup> Epilepsy: a public health imperative. Geneva: World Health Organization; 2019.

<sup>2</sup> Feigin VL, Vos T, Nichols E, Owolabi MO, Carroll WM, Dichgans M, et al. The global burden of neurological disorders: translating evidence into policy. *Lancet Neurol.* 2020 Mar;19(3):255-265. doi: 10.1016/S1474-4422(19)30411-9.

<sup>3</sup> ATLAS Country Resources for Neurological Disorders, second edition. Geneva: World Health Organization; 2017.

<sup>4</sup> WHO's Scientific Brief on Neurology and COVID-19 (<https://www.who.int/publications/i/item/WHO-2019-nCoV-Sci-Brief-Neurology-2021.1>, accessed 6 April 2022).



## SCOPE

12. The term “neurological disorders” is used to denote conditions of the central and peripheral nervous systems that include epilepsy; headache disorders (including migraine); neurodegenerative disorders (including dementia and Parkinson’s disease); cerebrovascular diseases (including stroke); neuroinfectious/neuroimmunological disorders (including meningitis, HIV, neurocysticercosis, cerebral malaria and multiple sclerosis); neuromuscular disorders (including peripheral neuropathy, muscular dystrophies and myasthenia gravis); neurodevelopmental disorders (including autism spectrum disorder and congenital neurological disorders); traumatic brain and spinal cord injuries; and cancers of the nervous system. While some neurological disorders are rare, they are still responsible for high morbidity and mortality.

13. In line with WHO’s International Classification of Functioning, Disability and Health, functioning and disability are considered the result of interactions between neurological conditions and contextual factors across the life course. For this reason, a holistic approach is required to account for medical, individual, social and environmental influences.

14. Addressing the needs of people with neurological conditions begins with increasing understanding and awareness and addressing stigma and discrimination, which impact well-being and act as barriers to seeking health care. Rather than adopting a disease-specific structure, the intersectoral global action plan on epilepsy and other neurological disorders 2022–2031 uses an integrated, person-centred framework for the prevention, diagnosis, treatment and care of people with neurological disorders. The prevention of neurological disorders rests upon the promotion and development of optimal brain health across the life course. Good brain health is a state in which every individual can learn, realize their potential and optimize their cognitive, psychological, neurophysiological and behavioural responses, while adapting to changing environments.

15. Other relevant areas or disciplines of public health are closely intertwined with and impact neurological disorders, such as mental health, violence, injuries, noncommunicable and infectious diseases, and environmental health. Many neurological conditions are woven into other WHO strategies, action plans or World Health Assembly resolutions. In addition, neurological disorders have strategic links to health systems and UHC, including the full range of essential health services, from health promotion to prevention, treatment, rehabilitation and palliative care. The intersectoral global action plan on epilepsy and other neurological disorders 2022–2031 is consistent with the 2030 Agenda and the SDGs and takes a life course approach, recognizing that there are strong linkages between maternal, newborn, child and adolescent health, reproductive health and ageing, and brain health and neurological disorders.

16. Linking the intersectoral global action plan on epilepsy and other neurological disorders 2022–2031 with other global commitments<sup>1</sup> reflects WHO’s responsiveness to focusing on the impact on people’s health and working in a cohesive and integrated manner.

17. The intersectoral global action plan on epilepsy and other neurological disorders 2022–2031 provides the vision, goal, guiding principles and strategic objectives with their action areas and targets. It suggests a range of proposed actions for Member States, the WHO Secretariat and international and

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<sup>1</sup> The list of resolutions and global commitments relevant to neurological disorders is available at <https://www.who.int/news/item/12-01-2022-draft-intersectoral-global-action-plan-on-epilepsy-and-other-neurological-disorders-2022-2031> (accessed 6 April 2022).

national partners. While targets are defined for achievement globally, each Member State can be guided by these to set its own national targets, taking into account national circumstances and challenges.<sup>1</sup>

## **VISION**

18. The vision of the intersectoral global action plan on epilepsy and other neurological disorders 2022–2031 is a world in which:

- brain health is valued, promoted and protected across the life course;
- neurological disorders are prevented, diagnosed and treated, and premature mortality and morbidity are avoided; and
- people affected by neurological disorders and their carers attain the highest possible level of health, with equal rights, opportunities, respect and autonomy.

## **GOAL**

19. The goal of the intersectoral global action plan on epilepsy and other neurological disorders 2022–2031 is to reduce the stigma, impact and burden of neurological disorders, including their associated mortality, morbidity and disability, and to improve the quality of life of people with neurological disorders, their carers and families.

20. In order to achieve the vision and goal defined above, the prevention, treatment and care of epilepsy and other neurological disorders should be strengthened, wherever possible, utilizing entry points and synergies to achieve the best results for all.

## **STRATEGIC OBJECTIVES**

21. The intersectoral global action plan on epilepsy and other neurological disorders 2022–2031 has the following strategic objectives:

- raise policy prioritization and strengthen governance;
- provide effective, timely and responsive diagnosis, treatment and care;
- implement strategies for promotion and prevention;
- foster research and innovation and strengthen information systems; and
- strengthen the public health approach to epilepsy.

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<sup>1</sup> A summary of global targets and indicators is available at <https://www.who.int/news/item/12-01-2022-draft-intersectoral-global-action-plan-on-epilepsy-and-other-neurological-disorders-2022-2031> (accessed 28 February 2022).

## GUIDING PRINCIPLES

22. The intersectoral global action plan on epilepsy and other neurological disorders 2022–2031 relies on the following six guiding principles.

(a) People-centred primary health care and universal health coverage

All people with neurological disorders and their families should participate in and have equitable access, without discrimination or risk of financial hardship, to a broad range of promotive, preventive, diagnostic, treatment, rehabilitation, palliative and social care, as well as to essential, effective, safe, affordable and quality medicines and other health products.

(b) Integrated approach to care across the life course

Integrated care for neurological disorders is essential for achieving better promotion, prevention and management outcomes. This is particularly important given the multimorbidity of neurological disorders with one another and with other health conditions, which are often linked by common preventable risk factors. Care for neurological disorders requires close alignment to other existing services and programmes, in line with the Framework on Integrated, People-centred Health Services,<sup>1</sup> as well as consideration of the health and social care needs at all stages of the life course.

(c) Evidence-informed policy and practice

Scientific evidence and/or best practices enable the development of public health policies and interventions for the prevention and management of neurological disorders that are cost-effective, sustainable and affordable. This includes existing knowledge, real-world, practice-based evidence, the preferences of people with neurological disorders and culture-based experience, as well as the translation of new evidence into policy and practice that work towards finding disease-modifying treatments or cures, effective prevention and innovative models of care.

(d) Intersectoral action

A comprehensive and coordinated response to neurological disorders requires partnerships and collaboration among all stakeholders. Achieving such collaboration requires leadership at governmental levels; clear delineation of roles and responsibilities among stakeholders; innovative coordination mechanisms, including public–private partnerships; engagement of all relevant sectors, such as health, social services, education, environment, finance, employment, justice and housing; and partnerships with civil society, academia, private sector actors and associations representing those with neurological disorders.

(e) Empowerment and involvement of persons with neurological disorders and their carers

The social, economic and educational needs and freedoms of persons and families affected by neurological disorders should be promoted, prioritized and protected. People with neurological disorders, their carers, local communities and organizations that represent them should be

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<sup>1</sup> See document A69/39; see also Framework on integrated people-centred health services (IPCHS) (<https://www.who.int/teams/integrated-health-services/clinical-services-and-systems/service-organizations-and-integration>, accessed 25 April 2022).

empowered through engagement and consultative mechanisms in care planning and service delivery as well as in policy and legislation development, programme implementation, advocacy, research, monitoring and evaluation.

(f) Gender, equity and human rights

Mainstreaming a gender perspective on a system-wide basis in all efforts to implement public health responses to neurological disorders is central to creating inclusive, equitable and healthy societies. Universal access to interventions for people with neurological disorders and their carers, as well as a focus on reaching the most vulnerable population groups, including migrants, children, women, older people, those living in poverty and those in emergency settings, are crucial to realizing the rights of people with neurological disorders and reducing stigma and discrimination. The implementation of the intersectoral global action plan on epilepsy and other neurological disorders 2022–2031 must explicitly address disparities specific to each national context and reduce inequalities.

### **STRATEGIC OBJECTIVE 1: RAISE POLICY PRIORITIZATION AND STRENGTHEN GOVERNANCE**

23. A broad public health approach grounded in principles of universal health coverage and human rights is needed to improve the care and quality of life of people with neurological disorders. To achieve this, strengthening governance for neurological disorders involves ensuring that strategic policy frameworks are established and supported by effective oversight, regulatory and accountability mechanisms.

24. Lack of knowledge and awareness needs to be addressed at all levels of society, including among government representatives, people with neurological disorders and other stakeholders, in order to change the major structural and attitudinal barriers to achieving positive brain health outcomes, reduce stigma and discrimination, promote the human rights of people with neurological disorders and improve their care and quality of life.

25. Effective advocacy can influence political commitment and mobilize resources to support policy prioritization of neurological disorders, including interlinkages with achieving broader international commitments such as those outlined in the 2030 Agenda for Sustainable Development and its Sustainable Development Goals and the Convention on the Rights of Persons with Disabilities.

26. The integration and mainstreaming of neurological disorders in relevant evidence-informed national policies, legislation and guidelines within and beyond the health sector, including in education, social protection and employment, is important to meet the multifaceted needs of people with neurological disorders.

27. Health financing is a core function of health systems that can enable progress towards achieving universal health coverage. It involves designing and implementing policies to ensure effective health system governance and service arrangements, including through raising revenue, pooling funds and purchasing services (such as the allocation of resources to health service providers) in order to support access to timely, affordable, resilient and quality services, support and treatment for neurological disorders.

**Global targets for strategic objective 1****Global target 1.1**

75% of countries will have adapted or updated existing national policies, strategies, plans or frameworks to include neurological disorders by 2031.

**Global target 1.2**

100% of countries will have at least one functioning awareness campaign or advocacy programme for neurological disorders by 2031.

**1.1 Advocacy**

28. Advocacy represents the first step in raising awareness and better public understanding of brain health and neurological disorders. It is necessary to improve neurological care, reduce stigma and discrimination, prevent violations and promote human rights. Advocacy also includes public and political awareness of the burden and impact of neurological disorders and the dissemination of evidence-based interventions, including the promotion of brain health and the prevention and treatment of neurological disorders.

29. Effective advocacy, including public awareness campaigns, requires tailoring approaches to reflect each country's cultural and social context. In addition, it requires involving people with neurological disorders in the centre of all advocacy efforts to achieve desired health and social outcomes. Public awareness campaigns should include information on the promotion and prevention of neurological disorders and should be designed for people living with neurological disorders.

**30. Proposed actions for Member States**

(a) Engage all relevant stakeholders, such as advocacy experts, health professionals and people with neurological disorders and their carers, to develop awareness-raising programmes to improve the understanding of neurological disorders, promote brain health and prevent and manage neurological conditions across the life course, including the identification of barriers to health seeking behaviours.

(b) Establish national and regional collaboration, knowledge translation and exchange mechanisms to raise awareness of the burden of disease associated with neurological disorders and the availability of and access to appropriate evidence-based promotive, preventive, management and care services for people with neurological disorders.

(c) Lead and coordinate intersectoral advocacy strategies for reducing stigma and discrimination and promoting the human rights of people with neurological disorders across the life course, including vulnerable groups. Integrate these within broader health promotion strategies, such as flexible educational and work environments for people with neurological disorders.

**31. Actions for the Secretariat**

- (a) Engage and include people with neurological disorders, their carers and families in decision-making within WHO's own processes on issues that concern them, through meaningful and structured mechanisms.
- (b) Provide technical support and advocacy tools for stigma reduction to help policymakers at national, regional and global levels to recognize the need to prioritise neurological disorders and integrate them into policies and plans.
- (c) Provide support and guidance to Member States in meaningfully engaging people with neurological disorders across all age groups by providing a convening platform, generating and leveraging evidence-based information and best practices, and engaging lived experience in decision-making processes.

**32. Proposed actions for international and national partners**

- (a) In partnership with other stakeholders, advocate for increasing the visibility of neurological disorders in the Sustainable Development Goals and other global commitments, as well as for prioritizing neurological disorders in policy agendas by raising awareness of the social and economic impacts of neurological disorders and the need for an integrated response across the life course and within health care systems.
- (b) Support advocacy efforts for protecting the human rights of people with neurological disorders, redressing inequities in access to neurological services for vulnerable populations and reducing stigma and discrimination. Ensure that people with neurological disorders are equally included in activities of the wider community in order to foster cultural, social and civic participation and enhance autonomy.
- (c) Provide a platform for dialogue between associations and organizations of people with neurological disorders and their carers, health and social workers, government sectors and other relevant actors at international, regional and national levels, while including young people and older people and ensuring gender-balanced representation. Engage with different sectors, such as the transportation, education, judicial, financial and employment sectors, in advocacy efforts for increasing the independence and autonomy of people with neurological disorders.

**1.2 Policy, plans and legislation**

33. The development of comprehensive intersectoral policies, plans and legislation based on scientific evidence and aligned with international human rights standards strengthens governance for neurological disorders and ensures that the complex needs of people with neurological disorders are addressed within the context of each country.

34. Collaboration between people with neurological disorders, technical experts who generate evidence, policymakers and programme managers who formulate, adapt and implement policies, plans, guidelines and legislation, as well as health professionals who provide care and services to people with neurological disorders, is essential to facilitate the development and implementation of evidence-based policies and plans across sectors.

35. Given the interlinkages between neurological disorders and other public health areas, numerous opportunities exist to integrate neurological disorders into policies and plans for these disciplines, for instance in the areas of noncommunicable and communicable diseases, mental health, maternal, children and adolescent health, ageing and disability.

36. Legislation that impacts the lives of people with neurological disorders, for example people with epilepsy, is frequently outdated and fails to protect and promote their human rights. It is crucial to update all laws relevant to persons with neurological disorders, such as those related to education, employment and women's rights, and ensure that they are more inclusive.

**37. Proposed actions for Member States**

(a) Develop or review, update, strengthen and implement national and/or subnational policies, plans and legislation based on context-specific evidence relating to neurological disorders, whether as separate instruments or by integrating them into other planned intersectoral actions for noncommunicable diseases, mental health, disability and other relevant areas across the care continuum of all ages. Formulate and implement national policies and legislation in consultation with people with neurological disorders, their carers and other stakeholders in order to promote and protect their rights and prevent stigma and discrimination.

(b) Establish monitoring and accountability mechanisms for resource allocation, including focal points, units or functional divisions responsible for neurological disorders within the health ministry (or equivalent body).

(c) Review disability and other relevant policies and laws to be more inclusive of people with neurological disorders, including by reviewing criteria to access disability benefits; providing funding to support people with disabilities in employment; establishing quota systems for active hiring; making working environments more accessible with employment regulations and labour laws that govern the public and private sectors; and strengthening mechanisms to address claims and complaints related to human rights violations and discrimination against people with neurological disorders through impartial recourse processes.

**38. Actions for the Secretariat:** Offer technical support, tools and guidance to Member States and policymakers to:

(a) share knowledge and evidence-based best practices to inform the development, strengthening, implementation and evaluation of national and/or subnational policies, plans and legislation that are aligned with international human rights standards for an integrated, intersectoral response to neurological disorders;

(b) strengthen accountability mechanisms and strategies for resolving claims and complaints to address human rights violations and discrimination that are related to people with neurological disorders, for example in employment, access to education, driving, fertility and women's rights;

(c) adopt legislation to ensure universal access to financial, social and disability benefits for people with neurological disorders and their carers;

(d) provide assistance in outlining mechanisms that proactively encourage and support the active participation of people with neurological disorders in all aspects of policy-making, planning and financing services; and

(e) provide ongoing monitoring, guidance and technical support to Member States in implementing the intersectoral global action plan on epilepsy and other neurological disorders 2022–2031, with the help of WHO regional and country offices across all levels.

**39. Proposed actions for international and national partners**

(a) Actively engage stakeholders across sectors to inform the development and implementation of evidence-based policies, plans and legislation, paying explicit attention to the human rights of people with neurological disorders and their carers and preventing stigma and discrimination.

(b) Support the creation and strengthening of associations and organizations of people with neurological disorders, their families and carers, and foster their collaboration with other organizations as partners in the implementation of policies for neurological disorders.

(c) Facilitate knowledge exchange and dialogue among associations of people with neurological disorders, their carers and families and their organizations, as well as health and social workers and governments, to ensure that Convention on the Rights of Persons with Disabilities principles such as empowerment, engagement and inclusion are embedded in legislation in order to promote the health of people with disabilities that are associated with neurological disorders.

### **1.3 Financing**

40. Neurological disorders lead to increased costs for governments, communities, families and individuals, as well as productivity losses for economies, many of which could be remedied by prevention, early detection and timely treatment. People with neurological disorders and their families face significant financial hardship due to health and social care costs, as well as reduced or foregone income. This is compounded by a lack of universal health insurance across all countries, with limited investment and resources to address neurological conditions.

41. Appropriately funded policies and programmes are required in order to ensure access to prevention, diagnosis, treatment and care for people with neurological disorders and their carers and reduce the financial impact of out-of-pocket health and social care costs. This investment will be offset by a reduction in the cost of neurological disability and will ultimately reduce long-term costs for governments.

**42. Proposed actions for Member States**

(a) Support sustainable funding for policies, plans and programmes for the prevention and management of neurological disorders, based on an integrated response across the life course, through dedicated domestic budgetary allocations, efficient and rational utilization of resources, voluntary innovative financing mechanisms and other means, including multilateral, bilateral, pooled funding and public–private partnerships.

(b) Produce and/or utilize the most recent data on the epidemiological and economic burden of neurological disorders, as well as the economic evidence base for investment and the projected costs of intervention scale-up in order to make informed decisions on budgets that are proportionate to the scale of the burden in the country and to allocate scarce resources optimally.



- (c) Develop financial and social protection mechanisms, including national health insurance plans and social security benefits, for addressing the direct and indirect costs related to accessing health care (such as transportation costs) and support affordable and accessible care for persons with neurological conditions, their carers and families.

**43. Actions for the Secretariat**

- (a) Promote collaboration and knowledge exchange at international, regional, and national levels to strengthen knowledge on the socioeconomic impact of investment for neurological disorders.
- (b) Offer technical support, tools and guidance to Member States in strengthening their national capacity to engage in intersectoral resource planning, budgeting and expenditure monitoring on neurological disorders.
- (c) Provide guidance for structured approaches to generating national investment for neurological disorders and brain health promotion, care and protection, in line with other existing investment case methods for supporting governments' choices.

**44. Proposed actions for international and national partners**

- (a) Support Member States in mobilizing sustainable financial resources and identifying functional gaps in resource allocation in order to support the implementation, monitoring and evaluation of national and/or subnational policies, programmes and services for neurological disorders.
- (b) Support the participation of people with neurological disorders and their carers in decision-making processes related to international financing mechanisms.
- (c) Support the development of innovative funding models, such as an international assistance fund to subsidize and fund the costs of diagnostics and therapeutics and offset the costs associated with referral, for example for travel and specialist services and interventions.
- (d) Support the accountability and efficiency of resource use in health care systems in order to allocate scarce resources optimally and improve quality and efficiency with minimum wastage of resources.

**STRATEGIC OBJECTIVE 2: PROVIDE EFFECTIVE, TIMELY AND RESPONSIVE DIAGNOSIS, TREATMENT AND CARE**

45. Neurological disorders are important causes of mortality, morbidity and disability. They require concerted intersectoral efforts to address the needs of people at risk of, or living with, neurological disorders by providing them with equitable access to effective health care and community-based, social, educational and vocational interventions and services.

46. Integrating care for neurological disorders into primary, secondary and tertiary health care levels and providing essential medicines, diagnostics, training and support for health care workers, carers and families of people with neurological disorders are actions consistent with the principles of universal health coverage, the 2030 Agenda and the Sustainable Development Goals.

47. A strong health system that embraces a people-centred and coordinated care approach and is directed towards ensuring effective, timely and responsive diagnosis, treatment and care over sustained periods is needed to improve the well-being and quality of life of people with neurological disorders, as well as to avoid complications, reduce hospitalization and costly interventions and prevent premature death and disability.

**Global targets for strategic objective 2****Global target 2.1**

75% of countries will have included neurological disorders in the universal health coverage benefits package by 2031.

**Global target 2.2**

80% of countries will provide the essential medicines and basic technologies required to manage neurological disorders in primary care by 2031.

**2.1 Care pathways**

48. Developing interdisciplinary care for people with neurological disorders requires guidelines that are grounded in evidence-based protocols and practices, organization by stages of care and a life course approach.

49. Services and care pathways, including access to quality emergency care, should be responsive to the needs of people with neurological disorders, their carers and families, who live in both urban and rural areas, and should be inclusive of vulnerable population groups, including socioeconomically disadvantaged individuals, children, older people, people affected by domestic and gender-based violence, prisoners, refugees, displaced populations and migrants, indigenous populations and other groups specific to each national context.

50. A care pathway should be oriented to each stage of the life course, from pregnancy through early childhood to care for older adults. This includes continuing care for children and adolescents with neurological disorders as they adapt to the challenges of transitioning into adulthood.

51. Neurological conditions impact people's functioning and often reduce their mobility, communication, cognitive functioning and self-care, which requires rehabilitation. However, the rehabilitation needs for people with neurological disorders are largely unmet, with only 16% of countries reporting specialized neurorehabilitation services and only 17% reporting general rehabilitation units that offer neurorehabilitation.<sup>1</sup>

52. Due to the complex needs and high levels of dependency and morbidity of people with neurological disorders, a range of coordinated health and social care is essential, including interventions such as palliative care to provide relief from pain; psychosocial, spiritual and advance care planning support; and interventions to enhance their quality of life.

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<sup>1</sup> ATLAS Country Resources for Neurological Disorders , second edition. Geneva: World Health Organization; 2017.

53. When possible, care pathways should include neurosurgical facilities for the surgical procedures required for the care of neurological conditions such as tumours, epilepsy and acute ischaemic stroke.

54. Continuity of care can be optimized using digital health solutions that foster greater information-sharing between providers, people with neurological disorder and their carers and allow for remote consultation through tele-health.

**55. Proposed actions for Member States**

(a) Develop evidence-based pathways of coordinated health and social services for people with neurological disorders across the life course within universal health coverage in order to enable their access to quality care, when and where required. This includes integration at multiple levels of the health and social care system, use of interdisciplinary care teams, service directories and medical health records, and referral mechanisms. In particular:

- enhance equitable access to quality care for acute (emergency) and chronic neurological conditions;
- strengthen care at primary, secondary and tertiary levels, including medical and surgical facilities;
- develop community-based neurological services, with the involvement of other care providers such as traditional healers, and promote self-care; and
- promote continuity of care between providers and health system levels, including through referral and follow-up, ensuring that primary care services are supported by specialist services in hospitals and community health services with efficient referral and back-referral mechanisms.

(b) Develop strategies to rationalize resources and enhance effective collaboration across public, private and nongovernmental actors through:

- the implementation of context-specific, innovative and integrated models of care, from diagnosis to end-of-life across health and social sectors;
- the promotion, implementation and scaling up of digital health solutions and technologies across health and social care; and
- the creation of interdisciplinary health and social care teams and networks and the capacity-building of health and social care professionals.

(c) Review existing related services, such as those on mental health, maternal, newborn, child and adolescent health, immunization and other relevant communicable and noncommunicable disease programmes in order to identify opportunities for the integration of prevention, early diagnosis and the management of neurological disorders and non-neurological comorbidities.

(d) Promote equitable access to rehabilitation for disabilities associated with neurological conditions by strengthening health systems at all levels, from specialized inpatient settings through to community-delivered rehabilitation.

(e) Develop new and/or strengthen existing services, guidance and protocols to support the implementation of early palliative care coordination and referral mechanisms, while also ensuring equitable access to palliative care for people with neurological disorders.

(f) Proactively identify and provide appropriate care and support to population groups at particular risk for neurological disorders or who have poor access to services, such as socioeconomically disadvantaged individuals, older people and other groups specific to each national context, and promote the continuity of integrated care between paediatric and adult providers for adolescents with neurological disorders as they transition into adulthood.

(g) In partnership with humanitarian actors, integrate support needs into emergency preparedness plans in order to enable access to safe and supportive services for people with pre-existing or emergency-induced neurological disorders such as traumatic injuries.

(h) Empower people with neurological disorders and their carers to participate in service planning and delivery, and enable them to make informed choices and decisions about care that meets their needs by providing evidence-based, accessible information, including on pathways from detection and diagnosis to treatment (including self-care) and care access.

#### **56. Actions for the Secretariat**

(a) Provide guidance and technical support to Member States to identify priority areas for possible intervention and to integrate cost-effective interventions for neurological disorders, their risk factors and comorbidities into health systems and universal health coverage benefit packages.

(b) Provide technical support to Member States in documenting and sharing best practices of evidence-based standards of care across the life course, including service delivery and interdisciplinary care coordination, emphasizing prevention, diagnosis, treatment (including management of comorbid conditions), rehabilitation and palliative care for people with neurological disorders.

(c) Offer technical assistance and policy guidance to support emergency preparedness and enable access to safe, supportive services for those with neurological conditions.

#### **57. Proposed actions for international and national partners**

(a) Actively engage all relevant stakeholders across sectors, including people with neurological disorders, their carers and families, in order to inform the development and implementation of intersectoral and interdisciplinary care coordination and integrated neurological care pathways across the continuum, including prevention, diagnosis, treatment, rehabilitation and palliative care.

(b) Facilitate knowledge exchange and dialogue to review and update health service strengthening efforts following humanitarian emergencies, in collaboration with relevant multilateral and regional agencies, organizations representing people with neurological disorders and other civil society organizations.

(c) Generate evidence and develop tools to support programmes for providing access to integrated care for people with neurological disorders.

(d) Facilitate initiatives, in partnership with relevant stakeholders, to support and encourage people with neurological disorders, their families and carers to access neurological care and services through evidence-based, user-friendly, technology-supported information and training tools such as iSupport<sup>1</sup> and/or by establishing national helplines and websites with accessible information.

## **2.2 Medicines, diagnostics and other health products**

58. Medicines, diagnostics and other health products, such as assistive technology, biological products, and cell and gene therapy, are essential for prevention, early diagnosis and treatment to reduce mortality and morbidity and improve the quality of life of people with neurological disorders.

59. Essential medicines have a crucial role for both the prevention and treatment of neurological disorders. For example, medicines for multiple sclerosis exist that slow disease progression and improve the quality of life for many people, but their availability and affordability are limited in low- and middle-income countries.

60. The use of medical devices, including imaging and in vitro diagnostics (e.g. neuroimaging, lumbar puncture and microscopy) can reduce morbidity through early detection and by slowing disease progression. Even when effective diagnostic tools are available, they may not be affordable or accessible due to the limited availability of laboratory infrastructure, equipment and trained personnel.

61. Assistive technology enables people to live healthy, productive, independent and dignified lives and reduce the need for formal health and support services, long-term care and the work of carers. Few people in need have access to assistive products due to high costs, lack of awareness, availability, trained personnel, policy and financing. To increase access to assistive products for those who need them the most, they should be available at all levels of health services, especially primary care, and within universal health coverage.

62. The rapid production of new medications and molecules in certain neurological disorders is a model for other neurological or health conditions. Current obstacles to accessing treatment and affordability should be identified in order to pave the way and remove barriers to make future and upcoming medications for neurological conditions available and affordable.

### **63. Proposed actions for Member States**

(a) Promote the inclusion, updating and availability of essential, effective, safe, affordable and quality medicines and health products for neurological disorders in national essential medicines lists, as guided by the WHO Model List of Essential Medicines, the WHO List of Priority Medical Devices for Management of Cardiovascular Diseases and Diabetes, the WHO List of Priority Medical Devices for Cancer Management and the WHO Priority Assistive Products List, while including access to controlled medicines and minimizing the risk of misuse. Identify key barriers to access across population groups (including in emergency settings) and strategies to systematically address these.

(b) Promote the appropriate, transparent and sustainable use of essential medicines for the prevention and management of neurological disorders through measures such as quality

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<sup>1</sup> iSupport for Dementia. Training and support manual for carers of people with dementia. Geneva: World Health Organization; 2019.

assurance, preferential registration procedures, generic and biosimilar substitution, the use of international non-proprietary names and financial incentives, where appropriate. Optimize the training of health professionals, people with neurological disorders and their carers, including by using evidence-based strategies to address the treatment of comorbidities, adverse events and drug interactions such as those due to polypharmacy.

(c) Enable the availability, access and use of appropriate relevant diagnostics as guided by the WHO Model List of Essential In Vitro Diagnostics, such as microscopy, electrophysiology, genetic testing and neuroimaging technology, for example computed tomography (CT) and magnetic resonance imaging (MRI). Improve infrastructure and train technicians and health care workers in the use of these technologies.

(d) Establish transparent regulatory frameworks, resources and capacity to ensure that quality, safety and ethical standards are met for health products and diagnostics such as biotherapeutic treatments, genetic testing, pre-implantation genetic testing and assistive products like hearing aids, wheelchairs and prostheses.

(e) Improve the availability of life-saving medicines and health products for managing neurological disorders during humanitarian emergencies.

#### **64. Actions for the Secretariat**

(a) Accelerate action and offer technical support to Member States to increase equitable access to medicines, diagnostics and other health products for people with neurological disorders, including through the setting of norms and standards at a global level; evidence-based, context-specific regulatory guidance; good practices for standards-based procurement and manufacturing; and technical, legislative and regulatory training.

(b) Update the WHO Model List of Essential Medicines, the WHO Model List of Essential In Vitro Diagnostics, the WHO Lists of Priority Medical Devices, the WHO Priority Assistive Products List and other relevant documents to ensure that they are appropriate for neurological conditions and that pathways are in place for the timely implementation and use of effective treatments and diagnostics.

#### **65. Proposed actions for international and national partners**

(a) Encourage all relevant stakeholders to engage in activities to promote efforts for improving access to affordable, safe, effective and quality medicines, diagnostics and other health products, such as neuroimaging.

(b) Support the global, regional, intergovernmental, national and/or subnational strengthening of regulatory and procurement processes (including through pooled procurement, innovative health financing mechanisms and human resource capacity-building) in order to promote access to and appropriate use of medicines, diagnostics and other health products.

(c) Encourage the involvement of people with neurological disorders and their carers in research, development and implementation processes for new medicines, diagnostics and other health products.

### 2.3 Health workers' capacity-building, training and support

66. Achieving improved health outcomes depends greatly on the combination of an adequate neurological workforce (e.g. adult neurologists, child neurologists, neurosurgeons); other health care providers, including but not limited to psychologists, psychiatrists, radiologists, physical therapists, occupational therapists and speech therapists; and competent health workers serving at the primary health care level who are trained in identifying and managing neurological disorders.

67. The training and education of an interdisciplinary workforce, including social care workers, rehabilitation specialists trained in neurological conditions, technicians (electrophysiological, imaging, laboratory), pharmacists, biomedical engineers, community health workers, family, carers and traditional healers, where appropriate, is required to support the delivery of person-centred care to people with neurological disorders, reduce their mortality and morbidity and improve their quality of life.

#### 68. Proposed actions for Member States

(a) Identify and apply context-appropriate evidence in order to establish:

- appropriately resourced programmes and policies to address projected health workforce needs for the future in light of demographic changes, increasing ageing populations and the prevalence of diseases such as dementia, stroke and Parkinson's disease; and
- adequate compensation and incentives for health and social care workers trained in neurological disorders to work in underserved areas and to promote the retention of workers in those areas.

(b) Strengthen health and social care workforce capacity to rapidly identify and address neurological disorders, including common comorbid and treatable conditions such as infectious diseases, hypoxic ischaemic perinatal brain injury, hypothyroidism, cataracts and noncommunicable diseases. These initiatives should focus on the enhanced capacity of the existing workforce, both specialist and generalist, including relevant associate health professionals, as appropriate to their roles, and should include:

- implementing various modes of training programmes (e.g. mental health gap action programme (mhGAP) e-learning course) for general and specialized health and social care workers to deliver evidence-based, culturally appropriate and human rights-oriented neurological care, including by addressing stigma and discrimination for all people across the life course;
- developing career tracks for the neurological workforce by strengthening postgraduate training and working in partnership with medical societies to raise awareness of the appeal of working in brain health;
- expanding existing educational curricula and providing continuing education on the care of people with neurological disorders;
- expanding the role of the neurological workforce to encompass the supervision and support of general health workers in providing neurological interventions;

- harnessing the potential of community health workers and strengthening – collaboration with other informal care providers, such as traditional healers, with effective training, support and supervision; and
- ensuring that people with neurological disorders are involved in the planning, development and delivery of training, as appropriate.

(c) Support health and social care workers to implement and scale-up services using information and communication technologies such as telemedicine and internet/mobile phone technologies in order to expand neurological care to remote and low-resource settings and support home-based services.

#### 69. **Actions for the Secretariat**

(a) Support Member States with adequate tools to incorporate neurological care needs into routine planning for health workers, based on the monitoring and collection of the best available data and following a health labour market approach. Planning considerations should include the identification of service gaps, neurological care training requirements and core competencies for health and social workers in the field, as well as advanced neurological care training.

(b) Support Member States in building health and social care workforce capacity, including informal care providers, by promoting, strengthening and developing guidance and tools and the application of the competency-based training models required for the diagnosis, treatment and care of neurological disorders.

#### 70. **Proposed actions for international and national partners**

(a) Facilitate the exchange of information on best practices and the dissemination of findings in health workers' development and training in order to support national efforts related to the prevention, management and care of people with neurological disorders.

(b) Support the implementation of capacity-building programmes, including training and education, for general and specialized health care workers to identify neurological disorders and provide evidence-based interventions to promote diagnosis, treatment and care for neurological disorders.

(c) Support national authorities in the development of appropriate health care infrastructure and institutional capacity for the training of health personnel in order to strengthen health systems and expand quality services.

## 2.4 **Carer support**

71. Neurological disorders have a profound impact on individuals, families and communities. Due to their chronic course, people with neurological disorders often require ongoing care that is provided in large part by informal carer providers.

72. Carers can be defined by their relationship to the person with a neurological condition and their care input. Many carers are relatives, but close friends or volunteers can also take on caregiving responsibilities. Carers provide “hands-on” care and support for people with neurological disorders and play a significant role in organizing lifelong care.



73. Challenges for carers include stress, role strain, financial burden, social isolation and bereavement in the event of loss. Roles and challenges may vary depending on the age of the carer and are also different when caring for children, adolescents or older adults.

74. Caring for a person with a neurological disorder may affect the carer's own health, well-being and social relationships. The global action plan on the public health response to dementia identifies key actions to support carers that are also relevant to other neurological conditions.

**75. Proposed actions for Member States**

(a) Develop mechanisms to involve people with neurological disorders and their carers into care planning, policy-making and legal review and remove barriers to enable their participation, while paying attention to the wishes and preferences of people with neurological disorders and their families.

(b) Provide accessible and evidence-based information on available resources in the community, such as training programmes, respite care, mental health services and other resources that are tailored to the needs of carers of people with neurological disorders.

(c) Within the context of community-based neurological care, provide training programmes, in collaboration with relevant stakeholders, for health and social care staff in the identification and reduction of carer stress.

(d) Develop or strengthen mechanisms to protect carers, such as through the implementation of social and financial benefits (e.g. pension, leave or flexible work hours) and policies and legislation aimed at reducing stigma and discrimination and supporting carers beyond their caregiving role.

**76. Actions for the Secretariat**

(a) Support Member States in developing and evaluating evidence-based information, data, training programmes and respite services for carers of people with neurological disorders through an intersectoral approach that is in line with the Convention on the Rights of Persons with Disabilities.

(b) Facilitate access to affordable, evidence-based resources for carers of people with neurological disorders in order to improve knowledge and skills related to neurological disorders, reduce emotional stress and improve coping, self-efficacy and health, using resources such as WHO's mhGAP, iSupport, mDementia,<sup>1</sup> the Caregivers Skills Training Programme for Children with Developmental Disorders or Delays and other education, skills training and social support resources.

**77. Proposed actions for international and national partners**

(a) Increase awareness of the impact of caring for people with neurological disorders, including the need to protect carers from discrimination, support their ability to continue to provide care throughout the disease progression and promote their self-advocacy.

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<sup>1</sup> Be Healthy Be Mobile. A handbook on how to implement mDementia. Geneva: World Health Organization; 2021.

- (b) Assist in implementing culturally sensitive, context-specific and person-centred training programmes for carers and families in order to promote well-being and enhance knowledge and caregiving skills throughout the progression of neurological disorders, starting with existing resources such as WHO's iSupport and mhGAP.

### **STRATEGIC OBJECTIVE 3: IMPLEMENT STRATEGIES FOR PROMOTION AND PREVENTION**

78. The promotion of brain health and the prevention of neurological disorders involves reducing modifiable risk factors and enhancing protective factors, including during critical periods of brain development.

79. Promoting optimal brain development across the life course starts with preconception, pregnancy, childhood and adolescence, is linked to healthy ageing and encourages healthy behaviour, adequate nutrition, infectious disease control, prevention of head and spinal trauma and reducing exposure to violence and environmental pollutants.

80. Universal health coverage represents a key component for promoting brain health and well-being. An important element includes addressing social and economic determinants through a coordinated intersectoral response in a gender-sensitive manner. Collaboration with local populations, including indigenous people, should be undertaken to explore culturally appropriate ways of preventing neurological disorders that respect local customs and values.

81. Incorporating a One Health<sup>1</sup> approach for neurological disorders to design and implement programmes, policies, legislation and research, with communication between multiple sectors, public health, animal and plant health and the environment will contribute towards achieving better health outcomes by preventing neurological disorders.

#### **Global targets for strategic objective 3**

##### **Global target 3.1**

80% of countries will have at least one functioning intersectoral programme for brain health promotion and the prevention of neurological disorders across the life course by 2031.

