This Working Paper highlights, from the perspective of the WHO South-East Asia Region, the resolutions endorsed, and decisions adopted, by the Seventy-sixth World Health Assembly (held on 21–30 May 2023) and the 152nd and 153rd sessions of the WHO Executive Board (held on 30 January–7 February 2023 and 31 May–1 June 2023, respectively) along with other important Agenda items. The issues are deemed to have important implications for the Member States of the WHO South-East Asia Region and the resolutions/decisions merit follow-up action by both Member States of the Region as well as the Organization at the regional and country levels.

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

The High-Level Preparatory (HLP) Meeting for the Seventy-sixth Session of the WHO Regional Committee for South-East Asia, held virtually in New Delhi on 4–5 September 2023, reviewed the attached Working Paper and noted the provisions of the selected resolutions endorsed and decisions adopted by the Seventy-sixth World Health Assembly and the 152nd 153rd sessions of the WHO Executive Board and other Agenda items deemed to have important implications for the WHO South-East Asia Region and merit follow-up actions at the regional and country levels.
The HLP Meeting, following a review of the document, made the following recommendations.

**Action by Member States**

(1) Implement the related provisions of the selected resolutions endorsed and decisions adopted by the Seventy-sixth World Health Assembly and the 152nd and 153rd sessions of the WHO Executive Board which merit follow-up actions at the regional as well as at the country level.

(2) Contribute to the upcoming UN High-Level Meetings to enable expansion of the ambition for health and well-being in the post-COVID World.

**Action by WHO**

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

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

1) Resolutions and Decisions of the Seventy-sixth World Health Assembly (which also cover the subjects of technical resolutions adopted by the 152nd and 153rd sessions of the Executive Board).

2) Regional One Voice (RoV) intervention(s) on select Agenda items delivered by Member States of the SE Asia Region during the Seventy-sixth World Health Assembly.

3) Report by the WHO Director-General on select Agenda items submitted to the Seventy-sixth World Health Assembly (in case there is no resolution/decision or RoV on this agenda).
Introduction

1. The Seventy-sixth World Health Assembly in May 2023 and the 152nd and 153rd Sessions of the WHO Executive Board in January 2023 and May–June 2023 respectively endorsed a number of resolutions and decisions during the course of their deliberations. These decisions and resolutions relate to health matters as well as Programme Budget and financial matters.

2. The summaries of resolutions and decisions on technical matters that have significant implications for the South-East Asia Region along with other important Agenda items are presented in this Working Paper. Salient information on the implications of the issues, and actions already taken and/or yet to be taken, are also included herein.

3. Also annexed to this Working Paper are copies of all the relevant resolutions and decisions adopted by the Seventy-sixth World Health Assembly, the Director-General’s report on select Agenda items presented to the Assembly and the text of the “Regional One Voice” statements delivered at the Seventy-sixth Health Assembly by the delegation of the Member States of the South-East Asia Region on select Agenda items, as applicable (these also cover the subjects of technical resolutions adopted by the 152nd and 153rd Sessions of the Executive Board).

4. The Working Paper was presented to the High-Level Preparatory (HLP) Meeting for the Seventy-sixth Session of the WHO Regional Committee for South-East Asia, which was held virtually in New Delhi on 4–5 September 2023. The HLP Meeting noted the provisions of the selected resolutions endorsed and decisions adopted by the Seventy-sixth World Health Assembly and the 152nd 153rd sessions of the WHO Executive Board and other Agenda items deemed to have important implications for the WHO South-East Asia Region and merit follow-up actions at the regional and country levels.

5. Following the review of the Working Paper, the HLP Meeting made recommendations for consideration by the Seventy-sixth Session of the WHO Regional Committee for South-East Asia, which will be held in New Delhi, India from 30 October to 2 November 2023 (recommendations of the HLP Meeting are provided in the Summary Box, which is available at the beginning of this Working Paper).
1) Global Strategy for Women’s, Children’s and Adolescents’ Health (2016–2030)

Background

1. The Seventy-sixth World Health Assembly held in May 2023 discussed the progress report of the Global Strategy for Women’s, Children’s and Adolescents’ Health (2016–2030).

2. This progress report highlights the resolution WHA69.2 on committing to implementation of the Global Strategy for Women’s, Children’s and Adolescents’ Health (2016–2030), and a summary of the progress made towards implementation of the following resolutions: WHA67.10 (2014) on the newborn health action plan; WHA63.17 (2010) on birth defects; WHA58.31 (2005) on working towards universal coverage of maternal, newborn and child health interventions; WHA45.25 (1992) on women, health and development; and WHA45.22 (1992) on child health and development.

3. Women’s, children’s and adolescents’ health is one of the highest priorities in the SE Asia Region under the Regional Flagship Priority Programmes.

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

4. The progress on implementation of the resolutions were reported to the Health Assembly under this Agenda item. More than 90 Member States took the floor. However, as most of the Member States are not progressing in achieving SDG targets related to the reproductive, maternal, newborn, child and adolescent health (RMNCAH) area, the discussions highlighted the importance of focusing on accelerated mortality reduction. Somalia, supported by many Member States, proposed for a resolution in 2024 on the Agenda item that would seem timely, since being five years to the SDGs and this far off target, it would seem a pragmatic way to stimulate the collective actions.

Actions already taken in the Region

5. The WHO South-East Asia Region achieved the Millennium Development Goal (MDG) 4 related to under-5 mortality rate (U5MR) in 2016, soon after the target date of December 2015. Eight of the 11 Member States of the Region achieved their respective MDG 4 targets in 2016. Three countries in the Region achieved the MDG 5A target for maternal mortality ratio (MMR) reduction in 2015 (Bhutan, Maldives and Timor-Leste). Globally, only nine countries achieved the MDG 5A target of a two-thirds reduction of MMR. Globally the SE Asia Region shows the highest MMR reduction (68.5%) between 2000 to 2020.
6. The Regional MMR decreased from 372 per 100,000 live births in 2000 to 148 in 2015 and 117 in 2020. As of 2020, seven countries achieved an MMR below 140 per 100,000 live births (Bangladesh, Bhutan, Democratic People’s Republic (DPR) of Korea, India, Maldives, Sri Lanka and Thailand). Such progress indicates that Bangladesh, Myanmar, Nepal and Timor-Leste are on track to achieve the SDG country target of a two-thirds reduction in their MMR from the 2010 value.

7. The scenario looks better for the under-5 mortality rate (U5MR) and neonatal mortality rates (NMR). As of 2021, five countries in the Region (DPR Korea, Indonesia, Maldives, Sri Lanka and Thailand) have already achieved the SDG3 targets for both the U5MR and NMR. Another five countries are on track to achieve the U5MR target, and four will achieve the SDG target by 2030, respectively. The Region will likely also achieve the SDG targets for U5MR and NMR but narrowly miss the MMR target. The regional coverage of high-impact, evidence-based interventions across the RMNCAH life-course has increased over time, but the increase has been uneven, with disparities within the countries.

8. In 2020–2021, the SE Asia Region demonstrated the highest reduction in stillbirths, at 55.8%, among WHO regions. Six countries have already reached the 2030 national target of stillbirths (<12/1000 total births) while two more countries are on track to achieve the national target in 2030.

9. A Regional Strategic Framework on sexual and reproductive health was developed and disseminated, and Member States supported developing national strategies. The Regional Office continues to support the implementation of hospital-based surveillance for stillbirths and birth defects within the ongoing WHO-SEARO (Regional Office for South-East Asia) Newborn and Birth Defects Database (NBBD), and the scale-up of maternal perinatal death surveillance and response (MPDSR).

10. The Regional Office completed the RMNCAH policy survey to identify the gaps in policies and mapped the implementation of WHO recommendations on antenatal care, intrapartum care and postnatal care. These were based on findings of Member States on the RMNACH policy survey and implementation of recommendations at the country level.

11. Capacity-building of Member States on the Programme Management course on RMNCAH has been completed. This training package is designed to give programme managers working in the ministries of health the essential knowledge and skills that they require to manage their programmes better.

12. To strengthen the capacity of Member States to improve the quality and coverage of family planning and comprehensive abortion services, a review of the policy, guidelines and programme was conducted, followed by an assessment of the availability of medical abortion drugs in the Region. The recommendations are useful to guide Member States in improving the sexual and reproductive health rights (SRHR) of the people.

13. Capacity-building of government officials and professional bodies in the Region was conducted through policy dialogue and training to improve access to the adolescent sexual and reproductive health (ASRH) services in countries.
14. The availability of essential services including on comprehensive abortion, post-abortion and post-abortion family planning in Member States has been ensured. The quality of these services is crucial to meet SRHR targets and is important in primary health care. The health facility assessment tool for comprehensive abortion care has been developed to support countries to use it during national health surveys.

15. WHO introduced new evidence-based guidance on kangaroo mother care (KMC)\textsuperscript{1} for preterm babies or low-birth-weight (LBW) babies to improve their outcomes. Zero Separation Policy, which refers to keeping the mother and newborns together, was adopted in the Region. National plans for managing pneumonia and diarrhoea were reviewed, and evidence-based guidance for managing childhood pneumonia was disseminated to strengthen national plans and guidelines.

16. Continuous monitoring of sexual, reproductive, maternal, newborn, child and adolescent health (SRMNCAH) services using the Health Management Information System (HMIS) indicators to understand the recovery of RMNCAH services after the pandemic has been performed.

17. For uniformity in data collection and reporting across Member States, the Family, Gender and Life-Course Department in the WHO Regional Office for South-East Asia in New Delhi has developed the SRMNCAH Monitoring Framework, including the gender, equity and rights approach, to standardize the definitions and use indicators as per country needs. This Monitoring Framework was disseminated to Member States during the last Regional Committee session in September 2022.

**Actions to be taken in the Region**

18. The Regional Office will develop the Regional Strategic Framework for Newborn and Child health (2022–2030) and Regional Strategic Directions on Adolescent Health (2022–2030) to support Member States.

19. The regional assessment of postnatal care in the Member States of the SE Asia Region will improve the postnatal care for mothers and babies. Additionally, priority countries will be supported to strengthen facility-based care of small and sick newborns at level-2 and -3 health facilities.

20. WHO will publish a guideline on a short programme review on RMNCAH to understand the gaps in implementing RMNCAH programmes. The Regional Office has updated the decision-making tool on family planning (FP) to improve counselling standards on family planning.

21. The Regional Office will conduct the regional capacity-building workshop on family planning using the updated training resource package (TRP) in Member States.

22. Currently, it is conducting a Regional Meeting on “Sustain, Accelerate and Innovate” strategies for reducing maternal, newborn and child mortality, with a focus on implementing and strengthening the provisions of ending preventable maternal mortality (EPMM) and essential newborn action plan (ENAP).

\textsuperscript{1} KMC refers to skin-to-skin contact given to preterm or low-birth-weight (LBW) babies (both well and sick), which is continuous and prolonged (at least 8 hours a day), that is accompanied by support for exclusive breastfeeding and is closely monitored if baby is sent home in KMC.
23. The Department of Family, Gender and Life-Course in the WHO Regional Office for South-East Asia will collaborate:

   a. with the Essential Medicines team to support countries to include medical abortion drugs in essential medical lists and establish quality assurance mechanisms; and

   b. with the Human Resources for Health team to develop a curriculum and training tool for pre-service training in the SRHR area.
2) **Political Declaration of the Third High-Level Meeting of the General Assembly on the prevention and control of noncommunicable diseases and mental health**

- Draft updated menu of policy options and cost-effective interventions for the prevention and control of noncommunicable diseases

**Background**


25. The Global Action Plan 2013–2020 carried the initial list of cost-effective interventions in its Appendix 3. The first revision to Appendix 3 was in 2017 with the update in 2022 being the second with the same criteria applied in 2017. All the interventions presented in the 2017 update have also been re-analysed in 2022.

26. In 2017, a total of 88 interventions (including overarching/enabling actions) were included in the Appendix 3 while in the update in 2022, a total of 90 interventions and 22 overarching/enabling actions are included.

27. In 2017, a total of 39 interventions were estimated with 16 being considered most cost-effective. In the 2022 update, 58 interventions were considered in the cost-effective estimation with 28 being considered most cost-effective and feasible for implementation with an average cost-effectiveness ratio of ≤Int$ 100 per healthy life year (HLY) gained in low- and lower-middle-income countries.

28. The Seventy-sixth World Health Assembly decided to:

   a. endorse the draft updated menu of policy options and cost-effective interventions for the prevention and control of NCDs;

   b. request the Director-General to submit a draft updated menu of policy options and cost-effective interventions for consideration by the Eightieth World Health Assembly, through the Executive Board at its 160th session, and to incorporate revised interventions to Appendix 3 of the WHO Global Action Plan for the prevention and control of NCDs (2013–2030) on a continuous basis, when data are available.

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

29. Since 2014, “Prevention and control of NCDs through multisectoral policies and plans, with focus on best buys” has been a Regional Flagship Priority.

30. In the WHO South-East Asia Region, though the probability of dying from major NCDs among those aged 30 and 70 years declined from 23.4% in 2010 to 21.6% in 2019, the Region is not on track to achieve the 2025 NCD and the 2030 Sustainable Development Goal targets. Moreover, the COVID-19 pandemic resulted in service delivery disruptions, highlighting the urgent need for acceleration of NCD prevention and control.

Actions already taken in the Region

31. The Implementation Roadmap for accelerating the prevention and control of NCDs in South-East Asia 2022–2030, approved at the Seventy-fifth Regional Committee for South-East Asia in 2022, is aligned to the Global Action Plan for the prevention and control of NCDs 2013–2030.

32. Information and data on NCDs in the Region are being updated on the NCD Dashboard of the WHO Regional Office for South-East Asia. The South-East Asia Region NCD Impact Simulation Tool provide simplified, dynamic, interactive data for enhanced decision-making.

33. The South-East Asia HEARTS initiative and the South-East Asia Cancer Grid are platforms to accelerate cardiovascular disease and cancer control.

Actions to be taken in the Region

34. The WHO Regional Office will technically support Member States to leverage guidance of the updated Appendix 3 to implement context-specific legislative, regulatory, fiscal policies and measures to reduce risk factors and scale up the delivery of NCD services.

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5 WHO South-East Asia Regional NCD Roadmap. World Health Organization. Regional Office for South-East Asia. South-East Asia Region NCD impact simulation tool | WHO South-East Asia Regional NCD Roadmap-accessed 25 August 2023.

3) **Substandard and falsified medical products**

**Background**

35. In 2012, the World Health Assembly established the Member State mechanism to address the issue of tackling substandard and falsified medical products in a transparent and inclusive way.

36. As per common practice, the two-year report from the Director-General on substandard and falsified medical products submitted to the Seventy-sixth World Health Assembly in May 2023 provided an overview of the activities performed during the tenth and eleventh meetings of the Member State mechanism on substandard and falsified medical products.

37. These discussions, however, took place in a highly sensitive context as since October 2022, there had been five global medical product alerts related to contaminated medicines published by WHO (the latest being in July 2023), which were associated with the deaths of over 300 children worldwide. Three Member States in the Region have been directly affected as countries producing or consuming these, while the source of these contaminations remains uncertain.

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

38. The Seventy-sixth World Health Assembly was invited to note this report and adopt the Executive Board recommended decision EB152(9): “The Seventy-sixth World Health Assembly, having considered the report on substandard and falsified medical products, decided to request the Director-General: (i) to facilitate the conduct of an independent evaluation of the Member State mechanism on substandard and falsified medical products in accordance with the terms of reference to be developed by the Steering Committee of the Member State mechanism; and (ii) to report on the outcome of the evaluation to the Governing Bodies consistent with existing reporting requirements of the Member State mechanism on substandard and falsified medical products.”

**Actions already taken in the Region**

39. During its December 2022 meeting, the Steering Group of the South-East Asia Regulatory Network (SEARN) requested a capacity-building programme in the Region to ensure the integrity of raw materials.

40. To address these needs and assist the Member States in protecting public health against these contaminated medicines, the Regional Office took the initiative to organize an urgent Regional Workshop on ensuring quality of medicines from contaminated substances which took place in Indonesia, Jakarta, from 2–4 May 2023. During this week, regulators from all the Regions discussed with global experts from WHO and our partners, the Australia regulator, the TGA (Therapeutic Goods Administration) and the United States Pharmacopoeia, on how to best address the issue of contaminated products. Participating regulatory authorities developed plans of actions tailored to their situation.
41. These discussions further fed the South-East Asia Regulatory Network (SEARN) Regional Strategy to ensure the integrity of excipients, which was adopted by the Health Assembly during its meeting on 26–27 July 2023. The work included a review of existing good practices for the manufacture, market control, surveillance and testing of excipients. The 2023–2024 workplan includes the implementation of the adopted Strategy.

42. As part of this Strategy, a Regional (virtual) Workshop on testing methods for ethylene glycol and diethylene glycol in oral liquid medicines for national regulatory authorities is planned on 17–18 October 2023.

**Actions to be taken in the Region**

43. In line with the strategy adopted by SEARN, actions to be taken include further exploring certain aspects of ensuring the integrity of excipients (formulation, traceability), encouraging participation of SEARN members in the Member States Mechanism on substandard and falsified medical products, engaging with stakeholders, facilitating the development of an MoU between countries, organizing a capacity-building programme in testing products for ethylene glycol/diethylene glycol (EG/DEG), facilitating the organization of inter-laboratory or proficiency testing, providing support in accessing reference standards and reagents, organizing a Regional Workshop on good storage and distribution practice (GSDP), and providing training on the formalized risk assessment for high-risk excipients.
4) Strengthening rehabilitation in health systems

Background

44. Despite the intense need and demonstrated cost-effectiveness of rehabilitation, many individuals simply do not receive the rehabilitation they require. The majority of those with unmet needs live in low- and middle-income countries, and half of those in need of rehabilitation do not receive it. There is, therefore, a need to strengthen rehabilitation in health systems, as part of universal health coverage, and to incorporate rehabilitation interventions in packages of essential services along with prevention, promotion, treatment and palliation interventions.

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

45. The Member States of the SE Asia Region stressed on integrated rehabilitation services through a community-based approach. Member States also highlighted the challenges of HR and capacity-building and urged WHO to support them on capacity-building and strengthening comprehensive rehabilitation services at all levels of healthcare.

46. Member States, especially from the SE Asia Region, brought forward the need for accessible and affordable assistive technology, which is an integral part of rehabilitation services.

Actions already taken in the Region

47. The Regional Strategic Framework on Community-Based Rehabilitation (CBR) in the South-East Asia Region 2012–2017, provided the impetus to strengthen the rehabilitation services within the Region.

48. Within the Region, three countries (Myanmar, Nepal and Sri Lanka) have completed the situational assessment and Myanmar has already developed the Strategic Plan and Monitoring Framework. Nepal has also undertaken deeper analysis of their rehabilitation workforce and integrated rehabilitation into their routine health information system.

49. The WHO Regional Office for South-East Asia conducted a workshop in 2023 on streamlining and strengthening the areas of disability, rehabilitation and assistive technology and undertook a baseline assessment of these intertwined areas which will form the basis of future work.

Actions to be taken in the Region

50. The following actions need to be taken in the Region:

a. Based on the workshop and the baseline assessment of disability, rehabilitation and assistive technology in the Region, a regional framework for strengthening these areas needs to be developed.

b. For strengthening the rehabilitation with focus on provisioning rehabilitation services at the PHC level, technical support needs to be provided to Member States.
5) **Draft Global Strategy on infection prevention and control**

**Background**

51. Infectious diseases (including health care-associated infections (HAIs) and antimicrobial resistance (AMR)) have revealed the devastating consequences of the inadequate implementation of infection prevention and control (IPC) programmes and have brought infection prevention and control to the forefront of the strong health systems.

52. Available data and mathematical models suggest that IPC is highly cost-effective and a “best buy” for public health as an approach to reducing infections, AMR, improving health and protecting health-care workers.

53. IPC was discussed in several high-level meetings during discussions on health system strengthening, AMR, health emergencies and communicable diseases. IPC was finally discussed as a substantive Agenda item at the Seventy-fifth World Health Assembly.

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

54. In response to World Health Assembly resolution WHA75.13 titled “Global Strategy on infection prevention and control” and building on the content of the WHO Global report on IPC, the Secretariat developed the draft Global Strategy on IPC through a wide consultative process within WHO (all three levels) and in consultation with Member States and stakeholders, including members of the Global Infection Prevention and Control Network and of civil society.

55. The draft Global Strategy was discussed at the 152nd Session of the WHO Executive Board held in January 2023. The Seventy-sixth World Health Assembly held in May 2023, vide its decision WHA76(11), unanimously adopted the WHO Global Strategy on infection prevention and control.

56. With the adoption of the Global Strategy on IPC, Member States are requested to prioritize infection prevention and control in health-care services. The Strategy provides Member States with strategic directions to substantially reduce the HAIs and other contagious diseases.

57. The IPC Strategy has been structured around the eight strategic directions, namely:
   a. Political commitment and policies;
   b. Active IPC programmes;
   c. IPC integration and coordination;
   d. IPC knowledge of health and care workers and career pathways for IPC professionals;
   e. Data for action;
   f. Advocacy and communication;
   g. Research and development; and
   h. Collaboration and stakeholders’ support.
58. As per the World Health Assembly resolution WHA75.13, WHO was also requested to further translate the Global Strategy on IPC in both health and long-term settings into a Global Action Plan (GAP) for IPC that includes a monitoring framework, with clear measurable targets to be achieved by 2030 for consideration by the Seventy-seventh World Health Assembly in May 2024 through the 154th Session of the WHO Executive Board to be held in January 2024.

