

WHO Global Standards for Long-Term Care

Convening an in-person stakeholder consultation

Concept note and facilitation guide for host institutions

Generic version for adaptation — working document, 18 August 2026

For national authorities, academic institutions, professional and provider associations and civil society organizations considering an in-person consultation as a contribution to the WHO global public consultation, open until 30 October 2026.

1. About this guide

This guide is for institutions considering convening an in-person consultation on the consultation draft of the WHO Global Standards for Long-Term Care. It sets out a tested session design — objectives, two format options, discussion questions, facilitation arrangements and a simple way of reporting the results to WHO — so that a host can run a productive session with modest preparation and return input that feeds directly into the global synthesis.

The design was piloted at the national stakeholder consultation in Seoul, Republic of Korea (2 June 2026, with the National Health Insurance Service) and adapted for the WHO South-East Asia regional expert consultation (Jodhpur, India, September 2026). Everything in this guide is meant to be adapted: the focus issues in particular should be sharpened with national specifics before the session (section 6).

A consultation under this guide is convened by the host institution as a contribution to the WHO global public consultation. WHO can provide the consultation draft and its concise summary, a standard slide set, briefing for the moderator and facilitators and, subject to availability, a WHO resource person joining in person or virtually. Hosts meet the costs of their own event. Use of the WHO name or emblem in connection with the event requires prior written agreement with WHO. Hosts are asked to discuss plans with the WHO contact (section 9) before the event, and to aim for a balanced mix of perspectives in the room.

2. Background: the standards and the global consultation

WHO is developing the Global Standards for Long-Term Care under action area 4 (long-term care) of the UN Decade of Healthy Ageing (2021–2030); they are the first global standards WHO has developed in this area. The consultation draft — eight chapters, with five foundational principles and 34 standards — was released in English on 18 May 2026, opening a global public consultation that runs until 30 October 2026. Input received through the consultation will shape the final version, planned for publication in 2027.

The standards set out, at a broad framework level, what long-term care systems should provide and protect. They are not operational or regulatory criteria such as staffing ratios or floor areas, nor facility accreditation criteria or reporting obligations for Member States. They are a reference that each country can apply and develop to fit its own system and resource environment — a starting point for policy where standards are absent, an international baseline where national standards exist, and a common reference for comparison, monitoring and technical cooperation.

Chapter	Title	Standards
1	Definitions and foundational principles	5 foundational principles
2	Home and community-based care	4 standards (1–4)
3	Long-term care facilities	4 standards (5–8)
4	Unpaid carers	5 standards (9–13)

Chapter	Title	Standards
5	Workforce	5 standards (14–18)
6	Financing	6 standards (19–24)
7	Governance	5 standards (25–29)
8	Quality monitoring	5 standards (30–34)

3. What WHO seeks to hear

Most of the standards command broad agreement in principle. A consultation session is therefore not a chapter-by-chapter review: it concentrates discussion where views genuinely differ, using three working questions that participants may answer from any chapter.

- **More important** — which standards are especially important in your context, or should be given greater emphasis?
- **Contentious** — which standards are contested, difficult or in need of revision when read against the realities of your context?
- **Missing** — which standards matter but are absent from the draft and should be added?

The three questions are a working distillation, for live discussion, of the five criteria used across the global consultation — relevance, comprehensiveness, clarity, feasibility, and priority and contribution. The host's report to WHO (Annex 2) maps the session's findings back to these criteria.

The discussion has a defined character, which facilitators help to protect:

- the frame is prospective: participants consider how each standard would work *if it were introduced or applied* in their context — the session does not review current national programmes for their own sake;
- it is a discussion of the global draft, not of current domestic policy disputes; national and local experience is used as evidence of how a standard would operate in practice; and
- detailed wording or drafting comments are welcome but belong in the written channels (section 8); group time is reserved for substance.

4. Participants and group design

The format works for roughly 20–60 participants, in discussion groups of six to eight, each group with a designated facilitator and note-taker. Aim for a balanced room: government and public agencies; researchers and academia; service providers and their associations; the care workforce; older people, families and unpaid carers; and civil society. An expert-only room also works; what matters is that the mix is deliberate.

Two group designs have been tested. Choose by the composition of the room:

- **Constituency groups (the Seoul model):** one group per stakeholder type — for example government, academia, providers, family carers. Each constituency finds its own voice, and differences between constituencies surface visibly in the plenary. Preferred when the room mixes distinct stakeholder types, and essential when older people and carers are present: give lived experience its own group and let it speak first in plenary.

- **Mixed groups (the Jodhpur model):** each group mixes constituencies, disciplines or regions. Preferred for expert audiences, where the value lies in comparing how a standard would operate across different settings.