##### **Global target 3.2**

The global targets relevant for prevention of neurological disorders are achieved, as defined in:

- the NCD-GAP;
- Defeating meningitis by 2030: a global road map; and
- Every newborn: an action plan to end preventable deaths.

<sup>1</sup> One Health. Q&A. Geneva: World Health Organization; 2017 (<https://www.who.int/news-room/q-a-detail/one-health>, accessed 1 December 2021).

### 3.1 Promoting healthy behaviour across the life course

82. Promoting and emphasizing brain health across the life course includes focusing on healthy behaviour. There are strong interrelationships between several neurological disorders, such as dementia and stroke, with noncommunicable diseases such as hypertension, diabetes, obesity and other related disorders, as well as with behavioural risk factors such as physical inactivity, unbalanced diets, tobacco use and the harmful use of alcohol.

83. An understanding of the risk factors contributing to the neurological burden of disease can inform preventive measures and lead to the development of better disease-modifying strategies.

84. Smoking is a behavioural risk factor associated with neurological disorders such as stroke, dementia and multiple sclerosis. Second-hand tobacco smoke was estimated to account for 4% of the global stroke burden in 2010.<sup>1</sup>

85. The harmful use of alcohol, such as heavy alcohol consumption, can directly affect the nervous system and result in neurological disorders such as cerebellar degeneration, neuropathy, myopathy, delirium tremens and thiamine deficiency leading to Wernicke encephalopathy or Korsakoff syndrome. It also contributes to road traffic crashes, violence, falls and associated brain and spinal cord injuries.

86. Good sleep hygiene is necessary for children's and adults' overall health and well-being. Irregular sleep can be a risk factor for certain neurological disorders and people with neurological disorders often experience sleep disturbances as a consequence of their underlying disorder.<sup>2</sup>

87. Behavioural risk-factor modification can strengthen the capacity to make healthier choices and follow healthy behaviour patterns that foster good brain health and reduce the burden of neurological disorders. For example, exercise and regular physical activity are associated with social, mental and brain health benefits and a better quality of life, improved functioning and lower caregiver burden in people with chronic neurological disorders such as Parkinson's disease.

#### 88. Proposed actions for Member States

(a) Support actions that have been shown to reduce the risk of neurological disorders across the life course by advancing strategies for healthy behaviours, such as promoting the cessation of tobacco use and excessive alcohol intake, vaccination and increasing physical activity, in line with the NCD-GAP, the global strategy to reduce the harmful use of alcohol, the WHO Guidelines on physical activity and sedentary behaviour and the WHO Guidelines on risk reduction of cognitive decline and dementia. These actions should be undertaken in collaboration with people with neurological disorders, their carers and other relevant stakeholders.

(b) Develop, implement and monitor appropriately resourced, population-wide strategies that promote healthy nutrition and diet, as outlined in the WHO's comprehensive implementation plan on maternal, infant and young child nutrition, the NCD-GAP and the 2030 Agenda.

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<sup>1</sup> Prüss-Üstün A, Wolf J, Corvalán CF., Bos R, Neira MP. Preventing disease through healthy environments: a global assessment of the burden of disease from environmental risks. 2016; World Health Organization.

<sup>2</sup> Worldwide Project on Sleep and Health. Project Overview. Geneva: World Health Organization; 2018.

- (c) Encourage urban planning that improves access to sport, education, transport and physical activity in leisure/recreation in order to promote activity and provide alternatives to a sedentary lifestyle.

**89. Actions for the Secretariat**

- (a) Provide technical support and strengthen global, regional and national capacities and capabilities to:

- raise awareness of the links between neurological disorders and other noncommunicable diseases; and
- implement strategies for the reduction and control of modifiable risk factors for neurological disorders by developing evidence-based guidelines for cost-effective, coordinated health care interventions and integrating relevant WHO guidelines into national health planning processes and development agendas.

- (b) Strengthen, share and disseminate evidence to support policy interventions for reducing potentially modifiable risk factors for neurological conditions by promoting healthy workplaces, health-promoting schools and other educational institutions, healthy cities initiatives, health-sensitive urban development and social and environmental protection.

**90. Proposed actions for international and national partners**

- (a) Promote and mainstream population brain health strategies that are age-inclusive, gender-sensitive and equity-based at national, regional and international levels in order to support healthy behaviour for people with neurological disorders, their carers and families.

- (b) Facilitate knowledge exchange on evidence-based best practices to support actions that have been shown to reduce the risk of neurological disorders across the life course, in line with WHO's Framework Convention on Tobacco Control, the global strategy to reduce harmful use of alcohol, the global strategy on diet, physical activity and health and other relevant strategies.

**3.2 Infectious disease control**

91. The neurological consequences of infectious diseases such as meningitis, encephalitis, neurocysticercosis, malaria, HIV, toxoplasmosis, polio, enterovirus, syphilis and rabies contribute to global morbidity and mortality, especially among the most vulnerable, marginalized populations and can result in lifelong consequences (e.g. vision and hearing loss, developmental delay, cognitive or motor impairment) that necessitate specialized follow-up care, including rehabilitation. Yet, many of these neurological consequences are preventable through immunization programmes and infectious disease control.

92. The emergence of neurotropic zoonotic infections can be attributed to several causes, including unsustainable agricultural intensification and the increased use and exploitation of wildlife.<sup>1</sup>

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<sup>1</sup> United Nations Environment Programme and International Livestock Research Institute. Preventing the Next Pandemic: Zoonotic diseases and how to break the chain of transmission. Nairobi, Kenya; 2017.

93. Despite advances in global infectious disease control, epidemic infections such as Zika and SARS-CoV-2 have underscored the importance of infectious disease control as a preventive measure for neurological disorders. For example, the COVID-19 pandemic is expected to impact brain health across the life course, with a wide spectrum of associated neurological manifestations in the acute and post-acute stages of illness.

94. **Proposed actions for Member States**

(a) Implement infectious disease management, eradication/elimination/control and immunization programmes based on WHO guidance, such as WHO's road map for neglected tropical diseases 2021–2030, the WHO guidelines on management of *Taenia solium* neurocysticercosis and the global road map on defeating meningitis by 2030. Include approaches for the control of other common and treatable neuroinfectious diseases such as encephalitides and their respective treatments within the health and agricultural sectors, as outlined in WHO's guidance on preventing disease through healthy environments.<sup>1</sup>

(b) Support and promote the availability of rapid and affordable diagnostics for infections of the nervous system (for example lumbar puncture, microscopy, neuroimaging).

(c) Collaborate with all relevant sectors and stakeholders to mitigate the risks of emerging infectious diseases that cause neurological disorders. Close coordination and intersectoral action within and beyond the health sector, including vector control, water and sanitation, animal and environmental health and education, will be needed to maximize synergies.

(d) Create national operational plans to deliver interventions for neurological diseases that are in line with a One Health approach, by developing a coordinated plan that outlines stakeholder accountability for human-, animal-, food- and ecosystem-related actions and by treating animals to prevent the transmission of neuro-infectious pathogens such as mass dog vaccinations for rabies prevention.

(e) Promote vaccination campaigns and sharing knowledge about the usefulness of vaccinations as a method of reducing neurological disabilities.

95. **Actions for the Secretariat**

(a) Offer technical support, tools and guidance to Member States in order to strengthen global, regional and national awareness of infectious disease control and reduce the risk of zoonotic infections and antimicrobial and insecticide resistance, including by establishing animal or livestock trading and farming policies.

(b) Highlight the neurological consequences of the COVID-19 pandemic and provide guidance on their management in order to strengthen countries' response and improve service delivery at all levels of the health system.

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<sup>1</sup> Prüss-Üstün A, Wolf J, Corvalán CF, Bos R, Neira MP. Preventing disease through healthy environments: a global assessment of the burden of disease from environmental risks. 2016; World Health Organization.

96. **Proposed actions for international and national partners**

- (a) Promote multistakeholder collaboration within and beyond the health sector, taking a One Health approach and in line with the 2030 Agenda and the Sustainable Development Goals.

**3.3 Preventing head/spinal trauma and associated disabilities**

97. Traumatic brain and spinal cord injury require complicated and costly medical care. In 2016, there were 27 million new cases of traumatic brain injury and close to 1 million new cases of spinal cord injury globally.<sup>1</sup> Road traffic injuries and falls constitute the highest number of new cases of traumatic brain injury, while other causes such as child abuse and intimate partner violence and sports injuries are also preventable.

98. Each year, 37 million falls are severe enough to require medical attention and mostly affect adults aged 60 years and older, particularly those with comorbidities that impair ambulation such as dementia, Parkinson's disease or multiple sclerosis.<sup>2</sup>

99. Key risk factors for road traffic injuries include speeding; alcohol or drug consumption; non-use of helmets; lack of seat belts and child restraints; inadequate visibility of pedestrians; driver distractions or fatigue; and inadequate enforcement of traffic laws.

100. Many sport-related injuries can also result in traumatic brain and spinal cord injury. Repetitive mild head trauma is associated with chronic traumatic encephalopathy and increases dementia risk. Awareness, laws and policies to educate sports professionals, parents and athletes and the implementation of helmet or protective devices policies are needed to prevent some cases of traumatic brain and spinal cord injury.

101. Despite the high number of head and spinal cord injuries in low- and middle-income countries, there remains a lack of services, capacity and trained specialists in neurosurgery and neurorehabilitation, which are vital in preventing long-term disability and providing follow-up care for survivors of traumatic brain and spinal cord injury.

102. **Proposed actions for Member States**

- (a) Implement the recommendations included in the World report on road traffic injury prevention and proposed by the Commission for Global Road Safety.<sup>3</sup> These cover road safety management, safer roads and mobility, safer vehicles, safer road users, increased responsiveness to post-crash emergencies and longer-term rehabilitation for victims.

- (b) Strengthen information systems to collect data on traumatic brain injury and spinal cord injury in order to improve understanding on the scale of the issue and its implications.

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<sup>1</sup> Global, regional, and national burden of traumatic brain injury and spinal cord injury, 1990-2016: a systematic analysis for the Global Burden of Disease Study 2016. *Lancet Neurol.*2019;18(1):56–87. doi: 10.1016/S1474-4422(18)30415-0.

<sup>2</sup> Prüss-Üstün A, Wolf J, Corvalán CF, Bos R, Neira MP. Preventing disease through healthy environments: a global assessment of the burden of disease from environmental risks. 2016; World Health Organization.

<sup>3</sup> Make Roads Safe: A New Priority for Sustainable Development. Commission for Global Road Safety; 2006.

(c) Promote safer contact sports and develop and implement policies and mandatory education for athletes, parents and coaches to inform them about the risks and neurological complications, such as epilepsy, that are associated with traumatic brain and spinal cord injury.

(d) Develop and implement policies, standards and effective interventions to address unsafe home and community environments for older adults, including poor lighting, slippery floors, loose rugs and beds without rails, as outlined in the Global strategy and action plan on ageing and health.

### 103. Actions for the Secretariat

(a) Collect and disseminate evidence and best practices to prevent or reduce traumatic brain injury and spinal cord injury, including the prevention of road traffic crashes and falls through the implementation of the Global Plan for the Decade of Action for Road Safety.

(b) Provide guidance, evidence-based practices and technical support for early rehabilitation and support to people affected by the long-term cognitive or physical consequences of traumatic brain and spinal cord injury in order to minimize both physical and psychological impacts and protect against discrimination and stigma.

### 104. Proposed actions for international and national partners

(a) Promote multistakeholder collaboration to raise awareness about the inherent safety and protective quality of road networks for the benefit of all road users, especially the most vulnerable (e.g. pedestrians, bicyclists and motorcyclists) in order to prevent traumatic brain and spinal cord injury.

(b) Encourage knowledge-sharing and facilitate the global, regional, intergovernmental and national strengthening of policies for safe driving, sports injuries and the promotion of national efforts for increasing helmet use in accordance with WHO's Helmets: a road safety manual for decision-makers and practitioners.

## 3.4 Reducing environmental risks

105. Exposure to environmental and occupational hazards can directly influence brain health. For example, in 2019 approximately 5% of the global stroke burden (in DALYs) was attributable to ambient air pollution.<sup>1</sup> Across the world, vulnerable communities are subject to greater exposure to environmental toxins due to the conditions in which they work and live.

106. Toxin-induced encephalopathies, including exposure to heavy metals such as lead,<sup>2</sup> mercury and air pollutants (e.g. carbon monoxide) can cause serious health and nervous system damage in all age groups.<sup>3</sup>

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<sup>1</sup> See GBD Compare.Viz Hub. Institute for Health Metrics and Evaluation; 2021 (<https://vizhub.healthdata.org/gbd-compare/>, accessed 1 December 2021).

<sup>2</sup> Global elimination of lead paint: why and how countries should take action: technical brief. Geneva: World Health Organization; 2020.

<sup>3</sup> Chemical safety. Geneva: World Health Organization ([https://www.who.int/health-topics/chemical-safety#tab=tab\\_1](https://www.who.int/health-topics/chemical-safety#tab=tab_1), accessed 1 December 2021).

107. Parkinson's disease has been associated with exposure to pesticides in occupational and non-occupational settings.<sup>1</sup> In addition, migraines can be triggered by environmental pollutants such as bright lights, poor air quality and noise.<sup>2</sup>

108. Climate change is one of several concurrent global environmental changes that simultaneously affect human health and neurological conditions, often in an interactive manner. For example, the transmission of vector-borne neurotropic viruses such as Zika, Japanese encephalitis and West Nile disease is jointly affected by climatic conditions, population movement, deforestation, land-use patterns, biodiversity losses, freshwater surface configurations and human population density.<sup>3</sup>

#### 109. **Proposed actions for Member States**

(a) Promote joint collaborations across relevant ministries (e.g. environment, health, water and sanitation) to link brain health promotion and the prevention of neurological disorders with strategies that focus on healthy living, working and environmental conditions, in line with WHO's guidance on preventing disease through healthy environments.<sup>4</sup> In particular:

- accelerate progress towards the global phase-out of lead paint through regulatory and legal measures;
- develop and implement health promotion and protection strategies and programmes across sectors in order to limit exposure to pesticides and other high-priority chemicals, such as trichloroethylene, which have been associated with neurotoxic effects; and
- address the health aspects of exposure to mercury and mercury compounds through collaboration between health authorities, environment authorities and others.

(b) In partnership with nongovernmental organizations, the private sector and other intersectoral stakeholders, integrate environmental determinants that are specific to brain health and neurological disorders into broader mitigation strategies for reducing the impact of climate change, including interventions and policies that promote access to clean air (ambient and household), such as the reduction of fossil fuels and the promotion of cleaner cookstoves and safe water, sanitation, and hygiene.

#### 110. **Actions for the Secretariat**

(a) Provide support to Member States in evaluating and implementing evidence-based options that suit their needs and capacities in order to assess the health impact of public policies, evidence generation and guidance regarding environmental risk such as air pollution, heavy metals,

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<sup>1</sup> Ascherio A, Schwarzschild MA. The epidemiology of Parkinson's disease: risk factors and prevention. *Lancet Neurol.* 2016;15(12):1257–1272. doi: 10.1016/S1474-4422(16)30230-7; Ascherio A, Chen H, Weisskopf MG, O'Reilly E, McCullough ML, Calle EE, et al. Pesticide exposure and risk for Parkinson's disease. *Ann Neurol.* 2006;60(2):197–203. doi: 10.1002/ana.20904.

<sup>2</sup> Prüss-Üstün A, Wolf J, Corvalán CF, Bos R, Neira MP. Preventing disease through healthy environments: a global assessment of the burden of disease from environmental risks. 2016; World Health Organization.

<sup>3</sup> Climate change and health. Key facts. Geneva: World Health Organization (<https://www.who.int/news-room/fact-sheets/detail/climate-change-and-health>, accessed 1 December 2021).



pesticide and industrial solvents for optimal brain health and the prevention of neurological disorders.

#### 111. **Proposed actions for international and national partners**

(a) Promote at national, regional and international levels WHO's guidance on preventing disease through healthy environments and highlight the importance of climate change on brain health, in line with the 2030 Agenda and the Sustainable Development Goals.

(b) Collaborate with stakeholders to support the development of international standards for environmental pollutants (e.g. emissions, second-hand smoke and levels of environmental toxins) to help guide legislation.

(c) Support research to understand the contribution of environmental risk factors to the morbidity and mortality of neurological disorders, especially in low-resource settings.

### 3.5 **Promotion of optimal brain development in children and adolescents**

112. The early stages of life, including the fetal stage and birth, present a particularly important opportunity to promote brain health and prevent neurological disorders that can have lifelong consequences as a child's brain develops and adapts rapidly in response to the surrounding environment, nutrition and stimulation.

113. Optimizing brain development in the formative stages involves creating conditions for nurturing care<sup>1</sup> and family and parenting support through public policies, programmes and services. These enable communities and caregivers to attend to children's good health, nutrition and protection from threats.

114. Access to formal education and inclusive education for children with disabilities have also been shown to improve brain health outcomes. All children and adolescents should be able to live, study and socialize in supportive, healthy and safe environments without stigma, discrimination or bullying. Exposure to early life adversity such as maltreatment, neglect, experience of war or conflict, inadequate maternal nutrition (such as lack of folic acid or iron), poor caregiver health, substance use, congenital infections (such as TORCH syndrome – toxoplasmosis, rubella, cytomegalovirus, herpes simplex) or birth complications can have a negative impact on the developing brain and carry lifelong implications for brain health.

115. Certain environmental pollutants are specifically known to affect neurodevelopment. These include air pollution, heavy metals in soil and water, lead in household paint, mercury in seafood and workplace exposure and pesticides.<sup>2</sup> Young children are especially vulnerable to lead toxicity and even low levels of exposure can result in reduced attention span, behavioural problems and reduced educational attainment.

116. Physical activity can confer health benefits for children and adolescents living with neurological conditions, hence limiting sedentary behaviour such as screen-based entertainment (television and

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<sup>1</sup> Nurturing care for early childhood development: a framework for helping children survive and thrive to transform health and human potential. Geneva: World Health Organization; 2018.

<sup>2</sup> Prüss-Üstün A, Wolf J, Corvalán CF, Bos R, Neira MP. Preventing disease through healthy environments: a global assessment of the burden of disease from environmental risks. 2016; World Health Organization.

computers) and digital communications such as mobile phones is recommended. In addition, adequate sleep regimens maximize health benefits and brain development for children and adolescents.

#### 117. **Proposed actions for Member States**

- (a) Develop, fund and implement strategies to promote healthy brain development and prevent neurological disorders in childhood and adolescence, focusing on early intervention and rehabilitation.
- (b) Optimize perinatal and child health care, including safe labour and delivery to prevent hypoxic ischaemic brain damage, neonatal intensive care, the use of birth attendants, skin to skin contact (kangaroo mother care), breastfeeding, maternal mental health care, adequate nutrition, immunization, and child development interventions for responsive caregiving and early learning in line with the WHO nurturing care framework. Encourage and strengthen neurodevelopmental assessment in children and adolescents for early diagnosis and intervention.
- (c) In partnership with relevant national regulatory authorities and other stakeholders, develop, strengthen and monitor breastfeeding and national food and nutrition policies and action plans in line with the global strategy for infant and young child feeding, the comprehensive implementation plan on maternal, infant and young child nutrition and WHO's set of recommendations on the marketing of foods and non-alcoholic beverages to children.<sup>1</sup>
- (d) Accelerate the full implementation of the WHO Framework Convention on Tobacco Control in order to reduce fetal exposure, childhood second-hand smoke exposure and adolescent smoking.
- (e) Develop and implement, as appropriate, comprehensive and intersectoral national policies and programmes to reduce the harmful use of alcohol during pregnancy so as to reduce complications such as fetal alcohol spectrum disorder.
- (f) Promote adolescent access to the recommended interventions in the Global Strategy for Women's, Children's and Adolescents' Health, including in humanitarian and fragile settings. Support interventions to promote adolescent brain health and development and establish, as appropriate, adolescent-friendly spaces as a first response to adolescent needs for protection, psychosocial well-being and nonformal education.
- (g) Develop appropriately resourced policies for the improved provision of quality physical education in educational settings, including opportunities for physical activity before, during and after the formal school day. Parks, trees and green areas within urban centres can improve local air quality and offer a refuge for children to play. Implement WHO Guidelines on physical activity and sedentary behaviour, including the recommendations on recreational screen time.
- (h) Strengthen surveillance mechanisms for the core indicators of brain health and development in children and adolescents, including protective and risk factors.

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<sup>1</sup> Guidance on ending the inappropriate promotion of foods for infants and young children: implementation manual. Geneva: World Health Organization; 2017.

**118. Actions for the Secretariat**

- (a) Offer technical support, tools and guidance to Member States and strengthen national capacity for the promotion of optimal brain development in children and adolescents by:
- enhancing leadership within health ministries and other sectors for the development, strengthening and implementation of evidence-based national and/or subnational strategies and associated intersectoral resource planning to optimize brain development in children and adolescents; and
  - compiling and sharing knowledge and best practices related to existing policies that address early childhood and adolescent development, including codes of practice and mechanisms to monitor the protection of human rights.

**119. Proposed actions for international and national partners**

- (a) Support the development and implementation of global, regional, national and/or subnational policies and programmes for children and adolescents to address maltreatment, neglect, inadequate maternal nutrition, poor caregiver health, substance use (such as alcohol and smoking), congenital infections, birth complications and environmental pollutants.

**STRATEGIC OBJECTIVE 4: FOSTER RESEARCH AND INNOVATION AND STRENGTHEN INFORMATION SYSTEMS**

120. Evidence generation through high-quality research is needed to inform policy, planning and programming for neurological disorders. It can provide insight into effective services, care models and treatment options, and foster innovation and equitable access to products such as health technology for prevention, risk reduction, early diagnosis, treatment and the potential for cure or care for neurological disorders.

121. The complexity surrounding brain and neurological research requires improved coordination in the research environment, with multistakeholder involvement and public–private partnerships and allocation of sufficient resources. In this context, cultivating an environment that fosters research collaborations, including data-sharing, is vital to reduce duplication, identify knowledge gaps, fast-track innovation and build capacity in low-income settings.

122. Implementation research, including health systems evaluation, should be prioritized to harness and scale prevention and treatment strategies for neurological disorders. Such an approach will facilitate the monitoring of interventions and allow for the replication and adaptation of successful interventions.

123. Better representation of low- and middle-income countries in the neuroscience research environment should also acknowledge country-specific and local needs so that strategies for diagnosis and management of neurological disorders are tailored to the context.

124. The meaningful engagement of people with neurological disorders, their carers and families to better support and guide the research and development of innovative solutions for neurological disorders is a principal component of the research agenda.

125. Robust, standardized and easily accessible data forms the basis for effective planning and the establishment of targeted interventions. Yet significant data gaps on neurological disorders exist not only in low- and middle-income countries but also in high-income countries.

#### **Global targets for strategic objective 4**

##### **Global target 4.1**

80% of countries routinely collect and report on a core set of indicators for neurological disorders through their national health data and information systems at least every three years by 2031.

##### **Global target 4.2**

The output of global research on neurological disorders doubles by 2031.

#### **4.1 Investment in research**

126. If the incidence of neurological disorders is to be reduced and the lives of people with neurological disorders are to be improved, sustained investment in biomedical, clinical, implementation and translational research is crucial to inform prevention, diagnosis, treatment and care and create the potential to cure more neurological disorders.

127. All research and innovation activities for neurological disorders must be rooted in equity, diversity and inclusiveness, with increased engagement of people with neurological disorders.

128. Investments in neurological research should be accompanied by increased collaboration between Member States and relevant stakeholders, with a particular focus on strengthening global and regional cooperation. Facilitating a global research agenda for neurology will increase the likelihood of effective progress towards better prevention, diagnosis, treatment and care for people with neurological disorders, while reducing redundancies and the duplication of research and costs.

129. Concerted action to build research infrastructure, strengthen human resources in research and development and increase collaboration among the research community, health professionals, people with neurological disorders and the private sector is needed to catalyze neurological research and development, particularly in low- and middle-income countries.

#### **130. Proposed actions for Member States**

(a) Increase investment and improve research governance as an integral component of the national response to address the burden of neurological disorders. Facilitate the development of new diagnostics, treatments, technology and innovations for people with, and at risk of developing, neurological disorders. Such innovations include, but are not limited to, the use of big data, AI, diagnostics, precision medicine, disease monitoring and assessment tools, assistive technologies, pharmaceuticals and new models of care.

(b) Support national, regional and international research collaboration on neurological disorders in order to generate new knowledge on the promotion, prevention, diagnosis, treatment and care of neurological disorders and translate existing evidence about neurological disorders into action. Encourage the sharing of, and open access to, research data.

- (c) Build the knowledge and capacity of decision-makers on the need for innovation in the area of brain health and highlight the importance of prioritizing funding for neurological disorders research in national research organizations.
- (d) Strengthen national institutional capacity for research and innovation, such as for the development of new drugs for neurological disorders, including for children, by improving research infrastructure, equipment and supplies.
- (e) Involve and support people with neurological disorders, their carers and the organizations that represent them in actively participating in the research process from planning to implementation.

### 131. **Actions for the Secretariat**

- (a) Support advocacy efforts for increased investment in research for neurological disorders through research prioritization and agenda-setting in the fields of biomedical, clinical, implementation and translational research at global, regional and national levels.
- (b) Engage WHO collaborating centres, academic institutions, research organizations and alliances to strengthen the capacity for research on neurological disorders.
- (c) Support international coordination mechanisms to facilitate harmonized global research efforts in neurology, and foster regular communication and information exchange between stakeholders to build a globally connected research community.
- (d) Offer guidance and technical support to Member States in developing new diagnostics, treatments and innovative technologies for neurological disorders and mechanisms in order to ensure equitable access and implementation, particularly in low-resource settings.

### 132. **Proposed actions for international and national partners**

- (a) Promote and mobilize financial support for research in neurological disorders, participate in priority-setting exercises and contribute to the dissemination of research findings in user-friendly language to policymakers, the public, people with neurological disorders, their carers and families.
- (b) Engage the research community, health professionals, policymakers and the private sector in promoting the innovation and development of new tools and treatments for neurological disorders, while ensuring equitable and affordable access of these products in low- and middle-income countries.
- (c) Support national efforts to strengthen capacity for research, development and innovation and knowledge exchange, including institutional capacity-building, research collaborations and the creation of fellowships and scholarships for the prevention, diagnosis, treatment and care of neurological disorders.
- (d) Support implementation research in low- and middle-income countries in order to generate knowledge about barriers to integrating the treatment of neurological disorders into widespread clinical care and about effective strategies to overcome such barriers.

## 4.2 Data and information systems

133. The availability of health and social care data on neurological disorders can support the identification of gaps in service delivery, improve the accessibility to and coordination of care for people with neurological disorders and promote better understanding and detection of population-level changes and trends.

134. Information systems for neurological disorders are often rudimentary or absent, especially in low-income countries, which complicates data acquisition on the availability and utilization of neurological services and the needs of people with neurological disorders and their carers.

135. The systematic integration of data collection into population-level and routine health information systems and the regular monitoring of neurological disorders based on a core set of measures forms the basis of evidence-based actions to improve services and measure progress towards implementing national programmes for neurological disorders and brain health.

### 136. Proposed actions for Member States

(a) Integrate the monitoring of neurological disorders into routine health information systems and across all levels of care in order to identify, collate and routinely report core data, disaggregated by sex, age and other equity measures, in order to improve neurological care service delivery and promotion and prevention strategies and provide an understanding of the social determinants of neurological disorders.

(b) Encourage patient registries, surveillance programmes, analysis and publication of data on the availability and evaluation of utilization and the coverage of services and effective treatments for neurological disorders.

(c) Support data collection and cross-referencing to other monitoring and accountability mechanisms in order to avoid duplication of efforts at country level.

### 137. Actions for the Secretariat

(a) Offer technical support to Member States to:

- develop and/or improve national data collection systems in order to strengthen data collection for neurological disorders;
- build national capacity and resources for the systematic collection and analysis of data related to neurological disorders and the facilitation of its use;
- develop a core set of indicators and targets in line with this and other global action plans and WHO monitoring frameworks in order to monitor outcomes related to neurological disorders.

### 138. Proposed actions for international and national partners

(a) Provide support to Member States in establishing surveillance, information systems and registries that capture core indicators and patient outcome measures on neurological disorders.

- (b) Advocate for and facilitate the involvement of people with neurological disorders, their families and carers in the collection, analysis and use of data on neurological disorders.
- (c) Support the creation of exchange and dialogue platforms between countries for best practices in collection, management and use of data.

## **STRATEGIC OBJECTIVE 5: STRENGTHEN THE PUBLIC HEALTH APPROACH TO EPILEPSY**

139. Epilepsy affects people of all ages, genders, races and income levels. Poor populations and those living in low- and middle-income countries bear a disproportionate disease burden, which poses a threat to public health and economic and social development.

140. In many parts of the world, people with epilepsy and their families suffer from stigmatization and discrimination due to ignorance, misconceptions and negative attitudes surrounding the disease. They often face serious difficulties in education, employment, marriage and reproduction.

141. The risk of premature death in people with epilepsy is three times higher than the general population. Important causes of death and injury include sudden unexpected deaths in epilepsy, status epilepticus, burns, drowning and suicide. Excess mortality is higher in low- and middle-income countries and is associated with lack of access to health facilities, large treatment gaps and a failure to address the potentially preventable causes of epilepsy.

142. Epilepsy often coexists with and can be compounded by other comorbid health conditions, including other neurological disorders, necessitating a synergistic approach to addressing co-existing conditions.

### **Global targets for strategic objective 5**

#### **Global target 5.1**

By 2031, countries will have increased service coverage for epilepsy by 50% from the current coverage in 2021.

#### **Global target 5.2**

80% of countries will have developed or updated their legislation with a view to promoting and protecting the human rights of people with epilepsy by 2031.

### **5.1 Access to services for epilepsy**

143. Epilepsy is a highly treatable condition and more than 70% of people with epilepsy could live seizure-free lives if they had access to appropriate anti-seizure treatment, the most cost-effective of which are included in the WHO Model List of Essential Medicines. Despite this, the current treatment

gap for epilepsy is estimated at 75% in low-income countries and is substantially higher in rural than in urban areas.<sup>1</sup>

144. Wide treatment gaps may result from a combination of decreased capacity in health care systems, the inequitable distribution of resources and the low priority assigned to epilepsy care. Factors that widen this gap include staff shortage, limited access to anti-seizure medicines, lack of knowledge and confidence of primary health care workers in the management of epilepsy, misconceptions and stigma.

145. Primary health care provides a platform to address the health needs of people with epilepsy through a person-centred approach. With political will and a combination of innovative strategies, epilepsy prevention, diagnosis and treatment can be integrated into primary health services in cost-effective ways, even in low-resource settings.

**146. Proposed actions for Member States**

(a) Develop and strengthen models of care for epilepsy that promote high-quality, people-centred primary care as the core of integrated health services throughout the life course. Strong and functional referral systems with specialist services, as well as care for refractory epilepsy, should be made available. Specialists support the integration of epilepsy care in primary health care by, for example, confirming the diagnosis of epilepsy, providing care for refractory epilepsy and assessing the need for resective surgery.

(b) Enhance training and support in epilepsy diagnosis and management of the primary health care workforce, including facility-, outreach- and community-based health workers, school staff and emergency care workers, as well as specialist training at secondary and tertiary levels.

(c) Develop strategies for the meaningful engagement of the community in order to increase the demand for epilepsy services.

(d) Implement strategies to make anti-seizure medicines more available, accessible and affordable, considering also the specific needs of children, adolescents and women of childbearing age.

Strategic options include:

- including essential anti-seizure medicines in national essential medicine lists and formularies;
- strengthening supply chains and systems of selection;
- increasing procurement and distribution; and
- improving access to controlled medicines such as phenobarbital.

(e) Improve care to prevent the common causes of epilepsy such as perinatal injury, including hypoxic ischaemic brain injury, central nervous system infections, stroke and traumatic brain injuries, by promoting safe pregnancies and births, preventing head trauma and controlling

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<sup>1</sup> Epilepsy: a public health imperative. Geneva: World Health Organization; 2019.



neuroinfectious diseases such as neurocysticercosis, meningitis, encephalitis and malaria, in line with other global initiatives.

(f) Provide people with epilepsy with information about their disorder to help them understand the importance and benefits of medication adherence, and raise awareness of seizure triggers and monitoring and fundamental strategies for self-management and self-care (e.g. through adequate sleep and regular meals).

(g) Strengthen the monitoring and evaluation of epilepsy services through well-functioning health information systems that generate reliable data and support the use of information for improved decision-making and learning by local, national and global actors. Data should be collected from multiple sources, including registries and disease-specific reporting systems, surveys and administrative and clinical data sets.

#### 147. **Actions for the Secretariat**

(a) Develop and disseminate technical guidance to address key gaps and strengthen actions for epilepsy at global and national levels by addressing key policy, implementation and research considerations.

(b) Provide guidance on strengthening the implementation of the epilepsy component of WHO's mental health gap action programme, including updated recommendations, to provide quality care and evidence-based interventions through primary health care and using digital technology.

(c) Offer support to Member States for documenting and sharing best practices of evidence-based epilepsy service delivery and care coordination.

#### 148. **Proposed actions for international and national partners**

(a) Establish community teams to support people with epilepsy, their carers and family in the community and strengthen mechanisms to engage with complementary and alternate medicine providers such as traditional healers.

(b) Advocate for the availability of anti-seizure medicines at affordable prices at all levels of the health care system, especially primary health care centres.

(c) Support people with epilepsy and their families and carers to access services, for example by developing evidence-based, user-friendly information and training tools for epilepsy and available services and/or by setting up websites with information and advice at local levels.

(d) Conduct implementation research, including the dissemination of lessons learned to accelerate the scale-up of successful strategies to strengthen epilepsy services.

## 5.2 **Engagement and support for people with epilepsy**

149. People with epilepsy and their families across all resource settings are subjected to stigmatization and discrimination as a result of the misconceptions and negative attitudes that surround epilepsy, including the belief that epilepsy is the result of possession by evil spirits or that it is contagious.

150. Stigmatization leads to human rights violations and social exclusion. In some settings, children with epilepsy may not be allowed to attend school, while adults with the condition may not be able to find suitable employment or to marry.

151. Innovative strategies are needed to strengthen international efforts and national leadership to support policies and laws for people living with epilepsy, improve public attitudes and reduce stigma, while fully respecting the human rights of people living with epilepsy.

152. People with epilepsy, their carers and organizations that represent them should be empowered and involved in advocacy, policy, planning, legislation, service provision, monitoring and research in epilepsy.

**153. Proposed actions for Member States**

(a) Encourage the inclusion of views and needs of people with epilepsy and their families in relevant health policies and all aspects of developing and strengthening services that support their autonomy. Strong attention to gender, diversity and equity is needed to empower the most vulnerable.

(b) Develop or strengthen legislation to promote and protect the rights of people with epilepsy and prohibit discrimination with respect to education, employment, marriage and family planning, obtaining a driving licence and recreation, among others. Improve accountability by setting up mechanisms, using existing independent bodies where possible, to monitor and evaluate the implementation of policies and legislation relevant to epilepsy in order to ensure compliance with the Convention on the Rights of Persons with Disabilities.

(c) Facilitate joint community initiatives, with strong community provider leadership and civil society engagement, as part of scaling up community-owned initiatives on epilepsy.

(d) Enhance access to a range of person-centred, culturally appropriate and responsive services, including liaison with local nongovernmental organizations and other stakeholders, in order to provide information that empowers people with epilepsy to make informed choices and decisions about their care.

**154. Actions for the Secretariat**

(a) Support the active participation of people with epilepsy and their families in the development of relevant technical products, norms and standards.

(b) Support Member States in developing key capacities to effectively engage in participatory processes that involve people with epilepsy and their families and to leverage these results for decision-making.

**155. Proposed actions for international and national partners**

(a) Ensure that people with epilepsy are included in the activities of the wider community and foster cultural, social and civic participation by enhancing their autonomy.

(b) Support advocacy efforts and public education activities related to epilepsy for community health workers, community leaders and people with epilepsy and their families in order to correct

misconceptions, counter negative attitudes towards people with epilepsy and provide knowledge of how to help a person having a seizure.

### 5.3 Epilepsy as an entry point for other neurological disorders

156. Epilepsy can result from genetic or other often unknown causes, but may also be a consequence of other neurological conditions. For example, epilepsy can be secondary to stroke, infections, brain tumours or traumatic brain injury. Epilepsy is also comorbid with other neurological conditions. For example, migraine occurs in about 19% of people with epilepsy and intellectual disability in approximately 26% of adults and 30–40% of children with epilepsy.<sup>1</sup>

157. A seizure can also be a manifestation of other conditions such as infections, metabolic imbalance, brain tumours and neurodegenerative diseases. It can also be a signal of deterioration or change in an underlying neurological condition.

158. Epilepsy and a wide range of other neurological disorders share similar diagnostic and therapeutic technologies, as well as similar research, pharmacological and psychosocial approaches.

159. A well-functioning epilepsy care service can present a good opportunity for strengthening the management of other neurological disorders. Epilepsy can therefore serve as an entry point for accelerating the strengthening of services and support for both epilepsy and other neurological disorders. Other neurological disorders, identified based on national priorities, should be considered concurrently alongside epilepsy treatment and care to achieve the best results for all. This approach may be applicable in some parts of the world, while in others stroke, dementia and neurodegenerative disorders, migraine and other headache disorders may serve as the entry point.

#### 160. Proposed actions for Member States

(a) Orient health systems to expand existing epilepsy prevention, diagnosis, treatment and care to the management of comorbidities as an essential component at all levels of care. For example, good interdisciplinary team care for epilepsy can be transferred to the care of other neurological disorders.

