



WORLD HEALTH ORGANIZATION

SIXTY-FIFTH WORLD HEALTH ASSEMBLY

GENEVA, 21–26 MAY 2012

**RESOLUTIONS AND DECISIONS
ANNEXES**

GENEVA
2012

ABBREVIATIONS

Abbreviations used in WHO documentation include the following:

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

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-fifth World Health Assembly was held at the Palais des Nations, Geneva, from 21 to 26 May 2012, in accordance with the decision of the Executive Board at its 129th session.

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A65/13	Early marriages, adolescent and young pregnancies
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A65/INF.DOC./2	Health conditions in the occupied Palestinian territory, including east Jerusalem, and in the occupied Syrian Golan (report by the Ministry of Health of the Syrian Arab Republic)
A65/INF.DOC./3	Health conditions in the occupied Palestinian territory, including east Jerusalem, and in the occupied Syrian Golan (report by the Ministry of Health of Israel)
A65/INF.DOC./4	Health conditions in the occupied Palestinian territory, including east Jerusalem, and in the occupied Syrian Golan (report by the Permanent Observer of Palestine to the United Nations and other International Organizations at Geneva)

A65/INF.DOC./5 Health conditions in the occupied Palestinian territory, including east Jerusalem, and in the occupied Syrian Golan (report of the Director of Health, UNRWA, for the year 2011)

A65/INF.DOC./6 WHO reform
High-level implementation and monitoring framework

Diverse documents

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A65/DIV/2 Guide for delegates to the World Health Assembly

A65/DIV/3 Decisions and list of resolutions

A65/DIV/4 List of documents

A65/DIV/5 Address by Her Royal Highness Princess Lalla Salma to the Sixty-fifth World Health Assembly

A65/DIV/6 Address by Mr Jonas Gahr Støre, Foreign Minister of Norway, to the Sixty-fifth World Health Assembly

OFFICERS OF THE HEALTH ASSEMBLY AND MEMBERSHIP OF ITS COMMITTEES

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Professor Thérèse Aya N'DRI-YOMAN
(Côte d'Ivoire)

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Dr Andrei USATHI (Republic of Moldova)
Professor ALI GHUFRON MUKTI
(Indonesia)
Dr Suraya DALIL (Afghanistan)
Mr Charles SIGOTO (Solomon Islands)

Secretary

Dr Margaret CHAN, Director-General

Committee on Credentials

The Committee on Credentials was composed of delegates of the following Member States: Guyana, Kyrgyzstan, Luxembourg, Malawi, Marshall Islands, Mexico, Niger, San Marino, Sao Tome and Principe, Thailand, United Arab Emirates, Viet Nam.

Chairman: Dr TRAN THI GIANG HUONG
(Viet Nam)

Vice-Chairman: Dr Robert GOERENS
(Luxembourg)

Secretary: Ms Françoise MOURAIN-SCHUT
(Senior Legal Officer)

General Committee

The General Committee was composed of the President and Vice-Presidents of the Health Assembly and the Chairmen of the main committees, together with delegates of the following Member States: Bahamas, Cambodia, Chad, China, Cuba, Denmark,

Djibouti, France, Kenya, Lesotho, Liberia, Mauritania, Nicaragua, Russian Federation, Turkmenistan, United Kingdom of Great Britain and Northern Ireland, United States of America.

Chairman: Professor Thérèse Aya N'DRI-YOMAN (Côte d'Ivoire)

Secretary: Dr Margaret 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 Lyonpo Zangley DUKPA
(Bhutan)

Vice-Chairmen: Dr Fenton FERGUSON
(Jamaica) and Mr Herbert BARNARD
(Netherlands)

Rapporteur: Dr Mohamed JIDDAWI (United Republic of Tanzania)

Secretary: Dr Manuel DAYRIT, Adviser,
Office of the Director-General

Committee B

Chairman: Professor Mohammad Hossein NICKNAM (Islamic Republic of Iran)

Vice-Chairmen: Professor Charles Kondi AGBA (Togo) and Dr Enrique TAYAG
(Philippines)

Rapporteur: Dr Paul GULLY (Canada)

Secretary: Dr Clive ONDARI, Coordinator,
Medicines Access and Rational Use

RESOLUTIONS AND DECISIONS

RESOLUTIONS

WHA65.1 Appointment of the Director-General

The Sixty-fifth World Health Assembly,

On the nomination of the Executive Board,

APPOINTS Dr Margaret Chan as Director-General of the World Health Organization.

(Seventh plenary meeting, 23 May 2012)

WHA65.2 Contract of the Director-General

The Sixty-fifth World Health Assembly,

I

Pursuant to Article 31 of the Constitution and Rule 107 of the Rules of Procedure of the World Health Assembly,

APPROVES the contract establishing the terms and conditions of appointment, salary and other emoluments for the post of Director-General;¹

II

Pursuant to Rule 110 of the Rules of Procedure of the World Health Assembly,

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

(Seventh plenary meeting, 23 May 2012)

WHA65.3 Strengthening noncommunicable disease policies to promote active ageing²

The Sixty-fifth World Health Assembly,

Having considered the reports on the outcomes of the High-level Meeting of the United Nations General Assembly on the Prevention and Control of Non-communicable Diseases and the First Global Ministerial Conference on Healthy Lifestyles and Noncommunicable Disease Control³ and the report

¹ See Annex 1.

² See Annex 5 for the financial and administrative implications for the Secretariat of this resolution.

³ Documents A65/6 and A65/6 Add.1.

on the implementation of the global strategy for the prevention and control of noncommunicable diseases and the action plan;¹

Recalling the Political Declaration of the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases, the Moscow Declaration adopted at the First Global Ministerial Conference on Healthy Lifestyles and Noncommunicable Disease Control (Moscow, 28 and 29 April 2011), and resolution WHA64.11 on preparations for the High-level Meeting of the United Nations General Assembly on the Prevention and Control of Non-communicable Diseases, following on the Moscow Conference;

Recalling also the Millennium Development Goals (MDGs) Follow-up Meeting (Tokyo, 2 and 3 June 2011), with the participation of more than 110 countries, and some 20 United Nations or regional organizations and civil society organizations, at which it was agreed that noncommunicable diseases are emerging global challenges for the post-2015 era that also threaten the achievement of the internationally agreed development goals including the Millennium Development Goals;

Noting that an estimated 36 million of the 57 million deaths in the world in 2008 were due to noncommunicable diseases, such as cardiovascular diseases, cancers, chronic respiratory diseases and diabetes, which are largely caused by four common risk factors, namely, tobacco use, harmful use of alcohol, unhealthy diet, and lack of physical activity, and that nearly 80% of those deaths occurred in developing countries;

Noting also that as noncommunicable diseases become more prevalent among older persons, there is an urgent need to prevent noncommunicable disease-related disabilities and to plan for long-term care;

Noting further, with profound concern, that ageing is among the major contributory factors to the rising incidence and prevalence of noncommunicable diseases, which are leading causes of preventable morbidity and disability;

Noting in addition that the ageing population would require access to affordable medicines in order to enhance healthy ageing;

Noting also the demographic change, with the world's population aged 60 years or more increasing at more than three times the overall population growth rate and being expected to rise to about 1200 million in 2025; the ageing of populations that has public health and economic implications, including rising rates of noncommunicable diseases; and the importance of lifelong health-promotion and disease-prevention activities that can prevent or delay, for example, the onset and severity of noncommunicable diseases and promote healthy ageing;

Recalling resolutions WHA52.7 and WHA58.16 on active ageing that, inter alia, urged Member States to take measures that ensure the highest attainable standard of health and well-being for the rapidly growing numbers of older persons in both developed and developing countries;

Recalling further United Nations General Assembly resolution 57/167, which endorsed the Political Declaration of the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases and the Madrid International Plan of Action on Ageing, 2002, as well as other relevant resolutions on ageing;

¹ Document A65/8.

Noting that the Political Declaration of the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases recognizes that mental and neurological disorders, including Alzheimer's disease, are an important cause of morbidity and contribute to the global burden of noncommunicable diseases, and therefore it is necessary to provide equitable access to effective health programmes and interventions, including for the whole population, from an early age;

Recognizing the importance of gender-based approaches, solidarity and mutual support for social development, of the realization of the human rights of older persons, of promoting quality of life, health equity and the prevention of age discrimination, and of promoting social integration of aged citizens;

Acknowledging the Rio Political Declaration on Social Determinants of Health, which expressed the determination to achieve social and health equity through actions on the social determinants of health and well-being with a comprehensive intersectoral approach;

Noting the WHO Framework Convention on Tobacco Control and related WHO strategies and action plans, underscoring the importance of addressing common risk factors for noncommunicable diseases;

Welcoming WHO's focus on prevention and control of noncommunicable diseases through public health action, a primary health care approach and comprehensive health system strengthening,

1. URGES Member States:¹

(1) to develop, implement, monitor and evaluate policies, programmes and multisectoral action on noncommunicable disease prevention and health promotion in order to strengthen healthy ageing policies and programmes and promote the highest standard of health and well-being for older persons;

(2) to strengthen intersectoral policy frameworks and institutional mechanisms, as appropriate, for integrated management of prevention and control of noncommunicable diseases, including health promotion, health care and social welfare services, in order to address the needs of older persons;

(3) to ensure, where appropriate, that national health strategies on noncommunicable diseases contribute to the achievement of the Millennium Development Goals;

(4) to promote, as appropriate, conditions that enable individuals, carers, families and communities to encourage healthy ageing, including care for, provision of support to and protection of older persons, taking into account physical and psychological aspects of ageing, and to focus on intergenerational approaches;

(5) to encourage the active participation of older people in society and in their local community;

(6) to strengthen cooperation and partnership among Member States¹ at all levels of government, among stakeholders, academia, research foundations, the private sector and civil society, in order to implement plans and programmes effectively;

¹ And, where applicable, regional economic integration organizations.

(7) to highlight the importance of a primary health care approach in national health-care planning, in close collaboration with social services, and of enabling integration of health promotion as well as prevention and control of noncommunicable diseases into ageing policies;

(8) to encourage making available measures and resources to provide health promotion, health care and social protection for healthy and active ageing, paying special attention to access to affordable medicines and the importance of training, education and capacity building of the health workforce in collaboration with WHO and partners;

(9) to strengthen further monitoring and evaluation systems for generating and analysing data on noncommunicable diseases that are disaggregated by age, sex and socioeconomic status, with the aim of developing equitable, evidence-based policies and planning for older persons;

2. REQUESTS the Director-General:

(1) to provide support to Member States in promoting and facilitating further implementation of commitments made at relevant United Nations conferences and summits on noncommunicable diseases and ageing;

(2) to provide support to Member States in placing emphasis on health promotion and disease prevention throughout the life-course starting at the earliest stage possible, including multisectoral approaches to healthy ageing, integrated care for older persons and support for providers of formal and informal welfare services;

(3) to support Member States in developing policies and programmes for access to affordable medicines for the ageing;

(4) to provide further support to Member States in raising awareness of healthy and active ageing and of the positive aspects of ageing by means that include ageing-specific policies and the mainstreaming of ageing in their national strategies;

(5) to support the advancement of country-level systems for monitoring noncommunicable diseases, as appropriate, and to continue to develop a comprehensive global monitoring system for prevention and control of noncommunicable diseases in order to track trends and monitor progress in implementation of the Political Declaration of the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases;

(6) to raise the priority given to prevention and control of noncommunicable diseases on the agendas of relevant forums and meetings of national and international leaders in advance of a post-2015 global development agenda;

(7) to consider making the focus of *The world health report 2014* the global status of ageing, recognizing the importance of strengthening information systems through the inclusion of older adults in the collection, analysis and dissemination of data and information on health status and risk factors;

(8) to report to the Sixty-sixth World Health Assembly, through the Executive Board, on progress made in implementing this resolution.

(Ninth plenary meeting, 25 May 2012 –
Committee A, first report)

WHA65.4 The global burden of mental disorders and the need for a comprehensive, coordinated response from health and social sectors at the country level¹

The Sixty-fifth World Health Assembly,

Having considered the report on the global burden of mental disorders and the need for a comprehensive, coordinated response from health and social sectors at the country level;²

Recalling resolution WHA55.10, which, inter alia, urged Member States to increase investments in mental health, both within countries and in bilateral and multilateral cooperation, as an integral component of the well-being of populations;

Recalling further United Nations General Assembly resolution 65/95, which recognized that mental health problems are of major importance to all societies and are significant contributors to the burden of disease and the loss of quality of life, and have huge economic and social costs, and which also welcomed the WHO report on mental health and development that highlighted the lack of appropriate attention to mental health and made the case for governments and development actors to reach out to people with mental disorders in the design of strategies and programmes that include those people in education, employment, health, social protection and poverty reduction policies;

Noting the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases (New York, 19 and 20 September 2011), at which it was recognized that mental and neurological disorders, including Alzheimer's disease, are an important cause of morbidity and contribute to the global noncommunicable disease burden, necessitating provision of equitable access to effective programmes and health-care interventions;

Recognizing that mental disorders can lead to disabilities, as reflected in the United Nations Convention on the Rights of Persons with Disabilities, which also notes that disability results from the interaction between persons with impairments and attitudinal and environmental barriers that hinder their full and effective participation in society on an equal basis with others, and that the *World report on disability 2011* charts the steps that are required to improve the participation and inclusion of people with disabilities, including those with mental disabilities;

Recognizing also that mental disorders fall within a wider spectrum that includes neurological and substance-use disorders, which also cause substantial disability and require a coordinated response from health and social sectors;

Concerned that millions of people worldwide are affected by mental disorders, and that in 2004, mental disorders accounted for 13% of the global burden of disease, defined as premature death combined with years lived with disability, and also that, when taking into consideration only the disability component of the burden of disease calculation, mental disorders accounted for 25.3% and 33.5% of all years lived with a disability in low- and middle-income countries, respectively;

Concerned also that exposure to humanitarian emergencies is a potent risk factor for mental health problems and psychological trauma, and that social structures and ongoing formal and informal care of persons with severe, pre-existing, mental disorders are disrupted;

¹ See Annex 5 for the financial and administrative implications for the Secretariat of this resolution.

² Document A65/10.

Recognizing further that the treatment gap for mental disorders is large all over the world, that between 76% and 85% of people with severe mental disorders in low- and middle-income countries receive no treatment for their mental health conditions, and that the corresponding figures for high-income countries, although lower – between 35% and 50% – are also high;

Recognizing in addition that a number of mental disorders can be prevented and that mental health can be promoted in the health sector and in sectors outside health;

Concerned that persons with mental disorders are often stigmatized, and underlining the need for health authorities to work with relevant groups to change attitudes to mental disorders;

Noting also that there is increasing evidence on the effectiveness and cost-effectiveness of interventions to promote mental health and prevent mental disorders, particularly in children and adolescents;

Noting further that mental disorders are often associated with noncommunicable diseases and a range of other priority health issues, including HIV/AIDS, maternal and child health, and violence and injuries, and that mental disorders often coexist with other medical and social factors, such as poverty, substance abuse and the harmful use of alcohol, and, in the case of women and children, greater exposure to domestic violence and abuse;

Recognizing that certain populations live in a situation that makes them particularly vulnerable to developing mental disorders, and the consequences thereof;

Recognizing also that the social and economic impact of mental disorders, including mental disabilities, is diverse and far-reaching;

Taking into account the work already carried out by WHO on mental health, particularly through its Mental Health Gap Action Programme,

1. URGES Member States:

(1) according to national priorities and within their specific contexts, to develop and strengthen comprehensive policies and strategies that address the promotion of mental health, prevention of mental disorders, and early identification, care, support, treatment and recovery of persons with mental disorders;

(2) to include in policy and strategy development the need to promote human rights, tackle stigmatization, empower service users, families and communities, address poverty and homelessness, tackle major modifiable risks, and as appropriate, promote public awareness, create opportunities for generating income, provide housing and education, provide health care services and community-based interventions, including de-institutionalized care;

(3) to develop, as appropriate, surveillance frameworks that include risk factors as well as social determinants of health to analyse and evaluate trends regarding mental disorders;

(4) to give appropriate priority to and to streamline mental health, including the promotion of mental health, the prevention of mental disorders, and the provision of care, support and treatment in programmes addressing health and development, and to allocate appropriate resources in this regard;

(5) to collaborate with the Secretariat in the development of a comprehensive mental health action plan;

2. REQUESTS the Director-General:

(1) to strengthen advocacy, and develop a comprehensive mental health action plan with measurable outcomes, based on an assessment of vulnerabilities and risks, in consultation with and for consideration by Member States, covering services, policies, legislation, plans, strategies and programmes to provide treatment, facilitate recovery and prevent mental disorders, promote mental health and empower persons with mental disorders to live a full and productive life in the community;

(2) to include, in the comprehensive mental health action plan, provisions to address:

(a) assessment of vulnerabilities and risks as a basis for developing the mental health action plan;

(b) protection, promotion and respect for the rights of persons with mental disorders including the need to tackle stigmatization of persons with mental disorders;

(c) equitable access to affordable, quality and comprehensive health services that integrate mental health into all levels of the health care system;

(d) development of competent, sensitive, adequate human resources to provide mental health services equitably;

(e) promotion of equitable access to quality health care including psychosocial interventions and medication and addressing physical health care needs;

(f) enhancement of initiatives, including in policy, to promote mental health and prevent mental disorders;

(g) access to educational and social services, including health care, schooling, housing, secure employment and participation in income-generation programmes;

(h) involvement of civil society organizations, persons with mental disorders, families and caregivers in voicing their opinions and contributing to decision-making processes;

(i) design and provision of mental health and psychosocial support systems that will enable community resilience and will help people to cope during humanitarian emergencies;

(j) participation of people with mental disorders in family and community life and civic affairs;

(k) design of mechanisms to involve the education, employment and other relevant sectors in Member States in the implementation of the mental health action plan;

(l) building upon the work already done and avoidance of duplication of action;

- (3) to collaborate with Member States and, as appropriate, with international, regional and national nongovernmental organizations, international development partners and technical agency partners in the development of the mental health action plan;
- (4) to work with Member States and technical agencies to promote academic exchange, through which to contribute to policy-making in mental health;
- (5) to submit the comprehensive mental health action plan, through the Executive Board at its 132nd session, for consideration by the Sixty-sixth World Health Assembly.

(Ninth plenary meeting, 25 May 2012 –
Committee A, first report)

WHA65.5 Poliomyelitis: intensification of the global eradication initiative¹

The Sixty-fifth World Health Assembly,

Having considered the report on poliomyelitis: intensification of the global eradication initiative,²

Recalling resolution WHA61.1 on poliomyelitis: mechanism for management of potential risks to eradication, which requested the Director-General, *inter alia*, to develop a new strategy to reinvigorate the fight to eradicate poliomyelitis from the remaining affected countries and to develop appropriate strategies and products for managing the long-term risks of reintroduction of poliovirus and re-emergence of poliomyelitis, including the eventual cessation of use of oral poliovirus vaccine in routine immunization programmes;

Recognizing the need to make rapidly available the necessary financial resources to eradicate the remaining circulating polioviruses and to minimize the risks of reintroduction of poliovirus and re-emergence of poliomyelitis after interruption of wild poliovirus transmission;

Noting the finding of the Independent Monitoring Board of the Global Polio Eradication Initiative in its report of October 2011 that “polio simply will not be eradicated unless it receives a higher priority – in many of the polio-affected countries, and across the world”³ and its recommendation in its April 2011 report that the World Health Assembly “considers a resolution to declare the persistence of polio a global health emergency”;

Noting the report of the meeting in November 2011 of the Strategic Advisory Group of Experts on immunization at which it stated unequivocally that the risk of failure to finish global polio eradication constitutes a programmatic emergency of global proportions for public health and is not acceptable under any circumstances;³

Recognizing the need for Member States to engage all levels of political and civil society so as to ensure that all children are vaccinated in order to eradicate poliomyelitis;

¹ See Annex 5 for the financial and administrative implications for the Secretariat of this resolution.

² Document A65/20.

³ Polio eradication. *Weekly epidemiological record*, 2012, **87**(1):1–16.

Having noted the current high cost and limited supplies of inactivated poliovirus vaccine that are hampering the introduction and scaling-up of inactivated poliovirus vaccine, resulting in major programmatic and financial implications to developing countries;

Noting that the technical feasibility of poliovirus eradication has been proved through the full application of new strategic approaches;

Noting that continuing poliovirus transmission anywhere will continue to pose a risk to poliomyelitis-free areas until such time as all poliovirus transmission is interrupted globally,

1. DECLARES the completion of poliovirus eradication a programmatic emergency for global public health, requiring the full implementation of current and new eradication strategies, the institution of strong national oversight and accountability mechanisms for all areas affected by poliovirus, and the application of appropriate vaccination recommendations for all travellers to and from areas affected with poliovirus;¹

2. URGES Member States with poliovirus transmission to declare such transmission to be a “national public health emergency” making poliovirus eradication a national priority programme, requiring the development and full implementation of emergency action plans that are updated every six months, until such time as poliovirus transmission has been interrupted;

3. URGES all Member States:

(1) to eliminate the unimmunized areas and to maintain very high population immunity against polioviruses through routine immunization programmes and, where necessary, supplementary immunization activities;

(2) to maintain vigilance for poliovirus importations, and the emergence of circulating vaccine-derived polioviruses, by achieving and sustaining certification-standard surveillance and regular risk assessment for polioviruses;

(3) to make available urgently the financial resources required for the full and continued implementation, to the end of 2013, of the necessary strategic approaches to interrupt wild poliovirus transmission globally, and to initiate planning for the financing to the end of 2018 of the polio endgame strategy;

(4) to engage in multilateral and bilateral cooperation, including exchanging epidemiological information, laboratory monitoring data, and carrying out supplementary immunization activities simultaneously as appropriate;

4. REQUESTS the Director-General:

(1) to plan for the renewed implementation through 2013 of the approaches to eradicating wild polioviruses outlined in the Global Polio Eradication Initiative Strategic Plan 2010–2012 and any new tactics that are deemed necessary to complete eradication, including the enhancement of the existing eradication initiative within the Organization;

(2) to strengthen accountability and monitoring mechanisms to ensure optimal implementation of eradication strategies at all levels;

¹ *International travel and health*. Geneva, World Health Organization, 2012 edition.

- (3) to undertake the development, scientific vetting, and rapid finalization of a comprehensive polio eradication and endgame strategy, and inform Member States of the potential timing of a switch from trivalent to bivalent oral poliovirus vaccine for all routine immunization programmes; and include budget scenarios to the end of 2018 that include risk management;
- (4) to coordinate with all relevant partners, including vaccine manufacturers, to promote the research, production and supply of vaccines, in particular inactivated poliovirus vaccines, in order to enhance their affordability, effectiveness and accessibility;
- (5) to continue mobilizing and deploying the necessary financial and human resources for the strategic approaches required through 2013 for wild poliovirus eradication, and for the eventual implementation of a polio eradication and endgame strategy to the end of 2018;
- (6) to report to the Sixty-sixth World Health Assembly and the subsequent two Health Assemblies, through the Executive Board, on progress in implementing this resolution.

(Tenth plenary meeting, 26 May 2012 –
Committee A, third report)

WHA65.6 Comprehensive implementation plan on maternal, infant and young child nutrition¹

The Sixty-fifth World Health Assembly,

Having considered the report on maternal, infant and young child nutrition: draft comprehensive implementation plan,²

1. ENDORSES the comprehensive implementation plan on maternal, infant and young child nutrition;³
2. URGES Member States,⁴ to put into practice, as appropriate, the comprehensive implementation plan on maternal, infant and young child nutrition, including:
 - (1) developing or, where necessary, strengthening nutrition policies so that they comprehensively address the double burden of malnutrition and include nutrition actions in overall country health and development policy, and establishing effective intersectoral governance mechanisms in order to expand the implementation of nutrition actions with particular emphasis on the framework of the global strategy on infant and young child feeding;
 - (2) developing or, where necessary, strengthening legislative, regulatory and/or other effective measures to control the marketing of breast-milk substitutes;

¹ See Annex 5 for the financial and administrative implications for the Secretariat of this resolution.

² Document A65/11.

³ Annex 2.

⁴ And, where applicable, regional economic integration organizations.

(3) establishing a dialogue with relevant national and international parties and forming alliances and partnerships to expand nutrition actions with the establishment of adequate mechanisms to safeguard against potential conflicts of interest;

(4) implementing a comprehensive approach to capacity building, including workforce development;

3. REQUESTS the Director-General:

(1) to provide clarification and guidance on the inappropriate promotion of foods for infants and young children cited in resolution WHA63.23, taking into consideration the ongoing work of the Codex Alimentarius Commission;

(2) to support Member States in the monitoring and evaluation of policies and programmes, including those of the global strategy for infant and young child feeding, with the latest evidence on nutrition;

(3) to develop risk assessment, disclosure and management tools to safeguard against possible conflicts of interest in policy development and implementation of nutrition programmes consistent with WHO's overall policy and practice;

(4) to report, through the Executive Board, to the Sixty-seventh World Health Assembly on progress in the implementation of the comprehensive implementation plan, together with the report on implementation of the International Code of Marketing of Breast-milk Substitutes and related Health Assembly resolutions.

(Tenth plenary meeting, 26 May 2012 –
Committee A, third report)

**WHA65.7 Implementation of the recommendations of the Commission on
Information and Accountability for Women's and Children's Health¹**

The Sixty-fifth World Health Assembly,

Having considered the report on implementation of the recommendations of the Commission on Information and Accountability for Women's and Children's Health,²

Recalling resolutions WHA63.15 on monitoring of the achievement of the health-related Millennium Development Goals and WHA64.12 on WHO's role in the follow-up to the United Nations High-level Plenary Meeting of the General Assembly on the Millennium Development Goals (New York, September 2010);

Expressing deep concern at the inadequate progress in achieving Millennium Development Goals 4 and 5 on reducing child mortality and on improving maternal health, respectively;

¹ See Annex 5 for the financial and administrative implications for the Secretariat of this resolution.

² Document A65/15.

Acknowledging that much more needs to be done in achieving the Millennium Development Goals as progress has been uneven among regions and between and within countries, despite the fact that developing countries have made significant efforts;

Acknowledging the pledges and commitments made by a large number of Member States and partners to the United Nations Secretary-General's Global Strategy for Women's and Children's Health since it was launched in September 2010;

Welcoming the final report of the Commission on Information and Accountability for Women's and Children's Health and its set of bold recommendations for strengthening accountability for resources and results in women's and children's health;

Commending the work and contributions of the Commission on Information and Accountability for Women's and Children's Health, including in particular the development of an accountability framework built on three interconnected processes – monitoring, reviewing and acting;

Noting that the key recommendations relate to strengthening national accountability processes both with regard to resources as well as monitoring of results;

Welcoming the steps taken to implement the recommendations of the Commission on Information and Accountability for Women's and Children's Health, including the development of a multistakeholder workplan for the implementation of the accountability framework;

Welcoming the establishment of a global review mechanism that will report annually to the United Nations Secretary-General;

Reaffirming WHO's key role in the implementation and follow-up of the recommendations of the Commission on Information and Accountability for Women's and Children's Health and acknowledging the crucial role of the Director-General in particular,

1. URGES Member States to honour their commitments to the United Nations Secretary-General's Global Strategy for Women's and Children's Health and to further strengthen efforts to improve women's and children's health;

2. ALSO URGES Member States to implement the recommendations provided by the Commission on Information and Accountability for Women's and Children's Health to improve the accountability of results and resources by:

- (1) strengthening the accountability mechanisms for health in their own countries;
- (2) strengthening their capacity to monitor, including utilizing local evidence, and evaluate progress to improve their own performance;
- (3) contributing to the strengthening and harmonization of existing international mechanisms to track progress on all commitments made;

3. REQUESTS the Director-General:

- (1) to work with and provide support to Member States in implementing the full scope of the recommendations;

- (2) to ensure WHO's effective engagement in collaboration with all stakeholders in the workplan to implement the recommendations of the Commission on Information and Accountability for Women's and Children's Health;
- (3) to provide support to the independent Expert Review Group in its work of assessing progress in the United Nations Secretary-General's Global Strategy for Women's and Children's Health and implementation of the accountability framework;
- (4) to report annually until 2015 to the World Health Assembly through the Executive Board on progress achieved in the follow-up of the recommendations of the Commission on Information and Accountability for Women's and Children's Health in connection with the agenda item concerning the Millennium Development Goals.

(Tenth plenary meeting, 26 May 2012 –
Committee A, third report)

WHA65.8 Outcome of the World Conference on Social Determinants of Health¹

The Sixty-fifth World Health Assembly,

Having considered the report on social determinants of health: outcome of the World Conference on Social Determinants of Health (Rio de Janeiro, Brazil, October 2011),²

Reiterating the determination to take action on social determinants of health as collectively agreed by the World Health Assembly and reflected in resolution WHA62.14 on reducing health inequities through action on the social determinants of health, which notes 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;

Recognizing the need to do more to accelerate progress in addressing the unequal distribution of health resources as well as conditions damaging to health at all levels;

Recognizing also the need to safeguard the health of populations regardless of global economic downturns;

Further acknowledging that health equity is a shared goal and responsibility and requires the engagement of all sectors of government, all segments of society, and all members of the international community, in "all-for-equity" and "health-for-all" global actions;

Recognizing the benefits of universal health coverage in enhancing health equity and reducing impoverishment;

Reaffirming the political will to make health equity a national, regional and global goal and to address current challenges, such as: eradicating hunger and poverty; ensuring food and nutritional security; access to affordable, safe, efficacious and quality medicines as well as to safe drinking-water and sanitation, employment and decent work and social protection; protecting environments; and

¹ See Annex 5 for the financial and administrative implications for the Secretariat of this resolution.

² Document A65/16.

delivering equitable economic growth through resolute action on social determinants of health across all sectors and at all levels;

Welcoming the discussions and results of the World Conference on Social Determinants of Health (Rio de Janeiro, Brazil, 19–21 October 2011),

1. ENDORSES the Rio Political Declaration on Social Determinants of Health adopted by the World Conference on Social Determinants of Health,¹ including as a key input to the work of Member States² and the WHO Secretariat;

2. URGES Member States:²

(1) to implement the pledges made in the Rio Political Declaration on Social Determinants of Health with regard to (i) better governance for health and development, (ii) promoting participation in policy-making and implementation, (iii) further reorienting the health sector towards reducing health inequities, (iv) strengthening global governance and collaboration, and (v) monitoring progress and increasing accountability;

(2) to develop and support policies, strategies, programmes and action plans that address social determinants of health, with clearly defined goals, activities and accountability mechanisms and with resources for their implementation;

(3) to support the further development of the “health-in-all-policies” approach as a way to promote health equity;

(4) to build capacities among policy-makers, managers and programme workers in health and other sectors to facilitate work on social determinants of health;

(5) to give due consideration to social determinants of health as part of the deliberations on sustainable development, in particular in the Rio+20 United Nations Conference on Sustainable Development and deliberations in other United Nations forums with relevance to health;

3. CALLS UPON the international community to support the implementation of the pledges made in the Rio Political Declaration on Social Determinants of Health for action on social determinants of health, including through:

(1) supporting the leading role of WHO in global health governance and promoting alignment of policies, plans and activities on social determinants of health with those of its partner organizations in the United Nations system, development banks and other key international organizations, including in joint advocacy, and in facilitating access to the provision of financial and technical support to countries and regions, in particular developing countries;

(2) strengthening international cooperation, with a view to promoting health equity in all countries, through facilitating transfer on mutually agreed terms of expertise, technologies and scientific data in the field of social determinants of health, as well as exchanging good practices for managing intersectoral policy development;

¹ See document EB130/2012/REC/1, Annex 3.

² And, where applicable, regional economic integration organizations.

- (3) facilitating access to financial resources;
4. URGES those developed countries that have pledged to achieve the target of 0.7% of gross national product for official development assistance by 2015, and those developed countries that have not yet done so, to make additional concrete efforts to fulfil their commitments in this regard, and also urges developing countries to build on progress achieved in ensuring that official development assistance is used effectively to help to achieve development goals and targets;
5. REQUESTS the Director-General:
- (1) to give due consideration to social determinants of health in the assessment of global needs for health, including in the WHO reform process and WHO's future work;
 - (2) to provide support to Member States in implementing the Rio Political Declaration on Social Determinants of Health through approaches such as "health-in-all policies" in order to address social determinants of health;
 - (3) to work closely with other organizations in the United Nations system on advocacy, research, capacity building and provision of direct technical support to Member States for work on social determinants of health;
 - (4) to continue to convey and advocate the importance of integrating social determinants of health perspectives into forthcoming United Nations and other high-level meetings related to health and/or social development;
 - (5) to report to the Sixty-sixth and Sixty-eighth World Health Assemblies, through the Executive Board, on progress in implementing this resolution and the Rio Political Declaration on Social Determinants of Health.

