



WORLD HEALTH ORGANIZATION

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# **SIXTY-SECOND WORLD HEALTH ASSEMBLY**

**GENEVA, 18–22 MAY 2009**

**RESOLUTIONS AND DECISIONS  
ANNEXES**

## ABBREVIATIONS

Abbreviations used in WHO documentation include the following:

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

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

## **PREFACE**

The Sixty-second World Health Assembly was held at the Palais des Nations, Geneva, from 18 to 22 May 2009, in accordance with the decision of the Executive Board at its 123rd session. Its proceedings are issued in three volumes, containing, in addition to other relevant material:

Resolutions and decisions, Annexes – document WHA62/2009/REC/1

Verbatim records of plenary meetings, list of participants – document WHA62/2009/REC/2

Summary records of committees; reports of committees – document WHA62/2009/REC/3

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

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

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



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    - C. Malaria, including proposal for establishment of World Malaria Day (resolution WHA60.18)
    - D. Implementation by WHO of the recommendations of the Global Task Team on Improving AIDS Coordination among Multilateral Institutions and International Donors (resolution WHA59.12)
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  - I. Rational use of medicines (resolution WHA60.16)
  - J. Better medicines for children (resolution WHA60.20)
  - K. Health technologies (resolution WHA60.29)
  - L. Multilingualism (resolution WHA61.12)
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A62/1 Rev.1	Agenda <sup>1</sup>
A62/2	Report of the Executive Board on its 123rd and 124th sessions
A62/3	Address by Dr Margaret Chan, Director-General to the Sixty-second World Health Assembly
A62/4	Medium-term strategic plan 2008–2013, including Proposed programme budget 2010–2011
A62/4 Add.1	Medium-term strategic plan, including Proposed programme budget 2010–2011: safety and security of staff and premises and the Capital Master Plan
A62/4 Add.2	Medium-term strategic plan, including Proposed programme budget 2010–2011: efficiency gains in 2010–2011
A62/5	Pandemic influenza preparedness: sharing of influenza viruses and access to vaccines and other benefits
A62/5 Add.1	Pandemic influenza preparedness: sharing of influenza viruses and access to vaccines and other benefits: outcome of the resumed Intergovernmental Meeting
A62/6	Implementation of the International Health Regulations (2005)
A62/7	Prevention of avoidable blindness and visual impairment <sup>2</sup>
A62/7 Add.1	Report on financial and administrative implications for the Secretariat of resolutions proposed for adoption by the Executive Board or Health Assembly
A62/8	Primary health care, including health system strengthening <sup>3</sup>
A62/9	Commission on Social Determinants of Health
A62/10	Monitoring of the achievement of the health-related Millennium Development Goals

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

<sup>2</sup> See Annexes 1 and 5.

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

A62/11	Climate change and health
A62/12	WHO's role and responsibilities in health research: draft WHO strategy on research for health
A62/13	Counterfeit medical products
A62/14	Counterfeit medical products: International Medical Products Anti-Counterfeiting Taskforce
A62/15	Human organ and tissue transplantation
A62/16	Public health, innovation and intellectual property: global strategy and plan of action <sup>1</sup>
A62/16 Add.1	Public health, innovation and intellectual property: global strategy and plan of action: proposed time frames and estimated funding needs <sup>1</sup>
A62/16 Add.2	Public health, innovation and intellectual property: global strategy and plan of action: proposed progress indicators <sup>1</sup>
A62/16 Add.3	Public health, innovation and intellectual property: global strategy and plan of action: open paragraphs on stakeholders <sup>1</sup>
A62/17	Chagas disease: control and elimination
A62/18	Strengthening the capacity of governments to constructively engage the private sector in providing essential health-care services
A62/18 Add.1	Report on financial and administrative implications for the Secretariat of resolutions proposed for adoption by the Executive Board or Health Assembly
A62/19	Strategic Approach to International Chemicals Management
A62/20	Prevention and control of multidrug-resistant tuberculosis and extensively drug-resistant tuberculosis <sup>2</sup>
A62/20 Add.1	Prevention and control of multidrug-resistant tuberculosis and extensively drug-resistant tuberculosis: ministerial meeting of countries with a high burden of multidrug-resistant tuberculosis and extensively drug-resistant tuberculosis and Beijing "Call for Action" on tuberculosis control and patient care

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<sup>1</sup> See Annexes 4 and 5.

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

## LIST OF DOCUMENTS

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A62/21	Food safety
A62/22	Viral hepatitis
A62/23	Progress reports on technical and health matters
A62/24 and A62/24 Corr.1	Health conditions in the occupied Palestinian territory, including east Jerusalem, and in the occupied Syrian Golan <sup>1</sup>
A62/24 Add.1	Report of the specialized health mission to the Gaza Strip <sup>1</sup>
A62/25	Programme budget 2006–2007: performance assessment
A62/26 and A62/26 Corr.1	Implementation of Programme budget 2008–2009: interim report
A62/27	Report of the Internal Auditor
A62/28	Unaudited Interim Financial Report for the year 2008
A62/28 Corr.1	Unaudited interim financial report of the accounts of WHO for 2008
A62/29	Interim report of the External Auditor
A62/30	Status of collection of assessed contributions, including Member States in arrears in the payment of their contributions to an extent that would justify invoking Article 7 of the Constitution
A62/31	Scale of assessments 2010–2011
A62/32	Amendments to the Financial Regulations and Financial Rules <sup>2</sup>
A62/33	The election of the Director-General of the World Health Organization
A62/34	Human resources: annual report
A62/35	Report of the International Civil Service Commission
A62/36	Amendments to the Staff Regulations and Staff Rules <sup>3</sup>
A62/37	Report of the United Nations Joint Staff Pension Board

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<sup>1</sup> See Annex 5.

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

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

A62/38	Appointment of representatives to the WHO Staff Pension Committee
A62/39	Partnerships
A62/40	Collaboration within the United Nations system and with other intergovernmental organizations
A62/41	Awards: amendments to the Statutes governing the Ihsan Dogramaci Family Health Foundation
A62/42	Committee on Credentials
A62/43	Implementation of Programme budget 2008–2009: interim report. First report of the Programme, Budget and Administration Committee of the Executive Board to the Sixty-second World Health Assembly
A62/44	Unaudited interim financial report on the accounts of WHO for 2008. Third report of the Programme, Budget and Administration Committee of the Executive Board to the Sixty-second World Health Assembly
A62/45	Report of the Internal Auditor. Second report of the Programme, Budget and Administration Committee of the Executive Board to the Sixty-second World Health Assembly
A62/46	Interim report of the External Auditor. Fourth report of the Programme, Budget and Administration Committee of the Executive Board to the Sixty-second World Health Assembly
A62/47	Status of collection of assessed contributions, including Member States in arrears in the payment of their contributions to an extent that would justify invoking Article 7 of the Constitution. Fifth report of the Programme, Budget and Administration Committee of the Executive Board to the Sixty-second World Health Assembly
A62/48 (Draft)	First report of Committee A
A62/49	Election of Members entitled to designate a person to serve on the Executive Board
A62/50 (Draft)	First report of Committee B
A62/51 (Draft)	Second report of Committee A
A62/52 (Draft)	Third report of Committee A
A62/53 (Draft)	Fourth report of Committee A

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A62/54	Second report of Committee B
A62/55 (Draft)	Fifth report of Committee A
MTSP/2008–2013 (Draft)	Medium-term strategic plan 2008–2013 (Amended (draft))
PPB/2010–2011	Proposed programme budget 2010–2011

### **Information documents**

A62/INF.DOC./1	Health conditions in the occupied Palestinian territory, including east Jerusalem, and in the occupied Syrian Golan
A62/INF.DOC./2	Health conditions in the occupied Palestinian territory, including east Jerusalem, and in the occupied Syrian Golan
A62/INF.DOC./3	Health conditions in the occupied Palestinian territory, including east Jerusalem, and in the occupied Syrian Golan
A62/INF.DOC./4	Voluntary contributions by fund and by donor for the financial period 2008

### **Diverse**

A62/DIV/1 Rev.1	List of delegates and other participants
A62/DIV/2	Guide for delegates to the World Health Assembly
A62/DIV/3	Decisions and list of resolutions
A62/DIV/4	List of documents
A62/DIV/5	Address by Ban Ki-moon, Secretary-General of the United Nations
A62/DIV/6	Address by Sarah Brown, Patron, White Ribbon Alliance for Safe Motherhood





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

### **President**

Mr N.S. DE SILVA (Sri Lanka)

### **Vice-Presidents**

Dr O. UGARTE UBILLUZ (Peru)

Mr A.M. FOUA (Cameroon)

Dr L.-E. HOLM (Sweden)

Dr A.Y. RASA'A (Yemen)

Dr A. MATTHEW (Marshall Islands)

### **Secretary**

Dr M. CHAN, Director-General

### **Committee on Credentials**

The Committee on Credentials was composed of delegates of the following Member States: Albania, Andorra, Belize, Brunei Darussalam, Cape Verde, Chad, Greece, Lao People's Democratic Republic, Maldives, Mozambique, Oman, and Venezuela (Bolivarian Republic of)

**Chairman:** Mr J. M. CASALS ALIS (Andorra)

**Vice-Chairman:** Mr I.A.S. DE CARVALHO (Cape Verde)

**Secretary:** Ms F. MOURAIN-SCHUT, Senior Legal Officer

### **General Committee**

The General Committee was composed of the President and Vice-Presidents of the Health Assembly and the Chairmen of the main committees, together with delegates of the following Member States: Afghanistan, Armenia, Bangladesh, China, Costa Rica, Côte d'Ivoire, Cuba, Czech Republic, Djibouti,

France, Guinea-Bissau, Kenya, Russian Federation, Rwanda, Swaziland, United Kingdom of Great Britain and Northern Ireland, and United States of America.

**Chairman:** Mr N.S. DE SILVA (Sri Lanka)

**Secretary:** Dr M. CHAN, Director-General

### **MAIN COMMITTEES**

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

#### **Committee A**

**Chairman:** Dr F. MENESES GONZÁLEZ (Mexico)

**Vice-Chairmen:** Dr M. RAMATLAPENG (Lesotho) and Dr M. BIN HAMAD BIN JABER AL-THANI (Qatar)

**Rapporteur:** Ms S.T. AYDIN (Turkey)

**Secretary:** Dr Q.M. ISLAM, Director, Making Pregnancy Safer

#### **Committee B**

**Chairman:** Mr S. MCKERNAN (New Zealand)

**Vice-Chairmen:** Dr U.S. SUTARJO (Indonesia) and Mr V. JAKSONS (Latvia)

**Rapporteur:** Dr E.G. ALLEN YOUNG (Jamaica)

**Secretary:** Dr M. DAYRIT, Director, Human Resources for Health



## RESOLUTIONS

### **WHA62.1      Prevention of avoidable blindness and visual impairment<sup>1</sup>**

The Sixty-second World Health Assembly,

Having considered the report and draft action plan on the prevention of avoidable blindness and visual impairment;<sup>2</sup>

Recalling resolutions WHA56.26 on elimination of avoidable blindness and WHA59.25 on prevention of avoidable blindness and visual impairment;

Recognizing that the action plan for the prevention of avoidable blindness and visual impairment complements the action plan for the global strategy for the prevention and control of noncommunicable diseases endorsed by the Health Assembly in resolution WHA61.14,

1. ENDORSES the action plan for the prevention of avoidable blindness and visual impairment;<sup>3</sup>
2. URGES Member States to implement the action plan for the prevention of avoidable blindness and visual impairment, in accordance with national priorities for health policies, plans and programmes;
3. REQUESTS the Director-General:
  - (1) to provide support to Member States in implementing the proposed actions in the plan for the prevention of avoidable blindness and visual impairment in accordance with national priorities;
  - (2) to continue to give priority to the prevention of avoidable blindness and visual impairment, within the framework of the Medium-term strategic plan 2008–2013 and the programme budgets in order to strengthen capacity of the Member States and increase technical capacity of the Secretariat;
  - (3) to report to the Sixty-fifth and Sixty-seventh World Health Assemblies, through the Executive Board, on progress in implementing the action plan for the prevention of avoidable blindness and visual impairment.

(Sixth plenary meeting, 21 May 2009 –  
Committee A, first report)

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<sup>1</sup> See Annex 5 for the financial and administrative implications for the Secretariat of the resolution.

<sup>2</sup> Document A62/7.

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

**WHA62.2 Health conditions in the occupied Palestinian territory, including east Jerusalem, and in the occupied Syrian Golan<sup>1</sup>**

The Sixty-second World Health Assembly,

Mindful of the basic principle established in the Constitution of WHO, which affirms that the health of all peoples is fundamental to the attainment of peace and security;

Recalling all its previous resolutions on health conditions in the occupied Arab territories;

Recalling resolution EB124.R4, adopted by the Executive Board at its 124th session, on the grave health situation caused by Israeli military operations in the occupied Palestinian territory, particularly in the occupied Gaza Strip;

Taking note of the report of the Director-General on the health conditions in the occupied Palestinian territory, including east Jerusalem, and in the occupied Syrian Golan;<sup>2</sup>

Noting with deep concern the findings in the report of the Director-General on the specialized health mission to the Gaza Strip;<sup>3</sup>

Stressing the essential role of UNRWA in providing crucial health and education services in the occupied Palestinian territory particularly in addressing the emergency needs in the Gaza Strip;

Expressing its concern at the deterioration of economic and health conditions as well as the humanitarian crisis resulting from the continued occupation and the severe restrictions imposed by Israel, the occupying power;

Expressing its deep concern also at the health crisis and rising levels of food insecurity in the occupied Palestinian territory, particularly in the Gaza Strip;

Affirming the need for guaranteeing universal coverage of health services and for preserving the functions of the public health services in the occupied Palestinian territory;

Recognizing that the acute shortage of financial and medical resources in the Palestinian Ministry of Health, which is responsible for running and financing public health services, jeopardizes the access of the Palestinian population to curative and preventive services;

Affirming the right of Palestinian patients and medical staff to have access to the Palestinian health institutions in occupied east Jerusalem;

Deploring the incidents involving lack of respect and protection for Palestinian ambulances and medical personnel by the Israeli army, which led to casualties among Palestinian medical personnel, as well as the restrictions on movement imposed on them by Israel, the occupying power, in violation of international humanitarian law;

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<sup>1</sup> See Annex 5 for the financial and administrative implications for the Secretariat of the resolution.

<sup>2</sup> Documents A62/24 and A62/24 Corr.1.

<sup>3</sup> Document A62/24 Add.1.

Expressing deep concern at the grave implication of the wall on the accessibility and quality of medical services received by the Palestinian population in the occupied Palestinian territory, including east Jerusalem;

Expressing deep concern also at the serious implications for pregnant women and patients of Israeli restriction of movement imposed on Palestinian ambulances and medical personnel,

1. DEMANDS that Israel, the occupying power:

(1) lift immediately the closure in the occupied Palestinian territory, particularly the closure of the crossing points of the occupied Gaza Strip that are causing the serious shortage of medicines and medical supplies therein, and comply in this regard with the provisions of the Israeli Palestinian Agreement on Movement and Access of November 2005;

(2) reverse its policies and measures that have led to the prevailing dire health conditions and severe food and fuel shortages in the Gaza Strip;

(3) comply with the Advisory Opinion rendered on 9 July 2004 by the International Court of Justice on the wall which, inter alia, has grave implications on the accessibility and quality of medical services received by the Palestinian population in the occupied Palestinian territory, including east Jerusalem;

(4) facilitate the access of Palestinian patients and medical staff to the Palestinian health institutions in occupied east Jerusalem and abroad;

(5) ensure unhindered and safe passage for Palestinian ambulances as well as respect and protection of medical personnel, in compliance with international humanitarian law;

(6) improve the living and medical conditions of Palestinian detainees, particularly children, women and patients;

(7) facilitate the transit and entry of medicine and medical equipment to the occupied Palestinian territory;

(8) shoulder its responsibility towards the humanitarian needs of the Palestinian people and their daily access to humanitarian aid, including food and medicine, in compliance with international humanitarian law;

(9) halt immediately all its practices, policies and plans, including its policy of closure, that seriously affect the health conditions of civilians under occupation;

(10) respect and facilitate the mandate and work of UNRWA and other international organizations, and ensure the free movement of their staff and aid provisions;

2. URGES Member States and intergovernmental and nongovernmental organizations:

(1) to help overcome the health crisis in the occupied Palestinian territory by providing assistance to the Palestinian people;

- (2) to help meet the urgent health and humanitarian needs, as well as the important health-related needs for the medium and long term, identified in the report of the Director-General on the specialized health mission to the Gaza Strip;<sup>1</sup>
  - (3) to help lift the restrictions and obstacles imposed on the Palestinian people in the occupied Palestinian territory;
  - (4) to remind Israel, the occupying power, to abide by the Fourth Geneva Convention relative to the Protection of Civilian Persons in Time of War of 1949;
  - (5) to support and assist the Palestinian Ministry of Health in carrying out its duties, including running and financing public health services;
  - (6) to provide financial and technical support to the Palestinian public health and veterinary services;
3. EXPRESSES its deep appreciation to the Director-General for the efforts to provide necessary assistance to the Palestinian people in the occupied Palestinian territory, including east Jerusalem, and to the Syrian population in the occupied Syrian Golan;
4. REQUESTS the Director-General:
- (1) to provide support to the Palestinian health and veterinary services including capacity building;
  - (2) to submit a fact-finding report on the health and economic situation in the occupied Palestinian territory, including east Jerusalem, and in the occupied Syrian Golan;
  - (3) to support the establishment of medical facilities and provide health-related technical assistance for the Syrian population in the occupied Syrian Golan;
  - (4) to continue providing necessary technical assistance in order to meet the health needs of the Palestinian people, including the handicapped and injured;
  - (5) to provide also support to the Palestinian health and veterinary services in preparing for a potential pandemic of influenza A(H1N1);
  - (6) to support the development of the health system in Palestine, including development of human resources;
  - (7) to make available the detailed report prepared by the specialized health mission to the Gaza Strip;
  - (8) to report on implementation of this resolution to the Sixty-third World Health Assembly.

(Seventh plenary meeting, 21 May 2009 –  
Committee B, first report)

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<sup>1</sup> Document A62/24 Add.1.

**WHA62.3      Unaudited interim financial report on the accounts of WHO for 2008**

The Sixty-second World Health Assembly,

Having examined the unaudited interim financial report for 2008;<sup>1</sup>

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

ACCEPTS the Director-General's unaudited interim financial report for the year 2008.

(Seventh plenary meeting, 21 May 2009 –  
Committee B, first report)

**WHA62.4      Status of collection of assessed contributions, including Member States in arrears in the payment of their contributions to an extent that would justify invoking Article 7 of the Constitution**

The Sixty-second World Health Assembly,

Having considered the fifth report of the Programme, Budget and Administration Committee of the Executive Board to the Sixty-second World Health Assembly on Status of collection of assessed contributions, including Member States in arrears in the payment of their contributions to an extent that would justify invoking Article 7 of the Constitution;<sup>3</sup>

Noting that, at the time of opening of the Sixty-second World Health Assembly, the voting rights of Argentina, Central African Republic, Comoros, Democratic Republic of the Congo, Dominica, Gambia, Guinea-Bissau, Solomon Islands, Somalia and Tajikistan were suspended, such suspension to continue until the arrears of the Member States concerned have been reduced, at the present or future Health Assemblies, to a level below the amount that would justify invoking Article 7 of the Constitution;

Noting that Cape Verde, Côte d'Ivoire, Marshall Islands, Palau and Zambia were in arrears at the time of the opening of the Sixty-second World Health Assembly to such an extent that it was necessary for the Health Assembly to consider, in accordance with Article 7 of the Constitution, whether or not the voting privileges of those countries should be suspended at the opening of the Sixty-third World Health Assembly,

DECIDES:

(1) that in accordance with the statement of principles set out in resolution WHA41.7 if, by the time of the opening of the Sixty-third World Health Assembly, Cape Verde, Côte d'Ivoire, Marshall Islands, Palau and Zambia are still in arrears in the payment of their contributions to

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<sup>1</sup> See documents A62/28 and A62/28 Corr.1.

<sup>2</sup> See document A62/44.