(b) Strengthen the capacity of health workers serving at the primary health care level to develop competencies that extend beyond epilepsy care to cut across other neurological disorders, including the treatment of comorbidities, drawing on WHO's mental health gap action programme.<sup>2</sup>

(c) Leverage epilepsy diagnostics such as the electroencephalogram (EEG), neuroimaging technology (including CT and MRI) and specialized referral services (e.g. surgery) to include facilities for diagnosis and management of other neurological disorders.

(d) Expand procurement systems developed for anti-seizure medicines to improve access to effective and quality medicines for other neurological disorders.

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<sup>1</sup> Epilepsy: a public health imperative. Geneva: World Health Organization; 2019.

<sup>2</sup> Mental Health Gap Action Programme (mhGAP). Geneva: World Health Organization (<https://www.who.int/teams/mental-health-and-substance-use/treatment-care/mental-health-gap-action-programme>, accessed 1 December 2021).

**161. Actions for the Secretariat**

(a) Support Member States to incorporate care for other neurological conditions in routine epilepsy services at primary care levels by providing strategies, processes and tools for countries to apply in order to strengthen the capacity of the health workforce.

(b) Promote and facilitate the exchange of best practices at international, regional and national levels in order to inform the implementation of integrated care models for epilepsy and other neurological disorders.

**162. Proposed actions for international and national partners**

(a) Activate national networks and lobby administrators, policymakers and other stakeholders to integrate care for comorbidities (i.e. physical and mental health conditions) as an integral part of epilepsy treatment and care services.

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## ANNEX 13

### **Action plan (2022–2030) to effectively implement the global strategy to reduce the harmful use of alcohol as a public health priority<sup>1,2</sup>**

[EB150/7, Add.1 – 11 January 2022]

#### **BACKGROUND**

##### **Setting the scene**

1. Alcohol consumption is deeply embedded in the social landscape of many societies. Several major factors have an impact on levels and patterns of alcohol consumption in populations – such as historical trends in alcohol consumption, the availability of alcohol, culture, economic status and trends in the marketing<sup>3</sup> of alcoholic beverages, as well as implemented alcohol control measures. At the individual level, the patterns and levels of alcohol consumption are determined by many different factors, including gender, age and individual biological and socioeconomic vulnerability factors, as well as the policy environment. Prevailing social norms that support drinking behaviour and mixed messages about the harms and benefits of drinking encourage alcohol consumption delay appropriate health-seeking behaviour and weaken community action.

2. Alcohol is a psychoactive substance with intoxicating and dependence-producing properties. The accumulated evidence indicates that alcohol consumption is associated with inherent health risks, although health consequences of alcohol consumption vary significantly in magnitude and nature among drinkers. At the population level, any level of alcohol consumption is associated with preventable net harms due to multiple health conditions such as injuries, alcohol use disorders (AUDs), liver diseases, cancers and cardiovascular diseases, as well as harms to persons other than drinkers. Several aspects of drinking have an impact on the health consequences of alcohol consumption, namely the volume of alcohol consumed over time; the pattern of drinking, in particular drinking to intoxication; the drinking context; and the quality of the alcoholic beverage or its contamination with toxic substances such as methanol. Repeated consumption of alcoholic beverages may lead to the development of AUDs, including alcohol dependence that is characterized by impaired regulation of alcohol consumption and manifested by impaired control over alcohol use, increasing precedence of alcohol use over other aspects of life and specific physiological features.<sup>4</sup>

3. The current action plan refers to the “harmful use of alcohol” as defined in the global strategy to reduce the harmful use of alcohol as “drinking that causes detrimental health and social consequences for the drinker, the people around the drinker and society at large, as well as patterns of drinking that

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<sup>1</sup> See decision WHA75(11).

<sup>2</sup> Published separately under the title *Global alcohol action plan 2022–2030*.

<sup>3</sup> In this document, the term “marketing” is used to mean any form of commercial communication or message that is designed to increase – or has the effect of increasing – the recognition, appeal and/or consumption of particular products and services. It comprises anything that acts to advertise or otherwise promote a product or service.

<sup>4</sup> International Classification of Diseases, 11th Revision (ICD-11). Geneva: World Health Organization; 2021.

are associated with increased risk of adverse health outcomes”.<sup>1</sup> Its concept is much broader than the clinical concept of diagnostic category of “harmful pattern of use”, which represents a part of the spectrum of “alcohol use disorders” in the International Classification of Diseases.

4. The impact of the harmful use of alcohol on health and well-being is not limited to health consequences; it incurs significant social and economic losses relating to costs in the justice sector, costs from lost workforce productivity and unemployment and the costs assigned to pain and suffering. The harmful use of alcohol can also result in harm to others, such as family members, friends, co-workers and strangers. Among the most dramatic manifestations of harm to persons other than drinkers are road traffic injuries and the consequences of prenatal alcohol exposure, which may result in the development of fetal alcohol spectrum disorders (FASDs). There is no safe limit established for alcohol consumption at any stage of pregnancy. The harms to others may be very tangible, specific and time-bound (e.g. injuries or damage) or may be less tangible and result from suffering, poor health and well-being and the social consequences of drinking (e.g. being harassed or insulted or feeling threatened).

5. Awareness and acceptance of the overall negative impact of alcohol consumption on a population’s health and safety is low among decision-makers and the general public. This is influenced by commercial messaging and poorly regulated marketing of alcoholic beverages, which deprioritize efforts to counter the harmful use of alcohol in favour of other public health issues. The COVID-19 pandemic highlighted the importance of appropriate policy and health system responses to reduce the harmful use of alcohol during health emergencies.

6. The health, economic and social burden attributable to alcohol consumption is largely preventable. Historically, in recognition of the intoxicating, toxic and dependence-producing properties of alcohol, there have always been attempts to regulate the production, distribution and consumption of alcoholic beverages. The protection of the health of populations by preventing and reducing the harmful use of alcohol is a public health priority and should be a focus of alcohol policies and alcohol control measures implemented at different levels.

## **Global strategy to reduce the harmful use of alcohol and its implementation**

### **The global strategy and its mandate**

7. The global strategy to reduce the harmful use of alcohol, which was endorsed by the Sixty-third World Health Assembly in May 2010 (resolution WHA63.13), remains the only global policy framework for reducing deaths and disabilities due to alcohol consumption in their entirety – from mental health conditions and noncommunicable diseases (NCDs) to injuries and alcohol-attributable infectious diseases. The global strategy builds on several WHO global and regional strategic initiatives and represents the commitment of WHO Member States to take sustained action at all levels. Following the endorsement of the global strategy, regional action plans aligned with the global strategy were developed or revised and adopted in WHO’s Region of the Americas (2011) and European Region (2012), while a regional strategy for reducing the harmful use of alcohol was developed and adopted in the WHO African Region (2013).

8. The global strategy was developed to promote and support local, regional and global actions to prevent and reduce the harmful use of alcohol. It outlines key components for global action and recommends a portfolio of policy options and measures that could be considered for implementation and adjusted as appropriate at the national level. These policy options take into account national circumstances such as religious and cultural contexts; national public health priorities; and resources,

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<sup>1</sup> Document WHA63/2010/REC/1, Annex 3.

capacities and capabilities. The global strategy also contains a set of principles that should guide the development and implementation of policies at all levels.

9. Since the endorsement of the global strategy in 2010, Member States' commitment to reducing the harmful use of alcohol has been reinforced by the adoption of the political declarations emanating from the high-level meetings of the United Nations General Assembly on the prevention and control of NCDs, including the declaration of 2011 and the subsequent adoption and implementation of the WHO Global action plan for the prevention and control of NCDs 2013–2020 (NCD-GAP). In 2019, the Seventy-second World Health Assembly (in resolution WHA72.11) extended the NCD-GAP to 2030, ensuring its alignment with the 2030 Agenda for Sustainable Development. The NCD-GAP lists the harmful use of alcohol as one of four key risk factors for major NCDs. It enables Member States and other stakeholders to identify and use opportunities for synergies to tackle more than one risk factor at the same time; strengthen coordination and coherence between measures for reducing the harmful use of alcohol and activities for preventing and controlling NCDs; and set voluntary targets for reducing the harmful use of alcohol and other risk factors for NCDs. In May 2013, the Sixty-sixth World Health Assembly adopted the comprehensive NCD Global Monitoring Framework, in which the voluntary global target for the harmful use of alcohol to be achieved by 2025 is defined as at least 10% relative reduction, as appropriate, within the national context, and measured by indicators across three domains, including total alcohol per capita consumption within a calendar year in litres of pure alcohol, age-standardized prevalence of heavy episodic drinking, and alcohol-related morbidity and mortality.<sup>1</sup>

10. The international mandate to reduce the harmful use of alcohol was further strengthened with the adoption of the 2030 Agenda and the Sustainable Development Goals 2030 (SDG 2030). Reducing the harmful use of alcohol will contribute to progress towards the attainment of the multiple goals and targets of the 2030 Agenda and the SDGs, including SDG goal 1 on ending poverty; SDG goal 4 on ensuring a quality education; SDG goal 5 on achieving gender equality; SDG goal 8 on promoting decent work and economic growth; SDG goal 10 on reducing inequalities within and among countries; and SDG goal 16 on promoting peace and providing justice and strong institutions. In view of the negative impact of the harmful use of alcohol on the development and outcomes of many diseases and health conditions, including major NCDs and injuries, the effective reduction of the harmful use of alcohol will make a substantial contribution towards the attainment of SDG goal 3 (Ensure healthy lives and promote well-being for all), in particular SDG target 3.5 (Strengthen the prevention and treatment of substance abuse, including narcotic drug abuse and harmful use of alcohol). This reflects the broader impact of the harmful use of alcohol on health in areas beyond NCDs and mental health (SDG target 3.4), such as road traffic accidents (SDG target 3.6), reproductive health (SDG target 3.7), universal health coverage (SDG target 3.8) and infectious diseases (SDG target 3.3).

11. One of the guiding principles of the global strategy states that public policies and interventions to prevent and reduce alcohol-related harm should be guided and formulated by public health interests and based on clear public health goals and the best available evidence. Evidence of the cost-effectiveness of alcohol policy options and interventions was updated in a revision of Appendix 3 to the NCD-GAP, which was endorsed by the Health Assembly in resolution WHA70.11. This resulted in a new set of enabling and recommended actions to reduce the harmful use of alcohol. The most cost-effective actions or best buys include increasing taxes on alcoholic beverages; enacting and enforcing bans or comprehensive restrictions on exposure to alcohol advertising across multiple types of media; and enacting and enforcing restrictions on the physical availability of retailed alcohol. By prioritizing the most cost-effective policy measures, the WHO Secretariat and partners launched the SAFER initiative, with the primary objective of supporting WHO Member States in reducing the harmful use of alcohol by enhancing the ongoing implementation of the global strategy and other WHO and United Nations strategies. The WHO-led SAFER initiative focuses on the support for implementation of cost-effective policy options and interventions. It also aims to protect public health-oriented policy-making against

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<sup>1</sup> Document WHA66/2013/REC/1, Annex 4, Appendix 2.

interference from commercial interests and establish strong monitoring systems to ensure accountability and track progress in the implementation of SAFER policy options and interventions.

### **Implementation of the global strategy since its endorsement<sup>1</sup>**

12. Since the endorsement of the global strategy, its implementation has been uneven across WHO regions as well as within regions and countries. The number of countries with a written national alcohol policy has steadily increased and many countries have revised their existing alcohol policies. However, the presence of written national alcohol policies continues to be most common in high-income countries and least common among low-income countries, with written national alcohol policies missing from most countries in the African Region and the Region of the Americas. The disproportionate prevalence of effective alcohol control measures in higher-income countries raises questions about global health equity. Specifically, it underscores the need for more resources and greater priority to be allocated to support the development and implementation of effective policies and actions in low- and middle-income countries.

### **Challenges in implementation of the global strategy**

13. Considerable challenges remain for the development and implementation of effective alcohol policies. These challenges relate to the complexity of the problem; differences in cultural norms and contexts; the intersectoral nature of cost-effective solutions, including pricing strategies, and associated limited levels of political will and leadership at the highest levels of government; and the influence of powerful commercial interests in policy-making and implementation. These challenges operate against a background of competing international economic commitments. The limited availability of comprehensive and reliable data on alcohol consumption and related harm, generated at the national level, presents additional challenges for the evaluation of the impact of implemented national policy responses in many countries. Coordination and cooperation at all levels for dealing with these challenges is further complicated by contexts in which the responsibility for actions to reduce the harmful use of alcohol is dispersed between different entities – including government departments, different professions and technical areas.

14. The production of alcoholic beverages has become increasingly concentrated and globalized in recent decades, particularly in the beer and spirits sectors. A significant proportion of alcoholic beverages is consumed at heavy drinking events associated with significant health risks and heavy drinking is often associated with the presence of AUDs. This highlights the inherent contradiction between the interests of alcohol producers and public health. At the same time, there is mounting evidence that any level of alcohol consumption is associated with health risks. Some countries experience substantial challenges in protecting alcohol policy development from commercial interests, while the issue of safeguarding alcohol policy development at all levels from alcohol industry interference is consistently presented as a major challenge in international policy dialogues. Strong international leadership is needed to counter interference from commercial interests in alcohol policy development and implementation in order to prioritize the public health agenda for alcohol in the face of the strong commercial interests associated with alcohol beverage production and trade. Competing interests across the whole of government at the country level, including interests related to the production and trade of alcohol and government revenues from alcohol taxation and sales, often result in policy incoherence and the weakening of alcohol control efforts. The situation varies at national and subnational levels and is heavily influenced by the commercial interests of alcohol producers and distributors, religious beliefs and spiritual and cultural norms. General trends towards deregulation in

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<sup>1</sup> See document EB146/7Add.1.



recent decades have often resulted in the weakening of alcohol controls, to the benefit of economic interests and at the expense of public health and well-being.

15. Alcohol remains the only psychoactive and dependence-producing substance that exerts a significant impact on global population health that is not controlled at the international level by legally binding regulatory instruments. This absence limits the ability of national and subnational governments to regulate the distribution, sale and marketing of alcohol within the context of international, regional and bilateral trade negotiations. It also hampers efforts as to protect the development of alcohol policies from interference by transnational corporations and commercial interests. This has prompted calls for a global normative law on alcohol at the intergovernmental level, modelled on the WHO Framework Convention on Tobacco Control.<sup>1</sup> Discussions about the feasibility and necessity of such a legally binding international instrument indicated a lack of consensus among Member States on this issue.

16. Informally and illegally produced alcohol accounts for an estimated 25% of total alcohol consumption per capita worldwide and in some jurisdictions exceeds half of all the alcohol consumed by the population. Informal and illegal production and trade are different in nature and require different policy and programme responses. Informal production and distribution of alcohol are often embedded in cultural traditions and the socioeconomic fabrics of communities. Illicit alcohol production is associated with significant health risks and challenges for regulatory and law enforcement sectors of governments. The capacity to deal with informal or illicit production, distribution and consumption of alcohol, including safety issues, is limited or inadequate, particularly in jurisdictions where unrecorded alcohol makes up a significant proportion of all the alcohol consumed.

17. Satellite and digital marketing present a growing challenge for the effective control of alcohol marketing and advertising. Alcohol producers and distributors have increasingly moved towards investing in digital marketing and using social media platforms, which are profit-making businesses with an infrastructure designed to allow “programmatically native advertising” that is data-driven and participatory. Internet marketing crosses borders with even greater ease than satellite television and is not easily subjected to national-level control. In parallel with the greater opportunity for marketing and selling alcohol through online platforms, delivery systems are rapidly evolving, imposing considerable challenges on the ability of governments to control alcohol sales. From a public health perspective, recent developments in marketing, advertising and promotional activities related to alcoholic beverages are of deep concern, including those implemented through cross-border marketing and those targeting or reaching out to children, adolescents and young people.

18. Limited technical capacity, human resources and funding hinder efforts to develop, implement, enforce and monitor effective alcohol control interventions at all levels. Technical expertise in alcohol control measures is often insufficient at national and subnational levels, as are the available human and financial resources at all levels of WHO for the provision of required technical assistance and the compilation, dissemination and application of technical knowledge in practice. Few civil society organizations prioritize alcohol as a health risk or motivate governments to take action compared to the number of organizations that support tobacco control. In the absence of philanthropic funding and with limited resources in WHO and other intergovernmental organizations, there has been little investment in capacity-building in low- and middle-income countries.

19. The lack of sufficiently developed national systems for monitoring alcohol consumption and the impact of alcohol on health reduces the capacity of advocacy for effective alcohol control policies and for monitoring their implementation and impact.

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<sup>1</sup> Au Yeung SL, Lam TH. Unite for a Framework Convention for Alcohol Control. *Lancet*. 2019;393(10183):1778–1779. doi: 10.1016/S0140-6736(18)32214-1.

## **Opportunities for reducing the harmful use of alcohol**

20. In recent years, alcohol consumption among young people has decreased in many countries throughout Europe and in some other high-income societies, with the exception of some disadvantaged groups. The decline seems to be continuing into the next age group as the cohort ages. Capitalizing on this trend offers a considerable opportunity for public health policies and programmes. There is also a trend towards an increase in the proportion of former drinkers among people aged 15 years and above. One contributory factor is the increasing awareness of the negative health and social consequences of the harmful use of alcohol and its causal relationships not only with alcohol-induced mental disorders, interpersonal violence and suicides but also with several types of cancer, liver and cardiovascular diseases, as well as its association with increased risk of infectious diseases such as tuberculosis and HIV/AIDS. Increasing the health literacy and health consciousness of the general public provides an opportunity for strengthening prevention activities by integrating and linking alcohol policies and action plans with those on major noncommunicable and communicable diseases, including national cancer control plans, as well as with those on psychoactive drugs and addictions, and by scaling up screening and brief interventions in health services.

21. While recognizing its negative influences and effects, social media also provides new opportunities for changing peoples' relationship with alcohol through increased awareness of the negative health consequences of drinking and new horizons for the communication and promotion of recreational activities as an alternative to drinking and intoxication. At the same time, social media can serve as a powerful source of marketing communication and brand promotion for alcoholic beverages.

22. Alcohol consumption and its impact on health have been increasingly recognized as factors in health inequality. Within a given society, adverse health impacts and social harm from a given level and pattern of drinking are greater for poorer individuals and societies. Increased alcohol consumption can exacerbate health and social inequalities between genders, social classes and communities. Policies and programmes to reduce health inequalities and promote sustainable development need to include sustained attention to alcohol policies and programmes.

23. The body of evidence for the effectiveness and cost-effectiveness of alcohol control measures has been significantly strengthened in recent years. The latest economic analysis undertaken under the auspices of WHO demonstrated high returns on investment for best buys in alcohol control. Every additional US\$ 1 invested in the most cost-effective interventions per person per year will yield a return of US\$ 9.13 by 2030, a return that is higher than a similar investment in tobacco control (US\$ 7.43) or prevention of physical inactivity (US\$ 2.80). The notion that economic savings are greater than implementation costs for effective alcohol control policies is supported by recent OECD estimates, showing that every US\$ 1 invested in a comprehensive policy package yields a return of up to US\$ 16 in economic benefits.<sup>1</sup>

24. The COVID-19 pandemic and measures to curb virus transmission (e.g. lockdowns, stay-at-home mandates) have had a significant impact on population health and well-being, as well as on patterns of alcohol consumption, alcohol-related harms and the implementation of existing policy and programme responses. The COVID-19 outbreak has underscored the importance of developing appropriate alcohol policy responses and alcohol-focused activities and interventions during public health emergencies, as well as the importance of including alcohol policy responses as a key element of preparedness for health emergencies. This will have important implications for reducing not only the harmful use of alcohol at

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<sup>1</sup> OECD (2021), Preventing Harmful Alcohol Use, OECD Health Policy Studies, OECD Publishing, Paris, (<https://doi.org/10.1787/6e4b4ffb-en>, accessed 9 December 2021).

national, regional and global levels but also the alcohol-related health burden and demand for health service interventions during pandemics and other health emergencies.

### **Scope of the action plan**

25. In its decision EB146(14) (2020), the Executive Board recognized the continuing relevance of the global strategy to reduce the harmful use of alcohol and requested the Director-General to review the global strategy and report to the Executive Board at its 166th session in 2030 for further action. It also requested the Director-General to develop an action plan (2022–2030) to effectively implement the global strategy to reduce the harmful use of alcohol as a public health priority, in consultation with Member States and relevant stakeholders, for consideration by the Seventy-fifth World Health Assembly, through the Executive Board at its 150th session in 2022.

26. The action plan is based on guidance provided by the global strategy with regard to global action, its key role and components, as well as on lessons learned from the implementation of the global strategy and regional strategies and action plans on alcohol over the last 10 years. The action plan aims to strengthen the implementation of the global strategy by accelerating actions at all levels and by supporting and complementing national responses to the public health problems caused by the harmful use of alcohol in the 10 target areas recommended by the global strategy for national action (see paragraph 34 below) and tailored to country contexts.

27. The action plan proposes specific actions and measures to be implemented at the global level in line with key roles and components of global action, as formulated in the global strategy, and the latest available evidence on the effectiveness and cost-effectiveness of policy options for reducing the harmful use of alcohol. The proposed actions and measures are presented in six action areas that correspond to the four key components of global action included in the global strategy: public health advocacy and partnership; technical support and capacity-building; production and dissemination of knowledge; and resource mobilization.<sup>1</sup> An action area on the implementation of high-impact strategies and interventions was also included in the action plan based on evidence of the effectiveness and cost-effectiveness of different policy options and reflecting the lessons learned from implementation of the global strategy. The proposed actions and measures included in action area 1 (Implementation of high-impact strategies and interventions), when implemented and enforced, have the highest potential for reducing the harmful use of alcohol. These measures are prioritized in the action plan in view of the evidence of their cost-effectiveness and the insufficient progress achieved globally in reducing the harmful use of alcohol to date. Their prioritization and implementation at the national and subnational levels, as well as the prioritization of other policy options and interventions recommended by the global strategy, is at the discretion of each Member State, depending on the needs and status of implementation of these measures in a given country. It is also dependent on national and subnational social, economic and cultural contexts, public health priorities, health system policies and available resources. National needs and contexts may require, at the discretion of a Member State, the implementation of more stringent measures than those proposed in the action plan.

28. The actions and measures proposed in the action plan are envisaged to support and complement policy measures and interventions implemented at the national level in the following 10 areas recommended in paragraph 16 of the global strategy: (1) leadership, awareness and commitment; (2) health services' response; (3) community action; (4) drink-driving policies and countermeasures; (5) availability of alcohol; (6) marketing of alcoholic beverages; (7) pricing policies; (8) reducing the negative consequences of drinking and alcohol intoxication; (9) reducing the public health impact of illicit alcohol and informally produced alcohol; and (10) monitoring and surveillance.

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<sup>1</sup> Document WHA63/2010/REC/1, paras 43–58.

29. As highlighted in the global strategy, its successful implementation requires concerted actions by Member States, effective global governance and the appropriate engagement of all relevant stakeholders. The action plan includes proposed actions for international partners and non-State actors such as civil society organizations, professional associations, academia and research institutions. The action plan also outlines proposed measures for economic operators in alcohol production and trade<sup>1</sup> in line with the mandates provided in paragraph 45(d) of the global strategy and other relevant policy guidance and policies, including but not limited to the WHO's framework of engagement with non-State actors.

30. The action plan is linked to and aligned with other relevant global action plans and commitments, including Agenda 2030; the political declaration of the high-level meeting on universal health coverage adopted by the United Nations General Assembly in 2019; the comprehensive mental health action plan 2013–2030; the NCD-GAP; the political declaration of the third high-level meeting of the General Assembly on the prevention and control of noncommunicable diseases; the global action plan on the public health response to dementia; and the global plan of action to address interpersonal violence.

31. The action plan is envisaged to strengthen the implementation of the global strategy at all levels, with the acknowledgement that the implementation of the action plan at national level and the prioritization of proposed actions and measures depend on national contexts.

## **GOAL OF THE ACTION PLAN**

32. The goal of the action plan is to boost the effective implementation of the global strategy to reduce the harmful use of alcohol as a public health priority and to significantly reduce morbidity and mortality due to alcohol consumption – over and above general morbidity and mortality trends – and associated social consequences. The action plan also aims to improve the health and well-being of populations globally.

33. The effective implementation of the action plan at the regional levels will require the development or elaboration and adaptation of region-specific action plans, in coordination with the WHO Secretariat, so that more efficient and consistent progress will be made.

## **OPERATIONAL OBJECTIVES OF THE ACTION PLAN**

34. The proposed operational objectives of the action plan 2022–2030 and its proposed action areas are aligned with the objectives of the global strategy<sup>2</sup> and the four key components of global action to reduce the harmful use of alcohol effectively.<sup>3</sup> However, the operational objectives of the action plan are not identical to those of the global strategy. The six operational objectives of the action plan reflect the action-oriented nature of the action plan, as well as more recent goals and objectives of other relevant global strategies and action plans, as well as lessons learned in implementing the global strategy since its endorsement:

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<sup>1</sup> In this document, the term “economic operators in alcohol production and trade” means manufacturers of alcoholic beverages, wholesale distributors, major retailers and importers that deal solely and exclusively in alcoholic beverages or whose primary income comes from trade in alcohol beverages, as well as business associations or other non-State actors representing any of the afore-mentioned entities.

<sup>2</sup> Document WHA63/2010/REC/1, Annex 3, paras 7–11.

<sup>3</sup> Document WHA63/2010/REC/1, Annex 3, paras 43–58.

1. Increase population coverage, implementation and enforcement of high-impact policy options and interventions to reduce the harmful use of alcohol worldwide for better health and well-being, taking into account gender perspective and a life-course approach.
2. Strengthen multisectoral action through effective governance, enhanced political commitment, leadership, dialogue and coordination of multisectoral action.
3. Enhance the prevention and treatment capacity of health and social care systems for disorders due to alcohol use and associated health conditions as an integral part of universal health coverage and aligned with the 2030 Agenda and its health targets.
4. Raise awareness of the risks and harms associated with alcohol consumption and its impact on the health and well-being of individuals, families, communities and nations, as well as of the effectiveness of different policy options for reducing consumption and related harm.
5. Strengthen information systems and research for monitoring alcohol consumption, alcohol-related harm, their determinants and modifying factors, and policy responses at all levels, with dissemination and application of information for advocacy in order to inform policy and intervention development and evaluation.
6. Significantly increase the mobilization of resources required for appropriate and sustained action to reduce the harmful use of alcohol at all levels.

## OPERATIONAL PRINCIPLES

35. The global strategy includes guiding principles for the development and implementation of alcohol policies at all levels<sup>1</sup> and in the action plan the guiding principles listed in the global strategy are complemented by the following **operational action-oriented guiding principles**:

**Multisectoral action.** The development, implementation and enforcement of alcohol control policies at all levels require concerted multisectoral action, with the engagement of the health sector and other relevant sectors, such as social welfare and employment, customs, agriculture, education, transport, sport, culture, finance and law enforcement, as appropriate, to address the harmful use of alcohol in their activities.

**Universal health coverage.** All individuals and communities, including those in rural areas, receive the health services they need, without suffering financial hardship, to reduce the health burden caused by the harmful use of alcohol, including the full spectrum of essential quality health services, from health promotion to prevention, treatment, rehabilitation and palliative care across the life course.

**Life-course approach.** Recognizing the importance and interrelationship of alcohol control measures and prevention and treatment strategies and interventions to prevent and reduce alcohol-related harm at all stages of a person's life and for all generations. This ranges from eliminating the marketing, advertising and sale of alcoholic products to minors and the protection of the unborn child from prenatal alcohol exposure to the prevention and management of the harms due to the use of alcohol in older people.

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<sup>1</sup> Global strategy to reduce the harmful use of alcohol. Geneva: World Health Organization,; 2010, page 9 (<https://apps.who.int/iris/handle/10665/44395>, accessed 5 June 2021).

**Protection from commercial interests.** The development of public policies to reduce the harmful use of alcohol should be protected, in accordance with national laws, from commercial and other vested interests that can interfere with and undermine public health objectives.

**Equity-based approach.** Public health policies and interventions to reduce the harmful use of alcohol should aim to reduce health inequalities and protect people in different groups (across social, biological, economical, demographical or geographical divides) from alcohol-related harm.

**Human rights approach.** Protection from alcohol-related harm and access to the prevention and treatment of AUDs in health systems contributes to the fulfilment of the right to the highest attainable standard of health; strategies and interventions to reduce the harmful use of alcohol should address and eliminate discriminatory practices (both real and perceived) and stigma with regard to preventive measures and health and social services for people with AUDs.

**Empowering of people and communities.** The development and implementation of strategies and interventions to reduce the harmful use of alcohol and protect people and communities from alcohol-related harm should provide opportunities for the active engagement and empowerment of people and communities, including people with lived experiences of alcohol-related harm or AUDs.

## **KEY AREAS FOR GLOBAL ACTION**

36. To achieve the goal and objectives set out above, the following key areas are proposed for action by Member States, the WHO Secretariat, international and national partners and, as appropriate, other stakeholders:

Action area 1: Implementation of high-impact strategies and interventions

Action area 2: Advocacy, awareness and commitment

Action area 3: Partnership, dialogue and coordination

Action area 4: Technical support and capacity-building

Action area 5: Knowledge production and information systems

Action area 6: Resource mobilization

37. At the national level, Member States have the primary responsibility for the development, implementation, monitoring and evaluation of public policies to reduce the harmful use of alcohol according to their national needs and contexts. The roles of other stakeholders may differ across Member States.

## **ACTION AREA 1: IMPLEMENTATION OF HIGH-IMPACT STRATEGIES AND INTERVENTIONS**

38. The limited global progress – or no progress at all in some parts of the world – achieved to date in reducing the harmful use of alcohol can be explained by insufficient uptake, implementation and enforcement of the most effective and cost-effective alcohol policies and interventions. The goal of considerably reducing morbidity and mortality due to alcohol consumption over and above general morbidity and mortality trends and associated social consequences can be achieved by tackling the

determinants that drive the acceptability, availability and affordability of alcohol consumption, while also strengthening the coverage and implementation of comprehensive and integrated policy options and measures with proven effectiveness.

39. The most effective and cost-effective policy options and interventions are summarized in the updated Appendix 3 of the NCD-GAP, endorsed by the Seventieth World Health Assembly.<sup>1</sup> These policy options and interventions constitute core elements of the SAFER initiative and SAFER technical package. Other policy options and interventions will be subject to cost-effectiveness analysis as evidence emerges regarding their effectiveness.

### **Global targets for action area 1**

**Global target 1.1:** By 2030, at least a 20% relative reduction (in comparison with 2010) in the harmful use of alcohol.<sup>2</sup>

**Global target 1.2:** By 2030, 70% of countries have introduced, enacted or maintained the implementation of high-impact policy options and interventions.<sup>3</sup>

### **Proposed actions for Member States**

- Action 1. On the basis of the evidence of the effectiveness and cost-effectiveness of policy measures, to promote the prioritization, according to national needs and contexts, of the sustainable implementation, continued enforcement, monitoring and evaluation of high-impact cost-effective policy options included in the WHO SAFER technical package,<sup>4</sup> as well as other interventions already proven to be cost-effective or subsequently proven to be cost-effective based on upcoming evidence, including the assurance of universal access to affordable treatment and care for people with AUDs within national health systems.
- Action 2. Consider, as appropriate for a national context, developing national action plans, road maps or action frameworks to accelerate the implementation of global and regional commitments.
- Action 3. Implement, as appropriate in national contexts, high-impact and effective strategies and interventions, supported by legislative measures, addressing: (a) the affordability of alcoholic beverages, by appropriate taxation and pricing policies; (b) the advertising and marketing of alcoholic beverages, through comprehensive and robust restrictions or bans across multiple types of media, including digital media; (c) the availability of alcohol, by enacting and enforcing restrictions on spatial and temporal availability of alcoholic beverages; (d) driving under the influence of alcohol, by enacting and enforcing drink-driving laws and regulations;

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<sup>1</sup> See document WHA70/2017/REC/1, Annex 3.

<sup>2</sup> The “at least 20% relative reduction” target is based on the latest available WHO data and trends since 2010 and exceeds the voluntary target set at the NCD Global Monitoring Framework (at least 10% relative reduction by 2025) to reflect the aims of the action plan as mandated by decision EB146(14) (2020) (“...to effectively implement the global strategy... as a public health priority...”) and its goal to considerably reduce morbidity and mortality due to alcohol consumption – over and above general morbidity and mortality trends.

<sup>3</sup> Included in the SAFER technical package and informed by upcoming updates.

<sup>4</sup> The SAFER technical package: five areas of intervention at national and subnational levels. Geneva: World Health Organization; 2019 (<https://www.who.int/publications/i/item/the-safer-technical-package>).

and (e) hazardous patterns of drinking and AUDs, by providing brief psychosocial interventions, treatment and care in health and social services.

- Action 4. Ensure that the development, implementation and evaluation of alcohol policy measures are based on public health goals and the best available evidence and are protected from the interference of commercial interests.
- Action 5. Build or strengthen and support broad partnerships and intragovernmental and intergovernmental mechanisms at different levels for collaboration across different sectors for the implementation of prioritized policy options.

### **Proposed actions for the WHO Secretariat**

- Action 1. Provide policy and technical guidance, advocacy and, as required, technical assistance for the assessment, development, implementation and evaluation of effective and cost-effective policy options.
- Action 2. Periodically review the evidence of the effectiveness and cost-effectiveness of alcohol policy options and interventions and formulate and disseminate recommendations for reducing the harmful use of alcohol.
- Action 3. Develop a portfolio of policy guidance for outlet locations, outlet densities and days and hours of sale; implementation of minimum pricing and taxation policies; regulating alcohol marketing, sponsorships, promotions and advertising, also via social media; the management of unrecorded alcohol; the management of conflicts of interest in policy design and implementation; and the development and implementation of warning labels.
- Action 4. Develop a comprehensive technical package to facilitate the development, implementation, monitoring and evaluation of recommended high-impact policy options and interventions.
- Action 5. Promote and support international collaboration in addressing cross-border alcohol marketing, advertisement and promotion, with a focus on the public health risks associated with new cross-border marketing practices.
- Action 6. Promote a comprehensive approach to tackling the determinants that drive the acceptability, availability and affordability of alcohol consumption, thereby ensuring a comprehensive portfolio of population-wide interventions, expanding from health promotion and prevention to screening and treatment interventions.

### **Proposed actions for international partners, civil society organizations and academia**

- Action 1. Major partners in the United Nations system and intergovernmental organizations are invited to increase their collaboration and cooperation with WHO on the development, implementation and evaluation of high-impact policy measures and by joining the WHO-led SAFER initiative.
- Action 2. Civil society organizations and academia are invited to strengthen their advocacy and support for the implementation of high-impact policy options by creating enabling environments; promoting the SAFER initiative; strengthening global and



regional networks and action groups, with appropriate engagement of community and cultural leaders; developing and strengthening accountability frameworks; and monitoring the activities and commitments of economic operators in alcohol production and trade.

### **Proposed measures for economic operators in alcohol production and trade**

Economic operators in alcohol production and trade are called on to focus on the implementation of measures that can contribute to reducing the harmful use of alcohol, which are stringently within their core roles as developers, producers, distributors, marketers and sellers of alcoholic beverages, and to abstain from interfering with alcohol policy development and refrain from activities that might prevent, delay or stop the development, enactment, implementation and enforcement of high-impact strategies and interventions to reduce the harmful use of alcohol.

## **ACTION AREA 2: ADVOCACY, AWARENESS AND COMMITMENT**

40. Strategic and well-developed international communication and advocacy are needed to raise awareness about alcohol-related harms and the effectiveness of policy measures among decision-makers and the general public in order to increase their support for the accelerated implementation of the global strategy. Special efforts and activities are needed to mobilize different stakeholders for coordinated actions to protect public health and foster broad political commitment to reduce the harmful use of alcohol.

41. It is necessary to raise awareness among decision-makers and the general public about the risks and harms associated with alcohol consumption. Appropriate attention should be given to the prevention of the initiation of drinking among children and adolescents; the prevention of drinking among pregnant women; and the protection of people from pressures to drink, especially in societies with high levels of alcohol consumption, in which heavy drinkers are encouraged to drink even more. The unique circumstances of indigenous populations require special culturally appropriate efforts in addressing the levels and patterns of alcohol consumption, alcohol-related harms and the social and economic factors that influence the impact of alcohol consumption on their health and well-being. An international day or week of awareness of alcohol-related harm or a “World no alcohol day/week” could help to focus and reinforce public attention on the problem. Public health advocacy is more likely to succeed if it is well supported by evidence and based on emerging opportunities and if the arguments are free from moralizing. International discourse on alcohol policy development and implementation should address the health inequalities associated with the harmful use of alcohol and its broad socioeconomic impacts, including the impact on the attainment of the health-related and other targets of the 2030 Agenda. Awareness of the impact of use of alcohol on health and well-being should not be limited to the impact on NCDs, including issues related to interactions between alcohol and medicines used in management of NCDs and mental health, and should be expanded to include other areas of health and development such as injuries, violence, infectious diseases, productivity at workplaces, family functioning and a “harm to others” perspective, including the impact on financial and psychological security. Modern communication technologies and multimedia materials are needed for successful advocacy and behavioural change campaigns, including social media engagement. Such awareness, along with the development and enforcement of alcohol policies, needs to be protected from the interference of commercial interests. Appropriate mechanisms that involve academia and civil society must be set up in order to systematically monitor, prevent and counteract such interference.

### **Global targets for action area 2**

**Global target 2.1:** By 2030, 75% of countries have developed and enacted national written alcohol policies.

**Global target 2.2:** By 2030, 50% of countries have produced periodic national reports on alcohol consumption and alcohol-related harm.