(Tenth plenary meeting, 26 May 2012 –
Committee A, third report)

WHA65.9 Health conditions in the occupied Palestinian territory, including east Jerusalem, and in the occupied Syrian Golan¹

The Sixty-fifth 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 Palestinian territory and other occupied Arab territories;

Taking note of the report of the Secretariat on the health conditions in the occupied Palestinian territory, including east Jerusalem, and in the occupied Syrian Golan;²

¹ See Annex 5 for the financial and administrative implications for the Secretariat of this resolution.

² Document A65/27 Rev.1.

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;

Affirming the need to guarantee universal coverage of health services and to preserve 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, medical staff and ambulances to have access to the Palestinian health institutions in occupied east Jerusalem;

Affirming that the blockade is continuing and that the crossing points are not entirely and definitely opened, meaning that the crisis and suffering that started before the Israeli attack on the Gaza Strip are continuing, hindering the efforts of the Ministry of Health of the Palestinian Authority to reconstruct the establishments destroyed by the Israeli military operations by the end of 2008 and in 2009;

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

1. DEMANDS that Israel, the occupying power:

- (1) immediately put an end to the closure of the occupied Palestinian territory, particularly the closure of the crossing points of the occupied Gaza Strip that is causing the serious shortage of medicines and medical supplies therein;
- (2) abandon 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 for 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, medical staff and ambulances to the Palestinian health institutions in occupied east Jerusalem and abroad;
- (5) improve the living and medical conditions of Palestinian detainees, particularly children, women and patients, and provide the detainees, who are suffering from serious medical conditions that are worsening every day, with the necessary medical treatment, and facilitate the transit and entry of medicine and medical equipment to the occupied Palestinian territory;
- (6) respect and facilitate the mandate and work of UNRWA and other international organizations, and ensure the free movement of their staff and aid supplies;

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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 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;¹
 - (3) to call upon the international community to exert pressure on the Government of Israel to lift the siege imposed on the occupied Gaza Strip in order to avoid a serious exacerbation of the humanitarian crisis therein and to help lift the restrictions and obstacles imposed on the Palestinian people, including the free movement of people and medical staff in the occupied Palestinian territory, and to bring Israel to respect its legal and moral responsibilities and ensure the full enjoyment of basic human rights for civilian populations in the occupied Palestinian territory, particularly in east Jerusalem;
 - (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, that is applicable to the occupied Palestinian territory including east Jerusalem;
 - (5) to call upon all international human rights organizations to intervene on an urgent and immediate basis vis-à-vis the occupying power, Israel, and compel it to provide adequate medical treatment to Palestinian prisoners and detainees who are suffering from serious medical conditions that are worsening every day, and urge civil society organizations to exercise pressure on the occupying power, Israel, to save the lives of detainees and ensure the immediate release of critical cases and to provide them with external treatment, and to allow Palestinian women prisoners to receive maternity care services and medical follow-up during pregnancy, delivery and postpartum care, and to allow them to give birth in healthy and humanitarian conditions in the presence of their relatives and family members, and immediately to release all children detained in Israeli prisons;
 - (6) to support and assist the Palestinian Ministry of Health in carrying out its duties, including running and financing public health services;
 - (7) to provide financial and technical support to the Palestinian public health and veterinary services;
3. EXPRESSES deep appreciation to the international donor community for its support of the Palestinian people in different fields, and urges donor countries and international health organizations to continue their efforts to ensure the provision of necessary political and financial support to enable the implementation of the 2008–2010 health plan of the Palestinian Authority and to create a suitable political environment to implement the plan with a view to putting an end to the occupation and establishing the state of Palestine as proposed by the Government of Palestine, which is working seriously to create the proper conditions for its implementation;
4. EXPRESSES its deep appreciation to the Director-General for her 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;

¹ Document A62/24 Add.1.

5. REQUESTS the Director-General:

- (1) to provide support to the Palestinian health and veterinary services, including capacity building;
- (2) to support the establishment of medical facilities and provide health-related technical assistance to the Syrian population in the occupied Syrian Golan;
- (3) to continue providing the necessary technical assistance in order to meet the health needs of the Palestinian people, including the handicapped and injured;
- (4) to also provide support to the Palestinian health and veterinary services in preparing for unusual emergencies;
- (5) to support the development of the health system in the occupied Palestinian territory, including development of human resources;
- (6) to report on implementation of this resolution to the Sixty-sixth World Health Assembly.

(Tenth plenary meeting, 26 May 2012 –
Committee B, first report)

**WHA65.10 Financial report and audited financial statements for the period
1 January 2010–31 December 2011**

The Sixty-fifth World Health Assembly,

Having examined the Financial report and audited financial statements for the period 1 January 2010–31 December 2011;¹

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

ACCEPTS the Director-General's Financial report and audited financial statements for the period 1 January 2010–31 December 2011.

(Tenth plenary meeting, 26 May 2012 –
Committee B, first report)

¹ Document A65/29.

² Document A65/45.

WHA65.11 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-fifth World Health Assembly,

Having considered the reports on the status of collection of assessed contributions,¹ including Member States in arrears in the payment of their contributions to an extent that would justify invoking Article 7 of the Constitution;²

Noting that, at the time of the opening of the Sixty-fifth World Health Assembly, the voting rights of Central African Republic, Comoros, Guinea-Bissau, Somalia and Tajikistan were suspended with 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 Afghanistan, Bangladesh, Gambia, Grenada, Micronesia (Federated States of), Saint Lucia, Sudan and the former Yugoslav Republic of Macedonia were in arrears at the time of the opening of the Sixty-fifth World Health Assembly to such an extent that it was necessary for the Health Assembly to consider, in accordance with Article 7 of the Constitution, whether or not the voting privileges of those countries should be suspended, for Afghanistan and Grenada at the opening of the Sixty-fifth World Health Assembly, and for the remaining Member States at the opening of the Sixty-sixth 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-sixth World Health Assembly, Bangladesh, Gambia, Micronesia (Federated States of), Saint Lucia, Sudan and the former Yugoslav Republic of Macedonia are still in arrears in the payment of their contributions to an extent that would justify invoking Article 7 of the Constitution, their voting privileges shall be suspended as from the said opening; and in accordance with resolutions WHA59.6 and WHA64.19 if, by the time of the opening of the Sixty-fifth World Health Assembly, Afghanistan and Grenada, respectively, are still in arrears in the payment of their rescheduled assessments, their voting privileges shall be suspended automatically;
- (2) that any suspension that takes effect as set out in subparagraph (1) above shall continue at the Sixty-seventh World Health Assembly and subsequent Health Assemblies, until the arrears of Afghanistan, Bangladesh, Gambia, Grenada, Micronesia (Federated States of), Saint Lucia, Sudan and the former Yugoslav Republic of Macedonia 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.

(Tenth plenary meeting, 26 May 2012 –
Committee B, first report)

¹ Documents A65/30 and A65/46.

² Document A65/30.

WHA65.12 Special arrangements for settlement of arrears: former Yugoslavia

The Sixty-fifth World Health Assembly,

Having considered that the outstanding arrears of the former Yugoslavia from 1991 to 2000 amounting to US\$ 5 532 592 have already been fully provided for and noting the United Nations General Assembly resolution 63/249 concerning unpaid assessed contributions of the former Yugoslavia,¹

DECIDES, in accordance with Financial Regulation 13.6, to approve the write-off of the unpaid arrears from the former Yugoslavia from 1991 to 2000 of US\$ 5 532 592.

(Tenth plenary meeting, 26 May 2012 –
Committee B, first report)

WHA65.13 Report of the External Auditor

The Sixty-fifth World Health Assembly,

Having considered the report of the External Auditor to the Health Assembly;²

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

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

(Tenth plenary meeting, 26 May 2012 –
Committee B, first report)

WHA65.14 Salaries of staff in ungraded posts and of the Director-General

The Sixty-fifth World Health Assembly,

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

1. ESTABLISHES the salaries of Assistant Directors-General and Regional Directors at US\$ 172 071 gross per annum before staff assessment, resulting in a modified net salary of US\$ 133 950 (dependency rate) or US\$ 121 297 (single rate);
2. ESTABLISHES the salary of the Deputy Director-General at US\$ 189 349 gross per annum before staff assessment, resulting in a modified net salary of US\$ 146 044 (dependency rate) or US\$ 131 432 (single rate);

¹ See documents A65/30 and A65/46.

² Document A65/32.

³ Document A65/47.

⁴ See document A65/36.

3. ESTABLISHES the salary of the Director-General at US\$ 232 859 gross per annum before staff assessment, resulting in a modified net salary of US\$ 176 501 (dependency rate) or US\$ 156 964 (single rate);
4. DECIDES that those adjustments in remuneration shall take effect on 1 January 2012.

(Tenth plenary meeting, 26 May 2012 –
Committee B, second report)

**WHA65.15 Election of the Director-General of the World Health Organization:
Report of the Working Group**

The Sixty-fifth World Health Assembly,

Guided by the purposes and principles of the Charter of the United Nations, *inter alia*, Article 101, paragraph 3;

Having regard to the Constitution of the World Health Organization, including Article 31;

Recalling resolution EB128.R14 on the Election of the Director-General of the World Health Organization, which established a time-bound and results-oriented working group on the process and methods of the election of the Director-General of the World Health Organization with a view to enhancing fairness, transparency and equity among the Member States of the six regions of the Organization with respect to the process of nomination and appointment of the Director-General of the World Health Organization;

Reaffirming that the qualifications of the candidates are of paramount importance in the selection and nomination process of the Director-General, and that due regard should be paid to the importance of recruiting future Directors-General on as wide a geographical basis as possible from Member States of the six regions of the Organization;

Reaffirming the critical importance of the role of the Executive Board in the screening and nomination process, and of the World Health Assembly in electing and appointing the Director-General, and therefore the need to consider ways to strengthen and improve relevant elements of these procedures;

Having considered the report of the Working Group of Member States on the Process and Methods of the Election of the Director-General of the World Health Organization,¹

1. DECIDES that:
 - (a) due regard shall be paid to the principle of equitable geographical representation in the overall process of nomination, election and appointment of the Director-General of the World Health Organization, being mindful at the same time that candidates appointed to this post have so far only come from three out of the six regions of the Organization, and that the paramount consideration of the necessity of securing the highest standard of efficiency, competence and integrity in the election and appointment of the Director-General shall be maintained;

¹ Document A65/38.

(b) the Executive Board will nominate three candidates for the Health Assembly's consideration for the appointment of the Director-General of the World Health Organization, paying due regard to equitable geographical representation;

(c) in exceptional circumstances, where the above is not practicable, such as where there are only one or two candidates, the Executive Board may decide to nominate fewer than three candidates for consideration by the Health Assembly for appointment as Director-General of the World Health Organization;

(d) a code of conduct, in line with Recommendation 7¹ of the report of the Joint Inspection Unit "Selection and Conditions of Service of Executive Heads in the United Nations System Organizations",² which candidates for the post of Director-General of the World Health Organization and Member States should undertake to observe and respect, will be developed by the Secretariat for consideration by the Sixty-sixth World Health Assembly through the Executive Board;

(e) a candidates' forum, open to all Member States,³ shall be established to provide a non-decision-making platform for candidates to make themselves and their vision known to Member States on an equal basis; the modalities of the candidates' forum will be developed by the Secretariat to be considered by the Sixty-sixth World Health Assembly through the Executive Board;

(f) the Executive Board should ensure that the nominated candidates fulfil the following criteria, while underscoring the paramount importance of professional qualifications and integrity and the need to pay due regard to equitable geographical representation, as well as gender balance in the process leading to the nomination of the candidate(s) that should be submitted to the Health Assembly; he or she should have:

- (1) a strong technical background in a health field, including experience in public health;
- (2) exposure to and extensive experience in international health;
- (3) demonstrable leadership skills and experience;
- (4) excellent communication and advocacy skills;
- (5) demonstrable competence in organizational management;
- (6) sensitivity to cultural, social and political differences;
- (7) strong commitment to the mission and objectives of WHO;
- (8) good health condition required of all staff members of the Organization;

¹ Recommendation 7: "The legislative/governing bodies of the United Nations system organizations should condemn and prohibit unethical practices such as promises, favours, invitations, gifts, etc., provided by candidates for the post of executive head or their supporting governments during the selection/election campaign, in return for favourable votes for certain candidates."

² Document JIU/REP/2009/8.

³ And, where applicable, regional economic integration organizations.

- (9) sufficient skill in at least one of the official working languages of the Executive Board and the Health Assembly;
- (g) appropriate tool(s) to enhance the Executive Board's effective application of the revised list of criteria will be developed by the Secretariat for consideration by the Sixty-sixth World Health Assembly through the Executive Board;
- (h) an evaluation, open to all Member States,¹ will be conducted by the Executive Board² within one year from the appointment of the next Director-General of the World Health Organization, to assess the efficacy of the revised process and methods, in order to discuss any need for further enhancing fairness, transparency and equity among the Member States of the six regions of WHO;
2. REQUESTS the Executive Board to give effect to all the provisions outlined in paragraph 1 above and to submit a report on the implementation of this resolution to the Sixty-sixth World Health Assembly, with the exception of the report referred to in paragraph 1(h) which will be submitted to a later session of the Health Assembly;
3. FURTHER REQUESTS the Executive Board, in implementing paragraph 2, to do so on the understanding that some of the existing procedures of the Executive Board and Health Assembly such as those involving secret ballots, shortlisting, voting and interviewing of candidates have proved to be useful and effective and should be continued; the Executive Board will also consider that the Director-General should be appointed by a clear and strong majority at the Health Assembly;
4. REQUESTS the Director-General to propose to the Executive Board amendments to the Rules of Procedure of the Executive Board in order to implement this resolution.

(Tenth plenary meeting, 26 May 2012 –
Committee B, second report)

WHA65.16 Agreement with the Commission of the African Union

The Sixty-fifth World Health Assembly,

Having considered the report on agreements with intergovernmental organizations,³

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

APPROVES the proposed agreement between the Commission of the African Union and the World Health Organization.⁴

(Tenth plenary meeting, 26 May 2012 –
Committee B, second report)

¹ And, where applicable, regional economic integration organizations.

² This agenda item shall be an open meeting as provided in Rule 7(b) of the Rules of Procedure of the Executive Board.

³ Document A65/42.

⁴ See Annex 3.

WHA65.17 Global vaccine action plan¹

The Sixty-fifth World Health Assembly,

Having considered the report on the draft global vaccine action plan;²

Recognizing the importance of immunization as one of the most cost-effective interventions in public health, which should be recognized as a core component of the human right to health;

Acknowledging the remarkable progress made in immunization in several countries to ensure that every eligible individual is immunized with all appropriate vaccines, irrespective of geographical location, age, gender, disability, educational level, socioeconomic level, ethnic group or work condition;

Applauding the contribution of successful immunization programmes in achieving global health goals, in particular in reducing childhood mortality and morbidity, and their potential for reducing mortality and morbidity across the life-course;

Noting that the introduction of new vaccines targeted against several important causes of major killer diseases such as pneumonia, diarrhoea and cervical cancer can be used as a catalyst to scale up complementary interventions and create synergies between primary health care programmes; and that beyond the mortality gains, these new vaccines will prevent morbidity with resulting economic returns even in countries that have already succeeded in reducing mortality;

Concerned that, despite the progress already made, disease eradication and elimination goals, such as the eradication of poliomyelitis, the elimination of measles, rubella, and maternal and neonatal tetanus, cannot be met without achieving and sustaining high and equitable coverage;

Concerned that low-income and middle-income countries, where the adoption of available vaccines has been slower, may not have the opportunity to access the newer and improved vaccines that are expected to become available during this decade;

Alarmed that, globally, routine immunization services are not reaching one child in five, and that substantial gaps persist in routine immunization coverage within countries;

Recalling resolutions WHA58.15 and WHA61.15 on the global immunization strategy,

1. ENDORSES the global vaccine action plan;³

2. URGES Members States:

(1) to apply the vision and the strategies of the global vaccine action plan in order to develop the vaccines and immunization components of their national health strategy and plans, paying particular attention to improving performance of the Expanded Programme on Immunization, and according to the epidemiological situation in their respective countries;

¹ See Annex 5 for the financial and administrative implications for the Secretariat of this resolution.

² Document A65/22.

³ See Annex 4.

- (2) to commit themselves to allocating adequate human and financial resources to achieve the immunization goals and other relevant key milestones;
 - (3) to report every year to the regional committees during a dedicated Decade of Vaccines session, on lessons learnt, progress made, remaining challenges and updated actions to reach the national immunization targets;
3. REQUESTS the Director-General:
- (1) to foster alignment and coordination of global immunization efforts by all stakeholders in support of the implementation of the global vaccine action plan;
 - (2) to ensure that the support provided to the global vaccine action plan's implementation at regional and country level includes a strong focus on strengthening routine immunization;
 - (3) to identify human and financial resources for the provision of technical support in order to implement the national plans of the global vaccine action plan and monitor their impact;
 - (4) to mobilize more financial resources in order to support implementation of the global vaccine action plan in low-income and middle-income countries;
 - (5) to monitor progress and report annually, through the Executive Board, to the Health Assembly, until the Seventy-first World Health Assembly, on progress towards achievement of global immunization targets, as a substantive agenda item, using the proposed accountability framework to guide discussions and future actions.

(Tenth plenary meeting, 26 May 2012 –
Committee B, second report)

WHA65.18 World Immunization Week¹

The Sixty-fifth World Health Assembly,

Having considered the report on the draft global vaccine action plan;²

Recalling resolutions WHA58.15 and WHA61.15 on the global immunization strategy, and the commitment to use the decade 2011–2020 to achieve immunization goals and milestones in vaccine research and development;

Recognizing the importance of immunization as one of the most cost-effective interventions in public health;

Acknowledging the significant achievements of the Expanded Programme on Immunization at the global level, including the eradication of smallpox, major advances towards eradicating poliomyelitis, eliminating measles and rubella, and the control of other vaccine-preventable diseases, such as diphtheria and tetanus;

¹ See Annex 5 for the financial and administrative implications for the Secretariat of this resolution.

² Document A65/22.

Noting the contribution of successful immunization programmes towards significant reductions in childhood mortality and improvements in maternal health, and thereby towards the attainment of Millennium Development Goals 4 (Reduce child mortality) and 5 (Improve maternal health), and towards cancer prevention;

Recognizing that initiatives such as regional vaccination weeks have contributed towards promoting immunization, advancing equity in the use of vaccines and universal access to vaccination services, and enabling cooperation on cross-border immunization activities;

Recognizing also that the initiative of vaccination weeks, a growing global movement that was first introduced in the Region of the Americas in 2003, was observed simultaneously in WHO's six regions in April 2012, with the participation of more than 180 Member States, territories and areas;

Acknowledging also the high level of political support and international visibility given so far to regional vaccination week initiatives, and noting that the flexibility of the vaccination week framework allows individual Member States and regions to tailor their participation in accordance with national and regional public health priorities;

Concerned that, despite all the achievements of immunization initiatives, many challenges remain, including maintaining immunization as a fundamental element of primary health care, administering vaccines to all vulnerable populations regardless of their location, protecting national immunization programmes against the growing threat of misinformation on vaccines and immunization, and ensuring that national programmes are considered a financial priority for Member States,

1. REQUESTS Member States to designate the last week of April, when appropriate, as World Immunization Week;
2. REQUESTS the Director-General:
 - (1) to support the annual implementation of World Immunization Week as the overarching framework for all regional initiatives that are dedicated to promoting the importance of vaccination across the life-course and working to ensure the universal access of individuals of all ages and in all countries to this essential preventive health service;
 - (2) to provide support to Member States in mobilizing the resources necessary to sustain World Immunization Week, and to encourage civil society organizations and other stakeholders to support the initiative.

(Tenth plenary meeting, 26 May 2012 –
Committee B, second report)

WHA65.19 Substandard/spurious/falsely-labelled/falsified/counterfeit medical products¹

The Sixty-fifth World Health Assembly,

Having considered the report of the Working Group of Member States on Substandard/Spurious/Falsely-Labelled/Falsified/Counterfeit Medical Products and its recommendations;²

¹ See Annex 5 for the financial and administrative implications for the Secretariat of this resolution.

² Document A65/23.

Welcoming the outcome of the sessions of the Working Group of Member States on Substandard/Spurious/Falsely-Labelled/Falsified/Counterfeit Medical Products;

Reaffirming the fundamental role of WHO in ensuring the availability of quality, safe and efficacious medical products;

Recognizing that many people in the world lack access to quality, safe, efficacious and affordable medicines and that such access is an important part of a health system;

Recognizing the importance of ensuring that combating “substandard/spurious/falsely-labelled/falsified/counterfeit medical products” does not result in hindering the availability of legitimate generic medicines;

Recognizing the need, as expressed in the Rio Political Declaration on the Social Determinants of Health (2011),¹ to promote access to affordable, safe, efficacious and quality medicines, including through the full implementation of WHO’s Global strategy and plan of action on public health, innovation and intellectual property;

Acknowledging the need for improving access to affordable, quality, safe and efficacious medicines as an important element in the effort to prevent and control medicines with compromised quality, safety and efficacy and in the decrease of “substandard/spurious/falsely-labelled/falsified/counterfeit medical products”;

Taking note of the United Nations Commission on Crime Prevention and Criminal Justice resolution 20/6 entitled “Countering fraudulent medicines, in particular their trafficking”;

Expressing concern regarding the lack of sufficient financing for WHO’s work in the area of quality, safety and efficacy of medicines;

Recognizing the need to enhance support to national and regional regulatory authorities to promote the availability of quality, safe and efficacious medical products,

1. REAFFIRMS the fundamental role of WHO in ensuring the quality, safety and efficacy of medical products; in promoting access to affordable, quality, safe and efficacious medicines; and in supporting national drug regulatory authorities in this area, in particular in developing countries and least-developed countries;
2. REITERATES that WHO should continue to focus on and intensify its measures to make medical products more affordable, strengthening national regulatory authorities and health systems that include national medicine policies, health risk-management systems, sustainable financing, human resource development and reliable procurement and supply systems; and to enhance and support work on prequalification and promotion of generics, and efforts in rational selection and use of medical products. In each of these areas, WHO’s function should be: sharing information and creating awareness; providing norms and standards and technical support to countries on country situation assessment; supporting national policy development; capacity building; and supporting product development and domestic production;
3. FURTHER REITERATES that WHO should increase its efforts to support Member States in strengthening national and regional regulatory infrastructure and capacity;

¹ See subparagraph 11.2 (xii).

4. DECIDES to establish a new Member State¹ mechanism for international collaboration among Member States, from a public health perspective, excluding trade and intellectual property considerations, regarding “substandard/spurious/falsely-labelled/falsified/counterfeit medical products” in accordance with the goals, objectives and terms of reference annexed to the present resolution;
5. FURTHER DECIDES to review the Member State mechanism referred to in paragraph 4 after three years of operation;
6. URGES Member States¹ to:
 - (1) on a voluntary basis, participate in and collaborate with the Member State mechanism referred to in paragraph 4;
 - (2) provide sufficient financial resources to strengthen the work of the Secretariat in this area;
7. REQUESTS the Director-General:
 - (1) to support the Member State mechanism referred to in paragraph 4;
 - (2) to support Member States in building capacity to prevent and control “substandard/spurious/falsely-labelled/falsified/counterfeit medical products”.

ANNEX

Member State mechanism on substandard/spurious/falsely-labelled/ falsified/counterfeit medical products

Goal, objectives and terms of reference

General goal

In order to protect public health and promote access to affordable, safe, efficacious and quality medical products, promote, through effective collaboration among Member States and the Secretariat, the prevention and control of substandard/spurious/falsely-labelled/falsified/counterfeit medical products² and associated activities.

Objectives

- (1) To identify major needs and challenges and make policy recommendations, and develop tools in the area of prevention, detection methodologies and control of “substandard/spurious/falsely-labelled/falsified/counterfeit medical products” in order to strengthen national and regional capacities.
- (2) To strengthen national and regional capacities in order to ensure the integrity of the supply chain.

¹ And, where applicable, regional economic integration organizations.

² The Member State mechanism shall use the term “substandard/spurious/falsely-labelled/falsified/counterfeit medical products” until a definition has been endorsed by the governing bodies of WHO.

- (3) To exchange experiences, lessons learnt, best practices, and information on ongoing activities at national, regional and global levels.
- (4) To identify actions, activities and behaviours that result in “substandard/spurious/falsely-labelled/falsified/counterfeit medical products” and make recommendations, including for improving the quality, safety and efficacy of medical products.
- (5) To strengthen regulatory capacity and quality control laboratories at national and regional levels, in particular for developing countries and least developed countries.
- (6) To collaborate with and contribute to the work of other areas of WHO that address access to quality, safe, efficacious and affordable medical products, including, but not limited to, the supply and use of generic medical products, which should complement measures for the prevention and control of “substandard/spurious/falsely-labelled/falsified/counterfeit medical products”.
- (7) To facilitate consultation, cooperation and collaboration with relevant stakeholders in a transparent and coordinated manner, including regional and other global efforts, from a public health perspective.
- (8) To promote cooperation and collaboration on surveillance and monitoring of “substandard/spurious/falsely-labelled/falsified/counterfeit medical products”.
- (9) To further develop definitions of “substandard/spurious/falsely-labelled/falsified/counterfeit medical products” that focus on the protection of public health.

Structure

- (1) The Member State mechanism will be open to all Member States.¹ The Member State mechanism should include expertise in national health and medical products regulatory matters.
- (2) The Member State mechanism may establish subsidiary working groups from among its members to consider and make recommendations on specific issues.
- (3) Regional groups will provide input into the Member State mechanism as appropriate.
- (4) The Member State mechanism shall make use of existing WHO structures.

Meetings

- (1) The Member State mechanism should meet not less than once a year and in additional sessions as needed.
- (2) The default venue for the Member State mechanism, and its subsidiary working groups, will be Geneva. Meetings may, however, be held from time to time outside Geneva, taking into account regional distribution, overall cost and cost-sharing, and relevance to the agenda.

¹ And, where applicable, regional economic integration organizations.

Relations with other stakeholders and experts

- (1) As needed, the Member State mechanism should seek expert advice on specific topics, following standard WHO procedures for expert groups.
- (2) As needed, the Member State mechanism will invite other stakeholders to collaborate and consult with the group on specific topics.

Reporting and review

- (1) The functioning of the Member State mechanism shall be reviewed by the World Health Assembly after three years of its operation.
- (2) The Member State mechanism shall submit a report to the Health Assembly through the Executive Board on progress and any recommendations annually as a substantive item for the first three years and every two years thereafter.

Transparency and conflict of interest

- (1) The Member State mechanism, including all invited experts, should operate in a fully inclusive and transparent manner.
- (2) Possible conflicts of interest shall be disclosed and managed in accordance with the policies and practice of WHO.

(Tenth plenary meeting, 26 May 2012 –
Committee B, third report)

WHA65.20 WHO's response, and role as the health cluster lead, in meeting the growing demands of health in humanitarian emergencies¹

The Sixty-fifth World Health Assembly,

Having considered the report on WHO's response, and role as the health cluster lead, in meeting the growing demands of health in humanitarian emergencies;²

Recognizing that humanitarian emergencies result in avoidable loss of life and human suffering, weaken the ability of health systems to deliver essential life-saving health services, produce setbacks for health development and hinder the achievement of the Millennium Development Goals;

Reaffirming the principles of neutrality, humanity, impartiality and independence in the provision of humanitarian assistance, and reaffirming the need for all actors engaged in the provision of humanitarian assistance in situations of complex humanitarian emergencies and natural disasters to promote and fully respect these principles;

¹ See Annex 5 for the financial and administrative implications for the Secretariat of this resolution.

² Document A65/25.

Recalling Article 2(d) of the Constitution of the World Health Organization on the mandate of WHO in emergencies, and resolutions WHA58.1 on health action in relation to crises and disasters and WHA59.22 on emergency preparedness and response;¹

Recalling United Nations General Assembly resolution 46/182 on the strengthening of the coordination of humanitarian emergency assistance of the United Nations, confirming the central and unique role for the United Nations in providing leadership and coordinating the efforts of the international community to support countries affected by humanitarian emergencies in full respect of the guiding principles therein, establishing, *inter alia*, the Inter-Agency Standing Committee, chaired by the Emergency Relief Coordinator, who should be supported by the United Nations Office for the Coordination of Humanitarian Affairs;

Taking note of the humanitarian response review in 2005, led by the Emergency Relief Coordinator and by the Principals of the Inter-Agency Standing Committee aiming at improving urgency, timeliness, accountability, leadership and surge capacity, and recommending the strengthening of humanitarian leadership, the improvement of humanitarian financing mechanisms and the introduction of the clusters as a means of sectoral coordination;

Taking note of the Inter-Agency Standing Committee Principals' Reform Agenda 2011–2012 to improve the international humanitarian response by strengthening leadership, coordination, accountability, building global capacity for preparedness and increasing advocacy and communications;

Recognizing United Nations General Assembly resolution 60/124 on strengthening of the coordination of emergency humanitarian assistance of the United Nations, and taking note of WHO's subsequent commitment to supporting the Inter-Agency Standing Committee transformative humanitarian agenda and contributing to the implementation of the Principals' priority actions designed to strengthen international humanitarian response to affected populations;

Reaffirming that it is the national authority that has the primary responsibility to take care of victims of natural disasters and other emergencies occurring on its territory, and that the affected State has the primary role in the initiation, organization, coordination and implementation of humanitarian assistance within its territory;

Taking note of the 2011 Inter-Agency Standing Committee guidance note on working with national authorities, that clusters should support and/or complement existing national coordination mechanisms for response and preparedness and where appropriate, government, or other appropriate national counterparts should be actively encouraged to co-chair cluster meetings with the Cluster Lead Agency;

Recalling resolution WHA64.10 on strengthening national health emergency and disaster management capacities and resilience of health systems, which urges Member States, *inter alia*, to strengthen all-hazards health emergency and disaster risk-management programmes;

Reaffirming also that countries are responsible for ensuring the protection of the health, safety and welfare of their people and for ensuring the resilience and self-reliance of the health system, which is critical for minimizing health hazards and vulnerabilities and delivering effective response and recovery in emergencies and disasters;

¹ See also resolutions WHA34.26, WHA46.6 and WHA48.2.

Recognizing the comparative advantage of the WHO Secretariat, through its presence in and its relationship with Member States, and through its capacity to provide independent expertise from a wide range of health-related disciplines, its history of providing the evidence-based advice necessary for prioritizing effective health interventions; and that the Organization is in a unique position to support health ministries and partners as the global health cluster lead agency in the coordination of preparing for, responding to and recovering from humanitarian emergencies;

Recalling WHO's reform agenda and the report in 2011 by the Director-General on reforms for a healthy future,¹ which was noted by the Sixty-fourth World Health Assembly and which led to the creation of a new WHO cluster, Polio, Emergencies and Country Collaboration, aimed at supporting regional and country offices to improve outcomes and increase WHO's effectiveness at the country level, by redefining its commitment to emergency work and placing the cluster on a more sustainable budgetary footing;

Welcoming the reform in 2011 transforming the WHO cluster Health Action in Crisis into the Emergency Risk Management and Humanitarian Response department as a means of implementing these reforms, ensuring that the Organization becomes faster, more effective and more predictable in delivering higher quality response in health, and that the Organization holds itself accountable for its performance;

Recalling resolutions WHA46.39 on health and medical services in times of armed conflict; WHA55.13 on protection of medical missions during armed conflict; and the United Nations General Assembly resolution 65/132 on safety and security of humanitarian personnel and protection of United Nations personnel, considers that there is a need of systematic data collection on attacks or lack of respect for patients and/or health workers, facilities and transports in complex humanitarian emergencies,

1. CALLS ON Member States² and donors:

- (1) to allocate resources for the health sector activities during humanitarian emergencies through United Nations Consolidated Appeal Process and Flash Appeals, and for strengthening WHO's institutional capacity to exercise its role as the Global Health Cluster Lead Agency and to assume health cluster lead in the field;
- (2) to ensure that humanitarian activities are carried out in consultation with the country concerned for an efficient response to the humanitarian needs, and to encourage all humanitarian partners, including nongovernmental organizations, to participate actively in the health cluster coordination;
- (3) to strengthen the national level risk management, health emergency preparedness and contingency planning processes and disaster management units in the health ministry, as outlined in resolution WHA64.10 and, in this context, as part of the national preparedness planning, with the Office for the Coordination of Humanitarian Affairs, where appropriate, identify in advance the best way to ensure that the coordination between the international humanitarian partners and existing national coordination mechanisms takes place in a complementary manner in order to guarantee an effective and well-coordinated humanitarian response;

¹ Documents A64/4 and WHA64/2011/REC/3, the summary record of the third meeting of Committee A.

² And, where applicable, regional economic integration organizations.