A moderator who is not a WHO staff member and is seen as neutral by all constituencies — a respected chair from the host institution, for example — makes a visible difference to how freely people speak.

5. Choosing the format

Two tested formats are offered. Times are shown from the start of the session (0:00); insert clock times once the slot is agreed. Format A fits inside a larger event; Format B, the full Seoul format, is for a standalone half-day and yields substantially richer input. In both, a short host opening (10–20 minutes) may precede the session proper.

Format A — compact session (2 hours)

Each group discusses one assigned focus issue in depth, then reviews the whole draft against the three questions. Assign the issues so that all are covered across the groups.

Time	Min	Item
0:00–0:25	25	Overview presentation of the standards and the consultation
0:25–0:30	5	Plenary clarifications — questions of understanding only
0:30–0:35	5	Format, group assignments and worksheet explained
0:35–1:20	45	Group discussions: assigned focus issue (about 30 minutes), then the three questions across the whole draft (about 15 minutes)
1:20–1:40	20	Group reports — three minutes per group, from the worksheet (Annex 1)
1:40–2:00	20	Open floor; WHO (or host) synthesis and how the feedback will be used

Format B — half-day session (about 3.5 hours; the Seoul format)

Every group discusses all focus issues with common materials and questions, so that outputs are comparable across groups; the plenary then concentrates on the sharpest points of divergence.

Time	Min	Item
0:00–0:25	25	Overview presentation of the standards and the consultation
0:25–0:35	10	Plenary clarifications — questions of understanding only
0:35–0:40	5	Format, groups and worksheet explained
0:40–2:10	90	Facilitated group discussions — introductions (10 minutes); the focus issues, about 15–20 minutes each (55–60 minutes); worksheet and report preparation (15–20 minutes)
2:10–2:25	15	Break — facilitators hand the moderator one line per group on the sharpest divergence; moderator selects two or three focal issues for the plenary
2:25–2:45	20	Group reports — three minutes per group, from the worksheet (Annex 1)
2:45–3:15	30	Moderated plenary on the focal issues — group representative first, then open floor; brief WHO (or host) framing to close each issue

Time	Min	Item
3:15–3:30	15	Synthesis: what was heard, how the feedback will be used, further channels; close

The overview presentation (25 minutes)

A standard slide set is available from WHO and covers: why global standards for long-term care, and their intended uses, with recent national standards (Australia, Canada, Ireland) as illustrations; what “standards” means here and what they are not; the shape of the draft (eight chapters, five principles, 34 standards); how the global consultation works and the timeline to 2027; and the three working questions. The presentation is given by a WHO resource person (in person or virtually) or by a host presenter briefed by WHO. It stays clear of debate: clarifications only, substance to the groups.

6. Focus issues — core set and menu

Discussion starts from a small number of pre-identified issues on which views genuinely differ. Three core issues, used in both Seoul and Jodhpur, travel well across systems; a menu of further issues allows the session to match national debates. Choose three to five in total; for Format A, assign one issue per group and double up the most salient — there is no need for as many issues as there are groups.

Localize before the session. The tensions below are written generically. Sharpen each with national specifics — the coverage scheme, the workforce categories, the financing arrangements, one or two figures — so that the opening questions land. WHO can share how the same issues were framed for the Republic of Korea and for the South-East Asia Region as worked examples.

Each issue gives the tension it carries, an opening question for the facilitator and the framing WHO offers in synthesis (not to be used to close down discussion in the group).

Core issues

Core issue 1. Unpaid and family carers — how far does public responsibility extend? (chapter 4)

In most systems a large share of long-term care is provided by families — mostly by women, often unrecognized and unsupported. The draft asks systems to identify unpaid carers, assess their needs and protect their health, income and pension rights. Support for carers can cut two ways: it can relieve, or it can entrench, the expectation that care is a family duty; and the balance between supporting families and building services divides opinion in almost every system.

Opening question. *If the unpaid-carer standards in chapter 4 were introduced here, what would help family carers most — and what would concern you most?*

WHO framing for the synthesis. Recognize and support unpaid carers as partners of the care system — without letting support for families substitute for building services.

Core issue 2. The care workforce — professionalization and decent work versus supply and cost (chapter 5)

The draft asks for defined competencies, training, decent working conditions and secure employment. Raising qualification and competency requirements lifts quality but tightens supply and raises costs — a tension felt in every system, whether the starting point is a largely informal workforce, a regulated but underpaid one, or heavy reliance on migrant care workers.

Opening question. *If the workforce standards in chapter 5 applied here, where would the effect be greatest — and which standards would be hardest to meet?*

WHO framing for the synthesis. Competencies and working conditions carry equal weight: quality of care and quality of work rise or fall together.