### **Proposed actions for Member States**

- Action 1. Develop and enact, as appropriate in national contexts, national written alcohol policies or continue effective implementation and updates, as necessary, of existing national alcohol policies.
- Action 2. On the basis of evidence of the nature and magnitude of alcohol-attributable public health problems, advocate for the development and implementation of high-impact strategies and interventions and other actions to prevent and reduce alcohol-related harm. This includes placing a special emphasis on protecting at-risk populations and those affected by the harmful drinking of others; preventing the initiation of drinking among children and adolescents; preventing drinking in pregnancy; and preventing FASDs, including by providing information about the risks of drinking when planning pregnancy or breastfeeding.
- Action 3. Raise awareness of health risks and harms associated with different levels and patterns of alcohol consumption with the aim of reducing the levels of alcohol consumption among drinkers.
- Action 4. Advocate for paying appropriate attention, congruous with the magnitude of related public health problems, to reducing the harmful use of alcohol in multisectoral policies and frameworks, as well as in national, economic, environmental, agricultural and other relevant policies and action plans.
- Action 5. Include a commitment to reduce the harmful use of alcohol and its impact on health and well-being in high-level national developmental and public health strategies, programmes and action plans, and support the creation and development of advocacy coalitions.
- Action 6. Public health authorities should regularly produce (every two to three years in most countries) national reports on alcohol consumption and alcohol-related harm, targeting decision-makers and the general public with information on alcohol's contribution to specific health and social problems and disseminating such information through available modern communication technologies.
- Action 7. Increase awareness of the health risks of alcohol consumption and its related overall impact on health and well-being through strategic, well-developed and long-term communication activities that target the general population, with a special focus on young people. This should include the option of a national alcohol-related harm awareness day/week/month to be implemented by public health agencies and organizations, involving countering misinformation and using targeted communication channels, including social media platforms.
- Action 8. Ensure appropriate consumer protection measures through the development and implementation of labelling requirements for alcoholic beverages that display essential information for health protection on alcohol content in a way that is understood by consumers and also provides information on other ingredients with potential impact on the health of consumers, caloric value and health warnings.

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- Action 9. Ensure consumer protection measures through the development and implementation of product quality control measures for alcoholic beverages.
- Action 10. Support education, training and networking activities on reducing the harmful use of alcohol for representatives of authorities at different levels, health and education professionals, civil society organizations, youth organizations, community and cultural leaders, journalists and mass media representatives, taking into consideration the ineffectiveness and risks of the current “responsible drinking” campaigns designed as marketing campaigns by alcohol producers and distributors.

### **Proposed actions for the WHO Secretariat**

- Action 1. Raise the priority given to the alcohol-attributable health and social burden and effective policy responses on the agendas of high-level global, regional and other international forums, meetings and conferences of international and intergovernmental organizations, professional associations and civil society groups, and seek the inclusion of alcohol policies in relevant social and development agendas.
- Action 2. Develop and implement an organization-wide communication plan to support actions to reduce the harmful use of alcohol that reflect emerging challenges (such as the COVID-19 pandemic), targeting different population groups and using different communication channels, and support activities to establish an international day or week of awareness of alcohol-related harm.
- Action 3. Prepare and disseminate every two to three years global status reports on alcohol and health in order to raise awareness of the alcohol-attributable burden and advocate for appropriate action at all levels.
- Action 4. Develop, test and disseminate technical and advocacy tools for the effective communication of consistent, scientifically sound and clear messages about alcohol-attributable health and social problems, the health risks associated with alcohol consumption and effective policy and programme responses.
- Action 5. Develop and disseminate information product(s) on the health implications of the interactions of alcohol with certain essential medicines and other psychoactive substances, as well as on the impact of alcohol consumption on compliance with treatment regimens and treatment outcomes.
- Action 6. Review, update and disseminate WHO nomenclature and definitions of alcohol-related terms, particularly in the area of alcohol policy and monitoring.
- Action 7. Ensure the timely countering of widespread myths and disinformation about the health effects of alcohol consumption and alcohol control measures and provide technical support to Member States in this regard, as required.
- Action 8. Develop technical guidance on the labelling of alcoholic beverages to inform consumers about the content of products and health risks associated with their consumption.
- Action 9. Facilitate dialogue and information exchange regarding the impact of international trade, including the marketing of alcoholic beverages, as well as trade agreements

on health and alcohol-attributable health burdens; advocate for appropriate consideration of these issues by parties in international trade negotiations; and seek international solutions within WHO's mandate if appropriate actions to protect the health of populations cannot be implemented.

- Action 10. Bridge knowledge and practice by organizing and supporting policy dialogues, webinars and round tables with a focus on particular technical areas that are pertinent to alcohol control, health promotion and the prevention of alcohol-related harm.

### **Proposed actions for international partners, civil society organizations and academia**

- Action 1. Major partners in the United Nations system and intergovernmental organizations are invited to include activities for reducing the harmful use of alcohol in their agendas and to ensure support for policy coherence between health and other sectors in international multisectoral policies, strategies and frameworks, as well as appropriate deference to public health interests in relation to competing interests.
- Action 2. Civil society organizations, professional associations and academia are invited to scale up their activities in support of global, regional and national awareness and advocacy campaigns, as well as in countering misinformation about alcohol consumption and associated health risks. They are also invited to motivate and engage different stakeholders, as appropriate, in the implementation of effective strategies and interventions to reduce the harmful use of alcohol and to monitor activities that undermine effective public health measures.

### **Proposed measures for economic operators in alcohol production and trade**

Economic operators in alcohol production and trade, as well as operators in other relevant sectors of the economy, are invited to strengthen their commitment and contribution to reducing the harmful use of alcohol within their core roles and to take concrete steps towards eliminating the marketing and advertising of alcoholic products to minors and, where relevant, towards developing and enforcing self-regulatory measures on marketing and advertising in conjunction with the development and enforcement of statutory regulations or within a co-regulatory framework. The economic operators are invited to refrain from promoting drinking; eliminate and prevent any positive health claims related to alcohol; and ensure, within regulatory or co-regulatory frameworks, the availability of easily understood consumer information on the labels of alcoholic beverages (including composition, age limits, health warnings and contraindications for alcohol consumption).

## **ACTION AREA 3: PARTNERSHIP, DIALOGUE AND COORDINATION**

42. New partnerships and the appropriate engagement of all relevant stakeholders are needed to build capacity and support the implementation of practical and focused technical packages that can ensure returns on investments within "Health for All" and "whole-of-society" approaches. Increased coordination between health and other sectors, such as social welfare, finance, transport, sport, culture, communication, education, trade, agriculture, customs and law enforcement, as well as a multisectoral accountability frameworks, are required for the implementation of effective multisectoral measures to reduce the harmful use of alcohol and ensure policy coherence. The WHO-led SAFER initiative and partnership to promote and support the implementation of best buys, alongside other recommended alcohol control measures at the country level, can invigorate action in countries through coordination with WHO's partners both within and outside the United Nations system. Effective alcohol control,

including measures to address unrecorded alcohol consumption, requires a “whole-of-government” and “whole-of-society” approach, with clear leadership by the public health sector and appropriate engagement of other government sectors, civil society organizations, academic institutions and, as appropriate, the private sector. There is a need to strengthen the role of civil society in alcohol policy development and implementation.

43. Global and regional networks of country focal points and WHO national counterparts for reducing the harmful use of alcohol, as well as technical experts, will facilitate country cooperation, knowledge transfer and capacity-building. The technical networks and platforms should focus on particularly challenging technical areas and situations such as the control of digital marketing, social media advertising and reducing the harmful use of alcohol during health emergencies such as the COVID-19 pandemic.

44. The continuing global dialogue with economic operators in alcohol production and trade should focus on industry’s contribution to reducing the harmful use of alcohol in their roles as developers, producers and distributors/sellers of alcoholic beverages. This dialogue should also aim for the implementation of comprehensive restrictions or bans on traditional, online or digital marketing<sup>1</sup> (including sponsorship), as well as on the role of economic operators in the regulation of sales, e-commerce, delivery, product formulation and labelling and on providing data on production and sales. The dialogue should engage, as appropriate, economic operators in other sectors of the economy that are directly involved in the distribution, sales and marketing of alcoholic beverages.

### **Global targets for action area 3**

**Global target 3.1:** By 2030, 50% of countries have an established national multisectoral coordination mechanism for the implementation and strengthening of national multisectoral alcohol policy responses.

**Global target 3.2:** By 2030, 50% of countries are engaged in the work of the global and regional networks of WHO national counterparts for international dialogue and coordination on reducing the harmful use of alcohol.

### **Proposed actions for Member States**

- Action 1. Encourage the mobilization and the active and appropriate engagement of all relevant entities and groups in reducing the harmful use of alcohol in a “whole-of-society” approach, including by advocating for appropriate coordination and accountability mechanisms, strategies and action plans in the context of the 2030 Agenda, taking into consideration and managing any stakeholder conflicts of interest.
- Action 2. Ensure effective national governance and effective coordination between different sectors and different levels of government, while maintaining policy coherence based on public health objectives.
- Action 3. Ensure the effective coordination of activities, as appropriate, of all relevant stakeholders in the implementation of national strategies, action plans and policies

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<sup>1</sup> In this document the term “marketing” is used with the meaning of any form of commercial communication or message that is designed to increase – or has the effect of increasing – the recognition, appeal and/or consumption of particular products and services. It could comprise anything that acts to advertise or otherwise promote a product or service.

to reduce the harmful use of alcohol in the 10 targets areas for action recommended in the global strategy to reduce the harmful use of alcohol.<sup>1</sup>

- Action 4. Build and support a broad multisectoral mechanism for formulating and implementing public health policies to reduce the harmful use of alcohol and adopt a “whole-of-government” approach to the protection of the health and well-being of populations from alcohol-related harm, while taking into consideration and managing any stakeholder conflicts of interest.
- Action 5. Collaborate with the WHO Secretariat on the implementation of the global strategy, including through representation in WHO’s global and regional networks of national counterparts and (technical) contributions to their working mechanisms, processes and structures.
- Action 6. Document and share experiences and information on the development, implementation and evaluation of multisectoral actions to reduce the harmful use of alcohol at national and subnational levels.

#### **Proposed actions for the WHO Secretariat**

- Action 1. Further develop and strengthen broad international partnerships on reducing the harmful use of alcohol and support international mechanisms for intersectoral collaboration with United Nations entities, civil society, academia and professional organizations.
- Action 2. Liaise and cooperate with major partners in the United Nations system and intergovernmental organizations and coordinate and develop collaborative activities through the functioning of inter-agency working mechanisms on reducing the harmful use of alcohol, including those established for mental health, NCDs and health promotion.
- Action 3. Provide support for the global and regional networks of WHO national counterparts and their working mechanisms and procedures by ensuring regular information exchange and their effective functioning. This may include the establishment of working groups or task teams to address priority areas for reducing the harmful use of alcohol.
- Action 4. Facilitate dialogue and information exchange on the impact of the international aspects of the alcohol market on the alcohol-attributable health burden and advocate for appropriate consideration of these aspects by parties in international trade negotiations.
- Action 5. Support international collaboration and information exchange among public health-oriented NGOs, academic institutions, professional associations and organizations of people with lived and living experience, with a special focus on facilitating multisectoral collaboration, ensuring policy coherence (with due consideration of differences in cultural contexts) and providing support for strengthening the contributions of civil society organizations to alcohol policy development and implementation.

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<sup>1</sup> See para. 28 above.

- Action 6. Every two years, organize an international forum on reducing the harmful use of alcohol within the WHO Forum on alcohol, drugs and addictive behaviours, with the participation of representatives of Member States, United Nations entities and other intergovernmental and international organizations, civil society organizations and professional associations and people with lived and living experiences, and support broader representation of civil society organizations from low- and middle-income countries.
- Action 7. Organize regular (every year or every two years, as considered necessary by the WHO Secretariat) global dialogues with economic operators in alcohol production and trade in line with relevant mandates and policies, including but not limited to the WHO framework of engagement with non-State actors, focused on and limited to industry partners' contribution to reducing the harmful use of alcohol as developers, producers and distributors/sellers of alcoholic beverages. Dialogues will not focus on the development of alcohol control policies.
- Action 8. Convene permanent dialogue with civil society, supporting coalition-building and strengthening the capacity of civil society organizations to advocate and lobby for effective measures to reduce the harmful use of alcohol.

#### **Proposed actions for international partners, civil society organizations and academia**

- Action 1. Major partners in the United Nations system and intergovernmental organizations are invited to include, as appropriate, implementation of the global strategy and action plan 2022–2030 in their developmental strategies and action plans and to develop horizontal multisectoral programmes and partnerships to reduce the harmful use of alcohol as a public health priority, in line with the guiding principles of the global strategy.
- Action 2. Civil society organizations, professional associations and academia are invited to prioritize and strengthen their activities on reducing the harmful use of alcohol by motivating and engaging their stakeholders in implementation of the global strategy within existing partnerships or by developing new collaborative frameworks, as well as by promoting and supporting, within their roles and mandates, intersectoral and multisectoral collaboration and dialogue while monitoring and countering undue influences from commercial vested interests that undermine attainment of public health objectives.

#### **Proposed measures for economic operators in alcohol production and trade**

Economic operators are invited to substitute, whenever possible, higher-alcohol products with no-alcohol and lower-alcohol products in their overall product portfolios, with the goal of decreasing the overall levels of alcohol consumption in populations and consumer groups, while avoiding the circumvention of existing regulations for alcoholic beverages and the targeting of new consumer groups with alcohol marketing, advertising and promotional activities. Economic operators in alcohol production and trade, as well as economic operators in other relevant sectors (such as retail, advertisements, hospitality, tourism, social media and communication), are encouraged to contribute to the elimination of marketing and sales of alcoholic beverages to minors and to the elimination of commercial activities targeted towards other high-risk groups, as well as to implement self-regulatory measures and take other actions to contribute to the

elimination of such marketing practices within regulatory and co-regulatory frameworks with a legislative basis.

#### **ACTION AREA 4: TECHNICAL SUPPORT AND CAPACITY-BUILDING**

45. There is a need to strengthen the capacity and capability of countries to create, enforce and sustain the necessary policy and legislative frameworks; develop infrastructure and sustainable mechanisms for their implementation at national and subnational levels; and ensure that implemented strategies and interventions are based on the best available scientific evidence and best practices of their implementation that have accumulated in different cultural, economic and social contexts. The implementation of alcohol policy measures at the country level based on national contexts, needs and priorities may require strong technical assistance, particularly in less-resourced countries and in technical areas such as taxation, legislation, regulations for digital marketing and their enforcement, or the consideration of health protection from alcohol-related harm in trade negotiations.

#### **Global targets for action area 4**

**Global target 4.1:** By 2030, 50% of countries have a strengthened capacity for the implementation of effective strategies and interventions to reduce the harmful use of alcohol at national level.

**Global target 4.2:** By 2030, 50% of countries have a strengthened capacity in health services to provide prevention and treatment interventions for health conditions due to alcohol use in line with the principles of universal health coverage.

#### **Proposed actions for Member States**

- Action 1. Develop national institutional capacities for applying population-wide initiatives to tackle the determinants that drive the acceptability, availability and affordability of hazardous and harmful drinking patterns, including for the provision of country-tailored technical assistance, strengthening governance mechanisms towards accountability, transparency and the participation of stakeholders.
- Action 2. Develop or strengthen technical capacity and infrastructure, with the involvement of public health-oriented civil society organizations, including youth organizations, for the implementation of high-impact strategies and interventions to reduce the harmful use of alcohol and, when appropriate, collaborate with the WHO Secretariat on the testing, dissemination, implementation and evaluation of WHO technical tools, recommendations and training materials.
- Action 3. Document and share with WHO good practices and examples of policy responses and implemented measures to reduce the harmful use of alcohol in different socioeconomic and cultural contexts, based on the 10 recommended target areas for policy options and interventions included in the global strategy.
- Action 4. Develop or strengthen the capacity of health professionals in health and social care systems, including health providers working in the areas of NCDs and mental health, to prevent, identify and manage hazardous drinking<sup>1</sup> and disorders due to alcohol use, and develop the capacity of health and social care systems in urban and rural

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<sup>1</sup> In the International Classification of Diseases, 11th revision (ICD-11) (Geneva: World Health Organization; 2019), the “hazardous alcohol use” is defined as a “pattern of alcohol use that appreciably increases the risk of harmful physical or mental health consequences to the user or to others to an extent that warrants attention and advice from health professionals”.



areas to ensure universal health coverage for people with AUDs and comorbid health conditions.

- Action 5. Support the capacity-building of health professionals, including health providers working in the areas of NCDs and mental health, as well as public health experts and representatives of civil society organizations, including mutual help groups and associations of affected individuals and their family members, to advocate for, implement, enforce and sustain the implementation of effective measures to reduce the harmful use of alcohol, including through screening and brief interventions for hazardous and harmful drinking, as well as through support for the relevant education and training programmes.
- Action 6. Develop and support the implementation of activities aimed at the prevention of alcohol-related violence towards women, children and the elderly, as well as activities aimed at the prevention of alcohol-related suicides, and ensure access to health services for those affected by alcohol-related violence or suicides.
- Action 7. Develop and support the implementation of activities for reducing the public health impact of illicitly or informally produced alcohol, taking into consideration the differences in strategies to address informally and illegally produced alcohol, including activities related to the assessment of the level of unrecorded alcohol consumption in populations, the efficient control of alcohol production and distribution, raising awareness of the associated health risks and community mobilization.
- Action 8. Promote policies for healthy settings (e.g., educational campus, sport sites, workplace); analyse, assess and develop guidance on population-based interventions related to risk exposure; support local and bottom-up initiatives for protecting against harmful alcohol consumption (e.g., integrated actions across sectors such as the education, social, health care and public health sectors); and support community actions that advocate for alcohol policy changes in various settings and populations, including high-risk groups (e.g., indigenous populations, young people, women).
- Action 9. Develop health promotion services based on learning loops and behavioural change, while ensuring links to promoting health interventions in primary health care.

### **Proposed actions for the WHO Secretariat**

- Action 1. Collect, compile and disseminate, through WHO information channels at global and regional levels, good practices and examples of policy responses and implemented measures to reduce the harmful use of alcohol in Member States, based on the 10 recommended target areas for policy options and interventions, including legislative provisions, and develop and maintain the global and regional repositories of good practice and examples, including those for workplaces and educational institutions.
- Action 2. Foster and strengthen global and regional networks of national technical counterparts by developing capacity-building platforms, in partnership with academia and civil society organizations, with a focus on particularly challenging areas such as digital marketing and social media advertising; protecting alcohol control in the context of supranational policy and regulatory frameworks; strengthening health service and social care responses; and building up national monitoring systems on alcohol and health or integrating these focus areas into existing national monitoring systems.

- Action 3. Develop, test and disseminate global evidence-based and ethical recommendations, standards, guidelines and technical tools, including a protocol for the comprehensive assessment of alcohol policies; propose, as deemed necessary and according to WHO procedures, other normative or technical instruments to provide normative and technical guidance on the effective and cost-effective prevention and treatment interventions in different settings; and provide support to Member States in implementing the global strategy according to the 10 recommended target areas for policy options and interventions.
- Action 4. Develop information products and technical tools to support the prevention, management and monitoring and surveillance of alcohol-related suicides and alcohol-related violence, including violence towards women, children and the elderly, as well as to provide technical guidance on the treatment and care of those affected by alcohol-related violence or suicides.
- Action 5. Increase the capacity of the Secretariat to provide technical assistance and support to countries in addressing cross-border alcohol marketing, advertising and promotional activities, as well as unrecorded alcohol<sup>1</sup> consumption and related harm.
- Action 6. Develop a global country support network of experts and strengthen the global coordination of relevant activities of WHO collaborating centres in order to increase the Secretariat's capacity to respond to Member States' requests for support for their efforts to develop, implement and evaluate strategies and programmes to reduce the harmful use of alcohol.
- Action 7. Develop, test and disseminate technical guidance and supporting technical tools for the assessment, prevention and reduction of alcohol-related harm in humanitarian settings.
- Action 8. Support the development and implementation of sustainable programmes on the identification and management of hazardous and harmful drinking in primary health care and other non-specialized and specialized health care programmes, such as programmes for noncommunicable or infectious diseases, and promote screening and brief interventions, as well as other interventions with proven effectiveness.
- Action 9. Develop a global programme of training and capacity-strengthening activities on priority areas for global action and target areas for action at national level, and implement this programme by organizing and supporting global, regional and intercountry workshops, seminars (including web-based seminars), online consultations and other capacity-building activities covering multisectoral responses and measures beyond the health sector.
- Action 10. Support and conduct capacity-building projects and activities on planning and implementing research and the dissemination of research findings, with a particular focus on alcohol policy research in low- and middle-income countries, as well as on data generation to produce reliable estimates of alcohol consumption, alcohol-related harm and treatment coverage for AUDs.

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<sup>1</sup> Unrecorded alcohol refers to alcohol that is not accounted for in official statistics on alcohol taxation or sales in the country where it is consumed, because it is usually produced, distributed and sold outside formal channels under government control.

- Action 11. Reconvene the WHO Expert Committee on Problems Related to Alcohol Consumption for a comprehensive review of the accumulated evidence on feasible and effective measures to address the harmful use of alcohol, monitoring the progress made and providing recommendations on the way forward, and ensure the convening of regular meetings of the Committee during the period of implementation of the action plan.

### **Proposed actions for international partners, civil society organizations and academia**

- Action 1. Major partners in the United Nations system and intergovernmental organizations are invited to prioritize technical assistance and capacity-building activities for accelerating implementation of the global strategy in their developmental assistance and country support activities and plans.
- Action 2. Civil society organizations, professional associations and research institutions are invited to develop capacity-building activities at national and, if appropriate, international levels within their roles and mandates. They are invited to contribute to capacity-building and provide technical assistance for activities undertaken by Member States, WHO or other international organizations, in line with the objectives and principles of the global strategy and the action plan.
- Action 3. International partners, civil society organizations and academia are encouraged to monitor and report activities that undermine effective public health measures and are encouraged to refrain from co-funding initiatives with economic operators in alcohol production and trade.

### **Proposed measures for economic operators in alcohol production and trade**

Economic operators in alcohol production and trade are invited to implement capacity-building activities for reducing the harmful use of alcohol within their core roles and sectors of alcohol production, distribution and sales, and to refrain from engagement in capacity-building activities outside their core roles that may undermine or compete with the activities of the public health community.

## **ACTION AREA 5: KNOWLEDGE PRODUCTION AND INFORMATION SYSTEMS**

46. The production and dissemination of knowledge facilitates advocacy, policy prioritization and evaluation and supports overall global actions to reduce the harmful use of alcohol. International collaborative research and knowledge production should focus on the generation of data that are highly relevant to understanding the epidemiology of the health risks associated with alcohol consumption and the development and implementation of alcohol policies. The effective monitoring of the levels and patterns of alcohol consumption in populations and of alcohol-related harm, including alcohol-attributable disease burden, is of the utmost importance for monitoring the progress of implementation of the global strategy at national, regional and global levels and should be conducted in conjunction with monitoring the implementation of alcohol policy measures. The effective monitoring of alcohol consumption, alcohol-related harm and policy responses requires streamlined data generation, collection, validation and reporting procedures that will allow regular updates of country-level data at one to two year intervals, with minimized time lags between data collection and reporting. The effective monitoring of treatment coverage for AUDs requires not only taking these actions but also developing better methods of monitoring treatment coverage, all within the framework of universal health coverage.

47. Significantly more resources are required for investment in international research on alcohol policy development and implementation in low- and middle-income countries, based on evidence of the uneven implementation of alcohol policy measures in different jurisdictions, including quantitative and qualitative analyses of barriers, enabling factors, the impact of different policy options and levels of implementation in different population groups. Research, including international research projects, is needed on the role of alcohol consumption in the development, progression and treatment outcomes of major NCDs, including cancers, as well as in the transmission, progression and treatment outcomes of some infectious diseases. There is a need to intensify international research activities on harm to others from drinking; the impact of the harmful use of alcohol on child development and maternal health; FASDs; and the consumption of informally and illegally produced alcohol and its health consequences. International studies are needed on effective ways to increase health literacy with regard to alcohol and the health of people who consume alcohol. Studies on the costs and benefits of alcohol control measures and the development of investment cases can help to overcome the resistance to effective alcohol control measures rooted in the financial and other revenues associated with alcohol production and trade.

### **Global targets for action area 5**

**Global target 5.1:** By 2030, 75% of countries have national data generated and regularly reported on alcohol consumption, alcohol-related harm and implementation of alcohol control measures.

**Global target 5.2:** By 2030, 50% of countries have national data generated and regularly reported on monitoring progress towards the attainment of universal health coverage for AUDs and major health conditions due to alcohol use.

### **Proposed actions for Member States**

- Action 1. Support the generation, compilation and dissemination of knowledge at the national level on the magnitude and nature of public health problems caused by the harmful use of alcohol and the effectiveness of different policy options, and undertake activities for informing the general public about health and other risks associated with alcohol consumption and alcohol-related health conditions in different populations.
- Action 2. In coordination with relevant stakeholders, develop or strengthen national and subnational monitoring systems and sets of national health system indicators and targets for monitoring alcohol consumption and its socioeconomic and behavioural modifiers, including on the affordability and availability of alcohol, the awareness of alcohol-related risks, the attitudes towards alcohol consumption and the exposure to digital marketing and the health and social consequences of alcohol consumption, as well as appropriate policy and programme responses, including treatment coverage for AUDs, in line with the SDGs and WHO indicators and their definitions.
- Action 3. Establish national monitoring centres or other appropriate institutional entities with the responsibility to collect and compile national data on alcohol consumption, alcohol-related harm and policy responses, as well as monitoring trends, and to report regularly to national authorities and the WHO's regional and global information systems on alcohol and health.
- Action 4. Support monitoring and research activities that are focused on alcohol consumption and related harms among particularly vulnerable population groups, such as young people, pregnant women, people with chronic health conditions that increase

vulnerability to alcohol-related harm, people in contact with criminal justice systems and people experiencing homelessness.

- Action 5. Support research activities on risk and protective factors for different patterns of alcohol use and its health consequences, including the development of AUDs, in order to inform national prevention and treatment strategies and interventions.
- Action 6. Include alcohol modules with recommended questions on alcohol consumption and related harms in the data-collection tools used in population-based surveillance activities at national and subnational levels in order to facilitate international comparisons, paying due attention to the possibilities for data disaggregation.
- Action 7. Collaborate with the WHO Secretariat on global surveys on alcohol and health by collecting, collating and reporting the information required, as well as by validating the country estimates and profiles received from the WHO Secretariat for inclusion in global and regional monitoring frameworks and databases.
- Action 8. Document, collate and disseminate practical experiences in the implementation of alcohol policy measures and interventions and support and promote the evaluation of their effectiveness, cost-effectiveness and impacts on alcohol-attributable harm in order to document the feasibility, effectiveness and cost-effectiveness of policy measures in different contexts and populations.

### **Proposed actions for the WHO Secretariat**

- Action 1. Maintain and further develop the WHO's Global Information System on Alcohol and Health (GISAH) and regional information systems by developing and integrating indicators for monitoring the implementation of the global strategy and the NCD-GAP; the further operationalization and standardization of GISAH indicators; the coordination of data collection activities at all levels; and the consolidation of information on the effectiveness and cost-effectiveness of policy measures and interventions to reduce the harmful use of alcohol and public health problems attributable to alcohol.
- Action 2. Support capacity-building for research, monitoring and surveillance on alcohol and health by establishing and supporting global and regional research networks and training and supporting data collection, analysis and dissemination.
- Action 3. Prepare and implement during the period 2022–2030 at least three waves of data collection on alcohol consumption, alcohol-related harm and alcohol policies from Member States through the WHO Global Survey on Alcohol and Health (tentatively in 2022, 2025 and 2028) and from other relevant information sources. Also, use computerized data-collection tools and web-based data-collection platforms and disseminate information through GISAH, regional information systems, and global and regional status reports on alcohol and health. Whenever necessary, organize data-consensus workshops for improving the quality of data.
- Action 4. Continually review, analyse and disseminate the emerging scientific evidence on the magnitude and nature of the public health problems that are attributable to alcohol consumption and the determinants of the availability and affordability of alcohol beverages, paying due attention given to the attitudes, risk awareness and inequities related to alcohol consumption, as well as the effectiveness and cost-effectiveness of

policy measures and interventions. This includes convening meetings of related technical advisory groups, including the WHO Technical Advisory Group on Alcohol and Drug Epidemiology.

- Action 5. Continue to generate comparable data on alcohol consumption, its determinants, alcohol-related mortality and morbidity and estimates of alcohol-attributable burden, with disaggregation, whenever possible, by gender, age and socioeconomic status, within the comparative risk assessment and global burden of disease estimates.
- Action 6. Continue and further develop collaboration with international organizations and United Nations agencies on data collection and analysis in order to harmonize data-collection tools and activities and facilitate international comparisons, as well as to continue dialogue and information exchange with alcohol producers, industry-supported data providers and research groups and organizations so as to improve the coverage and quality of data on alcohol production and distribution and the consumption of alcoholic beverages at global, regional and national levels.
- Action 7. Promote and support priority-setting for international research on alcohol and health, as well as specific international research projects, in low- and middle- income countries, with the engagement of WHO collaborating centres. This should include a particular focus on the epidemiology of alcohol consumption and alcohol-related harm, the evaluation of policy measures and interventions in health services, comparative effectiveness research and the relationship between harmful use of alcohol and social and health inequities. Initiate and implement in selected low- and middle-income countries international research projects on the determinants of alcohol consumption and alcohol-related harm, including research on FASDs, alcohol-related suicides and other mental health conditions, as well as the role of alcohol consumption in the development and progression of major NCDs, including cancers.
- Action 8. Develop methodology, core indicators and computerized data-collection tools and support the generation of comparable data on the implementation of effective policy measures at national level, using the system of indices and scores, and support information- and experience-sharing among countries, particularly those with similar socioeconomic and cultural contexts.

### **Proposed actions for international partners, civil society organizations and academia**

- Action 1. Major partners in the United Nations system and intergovernmental organizations are invited to support knowledge generation and monitoring activities on alcohol and health at all levels and to work with WHO on alcohol policy research, including the impact of differentiated policies according to the alcohol content of alcoholic beverages, as well as on harmonization of indicators and data-collection tools, and to support national monitoring capacities in line with the reporting commitments of major international monitoring frameworks.

- Action 2. Civil society organizations, professional associations and research institutions are invited to support WHO efforts on data collection and analysis to improve the coverage and quality of data on alcohol consumption, alcohol-related harm, policy responses and treatment coverage for AUDs at global, regional and national levels, as well as to support countries in their efforts to build and strengthen research and monitoring capacities in this area.

### **Proposed measures for economic operators in alcohol production and trade**

Economic operators in alcohol production and trade are called upon to disclose, with due regard for the limitations associated with the confidentiality of commercial information, data of public health relevance, including a description of the methodology used to generate such data, in order to contribute to the improvement of WHO estimates of alcohol consumption in populations. This includes data on the production and sales of alcoholic beverages, as well as data on consumer knowledge, attitudes and preferences regarding alcoholic beverages.

## **ACTION AREA 6: RESOURCE MOBILIZATION**

48. Lack of the required financial and human resources presents a primary barrier to introducing or accelerating global and national actions to reduce the harmful use of alcohol and reducing the inequities related to alcohol consumption and its consequences between and within different jurisdictions. Adequate resources need to be mobilized at all levels for implementation of the global strategy, namely for the development, implementation and monitoring of alcohol policies in low- and middle-income countries; international collaboration and research in this area and on the social, economic and environmental determinants of alcohol control; and civil society engagement at the international level to reduce the harmful use of alcohol. Such resources are not limited to funding, although this is a priority, but also include human resources and workforce capacity, appropriate infrastructures, international cooperation and partnerships.

49. The lack or insufficiency of available resources to finance alcohol control measures and programmes and interventions for the prevention and treatment of substance use disorders requires, as appropriate within national contexts, innovative funding mechanisms if the related targets of the SDGs are to be met. Several innovative approaches have been reported across countries and at the international level and several are being discussed, such as the United Nations catalytic fund for NCDs and mental health or the establishment of specific funds for the treatment, care and support of those affected by the harms due to the use of alcohol. There are existing examples of revenues from taxes on alcoholic beverages being used to fund health promotion initiatives; the health coverage of vulnerable populations; the prevention and treatment of alcohol and substance use disorders; and in some cases, support for international work in these areas. In some jurisdictions, earmarked funding for the prevention and treatment of AUDs and related conditions is provided with funds generated from state-owned retail monopolies, a levy on profits across the value chains for alcoholic beverages, taxation on alcohol advertising or fines for non-compliance with alcohol regulations.

### **Global targets for action area 6**

**Global target 6.1:** At least 50% of countries have dedicated resources for reducing the harmful use of alcohol by implementing alcohol policies and by increasing coverage and quality of prevention and treatment interventions for disorders due to alcohol use and associated health conditions.

**Proposed actions for Member States**

- Action 1. Increase the allocation of resources, including international and domestic financial resources generated by new or innovative ways and means to secure essential funding, for reducing the harmful use of alcohol and increasing the coverage and quality of prevention and treatment interventions, according to the scope and nature of public health problems caused by alcohol consumption.
- Action 2. Consider, when appropriate in national contexts, the development and implementation of earmarked funding or contributions from alcohol tax revenues or other revenues that are linked to alcohol beverage production and trade, or establishing a dedicated fund for reducing the harmful use of alcohol and increasing the coverage and quality of prevention and treatment interventions for disorders due to alcohol use and associated health conditions.
- Action 3. Ensure the availability and allocation of necessary resources by developing resource allocation plans and accountability frameworks for the implementation of community action and the support of community-based programmes, coalitions and interventions to reduce the harmful use of alcohol and associated inequalities, including programmes for indigenous populations and subpopulations at particular risk, such as young people, unemployed persons and family members of people with AUDs.
- Action 4. Increase the resources available for implementation of the global strategy and action plan by mainstreaming alcohol policy options and interventions in public health and developmental activities in other areas, such as maternal and child health, violence prevention, suicide prevention, road safety and infectious diseases.
- Action 5. Participate in and support international collaboration to increase the resources available for accelerating implementation of the global strategy and action plan to reduce the harmful use of alcohol and support provided to low- and middle-income countries in developing and implementing high-impact strategies and interventions.
- Action 6. Promote and support resource mobilization for the implementation of the global strategy and the action plan in the framework of broad developmental agendas such as the 2030 Agenda and responses to health emergencies such as the COVID-19 pandemic.
- Action 7. Share experiences at the international level, including with the WHO Secretariat and other international organizations, of good practice in financing policies and interventions to reduce the harmful use of alcohol.

**Proposed actions for the WHO Secretariat**

- Action 1. Collect, analyse and disseminate experiences and good practices in financing policies and interventions to reduce the harmful use of alcohol, especially in low- and middle-income countries, and promote the implementation of new or innovative ways and means to secure adequate funding for implementation of the global strategy and the action plan at all levels.
- Action 2. Develop and disseminate, in collaboration with international finance institutions, technical tools and information products in support of efforts to increase the



resources available for reducing the harmful use of alcohol, health promotion and increasing the coverage and quality of prevention and treatment interventions for disorders due to alcohol use and associated health conditions.

- Action 3. At global and regional levels, monitor the allocation of resources for the implementation of the global strategy and action plan.
- Action 4. Promote and support the pooling of resources and their effective use by better coordination and intensified collaboration between different programme areas within WHO, United Nations agencies and other international partners.
- Action 5. Promote the allocation of resources for alcohol policy development and implementation of the global strategy and action plan in bilateral and other cooperation agreements with donor countries and agencies.
- Action 6. Intensify fundraising and resource mobilization efforts to support the implementation of the global strategy in low- and middle-income countries by organizing donor conferences and meetings of interested parties.

#### **Proposed actions for international partners, civil society organizations and academia**

- Action 1. Major partners in the United Nations system and intergovernmental organizations are invited to mainstream their efforts to reduce the harmful use of alcohol in their developmental and public health strategies and action plans, and to promote and support financing policies and interventions in order to ensure the availability of adequate resources for accelerated implementation of the global strategy, while maintaining independence from funding from alcohol producers and distributors.
- Action 2. Civil society organizations, professional associations and research institutions are invited to promote and support new or innovative ways and means to secure required funding and to facilitate collaboration between the finance and health sectors to ensure the mobilization, allocation and accountability of the resources necessary to reduce the harmful use of alcohol and accelerate the implementation of the global strategy at all levels.

#### **Proposed measures for economic operators in alcohol production and trade**

Economic operators in alcohol production and trade are invited to allocate resources for the implementation of measures that can contribute to reducing the harmful use of alcohol within their core roles as developers, producers, distributors, marketers and sellers of alcoholic beverages; to refrain from funding public health and policy-related activities and research to prevent any potential bias in agenda-setting emerging from the conflict of interest; and to cease the sponsorship of scientific research on the public health dimensions of alcohol consumption and alcohol policies and its use for marketing or lobbying purposes.

### Indicators and milestones for achieving global targets

Global targets	Indicators	Milestones	Comments
1.1. By 2030, at least 20% relative reduction (in comparison with 2010) in the harmful use of alcohol. <sup>1</sup>	<p>1.1.1 Total alcohol per capita consumption defined as the estimated total (recorded plus unrecorded) alcohol per capita (aged 15 years and older) consumption within a calendar year in litres of pure alcohol, adjusted for tourist consumption.</p> <p>1.1.2. Age-standardized prevalence of heavy episodic drinking.</p> <p>1.1.3. Age-standardized alcohol-attributable deaths.</p> <p>1.1.4 Age-standardized alcohol-attributable DALYs.</p>	<p>2019</p> <p>2022</p> <p>2025</p> <p>2027</p> <p>2029/2030</p>	<p>This target and indicators are fully consistent with SDG and NCD global monitoring frameworks and data on these indicators have been periodically collected and regularly reported by WHO. WHO estimates for indicator 1.1.1 are produced annually – and for other indicators under this target are produced periodically. WHO estimates for all indicators under this target have been previously reported for 2010, 2012, and 2016.<sup>2</sup></p>
1.2. By 2030, 70% of countries have introduced, enacted or maintained the implementation of high-impact policy options and interventions.	<p>1.2.1 Number of countries (as a percentage of all WHO Member States) that have introduced, enacted or maintained the implementation of high-impact policy options across the following areas: (a) affordability of alcoholic beverages; (b) advertising and marketing of alcoholic beverages; (c) availability of alcoholic beverages; (d) drink-driving; (e) screening and brief interventions for risky patterns of alcohol use; and treatment of AUDs.</p>	<p>2019</p> <p>2022</p> <p>2025</p> <p>2027</p> <p>2029/2030</p>	<p>Data on all indicators under this target have been collected through WHO global surveys on alcohol and health and progress towards the attainment of SDG target 3.5. The data on alcohol policy indicators is available and periodically updated in the WHO's GISAH. SAFER monitoring and other relevant activities undertaken at the global, regional or country levels will provide additional information to improve the validity and reliability of data.</p>

<sup>1</sup> The target description is identical to the voluntary target agreed for the NCD Global Monitoring Framework. The “at least 20% relative reduction” target is based on the latest available WHO data.