<sup>3</sup> See document A62/47.

an extent that would justify invoking Article 7 of the Constitution, their voting privileges shall be suspended as from the said opening;

(2) that any suspension that takes effect as specified in paragraph (1) shall continue at subsequent Health Assemblies, until the arrears of Cape Verde, Côte d'Ivoire, Marshall Islands, Palau and Zambia have been reduced to a level below the amount that would justify invoking Article 7 of the Constitution;

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

(Seventh plenary meeting, 21 May 2009 –  
Committee B, first report)

### **WHA62.5      Scale of assessments 2010–2011**

The Sixty-second World Health Assembly,

Considering that the latest United Nations scale continues to be the same as that for the financial period 2008–2009,

ADOPTS the scale of assessments for Members for the biennium 2010–2011 as set out below:

<b>Members and Associate Members</b>	<b>WHO scale for 2010–2011 %</b>
Afghanistan	0.0010
Albania	0.0060
Algeria	0.0850
Andorra	0.0080
Angola	0.0030
Antigua and Barbuda	0.0020
Argentina	0.3250
Armenia	0.0020
Australia	1.7871
Austria	0.8871
Azerbaijan	0.0050
Bahamas	0.0160
Bahrain	0.0330
Bangladesh	0.0100
Barbados	0.0090
Belarus	0.0200
Belgium	1.1021
Belize	0.0010
Benin	0.0010
Bhutan	0.0010
Bolivia (Plurinational State of)	0.0060
Bosnia and Herzegovina	0.0060
Botswana	0.0140



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<b>Members and Associate Members</b>	<b>WHO scale for 2010–2011 %</b>
Brazil	0.8761
Brunei Darussalam	0.0260
Bulgaria	0.0200
Burkina Faso	0.0020
Burundi	0.0010
Cambodia	0.0010
Cameroon	0.0090
Canada	2.9772
Cape Verde	0.0010
Central African Republic	0.0010
Chad	0.0010
Chile	0.1610
China	2.6672
Colombia	0.1050
Comoros	0.0010
Congo	0.0010
Cook Islands	0.0010
Costa Rica	0.0320
Côte d'Ivoire	0.0090
Croatia	0.0500
Cuba	0.0540
Cyprus	0.0440
Czech Republic	0.2810
Democratic People's Republic of Korea	0.0070
Democratic Republic of the Congo	0.0030
Denmark	0.7391
Djibouti	0.0010
Dominica	0.0010
Dominican Republic	0.0240
Ecuador	0.0210
Egypt	0.0880
El Salvador	0.0200
Equatorial Guinea	0.0020
Eritrea	0.0010
Estonia	0.0160
Ethiopia	0.0030
Fiji	0.0030
Finland	0.5640
France	6.3015
Gabon	0.0080
Gambia	0.0010
Georgia	0.0030
Germany	8.5777
Ghana	0.0040
Greece	0.5960
Grenada	0.0010

<b>Members and Associate Members</b>	<b>WHO scale for 2010–2011 %</b>
Guatemala	0.0320
Guinea	0.0010
Guinea-Bissau	0.0010
Guyana	0.0010
Haiti	0.0020
Honduras	0.0050
Hungary	0.2440
Iceland	0.0370
India	0.4500
Indonesia	0.1610
Iran (Islamic Republic of)	0.1800
Iraq	0.0150
Ireland	0.4450
Israel	0.4190
Italy	5.0794
Jamaica	0.0100
Japan	16.6253
Jordan	0.0120
Kazakhstan	0.0290
Kenya	0.0100
Kiribati	0.0010
Kuwait	0.1820
Kyrgyzstan	0.0010
Lao People's Democratic Republic	0.0010
Latvia	0.0180
Lebanon	0.0340
Lesotho	0.0010
Liberia	0.0010
Libyan Arab Jamahiriya	0.0620
Lithuania	0.0310
Luxembourg	0.0850
Madagascar	0.0020
Malawi	0.0010
Malaysia	0.1900
Maldives	0.0010
Mali	0.0010
Malta	0.0170
Marshall Islands	0.0010
Mauritania	0.0010
Mauritius	0.0110
Mexico	2.2572
Micronesia (Federated States of)	0.0010
Monaco	0.0030
Mongolia	0.0010
Montenegro	0.0010
Morocco	0.0420
Mozambique	0.0010

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<b>Members and Associate Members</b>	<b>WHO scale for 2010–2011 %</b>
Myanmar	0.0050
Namibia	0.0060
Nauru	0.0010
Nepal	0.0030
Netherlands	1.8731
New Zealand	0.2560
Nicaragua	0.0020
Niger	0.0010
Nigeria	0.0480
Niue	0.0010
Norway	0.7821
Oman	0.0730
Pakistan	0.0590
Palau	0.0010
Panama	0.0230
Papua New Guinea	0.0020
Paraguay	0.0050
Peru	0.0780
Philippines	0.0780
Poland	0.5010
Portugal	0.5270
Puerto Rico	0.0010
Qatar	0.0850
Republic of Korea	2.1732
Republic of Moldova	0.0010
Romania	0.0700
Russian Federation	1.2001
Rwanda	0.0010
Saint Kitts and Nevis	0.0010
Saint Lucia	0.0010
Saint Vincent and the Grenadines	0.0010
Samoa	0.0010
San Marino	0.0030
Sao Tome and Principe	0.0010
Saudi Arabia	0.7481
Senegal	0.0040
Serbia	0.0210
Seychelles	0.0020
Sierra Leone	0.0010
Singapore	0.3470
Slovakia	0.0630
Slovenia	0.0960
Solomon Islands	0.0010
Somalia	0.0010
South Africa	0.2900
Spain	2.9682
Sri Lanka	0.0160

<b>Members and Associate Members</b>	<b>WHO scale for 2010–2011 %</b>
Sudan	0.0100
Suriname	0.0010
Swaziland	0.0020
Sweden	1.0711
Switzerland	1.2161
Syrian Arab Republic	0.0160
Tajikistan	0.0010
Thailand	0.1860
The former Yugoslav Republic of Macedonia	0.0050
Timor-Leste	0.0010
Togo	0.0010
Tokelau	0.0010
Tonga	0.0010
Trinidad and Tobago	0.0270
Tunisia	0.0310
Turkey	0.3810
Turkmenistan	0.0060
Tuvalu	0.0010
Uganda	0.0030
Ukraine	0.0450
United Arab Emirates	0.3020
United Kingdom of Great Britain and Northern Ireland	6.6425
United Republic of Tanzania	0.0060
United States of America	22.0000
Uruguay	0.0270
Uzbekistan	0.0080
Vanuatu	0.0010
Venezuela (Bolivarian Republic of)	0.2000
Viet Nam	0.0240
Yemen	0.0070
Zambia	0.0010
Zimbabwe	0.0080
<b>Total</b>	<b>100.0000</b>

(Seventh plenary meeting, 21 May 2009 –  
Committee B, first report)

**WHA62.6 Amendments to the Financial Regulations and Financial Rules<sup>1</sup>**

The Sixty-second World Health Assembly,

Having considered the report on amendments to the Financial Regulations and Financial Rules,<sup>2</sup>

Recalling resolution WHA60.9 on amendments to the Financial Regulations and Financial Rules: introduction of International Public Sector Accounting Standards,

1. ADOPTS the amendments to the Financial Regulations, to be effective as from 1 January 2010;
2. NOTES that the changes to the Financial Rules as confirmed by the Executive Board at its 124th session<sup>3</sup> shall be effective at the same time as the amendments to the Financial Regulations adopted in paragraph 1;
3. AUTHORIZES the Director-General to number the revised Financial Regulations and Financial Rules appropriately.

(Seventh plenary meeting, 21 May 2009 –  
Committee B, first report)

**WHA62.7 Amendments to Staff Regulations<sup>4</sup>**

The Sixty-second World Health Assembly,

Noting the recommendations of the Executive Board with regard to the reassignment of staff, including those not involving promotion,<sup>5</sup>

ADOPTS the proposed amendment to Staff Regulation 4.2;

ADOPTS the proposed amendment to Staff Regulation 4.3;

DECIDES that both amendments shall take effect on 1 June 2009.

(Seventh plenary meeting, 21 May 2009 –  
Committee B, first report)

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

<sup>2</sup> Document A62/32.

<sup>3</sup> Resolution EB124.R10.

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

<sup>5</sup> Document A62/36.

### **WHA62.8 Salaries of staff in ungraded posts and of the Director-General**

The Sixty-second World Health Assembly,

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

1. ESTABLISHES the salaries of Assistant Directors-General and Regional Directors at US\$ 177 032 per annum before staff assessment, resulting in a modified net salary of US\$ 128 071 (dependency rate) or US\$ 115 973 (single rate);
2. ESTABLISHES the salary of the Deputy Director-General at US\$ 194 820 per annum before staff assessment, resulting in a modified net salary of US\$ 139 633 (dependency rate) or US\$ 125 663 (single rate);
3. ESTABLISHES the salary of the Director-General at US\$ 239 632 gross per annum before staff assessment, resulting in a modified net salary of US\$ 168 761 (dependency rate) or US\$ 150 079 (single rate);
4. DECIDES that those adjustments in remuneration shall take effect on 1 January 2009.

(Seventh plenary meeting, 21 May 2009 –  
Committee B, first report)

### **WHA62.9 Appropriation resolution for the financial period 2010–2011**

The Sixty-second World Health Assembly,

1. NOTES the total effective budget under all sources of funds, that is, assessed and voluntary contributions, of US\$ 4 539 914 000, presented in three segments:

<b>Programme budget segment</b>	<b>US\$</b>
Base programmes	3 367 907 000
Special programmes and collaborative arrangements	822 007 000
Outbreak and crisis response	350 000 000
<b>Total effective budget</b>	<b>4 539 914 000</b>

2. RESOLVES to appropriate for the financial period 2010–2011 an amount of US\$ 1 023 840 000, financed by net assessments on Members of US\$ 928 840 000, estimated Miscellaneous Income<sup>2</sup> of US\$ 15 000 000, and transfer to Tax Equalization Fund of US\$ 80 000 000, as shown below:

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<sup>1</sup> Document A62/36.

<sup>2</sup> Miscellaneous Income is replaced by “Other Sources” in revisions to the Financial Regulations that will become effective on 1 January 2010, as a result of adoption of resolution WHA62.6.

<b>Appropriation section</b>	<b>Purpose of appropriation</b>	<b>Appropriations financed by net assessments and Miscellaneous Income (US\$)</b>
1	To reduce the health, social and economic burden of communicable diseases	74 035 000
2	To combat HIV/AIDS, malaria and tuberculosis	40 762 000
3	To prevent and reduce disease, disability and premature death from chronic noncommunicable diseases, mental disorders, violence and injuries and visual impairment	38 038 000
4	To reduce morbidity and mortality and improve health during key stages of life, including pregnancy, childbirth, the neonatal period, childhood and adolescence, and improve sexual and reproductive health and promote active and healthy ageing for all individuals	46 497 000
5	To reduce the health consequences of emergencies, disasters, crises and conflicts, and minimize their social and economic impact	16 090 000
6	To promote health and development, and prevent or reduce risk factors for health conditions associated with use of tobacco, alcohol, drugs and other psychoactive substances, unhealthy diets, physical inactivity and unsafe sex	31 368 000
7	To address the underlying social and economic determinants of health through policies and programmes that enhance health equity and integrate pro-poor, gender-responsive, and human rights-based approaches	15 456 000
8	To promote a healthier environment, intensify primary prevention and influence public policies in all sectors so as to address the root causes of environmental threats to health	30 198 000
9	To improve nutrition, food safety and food security, throughout the life-course, and in support of public health and sustainable development	18 748 000
10	To improve health services through better governance, financing, staffing and management, informed by reliable and accessible evidence and research	130 799 000
11	To ensure improved access, quality and use of medical products and technologies	27 631 000

Appropriation section	Purpose of appropriation	Appropriations financed by net assessments and Miscellaneous Income (US\$)
12	To provide leadership, strengthen governance and foster partnership and collaboration with countries, the United Nations system, and other stakeholders in order to fulfil the mandate of WHO in advancing the global health agenda as set out in the Eleventh General Programme of Work	179 551 000
13	To develop and sustain WHO as a flexible, learning organization, enabling it to carry out its mandate more efficiently and effectively	294 667 000
	<b>Subtotal</b>	943 840 000
	Transfer to Tax Equalization Fund	80 000 000
	<b>Grand total</b>	1 023 840 000

3. FURTHER RESOLVES that:

(1) notwithstanding the provisions of Financial Regulation 4.3, the Director-General is authorized to make transfers between the appropriation sections up to an amount not exceeding 10% of the amount appropriated for the section from which the transfer is made; all such transfers shall be reported in the financial report for the financial period 2010–2011; any other transfers required shall be made and reported in accordance with the provisions of Financial Regulation 4.3;

(2) amounts not exceeding the appropriations voted under paragraph 2 shall be available for the payment of commitments incurred during the financial period 1 January 2010 to 31 December 2011 in accordance with the provisions of the Financial Regulations; notwithstanding the provisions of the present paragraph, the Director-General shall limit the commitments to be incurred during the financial period 2010–2011 to sections 1 to 13;

(3) the amount of the contribution to be paid by individual Members shall be reduced by the sum standing to their credit in the Tax Equalization Fund; that reduction shall be adjusted in the case of those Members that require staff members to pay income taxes on their WHO emoluments, taxes which the Organization reimburses to said staff members; the amount of such tax reimbursements is estimated at US\$ 16 274 400, resulting in a total assessment on Members of US\$ 945 114 400;

4. DECIDES that the Working Capital Fund shall be maintained at its existing level of US\$ 31 000 000.

5. NOTES that the voluntary contributions required to meet the portion of the effective working budget not financed through net assessments on Members is US\$ 3 596 074 000.

(Eighth plenary meeting, 22 May 2009 –  
Committee A, first report)



**WHA62.10      Pandemic influenza preparedness: sharing of influenza viruses and access to vaccines and other benefits**

The Sixty-second World Health Assembly,

Having considered the reports on pandemic influenza preparedness: sharing of influenza viruses and access to vaccines and other benefits;<sup>1</sup>

Recalling resolution WHA60.28 on pandemic influenza preparedness: sharing of influenza viruses and access to vaccines and other benefits, which requested the Director-General to convene an intergovernmental meeting;

Recognizing that the Intergovernmental Meeting reached agreement on most elements of the Pandemic Influenza Preparedness Framework for the sharing of influenza viruses and access to vaccines and other benefits;<sup>2</sup>

Reaffirming the need for long-term solutions for pandemic influenza preparedness and response;

Recognizing also that further work needs to be done on some key remaining elements of the Pandemic Influenza Preparedness Framework,

REQUESTS the Director-General:

(1) to work with Member States to take forward the agreed parts of the Pandemic Influenza Preparedness Framework for the sharing of influenza viruses and access to vaccines and other benefits as contained in the report of the outcome of the Intergovernmental Meeting;<sup>3</sup>

(2) to facilitate a transparent process to finalize the remaining elements, including the Standard Material Transfer Agreements and its annex, and report the outcome to the Executive Board at its 126th session in January 2010.

(Eighth plenary meeting, 22 May 2009 –  
Committee A, second report)

**WHA62.11      Medium-term strategic plan 2008–2013, including Programme budget 2010–2011**

The Sixty-second World Health Assembly,

Recalling resolution WHA60.11 on the Medium-term strategic plan 2008–2013;

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<sup>1</sup> Documents A62/5 and A62/5 Add.1.

<sup>2</sup> Document A62/5 Add.1, Annex.

<sup>3</sup> Document A62/5 Add.1, Appendix.

Having considered the report on the Medium-term strategic plan 2008–2013, including Proposed programme budget 2010–2011;<sup>1</sup>

Having examined the draft amended Medium-term strategic plan 2008–2013,<sup>2</sup>

ENDORSES the amended Medium-term strategic plan 2008–2013, including its revised indicators and targets.

(Eighth plenary meeting, 22 May 2009 –  
Committee A, third report)

### **WHA62.12 Primary health care, including health system strengthening<sup>3</sup>**

The Sixty-second World Health Assembly,

Welcoming the efforts of the Director-General, and recognizing the pivotal role that WHO plays, in promoting primary health care globally;

Having considered the report on primary health care, including health system strengthening;<sup>4</sup>

Reaffirming the Declaration of Alma-Ata (1978) and the United Nations Millennium Declaration (2000);

Recalling the Ottawa Charter for Health Promotion (1986) and subsequent relevant resolutions of WHO regional committees and Health Assemblies;<sup>5</sup>

Recalling also the discussions at the series of summits and global, regional and national conferences that have reaffirmed the commitment of Member States to primary health care and strengthening health systems;<sup>6</sup>

Noting the growing consensus in the global health community that vertical approaches, such as disease-specific programmes, and integrated health systems approaches are mutually reinforcing and contribute to achieving the health-related Millennium Development Goals;

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<sup>1</sup> Document A62/4.

<sup>2</sup> See documents MTSP/2008–2013 (Amended (draft)) and PPB/2010–2011.

<sup>3</sup> See Annex 5 for the financial and administrative implications for the Secretariat of the resolution.

<sup>4</sup> Document A62/8.

<sup>5</sup> Resolutions WHA54.13, WHA56.6, WHA57.19, WHA58.17, WHA58.33, WHA60.22, WHA60.24, WHA60.27, WHA61.17 and WHA61.18.

<sup>6</sup> Including summits on health system strengthening, such as the G8 Hokkaido Toyako Summit (2008), International Conference on Global Action for Health System Strengthening (Tokyo, 2008), International Conference dedicated to the 30th Anniversary of the Alma-Ata Declaration of WHO/UNICEF on primary health care (Almaty, 2008), and G15 Summit (2004); WHO regional meetings on primary health care, such as those at Buenos Aires (2007), Beijing (2007), Bangkok (2008), Tallinn (2008), Ouagadougou (2008), Jakarta (2008) and Doha (2008); and conferences on health promotion, such as Ottawa (1986), Adelaide (1988), Sundsvall (1991), Jakarta (1997), Mexico City (2000), Bangkok (2005) and the MERCOSUR Task Force on Health (since 1995).

Recognizing the need to draw on the experiences, both positive and negative, of primary health care in the years since the Declaration of Alma-Ata and the Millennium Declaration;

Welcoming *The world health report 2008*,<sup>1</sup> published on the thirtieth anniversary of the international conference of Alma-Ata, that identifies four broad policy directions for reducing health inequalities and improving health for all: tackling health inequalities through universal coverage, putting people at the centre of care, integrating health into broader public policy, and providing inclusive leadership for health; and also welcoming the final report of the Commission on Social Determinants of Health;<sup>2</sup>

Reaffirming the need to build sustainable national health systems, strengthen national capacities, and honour fully financing commitments made by national governments and their development partners, as appropriate, in order to better fill the resource gaps in the health sector;

Reaffirming also the need to take concrete, effective and timely action, in implementing all agreed commitments on aid effectiveness and to increase the predictability of aid, while respecting recipient countries' control and ownership of their health system strengthening, all the more so given the potential effects on health and health systems of the current international financial and food crises and of climate change;

Strongly reaffirming the values and principles of primary health care, including equity, solidarity, social justice, universal access to services, multisectoral action, decentralization and community participation as the basis for strengthening health systems,

1. URGES Member States:

(1) to ensure political commitment at all levels to the values and principles of the Declaration of Alma-Ata, keep the issue of strengthening health systems based on the primary health care approach high on the international political agenda, and take advantage, as appropriate, of health-related partnerships and initiatives relating to this issue, particularly to support achievement of the health-related Millennium Development Goals;

(2) to accelerate action towards universal access to primary health care by developing comprehensive health services and by developing national equitable, efficient and sustainable financing mechanisms, mindful of the need to ensure social protection and protect health budgets in the context of the current international financial crisis;

(3) to put people at the centre of health care by adopting, as appropriate, delivery models focused on the local and district levels that provide comprehensive primary health care services, including health promotion, disease prevention, curative care and palliative care, that are integrated with other levels of care and coordinated according to need, while ensuring effective referral to secondary and tertiary care;

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<sup>1</sup> *The world health report 2008: Primary health care – now more than ever*. Geneva, World Health Organization, 2008.

<sup>2</sup> Commission on Social Determinants of Health. *Closing the gap in a generation: health equity through action on the social determinants of health*. Geneva, World Health Organization, 2008.

(4) to promote active participation by all people, and re-emphasize the empowering of communities, especially women, in the processes of developing and implementing policy and improving health and health care, in order to support the renewal of primary health care;

(5) to train and retain adequate numbers of health workers, with appropriate skill mix, including primary care nurses, midwives, allied health professionals and family physicians, able to work in a multidisciplinary context, in cooperation with non-professional community health workers in order to respond effectively to people's health needs;

(6) to encourage the development, integration and implementation of vertical programmes, including disease-specific programmes, in the context of integrated primary health care;

(7) to improve access to appropriate medicines, health products and technologies, all of which are required to support primary health care;

(8) to develop and strengthen health information and surveillance systems, relating to primary health care in order to facilitate evidence-based policies and programmes and their evaluation;

(9) to strengthen health ministries, enabling them to provide inclusive, transparent and accountable leadership of the health sector and to facilitate multisectoral action as part of primary health care;

2. REQUESTS the Director-General:

(1) to ensure that WHO reflects the values and principles of the Declaration of Alma-Ata in its work and that the overall organizational efforts across all levels contribute to the renewal and strengthening of primary health care, in accordance with the findings of the Commission on Social Determinants of Health;

(2) to strengthen the Secretariat's capacities, including those of regional and country offices, to support Member States' efforts to deliver on the four broad policy directions for renewal and strengthening of primary health care identified in *The world health report 2008*;

(3) to collate and analyse past and current experiences of Member States in implementing primary health care and facilitate the exchange of experience, evidence and information on good practice in achieving universal coverage and strengthening health systems;

(4) to foster alignment and coordination of global interventions for health system strengthening, basing them on the primary health care approach, in collaboration with Member States, relevant international organizations, international health initiatives, and other stakeholders in order to increase synergies between international and national priorities;

(5) to ensure adequate funding for health system strengthening and revitalizing primary health care in the Programme budget 2010–2011;

(6) to prepare implementation plans for the four broad policy directions: (a) dealing with inequalities by moving towards universal coverage; (b) putting people at the centre of service delivery; (c) multisectoral action and health in all policies; (d) inclusive leadership and effective governance for health; to ensure that these plans span the work of the entire Organization, and

to report on these plans through the Executive Board to the Sixty-third World Health Assembly and subsequently on progress every two years thereafter.