59. WHO will be closely working with the Member States in the implementation of the Global IPC Strategy in the national contexts, and also in the development of the WHO Global Action Plan and the monitoring framework.

**Actions already taken in the Region**

60. The situation in the context of IPC in Member States of the SE Asia Region has improved significantly and IPC has been accorded high importance, particularly after the onset of COVID-19 pandemic with countries promoting multimodal strategies while approaching IPC guidelines, education and training. IPC measures such as hand hygiene, social distancing, use of masks and PPEs, trainings on IPC, water, sanitation and hygiene (WASH) have been proven to be successful in helping Member States prevent and control the spread of the virus.

61. IPC is mostly addressed separately under several health programmes such as neonatal and maternal health, intensive care units (ICUs), surgeries, AMR, blood safety, injection safety, health emergencies, WASH, etc. However, an integrated IPC policy, strategy, implementation framework, programme and IPC national focal points do not exist in many of the Member States.

62. The WHO Global Report on IPC 2022 states that four out of the 11 Member States in the Region did not have an IPC programme or plan, or they had one but had not fully implemented it. This statistic is based on the few countries that participated in the Global Survey. This also underlines a dearth in data collection and also on monitoring and evaluation of IPC programs and services.

63. The following meetings and consultations have been held in the Region:

   i. Catalysing integrated approach to IPC, patient safety and quality of care, Bangkok, Thailand, 10–12 October 2022;

   ii. Regional SE Asia Region Member States Consultation (virtual) on the draft outline of the Global IPC Strategy, 29–30 September 2022;

   iii. Regional Meeting on blood transfusion safety (transmissible infections), Colombo, Sri Lanka, 26–27 July 2022; and

Actions to be taken in the Region

64. WHO Regional Office for South-East Asia will provide all necessary support in the implementation of all the elements of Global Strategy on IPC in the national contexts.

65. The Regional Office is organizing a virtual Regional Consultation in September 2023 to gather comments from the Member States on the Global Action Plan and Monitoring Framework (MF) of IPC. It will ensure inclusion of a regional context in the Global Action Plan and Monitoring Framework.
6) Global Health and Peace Initiative

Background

66. The Global Health for Peace Initiative (GHPI) was launched in November 2019 and is the World Health Organization’s operational response to the UN “Sustaining Peace Agenda” and the “Humanitarian-Development-Peace” nexus.

67. The health and peace approach to programming applies to all fragile, conflict-affected and vulnerable (FCV) settings. The aim of the Global Health for Peace Initiative was to contribute to peace, empower communities, and protect the health of populations in FCV settings, by strengthening the role of the health sector and WHO as an influencer of peace.

68. The initiative reflects the commitment of WHO and Member States to contribute to sustainable health, peace and well-being for all people. It promotes WHO’s Triple Billion Goals and the Sustainable Development Goals.

69. The Seventy-fifth World Health Assembly in 2022 recognized the Initiative, took note of the Director-General’s report, and adopted Decision WHA75(24) on “Global Health for Peace Initiative”. Through this decision, WHO was requested to consult with Member States and Observers and prepare a roadmap for the rollout the Initiative. This roadmap was to be presented for the consideration of the Seventy-Sixth World Health Assembly in May 2023.

70. In August 2022, the Secretariat commenced consultations with Member States and Observers on the proposed ways forward including online consultations. A total of 86 Member States and six Observers participated in consultations between August 2022 and May 2023.

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

71. The Seventy-sixth World Health Assembly in May 2023, vide Decision WHA76(12), took note of the Roadmap for Global Health and Peace Initiative. It further requested WHO to report on progress made on strengthening the Roadmap, as a living document, through consultations with Member States and observers and other stakeholders, to the Seventy-seventh World Health Assembly through the Executive Board at its 154th Session, for consideration.

Actions already taken in the Region

72. The Regional Office has been disseminating technical briefs to Member States and promoting the provision of feedback for the GHPI Roadmap.
Actions to be taken in the Region

73. The following actions are proposed to be taken by WHO in the Region:

a. support strengthening of the GHPI Roadmap including developing practical guides on health and peace;

b. support Member States in mainstreaming peacebuilding approaches in health programmes, which would be critical in achieving the Triple Billion targets in FCV settings;

c. secure financial resources to implement the GHPI activities; and

d. focus on building and strengthening capacities of Member States to progress in delivering the objectives of health and peace initiatives.
7) Social determinants of health

Background

74. Indigenous peoples constitute over 6 per cent of the world’s population and are spread across regions. Globally, there is an estimated 476.6 million indigenous peoples, of which 238.4 million are women and 238.2 million men. The Asia-Pacific is the Region where the highest proportion of indigenous peoples live (70.5%), followed by Africa (16.3%), Latin America and the Caribbean (11.5%), Northern America (1.6%) and Europe and Central Asia (0.1%).

75. Indigenous peoples often face worse health outcomes than the non-indigenous populations, for example, their life expectancy is estimated to be up to 20 years lower and they are more likely to experience disability and reduced quality of life and ultimately die younger than their non-indigenous counterparts. Indigenous mothers and children experience higher rates of mortality and morbidity than non-indigenous populations. In some countries indigenous women are up to six times more likely to die in childbirth than non-indigenous women.

76. In 2019, over 70,000 people died of drowning in the South-East Asia Region, corresponding to the second highest regional burden. In the SE Asia Region, drowning specifically affects children and young adults, and is a leading cause of death for this age group. Drowning can be prevented through the implementation of low-cost, evidence-based, community-level interventions, which have co-benefit to other health and development issues.

77. The problems of the “triple C”, namely, COVID-19, climate change and crises (sociopolitical and economic), around the world have exacerbated health inequities due to unequal distribution of power and conditions that are causes for the absence of health and well-being. Conditions affecting health across age groups are increasingly complex (encompassing urbanization, commercialization, digitalization, migration and ageing societies) and facing diversified contexts within and between countries.

78. A progress report on actions addressing the social determinants of health was developed and shared at the Seventy-fifth World Health Assembly in May 2022. The report was further updated with recommendations along with an operational framework for monitoring social determinants of health equity was presented to the Seventy-sixth World Health Assembly in May 2023. The Seventy-sixth World Health Assembly, vide its decision WHA76(23), noted the operational framework for monitoring social determinants of health equity and has also mandated that an updated report on social determinants of health, their impact on health and health equity, progress made so far in addressing them and recommendations for further action needs be submitted to the Seventy-seventh World Health Assembly in 2024, through the Executive Board at its 154th session.

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8 Ibid.
79. Chemicals, non-biodegradable waste and plastics are increasing concerns adding significantly to the burden of diseases. The resolution WHA76.17 on the impact of chemicals, waste, plastics and related pollution on human health aims to reduce the burden of disease that they lead to through the sound management of such pollutants and in connection with other health priorities such as maternal and child health, suicide prevention, health inequities, and health of those in vulnerable situations. This resolution provides additional support to previous resolutions on chemical safety, namely WHA59.15 (2006), WHA63.25 (2010), WHA63.26 (2010), WHA67.11 (2014), WHA 68.8 (2015) and WHA69.4 (2016). In addition to chemical safety, this resolution has made special reference to the WHO and health sectors’ involvement in the new Plastics Treaty and the new Science Policy Panel.

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

80. The resolution WHA76.16 on ‘The health of indigenous peoples’ requested the Director-General to:

a. develop, for the consideration of the Seventy-ninth World Health Assembly through the 158th Session of the WHO Executive Board, a Global Plan of Action for the health of indigenous peoples, in consultation with Member States, indigenous peoples, relevant UN and multilateral system agencies, as well as civil society, academia and other stakeholders, in line with WHO’s Framework of Engagement with non-State Actors, taking a life-course approach, with a particular emphasis on reproductive, maternal and adolescent health, and with a specific focus on those in vulnerable situations, and bearing in mind local context.

b. provide technical support, upon request of Member States, for the development of national plans for the promotion, protection and enhancement of the physical and mental health of indigenous peoples, including in the context of public health emergencies; and

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12 The UNEP Intergovernmental Negotiating Committee has proposed to develop an international legally binding instrument on plastic pollution, including in the marine environment (INC-2) at the United Nations Educational, Scientific and Cultural Organization (UNESCO) Headquarters in Paris, France-accessed 25 August 2023.


14 WHO/HQ is currently developing a comprehensive global situation analysis of indigenous health. The Secretariat has prepared a costing plan for development of a Global Plan of Action and related activities, whose total costing is USD 6.68 million over the three-year period (2023-2026). It will develop a zero draft of the Global Plan of Action in the first half of 2024.
c. propose, in consultation with Member States, strategic lines of action for the 
improvement of the health of indigenous peoples in the development of the 
Fourteenth WHO General Programme of Work.

81. The resolution WHA76.18 on ‘Accelerating action on global drowning prevention’ has also 
been adopted by the Seventy-Sixth World Health Assembly. The following are related 
developments:

a. During the Seventy-sixth World Health Assembly, Bangladesh made an intervention 
and highlighted that it has taken significant steps on drowning prevention and that 
swimming lessons in schools dramatically reduces drowning deaths. It was also 
informed to the Assembly that Bangladesh has implemented this successfully in 
collaboration with various international partners. Finally, Bangladesh proposed for the 
establishment of a “Global Alliance on Drowning Prevention”.

b. Multisectoral actions with health, education, environment, climate adaptation 
planning, rural economic development, fisheries, water transport and disaster risk 
reduction were considered to address the burden of injuries and death due to 
drowning.

c. The resolution requested the Director-General to:

i. encourage research on the context and risk factors for drowning;

ii. prepare a global status report on drowning prevention by the end of 2024 to 
guide future targeted actions; and

iii. establish a global alliance for drowning prevention with organizations of the 
United Nations system, international development partners and 
nongovernmental organizations.

82. The resolution WHA76.17 on the ‘Impact of chemicals, waste and pollution on human 
health’ calls upon Member States, taking into account national context and legislation to:

a. strengthen implementation of the “WHO Global Strategy on health, environment and 
climate change”\textsuperscript{15} and the “Role of the Health Sector in the Strategic Approach to 
International Chemicals Management towards the 2020 Goal and Beyond”\textsuperscript{16}

b. scale up work on plastics and health with advanced understanding of its impacts on 
human health and well-being, while recognizing the needs to cooperate and engage 
with UN agencies to make concert efforts to harmonize international treaties and 
commitments supporting scientific-based policy development.

\textsuperscript{15} WHO Global Strategy on health, environment and climate change, 
https://apps.searo.who.int/WSH/FrontLearnAboutIssue/WHO_global_strategy_on_health_environment_and_climate_change813997152.pdf

\textsuperscript{16} Role of the Health Sector in the Strategic Approach to International Chemicals Management towards the 2020 Goal 
and Beyond, https://apps.who.int/gho/ebwha/pdf_files/WHA74/A74_42-en.pdf
c. further explore, recognize and act on the linkages between chemicals, waste and pollution, and other health priorities at the domestic and international levels such as maternal and child health, antimicrobial resistance, and the importance of identifying, preventing and addressing environmentally related disease in universal health coverage, as well as recognize the importance of scientific-based domestic regulation of highly hazardous pesticides to reduce adverse occupational health effects, exposure to children and its consequences, particularly on neurological disorders.

83. Member States in South-East Asia have been working together to implement plans to phase out mercury-based medical devices and implement actions to eliminate paints containing lead. Building on current actions, the implications of this resolution would further enhance regional efforts.

84. Following Decision WHA76(23) on social determinants of health, Member States requested the Director-General to submit an updated report on social determinants of health, their impact on health and health equity, and progress made in addressing them and recommendations. During the Seventy-sixth World Health Assembly, Member States are called upon to:

   a. make concerted efforts together with WHO to implement the operational framework monitoring social determinants of health in alignment with the SDGs. The wide scope of SDH needs to be addressed through structural changes such as governance for health and well-being, responsive policies across sectors respecting rights to health, and reducing health inequities through a health in all policies approach.

   b. recognize issues such as racism, discrimination against and exclusion of migrants, people with disabilities, indigenous people and ethnic minorities in the spectrum of health inequities, which need to be addressed within the health system through the SDH lens in order to improve the quality of health services.

   c. generate robust information systems on health determinants, and where possible, a real-time dashboard, in order to take more responsive action in public health incorporating lessons learnt from the COVID-19 response, including the following: education and health literacy across age-groups; poverty, cultural practices, behaviours, and beliefs impacting health outcomes; and social protection and policies impacting health equity.

   d. foster or develop partnerships with other sectors at national and subnational levels to generate policy coherence and intersectoral/multisectoral action addressing social determinants of health including commercial determinants and urban health impacting health of population across age groups.
Actions already taken in the Region

85. The WHO Regional Office for South-East Asia organized a briefing on indigenous peoples and health in June 2022 for WHO Country Office focal points on gender, equity and human rights/violence against women, featuring presentations by WHO headquarters staff. The Member States of the SE Asia Region recognized that two-thirds of the world’s indigenous peoples live in the Asia-Pacific, which is home to more than 2000 civilizations and cultures and languages/dialects. These include groups that are often referred to as tribal peoples, hill tribes, scheduled tribes, janajati, orang asli, masyarakat adat, adivasis, ethnic minorities or nationalities, among others, in different countries.

86. The Regional Office developed and launched a Regional Status Report on drowning. Eleven Member States coordinated national meetings with multisectoral stakeholders to discuss drowning prevention and water safety, with key outputs submitted to WHO for the regional report. In response to Member States’ requests, a publication consisting of detailed country-specific reports on drowning was launched in November 2022. This publication provides a detailed situational assessment for drowning prevention in Member States and sets out key recommendations for drowning prevention for each country. Bangladesh is considered a global pioneer in increasing the evidence base for drowning prevention interventions in low-income settings. Maldives have started developing a National Drowning Prevention Strategy. India has started developing a National Injury Prevention Strategy which makes specific reference to drowning prevention. Thailand has made substantial drowning prevention campaigns.

87. In collaboration with Member States, the WHO Regional Office for South-East Asia organized a Regional Meeting on plastic pollution on 16 March 2023 to discuss the problem of microplastics in the marine environment. A white paper was prepared providing a practical way forward to deal with the issue. Indonesia, Maldives, Sri Lanka and Thailand provided country perspectives on microplastics and plastic pollution. A Regional Meeting to address health-care waste management in July 2023 aimed to strengthen systems and processes for the safe and sound management of health-care waste in line with advancing towards universal health coverage.

88. The Regional Strategic Framework on social determinants of health actions in South-East Asia (2023–2030) was developed in 2022 in consultation with Member States for the following results: i) guide actions for better health and well-being for all people in South-East Asia; ii) prepare strategic actions for future trends of sociodemographic transition and economic changes impacting people’s health; iii) support Member States in finding appropriate tools/approaches addressing SDH in the country context, and iv) guide health programmes and professions to accelerate actions addressing immediate, intermediate and structural determinants of health in appropriate contexts. The Regional Strategic Framework comprises strategic actions, a monitoring framework, and suggested benchmarks and outputs for each strategic action with periodic reporting timelines. The commercial and economic determinants of health are integrated into the framework.
89. Health in all policies approach has been implemented in several countries in the Region (Bhutan, Maldives, Nepal and Thailand). The approach has been used also to address health inequities and the social determinants of health in countries such as Thailand. Practical operations through the HiAP approach are whole-of-the-government and whole-of-society approaches that were used to address public health crisis during COVID-19 and its recovery process to promote health, well-being and resilience. Subnational governments, cities and municipalities, played important roles in addressing health determinants using these approaches and coordinated across sectors to generate better health and wellbeing through all urban policies/programmes/activities. The Regional Office conducted two meetings to support the WHO urban governance for health and well-being initiative and promote health in all urban policies/programmes in eight priority countries (Bangladesh, Bhutan, India, Indonesia, Nepal, Maldives, Sri Lanka and Thailand). Multisectoral action and comprehensive policies are being implemented in several health programmes across the life-course.

90. The SDH across the life-course approach is being applied in the Region with new initiatives on the “support parenting” programme where the Regional Office conducted a meeting on parenting and caregiver supports for early childhood development and adolescent health in October 2022. Subsequently WHO launched the new “Guidelines on parenting interventions to prevent maltreatment and enhance parent-child relationships with children aged 0–17 years” in June 2023. Social determinants of health have also been integrated in the actions for the UN Decade for Healthy Ageing, which is inclusive of combating ageism, social connection and an age-friendly environment.

Actions to be taken in the Region

91. In line with the costed plan for development of a Global Plan of Action on the health of Indigenous Peoples, the Regional Office intends to convene a Regional Consultation on the health of Indigenous Peoples in the second half of 2024.

92. All Member States observed the Global Drowning Prevention Day on 25 July 2023 to create awareness on drowning prevention. All Member States of the Region except DPR Korea have initiated data collection for the Global Status Report on drowning prevention. The data collection is expected to be completed by the end of 2023. Following the publication of the Global Status Report, the Regional Status Report on drowning prevention will also be published in 2024. The Regional Office has constantly supported Member States in developing a drowning prevention strategy and its implementation.

93. The Regional Office for South-East Asia will hold a regional workshop to establish and strengthen poisons centres in the Region between 28 and 31 August 2023 in Thailand in collaboration with the WHO Collaborating Centre for Prevention and Control of Poisoning, Ramathibodi Poison Centre. The Regional Office will continue working closely with two projects on mercury issues with the Ministry of Health, Sri Lanka, on “eliminating mercury skin lightening products” and with the Ministry of Health and Family Welfare, India, on “phasing out mercury measuring devices in health care”. In line with the resolution WHA76.17, WHO will work closely and explore with Member States for future involvement of WHO and the health sectors in the global agendas on chemicals and waste namely on (a) the Plastic Treaty; (b) Science Policy Panel on chemicals, waste and pollution prevention; (c) the Fourth meeting of the intersessional process
considering the strategic approach and sound management of chemical and waste beyond 2020; and (d) the Fifth session of the International Conference on Chemical Management (ICCMs) in Bonn, Germany, on 25–29 September 2023.

94. In line with Decision WHA76(23), Member States and the WHO Regional Office for South-East Asia will monitor health inequities across social gradients, accelerating people participation and engagement, develop appropriate national action plans addressing health inequities and promoting rights to health for all, along with multisectoral partnership to address social barriers, discrimination, stigma, and intergenerational inequities. Member States may develop national plans of action following the strategic direction and guidance provided in the Regional Strategic Framework for SDH Actions. Research and a life-course approach to SDH analysis will be an important step for health information with SDH lens and equity analysis that will foster evidence-based planning and programming, along with innovative actions which targeted for 2024.

95. In October 2023, the Regional Office for South-East Asia will organize the first consultation with Member States on commercial determinants of health to prioritize areas of attention/actions for the Region to understand the implications of commercial and economic systems and processes on population health and equity. Recognizing the importance of economic on national development, South-East Asia Member States may emphasize the positive aspects of economics of well-being that drive economic prosperity, stability and resilience. Orientation of the health sector on commercial determinants of health and appropriate action through health diplomacy will be initiated in 2024.

96. Through the HLP-SPPDM Meetings in September 2023, Member States were informed that the Royal Thai Government will promote the topics for possible inclusion in the draft Provision Agenda of the WHO Governing Body Meetings in 2024 on “Social participation” which will be driven through a proposed side-event a the upcoming Seventy-sixth Session of WHO Regional Committee or South-East Asia, and in the 154th Session of WHO Executive Board under the agenda item on “Social Determinants of Health” in consultation with Member States from SE Asia and other WHO region.

Background

97. The Report by the Director-General on the United Nations Decade of Action on Nutrition (2016–2025) submitted first to the 152nd Session of the WHO Executive Board in January 2023 and later to the Seventy-sixth World Health Assembly in May 2023, gave an overview of progress in implementing the United Nations Decade of Action (DoA) on Nutrition (2016–2025), as proclaimed by the UN General Assembly resolution UNGA70/259 of April 2016. The Decade of Action on Nutrition aimed to achieve the Global nutrition and diet-related noncommunicable disease (NCD) targets (as established by the World Health Assembly in 2012 (resolution WHA65.6) and 2013 (resolution WHA66.10)), which contribute to the realization of the Sustainable Development Goals by 2030.

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

98. The Seventy-sixth World Health Assembly noted the report on the United Nations Decade of Action on Nutrition (2016–2025) and Member States made suggestions regarding the format of the dialogues at the end of the Decade and on the way forward after the end of the Decade in 2025.

99. A resolution titled ‘Accelerating efforts for preventing micronutrient deficiencies and their consequences, including spina bifida and other neural tube defects, through safe and effective food fortification (WHA76.19) was adopted under the umbrella of the UN DoA on Nutrition.

100. The global nutrition targets cover child wasting, stunting and overweight; anaemia (women aged 15 to 49); low birth weight; exclusive breastfeeding; halting the rise in diabetes and obesity; and reducing the intake of salt/sodium. These Health Assembly nutrition targets and diet-related NCD targets are identified as timebound priority targets by all Member States. Progress on reducing stunting, wasting and anaemia is slow in some Member States and overweight and obesity prevalence is increasing. The effects of the COVID-19 pandemic, together with the disruption in the food supply caused by intensified conflicts and climate change have impeded progress in reducing all forms of malnutrition.