<sup>2</sup> See, respectively, Global status report on alcohol and health 2011. Geneva: World Health Organization; 2011; Global status report on alcohol and health 2014. Geneva: World Health Organization; 2014; and Global status report on alcohol and health 2018. Geneva: World Health Organization; 2018.

Global targets	Indicators	Milestones	Comments
<p>2.1. By 2030, 75% of countries have developed and enacted national written alcohol policies.</p> <p>2.2. By 2030, 50% of countries have produced periodic national reports on alcohol consumption and alcohol-related harm.</p>	<p>2.1.1 Number of countries (as a percentage of all WHO Member States) with a written and enacted national alcohol policy.</p> <p>2.2.1. Number of countries (as a percentage of all WHO Member States) producing at least two national reports within the last 8-year period on alcohol consumption and alcohol-related harm.</p>	<p>2019</p> <p>2022</p> <p>2025</p> <p>2027</p> <p>2029/2030</p>	<p>The data for these targets and indicators is collected through existing WHO global surveys on alcohol and health and on progress towards the attainment of SDG target 3.5, as well as other relevant monitoring activities at the global and regional levels. Data for indicator 2.1.1 have been previously reported by WHO for 2010, 2012, and 2016.<sup>1</sup> Data for indicator 2.2.1 will require minor adjustments in existing data collection tools for reporting on this indicator.</p>
<p>3.1. By 2030, 50% of countries have an established national multisectoral coordination mechanism for the implementation of national multisectoral alcohol policy responses.</p>	<p>3.1.1. Number of countries (as a proportion of all WHO Member States) with an established multisectoral national coordination mechanism for the implementation of national multisectoral alcohol policy responses.</p>	<p>2022</p> <p>2025</p> <p>2027</p> <p>2029/2030</p>	<p>“Multisectoral” refers to engagement with one or more government sectors outside of health, such as finances, criminal justice, social welfare etc. Data collected through WHO global surveys on alcohol and health and on progress towards the attainment of SDG target 3.5, as well as other relevant monitoring activities at the global and regional levels. The current data collection tools require minor adjustments for reporting on this indicator.</p>
<p>3.2. By 2030, 50% of countries are engaged in the work of the global and regional networks of WHO national counterparts for international dialogue and coordination on reducing the harmful use of alcohol.</p>	<p>3.2.1. Number of countries (as a proportion of all WHO Member States) actively represented in the global and regional networks of WHO national counterparts.</p>	<p>2022</p> <p>2025</p> <p>2027</p> <p>2029/2030</p>	<p>Information from WHO regional offices and headquarters collated on a regular basis.</p>

<sup>1</sup> See, respectively, Global status report on alcohol and health 2011. Geneva: World Health Organization; 2011; Global status report on alcohol and health 2014. Geneva: World Health Organization; 2014; and Global status report on alcohol and health 2018. Geneva: World Health Organization; 2018.

Global targets	Indicators	Milestones	Comments
4.1. By 2030, 50% of countries have a strengthened capacity for the implementation of effective strategies and interventions to reduce the harmful use of alcohol at national level.	4.1.1. Number of countries (as a proportion of all WHO Member States) that have increased governmental resources for implementation of effective alcohol policies at the national level.	2019 2022 2025 2027 2029/2030	This target is formulated by taking into consideration the number of countries with the developed capacity and infrastructure to address the harmful use of alcohol at national level. For these targets and indicators, data is collected through existing WHO global surveys on alcohol and health and on progress towards the attainment of SDG target 3.5, as well as other relevant monitoring activities at the global and regional levels. The current data collection tools require minor adjustments for reporting on these indicators.
4.2. By 2030, 50% of countries have a strengthened capacity in health services to provide prevention and treatment interventions for health conditions due to alcohol use, in line with the principles of universal health coverage.	4.2.1. Number of countries (as a proportion of all WHO Member States) that have increased service capacity to provide prevention and treatment interventions for health conditions due to alcohol use within health systems, in line with the principles of universal health coverage.	2019 2022 2025 2027 2029/2030	This target is formulated by taking into consideration the number of countries with the developed capacity and infrastructure to provide prevention and treatment interventions for health conditions due to alcohol use at national level. Data collected through WHO global surveys on progress towards the attainment of SDG target 3.5.
5.1. By 2030, 75% of countries have national data generated and regularly reported on alcohol consumption, alcohol-related harm and implementation of alcohol control measures.	5.1.1. Number of countries (as a proportion of all WHO Member States) that generate and report national data on per capita alcohol consumption, alcohol-related harm and policy responses.	2019 2022 2025 2027 2029/2030	Passive surveillance of available data and data collection through WHO global surveys on alcohol and health and progress towards the attainment of SDG health target 3.5, as well as other relevant monitoring activities at the global and regional levels. Data collection and reporting on this indicator is a part of WHO regular monitoring and reporting on alcohol-related indicators for the existing global monitoring frameworks, such as the SDGs and the NCD Global Monitoring Framework.

Global targets	Indicators	Milestones	Comments
5.2. By 2030, 50% of countries have national data generated and reported on monitoring progress towards the attainment of universal health coverage for AUDs and major health conditions due to alcohol use.	5.2.1. Number of countries (as a proportion of all WHO Member States) that have a core set of agreed indicators and generate and report national data on treatment coverage and treatment capacity for alcohol use disorders and related health conditions due to alcohol use.	2019 2022 2025 2027 2029/2030	Passive surveillance of available data and data collected through WHO global surveys on progress towards the attainment of SDG health target 3.5 and other relevant monitoring activities at global and regional levels. Data collected through activities undertaken for monitoring SDG indicator 3.5.1.
6.1. At least 50% of countries have dedicated resources for reducing the harmful use of alcohol by implementing alcohol policies and increasing the coverage and quality of prevention and treatment interventions for disorders due to substance use and associated health conditions.	6.1.1 Number (absolute) of countries that have secured dedicated resources for the implementation of alcohol policies at the national level. 6.1.2. Number (absolute) of countries that have secured dedicated resources for increasing the coverage and quality of prevention and treatment interventions within health systems for disorders due to substance use. 6.1.3. Number (absolute) of countries that introduced, when appropriate, dedicated funding for reducing the harmful use of alcohol from alcohol tax revenues or other revenues linked to alcohol production and trade.	2022 2025 2027 2029/2030	Data collected through existing WHO global surveys on alcohol and health and on progress towards the attainment of SDG target 3.5, as well as other relevant monitoring activities undertaken at the global and regional levels. The current data collection tools require some adjustments for reporting on these indicators.

## ANNEX 14

### **Recommendations for the prevention and management of obesity over the life course, including considering the development of targets in this regard<sup>1</sup>**

[EB150/7, Annex 9 – 11 January 2022]

#### **OBESITY KEY ANALYSIS**

1. Obesity is a complex multifactorial disease defined by excessive adiposity that impairs health.<sup>2</sup> Obesity is also one of the key risk factors for many noncommunicable diseases (NCDs) such as coronary heart disease; hypertension and stroke; certain types of cancer; type 2 diabetes; gallbladder disease; dyslipidaemia; musculoskeletal conditions such as osteoarthritis; gout; and pulmonary diseases, including sleep apnoea. Obesity is the most important modifiable risk factor for type 2 diabetes. In addition, people living with obesity often experience mental health issues alongside different degrees of functional limitations, i.e. obesity-related disability,<sup>3</sup> and they suffer from social bias, prejudice and discrimination.<sup>4</sup> Obesity has several root drivers and determinants, including genetics, biology, access to health care, mental health, diet, education, sociocultural factors, economics, environments and commercial interests, among others.
2. Body mass index (BMI) is a marker of adiposity calculated as weight divided by height in metres squared ( $\text{kg/m}^2$ ) and is used for population surveillance of obesity. The BMI categories for defining obesity vary by age and gender in infants, children and adolescents. For adults, obesity is defined by a BMI greater than or equal to  $30.00 \text{ kg/m}^2$ . A BMI ranging from  $25.00$  to  $29.99 \text{ kg/m}^2$  is also associated with increase disease risk and is referred to as pre-obesity. This continuum of risk is acknowledged by considering overweight, which includes adults with a BMI greater than  $25.00 \text{ kg/m}^2$ . For children aged 5–19 years, obesity is defined by a BMI-for-age greater than two standard deviations above the WHO growth reference median. For children under 5, overweight is used as the indicator, defined as weight-for-height greater than two standard deviations above WHO Child Growth Standards median.
3. Globally, the prevalence of overweight and obesity and the number of affected individuals have increased in all age groups and will continue rising during the next decade.<sup>5</sup>

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<sup>1</sup> See decision WHA75(11).

<sup>2</sup> ICD-11 Code 5B81.

<sup>3</sup> ICF-OB: a multidisciplinary questionnaire based on the International Classification of Functioning, Disability and Health to address disability in obesity. *Eur J Physical Rehab Med.* 2018;54(1):119-21. doi: 10.23736/S1973-9087.17.04836-5.

<sup>4</sup> Obesity: preventing and managing the global epidemic. Report of a WHO consultation. *World Health Organ Tech Rep Ser.* 2000;894:i–xii, 1–253.

<sup>5</sup> Estimates for children under 5 years are available in UNICEF–WHO–World Bank Joint Child Malnutrition Estimates for 2020 (<https://www.who.int/data/gho/data/themes/topics/joint-child-malnutrition-estimates-unicef-who-wb>, accessed 1 December 2021). The unpublished projections for 2030 prepared by WHO's Department of Nutrition and Food

	2000	2020	2030
Children under 5 with overweight	33.3 million	38.9 million	39.8 million
Children aged 5–19 with obesity	52.3 million	150 million	254 million
Adults with overweight	1.2 billion	1.9 billion	TBD <sup>1</sup>
Adults with obesity	0.3 billion	0.6 billion	TBD

4. The following alarming trends are surfacing:

- Almost half of children under 5 affected by overweight live in Asia and more than one quarter of them live in Africa.
- The prevalence of obesity among children 5–19 years in 2016 was about 20% or more in several countries in the Pacific, the Eastern Mediterranean, the Caribbean and the Americas.<sup>2</sup> Globally, there was a threefold increase in the number of obese children and adolescents from 2000 to 2016.<sup>3</sup>
- Among adults, rates of obesity are growing most rapidly in middle-income countries, particularly in Southeast Asia and Africa. Globally, 1 in 5 adults are predicted to have obesity by 2025, with all countries off track to meet targets to halt obesity by 2025.
- Most of the world’s population live in countries where overweight and obesity have a greater impact on the burden of disease than underweight.<sup>4</sup>

5. Overweight and obesity in childhood and adolescence are associated with adverse health consequences and with increased morbidity later in life. Preventing and controlling excess adiposity in children and adolescents is important for many reasons. Weight loss and maintenance after weight loss are hard to achieve,<sup>5</sup> therefore gaining excess weight in childhood and adolescence is likely to lead to overweight and obesity in adulthood.<sup>6</sup>

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Safety are being updated. They will be provided in the next version of the paper on estimates for children 5–19 years ([https://www.who.int/data/gho/data/indicators/indicator-details/GHO/prevalence-of-obesity-among-children-and-adolescents-bmi-2-standard-deviations-above-the-median-\(crude-estimate\)-\(-\)](https://www.who.int/data/gho/data/indicators/indicator-details/GHO/prevalence-of-obesity-among-children-and-adolescents-bmi-2-standard-deviations-above-the-median-(crude-estimate)-(-)), accessed 1 December 2021). Unpublished projections for 2030 are provided by the Department of Maternal, Newborn, Child and Adolescent Health and Ageing. See also Prevalence of obesity among adults, BMI  $\geq$  30 (crude estimate) (%) adults ([https://www.who.int/data/gho/data/indicators/indicator-details/GHO/prevalence-of-obesity-among-adults-bmi--30-\(crude-estimate\)-\(-\)](https://www.who.int/data/gho/data/indicators/indicator-details/GHO/prevalence-of-obesity-among-adults-bmi--30-(crude-estimate)-(-)), accessed 1 December 2021). Projections for 2030 are not yet available.

<sup>1</sup> Estimates currently under development.

<sup>2</sup> NCD Risk Factor Collaboration. Worldwide trends in body-mass index, underweight, overweight, and obesity from 1975 to 2016: a pooled analysis of 2416 population-based measurement studies in 128.9 million children, adolescents, and adults. *Lancet* 2017;390(10113):2627–2642. doi: 10.1016/S0140-6736(17)32129-3.

<sup>3</sup> Global Health Observatory. World Health Organization ([https://www.who.int/data/gho/data/indicators/indicator-details/GHO/prevalence-of-obesity-among-children-and-adolescents-bmi-2-standard-deviations-above-the-median-\(crude-estimate\)-\(-\)](https://www.who.int/data/gho/data/indicators/indicator-details/GHO/prevalence-of-obesity-among-children-and-adolescents-bmi-2-standard-deviations-above-the-median-(crude-estimate)-(-)), accessed 11 April 2022).

<sup>4</sup> Prevalence of Obesity. World Obesity (<https://www.worldobesity.org/about/about-obesity/prevalence-of-obesity>, accessed 1 December 2021).

<sup>5</sup> MacLean P, Higgins J, Giles E, Sherk V, Jackman M. The role for adipose tissue in weight regain after weight loss. *Obes Rev.* 2015;16 Suppl 1 (Suppl 1):45–54. doi: 10.1111/obr.12255.

<sup>6</sup> Singh AS, Mulder C, Twisk JW, van Mechelen W, Chinapaw MJ. Tracking of childhood overweight into adulthood: a systematic review of the literature. *Obes Rev.* 2008;9(5):474–488. doi: 10.1111/j.1467-789X.2008.00475.x.

- Being overweight in childhood and adolescence affects children's and adolescents' immediate health and is associated with greater risk and earlier onset of various NCDs, such as type 2 diabetes and cardiovascular disease.<sup>1,2,3,4</sup>
- Childhood and adolescent obesity has adverse psychosocial consequences; it affects school performance and quality of life, compounded by stigma, discrimination and bullying.<sup>5,6</sup>
- Children with obesity are very likely to remain obese as adults and are also at a higher risk of developing NCDs in adulthood.

6. Overweight and obesity in adult life, including in the ageing population, are associated with increased all-cause mortality. People with obesity have also a fourfold higher risk of developing severe coronavirus disease (COVID-19) than people with no obesity.<sup>7</sup>

7. People living with obesity are frequently subject to stigma and bias, including from health care professionals, with potential impact on the access and quality of care and treatment received.<sup>8</sup> Overweight and obesity also impair individuals' lifetime educational attainment and access to the labour market and place a significant burden on health care systems, family, employers and society as a whole.<sup>9,10,11</sup>

8. The costs of obesity and obesity-related diseases are increasing. It is estimated that the total cost to the health care system related to the current prevalence of excess BMI is US\$ 990 billion per year globally, representing more than 13% of all health care expenditure.<sup>12</sup> Obesity also results in indirect costs, such as impaired productivity, lost life years and reduced quality of life. The combined direct and

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<sup>1</sup> Must A, Jacques PF, Dallal GE, Bajema CJ, Dietz WH. Long-term morbidity and mortality of overweight adolescents. A follow-up of the Harvard Growth Study of 1922 to 1935. *N Engl J Med.* 1992;327(19):1350–1355. doi: 10.1056/NEJM199211053271904.

<sup>2</sup> Abdullah A, Wolfe R, Stoelwinder JU, De Courten, M, Stevenson C, Walls HL, et al. The number of years lived with obesity and the risk of all-cause and cause-specific mortality. *Int J Epidemiol.* 2011;40(4):985–996. doi: 10.1093/ije/dyr018.

<sup>3</sup> Park M, Falconer C, Viner R, Kinra S. The impact of childhood obesity on morbidity and mortality in adulthood: a systematic review. *Obes Rev.* 2012;13(11):985–1000. doi: 10.1111/j.1467-789X.2012.01015.x.

<sup>4</sup> Palma Dos Reis CR, et al. The fetal origins of disease: a prospective cohort study on the association of preeclampsia and childhood obesity. *J Dev Orig Health Dis.* 2021;1–7.

<sup>5</sup> Caird J, Kavanagh J, O'Mara-Eves A. Does being overweight impede academic attainment? A systematic review. *Health Educ J.* 2014;73:497–521.

<sup>6</sup> Quek YH, Tam WW, Zhang MW, Ho R. Exploring the association between childhood and adolescent obesity and depression: a meta-analysis. *Obes Rev.* 2017; 18(7):742–754. doi: 10.1111/obr.12535.

<sup>7</sup> Cai Z, Yang Y and Zhang J. Obesity is associated with severe disease and mortality in patients with coronavirus disease 2019 (COVID-19): a meta-analysis. *BMC Public Health* 2021; 21(1)1505. doi: 10.1186/s12889-021-11546-6.

<sup>8</sup> Phelan SM, Burgess DJ, Yeazel MW, Hellerstedt WL, Griffin JM, van Ryn M. Impact of weight bias and stigma on quality of care and outcomes for patients with obesity. doi: 10.1111/obr.12266.

<sup>9</sup> Muller-Riemenschneider F, Reinhold T, Berghofer A, Willich SN. Health-economic burden of obesity in Europe. *Eur J Epidemiol.* 2008;23:499–509. doi: 10.1007/s10654-008-9239-1.

<sup>10</sup> Report of the commission on ending childhood obesity. Geneva: WHO; 2016.

<sup>11</sup> Shekar M, Popkin B, eds. 2020. Obesity: Health and Economic Consequences of an Impending Global Challenge. Human Development Perspectives series. Washington, DC: World Bank. doi:10.1596/978-1-4648-1491-4.

<sup>12</sup> Calculating the costs of the consequences of obesity. World Obesity Federation;2017.



indirect health care costs of obesity are currently estimated at approximately 3.3% of total gross domestic product (GDP) in countries of the Organisation for Economic Co-operation and Development.<sup>1</sup>

9. In high-income countries with established obesity epidemics, prevalence is higher in low-socioeconomic status groups. In low-income countries, the prevalence of obesity is usually higher in urban, high-socioeconomic status groups, but can later expand to a broader cross-section of society in both urban and rural areas.<sup>2</sup>

## **EARLIER WHO WORK ON OBESITY**

10. A 1997 expert consultation report concluded that the fundamental causes of the obesity epidemic worldwide are sedentary lifestyles and high-fat energy-dense diets, both resulting from changes taking place in society and the behavioural patterns of communities as a consequence of increased urbanization and industrialization and the disappearance of traditional lifestyles. The report recommended: (a) the use of public health approaches to the prevention and management of overweight and obesity in populations, namely improving the knowledge and skills of the community and reducing population exposure to an obesity-promoting environment; and (b) adopting an integrated health care services approach in community settings for the prevention and management of overweight and obesity in at-risk individuals.

11. A 2002 expert consultation report highlighted the importance of: (a) promoting exclusive breastfeeding and ensuring the appropriate micronutrient intake needed to promote optimal linear growth for infants and young children; and (b) restricting the intake of energy-dense, micronutrient-poor foods (e.g. packaged snacks), restricting the intake of sugar-sweetened beverages, limiting television viewing and promoting active lifestyle for children and adolescents, among other interventions. In addition, the report also highlighted other measures, including limiting the exposure of children to intensive marketing practices, providing the necessary information and skills to make healthy food choices, modifying the environment to enhance physical activity in schools and communities, and creating more opportunities for family interaction (such as eating family meals). In the countries where undernutrition is prevalent, the report indicated that nutrition programmes designed to control or prevent undernutrition need to assess stature in combination with weight in order to prevent providing excess energy to children of low weight-for-age but normal weight-for-height. These recommendations were reflected in the global strategy on diet, physical activity and health.<sup>3</sup> Following the publication of the 2002 report, additional evidence has emerged regarding the complex drivers of obesity, including its role in maternal and fetal health, the role of mental health, sleep and other factors in obesity risk and the impact of metabolic changes on sustained weight loss, as well as developments in some clinical treatment options.

12. The 2012 comprehensive implementation plan on maternal, infant and young child nutrition established a global target of no increase in childhood overweight through 2025. Key interventions for reducing the risk of unhealthy weight gain in childhood included: (1) addressing early life exposures to improve nutritional status and growth patterns; (2) improving community understanding and social

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<sup>1</sup> The Heavy Burden of Obesity: The Economics of Prevention. OECD Health Policy Studies. Paris: OECD; 2019.

<sup>2</sup> Pampel FC, Denney JT, Krueger PM. Obesity, SES, and economic development: a test of the reversal hypothesis. *Soc Sci Med.* 2012;74(7):1073-1081. doi:10.1016/j.socscimed.2011.12.028.

<sup>3</sup> See resolution WHA57.17.

norms; (3) addressing exposure of children to marketing of foods; (4) influencing the food system and food environment; and (5) improving nutrition in neighbourhoods.

13. The 2016 Report of the Commission on Ending Childhood Obesity developed a comprehensive, integrated package of recommendations to address childhood obesity, including: (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; (2) implement comprehensive programmes that promote physical activity and reduce sedentary behaviours in children and adolescents; (3) integrate and strengthen guidance for NCD prevention with current guidance for preconception and antenatal care in order to reduce the risk of childhood obesity; (4) provide guidance on, and support for, healthy diet, sleep and physical activity in early childhood in order to ensure that children grow appropriately and develop healthy habits; (5) implement comprehensive programmes that promote healthy school environments, health and nutrition literacy and physical activity among school-age children and adolescents; and (6) provide family-based, multicomponent, lifestyle weight management services for children and young people who living with obesity.

14. This work, together with the wealth of country experiences developed in the last two decades, provides the basis for the following principles and recommendations. Work is ongoing to expand the evidence basis and develop additional policy approaches and service provision models.

## **GENERAL PRINCIPLES**

15. The prevention and management of obesity require healthy, supportive and conducive environments that allow the consumption of healthy and energy balanced diets, adequate physical activity levels and addressing mental health. The WHO Guideline on sugars intake for adults and children<sup>1</sup> recommend a level of consumption of free sugars that is lower than 10% of total energy, possibly lower than 5%. The WHO guidelines on physical activity and sedentary behaviour for children, adolescents, adults and older adults recommend that children and adolescents do at least 60 minutes a day of moderate- to vigorous-intensity physical activity across the week and that adults should do at least 150–300 minutes of moderate-intensity aerobic physical activity; or at least 75–150 minutes of vigorous-intensity aerobic physical activity; or an equivalent combination of moderate- and vigorous-intensity activity throughout the week. Adaptation of recommended physical activity might be needed in the ageing population.

16. Actions for overweight and obesity prevention and management need to adopt systemic approaches from specific areas or actions, including:

- a whole-of-government and whole-of-society approach;
- a life-course approach, in which primary preventive efforts are likely to have optimal effects if started in early childhood with parental involvement;<sup>2</sup>
- integrated health services that provide a continuum of care, such as health promotion, disease prevention, diagnosis, treatment and management.

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<sup>1</sup> Guideline: sugars intake for adults and children. Geneva: World Health Organization;2015.

<sup>2</sup> Wilkinson TM. Obesity, equity and choice. *J Med Ethics*. 2019 May;45(5):323–328. doi: 10.1136/medethics-2018-104848.

17. Policymakers need to ensure the impact of policies on gender across the life course, in all socioeconomic groups and in vulnerable populations. The environmental, social and commercial determinants of overweight and obesity should also be taken into consideration. A human rights approach is important both to strengthen the rationale for action and to guide policy choices.

## **RECOMMENDED ACTIONS FOR GOVERNMENTS**

18. Apply multisectoral and Health in All Policies approaches, actions and strategies at the different levels of the obesity causal chain, since the prevention and management of obesity can only be achieved by simultaneously influencing public policies in multiple domains. Those should address health, food systems, social protection, the built environment and physical activity, finance and trade, health literacy and education, among others. Comprehensive and evidence-informed national action plans for the prevention and management of obesity in all age and population groups should also be developed.

### **Health**

19. Provide a continuum of care by implementing health promotion, disease prevention, diagnosis, treatment and management of obesity, as components of the universal health coverage national plan.

20. Include obesity prevention and management in the primary care package. Health care benefit plans should include coverage of a range of obesity prevention and management services in order to avoid out-of-pocket fees for affected populations and their families.

21. Provide dietary, weight and breastfeeding counselling for both mother and child as part of antenatal and postnatal care, together with physical activity counselling and tobacco cessation, and measure gestational weight gain. Promote, protect and support breastfeeding, including the full implementation of the International Code of Marketing of Breast-Milk Substitutes and follow-up resolutions, and implement the Baby-Friendly Hospital Initiative.

22. Implement the WHO guideline to support primary health care workers to prevent, identify and manage childhood overweight or obesity<sup>1</sup> in the context of national priorities. Specific actions include the following.

(a) Measure the weight and height of all infants and children less than 5 years old presenting to primary health care facilities in order to determine weight-for-height and nutritional status according to WHO Child Growth Standards.<sup>2,3</sup> Comparing a child's weight with norms for its length/height is an effective way to assess for both wasting and overweight.

(b) Provide counselling to parents, family members and caregivers on health promotion, specifically on healthy diet and physical activity, including by promoting and supporting

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<sup>1</sup> Guideline: assessing and managing children at primary health facilities to prevent overweight and obesity in the context of the double burden of malnutrition. Updates for the integrated management of childhood illness (IMCI). Geneva: World Health Organization; 2017.

<sup>2</sup> WHO Child Growth Standards for children under 5 years.

<sup>3</sup> WHO Child Growth Reference for children aged between 5–19 years.

exclusive breastfeeding in the first 6 months after birth and continued breastfeeding until 24 months or beyond after birth,<sup>1</sup> linking such support with an appropriate nutritional plan.

(c) Develop a multidisciplinary plan for the management of children with obesity through a family-centred approach. This can be done by a health care professional at primary health care level and/or at community level if adequately trained or at a referral clinic or local hospital.

23. Ensure that health promotion activities, including weight monitoring and management, are equitably offered and progressively implemented for people of all ages, including as part of universal health coverage, and that people with obesity have access to trained health care professionals, weight measurement and screening, healthy nutrition, physical activity, psychological support, counselling, pharmacotherapy and surgery.

24. Integrate obesity prevention and management into multidisciplinary clinical teams to ensure that people with obesity receive adequate support and treatment, including for the comorbidities and co-conditions (mental health and disability) of obesity. Promote and provide equitable access to quality care.

25. Ensure that a sufficient number of health care professionals are adequately trained on obesity prevention and management through pre-service and post-service education.

### **Food systems**

26. Improve the accessibility and affordability of healthy diets for the entire population by taking the following actions.

(a) Build a more coherent and enabling agricultural policy to reinforce sustainable food system for the provision of a safe and healthy diet, with reduced daily calories from fats and sugars, and increased number of daily portions from whole grains, legumes, nuts, vegetables and fruits.<sup>2</sup> This includes encouraging food manufacturers to replace and/or reformulate their products.

(b) Shape the food environment (including digital environments)<sup>3</sup> through fiscal and price policies (taxation and incentives) that emphasize the consumption of whole grains, legumes, nuts, vegetables and fruit and reduce the demand for products high in fats, sugars and salt/sodium.

(c) Regulate the marketing of foods and beverages that are high in fats, sugars and salt/sodium, as well as the marketing of breast-milk substitutes and toddler milk, including digital marketing.

(d) Establish nutrition labelling to support consumers' understanding of nutrient contents in food, including through easy-to-understand information at the point of choice (e.g. through front-of-the-pack nutrition labelling or menu labelling).

(e) Design public food procurements and service policies that support procuring, distributing, selling, and/or serving foods that support healthy diets in schools and other public institutions,

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<sup>1</sup> Guideline: protecting, promoting and supporting breastfeeding in facilities providing maternity and newborn services. Geneva: World Health Organization; 2017.

<sup>2</sup> Obesity. Geneva: World Health Organization ([https://www.who.int/health-topics/obesity#tab=tab\\_3](https://www.who.int/health-topics/obesity#tab=tab_3), accessed 1 December 2021).

<sup>3</sup> Digital food environments. Factsheet. Geneva: World Health Organization; 2021.

such as government offices, childcare centres, nursing homes, hospitals, health centres, community centres, military bases and prisons.<sup>1</sup>

### **Social protection and welfare**

27. Design social protection programmes for healthy and sustainable food (including cash transfers) that facilitate the access to healthy diets and promote sustainability and socioeconomic equity. Such programmes can also help reduce gaps across food systems by linking agroecological small-scale producers and food systems operators to programmes and thereby promoting a virtuous and equitable system among beneficiaries and providers.

### **Built environment and physical activity**

28. Engage city-level governments in facilitating the access to healthy diets, such as through the establishment of fresh food markets and through zoning policies, as well as in the promotion of physical activity, such as through active mobility. The majority of the world's population live in environments in which the proliferation of cheap and available high energy-density food dominates and reduced opportunities to be physically active are leading to excess weight gain.

29. Adopt and implement WHO's guidelines and policy recommendations on physical activity and sedentary behaviour. WHO guidelines provide details for different age groups and specific population groups on how much physical activity is needed for good health.

30. Implement the recommended policy actions outlined in the WHO global action plan on physical activity 2018–2030, which provides recommendations on how countries can: (1) create positive social norms and attitudes by enhancing knowledge of the multiple benefits of regular physical activity, according to ability across the life course; (2) create supportive environments that promote and safeguard the rights of all people to have equitable access to safe places and spaces in their cities and communities, in which they can engage in regular physical activity; (3) ensure adequate and appropriate programmes and services across key settings that support people of all ages and abilities to engage in regular physical activity as individuals, families and communities; and (4) strengthen governance, data systems and investments to implement effective and coordinated international, national and subnational action in order to increase physical activity and reduce sedentary behaviour.

### **Health literacy and education**

31. Develop, adapt and implement national food-based dietary guidelines, which are among other things tools for promoting desirable food consumption patterns and improving nutritional well-being. Food-based dietary guidelines translate science-based guidance on diet, nutrition and health relationship into food-based guidance and messages, taking into consideration country contexts, vulnerable groups, populations' nutritional status, food availability, dietary habits and cultural contexts. Food-based dietary guidelines also serve as a tool for implementing national nutrition policies and programmes and provide guidance for food and agriculture policies.<sup>2</sup>

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<sup>1</sup> Raine KD, Atkey K, Dana L, Ferdinands A, Beaulieu D, Buhler S, et al. Healthy food procurement and nutrition standards in public facilities: evidence synthesis and consensus policy recommendations. *Health Promot Chronic Dis Prev Can.* 2018; 38(1): 6–17. doi: 10.24095/hpcdp.38.1.03.

<sup>2</sup> Herforth A, Arimond M, Álvarez-Sánchez C, Coates J, Christianson K, Muehlhoff E. A Global Review of FoodBased Dietary Guidelines. *Adv Nutr.* 2019;10(4):590–605. doi: 10.1093/advances/nmy130.

32. Implement campaigns for the promotion of healthy diets and physical activity to complement other actions that shape the food environment and orient people's lifestyles,<sup>1</sup> as one component of the obesity epidemic response, by collecting behavioural and cultural insights from the social sciences and health humanities to help design behavioural change actions, such as programmes to improve cooking skills.

### **Monitoring and evaluation**

33. Establish surveillance systems, including to monitor the weight, height, dietary intake and physical activity levels of individuals of all age groups.

34. Monitor and evaluate policy and programme implementation in different sectors, including to assess access to quality care and clinical interventions, the capacity of health care workers, the availability of healthy foods and the impact of actions taken on obesity reduction across the life course.

## **RECOMMENDED ACTIONS FOR OTHER SOCIETAL ACTORS**

### **Civil society**

35. Encourage governments to develop ambitious national responses in order to increase the availability, accessibility and affordability of healthy foods; promote the uptake of healthy diets and physical activity; and support the implementation and assess progress of related policies.

36. Ensure and amplify the voices of, and raise awareness about, people living with or affected by obesity.

37. Mobilize the public to increase popular demand for obesity-prevention policies, including on the refinement and streamlining of public information; the identification of effective obesity frames for each population; the strengthening of media advocacy; the building of citizen protest and engagement; and the development of a receptive political environment, with change agents embedded across organizations and sectors.

### **Academia**

38. Consolidate and expand the evidence base for obesity causes, determinants and consequences and for responses at individual, community and societal levels.

39. Design and implement policy evaluation programmes to assess the impact, feasibility and scalability of recommended interventions associated with cost-effectiveness analysis.

### **Economic operators in the food system**

40. Guarantee access to healthy diets, from production to distribution and promotion. Manufacturers should reformulate their products, particularly those intended for children (reducing sugar and salt content), and reduce portion sizes. All companies can offer healthy diets in their workplace canteens. Food distribution chains might facilitate the access to fresh products, particularly fruit and vegetables,

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<sup>1</sup> Updated Appendix 3 to the NCD–GAP. Geneva: World Health Organization; 2017.

and support their promotion through adequate product placement. Catering firms can take steps to align their offers with national food-based dietary guidelines.

### **Economic operators in the sports, exercise and recreation industries**

41. Strengthen the promotion and provision of physical activity in the workplace, improve access and affordability to gyms, clubs and recreation centres, promote wearable technologies and support strengthening the provision of physical education and school sports for all children.<sup>1</sup>

## **RECOMMENDED ACTIONS FOR WHO**

### **Guidance and tool development**

42. Expand guidance to health care professionals on the prevention and management of obesity in all age groups, including brief interventions.

43. Translate normative and technical guidance into operational manuals and tools and integrated approaches that can be adopted by Member States.

44. Advocate for the universal implementation of WHO guidance on healthy diets and policies intended to shape the food environment in order to ensure that all people have access to services to prevent and manage overweight and obesity, in all age groups and including in vulnerable and displaced populations.

45. Document and disseminate the good practices adopted by governments in the response to the prevention and management of obesity.

46. Engage other United Nations entities with shared mandates in this area, such as UNICEF and the Food and Agriculture Organization of the United Nations.

### **Capacity-building of service providers**

47. Contribute to increasing the number of health care professionals who are trained in nutrition and ensure the quality of their competencies and services provided. Most health care professionals are not adequately trained to address diet, physical activity and nutrition-related issues, including the prevention and management of obesity, thereby impacting the quality of care for the affected population and their family members and/or the caregivers. Training in nutrition and the prevention and management of obesity is not a mandatory requirement for the curricula of medical, nursing and of other professional schools in many countries.<sup>2</sup> Increasing the number of health care professionals who are provided with quality training in the prevention and management of obesity, including in preservice education, will improve the access, coverage and quality of the services provided to people living with obesity.

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<sup>1</sup> Huang TTK, Cawley JH, Ashe M, Costa SA, Frerichs LM, Zwicker L, et al. Mobilisation of public support for policy actions to prevent obesity. *Lancet*. 2015;385(9985):2422–31. doi: 10.1016/S0140-6736(14)61743-8.

<sup>2</sup> Kris-Etherton PM, Akaba SR, Douglas P, Kohlmeier M, Laur C, Lenders CM, et al. Nutrition competencies in health professionals' education and training: a new paradigm. *Adv Nutr*. 2015;6(1):83–7. doi: 10.3945/an.114.006734.

### **Policy dialogue and implementation support**

48. Engage in strategic and policy dialogues with ministries of health, making the case for action and the use of evidence-informed and cost-effective policy tools, as most appropriate to the country context. WHO will focus its efforts and resources on a number of priority countries with a high burden of overweight and obesity and who demonstrate a readiness to act.

49. Monitor the adoption of policies and their impacts and support country policy implementation.

### **TARGETS**

#### **Outcome targets**

50. The following outcome targets and indicators have been endorsed by the World Health Assembly and the United Nations General Assembly.

- (a) Halt the rise of obesity in children under 5,<sup>1</sup> adolescents and adults<sup>2</sup> by the year 2025 (against a 2010 baseline).
- (b) End all forms of malnutrition by the year 2030 (against a 2015 baseline).
- (c) Reach 3% or lower prevalence of overweight in children under five years of age by 2030.

#### **Intermediate outcome targets**

51. The establishment of intermediate outcome targets and process targets might benefit the scale-up of action. Intermediate outcome targets are linked to key steps on the causal pathway to the development of obesity. The targets may be related to the quality of the diet and to physical activity levels. Intermediate outcome targets include the following.

- (a) In both adults and children, WHO recommends reducing the intake of free sugars to less than 10% of total energy intake. This target is based on a strong recommendation in the WHO guidelines on sugars intake in adults and children published in 2015.<sup>3</sup>
- (b) Increase the rate of exclusive breastfeeding in first 6 months up to at least 50%. This is one of the six global nutrition targets endorsed by the World Health Assembly.<sup>1</sup>
- (c) A 15% relative reduction in the global prevalence of physical inactivity in adults and in adolescents by 2030.<sup>4</sup> This target was established by the World Health Assembly in 2010 and updated in WHO's global action plan on physical activity 2018–2030).

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<sup>1</sup> See document WHA65/2012/REC/1, Annex 2.

<sup>2</sup> See NCD-GAP.

<sup>3</sup> Guideline: sugars intake for adults and children. Geneva; World Health Organization (<https://www.who.int/publications/i/item/9789241549028>, accessed 1 December 2021).

<sup>4</sup> Using a 2016 baseline.