(Eighth plenary meeting, 22 May 2009 –  
Committee A, third report)

### **WHA62.13      Traditional medicine**

The Sixty-second World Health Assembly,

Having considered the report on primary health care, including health system strengthening;<sup>1</sup>

Recalling resolutions WHA22.54, WHA29.72, WHA30.49, WHA31.33, WHA40.33, WHA41.19, WHA42.43, WHA54.11, WHA56.31 and WHA61.21;

Recalling the Declaration of Alma-Ata which states, inter alia, that “The people have the right and duty to participate individually and collectively in the planning and implementation of their health care” and “Primary health care relies, at local and referral levels, on health workers, including physicians, nurses, midwives, auxiliaries and community workers as applicable, as well as traditional practitioners as needed, suitably trained socially and technically to work as a health team and to respond to the expressed health needs of the community”;

Noting that the term “traditional medicine” covers a wide variety of therapies and practices, which may vary greatly from country to country and from region to region;

Recognizing traditional medicine as one of the resources of primary health care services that could contribute to improved health outcomes, including those in the Millennium Development Goals;

Recognizing that Member States have different domestic legislation, approaches, regulatory responsibilities and delivery models related to primary health care;

Noting the progress that many governments have made to include traditional medicine into their national health systems;

Noting that progress in the field of traditional medicine has been achieved by a number of Member States through implementation of WHO’s traditional medicine strategy 2002–2005;<sup>2</sup>

Expressing the need for action and cooperation by the international community, governments, and health professionals and workers, to ensure proper use of traditional medicine as an important component contributing to the health of all people, in accordance with national capacity, priorities and relevant legislation;

Noting that the WHO Congress on Traditional Medicine took place from 7 to 9 November 2008, in Beijing, China, and adopted the Beijing Declaration on Traditional Medicine;

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<sup>1</sup> Document A62/8.

<sup>2</sup> Document WHO/EDM/TRM/2002.1.

Noting that African Traditional Medicine Day is commemorated annually on 31 August in order to raise awareness and the profile of traditional medicine in the African Region, as well as to promote its integration into national health systems,

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

- (1) to consider adopting and implementing the Beijing Declaration on Traditional Medicine in accordance with national capacities, priorities, relevant legislation and circumstances;
- (2) to respect, preserve and widely communicate, as appropriate, the knowledge of traditional medicine, treatments and practices, appropriately based on the circumstances in each country, and on evidence of safety, efficacy and quality;
- (3) to formulate national policies, regulations and standards, as part of comprehensive national health systems, to promote appropriate, safe and effective use of traditional medicine;
- (4) to consider, where appropriate, including traditional medicine into their national health systems based on national capacities, priorities, relevant legislation and circumstances, and on evidence of safety, efficacy and quality;
- (5) to further develop traditional medicine based on research and innovation, giving due consideration to the specific actions related to traditional medicine in the implementation of the Global strategy and plan of action on public health, innovation and intellectual property;
- (6) to consider, where appropriate, establishing systems for the qualification, accreditation or licensing of traditional medicine practitioners and to assist traditional medicine practitioners to upgrade their knowledge and skill in collaboration with relevant health providers, on the basis of traditions and customs of peoples and communities;
- (7) to consider strengthening communication between conventional and traditional medicine providers and, where appropriate, establishing appropriate training programmes with content related to traditional medicine for health professionals, medical students and relevant researchers;
- (8) to cooperate with each other in sharing knowledge and practices of traditional medicine and exchanging training programmes on traditional medicine, consistent with national legislation and relevant international obligations;

2. REQUESTS the Director-General:

- (1) to provide support to Member States, as appropriate and upon request, in implementing the Beijing Declaration on Traditional Medicine;
- (2) to update the WHO traditional medicine strategy 2002–2005, based on countries' progress and current new challenges in the field of traditional medicine;
- (3) to give due consideration to the specific actions related to traditional medicine in the implementation of the Global strategy and plan of action on public health, innovation and intellectual property and the WHO global strategy for prevention and control of noncommunicable diseases;

(4) to continue providing policy guidance to countries on how to integrate traditional medicine into health systems, especially to promote, where appropriate, the use of traditional/indigenous medicine for primary health care, including disease prevention and health promotion, in line with evidence of safety, efficacy and quality, taking into account the traditions and customs of peoples and communities;

(5) to continue providing technical guidance to support countries in ensuring the safety, efficacy and quality of traditional medicine, considering the participation of peoples and communities and taking into account their traditions and customs;

(6) to strengthen cooperation with WHO collaborating centres, research institutions and nongovernmental organizations in order to share evidence-based information, taking into account the traditions and customs of peoples and communities; and to support training programmes for national capacity building in the field of traditional medicine.

(Eighth plenary meeting, 22 May 2009 –  
Committee A, third report)

#### **WHA62.14 Reducing health inequities through action on the social determinants of health**

The Sixty-second World Health Assembly,

Having considered the report on the Commission on Social Determinants of Health;<sup>1</sup>

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

Noting the sixtieth anniversary of the establishment of WHO in 1948, and its Constitution, which affirms that the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition;

Noting the thirtieth anniversary of the International Conference on Primary Health Care at Alma-Ata in 1978, which reaffirmed the essential value of equity in health and launched the global strategy of primary health care to achieve health for all;

Recalling the principles of “Health for All”, notably the need for intersectoral action (resolution WHA30.43);

Confirming the importance of addressing the wider determinants of health and considering the actions and recommendations set out in the series of international health promotion conferences, from the Ottawa Charter on Health Promotion to the Bangkok Charter for Health Promotion in a Globalized World, making the promotion of health central to the global development agenda as a core responsibility of all governments (resolution WHA60.24);

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<sup>1</sup> Document A62/9.

Noting the global consensus of the United Nations Millennium Declaration to achieve the Millennium Development Goals by 2015 and the concern at the lack of sufficient progress towards many of these goals in some regions at the half-way point;

Welcoming in this regard resolution WHA61.18, which initiates annual monitoring by the Health Assembly of the achievement of health-related Millennium Development Goals;

Noting *The world health report 2008*<sup>1</sup> on primary health care and its focus on ways to improve health equity by reforming health and other societal systems;

Mindful about the fact that responses to environmental degradation and climate change include health equity issues and noting that the impact of climate change is expected to affect negatively the health of vulnerable and disadvantaged populations (resolution WHA61.19);

Mindful about the facts concerning widening gaps in life expectancy worldwide;

Attaching utmost importance to the elimination of gender-related health inequities;

Recognizing that millions of children globally are not reaching their full potential and that investing in comprehensive supports for early child development that are accessible to all children is a fundamental step in achieving health equity across the lifespan;

Acknowledging that improvement of unfavourable social conditions is primarily a social policy issue;

Noting the need to improve coordination among global, national and subnational efforts in tackling social determinants of health through work across sectors, while simultaneously promoting social and economic development, with the understanding that such action requires the collaboration of many partners, including civil society and private sector;

Mindful of the important role of existing global governance<sup>2</sup> mechanisms to support Member States in provision of basic services essential to health and the regulation of goods and services with a major impact on health, and the need for corporate responsibility,

1. EXPRESSES its appreciation for the work done by the Commission on Social Determinants of Health;
2. CALLS UPON the international community, including United Nations agencies, intergovernmental bodies, civil society and the private sector:

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<sup>1</sup> *The world health report 2008: primary health care – now more than ever*. Geneva, World Health Organization, 2008.

<sup>2</sup> See WHO web site: <http://www.who.int/trade/glossary/story038/en>, accessed 18 June 2009.



- (1) to take note of the final report of the Commission on Social Determinants of Health and its recommendations;<sup>1</sup>
  - (2) to take action in collaboration with WHO's Member States and the WHO Secretariat on assessing the impacts of policies and programmes on health inequities and on addressing the social determinants of health;
  - (3) to work closely with WHO's Member States and the WHO Secretariat on measures to enhance health equity in all policies in order to improve health for the entire population and reduce inequities;
  - (4) to consider health equity in working towards achievement of the core global development goals and to develop indicators to monitor progress, and to consider strengthening international collaboration in addressing the social determinants of health and in reducing health inequities;
3. URGES Member States:
- (1) to tackle the health inequities within and across countries through political commitment on the main principles of "closing the gap in a generation" as a national concern, as is appropriate, and to coordinate and manage intersectoral action for health in order to mainstream health equity in all policies, where appropriate, by using health and health equity impact assessment tools;
  - (2) to develop and implement goals and strategies to improve public health with a focus on health inequities;
  - (3) to take into account health equity in all national policies that address social determinants of health, and to consider developing and strengthening universal comprehensive social protection policies, including health promotion, disease prevention and health care, and promoting availability of and access to goods and services essential to health and well-being;
  - (4) to ensure dialogue and cooperation among relevant sectors with the aim of integrating a consideration of health into relevant public policies and enhancing intersectoral action;
  - (5) to increase awareness among public and private health providers on how to take account of social determinants when delivering care to their patients;
  - (6) to contribute to the improvement of the daily living conditions contributing to health and social well-being across the lifespan by involving all relevant partners, including civil society and the private sector;
  - (7) to contribute to the empowerment of individuals and groups, especially those who are marginalized, and take steps to improve the societal conditions that affect their health;

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

(8) to generate new, or make use of existing, methods and evidence, tailored to national contexts in order to address the social determinants and social gradients of health and health inequities;

(9) to develop, make use of, and, if necessary, improve health information systems and research capacity in order to monitor and measure the health of national populations, with disaggregated data such as age, gender, ethnicity, race, caste, occupation, education, income and employment where national law and context permit so that health inequities can be detected and the impact of policies on health equity measured;

4. REQUESTS the Director-General:

(1) to work closely with partner agencies in the multilateral system on appropriate measures that address the social determinants of health and promote policy coherence in order to minimize health inequities; and to advocate inclusion of this topic high on global development and research agendas;

(2) to strengthen capacity within the Organization with the purpose of giving sufficient priority to relevant tasks related to addressing the social determinants of health in order to reduce health inequities;

(3) to make social determinants of health a guiding principle for the implementation of measures, including objective indicators for the monitoring of social determinants of health, across relevant areas of work and promote addressing social determinants of health to reduce health inequities as an objective of all areas of the Organization's work, especially priority public health programmes;

(4) to support the primary role of Member States in promoting access to basic services essential to health and the regulation, as appropriate, of goods and services with a major impact on health;

(5) to ensure that ongoing work on the revitalization of primary health care is aligned with work on addressing the social determinants of health, as recommended by *The world health report 2008*;

(6) to provide support to Member States in implementing a health-in-all-policies approach to tackling inequities in health;

(7) to provide support to Member States, upon request, in implementing measures with the aim of integrating a focus on social determinants of health across relevant sectors and in designing, or if necessary redesigning, their health sectors to address this appropriately;

(8) to provide support to Member States, upon request, in strengthening existing efforts on measurement and evaluation of the social determinants of health and the causes of health inequities and in developing and monitoring targets on health equity;

(9) to support research on effective policies and interventions to improve health by addressing the social determinants of health that also serve to strengthen research capacities and collaborations;

- (10) to provide support to the regional directors in developing a regional focus on issues related to the social determinants of health and in engaging a broader range of countries in this issue, in accordance with the conditions and challenges of each region;
- (11) to convene a global event, with the assistance of Member States, before the Sixty-fifth World Health Assembly in order to discuss renewed plans for addressing the alarming trends of health inequities through addressing social determinants of health;
- (12) to assess the performance of existing global governance mechanisms to address the social determinants of health and reducing health inequities;
- (13) to report on progress in implementing this resolution to the Sixty-fifth World Health Assembly through the Executive Board.

(Eighth plenary meeting, 22 May 2009 –  
Committee A, third report)

#### **WHA62.15 Prevention and control of multidrug-resistant tuberculosis and extensively drug-resistant tuberculosis<sup>1</sup>**

The Sixty-second World Health Assembly,

Having considered the reports on the prevention and control of multidrug-resistant tuberculosis and extensively drug-resistant tuberculosis;<sup>2</sup>

Noting the progress made since 1991 towards achieving the international targets for 2005, the acceleration of efforts following the establishment of the Stop TB Partnership in response to resolution WHA51.13, and more recently following resolution WHA58.14 encouraging Member States to ensure availability of sufficient resources to achieve the internationally agreed goal relevant to tuberculosis contained in the United Nations Millennium Declaration by 2015;

Aware that the development of the Stop TB strategy as a holistic approach to tuberculosis prevention and control represents a significant expansion in the scale and scope of tuberculosis-control activities as a part of strengthening health systems within the context of primary health care and addressing social determinants of health;

Noting that the Stop TB Partnership's Global Plan to Stop TB 2006–2015<sup>3</sup> sets out the activities oriented towards implementing the Stop TB strategy and achieving the international targets for tuberculosis control set by the Stop TB Partnership – in line with the target of the internationally agreed development goal relevant to tuberculosis contained in the United Nations Millennium Declaration to “have halted by 2015 and begun to reverse the incidence of major diseases” – of halving tuberculosis prevalence and death rates by 2015 compared with 1990 levels;

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<sup>1</sup> See Annex 5 for the financial and administrative implications for the Secretariat of the resolution.

<sup>2</sup> Documents A62/20 and A62/20 Add.1.

<sup>3</sup> Document WHO/HTM/STB/2006.35.

Noting that the care and control of tuberculosis have progressed significantly during the past decade and the incidence of new cases is estimated to have fallen slightly each year since 2003;

Aware that a significant proportion – an estimated 37% of tuberculosis cases worldwide – remain un-notified and receive either no treatment or inappropriate treatment;

Recognizing that the rates of tuberculosis are disproportionately high in high-risk populations, including indigenous populations;

Recognizing that emergence and spread of multidrug-resistant and extensively drug-resistant tuberculosis are facilitated by not detecting sufficient cases of tuberculosis and not treating them appropriately by DOTS-based treatment;

Concerned that the highest levels of multidrug-resistance reported in WHO's fourth global report on anti-tuberculosis drug resistance<sup>1</sup> – an estimated half a million multidrug-resistant cases occurring globally, including 50 000 cases of extensively drug-resistant tuberculosis – pose a threat to global public health security;

Recognizing that there is an urgent need to invest in research for development of new diagnostics, medicines and vaccines and in operational research to prevent and manage tuberculosis, including multidrug-resistant and extensively drug-resistant tuberculosis, while exploring and, where appropriate, promoting a range of incentive schemes for research and development, including addressing, where appropriate, the de-linkage of the costs of research and development and the price of health products;

Noting that less than 3% of the estimated total number of cases of multidrug-resistant and extensively drug-resistant tuberculosis receive treatment according to WHO's recommended standards;

Concerned that the disease transmission occurs mostly in communities where there is a lack of appropriate infection control;

Concerned that the insufficient demand from countries for internationally quality-assured anti-tuberculosis medicines resulting in an inadequate supply through the Green Light Committee mechanism has been a major bottleneck to treating multidrug-resistant and extensively drug-resistant tuberculosis and that quality-assured fixed-dose drug combinations, developed as a tool to prevent the emergence of resistance, are not widely used;

Aware that the delays in implementing the Global Plan to Stop TB 2006–2015 will result in increasing numbers of tuberculosis cases and deaths, including those due to multidrug-resistant and extensively multidrug-resistant tuberculosis and to the impact of HIV, and therefore in delays in achieving by 2015 the international targets for tuberculosis control and the internationally agreed development goal relevant to tuberculosis contained in the United Nations Millennium Declaration;

Recalling resolution WHA60.19 on tuberculosis control in which the Health Assembly urged Member States to develop and implement long-term plans for tuberculosis including multidrug-resistant and extensively drug-resistant tuberculosis prevention and control in line with the Global

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<sup>1</sup> Document WHO/HTM/TB/2008.394.

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Plan to Stop TB 2006–2015 within the overall health development plans, and resolution WHA58.33 on achieving universal coverage;

Welcoming the Beijing Call for Action on tuberculosis control and patient care given jointly by representatives of 27 Member States carrying a high burden of multidrug-resistant and extensively drug-resistant tuberculosis, civil society, the private sector and others to address the alarming threat of multidrug-resistant and extensively drug-resistant tuberculosis,<sup>1</sup>

1. URGES all Member States:

(1) to achieve universal access to diagnosis and treatment of multidrug-resistant and extensively drug-resistant tuberculosis as part of the transition to universal health coverage, thereby saving lives and protecting communities, by means of:

(a) developing a comprehensive framework for management and care of multidrug-resistant and extensively drug-resistant tuberculosis that includes directly-observed treatment, community-based and patient-centred care, and which identifies and addresses the needs of persons living with HIV, the poor and other vulnerable groups, such as prisoners, mineworkers, migrants, drug users, and those dependent on alcohol, as well as the underlying social determinants of tuberculosis and multidrug-resistant and extensively drug-resistant tuberculosis;

(b) strengthening health information and surveillance systems to ensure detection and monitoring of the epidemiological profile of multidrug-resistant and extensively drug-resistant tuberculosis and monitor achievement in its prevention and control;

(c) aiming to ensure the removal of financial barriers to allow all tuberculosis patients equitable access to tuberculosis care, that their rights are protected, and that they are treated with respect and dignity in accordance with the local legislation;

(d) making available sufficiently trained and motivated staff in order to enable diagnosis, treatment and care of tuberculosis including multidrug-resistant and extensively drug-resistant tuberculosis, as an integral part of efforts to address the overall health workforce crisis;

(e) strengthening laboratory systems, through increasing capacity and adequate human resources, and accelerating access to faster and quality-assured diagnostic tests;

(f) engaging all relevant public and private health-care providers in managing tuberculosis including multidrug-resistant and extensively drug-resistant tuberculosis and tuberculosis-HIV coinfection according to national policies, and strengthening primary health care in early detection, effective treatment and support to patients;

(g) ensuring that national airborne infection-control policies are developed (as part of general infection prevention and control programmes) and implemented in every health-care facility and other high-risk settings and that there is sufficient awareness of tuberculosis infection control in the community;

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<sup>1</sup> Document A62/20 Add.1, Annex.

(h) ensuring an uninterrupted supply of first- and second-line medicines for tuberculosis treatment, which meet WHO prequalification standards or strict national regulatory authority standards, and that quality-assured fixed-dose combination medicines of proven bioavailability are prioritized within a system that promotes treatment adherence;

(i) strengthening mechanisms to ensure that tuberculosis medicines are sold on prescription only and that they are prescribed and dispensed by accredited public and private providers;

(j) undertaking effective advocacy, communication and social mobilization, avoiding stigmatization and discrimination, and spreading community awareness about policies and plans for prevention and control of tuberculosis including multidrug-resistant and extensively drug-resistant tuberculosis;

(k) establishing national targets in order to accelerate access to treatment, according to WHO guidelines, for multidrug-resistant and extremely drug-resistant tuberculosis patients;

(2) to enhance quality and coverage of DOTS in achieving 70% detection rate and 85% success rate of tuberculosis treatment, thereby preventing secondary multidrug-resistant tuberculosis;

(3) to use all possible financing mechanisms in order to fulfil the commitments made in resolutions WHA58.14 and WHA60.19, including the commitment to ensure sustainable domestic and external financing, thereby filling the funding gaps identified in the Global Plan to Stop TB 2006–2015;

(4) to increase investment by countries and all partners substantially in operational research and research and development for new diagnostics, medicines and vaccines to prevent and manage tuberculosis including multidrug-resistant and extensively drug-resistant tuberculosis;

## 2. REQUESTS the Director-General:

(1) to provide technical support to Member States in order to develop and implement response plans, based on a comprehensive framework for management of care, for the prevention and control of tuberculosis including multidrug-resistant and extensively drug-resistant tuberculosis;

(2) to provide support to Member States in developing and implementing strategies to engage all relevant public, voluntary, corporate and private health-care providers in the training for and scaling up of prevention and control of tuberculosis including multidrug-resistant and extensively drug-resistant tuberculosis and all aspects of tuberculosis-HIV coinfection;

(3) to advise and support Member States in bringing the standards of national drug regulatory agencies into line with international standards, thus enabling national pharmaceutical manufacturers to produce material of assured quality to be sold in the local and international markets;

- (4) to provide support to Member States for upgrading laboratory networks in order to have the capacity to diagnose and monitor multidrug-resistant and extensively drug-resistant tuberculosis and facilitate systematic evaluations of newer and faster diagnostic technology;
- (5) to strengthen the Green Light Committee mechanism in order to help to expand access to concessionally-priced and quality-assured first- and second-line medicines through encouraging and assisting WHO prequalification of locally manufactured pharmaceuticals in high-burden countries;
- (6) to explore and, where appropriate, promote a range of incentive schemes for research and development, including addressing, where appropriate, the de-linkage of the costs of research and development and the price of health products;
- (7) to work with countries to develop country indicators and to support monitoring and evaluation of the implementation of the measures outlined in this resolution;
- (8) to report through the Executive Board to the Sixty-third and Sixty-fifth World Health Assemblies on overall progress made.

(Eighth plenary meeting, 22 May 2009 –  
Committee A, fourth report)

## **WHA62.16 Global strategy and plan of action on public health, innovation and intellectual property<sup>1</sup>**

The Sixty-second World Health Assembly,

Recalling resolution WHA61.21 on the global strategy and plan of action on public health, innovation and intellectual property, and noting the information provided by the Secretariat;<sup>2</sup>

Welcoming the reference in the report by the Secretariat to the implementation of the African Network for Drugs and Diagnostics Innovations, which supports and promotes African-led health product innovation for the discovery, development and delivery of medicines and diagnostics for neglected tropical diseases, and reiterates the need to fast-track activities to reach neglected people who are sick and suffering from neglected tropical diseases,

### 1. DECIDES:

- (1) to incorporate into the plan of action the additional agreed stakeholders as outlined in document A62/16 Add.3; deleting “interested” before “governments” for specific action 2.3(c);
- (2) to incorporate into the plan of action the proposed time frames outlined in document A62/16 Add.1;

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<sup>1</sup> See Annex 5 for the financial and administrative implications for the Secretariat of the resolution.

<sup>2</sup> Documents A62/16, A62/16 Add.1, A62/16 Add.2 and A62/16 Add.3.