101. However, there are significant moves by Member States towards supporting sustainable food consumption patterns, with promotion and support of healthy diets through regulatory and other actions. Member States have addressed micronutrient deficiencies through dietary diversification, supplementation and fortification of staples. Fortification of salt with iodine is one of the significant successes in the Region. There have been efforts to expand food fortification with other micronutrients which must be done in an evidence-based manner, based on the country situation. Accountability is improving with nutrition data being provided through regular Member States’ surveys such as Demographic and Health Surveys (DHS), National Nutrition Surveys, Global School Health Surveys and STEPs which now contain expanded modules to cover healthy diets.
Actions already taken in the Region

102. The key action areas of the DoA on Nutrition on supporting sustainable, resilient food systems for healthy diets; health systems providing universal coverage of essential nutrition actions; trade and investment for improved nutrition, nutrition and social protection, supportive environments for nutrition and strengthened nutrition governance and accountability remain highly relevant to the Region. So does the resolution on micronutrient deficiency. The timeline and targets of the Strategic Action Plan to reduce the double burden of Malnutrition in the South-East Asia Region 2016–2025 are aligned to those of the DoA for Nutrition.

- The Regional Office has organized and supported several advocacy events and capacity-building meetings and other activities both at the regional level and country level to reduce stunting, wasting, anaemia and micronutrient deficiencies. These have included support for adolescent and maternal nutrition, breastfeeding, diets for young children and on anaemia and other micronutrient deficiencies.

- Thailand is identified as a frontrunner country in the WHO’s obesity acceleration plan. An intercountry obesity dialogue was completed in July 2023 jointly with the WHO Western Pacific Regional Office and WHO headquarters and in collaboration with the UNICEF and VIC Health, Australia, to support India, Indonesia, Sri Lanka and Thailand to accelerate actions on obesity.

- The Regional Office has supported Member States in promoting a healthy food environment through food labelling, marketing restrictions and fiscal policies through advocacy and capacity-building.

- Eliminating transfatty acids from the food supply, and population sodium reduction are high on the agenda for country support. The regional SEAHEARTS platform was created by the Regional Office (Department of Healthier Populations and Noncommunicable Diseases) to support both risk reduction and management of NCDs. Through this initiative salt and trans fatty acid reduction are promoted and supported.

Actions to be taken in the Region

103. The Regional Office for South-East Asia will continue to:

a. provide policy and technical guidance and support to Member States to prioritize essential nutrition actions within UHC with a focus on maternal and child nutrition as a key strategy for the health sector to contribute to optimum nutrition;

b. address micronutrient deficiencies and specially support actions in Member States to operationalize the new WHO recommendations on anaemia;
c. initiate the process of understanding and mitigating the effects of commercial
determinants on promotion of health and nutrition, and through a health promotion
meeting in October 2023;

d. continue to work through the SEAHEARTS platform to support Member States in
addressing dietary risk factors of CVDs, specifically in sodium reduction and trans-fatty
acid elimination; and

e. continue work on promoting and supporting a healthy food environment through
regulatory and other policies.
9) Behavioural sciences for better health

Background

104. The COVID-19 pandemic ushered in awareness about the importance of behavioural insights into public health emergencies and the contribution of community engagement and communication to bring about behavioural change at the population level that are essential to respond to and control the current and future pandemics.

105. During the Seventy-sixth World Health Assembly, Member States issued the following key messages on this Agenda item:

   a. There is the need to recognize the various contributions of behavioural science in achieving improved health outcomes, reducing risk factors, creating environments conducive to health and well-being, and acknowledging multidisciplinary scientific approaches of behavioural and social sciences that deal with complex human behaviours, including using behavioural science to inform policy development and decision making in public health.

   b. The application of behavioural sciences in public health matters and for health promotion has been common practice since the Ottawa Charter to the Shanghai Declaration on Health Promotion, with several UN declarations and commitments envisaging this.

   c. Health promotion and social determinants of health have utilized sociocultural, cognitive and behavioural insights to bring individual and collective behavioural change, as well as for decision-making to enhance healthy public policies. Member States reiterated that this approach should be complementary to the health promotion and well-being agenda and implementation of health in all policies (making healthier choices the easier choice), along with all healthy settings particularly from schools to workplaces and communities creating sustainable impacts.

106. The Director-General’s report demonstrated gaps in utilization of behavioural sciences in public health programmes across the health organizations of the world. Member States concurred with the need to mainstream utilization of behavioural sciences in all public health programmes, in designing informed policies and programmes for public health, particularly in emergencies and in vulnerable and fragile contexts.

107. The resolution was supported by three Member States from the SE Asia Region (Bangladesh, Maldives and Thailand) during the 152nd Session of the Executive Board (in January). The Executive Board noted the report on behavioural sciences for better health and adopted the Decision EB152(23), recommending to the Health Assembly the mainstreaming of behavioural science approaches in the work of the Organization. To integrate behavioural science in public health functions in all WHO offices, technical capacities for behavioural sciences need to be strengthened across organizations and Member States.
Main operative paragraph and implications on the collaborative activities with Member States

108. The resolution WHA76.7 on *Behavioural science for better health* urges Member States to consider their national and subnational circumstances, contexts and priorities to take initiatives such as:

   a. identify opportunities to use behavioural science in developing and strengthening effective, tailored, equitable and human-centred health-related policies and functions across sectors, in achieving the health-related SDG;

   b. use behavioural science in participatory approaches with providers and local stakeholders and empower communities in understanding public health problems, and designing and evaluating interventions to address them;

   c. establish behavioural science functions or units for generating, sharing and translating evidence, to inform a national strategy as appropriate, and to monitor, evaluate and share lessons learnt from subnational, national and regional levels responsible for the local implementation of behaviourally informed policies and interventions;

   d. strengthen the capacity of health professions through pre-service training, where possible, among academia, non-State Actors and civil society, where applicable, on behavioural science approaches in patient care and a variety of public health functions, as appropriate, intersectoral policy framework and institutional policies, etc.

109. The Director-General is requested to support the use of and mainstream behavioural science approaches in the work of the Organization; support Member States at their request in developing or strengthening of behavioural science function(s) or unit(s); establish a global repository of behavioural science evidence from empirical studies, including from randomized control trials on behavioural interventions that can be accessed and used in the strengthening of health promotion interventions among others with a view to achieve societal and lifestyle changes, and interventions that are aimed at tackling misinformation and disinformation related to public health, including vaccine hesitancy, and among vulnerable groups (PWD, mental challenge population, migrants, etc.). WHO is to provide behavioural science related technical support, normative guidance, capacity-building and knowledge-sharing to Member States upon their request including through the WHO Academy.

110. The Progress report implementing this resolution is to be considered at the Seventy-eighth World Health Assembly in 2025, and subsequent Health Assemblies in 2027 and 2029.

Actions already taken in the Region

111. Behavioural science insights and approaches have been integrated into the Regional Risk Communication Strategy 2019–2023, and several health studies and programmes in the Region such as integrated biological and behavioural study (IBBS) of key populations in HIV/STI infections, addressing stigma and discrimination to improve access to high-quality rights-based TB prevention and care, reduce treatment-seeking delays and risk behaviours, comprehensive school health and nutrition programmes and implementation of health promoting schools for healthy behaviours of children and adolescents, empowering youth participation in health and
development as a game-changer for urban development, health-oriented policy-making and development for urban leaders in healthy cities, addressing violence against women, gender mainstreaming, development of behavioural change strategies for indoor air quality improvement and promoting healthy housing, etc. Nevertheless, the efforts were not systematically planned and developed to enhance utilization of behavioural sciences.

112. During this period (2022–2023), behavioural science related capacity-building evolved around trainings on risk communication and community engagement (RCCE) and infodemic management, building community engagement toward ending TB, training on tobacco cessation, and urban leadership and inclusive community engagement. These capacity-building initiatives are directly toward understanding of behavioural sciences and implementation of the behavioural science approaches.

113. Member States in the South-East Asia Region have recognized the importance of behavioural science and have accordingly integrated it in a series of Regional Committee’s agendas/resolutions in the past, such as Agenda 10.1 of the Seventy-fifth session of the Regional Committee for South-East Asia (document SEA/RC75/15 titled “Key issues arising out of the Seventy-fifth World Health Assembly and 150th and 151st Sessions of the WHO Executive Board”); resolution SEA/RC75/R3 on “Enhancing social participation in support of primary health care and universal health coverage”; resolution SEA/RC74/R3 titled “Revitalizing the school health programme and health promoting schools in South-East Asia region”; and other resolutions related to disease control and immunization that require behavioural changes. These resolutions and regional commitments could be the edifice on which utilization of behavioural sciences on health approaches can be enhanced.

114. Focal points from WHO headquarters and the regions met in July 2023 to share experiences across countries and prepare to implement the resolution WHA76.7 on “Behavioural science for better health”.

Actions to be taken in the Region

115. Following the consultation among WHO regional focal points and headquarters, examples from other regions and good practices will be adapted for the SE Asia Region in the biennium 2024–2025. Specific actions to be considered are:

a. Sensitizing the behavioural science application and action points to all health programmes within WHO and Member States. As the resolution requests Member States and WHO to report progress biennially, reporting frameworks and indicators for country reports were proposed to WHO headquarters.

b. Mapping the current capacities and applications of behavioural sciences in public health programmes and country health priorities/policies.

c. Organizing a regional consultation with WHO representatives and country offices to mainstream behavioural sciences across the Organization.
d. Sharing knowledge on behavioural science tools, guidelines and lessons learnt from other regions.

e. Creating a regional technical working group on behavioural sciences to align behavioural sciences in health strategies and/or develop a regional strategy as well as provide technical support to Member States.

f. Setting up a technical advisory group or commission to provide strategic guidance for the Region and mobilize resources for Member States.
10) **Prevention of sexual exploitation, abuse and harassment**

**Background**

116. Sexual exploitation and abuse of the communities WHO serves is a grave violation of WHO’s commitment to serve and protect the vulnerable. Sexual harassment of WHO’s workforce is a serious failure of the Organization’s duty of care.

117. WHO uses “sexual misconduct” as an all-inclusive term used to address all forms of prohibited sexual behaviour by staff members and collaborators towards colleagues or members of the WHO staff community and collaborators.

118. From January 2023, WHO transitioned its work on sexual misconduct from the Management Response Plan (developed in response to findings of the Independent Commission that examined allegations related to the tenth Ebola outbreak in the Democratic Republic of the Congo) into WHO’s Three-Year Strategy (3YS) for the Prevention and Response to Sexual Misconduct (2023–2025).

119. A new policy on preventing and addressing all forms of sexual harassment was launched in March 2023.

120. The Seventy-sixth World Health Assembly took up Agenda item on “Prevention of Sexual Exploitation, Abuse and Harassment (PSEAH)” as part of its Committee B’s deliberations.

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

121. During the Health Assembly discussions, Bangladesh, India, Indonesia, Maldives and Timor-Leste were the Member States from the Region that took the floor. All speakers expressed their strong commitment to PSEAH, and commended WHO on its efforts and progress thus far.

122. The following are among Member States’ key recommendations:

   a. Strong support for a victim- and survivor-centred approach.

   b. Continued focus on fostering integrity, transparency, responsibility and accountability.

   c. Strengthening reporting, investigative and related functions, including through community-based complaint mechanisms.

   d. Integration of PSEAH across WHO’s operations and programmes.

   e. Strengthening a culture of honesty, openness and trust and protection from retaliation.
Actions already taken in the Region

123. Following are the actions already taken in the Region:

(i) on capacity-building:

a. All WHO Representatives have been oriented and all WHO country office focal points trained through country orientations on the new Policy on Preventing and Addressing (PASM) on PSEAH.

b. All WHO country office focal points have been oriented on the 3YS.

c. All WHO country office focal points have been trained in the use and uptake of the Learning Passport App, an online, mobile, and offline tech platform enabling high quality, flexible learning. The WHO Regional Office for South-East Asia along with WHO Headquarters participated in an innovation challenge organized by WHO Innovation Hub and is among the top ten contenders for scale up of the Learning App.

d. All WHO country office focal points have been trained in the use of the Implementing Partners Self-Assessment Tool.

e. A mission from the WHO Regional Office to Cox’s Bazar, Bangladesh, undertaken in August 2023.

(ii) Country-specific activities:

a. All WHO country offices are tracking progress on the 3YS indicators.

b. Five WHO country offices (Myanmar, Nepal, Sri Lanka, Thailand and Timor-Leste) have completed assessments of risks of sexual exploitation, abuse and sexual harassment. Risk assessments are underway in the other country offices and will be completed by December 2023.

c. Myanmar and Nepal country offices have completed mapping of their Implementing Partners for inclusion in the UN Partners' Portal (UNPP).

d. A full-time Coordinator for preventing and responding to sexual misconduct at P4 grade has been appointed in Cox’s Bazar, Bangladesh, given the high-risk geographical profile of the location in terms of SEAH.

e. PSEAH focused actions have been undertaken in Myanmar in the wake of hurricane Mocha, including mainstreaming in health emergency actions. Disasters disproportionately impact vulnerable populations, including women and girls. Existing and emerging evidence suggests that violence, including sexual violence against women and girls, increases in disaster settings. Risk factors for post-disaster sexual violence include increased life stressors, failure of law enforcement, exposure to high-risk environments, exacerbation of existing gender inequalities and unequal social norms. Actions in Myanmar include a rapid risk assessment to identify priority actions to address any increase in sexual misconduct; building capacities of WHO personnel and other dutybearers to reduce risks and ensure access to victim- and survivor-centred reporting and response mechanisms as required; and efforts to increase community level awareness on sexual exploitation, abuse and harassment.
f. All vendors and suppliers have been oriented in Nepal on PASM.


g. In Sri Lanka, in-person training of all WHO country office personnel was done in March 2023.

(iii) Evidence building:

A rapid review of laws regarding sexual harassment in the workplace in Member States of the SE Asia Region was completed in April 2023.

**Actions to be taken in the Region**

124. The following actions are proposed to be taken in the Region on this Agenda:

- a UN Partners' workshop in New Delhi on 26–28 September 2023;
- an in-person refresher and orientation session for all staff in the Regional Office on the new PASM;
- translation of WHO’s course on PASM into local languages in Myanmar and Nepal; and
- a Townhall by the Regional Director during the annual campaign on 16 Days of Activism Against Gender-Based Violence (25 November–10 December 2023).
11) WHO Global Action Plan on promoting the health of refugees and migrants, 2019–2023

Background

125. More than one billion people are on the move globally and one out of every seven human beings is a migrant, either an internally displaced person or a trans-border refugee. In 2020, there were 281 million international migrants and by June 2022, the number of forcibly displaced people had reached more than 100 million. The COVID-19 pandemic also exacerbated risk factors and pre-existing structural inequalities among refugees and migrants.


127. WHO launched the Global Action Plan for promoting the health of refugees and migrants, 2019–2023 (GAP) identifying six priority areas for action. These priorities included promoting health of refugees and migrants through a mix of short- and long-term public health interventions. The GAP also emphasized the need to ensuring continuity and quality of essential health care and mainstreaming of refugee and migrant health into regional and country agendas.

128. WHO works with entities across the United Nations system, including the International Organization for Migration and the United Nations High Commissioner for Refugees, as well as civil society and other intergovernmental and nongovernmental mechanisms.

129. The Global Action Plan was to expire at the end of 2023.

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

130. Member States including India and Indonesia supported the extension of Global Action Plan to 2030 and emphasized the need to incorporate the health of migrants and refugees into national health systems.

131. The Seventy-sixth World Health Assembly in May 2023 took note of the contribution of the Global Action Plan to meet the targets set in the Sustainable Development Goals, including those of Goals 3, 5 and 10, as well as the objectives of the Global Compact for Safe, Orderly and Regular Migration and the Global Compact on Refugees and decided to extend the time frame of the WHO Global Action Plan on promoting the health of refugees and migrants, 2019–2023 to 2030.
Actions already taken in the Region

132. The South-East Asia Region has implemented several activities to strengthen migration health activities including supporting the first Global Pilot of the WHO Refugee and Migrant Health: Country Assessment Tool, in Thailand, in October 2022, and hosting the Third Global School on refugee and migrant health in Dhaka, Bangladesh, in November 2022.

Actions to be taken in the Region

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

a. Provide technical assistance to strengthen health systems to ensure provision of essential health services to refugees and migrants.

b. Promote knowledge sharing within and among Member States on health and well-being of refugees and migrants.

c. Enhance coordination with relevant partners, and networks in implementing actions consistent with the Global Action Plan on promoting the health of refugees and migrants, 2019–2030.
12) WHO Traditional Medicine Strategy 2014–2023

Background

134. The Sixty-seventh session of the Regional Committee in September 2014 adopted the resolution SEA/RC67/R3, wherein Member States agreed to implement the WHO Traditional Medicine (TRM) Strategy 2014–2023. This led to a subsequent progress in terms of policy, regulation, and integration of traditional medicines all over the globe.

135. Notwithstanding the progress, challenges such as lack of research evidence and data, mechanisms for registering and controlling traditional medicine products, practices and practitioners, and policy and technical guidance on integration of traditional medicine into health system toward achieving UHC and SDGs have been reported by the Member States.

136. The current WHO Global Traditional Medicine Strategy 2014–2023 expires in year 2023. Therefore, the 152nd Session of the WHO Executive Board in January 2023 reviewed the Director-General’s report and the draft decision on the extension of the current Traditional Medicine Strategy and development of new Strategy for the next decade.

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

137. In United Nations General Assembly resolution on universal health coverage, the Heads of State and Government, in recommitting to achieve universal health coverage by 2030, committed to, inter alia, exploring “ways to integrate, as appropriate, safe and evidence-based traditional and complementary medicine services within national and/or subnational health systems, particularly at the level of primary health care, according to national context and priorities”.

138. Recognising the efforts made by Member States to assess the potential of traditional and complementary medicine, especially in health system readiness for and response to health emergencies, using an evidence-based methodology, including rigorous clinical studies, if appropriate and also recognising the importance, richness, and comprehensive traditional knowledge of local communities and Indigenous Peoples' cultures in addition to considering the consolidated report by the Director-General (Document A76/7 Rev.1.); the Seventy-sixth World Health Assembly decided to request the Director-General (vide Decision A76(20)):

(1) to extend the WHO Traditional Medicine Strategy 2014–2023 to 2025;

(2) to develop, guided by the WHO Traditional Medicine Strategy: 2014–2023 and in consultation with Member States and relevant stakeholders, a draft new Global Traditional Medicine Strategy for the period 2025–2034 and to submit the draft Strategy for consideration by the Seventy-eighth World Health Assembly in 2025, through the Executive Board at its 156th session.
Actions already taken in the Region

139. The South-East Asia Region has for decades actively highlighted the immense potential of traditional medicine, which across the Region, is widely available within the community, close to where people live and work, and is aligned with health-seeking behaviours.

140. All Member States of the Region have in place national policies for traditional medicine, and nine countries have formal training and education for traditional medicine practitioners. Six Member States have co-located traditional medicine services within their health systems. Five Member States have national essential medicines policies on traditional medicine, and the same number of countries provide insurance coverage for traditional medicine services.

141. On 19 April 2022, the WHO Global Centre for Traditional Medicine was launched in India. The Centre has a strategic focus on evidence and learning, data and analytics, sustainability and equity, and innovation and technology, with the aim of harnessing the contribution of traditional medicine to global health and sustainable development.

Actions to be taken in the Region

142. One of the top priorities is to complete the third WHO Global Survey on Traditional, Complementary and Integrative Medicines (TCIM).

143. Other priorities include technical products on traditional and complementary medicine currently at different stages of development as follows:

   (1) WHO International Herbal Pharmacopoeia;

   (2) the classification and qualification of traditional, complementary and integrative medicine practitioners;

   (3) benchmarks for training in and practice of different modalities, such as chiropractic, anthroposophical medicine, Tibetan medicine, traditional Chinese medicine, Yoga, cupping and Nuad Thai (under discussion);

   (4) WHO guidance document on clinical research in traditional medicine;

   (5) project on models for the appropriate integration of traditional and complementary medicine into health systems;

   (6) package tools and guidance for ensuring the safety and improving the quality of acupuncture are also under development;

   (7) inputs to the chapter on traditional medicine in the eleventh revision of the International Statistical Classification of Diseases and Related Health Problems;
(8) identification of gaps in the current strategy that need to be dealt with and inform about the new developments in the area of Traditional medicine that should be taken into account; and

(9) review of the strategy in the light of post pandemic, GPW14 and other rapidly changing scenarios.

144. There was significant regional participation in the first WHO Global Summit for Traditional Medicine held in Gandhinagar, Gujarat, India, on 17–18 August 2023, which included at the SE Asia Region-specific pre-Summit on 16 August 2023 with technical sessions, and digital as well as physical exhibitions. Around 50 nominees from the SE Asia Region Member States including high-level delegates such as honourable ministers, directors-general of health services, the WHO Regional Director for SE Asia Region and WHO representatives, in addition to resource persons, speakers and other distinguished guests, participated in various sessions of the Summit. Regional participation is also agreed upon in post-Summit workshops on intellectual property rights issues, research methodology, the Sowa-Rigpa forum. etc. that are upcoming.

145. There is a need for prioritizing and focusing on the setting up of the upcoming Global Centre for Traditional medicine at Jamnagar, Gujarat in terms of the mandate and consultations, and collaborative activities with other units.
13) **Voluntary Health Trust Fund for small island developing states**  
*(terms of reference)*

**Background**

146. Small island developing states (SIDS), as listed by the United Nations Office of the High Representative for the Least Developed Countries, and the landlocked developing countries are faced with grave developmental and health challenges, which are disproportionately posed by climate change, natural and human-made hazards, environmental degradation, health emergencies, the loss of biodiversity, the ongoing impact of the COVID-19 pandemic, external economic shocks, malnutrition, communicable and noncommunicable diseases, mental health and other health issues that exacerbate their vulnerability.