(4) to build the capacity of national authorities at all levels in managing the recovery process in synergy with the longer-term health system strengthening and reform strategies, as appropriate, in collaboration with WHO and the health cluster;

(5) to establish health response teams on a voluntary basis and develop a mechanism for deployment in case of humanitarian emergencies, depending on the choice of each Member State;

2. CALLS ON the Director-General:

(1) to have in place the necessary WHO policies, guidelines, adequate management structures and processes required for effective and successful humanitarian action at the country level, as well as the organizational capacity and resources to enable itself to discharge its function as the Global Health Cluster Lead Agency, in accordance with agreements made by the Inter-Agency Standing Committee Principals; and assume a role as Health Cluster Lead Agency in the field;

(2) to strengthen WHO's surge capacity with global health cluster partners and Member States including developing standby rapid response arrangements and mechanisms in order to deploy and sustain response teams with appropriate resources in response to humanitarian emergencies;

(3) to ensure that in humanitarian crises the Secretariat provides Member States and humanitarian partners with predictable support by coordinating rapid assessment and analysis of humanitarian needs, including as a part of the coordinated Inter-Agency Standing Committee response, building an evidence-based strategy and action plan, monitoring the health situation and health sector response, identifying gaps, mobilizing resources and performing the necessary advocacy for humanitarian health action;

(4) to define the core commitments, core functions and performance standards of the Organization in humanitarian emergencies, including its role as the Global Health Cluster Lead Agency and as Health Cluster Lead Agency in the field, and to ensure full engagement of country, regional and global levels of the Organization to their implementation according to established benchmarks, keeping in mind the ongoing work on the Inter-Agency Standing Committee transformative humanitarian agenda;

(5) to provide a faster, more effective and more predictable humanitarian response by operationalizing the Emergency Response Framework, with the performance benchmarks in line with the humanitarian reform, and to ensure the accountability of its performance against those standards;

(6) to establish necessary mechanisms to mobilize WHO's technical expertise across all disciplines and levels, for the provision of necessary guidance and support to Member States, as well as partners of the health cluster in humanitarian crises;

(7) to support Member States and partners in the transition to recovery, aligning the recovery planning, including emergency risk management as well as disaster risk-reduction and preparedness, with the national development policies and ongoing health sector reforms, and/or using the opportunities of post-disaster and/or post-conflict recovery planning;

(8) to provide leadership at the global level in developing methods for systematic collection and dissemination of data on attacks on health facilities, health workers, health vehicles, and patients in complex humanitarian emergencies, in coordination with other relevant United

Nations bodies, other relevant actors, and intergovernmental and nongovernmental organizations, avoiding duplication of efforts;

(9) to provide a report to the Sixty-seventh World Health Assembly, through the Executive Board, and thereafter every two years, on progress made in the implementation of this resolution.

(Tenth plenary meeting, 26 May 2012 –
Committee B, third report)

WHA65.21 Elimination of schistosomiasis¹

The Sixty-fifth World Health Assembly,

Having considered the report on the elimination of schistosomiasis;²

Recalling resolutions WHA3.26, WHA28.53, WHA29.58 and WHA54.19 on schistosomiasis;

Noting the resolution EM/RC54/R.3 on neglected tropical diseases: an emerging public health problem in the Eastern Mediterranean Region, adopted by the Regional Committee for the Eastern Mediterranean, which called on Member States, inter alia, to sustain successful control activities in areas of low transmission in order to eliminate schistosomiasis;

Expressing concern that schistosomiasis remains a major public health problem in countries endemic for the disease, and that the goal set in resolution WHA54.19 of attaining a minimum target of regular administration of chemotherapy to at least 75% of school-age children at risk of morbidity was not achieved by 2010;

Noting the extension in coverage of treatment of schistosomiasis from 12 million people in 2006 to 32.6 million people in 2010, the greater access to praziquantel as a result of donations of the medicine, and increased support from partners to countries endemic for the disease for control of neglected tropical diseases;

Congratulating Member States, the Secretariat and partners for increasing access to praziquantel and resources to scale up schistosomiasis control;

Encouraged that some countries endemic for schistosomiasis have interrupted its transmission;

Congratulating those countries endemic for schistosomiasis that, with strengthened control programmes and surveillance, have reported no new autochthonous cases of schistosomiasis,

1. CALLS ON all countries endemic for schistosomiasis:

(1) to attach importance to prevention and control of schistosomiasis, to analyse and develop applicable plans with progressive targets, to intensify control interventions and to strengthen surveillance;

¹ See Annex 5 for the financial and administrative implications for the Secretariat of this resolution.

² Document A65/21.

- (2) to take full advantage of non-health programmes to improve the environment, in order to cut the transmission of schistosomiasis and accelerate the elimination of the intermediate host;
 - (3) to ensure the provision of essential medicines;
2. URGES Member States, the Secretariat and partners to provide support to countries endemic for schistosomiasis to expand control programmes;
 3. REQUESTS the Director-General:
 - (1) to encourage Member States and the international community to make available the necessary and sufficient means and resources, particularly medicines, and water, sanitation, and hygiene interventions, to intensify control programmes in most disease-endemic countries and initiate elimination campaigns, where appropriate;
 - (2) to prepare guidance for Member States in order to determine when to initiate elimination campaigns, along with methods for implementing programmes and documenting success;
 - (3) to assess, on request, the interruption of transmission in the appropriate Member States, to analyse the global status of schistosomiasis prevention and control, the epidemic model, and key challenges, so as to provide targeted recommendations and guidance;
 - (4) to elaborate a procedure to evaluate the interruption of transmission of schistosomiasis in the countries concerned with a view to certifying that transmission has been eliminated in these countries;
 - (5) during the post-elimination phase, to support countries that have been certified free of schistosomiasis to pursue preventive actions designed to avoid the reintroduction of transmission of the disease;
 - (6) to report every three years through the Executive Board to the World Health Assembly on progress in implementing this resolution.

(Tenth plenary meeting, 26 May 2012 –
Committee B, third report)

WHA65.22 Follow-up of the report of the Consultative Expert Working Group on Research and Development: Financing and Coordination¹

The Sixty-fifth World Health Assembly,

Having considered the report of the Consultative Expert Working Group on Research and Development: Financing and Coordination;²

Recalling resolution WHA63.28 which requested the Director-General, inter alia, to establish a Consultative Expert Working Group in order to take forward the work of the Expert Working Group earlier established under resolution WHA61.21, and to submit the final report to the Sixty-fifth World Health Assembly;

¹ See Annex 5 for the financial and administrative implications for the Secretariat of this resolution.

² Documents A65/24, Annex and A65/24 Corr.1.

Further recalling resolutions WHA59.24, WHA61.21 and WHA62.16,

1. WELCOMES the analysis of the Consultative Expert Working Group on Research and Development: Financing and Coordination report and expresses its appreciation to the Chair, Vice-Chair and all the members of the Consultative Expert Working Group for their work;
2. URGES Member States:¹
 - (1) to hold national level consultations among all relevant stakeholders, in order to discuss the Consultative Expert Working Group report and other relevant analyses, resulting in concrete proposals and actions;
 - (2) to participate actively in the meetings at regional and global level referred to in this resolution;
 - (3) to implement, where feasible, in their respective countries, proposals and actions identified by national consultations;
 - (4) to establish and/or strengthen mechanisms for improved coordination of research and development² in collaboration with WHO and other relevant partners, as appropriate;
3. CALLS UPON Member States,¹ the private sector, academic institutions and nongovernmental organizations to increase investments in health 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;
4. REQUESTS regional committees to discuss at their 2012 meetings the report of the Consultative Expert Working Group in the context of the implementation of the global strategy and plan of action on public health, innovation and intellectual property³ in order to contribute to concrete proposals and actions;
5. REQUESTS the Director-General to hold an open-ended meeting of Member States¹ that will thoroughly analyse the report and the feasibility of the recommendations proposed by the Consultative Expert Working Group, taking into account, as appropriate, related studies as well as the results from national consultations and regional committee discussions, and will develop proposals or options relating to (1) research coordination, (2) financing and (3) monitoring of research and development expenditures,⁴ to be presented under a substantive item dedicated to the follow-up of the Consultative Expert Working Group report at the Sixty-sixth World Health Assembly, through the Executive Board at its 132nd session.

(Tenth plenary meeting, 26 May 2012 –
Committee A, fourth report)

¹ And, where applicable, regional economic integration organizations.

² In the context of this resolution, research and development shall refer to health 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.

³ Resolutions WHA61.21 and WHA62.16.

⁴ As defined in WHO's Global strategy and plan of action on public health, innovation and intellectual property.

WHA65.23 Implementation of the International Health Regulations (2005)¹

The Sixty-fifth World Health Assembly,

Having considered the reports on implementation of the International Health Regulations (2005);²

Recalling resolution WHA58.3 on revision of the International Health Regulations, which underscored the continued importance of the International Health Regulations as the key global instrument for the protection against the international spread of disease, and which urged Member States, *inter alia*, to build, strengthen and maintain the capacities required under the International Health Regulations (2005) and to mobilize the resources necessary for that purpose;

Recalling that Articles 5.1 and 13.1 of the International Health Regulations (2005) provide that each State Party shall, as soon as possible but no later than five years from entry into force of the Regulations for that State Party, develop, strengthen and maintain the capacity to detect, assess, notify and report events, in accordance with the Regulations, as specified in Annex 1 therein, and to respond promptly and effectively to public health risks and public health emergencies of international concern as set out in that Annex, and that the date for having these core public health capacities falls in June 2012 for all but a small number of States Parties which have later dates;³

Also recalling resolution WHA61.2 on implementation of the International Health Regulations (2005), which urged Member States to take steps to ensure that the national core capacity requirements specified in Annex 1 to the Regulations are developed, strengthened and maintained, in accordance with Articles 5 and 13 of the International Health Regulations (2005);

Recognizing that difficulties still exist in the implementation of International Health Regulations (2005), especially regarding points of entry, including with respect to the operational understanding of the Regulations, which makes it necessary to strengthen the capacities related to Annex 1B;

Recognizing the importance of having available tools and procedures for continuous monitoring of core capacities related to Annex 1A and 1B of the International Health Regulations (2005);

Further recalling resolution WHA64.1 on implementation of the International Health Regulations (2005), which urged Member States to support the implementation of the recommendations contained in the final report of the Review Committee on the Functioning of the International Health Regulations (2005) in relation to Pandemic (H1N1) 2009,⁴ which in its first recommendation noted the need to accelerate implementation of the core capacities required by the Regulations;

¹ See Annex 5 for the financial and administrative implications for the Secretariat of this resolution.

² Documents A65/17 and A65/17 Add.1.

³ The time frames for the States Parties that made reservations to the International Health Regulations (2005) (United States of America and India) are slightly later (entry into force for United States of America on 18 July 2007, and for India on 8 August 2007). The time frame was also later for Montenegro (entry into force 5 February 2008), which became a State Party after entry into force of the Regulations on 15 June 2007; and for Liechtenstein (which became a State Party on 28 March 2012).

⁴ Document A64/10.

Recognizing the need to strengthen the role and capacity of States Parties and international organizations, in effective implementation of the International Health Regulations (2005), which requires constructive engagement of stakeholders, in health and non-health sectors as well as regional and trans-regional networks of States Parties;

Recognizing that States Parties may, as provided for in the International Health Regulations (2005), report to WHO and obtain, on the basis of a justified need and an implementation plan, an extension of two years in which to fulfil their obligations, and acknowledging in particular the decision of many Member States of WHO to seek such an extension,

1. AFFIRMS its renewed commitment to full implementation of the International Health Regulations (2005);

2. URGES States Parties:¹

(1) to ensure identification of remaining gaps including institutional, human and financial resources in the development, strengthening and maintenance of the core public health capacities required under the International Health Regulations (2005), including Articles 5 and 13 and Annex 1, in accordance with their national implementation plans;

(2) to take the necessary steps to prepare and carry out appropriate national implementation plans in order to ensure the required strengthening, development and maintenance of the core public health capacities as provided for in the International Health Regulations (2005);

(3) to respect time frames stipulated in the International Health Regulations (2005) in Articles 5 and 13 and Annex 1 for undertaking and completing activities and communications relating to implementation of core capacity requirements and procedures concerning related extensions;

(4) to strengthen coordination and collaboration among and within States Parties intersectorally and multisectorally to develop, establish and maintain the core public health capacities and operational functions required under the International Health Regulations (2005);

(5) to further strengthen active collaboration among States Parties, WHO and other relevant organizations and partners as appropriate, by measures including the mobilization of technical, financial and logistical support for building core public health capacities, so as to ensure full implementation of the International Health Regulations (2005);

(6) to reconfirm their support to developing countries and countries with economies in transition upon their request in the building, strengthening and maintenance of the core public health capacities required under the International Health Regulations (2005);

3. REQUESTS the Director-General:

(1) to build and strengthen the capacities of the Secretariat to perform fully and effectively the functions entrusted to it under the International Health Regulations (2005), in particular through strategic health operations that provide support to countries, regional and trans-regional networks of States Parties in detection, reporting and assessment of, response to, and capacity strengthening in public health emergencies;

¹ And, where applicable, regional economic integration organizations.

- (2) to collaborate with and assist States Parties through health ministries as well as all other relevant ministries and sectors in the mobilization of technical support and financial resources to support building, strengthening and maintaining the core capacities required under the International Health Regulations (2005), in particular those related to Annex 1B in relation to core capacity requirements for points of entry including technical support to help interested countries to assess their own needs and to make the business case for investment in implementing the Regulations, in accordance with national plans;
- (3) to promote the engagement with relevant international organizations and stakeholders to strengthen their contribution towards effective implementation of the International Health Regulations (2005);
- (4) to ensure the transparent sharing of information on progress of States Parties in the full implementation of the national core capacities required under the International Health Regulations (2005), so as to facilitate provision of appropriate support including guidance and training as needed, by posting the list of States Parties that have requested and received extensions to the initial deadline on the restricted WHO web site for National IHR Focal Points;
- (5) to facilitate the provision of appropriate support between and among States Parties for the establishment of the national core capacities required under the International Health Regulations (2005) by posting a relevant summary of the country information collected through the IHR core capacity monitoring framework on the restricted WHO web site for National IHR Focal Points;
- (6) to monitor the progress of each State Party that has received an extension to the initial deadline using the implementation plans submitted with the request for extension and the annual reports required under Articles 5.2 and 13.2 of the International Health Regulations (2005) from all States Parties receiving extensions;
- (7) to monitor the maintenance of the national core capacities required under the International Health Regulations (2005) in all States Parties not requesting extensions to the deadline through the development of appropriate methods of assessing effective functioning of the established core capacities;
- (8) to develop and publish the criteria to be used in 2014 by the Director-General, in conjunction with the advice of the Review Committee of the International Health Regulations (2005), when making decisions about the granting of any further extensions to the timeline for establishment of the national core capacities as provided for in Articles 5.2 and 13.2;
- (9) to submit an interim progress report to the Sixty-sixth World Health Assembly through the Executive Board at its 132nd session;
- (10) to report to the Sixty-seventh World Health Assembly, through the Executive Board at its 134th session, on progress made by States Parties and the Secretariat in implementing this resolution.

(Tenth plenary meeting, 26 May 2012 –
Committee A, fourth report)

DECISIONS

WHA65(1) Composition of the Committee on Credentials

The Sixty-fifth World Health Assembly appointed a Committee on Credentials consisting of delegates of the following Member States: Guyana, Kyrgyzstan, Luxembourg, Malawi, Marshall Islands, Mexico, Niger, San Marino, Sao Tome and Principe, Thailand, United Arab Emirates, Viet Nam.

(First plenary meeting, 21 May 2012)

WHA65(2) Election of officers of the Sixty-fifth World Health Assembly

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

President: Professor Thérèse Aya N'Dri-Yoman (Côte d'Ivoire)

Vice-Presidents: Dr Esperanza Martínez (Paraguay)
Dr Andrei Usatii (Republic of Moldova)
Professor Ali Ghufron Mukti (Indonesia)
Dr Suraya Dalil (Afghanistan)
Mr Charles Sigoto (Solomon Islands)

(First plenary meeting, 21 May 2012)

WHA65(3) Establishment of the General Committee

The Sixty-fifth World Health Assembly, after considering the recommendations of the Committee on Nominations, elected the delegates of the following 17 countries as members of the General Committee: Bahamas, Cambodia, Chad, China, Cuba, Denmark, Djibouti, France, Kenya, Lesotho, Liberia, Mauritania, Nicaragua, Russian Federation, Turkmenistan, United Kingdom of Great Britain and Northern Ireland, United States of America.

(First plenary meeting, 21 May 2012)

WHA65(4) Election of officers of the main committees

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

Committee A:	Chairman	Dr Lyonpo Zangley Dukpa (Bhutan)
Committee B:	Chairman	Professor Mohammad Hossein Nicknam (Islamic Republic of Iran)

(First plenary meeting, 21 May 2012)

The main committees subsequently elected the following officers:

Committee A:	Vice-Chairmen	Dr Fenton Ferguson (Jamaica) Mr Herbert Barnard (Netherlands)
	Rapporteur	Dr Mohamed Jiddawi (United Republic of Tanzania)
Committee B:	Vice-Chairmen	Professor Charles Kondi Agba (Togo) Dr Enrique Tayag (Philippines)
	Rapporteur	Dr Paul Gully (Canada)

(First meetings of Committees A and B, 21 and 23 May 2012, respectively)

WHA65(5) Adoption of the agenda

The Sixty-fifth World Health Assembly adopted the provisional agenda prepared by the Executive Board at its 130th session, with the deletion of two items.

(Second plenary meeting, 21 May 2012)

WHA65(6) Verification of credentials

The Sixty-fifth World Health Assembly recognized the validity of the credentials of the following delegations: Afghanistan; Albania; Algeria; Andorra; Angola; Argentina; Armenia; Australia; Austria; Azerbaijan; Bahamas; Bahrain; Bangladesh; Barbados; Belarus; Belgium; 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; Dominica; Dominican Republic; Ecuador; Egypt; El Salvador; Equatorial Guinea; Eritrea; Estonia; Ethiopia; Fiji; Finland; France; Gabon; Gambia; Georgia; Germany; Ghana; Greece; Guatemala; Guinea; Guyana; Haiti; Honduras; Hungary; Iceland; India; Indonesia; Iran (Islamic Republic of); Iraq; Ireland; Israel; Italy; Jamaica; Japan; Jordan; Kazakhstan; Kenya; Kiribati; Kuwait; Kyrgyzstan; Lao People's Democratic Republic; Latvia; Lebanon; Lesotho; Liberia; Libya; Lithuania; Luxembourg; Madagascar; Malawi; Malaysia; Maldives; Mali; Malta; Marshall Islands; Mauritania; Mauritius; Mexico; Micronesia (Federated States of); Monaco; Mongolia; Montenegro; Morocco; Mozambique; Myanmar; Namibia; Nauru; Nepal; Netherlands; New Zealand; Nicaragua; Niger; Nigeria; Norway; Oman; Pakistan; Palau; Panama; Papua New Guinea; Paraguay; Peru; Philippines; Poland; Portugal; Qatar; Republic of Korea; Republic of Moldova; Romania; Russian Federation; Rwanda; Saint Kitts and Nevis; Samoa; San Marino; Sao Tome and Principe; Saudi Arabia; Senegal; Serbia; Seychelles; Sierra Leone; Singapore; Slovakia; Slovenia; Solomon Islands; Somalia; South Africa; South Sudan; Spain; Sri Lanka; Sudan; Swaziland; Sweden; Switzerland; Syrian Arab Republic; 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, 23 May 2012)

WHA65(7) Election of Members entitled to designate a person to serve on the Executive Board

The Sixty-fifth 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: Australia, Azerbaijan, Belgium, Chad, Croatia, Cuba, Islamic Republic of Iran, Lebanon, Lithuania, Malaysia, Maldives, Panama.

(Ninth plenary meeting, 25 May 2012)

WHA65(8) Prevention and control of noncommunicable diseases: follow-up to the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases

The Sixty-fifth World Health Assembly,

Recalling the Political Declaration of the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases,¹ in particular paragraph 62, to prepare recommendations, before the end of 2012, for a set of voluntary global targets for the prevention and control of noncommunicable diseases and the commitments made to address noncommunicable diseases, principally cardiovascular diseases, cancers, chronic respiratory diseases and diabetes and their common underlying risk factors, namely tobacco use, unhealthy diet, physical inactivity and harmful use of alcohol;

Reaffirming the leading role of WHO as the primary specialized agency for health, as recognized by the United Nations General Assembly in the Political Declaration of the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases, and its responsibility, with the full participation of Member States² pursuant to paragraphs 61 and 62 of the Political Declaration, toward development of a comprehensive global monitoring framework, including a set of indicators, capable of application across regional and country settings, and a set of voluntary global targets for the prevention and control of noncommunicable diseases, before the end of 2012;

Recalling the commitment made in resolution WHA60.23 to achieve the target of reducing death rates from noncommunicable diseases by 2% annually during the period 2006–2015,

(1) Welcomed the reports on prevention and control of noncommunicable diseases³ and recognized the significant progress made in close collaboration with Member States pursuant to paragraphs 61 and 62 of the Political Declaration of the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases;

(2) Decided to adopt a global target of a 25% reduction in premature mortality from noncommunicable diseases by 2025;

¹ United Nations General Assembly resolution 66/2.

² And, where applicable, regional economic integration organizations.

³ Documents A65/6 and A65/6 Add.1.

- (3) Expressed strong support for additional work aimed at reaching consensus on targets relating to the four main risk factors, namely tobacco use, unhealthy diet, physical inactivity and harmful use of alcohol;
- (4) Noted the wide support expressed by Member States¹ and other stakeholders around global voluntary targets considered so far including those relating to raised blood pressure, tobacco use, salt/sodium and physical inactivity;
- (5) Further noted that consultations to date, including discussions during the Sixty-fifth World Health Assembly, indicated support from Member States¹ and other stakeholders for the development of targets relating to obesity, fat intake, alcohol, cholesterol and health system responses such as availability of essential medicines for noncommunicable diseases;
- (6) Noted that other targets or indicators may emerge in the remainder of the noncommunicable diseases follow-up process established by resolution EB130.R7;
- (7) Urged all Member States¹ to participate fully in all remaining steps of the noncommunicable diseases follow-up process described in resolution EB130.R7 including regional and global level consultations;
- (8) Requested the Director-General:
 - (1) to undertake further technical work on targets and indicators and prepare a revised discussion paper on the comprehensive global monitoring framework that reflects all discussions and submissions to date and takes into account measurability, feasibility, achievability and WHO's existing strategies in this area;
 - (2) to consult with Member States,¹ including through regional committees and, where appropriate, regional technical/expert working groups which report to regional committees through the Secretariat, on this revised discussion paper;
 - (3) to continue to consult with all relevant stakeholders in a transparent manner on the revised discussion paper mentioned in subparagraph (8)(1);
 - (4) to prepare a report summarizing the results of the discussions in each of the regional committees and the inputs from the dialogues with stakeholders mentioned in subparagraph (8)(3);
 - (5) to convene a formal meeting of Member States,¹ to be held before the end of October 2012, to conclude the work on the comprehensive global monitoring framework, including indicators, and a set of global voluntary targets for the prevention and control of noncommunicable diseases;
 - (6) to submit a substantive report on the recommendations relating to paragraphs 61 and 62 of the Political Declaration of the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases, through the Executive Board at its 132nd session, to the Sixty-sixth World Health Assembly.

(Tenth plenary meeting, 26 May 2012)

¹ And, where applicable, regional economic integration organizations.

WHA65(9) WHO reform

The Sixty-fifth World Health Assembly,

Having considered the documents on WHO reform presented to the World Health Assembly;¹

Having taken into account the deliberations held and the decisions made on WHO reform by the Executive Board during its 129th session in May 2011, the special session on reform in November 2011, and its 130th session in January 2012, and the meeting of Member States on programmes and priority setting in February 2012,

DECIDED:

Programmatic reforms

- (1) (a) to welcome the report of the Chairman of the Executive Board on the meeting of Member States on programmes and priority setting and the criteria, categories and timeline set out in its three appendices;²
- (b) to request the Director-General to use the agreed framework³ and guidance provided by the Sixty-fifth World Health Assembly, especially concerning health determinants and equity, in the formulation of the draft twelfth general programme of work and the proposed programme budget 2014–2015;

Governance reforms

- (2) to endorse the decision of the Executive Board at its special session in November 2011⁴ to strengthen, streamline and improve the methods of work and roles of the governing bodies;
- (3) to maintain the present schedule of the governing bodies meetings and return to the topic at the session of the Executive Board in January 2013 and, in preparation, to present a feasibility study on the possibility of shifting the financing year;
- (4) to endorse the following proposals for enhancing alignment between the regional committees and the Executive Board:
 - (a) that regional committees be asked to comment and provide input to all global strategies, policies and legal instruments such as conventions, regulations and codes;
 - (b) that the Health Assembly refer specific items to the regional committees in order to benefit from diverse regional perspectives;
 - (c) that regional committees adapt and implement global strategies as appropriate;

¹ Documents A65/5, A65/5 Add.1, A65/5 Add.2, A65/40, A65/43 and A65/INF.DOC./6.

² See document A65/40.

³ See document A65/5 Add.1.

⁴ Decision EBSS2(2).

(d) that chairpersons of the regional committees routinely submit a summary report of the committees' deliberations to the Board;

(5) to endorse the following proposals for increasing harmonization across the regional committees in relation to the nomination of regional directors, the review of credentials, and participation of observers;

Nomination of regional directors

(a) that regional committees that have not yet done so, in line with principles of fairness, accountability and transparency, establish:

- (i) criteria for the selection of candidates; and
- (ii) a process for assessment of all candidates' qualifications;

Review of credentials of Member States

(b) that regional committees that have not yet done so, appoint credentials committees or entrust the task of reviewing credentials to the officers of the regional committee;

Participation of observers

(c) that regional committees that have not yet done so, ensure that there are relevant rules within their Rules of Procedure that enable them to invite observers to attend their sessions, including as appropriate, Member States from other regions, intergovernmental and nongovernmental organizations;

(6) to note that the revised terms of reference for the Programme, Budget and Administration Committee will be submitted to the Executive Board at its 131st session;

(7) to endorse the following proposals for streamlining decision-making and to improve governing body meetings;

(a) that the Officers of the Board use criteria, including those used for priority setting in the draft general programme of work, in reviewing items for inclusion on the Board's agenda;

(b) that the Board consider amending its Rules of Procedure in order to manage the late submission of draft resolutions;

(c) that the governing bodies make better use of the Chairman's summaries, reported in the official record, with the understanding that they do not replace formal resolutions;

(8) to request the Director-General in consultation with Member States:

(a) to propose options on possible changes needed in the Rules of Procedure of the governing bodies to limit the number of agenda items and resolutions;

(b) to propose options on how to streamline the reporting of and communication with Member States;

- (9) to request the Director-General:
- (a) to present a draft policy paper on WHO's engagement with nongovernmental organizations to the Executive Board at its 132nd session in January 2013;
 - (b) to present a draft policy paper on the relationships with private commercial entities to the Executive Board at its 133rd session in May 2013;
 - (c) to present a report on WHO's hosting arrangements of health partnerships and proposals for harmonizing work with hosted partnerships to the Executive Board at its 132nd session;

and further, in support of the development of the documents described in subparagraphs (9)(a), (b) and (c), that the Director-General be guided by the following principles:

- (i) the intergovernmental nature of WHO's decision-making remains paramount;
- (ii) the development of norms, standards, policies and strategies, which lies at the heart of WHO's work, must continue to be based on the systematic use of evidence and protected from influence by any form of vested interest;
- (iii) the need for due consultation with all relevant parties keeping in mind the principles and guidelines laid down for WHO's interactions with Member States and other parties;
- (iv) any new initiative must have clear benefits and add value in terms of enriching policy or increasing national capacity from a public health perspective;
- (v) building on existing mechanisms should take precedence over creating new forums, meetings or structures, with a clear analysis provided of how any additional costs can lead to better outcomes;

Managerial reforms

- (10) to note progress made in relation to strengthening technical and policy support to all Member States;
- (11) to note progress made in relation to staffing policy and practice;
- (12) to request the Director-General, based on guidance received from the Sixty-fifth World Health Assembly, to further develop the proposals to increase the transparency, predictability and flexibility of WHO's financing, for presentation to the Executive Board at its 132nd session;
- (13) to note progress on developing WHO's internal control framework;
- (14) to note progress made in the areas of accountability, risk management, conflict of interest, and the establishment of an ethics office;
- (15) to note that the draft WHO evaluation policy will be presented to the Executive Board at its 131st session;

(16) (a) to note the findings and recommendations of the Stage one evaluation report presented by the External Auditor;¹

(b) to note the proposed terms of reference of the second stage of the independent evaluation as outlined in the report of the External Auditor and to request the Director-General to provide a paper on the specific modalities of this evaluation for consideration by the Executive Board at its 132nd session;

(17) to note progress made in the area of strategic communications;

(18) to endorse the decisions and conclusions reached by the Board at its special session on reform with regard to organizational effectiveness, alignment and efficiency; financing of the Organization; human resources policies and management; results-based planning, management and accountability, and strategic communications;²

(19) to request the Director-General to report, through the Executive Board at its 132nd session, to the Sixty-sixth World Health Assembly, on progress in the implementation of WHO reform on the basis of a monitoring and implementation framework.

(Tenth plenary meeting, 26 May 2012)

WHA65(10) United Nations Joint Staff Pension Fund: appointment of representatives to the WHO Staff Pension Committee

The Sixty-fifth World Health Assembly nominated Dr Ali Jaffer Mohamed of the delegation of Oman as a member, and Dr Michel Tailhades of the delegation of Switzerland as alternate member of the WHO Staff Pension Committee for a three-year term until May 2015.

(Tenth plenary meeting, 26 May 2012)

WHA65(11) Selection of the country in which the Sixty-sixth World Health Assembly would be held

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

(Tenth plenary meeting, 26 May 2012)

¹ Document A65/5 Add.2.

² Decision EBSS2(3).

ANNEXES

ANNEX 1

CONTRACT OF THE DIRECTOR-GENERAL¹

[A65/4 Rev.1 – 26 April 2012]

THIS CONTRACT is made this twenty-third day of May of the year two thousand and twelve between the World Health Organization (hereinafter called the Organization) of the one part and Dr Margaret Fu Chun Chan Fung (hereinafter called the Director-General) of the other part.

WHEREAS

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

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

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

I. (1) The Director-General shall serve from the first day of July of the year two thousand and twelve until the thirtieth day of June of the year two thousand and seventeen, on which date the appointment and this Contract shall terminate.

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

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

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

(5) The Director-General may at any time give six months' notice of resignation in writing to the Board, which is authorized to accept such resignation on behalf of the Health Assembly; in which

¹ See resolution WHA65.1.

case, upon the expiration of the said period of notice, the Director-General shall cease to hold the appointment and this Contract shall terminate.

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

II. (1) As from the first day of July of the year two thousand and twelve the Director-General shall receive from the Organization an annual salary of two hundred and thirty-two thousand eight hundred and fifty-nine United States dollars, before staff assessment, resulting in a net salary (to be paid monthly) of one hundred and seventy-six thousand five hundred and one United States dollars per annum at the dependency rate (one hundred and fifty-six thousand nine hundred and sixty four United States dollars at the single rate) or its equivalent in such other currency as may be mutually agreed between the parties to this Contract.

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

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

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

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

[signed]

Dr Margaret Chan
Director-General

[signed]

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President of the World Health Assembly

ANNEX 2

Comprehensive implementation plan on maternal, infant and young child nutrition¹

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RATIONALE

Global nutrition challenges are multifaceted

1. Adequate provision of nutrients, beginning in early stages of life, is crucial to ensure good physical and mental development and long-term health. Poor availability or access to food of adequate nutritional quality or the exposure to conditions that impair absorption and use of nutrients has led to large sections of the world's population being undernourished, having poor vitamin and mineral status or being overweight and obese, with large differences among population groups. These conditions are often present simultaneously and are interconnected.

2. In women, both low body mass index and short stature are highly prevalent in low-income countries, leading to poor fetal development, increased risk of complications in pregnancy, and the need for assisted delivery.² In some countries in south-central Asia, more than 10% of women aged 15–49 years are shorter than 145 cm. In sub-Saharan Africa, south-central and south-eastern Asia, more than 20% of women have a body mass index less than 18.5 kg/m² and this figure is as high as 40% in Bangladesh, Eritrea and India. Conversely, an increased proportion of women start pregnancy with a body mass index greater than 30 kg/m² leading to increased risk of complications in pregnancy and delivery as well as heavier birth weight and increased risk of obesity in children.