2. ADOPTS the final plan of action, as amended in paragraph 1, in respect of specific actions, stakeholders and time frames;<sup>1</sup>
3. NOTES the estimated funding needs related to the plan of action;<sup>2</sup>
4. ACCEPTS the proposed progress indicators,<sup>3</sup> taking note of the need periodically to review and refine them; where the indicators are quantitative, the Secretariat shall provide complementary information on the implementation of the specific actions;
5. REQUESTS the Director-General to provide significantly increased support for greater efficiency and effectiveness in the implementation of the global strategy and plan of action on public health, innovation and intellectual property and prioritize concrete actions in the area of capacity-building and access;
6. FURTHER REQUESTS the Director-General, in addition to continued monitoring, to conduct an overall programme review of the global strategy and plan of action in 2014 on its achievements, remaining challenges and recommendations on the way forward to the Health Assembly in 2015 through the Executive Board.

(Eighth plenary meeting, 22 May 2009 –  
Committee B, second report)

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

<sup>2</sup> Document A62/16 Add.1.

<sup>3</sup> Document A62/16 Add.2.



## DECISIONS

### WHA62(1)      **Composition of the Committee on Credentials**

The Sixty-second World Health Assembly appointed a Committee on Credentials consisting of delegates of the following Member States: Albania, Andorra, Belize, Brunei Darussalam, Cape Verde, Chad, Greece, Lao People's Democratic Republic, Maldives, Mozambique, Oman, Venezuela (Bolivarian Republic of).

(First plenary meeting, 18 May 2009)

### WHA62(2)      **Election of officers of the Sixty-second World Health Assembly**

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

**President:**                      Mr N.S. de Silva (Sri Lanka)

**Vice-Presidents:**            Dr O.Ugarte Ubilluz (Peru)  
Mr A.M. Fouda (Cameroon)  
Dr L.-E. Holm (Sweden)  
Dr A.Y. Rasa'a (Yemen)  
Dr A. Matthew (Marshall Islands)

(First plenary meeting, 18 May 2009)

### WHA62(3)      **Election of officers of the main committees**

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

**Committee A:      Chairman**            Dr F. Meneses González (Mexico)

**Committee B:      Chairman**            Mr S. McKernan (New Zealand)

(First plenary meeting, 18 May 2009)

The main committees subsequently elected the following officers:

**Committee A:      Vice-Chairmen**    Dr M. Ramatlapeng (Lesotho)  
Dr M. bin Hamad bin Jaber Al-Thani (Qatar)

**Rapporteur**                      Ms S.T. Aydin (Turkey)

**Committee B: Vice-Chairmen** Dr U.S. Sutarjo (Indonesia)  
Mr V. Jaksons (Latvia)

**Rapporteur** Dr E.G. Allen Young (Jamaica)

(First meetings of Committees A and B, 18 and 20 May 2009)

#### **WHA62(4) Establishment of the General Committee**

The Sixty-second World Health Assembly elected the delegates of the following 17 countries as members of the General Committee: Afghanistan, Armenia, Bangladesh, China, Costa Rica, Côte d'Ivoire, Cuba, Czech Republic, Djibouti, France, Guinea-Bissau, Kenya, Russian Federation, Rwanda, Swaziland, United Kingdom of Great Britain and Northern Ireland, United States of America.

(First plenary meeting, 18 May 2009)

#### **WHA62(5) Adoption of the agenda**

The Sixty-second World Health Assembly adopted, with amendments, the provisional agenda prepared by the Executive Board at its 124th session.

(Second plenary meeting, 18 May 2009)

#### **WHA62(6) Verification of credentials**

The Sixty-second World Health Assembly recognized the validity of the credentials of the following delegations: Afghanistan; Albania; Algeria; Andorra; Angola; Antigua and Barbuda; Argentina; Armenia; Australia; Austria; Azerbaijan; Bahamas; Bahrain; Bangladesh; Barbados; Belgium; Belize; Benin; Bhutan; Bolivia (Plurinational State of); Bosnia and Herzegovina; Botswana; Brazil; Brunei Darussalam; Bulgaria; Burkina Faso; Burundi; Cambodia; Cameroon; Canada; Cape Verde; Central African Republic; Chad; Chile; China; Colombia; Comoros; Congo; Cook Islands; Costa Rica; Côte d'Ivoire; Croatia; Cuba; Cyprus; Czech Republic; Democratic People's Republic of Korea; Democratic Republic of the Congo; Denmark; Djibouti; Dominican Republic; Ecuador; Egypt; El Salvador; Equatorial Guinea; Eritrea; Estonia; Ethiopia; Fiji; Finland; France; Gabon; Gambia; Georgia; Germany; Ghana; Greece; Grenada; Guatemala; Guinea; Guinea-Bissau; Guyana; Haiti; Honduras; Hungary; Iceland; India; Indonesia; Iran (Islamic Republic of); Iraq; Ireland; Israel; Italy; Jamaica; Japan; Jordan; Kazakhstan; Kenya; Kuwait; Kyrgyzstan; Lao People's Democratic Republic; Latvia; Lebanon; Lesotho; Liberia; Libyan Arab Jamahiriya; Lithuania; Luxembourg; Madagascar; Malaysia; Maldives; Mali; Malta; Marshall Islands; Mauritania; Mauritius; Mexico; Micronesia (Federated States of); Monaco; Mongolia; Montenegro; Morocco; Mozambique; Myanmar; Namibia; Nauru; Nepal; Netherlands; New Zealand; Nicaragua; Niger; Nigeria; Norway; Oman; Pakistan; Panama; Papua New Guinea; Paraguay; Peru; Philippines; Poland; Portugal; Qatar; Republic of Korea; Republic of Moldova; Romania; Russian Federation; Rwanda; Saint Kitts and Nevis; Saint Lucia; Saint Vincent and the Grenadines; Samoa; San Marino; Sao Tome and Principe; Saudi Arabia; Senegal; Serbia; Seychelles; Sierra Leone; Singapore; Slovakia; Slovenia; Solomon Islands; Somalia; South Africa; Spain;

Sri Lanka; Sudan; Suriname; Swaziland; Sweden; Switzerland; Syrian Arab Republic; Tajikistan; Thailand; The former Yugoslav Republic of Macedonia; Timor-Leste; Togo; Tonga; Trinidad and Tobago; Tunisia; Turkey; Turkmenistan; Tuvalu; Uganda; Ukraine; United Arab Emirates; United Kingdom of Great Britain and Northern Ireland; United Republic of Tanzania; United States of America; Uruguay; Uzbekistan; Vanuatu; Venezuela (Bolivarian Republic of); Viet Nam; Yemen; Zambia; Zimbabwe.

(Sixth plenary meeting, 21 May 2009)

**WHA62(7) Election of Members entitled to designate a person to serve on the Executive Board**

The Sixty-second World Health Assembly, after considering the recommendations of the General Committee, elected the following as Members entitled to designate a person to serve on the Executive Board: Brunei Darussalam, Burundi, Canada, Chile, Estonia, France, Germany, India, Japan, Serbia, Somalia, Syrian Arab Republic.

(Seventh plenary meeting, 21 May 2009)

**WHA62(8) United Nations Joint Staff Pension Fund: appointment of representatives to the WHO Staff Pension Committee**

The Sixty-second World Health Assembly nominated Dr A.J. Mohamad of the delegation of Oman as a member and Dr H. Siem of the delegation of Norway as an alternate member of the WHO Staff Pension Committee for a three-year term until May 2012.

(Seventh plenary meeting, 21 May 2009)

**WHA62(9) Selection of the country in which the Sixty-third World Health Assembly would be held**

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

(Eighth plenary meeting, 22 May 2009)

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## **ANNEXES**



## ANNEX 1

### **Action plan for the prevention of avoidable blindness and visual impairment<sup>1</sup>**

[A62/7 – 2 April 2009]

1. According to the latest WHO estimates, about 314 million people worldwide live with visual impairment due to either eye diseases or uncorrected refractive errors. Of these, 45 million are blind, of whom 90% live in low-income countries. The major causes of blindness are cataract (39%), uncorrected refractive errors (18%), glaucoma (10%), age-related macular degeneration (7%), corneal opacity (4%), diabetic retinopathy (4%), trachoma (3%), eye conditions in children (3%), and onchocerciasis (0.7%). The actual magnitude of blindness and visual impairment is likely to be higher than estimates indicate, as detailed epidemiological information on some causes (e.g. presbyopia) is still lacking.

2. With today's knowledge and technology, up to 80% of global blindness is preventable or treatable. Cost-effective interventions are available for the major causes of avoidable blindness. Major international partnerships have been established in recent years, including the African Programme for Onchocerciasis Control, the Onchocerciasis Elimination Program for the Americas, the WHO Alliance for the Global Elimination of Blinding Trachoma and VISION 2020: the Right to Sight.

3. Two recently adopted Health Assembly resolutions (WHA56.26 and WHA59.25) focused on avoidable blindness and visual impairment, urging Member States to work on prevention, mainly through specific plans and inclusion of the subject in national health plans and programmes. Despite significant progress in the area of eye health, the prevalence of avoidable blindness remains unacceptably high in many countries and communities.

#### **PURPOSE**

4. The plan aims to expand efforts by Member States, the Secretariat and international partners in preventing blindness and visual impairment by developing comprehensive eye-health programmes at national and subnational levels.

5. In order to intensify and coordinate existing activities, especially in low- and middle-income countries, the plan seeks to:

- (a) increase political and financial commitment to eliminating avoidable blindness;
- (b) facilitate the preparation of evidence-based standards and guidelines, and use of the existing ones, for cost-effective interventions;

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<sup>1</sup> See resolution WHA62.1.

- (c) review international experience and share lessons learnt and best practices in implementing policies, plans and programmes for the prevention of blindness and visual impairment;
- (d) strengthen partnerships, collaboration and coordination between stakeholders involved in preventing avoidable blindness;
- (e) collect, analyse and disseminate information systematically on trends and progress made in preventing avoidable blindness globally, regionally and nationally.

## SCOPE

6. This plan focuses on the major causes of avoidable blindness and visual impairment, as defined in the draft eleventh revision of the International Statistical Classification of Diseases and Related Health Problems.<sup>1</sup> The plan does not deal with categories of milder visual impairment or eye conditions for which evidence-based prevention and/or treatment interventions are not available; these cases will require effective and appropriate rehabilitation measures that enable people with disabilities to attain and maintain maximum independence and full inclusion and participation in all aspects of life.

7. Since blinding conditions are chronic and mostly due to noncommunicable causes, this plan complements the action plan for the global strategy for the prevention and control of noncommunicable diseases adopted by the Health Assembly in resolution WHA61.14. Prevention strategies differ significantly, however, as most blinding conditions do not share the risk factors, other than tobacco use, addressed in the noncommunicable disease plan. Although, as with noncommunicable diseases, primary health-care and community-based interventions are essential for preventing blindness and visual impairment, the provision of high-quality eye-care services needs specific skills, technology and infrastructure.

8. Evidence indicates that the magnitude of avoidable blindness caused by communicable diseases like trachoma and onchocerciasis and ophthalmological complications in measles is decreasing, whereas noncommunicable age-related eye conditions (e.g. cataract, glaucoma and diabetic retinopathy) are increasing. Programmes against both onchocerciasis and trachoma need continued efforts for control and to avoid recurrence. A coordinated intersectoral approach to both communicable and noncommunicable conditions is needed.

9. In view of the adverse global economic climate it is essential to maximize the impact of existing resources and technical programmes across WHO that contribute to the prevention of blindness, and also influence the conditions that make populations vulnerable to visual impairment. An example of this is the use of immunization, and vitamin A supplementation in vulnerable populations, to reduce the risk of blindness due to corneal opacities.

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<sup>1</sup> “Blindness” is defined as a presenting visual acuity of less than 3/60, or a corresponding visual field loss to less than 10° in the better eye with the available correction. “Severe visual impairment” is defined as a presenting visual acuity of between less than 6/60 and 3/60, and “moderate visual impairment” is defined as a presenting visual acuity of less than 6/18 to 6/60. In this document “visual impairment” includes both severe and moderate visual impairment.



## RELATION TO EXISTING STRATEGIES AND PLANS

10. Prevention of avoidable blindness and visual impairment has been the subject of several resolutions adopted by the Health Assembly,<sup>1</sup> which, inter alia, encouraged several international partnerships and alliances to work at the global level in this field. The action plan supports implementation of WHO's Eleventh General Programme of Work 2008–2013 and the Medium-term strategic plan 2008–2013, particularly strategic objective 3, which covers work on prevention and control of avoidable blindness and visual impairment. It also supports the implementation of existing regional resolutions and plans.<sup>2</sup>

## RESOURCES

11. The Programme budget 2008–2009 describes the financial resources required by the Secretariat for work to meet strategic objective 3. For future bienniums, additional resources will be required. Further progress in preventing avoidable blindness and visual impairment globally, regionally and nationally will depend on the amount of additional resources available. All partners – including intergovernmental and nongovernmental organizations, academic and research institutions and the private sector – will need to do more for resource mobilization at all levels.

## TIME FRAME

12. This action plan is designed to cover the period 2009–2013, that is, the remaining five years of the Medium-term strategic plan.

## SITUATION ANALYSIS

### **Magnitude, causes and impact of blindness and visual impairment**

13. Determining the causes and magnitude of blindness is necessary for setting priorities, designing targeted strategies and establishing international blindness-prevention cooperation and alliances. Recent years have seen much better availability of data on the causes and magnitude of blindness and visual impairment around the world. In the past, surveys on the causes used a variety of methods and definitions, but WHO's development of standardized and feasible methodologies has facilitated collection from Member States of comparable epidemiological and health-system data, for example on the rapid assessment of surgical services for cataract and of avoidable blindness. The childhood blindness protocol is another example of such progress.

14. To date, epidemiological surveys have been conducted in 65 countries. However, the absence of surveys and lack of data in the remaining countries have greatly hampered detailed planning, monitoring and evaluation of interventions. In addition, missing epidemiological data on the status of

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<sup>1</sup> Resolutions WHA22.29, WHA25.55, WHA28.54, WHA47.32, WHA51.11, WHA56.26 on elimination of avoidable blindness and WHA59.25 on prevention of avoidable blindness and visual impairment.

<sup>2</sup> See resolution EM/RC49/R.6 on VISION 2020: The Right to Sight – elimination of avoidable blindness, resolution EM/RC52/R.3 on Prevention of avoidable blindness and visual impairment, document AFR/RC57/6 (Accelerating the elimination of avoidable blindness – a strategy for the WHO African Region) and PAHO: Draft Ocular Health Strategy and Plan of Action 2008–2012.

visual health in the population limits further analysis of the trends of visual impairment and the timely development of appropriate public health interventions.

15. Collection of reliable and standardized epidemiological data is a priority for countries where such data are not available. Action is also needed to develop modelling approaches in order to determine trends and set targets, so that the planning of efforts to prevent avoidable blindness and visual impairment can be more focused and evidence-based. Also required is an improved mechanism for systematically collecting standardized information on human resources, infrastructure and available technologies, and countries must be ready to respond to the observed needs.

### **Prevention of blindness and visual impairment as part of national health development plans and WHO technical collaboration with Member States**

16. Despite the availability of WHO information on the magnitude and causes of blindness and strategies for their prevention, policy-makers and health providers in some countries are evidently not fully aware of available eye-care interventions, their cost-effectiveness and their potential to prevent or treat the 80% of global blindness that is avoidable. Country cooperation strategies reflect the agreed joint agenda between health ministries and WHO. So far, the inclusion of blindness prevention in such documents has been minimal, despite seven resolutions of the Health Assembly relating to prevention of avoidable blindness and visual impairment, the existence of WHO's major, long-standing international partnerships on prevention of blindness, and major successes in reducing avoidable blindness, such as WHO's Onchocerciasis Control Programme. Lack of adequate resources for preventing blindness at the country level is a major impediment. Additionally, faced with increasingly limited resources, donor and recipient countries often give higher priority to mortality-related disease control programmes than to those dealing with problems of disability. Also, experienced staff to coordinate blindness-prevention activities at the regional and country levels are in short supply.

17. Greater priority should be given to preventing blindness in health development plans and country cooperation strategies. Action is also needed to strengthen technical support and enhance the provision of expert advice to Member States where blindness and visual impairment are a major health problem.

### **National eye health and prevention of blindness committees**

18. It is important to establish national committees and programmes for eye health and blindness prevention. Their role is to liaise with all key domestic and international partners, to share information and to coordinate such activities as implementing the national eye health and blindness-prevention plan. A functional national committee is a prerequisite for developing the national blindness-prevention plan and its implementation, monitoring and periodic assessment. Some countries, particularly those with decentralized or federated management structures, have similar committees at subnational level.

19. By the end of 2008, 118 Member States had reported the establishment of a national committee. However, not all national committees are functional and, unfortunately, in many cases such committees have not successfully initiated effective action. In some instances, selected individuals, often dedicated eye-care professionals, are relied on to provide leadership and serve as the driving force for blindness-prevention plans and programmes. The committees' membership is often not uniform, ranging from the ideal scenario, in which all key partners are represented (including the national health-care authorities), to a minimal group of dedicated eye-care professionals.

## **National eye health and prevention of blindness plans**

20. Experience has shown that, in low- and middle-income countries, a comprehensive national plan containing targets and indicators that are clearly specified, time-linked and measurable leads to substantially improved provision of eye health-care services.

21. Most low- and middle-income countries (104 Member States by the end of 2008) have reported the development of national eye health and blindness-prevention plans, but reporting on and assessment of their implementation and impact have been insufficient. Some national plans do not include measurable targets, an implementation timeline and adequate tools for monitoring and evaluation. In some countries, the plans have only been partially implemented. In addition, because of lack of resources and leadership, some countries have made only slow or fragmented progress and their plans for eye health and national prevention of blindness have not yielded tangible improvements in the provision of eye-care services. It is necessary to ensure that the implementation phase of national plans is well managed, and a standardized approach to monitoring and evaluation of national and subnational eye health and blindness-prevention plans must be taken.

## **WHO's strategies for prevention of blindness and visual impairment and provision of technical support**

22. WHO's strategy for the prevention of avoidable blindness and visual impairment is based on three core elements: strengthening disease control, human resource development, and infrastructure and technology. This approach has been promoted since 1999 by the global initiative "VISION 2020: the Right to Sight", which was established as a partnership between WHO and the International Agency for the Prevention of Blindness. The past decade has seen major progress in the development and implementation of WHO's approaches to controlling communicable causes of blindness and visual impairment. Achievements in controlling onchocerciasis and trachoma were based, respectively, on implementation of WHO's strategies of community-directed treatment with ivermectin and the SAFE strategy for trachoma control, and their adoption by Member States and international partners. This unified approach facilitated preventive efforts aimed at millions of individuals at risk of visual loss, and convinced major donors that long-term commitment is required.

23. Subsequently, major shifts in the pattern of causes of blindness have been documented, with a declining trend for the communicable causes and a progressive increase in age-related chronic eye conditions. Public health interventions for some of the major conditions such as cataract and diabetic retinopathy have been systematically reviewed and respective WHO recommendations have been formulated. Strategies are needed to control other conditions such as glaucoma.

24. By the end of 2008, 150 Member States have held national or subnational VISION 2020 workshops to introduce WHO's strategies for eye health. These workshops were the platform for sharing expertise about community eye health and facilitated the process of needs assessment and subsequent formulation of national and subnational blindness-prevention plans.

## **Prevention of avoidable blindness and visual impairment as a global health issue**

25. Reliable epidemiological data and the availability of cost-effective interventions for the control of most of the major causes of avoidable blindness have demonstrated the importance of strengthening national initiatives in preserving eye health. In resolutions WHA56.26 and WHA59.25, the Health Assembly recommended a unified approach to blindness-prevention activities, urging Member States to establish national committees, to set up national blindness-prevention plans, and to devise strong monitoring and evaluation mechanisms for their implementation. In addition, it has been recognized

that advocacy for preventing visual loss needs to reach a wider audience, and that the importance of preserving eye health needs to be further promoted in the public health domain and the community.

26. In some countries the impact of Health Assembly resolutions on allocation of new resources for development and implementation of blindness-prevention plans has fallen short of expectations. In most countries action is slow and progress in implementing adequate blindness-prevention activities is limited.

27. Plans and programmes on blindness prevention exist at global level and in some cases at regional and national levels, but action is now required to provide support to Member States that have not yet developed such programmes in applying international experience and scientific evidence in order to develop and implement their own blindness-prevention measures. Action is also required to integrate the eye-health agenda and its impact on poverty alleviation in the overall development agenda.

### **International partnerships**

28. Over the past decade, major international partnerships have been forged to assist WHO in providing support to Member States in their efforts to prevent blindness, such as “VISION 2020: the Right to Sight”. The partnerships have made substantial progress, mostly in combating infectious causes of blindness. They have also encouraged and supported long-term resource mobilization, including donation programmes (e.g. the Merck donation programme for ivermectin to control onchocerciasis, and distribution of azithromycin under a donation programme by Pfizer to control trachoma). Global partnerships have united and substantially strengthened the key international stakeholders in their action to prevent blindness, using WHO disease control strategies.

29. Coordination and timely evaluation of work undertaken by international partners is required so that their approaches are aligned with other activities in the area of blindness prevention. Despite some notable improvements in collecting data on blindness-prevention activities at the country and subnational levels, consolidated reporting remains limited. One reason is the weakness of many countries’ monitoring systems, another being the limited information sharing and exchange between countries and their international partners.

30. The action now required is to improve coordination and information exchange between all stakeholders.

### **Human resources and infrastructure**

31. Despite efforts to strengthen human resources for eye health, a crucial shortage of eye-care personnel persists in many low-income countries. Many countries in the African Region, for instance, have less than one ophthalmologist per million inhabitants. In addition, the existing human resources are often concentrated in larger urban agglomerations, leaving the rural areas with a poor or non-existent service. Furthermore, well-trained personnel leave low-paid positions in many of the public and university health-care establishments, seeking work in the domestic private health-care sector or even work opportunities abroad. It is thus the poorest areas of low-income countries that are most seriously disadvantaged by a suboptimal workforce beset by shortages, low productivity and uneven distribution.