147. The Seventy-fifth World Health Assembly acknowledged and recognized the need to further develop the capacities of SIDS to address these matters and stimulate their participation in the work of the Secretariat in these areas. Therefore, the Seventy-fifth World Health Assembly decided to propose a Voluntary Health Fund for SIDS, with the terms of reference to be tabled at the Seventy-sixth World Health Assembly in 2023, with a view, inter alia, to facilitating the participation of SIDS in WHO meetings and supporting the provision of technical assistance and capacity-building in favour of SIDS on issues of direct relevance to SIDS.

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

148. The overall purpose of the Fund is to facilitate the participation in WHO meetings of SIDS that are Member States of WHO and to support the provision of technical assistance and capacity-building in favour of SIDS on issues of direct relevance to their situation, namely:

   a. to facilitate their participation in annual World Health Assembly sessions and any other formal meetings of bodies established by any of the WHO governing bodies, including negotiating sessions, in particular, by providing travel and accommodation, where appropriate, in line with current practices for funding the participation of Member States in WHO meetings, and consistent with WHO’s rules, regulations, policies and procedures; and

   b. to support the provision of technical assistance and capacity-building on key principal health concerns and challenges for SIDS, as indicated in the preamble of resolution WHA75.18.

149. The support of the Fund will be available to delegations of SIDS, both resident and non-resident, in Geneva. There are two SIDS countries in the SE Asia Region, Maldives and Timor-Leste, that will benefit from the Fund.
Actions already taken in the Region

150. The key action areas of the ToRs, as adopted by the World Health Assembly are shared and available for Member States:

- The Regional Office for South-East Asia has organized and supported several advocacy events and capacity-building meetings and other activities at global, regional and country levels to address NCDs, mental health, climate change and other important areas for SIDS including the organization of the SIDS Ministerial Meeting on NCDs and mental health in 2023.

- WHO, as the Fund Manager, will prepare annual consolidated programmatic and financial reports covering the funding received, its utilization and the results achieved, and will make these reports publicly available. The Fund will be subject to the full oversight practices of WHO, including the internal and external audit procedures of WHO.

Actions to be taken in the Region

151. The SIDS Voluntary Health Fund Selection Committee will be established consisting of six representatives, one from each WHO region, with preference given to SIDS that are Member States of WHO in that Region, if any. The terms of reference will be reviewed by the World Health Assembly every four years.
Annexure
South-East Asia Regional One Voice (ROV): Delivered by Sri Lanka

Seventy-sixth World Health Assembly (WHA76)
21–30 May 2023

Agenda Item 12: Global Strategy for Women’s, Children’s and Adolescents’ Health (2016-2030)

The South-East Asia Member States remained committed to achieving the 2030 SDG especially SDG indicators 3.1, 3.2 and 3.7 directly related to maternal, newborn and child, recognizing that other SDGs also contribute significantly to health and well-being of people.

The Global Strategy for Women’s, Children’s and Adolescent Health, presented to the World Health Assembly seven years ago, addresses the health needs of the women and children. The SE Asia Region continued to commit the implementation of the Global Strategy as one of the Regional Flagships in the last decade.

Remarkable reductions in maternal and newborn mortality have been achieved in the Region. Five countries have already achieved the under-five mortality rate target below 25 per 1000 live births. The neonatal mortality rate in these countries has also fallen below 12 per 1000 live births. Though challenges also remain in maternal mortality ratios in certain countries worldwide. Despite these achievements, gaps remain to be solved on within country disparity across rich-poor, urban-rural, ethnicity and education; all of which are social determinants of health disparity.

Increase coverage of high impact interventions especially institutional deliveries, quality antenatal care, and postnatal care for mothers and newborns can jointly contribute to further reduction of neonatal mortality. These can be done through strengthening of technical advisory groups for RMNCAH, capacity building of programme managers, application the Point of Care Quality Improvement (POCQI) model.

COVID-19 disrupts the provision of essential health service including RMNCH services. In the post pandemic period, all WHO Member States need to strengthen PHC and implement UHC, both of which will support the achievement of WCAH goals.

Thank you Chair.
Political declaration of the third high-level meeting of the General Assembly on the prevention and control of non-communicable diseases, and mental health

The Seventy-sixth World Health Assembly, having considered the consolidated report by the Director-General,¹

Decided:

(1) to endorse the draft updated menu of policy options and cost-effective interventions for the prevention and control of noncommunicable diseases (2022 update of Appendix 3 of the WHO global action plan for the prevention and control of noncommunicable diseases 2013–2030);

(2) to request the Director-General to submit a draft updated menu of policy options and cost-effective interventions for the prevention and control of noncommunicable diseases for consideration by the Eightieth World Health Assembly, through the Executive Board at its 160th session, and to incorporate revised interventions to Appendix 3 of the WHO global action plan for the prevention and control of noncommunicable diseases 2013–2030 on a continuous basis, when data are available.

Ninth plenary meeting, 30 May 2023
A76/VR/9

¹ Document A76/7 Rev.1.
South-East Asia Regional One Voice (ROV): Delivered by Bhutan

Seventy-sixth World Health Assembly (WHA76)
21–30 May 2023

Agenda Item 13.2: Political declaration of the third high-level meeting of the General Assembly on the prevention and control of non-communicable diseases, and mental health

Thank you Chair,

Bhutan delivers this statement on behalf of WHO South-East Asia Member States.

We commend WHO for prioritizing NCDs and mental health, recognizing universal health coverage in addressing NCDs and mental health.

We recognize that if implemented effectively, the updated menu of cost-effective policy options can address NCD challenges faced by the Region in a timely manner.

Although the report notes the decreasing trend in NCDs mortality, the voluntary targets may not be achievable within the agreed time frame unless we intensify our efforts, though the disruption to NCD and mental health services by the pandemic need to be rectified soonest.

While we endorsed the updated annex 3 of cost effective NCD interventions in the Global NCD Action Plan, geographically dispersed low-resource small communities, including Small Island States, face unique challenges that require contextualized solutions and support.

Therefore, South-East Asia Region proposes concrete action to address NCD and mental health by integrating these services into primary healthcare which are able to provide the whole range of NCD services including prevention, promotion and treatment and maximize the use of digital technologies, while introducing price increases of health harming products and other best buy interventions at national level. We recognize social participation—especially by youth leaders, is critical to create awareness about NCDs and mental health in the community and address commercial determinants of NCD.

Recognize that commercial sectors always interfere with government policies to contain tobacco, vaping, alcohol, and unhealthy diet. Good governance and transparency are critical in safeguarding the health of the population.
Chair,

At the South-East Asia Regional Committee meeting in 2022, we adopted the Paro Declaration. This historic commitment reaffirms our dedication to achieving **Universal Access to People-centered Mental Health Care and Services**.

In addition, Bhutan has proposed a side event on Universal Health Coverage of People-Centered Mental Health Services at the 78th UN General Assembly High-Level Meeting in New York this year. This event will be a platform to amplify our voices, share experiences, and foster partnerships that will drive effective strategies and policies to promote mental well-being through a multi-sectoral and interdisciplinary approach.

With this, we earnestly urge the WHO to intensify its efforts to advocate Member States and relevant stakeholders to accord utmost priority to NCDs and mental health and ensure that the agenda garners the attention and resources it undeniably warrants.

Together, let us seize this pivotal moment to catalyse comprehensive action, strengthen collaborations, and champion the cause of NCDs and mental health so that we pave the way for a transformative and inclusive future.

THANK YOU AND TASHI DELEK!
Substandard and falsified medical products

The Seventy-sixth World Health Assembly, having considered the consolidated report by the Director-General,¹

Decided to request the Director-General:

(1) to facilitate the conduct of an independent evaluation of the Member State mechanism on substandard and falsified medical products in accordance with the terms of reference to be developed by the Steering Committee of the Member State mechanism;

(2) to report on the outcome of the evaluation to the governing bodies consistent with existing reporting requirements of the Member State mechanism on substandard and falsified medical products.

Ninth plenary meeting, 30 May 2023
A76/VR/9

¹ Document A76/7 Rev.1.
Strengthening rehabilitation in health systems

The Seventy-sixth World Health Assembly,

Having considered the consolidated report by the Director-General;¹

Considering that the need for rehabilitation is increasing due to the epidemiological shift from communicable to noncommunicable diseases, while taking note of the fact that there are also new rehabilitation needs emerging from infectious diseases like coronavirus disease (COVID-19);

Considering further that the need for rehabilitation is increasing due to the global demographic shift towards rapid population ageing accompanied by a rise in physical and mental health challenges, injuries, in particular road traffic accidents, and comorbidities;

Expressing deep concern that rehabilitation needs are largely unmet globally and that in many countries more than 50% of people do not receive the rehabilitation services they require;

Recognizing that rehabilitation requires more attention by policy-makers and domestic and international actors when setting health priorities and allocating resources, including with regard to research, cooperation and technology transfer on voluntary and mutually agreed terms and in line with their international obligations;

Deeply concerned that most countries, especially developing countries, are not sufficiently equipped to respond to the sudden increase in rehabilitation needs created by health emergencies;

Emphasizing that rehabilitation services are key to the achievement of Sustainable Development Goal 3 (ensure healthy lives and promote well-being for all at all ages), as well as an essential part of achieving target 3.8 (achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all);

Reaffirming that rehabilitation services contribute to the enjoyment of human rights, such as the right to the enjoyment of the highest attainable standard of physical and mental health, including sexual and reproductive health, the right to work and the right to education, among others, and that Member States’ obligations and commitments in this regard are consistent with the United Nations Convention on the Rights of Persons with Disabilities;

Noting the Declaration of Astana, which emphasizes that rehabilitation is an essential element of universal health coverage and an essential health service for primary health care;

¹ Document A76/7 Rev.1
Recalling resolution WHA54.21 (2001) and the International Classification of Functioning, Disability and Health, which provides a standard language and a conceptual basis for the definition and measurement of health, functioning and disability;

Recalling also the role of rehabilitation for effective implementation of: resolution WHA66.10 (2013), in which the Health Assembly endorsed the global action plan for the prevention and control of noncommunicable disease 2013–2020; resolution WHA69.3 (2016) on the global strategy and action plan on ageing and health 2016–2020; resolution WHA71.8 (2018) on improving access to assistive technology; decision WHA73(33) (2020) on the road map for neglected tropical diseases 2021–2030; resolution WHA74.7 (2021) on strengthening WHO preparedness for and response to health emergencies; and resolution WHA74.8 (2021) on the highest attainable standard of health for persons with disabilities;

Recalling further the political declaration of the high-level meeting on universal health coverage (2019), including the commitment therein to increase access to health services for all persons with disabilities, remove physical, attitudinal, social, structural, and financial barriers, provide quality standard of care and scale up efforts for their empowerment and inclusion;

Noting that persons in marginalized or vulnerable situations often lack access to affordable, quality and appropriate rehabilitation services and to assistive technology, accessible products, services and environments, which impacts their health, well-being, educational achievement, economic independence and social participation;

Concerned about the affordability of accessing rehabilitation services, related health products and assistive technology, and inequitable access to such products within and among Member States, as well as the financial hardships associated with high prices, which impede progress towards achieving universal health coverage;

Reaffirming that universal health coverage implies that all people have access, without discrimination, to nationally determined sets of needed treatment, promotive, preventive, rehabilitative and palliative essential health services, while recognizing that, for most people, rehabilitation services and access to rehabilitation-related assistive technology are often an out-of-pocket expense, and ensuring that users’ access to these services is not restricted by financial hardship or other barriers;

Noting with concern that, in most countries, the current rehabilitation-related workforce is insufficient in number and quality to serve the needs of the population, and that the shortage of rehabilitation professionals is higher in low- and middle-income countries and in rural, remote and hard-to-reach areas;

Stressing that disability-sensitive, quality, basic and continued education and training of health professionals, including effective communication skills, are crucial to ensure that they have the adequate professional skills and competencies in their respective roles and functions to provide safe, quality, accessible and inclusive health services;

Noting that rehabilitation is a set of interventions designed to optimize functioning in individuals with health conditions or impairments in interaction with their environment and, as such, is an essential health strategy for achieving universal health coverage, increasing health and well-being, improving quality of life, delaying the need for long-term care and empowering persons to achieve their full potential and participate in society;
Noting as well that the benefits of improving access to affordable assistive technology, accessible products, services and infrastructures and rehabilitation include improved health outcomes following a range of interventions, as well as facilitated participation in education, employment and other social activities, and significantly reduced health care costs and burden of care providers, and that telerehabilitation can contribute to the process of rehabilitation;

Further noting that rehabilitation requires a human-centred, goal-oriented and holistic approach, guiding coordinated cross-governmental mechanisms that integrate measures linked to public health, education, employment, social services and community development and to work in collaboration with civil society organizations, representative organizations and other relevant stakeholders;

Recognizing that the provision of timely care for the acutely ill and injured will prevent millions of deaths and long-term disabilities and contribute to universal health coverage;

Concerned that lack of access to rehabilitation may expose persons with rehabilitation needs to higher risks of marginalization in society, poverty, vulnerability, complications and comorbidities, and impact on function, participation and inclusion in society;

Noting with concern that the fragmentation of rehabilitation governance in many countries and the lack of integration of rehabilitation into health systems and services and along the continuum of care result in inefficiencies and failure to respond to individual and populations’ needs;

Also noting with concern that the lack of awareness among health care providers of the relevance of rehabilitation across the life course and for a wide range of health conditions leads to preventable complications, comorbidities and long-term loss of functioning;

Appreciating the efforts made by Member States, the WHO Secretariat and international partners in recent years to strengthen rehabilitation in health systems, but mindful of the need for further action;

Deeply concerned that, without concerted action, including through international cooperation, for strengthening rehabilitation in health systems, rehabilitation needs will continue to go unmet with long-term consequences for persons and their families, societies and economies;

Noting the Rehabilitation 2030 Initiative, which acknowledges the profound unmet need of rehabilitation, emphasizes the need for equitable access to quality rehabilitation and identifies priority actions to strengthen rehabilitation in health systems,

1. **URGES** Member States:

   (1) to raise awareness of and build national commitment for rehabilitation, including for assistive technology, and strengthen planning for rehabilitation, including its integration into national health plans and policies, as appropriate, while promoting interministerial and intersectoral work and meaningful participation of rehabilitation users, particularly persons with disabilities, older persons, persons in need of long-term care, community members, and community-based and civil society organizations at all stages of planning and delivery;

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1 And, where applicable, regional economic integration organizations.
(2) to incorporate appropriate ways to strengthen financing mechanisms for rehabilitation services and the provision of technical assistance, including by incorporating rehabilitation into packages of essential care where necessary;

(3) to expand rehabilitation to all levels of health, from primary to tertiary, and to ensure the availability and affordability of quality and timely rehabilitation services, accessible and usable for persons with disabilities, and to develop community-based rehabilitation strategies, which will allow rehabilitation to reach underserved rural, remote and hard-to-reach areas, while implementing person-centred strategies and participatory, specialized and differentiated intensive rehabilitation services to meet the requirements of persons with complex rehabilitation needs;

(4) to ensure the integrated and coordinated provision of high-quality, affordable, accessible, gender-sensitive, appropriate and evidence-based interventions for rehabilitation along the continuum of care, including strengthening referral systems and the adaptation, provision and servicing of assistive technology related to rehabilitation, including after rehabilitation, and promoting inclusive, barrier-free environments;

(5) to develop strong multidisciplinary rehabilitation skills suitable to the country context, including in all relevant health workers; to strengthen capacity for analysis and prognosis of workforce shortages as well as to promote the development of initial and continuous training for professionals and staff working in rehabilitation services; and to recognize and respond to different types of rehabilitation needs, such as needs related to physical, mental, social and vocational functioning, including the integration of rehabilitation in early training of health professionals, so that rehabilitation needs can be identified at all levels of care;

(6) to enhance health information systems to collect information relevant to rehabilitation, including system-level rehabilitation data, and information on functioning, utilizing the International Classification of Functioning, Disability and Health, ensuring data disaggregation by sex, age, disability and any other context-relevant factor, and compliance with data protection legislation, for a robust monitoring of rehabilitation outcomes and coverage;

(7) to promote high-quality rehabilitation research, including health policy and systems research;

(8) to ensure timely integration of rehabilitation into emergency preparedness and response, including emergency medical teams;

(9) to urge public and private stakeholders to stimulate investment in the development of available, affordable and usable assistive technology and support for implementation research and innovation for efficient delivery and equitable access with a view to maximizing impact and cost effectiveness;

2. INVITES international organizations and other relevant stakeholders, including intergovernmental and nongovernmental organizations and organizations of persons with disabilities, private sector companies and academia:

   (1) to support Member States,¹ as appropriate, in their national efforts to implement the actions in the Rehabilitation 2030 Initiative and to strengthen advocacy for rehabilitation, as well as

¹ And, where applicable, regional economic integration organizations.
support and contribute to the WHO-hosted World Rehabilitation Alliance, a multistakeholder initiative to advocate for health system strengthening for rehabilitation;

(2) to harness and invest in research and innovation in relation to rehabilitation, inclusive of available, affordable and usable assistive technology, including the development of new technologies, and support Member States, as appropriate, in collecting health policy and system research to ensure future evidence-based rehabilitation policies and practices;

3. REQUESTS the Director-General:

(1) to develop, with input from Member States and in collaboration with relevant international organizations and other stakeholders, and to publish, before the end of 2026, a WHO baseline report with information on the capacity of Member States to respond to existing and foreseeable rehabilitation needs;

(2) to develop feasible global health system rehabilitation targets and indicators for effective coverage of rehabilitation services for 2030, focusing on tracer health conditions, for consideration by the Seventy-ninth World Health Assembly, through the 158th session of the Executive Board;

(3) to develop and continuously support the implementation of technical guidance and resources to provide support to Member States in their national efforts to implement the actions of the Rehabilitation 2030 Initiative, building on their national situations in access to physical, mental, social and vocational rehabilitation;

(4) to ensure that there are appropriate resources as regards the institutional capacity of WHO, at headquarters and at regional and local levels, to support Member States in strengthening and increasing the variety of available rehabilitation services and access to available, affordable and usable assistive technology, and to facilitate international collaboration in this regard;

(5) to support Member States to systematically integrate rehabilitation and assistive technology into their emergency preparedness and response as part of their investment in strengthening their own emergency medical teams, including by addressing the long-term rehabilitation needs of those affected by health emergencies, including COVID-19;

(6) to report on progress in the implementation of this resolution to the Health Assembly in 2026, 2028 and 2030.
Global strategy on infection prevention and control

The Seventy-sixth World Health Assembly, having considered the consolidated report by the Director-General,¹

Decided to adopt the WHO global strategy on infection prevention and control.

Ninth plenary meeting, 30 May 2023
A76/VR/9

¹ Document A76/7 Rev.1.
Global Health and Peace Initiative

The Seventy-sixth World Health Assembly, having considered the consolidated report by the Director-General,¹

Decided:

(1) to take note of the Roadmap for the Global Health and Peace Initiative as referenced in document A76/7 Rev.1;²

(2) to request the Director-General to report on progress made on strengthening the Roadmap, as a living document, through consultations with Member States³ and observers⁴ and other stakeholders, as decided by Member States, to the Seventy-seventh World Health Assembly through the Executive Board at its 154th session, for consideration.