3. Iron-deficiency anaemia affects 30% women of reproductive age (468 million), and 42% of pregnant women (56 million). Maternal anaemia is associated with reduced birth weight and increased risk of maternal mortality. Anaemia rates have not improved appreciably over the past two decades.³

4. Every year an estimated 13 million children are born with intrauterine growth restriction⁴ and about 20 million with low birth weight.⁵ A child born with low birth weight has a greater risk of

¹ Endorsed by the Sixty-fifth World Health Assembly in resolution WHA65.6.

² Black RE et al. Maternal and Child Undernutrition Study Group. Maternal and child undernutrition: global and regional exposures and health consequences. *Lancet*, 2008; **371**:243-260. Data are also taken from the Monitoring and Evaluation to Assess and Use Results Demographic and Health Surveys (MEASURE DHS) project (<http://www.measuredhs.com/Data/>, accessed 27 March 2012).

³ United Nations System Standing Committee on Nutrition. *Progress in nutrition: Sixth report on the world nutrition situation*. Geneva, United Nations System Standing Committee on Nutrition Secretariat, 2010.

⁴ de Onis M, Blössner M, Villar J. Levels and patterns of intrauterine growth retardation in developing countries. *European Journal of Clinical Nutrition*, 1998; **52**(Suppl.1):S5-S15.

⁵ United Nations Children's Fund and World Health Organization, *Low birthweight: country, regional and global estimates*. New York, United Nations Children's Fund, 2004.

morbidity and mortality and is also more likely to develop noncommunicable diseases, such as diabetes and hypertension, later in life.

5. In 2010 about 115 million children worldwide were underweight, 55 million had low weight for their height and 171 million under the age of five years had stunted growth.¹ The proportion of children under the age of five years in developing countries who were underweight is estimated to have declined from 29% to 18% between 1990 and 2010, a rate that is still inadequate to meet the Millennium Development Goal 1, Target 1.C of halving levels of underweight between 1990 and 2015. Sufficient decline took place in Asia and Latin America, but considerable efforts are still needed in Africa. In addition, in 2010, 43 million preschool children in developing and developed countries were overweight or obese.² The prevalence of childhood obesity in low- and middle-income countries has been accelerating in the past 10 years; WHO estimates that in 2015 the rate will reach 11%, close to the prevalence in upper-middle-income countries (12%). Obese children are likely to grow into obese adults; have an increased risk of type 2 diabetes, liver disease and sleep-associated breathing disorders; and have diminished chances of social and economic performance in adult life.

6. Anaemia affects 47.4% (293 million children) of the preschool-age population,³ and 33.3% (190 million) of the preschool-age population globally is deficient in vitamin A.⁴

7. Nutritional status is also influenced by several environmental factors. In countries where the prevalence of HIV infection is high, HIV infection has both a direct impact on the nutritional status of women and children who are infected and an indirect effect through alterations in household food security and inappropriate choices of infant-feeding practices in order to prevent mother-to-child transmission of HIV. Poor food security also increases risk-taking behaviour by women that places them at increased risk of becoming infected with HIV. Tobacco use (both smoking and smokeless tobacco) during pregnancy adversely affects fetal health. Direct maternal smoking as well as exposure to second-hand smoke during pregnancy increases the risk of complications in pregnancy, including low birth weight and preterm birth. More people are smoking in many low- to middle-income countries, in particular young girls and women of reproductive age. Although the proportion of women smoking is low in many countries, women and their offspring still face substantial risks of adverse pregnancy outcomes because of their exposure to second-hand smoke. Use of tobacco transmits tobacco contaminants to the fetus through the placenta and to neonates through breast milk. Expenditure on tobacco also limits the capacity of families to provide better nutrition for pregnant women and children.

8. Childhood malnutrition is the underlying cause of death in an estimated 35% of all deaths among children under the age of five years. More than two million children die each year as a result of undernutrition before the age of five years and iron-deficiency anaemia is estimated to contribute to a significant number of maternal deaths every year in low- and middle-income countries. Maternal and child undernutrition account for 11% of the global burden of disease.⁵

¹ Underweight and stunting, in: *World health statistics 2010*, Geneva, World Health Organization, 2010.

² de Onis M, Bloessner M, Borghi E. Global prevalence and trends of overweight and obesity among preschool children. *The American Journal of Clinical Nutrition* 2010;92:1257–64.

³ De Benoist B, McLean E, Egli I, Cogswell M (Eds). *Worldwide prevalence of anaemia 1993–2005: WHO global database on anaemia*. Geneva, World Health Organization, 2008, pp.1–40.

⁴ *Global prevalence of vitamin A deficiency in populations at risk 1995–2005: WHO global database on vitamin A deficiency*. Geneva, World Health Organization, 2009.

⁵ Black RE et al. Maternal and Child Undernutrition Study Group. Maternal and child undernutrition: global and regional exposures and health consequences. *Lancet*. 2008; **371**:243-260.

9. Malnutrition has a negative impact on cognitive development, school performance and productivity. Stunting and iodine and iron deficiencies, combined with inadequate cognitive stimulation, are leading risk factors contributing to the failure of an estimated 200 million children to attain their full development potential. Each 1% increase in adult height is associated with a 4% increase in agricultural wages¹ and eliminating anaemia would lead to an increase of 5% to 17% in adult productivity. Malnutrition is an impediment to the progress towards achieving Millennium Development Goals 1 (Eradicate extreme poverty and hunger), 2 (Achieve universal primary education), 3 (Promote gender equality and empower women), 4 (Reduce child mortality), 5 (Improve maternal health) and 6 (Combat HIV/AIDS, malaria and other diseases).

Effective nutrition actions exist but are not implemented on a sufficiently large scale

10. A review and policy analysis of Member States in 2009–2010² indicated that most countries have a range of policies and programmes on nutrition. However, such policies are often inadequate in face of the complexity of the challenges of maternal, infant and young child nutrition and do not produce the expected impact.

11. Even when nutrition policies exist, they have not always been officially adopted, often do not articulate operational plans and programmes of work with clear goals and targets, timelines and deliverables; they do not specify roles and responsibilities for those involved, or identify workforce and capacity needs; and they do not include process and outcome evaluation.

12. The policy review indicated that correcting maternal undernutrition was not a priority in countries with a high burden of maternal mortality. Few of the 36 countries with the greatest burden of undernutrition implement on a national scale the full set of effective interventions to prevent child underweight and maternal undernutrition and to foster early child development.

13. Interventions that can be managed directly by the health sector lack detailed implementation guidance and are only partially implemented where health systems are weak. Many countries have adopted integrated strategies for maternal, newborn and child health that incorporate nutrition interventions, but the actual delivery of nutrition support in health services is often inadequate and few indicators are available to measure the coverage.

14. National development strategies do not give due consideration to nutrition. National food and nutrition policies often focus on information and informed-choice models and give little attention to structural, fiscal and regulatory actions aimed at changing unfavourable food environments.

15. Programme implementation is not well coordinated among different actors. In all regions most coordination and administration of policies occurred within health ministries, with variable input from ministries of education, agriculture, food and welfare. Policy and programme implementation often depends on external funding and is not sustainable. Monitoring of activities is either not regularly done or is poorly done.

16. The implementation of the International Code of Marketing of Breast-milk Substitutes and subsequent related Health Assembly resolutions is not consistent among countries. Statutory regulations have been put in place in 103 Member States and have been drafted in 9; 37 Member

¹ Haddad L, Bouis HE. *The impact of nutritional status on agricultural productivity: wage evidence from the Philippines*. Warwick (United Kingdom of Great Britain and Northern Ireland), Development Economics Research Centre. Papers, No. 97, 1989.

² *A review of food and nutrition policies*. Geneva, World Health Organization, 2012.

States rely on voluntary compliance by infant formula manufacturers, and 25 Member States have not taken action to enforce the Code; information is missing for 20 Member States.¹

17. In most of those 103 Member States, the legislation makes provisions for the prohibition of promotion of designated products to the general public and health workers and in health-care facilities, and sets labelling requirements. Fewer Member States have provisions on contamination warnings, and bans on nutrition and health claims.

18. Less than 50% of countries with legal measures also have legal provisions on monitoring implementation of the Code. Only 37 of those countries have established functioning monitoring and/or enforcement mechanisms, and limited information on the composition, mandate and functions of such mechanisms is available.

19. Regional offices continue to update the information on implementation of the Code. A recent PAHO review on implementation over the period 1981–2011² indicated that 16 countries have legal measures and six of them regulate the implementation of the relevant law. In a review in 2007, UNICEF found that, of 24 West and Central African countries,³ half had comprehensive legal measures in place.

OBJECTIVE, TARGETS AND TIME FRAME

20. The plan aims to alleviate the double burden of malnutrition in children, starting from the earliest stages of development. Substantial benefits can be obtained by concentrating efforts from conception through the first two years of life, but at the same time a life-course approach needs to be considered so that good nutritional status can be maintained.

21. Progress can be made in the short term, and most nutrition challenges can be resolved within the current generation. For example, currently available nutrition interventions should be able to avert at least one third of the cases of stunting in the short term.⁴ However, full elimination of some conditions may require a longer time frame. Commitment to a decade of investment to expand nutrition interventions should be made, with the aim of averting one million child deaths per year. Taking into account the need to align the implementation of the plan to other development frameworks that also consider nutrition, it is proposed that this plan has a 13-year time frame (2012–2025). Reporting will be done biennially until 2022 and the last report will be done in 2025.

22. Global targets are important to identify priority areas and to catalyse global change. Global targets may inspire choices of priorities and ambitions established at country level. They are not meant to dictate the choices of individual countries and regions. Global targets may be used to measure achievements and to develop accountability frameworks. Targets are needed for nutrition conditions

¹ Information from UNICEF; these countries also include all Member States that reported on implementation of the Code, as required its Articles 11.6 and 11.7. Questionnaires were sent to Member States in 2007 and 2009 and the results were summarized in documents A61/17 Add.1, section F, and A63/9.

² Sokol E, Aguayo V, Clark D. *Protecting breastfeeding in West and Central Africa: 25 years implementing the International Code of Marketing of Breast-milk Substitutes*. Dakar, UNICEF Regional Office for West and Central Africa, 2007.

³ 30 años del Código en América Latina: Un recorrido sobre diversas experiencias de aplicación del Código Internacional de Comercialización de Sucedáneos de la Leche Materna en la Región entre 1981 y 2011. Washington DC, PAHO, 2011.

⁴ Bhutta ZA et al. for the Maternal and Child Undernutrition Study Group. What works? Interventions for maternal and child undernutrition and survival. *Lancet*, 2008, 371:417-440.

that are responsible for a large burden of nutrition-related morbidity and mortality from conception through the first two years of life: stunting, maternal anaemia and low birth weight.¹ Child underweight – of which stunting represents the largest fraction – is the largest cause of deaths and disability-adjusted life years in children under the age of five years, and iron deficiency contributes to maternal mortality in low- and middle-income countries. Such targets would complement and underpin Target 1.C of Millennium Development Goal 1 in relation to reducing the prevalence of underweight children. Under that Goal, a fourth target on childhood overweight is warranted, given the rapid increase observed globally in the prevalence of that condition. The proposed targets are based on country experiences and the existence of effective interventions.

23. Global target 1: by 2025, a 40% reduction of the global number of children under five who are stunted. This target implies a relative reduction of 40% of the number of children stunted by the year 2025, compared to the baseline of 2010. This would translate into a 3.9% relative reduction per year between 2012 and 2025² and implies reducing the number of stunted children from the 171 million in 2010 to approximately 100 million, i.e. approximately 25 million less than what this number would be if current trends are not changed.³ An analysis of 110 countries for which stunting prevalence is available on at least two occasions in the 1995–2010 period⁴ reveals that global stunting is dropping at the rate of 1.8% per year (2.6% in countries with prevalence higher than 30%). In this period 20% of the countries have reduced stunting at a rate of 3.9 % or higher.

24. Global target 2: by 2025, a 50% reduction of anaemia in women of reproductive age. This target implies a relative reduction of 50% of the number of non-pregnant women of reproductive age (15–49 years) affected by anaemia by the year 2025, compared to a baseline set in the period 1993–2005 and used as a reference starting point. This would translate into a 5.3% relative reduction per year between 2012 and 2025 and implies reducing the number of anaemic non-pregnant women to approximately 230 million. Several countries have demonstrated a reduction in anaemia prevalence in non-pregnant women, as indicated by repeated national surveys reported in the Sixth report on the world nutrition situation of the United Nations Standing Committee on Nutrition:⁵ China from 50% to 19.9% in 21 years (1981–2002); Nepal from 65% to 34% in 8 years (1998–2006); Sri Lanka from 59.8% to 31.9% in 13 years (1988–2001); Cambodia from 56.2% to 44.4% in 6 years (2000–2006); Viet Nam from 40% to 24.3% in 14 years (1987–2001); and Guatemala from 35% to 20.2% in 7 years (1995–2002). These estimates point to a 4% to 8% relative reduction per year.

25. Global target 3: by 2025, a 30% reduction of low birth weight. The target implies a relative reduction of 30% of the number of infants born with a weight lower than 2500 grams by the year 2025, compared to a baseline set in 2006–2010 and used as a reference starting point. This would translate into a 3.9% relative reduction per year between 2012 and 2025. In Bangladesh and India, where around half the world's children with low birth weight are born, the prevalence of low birth weight decreased, respectively from 30.0% to 21.6% (between 1998 and 2006) and from 30.4% to 28.0% (between 1999 and 2005). Reduction in the prevalence of low birth weight has been observed in El Salvador (from 13% to 7% between 1998 and 2003), South Africa (15.1% to 9.9% from 1998 to 2003),

¹ The development of global targets has been requested by Member States during regional consultation. Draft targets have been discussed at the regional consultations in the Region of the Americas and the Eastern Mediterranean Region but broader discussion with Member States is required at the Executive Board and through electronic consultation.

² $r = \ln(P1/P2)/t$.

³ de Onis M, Bloessner M, Borghi E. Prevalence and trends of stunting among pre-school children, 1990–2020. *Public Health Nutrition*, 2012, 15:142–148.

⁴ Obtained from 430 data points.

⁵ United Nations Standing Committee on Nutrition. Sixth report on the world nutrition situation. Geneva, 2010.

and the United Republic of Tanzania (from 13.0% to 9.5% between 1999 and 2005). In these examples, the recorded reductions are in the order of 1% to 12% per year. The higher reduction rates have been observed in countries where a large proportion of the low birth weight is accounted for by intrauterine growth restriction, which is more amenable to reduction than pre-term birth.

26. **Global target 4: by 2025, no increase in childhood overweight.** The target implies that the global prevalence of 6.7% (95% confidence interval (CI) 5.6–7.7) estimated for 2010 should not rise to 10.8% (in 2025) as per current trends¹ and that the number of overweight children under five years should not increase from 43 million to approximately 70 million as it could be forecast. The rates of increase are variable in different parts of the world, with more rapid increases in countries that are rapidly expanding their food systems, such as in North Africa. In higher income countries national and regional level information indicate that higher socioeconomic groups have a lower increase in childhood obesity. Lifestyle and environmental interventions used in such circumstances can be used as an example of good practice. In low- and middle-income countries little programmatic experience exists. Programmes aimed at curbing childhood obesity have mainly targeted school age children.² It would also be important to prevent an increase in childhood overweight in countries that are addressing the reduction of stunting.

27. **Global target 5: by 2025, increase the rate of exclusive breastfeeding in the first six months up to at least 50%.** This target implies that the current global average, estimated to be 37% for the period 2006–2010, should increase to 50% by 2025. This would involve a 2.3% relative increase per year and would lead to approximately 10 million more children being exclusively breastfed until six months of age. Globally, exclusive breastfeeding rates increased from 14% in 1985 to 38% in 1995, but decreased subsequently in most regions. However, rapid and substantial increases in exclusive breastfeeding rates, often exceeding the proposed global target, have been achieved in individual countries in all regions, such as Cambodia (from 12% to 60% between 2000 and 2005), Mali (from 8% to 38% between 1996 and 2006) and Peru (from 33% to 64% between 1992 and 2007).

28. **Global target 6: by 2025, reduce and maintain childhood wasting to less than 5%.** This target implies that the global prevalence of childhood wasting of 8.6% estimated for 2010 should be reduced to less than 5% by 2025 and maintained below such levels.³ In the period 2005–2010, 53 countries reported childhood wasting rates above 5% at least once. Wasting reduction requires the implementation of preventive interventions such as improved access to high-quality foods and to health care; improved nutrition and health knowledge and practices; promotion of exclusive breastfeeding for the first six months and promotion of improved complementary feeding practices for all children aged 6–24 months; and improved water and sanitation systems and hygiene practices to protect children against communicable diseases. Large numbers of children with severe wasting can be treated in their communities without being admitted to a health facility or a therapeutic feeding centre.⁴ For moderate acute malnutrition, treatment should be based on optimal use of locally available food, complemented when necessary by specially formulated supplementary foods.

¹ de Onis M, Bloessner M, Borghi E. Global prevalence and trends of overweight and obesity among preschool children. *American Journal of Clinical Nutrition*, 2010, 92:1257–1264.

² Population-based prevention strategies for childhood obesity: report of a WHO forum and technical meeting, Geneva, 15–17 December 2009.

³ WHO global and regional trend estimates for child malnutrition.

⁴ Community-based management of severe acute malnutrition. A Joint Statement by the World Health Organization, the World Food Programme, the United Nations System Standing Committee on Nutrition and the United Nations Children's Fund. WHO, Geneva, 2007.

ACTIONS

29. This action plan illustrates a series of priority actions that should be jointly implemented by Member States and international partners. Specific regional and country adaptation will be needed, led by the relevant national and regional institutions.

ACTION 1: To create a supportive environment for the implementation of comprehensive food and nutrition policies

30. Progress towards nutrition goals requires high-level policy commitment and broad societal support. Existing food and nutrition policies need to be reviewed so that they comprehensively meet all main nutrition challenges and deal with the distribution of those problems within society. A further aim of such review is to ensure that nutrition is placed centrally in other sectoral policies and in overall development policy. Crucial factors for the successful implementation of these policies are: (a) official adoption by relevant governmental bodies; (b) the establishment of an intersectoral governance mechanism; (c) the engagement of development partners; and (d) the involvement of local communities. The private sector may also contribute to a better food supply and to increased employment and therefore income. Adequate safeguards to prevent potential conflicts of interest should be put in place.

31. Proposed activities for Member States

- (a) revise nutrition policies so that they comprehensively address the double burden of malnutrition with a human rights-based approach and an official endorsement of parliament or government;
- (b) include nutrition in the country's overall development policy, Poverty Reduction Strategy Papers and relevant sectoral strategies;
- (c) establish effective intersectoral governance mechanisms for implementation of nutrition policies at national and local levels that contribute towards policy integration across sectors;
- (d) engage local governments and communities in the design of plans to expand nutrition actions and ensure their integration in existing community programmes;
- (e) establish a dialogue with relevant national and international parties and form alliances and partnerships to expand nutrition actions with the establishment of adequate mechanisms to safeguard against potential conflicts of interest.

32. Proposed activities for the Secretariat

- (a) provide support to Member States, on request, in strengthening national nutrition policies and strategies, and nutrition components of other sectoral policies including national development policies and Poverty Reduction Strategy Papers;
- (b) improve access to normative and policy guidelines, knowledge products, tools and expert networks.

33. Proposed activities for international partners

- (a) implement global advocacy initiatives that increase public awareness of the need to expand actions on nutrition;
- (b) strengthen international cooperation on nutrition in order to harmonize standards, policies and actions through adequate mechanisms and intergovernmental bodies, such as the World Health Assembly, the Committee on World Food Security and the United Nations Economic and Social Council;
- (c) engage in international coordination mechanisms or partnerships, including the Scaling Up Nutrition movement and the United Nations System Standing Committee on Nutrition.

ACTION 2: To include all required effective health interventions with an impact on nutrition in national nutrition plans

34. Many diverse interventions aimed at changing behaviours, providing nutritional support and reducing the exposure to several environmental risk factors have been shown to be effective and should be considered for implementation at national scale. Effective direct nutrition interventions and health interventions that have an impact on nutrition and that can be delivered by the health system are summarized in a background paper to this plan¹ and reported in the WHO e-Library of Evidence for Nutrition Actions. The lists include interventions that need to be considered either for selected population groups or in special circumstances, including emergencies. WHO's guideline process ensures that evidence is continuously updated and that gaps in research are identified. Such interventions are intended as options that could be implemented on the basis of country needs.

35. The greatest benefits result from improving nutrition in the early stages of life. However, a life-course approach to improving nutrition is also needed, with activities targeting older children and adolescents besides infants and young children, in order to ensure the best possible environment for mothers before conception so as to reduce the incidence of low birth weight and to break the intergenerational cycle of malnutrition. Management of childhood overweight would also require action throughout the school years.²

36. Interventions should be integrated into existing health-care systems to the extent possible. They should be linked to existing programmes and delivered as packages, in order to improve cost efficiency. Implementation of WHO's approaches and interventions – Integrated Management of Childhood Illness, Integrated Management of Adolescent and Adult Illness and Integrated Management of Pregnancy and Childbirth – will be essential. Furthermore, strengthening health systems forms a central element of a successful nutrition strategy.

37. The design of packages of intervention can be based on country needs and the level of investment. Community-based programmes that integrate different direct nutrition interventions in primary care, with systems to ensure universal access, should be prioritized as being cost-effective. A group of organizations in the United Nations system has jointly produced the United Nations OneHealth Costing Tool – software that can easily be adapted to different country contexts.

¹ *Essential nutrition actions. Improving maternal-newborn-infant and young child health and nutrition.* Geneva, World Health Organization, 2012.

² *Population-based prevention strategies for childhood obesity: report of a WHO forum and technical meeting, Geneva, 15–17 December 2009.* Geneva, World Health Organization, 2010.

38. Proposed activities for Member States

- (a) include all proven nutrition interventions relevant for the country in maternal, child and adolescent health services and ensure universal access;
- (b) reflect the global strategy on infant and young child nutrition, the global strategy on diet and physical activity and the WHO nutrition guidelines in national policies;
- (c) strengthen health systems, promote universal coverage and principles of primary health care;
- (d) develop or where necessary strengthen legislative, regulatory and/or other effective measures to control the marketing of breast-milk substitutes in order to ensure implementation of the International Code of Marketing of Breast-milk Substitutes and relevant resolutions adopted by the Health Assembly;
- (e) engage in vigorous campaigns to promote breastfeeding at the local level.

39. Proposed activities for the Secretariat

- (a) review, update and expand WHO's guidance on and tools for effective nutrition actions, highlight good practice of delivery mechanisms and disseminate the information;
- (b) apply cost-effectiveness analysis to health interventions with an impact on nutrition;
- (c) provide support to Member States, on request, in implementing policies and programmes aimed at improving nutritional outcomes;
- (d) provide support to Member States, on request, in their efforts to develop or where necessary strengthen and monitor legislative, regulatory and other effective measures to control marketing of breast-milk substitutes;
- (e) convene a meeting with academic partners to develop a prioritized research agenda.

40. Proposed activities for international partners

- (a) align plans for development assistance to nutrition actions recognized as effective;
- (b) support the nutrition components of health strategies for maternal and child health, such as the Integrated Maternal Newborn and Child Health Strategy.

ACTION 3: To stimulate development policies and programmes outside the health sector that recognize and include nutrition

41. Sectoral development strategies that are sensitive to issues of nutrition are needed in order to reduce the double burden of undernutrition and overweight; these should aim to promote the demand for and supply of healthier food and to eliminate constraints to its access and to use of healthier food. Many sectors should be engaged, but mainly agriculture, food processing, trade, social protection, education, labour and public information. Cross-cutting issues such as gender equality, quality of governance and institutions, and peace and security should also be considered. These matters could be

considered in the development and implementation of a framework akin to the WHO Framework Convention on Tobacco Control, which has provided substantial impetus to the control of tobacco use.

42. The Committee on World Food Security is preparing a global strategic framework on food security and nutrition. In the meantime, a series of general principles can be derived from existing policy frameworks, country experience and analysis of the evidence. For example, chronic malnutrition has been successfully reduced in some countries in South-East Asia and Latin America thanks to the simultaneous implementation of policies and programmes aimed at improving food security, reducing poverty and social inequalities, and enhancing maternal education.

43. For food security, increased access to foods of good nutritional quality¹ should be ensured in all local markets at an affordable price all year round, particularly through support to smallholder agriculture and women's involvement but with consideration being given to the potential negative impact of labour-displacing mechanization and cash-crop production and of pressure on women's time. In food manufacture, the nutrient profile, including better micronutrient content and reduced content of salt, sugar and saturated and *trans*-fats, needs to be improved. In the area of education, better women's education and improvements in water and sanitation are associated with better child nutrition.

44. Employment policies are crucial to household food security, but labour policies should also ensure adequate maternity protection and that employees could work in a better environment, including protection from second-hand smoke, and access to healthy food. An adequate environment should be created in the workplace for breastfeeding mothers. Social protection is needed to redress inequalities and must reach the most vulnerable. Cash transfers to the poor are used to guarantee food needs. Conditional cash transfers, linking the receipt of cash to bringing children to health centres and school, can have a positive impact on children's nutritional status, including increase in height and birth weight.

45. Trade measures, taxes and subsidies are an important means of guaranteeing access and enabling healthy dietary choices. They can be powerful tools when associated with adequate information for consumers through nutrition labelling and responsible food marketing, and with social marketing and promotion of healthy diets and healthy lifestyles.

46. Examples of policy measures engaging different relevant sectors that may be considered include: investment in small-scale agriculture, the promotion of fruit and vegetable production and of micronutrient-rich crop varieties (agriculture); the promotion of micronutrient fortification of foods and of reduced content of salt, sugars, saturated and *trans*-fatty acids in foods (food production); improvements in water and sanitation (infrastructure); investments in women's primary and secondary education and school nutrition policies (education); maternity protection in the workplace and healthy workplaces (labour); cash transfers and food aid (social protection); healthy built environments (urban planning); regulation of advertising food and beverages to children, food-labelling schemes, food-price regulatory measures, implementation of the International Code of Marketing of Breast-milk substitutes (trade); use of excise taxes on tobacco and alcohol to finance expansion of nutrition programmes (finance); mass media campaigns and social marketing for breastfeeding promotion, and healthy diet and physical activity (information and social mobilization).

¹ Food with high nutrient density and low concentrations of nutrients associated with increased risk of noncommunicable diseases.

47. Proposed activities for Member States

- (a) review sectoral policies in agriculture, social protection, education, labour and trade to determine their impact on nutrition and include nutrition indicators in their evaluation frameworks;
- (b) establish a dialogue between health and other government sectors in order to consider policy measures that could improve the nutritional status of the population and to address potential conflict between current sectoral policies and health policies aimed at improving nutrition;
- (c) implement the recommendations on the marketing of food and non-alcoholic beverages to children (resolution WHA63.14).

48. Proposed activities for the Secretariat

- (a) develop methodological guidelines on the analysis of the health and nutrition impact of sectoral policies, including that on different socioeconomic and other vulnerable groups (e.g. indigenous peoples);
- (b) identify and disseminate examples of good practice of sectoral policy measures benefiting nutrition.

49. Proposed activities for international partners

- (a) engage in consultations in order to analyse the health and nutrition implications of existing policies involving trade, agriculture, labour, education, and social protection, with the aim of identifying and describing policy options to improve nutritional outcomes;
- (b) analyse evidence of effectiveness of interventions aimed at improving food security, social welfare and education in low-income countries.

ACTION 4: To provide sufficient human and financial resources for the implementation of nutrition interventions

50. Technical and managerial capabilities are needed for implementation of nutrition programmes at full scale and for the design and implementation of multisectoral policies. Capacity development should be an integral part of plans to extend nutrition interventions. The availability of human resources limits the expansion of nutrition actions, and the proportion of primary care workers to the population is a major determinant of programme effectiveness. Capacity building in nutrition is required in both the health sector at all levels and other sectors.

51. More financial resources are needed to increase the coverage of nutrition interventions. Currently, nutrition programmes receive less than 1% of overall development assistance. The World Bank has calculated that US\$ 10 500 million would be needed each year to implement on a national scale top-priority nutrition interventions in the countries with the highest burden of maternal and child

undernutrition.¹ Furthermore, predictable resources are essential to sustain an increased level of programme delivery.

52. Joint efforts are required of both governments and donors. Increased resources may come from innovative financing mechanisms, such as the ones discussed in the context of maternal and child health.

53. Governments need to establish a budget line for nutrition programmes and identify financing targets for nutrition programmes. Excise taxes (for example, on tobacco and alcohol) may be used to establish national funds to expand nutrition interventions.

54. At the international level, mechanisms considered for maternal and child health promotion include an international financing facility, advance market commitments to fund research and development, a “De-Tax” to earmark a share of value-added taxes on goods and services for development, and voluntary solidarity contributions through electronic airline ticket sales or mobile phone contracts. Results-based funding as an incentive to achieve targets has also been considered by donors.

55. From the expense side, greater efficiency needs to be sought in funding programmes, including better alignment of donors’ investments with national priorities, and measures to reduce the cost of micronutrient supplements and ready-to-use therapeutic food, also by reducing patenting fees.

56. Financial monitoring and transparency in the use of resources will be needed for better accountability and increased efficiency.

57. **Proposed activities for Member States**

- (a) identify and map capacity needs, and include capacity-development in plans to expand nutrition actions;
- (b) implement a comprehensive approach to capacity building, including workforce development as well as leadership development, academic institutional strengthening, organizational development and partnerships;
- (c) cost the expansion plan and quantify the expected benefits, including the proportion needed for capacity development and strengthening the delivery of services;
- (d) provide support to local communities for the implementation of community-level nutrition actions;
- (e) establish a budget line and national financial targets for nutrition;
- (f) channel funds obtained from excise taxes to nutrition interventions.

¹ Horton S, et al. *Scaling up nutrition. What will it cost?* Washington, DC, The World Bank, 2010.

58. **Proposed activities for the Secretariat**

- (a) support workforce development, leadership, technical and managerial capacities in nutrition in Member States through workshops, distance learning and communities of practice, and provision of training materials;
- (b) make available refined tools for capacity building, and support the capacity-building efforts of Member States;
- (c) provide costing tools for nutrition interventions.

59. **Proposed activities for international partners**

- (a) follow the principles of the Paris Declaration on Aid Effectiveness and the Accra Agenda for Action, and align donor support at country level;
- (b) set international competency standards, specific to the development of the public health nutrition workforce, that recognize different tiers in the workforce (frontline workers, managers and specialists) and different contexts for policy (i.e. capacities for intersectoral action) and practice (i.e. the double burden of malnutrition), and support revisions of curricula for pre-service and in-service training of all levels of health workers;
- (c) establish academic alliances aimed at providing institutional support to capacity development in Member States;
- (d) explore innovative financing tools for funding the expansion of nutrition programmes.

ACTION 5: To monitor and evaluate the implementation of policies and programmes

60. A well-defined monitoring framework is needed to assess progress made towards the objectives of the comprehensive implementation plan. The framework has to provide accountability for the actions implemented, resources and results and include indicators for input (policy and legislative frameworks and human resources), output and outcome (nutrition programme implementation and food security) and impact (nutritional status and mortality).

61. A proposed set of indicators is provided in the background document developed by WHO in preparation of this plan.¹ Indicators need to be adapted to the country context and priorities, but will be retained for assessment purposes at the global level. Additional indicators should be considered for monitoring progress in intersectoral action.

62. Surveillance systems should be established to ensure regular flow of information to policy-makers. Reporting time should be in line with national priorities and the requirements of the governing bodies.²

¹ *Indicators to monitor the implementation and achievements of initiatives to scale up nutrition actions*. Geneva, World Health Organization, 2012.

² Reporting implementation of the plan could be combined with the biennial reporting to the Health Assembly called for in Article 11.7 of the International Code of Marketing of Breast-milk Substitutes, adopted by the Health Assembly in resolution WHA34.22.

63. Proposed activities for Member States

- (a) develop or strengthen surveillance systems for the collection of information on selected input, output/outcome and impact indicators;
- (b) implement the WHO child growth standards to monitor individual growth patterns and population levels of stunting, wasting and overweight;
- (c) ensure that nutrition indicators are adequately reported in the annual review process recommended by the Commission on Information and Accountability for Women's and Children's Health in countries with lowest income and highest burden of maternal and child deaths and that social differentials are adequately highlighted.

64. Proposed activities for the Secretariat

- (a) provide methodological support for the collection of selected input, output/outcome and impact indicators, including protocols and design of surveillance systems;
- (b) establish a database of selected input, output/outcome and impact indicators;
- (c) report on global progress in developing, strengthening and implementing national nutrition plans, policies and programmes;
- (d) support Member States in implementing the WHO child growth standards.