## Process targets

52. Process targets are related to the presence of WHO recommended policies and the effective coverage of services that would lead to the desired changes in intermediate outcomes (diet and physical activity) and in final outcomes (obesity prevalence). Process targets, to be achieved by the year 2030, include:

- (a) increasing the coverage of primary health care services that include the prevention, diagnosis and management of obesity in children and adolescents;
- (b) increasing the nutrition professional density to a minimum level of 10/100 000 (rationale: indicator already included in the Global Nutrition Monitoring Framework<sup>1</sup> and reported in the Nutrition Landscape Information System;<sup>2</sup> baseline 2016–2017: 2.2/100 000);
- (c) increasing the adoption of regulations to control the marketing of foods and non-alcoholic beverages to children (indicator collected through the Global Nutrition Policy Review<sup>3</sup> and NCD Country Capacity Survey;<sup>4</sup> baseline: 47 countries (Global database on the Implementation of Nutrition Action));
- (d) all countries implement national public education communication campaigns on physical activity (aligned with use within NCD progress monitoring and recommended NCD best buy in 2018); and
- (e) all countries have a national protocol for assessing and counselling on physical activity in primary care (aligned with use within NCD progress monitoring and recommended NCD good buy in 2018).

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<sup>1</sup> Global Nutrition Monitoring Framework: operational guidance for tracking progress in meeting targets for 2025. WHO and UNICEF (<https://apps.who.int/iris/bitstream/handle/10665/259904/9789241513609-eng.pdf?sequence=1&isAllowed=y>, accessed 1 December 2021).

<sup>2</sup> Nutrition Landscape Information System: GNMF Profile (who.int)(NLiS). Geneva: World Health Organization (<https://apps.who.int/nutrition/landscape/global-monitoring-framework>).

<sup>3</sup> Global nutrition policy review 2016-2017: country progress in creating enabling policy environments for promoting healthy diets and nutrition. Geneva; World Health Organization (<https://www.who.int/publications/i/item/9789241514873>, accessed 1 December 2021).

<sup>4</sup> NCD Country Capacity Survey. Geneva: World Health Organization (<https://www.who.int/teams/ncds/surveillance/monitoring-capacity/ncdccc>, accessed 1 December 2021).

## ANNEX 15

### **Workplan for the global coordination mechanism on the prevention and control of noncommunicable diseases 2022–2025<sup>1</sup>**

[EB150/7, Annex 10 – 11 January 2022]

[Paragraphs 1–5 described the mandate for and development process of the workplan.]

#### **Scope, purpose and modalities**

6. The workplan is organized around the priority areas of work provided for the global coordination mechanism on the prevention and control of noncommunicable diseases (GCM/NCD) by Member States in decision WHA74(11). In addition, guidance and recommendations provided in the preliminary and final<sup>2,3</sup> evaluations of the GCM/NCD and in the midpoint evaluation of the implementation of WHO's Global Action Plan for the Prevention and Control of Noncommunicable Diseases 2013–2020 (NCD-GAP)<sup>4</sup> have informed the workplan and theory of change and logic model. The priority areas ensure a more focused approach to the implementation of the five functions, in line with the scope and purpose of the GCM/NCD, as provided by its terms of reference, as well as with WHO's programmes related to noncommunicable diseases (NCDs).
7. Implementation models across all activities of the workplan are designed to formalize more effective engagement with GCM/NCD participants, improve the accountability and responsiveness of GCM/NCD to the needs of Member States and enhance country-level impacts in order to ensure focused support implementation of the NCD-GAP through strengthened national capacity, leadership, governance, multisectoral action and partnerships to accelerate country response for the prevention and control of NCDs and address their risk factors.
8. During the implementation of the workplan, the GCM/NCD will continuously engage with relevant stakeholders across WHO, including regional and country offices, in order to amplify and foster meaningful engagement among WHO, Member States and non-State-actors, including civil society, people living with or affected by NCDs, relevant private sector entities and academia. Performance measures will track progress towards objectives over time and will inform timely adaptation.
9. This workplan and the related theory of change and logic model will be refined based on continuing input from Member States and the ongoing strategic planning process and will be enhanced by qualitative and quantitative data, case studies and other performance measures.

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<sup>1</sup> See decision WHA75(11).

<sup>2</sup> See document A71/14 Add.1.

<sup>3</sup> See document A74/10 Add.2.

<sup>4</sup> See document A74/10 Add.1.

## PRIORITY AREAS, ACTIONS AND PERFORMANCE MEASURES

### Priority area 1

**Operational backbone for knowledge collaboration and the dissemination of innovative multistakeholder responses at country level, based on raising awareness and promoting knowledge collaboration among Member States and non-State actors and on co-creating, enhancing and disseminating evidence-based information to support governments in adopting effective multisectoral and multistakeholder approaches.**

**Action 1.1:** Enhance and realign the Knowledge Action Portal (KAP) to support GCM/NCD activities and GCM/NCD participants.

**Activity 1.1.1** (2022–2025): Expand data and information, including stocktaking of global, regional and country-level multisectoral and multistakeholder experiences, community engagement and action, best practices and success stories from GCM/NCD participants.

**Expected outcome:** KAP updated to include up-to-date and relevant information on multisectoral and multistakeholder experiences, community engagement and action that is utilized by countries and GCM participants to inform national and subnational plans and strengthen country-level responses.

**Performance measures:**

- KAP site traffic increased by 25% by 2025 over 2021 baseline (including page views; click-through rate, time on site).
- Number of submissions of content by WHO, Member States and other GCM/NCD participants from 2022 to 2025.

**Activity 1.1.2** (third quarter 2022): Adapt KAP to enhance the functionalities for improved knowledge collaboration of GCM/NCD participants across the workplan activities.

**Expected outcome:** Refined KAP utilized by countries and other WHO stakeholders to enhance engagement and collaboration and align GCM/NCD outputs with country needs.

**Performance measures:**

- KAP site traffic increased by 25% over 2021 baseline by 2025 (including page views, click-through rate, time on site).
- Analytics of unique visits to specific pages enhanced or added to the KAP since 2021.

**Action 1.2:** Provide information on the health needs of marginalized groups and population groups living in vulnerable situations in order to advance equity in the prevention and control of NCDs.

**Activity 1.2.1** (2022–2025): Conduct the “NCD Voices in the Decade of Action” webinar series.

**Expected outcome:** national NCD responses informed by the perspective and health needs of marginalized groups and vulnerable populations, ensuring that the most at risk are not left behind.

**Performance measures:**

- At least 10 webinars launched by 2025.
- Analytics on participation and satisfaction with the webinars through polling surveys of participants.

**Priority area 2****Enabler for the global stocktaking of multistakeholder action at country level and for co-designing and scaling up innovative approaches, solutions or initiatives to strengthen effective multisectoral and multistakeholder action.**

**Action 2.1:** Develop an online registry and a special report on successful multisectoral actions for the prevention and control of NCDs and mental health conditions.

**Activity 2.1.1** (2022–2025): Develop and manage an online registry of examples of national or subnational multisectoral approaches and experiences on the prevention and control of NCDs and mental health conditions, including information on evidence underlying or evaluating the approaches.

**Expected outcome:** registry utilized by countries to build on lessons learned for effective multisectoral actions on NCDs and mental health conditions at the national and subnational levels.

**Performance measures:**

- Balanced representation of Member States in registry, with a special focus on experiences of low- and middle-income countries across WHO regions.
- Analytics of unique visits to registry and download of case studies in the first year after its launch.

**Activity 2.1.2** (2023): Develop a special report on multisectoral approaches and experiences at national or subnational levels across WHO regions for the prevention and control of NCDs and mental health conditions.

**Expected outcome:** special report with analysis of best practices, experiences and approaches utilized by Member States and other stakeholders to develop national and subnational multisectoral responses for the prevention and control of NCDs and mental health conditions.

**Performance measures:**

- At least 100 participants attending the launch event or other activities, with representation of Member States across all WHO regions.
- Analytics of unique downloads of special report in the first year after its launch.

**Action 2.2:** Second general meeting of the WHO's GCM/NCD.

**Activity 2.2.1** (2023): Convene general meeting of GCM/NCD, including the participation of people living with NCDs.

**Expected outcome:** meeting of GCM/NCD participants to share lessons learned, assess uptake and effectiveness of resources, as well as to galvanize commitments and accelerate multisectoral and multistakeholder action at the local, national, regional and global levels to meet the NCD targets of the NCD-GAP as well as SDG target 3.4 and the other NCD-related goals and targets of the 2030 Agenda (outcomes will inform the adaptation required by the GCM/NCD for the next implementation phase).

**Performance measures:**

- At least 100 Member States and 80% of GCM/NCD participants attending the general meeting, with representation of Member States across all WHO regions and income settings.
- Report emanating from general meeting of the GCM/NCD, including meaningful contributions from GCM/NCD participants and success stories from Member States across WHO regions and income settings on implementation of multisectoral and multistakeholder responses with the support of the GCM/NCD.

### Priority area 3

**Providing and updating guidance to Member States on engagement with non-State actors, including on the prevention and management of potential risks.**

**Action 3.1:** Provide guidance to Member States concerning benefits and risk management approaches when considering engagement with non-State-actors, beginning with the private sector, for the prevention and control of NCDs, through a tool to guide the informed decision-making process by countries, building on the guidance, experience and expertise of WHO and other relevant stakeholders.

**Activity 3.1.1** (fourth quarter 2022): Conduct a comprehensive consultative process across WHO, Member States and relevant non-State actors in order to develop a tool to guide decision-making by Member States on private sector engagement for prevention and control of NCDs.

**Expected outcome:** Member States supported in the use of risk management approaches in considering engagement with non-State actors, including the private sector, taking into account national NCD priorities to achieve SDG target 3.4, while assessing benefits against risks, including mitigation strategies.

**Performance measures:**

- Engagement across the three levels of WHO, Member States and GCM/NCD non-State actors participants to support the development of the tool.
- At least 100 participants attending the launch event for the tool, with representation of Member States across all WHO regions and income settings.
- Analytics of unique downloads of the tool in the first year after its launch.

**Activity 3.1.2** (2024–2025): Provide capacity development to countries in contextualizing and using the WHO tool to support benefit- and risk-informed decision-making on private sector engagement for the prevention and control of NCDs.

**Expected outcome:** capacity of Member States to make informed decisions on engagement with the private sector for the prevention and control of NCDs enhanced by the tool and by WHO's technical support for its implementation in order to respond to national priorities and achieve SDG target 3.4, while giving due regard to assessing and managing benefits and risks.

**Performance measures:**

- At least six countries supported to implement the tool by 2025, including at least four low- and middle-income countries.
- Uptake by WHO regional and country offices (e.g. specific requests to headquarters by country offices and/or regional offices, adaptation of the tool by regional offices/country offices, inclusion in WHO toolkits and featuring of the tool on institutional websites).

**Action 3.2:** Support the WHO Civil Society Working Group for meaningful civil society engagement for NCDs and UHC.

**Activity 3.2.1** (2022–2025): Establish third phase of WHO Civil Society Working Group (CSWG) on NCDs.

**Expected outcome:** civil society guidance and recommendations provided to WHO Director-General in support of effective policies, programmes and services for the prevention and control of NCDs and WHO's engagement with civil society for NCDs operationalized.

**Performance measures:**

- Membership increased from baseline 2021, with balanced representation across NCD and NCD-related areas and people living with NCDs and mental health conditions, as well as across WHO regions and income settings.
- Number of statements, policy briefs, webinars, advocacy products and side events delivered, presented and communicated through WHO channels by 2025, per the terms of reference of the CSWG, benchmarked against previous years.
- Summary report of CSWG deliverables disseminated through GCM/NCD platforms and dialogues.

## Priority area 4

**Global facilitator for the strengthened capacity of Member States and civil society to develop national multistakeholder responses for the prevention and control of NCDs.**

**Action 4.1:** Develop and support implementation of a guidance framework for national multisectoral and multistakeholder coordination mechanisms for the prevention and control of NCDs and mental health conditions.

**Activity 4.1.1** (second quarter 2022): Develop a WHO guidance framework for national multisectoral and multistakeholder coordination mechanisms for the prevention and control of NCDs through a co-creation approach with Member States, civil society organizations, people living with NCDs and other stakeholders.

**Expected outcome:** Heads of State and Government supported by WHO in fulfilling their commitment to provide strategic leadership for NCD responses by promoting policy coherence and coordination for the development of whole-of-government, Health in All Policies approaches and for the engagement of stakeholders in whole-of-society action, in line with national NCD and SDG action plans and targets, through the establishment or strengthening of national multisectoral and multistakeholder mechanisms.

**Performance measures:**

- Engagement across the three levels of WHO, Member States and additional GCM/NCD participants to support the development of the guidance framework.
- At least 100 participants attending the launch webinar, with balanced representation of Member States across WHO regions and a special focus on experiences of low- and middle-income countries.
- Analytics of unique downloads of the guidance framework in the first year after launch.

**Activity 4.1.2** (2022–2025): Provide capacity development to countries to contextualize and use the WHO guidance framework for national multisectoral and multistakeholder coordination mechanism in order to develop or strengthen country-tailored multisectoral and multistakeholder coordination mechanisms.

**Expected outcome:** guidance framework and online resources utilized by countries to establish or strengthen national and subnational coordination mechanisms in order to enhance policy coherence and coordination for the development of whole-of-government, Health in All Policies approaches and for the engagement of stakeholders in whole-of-society action, in line with national NCD targets and SDG 3.4.

**Performance measures:**

- Technical support provided to at least six countries, including low- and middle-income countries, by 2025.
- Guidance framework presented and discussed in relevant international and regional forums.
- Uptake by WHO regional and country offices (such as specific requests to headquarters by country offices and/or regional offices, adaptation of the guidance framework by country offices, its inclusion in WHO toolkits and its featuring of in institutional websites).

**Action 4.2:** Strengthen the role of GCM/NCD participants in accelerating multistakeholder actions towards meeting SDG target 3.4.

**Activity 4.2.1** (2022–2025): Develop and implement an engagement strategy with GCM/NCD participants.

**Expected outcome:** engagement strategy disseminated and utilized by GCM/NCD to improve coordination and collaboration with and among GCM/NCD participants to support WHO and Member States in enhancing multistakeholder action at the local, national, regional and global levels in order to contribute to the implementation of the NCD-GAP, while safeguarding WHO and public health from any undue influence by any form of real, perceived or potential conflicts of interest.

**Performance measures:**

- 80% of GCM/NCD participants participating in the development of the engagement strategy, with balanced representation of the four GCM/NCD constituencies.
- At least 50% of GCM/NCD participants supporting WHO and Member States enhance multistakeholder action through the implementation of activities of the GCM/NCD workplan.
- Number of Member States across WHO regions and WHO regional and country offices supported by the GCM/NCD.

**Activity 4.2.2** (2025): Produce case studies on the commitments and contributions of GCM/NCD participants to support countries in advancing the implementation of the NCD-GAP and accelerate progress towards meeting SDG target 3.4.

**Expected outcome:** case studies utilized by Member States and non-State actors to inform more effective national and subnational multistakeholder responses.

**Performance measures:**

- Case studies from each of the four constituencies of GCM/NCD participants published by 2025.
- Analytics of unique downloads of case studies in the first year after their launch.

## Priority area 5

**Convener of civil society, including people living with NCDs, to raise awareness and build capacity for their meaningful participation in national NCD responses.**

**Action 5.1:** Support the co-development of a WHO framework for the meaningful engagement of people living with NCDs and mental health conditions.

**Activity 5.1.1** (fourth quarter 2022): Develop a WHO framework on the meaningful engagement of people living with NCDs and mental health conditions.

**Expected outcome:** WHO framework utilized by headquarters, regional and country offices and Member States to meaningfully engage people living with NCDs and mental



health conditions in the co-development and co-design of NCD principles, policies, programmes and services.

**Performance measures:**

- WHO framework includes balanced representation of Member States, with special focus on experiences of low- and middle-income countries across WHO regions.
- Analytics of unique downloads of the WHO framework by 2025.
- At least six countries supported in implementing the framework, including at least four low- and middle-income countries, by 2025.
- WHO framework presented and discussed in relevant international and regional forums (such as informal consultations, workshops, events and symposiums).
- Uptake by regional and country offices (such as specific requests to headquarters by country offices and/or regional offices, adaptation of the WHO framework, its inclusion in WHO toolkits and its featuring in institutional websites).

**Activity 5.1.2** (third and fourth quarters 2023): Develop policy briefs with regional offices on the principles, policies, strategies and structures necessary for meaningful engagement of people living with NCDs and mental health conditions.

**Expected outcome:** policy briefs utilized by Member States to inform country-level engagement with people living with NCDs and mental health conditions.

**Performance measures:**

- Six policy briefs developed and utilized by six Member States, including at least four low- and middle-income countries, by 2024.
- Analytics of unique downloads of the policy briefs by 2025.

**Activity 5.1.2** (January 2023): Conduct cycles 2, 3 and 4 of the NCD Lab in order to identify innovations that inform NCD- and NCD-related global health agendas.

**Expected outcome:** innovative solutions, contextualized to country context and available online, that target policy-level change, systems change or individual-level change, identified and disseminated through WHO platforms.

**Performance measures:**

- Labs conducted for cycles, 2, 3 and 4 for all thematic areas by 2023.
- 500 proposals submitted over the next two cycles by 2023.
- Analytics on unique views of NCD Lab webpages.

**Action 5.2:** Facilitate the meaningful engagement of people living with NCDs and mental health conditions within WHO and with Member States.

**Activity 5.2.1** (2022–2025): Establish and service a WHO symposium on people living with NCDs and mental health conditions in order to facilitate meaningful engagement and dialogue, support a co-creation process and mobilize individuals with lived experience for a highly successful fourth high-level meeting of the United Nations General Assembly on the prevention and control of noncommunicable diseases in 2025.

**Expected outcome:** ongoing dialogue and meaningful engagement with people living with NCDs and application of their lived experience and lessons learned that informs WHO's strategy to deliver on its key strategic objectives for the prevention and control of NCDs and mental health conditions.

**Performance measures:**

- Inclusive and diverse participation in a WHO symposium on people living with NCDs and mental health conditions, with structures that ensure adequate representation of different lived experiences, stakeholder groups, geographical regions and income settings.
- At least three WHO symposiums on people living with NCDs and mental health conditions held by 2025.
- At least 10 advocacy activities and outputs completed before the fourth high-level meeting of the United Nations General Assembly on the prevention and control of noncommunicable diseases in 2025.

**Activity 5.2.2** (second to fourth quarters 2023): Develop guidance on implementation of the guidance framework on the meaningful engagement of people living with NCDs and mental health conditions at country and regional levels.

**Expected outcome:** Guide, including adaptation process, conceptualization of the guidance framework, adaptation monitoring and evaluation and adaptation governance, utilized by country offices to support meaningful engagement with people living with NCDs and develop country-tailored national and subnational policies and programmes.

**Performance measure:** guide accessed by six Member States, including at least four low- and middle-income countries, and utilized to inform national plans by 2025.

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## ANNEX 16

### **Written statements – Guidelines for Member States<sup>1</sup>**

[A75/30 – 12 April 2022]

1. The following guidelines apply to written statements by Member States, relating to sessions of the World Health Assembly and Executive Board, to be posted on the dedicated WHO webpage.
2. Written statements are made available for information purposes. They are intended to stimulate debate and enable delegations to complement their oral interventions during the meetings of the WHO governing bodies. For example, they may expand upon the information provided by the Member State concerned during the discussion or may describe country experiences relevant to the agenda item concerned. Written statements may be submitted independently from the delivery of an oral intervention during the meeting, provided that they relate to an item on the agenda.
3. Member States may submit written statements by sending them to the following email address: [statements@who.int](mailto:statements@who.int). Statements intended for oral delivery must be submitted separately to the email address: [interpret@who.int](mailto:interpret@who.int).
4. Written statements may be submitted until the closure of the relevant session of the Health Assembly or Executive Board. Such statements will remain published until the closure of the relevant body's equivalent session two years later. Statements submitted after the closure of the relevant session of the Health Assembly or Executive Board will not be accepted.
5. For readability purposes, Member States are invited to limit their statements, as well as statements submitted on behalf of a region or group of countries, to 500 words and 800 words, respectively.
6. Each statement should clearly identify:
  - (a) the Member State submitting it or, in the event of regional statements, the region or group of countries on behalf of which the statement is submitted; and
  - (b) the governing body session and specific agenda item to which the statement relates.
7. Written statements should contain text only. No photographs, diagrams, maps or other media materials may be included.
8. Written statements may be provided in any of the six WHO official languages (Arabic, Chinese, English, French, Russian and Spanish) and will be published in the format and language of submission. Member States may provide translations of their written statements into one or more of WHO official languages, if they so wish. Such translations should be clearly marked with the words "unofficial translation".

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<sup>1</sup> See decision WHA75(11). See also document EB149/2021/REC/1, Annex 2.

9. Member States assume full responsibility for the content of their statements.
  10. Written statements should address the agenda item in respect of which they are submitted. They must not include any offensive language, including with respect to other Member States.
  11. The opportunity to post written statements on the dedicated webpage is without prejudice to the content of Member States' oral interventions during the meetings of the WHO governing bodies.
  12. Written statements do not replace or supplement the official records of the relevant meetings of the WHO governing bodies and do not constitute official WHO documents. The official records of meetings of the WHO governing bodies are exclusively based on statements delivered orally during the meeting, not the content of any written statement that the delegation concerned may have also submitted. The official records constitute the exclusive authoritative record of proceedings.
  13. The WHO logo will not appear on the statements but will appear on the webpage where the statements are posted.
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## ANNEX 17

### **Text of amended statutes of the Ihsan Dođramaci Family Health Foundation**

[A75/INF./3, Annex 2 – 18 May 2022]

#### *Article 6*

#### *Administration*

The Foundation shall be administrated by its Administrator, namely the Director-General of the World Health Organization. The Administrator shall implement the decisions of the Foundation Selection Panel, consisting of the Chairman of the Executive Board, the Chair of the Board of Trustees of Bilkent University, Turkey, or the Chair's appointee and a representative of the International Children's Center (Ankara) appointed by its Bureau. The presence of all members of the Panel shall be required for the taking of decisions.

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## ANNEX 18

### **Financial and administrative implications for the Secretariat of resolutions and decisions adopted by the Health Assembly**

<b>Resolution WHA75.6:</b> Extension of the Thirteenth General Programme of Work, 2019–2023 to 2025
<b>A. Link to the approved Programme budget 2022–2023</b>
<p><b>1. Output(s) in the approved Programme budget 2022–2023 to which this resolution would contribute:</b> The resolution would contribute to all outputs in the approved Programme budget 2022–2023. It is intended to extend the GPW 13 and would be implemented throughout the entirety of the approved Programme budget.</p>
<p><b>2. Short justification for considering the resolution, if there is no link to the results as indicated in the approved Programme budget 2022–2023:</b> Not applicable.</p>
<p><b>3. Any additional Secretariat work during the biennium 2022–2023 that cannot be covered by the approved Programme budget 2022–2023:</b> Not applicable.</p>
<p><b>4. Estimated timeframe (in years or months) to implement the resolution:</b> Two and a half years.</p>
<b>B. Resource implications for the Secretariat for implementation of the resolution</b>
<p><b>1. Total resource requirements to implement the resolution, in US\$ millions:</b> Work to be carried out relates to the ongoing work of the Organization as approved through the Programme budget so no additional costs foreseen to implement the resolution.</p>
<p><b>2.a. Estimated resource requirements already planned for in the approved Programme budget 2022–2023, in US\$ millions:</b> Not applicable.</p>
<p><b>2.b. Estimated resource requirements in addition to those already planned for in the approved Programme budget 2022–2023, in US\$ millions:</b> Not applicable.</p>
<p><b>3. Estimated resource requirements to be considered for the proposed programme budget for 2024–2025, in US\$ millions:</b> Not applicable.</p>
<p><b>4. Estimated resource requirements to be considered for the proposed programme budgets of future bienniums, in US\$ millions:</b> Not applicable.</p>

<p><b>5. Level of available resources to fund the implementation of the resolution in the current biennium, in US\$ millions:</b></p> <ul style="list-style-type: none"> <li>– <b>Resources available to fund the resolution in the current biennium:</b> Not applicable.</li> <li>– <b>Remaining financing gap in the current biennium:</b> Not applicable.</li> <li>– <b>Estimated resources, not yet available, if any, which would help to close the financing gap in the current biennium:</b> Not applicable.</li> </ul>
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GPW 13: Thirteenth General Programme of Work, 2019–2023.

<p><b>Resolution WHA75.7:</b> Strengthening health emergency preparedness and response in cities and urban settings</p>
<p><b>A. Link to the approved Programme budget 2022–2023</b></p>
<p><b>1. Output(s) in the approved Programme budget 2022–2023 to which this resolution would contribute:</b></p> <p>2.1.2. Capacities for emergency preparedness strengthened in all countries</p> <p>2.1.3. Countries operationally ready to assess and manage identified risks and vulnerabilities</p>
<p><b>2. Short justification for considering the resolution, if there is no link to the results as indicated in the approved Programme budget 2022–2023:</b></p> <p>Not applicable.</p>
<p><b>3. Any additional Secretariat work during the biennium 2022–2023 that cannot be covered by the approved Programme budget 2022–2023:</b></p> <p>Not applicable.</p>
<p><b>4. Estimated time frame (in years or months) to implement the resolution:</b></p> <p>Two years.</p>
<p><b>B. Resource implications for the Secretariat for implementation of the resolution</b></p>
<p><b>1. Total resource requirements to implement the resolution, in US\$ millions:</b></p> <p>US\$ 6.32 million.</p>
<p><b>2.a. Estimated resource requirements already planned for in the approved Programme budget 2022–2023, in US\$ millions:</b></p> <p>US\$ 5.16 million.</p>
<p><b>2.b. Estimated resource requirements in addition to those already planned for in the approved Programme budget 2022–2023, in US\$ millions:</b></p> <p>Not applicable.</p>
<p><b>3. Estimated resource requirements to be considered for the proposed programme budget for 2024–2025, in US\$ millions:</b></p> <p>US\$ 1.16 million.</p>

<p><b>4. Estimated resource requirements to be considered for the proposed programme budgets of future bienniums, in US\$ millions:</b></p> <p>Not applicable.</p>
<p><b>5. Level of available resources to fund the implementation of the resolution in the current biennium, in US\$ millions</b></p> <p>– <b>Resources available to fund the resolution in the current biennium:</b></p> <p>US\$ 1.60 million.</p> <p>– <b>Remaining financing gap in the current biennium:</b></p> <p>US\$ 3.56 million.</p> <p>– <b>Estimated resources, not yet available, if any, which would help to close the financing gap in the current biennium:</b></p> <p>Not applicable.</p>

**Table. Breakdown of estimated resource requirements (in US\$ millions)**

Biennium	Costs	Region						Headquarters	Total
		Africa	The Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific		
2022–2023 resources already planned	Staff	0.52	0.43	0.40	0.45	0.47	0.45	0.99	3.71
	Activities	0.14	0.15	0.15	0.15	0.15	0.15	0.56	1.45
	Total	0.66	0.58	0.55	0.60	0.62	0.60	1.55	5.16
2022–2023 additional resources	Staff	–	–	–	–	–	–	–	–
	Activities	–	–	–	–	–	–	–	–
	Total	–	–	–	–	–	–	–	–
2024–2025 resources to be planned	Staff	0.14	0.12	0.11	0.12	0.13	0.12	0.27	1.01
	Activities	0.01	0.01	0.01	0.01	0.01	0.01	0.09	0.15
	Total	0.15	0.13	0.12	0.13	0.14	0.13	0.36	1.16
Future bienniums resources to be planned	Staff	–	–	–	–	–	–	–	–
	Activities	–	–	–	–	–	–	–	–
	Total	–	–	–	–	–	–	–	–

<p><b>Resolution WHA75.8:</b> Strengthening clinical trials to provide high-quality evidence on health interventions and to improve research quality and coordination</p>
<p><b>A. Link to the approved Programme budget 2022–2023</b></p>
<p><b>1. Output(s) in the approved Programme budget 2022–2023 to which this resolution would contribute:</b></p> <p>4.1.3. Strengthened evidence base, prioritization and uptake of WHO generated norms and standards and improved research capacity and the ability to effectively and sustainably scale up innovations, including digital technology, in countries.</p>
<p><b>2. Short justification for considering the resolution, if there is no link to the results as indicated in the approved Programme budget 2022–2023:</b></p> <p>Not applicable.</p>



<b>3. Any additional Secretariat work during the biennium 2022–2023 that cannot be covered by the approved Programme budget 2022–2023:</b>
Not applicable.
<b>4. Estimated time frame (in years or months) to implement the resolution:</b>
One year.
<b>B. Resource implications for the Secretariat for implementation of the resolution</b>
<b>1. Total resource requirements to implement the resolution, in US\$ millions:</b>
US\$ 4.15 million.
<b>2.a. Estimated resource requirements already planned for in the approved Programme budget 2022–2023, in US\$ millions:</b>
US\$ 4.15 million.
<b>2.b. Estimated resource requirements in addition to those already planned for in the approved Programme budget 2022–2023, in US\$ millions:</b>
Not applicable.
<b>3. Estimated resource requirements to be considered for the proposed programme budget for 2024–2025, in US\$ millions:</b>
Not applicable.
<b>4. Estimated resource requirements to be considered for the proposed programme budgets of future bienniums, in US\$ millions:</b>
Not applicable.
<b>5. Level of available resources to fund the implementation of the resolution in the current biennium, in US\$ millions</b>
– <b>Resources available to fund the resolution in the current biennium:</b>
Zero.
– <b>Remaining financing gap in the current biennium:</b>
US\$ 4.15 million.
– <b>Estimated resources, not yet available, if any, which would help to close the financing gap in the current biennium:</b>
Not applicable.

**Table. Breakdown of estimated resource requirements (in US\$ millions)**

Biennium	Costs	Region						Headquarters	Total
		Africa	The Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific		
2022–2023 resources already planned	Staff	0.37	0.38	0.28	0.38	0.28	0.30	1.66	3.65
	Activities	0.03	0.02	0.02	0.02	0.02	0.05	0.34	0.50
	Total	0.40	0.40	0.30	0.40	0.30	0.35	2.00	4.15
2022–2023 additional resources	Staff	–	–	–	–	–	–	–	–
	Activities	–	–	–	–	–	–	–	–
	Total	–	–	–	–	–	–	–	–
2024–2025 resources to be planned	Staff	–	–	–	–	–	–	–	–
	Activities	–	–	–	–	–	–	–	–
	Total	–	–	–	–	–	–	–	–
Future bienniums resources to be planned	Staff	–	–	–	–	–	–	–	–
	Activities	–	–	–	–	–	–	–	–
	Total	–	–	–	–	–	–	–	–

<b>Resolution WHA75.11:</b> Health emergency in Ukraine and refugee-receiving and -hosting countries, stemming from the Russian Federation's aggression
<b>A. Link to the approved Programme budget 2022–2023</b>
<b>1. Output(s) in the approved Programme budget 2022–2023 to which this resolution would contribute:</b> 13.3.2. Acute health emergencies rapidly responded to, leveraging relevant national and international capacities.
<b>2. Short justification for considering the resolution, if there is no link to the results as indicated in the approved Programme budget 2022–2023:</b> Not applicable.
<b>3. Any additional Secretariat work during the biennium 2022–2023 that cannot be covered by the approved Programme budget 2022–2023:</b> Not applicable.
<b>4. Estimated time frame (in years or months) to implement the resolution:</b> Seven months.
<b>B. Resource implications for the Secretariat for implementation of the resolution</b>
<b>1. Total resource requirements to implement the resolution, in US\$ millions:</b> US\$ 147.50 million.
<b>2.a. Estimated resource requirements already planned for in the approved Programme budget 2022–2023, in US\$ millions:</b> Not applicable.
<b>2.b. Estimated resource requirements in addition to those already planned for in the approved Programme budget 2022–2023, in US\$ millions:</b> US\$ 147.50 million.



<b>Resolution WHA75.12:</b> Amendments to the International Health Regulations (2005)
<b>A. Link to the approved Programme budget 2022–2023</b>
<b>1. Output(s) in the approved Programme budget 2022–2023 to which this resolution would contribute:</b> 2.2.3. Mitigate the risk of the emergence and re-emergence of high-threat pathogens and improve pandemic preparedness
<b>2. Short justification for considering the resolution, if there is no link to the results as indicated in the approved Programme budget 2022–2023:</b> Not applicable.
<b>3. Any additional Secretariat work during the biennium 2022–2023 that cannot be covered by the approved Programme budget 2022–2023:</b> Not applicable.
<b>4. Estimated time frame (in years or months) to implement the resolution:</b> Two years.
<b>B. Resource implications for the Secretariat for implementation of the resolution</b>
<b>1. Total resource requirements to implement the resolution, in US\$ millions:</b> Zero.
<b>2.a. Estimated resource requirements already planned for in the approved Programme budget 2022–2023, in US\$ millions:</b> Not applicable.
<b>2.b. Estimated resource requirements in addition to those already planned for in the approved Programme budget 2022–2023, in US\$ millions:</b> Not applicable.
<b>3. Estimated resource requirements to be considered for the proposed programme budget for 2024–2025, in US\$ millions:</b> Not applicable.
<b>4. Estimated resource requirements to be considered for the proposed programme budgets of future bienniums, in US\$ millions:</b> Not applicable.
<b>5. Level of available resources to fund the implementation of the resolution in the current biennium, in US\$ millions</b> – <b>Resources available to fund the resolution in the current biennium:</b> Not applicable. – <b>Remaining financing gap in the current biennium:</b> Not applicable. – <b>Estimated resources, not yet available, if any, which would help to close the financing gap in the current biennium:</b> Not applicable.

<b>Resolution WHA75.13:</b> Global strategy on infection prevention and control	
<b>A. Link to the approved Programme budget 2022–2023</b>	
<b>1. Output(s) in the approved Programme budget 2022–2023 to which this resolution would contribute:</b>	1.1.1. Countries enabled to provide high-quality, people-centred health services, based on primary health care strategies and comprehensive essential service packages.
<b>2. Short justification for considering the resolution, if there is no link to the results as indicated in the approved Programme budget 2022–2023:</b>	Not applicable.
<b>3. Any additional Secretariat work during the biennium 2022–2023 that cannot be covered by the approved Programme budget 2022–2023:</b>	Not applicable.
<b>4. Estimated timeframe (in years or months) to implement the resolution:</b>	Nine years (2023–2031).
<b>B. Resource implications for the Secretariat for implementation of the resolution</b>	
<b>1. Total resource requirements to implement the resolution, in US\$ millions:</b>	US\$ 16.46 million.
<b>2.a. Estimated resource requirements already planned for in the approved Programme budget 2022–2023, in US\$ millions:</b>	US\$ 2.44 million.
<b>2.b. Estimated resource requirements in addition to those already planned for in the approved Programme budget 2022–2023, in US\$ millions:</b>	Not applicable.
<b>3. Estimated resource requirements to be considered for the proposed programme budget for 2024–2025, in US\$ millions:</b>	US\$ 3.53 million.
<b>4. Estimated resource requirements to be considered for the proposed programme budgets of future bienniums, in US\$ millions:</b>	US\$ 10.49 million.
<b>5. Level of available resources to fund the implementation of the resolution in the current biennium, in US\$ millions:</b>	<ul style="list-style-type: none"> <li>– Resources available to fund the resolution in the current biennium: US\$ 0.45 million.</li> <li>– Remaining financing gap in the current biennium: US\$ 1.99 million.</li> </ul>
	<ul style="list-style-type: none"> <li>– Estimated resources, not yet available, if any, which would help to close the financing gap in the current biennium: US\$ 0.50 million.</li> </ul>

**Table. Breakdown of estimated resource requirements (in US\$ millions)**

Biennium	Costs	Region						Headquarters	Total
		Africa	The Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific		
2022–2023 resources already planned	Staff	0.08	0.07	0.06	0.07	0.06	0.04	1.28	1.66
	Activities	0.05	0.05	0.05	0.05	0.05	0.05	0.48	0.78
	Total	0.13	0.12	0.11	0.12	0.11	0.09	1.76	2.44
2022–2023 additional resources	Staff	–	–	–	–	–	–	–	–
	Activities	–	–	–	–	–	–	–	–
	Total	–	–	–	–	–	–	–	–
2024–2025 resources to be planned	Staff	0.11	0.09	0.09	0.10	0.08	0.09	1.90	2.46
	Activities	0.10	0.10	0.10	0.10	0.10	0.10	0.47	1.07
	Total	0.21	0.19	0.19	0.20	0.18	0.19	2.37	3.53
Future bienniums resources to be planned	Staff	0.33	0.28	0.26	0.29	0.24	0.26	5.23	6.89
	Activities	0.30	0.30	0.30	0.30	0.30	0.30	1.80	3.60
	Total	0.63	0.58	0.56	0.59	0.54	0.56	7.03	10.49

**Resolution WHA75.14:** Global strategy and plan of action on public health, innovation and intellectual property

**A. Link to the approved Programme budget 2022–2023**

**1. Output(s) in the approved Programme budget 2022–2023 to which this resolution would contribute:**

1.3.1. Provision of authoritative guidance and standards on quality, safety and efficacy of health products, essential medicines and diagnostics lists

1.3.2. Improved and more equitable access to health products through global market shaping and supporting countries to monitor and ensure efficient and transparent procurement and supply systems

1.3.3. Country and regional regulatory capacity strengthened, and supply of quality-assured and safe health products improved, including through prequalification services

1.3.4. Research and development agenda defined and research coordinated in line with public health priorities

**2. Short justification for considering the resolution, if there is no link to the results as indicated in the approved Programme budget 2022–2023:**

Not applicable.

**3. Any additional Secretariat work during the biennium 2022–2023 that cannot be covered by the approved Programme budget 2022–2023:**

Not applicable.

**4. Estimated time frame (in years or months) to implement the resolution:**

Eight years.