Ninth plenary meeting, 30 May 2023
A76/VR/9

¹ Document A76/7 Rev.1.
² Available at https://www.who.int/publications/m/item/roadmap-for-the-global-health-for-peace-initiative--draft.
³ And, where applicable, regional economic integration organizations.
⁴ As described in paragraph 3 of document EB146/43.
The health of Indigenous Peoples

The Seventy-sixth World Health Assembly,

Recalling that Indigenous individuals have an equal right to the enjoyment of the highest attainable standard of physical and mental health, as declared by the United Nations Declaration on the Rights of Indigenous Peoples adopted by the United Nations General Assembly through resolution 61/295;

Recalling the commitments of the World Conference on Indigenous Peoples in 2014 to intensifying efforts to reduce rates of HIV and AIDS, malaria, tuberculosis and noncommunicable diseases and to ensure their access to sexual and reproductive health, as reflected in resolution 69/2;


Recalling the Constitution of the World Health Organization, which recognizes that health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity;

Recalling the Expert Mechanism on the Rights of Indigenous Peoples, including its study on Right to Health and Indigenous Peoples with a focus on children and youth (A/HRC/33/57), as well as taking note of the work of the United Nations Permanent Forum on Indigenous Issues and the United Nations Special Rapporteur on the Rights of Indigenous Peoples, recognizing the contribution that Indigenous Peoples make to these discussions;

Recalling also resolutions WHA62.14 (2009) on reducing health inequities through action on the social determinants of health, WHA65.8 (2012) that endorsed the Rio Political Declaration on Social Determinants of Health and WHA74.16 (2021) on the Social Determinants of Health;

Recognizing regional WHO activities on the health of Indigenous Peoples;

Recalling the United Nations General Assembly resolutions 75/168 (2020), 76/148 (2021) and 77/203 (2022) on the rights of Indigenous Peoples, the latter of which reaffirms that Indigenous Peoples have the right to their traditional medicines and to maintain their health practices, including the conservation of their vital medicinal plants, and also reaffirms that Indigenous individuals have the right to access, without any discrimination, to all social and health services;

Also recalling United Nations General Assembly resolution 74/2 (2019), entitled “Political declaration of the high-level meeting on universal health coverage”, which recognizes the need to tackle health inequities and inequalities within and among countries through political commitment, policies and international cooperation, including those that address social, economic and environmental and other determinants of health;
Recognizing the importance of holding consultations and cooperating in good faith with the Indigenous Peoples concerned through their own representative institutions in order to obtain their free, prior and informed consent before adopting and implementing legislative or administrative measures that may affect them as outlined in the United Nations Declaration on the Rights of Indigenous Peoples;

Recognizing that the health needs and vulnerabilities of Indigenous Peoples vary as they are heterogenous groups of peoples and live in different environmental and social contexts;

Recalling that the United Nations Declaration on the Rights of Indigenous Peoples expressed concern that Indigenous Peoples have suffered from historic injustices as a result of, inter alia, their colonization and dispossession of their lands, territories and resources, thus preventing them from exercising, in particular, their right to development in accordance with their own needs and interests;

Noting reports of the United Nations Department of Economic and Social Affairs, according to which life expectancy can be considerably lower for Indigenous Peoples, lack of access to medical services is higher among Indigenous Peoples, and, as to social, economic and environmental determinants of health, Indigenous Peoples are disproportionally subject to poverty, poor housing, cultural barriers, violence, including gender-based violence, racism, experiencing disability, pollution and lack of access to education, economic opportunities, social protection, water and sanitation, as well as appropriate resilience planning for climate change and natural and other emergencies;

Also noting with concern that Indigenous women often experience disproportionally poorer maternal health outcomes and face considerable barriers to accessing primary health care and other essential health care services, with particular risks to young mothers;

Recognizing the particular vulnerability of Indigenous youth, caused by the changing living environments, including social, cultural, economic and environmental determinants;

Recognizing further that the political, social and economic empowerment, inclusion and non-discrimination of all Indigenous Peoples can support and promote the building of sustainable and resilient communities and facilitate addressing social determinants of health and challenges during public health emergencies;

Recognizing also the need to mainstream a gender perspective and support the full, equal and meaningful participation and leadership at all levels of Indigenous women and girls, and protect their human rights;

Recognizing that Indigenous Peoples are likely to disproportionately experience disability as compared with the general population.¹

1. URGES Member States, taking into account their national contexts and priorities, and the limitations set out in the United Nations Declaration on the Rights of Indigenous Peoples Article 46.2, and in consultation with Indigenous Peoples, with their free, prior and informed consent:

(1) to develop knowledge about the health situation for Indigenous Peoples through ethical data collection about the health situation for Indigenous Peoples in national contexts with the

¹ Indigenous Peoples are often likely to experience disability disproportionately as compared with the general population with some research indicating rates as high as 20–33% (IASG Thematic Paper – Rights of Indigenous Peoples/Persons with Disabilities, 2014).
purpose to identify specific needs and gaps in access to and coverage by current physical and
mental health services and obstacles in their use, identification of reasons for these gaps and
recommendations on how to address them;¹

(2) to develop, fund and implement national health plans, strategies or other measures for
Indigenous Peoples, as applicable, to reduce gender inequality as well as social, cultural and
geographic barriers to their equitable access to quality health services, provided in Indigenous
languages, including during public health emergencies, and taking a life course approach with a
particular emphasis on the reproductive, maternal and adolescent health, while recognizing the
Indigenous health practices, as appropriate;

(3) to pay particular attention to ensuring universal access to sexual and reproductive health
care services, including for family planning, information and education, and the integration of
reproductive health into national strategies and programmes;

(4) to incorporate an intercultural and intersectoral approach in the development of public
policies on the health of Indigenous Peoples that also accounts for equitable opportunities for
partaking in participatory platforms, overcoming gender inequality as well as barriers related to
demographical remoteness, disability, age, language, information availability and accessibility,
digital connectivity and other factors;

(5) to explore ways to integrate, as appropriate, safe and evidence-based traditional and
complementary medicine services, within national and/or subnational health systems, particularly
at the level of primary health care, and mental health and wellness services;

(6) to adopt an inclusive and participatory approach in the development and implementation
of research and development to promote Indigenous health, taking into account their traditional
knowledge and practices;

(7) to encourage the attraction, training, recruitment and retention of Indigenous Peoples as
health workers, as well as training and capacity-building of human resources to care for
Indigenous Peoples with an intercultural approach, including in the context of public health
emergencies;

(8) to contribute to capacity-building for Indigenous Peoples so that they may conduct health
and environmental monitoring and surveillance in Indigenous territories, with appropriate
consideration to the specific conditions of vulnerability, marginalization and discrimination
experienced by Indigenous Peoples, and recalling their right to maintain, control, protect and
develop their cultural heritage, traditional knowledge and traditional cultural expressions, as well
as the manifestations of their sciences, technologies and cultures, including, inter alia, human and
genetic resources, seeds, medicines and knowledge of the properties of fauna and flora;

(9) to address the health needs of Indigenous Peoples, strengthening access to mental health
services and care and adequate nutrition, with full consideration to their social, cultural and
geographic realities, providing access, without discrimination, to nationally determined sets of
the needed promotive, preventive, curative, rehabilitative and palliative essential health services
and strengthening access to immunization in Indigenous territories and for Indigenous Peoples
irrespective of where they live;

¹ See for example, https://datascience.codata.org/articles/10.5334/dsj-2020-043/.
(10) to promote basic, accessible and intercultural information and support health promotion and disease prevention in Indigenous communities that are not in voluntary isolation;

2. CALLS ON relevant actors in consultation with Indigenous Peoples, with their free, prior and informed consent:

(1) to engage and support full, effective and equal participation of Indigenous Peoples, through their own representative institutions, in the development, as well as monitoring and evaluation of the implementation, of the relevant health plans, strategies or other measures for Indigenous Peoples, including those related to public health emergencies;

(2) to foster the appropriate funding of research and development related to the health of Indigenous Peoples including through the relevant resources and collaboration, while ensuring that rights related to Indigenous Peoples’ cultural heritage, traditional knowledge and cultural expressions, and the valuing of Indigenous knowledge systems are respected;

(3) to follow the highest ethical principles when carrying out research and development related to the health of Indigenous Peoples using appropriate culturally diverse consensual approaches and observing the rights of Indigenous Peoples over their traditional lands, territories and resources, cultural heritage, traditional knowledge and traditional cultural expressions, as set out in the United Nations Declaration on the Rights of Indigenous Peoples;

(4) to engage in dialogue and cooperate with relevant sectors with the aim of ensuring that equity guides all policies that address the social and cultural determinants of health which have an adverse impact on Indigenous Peoples, including through ensuring the highest quality, availability and affordability of goods and services essential to their health and well-being, including during public health emergencies, as set out in the United Nations Declaration on the Rights of Indigenous Peoples;

3. REQUESTS the Director-General:

(1) to develop, for the consideration of the Seventy-ninth World Health Assembly through the 158th session of the Executive Board, a Global Plan of Action for the Health of Indigenous Peoples, in consultation with Member States, Indigenous Peoples, relevant United Nations and multilateral system agencies, as well as civil society, academia and other stakeholders, in line with WHO’s Framework of Engagement with Non-State Actors, taking a life course approach, with a particular emphasis on the reproductive, maternal and adolescent health, and with a specific focus on those in vulnerable situations, and bearing in mind local context;

(2) to provide technical support, upon request of the Member States, for the development of national plans for the promotion, protection and enhancement of the physical and mental health of Indigenous Peoples, including in the context of public health emergencies;

(3) to propose, in consultation with Member States, strategic lines of action for the improvement of the health of Indigenous Peoples in the development of the fourteenth WHO General Programme of Work.

Ninth plenary meeting, 30 May 2023
A76/VR/9
The impact of chemicals, waste and pollution on human health

The Seventy-sixth World Health Assembly,

Reaffirming that the objective of WHO is the attainment by all peoples of the highest possible level of health and its function, inter alia, as the directing and coordinating authority on international health work;

Reaffirming also that the Constitution of WHO defines health as a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, and declares 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;

Recognizing that the health sector has a critical role and unique expertise to contribute to the sound management of chemicals and waste and protecting from their harmful impacts on health and well-being;

Recognizing the importance of the One Health approach, including the work of the One Health High-Level Expert Panel, as well as the importance of WHO’s role in this integrated, unifying approach in collaborating with the other Quadripartite Organizations (Food and Agriculture Organization of the United Nations (FAO), the United Nations Environment Programme (UNEP), the World Organisation for Animal Health (WOAH, founded as OIE) and their 2022–2026 One Health Joint Plan of Action;

Recalling WHO’s longstanding recognition of the importance of sound chemicals management for human health, the key role of WHO in providing leadership and coordination on the human health aspects of the sound management of chemicals throughout their life cycle, and the necessity of health sector participation in, and contribution to, these efforts as set out in: resolution WHA59.15 (2006) on the Strategic Approach to International Chemicals Management; resolution WHA63.25 (2010) on improvement of health through safe and environmentally sound waste management; resolution WHA63.26 (2010) on improvement of health through sound management of obsolete pesticides and other obsolete chemicals; resolution WHA67.11 (2014) on public health impacts of exposure to mercury and mercury compounds; resolution WHA68.8 (2015) on health and the environment: addressing the health impact of air pollution; and WHA69.4 (2016) on the role of the health sector in the Strategic Approach to International Chemicals Management towards the 2020 goal and beyond;

Recalling the WHO Road map to enhance health sector engagement in the Strategic Approach to International Chemicals Management towards the 2020 goal and beyond and recognizing it as a tool to facilitate cross-sectoral collaboration and to identify concrete actions towards the achievement of the sound management of chemicals;
Recalling the WHO Global strategy on health, environment and climate change: the transformation needed to improve lives and well-being sustainably through healthy environments, that builds on: scaling up primary prevention; acting on determinants of health in all policies and sectors; strengthening health sector leadership, governance and coordination; building mechanisms for governance, and political and social support; generating the evidence base on risks and solutions; and monitoring progress;

Welcoming the resolution 5/8 on the establishment of a science-policy panel to contribute further to the sound management of chemicals and waste and prevent pollution, adopted by the fifth session of the United Nations Environment Assembly and the invitation to WHO to play a role in the meetings of the ad-hoc open-ended working group to prepare proposals for the science-policy panel, as appropriate;

Further welcoming the resolution 5/14 entitled “End plastic pollution – Towards an international legally binding instrument”, also adopted by the fifth session of the United Nations Environment Assembly;

Noting the adoption of Human Rights Council resolution 48/13 and General Assembly resolution 76/300 entitled “The human right to a clean, healthy and sustainable environment”;

Recognizing the work on the promotion of the sound management of chemicals and waste and the prevention of pollution by multilateral agreements and intergovernmental bodies, including the Inter-Organization Programme for the Sound Management of Chemicals (IOMC) and the International Conference on Chemicals Management (ICCM), and welcoming the continuation of their work to contribute further to the sound management of chemicals and waste and to prevent pollution;

Recognizing that unsound management of chemicals and waste, as well as pollution, can cause significant adverse effects on human health and the environment, and these are important factors in many noncommunicable diseases;

Recognizing further the linkages between the health impacts of chemicals, waste and pollution and other priority global health issues including inequity and vulnerability, maternal and child health, antimicrobial resistance and the meaningful achievement of Universal Health Coverage, and that inaction on these linkages limits our collective capacity to strengthen our health systems, including in the context of health emergencies;

Noting that the market and non-market costs of inaction could be as high as 10% of global gross domestic product\(^1\) and that 2 million lives and 53 million disability-adjusted life years were lost in 2019 due to exposures to selected chemicals\(^2\) with nearly half of those deaths attributable to lead exposure and resulting cardiovascular disease and 138 000 deaths from pesticides involved in suicides representing 20% of all global suicides.\(^3\)

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\(^1\) UNEP Global Chemicals Outlook II – Part 1 page 170


\(^3\) https://www.who.int/publications/i/item/9789240026629 WHO LIVE LIFE: An implementation guide for suicide prevention in countries.
Recognizing that robust data is only available for a small number of potential chemical exposures, and that people are exposed to many more chemicals in their daily lives, and noting that children are particularly vulnerable to these exposures resulting in childhood death, illnesses and disability, particularly in developing countries;¹

Emphasizing the cross-cutting nature and relevance of the sound management of chemicals and waste and the prevention of pollution to many of the goals and targets of the 2030 Agenda for Sustainable Development, including for human health, gender equality, nutrition, sustainable consumption and production patterns, climate change, oceans and seas, clean air and water and biodiversity;²

Aware that production, consumption and the use of chemicals and the amount of waste generated will grow substantially over the coming years, and expressing great concern with regard to the unsound management of chemicals and waste and its adverse effects on human, animal and plant health and the environment;

Welcoming the acknowledgement of the interlinkages between biodiversity and health and the three objectives of the Convention for Biological Diversity in the Kunming-Montreal Global Biodiversity Framework, agreeing that that framework is to be implemented by States Parties, with consideration of the One Health approach, among other holistic approaches that are based on science, mobilize multiple sectors, disciplines and communities to work together and aim to sustainably optimize the health of people, animals and plants and the equilibrium of ecosystems based on scientific evidence and on risk assessments developed by relevant international organizations, and recalling decision 14/4 of the Conference of the Parties of the Convention on Biological Diversity which requested the Executive Secretary and the World Health Organization, as well as other partners, to continue the development of a draft global action plan to mainstream biodiversity and health linkages into national policies, strategies, programmes and accounts;

Aware of the extensive WHO research concerning the linkages between pollution and health risks, including on the disproportionate effect it has on persons in vulnerable situations;³

Noting that the negotiations for the new international instrument for the Strategic Approach and sound management of chemicals and waste beyond 2020 are in progress for consideration at the 5th International Conference on Chemicals Management (ICCM5), it is timely to highlight the importance of health sector engagement in efforts to address the impacts of chemicals, waste and pollution;

Concerned that the production, consumption and disposal of plastic products, including microplastics and related chemicals, which can be released to the environment, may potentially impact human, plant and animal health as well as the environment, directly or indirectly;


² The water–health nexus was highlighted at the UN 2023 Water Conference, with access to drinking water, sanitation, and hygiene services (WASH) as an essential for positive health outcomes and the achievement of the Sustainable Development Goals.

³ Agreed language taken from resolutions WHA75.19, WHA74.4, WHA74.5, WHA74.15, WHA74.16.
Recalling the adoption by the fifth session of the United Nations Environment Assembly resolution 5/7 on the Sound management of chemicals and waste which requested the Executive Director, subject to availability of resources, in cooperation with the World Health Organization, to update the report entitled State of the Science of Endocrine Disrupting Chemicals 2012 and to present a full range of options for addressing asbestos contaminants in products and the environment;

Reaffirming the importance of the Rio Principles in addressing the sound management of chemicals for health;

Recognizing the importance of science and risk-based assessments to inform the development of policies and strategies concerning public health issues;

Convinced that the availability of policy-relevant scientific evidence and findable, accessible, interoperable and reusable (FAIR) data on the impacts of and interactions between chemicals, waste and pollution could help countries design effective public health policies, as well as better abide by their international obligations, and that it could further intergovernmental bodies, the private sector and other relevant stakeholders in their work,

1. CALLS UPON Member States,\(^1\) taking into account national contexts and legislation:

   (1) to strengthen implementation of the WHO Global Strategy on Health, Environment and Climate and the WHO Road Map to enhance the engagement of the health sector in the Strategic Approach to International Chemicals Management towards the 2020 goal and beyond, taking a health-in-all policies approach;

   (2) to support WHO in scaling up work on plastics and health to enable better information of the potential human health impacts associated with plastic, including plastic pollution, with the aim of strengthening the public health aspects, including under the work of the Intergovernmental Negotiating Committee (INC) to develop an international legally binding instrument on plastic pollution;

   (3) to encourage the health sector to strengthen partnerships and collaborative efforts to develop and update regulatory frameworks, including the harmonization of protocols for national human biomonitoring and surveillance programmes particularly for chemicals of concern such as cadmium, lead, mercury, highly hazardous pesticides and endocrine disrupting chemicals (EDCs);

   (4) to further explore, recognize and act on the linkages between chemicals, waste and pollution and other health priorities at the domestic and international levels, such as maternal and child health, antimicrobial resistance, and the importance of identifying, preventing and addressing environmentally related disease in Universal Health Coverage;

   (5) to engage in the ad hoc open-ended working group established by United Nations Environment Assembly decision 5/8 to prepare proposals for the science-policy panel to contribute further to the sound management of chemicals and waste and prevent pollution,

\(^1\) And, where applicable, regional economic integration organizations.
particularly with regard to inclusion of health aspects and participation of the health sector in the eventual panel;

(6) to recognize the importance of science-based domestic regulation of highly hazardous pesticides, in efforts to reduce adverse occupational health effects, exposure of children, and the consequences of highly hazardous pesticides on human health and diseases, including to address suicide and neurological disorders;¹

2. ENCOURAGES, as articulated in resolution WHA69.4, the continued participation of the health sector, including WHO within its functions and Member States, during the negotiations for the new international instrument for the Strategic Approach and sound management of chemicals and waste beyond 2020 to be considered at the 5th International Conference on Chemicals Management (ICCM5), and invites the governing bodies of relevant multilateral agreements, other international instruments and intergovernmental bodies, such as the International Conference on Chemicals Management, the Strategic Approach to International Chemicals Management (SAICM) Secretariat and the United Nations Environment Programme, to consider the present resolution, as appropriate and to recognize this resolution and the work of the health sector and to facilitate this engagement;

3. INVITES the governing bodies of relevant multilateral agreements, other international instruments, and intergovernmental bodies to consider the present resolution, as appropriate;

4. REQUESTS the Director General:

(1) to publish a report, incorporating science and risk based-assessments and conclusions on the human health implications of chemicals, waste and pollution as well as reporting on existing data gaps, including from a One Health approach, ensuring data disaggregation by sex, age, disability and any other relevant factor, that takes into account persistent and bio accumulative and persistent and mobile substances, as well as substances that are carcinogenic, mutagenic or reprotoxic, neurotoxic, immunotoxin or harmful to cardiovascular, respiratory and other organ systems, or endocrine disruptors;

(2) in consultation with other One Health Quadripartite members, to further develop research on the linkages among human and animal health and the environment, such as in the case of chemicals, waste and pollution;

(3) to work jointly with the United Nations Environment Programme, to update the report entitled State of the Science of Endocrine Disrupting Chemicals 2012 to be prepared prior to the sixth session of the United Nations Environment Assembly, in line with the United Nations Environment Assembly resolution 5/7;

(4) to continue to provide technical support to countries, in particular developing countries, upon request, to build capacity to conduct science-based assessments and research, including on the association of pollution from plastics, including microplastics, as well as cadmium, arsenic, lead, agrochemical pesticides, among others, with known health effects, in order to inform the development of public health policies and support the strengthening of health systems in this area;

¹ https://www.who.int/publications/i/item/9789240026629 WHO LIVE LIFE: An implementation guide for suicide prevention in countries.
(5) to develop an awareness-raising campaign including an online platform that could be replicated by national and local authorities, on the health impacts of chemicals, waste and pollution, including as contaminants in drinking water and food, as well as preventing suicidal deaths using highly hazardous pesticides;

(6) to advocate for a multisectoral, multistakeholder approach to addressing pollution, including the animal and human health sectors both as a contributor to pollution as well as in its work to identify, prevent, mitigate and treat the health impacts of pollution especially at country level;

(7) to establish organizational work and support lines in relation to the overall orientation and guidance of the Strategic Approach to International Chemicals Management (SAICM), and the intersessional work of the International Conference on Chemicals Management, building on WHO’s existing relevant work, as well as the SAICM Health Sector Strategy;

(8) to actively contribute, in accordance with its mandate, to the work of the Intergovernmental Negotiating Committee, that is in charge of developing a legally binding instrument on plastic pollution; and the Ad Hoc Open-Ended Working Group to establish a Science-Policy Panel to contribute further to the sound management of chemicals and waste and to prevent pollution, and to explore the full range of options for the future involvement of WHO for the consideration by the Seventy-seventh World Health Assembly through the Executive Board at its 154th session, considering its collaboration with the United Nations Environment Programme and other organizations, as applicable, including within the framework of the Inter-Organization Programme for the Sound Management of Chemicals (IOMC);

(9) to submit, when complete, the outcome of the intersessional process to prepare recommendations regarding the Strategic Approach and sound management of chemicals and waste beyond 2020 to the Seventy-eighth World Health Assembly for consideration through the Executive Board at its 156th session, along with a report on any updates needed to the WHO Roadmap to enhance the engagement of the health sector in the new instrument;

(10) to work including within the framework of the Inter-Organization Programme for the Sound Management of Chemicals (IOMC) to encourage science-based review, research and regulation of highly hazardous pesticides used in agriculture to reduce human, animal and environmental hazards;

(11) to continue to collaborate with the Inter-Organization Programme for the Sound Management of Chemicals (IOMC) to promote broad engagement and coordination of relevant intergovernmental organizations, further strengthening international cooperation and multisectoral engagement in the sound management of chemicals and waste;

(12) to support countries upon request, especially developing countries, to develop national, or regional, human biomonitoring programmes for chemicals of concern, through capacity-building and technology transfer on voluntary and mutually agreed terms and in line with international obligations, aiming at helping to identify potential risks in the territories regarding population groups; to collect data to support the development of public policies; as well as to support the improvement of national health systems;
(13) to report on the implementation of this resolution to the Seventy-seventh World Health Assembly in 2024 through the Executive Board at its 154th session, the Seventy-eighth World Health Assembly in 2025 through the Executive Board at its 156th session and submit progress reports to the Health Assembly in 2027 and 2029.