65. Proposed activities for international partners

- (a) adopt the proposed framework of indicators as a tool to monitor the implementation of development activities;
 - (b) support the collection and exchange of information between organizations, with the aim of ensuring global coverage of the databases of input, output/outcome and impact indicators.
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ANNEX 3

Agreement between the Commission of the African Union and the World Health Organization

[A65/42, Annex – 23 May 2012]

The Commission of the African Union (hereinafter referred to as the “AU Commission”) on the one hand; and

The World Health Organization (hereinafter referred to as “WHO”) on the other hand;

Hereinafter separately and collectively respectively referred to as the “Party” and the “Parties”

Considering that one of the objectives of the African Union (hereinafter referred to as the “AU”) is, as set out in the Constitutive Act of the AU of 11 July 2000, to achieve greater unity and solidarity between the African countries and the peoples of Africa; to promote co-operation in all fields of human activity; to raise the living standards of African peoples, and in this regard to work with relevant international partners to achieve the common objectives;

Considering that the AU is called upon to undertake certain tasks of a continental nature, in harmony with those pursued on a worldwide scale by WHO;

Considering that the objective of WHO is the attainment by all peoples of the highest possible level of health and that in order to achieve that objective WHO acts as the directing and coordinating authority on international health matters;

Considering the regional arrangements made by WHO as set forth in Chapter XI of its Constitution and in particular Article 50(d) thereof;

Recalling the cooperation between the erstwhile Organization of African Unity and WHO pursuant to the Agreement between the World Health Organization and the erstwhile Organization of African Unity of 24 September 1969 and the Arrangements for the Practical Implementation of Cooperation Between the World Health Organization and the erstwhile Organization of African Unity of 11 May 1982 while recognizing the need to replace these instruments in the light of the establishment of the AU.

Have agreed on the following:

Article I – Status of this Agreement

This Agreement shall govern the relations between the AU Commission and WHO.

Article II – Objectives and principles

1. The objective of this Agreement is to strengthen cooperation between the AU Commission and WHO.

2. In furtherance of this objective, the AU Commission and WHO shall cooperate in all matters arising in the field of health that are connected with the activities and commitments of the two Organizations, including promoting and improving health, reducing avoidable mortality and disability, preventing disease, countering potential threats to health, making contributions towards ensuring a high level of health protection and placing health at the core of the international development agenda in the fight against poverty, the protection of the environment, the promotion of social development, and the raising of living and working conditions.

3. The AU Commission and WHO reaffirm, in accordance with their respective mandates, their complementary commitments to serve the needs of their respective Member States and partner countries through all appropriate means, including by:

- (a) helping in the development and maintenance of effective health interventions and systems;
- (b) engaging the various actors and stakeholders in promoting health development and total well-being, in forming collaborative associations aimed at improving health and delivering health-related interventions;
- (c) containing crises and outbreaks of disease, and imparting knowledge and skills;
- (d) drawing from the expertise and resources of their respective organizations and Member States to add value to their efforts and achieve coordination in the design and implementation of health and health-related policies; and
- (e) forging harmonious relations and avoiding duplication of effort in pursuing common goals.

4. Cooperation between the Parties shall respect the differences in institutional and operational arrangements governing their action, their core competencies and comparative advantages in order to make their collaboration in the field of health complementary and mutually reinforcing.

Article III – Areas of cooperation

1. Cooperation between the AU Commission and WHO shall extend to all questions connected with health and related fields that are within the competence of the Parties, including, as necessary and appropriate, to:

- (a) generating, collecting, processing and disseminating authoritative information and data for use by national administrations, professionals and other parties with a competence in the field of health, while respecting data protection requirements;
- (b) developing methodologies and tools for health monitoring and disease surveillance, analysing and targeting action to specific health and health-related problems, assessing and prioritizing health interventions, and aiding health system development and strengthening;
- (c) promoting health-related research and technological development, taking stock of its results, and developing advice on applications in the health and health-related fields;

- (d) mobilizing, managing and coordinating, where appropriate, resources for health interventions in collaboration with recognized actors in this field and cooperating in emergencies such as those resulting from civil strife, war and natural catastrophes;
 - (e) seconding staff for the purpose of mutual provision of expertise.
2. If and when such cooperation would involve expenditure, consultation shall take place with a view to determining the feasibility and/or manner of meeting such expenditure.

Article IV – Priorities

Without prejudice to the priorities of the AU Commission and WHO that may take precedence over areas of emphasis of this Agreement and subject to the results of joint periodic reviews, priorities for cooperation shall include:

1. The strengthening of health system and human resources capacity;
2. The promotion of access to prevention, treatment, care and support for both communicable and noncommunicable diseases, as well including geographical and financial access for the poor and vulnerable populations;
3. The development of sound policies and efficient systems geared towards sustainable health development, including the alleviation of poverty, the effective preparedness and response to prioritized health scourges and threats and the combining of efforts to help developing and the least developed countries;
4. The development of methodologies and standards for analysis and reporting, and the provision of advice on responses to, in particular, malaria, HIV/AIDS, tuberculosis, emerging diseases and antimicrobial resistance threats, while respecting the human rights of those affected by such afflictions;
5. The strengthening of communicable disease surveillance and health monitoring networks and the establishment of strategies for emergency preparedness and response to epidemics;
6. The development of health indicators and the collection and dissemination of data on health status and health policies and systems, promoting evidence-based approaches.

Article V – Privileges and immunities and facilities

Nothing in this Agreement may be interpreted or construed as a waiver or a modification of the privileges, immunities and facilities that the AU Commission and WHO enjoy by virtue of the international agreements and national laws applicable to the organizations.

Article VI – Exchange of information

1. The AU Commission and WHO shall exchange information relating to activities on subjects of common interest, subject to any measures which might be necessary to safeguard requirements of confidentiality or privilege.
2. Such exchanges shall be supplemented, as necessary, by periodic contacts between members of the AU Commission and the Secretariat of WHO for the purpose of consultations as regards information or activities of common interest.

Article VII – Procedures

The AU Commission and WHO shall establish, in accordance with their respective rules of procedure, the following reciprocal arrangements:

1. Representatives of WHO may be invited to attend sessions of the Assembly and the Executive Council of the AU, as well as AU conferences or meetings, at which matters of interest to WHO are to be discussed, and to participate, without vote, in the deliberations of these bodies with respect to items on their agenda in which WHO has an interest.

2. Representatives of the AU may be invited to attend the World Health Assembly and the sessions of its Committees, the Executive Board and the Regional Committees concerned, as well as WHO conferences or meetings, at which matters of interest to the AU are to be discussed, and to participate, without vote, in the deliberations of these bodies with respect to items on their agenda in which AU has an interest.

3. As regards the relations between, on the one hand, the AU Commission and the Secretariat of WHO and on the other:

(a) The Chairperson of the AU Commission and the Director-General of WHO shall consult each other whenever necessary on questions of mutual interest. These consultations shall aim at achieving coordination and the widest possible application of relevant instruments and other documents adopted by the Parties;

(b) Suitable measures to ensure close liaison and cooperation between officials of the Parties shall be taken. For this purpose, an official may be appointed by each Organization to follow the progress of cooperation and act as a point of contact and coordination in this respect.

4. Complementary and practical arrangements:

(a) Meetings shall be held, as a general rule once a year, between appropriate officials of the AU Commission and WHO. These meetings shall review progress of work in the priority areas of cooperation, exchange of information and examine future collaborative projects and identify meetings and events calling for a cooperative effort and coordination;

(b) Regular and ad hoc meetings may be held between officials of the Parties with notification to, and participation of, as far as possible, designated liaison officials at the relevant levels, covering practical matters of cooperation, in particular the implementation of projects and the participation in committees, groups and working parties and the preparation of documents.

5. Financial cooperation:

Any financial cooperation between the AU Commission and WHO shall be subject to their respective rules and procedures. Progress on projects in the context of financial cooperation shall be reviewed by the AU Commission and WHO as appropriate. Funds received by the AU Commission or WHO from donors having earmarked the funds for collaborative activity shall be managed in accordance with the financial regulations, rules and administrative practices of the receiving Party.

Article VIII – Law and settlement of disputes

Any dispute, controversy, or claim that may arise over the interpretation or application of this Agreement shall be settled amicably by negotiation between the Parties. Should attempts at amicable negotiation fail, any such dispute shall, upon request by either Party, be referred to the arbitration in accordance with the United Nations Commission on International Trade Law (UNCITRAL) Arbitration Rules in force.

Article IX – Amendment or revision and denunciation

1. Nothing in this Agreement may be amended or revised without the consent of the Parties and provided that a written notification of the proposed amendment is sent by either Party to the other Party. The said amendment shall take effect three (3) months after the other Party has given its consent in writing.

2. Either Party may denounce this Agreement by giving one (1) year's notice in writing to the other Party. In the event of denunciation the Parties shall agree that provisions must be made for the completion of ongoing activities or activities under way, in the interests of the peoples of their respective Member States.

Article X – Replacement and entry into force

1. This Agreement shall enter into force on the date of signature by the duly authorized representatives of the Parties, subject to their respective constitutional principles and the relevant rules and regulations.

2. This Agreement, on the date of its entry into force shall replace and supersede the Agreement signed between the World Health Organization and the Organization of African Unity of 24 September 1969 and the Arrangements for the Practical Implementation of Cooperation between the two Parties signed on 11 May 1982.

IN WITNESS WHEREOF the duly authorized representatives whose names are stated below have signed this Agreement at the dates indicated below their signature.

Done in eight copies in Arabic, English, French and Portuguese, each of the four texts being equally authentic.

For the Commission of the African Union

For the World Health Organization

[Signed]
H.E. Advocate Bience Philomina Gawanas
Commissioner for Social Affairs
6 July 2012

[Signed]
Dr Margaret Chan
Director-General
6 July 2012

ANNEX 4¹

Global vaccine action plan

[A65/22 – 11 May 2012]

INTRODUCTION

1. The global vaccine action plan builds on the success of the Global Immunization Vision and Strategy, 2006–2015, which was launched in 2005 as the first 10-year strategic framework to realize the potential of immunization. Developing the plan has brought together multiple stakeholders involved in immunization, including governments and elected officials, health professionals, academia, manufacturers, global agencies, development partners, civil society, media and the private sector, to define collectively what the immunization community wants to achieve over the next decade. In total, the global consultation process reached over 1100 individuals representing more than 140 countries and 290 organizations, and included two special sessions to brief representatives of the Permanent Missions of the United Nations Offices and other Intergovernmental Organizations in Geneva and New York.

2. Immunization is, and should be recognized as, a core component of the human right to health and an individual, community and governmental responsibility. Vaccination prevents an estimated 2.5 million deaths each year. Protected from the threat of vaccine-preventable diseases, immunized children have the opportunity to thrive and a better chance of realizing their full potential. These advantages are further increased by vaccination in adolescence and adulthood. As part of a comprehensive package of interventions for disease prevention and control, vaccines and immunization are an essential investment in a country's – indeed, in the world's – future.

3. Now is the time for showing commitment to achieving the full potential of immunization. The collective recognition of this opportunity has led the global health community to call for a Decade of Vaccines, in line with the requests made in resolution WHA61.15 on the global immunization strategy. The vision for the Decade of Vaccines (2011–2020) is of a world in which all individuals and communities enjoy lives free from vaccine-preventable diseases. The mission of the Decade of Vaccines is to extend, by 2020 and beyond, the full benefit of immunization to all people, regardless of where they are born, who they are or where they live.

4. The global vaccine action plan reiterates existing goals and sets new goals for the decade, proposes six strategic objectives and the actions that will support their achievement, and provides an initial estimate of resource requirements and return on investment. Appendix 1 summarizes recommended indicators to monitor and evaluate progress. Beyond the action plan, country, regional and global stakeholders need to take responsibility for specific actions, translate the action plan into detailed operational plans (updating both the action plan and the operational plans as new information becomes available), complete the development of an accountability framework for the Decade of Vaccines (2011–2020) and mobilize resources to ensure that the vision for the Decade of Vaccines becomes a reality. Accomplishing this will require global and national institutions to innovate and to change the way they work. Appendix 2 provides a summary of stakeholder responsibilities.

¹ See resolution WHA65.17.

5. The last century was, in many respects, the century of treatment, resulting in dramatic reductions in morbidity and mortality, with the discovery and use of antibiotics as one of the biggest agents of change in health. This century promises to be the century of vaccines, with the potential to eradicate, eliminate or control a number of serious, life-threatening or debilitating infectious diseases, and with immunization at the core of preventive strategies. Ensuring that the vision for the Decade of Vaccines becomes a reality is a powerful step in that direction.

THE IMMUNIZATION LANDSCAPE TODAY

Important progress in the last decade

6. In the last 10 years, great advances have been made in developing and introducing new vaccines and expanding the reach of immunization programmes. More people than ever before are being vaccinated and access and use of vaccines by age groups other than infants is expanding. As a result of immunization combined with other health care and development interventions – including improved access to clean water and sanitation, better hygiene and education – the annual number of deaths among children under five years of age fell from an estimated 9.6 million in 2000 to 7.6 million in 2010, despite an increase in the number of children born each year.

7. Immunization has helped drive this reduction in child mortality: coverage of vaccines that have been in use since the inception of the Expanded Programme on Immunization has expanded, and new vaccines have been introduced. Vaccines against hepatitis B and *Haemophilus influenzae* type b have become part of national immunization schedules in 179 and 173 countries, respectively; poliomyelitis is nearing eradication; and a large number of deaths from measles are being averted every year. The number of deaths caused by traditional vaccine-preventable diseases (diphtheria, measles, neonatal tetanus, pertussis and poliomyelitis) has fallen from an estimated 0.9 million in 2000 to 0.4 million in 2010.¹

8. New and increasingly sophisticated vaccines that have become available in the last decade, including pneumococcal conjugate vaccine and vaccines against infection with rotavirus and human papillomavirus, are currently being rolled out globally. Efforts are being made to shorten the time lag that has historically existed in the introduction of new vaccines between high- and low-income countries. For example, the 13-valent pneumococcal conjugate vaccine was introduced in a low-income country a little more than a year after it had been introduced in a high-income country.

9. Through an innovative international collaboration, an affordable conjugate vaccine against *Neisseria meningitidis* serogroup A was developed and is now in use in the African meningitis belt. There are now licensed vaccines being used to prevent, or contribute to the prevention and control of, 25 vaccine-preventable infections (Table 1).

¹ Sources for estimates: measles and neonatal tetanus, in *World Health Statistics 2012*, Geneva, World Health Organization, 2012; diphtheria and poliomyelitis, for 2000: http://www.who.int/healthinfo/global_burden_disease/estimates_regional_2000_v3/en/index.html (accessed 5 April 2012), for 2008: <http://apps.who.int/ghodata/> (accessed 5 April 2012); pertussis, WHO Secretariat provisional data.

Table 1. Vaccine-preventable infectious agents or diseases

• Anthrax	• Measles	• Rubella
• Cholera	• Meningococcal disease	• Influenza
• Diphtheria	• Mumps	• Tetanus
• Hepatitis A	• Pertussis	• Tuberculosis
• Hepatitis B	• Pneumococcal disease	• Typhoid fever
• Hepatitis E	• Poliomyelitis	• Tick-borne encephalitis
• <i>Haemophilus influenzae</i> type b	• Rabies	• Varicella and herpes zoster (shingles)
• Human papillomavirus	• Rotavirus gastroenteritis	• Yellow fever
• Japanese encephalitis		

10. The strengthening by countries of national programmes, aided by improved support from and coordination among local, national, regional and international stakeholders, has succeeded in improving immunization coverage rates. Financing from domestic budgets allocated to immunization programmes has risen over the past decade, as has the flow of international resources dedicated to immunization. According to the immunization programme data for 2010,¹ 154 of the 193 Member States report having a specific budget line item for immunization, and 147 have developed multi-year national plans to sustain the gains achieved, further enhance performance to reach desired goals and introduce appropriate new vaccines.

11. Global and regional immunization initiatives have supported countries in building up their systems and introducing new vaccines. Global goals and milestones established through the Global Immunization Vision and Strategy 2006–2015, the United Nations Millennium Declaration, the United Nations World Summit for Children, the United Nations General Assembly Special Session on Children, and, more recently, the United Nations Secretary-General's Global Strategy for Women's and Children's Health have stimulated expansion of national immunization programmes. In low- and middle-income countries these have been supported by initiatives such as the GAVI Alliance, the Global Polio Eradication Initiative, the Measles Initiative, the vaccine procurement services of UNICEF, and PAHO's Revolving Fund for Vaccine Procurement.

Significant unmet needs remain

12. Despite this progress, vaccine-preventable diseases remain a major cause of morbidity and mortality. Adoption of new vaccines by low- and middle-income countries (where disease burdens are often the highest) has been slower than in high-income countries. In 2010, for example, only 13% of the total high-income country birth cohort lived in countries that did not have pneumococcal conjugate vaccines in their immunization schedules. Of the total low-income country birth cohort, 98% lived in countries that did not have pneumococcal conjugate vaccines in their schedules.

¹ http://www.who.int/immunization_monitoring/data/en/ (accessed 13 April 2012).

13. Coverage gaps persist between countries, as well as within countries. The average coverage with three doses of diphtheria-tetanus-pertussis-containing vaccine and with measles-containing vaccine in low-income countries was 16% and 15% below that of high-income countries in 2010, respectively. However, this represents a positive trend in comparison with the coverage gap of 30% for both vaccines in the year 2000.

14. In some countries, coverage of measles-containing vaccine in rural areas is 33% lower than in urban areas. Similarly, the measles vaccine coverage rate for the richest fifth of the population in some countries is up to 58% higher than for the poorest fifth. Coverage can also be very low in settlements of the urban poor, especially in cities with transitory migrant populations, and in indigenous communities.

15. Geographical distance from health centres is not the only determinant of low coverage; inequities are also associated with other socioeconomic determinants, such as income levels and the educational status of the mother. A special geographic focus is needed on lower-middle-income countries with large populations, where the majority of the unvaccinated live. Reaching underserved populations will be especially challenging, but inequities need to be tackled because these populations often carry a heavier disease burden and may lack access to medical care and basic services, with the fragile economies of individuals and their families suffering a severe disease-related impact as a consequence.

New opportunities and challenges for the Decade of Vaccines (2011–2020)

16. Individuals and communities, governments and health professionals have primary responsibility for exploiting the opportunities and confronting the challenges that this decade will bring. New and improved vaccines are expected to become available, based on a robust pipeline that includes several vaccines for diseases that are not currently preventable through vaccination. The introduction of new vaccines targeted against several important causes of major killer diseases, such as pneumonia, diarrhoea and cervical cancer can be used as a catalyst to scale up complementary interventions. In addition to reducing mortality, these new vaccines will prevent morbidity with resulting economic returns even in countries that have already succeeded in improving mortality rates. Innovations in existing vaccines will bring additional benefits, such as greater effectiveness, thermostability, easier administration and lower cost.

17. At the same time, the development of vaccines and other immunization innovations is facing increasingly complex manufacturing and regulatory processes, as well as rising research, development and production costs. As new vaccines (for example, against dengue and malaria) become available and underutilized vaccines (for example, those against cholera, human papillomavirus, rabies, rotavirus, rubella and typhoid) are administered more widely, supply and logistics systems – already burdened – will face an even greater need for innovations. Finally, the number of health workers, as well as their knowledge and skills, will need to be enhanced, better coordinated and better supervised. While the challenges are many, the introduction of new vaccines also represents an opportunity to strengthen immunization systems and to act as a catalyst to implement many of the required reforms. As national immunization investments increase, so must government oversight and accountability.

18. Immunization funding needs in the areas of research and development, procurement and delivery are expected to more than double in the coming decade. New and more complex vaccines will bring new funding requirements and countries will be confronted with difficult decisions in dealing with competing health priorities. Resources will need to be allocated more efficiently, with the relevant decisions guided by national priorities, capacity, clear information on the costs and benefits of choices, and improved financial management. Expenditures must be linked to outputs and impacts, showing a clear investment case for immunization.

19. As the economies of many low- and middle-income countries continue to grow, so will their potential to fund immunization. Countries that have relied on development assistance will be able to fund an increasing proportion of their immunization programmes, and may even, eventually, be able to fully sustain them. Some will be able to extend new financial and technical support to global immunization projects. At the same time, vaccine manufacturers in some of these countries will be expected to make an even more significant contribution to the supply of high-quality, affordable vaccines, spreading the sources of production more widely and increasing competition.

20. The growing availability of information and penetration of mobile telephone and social networks can boost public demand for immunization, and ensure that people are made aware of both the benefits derived from vaccines and their potential risks. The immunization community can take advantage of social networks and electronic media to more effectively allay fears, increase awareness and build trust.

21. The lessons learnt from past decades, the unmet needs, and the opportunities and challenges that this decade presents have been carefully considered in the formulation of the guiding principles, measures of success and recommended actions that are articulated in the following sections.

SIX GUIDING PRINCIPLES

22. Six principles have guided the elaboration of the global vaccine action plan.

- **Country ownership:** countries have primary ownership and responsibility for establishing good governance and for providing effective and quality immunization services for all.
- **Shared responsibility and partnership:** immunization against vaccine-preventable diseases is an individual, community and governmental responsibility that transcends borders and sectors.
- **Equity:** equitable access to immunization is a core component of the right to health.
- **Integration:** strong immunization systems, as part of broader health systems and closely coordinated with other primary health care delivery programmes, are essential for achieving immunization goals.
- **Sustainability:** informed decisions and implementation strategies, appropriate levels of financial investment, and improved financial management and oversight are critical to ensuring the sustainability of immunization programmes.
- **Innovation:** the full potential of immunization can only be realized through learning, continuous improvement and innovation in research and development, as well as innovation and quality improvement across all aspects of immunization.

23. These six fundamental principles can realistically and effectively guide the full spectrum of immunization activities throughout the Decade of Vaccines (2011–2020). Although the global vaccine action plan will need to be translated into specific regional, country and community contexts, these guiding principles are universally applicable and relevant to each of the Decade of Vaccines' goals and strategic objectives described below.

MEASURES OF SUCCESS

24. The Decade of Vaccines is about taking action to achieve ambitious goals. Early in the decade, this means achieving already established elimination and eradication goals. It means dealing with the public health emergency constituted by wild poliovirus transmission in order to secure a world free of poliomyelitis. It also means assuring the global or regional elimination of measles, rubella and neonatal tetanus.¹ Completing this agenda has never been more critical. Success will encourage the achievement of additional ambitious goals. Failure will mean that millions of preventable cases of disease and death will continue to occur.

25. Later in the decade, success will be recorded in terms of the expansion of immunization services to meet vaccination coverage targets in every region, country and community. In 2015, the coverage of target populations should reach the goal of the Global Immunization Vision and Strategy, 2006–2015 of at least 90% national vaccination coverage and at least 80% vaccination coverage in every district or equivalent administrative unit (the marker for this being coverage for diphtheria-tetanus-pertussis-containing vaccines). By 2020, coverage of target populations should reach these levels for all vaccines in national immunization programmes unless alternative targets exist. Vaccine introductions should also be monitored, with the goal of at least 80 low- or middle-income countries introducing one or more appropriate new or underutilized vaccines by 2015. These technical accomplishments will not be sustained unless countries take full ownership of their routine immunization programmes (see strategic objective 1 below).

26. During this decade millions of additional deaths and cases of disease should become preventable as a result of the development, licensure and introduction of new and improved vaccines and technologies for high-burden diseases. Specifically, progress towards the licensure and launch of vaccines should be tracked against one or more major pathogens not currently vaccine preventable (such as, cytomegalovirus, dengue virus, group A streptococcus, hepatitis C virus, hookworm, leishmania and respiratory syncytial virus) and at least one new platform delivery technology.

Goals of the Decade of Vaccines (2011–2020)

Achieve a world free of poliomyelitis
 Meet global and regional elimination targets
 Meet vaccination coverage targets in every region, country and community
 Develop and introduce new and improved vaccines and technologies
 Exceed the Millennium Development Goal 4 target for reducing child mortality

27. If these immunization-specific goals are achieved, hundreds of millions of cases and millions of future deaths will be averted by the end of the decade, billions of dollars of productivity will be gained, and immunization will contribute to exceeding the Millennium Development Goal 4 target for reducing child mortality (and the target that succeeds it post-2015). For example, it is estimated that if the coverage targets for introduction and/or sustained use of 10 vaccines alone (those against hepatitis B, *Haemophilus influenzae* type b, human papillomavirus, Japanese encephalitis, measles, meningococcus A, pneumococcus, rotavirus, rubella and yellow fever) in 94 countries during the decade are met, between 24 and 26 million future deaths could be averted compared with a

¹ By 2015, achieve maternal and neonatal tetanus elimination (defined as less than one case of neonatal tetanus per 1000 live births) in every district, measles elimination in at least four WHO regions and rubella elimination in at least two WHO regions. By 2020, achieve measles and rubella elimination in at least five WHO regions.

hypothetical scenario under which these vaccines have zero coverage (see also paragraphs 88–98 below).

Six strategic objectives

28. Continuous progress towards the following six strategic objectives will enable the achievement of the goals of the Decade of Vaccines (2011–2020).

(i) **All countries commit to immunization as a priority.** Key indicators to monitor progress towards this strategic objective at the country level are the presence of a legal framework or legislation that guarantees financing for immunization and the presence of an independent technical advisory group that meets defined criteria.

(ii) **Individuals and communities understand the value of vaccines and demand immunization as both their right and responsibility.** Progress towards increased understanding and demand can be evaluated by monitoring the level of public trust in immunization, measured by surveys on knowledge, attitudes, beliefs and practices.¹

(iii) **The benefits of immunization are equitably extended to all people.** Progress towards greater equity can be evaluated by monitoring the percentage of districts with less than 80% coverage with three doses of diphtheria-tetanus-pertussis-containing vaccine and coverage gaps between lowest and highest wealth quintile (or another appropriate equity indicator).

(iv) **Strong immunization systems are an integral part of a well-functioning health system.** The strength of health systems can be evaluated based on dropout rates between the first dose of diphtheria-tetanus-pertussis-containing vaccine and the first dose of measles-containing vaccine. The quality of data is important for monitoring the functioning of a health system. Data quality can be evaluated by monitoring whether immunization coverage data are assessed as high quality by WHO and UNICEF.

(v) **Immunization programmes have sustainable access to predictable funding, quality supply and innovative technologies.** Key indicators to monitor progress towards this strategic objective will be the percentage of routine immunization costs financed through government budgets and globally installed capacity for production of universally recommended vaccines within five years of licensure/potential demand.

(vi) **Country, regional and global research and development innovations maximize the benefits of immunization.** Key indicators of progress towards this strategic objective include proof of concept for a vaccine that shows greater or equal to 75% efficacy for HIV/AIDS, tuberculosis or malaria and the initiation of phase III trials for a first generation universal influenza vaccine. In addition, country research and development capacity can be measured by the institutional and technical capacity to manufacture vaccines and/or carry out related clinical trials and operational and organizational research.

29. Achieving the vision and goals of the Decade of Vaccines (2011–2020) will only be possible if all stakeholders involved in immunization commit themselves to, and take action to achieve, the six strategic objectives; uphold the Decade of Vaccines guiding principles when implementing all the

¹ The Strategic Advisory Group of Experts on immunization working group on vaccine hesitancy will develop a definition of vaccine hesitancy and recommend specific questions from surveys (either existing or new) to fully formulate this indicator.

actions; and regularly monitor and evaluate progress towards both strategic objectives and goals using the indicators described above (see also Appendix 1).

30. An accountability framework is needed that defines the methodology and source of data for these indicators, identifies which stakeholders will be responsible for what actions, and articulates the process and responsibilities for monitoring and evaluating progress over the course of the Decade. The global vaccine action plan lays the groundwork for each of these elements. Further development and implementation of the accountability framework at country, regional and global levels could take place over the course of 2012 by leveraging the findings of the Commission on Information and Accountability for Women's and Children's Health and aligning work, wherever possible, with other accountability efforts and initiatives by all stakeholders at the country level to deliver and monitor progress.

ACTIONS TO ACHIEVE STRATEGIC OBJECTIVES

Strategic objective 1: all countries commit to immunization as a priority.

31. Committing to immunization as a priority first and foremost means recognizing the importance of immunization as a critical public health intervention and the value that immunization represents in terms of health and economic returns. Countries demonstrate a commitment to immunization by setting ambitious but attainable national targets and allocating adequate financial and human resources to programmes to achieve these targets; ensuring that their national immunization plans are fully integrated into national health plans, with appropriate budgets and formulated with the participation of all major stakeholders; and demonstrating good stewardship and implementation of their national health plans. Country commitment to immunization does not, however, imply that immunization programmes will be prioritized or funded at the expense of other vital health programmes.

32. National legislation, policies and resource allocation decisions should be informed by credible and current evidence regarding the direct and indirect impact of immunization. Much of the evidence base exists but does not reach policy-makers, as those who generate the evidence are not always those who interact with these decision-makers. Collaboration between, on the one hand, technical experts who generate the evidence and, on the other, the champions of immunization who construct context-specific messages that highlight the importance of immunization within health and social services, can unequivocally articulate the value of immunization and how immunization supports equity and economic development.

33. Independent bodies, such as regional or national immunization technical advisory groups, that can guide country policies and strategies based on local epidemiology and cost effectiveness should be established or strengthened, thus reducing dependency on external bodies for policy guidance. These bodies can readily be supported by institutions or individuals charged with collating and synthesizing information required for informed decision-making. Regional support systems and initiatives, such as the PAHO ProVac initiative,¹ can be expanded to support countries in strengthening their decision-making. It is important that national immunization technical advisory groups or their regional equivalents, engage with academia, professional societies, and other national agencies and committees, such as the vaccine regulatory agencies, national health sector coordination committees, and interagency coordination committees, in order to ensure a cohesive and coordinated approach to

¹ ProVac is a package of tools to support: (i) the estimation of cost-effectiveness and epidemiological and economic impact of new vaccines; (ii) training; and (iii) the strengthening of national infrastructure for decision-making.

achieving national health priorities. Strong links between ministries of health, education¹ and finance, as well as human resources and legislators are also essential for sustainable programme implementation.

34. Support and formal endorsement of national policies and plans at the highest political and administrative levels, nationally and subnationally, is considered essential for ensuring commitment and sustainability. Governments and elected officials are responsible for putting in place necessary legislation and budget allocations. As immunization is a strong indicator of the overall ability of the health system to deliver services, legislators should be encouraged to scrutinize, defend and closely follow immunization budgets, disbursements and immunization programme activities, both at the national level and within their respective constituencies. Civil society organizations can effectively advocate for greater commitment and hold governments accountable for commitments once they are made. Immunization programmes need to have management structures for programme implementation to be effective. Officials at the national and subnational levels responsible for implementation of the immunization plans can be held accountable for programme performance when they are sufficiently empowered to provide effective leadership and have the required management and programme monitoring skills.

35. For high- and middle-income countries, commitment to immunization should cover the same areas, but may also include maintaining or assuming the role of development partners. Together with global agencies, development partner countries can coordinate the sharing of information and best practices among countries, help bridge temporary funding gaps, and support capacity strengthening by working with stakeholders in different country settings.

Table 2. Summary of recommended actions for strategic objective 1

All countries commit to immunization as a priority.	
Establish and sustain commitment to immunization.	<ul style="list-style-type: none"> • Ensure legislation or legal framework in all countries, including provisions for a budget line for immunization, and for monitoring and reporting. • Develop comprehensive national immunization plans that are part of overall national health plans through a bottom-up process that includes all stakeholders. • Set ambitious but attainable country-specific targets within the context of morbidity and mortality reduction goals. • Scrutinize, defend and follow more closely immunization budgets, disbursements and immunization programme activities. • Support local civil society organizations and professional associations to contribute to national discussions on immunization and health.
Inform and engage opinion leaders on the value of immunization.	<ul style="list-style-type: none"> • Explore models to promote collaboration between the stakeholders that generate evidence on immunization and those who use it in order to set priorities and formulate policies.

¹ Especially important for delivering immunization to older children and adolescents through school health programmes and for monitoring school entry requirements with immunization.

All countries commit to immunization as a priority.	
	<ul style="list-style-type: none"> • Develop and disseminate the evidence base on the public health value of vaccines and immunization and the added value of achieving equity in access and use of immunization. • Develop and disseminate the evidence base for the broad economic benefits of immunization for individuals, households, communities, and countries. • Include immunization in the agendas of governing body meetings at all levels and in other social, health and economic forums.
Strengthen national capacity to formulate evidence-based policies.	<ul style="list-style-type: none"> • Create, or strengthen existing, independent bodies that formulate national immunization policies (for example, national immunization technical advisory groups or regional technical advisory groups). • Develop more effective ways for national regulatory agencies, health sector coordination committees, and interagency coordination committees to support immunization programmes as part of disease control programmes and preventive health care. • Create regional forums and peer-to-peer exchange of information, best practices and tools. • Create expanded and more transparent mechanisms for aggregating, sharing and using information to monitor commitments.

Strategic objective 2: individuals and communities understand the value of vaccines and demand immunization as both their right and responsibility.