32. Although recent technological developments in eye care have resulted in advanced methods of diagnostics and treatment, the cost of properly equipping a secondary and/or tertiary eye-care centre is prohibitive for many low-income countries.

33. Urgent action is required within countries to train more eye-health personnel and redress the distribution of the available workforce between urban and rural areas.

### **Resource mobilization**

34. Strong international partnerships have been instrumental in convincing international and domestic donors to support blindness-prevention activities (e.g. the African Programme for Onchocerciasis Control, the Onchocerciasis Elimination Program for the Americas, the WHO Alliance for the Global Elimination of Blinding Trachoma, and VISION 2020: the Right to Sight). Despite these disease-specific achievements, there have been major shortfalls in the resources available for national programmes of eye health and blindness prevention. Moreover, the potential for generating additional international and domestic resources has not been fully explored. The lack of adequate resources for blindness prevention and visual impairment activities could seriously jeopardize advances in eye-health care.

35. The action now required is to review the current approaches to financing eye-health systems, highlight the socioeconomic impact of blindness, the cost-effectiveness of eye-health interventions, and the financial benefits of early prevention of blindness and visual impairment.

### **Integration of eye health into broad development plans**

36. The creation of comprehensive, integrated health services and sharing of resources and infrastructure will be facilitated by incorporating eye health in broader intersectoral development plans. An added value was recorded in countries where prevention of blindness was integrated into the broader health development plans and/or socioeconomic development programmes.

37. Despite reported links between visual impairment and decreased socioeconomic opportunities for the affected individuals, prevention of blindness has not been sufficiently addressed in many major international and domestic development agendas. There has been insufficient research on the impact of blindness in various socioeconomic settings as well as on limitations of access to eye care for low-income groups, and the action now required is to promote further research in these areas.

## **OBJECTIVES AND ACTION**

### **OBJECTIVE 1. Strengthen advocacy to increase Member States' political, financial and technical commitment in order to eliminate avoidable blindness and visual impairment**

38. International advocacy for the preservation of visual health aims to increase awareness of current blindness-prevention plans, especially the cost-effective interventions available and international experience in their implementation. This advocacy effort should target health-care professionals and policy-makers in order to encourage the intersectoral action needed to improve eye health-care systems, to integrate them in national health systems, and incorporate eye health in broader health-care and development plans. It should also target potential donors and those who set research priorities and funding levels so as to accumulate evidence on prevention of blindness and visual impairment and their impact.

39. Further research is needed on the impact of risk factors such as smoking, ultraviolet radiation and lack of hygiene. Inequities in access to eye-care services also need to be further researched.

40. Special attention should be paid to raising public awareness and finding appropriate ways of communicating information on prevention of visual loss and ways of treating eye conditions.

**Proposed action for Member States**

41. Establish and support national coordinating mechanisms, such as national coordinators posts for eye health and prevention of blindness at health ministries and other key institutions, as appropriate.
42. Consider budgetary appropriations for eye health and prevention of blindness.
43. Promote and integrate eye health at all levels of health-care delivery.
44. Observe World Sight Day.
45. Integrate eye-health preservation in health promotion agendas.

**Action for the Secretariat**

46. Conduct political analyses to determine the best way of securing support of high-level decision-makers and their commitment to promoting eye health, and explore the potential impact and ways of integrating blindness prevention in socioeconomic policies and programmes [2009–2011].
47. Make policy-makers aware of the relationship between eye diseases, gender, poverty and development, using evidence-based information and epidemiological data and take forward the work on social determinants of health as it relates to eye-health problems [2009–2010].
48. Harmonize the advocacy messages used by international partners in various health and development forums [2009–2010].
49. Promote collaboration by programmes and groups across the Organization in work on tackling major risk factors for visual impairment.

**Proposed action for international partners**

50. Support WHO in involving all stakeholders in advocacy in order to raise awareness of the magnitude of blindness and visual impairment, the availability of cost-effective interventions, and international experience in applying them.
51. Support Member States in establishing forums where key stakeholders – including nongovernmental organizations, professional associations, academia, research institutions and the private sector – can agree on concerted action against avoidable blindness and visual impairment.

**OBJECTIVE 2. Develop and strengthen national policies, plans and programmes for eye health and prevention of blindness and visual impairment**

52. National policies, plans and programmes for eye health and prevention of avoidable blindness and visual impairment are essential instruments for coordinated, evidence-based, cost-effective, sustainable interventions. Integration of eye health into relevant national health policies, including those relating to school and occupational health, facilitates a coordinated multidisciplinary approach and development of comprehensive eye care, with emphasis on primary eye care.
53. Evidence-based WHO strategies for tackling several main causes of avoidable blindness and visual impairment have been designed in order to support the formulation of policies and programmes. Some strategies are already in place for the control of trachoma, onchocerciasis, vitamin A deficiency,

diabetic retinopathy and some aspects of cataract-related visual loss, but strategies for emerging major causes of visual loss need to be developed.

### **Proposed action for Member States**

54. Where sufficient capacity exists, develop national strategies and corresponding guidelines for the prevention of blindness and visual impairment; otherwise consider adapting those recommended by WHO.
55. Review existing policies addressing visual health, identify gaps and develop new policies in favour of a comprehensive eye-care system.
56. Incorporate prevention of blindness and visual impairment in poverty-reduction strategies and relevant socioeconomic policies.
57. Involve relevant government sectors in designing and implementing policies, plans and programmes to prevent blindness and visual impairment.
58. Develop an eye-health workforce including paramedical professionals and community health workers through training programmes that include a community eye-health component.

### **Action for the Secretariat**

59. Review the experience of public health strategies for the control of uncorrected refractive errors including presbyopia, glaucoma, age-related macular degeneration, corneal opacity, hereditary eye disease, and selected eye conditions in children including sequelae of vitamin A deficiency [2009–2011].
60. Facilitate establishment and activities of eye health and national blindness-prevention committees, advise Member States on their composition, role and function, and provide direct technical support for developing, implementing and evaluating national plans.
61. Develop a coordinated and standardized approach to the collection, analysis and dissemination of information on the implementation of national eye health-related policies, best practices in the public health aspects of blindness prevention, including information on the available health insurance systems, and their impact on the various aspects of eye-care provision [2009–2011].
62. Promote collaboration with other major programmes and partnerships (e.g. the WHO Global Health Workforce Alliance) to promote the development of human resources for eye-care provision at primary, secondary and tertiary levels [2009–2010].
63. Review educational curricula and best practices for education and training of eye health-care professionals [2010–2011].
64. Strengthen the capacity of regional and country offices to provide technical support for eye health/prevention of blindness.

### **Proposed action for international partners**

65. Promote WHO-recommended strategies and guidelines for prevention of blindness and visual impairment, and, with the assistance of Member States, contribute to the collection of national information on their implementation.

66. Generate resources for, and support the implementation of, national blindness-prevention plans in order to avoid duplication of effort.

67. Provide continued support to programmes controlling nutritional and communicable causes of blindness.

### **OBJECTIVE 3. Increase and expand research for the prevention of blindness and visual impairment**

68. Public-health action to prevent blindness and visual impairment needs to be evidence-based and cost-effective. International collaboration in promoting multidimensional and multisectoral research is essential for developing eye-care systems that are comprehensive, integrated, equitable, high-quality and sustainable. Further research is needed on ways to capitalize on available evidence. Special emphasis should be placed on evaluating interventions and different strategies for early detection and screening of the causes of blindness and visual impairment in different population groups, including children.

#### **Proposed action for Member States**

69. Promote research by national research institutions on socioeconomic determinants, the role of gender, the cost-effectiveness of interventions, and identification of high-risk population groups.

70. Assess the economic cost of blindness and visual impairment and its impact on socioeconomic development.

71. Determine the impact of poverty and other determinants on the gradient of socioeconomic disparity in individuals' access to eye-care services.

72. Include epidemiological, behavioural, health-system and health-workforce research as part of national programmes for eye health and prevention of blindness and visual impairment.

#### **Action for the Secretariat**

73. Collate, in collaboration with other partners, existing data on risk factors, such as smoking, unhealthy diet, physical inactivity, ultraviolet radiation and lack of hygiene, and coordinate the development of a prioritized research agenda related to the causes and prevention of blindness with special emphasis on low- and middle-income countries [2009–2011].

74. Support Member States in assessing the impact of public health policies and strategies on the status of eye health and share the results.

75. Facilitate development of projection models on trends in the causes and magnitude of blindness and visual impairment and prioritize development of, and target setting for, eye-care systems [2010–2011].

#### **Proposed action for international partners**

76. Support low- and middle-income countries in building capacity for epidemiological and health systems research, including the analytical and operational research required for programme implementation and evaluation in the area of eye disease.



77. Support collaboration between institutions in low- and middle-income countries and high-income countries.

78. Support and prioritize in coordination with Member States research on eye diseases at the global, regional and subregional levels.

79. Strengthen and support WHO Collaborating Centres and national research institutions in research related to prevention of blindness and visual impairment.

#### **OBJECTIVE 4. Improve coordination between partnerships and stakeholders at national and international levels for the prevention of blindness and visual impairment**

80. Large international partnerships and alliances have been instrumental in developing effective public health responses for the prevention of blindness and visual impairment. Member States, United Nations agencies, other international institutions, academia, research centres, professional health-care organizations, nongovernmental organizations, service organizations, civil society and the corporate sector are key stakeholders in this process. The challenges are to strengthen global and regional partnerships and to incorporate the prevention of blindness into broader development initiatives that include efforts to establish new intersectoral forms of collaboration and alliances.

#### **Proposed action for Member States**

81. Promote participation in, and actively support, existing national and international partnerships and alliances for the prevention of avoidable blindness and visual impairment, including coordination with noncommunicable disease control programmes and neglected tropical disease prevention and control.

82. Promote partnerships between the public, private and voluntary sectors at national and subnational levels.

#### **Action for the Secretariat**

83. Convene the WHO Monitoring Committee for the Elimination of Avoidable Blindness pursuant to resolution WHA56.26 [2009].

84. Support and strengthen the role of WHO Collaborating Centres by linking their workplans to the implementation of this plan [2009–2010].

#### **Proposed action for international partners**

85. Collaborate closely with and provide support to Member States and the Secretariat in implementing the various components of this plan.

86. Liaise with other international organizations and agencies with broader development agendas in order to identify opportunities for collaboration.

87. Continue to support the existing partnerships for onchocerciasis and trachoma control until these diseases are eliminated as public health problems.

**OBJECTIVE 5. Monitor progress in elimination of avoidable blindness at national, regional and global levels**

88. Information on causes, the magnitude and geographical distribution of blindness and visual impairment, together with their trends, is essential for evidence-based advocacy and planning. Likewise, understanding the constraints and gaps in current service delivery and monitoring how these are corrected by Member States are crucial to successful implementation. Necessary and timely adjustments can only be made on the basis of continuous monitoring and periodic evaluation of action to prevent blindness.

**Proposed action for Member States**

89. Provide regularly updated data and information on prevalence and causes of blindness and visual impairment, disaggregated by age, gender and socioeconomic status.

90. Strengthen standardized data collection and establish surveillance systems using existing WHO tools (for example, those used for cataract, trachoma and onchocerciasis).

91. Provide regular reports using the WHO standardized reporting system, on progress made in implementing national blindness-prevention strategies and plans.

**Action for the Secretariat**

92. In collaboration with the main stakeholders, review and update the list of indicators for monitoring and periodic evaluation of action to prevent blindness and visual impairment, and determine targets and timelines [2009–2011].

93. Review data inputs in order to determine the impact of action to prevent avoidable blindness and visual impairment at country level, with the aim of showing a reduction in the magnitude of avoidable blindness, pursuant to resolution WHA56.26 [2009–2011].

94. Document, from countries with successful blindness prevention programmes, good practices and blindness prevention systems or models that could be modified or applied in other countries, pursuant to resolution WHA56.26 [2009–2010].

95. Initiate periodic independent evaluation of work on preventing blindness and visual impairment, including that of international partnerships, to be reviewed by the WHO Monitoring Committee for the Elimination of Avoidable Blindness [2009–2010].

96. Contribute to the Global Burden of Disease 2005 study<sup>1</sup> [2009–2010].

**Proposed action for international partners**

97. Provide collaborative support to Member States and the Secretariat in monitoring and evaluating progress in prevention and control of blindness and visual impairment at regional and global levels.

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<sup>1</sup> <http://www.globalburden.org>.

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98. Collaborate with WHO in establishing a network for review of regional and global monitoring and evaluation of progress in the prevention of blindness and visual impairment.

## **INDICATORS**

99. In order to assess trends in the causes of blindness and visual impairment, to measure the progress made by Member States in preventing blindness and visual impairment, and to monitor implementation of this action plan, a set of core process and outcome indicators needs to be identified and defined. The indicators will mostly focus on action taken by the Secretariat and by Member States. Each country may develop its own set of indicators based on priorities and resources; however, in order to track progress globally and regionally, data and information collection needs to be standardized. The current set of indicators used by WHO in monitoring and reporting on the global status of the prevention of blindness and visual impairment<sup>1</sup> should be reviewed and updated. Baseline values are available in WHO for many of the indicators; for those for which there are no baseline values, mechanisms will be established for collecting relevant data.

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<sup>1</sup> Document WHO/PBL/03.92.

## ANNEX 2

### Financial Regulations of the World Health Organization<sup>1</sup>

[A62/32 – 26 March 2009]

#### *Regulation I – Applicability and delegation of authority*

- 1.1 These Regulations shall govern the financial administration of the World Health Organization.
- 1.2 The Director-General is responsible for ensuring effective financial administration of the Organization in accordance with these Regulations.
- 1.3 Without prejudice to Regulation 1.2 the Director-General may delegate in writing to other officers of the Organization such authority and related accountability as he or she considers necessary for the effective implementation of these Regulations.
- 1.4 The Director-General shall establish Financial Rules, including relevant guidelines and limits for the implementation of these Regulations, in order to ensure effective financial administration, the exercise of economy, and safeguard of the assets of the Organization.

#### *Regulation II – The financial period*

- 2.1 The financial period for the programme budget shall be two consecutive calendar years beginning with an even-numbered year.

#### *Regulation III – The budget*

- 3.1 The budget estimates for the financial period, as referred to in Article 55 of the Constitution (hereinafter referred to as “budget proposals”), shall be prepared by the Director-General. The budget proposals shall be presented in United States dollars.
- 3.2 The budget proposals shall be divided into parts, sections and chapters, and shall include such information, annexes and explanatory statements as may be requested by, or on behalf of, the Health Assembly and such further annexes or statements as the Director-General may deem necessary and useful.
- 3.3 The Director-General shall submit the budget proposals at least 12 weeks before the opening of the regular session of the Health Assembly, and before the opening of the appropriate session of the Executive Board, at which they are to be considered. At the same time, the Director-General shall transmit these proposals to all Members (including Associate Members).

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<sup>1</sup> Text amended in accordance with resolution WHA62.6.

3.4 The Executive Board shall submit these proposals, and any recommendations it may have thereon, to the Health Assembly.

3.5 The budget for the following financial period shall be approved by the Health Assembly in the year preceding the biennium to which the budget proposals relate, after consideration and report on the proposals by the appropriate main committee of the Health Assembly.

3.6 Should the Director-General, at the time of the session of the Executive Board that submits the budget proposals and its recommendations thereon to the Health Assembly, have information which indicates that there may, before the time of the Health Assembly, be a need to alter the proposals in the light of developments, he or she shall report thereon to the Executive Board, which shall consider including in its recommendations to the Health Assembly an appropriate provision therefore.

3.7 Should developments subsequent to the session of the Executive Board that considers the budget proposals, or any of the recommendations made by it, necessitate or render desirable in the opinion of the Director-General an alteration in the budget proposals, the Director-General shall report thereon to the Health Assembly.

3.8 Supplementary proposals may be submitted to the Board by the Director-General whenever necessary to increase the appropriations previously approved by the Health Assembly. Such proposals shall be submitted in a form and manner consistent with the budget proposals for the financial period.

*Regulation IV – Regular budget appropriations*

4.1 The appropriations approved by the Health Assembly shall constitute an authorization to the Director-General to incur contractual obligations and make payments for the purposes for which the appropriations were approved and up to the amounts so approved.

4.2 Appropriations shall be available for making commitments in the financial period to which they relate for delivery in that financial period or the subsequent calendar year.

4.3 The Director-General is authorized, with the prior concurrence of the Executive Board or of any committee to which it may delegate appropriate authority, to transfer credits between sections. When the Executive Board or any committee to which it may have delegated appropriate authority is not in session, the Director-General is authorized, with the prior written concurrence of the majority of the members of the Board or such committee, to transfer credits between sections. The Director-General shall report such transfers to the Executive Board at its next session.

4.4 At the same time as budget proposals are approved an exchange rate facility shall be established by the Health Assembly, which shall set the maximum level that may be available to protect against losses on foreign exchange. The purpose of the facility shall be to make it possible to maintain the level of the budget so that the activities that are represented by the budget approved by the Health Assembly may be carried out irrespective of the effect of any fluctuation of currencies against the United States dollar at the official United Nations exchange rate.

*Regulation V – Provision of regular budget funds*

5.1 Appropriations shall be financed by assessed contributions from Members, according to the scale of assessments determined by the Health Assembly, and by projected interest earned on regular budget, prior period collection of arrears and any other income attributable to the regular budget.

5.2 The amount to be financed by contributions from Members shall be calculated after adjusting the total amount appropriated by the Health Assembly to reflect that proportion of the regular budget to be financed by the other sources noted in Regulation 5.1 above.

5.3 In the event that the total financing for appropriations is less than the amount approved by the Health Assembly under the regular budget proposals, the Director-General shall review implementation plans for the regular budget in order to make any adjustments that may be necessary.

*Regulation VI – Assessed contributions*

6.1 The assessed contributions of Members based on the scale of assessments shall be divided into two equal annual instalments. In the first year of the financial period, the Health Assembly may decide to amend the scale of assessments to be applied to the second year of the financial period.

6.2 After the Health Assembly has adopted the budget, the Director-General shall inform Members of their commitments in respect of contributions for the financial period and request them to pay the first and second instalments of their contributions.

6.3 If the Health Assembly decides to amend the scale of assessments, or to adjust the amount of the appropriations to be financed by contributions from Members for the second year of a biennium, the Director-General shall inform Members of their revised commitments and shall request Members to pay the revised second instalment of their contributions.

6.4 Instalments of contributions shall be due and payable as of 1 January of the year to which they relate.

6.5 As of 1 January of the following year, the unpaid balance of such contributions shall be considered to be one year in arrears.

6.6 Contributions shall be assessed in United States dollars, and shall be paid in either United States dollars, euros or Swiss francs, or such other currency or currencies as the Director-General shall determine.

6.7 The acceptance by the Director-General of any currency that is not fully convertible shall be subject to a specific, annual approval on a case-by-case basis by the Director-General. Such approvals will include any terms and conditions that the Director-General considers necessary to protect the World Health Organization.

6.8 Payments made by a Member shall be credited to the Member's account and applied first against the oldest amount outstanding.

6.9 Payments in currencies other than United States dollars shall be credited to Members' accounts at the United Nations rate of exchange ruling on the date of receipt by the World Health Organization.

6.10 The Director-General shall submit to the regular session of the Health Assembly a report on the collection of contributions.

6.11 New Members shall be required to make a contribution for the financial period in which they become Members at rates to be determined by the Health Assembly. Such contributions shall be recorded as income in the year in which they are due.

*Regulation VII – Working Capital Fund and internal borrowing*

7.1 Pending the receipt of assessed contributions, implementation of the regular budget may be financed from the Working Capital Fund, which shall be established as part of the regular budget approved by the Health Assembly, and thereafter by internal borrowing against available cash reserves of the Organization, excluding Trust Funds.

7.2 The level of the Working Capital Fund shall be based on a projection of financing requirements taking into consideration projected income and expenditure. Any proposals that the Director-General may make to the Health Assembly for varying the level of the Working Capital Fund from that previously approved shall be accompanied by an explanation demonstrating the need for the change.

7.3 Any repayments of borrowing under Regulation 7.1 shall be made from the collection of arrears of assessed contributions and shall be credited first against any internal borrowing outstanding and secondly against any borrowing outstanding from the Working Capital Fund.

*Regulation VIII – Revenue: other sources*

8.1 The Director-General is delegated the authority, under Article 57 of the Constitution, to accept gifts and bequest, either in cash or in kind, provided that he or she has determined that such contributions can be used by the Organization, and that any conditions which may be attached to them are consistent with the objective and policies of the Organization.

8.2 The Director-General is authorized to levy a charge on extrabudgetary contributions in accordance with any applicable resolution of the Health Assembly. This charge shall be credited to the Special Account for Servicing Costs, together with any interest earnings or earnings from investments of extrabudgetary contributions, and used to reimburse all, or part of, the indirect costs incurred by the Organization in respect of the generation and administration of such resources. All direct costs of the implementation of programmes that are financed by extrabudgetary resources shall be charged against the relevant budget.

*Regulation IX – Funds*

9.1 Funds shall be established to enable the Organization to record income and expenditure. These funds shall cover all sources of income: regular budget, extrabudgetary resources, Trust Funds, and any other source of income as may be appropriate.

9.2 Accounts shall be established for amounts received from donors of extrabudgetary contributions and for any Trust Funds so that relevant income and expenditures may be recorded and reported upon.

9.3 Other accounts shall be established as necessary as reserves or to meet the requirements of the administration of the Organization, including capital expenditure.

9.4 The Director-General may establish revolving funds so that activities may be operated on a self-financing basis. The purpose of such accounts shall be reported to the Health Assembly, including details of sources of income and expenditures charged against such funds, and the disposition of any surplus balance at the end of a financial period.