Ninth plenary meeting, 30 May 2023
A76/VR/9
Accelerating action on global drowning prevention

The Seventy-sixth World Health Assembly,

Having considered the consolidated report by the Director-General;¹

Recalling resolution WHA64.27 (2011), which recognized drowning as a leading global cause of child death from unintentional injury,² requiring multisectoral approaches to prevention through the implementation of evidence-based interventions;

Recalling also resolution WHA74.16 (2021), which recognized the need to strengthen efforts to address the social, economic, gender-related and environmental determinants of health,³ including the need to address the consequence of the adverse impact of climate change, natural disasters and extreme weather events;

Recalling as well the adoption of resolution 75/273 (2021) by the United Nations General Assembly on global drowning prevention,⁴ inviting WHO to assist Member States in their drowning prevention efforts and to coordinate actions within the United Nations system among relevant United Nations entities;

Recalling further the publication by the WHO Secretariat of the Global report on drowning,⁵ as well as subsequent guidance⁶ showing that drowning is a serious and neglected public health issue that can be prevented with feasible, low-cost, effective and scalable interventions;

Deeply concerned that drowning has been the cause of over 2.5 million preventable deaths in the past decade but has been largely unrecognized relative to its impact, and that peak drowning rates are among children;

¹ Document A76/7 Rev. 1.
Recognizing the interlinkages between drowning and development, and noting that over 90% of deaths occur in low- and middle-income countries;¹

Noting with concern that the official global estimate of 235 000 deaths per annum² excludes drownings attributable to flood-related climatic events and water transport incidents, resulting in a significant under-representation of drowning deaths;

Underlining that drowning has connections with the social determinants of health, including through increased vulnerabilities to the effects of climate change, in particular flooding events, which are predicted to increase in severity and frequency, unsafe modes of water transport and inherently riskier livelihoods dependent on exposure to water;

Underlining further that in all countries other connections with the social determinants of health include drowning being a high risk in poor rural communities with close proximity to water bodies, where poverty prevents implementation of drowning-prevention interventions, livelihood needs may lead to children being unsupervised and where long-term economic and social impacts of drowning exacerbate and prolong socioeconomic marginalization;

Emphasizing that drowning prevention requires the urgent development of an effective coordinated response among relevant stakeholders in this regard,

1. WELCOMES the invitation of the United Nations General Assembly¹ for WHO to assist Member States, upon their request, in their drowning prevention efforts, and further accepts for WHO to coordinate actions within the United Nations system among relevant United Nations entities and to facilitate the observance of World Drowning Prevention Day³ on 25 July each year;

2. URGES Member States:

   (1) to assess their national situations concerning the burden of drowning, ensuring targeted efforts to address national priorities, including through the appointment of a national drowning prevention focal point, as appropriate, and assuring that resources available are commensurate with the extent of the problem;

   (2) to develop and implement national multisectoral drowning-prevention programmes, with a focus on community, including emergency response planning and linkage with community first aid response and emergency care systems, as appropriate, in line with WHO recommended interventions, particularly in countries with a high burden of drowning;

   (3) to ensure that policy planning and implementation across sectors such as health, education, environment, climate adaptation planning, rural economic development, fisheries, water transport and disaster risk reduction, particularly policies that address the underlying drivers of increased flood risk, are undertaken in a manner that reduces drowning risks;

(4) to promote drowning prevention through community engagement and public awareness and behavioural change campaigns;

(5) to promote capacity-building and support international cooperation by sharing lessons learned, experiences and best practices, within and among the regions;

3. REQUESTS the Director-General:

(1) to encourage research on the context and risk factors for drowning, facilitate adaptation of effective drowning prevention and safe rescue and resuscitation measures that can be applied in local communities, and evaluate the effectiveness of drowning-prevention programmes;

(2) to prepare a global status report on drowning prevention by the end of 2024 to guide future targeted actions;

(3) to provide Member States, upon their request, with technical knowledge and support to implement and evaluate public health, urban and environmental policies and programmes for drowning prevention and mitigation of its consequences;

(4) to foster capacity-building and facilitate knowledge exchange among Member States and relevant stakeholders, promoting dissemination and uptake of evidence-based guidance for drowning prevention;

(5) to establish a global alliance for drowning prevention with organizations of the United Nations system, international development partners and nongovernmental organizations;

(6) to report on progress in the implementation of this resolution to the Health Assembly in 2025, to include reporting on the global status report on drowning prevention and reflect on contributions to the agenda of the Thirteenth General Programme of Work, 2019–2025, and subsequently in 2029, to include reporting on achievements of the global alliance and intersections with broader agendas, including the Sustainable Development Goals and the Sendai Framework for Disaster Risk Reduction 2015–2030.

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Social determinants of health

The Seventy-sixth World Health Assembly, having considered the consolidated report by the Director-General and its addendum on social determinants of health,1

Decided:

(1) to note the operational framework for monitoring social determinants of health equity;

(2) to request the Director-General to submit the updated report on social determinants of health, their impact on health and health equity, progress made so far in addressing them and recommendations for further action, to the Seventy-seventh World Health Assembly in 2024, through the Executive Board at its 154th session.

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1 Documents A76/7 Rev.1 and A76/7 Rev.1 Add.1.
Grouping of four Agenda items under Agenda 16
16.1 - Well-being and health promotion;
16.2 - Ending violence against children through health systems strengthening and multisectoral approaches;
16.3 - Social determinants of health; and
16.5 - United Nations Decade of Action on Nutrition (2016−2025)

Thank you, Chair, Thailand delivers this statement on behalf of the SE Asia Region.

Nature and well-being are the foundations of human development.

Well-being of population is the outcomes of broader and complex determinants of health.

Well-being societies are the foundations for all members to thrive on a healthy planet. Social and commercial determinants of health such as poverty, unequal access to health care, lack of education, stigma, and racism are underlying causes of health inequities.

South-East Asia Member States host over a quarter of the world's population and faces significant challenges including poverty, lack of education, malnutrition, access to healthcare and live in unhealthy ecosystem, particularly marginalized populations; all of which leading to lack of well-being. Poverty contributes to malnutrition, while poverty and malnutrition are important risk factors driving NCD and tuberculosis.

Though child homicide, 1 per 100 000 children in 2017 in the South-East Asia, was lower than global average of 1.7; it is still a public health concern in the Region and multi-sectoral policies are required. The understanding of social-ecological factors and participation by the community, family and children, can inform policies and interventions to ensure safe environments and prevent violence.

Chair,

The SE Asia Region highlights the need for policy coherence in addressing both social and commercial determinants of health as well as the structural determinants of health inequity, all of which are the root causes of ill health and stark inequities.
In addressing social and commercial determinants of health, implementing WHO best buy interventions, as measured by 100 international dollars per DALY averted in LMIC, require strong leadership from multi-partners such as Finance and other related ministries. Controlling consumption of unhealthy products requires multi-sectoral government regulatory frameworks and enforcement. Multi-sectoral actions are possible only when all partners have a shared vision towards health and well-being of the population, supported by good governance including transparency, and prevention of conflicts of interest.

Addressing structural determinants of health inequity, as Sir Marmot said, needs strongest political commitment and policy coherence across successive governments. The South-East Asia Regional Strategic Framework on social determinants of health is being developed to support implementation. Further, an annual UHC and health-related SDG report, as mandated by Regional Committee resolution, has been published and launched at the annual Regional Committee meeting since 2018. These evidence informed policy in the Region.

While adopting the resolutions on 1) accelerating action on global drowning prevention, led by Bangladesh, and the resolution 2) safe and effective food fortification; South-East Asia also supports the adoption of 3) the WHO operational framework for monitoring social determinants of health equity and 4) Well-being framework using health promotion approach.

Thank you.
Accelerating efforts for preventing micronutrient deficiencies and their consequences, including spina bifida and other neural tube defects, through safe and effective food fortification

The Seventy-sixth World Health Assembly,

Having considered the consolidated report by the Director-General;¹

Recalling resolutions WHA39.31 (1986) on prevention and control of iodine disorders; WHA45.33 (1992) on national strategies for prevention and control of micronutrient malnutrition; WHA58.24 (2005) on sustaining the elimination of iodine deficiency disorders; WHA65.6 (2012) on comprehensive implementation plan on maternal, infant and young child nutrition; and WHA68.19 (2015) on outcome of the Second International Conference on Nutrition, which promote food fortification as a mechanism to prevent micronutrient deficiencies and birth defects associated with nutritional deficiencies;

Recalling also resolution WHA63.17 (2010) on birth defects, which requested the Director-General to support Member States in developing national plans for implementation of effective interventions to prevent and manage birth defects within their national maternal, newborn and child health plan, and food fortification strategies, among others, for the prevention of birth defects, and promoting equitable access to such services; and urged Member States to increase coverage of effective prevention measures, including folic acid supplementation;

Recognizing that micronutrient deficiencies are a public health concern as they constitute a risk factor for many diseases, and they may lead to increasing morbidity and mortality rates; and that the latest estimates indicate that 372 million preschool children and 1.2 billion women of reproductive age worldwide are at risk of at least one micronutrient deficiency;

Recognizing the primary role of healthy, balanced and diverse diets and sustainable food systems that help to reduce the prevalence of nutritional deficiencies, complemented with population strategies, such as food fortification, and/or supplementation, across the life cycle;

Recognizing that anaemia in 2019 globally affected 570 million women of reproductive age (29.9%), 31.9 million pregnant women (36.5%) and 269 million children 6 to 59 months of age (40%), worldwide, impairing their physical capacity and work performance and, when women were pregnant, increasing the risk of complications and maternal and neonatal mortality;

¹ Document A76/7 Rev. 1.
Recognizing that while the number of countries with adequate and safe iodine intake reached 118 in 2020, several countries still require increased efforts to ensure adequate iodine intake; that vitamin A deficiency in children 6 to 59 months of age remains a public health concern affecting 29% of them in 2013, putting them at increased risk of mortality; and that the lack of vitamin D exposes children to rickets and osteomalacia and adults to osteoporosis;

Concerned that surveys evaluating folate insufficiency among women of reproductive age show that this condition is highly prevalent in more than 40%, increasing their probability of having babies with neural tube defects; and that an estimated 240 000 newborns worldwide die within 28 days of birth each year due to birth defects, that birth defects can lead to long-term disability, taking a significant toll on individuals, families, health systems and societies, and that nine out of 10 children born with a major birth defect are in low- and middle-income countries;

Noting the availability of new or updated guidance and tools to support Member States in the design, development, operation, evaluation and monitoring of their fortification programmes, including WHO guidelines on fortification of different products; a Manual for millers, regulators, and programme managers, and the Micronutrient survey manual and companion toolkit, among others;

Acknowledging the scientific evidence of the protective effect of fortifying foods with folic acid and other micronutrients of concern within populations, such as iron, vitamin A, zinc, calcium and vitamin D, when implemented as to not exceed Tolerable Upper Intake Levels; and recognizing that, according to national circumstances, safe and effective food fortification and/or supplementation policies, when adequately designed and implemented, can be a safe, proven and cost-effective intervention that improves micronutrient status and other health outcomes, including by preventing spina bifida and anencephaly;

Acknowledging the challenges that countries face to plan, implement, monitor and educate on food fortification programmes, upon a science-based risk–benefit assessment, as well as to assess the impact on the population of these measures,

1. **URGES** Member States,\(^1\) taking into account their national circumstances and capacities:

   (1) to recognize the importance of, and promote, healthy and balanced diets, and nutritional education for all populations, including in regular health and promotion of maternal and child health programmes;

   (2) to make decisions on food fortification with micronutrients and/or supplementation, including to prevent birth defects on the basis of public health needs and a risk–benefit assessment, using as vehicles foodstuffs considered most appropriate in the country, and carrying out regular monitoring;

   (3) to conduct dialogues among government officials, health professionals and civil society on the importance of preventing micronutrient deficiencies and birth defects through the promotion of healthy diets, and safe and effective food fortification and/or supplementation policies, adequately designed and implemented;

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\(^1\) And, where applicable, regional economic integration organizations.
(4) to build multisectoral collaborations among health ministries and national health authorities, agriculture, social protection, trade, development, the food and food processing industry, and other stakeholders to consider implementing safe and effective food fortification and/or supplementation policies;

(5) to consider further strengthening surveillance and national estimates of anaemia, neural tube defects and other birth defects to better monitor progress towards prevention and to ensure accountability for improved health outcomes;

(6) to establish systems for newborn screening diagnosis and early management of anaemia, neural tube defects and other birth defects in newborns and children under 5 years;

(7) to consider, in accordance with national circumstances, appropriate ways to strengthen financing mechanisms and other enhancements for food fortification and/or supplementation programmes to ensure quality implementation, capacity to monitor compliance, impact and regular reporting of programme performance, coverage, quality and evolution of the micronutrient status, including attention to consequences of intake, coverage and status;

(8) to share information, as appropriate and through WHO, within the framework of the report on implementation of this resolution, on the status of food fortification in each respective country and its impact on the population, including possible adverse effects;

2. REQUESTS the Director-General:

(1) to continue providing normative evidence-based guidance and standards to Member States on food fortification and supplementation, with micronutrients and its implementation in appropriate vehicles, and the assessment of the micronutrient status and the causes of the deficiencies, based on the nutritional status of the population, in particular to prevent birth defects;

(2) to provide guidance on risk–benefit assessment, monitoring of compliance, and periodic evaluation of coverage and impact of the food fortification and supplementation programmes;

(3) to develop technical and quality assurance guidance for food fortification and, within available resources, for supplementation, to non-State actors who produce and process food; ensuring the establishment of quality assurance and quality control systems in accordance with national standards as well as governmental inspection and technical audit, auditing to enforce them; and to strengthen the existing quality infrastructure through capacity-building and experience sharing;

(4) to develop a report on the global status of food fortification and supplementation, and use it to identify global and national priorities to periodically evaluate that food fortification programmes adhere to WHO recommendations, including not to exceed the Tolerable Upper Intake Levels for each nutrient, to allow the adjustment and promotion of food fortification programmes towards 2030;

(5) to provide technical support to Member States to conduct needs and feasibility assessments, design fortification programmes, strengthen surveillance, to develop estimates on micronutrient deficiencies; and the prevention and management of neural tube and other birth defects;
(6) to report on the implementation of this resolution through biennial reports to the Health Assembly until 2030, beginning with the Seventy-ninth World Health Assembly, to be issued in 2026, 2028 and 2030, respectively.

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The Seventy-sixth World Health Assembly,

Having considered the consolidated report by the Director-General;¹

Noting that behavioural science is a multidisciplinary scientific approach that deals with human action and its psychological, social and environmental drivers, determinants and influencing factors, and that it is applied in protecting and improving people’s health by informing the development of public health policies, programmes and interventions that can range from legislation and fiscal measures to communications and social marketing, as well as to support other public health efforts;

Acknowledging, while noting the contribution of behavioural science in achieving improved health outcomes, the centrality of epidemiological data on the incidence and prevalence of diseases and their risk factors in public health and in informing the development of health policies and the health system;

Recognizing the value of high-quality data about behaviours collected with a variety of methods in guiding the health sector, including in health in all policies and whole-of-government activities, aimed at reducing risk factors, addressing health determinants, creating environments conducive to health and well-being and increasing equal access to healthy options, and informing the development of behavioural interventions;

Acknowledging that supporting individuals to enact healthier behaviours to achieve improved health outcomes is challenging due both to the complexity inherent in human behaviour and the different national contexts, and that no single discipline can provide a complete understanding of the matter, and that developing interventions to change behaviour of either individuals regarding their own health or health service employees and health professionals requires a comprehensive and interdisciplinary approach that includes but is not limited to anthropology, communications, economics, neuroscience, psychology and sociology;²

Noting that individuals, communities and populations are often exposed to multiple behavioural influences including by all types of public and private sector communications, and that behavioural science can facilitate the understanding on how such influences and communications guide decision-making;

¹ Document A76/7 Rev.1.
Recognizing the interest among the Member States in strengthening the use of behavioural science in informing policy development and decision-making for public health and taking note of behavioural science-related initiatives on the national, regional and global level;

Understanding that behavioural factors at the individual, collective and institutional levels, shaped by economic, environmental and social determinants of health, many of which are not amenable by individual action alone, are important contributors to increasing trends in both communicable and noncommunicable diseases and their risk factors, injuries, and health emergency risks as well as other health challenges that pose a significant challenge to health systems and increase disease burden globally, and that behavioural science can affect these outcomes therefore, improving the health and well-being of citizens is also the responsibility of the governments and in relevant contexts, nongovernmental organizations, civil society and health providers, and in private-sector entities whose products, services or other influences have a role in protecting and promoting the health of the population and preventing diseases;

Taking note of the United Nation’s Secretary-General’s Guidance Note on Behavioural Science, which encourages United Nations agencies to invest in behavioural science and work in a connected and collaborative interagency community to realize its tremendous potential to achieve impact;¹

Recalling the Ottawa Charter for Health Promotion (1986), resolution WHA57.16 (2004) on health promotion and healthy lifestyles, the Rio Political Declaration on Social Determinants of Health (2011),² the Moscow Declaration on Healthy Lifestyles and Noncommunicable Disease Control (2011), the Shanghai Declaration on Health Promotion (2016),³ the WHO Global Report on Health Equity for Persons with Disabilities (2022) and the United Nations Framework Convention on Climate Change and the Paris Agreement, and emphasizing the need to address health-related behaviours;

Acknowledging that participatory approaches of behavioural science that meet WHO principles for respectful care are fundamental to optimizing the design and uptake of health services and other care services, maximizing adherence to treatment and improving self-management support and reducing risk behaviours;

Highlighting the contribution of behavioural science in achieving universal health coverage and in strengthening prevention of, preparedness for and response to public health emergencies including through strong and resilient health systems, taking into account the lessons learned from the coronavirus disease (COVID-19) pandemic;

Concerned about the impact on behaviours of health-related misinformation and disinformation, including during the COVID-19 pandemic;

Recognizing that cost effective and secure use of information and communication technologies in support of health and health-related fields has a potential to improve the quality and coverage of

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³ Shanghai Declaration on Promoting Health in the 2030 Agenda for Sustainable Development (2016), adopted at the 9th Global Conference on Health Promotion, held in China from 21–24 November 2016.
health services, increase access to health information and skills, and promote positive changes in health behaviours;

Welcoming WHO’s work on behavioural sciences for better health as part of a comprehensive approach to equity in health, healthier behaviours and to achieve improved health and well-being including mental health and mental well-being;

Recognizing the importance of building capacity to systematically adopt evidence, including from behavioural science and implementation studies, in order to: (i) understand the methods that promote systematic uptake of effective approaches to impact routine individual practices and beyond, including at the professional, organization and government levels, and (ii) understand and examine drivers of behaviour among people and what can sustain or change behaviour,

1. **URGES** Member States, taking into account their national and subnational circumstances, contexts and priorities:

   (1) to acknowledge the role of behavioural science, through the provision of an improved understanding of individual behaviours, in the generation of evidence to inform health policies, public health activities and clinical practices, integrated with collective action through health in all policies, whole-of-government and whole-of-society approaches on economic, environmental and social determinants of health;

   (2) to identify opportunities to use behavioural science in developing and strengthening effective, tailored, equitable and human-centred health-related policies and functions across sectors, while ensuring commitment, capability and coordination across sectors in achieving the health-related Sustainable Development Goals;

   (3) to use behavioural science in participatory approaches including bidirectional communication with providers and local stakeholders and empower communities in understanding public health problems and designing and evaluating interventions to address them, in order to further enhance the effectiveness, local ownership and sustainability of interventions;

   (4) to develop and allocate sustainable human and financial resources for building or strengthening technical capacity for the use of behavioural science in public health;

   (5) to establish behavioural science functions or units for generating, sharing and translating evidence, to inform a national strategy as appropriate, and to monitor, evaluate and share lessons learned from subnational, national and regional levels responsible for the local implementation of behaviourally informed policies and interventions;

   (6) to promote enabling environments and incentives, including appropriate measures in other policy areas, that encourage and facilitate behaviours that are beneficial to the physical and mental health of individuals as well as to the environment, and supportive to the development of healthy, safe and resilient communities;

   (7) to strengthen the capacity of health professionals through pre-service training, where possible, among academia, non-State actors and civil society, where applicable, on behavioural

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1 And, where applicable, regional economic integration organizations.
science approaches in patient care and a variety of public health functions, as appropriate, intersectoral policy frameworks and institutional policies;

(8) to promote and support cooperation and partnership among Member States, between non-State actors, relevant stakeholders, health organizations, academic institutions, research foundations, the private sector and civil society, to implement plans and programmes based on behavioural science and to improve the quality of behavioural science insights by appropriate means, including the generation and sharing of evidence-based data which should follow the principles of interoperability and openness;

2. REQUESTS the Director-General:

(1) to support the use of behavioural science approaches in the work of the Organization, across programmes and activities, and to continue to advocate an evidence- and behavioural science-based approach in informing health-related policies;

(2) to mainstream behavioural science approaches in the work of the Organization and to advocate for necessary structural considerations, including as appropriate behavioural science teams, units or functions and for the allocation of sufficient funding and human resources;

(3) to support Member States, at their request, in developing or strengthening of behavioural science function(s) or unit(s);

(4) to evaluate, within existing resources, based on a prior request by the Member State(s) concerned, the behavioural science initiatives such as policies, interventions, programmes and research and share the results of such evaluations;

(5) to establish a global repository of behavioural science evidence from empirical studies, including from randomized controlled trials on behavioural interventions that can be accessed and used in the strengthening of health promotion interventions, among others, with a view to achieve societal and lifestyle changes, and interventions aimed at tackling misinformation and disinformation related to public health, including studies with positive and no or negative outcomes;

(6) to provide behavioural science-related technical support, normative guidance, capacity-building and knowledge sharing to Member States upon their request including through the WHO Academy;

(7) to compile and disseminate evidence on improved outcomes resulting from the application of the behavioural sciences to public health;

(8) to develop guidance, including through application of behavioural science, that addresses public health priorities including vaccine hesitancy, as well as misinformation and disinformation that conflicts with public health-based evidence, in particular among vulnerable groups, including migrants;
(9) to create synergies and find ways to better integrate behavioural science approaches aimed at promoting health and addressing the social determinants of health;

(10) to report on progress in implementing this resolution to the Seventy-eighth World Health Assembly in 2025, the Eightieth World Health Assembly in 2027 and the Eighty-second World Health Assembly in 2029.