36. Significant improvements in coverage and programme sustainability are possible if individuals and communities understand the benefits and risks of immunization; are encouraged to seek services; are empowered to make demands on the health system; and have ownership of the planning and implementation of programmes within their local communities. Although there has generally been a high demand for vaccination services, accessing hard-to-reach populations, attaining higher coverage levels and achieving equity objectives may require additional approaches to stimulate demand for vaccination.

37. Generating individual, household and community demand will require using traditional platforms more effectively as well as new strategies to convey the benefits of immunization, emphasize immunization as a core component of the right to health and encourage greater use of services. New efforts could take advantage of social media and approaches used by commercial and social marketing efforts to promote immunization and address concerns. New mobile and Internet technologies should also be utilized, drawing on the experiences and successes of other innovative public health campaigns. Communications and social research to identify the barriers to and drivers of vaccination should inform the development of context-specific messages. Lessons on vaccines and immunization should be included in the primary school education curriculum. Multisectoral approaches that promote efforts, such as female education and empowerment, will help improve utilization of immunization and health services in general.

38. Where appropriate, programme strategies could also include measures to provide an incentive both to households to seek immunization services and to health care providers to improve their

performance in vaccinating children, particularly those that have not been reached previously. At the household level, conditional cash transfer programmes often include vaccination of children as a requirement for receiving household income transfers. There is evidence that such programmes may have a positive impact on immunization coverage rates, even in countries with high coverage rates, and particularly for more marginalized populations. Because conditional cash transfer programmes are often administered in countries as part of a broad package of social protection or poverty alleviation measures, these programmes provide an opportunity to link immunization programmes and health ministries with other broader development initiatives, including those administered by other ministries.

39. At the health facility level, both households and health care providers can be further motivated by in-kind gifts at the time of vaccination, or by giving performance-based financing bonuses to providers. There is some early evidence to suggest that performance-based financing of immunization services leads to increasing numbers of children being vaccinated, although more rigorous analysis of the impact of performance-based financing on immunization is still being carried out.

40. Providing incentives to health care workers and households through monetary and in-kind gifts has implementation challenges that need to be carefully addressed. These schemes need to respect the autonomy of beneficiaries. Social research is also needed to determine the conditions under which incentives contribute to improved coverage and the types and levels of incentives that are appropriate for a given context. Demand-generation activities must be coupled with mechanisms to ensure reliability of vaccine supply.

41. Some reasons for hesitancy are undoubtedly amenable to improved communications and advocacy initiatives designed to counteract growing anti-vaccination lobby groups and to increase understanding of the value of vaccines or of the danger of diseases. However, others are best addressed by ensuring the quality of the services provided. Individuals will be less hesitant to use services if they perceive the quality of those services to be acceptable. They are more likely to come to vaccination sessions when scheduled services are convenient and predictably available; when practical counselling is offered about where and when to come for vaccination and why, and about what to expect following vaccination; when the health workers have a welcoming attitude; when waiting times are reasonable; and when services are offered without charge. Health care workers should receive training in effective communication to enable them to deal with the media and with local communities when there are reports of serious adverse events following immunization, in order to allay fears and tackle vaccine hesitancy.

42. Bringing about change will require the participation of individuals, households and communities in the development and implementation of all demand-generation strategies. It will also require new and stronger community-based advocates with local knowledge, credibility and the front-line experience necessary to drive change. The participation of in-country civil society organizations will be crucial to develop strong advocacy efforts and should be supported by capacity building. Here again, an effort that promotes collaboration between evidence generators and evidence users could provide training for champions and link with local social and professional networks, which are an important source of grass-roots immunization champions. This will especially be required as country programmes embrace a life-course approach to immunization.

43. Current advocates must recruit new voices – potentially including educators, religious leaders, traditional and social media personalities, family physicians, community health workers and immunization champions. Researchers and technical experts will also have an important role in creating greater community awareness and providing credible responses to misinformation regarding immunization.

44. Generating individual and community demand will reinforce country commitment to vaccines and immunization (strategic objective 1). Activities to generate demand for vaccines and

immunization should build on the broader movement in order to help people to hold their governments accountable for access to health services.

Table 3. Summary of recommended actions for strategic objective 2

Individual and communities understand the value of vaccines and demand immunization as both their right and responsibility.	
Engage individuals and communities on the benefits of immunization and hear their concerns.	<ul style="list-style-type: none"> • Engage in a dialogue which both transmits information and responds to people's concerns and fears. • Utilize social media tools and lessons learnt from commercial and social marketing efforts. • Leverage new mobile and Internet-based technologies. • Include immunization in the basic education curriculum. • Conduct communications research.
Create incentives to stimulate demand.	<ul style="list-style-type: none"> • Create incentives for households and health workers in favour of immunization, where appropriate, while respecting the autonomy of beneficiaries (for example, cash or in-kind transfers, bundling of services, media recognition). • Conduct social research to improve the delivery of immunization services and the ability to meet the needs of diverse communities.
Build advocacy capacity.	<ul style="list-style-type: none"> • Recruit new voices, including those of educators, religious leaders, traditional and social media personalities, family physicians, community health workers, and trained immunization champions (among others). • Train health-care workers in effective communication techniques, especially to address vaccine hesitancy and to respond to reports of serious adverse events following immunization in order to maintain trust and allay fears. • Engage, enable and support in-country civil society organizations to advocate the value of vaccines to local communities and policy-makers and local and global media. • Create national or regional advocacy plans that involve in-country civil society organizations. • Link global, national and community advocacy efforts with professional and academic networks.

Strategic objective 3: the benefits of immunization are equitably extended to all people.

45. Today, four out of every five children receive at least a basic set of vaccinations during infancy and are therefore able to lead healthier, more productive lives. Unfortunately, this means one child in every five is not being reached. In this decade, the benefits of immunization should also be more equitably extended to all children, adolescents and adults. Achieving this strategic objective will mean that every eligible individual is immunized with all appropriate vaccines – irrespective of geographic location, age, gender, disability, educational level, socioeconomic level, ethnic group or work condition – thereby reaching underserved populations and reducing disparities in immunization both

within and between countries. Because disease burdens tend to be disproportionately concentrated in more marginalized populations, reaching more people will not only achieve a greater degree of equity, but will also achieve a greater health impact and contribute to economic development. Furthermore, disease eradication and elimination goals cannot be met without achieving and sustaining high and equitable coverage.

46. In 2002, WHO, UNICEF and other partners introduced the concept of “Reaching Every District”, a first step toward achieving more equitable coverage. Through its various operational components, which include re-establishing outreach services, providing supportive supervision, engaging with communities, monitoring and use of data and district planning and resource management, the Reaching Every District strategy was able to expand the provision of immunization services. Similarly, initiatives aimed at disease eradication and elimination or rapid mortality reduction have used strategies, such as national or subnational immunization days (for poliomyelitis eradication) and supplementary immunization activities (for measles and rubella elimination, measles mortality reduction and neonatal tetanus elimination). More recently, strategies collectively referred to as periodic intensification of routine immunization have been used to extend immunization to the unreached, packaged together with other primary health care interventions.

47. Even these strategies continue to miss populations, for example those that reside outside traditional social and governmental structures. To sustain the gains of these historical efforts and to achieve and sustain disease control goals, the Reaching Every District strategic approach should be recast as “Reaching Every Community”. To attain more equitable coverage, the definition of community should be expanded beyond geographically defined communities. Reaching every community will mean aiming to encompass every eligible individual, even those beyond typical government outreach.

48. Reaching every community will call for an understanding of the barriers to access and use of immunization; it will also require the underserved to be identified, and micro-plans at the district and community levels to be reviewed and revised in order to ensure that these barriers can be overcome. The rapid expansion of information technology should be leveraged to establish immunization registries and electronic databases that will allow each individual’s immunization status to be tracked, timely reminders to be sent when immunization is due and data to be accessed easily to inform actions. The introduction of unique identification numbers could be a catalyst for the establishment of such systems.

49. Drawing on the experiences of successful poliomyelitis vaccination campaigns, decentralized planning and outreach should be used to reach populations that are remote or nomadic or that have been historically marginalized. New strategies for reaching the urban poor and urban migrants will also be necessary. Given the tenuous and evolving community structures and the inadequate security involved, new approaches to community outreach will be especially critical for reaching these groups. This is all the more true in view of the fact that sometimes the most unifying force in these urban and peri-urban areas is a shared and deep-seated mistrust of outsiders, especially governments.

50. Implementing strategies to reach all underserved populations will require engagement with the nongovernmental sector, including civil society organizations and private sector organizations, and will need to involve all aspects of immunization including advocacy, social mobilization, service delivery and monitoring programme performance. To support such collaboration, governments should allocate increased resources to underserved communities and ensure that programmes have sufficient, well-trained personnel to execute strategies effectively. Partnerships across government sectors (for example, with educational institutions) and coordination with programmes that focus on vulnerable populations will be essential. In addition, efforts to provide high-quality immunization services to all children will need to continue unabated in order to protect gains already recorded.

51. There are other dimensions of equity that merit consideration during the Decade of Vaccines (2011–2020), including disparities between countries, adolescent and adult immunization, and immunization during emergencies.

52. Historically, it took decades before new vaccines used in high-income countries became available in low- and middle-income countries. Steps are being taken to address this inequity, including the introduction of new vaccines, with the support of the GAVI Alliance. However, much more needs to be done to sustain and extend these gains, particularly to middle-income countries.

53. A “life-course” approach must also be taken in order to make the benefits of immunization available to all those at risk in every age group. As diseases are being successfully controlled through infant immunization, the need to boost immunity to sustain and extend these gains is increasingly being recognized. In addition, new and existing vaccines that are beneficial for school children, adolescents and adults at special risk – such as health workers, immunocompromised individuals, animal handlers, and the elderly – (for example, vaccines against human papillomavirus, influenza and rabies) are now available and being increasingly used. The success of efforts to eliminate maternal and neonatal tetanus and the benefits to both women and infants of influenza vaccination during pregnancy have increased interest in exploring the development of other vaccines that could be used during pregnancy (for example, group B streptococcus or respiratory syncytial virus vaccines). This will mean creating strategies for reaching individuals throughout their life course, and developing plans for the systems that will monitor and track progress.

54. Likewise, targeted plans are needed to ensure access to immunization during humanitarian crises, outbreaks and in conflict zones. These plans should include a focus on communication and provision for the development of vaccine stockpiles.

55. Social and operational research is needed to inform the design and test the effectiveness of the delivery strategies mentioned above. Key areas of focus for this research could include identifying the main causes of low coverage in particular areas and communities, assessing economic barriers to immunization, understanding the best approaches for reaching individuals of various ages, and assessing the most effective incentives for reaching different groups.

Table 4. Summary of recommended actions for strategic objective 3

The benefits of immunization are equitably extended to all people.	
Develop and implement new strategies to tackle inequities.	<ul style="list-style-type: none"> • Recast “Reaching Every District” to “Reaching Every Community” in order to deal with inequities within districts. • Engage underserved and marginalized groups to develop locally tailored, targeted strategies for reducing inequities. • Introduce appropriate new vaccines into national immunization programmes (see also objective 5). • Establish a life-course approach to immunization planning and implementation, including new strategies to ensure equity across the life span. • Prevent and respond to vaccine-preventable diseases during disease outbreaks and humanitarian crises, and in conflict zones.

The benefits of immunization are equitably extended to all people.	
Build knowledge base and capacity for enabling equitable delivery.	<ul style="list-style-type: none"> • Track each individual's immunization status, leveraging immunization registries, electronic databases and national identification number systems. • Take advantage of community structures to enhance communication and deliver services (for example, traditional birth attendants, birth registries). • Involve civil society organizations in community outreach and planning. • Develop new approaches to community engagement for urban and peri-urban areas. • Train health workers and civil society organizations in engaging communities, in identifying influential people who can assist in planning, organizing and monitoring health and immunization programmes, as well as community needs, and in working with communities to meet those needs. • Conduct operational and social science research to identify successful strategies to reduce inequities and improve the quality and delivery of immunization services.

Strategic objective 4: strong immunization systems are an integral part of a well-functioning health system.

56. The success of national immunization programmes in introducing new vaccines, attaining goals for quality, equity and coverage, and becoming financially sustainable depends upon a well-functioning health system. The many interconnected components of an immunization system require multi-disciplinary attention in order to build a cohesive, non-fragmented and well-functioning programme that coordinates and works in synergy with other primary health care programmes.

57. Health systems encompass a range of functions from policy and regulation to information and supply chain systems, human resources, overall programme management and financing. Health systems include both the public and private sectors, and in some countries the private sector can play a valuable role in educating households about the need for and benefits of vaccination, as well as providing health care. Some of these functions have been dealt with in other sections of this document. This section discusses the actions required to foster greater coordination between immunization and other programmes within health systems and to strengthen the information, human resources, supply chain and logistics components of health systems.

58. Immunization service delivery should continue to serve as a platform for providing other priority public health interventions, such as those for vitamin A supplementation, deworming, and insecticide-treated bednets. Other priority programmes should also serve as a platform for delivering immunization. Every contact with the health sector should be used as an opportunity to verify immunization status and provide immunization where indicated. Furthermore, as new vaccines become available that target some but not all pathogens that cause particular syndromes, such as pneumonia, diarrhoea and cervical cancer, it is important that their introduction be an opportunity to scale up the delivery of complementary interventions. For example, the vaccines against pneumococcus and rotavirus should be complemented with other actions to protect, prevent and treat related respiratory and diarrhoeal diseases.

59. New vaccine deployment should therefore be accompanied by comprehensive disease-control plans both within countries and globally. Coordination of immunization with other services should take place at all levels of a country's programmes, involve outreach efforts and participation by health centres, and be a part of programme management. Coordinating immunization with integrated primary health-care programmes may also facilitate social mobilization efforts, helping to generate community demand for services (strategic objective 2) and address inequity (strategic objective 3). Additionally, efforts should be made to ensure that global vaccine programmes focused on eradication and elimination goals (for example, poliomyelitis and measles campaigns) do not operate in silos. The choice of mechanisms to promote greater interaction and coordination between different programmes should be made by countries according to their local context. The synergies and efficiencies as a result of integration and coordination will be particularly beneficial in countries with fragile health systems.

60. Access to timely high-quality information is essential for effective immunization. Critical information includes process indicators that allow programmes to monitor their performance and take corrective action, and outcome indicators that measure the impact of programmes. Output and impact indicators need to be analysed along with expenditures in order to identify bottlenecks and best practices and to gauge overall programme efficiency (value for money). Immunization information systems need to be linked to broader health information systems, while remaining readily accessible and meeting immunization programme needs.

61. Monitoring of immunization coverage and dropout rates has been in place since the launch of the Expanded Programme on Immunization to ensure programme effectiveness. Although the quality and timeliness of data reporting have improved steadily over the years, the quality of administrative coverage data is still inadequate in many countries. Furthermore, the use of data in order to take corrective action at district and community levels is still unsatisfactory. New approaches to immunization tracking through unique identification numbers (discussed in strategic objective 3) can improve the quality of immunization coverage data and facilitate the development of comprehensive immunization registries. New technologies, including hand-held communication devices and mobile phones, can support this effort and facilitate data-sharing. Armed with higher-quality data and new data-analysis tools, programme managers at all administrative levels can use information to improve programme performance, allocate funding appropriately, and track progress more effectively.

62. Disease surveillance is critical for informing decision-making on the adoption of new vaccines and on the strategies for their use in their respective national programmes. Such surveillance is also essential for monitoring the impact of immunization and changes in disease epidemiology, and for supporting sustained use. Robust epidemiological data will also be crucial for understanding vaccine effectiveness and guiding priorities in the research and development community, and will help to identify the areas where research and development is most needed (strategic objective 6). Disease surveillance platforms need to be strengthened to improve the quality and sharing of information. This will include strengthening laboratory capacity for microbiological confirmation of diagnosis and for tracking the spread of diseases using molecular typing techniques.

63. On rare occasions, adverse reactions can affect the health of vaccine recipients. More frequently, coincidental health events can follow immunization and may be wrongly attributed to vaccines. In both instances, it is extremely important to detect and analyse promptly serious adverse events following immunization. To support low- and middle-income countries in managing such important issues, WHO and its partners have developed the Global Vaccine Safety Blueprint. This strategic plan will enable the countries concerned to have at least minimal capacity for vaccine safety activities; it will also enhance capacity for vaccine safety assessment in countries that introduce newly developed vaccines, that introduce vaccines in settings with novel characteristics or that both manufacture and use prequalified vaccines; and it will establish a global vaccine safety support structure. Implementing the Global Vaccine Safety Blueprint strategies to build capacity for safety surveillance during the Decade of Vaccines (2011–2020) will ensure that everyone everywhere

receives the safest vaccines possible and that safety concerns are not a cause of hesitancy in using vaccines.

64. The increasing complexity of immunization programmes and ambitious new goals, mean that more trained health workers are needed to manage the increased burden of work, including programme managers at the national and subnational levels as well as front-line workers who deliver services and interact directly with communities. Programme managers need to be equipped with technical knowledge about vaccines and immunization, as well as with management skills. Front-line health workers, who deliver not only vaccinations but also primary health care interventions and health education, need coordinated, comprehensive and very practical pre- and in-service training, with updated, relevant curricula and post-training supervision. Health-care workers need to be able not only to explain why immunization is important, but also to give advice to individuals and communities on nutrition, create a healthier environment and recognize the danger signs when someone falls ill. Immunization programmes should ensure that this training and supervision is effectively extended to community-based health workers. Civil society organizations can help with training and coordinating such workers.

65. Health workers can only be effective if sufficient supplies (vaccines, supplements and medicines) are available when they need them. The influx of new vaccines has outstripped the capacity of the current cold-chain system in many countries. Thus, supply chains and waste management systems urgently need to be expanded and made more efficient and reliable. They should be streamlined to maximize effectiveness. They should also take into account and make an effort to minimize the environmental impact of energy, materials and processes used for immunization both within countries and globally. The availability of new technologies provides the opportunity to innovate, not only to improve immunization supply chain management, but also to seek increased synergies with other sectors and supply systems for other health interventions. Another potential area of innovation concerns understanding the lessons learnt from private-sector practices and supply chain management. In addition, tasks that could be outsourced to private sector companies in order to create greater efficiency should be explored.

66. It will be essential to ensure that immunization supply systems are staffed with adequate numbers of competent, motivated and empowered personnel at all levels. Likewise, improvements to health information systems should also support the management of resources, helping staff to ensure that adequate quantities of vaccines are always available to meet demand. Efforts to strengthen supply chains should be implemented in such a way that they benefit both immunization programmes and broader national health efforts.

67. Developing stronger, more efficient, comprehensive approaches to disease control and immunization will require health ministries to take the lead in strengthening and coordinating immunization programmes and health systems more broadly, including engaging civil society organizations, academia and private practitioners. They can draw on the expertise of academics to help develop and deploy new tools and approaches to service delivery. Civil society organizations can contribute to the development of integrated programmes so that they are aligned with local realities and incorporate community-based human resources. Communities can ultimately hold their governments accountable by demanding integrated services. Regional and global organizations can also help by ensuring that data and best practices are shared in and across countries and that country programmes have access to analytical tools. Development partners can provide supplemental financial resources if needed.

Table 5. Summary of recommended actions for strategic objective 4

Strong immunization systems that are an integral part of a well-functioning health system.	
Develop comprehensive and coordinated approaches.	<ul style="list-style-type: none"> • Ensure that global vaccine programmes focusing on eradication and elimination goals (for example, poliomyelitis and measles campaigns) are incorporated into national immunization programmes and do not operate independently. • Ensure that new vaccine deployment is accompanied by comprehensive plans to control targeted diseases. • Ensure coordination between the public and private sectors for new vaccine introduction, reporting of vaccine-preventable diseases and administration of vaccines, and ensure quality of vaccination in the public and private sectors. • Consider the inclusion of vaccines (as appropriate to national priorities) in health programmes across the life-course.
Strengthen monitoring and surveillance systems.	<ul style="list-style-type: none"> • Improve the quality of all administrative data concerning immunization and promote its analysis and use at all administrative levels to improve programme performance. • Develop and promote the use of new technologies for collection, transmission and analysis of immunization data. • Further strengthen and expand disease surveillance systems to generate information for decision-making, monitoring the impact of immunization on morbidity and mortality and changes in disease epidemiology. • Ensure capacity for vaccine safety activities, including capacity to collect and interpret safety data, with enhanced capacity in countries that introduce newly developed vaccines.
Strengthen capacity of managers and frontline workers.	<ul style="list-style-type: none"> • Ensure that immunization and other primary health-care programmes have adequate human resources to schedule and deliver predictable services of acceptable quality. • Increase levels of pre-service, in-service and post-service training for human resources, and develop new, relevant curricula that approach immunization as a component of comprehensive disease control. • Promote coordinated training and supervision of community-based health workers.
Strengthen infrastructure and logistics.	<ul style="list-style-type: none"> • Innovate to improve cold-chain capacity and logistics, as well as waste management. • Minimize the environmental impact of energy, materials and processes used in immunization supply systems, both within countries and globally. • Staff supply systems with adequate numbers of competent, motivated and empowered personnel at all levels. • Establish information systems that help staff to track the available supply accurately.

Strategic objective 5: immunization programmes have sustainable access to predictable funding, quality supply and innovative technologies.

68. To meet goals of the Decade of Vaccines (2011–2020), actions must be taken both within countries and globally to increase the total amount of available funding for immunization from both countries and development partners. Countries should ensure the financial sustainability of national immunization programmes through regular evaluation of resource needs; efficiency in service delivery; availability of adequate domestic financing; and resource mobilization from development partners to meet any funding gaps. Governments also need to explore alternative and innovative financing mechanisms for health and immunization. Some countries have established trust funds or use dedicated tax revenues, among other strategies. In addition, it is important to move beyond budgets and into expenditures. Governments can improve vaccine access and prevent shortages of vaccines, immunization equipment or health workers by assuring that budgeted funds are disbursed in an ongoing and timely fashion that responds to programmes' needs.

69. Although the financing of immunization services is first and foremost a core responsibility of governments, development partners should support national strategies through more predictable, longer-term financing, and should also explore the next generation of innovative financing mechanisms. Emphasis needs to be placed on mutual accountability between countries and their development partners in terms of immunization financing. One possible approach is to undertake annual resource tracking of immunization financing from partners and governments alike. For both countries and development partners, evidence-based advocacy and policy efforts should be focused on obtaining a renewed commitment to past funding pledges.

70. There is also a need to improve the allocation, accountability and sustainability of funding. Coordinating funding support from development partners and other external sources to target national budget priorities will ensure that funds are addressing the most pressing country needs. Funding allocation strategies should be revised periodically to confirm they are achieving goals, such as eradication and elimination of disease, as quickly and as effectively as possible. Feedback loops should be established to enhance programme sustainability, results and impact. One potential methodology to explore is a pay-for-performance funding system. However, the merits of this approach must be balanced against the importance of ensuring the predictability of funding, the risks of creating perverse incentives, and the fact that implementation of such a scheme requires high-quality data. This would include linking international, national, and local funding distribution to specific performance metrics and leveraging the resulting metrics to promote programme improvement.

71. Innovative pricing and procurement mechanisms are needed to alleviate funding pressure and to support the development and scale-up of new and existing vaccines. Innovations will be particularly important for those lower-middle-income countries that do not have access to the PAHO, UNICEF and GAVI Alliance pricing and procurement mechanisms. Mechanisms to explore include differential pricing using new approaches to define price tiers and pooled negotiation or procurement methods for lower-middle-income countries. Current pooled procurement models exist in both the vaccines and pharmaceuticals markets. One example is the PAHO revolving fund pooled procurement and short-term credit mechanism. This and other models could be assessed and modified to best suit the needs of the lower-middle-income countries and the individual vaccine markets.

72. The provision of long-term sustainable funding will be an incentive to manufacturers, thereby improving supply security. In addition, supply-side interventions are needed. A growing proportion of affordable vaccines that are used to immunize the world's population are manufactured in middle- and lower-middle-income countries. In the coming decade, these countries will not only have a requirement to ensure the quality, safety and efficacy of vaccines used domestically, but also a growing global obligation to protect and enhance the security of the global immunization enterprise.

Potential supply-side interventions to ensure quality, safety and efficacy include identifying and disseminating best practices in manufacturing and quality control, investing in research and development capabilities, and initiating technology transfers and co-development agreements.

73. A crucial but often overlooked key driver underpinning all these interventions is the quality assurance of vaccines. Good-quality assurance relies crucially on effective standardization, which ensures that each vaccine product can be manufactured consistently and also enables multiple manufacturers to make similar products of the same quality. Normative processes to achieve globally harmonized standards for vaccines already exist, including international biological reference materials, but action is needed to strengthen global standardization.

74. In addition, each country should develop the capacity to monitor and assure the safe use of vaccines, in line with the strategy defined in the WHO Global Vaccine Safety Blueprint initiative (as discussed under strategic objective 4). Action should also be taken to strengthen national regulatory systems and develop globally harmonized regulations in order to ensure that the increasing demand for regulatory reviews can be managed in an effective and timely manner. This is an issue not just for low- and middle-income countries involved in technology transfer, but also for regulatory agencies in high-income countries where expertise and resources need to be maintained. These supply-side interventions need to be based on solid business cases developed by countries to ensure the impact of these significant and long-term investments.

75. Making change happen with respect to sustainable funding will require commitments from governments and development partners to increase resources and improve programme efficiencies, as well as from additional countries joining the development partner ranks. Likewise, sustainable supply will require the multisectoral involvement of governments (for example, the science and technology, trade, industry and health sectors) in order to create an environment that helps suppliers to strengthen their capabilities. Emerging economies have a particularly important role to play in both cases, given their high rate of economic growth and the rapid expansion of the supply base there.

76. To increase alignment, activities currently performed by the UNICEF Supply Division and the GAVI Alliance to improve communication and coordination among countries, vaccine manufacturers and public-sector organizations should be further expanded. Countries need a forum where they can more clearly communicate expected demand for new vaccines and provide guidance on desired product profiles. This first-hand information would enable suppliers to make more informed product development and capacity planning decisions, thereby mitigating product development and supply risk. This information would also help development partners and other public-sector organizations to establish more defensible and reliable strategies and support plans. This forum could further be utilized to enable suppliers to accurately communicate the possible current and future range of pricing and supply to countries, and for countries to share information on and experience with vaccine procurement.

Table 6. Summary of recommended actions for strategic objective 5

Immunization programmes have sustainable access to long-term funding and quality supply.	
Increase total amount of funding.	<ul style="list-style-type: none"> • Establish a commitment for governments to invest in immunization according to their ability to pay and the expected benefits. • Engage new potential domestic and development partners and diversify sources of funding. • Develop the next generation of innovative financing mechanisms.

Immunization programmes have sustainable access to long-term funding and quality supply.	
Increase affordability for middle-income countries.	<ul style="list-style-type: none"> • Explore differential pricing approaches to define explicit criteria for price tiers and the current and future prices to be made available to lower middle-income and middle-income countries. • Explore pooled negotiation or procurement mechanisms for lower-middle-income and middle-income countries.
Improve allocation of funding in low- and middle-income countries.	<ul style="list-style-type: none"> • Strengthen budgeting and financial management in-country to better integrate financial and health care planning and priority setting. • Coordinate funding support from development partners and other external sources. • Evaluate and improve funding support mechanisms on the basis of their effectiveness in reaching disease goals. • Base funding on transparency and objectivity in order to ensure the sustainability of programmes. • Promote the use of cost and cost-benefit arguments in fund raising, decision-making, and in defence of immunization funding. • Explore pay-for-performance funding systems.
Secure quality supply.	<ul style="list-style-type: none"> • Build and support networks of regulators and suppliers to share best practices and to improve quality assurance capabilities and quality control. • Develop tools to strengthen global standardization of manufacturing and regulatory processes. • Strengthen national regulatory systems and develop globally harmonized regulations. • Provide a forum where countries can communicate expected demand for vaccines and technologies and provide guidance to manufacturers on desired product profiles.

Strategic objective 6: country, regional and global research and development innovations maximize the benefits of immunization.

77. In the coming decade, targeted and innovative research and development efforts are needed across discovery, development and delivery. Innovative research and development efforts will lead to: (1) identification of mechanisms of protection and pathogenesis; (2) well-defined and novel antigenic targets for development of new vaccines; (3) development of bio-processing, formulation, manufacturing and delivery technologies for new and improved vaccines; and (4) development of disease-burden and cost-effectiveness data for in-country decision-making.

78. WHO has conducted a detailed study of disease prioritization and the Institute of Medicine in the United States of America is in the process of developing a model designed to assist decision-makers in prioritizing preventive vaccines based on health, economic, demographic, programmatic and social impact criteria, as well as scientific, technical and business opportunities. The Decade of Vaccines collaboration has not undertaken a vaccine or disease prioritization exercise. To complement the above efforts, a spectrum of research and development needs is presented across discovery, development and delivery, from which stakeholders can choose to invest according to their own priorities and perceptions of the return on their investments.

79. Across all research and development activities, increased engagement and consultation with end-users is needed to ensure that technologies and innovation are prioritized according to real demand and added value. New arrangements will also be required to facilitate the transfer of technologies and access to and sharing of associated information, while acknowledging and respecting intellectual property rights. In order to support this work and maximize its effectiveness, scientists from disciplines not previously engaged in vaccine research (systems biology, nanotechnology, structural biology and metabolomics) will need to be recruited. Chemical and mechanical engineers, chemists and information technology specialists will also have key roles to play in this endeavour.

80. In addition, capacity building and human resource development are needed in low- and middle-income countries to conduct research and development, including finding better ways to conduct operational research and evaluate immunization programmes. Research and development is being conducted in institutions of excellence in many low- and middle-income countries. This capacity is producing indigenous data, as well as fostering bilateral and multilateral collaboration in basic sciences and vaccine development. Capacity can be further strengthened through peer-to-peer training and exchanges between countries. Greater networking among research centres (from discovery to clinical trials) will facilitate the exchange of ideas and the efficient building of partnerships among institutions in high-, middle- and low-income countries.

81. Discovery and basic research will lay the groundwork for impact in future decades. Research at the interface between host and pathogen is needed to enable the development of new vaccines. Advancing knowledge of innate and adaptive immune responses will permit more rational vaccine design. Strengthening the understanding of immunologic and molecular characteristics of microbes through systems biology will permit the identification of new antigenic targets for vaccine development and effective ways of predicting protective immune responses and mechanisms of protection. Appropriate studies of host genetics and biomarkers will contribute to understanding the causes of variation in human population responses to vaccines, or susceptibility to adverse effects.

82. For the development of new and improved vaccines and vaccine technologies, the research and development community will benefit from adopting best practices in portfolio and partnership management, including the identification of early indicators of success and failure to inform milestone-based investments. The community should also consider new approaches to ensure promising vaccine candidates are advanced from discovery to development, particularly where market incentives are insufficient. This is especially important for vaccines to prevent “neglected” diseases.

83. Research is needed to accelerate development, licensing and uptake of vaccines that are currently in early development, including development of technologies for more efficacious and less expensive manufacturing of vaccines. Greater access to the technology and associated information for adjuvants and their formulation into vaccines is needed for advances in developing new and more effective vaccines. Non-syringe delivery mechanisms and vaccine packaging that best suit the needs and constraints of countries, as well as thermostable vaccines and new bioprocessing and manufacturing technologies, are priority research areas for accelerating the development of next-generation vaccines that are more effective, less expensive and easier to manufacture and deliver.

84. Additionally, the elaboration and aggressive pursuit of a global regulatory science agenda will improve manufacturing efficiency, better characterize products, improve clinical trial design and safeguard the highest standards for vaccine safety and efficacy. The challenge is considerable in achieving understanding of the adverse effects, finding ways to avoid them and yet not compromising the known efficacy of the existing product – and without incurring the costs of developing, testing and registering a new product. In this dimension, research on animal models and *in vitro* systems that better predict safety and efficacy would shorten the time for developing safe and effective vaccines and for making them available to communities. Knowledge of the correlates of protection and safety will greatly help to bring these second-generation products to licensure and use.

85. With respect to delivery, priority areas to improve programme efficiency and increase vaccine coverage and impact should include research on the use of effective information through modern communication technologies and social research in order to understand the cultural, economic and organizational determinants of immunization. Health economic analysis will guide the introduction and prioritization of vaccines, and hence representative epidemiological, immunological and operational studies and studies of vaccine impact will be needed.

86. Operational research on the most effective delivery approaches is also needed in order to overcome the challenges posed by life-course immunization (newborn, infant, adolescent, pregnant women, elderly, among others) and vaccination in emergency and outbreak situations. Research on immunological interference effects and optimization of delivery schedules will be required as more new vaccines are introduced into routine programmes and immunization is extended beyond the first year of life. In the case of special populations, such as pregnant women, confirmation of safety will be particularly important. Furthermore, research is required in order to develop biomarkers for validating immunization coverage estimates and enabling better measurement of population-level immunity profiles. In addition, research to develop field-usable and cost-effective diagnostic tools for establishing etiology that are suited for use at point-of-care in low-income countries will be valuable additions to improving surveillance quality.