9.5 The purpose of any account established under Regulations 9.3 and 9.4 shall be specified and shall be subject to these Financial Regulations and such Financial Rules as are established by the Director-General under Regulation 12.1, prudent financial management, and any specific conditions agreed with the appropriate authority.

*Regulation X – Custody of cash and cash equivalents*

10.1 The Director-General shall designate the bank or banks or financial institutions in which cash and cash equivalents in the custody of the Organization shall be kept.

10.2 The Director-General may designate any investment (or asset) managers and/or custodians that the Organization may wish to appoint for the management of the cash and cash equivalents in its custody.

*Regulation XI – Investment of cash and cash equivalents*

11.1 Any cash not required for immediate payment may be invested and may be pooled in so far as this benefits the return that may be generated.

11.2 Income from investments shall be credited as income to the Special Account for Servicing Costs in accordance with Regulation 8.2, unless otherwise provided in the regulations, rules or resolutions relating to a specific fund or account.

11.3 Investment policies and guidelines shall be drawn up in accordance with best industry practice, having due regard for the preservation of capital and the return requirements of the Organization.

*Regulation XII – Internal control*

12.1 The Director-General shall:

- (a) establish operating policies and procedures in order to ensure effective financial administration, the exercise of economy, and safeguard of the assets of the Organization;
- (b) designate the officers who may receive funds, incur financial commitments and make payments on behalf of the Organization;
- (c) maintain an effective internal control structure to ensure the accomplishment of established objectives and goals for operations; the economical and efficient use of resources; the reliability and integrity of information; compliance with policies, plans, procedures, rules and regulations; and the safeguarding of assets;
- (d) maintain an internal audit function which is responsible for the review, evaluation and monitoring of the adequacy and effectiveness of the Organization's overall systems of internal control. For this purpose, all systems, processes, operations, functions and activities within the Organization shall be subject to such review, evaluation and monitoring.

*Regulation XIII – Accounts and financial statements*

13.1 The Director-General shall establish such accounts as are necessary and shall maintain them in accordance with International Public Sector Accounting Standards.

13.2 Financial statements shall be prepared annually in accordance with International Public Sector Accounting Standards, together with such other information as may be necessary to indicate the current financial position of the Organization.

13.3 The financial statements shall be presented in United States dollars. The accounting records may, however, be kept in such currency or currencies as the Director-General may deem necessary.



13.4 The financial statements shall be submitted to the External Auditor(s) not later than 31 March following the end of the year to which they relate.

13.5 The Director-General may make such ex gratia payments as deemed to be necessary in the interest of the Organization. A statement of such payments shall be included with the final accounts.

13.6 The Director-General may authorize, after full investigation, the writing-off of the loss of any asset, other than arrears of contributions. A statement of such losses written off shall be included with the final accounts.

#### *Regulation XIV – External audit*

14.1 External Auditor(s), each of whom shall be the Auditor-General (or officer holding equivalent title or status) of a Member government, shall be appointed by the Health Assembly, in the manner decided by the Assembly. External Auditor(s) appointed may be removed only by the Assembly.

14.2 Subject to any special direction of the Health Assembly, each audit which the External Auditor(s) performs/performs shall be conducted in conformity with generally accepted common auditing standards and in accordance with the Additional Terms of Reference set out in the Appendix to these Regulations.

14.3 The External Auditor(s) may make observations with respect to the efficiency of the financial procedures, the accounting system, the internal financial controls and, in general, the administration and management of the Organization.

14.4 The External Auditor(s) shall be completely independent and solely responsible for the conduct of the audit and, except as permitted under Regulation 14.7 below, any local or special examination.

14.5 The Health Assembly may request the External Auditor(s) to perform certain specific examinations and issue separate reports on the results.

14.6 The Director-General shall provide the External Auditor(s) with the facilities required for the performance of the audit.

14.7 For the purpose of making a local or special examination or for effecting economies of audit cost, the External Auditor(s) may engage the services of any national Auditor-General (or equivalent title) or commercial public auditors of known repute or any other person or firm that, in the opinion of the External Auditor(s), is technically qualified.

14.8 The External Auditor(s) shall issue a report on the audit of the biennium financial report prepared by the Director-General pursuant to Regulation XIII. The report shall include such information as he/she/they deem(s) necessary in regard to Regulation 14.3 and the Additional Terms of Reference.

14.9 The report(s) of the External Auditor(s) shall be transmitted through the Executive Board, together with the audited financial report, to the Health Assembly not later than 1 May following the end of the financial period to which the final accounts relate. The Executive Board shall examine the interim and biennium financial reports and the audit report(s) and shall forward them to the Health Assembly with such comments as it deems necessary.

*Regulation XV – Resolutions involving expenditures*

15.1 Neither the Health Assembly nor the Executive Board shall take a decision involving expenditures unless it has before it a report from the Director-General on the administrative and financial implications of the proposal.

15.2 Where, in the opinion of the Director-General, the proposed expenditure cannot be made from the existing appropriations, it shall not be incurred until the Health Assembly has made the necessary appropriations.

*Regulation XVI – General provisions*

16.1 These Regulations shall be effective as of the date of their approval by the Health Assembly, unless otherwise specified by the Health Assembly. They may be amended only by the Health Assembly.

16.2 In case of doubt as to the interpretation and application of any of the foregoing regulations, the Director-General is authorized to rule thereon, subject to confirmation by the Executive Board at its next session.

16.3 The Financial Rules established by the Director-General as referred to in Regulation 1.4 above, and the amendments made by the Director-General to such rules, shall enter into force after confirmation by the Executive Board. They shall be reported upon to the Health Assembly for its information.

## **ANNEX 3**

### **Amendments to the Staff Regulations<sup>1</sup>**

[A62/36 – 9 April 2009]

#### **IV. APPOINTMENT AND PROMOTION**

...

4.2 The paramount consideration in the appointment, transfer, reassignment or promotion of the staff shall be the necessity of securing the highest standards of efficiency, competence and integrity. Due regard shall be paid to the importance of recruiting and maintaining the staff on as wide a geographical basis as possible.

4.3 Selection of staff members shall be without regard to race, creed or sex. So far as is practicable, selection shall be made on a competitive basis; however, the foregoing shall not apply to the filling of a position by transfer or reassignment of a staff member without promotion in the interest of the Organization.

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<sup>1</sup> Resolution WHA62.7.

## ANNEX 4

### Plan of action on public health, innovation and intellectual property<sup>1</sup>

[A62/16 Add.1 – 26 March 2009]

1. The Sixty-first World Health Assembly adopted the global strategy<sup>2</sup> and the agreed parts of the plan of action on public health, innovation and intellectual property in resolution WHA61.21. That resolution requested the Director-General, inter alia, to finalize the outstanding components of the plan of action, including time frames and estimated funding needs, and submit the final plan for consideration by the Sixty-second World Health Assembly through the Executive Board. The Board at its 124th session took note of the Secretariat's report on the global strategy and plan of action.<sup>3</sup>
2. The Secretariat has undertaken further work to propose time frames for the specific actions in the plan of action.

...

[A62/16 Add.2 – 7 May 2009]

1. Resolution WHA61.21 requested the Director-General, inter alia, to finalize the outstanding components of the plan of action, including progress indicators, and submit them for consideration to the Sixty-second World Health Assembly. A set of progress indicators was presented to the Executive Board at its 124th session and, based on comments received,<sup>3</sup> a revised set [was presented in document A62/16 Add.2].

...

[A62/16 Add.3 – 18 May 2009]

As a result of informal consultations among Member States in order to reach agreement on the open paragraphs on stakeholders in the plan of action,<sup>4</sup> [the final proposals for the remaining specific actions were presented in document A62/16 Add.3].

[The progress indicators are set out by element below. The time frames and finalized paragraphs on stakeholders have been incorporated into the finalized plan of action which is also reproduced below.]

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<sup>1</sup> See resolution WHA62.16.

<sup>2</sup> See resolution WHA61.21, Annex.

<sup>3</sup> Document EB124/2009/REC/2, summary record of the tenth meeting.

<sup>4</sup> Document A62/16, paragraph 12.

## PROGRESS INDICATORS

### INDICATORS BY ELEMENT

#### **Element 1. Prioritizing research and development needs**

##### *Indicators*

- analysis of research and development gaps, including the public health consequences of these gaps in developing countries, completed and a report on this analysis produced, published and disseminated
- number of developing countries with national health-related research and development capacity-building plans which prioritize research and development based on identified public health needs and research and development gaps
- number of consensus reports published on global research needs and priorities for a disease or type of intervention.

#### **Element 2. Promoting research and development**

##### *Indicators*

- number of countries whose national strategic plans for the health workforce and related professionals include a research and development component
- number of new or strengthened national, regional and global coordination initiatives on health-related research and development, including between public and private entities
- number of new or strengthened initiatives aimed at providing efficient and affordable access to publications and information such as research knowledge, results and technology
- number of new or strengthened initiatives aimed at enhancing capacities to analyse and manage clinical trial data
- proportion of peer-reviewed publications where the main author's institution is in a developing country.

#### **Element 3. Building and improving innovative capacity**

##### *Indicators*

- number of new and existing research centres in developing countries strengthened through comprehensive institutional development and support
- proportion of developing countries in which national health research systems meet international standards
- number of countries whose national regulatory authorities have been assessed, supported and accredited

- number of new or updated global quality and ethical standards, reference preparations, guidelines and tools for promoting the quality and effective regulation of health products<sup>1</sup> and technologies
- number of countries with a national traditional medicines policy that includes research and development.

#### **Element 4. Transfer of technology**

##### *Indicators*

- number of national, regional and global coordination and collaboration initiatives aimed at increasing and facilitating transfer of health-related technology, including between public and private entities
- number of countries with technology transfer strategies that include health-related technologies and relevant capacity-building components.

#### **Element 5. Application and management of intellectual property to contribute to innovation and promote public health**

##### *Indicators*

- number of countries engaged in initiatives to strengthen capacities to manage and apply intellectual property rights to contribute to innovation and promote public health
- number of countries promoting and supporting efforts to strengthen capacities in the management and application of intellectual property rights in a manner oriented to public health needs and priorities of developing countries
- number of countries integrating flexibilities for protection of public health of the WTO Agreement on Trade-Related Aspects of Intellectual Property Rights into national legislation
- number and type of initiatives between secretariats and governing bodies of relevant regional and international organizations aimed at coordinating work relating to intellectual property and public health.

#### **Element 6. Improving delivery and access**

##### *Indicators*

- number of countries formulating and implementing official national policies on access, quality and use of essential medical products and technologies

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<sup>1</sup> The term “health products” hereafter should be understood to include vaccines, diagnostics and medicines in accordance with resolution WHA59.24.

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- number of countries designing or strengthening comprehensive national procurement and supply systems
  - number of priority health products and diagnostic tools that have been assessed and prequalified for procurement by the United Nations
  - number of countries possessing and implementing national or regional strategic plans for the health workforce and related professionals, including policies and management practices on incentives, regulation and retention
  - number of countries that have an adequate number of qualified or trained health-related regulatory professionals and the specific areas of specialization where gaps exist.

#### **Element 7. Promoting sustainable financing mechanisms**

##### *Indicators*

- submission of report of expert working group on research and development and financing
- number of new or strengthened sustainable financing initiatives including public–private initiatives
- increase in sustainable health-related research and development funding relevant to the strategy<sup>1</sup> over the reporting period.

#### **Element 8. Establishing monitoring and reporting systems**

##### *Indicators*

- regular reporting on progress towards the implementation of the strategy<sup>2</sup>
- number of new or strengthened sustainable initiatives at national, regional and global levels, including those by nongovernmental stakeholders, to promote the implementation of the strategy
- submission of reports on the respective issues addressed in Element 8 of the strategy.

#### **Additional overarching strategic indicators**

- number of new and improved health products receiving internationally recognized approval for use, including information on the nature and novelty of these products
- number of new and improved interventions and implementation strategies whose effectiveness has been determined and the evidence made available to appropriate institutions for policy decisions.

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<sup>1</sup> Baselines/guidance to be provided by the expert working group on research and development and financing, established in accordance with resolution WHA61.21.

<sup>2</sup> A qualitative assessment measuring progress on the objectives of the strategy to be included as a key component in the comprehensive four-year evaluation required by paragraph 41 of the Global strategy.

## PLAN OF ACTION

### Explanatory notes

#### \* **Stakeholder(s)**

Lead stakeholders are indicated by bold typeface.

Reference to **Governments** means that Member States<sup>1</sup> are urged to take action.

**WHO** means that the Director-General is requested to take action.

**Other international intergovernmental organizations**, both global and regional, means that Member States, or the WHO Secretariat as mandated by Member States through this plan of action, invite these organizations to take action. Member States are urged to raise appropriate issues in the governing bodies of the organizations. The Director-General is requested to bring this global strategy and plan of action to the attention of all relevant international organizations and invite them to consider the relevant provisions of this global strategy and plan of action.

**Other relevant stakeholders** means that Member States, or the WHO Secretariat as mandated by its Member States through this plan of action, invite these relevant actors to take action. These include, inter alia, as appropriate, international and national research institutions; academia; national and regional regulatory agencies; relevant health-related industries, including both public and private; public-private partnerships; public-private and product development partnerships; nongovernmental organizations; concerned communities; development partners; charitable foundations; publishers; research and development groups; and regional bodies; and regional organizations.

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<sup>1</sup> Where applicable, also regional economic integration organizations.



Elements and sub-elements	Specific actions		Stakeholder(s)*	Time frame
<b>Element 1. Prioritizing research and development needs</b> (1.1) mapping global research and development with a view to identifying gaps in research and development on diseases that disproportionately affect developing countries	(a) develop methodologies and mechanisms to identify gaps in research on Type II and Type III diseases and on developing countries' specific research and development needs in relation to Type I diseases	<b>WHO;</b> Governments; other relevant stakeholders	2008–2015	
	(b) disseminate information on identified gaps, and evaluate their consequences on public health	<b>WHO;</b> Governments; other relevant stakeholders	2008–2015	
	(c) provide an assessment of identified gaps at different levels – national, regional and international – to guide research aimed at developing affordable and therapeutically sound products to meet public health needs	<b>WHO;</b> Governments; other relevant stakeholders	2008–2015	
(1.2) formulating explicit prioritized strategies for research and development at country and regional and interregional levels	(a) set research priorities so as to address public health needs and implement public health policy based on appropriate and regular needs assessments	<b>Governments; regional organizations</b>	2008–2015	
	(b) conduct research appropriate for resource-poor settings and research on technologically appropriate products for addressing public health needs to combat diseases in developing countries	Governments; WHO; other relevant stakeholders (including academia, relevant health-related industries, national research institutions and public-private partnerships)	2008–2015	
	(c) include research and development needs on health systems in a prioritized strategy	Governments; WHO; other relevant stakeholders (including academia, national	2008–2015	

	<p>research institutions, and public-private partnerships)</p> <p><b>WHO</b>; Governments; other international intergovernmental organizations; other relevant stakeholders (including private sector)</p>	2008–2015
<p>(d) urge the leadership and commitment of governments, regional and international organizations and the private sector in determining priorities for research and development to address public health needs</p> <p>(e) increase overall research and development efforts on diseases that disproportionately affect developing countries, leading to the development of quality products to address public health needs, that are user friendly (in terms of use, prescription and management) and accessible (in terms of availability and affordability)</p>	<p><b>Governments</b>; WHO; other relevant stakeholders (including academia, relevant health-related industries, national research institutions, and public-private partnerships)</p>	2008–2015
<p>(1.3) encouraging research and development in traditional medicine in accordance with national priorities and legislation, and taking into account the relevant international instruments, including, as appropriate, those concerning traditional knowledge and the rights of indigenous peoples</p>	<p>(a) set research priorities in traditional medicine</p> <p>(b) support developing countries to build their capacity in research and development in traditional medicine</p>	2008–2015
	<p><b>Governments</b>; WHO; other international intergovernmental organizations; other relevant stakeholders (including academia; national research institutions; public-private partnerships; and concerned communities)</p> <p><b>Governments</b>; WHO; other international intergovernmental organizations; other relevant stakeholders (including academia, relevant health-related industries, national research institutions, public-private partnerships)</p>	2008–2015

<b>Elements and sub-elements</b>		<b>Stakeholder(s)*</b>	<b>Time frame</b>
<b>Element 2. Promoting research and development</b>	(c) promote international cooperation and the ethical conduct of research	<b>Governments; WHO;</b> other international intergovernmental organizations; other relevant stakeholders	2008–2015
	(d) support South–South cooperation in information exchange and research activities	<b>Governments; WHO;</b> other international intergovernmental organizations; regional organizations; other relevant stakeholders	2008–2015
	(e) support early-stage drug research and development in traditional medicine systems in developing countries	<b>Governments; WHO;</b> other international intergovernmental organizations; other relevant stakeholders	2008–2015
	<b>Specific actions</b>		
(2.1) supporting governments to develop or improve national health research programmes and establish, where appropriate, strategic research networks to facilitate better coordination of stakeholders in this area	(a) promote cooperation between private and public sectors on research and development	<b>Governments; WHO;</b> other international intergovernmental organizations; other relevant stakeholders	2008–2015
	(b) provide support for national health research programmes in developing countries through political action and, where feasible and appropriate, long-term funding	<b>Governments; regional organizations; WHO</b> (technical assistance); other relevant stakeholders	2008–2015
	(c) support governments in establishing health-related innovation in developing countries	<b>Governments; regional organizations; WHO</b> (technical assistance); other relevant stakeholders	2008–2015
(2.2) promoting upstream research and product development in developing countries	(a) support discovery science, including, where feasible and appropriate, voluntary open-source methods, in order to develop a sustainable portfolio of new products	<b>Governments; WHO;</b> other international intergovernmental organizations; other relevant stakeholders	2008–2015

<p>(b) promote and improve accessibility to compound libraries through voluntary means, provide technical support to developing countries and promote access to drug leads identified through the screening of compound libraries</p>	<p><b>Governments; WHO; other</b> international intergovernmental organizations; other relevant stakeholders</p>	2008–2015
<p>(c) identify incentives and barriers, including intellectual property-related provisions, at different levels – national, regional and international – that might affect increased research on public health, and suggest ways to facilitate access to research results and research tools</p>	<p><b>Governments; WHO; other</b> international intergovernmental organizations (including WIPO and WTO); other relevant stakeholders</p>	2008–2015
<p>(d) support basic and applied scientific research on Type II and Type III diseases and on the specific research and development needs of developing countries in relation to Type I diseases</p>	<p><b>Governments; WHO; other</b> international intergovernmental organizations; other relevant stakeholders</p>	2008–2015
<p>(e) support early-stage drug research and development in developing countries</p>	<p><b>Governments; WHO; other</b> international intergovernmental stakeholders (including relevant health-related industries, academia, international and national research institutions; donor agencies; development partners; nongovernmental organizations)</p>	2008–2015
<p>(f) build capacity to conduct clinical trials and promote public and other sources of funding for clinical trials</p>	<p><b>Governments; WHO; other</b> international intergovernmental organizations; other relevant</p>	2008–2015

	<p>and other mechanisms for stimulating local innovation, taking into account international ethical standards and the needs of developing countries</p>	<p>stakeholders (including relevant health-related industries; academia; development partners; charitable foundations; public-private partnerships; nongovernmental organizations)</p>	
<p>(g) promote the generation, transfer, acquisition upon agreed terms and voluntary sharing, of new knowledge and technologies, consistent with national law and international agreements, to facilitate the development of new health products and medical devices to tackle the health problems of developing countries</p>	<p><b>Governments; WHO; other international intergovernmental organizations, other relevant stakeholders (including; academia, international and national research institutions; relevant health-related industries and development partners)</b></p>	<p><b>Governments; WHO; other international intergovernmental organizations, other relevant stakeholders (including; academia, international and national research institutions; relevant health-related industries and development partners)</b></p>	<p>2008–2015</p>
<p>(2.3) improving cooperation, participation and coordination of health and biomedical research and development</p>	<p>(a) stimulate and improve global cooperation and coordination in research and development, in order to optimize resources</p>	<p><b>Governments; WHO; other international intergovernmental organizations; other relevant stakeholders</b></p>	<p>2008–2015</p>
<p>(b) enhance existing fora and examine the need for new mechanisms, in order to improve the coordination and sharing of information on research and development activities</p>	<p><b>Governments; WHO; other relevant stakeholders</b></p>	<p><b>Governments; WHO; other relevant stakeholders</b></p>	<p>2008–2015</p>
<p>(c) encourage further exploratory discussions on the utility of possible instruments or mechanisms for essential health and biomedical research and development, including inter alia, an essential health and</p>	<p><b>Governments; other relevant stakeholders (including nongovernmental organizations)</b></p>	<p><b>Governments; other relevant stakeholders (including nongovernmental organizations)</b></p>	<p>2008–2010</p>

	biomedical research and development treaty			
	(d) support active participation of developing countries in building technological capacity	<b>Governments; WHO; other</b> relevant stakeholders		2008–2015
	(e) promote the active participation of developing countries in the innovation process	<b>Governments; WHO; other</b> relevant stakeholders		2008–2015
(2.4) promoting greater access to knowledge and technology relevant to meet public health needs of developing countries	(a) promote the creation and development of accessible public health libraries in order to enhance availability and use of relevant publications by universities, institutes and technical centres, especially in developing countries	<b>Governments; WHO; other</b> international intergovernmental organizations; other relevant stakeholders (including academia, research institutions, relevant health-related industries; nongovernmental organizations; publishers)		2008–2015
	(b) promote public access to the results of government-funded research, by strongly encouraging all investigators funded by governments to submit to an open access database an electronic version of their final, peer-reviewed manuscripts	<b>Governments; WHO; other</b> international intergovernmental organizations; other relevant stakeholders (including academia and research institutions)		2008–2015
	(c) support the creation of voluntary open databases and compound libraries including voluntary provision of access to drug leads identified through the screening of such compound libraries	<b>Governments; WHO; other</b> international intergovernmental organizations (including WIPO); other relevant stakeholders (including relevant health-related industries)		2008–2015
	(d) encourage the further development and dissemination of publicly or donor-funded medical	<b>Governments; WHO; other</b> international intergovernmental organizations; other relevant		2008–2015