**B. Resource implications for the Secretariat for implementation of the resolution**

**1. Total resource requirements to implement the resolution, in US\$ millions:**

US\$ 33.15 million for the period from 2023 to 2030.

<b>2.a. Estimated resource requirements already planned for in the approved Programme budget 2022–2023, in US\$ millions:</b>	US\$ 3.83 million.
<b>2.b. Estimated resource requirements in addition to those already planned for in the approved Programme budget 2022–2023, in US\$ millions:</b>	Zero.
<b>3. Estimated resource requirements to be considered for the proposed programme budget for 2024–2025, in US\$ millions:</b>	US\$ 7.96 million.
<b>4. Estimated resource requirements to be considered for the proposed programme budgets of future bienniums, in US\$ millions:</b>	US\$ 21.36 million (cumulative from 2026 to 2030).
<b>5. Level of available resources to fund the implementation of the resolution in the current biennium, in US\$ millions</b>	
– <b>Resources available to fund the resolution in the current biennium:</b>	US\$ 1.27 million.
– <b>Remaining financing gap in the current biennium:</b>	US\$ 2.56 million.
– <b>Estimated resources, not yet available, if any, which would help to close the financing gap in the current biennium:</b>	Discussions are ongoing with Member States and other donors to mobilize additional resources.

**Table. Breakdown of estimated resource requirements (in US\$ millions)<sup>a</sup>**

Biennium	Costs	Region						Headquarters	Total
		Africa	The Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific		
2022–2023 resources already planned	Staff	0.0	0.0	0.0	0.0	0.0	0.0	1.4	2.3
	Activities	0.0	0.0	0.0	0.0	0.0	0.0	0.9	1.5
	Total	0.0	0.0	0.0	0.0	0.0	0.0	2.3	3.8
2022–2023 additional resources	Staff	–	–	–	–	–	–	–	–
	Activities	–	–	–	–	–	–	–	–
	Total	–	–	–	–	–	–	–	–
2024–2025 resources to be planned	Staff	0.0	0.0	0.0	0.0	0.0	0.0	2.9	4.8
	Activities	0.0	0.0	0.0	0.0	0.0	0.0	1.9	3.2
	Total	0.0	0.0	0.0	0.0	0.0	0.0	4.8	8.0
Future bienniums resources to be planned	Staff	0.0	0.0	0.0	0.0	0.0	0.0	7.7	12.8
	Activities	0.0	0.0	0.0	0.0	0.0	0.0	5.1	8.5
	Total	0.0	0.0	0.0	0.0	0.0	0.0	12.8	21.4

<sup>a</sup> The row and column totals may not always add up, due to rounding.

Note: The difference between the total cost and the WHO headquarters cost is the total for investment in regions. At present, the work being carried out is in a fluid state where regional investment is planned to be scaled up, but the breakdown between regions is not yet finalized. The amounts required for headquarters as a whole are more easily calculated at present than for other major offices at the individual level.

<b>Resolution WHA75.17:</b> Human resources for health
<b>A. Link to the approved Programme budget 2022–2023</b>
<b>1. Output(s) in the approved Programme budget 2022–2023 to which this resolution would contribute:</b> 1.1.5. Countries enabled to strengthen their health and care workforce.
<b>2. Short justification for considering the resolution, if there is no link to the results as indicated in the approved Programme budget 2022–2023:</b> Not applicable.
<b>3. Any additional Secretariat work during the biennium 2022–2023 that cannot be covered by the approved Programme budget 2022–2023:</b> Not applicable.
<b>4. Estimated timeframe (in years or months) to implement the resolution:</b> Nine years (2022–2030).
<b>B. Resource implications for the Secretariat for implementation of the resolution</b>
<b>1. Total resource requirements to implement the resolution, in US\$ millions:</b> US\$ 445.17 million. These costs have been presented previously for resolution WHA74.14 in May 2021 and refined slightly to take into account lessons learned from the implementation process as well as minor changes in actual costs. This costing would replace the amount costed for resolution WHA74.14.
<b>2.a. Estimated resource requirements already planned for in the approved Programme budget 2022–2023, in US\$ millions:</b> US\$ 74.78 million.
<b>2.b. Estimated resource requirements in addition to those already planned for in the approved Programme budget 2022–2023, in US\$ millions:</b> Not applicable.
<b>3. Estimated resource requirements to be considered for the proposed programme budget for 2024–2025, in US\$ millions:</b> US\$ 107.68 million.
<b>4. Estimated resource requirements to be considered for the proposed programme budgets of future bienniums, in US\$ millions:</b> US\$ 262.71 million.
<b>5. Level of available resources to fund the implementation of the resolution in the current biennium, in US\$ millions:</b> – <b>Resources available to fund the resolution in the current biennium:</b> US\$ 39.34 million. – <b>Remaining financing gap in the current biennium:</b> US\$ 35.44 million. – <b>Estimated resources, not yet available, if any, which would help to close the financing gap in the current biennium:</b> US\$ 3.00 million.



**Table. Breakdown of estimated resource requirements (in US\$ millions) <sup>a</sup>**

Biennium	Costs	Region						Headquarters	Total
		Africa	The Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific		
2022–2023 resources already planned	Staff	16.16	1.62	3.18	1.16	4.75	2.13	11.04	40.05
	Activities	12.72	2.85	3.15	1.40	3.69	3.29	7.63	34.73
	Total	28.88	4.47	6.33	2.56	8.44	5.42	18.67	74.78
2022–2023 additional resources	Staff	–	–	–	–	–	–	–	–
	Activities	–	–	–	–	–	–	–	–
	Total	–	–	–	–	–	–	–	–
2024–2025 resources to be planned	Staff	23.28	2.34	4.57	1.67	6.83	3.07	15.90	57.67
	Activities	18.32	4.11	4.53	2.02	5.31	4.73	10.99	50.01
	Total	41.60	6.45	9.10	3.69	12.14	7.80	26.89	107.68
Future bienniums resources to be planned	Staff	56.79	5.71	11.16	4.08	16.67	7.48	38.80	140.69
	Activities	44.70	10.03	11.05	4.93	12.96	11.54	26.80	122.02
	Total	101.49	15.74	22.21	9.01	29.63	19.02	65.60	262.71

<sup>a</sup> The row and column totals may not always add up, due to rounding.

<b>Resolution WHA75.18:</b> Outcome of the SIDS Summit for Health: For a healthy and resilient future in small island developing States
<b>A. Link to the approved Programme budget 2022–2023</b>
<b>1. Output(s) in the approved Programme budget 2022–2023 to which this resolution would contribute:</b> 3.1.1. Countries enabled to address social determinants of health across the life course 3.3.1. Countries enabled to address environmental determinants, including climate change
<b>2. Short justification for considering the resolution, if there is no link to the results as indicated in the approved Programme budget 2022–2023:</b> Not applicable.
<b>3. Any additional Secretariat work during the biennium 2022–2023 that cannot be covered by the approved Programme budget 2022–2023:</b> Not applicable.
<b>4. Estimated time frame (in years or months) to implement the resolution:</b> Two years.
<b>B. Resource implications for the Secretariat for implementation of the resolution</b>
<b>1. Total resource requirements to implement the resolution, in US\$ millions:</b> US\$ 3.35 million.
<b>2.a. Estimated resource requirements already planned for in the approved Programme budget 2022–2023, in US\$ millions:</b> US\$ 3.35 million.
<b>2.b. Estimated resource requirements in addition to those already planned for in the approved Programme budget 2022–2023, in US\$ millions:</b> Not applicable.



<b>Resolution WHA75.19: Well-being and health promotion</b>	
<b>A. Link to the approved Programme budget 2022–2023</b>	
<b>1. Output(s) in the approved Programme budget 2022–2023 to which this resolution would contribute:</b>	<p>3.2.1. Countries enabled to address risk factors through multisectoral actions</p> <p>3.2.2. Countries enabled to reinforce partnerships across sectors, as well as governance mechanisms, laws and fiscal measures</p> <p>3.3.1. Countries enabled to address environmental determinants, including climate change</p> <p>3.3.2. Countries supported to create an enabling environment for healthy settings</p>
<b>2. Short justification for considering the resolution, if there is no link to the results as indicated in the approved Programme budget 2022–2023:</b>	Not applicable.
<b>3. Any additional Secretariat work during the biennium 2022–2023 that cannot be covered by the approved Programme budget 2022–2023:</b>	Not applicable.
<b>4. Estimated time frame (in years or months) to implement the resolution:</b>	Ten years (2022–2031).
<b>B. Resource implications for the Secretariat for implementation of the resolution</b>	
<b>1. Total resource requirements to implement the resolution, in US\$ millions:</b>	US\$ 10.58 million.
<b>2.a. Estimated resource requirements already planned for in the approved Programme budget 2022–2023, in US\$ millions:</b>	US\$ 1.96 million.
<b>2.b. Estimated resource requirements in addition to those already planned for in the approved Programme budget 2022–2023, in US\$ millions:</b>	Not applicable.
<b>3. Estimated resource requirements to be considered for the proposed programme budget for 2024–2025, in US\$ millions:</b>	US\$ 1.99 million.
<b>4. Estimated resource requirements to be considered for the proposed programme budgets of future bienniums, in US\$ millions:</b>	US\$ 6.63 million.
<b>5. Level of available resources to fund the implementation of the resolution in the current biennium, in US\$ millions</b>	
– <b>Resources available to fund the resolution in the current biennium:</b>	US\$ 1.96 million.
– <b>Remaining financing gap in the current biennium:</b>	Not applicable.
– <b>Estimated resources, not yet available, if any, which would help to close the financing gap in the current biennium:</b>	Not applicable.

**Table. Breakdown of estimated resource requirements (in US\$ millions)**

Biennium	Costs	Region						Headquarters	Total
		Africa	The Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific		
2022–2023 resources already planned	Staff	0.12	0.10	0.10	0.12	0.09	0.09	0.20	0.82
	Activities	0.11	0.10	0.11	0.11	0.11	0.10	0.50	1.14
	Total	0.23	0.20	0.21	0.23	0.20	0.19	0.70	1.96
2022–2023 additional resources	Staff	–	–	–	–	–	–	–	–
	Activities	–	–	–	–	–	–	–	–
	Total	–	–	–	–	–	–	–	–
2024–2025 resources to be planned	Staff	0.12	0.10	0.10	0.12	0.09	0.09	0.21	0.83
	Activities	0.11	0.10	0.11	0.11	0.11	0.10	0.52	1.16
	Total	0.23	0.20	0.21	0.23	0.20	0.19	0.73	1.99
Future bienniums resources to be planned	Staff	0.41	0.34	0.34	0.41	0.30	0.30	0.68	2.78
	Activities	0.37	0.34	0.37	0.37	0.37	0.34	1.69	3.85
	Total	0.78	0.68	0.71	0.78	0.67	0.64	2.37	6.63

<b>Resolution WHA75.20:</b> The global health sector strategies on, respectively, HIV, viral hepatitis and sexually transmitted infections
<b>A. Link to the approved Programme budget 2022–2023</b>
<p><b>1. Output(s) in the approved Programme budget 2022–2023 to which this resolution would contribute:</b></p> <p>1.1.1. Countries enabled to provide high-quality, people-centred health services, based on primary health care strategies and comprehensive essential service packages</p> <p>1.1.2. Countries enabled to strengthen their health systems to deliver on condition- and disease-specific service coverage results</p> <p>1.1.3. Countries enabled to strengthen their health systems to address population-specific health needs and barriers to equity across the life course</p> <p>1.3.2. Improved and more equitable access to health products through global market shaping and supporting countries to monitor and ensure efficient and transparent procurement and supply systems</p>
<p><b>2. Short justification for considering the resolution, if there is no link to the results as indicated in the approved Programme budget 2022–2023:</b></p> <p>Not applicable.</p>
<p><b>3. Any additional Secretariat work during the biennium 2022–2023 that cannot be covered by the approved Programme budget 2022–2023:</b></p> <p>Not applicable.</p>
<p><b>4. Estimated time frame (in years or months) to implement the resolution:</b></p> <p>Nine years.</p>
<b>B. Resource implications for the Secretariat for implementation of the resolution</b>
<p><b>1. Total resource requirements to implement the resolution, in US\$ millions:</b></p> <p>US\$ 696.70 million.</p>

<p><b>2.a. Estimated resource requirements already planned for in the approved Programme budget 2022–2023, in US\$ millions:</b></p> <p>US\$ 149.40 million.</p> <p><b>2.b. Estimated resource requirements in addition to those already planned for in the approved Programme budget 2022–2023, in US\$ millions:</b></p> <p>Not applicable.</p>
<p><b>3. Estimated resource requirements to be considered for the proposed programme budget for 2024–2025, in US\$ millions:</b></p> <p>US\$ 152.40 million.</p>
<p><b>4. Estimated resource requirements to be considered for the programme budgets of future bienniums, in US\$ millions:</b></p> <p>US\$ 394.90 million.</p>
<p><b>5. Level of available resources to fund the implementation of the resolution in the current biennium, in US\$ millions</b></p> <p>– <b>Resources available to fund the resolution in the current biennium:</b></p> <p>US\$ 112.10 million.</p> <p>– <b>Remaining financing gap in the current biennium:</b></p> <p>US\$ 37.30 million.</p> <p>This includes the resources to fully fund the WHO Regional Office for Africa and to address the shortfall in funding for viral hepatitis and sexually transmitted infections programme activities across the three levels of the Organization.</p> <p>– <b>Estimated resources, not yet available, if any, which would help to close the financing gap in the current biennium:</b></p> <p>Not applicable.</p>

**Table. Breakdown of estimated resource requirements (in US\$ millions)**

Biennium	Costs	Region						Headquarters	Total
		Africa	The Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific		
2022–2023 resources already planned	Staff	36.20	5.10	9.10	5.20	5.10	9.30	34.70	104.70
	Activities	15.50	2.10	3.90	2.30	2.10	4.00	14.80	44.70
	Total	51.70	7.20	13.00	7.50	7.20	13.30	49.50	149.40
2022–2023 additional resources	Staff	–	–	–	–	–	–	–	–
	Activities	–	–	–	–	–	–	–	–
	Total	–	–	–	–	–	–	–	–
2024–2025 resources to be planned	Staff	36.90	5.20	9.20	5.40	5.30	9.50	35.40	106.90
	Activities	15.80	2.20	3.90	2.30	2.20	4.00	15.10	45.50
	Total	52.70	7.40	13.10	7.70	7.50	13.50	50.50	152.40
Future bienniums resources to be planned	Staff	95.70	13.40	23.90	13.90	13.60	24.50	91.50	276.50
	Activities	41.00	5.70	10.20	6.00	5.80	10.50	39.20	118.40
	Total	136.70	19.10	34.10	19.90	19.40	35.00	130.70	394.90

<b>Decision WHA75(8):</b> Sustainable financing
<b>A. Link to the approved Programme budget 2022–2023</b>
<p><b>1. Output(s) in the approved Programme budget 2022–2023 to which this decision would contribute:</b></p> <p>4.2.1. Leadership, governance and external relations enhanced to implement GPW 13 and drive impact in an aligned manner at the country level, on the basis of strategic communications and in accordance with the Sustainable Development Goals in the context of United Nations reform</p> <p>4.2.3. Strategic priorities resourced in a predictable, adequate and flexible manner through strengthening partnerships</p> <p>4.2.4. Planning, allocation of resources, monitoring and reporting based on country priorities, carried out to achieve country impact, value-for-money and the strategic priorities of GPW 13</p>
<p><b>2. Short justification for considering the decision, if there is no link to the results as indicated in the approved Programme budget 2022–2023:</b></p> <p>Not applicable.</p>
<p><b>3. Any additional Secretariat work during the biennium 2022–2023 that cannot be covered by the approved Programme budget 2022–2023:</b></p> <p>Not applicable.</p>
<p><b>4. Estimated time frame (in years or months) to implement the decision:</b></p> <p>One year (June 2022–May 2023).</p>
<b>B. Resource implications for the Secretariat for implementation of the decision</b>
<p><b>1. Total resource requirements to implement the decision, in US\$ millions:</b></p> <p>US\$ 3.0 million.</p>
<p><b>2.a. Estimated resource requirements already planned for in the approved Programme budget 2022–2023, in US\$ millions:</b></p> <p>US\$ 3.0 million.</p>
<p><b>2.b. Estimated resource requirements in addition to those already planned for in the approved Programme budget 2022–2023, in US\$ millions:</b></p> <p>Not applicable.</p>
<p><b>3. Estimated resource requirements to be considered for the proposed programme budget for 2024–2025, in US\$ millions:</b></p> <p>Not applicable.</p>
<p><b>4. Estimated resource requirements to be considered for the proposed programme budgets of future bienniums, in US\$ millions:</b></p> <p>Not applicable.</p>
<p><b>5. Level of available resources to fund the implementation of the decision in the current biennium, in US\$ millions</b></p> <p>– <b>Resources available to fund the decision in the current biennium:</b> US\$ 3.0 million (assuming full distribution of flexible funds to carry out these fully enabling functions).</p>
<p>– <b>Remaining financing gap in the current biennium:</b> Zero.</p>
<p>– <b>Estimated resources, not yet available, if any, which would help to close the financing gap in the current biennium:</b> Not applicable.</p>

**Table. Breakdown of estimated resource requirements (in US\$ millions)**

Biennium	Costs	Region						Headquarters	Total
		Africa	The Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific		
2022–2023 resources already planned	Staff	0.28	0.14	0.21	0.23	0.19	0.21	0.94	2.20
	Activities	0.04	0.04	0.04	0.04	0.04	0.04	0.56	0.80
	Total	0.32	0.18	0.25	0.27	0.23	0.25	1.50	3.00
2022–2023 additional resources	Staff	–	–	–	–	–	–	–	–
	Activities	–	–	–	–	–	–	–	–
	Total	–	–	–	–	–	–	–	–
2024–2025 resources to be planned	Staff	–	–	–	–	–	–	–	–
	Activities	–	–	–	–	–	–	–	–
	Total	–	–	–	–	–	–	–	–
Future bienniums resources to be planned	Staff	–	–	–	–	–	–	–	–
	Activities	–	–	–	–	–	–	–	–
	Total	–	–	–	–	–	–	–	–

<b>Decision WHA75(9):</b> Strengthening WHO preparedness for and response to health emergencies
<b>A. Link to the approved Programme budget 2022–2023</b>
<b>1. Output(s) in the approved Programme budget 2022–2023 to which this decision would contribute:</b> 2.1.1. All-hazards emergency preparedness capacities in countries assessed and reported 2.1.2. Capacities for emergency preparedness strengthened in all countries
<b>2. Short justification for considering the decision, if there is no link to the results as indicated in the approved Programme budget 2022–2023:</b> Not applicable.
<b>3. Any additional Secretariat work during the biennium 2022–2023 that cannot be covered by the approved Programme budget 2022–2023:</b> Not applicable.
<b>4. Estimated time frame (in years or months) to implement the decision:</b> 24 months (June 2022–May 2024).
<b>B. Resource implications for the Secretariat for implementation of the decision</b>
<b>1. Total resource requirements to implement the decision, in US\$ millions:</b> US\$ 6.75 million. The activities referred to in paragraph 4(a) (i) and (ii) of the decision have already been costed under resolution WHA74.7 (2021) and so are not costed again here.
<b>2.a. Estimated resource requirements already planned for in the approved Programme budget 2022–2023, in US\$ millions:</b> US\$ 5.75 million.
<b>2.b. Estimated resource requirements in addition to those already planned for in the approved Programme budget 2022–2023, in US\$ millions:</b> Not applicable.





<b>Decision WHA75(10):</b>	Health conditions in the occupied Palestinian territory, including east Jerusalem, and in the occupied Syrian Golan
<b>A. Link to the approved Programme budget 2022–2023</b>	
<b>1. Output(s) in the approved Programme budget 2022–2023 to which this decision would contribute:</b>	<p>4.2.1. Leadership, governance and external relations enhanced to implement GPW 13 and drive impact in an aligned manner at the country level, on the basis of strategic communications and in accordance with the Sustainable Development Goals in the context of United Nations reform.</p> <p>4.2.4. Planning, allocation of resources, monitoring and reporting based on country priorities, carried out to achieve country impact, value-for-money and the strategic priorities of GPW 13.</p> <p>4.3.4. Safe and secure environment, with efficient infrastructure maintenance, cost-effective support services and responsive supply chain, including occupational health and safety.</p> <p>13.3.1. Health emergencies rapidly detected and responded to.</p> <p>13.3.3. Essential health services and systems maintained and strengthened in fragile, conflict-affected and vulnerable settings.</p>
<b>2. Short justification for considering the decision, if there is no link to the results as indicated in the approved Programme budget 2022–2023:</b>	Not applicable.
<b>3. Any additional Secretariat work during the biennium 2022–2023 that cannot be covered by the approved Programme budget 2022–2023:</b>	Not applicable.
<b>4. Estimated time frame (in years or months) to implement the decision:</b>	One year (May 2022–May 2023).
<b>B. Resource implications for the Secretariat for implementation of the decision</b>	
<b>1. Total resource requirements to implement the decision, in US\$ millions:</b>	US\$ 12.00 million.
<b>2.a. Estimated resource requirements already planned for in the approved Programme budget 2022–2023, in US\$ millions:</b>	US\$ 10.00 million.
<b>2.b. Estimated resource requirements in addition to those already planned for in the approved Programme budget 2022–2023, in US\$ millions:</b>	US\$ 2.00 million.
<b>3. Estimated resource requirements to be considered for the proposed programme budget for 2024–2025, in US\$ millions:</b>	Not applicable.
<b>4. Estimated resource requirements to be considered for the proposed programme budgets of future bienniums, in US\$ millions:</b>	Not applicable.



<b>Decision WHA75(11):</b>	Follow-up to the political declaration of the third high-level meeting of the General Assembly on the prevention and control of non-communicable diseases <sup>1</sup>
<b>A. Link to the approved Programme budget 2022–2023</b>	
<b>1. Output(s) in the approved Programme budget 2022–2023 to which this decision would contribute:</b>	<p>1.1.1. Countries enabled to provide high-quality, people-centred health services, based on primary health care strategies and comprehensive essential service packages</p> <p>1.1.2. Countries enabled to strengthen their health systems to deliver on condition- and disease-specific service coverage results</p> <p>1.3.2. Improved and more equitable access to health products through global market shaping and supporting countries to monitor and ensure efficient and transparent procurement and supply systems</p> <p>2.3.3. Essential health services and systems maintained and strengthened in fragile, conflict-affected and vulnerable settings</p> <p>3.2.1. Countries enabled to address risk factors through multisectoral actions</p> <p>3.2.2. Countries enabled to reinforce partnerships across sectors, as well as governance mechanisms, laws and fiscal measures</p> <p>3.3.1. Countries enabled to address environmental determinants, including climate change</p>
<b>2. Short justification for considering the decision, if there is no link to the results as indicated in the approved Programme budget 2022–2023:</b>	Not applicable.
<b>3. Any additional Secretariat work during the biennium 2022–2023 that cannot be covered by the approved Programme budget 2022–2023:</b>	Not applicable.

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<sup>1</sup> Note: This costing derives from the combined costings of eight separate appendices. This applies both to the different amounts and to the implementation time frames. Individual costings are presented as appendices to this Annex.

The individual appendices are:

1. Implementation road map 2023–2030 for the global action plan for the prevention and control of noncommunicable diseases 2013–2030 (see Annex 8)
2. Recommendations to strengthen and monitor diabetes responses within national noncommunicable disease programmes, including targets (see Annex 9)
3. Global strategy on oral health (see Annex 10)
4. Recommendations on how to strengthen the design and implementation of policies, including those for resilient health systems and health services and infrastructure, to treat people living with noncommunicable diseases and to prevent and control their risk factors in humanitarian emergencies (see Annex 11)
5. Intersectoral global action plan on epilepsy and other neurological disorders 2022–2031 (see Annex 12)
6. Action plan (2022–2030) to effectively implement the global strategy to reduce the harmful use of alcohol as a public health priority (see Annex 13)
7. Recommendations for the prevention and management of obesity over the life course, including considering the development of targets in this regard (see Annex 14)
8. Workplan for the global coordination mechanism on the prevention and control of noncommunicable diseases 2022–2025 (see Annex 15).

<b>4. Estimated time frame (in years or months) to implement the decision:</b> 10 years.
<b>B. Resource implications for the Secretariat for implementation of the decision</b>
<b>1. Total resource requirements to implement the decision, in US\$ millions:</b> US\$ 252.62 million.
<b>2.a. Estimated resource requirements already planned for in the approved Programme budget 2022–2023, in US\$ millions:</b> US\$ 38.51 million.
<b>2.b. Estimated resource requirements in addition to those already planned for in the approved Programme budget 2022–2023, in US\$ millions:</b> Zero.
<b>3. Estimated resource requirements to be considered for the proposed programme budget for 2024–2025, in US\$ millions:</b> US\$ 63.72 million.
<b>4. Estimated resource requirements to be considered for the proposed programme budgets of future bienniums, in US\$ millions:</b> US\$ 150.39 million.
<b>5. Level of available resources to fund the implementation of the decision in the current biennium, in US\$ millions</b> <ul style="list-style-type: none"> <li>– <b>Resources available to fund the decision in the current biennium:</b> US\$ 23.75 million.</li> <li>– <b>Remaining financing gap in the current biennium:</b> US\$ 14.76 million.</li> <li>– <b>Estimated resources, not yet available, if any, which would help to close the financing gap in the current biennium:</b> Various donor negotiations are ongoing.</li> </ul>

**Table. Breakdown of estimated resource requirements (in US\$ millions)<sup>a</sup>**

Biennium	Costs	Region						Headquarters	Total
		Africa	The Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific		
2022–2023 resources already planned	Staff	2.19	1.53	1.09	1.90	1.06	1.11	10.72	19.60
	Activities	2.50	1.80	1.35	2.00	2.10	1.45	7.71	18.91
	Total	4.69	3.33	2.44	3.90	3.16	2.56	18.43	38.51
2022–2023 additional resources	Staff	–	–	–	–	–	–	–	–
	Activities	–	–	–	–	–	–	–	–
	Total	–	–	–	–	–	–	–	–
2024–2025 resources to be planned	Staff	4.21	3.13	2.76	2.92	2.84	2.48	9.66	28.02
	Activities	5.53	3.80	4.41	4.25	5.00	4.37	8.34	35.70
	Total	9.74	6.93	7.17	7.17	7.84	6.85	18.01	63.72
Future bienniums resources to be planned	Staff	7.15	6.49	5.66	6.66	4.22	5.49	17.55	53.21
	Activities	14.50	13.40	13.83	14.22	12.78	13.91	14.54	97.18
	Total	21.65	19.89	19.48	20.88	17.01	19.40	32.08	150.39

<sup>a</sup> The row and column totals may not always add up, due to rounding.

<b>Decision WHA75(17):</b> Availability, safety and quality of blood products
<b>A. Link to the approved Programme budget 2022–2023</b>
<b>1. Output(s) in the approved Programme budget 2022–2023 to which this decision would contribute:</b> 1.3.3. Country and regional regulatory capacity strengthened, and supply of quality-assured and safe health products improved, including through prequalification services
<b>2. Short justification for considering the decision, if there is no link to the results as indicated in the approved Programme budget 2022–2023:</b> Not applicable.
<b>3. Any additional Secretariat work during the biennium 2022–2023 that cannot be covered by the approved Programme budget 2022–2023:</b> Not applicable.
<b>4. Estimated time frame (in years or months) to implement the decision:</b> Eight years.
<b>B. Resource implications for the Secretariat for implementation of the decision</b>
<b>1. Total resource requirements to implement the decision, in US\$ millions:</b> Zero. Work to be carried out involves the preparation of reports on progress made so no additional costs are foreseen to implement the decision.

<p><b>2.a. Estimated resource requirements already planned for in the approved Programme budget 2022–2023, in US\$ millions:</b></p> <p>Zero.</p>
<p><b>2.b. Estimated resource requirements in addition to those already planned for in the approved Programme budget 2022–2023, in US\$ millions:</b></p> <p>Zero.</p>
<p><b>3. Estimated resource requirements to be considered for the proposed programme budget for 2024–2025, in US\$ millions:</b></p> <p>Zero.</p>
<p><b>4. Estimated resource requirements to be considered for the proposed programme budgets of future bienniums, in US\$ millions:</b></p> <p>Zero.</p>
<p><b>5. Level of available resources to fund the implementation of the decision in the current biennium, in US\$ millions</b></p> <p>– <b>Resources available to fund the decision in the current biennium:</b></p> <p>Not applicable.</p> <p>– <b>Remaining financing gap in the current biennium:</b></p> <p>Not applicable.</p>
<p>– <b>Estimated resources, not yet available, if any, which would help to close the financing gap in the current biennium:</b></p> <p>Not applicable.</p>

<p><b>Decision WHA75(18):</b> Human organ and tissue transplantation</p>
<p><b>A. Link to the approved Programme budget 2022–2023</b></p>
<p><b>1. Output(s) in the approved Programme budget 2022–2023 to which this decision would contribute:</b></p> <p>1.3.3. Country and regional regulatory capacity strengthened, and supply of quality-assured and safe health products improved, including through prequalification services</p>
<p><b>2. Short justification for considering the decision, if there is no link to the results as indicated in the approved Programme budget 2022–2023:</b></p> <p>Not applicable.</p>
<p><b>3. Any additional Secretariat work during the biennium 2022–2023 that cannot be covered by the approved Programme budget 2022–2023:</b></p> <p>Not applicable.</p>
<p><b>4. Estimated time frame (in years or months) to implement the decision:</b></p> <p>Eight years.</p>

<b>B. Resource implications for the Secretariat for implementation of the decision</b>
<p><b>1. Total resource requirements to implement the decision, in US\$ millions:</b> Zero. Work to be carried out involves the preparation of reports on progress made so no additional costs are foreseen to implement the decision.</p>
<p><b>2.a. Estimated resource requirements already planned for in the approved Programme budget 2022–2023, in US\$ millions:</b> Zero.</p>
<p><b>2.b. Estimated resource requirements in addition to those already planned for in the approved Programme budget 2022–2023, in US\$ millions:</b> Zero.</p>
<p><b>3. Estimated resource requirements to be considered for the proposed programme budget for 2024–2025, in US\$ millions:</b> Zero.</p>
<p><b>4. Estimated resource requirements to be considered for the proposed programme budgets of future bienniums, in US\$ millions:</b> Zero.</p>
<p><b>5. Level of available resources to fund the implementation of the decision in the current biennium, in US\$ millions</b></p> <ul style="list-style-type: none"> <li>– <b>Resources available to fund the decision in the current biennium:</b> Not applicable.</li> <li>– <b>Remaining financing gap in the current biennium:</b> Not applicable.</li> <li>– <b>Estimated resources, not yet available, if any, which would help to close the financing gap in the current biennium:</b> Not applicable.</li> </ul>

<b>Decision WHA75(19):</b> Traditional medicine
<b>A. Link to the approved Programme budget 2022–2023</b>
<p><b>1. Output(s) in the approved Programme budget 2022–2023 to which this decision would contribute:</b> 1.1.1. Countries enabled to provide high-quality, people-centred health services, based on primary health care strategies and comprehensive essential service packages</p>
<p><b>2. Short justification for considering the decision, if there is no link to the results as indicated in the approved Programme budget 2022–2023:</b> Not applicable.</p>

<p><b>3. Any additional Secretariat work during the biennium 2022–2023 that cannot be covered by the approved Programme budget 2022–2023:</b> Not applicable.</p>
<p><b>4. Estimated time frame (in years or months) to implement the decision:</b> One year (June 2022–May 2023).</p>
<p><b>B. Resource implications for the Secretariat for implementation of the decision</b></p>
<p><b>1. Total resource requirements to implement the decision, in US\$ millions:</b> Zero. Work to be carried out involves the preparation of a final report on progress made so no additional costs are foreseen to implement the decision.</p>
<p><b>2.a. Estimated resource requirements already planned for in the approved Programme budget 2022–2023, in US\$ millions:</b> Not applicable.</p>
<p><b>2.b. Estimated resource requirements in addition to those already planned for in the approved Programme budget 2022–2023, in US\$ millions:</b> Not applicable.</p>
<p><b>3. Estimated resource requirements to be considered for the proposed programme budget for 2024–2025, in US\$ millions:</b> Not applicable.</p>
<p><b>4. Estimated resource requirements to be considered for the proposed programme budgets of future bienniums, in US\$ millions:</b> Not applicable.</p>
<p><b>5. Level of available resources to fund the implementation of the decision in the current biennium, in US\$ millions</b></p> <ul style="list-style-type: none"> <li>– <b>Resources available to fund the decision in the current biennium:</b> Not applicable.</li> <li>– <b>Remaining financing gap in the current biennium:</b> Not applicable.</li> <li>– <b>Estimated resources, not yet available, if any, which would help to close the financing gap in the current biennium:</b> Not applicable.</li> </ul>



<b>Decision WHA75(20):</b> Public health dimension of the world drug problem
<b>A. Link to the approved Programme budget 2022–2023</b>
<p><b>1. Output(s) in the approved Programme budget 2022–2023 to which this decision would contribute:</b></p> <p>1.1.2. Countries enabled to strengthen their health systems to deliver on condition- and disease-specific service coverage results</p> <p>1.3.1. Provision of authoritative guidance and standards on quality, safety and efficacy of health products, essential medicines and diagnostics lists</p> <p>3.2.1. Countries enabled to address risk factors through multisectoral actions</p>
<p><b>2. Short justification for considering the decision, if there is no link to the results as indicated in the approved Programme budget 2022–2023:</b></p> <p>Not applicable.</p>
<p><b>3. Any additional Secretariat work during the biennium 2022–2023 that cannot be covered by the approved Programme budget 2022–2023:</b></p> <p>Not applicable.</p>
<p><b>4. Estimated time frame (in years or months) to implement the decision:</b></p> <p>Eight years (2023–2030).</p>
<b>B. Resource implications for the Secretariat for implementation of the decision</b>
<p><b>1. Total resource requirements to implement the decision, in US\$ millions:</b></p> <p>US\$ 20.71 million.</p>
<p><b>2.a. Estimated resource requirements already planned for in the approved Programme budget 2022–2023, in US\$ millions:</b></p> <p>US\$ 2.39 million.</p>
<p><b>2.b. Estimated resource requirements in addition to those already planned for in the approved Programme budget 2022–2023, in US\$ millions:</b></p> <p>Not applicable.</p>
<p><b>3. Estimated resource requirements to be considered for the proposed programme budget for 2024–2025, in US\$ millions:</b></p> <p>US\$ 4.97 million.</p>
<p><b>4. Estimated resource requirements to be considered for the proposed programme budgets of future bienniums, in US\$ millions:</b></p> <p>US\$ 13.35 million (2026–2030).</p>
<p><b>5. Level of available resources to fund the implementation of the decision in the current biennium, in US\$ millions</b></p> <p>– <b>Resources available to fund the decision in the current biennium:</b></p> <p>US\$ 0.94 million.</p> <p>– <b>Remaining financing gap in the current biennium:</b></p> <p>US\$ 1.45 million.</p> <p>– <b>Estimated resources, not yet available, if any, which would help to close the financing gap in the current biennium:</b></p> <p>US\$ 1.5 million.</p>

**Table. Breakdown of estimated resource requirements (in US\$ millions)**

Biennium	Costs	Region						Headquarters	Total
		Africa	The Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific		
2022–2023 resources already planned	Staff	0.00	0.00	0.00	0.00	0.00	0.00	1.84	1.84
	Activities	0.00	0.00	0.00	0.00	0.00	0.00	0.55	0.55
	Total	0.00	0.00	0.00	0.00	0.00	0.00	2.39	2.39
2022–2023 additional resources	Staff	–	–	–	–	–	–	–	–
	Activities	–	–	–	–	–	–	–	–
	Total	–	–	–	–	–	–	–	–
2024–2025 resources to be planned	Staff	0.00	0.00	0.00	0.00	0.00	0.00	3.49	3.49
	Activities	0.00	0.00	0.00	0.00	0.00	0.00	1.48	1.48
	Total	0.00	0.00	0.00	0.00	0.00	0.00	4.97	4.97
Future bienniums resources to be planned	Staff	0.00	0.00	0.00	0.00	0.00	0.00	9.37	9.37
	Activities	0.00	0.00	0.00	0.00	0.00	0.00	3.98	3.98
	Total	0.00	0.00	0.00	0.00	0.00	0.00	13.35	13.35

Note: The activities carried out to implement this decision are coordinated at the WHO headquarters level through expert committees and other advisory groups. Because of the normative nature of the activities, most of the work is similarly carried out at the headquarters level. These activities involve the participation of country experts from all WHO regions who contribute to this work in their personal capacity.

<b>Decision WHA75(21):</b> Maternal, infant and young child nutrition
<b>A. Link to the approved Programme budget 2022–2023</b>
<b>1. Output(s) in the approved Programme budget 2022–2023 to which this decision would contribute:</b> 3.1.2. Countries enabled to strengthen equitable access to safe, healthy and sustainably produced foods through a One Health approach
<b>2. Short justification for considering the decision, if there is no link to the results as indicated in the approved Programme budget 2022–2023:</b> Not applicable.
<b>3. Any additional Secretariat work during the biennium 2022–2023 that cannot be covered by the approved Programme budget 2022–2023:</b> Not applicable.
<b>4. Estimated time frame (in years or months) to implement the decision:</b> 18 months.
<b>B. Resource implications for the Secretariat for implementation of the decision</b>
<b>1. Total resource requirements to implement the decision, in US\$ millions:</b> US\$ 0.60 million.
<b>2.a. Estimated resource requirements already planned for in the approved Programme budget 2022–2023, in US\$ millions:</b> US\$ 0.60 million.
<b>2.b. Estimated resource requirements in addition to those already planned for in the approved Programme budget 2022–2023, in US\$ millions:</b> Not applicable.