Ninth plenary meeting, 30 May 2023
A76/VR/9
Consolidated report by the Director-General

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

Agenda 22. - Review of and update on matters considered by the Executive Board

Management, legal and governance matters

Agenda item 22.1 - Prevention of sexual exploitation, abuse and harassment

23. The Executive Board at its 152nd session noted the report on prevention of sexual exploitation, abuse and harassment. In the discussions, Board members welcomed the transition from the Management Response Plan to the new three-year strategy on preventing and responding to sexual misconduct and the draft policy on preventing and addressing sexual misconduct. They expressed support for WHO’s investment in staff training and efforts to strengthen its investigative capacity.

24. Under a separate agenda item, the Board adopted decision EB152(1) in which it decided to extend the temporary suspension of Financial Rule XII, 112.1, in part, to enable the Chief, Investigations of Sexual Misconduct and other Abusive Conduct to have the same reporting lines, the same type of access, the same channels for reporting the results of work undertaken, including to the Executive Board, and the same authority as those currently granted to the Director, Internal Oversight Services, in this area. The extension will remain in effect until the 153rd session of the Executive Board.

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1 Document EB152/31; see also the summary records of the Executive Board at its 152nd session, fourth meeting, section 2.
3 The policy entered into force on 8 March 2023 and is available at the following link: https://www.who.int/publications/m/item/WHO-DGO-PRS-2023.4.
Prevention of sexual exploitation, abuse and harassment

Report of the Programme, Budget and Administration Committee of the Executive Board to the Seventy-sixth World Health Assembly

1. Updating the report of the Director-General to the Health Assembly,¹ the Secretariat presented action undertaken by the Organization as it transitioned from the Management Response Plan to the new three-year strategy on preventing and responding to sexual misconduct, drawing attention to both key achievements and key challenges. The Committee was informed that progress on the implementation of the three-year strategy, communicated at quarterly Member State briefings, would be reported to the Committee’s thirty-ninth meeting in January 2024.

2. The Committee commended the Director-General and WHO on the progress made thus far in prioritizing action taken to prevent and respond to sexual exploitation, abuse and harassment. It welcomed the three-year strategy, and asked to be kept fully informed on its implementation. It raised some concerns regarding the delays in concluding the processes related to allegations made following the tenth Ebola outbreak in the Democratic Republic of the Congo, while acknowledging that these are attributed to delays within the United Nations Office of Internal Oversight Services in finalizing reports on those matters. The Committee wondered whether further cases of abuse might still emerge, and stressed the need for timely reporting on issues of sexual misconduct, underlining the need to prioritize prevention in crisis and emergency situations. In response to a question concerning the publication of the list of perpetrators of sexual misconduct, the Secretariat informed the Committee that an anonymized list was available publicly on the WHO dashboard on investigations into sexual misconduct that included the grades and regions of perpetrators. The Committee called for a comprehensive stock-taking exercise of all prevention and response actions, overseen by the Independent Expert Oversight Advisory Committee and the Independent Oversight and Advisory Committee for the WHO Health Emergencies Programme, to be completed no later than May 2025 in order to evaluate whether those actions have led to the intended results of the three-year strategy, including those for WHO’s accountability systems and culture. In response to a concern expressed regarding the use of the term “sexual misconduct”, which could obscure the gravity of certain behaviour, the Secretariat responded that in practice, the term sexual misconduct was proving to be easily understood by personnel, partners, those at risk and even the media, and that this was part of the Organization’s victim- and survivor-centred approach where the term sexual misconduct puts the focus on perpetrators rather than on the victims.

3. In response to a concern regarding the risk of misconduct among WHO’s implementing partners, the Secretariat informed the Committee that the Organization’s awareness-raising and training activities extended well beyond the closed circle of WHO personnel, reaching to all institutions, agencies, nongovernmental organizations and others engaged in implementing WHO’s programmes. However, the Secretariat cautioned that the Organization is still at the beginning of a long journey and that many

¹ Document A76/7 Rev.1.
high-risk situations exist, especially in the area of health emergency response. The Secretariat drew attention to the need for allocations to be made in health emergency response funding in support of work on safeguarding from sexual misconduct.

4. The Director-General thanked the Committee for its inputs. The approach taken was a comprehensive one, based on zero tolerance; safe and trusted reporting; swift and credible investigations; and a victim- and survivor-centred focus. Zero tolerance implied ethical conduct based on WHO’s values, noting that the WHO updated Code of Ethics and the new policy on Preventing and Addressing retaliation were now ready. The accountability framework was in the process of finalization. He invited Member States to propose alternative words to replace the umbrella term “sexual misconduct”. Gender parity was another very important element of zero tolerance, and the Director-General informed the Committee that the percentage of Director-level positions at headquarters occupied by female staff had increased from 28.3% in July 2017 to 41.0% in May 2023, demonstrating the Secretariat’s commitment to the policy of gender parity.

RECOMMENDATIONS TO THE HEALTH ASSEMBLY

5. The Committee, on behalf of the Executive Board, recommended that the Health Assembly should note the report, and proposed, as guidance for the Secretariat’s implementation of existing mandates, that the Secretariat should:

   (a) conclude processes related to allegations around the tenth Ebola outbreak in the Democratic Republic of the Congo as soon as possible and ensure that full accountability of actors is achieved;

   (b) continue to request regular updates from the United Nations Office of Internal Oversight Services on its handling of outstanding investigations, as well as on whether any additional allegations of misconduct have been discovered while addressing the original cases referred;

   (c) analyse disaggregated data once investigation results are received from the United Nations Office of Internal Oversight Services to identify additional gaps in WHO systems and workflows;

   (d) once the majority of key actions and reforms have been implemented, but no later than May 2025, organize a comprehensive stock-taking exercise, conducted by an independent entity and overseen by the Independent Expert Oversight Advisory Committee and the Independent Oversight and Advisory Committee for the WHO Health Emergencies Programme, in order to evaluate whether those actions have led to the intended results for WHO’s three-year strategy, including its accountability systems and culture;

   (e) finalize the accountability framework and ensure that it will be able to attribute accountability to individual staff and their functions; and

   (f) continue its efforts around open communication and transparency.
Prevention of sexual exploitation, abuse and harassment

Report by the Director-General

1. This report provides an update of the report by the Director-General on actions taken by the Secretariat in response to decision EB148(4) (2021) on preventing sexual exploitation, abuse and harassment that was noted by the Seventy-fifth World Health Assembly. It also describes the implementation of the more comprehensive plan to strengthen the Organization’s efforts to address this matter during the period February 2022 to October 2022. Earlier versions of this report were considered by the Executive Board at its 150th session in January 2022 as well as the Health Assembly in May 2022. The Board also adopted decision EB150(23) (2022), in which it decided to temporarily suspend in part Financial Rule XII, 112.1 in order to fast-track investigations of sexual exploitation and abuse or abusive conduct, and in its subsequent 151st session in May 2022 it adopted decision EB151(12) in which it decided to extend the temporary suspension of that Financial Rule with that provision to remain in effect until the 152nd session of the Executive Board.

2. During the period under review, the Secretariat continued to make progress on implementing the management response to the report of the Independent Commission to investigate allegations of sexual exploitation and abuse during the 10th Ebola virus disease outbreak in the provinces of North Kivu and Ituri of the Democratic Republic of the Congo. The Implementation Plan of the Management Response provides a unified framework for the prevention of and response to sexual exploitation, abuse and harassment (PRSEAH) across the Organization. The Implementation Plan is a living document that

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1 Document A75/29, noted by the Seventy-fifth World Health Assembly, see also document WHA75/2022/REC/3, summary record of the first meeting of Committee B.

2 Documents EB150/33 and EB150/33 Add.1.


incorporates new recommendations (see paragraph 4) and is updated regularly and is available on WHO’s public website.\(^1\)

3. The Management Response is aimed at not only enacting the recommendations of the Independent Commission, but also realizing WHO’s commitment to zero tolerance for any form of sexual misconduct by the Secretariat’s staff and collaborators. Spanning the period November 2021–December 2022, it focuses on a set of short-term actions, primarily to respond to the most urgent matters identified in the Commission’s report, and a set of medium-term interventions under three pillars: shift WHO’s activities to a victim- and survivor-centred approach; strengthen the capacity and accountability of the WHO workforce to prevent and respond to sexual exploitation, abuse and harassment with a focus on the role of leadership; and reform the structures, systems and culture of the Organization. A more comprehensive three-year strategy for PRSEAH, scheduled to come into effect in 2023, is planned as a final deliverable of the Management Response Plan.

4. By early October 2022, 38% of the actions in the Implementation Plan had been fully implemented and 59% were in progress. Only 3% had not been initiated. In addition, recommendations made relating to PRSEAH since the launch of the plan have been tracked by the Secretariat: of the recommendations made by the Independent Oversight and Advisory Committee for the WHO Health Emergencies Programme, 45% have been fully implemented, 41% were in progress and 14% not yet initiated; of those made by WHO’s Independent Expert Oversight Advisory Committee, which now monitors the work of the Secretariat in PRSEAH, 22% had been completed, 67% were in progress and 11% not initiated. All recommendations made by the Board at its 150th session and by the Programme, Budget and Administration Committee\(^2\) in January 2022 have been implemented.

**SHIFTING TO A VICTIM- AND SURVIVOR-CENTRED APPROACH**

5. WHO’s victim- and survivor-centred approach is based on the United Nations Protocol on the Provision of Assistance to Victims of Sexual Exploitation and Abuse,\(^3\) which states that agencies are “responsible for providing assistance to any victim of sexual exploitation and abuse perpetrated by personnel of their respective agency, fund or programme and, where appropriate, by personnel of implementing partners. Assistance is provided in accordance with the referral pathways at country-level; assistance may be provided directly by the United Nations agency, fund or programme, through contractual partnerships, and/or through collaboration with appropriate service providers at country-level.” In September 2021, the Secretariat set up a Survivor Assistance Fund to provide holistic support to victims and survivors\(^4\) starting with those identified in the report of the Independent Commission. An initial sum of US$ 2 million was allocated to this Fund and to date around US$ 350 000 has been transferred to UNFPA and local nongovernmental organizations in the Democratic Republic of the Congo to provide a range of services (medical, psychosocial, legal, and economic rehabilitation through

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2. Document EB150/5.


4. The term “victim” is used by United Nations documents and instruments and by medical and legal sectors. The term “survivor” is thought to be more respectful and empowering. However, the Secretariat acknowledges that it is individuals who are affected by sexual exploitation, abuse and harassment who have the right to decide how they are referred to. Therefore, WHO uses the terms victim and survivor interchangeably.
livelihood training and financial support for survivors to start their own businesses). A local, women-led nongovernmental organization provides free legal services to survivors who want to pursue legal action in local courts. To date, 53% of identified survivors have received support. Partners on the ground cite several challenges that have hindered the provision of support including insecurity and conflict in affected areas, the difficulties in identifying survivors due to a lack of complete or incorrect information, and the need to ensure that survivors are not further endangered or stigmatized in the process. WHO has agreed to extend the agreement with UNFPA and to expand the service providers for victim and survivor support including more direct financial support to the Office of the Victims’ Rights Advocate’s field officer in the country. Smaller allocations from the Fund have been made to provide urgent care, travel and other costs related to victim and survivor support in several other countries, mainly in the African Region.

6. The Secretariat is developing a broader policy framework for elaborating and implementing a victim- and survivor-centred approach that incorporates the principles of the United Nations Protocol on the Provision of Assistance to Victims of Sexual Exploitation and Abuse, and expands the scope to include victims of sexual harassment within the Secretariat’s workforce. The framework will encompass the whole safeguarding cycle, which includes identifying risks, taking preventive measures, ensuring safe and accessible reporting, responding effectively with investigation and services, and strengthening institutional learning.

7. A recent review\(^1\) has confirmed the lack of shared understanding of a victim- and survivor-centred approach across the United Nations and humanitarian systems and highlighted the need to significantly revise community-based complaint mechanisms. In many countries where WHO is operational, gender-based violence referral services are weak and need strengthening. Frontline health workers need capacity to deal effectively and sensitively with survivors.

8. The Secretariat is proactive in taking this work forward with partner agencies and the Inter-Agency Standing Committee’s Champion on Protection from Sexual Exploitation and Abuse and Sexual Harassment.\(^2\)

9. A WHO working group on a victim- and survivor-centred approach has defined guiding principles and will make further recommendations for integrating the approach into the Organization’s policies, procedures and practice.

**STRENGTHENING CAPACITY AND ENSURING ACCOUNTABILITY**

10. By September 2022, the United Nations mandatory training on PRSEAH, introduced in October 2021, had been assigned to 16 157 persons – staff and non-staff members – with a global completion rate of 93%. WHO’s global induction programme continued to offer a module on PRSEAH. Materials are being developed for introduction into many training courses, for example: pre-deployment of health emergency responders, country readiness, Health Cluster Coordinators, frontline polio workers and Emergency Medical Teams, and members of the Global Outbreak and Alert Response Network and other networks and partners associated with WHO, including the WHO’s Public Health Emergency


Operations Centre Network. The training applies lessons learned and best practices from the United Nations system and the Inter-Agency Standing Committee.

11. In March 2022, WHO assigned its workforce a new United Nations mandatory training course – United to Respect: preventing sexual harassment and other prohibited conduct.¹ The completion rate as at September 2022 was 91% for all personnel and 89% for the additional module for managers. Nearly 9 out of 10 WHO managers have completed the module aimed at strengthening their skills to manage others for a more respectful workplace.

12. The engagement of personnel for preventing and responding to sexual exploitation, abuse and harassment intensified throughout 2022 as part of a #NoExcuse engagement campaign to ensure that each person working for and with WHO has a clear understanding of the zero-tolerance goals, knows and acts on their responsibility to report any suspicions, and is aware of the enhanced responsibilities of supervisors and managers. The Secretariat’s global team held briefings and training sessions for more than 15,000 staff members between January 2022 and September 2022, and WHO regional and country offices have held events that have reached thousands more.

13. WHO vacancy notices and procurement contracts now specify WHO’s position and conditions regarding PRSEAH. The #NoExcuse campaign was observed by all WHO personnel during WHO’s Goals Week (28 February–4 March 2022) when staff members and supervisors discussed performance goals and objectives for the year, including those related to PRSEAH. The week started with a letter from the Director-General and all six Regional Directors to each member of the WHO workforce outlining their expectations related to zero tolerance for sexual exploitation, abuse and harassment and for inaction against it. For the electronic performance management and development system in 2022, all supervisors were required to hold at least one team meeting to discuss PRSEAH and, with their teams, to select a team goal to be achieved. Staff members were expected to complete a series of learning, capacity-development and engagement activities throughout 2022, and all staff members must re-affirm their commitment to relevant policies before being able to submit their forms. As of the end of the year, supervisors are required to attest that everyone under their supervision has completed all mandatory training.

14. To develop skills for speaking up and to counteract the tendency towards silent bystanding, the Secretariat, together with the WHO staff associations, launched in October 2022 a series of seven multilingual webinars with a reputed service provider on skills for a “speak-up” culture.

15. Accountabilities and key performance indicators on PRSEAH have been codified in the latest version of WHO’s Emergency Response Framework, which will be further expanded to create an Organization-wide accountability framework for PRSEAH by the end of 2022. The framework being developed will clarify the responsibilities of all personnel and the accountabilities of managers and leaders.

16. WHO’s institutional capacity has been significantly strengthened during 2022. The Secretariat has allocated US$ 50 million for work on PRSEAH at headquarters, regional and country offices. Funds have been distributed to all regional offices. About US$ 30 million has been designated with country

impact in mind, with 46% of the funds being allocated to country offices, 18% to regional offices, 13% to headquarters and 23% to cross-organizational activities at all levels, including the Survivors Assistance Fund. About US$ 10 million has been allocated to creating strong institutional capacity for investigational services into sexual exploitation, sexual abuse and sexual harassment and other forms of abusive conduct, and a further US$ 10 million for reforming, streamlining and strengthening related accountability functions across the Organization. Guidance has been drafted outlining 10 core activities for PRSEAH at country level and the headquarters global team is supporting regional offices to include these funds and related budgeting in public health and health emergency programmes and initiatives.

**REFORMING WHO’S SYSTEMS, STRUCTURES AND CULTURE**

17. The new comprehensive policy framework (see paragraph 6) includes the following: prioritizing a victim- and survivor-centred approach and aiming to attain and sustain zero tolerance for any form of sexual misconduct. It includes elements such as:

- a WHO policy on preventing and addressing sexual misconduct – the collective term encompassing sexual exploitation, abuse and harassment – bringing all misconduct of a sexual nature under a single framework, as the drivers and principles and mechanisms for action of prevention and response are similar;

- amendments to the WHO policy on Preventing and Addressing Abusive Conduct policy\(^1\) and procedures; these changes have been made in order to address overlap and inconsistencies with the new policy;

- a new policy on preventing and addressing retaliation, covering any form of retaliation, beyond sexual misconduct, and replacing the former policy and procedures of 2015.

18. The Secretariat is also developing an updated Code of Ethics and a new WHO legal framework for addressing non-compliance with standards of conduct with accompanying implementation guidance and tools for all planned policies in this framework. These policies and supporting material will be available on an interactive electronic/web-platform to ensure a user-friendly approach for the whole WHO workforce and external stakeholders.

19. End-to-end procedures for management of sexual misconduct incidents have been developed and are being tested. The aim is to ensure that gaps, delays, inefficiencies and lack of transparency are proactively addressed so that all the workforce and mandated officials involved in the process are enabled to play their role effectively, and that victims and survivors are treated fairly and respectfully while accessing the services they require. Standard operating procedures and related tools will be further developed.

20. In 2022 the Secretariat reformed and expanded its capacity to investigate allegations of sexual misconduct. A new Head of Investigations, empowered by decisions of the Executive Board to fast-track investigations into sexual exploitation, abuse and harassment,\(^2\) has successfully established a team of 18 qualified investigators who use trauma-informed investigative approaches. The team cleared the backlog of cases by May 2022, and has set and is meeting a 120-day benchmark for completing investigations.

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\(^2\) Decision EB148(4) (2021) and decision EB150(23) (2022).
investigations into new allegations of sexual misconduct. The same team also handles abusive conduct investigations and is working towards clearing the backlog of these cases. The lessons learned during this interim arrangement and international standards are contributing to the reform and structure of the Office of Internal Oversight Services to ensure it is fit-for-purpose. The misconduct investigation team makes public the aggregate figures on the WHO website. The WHO integrity hotline has been streamlined and moved from the Department of Compliance, Risk Management and Ethics to the misconduct investigation team in the Office of Internal Oversight Services to further increase efficiency and reduce delays. In the past 12 months 60 cases of sexual exploitation and abuse and 35 cases of sexual harassment have been recorded – a steep rise in numbers of sexual misconduct reports that is believed to be due to increased awareness, concerted capacity-building, improved efficiencies in the investigation function and transparency measures such as the dashboard on investigations into sexual misconduct, all helping to enhance trust in the system.

21. A dedicated Department of Prevention of and Response to Sexual Misconduct has been established and funded, with five staff members recruited. Senior regional coordinators have been recruited for the regional offices for Africa and the Western Pacific, with others being recruited for the remaining four regional offices. Full-time experts have been recruited in six countries in the African Region and 10 more are being recruited in other priority counties. All heads of WHO country offices are now required to assign and empower at least one part-time PRSEAH focal point in their respective offices. By October 2022 WHO had a network of more than 311 such focal points in 131 countries, who are being supported with capacity-building and training activities; each one is required initially to complete a six-week certified external course on safeguarding.

22. A key activity of the Management Response to the report of the Independent Commission and the Implementation Plan was an independent audit to identify systemic barriers and weaknesses and to specify improvements to policy, process and procedures regarding the Organization’s prevention and detection of and response to sexual exploitation, abuse and harassment. The audit was conducted by an international professional services network and was overseen by the Independent Expert Oversight Advisory Committee. The audit focused on the effectiveness of processes related to the reporting of allegations of sexual exploitation, abuse and harassment and the management of investigations as applied through the Office of Internal Oversight Services and Department of Compliance, Risk Management and Ethics between mid-2018 and mid-2021. The audit report, released in August 2022, contains 45 recommendations in the areas of: culture; organizational set up; roles and responsibilities; process guidelines and procedures; accessibility of information and resources; protection against retaliation; systems and support; training, policies guidelines and procedures; and awareness and access to information and resources. The findings and the recommendations largely align with the findings of the Independent Commission and with the WHO’s Management Response Plan to the Commission’s report. The report also corroborates the previously identified need for a review of the mandates, functions and structures of the Office of Internal Oversight Services and the Department of Compliance, Risk Management and Ethics, and highlights the need for the greater cultural change and protection against retaliation. The Secretariat is committed to implementing all the recommendations of the audit.

23. By mid-October 2022, the Director-General had approved a new structure for the Office of Internal Oversight Services which will be implemented by January 2023 and the Secretariat will follow-up with adjustments to roles and structures of other accountability departments. These actions will help to implement the end-to-end incident management system for allegations and introduce a victim- and

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1 See also document EB152/48.

survivor-centred approach to all work on preventing and responding to sexual misconduct by WHO personnel. The implementation of the audit recommendations will be integrated into the Management Response Implementation Plan and will be monitored by the Independent Expert Oversight Advisory Committee. Some longer-term recommendations, for example for culture change, will be integrated into the three-year strategy for PRSEAH that will come into effect in January 2023.