	<p>inventions and know-how through appropriate licensing policies, including but not limited to open licensing, that enhance access to innovations for development of products of relevance to the public health needs of developing countries on reasonable, affordable and non-discriminatory terms</p> <p>(e) consider, where appropriate, use of a “research exception” to address public health needs in developing countries consistent with the Agreement on Trade-Related Aspects of Intellectual Property Rights</p>	<p>stakeholders (including academia and national research institutions)</p>	
<p>2.5 establishing and strengthening national and regional coordinating bodies on research and development</p>	<p>(a) develop and coordinate a research and development agenda</p> <p>(b) facilitate the dissemination and use of research and development outcomes</p>	<p><b>Governments</b></p>	<p>2008–2015</p>
<p><b>Elements and sub-elements</b></p>	<p><b>Specific actions</b></p>	<p><b>Stakeholder(s)*</b></p>	<p><b>Time frame</b></p>
<p><b>Element 3. Building and improving innovative capacity</b></p> <p>(3.1) building capacity of developing countries to meet research and development needs for health products</p>	<p>(a) support investment by developing countries in human resources and knowledge bases, especially in education and training including in public health</p> <p>(b) support existing and new research and development groups and institutions, including regional centres of excellence, in developing countries</p>	<p><b>Governments;</b> other international intergovernmental organizations; other relevant stakeholders (including development partners)</p> <p><b>Governments;</b> other international intergovernmental organizations; other relevant stakeholders</p>	<p>2008–2015</p> <p>2008–2015</p>

	(including research and development groups, relevant health-related industries and development partners)		
(c) strengthen health surveillance and information systems	<b>Governments; WHO;</b> other international intergovernmental organizations; other relevant stakeholders (including nongovernmental organizations, research institutions, academia)	2008–2015	
(3.2) framing, developing and supporting effective policies that promote the development of capacities for health innovation	(a) establish and strengthen regulatory capacity in developing countries	<b>Governments; WHO;</b> other relevant stakeholders (including national and regional regulatory agencies)	2008–2015
	(b) strengthen human resources in research and development in developing countries through long-term national capacity-building plans	<b>Governments;</b> other international intergovernmental organizations; other relevant stakeholders (including development partners; international and national research institutions)	2008–2015
	(c) encourage international cooperation to develop effective policies for retention of health professionals including researchers in developing countries	<b>Governments; WHO;</b> other international intergovernmental organizations (including IOM and ILO); other relevant stakeholders	2008–2015
	(d) urge Member States to establish mechanisms to mitigate the adverse impact of the loss of health personnel in developing countries, particularly researchers, through migration, including by ways for both receiving and originating	<b>Governments</b>	2008–2015



	countries to support the strengthening of national health and research systems, in particular human resource development in the countries of origin, taking into account the work of WHO and other relevant organizations		
(3.3) providing support for improving innovative capacity in accordance with the needs of developing countries	(a) develop successful health innovation models in developing innovative capacity	<b>Governments; WHO; other international intergovernmental organizations (including WIPO, OECD and UNCTAD); other relevant stakeholders (including academia; research institutions; health-related industries and developmental partners)</b>	2008–2015
(b) intensify North–South and South–South partnerships and networks to support capacity building		<b>Governments; WHO; other international intergovernmental organizations; other relevant stakeholders (including academia, research institutions, relevant health-related industries)</b>	2008–2015
(c) establish and strengthen mechanisms for ethical review in the research and development process, including clinical trials, especially in developing countries		<b>Governments; WHO; other relevant stakeholders (including academia and research institutions)</b>	2008–2015
(3.4) supporting policies that will promote innovation based on traditional medicine within an evidence-based framework in accordance with national priorities and taking into account the relevant provisions of relevant international instruments	(a) establish and strengthen national and regional policies to develop, support and promote traditional medicine	<b>Governments; WHO; other international intergovernmental organizations; other relevant stakeholders (including concerned communities)</b>	2008–2015

<p>(b) encourage and promote policies on innovation in the field of traditional medicine</p>	<p><b>Governments; WHO; other international intergovernmental organizations; other relevant stakeholders (including international and national research institutions, concerned communities)</b></p>	<p>2008–2015</p>
<p>(c) promote standard setting to ensure the quality, safety and efficacy of traditional medicine, including by funding the research necessary to establish such standards</p>	<p><b>Governments; WHO; other international intergovernmental organizations; other relevant stakeholders (including national and regional regulatory agencies; international and national research institutions; development partners; concerned communities)</b></p>	<p>2008–2015</p>
<p>(d) encourage research on mechanisms for action and pharmacokinetics of traditional medicine</p>	<p><b>Governments; WHO; other international intergovernmental organizations; other relevant stakeholders (including academia; international and national research institutions; relevant health-related industries; concerned communities)</b></p>	<p>2008–2015</p>
<p>(e) promote South–South collaboration in traditional medicine</p>	<p><b>Governments; WHO; other international intergovernmental organizations; other relevant stakeholders (including research institutions, regional bodies, academia)</b></p>	<p>2008–2015</p>
<p>(f) formulate and disseminate guidelines on good manufacturing practices for traditional medicines</p>	<p><b>Governments; WHO; other international intergovernmental organizations; other relevant</b></p>	<p>2008–2015</p>

	and laying down evidence-based standards for quality and safety evaluation	stakeholders (including national and regional regulatory agencies, relevant health-related industries)	
(3.5) developing and implementing, where appropriate, possible incentive schemes for health-related innovation	(a) encourage the establishment of award schemes for health-related innovation	<b>Governments; WHO; other international intergovernmental organizations (including WIPO); other relevant stakeholders (including academia; international and national research institutions; development partners; charitable foundations)</b>	2008–2015
	(b) encourage recognition of innovation for purposes of career advancement for health researchers	<b>Governments; WHO; other international intergovernmental organizations; other relevant stakeholders (including academia; international and national research institutions; development partners; charitable foundations)</b>	2008–2015
<b>Elements and sub-elements</b>		<b>Stakeholder(s)*</b>	<b>Time frame</b>
<b>Element 4. Transfer of technology</b>			
(4.1) promoting transfer of technology and the production of health products in developing countries	(a) explore possible new mechanisms and make better use of existing mechanisms to facilitate transfer of technology and technical support to build and improve innovative capacity for health-related research and development, particularly in developing countries	<b>Governments; WHO; other international intergovernmental organizations (including WIPO, WTO, UNCTAD, UNIDO); other relevant stakeholders (including international and national research institutions; relevant health-related industries)</b>	2008–2015

	(b) promote transfer of technology and production of health products in developing countries through investment and capacity building	<b>Governments; WHO; other</b> intergovernmental organizations; other relevant stakeholders (including <b>health-related industries</b> )	2008–2015
	(c) promote transfer of technology and production of health products in developing countries through identification of best practices, and investment and capacity building provided by developed and developing countries where appropriate	<b>Governments; WHO; other</b> international intergovernmental organizations; other relevant stakeholders (including <b>relevant health-related industries; academia; nongovernmental organizations; development partners; charitable foundations</b> )	2008–2015
(4.2) supporting improved collaboration and coordination of technology transfer for health products, bearing in mind different levels of development	(a) encourage North–South and South–South cooperation for technology transfers, and collaboration between institutions in developing countries and the pharmaceutical industry	<b>Governments; WHO; other</b> international intergovernmental organizations (including <b>WIPO</b> ); other relevant stakeholders (including relevant health-related industries; international and national research institutions; academia; nongovernmental organizations; development partners)	2008–2015
	(b) facilitate local and regional networks for collaboration on research and development and transfer of technology	<b>Governments; WHO; other</b> international intergovernmental organizations; other relevant stakeholders (including relevant health-related industries, national research institutions, academia; nongovernmental organizations)	2008–2015

	<p>(c) continue to promote and encourage technology transfer to least-developed country members of the WTO consistent with Article 66.2 of the Agreement on Trade-Related Aspects of Intellectual Property Rights</p> <p>(d) promote the necessary training to increase absorptive capacity for technology transfer</p>	<p><b>Governments</b></p>	2008–2015
	<p>(a) examine the feasibility of voluntary patent pools of upstream and downstream technologies to promote innovation of and access to health products and medical devices</p>	<p><b>Governments; WHO; other international intergovernmental organizations (including WIPO); other relevant stakeholders (including international and national research institutions; relevant health-related industries, nongovernmental organizations; academia)</b></p>	2008–2015
<p>(4.3) developing possible new mechanisms to promote transfer of and access to key health-related technologies</p>	<p>(b) explore and, if feasible, develop possible new mechanisms to promote transfer of and access to key health-related technologies of relevance to public health needs of developing countries especially on Type II and III diseases and the specific research and development needs of developing countries in respect of Type I diseases, which are consistent with the provisions of the</p>	<p><b>Governments; WHO; other international intergovernmental organizations (including WIPO, WTO); other relevant stakeholders (including health-related industries)</b></p>	2008–2015

Elements and sub-elements	Specific actions	Stakeholder(s)*	Time frame
<p><b>Element 5. Application and Management of intellectual property to contribute to innovation and promote public health</b></p> <p>(5.1) support information sharing and capacity building in the application and management of intellectual property with respect to health-related innovation and the promotion of public health in developing countries</p>	<p>Agreement on Trade-Related Aspects of Intellectual Property Rights and instruments related to that Agreement, which provide flexibilities to take measures to protect public health</p> <p>(a) encourage and support the application and management of intellectual property in a manner that maximizes health-related innovation and promotes access to health products and that is consistent with the provisions in the Agreement on Trade-Related Aspects of Intellectual Property Rights and other WTO instruments related to that Agreement and meets the specific research and development needs of developing countries</p> <p>(b) promote and support, including through international cooperation, national and regional institutions in their efforts to build and strengthen capacity to manage and apply intellectual property in a manner oriented to public health needs and priorities of developing countries</p>	<p><b>Governments; WHO; other international intergovernmental organizations (including WIPO, WTO, UNCTAD); other relevant stakeholders (including international and national research institutions and development partners)</b></p> <p><b>Governments; WHO; other international intergovernmental organizations (including WIPO, WTO, UNCTAD); other relevant stakeholders (including international and national research institutions and development partners)</b></p>	<p>2008–2015</p> <p>2008–2015</p>

	<p>(c) facilitate widespread access to, and promote further development of, including, if necessary, compiling, maintaining and updating, user-friendly global databases which contain public information on the administrative status of health-related patents, including supporting the existing efforts for determining the patent status of health products, in order to strengthen national capacities for analysis of the information contained in those databases, and improve the quality of patents</p> <p>(d) stimulate collaboration among pertinent national institutions and relevant government departments, as well as between national, regional and international institutions, in order to promote information sharing relevant to public health needs</p>	<p>Governments; WHO; other international intergovernmental organizations (including WIPO, WTO, UNCTAD); other relevant stakeholders (including international and national research institutions and development partners)</p>	2008–2015
	<p>(e) strengthen education and training in the application and management of intellectual property, from a public health perspective taking into account the provisions contained in the Agreement on Trade-Related Aspects of Intellectual Property Rights, including the flexibilities</p>	<p><b>Governments;</b> WHO; other international intergovernmental organizations (including WIPO, WTO, UNCTAD); other relevant stakeholders (including international and national research institutions and development partners)</p>	2008–2015

	<p>recognized by the Doha Declaration on the TRIPS Agreement and Public Health and other WTO instruments related to the TRIPS agreement</p> <p>(f) facilitate, where feasible and appropriate, possible access to traditional medicinal knowledge information for use as prior art in examination of patents, including, where appropriate, the inclusion of traditional medicinal knowledge information in digital libraries</p>	<p><b>Governments; concerned communities</b></p>	2008–2015
	<p>(g) promote active and effective participation of health representatives in intellectual property-related negotiations, where appropriate, in order that such negotiations also reflect public health needs</p>	<p><b>Governments</b></p>	2008–2015
	<p>(h) strengthen efforts to effectively coordinate work relating to intellectual property and public health among the Secretariats and governing bodies of relevant regional and international organizations in order to facilitate dialogue and dissemination of information to countries</p>	<p><b>Governments; WHO; other international intergovernmental organizations (including WIPO, WTO, and UNCTAD)</b></p>	2008–2015
<p>(5.2) providing as appropriate, upon request, in collaboration with other competent international organizations technical support, including, where appropriate, to policy processes, to countries that intend to make use of the provisions contained in the Agreement on Trade-Related Aspects of Intellectual Property Rights, including the flexibilities recognized by the Doha Declaration on the TRIPS Agreement and Public Health and</p>	<p>(a) consider, whenever necessary, adapting national legislation in order to use to the full the flexibilities contained in the Agreement on Trade-Related Aspects of Intellectual Property Rights, including those recognized by the</p>	<p><b>Governments; WHO; other international intergovernmental organizations (including WIPO, WTO and UNCTAD)</b></p>	2008–2015



<p>other WTO instruments related to the TRIPS agreement, in order to promote access to pharmaceutical products</p>	<p>Doha Declaration on the TRIPS Agreement and Public Health and the WTO decision of 30 August 2003</p>	<p><b>Governments;</b> WHO; other international intergovernmental organizations (including WIPO, WTO and UNCTAD)</p>	<p>2008–2015</p>
	<p>(b) take into account, where appropriate, the impact on public health when considering adopting or implementing more extensive intellectual property protection than is required by the Agreement on Trade-Related Aspects of Intellectual Property Rights, without prejudice to the sovereign rights of Member States</p>	<p><b>Governments</b></p>	<p>2008–2015</p>
	<p>(c) take into account in trade agreements the flexibilities contained in the Agreement on Trade-Related Aspects of Intellectual Property Rights and including those recognized by the Doha Declaration on the TRIPS Agreement and Public Health and the WTO decision of 30 August 2003</p>	<p><b>Governments</b></p>	<p>2008–2015</p>
	<p>(d) consider, where appropriate, taking necessary measures in countries with manufacturing capacity to facilitate through export access to pharmaceutical products in countries with insufficient or no manufacturing capacity in the pharmaceutical sector in a manner consistent with the Agreement on Trade-Related Aspects of</p>	<p><b>Governments</b></p>	<p>2008–2015</p>

	Intellectual Property Rights, the Doha Declaration on the TRIPS Agreement and Public Health and the WTO decision of 30 August 2003			2008–2015
	(e) encourage finding ways, in ongoing discussions, to prevent misappropriation of health-related traditional knowledge, and consider where appropriate, legislative and other measures to help prevent misappropriation of such traditional knowledge			<b>Governments; WHO; other international intergovernmental organizations (including WIPO, WTO, UNEP/Secretariat of the Convention on Biological Diversity); other relevant stakeholders (including concerned communities)</b>
(5.3) exploring and, where appropriate, promoting possible incentive schemes for research and development on Type II and Type III diseases and on developing countries' specific research and development needs in relation to Type I diseases	(a) explore and, where appropriate, promote a range of incentive schemes for research and development including addressing, where appropriate, the de-linkage of the costs of research and development and the price of health products, for example through the award of prizes, with the objective of addressing diseases which disproportionately affect developing countries			2008–2015
<b>Elements and sub-elements</b>				<b>Stakeholder(s)*</b>
<b>Element 6. Improving delivery and access</b>				<b>Time frame</b>
(6.1) encouraging increased investment in the health-delivery infrastructure and financing of health products in order to strengthen the health system	(a) invest in developing health-delivery infrastructure and encourage financing of health products			2008–2015
				<b>Governments; WHO; other international intergovernmental organizations; other relevant stakeholders (including development partners, charitable foundations, private</b>

		sector and relevant health-related industries)	
(b) develop effective and sustainable mechanisms in least-developed countries in order to improve access to existing medicines, acknowledging the transitional period until 2016 <sup>1</sup>	<b>Governments; WHO; other international intergovernmental organizations (including WTO); other relevant stakeholders</b>	2008–2015	
(c) prioritize health care in national agendas	<b>Governments</b>	2008–2015	
(d) encourage health authorities to improve domestic management capacities in order to improve delivery and access to medicines and other health products with quality, efficacy, safety and affordability and, where appropriate, to develop strategies to promote rational use of medicines	<b>Governments; WHO</b>	2008–2015	
(e) increase investment in human resource development in the health sector	<b>Governments; WHO; other international intergovernmental organizations; other relevant stakeholders (including development partners; nongovernmental organizations; charitable foundations)</b>	2008–2015	
(f) develop effective country poverty-reduction strategies that contain clear health objectives	<b>Governments; other relevant stakeholders (including development partners)</b>	2008–2015	

<sup>1</sup> In line with the extension, provided to least-developed countries, by Article 7 of the Doha Declaration on the TRIPS Agreement and Public Health.

	(g) encourage pooled procurement mechanisms for health products and medical devices, where appropriate	<b>Governments; WHO;</b> other international intergovernmental organizations; other relevant stakeholders	2008–2015
(6.2) establishing and strengthening mechanisms to improve ethical review and regulate the quality, safety and efficacy of health products and medical devices	(a) develop and/or strengthen the capacity of national regulatory authorities to monitor the quality, safety and efficacy of health products while sustaining ethical review standards	<b>Governments; WHO;</b> other relevant stakeholders (including national and regional regulatory agencies and development partners)	2008–2015
	(b) promote operational research to maximize the appropriate use of new and existing products, including cost-effective and affordable products in high disease-burden settings	<b>Governments; WHO;</b> other international intergovernmental organizations; other relevant stakeholders (including international and national research institutions; nongovernmental organizations, development partners and charitable foundations)	2008–2015
	(c) comply with good manufacturing practices for safety standards, efficacy and quality of health products	<b>Governments; WHO;</b> other relevant stakeholders (including national regulatory bodies; relevant health-related industries; development partners)	2008–2015
	(d) strengthen the WHO pre-qualification programme	<b>Governments; WHO;</b> other international intergovernmental organizations; other relevant stakeholders (including development partners)	2008–2015
	(e) where appropriate, initiate programmed actions on regional and sub-regional levels with the ultimate goal of harmonization of processes employed by the regulatory	<b>Governments; WHO;</b> other relevant stakeholders (including national and regional regulatory agencies, regional bodies and	2008–2015

	authorities for drug marketing approvals	development partners)	
	(f) promote ethical principles for clinical trials involving human beings as a requirement of registration of medicines and health-related technologies, with reference to the Declaration of Helsinki, and other appropriate texts, on ethical principles for medical research involving human subjects, including good clinical practice guidelines	<b>Governments; WHO;</b> other international intergovernmental organizations; other relevant stakeholders (including national and regional regulatory agencies)	2008–2015
	(g) support regional networks and collaborative efforts to strengthen the regulation and implementation of clinical trials using appropriate standards for medicines evaluation and approval	<b>Governments; WHO;</b> other relevant stakeholders (including national and regional regulatory agencies, international and national research institutions, regional bodies and development partners)	2008–2015
(6.3) promoting competition to improve availability and affordability of health products consistent with public health policies and needs	(a) support the production and introduction of generic versions, in particular of essential medicines, in developing countries, through the development of national legislation and/or policies that encourage generic production and entry, including a “regulatory exception” or “Bolar”-type provision, and which are consistent with the Agreement on Trade-Related Aspects of Intellectual Property Rights and instruments related to that agreement	<b>Governments</b>	2008–2015

	<p>(b) frame and implement policies to improve access to safe and effective health products, especially essential medicines, at affordable prices, consistent with international agreements</p>	<p><b>Governments; WHO; other international intergovernmental organizations (including WTO and WIPO); other relevant stakeholders</b></p>	2008–2015
	<p>(c) consider where appropriate, inter alia, the reduction or elimination of import tariffs on health products and medical devices and the monitoring of supply and distribution chains and procurement practices to minimize cost and increase access</p>	<p><b>Governments</b></p>	2008–2015
	<p>(d) encourage pharmaceutical companies and other health-related industries to consider policies, including differential pricing policies, that are conducive to promoting access to quality, safe, efficacious and affordable health products in developing countries, consistent with national law</p>	<p><b>Governments; WHO; other international intergovernmental organizations; other relevant stakeholders (including relevant health-related industries)</b></p>	2008–2015
	<p>(e) consider, where appropriate, the development of policies to monitor pricing and to improve affordability of health products; further support WHO's ongoing work on pharmaceutical pricing</p>	<p><b>Governments</b></p>	2008–2015
	<p>(f) consider, where necessary, and provided that they are consistent with the provisions of the Agreement on Trade-Related Aspects of Intellectual Property Rights, taking appropriate measures to prevent the abuse of intellectual property rights by right holders or</p>	<p><b>Governments</b></p>	2008–2015

	<p>the resort to practices which unreasonably restrain trade or adversely affect the international transfer of technology, in the field of health products</p> <p>(g) increase information among policy makers, users, doctors and pharmacists regarding generic products</p>		
<b>Elements and sub-elements</b>			
<b>Element 7. Promoting sustainable financing mechanisms</b>			
<p>(7.1) endeavouring to secure adequate and sustainable financing for research and development, and improve coordination of its use, where feasible and appropriate, in order to address the health needs of developing countries</p>	<p>(a) establish a results-oriented and time-limited expert working group under the auspices of WHO and linking up with other relevant groups to examine current financing and coordination of research and development, as well as proposals for new and innovative sources of financing to stimulate research and development related to Type II and Type III diseases and the specific research and development needs of developing countries in relation to Type I diseases</p> <p>(b) consider channelling additional funds to health-oriented research organizations as appropriate in both the private and public sector of developing countries and promote good financial management to maximize its effectiveness as recommended by resolution WHA58.34</p>	<p><b>Stakeholder(s)*</b></p> <p>Governments; WHO other relevant stakeholders (including nongovernmental organizations and relevant health-related industry)</p> <p>Governments; WHO; other international intergovernmental organizations; other relevant stakeholders</p> <p>Governments; WHO; other international intergovernmental organizations; other relevant stakeholders (including development partners, charitable foundations, international and national research institutions, academia, private sector and relevant health-related industries)</p>	<p>2008–2010</p> <p>2008–2015</p>