87. Concerted action among the research community, manufacturers, health professionals, programme managers, national immunization technical advisory groups, vaccine regulatory agencies and development partners will be needed to attain the full potential of research and development in the next decade. Methods and arguments for prioritization and allocation of scarce resources will have to be agreed upon by these groups, balancing the tensions between country-driven choices and the need for large-scale research efforts and markets in order to sustain development and commercialization. Health professionals, programme managers, vaccine regulatory agencies and national immunization technical advisory groups can help to identify areas where innovations could be made, and assess their real demand and added value. Development partners can help promote a judicious allocation of some resources for research and development, according to the agreed priorities. The research community and manufacturers will have prime responsibility for promoting innovation and pursuing the research agenda defined above.

Table 7. Summary of recommended actions for strategic objective 6

Country, regional, and global research and development innovations maximize the benefits of immunization.	
Expand capabilities and increase engagement with end-users.	<ul style="list-style-type: none"> • Engage with end-users to prioritize vaccines and innovations according to perceived demand and added value. • Establish platforms for exchange of information on immunization research and consensus building. • Build more capacity and human resources in low- and middle-income countries to conduct research and development and operational research. • Increase networking among research centres for efficient building of partnerships among the institutions of high-, middle- and low-income countries. • Promote collaboration between traditional research disciplines and scientists from disciplines not previously engaged in vaccine research.

Country, regional, and global research and development innovations maximize the benefits of immunization.	
Enable the development of new vaccines.	<ul style="list-style-type: none"> • Research on the fundamentals of innate and adaptive immune responses, particularly in humans. • Research on immunological and molecular characteristics of microbes. • Improve understanding of the extent and causes of variation in pathogens and human population responses to vaccines.
Accelerate development, licensing and uptake of vaccines.	<ul style="list-style-type: none"> • Promote greater access to technology, expertise and intellectual property for adjuvants and their formulation into vaccines. • Develop non-syringe delivery mechanisms and vaccine packaging that best suit the needs and constraints of national programmes. • Develop thermostable rotavirus and measles vaccines. • Develop new bioprocessing and manufacturing technologies. • Develop a global, regulatory science research agenda. • Adopt best practices in portfolio and partnership management for research and development.
Improve programme efficiencies and increase coverage and impact.	<ul style="list-style-type: none"> • Research the use of more effective information through modern communication technologies. • Conduct representative epidemiological, immunological, social and operational studies and investigations of vaccine impact to guide health economics analysis. • Perform operational research on improved delivery approaches for life-course immunization, and vaccination in humanitarian emergencies, so-called fragile States and countries in and emerging from conflict. • Perform research on interference effects and optimum delivery schedules. • Perform research to develop improved diagnostic tools for conducting surveillance in low-income countries.

HEALTH RETURNS ON INVESTMENT IN IMMUNIZATION

88. The global vaccine action plan has outlined a set of ambitious goals and strategic objectives for the decade to broaden the impact and reach of immunization across the globe. By extending coverage for existing vaccines, introducing new vaccines and pursuing elimination and eradication for specific diseases, millions of deaths can be averted and billions of dollars in economic benefit can be generated.

89. It is projected that costs to sustain and scale up current immunization programmes, introduce new and underutilized vaccines, and conduct supplemental immunization activities to reach elimination and eradication goals in the world's 94 low- and lower-middle-income countries will rise from between US\$ 3500 million and US\$ 4500 million in 2011 to between US\$ 6000 million and US\$ 8000 million in 2020, costing approximately between US\$ 50 000 million and US\$ 60 000 million cumulatively over the course of the decade (from 2011 to 2020). The following estimates all pertain to these 94 countries.¹

90. An estimated US\$ 42 000 million to US\$ 51 000 million of these costs (roughly 85% of the total) will support expanding routine immunization coverage and introducing additional vaccines to routine immunization programmes.² For example, pneumococcal vaccine coverage for the birth cohort in the 94 countries is projected to go from 8% in 2011 to approximately 90% by 2020. Similarly, coverage with the pentavalent vaccine (against diphtheria-tetanus-pertussis hepatitis B and Hib) is projected to move from 50% in 2011 to more than 90% by 2020. To take another example, it is anticipated that up to five additional vaccines that are currently not licensed or widely used in low- and lower-middle-income countries will be introduced across many of the countries in the analysis during the decade: vaccines against cholera, dengue and malaria, inactivated poliovirus vaccine, and typhoid Vi conjugate vaccine. Delivery programmes will need to be strengthened to ensure they meet current needs, are well-maintained over the decade, have sufficient capacity to accommodate additional vaccines that are planned to be introduced, and facilitate immunization coverage aspirations across low- and lower-middle-income countries. As a consequence, the costs of annual routine immunization will increase from approximately US\$ 2500 million in 2011 to US\$ 7500 million by 2020.

91. Of these costs, an estimated cumulative figure of between US\$ 8000 million and US\$ 9000 million (the remaining 15% of the total) will be for supplementary immunization activities for accelerated disease control and eradication and elimination efforts throughout the decade, which will complement routine immunization programmes. This analysis assumes that these efforts will be focused on measles, meningococcus A meningitis, poliomyelitis, rubella, tetanus and yellow fever.

92. The costs described above for routine and supplementary immunization activities encompass the projected costs of the acquisition of vaccines and injection supplies, as well as the delivery of those vaccines and supplies, including transportation and cold chain logistics, human resources, training,

¹ Countries included in the scope of the costing analysis include 92 low- and lower-middle-income countries according to the July 2011 World Bank Classification (available at <http://www.icsoffice.org/Documents/DocumentsDownload.aspx?Documentid=474>, accessed 11 April 2012) in addition to two upper-middle-income countries (Azerbaijan and Cuba) which receive GAVI Alliance support for existing vaccines, but which have graduated from support for future vaccines.

² Diseases covered by the vaccines included in the scope of the costing analysis include: diphtheria-tetanus-pertussis, hepatitis B, *Haemophilus influenzae* type b, human papillomavirus, Japanese encephalitis, measles, meningococcus A, mumps, pneumococcus, poliomyelitis, rotavirus, rubella, tuberculosis and yellow fever.

social mobilization, surveillance and programme management. These costs do not include the additional costs or efficiencies that may be generated through the actions recommended in the global vaccine action plan where there is an insufficient evidence base for these costs at this time. Specifically, it does not include the additional cost of scaling up seasonal influenza vaccination or the additional resource needs for increased surveillance, increased civil society engagement, and current and additional technical agency support to implement the global vaccine action plan. Nevertheless, the costs do represent the majority of the cost of achieving the strategic objectives of the Decade of Vaccines (2011–2020).

93. The governments of low- and lower-middle-income countries will continue to play a pivotal role in meeting resource needs. Assuming that country funding for immunization grows in line with projected gross domestic product and all GAVI Alliance-eligible countries fully meet its co-financing requirements, it is estimated that the available funding from country governments for routine immunization and supplemental immunization activities could total approximately US\$ 20 000 million over the decade. In addition, if the GAVI Alliance renews its current level of funding for the 2016–2020 period, its resources will generate an estimated additional US\$ 12 000 million of funds for the decade, approximately US\$ 11 000 million for routine immunization programmes and approximately US\$ 1000 million for programmes involving supplementary immunization activities. Based on these assumptions, country governments and the GAVI Alliance combined could provide a total of approximately US\$ 32 000 million in funding for the decade. These estimates could be considered the minimum available financing over the decade because they do not include contributions from development partners beyond that provided through the GAVI Alliance (owing to the considerable uncertainty surrounding future levels of development partner financing).

94. Meeting the estimated US\$ 18 000 million to US\$ 28 000 million in additional funding will require commitment from all stakeholders, with governments needing to continue making immunization a priority in resource allocation decisions; development partners needing to sustain and bolster access to funding for immunization in spite of competing priorities; and the entire community needing to continue efforts to reduce the cost of vaccine acquisition and immunization service delivery.

95. All stakeholders investing together will drive a significant health and economic impact. Work to sustain or extend coverage of existing vaccines and efforts to introduce new vaccines, if undertaken together, have the potential to avert millions of future deaths, as well as hundreds of millions of cases of disease, and generate billions of dollars in economic impact over the decade.

96. As an example of the potential impact of immunization, a sub-analysis of 10 vaccines, delivered during the decade,¹ that represent an estimated US\$ 42 000 million of the US\$ 50 000 million to US\$ 60 000 million cost for the decade, have the potential to avert in total between 24 and 26 million future deaths (Table 8) as compared with a hypothetical scenario under which these vaccines have zero coverage.²

¹ Vaccines included in health benefits analysis cover the following diseases in countries representing 99.5% of the birth cohort of the 94 countries included in the costing analysis: hepatitis B, *Haemophilus influenzae* type b, human papillomavirus, Japanese encephalitis, meningitis A, pneumococcus, rotavirus, rubella, yellow fever and measles.

² Data were insufficient to estimate morbidity averted through immunization in these countries.

Table 8. Total future deaths averted, 2011–2020, assuming no vaccination as the counterfactual

Group	Vaccine	No. of future deaths averted (million) ^{a,b}
Original Expanded Programme on Immunization vaccine ^c	Measles 1st dose	10.6
	Measles 2nd dose	0.4
	Measles supplementary immunization activities	3.1
New or underutilized vaccines	Hepatitis B ^d	5.3–6.0
	<i>Haemophilus influenzae</i> type b	1.4–1.7
	Pneumococcus	1.6–1.8
	Rotavirus	0.8–0.9
	Human papillomavirus	0.5
	Yellow fever ^e	0.03–0.04
	Meningococcal A meningitis ^f	0.03
	Japanese encephalitis ^g	0.07
Rubella	0.4	
	Total (2011–2020)	24.6–25.8

^a The estimated figure for future deaths averted was developed by a working group that included staff from WHO, the GAVI Alliance, the Bill & Melinda Gates Foundation and PATH. The estimate uses a mix of static and dynamic cohort models and various data sources across the 10 vaccines, including the Lives Saved Tool. Vaccine coverage projections are from the GAVI Strategic Demand Forecast 4.0 (4 October 2011) and from the GAVI Adjusted Demand Forecast.

^b Ranges shown for estimates where alternative assumptions were considered for the scope of countries and the demand forecast.

^c Data were insufficient to allow estimation of deaths averted from BCG, diphtheria, tetanus or pertussis vaccines.

^d Scaled up in the decade 2001 to 2010.

^e Disease burden limited to only a few regions.

^f Same as above.

^g Same as above.

97. The figures for future deaths averted represent the full estimated benefits that can be achieved during the decade for these 10 vaccines, through sustaining or enhancing current immunization levels and introducing additional vaccines into the national immunization programmes of the selected countries, using no vaccination as the counterfactual. They are not limited to only the incremental benefits of the additional actions undertaken during the Decade of Vaccines (2011–2020).

98. The current projections of costs, available funding and health impact will evolve as additional analysis is completed and new and better data become available. Additional analysis will allow for the expansion of the scope described by this document, including increasing the number of diseases covered by the cost and health benefits analysis, quantifying impact on morbidity, quantifying economic benefits and further increasing the level of detail of costing and funding projections. Additional analysis is needed in order to better understand vaccine research and development costs and benefits, which are not included in the current projections. New and better data will, among other things, enhance the analysis with revised disease burden statistics, better vaccine price forecasts, improved population information and more consistent data across all countries. In addition, a process should be developed and maintained to allow for updates to cost, funding, and health and economic impact estimates at the country and global levels, ideally on an annual basis. This will facilitate

enhanced planning, coordination and engagement among the many stakeholders that will be required to achieve the strategic objectives and goals of the Decade of Vaccines (2011–2020).

CONTINUING MOMENTUM FOR THE DECADE OF VACCINES (2011–2020)

99. Ensuring success throughout the Decade of Vaccines requires additional focus and action beyond the development of the global vaccine action plan. Four critical sets of activities will be required in order to translate the action plan into actions and results: development of tools for translation of the plan; development of a complete accountability framework; securing commitments from the stakeholder community; and communicating Decade of Vaccines opportunities and challenges.

100. Tools are needed that provide the full thinking behind the global vaccine action plan, together with details, in order to enable implementation. The production, publication and communication of these tools will help stakeholders better understand how to translate the actions recommended in the action plan into the local context.

101. The global vaccine action plan lays the groundwork for an accountability framework, which will be finalized with more detailed roles and responsibilities for stakeholders, a complete set of indicators, the methodology and data sources for each indicator detailed and baselines established where required. Investments are needed to improve data quality and develop more robust in-country monitoring and evaluation systems. Regular audits should be conducted to verify data quality. Progress should be reviewed annually, beginning in 2013, by country, the WHO regional committees and the Health Assembly.

102. Commitments aligned to the global vaccine action plan from countries, civil society organizations, multilateral agencies, development partners and vaccine manufacturers can transform the action plan from a document to a movement. Efforts to build these commitments and a strategy for coordinating them will be required at the global, regional and country levels. Appropriate channels must be identified and targeted communications developed to ensure that Decade of Vaccines messages reach and resonate with all stakeholders.

103. The period of time immediately following the Sixty-fifth World Health Assembly will be critical for ensuring that the agenda-setting translates into effective action. Key opportunities to sustain and build on the current momentum during the remainder of 2012 include the WHO regional committee meetings, the meeting of the Board of the GAVI Alliance, the UNICEF Executive Board meeting, the GAVI Alliance Partners' Forum and the Child Survival: A Call to Action summit.

104. The Decade of Vaccines collaboration is a time-limited effort that ends with the completion of the global vaccine action plan and related activities identified above. There will be no new structure to support the implementation phase of the Decade of Vaccines/global vaccine action plan. Lead stakeholders need to assume ownership to support implementation and progress monitoring.

105. WHO will play a leadership role for the action plan as the normative lead agency in global health, including the defining of norms and standards for production and quality control of vaccines, as well for strengthening immunization delivery, programme monitoring and surveillance systems. In collaboration with other stakeholders, the WHO Secretariat will also advocate for and provide technical support to Member States in promoting greater country ownership, creating synergies between immunization and other primary health-care programmes and implementing research, notably to increase programme efficiencies and impact.

APPENDIX 1

SUMMARY OF RECOMMENDED INDICATORS

Goal-level indicators

Goal	By 2015	By 2020
Achieve a world free of poliomyelitis	<ul style="list-style-type: none"> Interrupt wild poliovirus transmission globally 	<ul style="list-style-type: none"> Certification of poliomyelitis eradication
Meet global and regional elimination targets	<ul style="list-style-type: none"> Neonatal tetanus eliminated in all WHO regions Measles eliminated in at least four WHO regions Rubella/congenital rubella syndrome eliminated in at least two WHO regions 	<ul style="list-style-type: none"> Measles and rubella eliminated in at least five WHO regions
Meet vaccination coverage targets in every region, country and community	<ul style="list-style-type: none"> At least 80 low- and middle-income countries have introduced one or more new or underutilized vaccines Reach 90% national coverage and 80% in every district or equivalent administrative unit for diphtheria-tetanus-pertussis-containing vaccines 	<ul style="list-style-type: none"> Reach 90% national coverage and 80% in every district or equivalent administrative unit for all vaccines in national programmes, unless otherwise recommended
Develop and introduce new and improved vaccines and technologies		<ul style="list-style-type: none"> Licensure and launch of vaccine or vaccines against one or more major diseases for which a vaccine does not currently exist (such as dengue, hepatitis C, cytomegalovirus, respiratory syncytial virus, leishmaniasis, hookworm and group A streptococcus) Licensure and launch of at least one platform delivery technology
Exceed the Millennium Development Goal 4 target for reducing child mortality	<ul style="list-style-type: none"> Reduce under five mortality rate by two thirds (compared to 1990) 	<ul style="list-style-type: none"> Exceed the Millennium Development Goal 4 target for reducing child mortality.

Strategic objective level indicators

Strategic objective	Indicators
All countries commit to immunization as a priority	<ul style="list-style-type: none"> • Presence of a legal framework or legislation that guarantees immunization financing • Presence of an independent technical advisory group that meets defined criteria
Individuals and communities understand the value of vaccines and demand immunization both as a right and a responsibility	<ul style="list-style-type: none"> • Level of public trust in immunization, measured by surveys on knowledge, attitudes, beliefs and practices¹
The benefits of immunization are equitably extended to all people	<ul style="list-style-type: none"> • Percentage of districts with less than 80% coverage with 3 doses of diphtheria-tetanus-pertussis-containing vaccine • Reduction in coverage gaps between lowest and highest wealth quintile (or another appropriate equity indicator)
Strong immunization systems are an integral part of a well-functioning health system	<ul style="list-style-type: none"> • Dropout rate between first dose of diphtheria-tetanus-pertussis-containing vaccine and first dose of measles-containing vaccine • Immunization coverage data assessed as high quality by WHO and UNICEF
Immunization programmes have sustainable access to predictable funding, quality supply and innovative technologies	<ul style="list-style-type: none"> • Percentage of routine immunization costs financed through government budgets • Installed capacity for production of universally recommended vaccines within five years of licensure/potential demand
Country, regional and global research and development innovations maximize the benefits of immunization	<ul style="list-style-type: none"> • Proof of concept for a vaccine that shows greater than or equal to 75% efficacy for HIV/AIDS, tuberculosis, or malaria • Phase III clinical trials of a first generation universal influenza vaccine initiated • Progress towards institutional and technical capacity to make vaccines and/or carry out related clinical trials, operational and organizational research

¹ The working group on vaccine hesitancy of WHO's Strategic Advisory Group of Experts on immunization will develop a definition of vaccine hesitancy and recommend specific questions from surveys (either existing or new) to fully formulate this indicator.

APPENDIX 2

STAKEHOLDER RESPONSIBILITIES

There is an opportunity to achieve real progress in the next decade. Realization of this potential is contingent upon all stakeholders having clearly defined and coordinated responsibilities. Primary responsibility is held by individuals and communities, governments and health professionals, as recipients and providers of immunization respectively. Other stakeholders also have an important role in achieving the objectives.

Individuals and communities, as recipients of immunization, should do the following:

- Understand the risk and benefits of vaccines and immunization, viewing this as part of being a responsible citizen.
- Demand safe and effective immunization programmes as a right from their leaders and government, and hold leaders and government accountable for providing them.
- Participate in public-health discussions and be involved in key decisions about immunization processes.
- Participate and contribute to the immunization delivery process and convey the needs and perspectives of their communities to the policy-makers.

Governments, as the main providers of immunization, should do the following:

- Increase support for national immunization programmes and ensure financial sustainability by 2020.
- Depending upon countries' income and as economies grow, fund an increasing proportion of domestic immunization programmes, progressing to the full funding of domestic programmes, and then funding global immunization efforts.
- Develop and introduce laws, regulations, and policies that support immunization programmes and a secure, high-quality supply base, if necessary.
- Develop region- and country-specific plans, together with other stakeholders in region/country.
- Prioritize and assume full ownership of national immunization programmes in order to create equity-driven programmes that reach every community.
- Work with stakeholders within and outside governments.
- Respond with timely information when public concerns are raised about safety and efficacy to sustain public trust.
- Ensure immunization programmes are adequately staffed with personnel who are well trained and given appropriate incentives to manage the programme and deliver services.

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- Increase awareness of the importance of immunization to improve a population's health and its contributions to strengthening health systems and primary health care.
 - Effectively convey messages on vaccines to create demand.
 - Engage in dialogue with communities and media and use effective communications techniques to convey messages about vaccines and to address safety concerns.
 - Encourage and support research on vaccines and vaccination issues; and encourage education at all levels on vaccines.
 - Collaborate regionally and internationally in advocacy programmes, evidence sharing, and coordinated preparedness.
 - Participate in open dialogues with manufacturers to ensure affordability of current and new vaccines.

Health professionals should do the following:

- Provide high-quality immunization services and information on them.
- Introduce vaccine educational courses on immunization at universities and institutions training health-care professionals as well as continuing education for all health-care providers (medical, nursing, pharmacy and public health practitioners).
- Identify areas where immunization services could be improved and innovations made.
- Serve as proactive, credible voices for the value of vaccines and recruit other advocacy voices.
- Use existing and emerging technologies to improve delivery and better capture information.
- Engage in dialogue with communities and the media and use effective communications techniques to convey messages about vaccines and to address safety concerns.

Academia should do the following:

- Promote innovation to accelerate the development of new and improved vaccines, contribute to the optimization of vaccine formulation and immunization programme logistics, and lay the groundwork for the impact of immunization in future decades.
- Pursue a multidisciplinary research agenda that focuses on transformational impact and is based on the needs of end users.
- Develop vaccines and technologies that will optimize and maximize vaccine delivery.
- Embrace new ways of working that speed up scientific progress.
- Improve dialogue with other researchers, regulators and manufacturers in order to align actions and increase effectiveness in responding to local and global immunization challenges.

- Provide the core data, methods and arguments that help drive the continued prioritization of immunization both globally and locally.
- Engage more with systematic reviews to identify areas where solid scientific evidence exists (which should be the basis of health policies) and those areas where such evidence is lacking (which would be the basis for future primary research).
- Provide evidence and outline best immunization practices.
- Support the development of manufacturing capabilities.
- Promote budget allocation for vaccine and immunization research.

Manufacturers should do the following:

- Continue to develop, produce and supply innovative and high-quality vaccines that meet countries' needs.
- Support research and an education agenda for immunization.
- Participate in open dialogues with countries and the public sector to ensure sustainable access to current and new vaccines.
- Continue to innovate manufacturing processes and pricing structures.
- Support the media outreach for the Expanded Programme on Immunization to increase awareness.
- Support rapid scale-up and adoption as new or improved vaccines emerge.
- Develop partnerships that support the growth of manufacturing capabilities and increase vaccine supply and innovation.
- Work in coordination with other partners on vaccine and immunization advocacy.

Global agencies, such as WHO, UNICEF, the World Bank, regional development banks and the GAVI Alliance, should do the following:

- Advocate for and provide technical support to promote country ownership.
- Strengthen national capabilities and regional infrastructure.
- Continue to define norms and guidelines to improve vaccine and immunization services, striving to achieve greater equity and sensitivity to gender and subpopulation (including, among others, minorities and age groups).
- Promote synergies between immunization and other health services as well with other sectors such as, education, economic development and financing.
- Fund the provision of vaccines and immunization-related activities.

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- Work with all stakeholders to improve technical support to strengthen immunization and other components of health systems.
 - Encourage, share and support evidence-based decision-making across the spectrum of development, health and immunization stakeholders.
 - Engage partners to generate popular demand for immunization and support programme research and improvements.
 - Promote the idea of sustainable national funding and engage rapidly emerging economies as funding partners.
 - Develop mechanisms for mutual accountability that hold all governments, programmes and development partners responsible for committed levels of support.
 - Promote a dialogue between manufacturers and countries to align supply and demand.
 - Pursue innovative financing and procurement mechanisms that reinforce country ownership, and promote equity and affordability for low- and middle-income countries.

Development partners, such as bilateral agencies, foundations and philanthropists, should do the following:

- Fulfil institutional mandates and missions in the health field.
- Support countries and regional entities to achieve national and regional goals, and contribute to the advancement of their priorities.
- Promote country ownership and country-led health, vaccine and immunization plans that include budgets for improving access to services and reducing the equity gap in coverage.
- Promote comprehensive, integrated packages of essential interventions and services that include vaccines and immunization and strengthen health systems.
- Provide predictable long-term funding aligned with national plans and encourage new and existing partners to fund vaccines and immunization.
- Build civil society capacity and support civil society organization activities in countries.
- Participate in international advocacy through access to open evidence that can be shared.
- Maintain transparent and coordinated funding, accompanied by performance-based evaluation.

Civil society, including nongovernmental organizations and professional societies, should do the following:

- Get involved in the promotion and implementation of immunization programmes at both country and global level.
- Participate in the development and testing of innovative approaches to deliver immunization services that reach the most vulnerable people.

- Follow national guidelines and regulations in the design and delivery of immunization programmes that fulfil the duty of accountability to national authorities.
- Educate, empower and engage vulnerable groups and communities on their right to health, including vaccines and immunization.
- Build grass-roots initiatives within communities to track progress and hold governments, development partners and other stakeholders accountable for providing high-quality immunization services.
- Contribute to improved evaluation and monitoring systems within countries.
- Engage in country, regional and global advocacy beyond the immunization community to ensure vaccines and immunization are understood as a right for all.
- Collaborate within and across countries to share strategies and build momentum for improved health, vaccines and immunization.

Media should do the following:

- Understand the benefits of, and concerns about, immunization in order to accurately report on and effectively promote immunization programmes.
- Engage in country, regional and global advocacy beyond the immunization community to ensure vaccines and immunization are understood as a right for all.
- Use effective communications techniques to convey messages about vaccines and to address safety concerns.

The private sector should do the following:

- Support the diversification of funding sources for immunization programmes (among others, private sector, insurance providers and patients).
 - Engage in country, regional and global advocacy beyond the immunization community and serve as champions for immunization to ensure vaccines and immunization are understood as a right for all.
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ANNEX 5

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

<p>1. Resolution WHA65.3 Strengthening noncommunicable disease policies to promote active ageing</p>
<p>2. Linkage to the Programme budget 2012–2013 (see document A64/7 http://apps.who.int/gb/ebwha/pdf_files/WHA64/A64_7-en.pdf)</p> <p>Strategic objective(s): 4 Organization-wide expected result(s): 4.8</p> <p>How would this resolution contribute to the achievement of the Organization-wide expected result(s)? The resolution requests the Director-General to provide support to Member States in promoting and facilitating further implementation of commitments made at relevant United Nations conferences and summits on noncommunicable diseases and ageing; and to continue development of a comprehensive global monitoring system for prevention and control of noncommunicable diseases to monitor progress. This is in line with the Organization-wide expected result mentioned above.</p> <p>Does the programme budget already include the products or services requested in this resolution? (Yes/no) No</p>
<p>3. Estimated cost and staffing implications in relation to the Programme budget</p> <p>(a) Total cost</p> <p>Indicate (i) the lifespan of the resolution during which the Secretariat’s activities would be required for implementation and (ii) the cost of those activities (estimated to the nearest US\$ 10 000).</p> <p>(i) Three years (covering the period 2012–2014) (ii) Total: US\$ 1.49 million (staff US\$ 290 000; activities: US\$ 1.20 million)</p> <p>(b) Cost for the biennium 2012–2013</p> <p>Indicate how much of the cost indicated in 3 (a) is for the biennium 2012–2013 (estimated to the nearest US\$ 10 000)</p> <p>Total: US\$ 1.09 million (staff US\$ 290 000; activities: US\$ 800 000)</p> <p>Indicate at which levels of the Organization the costs would be incurred, identifying specific regions where relevant</p> <p>Headquarters</p> <p>Is the estimated cost fully included within the approved Programme budget 2012–2013? (Yes/no) No</p> <p>If “no”, indicate how much is not included. US\$ 1.09 million</p>

(c) Staffing implications

Could the resolution be implemented by existing staff? (Yes/no)

No

If “no” indicate how many additional staff – full-time equivalents – would be required, identifying specific regions and noting the necessary skills profile(s), where relevant.

An epidemiologist/public health expert would be required at headquarters to oversee the overall draft of *The world health report 2014* and provide technical support to countries. The post would be a 50% full-time equivalent at grade P.5.

4. Funding

Is the estimated cost for the biennium 2012–2013 indicated in 3 (b) fully funded? (Yes/no)

No

If “no”, indicate the funding gap and how the funds would be mobilized (provide details of expected source(s) of funds).

US\$ 1.09 million; source(s) of funds: voluntary contributions from bilateral donors.

1. Resolution WHA65.4 The global burden of mental disorders and the need for a comprehensive, coordinated response from health and social sectors at the country level

2. Linkage to the Programme budget 2012–2013 (see document A64/7 http://apps.who.int/gb/ebwha/pdf_files/WHA64/A64_7-en.pdf)

Strategic objective(s): 3

Organization-wide expected result(s): 3.1, 3.2, 3.5 and 3.6

How would this resolution contribute to the achievement of the Organization-wide expected result(s)?

The implementation of the resolution would increase political, financial and technical commitment in Member States to tackle mental disorders. It would also provide support for the development of services, policies, plans, strategies, programmes and legislation to enable people with mental disorders to live full and productive lives in the community through the adoption of a coordinated and integrated approach across all sectors including health, social services and housing, education and employment.

Does the programme budget already include the products or services requested in this resolution? (Yes/no)

No

3. Estimated cost and staffing implications in relation to the Programme budget**(a) Total cost**

Indicate (i) the lifespan of the resolution during which the Secretariat’s activities would be required for implementation and (ii) the cost of those activities (estimated to the nearest US\$ 10 000).

(i) One year to develop the action plan (covering the period 2012)

(ii) Total: US\$ 180 000 (staff: US\$ 160 000; activities: US\$ 20 000)

(b) Cost for the biennium 2012–2013

Indicate how much of the cost indicated in 3 (a) is for the biennium 2012–2013 (estimated to the nearest US\$ 10 000).

Total: US\$ 180 000 (staff: US\$ 160 000; activities: US\$ 20 000)

Indicate at which levels of the Organization the costs would be incurred, identifying specific regions where relevant.

The costs would be incurred at all levels of the Organization.

Is the estimated cost fully included within the approved Programme budget 2012–2013? (Yes/no)

The cost will be covered by relocating funds within the approved Programme budget.

If “no”, indicate how much is not included.

(c) Staffing implications

Could the resolution be implemented by existing staff? (Yes/no)

Yes

If “no” indicate how many additional staff – full-time equivalents – would be required, identifying specific regions and noting the necessary skills profile(s), where relevant.

4. Funding

Is the estimated cost for the biennium 2012–2013 indicated in 3 (b) fully funded? (Yes/no)

Yes

If “no”, indicate the funding gap and how the funds would be mobilized (provide details of expected source(s) of funds).

US\$ n/a; source(s) of funds: n/a.

1. Resolution WHA65.5 Poliomyelitis: intensification of the global eradication initiative

2. Linkage to the Programme budget 2012–2013 (see document A64/7 http://apps.who.int/gb/ebwha/pdf_files/WHA64/A64_7-en.pdf)

Strategic objective(s): 1

Organization-wide expected result(s): 1.2

How would this resolution contribute to the achievement of the Organization-wide expected result(s)?

It would support the interruption of circulation of wild poliovirus, and the minimization and management of long-term poliovirus risks.

Does the programme budget already include the products or services requested in this resolution? (Yes/no)

Yes, the products and services are included; however, as a result of delays against critical programme indicators in the biennium 2010–2011, additional activities are required in order to achieve the Organization-wide expected result mentioned above. In 2010–2011, the operating budget for poliomyelitis eradication (US\$ 909 million) was 99.8% funded through voluntary contributions earmarked for this purpose; approximately 92% of this budget is reflected under the Special programmes and collaborative arrangements budget segment, and approximately 8% reflected under the Base programmes segment. The operating budget for poliomyelitis eradication represents approximately 2% of the Base programmes segment and approximately 50% of the Special programmes and collaborative arrangements segment. Of note, the Base programmes budget segment for poliomyelitis eradication is also funded through earmarked voluntary contributions.

3. Estimated cost and staffing implications in relation to the Programme budget

(a) Total cost

Indicate (i) the lifespan of the resolution during which the Secretariat’s activities would be required for implementation and (ii) the cost of those activities (estimated to the nearest US\$ 10 000).

(i) Six years (covering the period 2013–2018)

(ii) Total: US\$ 1896 million (staff: US\$ 658 million; activities: US\$ 1238 million) projected to be funded through earmarked voluntary contributions.

(b) Cost for the biennium 2012–2013

Indicate how much of the cost indicated in 3 (a) is for the biennium 2012–2013 (estimated to the nearest US\$ 10 000).

Total: US\$ 935 million (staff: US\$ 281 million; activities: US\$ 654 million); projected to be funded through earmarked voluntary contributions.

Indicate at which levels of the Organization the costs would be incurred, identifying specific regions where relevant.

8% of total costs incurred at headquarters level, 6% at regional level and 86% at country level.

Is the estimated cost fully included within the approved Programme budget 2012–2013? (Yes/no)

No. US\$ 441 million are in the approved Programme budget 2012–2013, mainly under the Special programmes and collaborative arrangements budget segment; this figure is projected to be funded through earmarked voluntary contributions.

If “no”, indicate how much is not included.

US\$ 494 million. The budget increase would be under the Special programmes and collaborative arrangements segment, and is projected to be funded through earmarked voluntary contributions.

(c) Staffing implications

Could the resolution be implemented by existing staff? (Yes/no)

Yes.

If “no” indicate how many additional staff – full-time equivalents – would be required, identifying specific regions and noting the necessary skills profile(s), where relevant.