Core issue 3. The appropriate setting — home and community care, and the place of facilities (principle 4; chapters 2–3)

The draft frames long-term care around the setting appropriate to each person's needs and preferences, with home and community care as the default and facilities as part of the continuum. Systems differ in what this challenges: where facility care dominates, the shift towards home and community; where formal services are thin, the risk that “home by default” means “family by default”; everywhere, the question of when facility care is the right answer rather than the last resort.

Opening question. *If “ageing in the right place” became the organizing principle here, what would it take — and where are facilities indispensable?*

WHO framing for the synthesis. The appropriate setting is the one matched to needs and preferences along a home–facility continuum: neither a home-first ideology nor a mandate for family care by default.

Menu of additional issues — choose by national debate

Menu issue A. Paying for care — pooled financing and protection from catastrophic care costs (chapter 6)

The draft asks for progressively pooled financing, costs shared across society and protection from catastrophic care costs. The live questions differ by system: where care is financed mainly out of pocket, what realistic first steps towards pooling look like; where a long-term care insurance or benefit scheme exists, how its coverage, benefit design and sustainability measure up to the standards.

Opening question. *If protection from catastrophic care costs, as framed in chapter 6, were applied here, what would be feasible first — and what would be most contested?*

WHO framing for the synthesis. The costs of care are shared by society as a whole, not borne by older people and their families alone.

Menu issue B. Governance and oversight of providers (chapter 7)

The draft requires the registration, licensing and inspection of all providers, with public reporting. Where much provision is private, charitable or informal, the question is sequencing oversight without choking scarce supply; where regulation is mature, whether inspection and reporting as framed add value or duplicate existing regimes — and whether the standards say enough about enforcement.

Opening question. *If the governance standards in chapter 7 were applied here, what would change in practice — and what burden would be proportionate?*

WHO framing for the synthesis. Oversight should be universal in coverage and proportionate in form.

Menu issue C. Measuring quality — beyond clinical and administrative indicators (chapter 8)

The draft requires quality measurement that includes users' experience, with data systems and public reporting. In systems with established quality regimes, the debate is whether experience, dignity and quality of life can be measured meaningfully and compared fairly; in others, what a minimum viable quality-monitoring system looks like.

Opening question. *If the quality-monitoring standards in chapter 8 were applied here, what should be measured first — and can dignity and experience be captured without collapsing into clinical and administrative indicators?*

WHO framing for the synthesis. Quality is measured from the perspective of the person receiving care, not only the service delivering it.

A further reserve question for each chapter is at Annex 3, for groups with time in hand. Groups should also raise any issue they consider contested or missing — the chosen issues are a starting point, not a boundary.

7. Roles and facilitation guidance

Role	Task
Moderator	Runs the session; keeps time; chairs reports and plenary; redistributes speaking turns; in Format B, selects the plenary focal issues at the break. A neutral chair, not a WHO staff member.
Presenter	The overview presentation and clarifications: a WHO resource person (in person or virtual) or a host presenter briefed by WHO.
Group facilitators	One per group; run the group discussions following this guide.
Note-takers	One per group; structured notes (emphasize, contentious, missing, with chapter and standard numbers); support the worksheet.
Group rapporteurs	One participant per group, identified during the discussion, delivers the three-minute report.
Host rapporteur	Consolidates worksheets, notes and the plenary into the report to WHO (Annex 2).

For group facilitators

- Open each issue with its opening question; let two or three concrete experiences surface before turning to *“if this standard were introduced here, what would happen?”*
- Keep interventions to two or three minutes; invite quieter voices first, by name if needed. Where older people, carers or care workers are in the group, their experience comes first.
- Hold the prospective frame. When discussion drifts into a domestic policy dispute or an institutional grievance, bring it back: what does that experience tell us about the standard?
- Park wording-level comments in the corner of the worksheet for the written channels; do not spend group time on drafting.
- Do not force convergence: where views split, name the split and record it — the divergence is the finding.
- Fifteen minutes before the end of group time, move to the worksheet; agree the one or two points that must reach plenary; confirm the rapporteur.

In plenary

- Reports are delivered by participants, not facilitators, three minutes each, from the worksheet.
- In Format B, the moderator takes two or three focal issues where groups diverged most: the relevant group representative speaks first, the floor opens for five to six minutes, and WHO (or the host presenter) closes each issue with a two-minute framing.
- Lived-experience voices speak before institutional ones wherever both are in the room.