(7.2) facilitating the maximum use of, and complementing as appropriate, existing financing, including that through public-private and product development partnerships, in order to develop and deliver safe, effective and affordable health products and medical devices	(c) create a database of possible sources of financing for research and development	<b>Governments; WHO; other</b> relevant stakeholders	2008–2015
	(a) document and disseminate best practices in public-private and product development partnerships	Governments; <b>WHO</b> ; other relevant stakeholders (including research institutions, public-private and product development partnerships)	2008–2015
	(b) develop tools for periodic assessment of performance of public-private and product development partnerships	Governments; <b>WHO</b> ; other relevant stakeholders (including research institutions; public-private and product development partnerships; charitable foundations)	2008–2009
	(c) support public-private and product development partnerships and other appropriate research and development initiatives in developing countries	Governments; WHO; other international intergovernmental organizations; other relevant stakeholders (including relevant health-related industries, charitable foundations, development partners, nongovernmental organizations; academia; research institutions)	2008–2015
<b>Elements and sub-elements</b>	<b>Specific actions</b>	<b>Stakeholder(s)*</b>	<b>Time frame</b>
<b>Element 8. Establishing monitoring and reporting systems</b>			
(8.1) measuring performance and progress towards objectives contained in the strategy and plan of action	(a) establish systems to monitor performance and progress of the implementation of each element of the global strategy and plan of action (b) monitor and report periodically to WHO's governing bodies on the gaps and needs related to health products and medical devices in developed and developing countries	Governments; <b>WHO</b>	2009–2015
		Governments; <b>WHO</b>	2009–2015



	(c) to continue to monitor, from a public health perspective, in consultation as appropriate with other international organizations, the impact of intellectual property rights and other issues addressed in the Report of the Commission on Intellectual Property Rights, Innovation and Public Health, on the development of, and access to, health care products, and to report thereon to the Health Assembly	Governments; <b>WHO</b> ; other international intergovernmental organizations (including WIPO and WTO); other relevant stakeholders	2009–2015
	(d) monitor and report on the impact of incentive mechanisms on innovation of and access to health products and medical devices	<b>Governments; WHO</b> ; other international intergovernmental organizations (including WIPO and WTO); other relevant stakeholders	2009–2015
	(e) monitor and report on investment in research and development to address the health needs of developing countries	Governments; <b>WHO</b> ; other relevant stakeholders	2009–2015

(Eighth plenary meeting, 24 May 2008 –  
Committee A, fifth report)

## ANNEX 5

### Financial and administrative implications for the Secretariat of resolutions adopted by the Health Assembly

<b>1. Resolution WHA62.1</b> Prevention of avoidable blindness and visual impairment	
<b>2. Linkage to programme budget</b>	
Strategic objective:	Organization-wide expected result:
3. To prevent and reduce disease, disability and premature death from chronic noncommunicable diseases, mental disorders, violence and injuries and visual impairment.	3.1 Advocacy and support provided to increase political, financial and technical commitment in Member States in order to tackle chronic noncommunicable diseases, mental and neurological disorders, violence, injuries and disabilities and visual impairment, including blindness.
	3.2 Guidance and support provided to Member States for the development and implementation of policies, strategies and regulations in respect of chronic noncommunicable diseases, mental and neurological disorders, violence, injuries and disabilities and visual impairment, including blindness.
	3.3 Improvements made in Member States' capacity to collect, analyse, disseminate and use data on the magnitude, causes and consequences of chronic noncommunicable diseases, mental and neurological disorders, violence, injuries and disabilities and visual impairment, including blindness.
	3.4 Improved evidence compiled by WHO on the cost-effectiveness of interventions to tackle chronic noncommunicable diseases, mental and neurological and substance-use disorders, violence, injuries and disabilities and visual impairment, including blindness.
	3.5 Guidance and support provided to Member States for the preparation and implementation of multisectoral, population-wide programmes to promote mental health and to prevent mental and neurological disorders, violence and injuries, together with hearing and visual impairment, including blindness.
	3.6 Guidance and support provided to Member States to improve the ability of their health and social systems to prevent and manage chronic noncommunicable diseases, mental and neurological disorders, violence, injuries and disabilities and impairment, including blindness.

**(Briefly indicate the linkage with expected results, indicators, targets, baseline)**

The resolution and the draft action plan are consistent with the expected results. Three indicators exist: 3.2.5, 3.3.5 and 3.5.3. Additional indicators will be designed as needed.

**3. Financial implications****(a) Total estimated cost for implementation over the life-cycle of the resolution (estimated to the nearest US\$ 10 000, including staff and activities)**

US\$ 14.2 million is needed for the implementation of the action plan.

**(b) Estimated cost for the biennium 2008–2009 (estimated to the nearest US\$ 10 000 including staff and activities, and indicating at which levels of the Organization the costs will be incurred, identifying specific regions where relevant)**

Total costs are estimated at US\$ 925 000 for the remaining six months of the biennium.

**(c) Of the estimated cost noted in (b), what can be subsumed under existing programmed activities for the biennium 2008–2009?**

US\$ 320 000 is available for the remaining for period of the biennium 2008–2009. This implies the need for an additional provision of US\$ 600 000.

**(d) For the amount that cannot be subsumed under existing programmed activities, how will the additional costs be financed? (indicate potential sources of funds)**

Additional funding from international partners is expected through active resource mobilization.

**4. Administrative implications****(a) Implementation locales (indicate the levels of the Organization at which the work will be undertaken, identifying specific regions where relevant)**

Currently most activities are performed at headquarters and in the regional offices for Africa, the Americas and the Eastern Mediterranean. Additional positions would need to be established in the regional offices for Europe, South-East Asia and the Western Pacific.

**(b) Additional staffing requirements (indicate additional required staff – full-time equivalents – by levels of the Organization, identifying specific regions where relevant and noting necessary skills profile)**

At headquarters, one additional full-time equivalent will be required in the professional category together with one staff member in the general service category. One full-time position in the professional category and one full-time position in the general service category will be required in the regional offices for Europe, South-East Asia and the Western Pacific.

**(c) Time frames (indicate broad time frames for implementation)**

Remaining five years of the Medium-term strategic plan, namely 2009 to 2013.

**1. Resolution WHA62.2 Health conditions in the occupied Palestinian territory, including east Jerusalem, and in the occupied Syrian Golan****2. Linkage to programme budget**

Strategic objective:

5. To reduce the health consequences of emergencies, disasters, crises and conflicts and minimize their social and economic impact.

Organization-wide expected result:

5.3 Norms and standards developed and capacity built to enable Member States to assess needs and for planning interventions during the transition and recovery phases of conflicts and disasters.

**(Briefly indicate the linkage with expected results, indicators, targets, baseline)**

If fully funded and implemented, the resolution is expected to have an impact on the targets for the second and third indicators for this expected result.

**3. Financial implications****(a) Total estimated cost for implementation over the life-cycle of the resolution (estimated to the nearest US\$ 10 000, including staff and activities)**

US\$ 3 970 000 over the one-year period of the resolution, including staff, travel, training activities, technical assistance, health supplies, security and operational equipment.

A substantial proportion of these resources have been raised as humanitarian voluntary contributions for addressing humanitarian health needs, implementing life-saving interventions, re-establishing the functionality of the disrupted health services and rolling out the Interagency Standing Committee health cluster.

The breakdown of the estimated cost of operative paragraph 4 is as follows:

Subparagraph (1)	US\$ 100 000
Subparagraph (2)	US\$ 70 000
Subparagraph (3)	US\$ 50 000
Subparagraph (4)	US\$ 200 000
Subparagraph (5)	US\$ 500 000
Subparagraph (6)	US\$ 3 000 000
Subparagraph (7)	US\$ 50 000
Total	US\$ 3 970 000

**(b) Estimated cost for the biennium 2008–2009 (estimated to the nearest US\$ 10 000 including staff and activities)**

US\$ 3 970 000 (one year life-cycle).

**(c) Of the estimated cost noted in (b), what can be subsumed under existing programmed activities for the biennium 2008–2009? Seventy-five per cent of US\$ 3 970 000 at headquarters, Regional and Jerusalem Office levels.****(d) For the amount that cannot be subsumed under existing programmed activities, how will the additional costs be financed? (indicate potential sources of funds)**

Not applicable.

**4. Administrative implications****(a) Implementation locales (indicate the levels of the Organization at which the work will be undertaken, identifying specific regions where relevant)**

The activities will be primarily implemented through the WHO Office in Jerusalem, responsible for WHO's cooperation programme with the Palestine Authority. WHO's country-level efforts will be supplemented by support from the Regional Office for the Eastern Mediterranean, and by the headquarters clusters working in the areas of health action in crises, health security and environment.

**(b) Additional staffing requirements (indicate additional required staff – full-time equivalents – noting necessary skills profile)**

It will be necessary to sustain beyond May 2009 the presence at country level of the national and international staff recruited to implement humanitarian health activities and interventions in the occupied Palestinian territory.

**(c) Time frames (indicate broad time frames for implementation)**

One year.

**1. Resolution WHA62.12 Primary health care, including health system strengthening****2. Linkage to programme budget**

Strategic objective:

Organization-wide expected result:

Strategic objectives 1–11 (all technical objectives).

All Organization-wide expected results under strategic objectives 1–11.

**(Briefly indicate the linkage with expected results, indicators, targets, baseline)**

This resolution requires a broad re-examination of WHO's programmatic priorities with a view to ensuring the Organization is well positioned to support Member States as they seek to strengthen their health systems based on the primary health care approach. There are likely to be implications for the Organization-wide expected results and indicators in the Medium-term strategic plan 2008–2013, which will be presented to the governing bodies for their consideration as appropriate.

**3. Financial implications****(a) Total estimated cost for implementation over the life-cycle of the resolution (estimated to the nearest US\$ 10 000, including staff and activities)**

Although the scope of this resolution is a long-term one, the cost implications considered here are only for the period 2008–2013; any future costs will be presented to Member States for their consideration at the appropriate time. Given the comprehensive nature of the primary health care approach, the costs implied by WHO's implementation of the resolution will essentially be accounted for by a cost-neutral revisiting of the workplans under each strategic objective, aligning them with the policy directions given by the resolution.

However, specific funding needs to be allocated for (i) coordination of organizational alignment and capacity building, (ii) cross-cutting strategic activities and initiatives (e.g. reviews of primary health care policy, consultations, and monitoring progress of efforts to revitalize primary health care) and (iii) stepping up support to and exchange between countries.

Biennium	Task	Estimated cost (US\$ thousands)
2008–2009	• Organizational alignment and capacity building	800
	• Cross-cutting strategic initiatives	1 000
	• Country support and exchange	100
2010–2011	• Organizational alignment and capacity building	500
	• Cross-cutting strategic initiatives	500
	• Country support and exchange	1 000
2012–2013	• Organizational alignment and capacity building	100
	• Cross-cutting strategic initiatives	300
	• Country support and exchange	600

- (b) Estimated cost for the biennium 2008–2009 (estimated to the nearest US\$ 10 000 including staff and activities, and indicating at which levels of the Organization the costs will be incurred, identifying specific regions where relevant)**

US\$ 1.9 million (see note above).

- (c) Of the estimated cost noted in (b), what can be subsumed under existing programmed activities for the biennium 2008–2009?**

50%, or US\$ 950 000.

- (d) For the amount that cannot be subsumed under existing programmed activities, how will the additional costs be financed? (indicate potential sources of funds)**

The additional amount will need to be mobilized in the form of voluntary contributions; initial consultations have already begun with funding sources and prospects are positive.

#### 4. Administrative implications

- (a) Implementation locales (indicate the levels of the Organization at which the work will be undertaken, identifying specific regions where relevant)**

All levels of the Organization will be involved.

- (b) Additional staffing requirements (indicate additional required staff – full-time equivalents – by levels of the Organization, identifying specific regions where relevant and noting necessary skills profile)**

To the extent possible, secondments (supported by Member States) are being used for portions of the additional work. The need for any additional WHO staff in 2010 and beyond will be reviewed during 2009.

- (c) Time frames (indicate broad time frames for implementation)**

A progress report will be submitted to the Health Assembly every two years, starting with the Sixty-third World Health Assembly in 2010.

#### 1. Resolution WHA62.15 Prevention and control of multidrug-resistant tuberculosis and extensively drug-resistant tuberculosis

##### 2. Linkage to programme budget

Strategic objective:

2. To combat HIV/AIDS, tuberculosis and malaria

Organization-wide expected result:

2.1 Guidelines, policy, strategy and other tools developed for prevention of, and treatment and care for patients with, HIV/AIDS, tuberculosis and malaria, including innovative approaches for increasing coverage of the interventions among poor people, and hard-to-reach and vulnerable populations.

2.2 Policy and technical support provided to countries towards expanded gender-sensitive delivery of prevention, treatment and care interventions for HIV/AIDS, tuberculosis and malaria, including integrated training and service delivery; wider service-provider networks; and strengthened laboratory capacities and better linkages with other health services, such as those for sexual and reproductive health, maternal, newborn and child health, sexually transmitted infections, nutrition, drug-dependence

treatment services, respiratory care, neglected diseases and environmental health.

2.3 Global guidance and technical support provided on policies and programmes in order to promote equitable access to essential medicines, diagnostic tools and health technologies of assured quality for the prevention and treatment of HIV/AIDS, tuberculosis and malaria, and their rational use by prescribers and consumers, and, in order to ensure uninterrupted supplies of diagnostics, safe blood and blood products, injections and other essential health technologies and commodities.

2.4 Global, regional and national systems for surveillance, evaluation and monitoring strengthened and expanded to keep track of progress towards targets and allocation of resources for HIV/AIDS, tuberculosis and malaria control and to determine the impact of control efforts and the evolution of drug resistance.

2.5 Political commitment sustained and mobilization of resources ensured through advocacy and nurturing of partnerships on HIV/AIDS, tuberculosis and malaria at country, regional and global levels; support provided to countries as appropriate to develop or strengthen and implement mechanisms for resource mobilization and utilization and increase the absorption capacity of available resources; and engagement of communities and affected persons increased to maximize the reach and performance of HIV/AIDS, tuberculosis and malaria control programmes.

**(Briefly indicate the linkage with expected results, indicators, targets, baseline)**

The resolution builds on the Stop TB strategy, the Stop TB Partnership's Global Plan to Stop TB, 2006–2015, resolutions WHA58.14 and WHA60.19, and the Beijing Call for Action on tuberculosis control and patient care. It provides a framework for achieving the array of expected results, targets and baseline figures in respect of tuberculosis control outlined in strategic objective 2 for the Medium-term Strategic Plan 2008–2013. Furthermore, it is aligned with the expected results and indicators included in the workplan for tuberculosis for the biennium 2008–2009.

### **3. Financial implications**

**(a) Total estimated cost for implementation over the life-cycle of the resolution (estimated to the nearest US\$ 10 000, including staff and activities)**

The life-cycle of the resolution covers the period 2009–2015. The estimated cost for the Secretariat's implementation responsibilities – including actions at WHO headquarters, in all regional offices and in relevant country offices – is US\$ 175 million.

**(b) Estimated cost for the biennium 2008–2009 (estimated to the nearest US\$ 10 000 including staff and activities, and indicating at which levels of the Organization the costs will be incurred, identifying specific regions where relevant)**

For the remainder of the biennium, a total of US\$ 11.5 million is needed, of which US\$ 6 million is for the regional offices and relevant country offices. In order to fulfil WHO's responsibilities as outlined in the resolution, US\$ 50 million will be required for the biennium 2010–2011 at headquarters and regional offices and in country offices in all countries with a high burden of multidrug-resistant tuberculosis and extensively drug-resistant tuberculosis.

**(c) Of the estimated cost noted in (b), what can be subsumed under existing programmed activities for the biennium 2008–2009?**

Of the total of US\$ 11.5 million, US\$ 5.2 million can be subsumed under existing programmed activities in this biennium.

**(d) For the amount that cannot be subsumed under existing programmed activities, how will the additional costs be financed? (indicate potential sources of funds)**

Additional funding from a range of partners will be sought through active resource mobilization, building on strong existing partnerships, including those with the Global Fund to Fight AIDS, Tuberculosis and Malaria, the International Drug Purchase Facility (UNITAID), and several bilateral agencies and foundations.

**4. Administrative implications**

**(a) Implementation locales (indicate the levels of the Organization at which the work will be undertaken, identifying specific regions where relevant)**

Multidrug-resistant tuberculosis and extensively drug-resistant tuberculosis pose a major threat in all regions; intensifying the response will require action at headquarters, the regional offices and in country offices in at least the 27 countries on which multidrug-resistant tuberculosis and extensively drug-resistant tuberculosis place the heaviest burden.

**(b) Additional staffing requirements (indicate additional required staff – full-time equivalents – by levels of the Organization, identifying specific regions where relevant and noting necessary skills profile)**

Additional positions will need to be established in the regional offices for Africa, the Americas, South-East Asia, the Eastern Mediterranean and the Western Pacific.

**(c) Time frames (indicate broad time frames for implementation)**

The period 2009–2015, with interim annual and biennial reports on progress.

**1. Resolution WHA62.16 Global strategy and plan of action on public health, innovation and intellectual property**

**2. Linkage to programme budget**

Strategic objective:

1. To reduce the health, social and economic burden of communicable diseases.

2. To combat HIV/AIDS, tuberculosis and malaria.

10. To improve health services through better governance, financing, staffing and management, informed by reliable and accessible evidence and research.

Organization-wide expected result:

1.5 New knowledge, intervention tools and strategies that meet priority needs for the prevention and control of communicable diseases developed and validated, with scientists from developing countries increasingly taking the lead in this research.

2.6 New knowledge, intervention tools and strategies developed and validated to meet priority needs for the prevention and control of HIV/AIDS, tuberculosis and malaria, with scientists from developing countries increasingly taking the lead in this research.

10.5 Better knowledge and evidence for health decision-making assured through consolidation and publication of existing evidence, facilitation of knowledge generation in priority areas, and global leadership in health research policy and coordination, including with regard to ethical conduct.

10.6 National health research for development of health systems strengthened in the context of regional and



11. To ensure improved access, quality and use of medical products and technologies.

international research and engagement of civil society.

11.1 Formulation and monitoring of comprehensive national policies on access, quality and use of essential medical products and technologies advocated and supported.

11.2 International norms, standards and guidelines for the quality, safety, efficacy and cost-effective use of medical products and technologies developed and their national and/or regional implementation advocated and supported.

12. To provide leadership, strengthen governance and foster partnership and collaboration with countries, the United Nations system, and other stakeholders in order to fulfil the mandate of WHO in advancing the global health agenda as set out in the Eleventh General Programme of Work.

12.3 Global health and development mechanisms established to provide more sustained and predictable technical and financial resources for health on the basis of a common health agenda which responds to the health needs and priorities of Member States.

**(Briefly indicate the linkage with expected results, indicators, targets, baseline)**

The resolution builds on resolution WHA61.21 and is consistent with the above-mentioned strategic objectives and Organization-wide expected results of the Programme budget 2008–2009 and the Medium-term strategic plan 2008–2013.

### 3. Financial implications

**(a) Total estimated cost for implementation over the life-cycle of the resolution (estimated to the nearest US\$ 10 000, including staff and activities)**

WHO has the role of lead or co-lead stakeholder and implementing entity in almost half the 106 specific actions of the plan of action and is identified as stakeholder/implementing entity in a number of other specific actions. Based on the estimated funding needs outlined in document A62/16 Add.1, the financial and administrative implications of implementing the global strategy and plan of action by WHO (involving the relevant departments at headquarters and regional and country offices) over the envisaged seven-year period (2009–2015) are estimated at US\$ 350 million. It is further estimated that 40% of this amount can be subsumed within existing and future budget.

**(b) Estimated cost for the biennium 2008–2009 (estimated to the nearest US\$ 10 000 including staff and activities, and indicating at which levels of the Organization the costs will be incurred, identifying specific regions where relevant)**

Costs are estimated at US\$ 15 million.

**(c) Of the estimated cost noted in (b), what can be subsumed under existing programmed activities for the biennium 2008–2009? US\$ 7 million.**

**(d) For the amount that cannot be subsumed under existing programmed activities, how will the additional costs be financed? (indicate potential sources of funds)**

Financing will be sought from interested Member States, development partners, charitable foundations and other donors.

### 4. Administrative implications

**(a) Implementation locales (indicate the levels of the Organization at which the work will be undertaken, identifying specific regions where relevant)**

In the biennium 2008–2009, work will be largely performed at headquarters and in the regional offices.

**(b) Additional staffing requirements (indicate additional required staff – full-time equivalents – by levels of the Organization, identifying specific regions where relevant and noting necessary skills profile)**

In order to implement the global strategy, six additional staff in the professional category and four additional staff in the general service category will be required at headquarters. In addition, two additional staff in the professional category and one staff member in the general service category will be required in each regional office.

**(c) Time frames (indicate broad time frames for implementation)**

This report covers implementation of the plan of action in the biennium 2008–2009 and the following three bienniums. The plan of action adopted by the Sixty-second World Health Assembly defines time frames for implementation of the global strategy over the full life-cycle. The global strategy requires a progress report to be submitted to the Health Assembly through the Executive Board every two years, and a comprehensive evaluation of the strategy to be undertaken after four years.

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