4. Funding

Is the estimated cost for the biennium 2012–2013 indicated in 3 (b) fully funded? (Yes/no)

No. Funding of US\$ 339 million is confirmed or projected.

If “no”, indicate the funding gap and how the funds would be mobilized (provide details of expected source(s) of funds).

US\$ 596 million; source(s) of funds: earmarked voluntary contributions from WHO Member States, multilateral organizations (including the European Commission and development banks), the private sector (including the Bill & Melinda Gates Foundation and Rotary International).

1. Resolution WHA65.6 Comprehensive implementation plan on maternal, infant and young child nutrition

2. Linkage to the Programme budget 2012–2013 (see document A64/7 http://apps.who.int/gb/ebwha/pdf_files/WHA64/A64_7-en.pdf)

Strategic objective(s): 9

Organization-wide expected result(s): 9.1, 9.2, 9.3 and 9.4

How would this resolution contribute to the achievement of the Organization-wide expected result(s)?

The resolution would: support Member States' commitment to nutrition in collaboration with several partners, with clearly measurable targets (see indicators 9.1.1 and 9.1.2); highlight the need to implement evidence-based interventions (Organization-wide expected result 9.2); identify specific areas for prioritization and scaling up in the health sector (Organization-wide expected result 9.4); and clarify reporting requirements and stimulate better surveillance (Organization-wide expected result 9.3).

Does the programme budget already include the products or services requested in this resolution? (Yes/no)

Yes, most of the products are already included.

3. Estimated cost and staffing implications in relation to the Programme budget

(a) Total cost

Indicate (i) the lifespan of the resolution during which the Secretariat's activities would be required for implementation and (ii) the cost of those activities (estimated to the nearest US\$ 10 000).

- (i) 10 years (covering the period 2012–2021)
- (ii) Total: US\$ 32.40 million (staff: US\$ 23.90 million; activities: US\$ 8.50 million)

(b) Cost for the biennium 2012–2013

Indicate how much of the cost indicated in 3 (a) is for the biennium 2012–2013 (estimated to the nearest US\$ 10 000).

Total: US\$ 8.28 million (staff: US\$ 4.78 million; activities: US\$ 3.5 million)

Indicate at which levels of the Organization the costs would be incurred, identifying specific regions where relevant.

Headquarters: US\$ 1.07 million (staff); US\$ 1.20 million (activities)

Regional offices/country offices: US\$ 3.71 million (staff); US\$ 2.30 million (activities).

Is the estimated cost fully included within the approved Programme budget 2012–2013? (Yes/no)

No

If “no”, indicate how much is not included.

Although the implementation of the comprehensive implementation plan on maternal, infant and young child nutrition is already included in the approved Programme budget, the resolution calls for further action by the Secretariat in two areas:

- (a) the development of guidance on multisectoral policy measures on nutrition;
- (b) the development of guidelines on the marketing of complementary foods.

The cost of such additional activities would amount to approximately US\$ 600 000.

(c) Staffing implications

Could the resolution be implemented by existing staff? (Yes/no)

No

If “no” indicate how many additional staff – full-time equivalents – would be required, identifying specific regions and noting the necessary skills profile(s), where relevant.

Although most of the Secretariat activities requested by the resolution can be implemented by current staff, the provision of support to Member States in strengthening national health and development policies that include proven nutrition actions would require additional human resources in the regional offices.

4. Funding

Is the estimated cost for the biennium 2012–2013 indicated in 3 (b) fully funded? (Yes/no)

No

If “no”, indicate the funding gap and how the funds would be mobilized (provide details of expected source(s) of funds).

For the biennium 2012–2013, US\$ 4.60 million are available for the implementation of the resolution, as part of currently available resources. Additional funding of US\$ 3.68 million would need to be secured through active fundraising.

<p>1. Resolution WHA65.7 Implementation of the recommendations of the Commission on Information and Accountability for Women's and Children's Health</p>
<p>2. Linkage to the Programme budget 2012–2013 (see document A64/7 http://apps.who.int/gb/ebwha/pdf_files/WHA64/A64_7-en.pdf) Strategic objective(s): 10 Organization-wide expected result(s): 10.4 and 10.10</p> <p>How would this resolution contribute to the achievement of the Organization-wide expected result(s)? It would support the strengthening of (i) country health information and accountability systems and (ii) global monitoring of results and resources.</p> <p>Does the programme budget already include the products or services requested in this resolution? (Yes/no) Yes, some are included.</p>
<p>3. Estimated cost and staffing implications in relation to the Programme budget</p> <p>(a) Total cost Indicate (i) the lifespan of the resolution during which the Secretariat's activities would be required for implementation and (ii) the cost of those activities (estimated to the nearest US\$ 10 000). (i) Four years (covering the period 2012–2015) (ii) Total US\$ 22.0 million (staff US\$ 16.0 million; activities: US\$ 6.0 million)</p> <p>(b) Cost for the biennium 2012–2013 Indicate how much of the cost indicated in 3 (a) is for the biennium 2012–2013 (estimated to the nearest US\$ 10 000) Total US\$ 11.0 million (staff US\$ 8.0 million; activities: US\$ 3.0 million) Indicate at which levels of the Organization the costs would be incurred, identifying specific regions where relevant Headquarters and regional offices Is the estimated cost fully included within the approved Programme budget 2012–2013? (Yes/no) No If "no", indicate how much is not included. US\$ 5.5 million, about 50%.</p> <p>(c) Staffing implications Could the resolution be implemented by existing staff? (Yes/no) Yes If "no" indicate how many additional staff – full-time equivalents – would be required, identifying specific regions and noting the necessary skills profile(s), where relevant.</p>
<p>4. Funding Is the estimated cost for the biennium 2012–2013 indicated in 3 (b) fully funded? (Yes/no) No If "no", indicate the funding gap and how the funds would be mobilized (provide details of expected source(s) of funds). US\$ 4.0 million; source(s) of funds: many other potential donors are being approached.</p>

<p>1. Resolution WHA65.8 Outcome of the World Conference on Social Determinants of Health</p>
<p>2. Linkage to the Programme budget 2012–2013 (see document A64/7 http://apps.who.int/gb/ebwha/pdf_files/WHA64/A64_7-en.pdf)</p> <p>Strategic objective(s): 7 and 10 Organization-wide expected result(s): 7.1, 7.2, 7.3 and 10.5</p> <p>How would this resolution contribute to the achievement of the Organization-wide expected result(s)? The resolution would contribute to the achievement of the Organization-wide expected results mentioned above by requesting the Secretariat to scale up action on the social determinants of health, as identified in the Rio Political Declaration on Social Determinants of Health (2011).</p> <p>Does the programme budget already include the products or services requested in this resolution? (Yes/no) No</p>
<p>3. Estimated cost and staffing implications in relation to the Programme budget</p> <p>(a) Total cost Indicate (i) the lifespan of the resolution during which the Secretariat's activities would be required for implementation and (ii) the cost of those activities (estimated to the nearest US\$ 10 000).</p> <p>(i) Six years (covering the period 2012–2017) (ii) Total: US\$ 33.60 million (staff: US\$ 10.90 million; activities: US\$ 22.70 million)</p> <p>(b) Cost for the biennium 2012–2013 Indicate how much of the cost indicated in 3 (a) is for the biennium 2012–2013 (estimated to the nearest US\$ 10 000). Total: US\$ 8.00 million (staff: US\$ 3.60 million; activities: US\$ 4.40 million) Indicate at which levels of the Organization the costs would be incurred, identifying specific regions where relevant. Headquarters: US\$ 1.30 million; regional offices: US\$ 3.70 million; country offices: US\$ 3.00 million Is the estimated cost fully included within the approved Programme budget 2012–2013? (Yes/no) No If "no", indicate how much is not included. US\$ 8.00 million</p> <p>(c) Staffing implications Could the resolution be implemented by existing staff? (Yes/no) No If "no" indicate how many additional staff – full-time equivalents – would be required, identifying specific regions and noting the necessary skills profile(s), where relevant. In order to implement the resolution, six staff at grade P.4 and six at grade G.4 would be required at the country and regional levels, and one staff member at grade P.4 would be needed at headquarters.</p>
<p>4. Funding Is the estimated cost for the biennium 2012–2013 indicated in 3 (b) fully funded? (Yes/no) No If "no", indicate the funding gap and how the funds would be mobilized (provide details of expected source(s) of funds). US\$ 8.00 million; source(s) of funds: voluntary contributions from countries, private donors and multilateral organizations.</p>

<p>1. Resolution WHA65.9 Health conditions in the occupied Palestinian territory, including east Jerusalem, and in the occupied Syrian Golan</p>
<p>2. Linkage to the Programme budget 2012–2013 (see document A64/7 http://apps.who.int/gb/ebwha/pdf_files/WHA64/A64_7-en.pdf)</p> <p>Strategic objective(s): 5 Organization-wide expected result(s): 5.7</p> <p>How would this resolution contribute to the achievement of the Organization-wide expected result(s)? If the resolution is fully funded, implementation will contribute to the expected result by supporting a coordinated health sector response and recovery in humanitarian emergencies.</p> <p>Does the programme budget already include the products or services requested in this resolution? (Yes/no) Yes</p>
<p>3. Estimated cost and staffing implications in relation to the Programme budget</p> <p>(a) Total cost</p> <p>Indicate (i) the lifespan of the resolution during which the Secretariat’s activities would be required for implementation and (ii) the cost of those activities (estimated to the nearest US\$ 10 000).</p> <p>(i) One year (covering the period mid-2012 to mid-2013)</p> <p>(ii) Total: US\$ 1.20 million (staff: US\$ 800 000; activities: US\$ 400 000)</p> <p>(b) Cost for the biennium 2012–2013</p> <p>Indicate how much of the cost indicated in 3 (a) is for the biennium 2012–2013 (estimated to the nearest US\$ 10 000)</p> <p>Total: US\$ 1.20 million (staff: US\$ 800 000; activities: US\$ 400 000)</p> <p>Indicate at which levels of the Organization the costs would be incurred, identifying specific regions where relevant</p> <p>The activities will be primarily implemented through the WHO Office in Jerusalem, which is responsible for WHO’s cooperation programme with the Palestinian 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 on operations against poliomyelitis and on emergency response and country cooperation as well as on health security and the environment.</p> <p>Is the estimated cost fully included within the approved Programme budget 2012–2013? (Yes/no)</p> <p>Yes</p> <p>If “no”, indicate how much is not included.</p> <p>(c) Staffing implications</p> <p>Could the resolution be implemented by existing staff? (Yes/no)</p> <p>No</p> <p>If “no” indicate how many additional staff – full-time equivalents – would be required, identifying specific regions and noting the necessary skills profile(s), where relevant.</p> <p>Implementation of the humanitarian health activities and interventions requested in the resolution will require the Secretariat to sustain beyond May 2012 the necessary national and international staff presence at country level, particularly in respect of the Health Cluster Coordinator.</p>

4. Funding

Is the estimated cost for the biennium 2012–2013 indicated in 3 (b) fully funded? (Yes/no)

No

If “no”, indicate the funding gap and how the funds would be mobilized (provide details of expected source(s) of funds).

US\$ 1 185 000; source(s) of funds: it is envisaged that these resources will be raised as humanitarian voluntary contributions through the Consolidated Appeal Process. US\$ 15 000 have already been raised through the Process this year.

1. Resolution WHA65.17 Global vaccine action plan

2. Linkage to the Programme budget 2012–2013 (see document A64/7 http://apps.who.int/gb/ebwha/pdf_files/WHA64/A64_7-en.pdf)

Strategic objective(s): 1 and 11

Organization-wide expected result(s): 1.1, 1.2, 1.4, 1.5, 11.1 and 11.3

How would this resolution contribute to the achievement of the Organization-wide expected result(s)?

This resolution would contribute to: accelerating progress towards global and regional goals for the eradication of poliomyelitis, the elimination of measles, rubella and tetanus and the control of hepatitis B infection; reducing preventable child mortality, especially from pneumonia and diarrhoea; reducing cases of and deaths due to cervical cancer; reducing morbidity and mortality from influenza and the risk of pandemic influenza; and strengthening immunization and broader health systems.

Does the programme budget already include the products or services requested in this resolution? (Yes/no)

Yes

3. Estimated cost and staffing implications in relation to the Programme budget**(a) Total cost**

Indicate (i) the lifespan of the resolution during which the Secretariat’s activities would be required for implementation and (ii) the cost of those activities (estimated to the nearest US\$ 10 000).

(i) Ten years (covering the period 2011–2020)

(ii) Total: US\$ 2345 million (staff: US\$ 722 million; activities: US\$ 1623 million)

Note: this figure does not include the cost of implementing the resolution on intensification of the Global Polio Eradication Initiative.

(b) Cost for the biennium 2012–2013

Indicate how much of the cost indicated in 3 (a) is for the biennium 2012–2013 (estimated to the nearest US\$ 10 000)

Total: US\$ 403 million (staff: US\$ 128 million; activities: US\$ 275 million)

Note: this figure does not include the cost of implementing the resolution on intensification of the Global Polio Eradication Initiative.

Indicate at which levels of the Organization the costs would be incurred, identifying specific regions where relevant

30% at headquarters, 35% at regional level and 35% at country level.

Is the estimated cost fully included within the approved Programme budget 2012–2013? (Yes/no)

No

If “no”, indicate how much is not included.

US\$ 45 million.

(c) Staffing implications

Could the resolution be implemented by existing staff? (Yes/no)

Not for the full period of the resolution

If “no” indicate how many additional staff – full-time equivalents – would be required, identifying specific regions and noting the necessary skills profile(s), where relevant.

A small number of additional staff would be needed at headquarters, in the regional offices and in intercountry support teams in the African Region. Some national staff will also be needed in countries to enable activities to be scaled up in anticipation of an increase in the number of vaccines introduced in national immunization programmes.

4. Funding

Is the estimated cost for the biennium 2012–2013 indicated in 3 (b) fully funded? (Yes/no)

No

If “no”, indicate the funding gap and how the funds would be mobilized (provide details of expected source(s) of funds).

The current gap is US\$ 210 million. Proposals are under discussion for annually renewed and new grants totalling US\$ 125 million. If these grants are confirmed, there will remain a gap of US\$ 85 million.

1. Resolution WHA65.18 World Immunization Week

2. Linkage to the Programme budget 2012–2013 (see document A64/7 http://apps.who.int/gb/ebwha/pdf_files/WHA64/A64_7-en.pdf)

Strategic objective(s): 1

Organization-wide expected result(s): 1.1

How would this resolution contribute to the achievement of the Organization-wide expected result(s)?

Immunization Weeks help to: (i) raise global and local awareness of the benefits of vaccination; (ii) increase the population’s acceptance of, and demand for, immunization services; (iii) enhance political commitment; (iv) provide an additional opportunity to deliver vaccines to people, and, consequently, contribute to improving vaccine coverage.

Does the programme budget already include the products or services requested in this resolution? (Yes/no)

Yes

3. Estimated cost and staffing implications in relation to the Programme budget

(a) Total cost

Indicate (i) the lifespan of the resolution during which the Secretariat’s activities would be required for implementation and (ii) the cost of those activities (estimated to the nearest US\$ 10 000).

(i) Implementation would be on a continuing basis, subject to review by the governing bodies.

(ii) Total additional cost: US\$ 150 000 per annum (staff US\$ 30 000; activities: US\$ 120 000).

Note: All WHO regions have adopted their own resolutions on Regional Immunization Weeks; four regions have been implementing Immunization Weeks for a number of years, with the African and South-East Asia regions joining them in 2012. Consequently, the cost of Regional Immunization Weeks has already been planned for and funded, and the increase in cost due to the introduction of the World Immunization Week would be minimal and would simply reflect some additional staff time at the global level needed for coordination, additional media and communication materials, and a small coordination meeting.

(b) Cost for the biennium 2012–2013

Indicate how much of the cost indicated in 3 (a) is for the biennium 2012–2013 (estimated to the nearest US\$ 10 000)

Total additional cost: US\$ 300 000 (staff US\$ 60 000; activities: US\$ 240 000)

Indicate at which levels of the Organization the costs would be incurred, identifying specific regions where relevant

Headquarters

Is the estimated cost fully included within the approved Programme budget 2012–2013? (Yes/no)

Yes

If “no”, indicate how much is not included.

(c) Staffing implications

Could the resolution be implemented by existing staff? (Yes/no)

Yes

If “no” indicate how many additional staff – full-time equivalents – would be required, identifying specific regions and noting the necessary skills profile(s), where relevant.

4. Funding

Is the estimated cost for the biennium 2012–2013 indicated in 3 (b) fully funded? (Yes/no)

Yes

If “no”, indicate the funding gap and how the funds would be mobilized (provide details of expected source(s) of funds).

US\$ n/a; source(s) of funds: n/a.

1. Resolution WHA65.19 Substandard/spurious/falsely-labelled/falsified/counterfeit medical products**2. Linkage to the Programme budget 2012–2013 (see document A64/7 http://apps.who.int/gb/ebwha/pdf_files/WHA64/A64_7-en.pdf)**

Strategic objective(s): 11

Organization-wide expected result(s): 11.1 and 11.2

How would this resolution contribute to the achievement of the Organization-wide expected result(s)?

It responds to the strategic approach outlined in expected result 11.1 regarding “substandard/spurious/falsely-labelled/falsified/counterfeit medical products”.

Does the programme budget already include the products or services requested in this resolution? (Yes/no)

No

3. Estimated cost and staffing implications in relation to the Programme budget**(a) Total cost**

Indicate (i) the lifespan of the resolution during which the Secretariat’s activities would be required for implementation and (ii) the cost of those activities (estimated to the nearest US\$ 10 000).

(i) Three years (covering the period 2012–2015) subject to the decision of the Health Assembly.

(ii) Total: between US\$ 3.56 million and US\$ 4.84 million (staff: between US\$ 2.72 million and US\$ 4.00 million; activities: US\$ 840 000). Conservative estimation based on a single annual meeting of the Member State mechanism. This only covers the cost of activities for one meeting as the terms of reference still need to be confirmed.

(b) Cost for the biennium 2012–2013

Indicate how much of the cost indicated in 3 (a) is for the biennium 2012–2013 (estimated to the nearest US\$ 10 000)

Total: between US\$ 2.37 million and US\$ 3.23 million (staff: between US\$ 1.81 million and US\$ 2.67 million; activities US\$ 560 000).

Indicate at which levels of the Organization the costs would be incurred, identifying specific regions where relevant

Headquarters

Is the estimated cost fully included within the approved Programme budget 2012–2013? (Yes/no)

No

If “no”, indicate how much is not included.

Between US\$ 2.37 million and US\$ 3.23 million

(c) Staffing implications

Could the resolution be implemented by existing staff? (Yes/no)

No

If “no” indicate how many additional staff – full-time equivalents – would be required, identifying specific regions and noting the necessary skills profile(s), where relevant.

Two staff members in the professional and higher categories (grades P.4 and P.5) together with one staff member in the general services category (grade G.5).

4. Funding

Is the estimated cost for the biennium 2012–2013 indicated in 3 (b) fully funded? (Yes/no)

No

If “no”, indicate the funding gap and how the funds would be mobilized (provide details of expected source(s) of funds).

Between US\$ 2.37 million and US\$ 3.23 million; source(s) of funds:

It is likely that seed money will be needed in the form of voluntary contributions from interested Member States, as technical activities are currently not defined with enough detail to address donors. Also, the project falls outside the current scope of donors in the medicines area.

1. Resolution WHA65.20 WHO’s response, and role as the health cluster lead, in meeting the growing demands of health in humanitarian emergencies**2. Linkage to the Programme budget 2012–2013 (see document A64/7 http://apps.who.int/gb/ebwha/pdf_files/WHA64/A64_7-en.pdf)**

Strategic objective(s): 5

Organization-wide expected result(s): 5.1 and 5.7

How would this resolution contribute to the achievement of the Organization-wide expected result(s)?

The resolution would support WHO in fulfilling its role as (i) lead agency of the health cluster in humanitarian emergencies and (ii) lead agency for the Inter-Agency Standing Committee Global Health Cluster. It would also strengthen WHO’s new cross-organizational approach to emergency response. The resolution contains a call to the Director-General to put in place the necessary WHO policies, guidelines, adequate management structures and processes, required for effective and successful humanitarian action at the country level, as well as the organizational capacity and resources to best fulfil its role as the Global Health Cluster lead agency. Thus, implementation would enhance the achievement of Organization-wide expected result 5.7 by giving direction, structure and impetus to the Organization’s work to lead a coordinated health-sector response and recovery in humanitarian emergencies.

Does the programme budget already include the products or services requested in this resolution? (Yes/no)

Yes

3. Estimated cost and staffing implications in relation to the Programme budget

(a) Total cost

Indicate (i) the lifespan of the resolution during which the Secretariat's activities would be required for implementation and (ii) the cost of those activities (estimated to the nearest US\$ 10 000).

(i) The key period for this resolution would be the biennium 2012–2013. During this period, WHO would implement, evaluate and refine its new institutional approach. After 2013, it is expected that the underlying principles of this resolution would continue to guide WHO's work in emergencies.

(ii) Total first year: US\$ 29.5 million (staff: US\$ 23.6 million; activities: US\$ 5.9 million); total subsequent years: US\$ 42.5 million (staff: US\$ 34.0 million; activities: US\$ 8.5 million).

The implementation of this resolution over the first year is expected to be gradual at the regional and country levels and is therefore estimated at 70% of the cost of implementation in the last year of the biennium.¹

(b) Cost for the biennium 2012–2013

Indicate how much of the cost indicated in 3 (a) is for the biennium 2012–2013 (estimated to the nearest US\$ 10 000).

Total: US\$ 72.0 million (staff: US\$ 57.6 million; activities: US\$ 14.4 million)

Indicate at which levels of the Organization the costs would be incurred, identifying specific regions where relevant.

This resolution would be implemented across the Organization. WHO's country-level efforts would be supported by the relevant regional offices and by headquarters (US\$ 32.0 million at headquarters; US\$ 13.5 million in the regional offices; and US\$ 26.5 million in key country offices, with a focus on high-risk countries in the African and Eastern Mediterranean regions).¹

Is the estimated cost fully included within the approved Programme budget 2012–2013? (Yes/no)

Yes

If "no", indicate how much is not included.

(c) Staffing implications

Could the resolution be implemented by existing staff? (Yes/no)

No

If "no" indicate how many additional staff – full-time equivalents – would be required, identifying specific regions and noting the necessary skills profile(s), where relevant.

The total number of core staff would be similar to that of the biennium 2010–2011; however, the staff concerned would have different skill sets and there would be a different geographic distribution of posts, following the downsizing at headquarters in 2011 and the anticipated increase in staffing at the regional and country levels. At the country office level it is envisaged that the current complement of 35 core staff in the professional and higher categories would double to 70, with an emphasis on countries in the African and Eastern Mediterranean regions. Staff increases would also be required at the regional office level to ensure that the necessary competencies were present for overseeing and for fulfilling a backstopping role for the country offices. At the regional office level, it is likely that the current complement of 24 core professional staff would need to increase to 36, with an emphasis on the regional offices for Africa and the Eastern Mediterranean. Headquarters would require no additional staff as the relevant department was restructured and significantly downsized in 2011.

¹ The figures given do not include the additional resources that would be mobilized for specific emergencies.

4. Funding

Is the estimated cost for the biennium 2012–2013 indicated in 3 (b) fully funded? (Yes/no)

No

If “no”, indicate the funding gap and how the funds would be mobilized (provide details of expected source(s) of funds).

US\$ 44.0 million; source(s) of funds: assessed contributions, voluntary contributions and programme monitoring and reporting funds. Response and recovery activities would be funded by any funding for outbreak and crisis response received against the consolidated and flash appeals for specific emergencies.

1. Resolution WHA65.21 Elimination of schistosomiasis**2. Linkage to the Programme budget 2012–2013 (see document A64/7 http://apps.who.int/gb/ebwha/pdf_files/WHA64/A64_7-en.pdf)**

Strategic objective(s): 1

Organization-wide expected result(s): 1.3

How would this resolution contribute to the achievement of the Organization-wide expected result(s)?

Support would be provided to Member States in confirming that they have satisfied the criteria for the elimination of schistosomiasis within their national borders.

Does the programme budget already include the products or services requested in this resolution? (Yes/no)

Yes

3. Estimated cost and staffing implications in relation to the Programme budget**(a) Total cost**

Indicate (i) the lifespan of the resolution during which the Secretariat’s activities would be required for implementation and (ii) the cost of those activities (estimated to the nearest US\$ 10 000).

(i) 14 years (covering the period 2012–2025)

(ii) Total: US\$ 700 000 (staff: US\$ nil; activities: US\$ 700 000)

(b) Cost for the biennium 2012–2013

Indicate how much of the cost indicated in 3 (a) is for the biennium 2012–2013 (estimated to the nearest US\$ 10 000)

Total: US\$ 100 000 (staff: US\$ nil; activities: US\$ 100 000)

Indicate at which levels of the Organization the costs would be incurred, identifying specific regions where relevant

Headquarters

Is the estimated cost fully included within the approved Programme budget 2012–2013? (Yes/no)

Yes

If “no”, indicate how much is not included.

(c) Staffing implications

Could the resolution be implemented by existing staff? (Yes/no)

Yes

If “no” indicate how many additional staff – full-time equivalents – would be required, identifying specific regions and noting the necessary skills profile(s), where relevant.

4. Funding

Is the estimated cost for the biennium 2012–2013 indicated in 3 (b) fully funded? (Yes/no)

Yes

If “no”, indicate the funding gap and how the funds would be mobilized (provide details of expected source(s) of funds).

US\$ n/a; source(s) of funds: n/a.

1. Resolution WHA65.22 Follow-up of the report of the Consultative Expert Working Group on Research and Development: Financing and Coordination

2. Linkage to the Programme budget 2012–2013 (see document A64/7 http://apps.who.int/gb/ebwha/pdf_files/WHA64/A64_7-en.pdf)

Strategic objective(s): 11

Organization-wide expected result(s): 11.1

How would this resolution contribute to the achievement of the Organization-wide expected result(s)?

Access to essential medicines and medical technologies is a fundamental pillar of national medicine policies. Research and development of new medicines and technologies for effectively tackling the diseases that disproportionately affect developing countries is critical to improving access. It is also very important that new technologies, when developed, are affordable. Currently, spending on research and development is insufficient, and even when new medicines are developed they are not affordable. This resolution will support discussions and consultations among Member States on the feasibility of the recommendations of the report of the Consultative Expert Working Group on Research and Development: Financing and Coordination aimed at enhancing sustainable funding for research and development and ensuring that the resulting products and technologies are affordable.

Does the programme budget already include the products or services requested in this resolution? (Yes/no)

No.

3. Estimated cost and staffing implications in relation to the Programme budget

(a) Total cost

Indicate (i) the lifespan of the resolution during which the Secretariat’s activities would be required for implementation and (ii) the cost of those activities (estimated to the nearest US\$ 10 000).

(i) One year (covering the period 2012–2013)

(ii) Total: US\$ 1.37 million (staff: US\$ 370 000; activities: US\$ 1 million)

(b) Cost for the biennium 2012–2013

Indicate how much of the cost indicated in 3 (a) is for the biennium 2012–2013 (estimated to the nearest US\$ 10 000).

Total: US\$ 1.37 million (staff: US\$ 370 000; activities: US\$ 1 million)

Indicate at which levels of the Organization the costs would be incurred, identifying specific regions where relevant.

Headquarters and regional offices.

Is the estimated cost fully included within the approved Programme budget 2012–2013? (Yes/no)

No.

If “no”, indicate how much is not included.

US\$ 1.37 million

(c) Staffing implications

Could the resolution be implemented by existing staff? (Yes/no)

No.

If “no” indicate how many additional staff – full-time equivalents – would be required, identifying specific regions and noting the necessary skills profile(s), where relevant.

For the secretariat of the open-ended Member States meeting: one staff member at grade P.3 and one staff member at grade G.4 for one year.

4. Funding

Is the estimated cost for the biennium 2012–2013 indicated in 3 (b) fully funded? (Yes/no)

No.

If “no”, indicate the funding gap and how the funds would be mobilized (provide details of expected source(s) of funds).

US\$ 1.37 million; source(s) of funds: funding proposals will be sent to selected Member States and donor agencies.

1. Resolution WHA65.23 Implementation of the International Health Regulations (2005)**2. Linkage to the Programme budget 2012–2013 (see document A64/7 http://apps.who.int/gb/ebwha/pdf_files/WHA64/A64_7-en.pdf)**

Strategic objective(s): 1, 5 and 8

Organization-wide expected result(s): 1.6, 1.7, 1.8, 5.1 and 8.1

How would this resolution contribute to the achievement of the Organization-wide expected result(s)?

The resolution would sustain WHO in its role of providing support to Member States in implementing the International Health Regulations (2005); it would also maintain the Organization’s capacity to operate its global alert and response system. The resolution calls for a renewed commitment from Member States and links directly to indicator 1.6.1. In addition, the resolution emphasizes the whole hazard-related, multisectoral approach to the implementation of the International Health Regulations (2005). In this way, it links expected results 1.6, 1.7 and 1.8 to expected result 5.1 and expected result 8.1.

Does the Programme budget already include the products or services requested in this resolution? (Yes/no)

Yes.

3. Estimated cost and staffing implications in relation to the Programme budget**(a) Total cost**

Indicate (i) the lifespan of the resolution during which the Secretariat’s activities would be required for implementation and (ii) the cost of those activities (estimated to the nearest US\$ 10 000).

(i) Three years (covering the period 2012–2014)

(ii) Total: US\$ 247.31 million (staff: US\$ 110.44 million; activities: US\$ 136.87 million)

(b) Cost for the biennium 2012–2013

Indicate how much of the cost indicated in 3 (a) is for the biennium 2012–2013 (estimated to the nearest US\$ 10 000).

Total: US\$ 164.88 million (staff: US\$ 73.63 million; activities: US\$ 91.25 million)

Indicate at which levels of the Organization the costs would be incurred, identifying specific regions where relevant.

All levels of the Organization.

Is the estimated cost fully included within the approved Programme budget 2012–2013? (Yes/no)

Yes.

If “no”, indicate how much is not included.

(c) Staffing implications

Could the resolution be implemented by existing staff? (Yes/no)

Yes.

If “no” indicate how many additional staff – full-time equivalents – would be required, identifying specific regions and noting the necessary skills profile(s), where relevant.

4. Funding

Is the estimated cost for the biennium 2012–2013 indicated in 3 (b) fully funded? (Yes/no)

No.

If “no”, indicate the funding gap and how the funds would be mobilized (provide details of expected source(s) of funds).

US\$ 83 million; source(s) of funds: voluntary contributions.

1. Decision WHA65(8): Prevention and control of noncommunicable diseases: follow-up to the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases

2. Linkage to the Programme budget 2012–2013 (see document A64/7 http://apps.who.int/gb/ebwha/pdf_files/WHA64/A64_7-en.pdf)

Strategic objective(s): 3 and 6

Organization-wide expected result(s): 3.3, 6.2 and 6.3

How would this resolution contribute to the achievement of the Organization-wide expected result(s)?

The resolution requests the preparation of a revised discussion paper on the global monitoring framework, including indicators and a set of voluntary global targets that reflects the discussions to date. This activity would be in accordance with paragraphs 61 and 62 of United Nations General Assembly resolution 66/2 and would thus support the expected results mentioned above.

Does the programme budget already include the products or services requested in this resolution? (Yes/no)

Yes

3. Estimated cost and staffing implications in relation to the Programme budget

(a) Total cost

Indicate (i) the lifespan of the resolution during which the Secretariat’s activities would be required for implementation and (ii) the cost of those activities (estimated to the nearest US\$ 10 000).

(i) Two years (covering the period 2012–2013)

(ii) Total: US\$ 2.8 million (staff: US\$ 1.5 million; activities: US\$ 1.3 million)

(b) Cost for the biennium 2012–2013

Indicate how much of the cost indicated in 3 (a) is for the biennium 2012–2013 (estimated to the nearest US\$ 10 000)

Total: US\$ 2.8 million (staff: US\$ 1.5 million; activities: US\$ 1.3 million)

Indicate at which levels of the Organization the costs would be incurred, identifying specific regions where relevant

At headquarters and in all six regions.

Is the estimated cost fully included within the approved Programme budget 2012–2013? (Yes/no)

Yes

If “no”, indicate how much is not included.

(c) Staffing implications

Could the resolution be implemented by existing staff? (Yes/no)

Yes

If “no” indicate how many additional staff – full-time equivalents – would be required, identifying specific regions and noting the necessary skills profile(s), where relevant.

4. Funding

Is the estimated cost for the biennium 2012–2013 indicated in 3 (b) fully funded? (Yes/no)

No

If “no”, indicate the funding gap and how the funds would be mobilized (provide details of expected source(s) of funds).

US\$ 2.3 million; source(s) of funds: voluntary contributions from bilateral donors.