8. Outputs: reporting the results to WHO

The session produces one completed worksheet per group (Annex 1) and the notes and plenary record. Within two weeks of the session — and no later than 30 October 2026 — the host consolidates these into the reporting form at Annex 2 and submits it to lrc@who.int as a single institutional response. The report is logged and analysed alongside all other consultation input and feeds the global synthesis that informs the revision of the standards; quotations are used only with consent and unattributed.

Participants should also be encouraged to respond individually through the multilingual online survey (link and QR code available from WHO, shown at the session), and organizations represented in the room may submit their own written responses to lrc@who.int, in any WHO official language, until 30 October 2026. Multiple channels are welcome; they are read together.

Materials available from WHO: the consultation draft (English) and its concise summary; the standard slide set; the consultation guide with the five criteria and guiding questions; translation resources in several languages; and the worked examples of localized focus issues (Republic of Korea; South-East Asia Region).

9. Planning checklist and timeline

Three to four weeks before. Contact WHO to confirm the plan, the format, language needs and WHO participation (in person or virtual); set the date — leaving room to report by 30 October 2026; invite a deliberately balanced participant list; book a room that seats groups of six to eight at separate or well-spaced tables.

One to two weeks before. Circulate the concise summary (or full draft) and the discussion questions; localize the focus issues; confirm the moderator, facilitators and note-takers, and brief them (30 minutes, using sections 6 and 7); fix group assignments; print worksheets (A3), focus-issue cards, the one-page list of the 34 standards and QR cards for the survey.

On the day. Room set before arrival; microphones for the plenary; a visible time signal; a photograph of each completed worksheet before participants leave.

Within two weeks after. Submit the Annex 2 report to lrc@who.int (by 30 October 2026 at the latest); share it with participants for transparency where the host wishes.

Contact. WHO headquarters, Older People and Healthy Ageing: Hyobum Jang (jangh@who.int); consultation mailbox: lrc@who.int.

Annex 1. Group worksheet

Group number _____ Issue(s) covered _____ Rapporteur (participant)
_____ Note-taker _____

A. Emphasize — standards especially important in this context, deserving greater weight (note chapter or standard numbers where possible)

B. Contentious — standards contested or difficult in this context, and why (a divided view is a finding — record both sides)

C. Missing — what the draft should cover but does not

D. For plenary — the one or two points that must reach the plenary — the rapporteur's three-minute report covers A–D

Wording-level or editorial comments: note them here; the host includes them in the report, or submits them separately to lrc@who.int (by 30 October 2026).

Annex 2. Host report to WHO — one form per session

Submit to lrc@who.int within two weeks of the session and no later than 30 October 2026, as a single institutional response. Attach the group worksheets (or photographs of them) where possible.

1. Session details — host institution; date and place; format (A or B); language(s); contact person and email
2. Participants — total number; breakdown by constituency (government, academia, providers, workforce, older people and carers, civil society, other)
3. Standards to emphasize — with chapter and standard numbers, and the reasons given
4. Contentious standards — with chapter and standard numbers, the arguments on each side, and whether views converged or stayed divided
5. Missing elements — what the draft should cover but does not, and why it matters in this context
6. Feasibility notes — standards already met; achievable short term; requiring long-term effort; the main barriers (financing, workforce, law and institutions, awareness)
7. Quotations — one to three formulations worth keeping, unattributed, with consent confirmed
8. Wording and editorial comments — or attach separately

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Annex 3. Reserve questions by chapter

For groups with time in hand after the chosen focus issues, or wishing to go deeper on a particular chapter. Use at most one or two; the prospective frame applies throughout.

Chapter	Question
1. Definitions and foundational principles	The draft puts what matters to the older person first. How should the standards treat decision-making when the person's preferences and their assessed needs — or their family's views — differ?
2. Home and community-based care	The draft requires home-based care to be coordinated with health services (primary care, hospitals). Where health and social sectors are organized and financed separately, what would make this coordination real?
3. Long-term care facilities	The draft frames facility care around those who cannot remain at home. What should count as “cannot remain at home” — and is choosing a facility by preference legitimate?
4. Unpaid carers	The draft asks systems to identify unpaid carers and assess their needs separately. How would identification and assessment work in practice here?
5. Workforce	Between raising competencies and improving pay and job security, which is more urgent for care workers here — and where do the two collide?
6. Financing	The draft asks for protection from catastrophic care costs, distinct from catastrophic health spending. How should catastrophic care costs be defined and protected here?
7. Governance	The draft requires registration, licensing and inspection of all providers, with public reporting. What sequence of oversight is realistic here — and what burden is proportionate?
8. Quality monitoring	The draft requires quality measurement that includes users' experience. How can dignity and experience be measured without collapsing into clinical and administrative indicators?