24. The Secretariat has made good progress on integrating sexual exploitation, abuse and harassment into the enterprise risk register and risk management approach. Following a full review of relevant existing risk assessment and management tools in other entities in the United Nations system, it piloted assessing risk in five countries. The tools assess inherent risks in countries (part A, to be completed by the WHO country office with United Nations entities and partner agencies), the risks posed by the WHO country presence (part B, to be completed by the country office), as well as the additional risks posed by operations entailing direct contact with communities or health emergencies (part C, to be completed by those leading the operations). Parts A and B will be part of the mandatory compliance tasks for the Head of each WHO Country Office on an annual basis. Part C will be done as needed and repeated more frequently. The risk assessment and mitigation exercise will be introduced in 2023 in all WHO country offices accompanied by training and field support by the global and regional PRSEAH experts and officials.

25. The Secretariat has initiated work to design actions for changing organizational culture and behaviour in its workforce. First, all recent data from WHO’s commissioned culture-related work on PRSEAH, diversity, equity and inclusion and United Nations’ and WHO’s surveys, and reports were analysed. In October 2022, an external service provider, identified through a competitive process, commenced work, using one-on-one interviews with leaders and other stakeholders, focus group discussions with the workforce and an Organization-wide survey using an adapted version of an industry standard tool (diagnostic survey of institutional culture). This work aims to identify interventions to be integrated into the three-year strategy for PRSEAH.

SAFEGUARDING IN HIGH-RISK SETTINGS

26. Sexual misconduct by WHO’s personnel and partners can occur in any setting but the risk is significantly increased during health emergencies and in programmes that bring WHO personnel and their partners into direct contact with communities in need of assistance. The two WHO programmes with the largest field presence in vulnerable settings – the WHO Health Emergency Programme and the Polio Eradication Initiative – are standing members of the Secretariat’s Organization-wide PRSEAH task team. They have augmented their prevention and response capacity during 2022, establishing a special unit and placing a senior staff member in the director’s office, respectively.

27. The Polio Eradication Initiative has incorporated PRSEAH in the polio outbreak response guideline, screened the database of experts for polio work through ClearCheck, stepped up training for personnel to be deployed, and contributed to strengthening of policy, practice and capacity at global level. It has also made funds available for hiring full-time PRSEAH experts in priority counties.

28. WHO’s Emergency Response Framework has been updated by incorporating PRSEAH in emergency responses to facilitate mainstreaming and safe programming in field operations in order to reduce risks and ensure access to victim- and survivor-centred reporting and response mechanisms when needed. The Framework sets key performance indicators and defines accountabilities of emergency response leaders and heads of WHO country offices for PRSEAH.
29. Until a minimum package of interventions can be introduced in all graded emergencies, safeguarding against sexual exploitation, abuse and harassment is prioritized in response to grade 2 and 3 emergencies. Key actions in WHO’s emergency response operations include the following:

(a) safeguarding measures for recruitment and deployment: screening through ClearCheck, requiring all WHO personnel to sign a PRSEAH Code of Conduct that includes a clause on compliance with applicable WHO policies related to prevention of sexual exploitation, abuse and harassment and abusive conduct in all contractual modalities for WHO personnel and requiring all members of WHO’s workforce (staff and non-staff personnel and other individuals who work at WHO) to undertake mandatory pre-deployment training on PRSEAH, with regular induction and refresher training courses during the deployment period;

(b) safeguarding provisions for WHO Collaborating Centres and entities in official relations with WHO to ensure that external partners are well-informed of the Organization’s policies and zero tolerance approach towards any form of sexual misconduct or other types of abusive or fraudulent conduct. Contractual provisions include measures to ensure that the conduct of the employees and any other persons engaged by external partners to perform any activities or to provide any services for WHO on behalf of the entities is consistent with the WHO standards of conduct, together with measures to ensure that external partners take action for prevention, protection, reporting, response, cooperation (with the Office of Internal Oversight Services), corrective measures, and disciplinary sanctions;

(c) embedding a specialist for PRSEAH in the event-specific Incident Management System at the outset when an Incident Management System team is being established, reporting directly to the Incident Manager; these experts work with PRSEAH Focal Points in WHO country offices;

(d) conducting risk assessments for sexual misconduct: a rapid risk assessment at the outset of the response operations followed by a comprehensive risk and needs assessment later in the response. The comprehensive risk assessment is either WHO-specific or implemented as a joint intervention under the coordination and leadership of the Inter-Agency Standing Committee PSEA Network or Task Force Coordinator. Joint rapid-risk and needs assessments for gender-based violence and sexual exploitation, abuse and harassment have been implemented in Poland and are underway for the responses to both the flood response operations in Pakistan and refugee operations in Ukraine;

(e) integrating PRSEAH mitigation measures into plans of action, informed by a risk and capacity needs assessment within the Secretariat’s Emergency Response Framework, response strategy, budget, advocacy and resource mobilization plan. Such integration is being done systematically for grade 2 and grade 3 emergencies. The WHO Health Emergencies Programme has developed generic planning templates and standard operating procedures for integrating PRSEAH needs in funding proposals to facilitate planning and resource mobilization at operational level;

(f) collaborating and working with the Inter-Agency Coordination Mechanisms, such as the Gender in Emergencies working group and the Inter-Agency Standing Committee Technical Advisory Group, and contributing to the joint efforts of the sub-working groups, including those on accountability to affected populations, gender-based violence and global and child protection;

(g) working with others to increase community level awareness on sexual exploitation, abuse and harassment, and supporting community-based complaint mechanisms.
30. To date, the Secretariat’s specialists on PRSEAH deployed to ongoing emergencies have contributed to dissemination of standardized community messages and training, gender-based violence referral pathways, and sexual and reproductive health. In response operations in Ukraine, WHO is supporting the Inter-Agency Standing Committee’s PSEA Task Force on the mainstreaming of protection from sexual exploitation and abuse among implementing partners, including coordination of their capacity assessments.

31. In all operations where Health Cluster mechanisms exist, efforts are being made to ensure mainstreaming and programming of PRSEAH in their activities. In the Ukraine response, Health Cluster partners are under consideration for capacity assessment and development as implementing partners to mitigate potential risks of sexual exploitation, abuse and harassment and to ensure compliance by implementing partners. In all operations, Health Cluster partners have been sensitized on PRSEAH, including the need for compliance.

32. WHO is currently operating in more than 51 high-risk countries. Safeguarding measures (paragraph 28) were implemented during the response to the 13th Ebola virus disease outbreak in the Democratic Republic of the Congo and are currently being implemented in responses to the crisis in north-eastern Ethiopia, the Lassa fever outbreak in Nigeria and the flooding in Malawi, and will be applied systematically within the WHO Health Emergencies Programme. All funding requests for preliminary emergency response operations benefiting from WHO’s Contingency Fund for Emergencies are required to include a budget line on prevention of and response to sexual exploitation, abuse and harassment, with clearly articulated activities for implementation during the initial response period. At least 10 requests for such funding in 2022 thus far have satisfied this requirement, for instance WHO’s responses to disease outbreaks in Afghanistan, Cameroon and Nigeria; flooding in Madagascar and South Sudan; the conflict in Ukraine; civil unrest in Sudan; COVID-19 in Guinea and Sierra Leone; and flooding and poliomyelitis in Malawi. In the Democratic Republic of the Congo, WHO contributed to the joint operational review of measures to prevent and respond to sexual exploitation, abuse and harassment following the containment of the 13th Ebola virus disease outbreak. This approach, with its enhanced focus on embedding PRSEAH in all emergency operations, aims to ensure the sustainability of safeguarding measures.

33. The capacity for PRSEAH of national governments where WHO has field operations, including their engagement to hold their personnel and partners accountable and to address inherent gaps in national capacities, remains an issue of concern requiring more advocacy and attention, especially in the context of mainstreaming and programming the matter in development settings. WHO is working closely with UNICEF and other United Nations entities on a global cooperation framework for prevention of and response to sexual exploitation and abuse with governments.

34. The WHO Health Emergencies Programme holds monthly meetings with heads of WHO country offices in fragile and conflict-affected countries to provide guidance and support, build capacity and strengthen leadership and senior management commitment in this area. A learning pathway on PRSEAH for all the Programme’s staff members and focal points was introduced in January 2022. Further efforts continue on mainstreaming and integrating PRSEAH into all health cluster coordination platforms; to ensure improved gender balance in the Programme’s operations; and to mitigate the risks of sexual exploitation, sexual abuse and sexual harassment. To deploy experts on PRSEAH to cope with its multiple emergency response operations, WHO is reinforcing its collaboration and partnerships with the standby partner mechanisms.
WORKING WITH UNITED NATIONS AND HUMANITARIAN STAKEHOLDERS

35. WHO continued to collaborate closely with other United Nations, Inter-Agency Standing Committee and humanitarian partners on PRSEAH. Key collaborations during the period under review include the following.

(a) As part of the United Nations-wide collaboration, WHO adhered to planning and reporting requirements (including entering data on sexual exploitation and abuse on the United Nations iReport platform). WHO and the newly-appointed United Nations Secretary-General’s Special Coordinator on improving United Nations response to sexual exploitation and abuse prioritized three areas of collaboration for 2022: provision of support to implement the guidance note on information sharing on sexual exploitation and abuse; strengthening and reforming investigation services across the United Nations and humanitarian systems; and funding of two additional senior coordinators in priority countries. WHO already funds an Inter-Agency Standing Committee coordinator in Goma, Democratic Republic of the Congo.

(b) Victim- and survivor-centred approach: examples include collaboration with the Office of the Victims’ Rights Advocate in the development of WHO’s PRSEAH strategy, which will put a victim-centred approach at its core; and collaboration in piloting consultations with and feedback from sexual exploitation and abuse victims and survivors in the Democratic Republic of the Congo and Haiti.

(c) Training and learning: with United Nations Volunteers, WHO ran in June 2022 two workshops, in English and French, on sexual exploitation, abuse and harassment to 60 volunteers serving with WHO. WHO is supporting the International Organization for Migration in the review of the course content, and facilitated the delivery of the Inter-Agency Standing Committee coordinators’ training on prevention of sexual exploitation and abuse (July 2022 and November 2022).

(d) Expanding PRSEAH capacity: WHO is working with UNICEF and other United Nations entities to develop a global framework for cooperation with governments on prevention of sexual exploitation and abuse, within the context of all public health and humanitarian responses, that establishes shared obligations and a coordination structure for receiving and referring allegations of sexual exploitation and abuse.

(e) Implementing partners: WHO is a member of the Implementing Partners Prevention of Sexual Exploitation and Abuse Working Group (UNHCR, UNICEF, WFP, UNFPA, WHO, United Nations Office for Project Services, International Organization for Migration, UN Women) that developed a package of resources to facilitate the operationalization of the United Nations Implementing Partners Protocol, including training. WHO is supporting the Inter-Agency Standing Committee Secretariat to pilot this package on assessment and capacity-building for implementing partners in the refugee response in Ukraine. The Working Group has also developed a module on preventing sexual exploitation and abuse for the United Nations Partners Portal that should be operational by the end of the year.

WHO worked closely with the Inter-Agency Standing Committee Champion on Protection from Sexual Exploitation and Abuse and Sexual Harassment\(^1\) as an active member of the IASC Technical Advisory Group. WHO contributed to and supports the delivery of the IASC Vision and Strategy: Protection from sexual exploitation and abuse and sexual harassment (2022–2026) that comprises three strategic priority commitments: (1) operationalization of a victim- and survivor-centred approach; (2) promotion of lasting change in organizational culture, behaviour, and attitudes towards all forms of sexual misconduct in humanitarian organizations; and (3) supporting country capacity, prioritizing identified high-risk contexts, ensuring that PSEA capacity is a systematic part of scale-up in response to crises.

**OVERSIGHT**

36. The Secretariat has provided quarterly updates to Member States as requested by the Board in decision EB148(4) (2021), together with ad hoc updates and briefings to Member States individually and in groups upon request. The Secretariat’s work on PRSEAH is regularly monitored by the IEOAC.

37. The Secretariat met with the Independent Oversight and Advisory Committee for the WHO Health Emergencies Programme, which is mandated to oversee WHO’s progress on PRSEAH (see paragraph 4), the Management Response Plan and other recommendations made by governing bodies.

38. The Secretariat provides updated information on the public website, the sexual exploitation, abuse and harassment and misconduct investigation dashboard for all stakeholders, and responded to media queries.

**CHALLENGES**

39. The Secretariat has made progress on PRSEAH throughout 2022, but several challenges remain, some beyond the Organization’s control.

   (a) Addressing sexual exploitation, abuse and harassment is a shared responsibility across the United Nations and led by the United Nations Resident Coordinator/Humanitarian Coordinator in countries. However, many coordinators are not fully conversant with risks for sexual exploitation, abuse and harassment, and only a limited number of countries have coordinators or experts to support and coordinate the United Nations Country Team or Humanitarian Country team, and to develop and monitor a strategy on protection from sexual exploitation and abuse at country level. Without this capacity, community-based complaint mechanisms and national complaints hotlines and expanding preventive actions in joint operations (such as in health emergencies) will remain weak and ineffective.

   (b) The engagement with governments and authorities in countries where WHO has programmes and operations needs strengthening. This is essential for gender-based violence referral services so that all victims and survivors, including those affected by sexual exploitation, abuse and harassment can safely access services. In joint operations with government personnel such as in outbreak responses, the engagement of the host government is essential for a collective

\(^1\) IASC Champion on Protection from Sexual Exploitation and Abuse and Sexual Harassment. New York, Inter-Agency Standing Committee; 2022 (interagencystandingcommittee.org, accessed 14 November 2022).
and coordinated approach to and to ensure that national authorities are aware of WHO’s policies on preventing and addressing sexual misconduct and on preventing and addressing retaliation.

(c) The work on PRSEAH with implementing partners requires expansion in terms of institutional arrangements and capacity.

(d) The pool of experts available for PRSEAH roles and for deployment into health emergency operations remains small and needs a broader United Nations systems approach.

CONCLUSION

40. WHO is fully committed to realizing and sustaining zero tolerance for sexual exploitation, abuse and harassment and for inaction against it. The work done so far has contributed to setting the Organization on the right track and laid the foundation for years to come. WHO’s three-year strategy for PRSEAH (2023–2025) aims to institutionalize the gains made in 2022 across the Organization. The Secretariat acknowledges that it has a long journey ahead.

ACTION BY THE EXECUTIVE BOARD

41. The Executive Board is invited to note the report; it is further invited to provide guidance in respect of the following questions:

(i) How can all Member States, particularly countries where WHO has operations, engage more with the Secretariat’s efforts to safeguard against any form of sexual misconduct?

(ii) How can gender-based violence referral systems be strengthened in countries where WHO has presence, operations and programmes?

(iii) How can resources be mobilized in a predictable way for PRSEAH work, especially in high-risk contexts such as health and humanitarian emergencies?

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Extension of the WHO global action plan on promoting the health of refugees and migrants, 2019–2023 to 2030

The Seventy-sixth World Health Assembly,

Having considered the consolidated report by the Director-General;¹

Recalling resolution WHA61.17 (2008) on the health of migrants, and resolution WHA70.15 (2017) and decision WHA72(14) (2019) on promoting the health of refugees and migrants, as well as the commitments made in the 2019 political declaration of the high-level meeting on universal health coverage,² to ensure that no one is left behind;

Recognizing the role that the WHO global action plan on promoting the health of refugees and migrants, 2019–2023 plays in advancing and coordinating WHO’s work on refugee and migrant health, in line with the Thirteenth General Programme of Work, 2019–2025 and in collaboration with IOM, UNHCR and other relevant international organizations, including but not limited to UNFPA and UNICEF, and stakeholders, avoiding duplication;

Reaffirming the goals and objectives of the WHO global action plan on promoting the health of refugees and migrants, 2019–2023, and recognizing its contribution and prioritization effort to improve global health equity by addressing the physical and mental health and well-being of refugees and migrants, as evidenced during the coronavirus disease (COVID-19) pandemic;

Noting the contribution of the WHO global action plan on promoting the health of refugees and migrants, 2019–2023 to meet the targets set in the Sustainable Development Goals, including those of Goals 3, 5 and 10, as well as the objectives of the Global Compact for Safe, Orderly and Regular Migration and the Global Compact on Refugees,

1. DECIDES to extend the time frame of the WHO global action plan on promoting the health of refugees and migrants, 2019–2023 from 2023 to 2030;

2. URGES Member States:

   (1) to continue to address the health needs and multiple situations of vulnerability of migrants and refugees, in line with national contexts and priorities and in accordance with relevant international obligations and commitments;

¹ Document A76/7 Rev.1.
² United Nations General Assembly resolution 74/2, adopted on 10 October 2019.
(2) to strengthen the integration of refugee and migrant health in global, regional and national initiatives, in collaboration with donors and other relevant stakeholders and partnerships including health and migration forums, to accelerate progress towards target 3.8 of the Sustainable Development Goals;

(3) to identify and share, through informal consultations to be convened by the Secretariat at least every two years, challenges, lessons learned and best practices related to the implementation of actions within the WHO global action plan on promoting the health of refugees and migrants, 2019–2030;

3. ENCOURAGES relevant stakeholders and networks to engage with Member States in the implementation of actions consistent with the WHO global action plan on promoting the health of refugees and migrants, 2019–2030;

4. REITERATES to the Director-General the importance of allocating the necessary resources to implement the WHO global action plan on promoting the health of refugees and migrants, 2019–2030;

5. REQUESTS the Director-General:

(1) to continue implementing the WHO global action plan on promoting the health of refugees and migrants, 2019–2030;

(2) to continue to provide technical assistance, develop guidelines and promote knowledge sharing as well as collaboration and coordination within and among Member States, for the implementation of actions consistent with the WHO global action plan on promoting the health of refugees and migrants, 2019–2030;

(3) to promote the production of knowledge through surveillance and research and support efforts to translate the WHO global action plan on promoting the health of refugees and migrants, 2019–2030 into concrete capacity-building actions, with a focus on the specific health needs of refugees and migrants, while taking into account their situations of vulnerability;

(4) to submit a progress report to the Health Assembly in 2025, 2027 and 2029 on the implementation of this resolution and on the WHO global action plan on promoting the health of refugees and migrants, 2019–2030.

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Extension of the WHO traditional medicine strategy: 2014–2023 to 2025

The Seventy-sixth World Health Assembly,

Having considered the consolidated report by the Director-General;¹

Recognizing United Nations General Assembly resolution 70/1 (2015), entitled Transforming our world: the 2030 Agenda for Sustainable Development, Sustainable Development Goal 3 (Ensure healthy lives and promote well-being for all at all ages) and target 3.8 (Achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all);

Noting that in United Nations General Assembly resolution 74/2 (2019), entitled Political declaration of the high-level meeting on universal health coverage, Heads of State and Government recommitted to achieve universal health coverage by 2030 by, inter alia, exploring ways to integrate, as appropriate, safe and evidence-based traditional and complementary medicine services within national and/or subnational health systems, particularly at the level of primary health care, according to national context and priorities;

Noting also the WHO global report on traditional and complementary medicine 2019,² and progress made in the implementation of the WHO traditional medicine strategy: 2014–2023;

Highlighting the importance of WHO’s role in providing technical support for the integration of evidence-based traditional and complementary medicine, as appropriate, into health systems and services by Member States, as well as in supporting measures to regulate traditional and complementary medicine practice, including legal and sustainable resources of traditional and complementary medicine, and for the protection and conservation of traditional and complementary medicine resources, in particular knowledge and natural resources,³ according to national laws and regulations;

Noting the reported use of traditional and complementary medicine during the coronavirus disease (COVID-19) pandemic in several Member States;

Recognizing the efforts of Member States to evaluate through an evidence-based approach, including rigorous clinical trials, as appropriate, the potential of traditional and complementary medicine, including in health system preparedness for and response to health emergencies;

¹ Document A76/7 Rev.1.
³ All activities will be in compliance with Member State obligations pursuant to the Convention on International Trade in Endangered Species of Wild Fauna and Flora and other international agreements on the protection of endangered species of wild fauna and flora.
Recognizing also the value and the diversity of the cultures of Indigenous Peoples and local communities and their holistic traditional knowledge,\(^1\)

Decided to request the Director-General:

(1) to extend the WHO traditional medicine strategy: 2014–2023 to 2025;

(2) to develop, guided by the WHO traditional medicine strategy: 2014–2023 and in consultation with Member States\(^2\) and relevant stakeholders, a draft new global traditional medicine strategy for the period 2025–2034 and to submit the draft strategy for consideration by the Seventy-eighth World Health Assembly in 2025, through the Executive Board at its 156th session.

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\(^2\) And, where applicable, regional economic integration organizations.
Voluntary Health Fund for small island developing States (terms of reference)

The Seventy-sixth World Health Assembly, having considered the draft terms of reference for a Voluntary Health Fund for Small Island Developing States and the request to postpone the convening of the second SIDS Summit for Health until 2024, ¹

Decided:

(1) to adopt the terms of reference for a Voluntary Health Fund for Small Island Developing States; ¹

(2) to request the Director-General:

(a) to make the necessary arrangements to make the Health Fund operational;

(b) to report on the Health Fund’s operations, including its terms of reference, at the Eightieth World Health Assembly, as indicated in the relevant section of the Fund’s terms of reference.

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¹ Document A76/34, Annex.