<b>3. Estimated resource requirements to be considered for the proposed programme budget for 2024–2025, in US\$ millions:</b> Not applicable.
<b>4. Estimated resource requirements to be considered for the programme budgets of future bienniums, in US\$ millions:</b> Not applicable.
<b>5. Level of available resources to fund the implementation of the decision in the current biennium, in US\$ millions</b> – <b>Resources available to fund the decision in the current biennium:</b> US\$ 0.60 million. – <b>Remaining financing gap in the current biennium:</b> Not applicable. – <b>Estimated resources, not yet available, if any, which would help to close the financing gap in the current biennium:</b> Not applicable.

**Table. Breakdown of estimated resource requirements (in US\$ millions)**

Biennium	Costs	Region						Headquarters	Total
		Africa	The Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific		
2022–2023 resources already planned	Staff	0.00	0.00	0.00	0.00	0.00	0.00	0.40	0.40
	Activities	0.00	0.00	0.00	0.00	0.00	0.00	0.20	0.20
	Total	0.00	0.00	0.00	0.00	0.00	0.00	0.60	0.60
2022–2023 additional resources	Staff	–	–	–	–	–	–	–	–
	Activities	–	–	–	–	–	–	–	–
	Total	–	–	–	–	–	–	–	–
2024–2025 resources to be planned	Staff	–	–	–	–	–	–	–	–
	Activities	–	–	–	–	–	–	–	–
	Total	–	–	–	–	–	–	–	–
Future bienniums resources to be planned	Staff	–	–	–	–	–	–	–	–
	Activities	–	–	–	–	–	–	–	–
	Total	–	–	–	–	–	–	–	–

<b>Decision WHA75(22):</b> WHO global strategy for food safety
<b>A. Link to the approved Programme budget 2022–2023</b>
<b>1. Output(s) in the approved Programme budget 2022–2023 to which this decision would contribute:</b> 3.1.2. Countries enabled to strengthen equitable access to safe, healthy and sustainably produced foods through a One Health approach
<b>2. Short justification for considering the decision, if there is no link to the results as indicated in the approved Programme budget 2022–2023:</b> Not applicable.

<b>3.</b>	<b>Any additional Secretariat work during the biennium 2022–2023 that cannot be covered by the approved Programme budget 2022–2023:</b> Not applicable.
<b>4.</b>	<b>Estimated time frame (in years or months) to implement the decision:</b> Eight years.
<b>B.</b>	<b>Resource implications for the Secretariat for implementation of the decision</b>
<b>1.</b>	<b>Total resource requirements to implement the decision, in US\$ millions:</b> US\$ 24.40 million.
<b>2.a.</b>	<b>Estimated resource requirements already planned for in the approved Programme budget 2022–2023, in US\$ millions:</b> US\$ 4.70 million.
<b>2.b.</b>	<b>Estimated resource requirements in addition to those already planned for in the approved Programme budget 2022–2023, in US\$ millions:</b> Zero.
<b>3.</b>	<b>Estimated resource requirements to be considered for the proposed programme budget for 2024–2025, in US\$ millions:</b> US\$ 6.60 million.
<b>4.</b>	<b>Estimated resource requirements to be considered for the proposed programme budgets of future bienniums, in US\$ millions:</b> US\$ 13.10 million.
<b>5.</b>	<b>Level of available resources to fund the implementation of the decision in the current biennium, in US\$ millions</b>  – <b>Resources available to fund the decision in the current biennium:</b> US\$ 1.80 million.  – <b>Remaining financing gap in the current biennium:</b> US\$ 2.90 million.  – <b>Estimated resources, not yet available, if any, which would help to close the financing gap in the current biennium:</b> US\$ 0.30 million.

**Table. Breakdown of estimated resource requirements (in US\$ millions)**

Biennium	Costs	Region						Headquarters	Total
		Africa	The Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific		
2022–2023 resources already planned	Staff	0.20	0.20	0.20	0.20	0.20	0.20	0.80	2.00
	Activities	0.30	0.30	0.30	0.30	0.30	0.30	0.90	2.70
	Total	0.50	0.50	0.50	0.50	0.50	0.50	1.70	4.70
2022–2023 additional resources	Staff	–	–	–	–	–	–	–	–
	Activities	–	–	–	–	–	–	–	–
	Total	–	–	–	–	–	–	–	–
2024–2025 resources to be planned	Staff	0.30	0.30	0.20	0.30	0.20	0.30	1.10	2.70
	Activities	0.80	0.60	0.50	0.50	0.60	0.60	0.30	3.90
	Total	1.10	0.90	0.70	0.80	0.80	0.90	1.40	6.60
Future bienniums resources to be planned	Staff	0.70	0.60	0.50	0.60	0.50	0.50	2.20	5.60
	Activities	1.60	1.20	1.00	1.10	1.20	1.10	0.30	7.50
	Total	2.30	1.80	1.50	1.70	1.70	1.60	2.50	13.10

**Decision WHA75(23):** Reducing public health risks associated with the sale of live wild animals of mammalian species in traditional food markets – infection prevention and control

**A. Link to the approved Programme budget 2022–2023**

**1. Output(s) in the approved Programme budget 2022–2023 to which this decision would contribute:**

3.1.2. Countries enabled to strengthen equitable access to safe, healthy and sustainably produced foods through a One Health approach

**2. Short justification for considering the decision, if there is no link to the results as indicated in the approved Programme budget 2022–2023:**

Not applicable.

**3. Any additional Secretariat work during the biennium 2022–2023 that cannot be covered by the approved Programme budget 2022–2023:**

Not applicable.

**4. Estimated time frame (in years or months) to implement the decision:**

Eight years.

**B. Resource implications for the Secretariat for implementation of the decision**

**1. Total resource requirements to implement the decision, in US\$ millions:**

US\$ 17.30 million.

**2.a. Estimated resource requirements already planned for in the approved Programme budget 2022–2023, in US\$ millions:**

US\$ 1.40 million.

**2.b. Estimated resource requirements in addition to those already planned for in the approved Programme budget 2022–2023, in US\$ millions:**

Zero.

<b>3. Estimated resource requirements to be considered for the proposed programme budget for 2024–2025, in US\$ millions:</b> US\$ 5.30 million.
<b>4. Estimated resource requirements to be considered for the proposed programme budgets of future bienniums, in US\$ millions:</b> US\$ 10.60 million.
<b>5. Level of available resources to fund the implementation of the decision in the current biennium, in US\$ millions</b> – <b>Resources available to fund the decision in the current biennium:</b> US\$ 0.90 million.  – <b>Remaining financing gap in the current biennium:</b> US\$ 0.50 million.  – <b>Estimated resources, not yet available, if any, which would help to close the financing gap in the current biennium:</b> Zero.

**Table. Breakdown of estimated resource requirements (in US\$ millions)<sup>a</sup>**

Biennium	Costs	Region						Headquarters	Total
		Africa	The Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific		
<b>2022–2023</b> resources already planned	Staff	0.09	0.08	0.07	0.08	0.07	0.07	0.40	0.90
	Activities	0.00	0.00	0.00	0.00	0.00	0.00	0.50	0.50
	Total	0.09	0.08	0.07	0.08	0.07	0.07	0.90	1.40
<b>2022–2023</b> additional resources	Staff	–	–	–	–	–	–	–	–
	Activities	–	–	–	–	–	–	–	–
	Total	–	–	–	–	–	–	–	–
<b>2024–2025</b> resources to be planned	Staff	0.40	0.10	0.30	0.10	0.10	0.10	0.70	1.80
	Activities	0.70	0.60	0.40	0.40	0.50	0.40	0.50	3.50
	Total	1.10	0.70	0.70	0.50	0.60	0.50	1.20	5.30
<b>Future bienniums</b> resources to be planned	Staff	0.70	0.20	0.70	0.20	0.20	0.20	1.40	3.60
	Activities	1.00	1.00	1.00	1.00	1.00	1.00	1.00	7.00
	Total	1.70	1.20	1.70	1.20	1.20	1.20	2.40	10.60

<sup>a</sup> The row and column totals may not always add up, due to rounding.

<b>Decision WHA75(24):</b>	Global Health for Peace Initiative
<b>A. Link to the approved Programme budget 2022–2023</b>	
<b>1. Output(s) in the approved Programme budget 2022–2023 to which this decision would contribute:</b>	2.3.3. Essential health services and systems maintained and strengthened in fragile, conflict-affected and vulnerable settings
<b>2. Short justification for considering the decision, if there is no link to the results as indicated in the approved Programme budget 2022–2023:</b>	Not applicable.
<b>3. Any additional Secretariat work during the biennium 2022–2023 that cannot be covered by the approved Programme budget 2022–2023:</b>	Not applicable.
<b>4. Estimated time frame (in years or months) to implement the decision:</b>	One year, with a report to be submitted to the Executive Board at its 152nd session in January 2023.
<b>B. Resource implications for the Secretariat for implementation of the decision</b>	
<b>1. Total resource requirements to implement the decision, in US\$ millions:</b>	US\$ 0.642 million.
<b>2.a. Estimated resource requirements already planned for in the approved Programme budget 2022–2023, in US\$ millions:</b>	US\$ 0.642 million, including staff time at WHO headquarters and in regions, consultations with relevant stakeholders, and three missions for consultative meetings in three regions.
<b>2.b. Estimated resource requirements in addition to those already planned for in the approved Programme budget 2022–2023, in US\$ millions:</b>	Not applicable.
<b>3. Estimated resource requirements to be considered for the proposed programme budget for 2024–2025, in US\$ millions:</b>	Not applicable
<b>4. Estimated resource requirements to be considered for the proposed programme budgets of future bienniums, in US\$ millions:</b>	Not applicable.
<b>5. Level of available resources to fund the implementation of the decision in the current biennium, in US\$ millions</b>	<ul style="list-style-type: none"> <li>– <b>Resources available to fund the decision in the current biennium:</b> US\$ 0.642 million.</li> <li>– <b>Remaining financing gap in the current biennium:</b> Not applicable.</li> <li>– <b>Estimated resources, not yet available, if any, which would help to close the financing gap in the current biennium:</b> Not applicable</li> </ul>

**Table. Breakdown of estimated resource requirements (in US\$ millions)<sup>a</sup>**

Biennium	Costs	Region						Headquarters	Total
		Africa	The Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific		
2022–2023 resources already planned	Staff	0.010	0.010	0.010	0.010	0.010	0.010	0.107	0.168
	Activities	0.071	0.020	0.005	0.067	0.080	0.005	0.226	0.474
	Total	0.081	0.030	0.015	0.077	0.090	0.015	0.333	0.642
2022–2023 additional resources	Staff	–	–	–	–	–	–	–	–
	Activities	–	–	–	–	–	–	–	–
	Total	–	–	–	–	–	–	–	–
2024–2025 resources to be planned	Staff	–	–	–	–	–	–	–	–
	Activities	–	–	–	–	–	–	–	–
	Total	–	–	–	–	–	–	–	–
Future bienniums resources to be planned	Staff	–	–	–	–	–	–	–	–
	Activities	–	–	–	–	–	–	–	–
	Total	–	–	–	–	–	–	–	–

<sup>a</sup> The row and column totals may not always add up, due to rounding.

<b>Decision WHA75(25):</b> Standardization of medical devices nomenclature
<b>A. Link to the approved Programme budget 2022–2023</b>
<p><b>1. Output(s) in the approved Programme budget 2022–2023 to which this decision would contribute:</b>  1.3.1. Provision of authoritative guidance and standards on quality, safety and efficacy of health products, essential medicines and diagnostics lists  1.3.3. Country and regional regulatory capacity strengthened, and supply of quality-assured and safe health products improved, including through prequalification services</p>
<p><b>2. Short justification for considering the decision, if there is no link to the results as indicated in the approved Programme budget 2022–2023:</b>  Not applicable.</p>
<p><b>3. Any additional Secretariat work during the biennium 2022–2023 that cannot be covered by the approved Programme budget 2022–2023:</b>  Not applicable.</p>
<p><b>4. Estimated time frame (in years or months) to implement the decision:</b>  One and a half years.  This includes the time required to: continue the mapping work, update country data and provide a selection of nomenclature systems for Member States that do not have one, and submit a report to the Seventy-sixth World Health Assembly in 2023.</p>
<b>B. Resource implications for the Secretariat for implementation of the decision</b>
<p><b>1. Total resource requirements to implement the decision, in US\$ millions:</b>  US\$ 1.60 million.</p>



<b>2.a. Estimated resource requirements already planned for in the approved Programme budget 2022–2023, in US\$ millions:</b> US\$ 1.60 million.
<b>2.b. Estimated resource requirements in addition to those already planned for in the approved Programme budget 2022–2023, in US\$ millions:</b> Not applicable.
<b>3. Estimated resource requirements to be considered for the proposed programme budget for 2024–2025, in US\$ millions:</b> Not applicable.
<b>4. Estimated resource requirements to be considered for the programme budgets of future bienniums, in US\$ millions:</b> Not applicable.
<b>5. Level of available resources to fund the implementation of the decision in the current biennium, in US\$ millions</b> <ul style="list-style-type: none"> <li>– <b>Resources available to fund the decision in the current biennium:</b> Zero.</li> <li>– <b>Remaining financing gap in the current biennium:</b> US\$ 1.60 million.</li> <li>– <b>Estimated resources, not yet available, if any, which would help to close the financing gap in the current biennium:</b> US\$ 1.60 million.</li> </ul>

**Table. Breakdown of estimated resource requirements (in US\$ millions)<sup>a</sup>**

Biennium	Costs	Region						Headquarters	Total
		Africa	The Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific		
<b>2022–2023</b> resources already planned	Staff	0.08	0.07	0.06	0.07	0.06	0.07	0.50	0.90
	Activities	0.05	0.05	0.05	0.05	0.05	0.05	0.40	0.70
	Total	0.13	0.12	0.11	0.12	0.11	0.12	0.90	1.60
<b>2022–2023</b> additional resources	Staff	–	–	–	–	–	–	–	–
	Activities	–	–	–	–	–	–	–	–
	Total	–	–	–	–	–	–	–	–
<b>2024–2025</b> resources to be planned	Staff	–	–	–	–	–	–	–	–
	Activities	–	–	–	–	–	–	–	–
	Total	–	–	–	–	–	–	–	–
<b>Future bienniums</b> resources to be planned	Staff	–	–	–	–	–	–	–	–
	Activities	–	–	–	–	–	–	–	–
	Total	–	–	–	–	–	–	–	–

<sup>a</sup> The row and column totals may not always add up, due to rounding.

## Appendix 1

**Financial and administrative implications for the Secretariat of decisions adopted by the Health Assembly<sup>1</sup>**

<b>Decision:<sup>1</sup></b> Implementation road map 2023–2030 for the global action plan for the prevention and control of noncommunicable diseases 2013–2030
<b>A. Link to the approved Programme budget 2022–2023</b>
<b>1. Output(s) in the approved Programme budget 2022–2023 to which this decision would contribute:</b> 1.1.2. Countries enabled to strengthen their health systems to deliver on condition- and disease-specific service coverage results
<b>2. Short justification for considering the decision, if there is no link to the results as indicated in the approved Programme budget 2022–2023:</b> Not applicable.
<b>3. Any additional Secretariat work during the biennium 2022–2023 that cannot be covered by the approved Programme budget 2022–2023:</b> Not applicable.
<b>4. Estimated time frame (in years or months) to implement the decision:</b> One year.
<b>B. Resource implications for the Secretariat for implementation of the decision</b>
<b>1. Total resource requirements to implement the decision, in US\$ millions:</b> US\$ 0.30 million.
<b>2.a. Estimated resource requirements already planned for in the approved Programme budget 2022–2023, in US\$ millions:</b> US\$ 0.30 million.
<b>2.b. Estimated resource requirements in addition to those already planned for in the approved Programme budget 2022–2023, in US\$ millions:</b> Zero.
<b>3. Estimated resource requirements to be considered for the proposed programme budget for 2024–2025, in US\$ millions:</b> Zero.
<b>4. Estimated resource requirements to be considered for the proposed programme budgets of future bienniums, in US\$ millions:</b> Zero.

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<sup>1</sup> See decision WHA75(11), Follow-up to the political declaration of the third high-level meeting of the General Assembly on the prevention and control of non-communicable diseases, and Annex 8.



## Appendix 2

**Financial and administrative implications for the Secretariat of decisions adopted by the Health Assembly<sup>1</sup>**

<b>Decision:</b> <sup>1</sup> Recommendations to strengthen and monitor diabetes responses within national noncommunicable disease programmes, including targets
<b>A. Link to the approved Programme budget 2022–2023</b>
<p><b>1. Output(s) in the approved Programme budget 2022–2023 to which this decision would contribute:</b></p> <p>1.1.1. Countries enabled to provide high-quality, people-centred health services, based on primary health care strategies and comprehensive essential service packages</p> <p>1.1.2. Countries enabled to strengthen their health systems to deliver on condition- and disease-specific service coverage results</p> <p>1.3.2. Improved and more equitable access to health products through global market shaping and supporting countries to monitor and ensure efficient and transparent procurement and supply systems</p> <p>3.2.1. Countries enabled to address risk factors through multisectoral actions</p>
<p><b>2. Short justification for considering the decision, if there is no link to the results as indicated in the approved Programme budget 2022–2023:</b></p> <p>Not applicable.</p>
<p><b>3. Any additional Secretariat work during the biennium 2022–2023 that cannot be covered by the approved Programme budget 2022–2023:</b></p> <p>Not applicable.</p>
<p><b>4. Estimated time frame (in years or months) to implement the decision:</b></p> <p>Nine years.</p>
<b>B. Resource implications for the Secretariat for implementation of the decision</b>
<p><b>1. Total resource requirements to implement the decision, in US\$ millions:</b></p> <p>US\$ 96.00 million.</p>
<p><b>2.a. Estimated resource requirements already planned for in the approved Programme budget 2022–2023, in US\$ millions:</b></p> <p>US\$ 3.30 million.</p>
<p><b>2.b. Estimated resource requirements in addition to those already planned for in the approved Programme budget 2022–2023, in US\$ millions:</b></p> <p>Zero.</p>
<p><b>3. Estimated resource requirements to be considered for the proposed programme budget for 2024–2025, in US\$ millions:</b></p> <p>US\$ 13.30 million.</p>

<sup>1</sup> See decision WHA75(11), Follow-up to the political declaration of the third high-level meeting of the General Assembly on the prevention and control of non-communicable diseases, and Annex 9.

<p><b>4. Estimated resource requirements to be considered for the proposed programme budgets of future bienniums, in US\$ millions:</b></p> <p>US\$ 79.40 million.</p>
<p><b>5. Level of available resources to fund the implementation of the decision in the current biennium, in US\$ millions</b></p> <p>– <b>Resources available to fund the decision in the current biennium:</b></p> <p>US\$ 3.30 million.</p> <p>– <b>Remaining financing gap in the current biennium:</b></p> <p>Zero.</p> <p>– <b>Estimated resources, not yet available, if any, which would help to close the financing gap in the current biennium:</b></p> <p>Not applicable.</p>

**Table. Breakdown of estimated resource requirements (in US\$ millions)**

Biennium	Costs	Region						Headquarters	Total
		Africa	The Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific		
2022–2023 resources already planned	Staff	0.08	0.06	0.06	0.07	0.06	0.07	1.10	1.50
	Activities	0.20	0.35	0.20	0.20	0.20	0.20	0.45	1.80
	Total	0.28	0.41	0.26	0.27	0.26	0.27	1.55	3.30
2022–2023 additional resources	Staff	–	–	–	–	–	–	–	–
	Activities	–	–	–	–	–	–	–	–
	Total	–	–	–	–	–	–	–	–
2024–2025 resources to be planned	Staff	0.60	0.60	0.40	0.50	0.40	0.50	1.10	4.10
	Activities	1.30	1.30	1.50	1.40	1.50	1.40	0.80	9.20
	Total	1.90	1.90	1.90	1.90	1.90	1.90	1.90	13.30
Future bienniums resources to be planned	Staff	1.90	1.90	1.50	1.60	1.40	1.50	3.60	13.40
	Activities	10.60	10.60	10.60	10.60	10.60	10.60	2.40	66.00
	Total	12.50	12.50	12.10	12.20	12.00	12.10	6.00	79.40

## Appendix 3

**Financial and administrative implications for the Secretariat of decisions adopted by the Health Assembly<sup>1</sup>**

<b>Decision:<sup>1</sup></b> Global strategy on oral health
<b>A. Link to the approved Programme budget 2022–2023</b>
<b>1. Output(s) in the approved Programme budget 2022–2023 to which this decision would contribute:</b> 1.1.1. Countries enabled to provide high-quality, people-centred health services, based on primary health care strategies and comprehensive essential service packages 1.1.2. Countries enabled to strengthen their health systems to deliver on condition- and disease-specific service coverage results 3.3.1. Countries enabled to address environmental determinants, including climate change
<b>2. Short justification for considering the decision, if there is no link to the results as indicated in the approved Programme budget 2022–2023:</b> Not applicable.
<b>3. Any additional Secretariat work during the biennium 2022–2023 that cannot be covered by the approved Programme budget 2022–2023:</b> Not applicable.
<b>4. Estimated time frame (in years or months) to implement the decision:</b> Nine years.
<b>B. Resource implications for the Secretariat for implementation of the decision</b>
<b>1. Total resource requirements to implement the decision, in US\$ millions:</b> US\$ 22.20 million.
<b>2.a. Estimated resource requirements already planned for in the approved Programme budget 2022–2023, in US\$ millions:</b> US\$ 3.00 million.
<b>2.b. Estimated resource requirements in addition to those already planned for in the approved Programme budget 2022–2023, in US\$ millions:</b> Zero.
<b>3. Estimated resource requirements to be considered for the proposed programme budget for 2024–2025, in US\$ millions:</b> US\$ 6.00 million.
<b>4. Estimated resource requirements to be considered for the proposed programme budgets of future bienniums, in US\$ millions:</b> US\$ 13.20 million.

<sup>1</sup> See decision WHA75(11), Follow-up to the political declaration of the third high-level meeting of the General Assembly on the prevention and control of non-communicable diseases, and Annex 10.

**5. Level of available resources to fund the implementation of the decision in the current biennium, in US\$ millions**

– **Resources available to fund the decision in the current biennium:**

US\$ 2.40 million.

– **Remaining financing gap in the current biennium:**

US\$ 0.60 million.

– **Estimated resources, not yet available, if any, which would help to close the financing gap in the current biennium:**

Ongoing donor negotiations are expected to produce the resources required in the current biennium.

**Table. Breakdown of estimated resource requirements (in US\$ millions)**

Biennium	Costs	Region						Headquarters	Total
		Africa	The Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific		
<b>2022–2023</b> resources already planned	Staff	0.60	0.00	0.00	0.00	0.00	0.00	1.80	2.40
	Activities	0.20	0.00	0.00	0.00	0.00	0.00	0.40	0.60
	Total	0.80	0.00	0.00	0.00	0.00	0.00	2.20	3.00
<b>2022–2023</b> additional resources	Staff	–	–	–	–	–	–	–	–
	Activities	–	–	–	–	–	–	–	–
	Total	–	–	–	–	–	–	–	–
<b>2024–2025</b> resources to be planned	Staff	0.60	0.40	0.40	0.00	0.60	0.00	1.80	3.80
	Activities	0.30	0.20	0.30	0.30	0.20	0.30	0.60	2.20
	Total	0.90	0.60	0.70	0.30	0.80	0.30	2.40	6.00
<b>Future bienniums</b> resources to be planned	Staff	1.20	0.80	0.80	0.60	1.20	0.60	3.60	8.80
	Activities	0.60	0.40	0.60	0.60	0.40	0.60	1.20	4.40
	Total	1.80	1.20	1.40	1.20	1.60	1.20	4.80	13.20

## Appendix 4

**Financial and administrative implications for the Secretariat of decisions adopted by the Health Assembly<sup>1</sup>**

<b>Decision:<sup>1</sup></b> Recommendations on how to strengthen the design and implementation of policies, including those for resilient health systems and health services and infrastructure, to treat people living with noncommunicable diseases and to prevent and control their risk factors in humanitarian emergencies
<b>A. Link to the approved Programme budget 2022–2023</b>
<p><b>1. Output(s) in the approved Programme budget 2022–2023 to which this decision would contribute:</b></p> <p>1.1.1. Countries enabled to provide high-quality, people-centred health services, based on primary health care strategies and comprehensive essential service packages</p> <p>1.1.2. Countries enabled to strengthen their health systems to deliver on condition- and disease-specific service coverage results</p> <p>2.3.3. Essential health services and systems maintained and strengthened in fragile, conflict-affected and vulnerable settings</p>
<p><b>2. Short justification for considering the decision, if there is no link to the results as indicated in the approved Programme budget 2022–2023:</b></p> <p>Not applicable.</p>
<p><b>3. Any additional Secretariat work during the biennium 2022–2023 that cannot be covered by the approved Programme budget 2022–2023:</b></p> <p>Not applicable.</p>
<p><b>4. Estimated time frame (in years or months) to implement the decision:</b></p> <p>Four years.</p>
<b>B. Resource implications for the Secretariat for implementation of the decision</b>
<p><b>1. Total resource requirements to implement the decision, in US\$ millions:</b></p> <p>US\$ 27.50 million.</p>
<p><b>2.a. Estimated resource requirements already planned for in the approved Programme budget 2022–2023, in US\$ millions:</b></p> <p>US\$ 10.00 million.</p>
<p><b>2.b. Estimated resource requirements in addition to those already planned for in the approved Programme budget 2022–2023, in US\$ millions:</b></p> <p>Zero.</p>
<p><b>3. Estimated resource requirements to be considered for the proposed programme budget for 2024–2025, in US\$ millions:</b></p> <p>US\$ 17.50 million.</p>

<sup>1</sup> See decision WHA75(11), Follow-up to the political declaration of the third high-level meeting of the General Assembly on the prevention and control of non-communicable diseases, and Annex 11.





## Appendix 5

**Financial and administrative implications for the Secretariat of decisions adopted by the Health Assembly<sup>1</sup>**

<b>Decision:<sup>1</sup></b> Intersectoral global action plan on epilepsy and other neurological disorders 2022–2031
<b>A. Link to the approved Programme budget 2022–2023</b>
<b>1. Output(s) in the approved Programme budget 2022–2023 to which this decision would contribute:</b> 1.1.2. Countries enabled to strengthen their health systems to deliver on condition- and disease-specific service coverage results
<b>2. Short justification for considering the decision, if there is no link to the results as indicated in the approved Programme budget 2022–2023:</b> Not applicable.
<b>3. Any additional Secretariat work during the biennium 2022–2023 that cannot be covered by the approved Programme budget 2022–2023:</b> Not applicable.
<b>4. Estimated time frame (in years or months) to implement the decision:</b> 10 years.
<b>B. Resource implications for the Secretariat for implementation of the decision</b>
<b>1. Total resource requirements to implement the decision, in US\$ millions:</b> US\$ 37.68 million.
<b>2.a. Estimated resource requirements already planned for in the approved Programme budget 2022–2023, in US\$ millions:</b> US\$ 7.11 million.
<b>2.b. Estimated resource requirements in addition to those already planned for in the approved Programme budget 2022–2023, in US\$ millions:</b> Zero.
<b>3. Estimated resource requirements to be considered for the proposed programme budget for 2024–2025, in US\$ millions:</b> US\$ 7.37 million.
<b>4. Estimated resource requirements to be considered for the proposed programme budgets of future bienniums, in US\$ millions:</b> US\$ 23.20 million.

<sup>1</sup> See decision WHA75(11), Follow-up to the political declaration of the third high-level meeting of the General Assembly on the prevention and control of non-communicable diseases, and Annex 12.

- 5. Level of available resources to fund the implementation of the decision in the current biennium, in US\$ millions**
- **Resources available to fund the decision in the current biennium:**  
US\$ 1.00 million.
  - **Remaining financing gap in the current biennium:**  
US\$ 6.11 million.
  - **Estimated resources, not yet available, if any, which would help to close the financing gap in the current biennium:**  
Not applicable.

**Table. Breakdown of estimated resource requirements (in US\$ millions)**

Biennium	Costs	Region						Headquarters	Total
		Africa	The Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific		
<b>2022–2023</b> resources already planned	Staff	0.56	0.52	0.43	0.48	0.40	0.44	1.17	4.00
	Activities	0.31	0.31	0.31	0.31	0.31	0.31	1.25	3.11
	Total	0.87	0.83	0.74	0.79	0.71	0.75	2.42	7.11
<b>2022–2023</b> additional resources	Staff	–	–	–	–	–	–	–	–
	Activities	–	–	–	–	–	–	–	–
	Total	–	–	–	–	–	–	–	–
<b>2024–2025</b> resources to be planned	Staff	0.58	0.54	0.45	0.50	0.42	0.46	1.21	4.16
	Activities	0.32	0.32	0.32	0.32	0.32	0.32	1.29	3.21
	Total	0.90	0.86	0.77	0.82	0.74	0.78	2.50	7.37
<b>Future bienniums</b> resources to be planned	Staff	1.88	1.77	1.46	1.63	1.35	1.49	3.96	13.54
	Activities	0.96	0.96	0.96	0.96	0.96	0.96	3.90	9.66
	Total	2.84	2.73	2.42	2.59	2.31	2.45	7.86	23.20

## Appendix 6

**Financial and administrative implications for the Secretariat of  
decisions adopted by the Health Assembly<sup>1</sup>**

<b>Decision:</b> <sup>1</sup> Action plan (2022–2030) to effectively implement the global strategy to reduce the harmful use of alcohol as a public health priority
<b>A. Link to the approved Programme budget 2022–2023</b>
<b>1. Output(s) in the approved Programme budget 2022–2023 to which this decision would contribute:</b> 1.1.2. Countries enabled to strengthen their health systems to deliver on condition- and disease-specific service coverage results 3.2.1. Countries enabled to address risk factors through multisectoral actions
<b>2. Short justification for considering the decision, if there is no link to the results as indicated in the approved Programme budget 2022–2023:</b> Not applicable.
<b>3. Any additional Secretariat work during the biennium 2022–2023 that cannot be covered by the approved Programme budget 2022–2023:</b> Not applicable.
<b>4. Estimated time frame (in years or months) to implement the decision:</b> Nine years.
<b>B. Resource implications for the Secretariat for implementation of the decision</b>
<b>1. Total resource requirements to implement the decision, in US\$ millions:</b> US\$ 46.47 million.
<b>2.a. Estimated resource requirements already planned for in the approved Programme budget 2022–2023, in US\$ millions:</b> US\$ 8.55 million.
<b>2.b. Estimated resource requirements in addition to those already planned for in the approved Programme budget 2022–2023, in US\$ millions:</b> Zero.
<b>3. Estimated resource requirements to be considered for the proposed programme budget for 2024–2025, in US\$ millions:</b> US\$ 11.55 million.
<b>4. Estimated resource requirements to be considered for the proposed programme budgets of future bienniums, in US\$ millions:</b> US\$ 26.37 million.

<sup>1</sup> See decision WHA75(11), Follow-up to the political declaration of the third high-level meeting of the General Assembly on the prevention and control of non-communicable diseases, and Annex 13.

- 5. Level of available resources to fund the implementation of the decision in the current biennium, in US\$ millions**
- **Resources available to fund the decision in the current biennium:**  
US\$ 8.55 million.
  - **Remaining financing gap in the current biennium:**  
Zero.
  - **Estimated resources, not yet available, if any, which would help to close the financing gap in the current biennium:**  
Not applicable.

**Table. Breakdown of estimated resource requirements (in US\$ millions)<sup>a</sup>**

Biennium	Costs	Region						Headquarters	Total
		Africa	The Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific		
<b>2022–2023</b> resources already planned	Staff	0.25	0.60	0.25	1.00	0.00	0.25	3.20	5.55
	Activities	0.10	0.30	0.10	0.40	0.00	0.10	2.00	3.00
	Total	0.35	0.90	0.35	1.40	0.00	0.35	5.20	8.55
<b>2022–2023</b> additional resources	Staff	–	–	–	–	–	–	–	–
	Activities	–	–	–	–	–	–	–	–
	Total	–	–	–	–	–	–	–	–
<b>2024–2025</b> resources to be planned	Staff	0.85	0.90	0.85	1.22	0.00	0.85	2.34	7.00
	Activities	0.50	0.25	0.45	0.50	0.00	0.37	2.49	4.55
	Total	1.35	1.15	1.30	1.72	0.00	1.22	4.82	11.55
<b>Future bienniums</b> resources to be planned	Staff	1.62	1.75	1.62	2.55	0.00	1.62	5.84	15.00
	Activities	1.24	0.62	1.12	1.24	0.00	0.93	6.21	11.37
	Total	2.86	2.37	2.74	3.79	0.00	2.55	12.05	26.37

<sup>a</sup> The row and column totals may not always add up, due to rounding.

## Appendix 7

**Financial and administrative implications for the Secretariat of decisions adopted by the Health Assembly<sup>1</sup>**

<b>Decision:</b> <sup>1</sup> Recommendations for the prevention and management of obesity over the life course, including considering the development of targets in this regard
<b>A. Link to the approved Programme budget 2022–2023</b>
<b>1. Output(s) in the approved Programme budget 2022–2023 to which this decision would contribute:</b> 3.2.1. Countries enabled to address risk factors through multisectoral actions
<b>2. Short justification for considering the decision, if there is no link to the results as indicated in the approved Programme budget 2022–2023:</b> Not applicable.
<b>3. Any additional Secretariat work during the biennium 2022–2023 that cannot be covered by the approved Programme budget 2022–2023:</b> Not applicable.
<b>4. Estimated time frame (in years or months) to implement the decision:</b> Nine years.
<b>B. Resource implications for the Secretariat for implementation of the decision</b>
<b>1. Total resource requirements to implement the decision, in US\$ millions:</b> US\$ 15.22 million.
<b>2.a. Estimated resource requirements already planned for in the approved Programme budget 2022–2023, in US\$ millions:</b> US\$ 3.00 million.
<b>2.b. Estimated resource requirements in addition to those already planned for in the approved Programme budget 2022–2023, in US\$ millions:</b> Zero.
<b>3. Estimated resource requirements to be considered for the proposed programme budget for 2024–2025, in US\$ millions:</b> US\$ 4.00 million.
<b>4. Estimated resource requirements to be considered for the proposed programme budgets of future bienniums, in US\$ millions:</b> US\$ 8.22 million.

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<sup>1</sup> See decision WHA75(11), Follow-up to the political declaration of the third high-level meeting of the General Assembly on the prevention and control of non-communicable diseases, and Annex 14.

- 5. Level of available resources to fund the implementation of the decision in the current biennium, in US\$ millions**
- **Resources available to fund the decision in the current biennium:**  
US\$ 1.00 million.
  - **Remaining financing gap in the current biennium:**  
US\$ 2.00 million.
  - **Estimated resources, not yet available, if any, which would help to close the financing gap in the current biennium:**  
Not applicable.

**Table. Breakdown of estimated resource requirements (in US\$ millions)<sup>a</sup>**

Biennium	Costs	Region						Headquarters	Total
		Africa	The Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific		
<b>2022–2023</b> resources already planned	Staff	0.20	0.10	0.10	0.10	0.10	0.10	0.20	0.90
	Activities	0.40	0.30	0.20	0.30	0.30	0.30	0.30	2.10
	Total	0.60	0.40	0.30	0.40	0.40	0.40	0.50	3.00
<b>2022–2023</b> additional resources	Staff	–	–	–	–	–	–	–	–
	Activities	–	–	–	–	–	–	–	–
	Total	–	–	–	–	–	–	–	–
<b>2024–2025</b> resources to be planned	Staff	0.27	0.13	0.13	0.14	0.13	0.13	0.27	1.20
	Activities	0.53	0.40	0.27	0.40	0.40	0.40	0.40	2.80
	Total	0.80	0.53	0.40	0.54	0.53	0.53	0.67	4.00
<b>Future bienniums</b> resources to be planned	Staff	0.55	0.27	0.27	0.27	0.27	0.27	0.55	2.47
	Activities	1.10	0.82	0.55	0.82	0.82	0.82	0.82	5.75
	Total	1.64	1.10	0.82	1.10	1.10	1.10	1.37	8.22

<sup>a</sup> The row and column totals may not always add up, due to rounding.

## Appendix 8

**Financial and administrative implications for the Secretariat of  
decisions adopted by the Health Assembly<sup>1</sup>**

<b>Decision:<sup>1</sup></b> Workplan for the global coordination mechanism on the prevention and control of noncommunicable diseases 2022–2025
<b>A. Link to the approved Programme budget 2022–2023</b>
<b>1. Output(s) in the approved Programme budget 2022–2023 to which this decision would contribute:</b> 3.2.2. Countries enabled to reinforce partnerships across sectors, as well as governance mechanisms, laws and fiscal measures
<b>2. Short justification for considering the decision, if there is no link to the results as indicated in the approved Programme budget 2022–2023:</b> Not applicable.
<b>3. Any additional Secretariat work during the biennium 2022–2023 that cannot be covered by the approved Programme budget 2022–2023:</b> Not applicable.
<b>4. Estimated time frame (in years or months) to implement the decision:</b> Four years.
<b>B. Resource implications for the Secretariat for implementation of the decision</b>
<b>1. Total resource requirements to implement the decision, in US\$ millions:</b> US\$ 7.25 million.
<b>2.a. Estimated resource requirements already planned for in the approved Programme budget 2022–2023, in US\$ millions:</b> US\$ 3.25 million.
<b>2.b. Estimated resource requirements in addition to those already planned for in the approved Programme budget 2022–2023, in US\$ millions:</b> Zero.
<b>3. Estimated resource requirements to be considered for the proposed programme budget for 2024–2025, in US\$ millions:</b> US\$ 4.00 million.
<b>4. Estimated resource requirements to be considered for the proposed programme budgets of future bienniums, in US\$ millions:</b> Zero.

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<sup>1</sup> See decision WHA75(11), Follow-up to the political declaration of the third high-level meeting of the General Assembly on the prevention and control of non-communicable diseases and, Annex 15.



