



WORLD HEALTH ORGANIZATION

SIXTY-FOURTH WORLD HEALTH ASSEMBLY

GENEVA, 16–24 MAY 2011

**RESOLUTIONS AND DECISIONS
ANNEXES**

GENEVA
2011

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 (formerly ACC)	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-fourth World Health Assembly was held at the Palais des Nations, Geneva, from 16 to 24 May 2011, in accordance with the decision of the Executive Board at its 127th session.

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² See Annex 6.

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¹ See Annex 5.

- A64/45 Implementation of Programme budget 2010–2011: interim report. First report of the Programme, Budget and Administration Committee of the Executive Board to the Sixty-fourth World Health Assembly
- A64/46 Medium-term strategic plan 2008–2013: interim assessment. Third report of the Programme, Budget and Administration Committee of the Executive Board to the Sixty-fourth World Health Assembly
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A64/DIV/6	Address by Mr Bill Gates to the Sixty-fourth World Health Assembly

OFFICERS OF THE HEALTH ASSEMBLY AND MEMBERSHIP OF ITS COMMITTEES

President

Dr Christos PATSALIDES (Cyprus)

Vice-Presidents

Professor C.O. ONYEBUCHI CHUKWU
(Nigeria)

Mr RI Jang Gon (Democratic People's
Republic of Korea)

Dr Enrique T. ONA (Philippines)

Dr Mohammad Hussein NICKNAM
(Islamic Republic of Iran)

Mrs Therese BAPTISTE-CORNELIS
(Trinidad and Tobago)

Secretary

Dr Margaret CHAN, Director-General

Committee on Credentials

The Committee on Credentials was composed of delegates of the following Member States: Barbados, Costa Rica, Fiji, Gabon, Guinea Bissau, Latvia, Malawi, Maldives, New Zealand, Pakistan, Serbia, Uzbekistan.

Chairman: Dr K. WOODS (New Zealand)

Vice-Chairman: Professor D. MPHANDE
(Malawi)

Secretary: Mr Xavier DANNEY, 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: Albania, Botswana, China, Cuba, Egypt, Eritrea, Ethiopia, France, Gambia, Guinea, Hungary, India,

United Kingdom of Great Britain and Northern Ireland, Micronesia (Federated States of), Paraguay, Russian Federation and United States of America.

Chairman: Dr Christos PATSALIDES (Cyprus)

Secretary: Dr Margaret CHAN, Director-
General

MAIN COMMITTEES

Under Rule 33 of the Rules of Procedure of the World Health Assembly, each delegation is entitled to be represented on each main committee by one of its members.

Committee A

Chairman: Dr Walid AMMAR (Lebanon)

Vice-Chairmen: Dr Henry MADZORERA
(Zimbabwe) and Mr Nandi GLASSIE
(Cook Islands)

Rapporteur: Dr Mast KULZHANOV
(Kazakhstan)

Secretary: Dr Maged YOUNES, Director,
Food Safety, Zoonoses and Foodborne
Diseases

Committee B

Chairman: Dr Maria Teresa VALENZUELA
(Chile)

Vice-Chairman: Dr Ante-Zvonimir GOLEM
(Croatia) and Mr Zangley DUKPA
(Bhutan)

Rapporteur: Dr T. Tuitama Leao TUITAMA
(Samoa)

Secretary: Dr Manuel DAYRIT, Director,
Human Resources for Health

RESOLUTIONS

WHA64.1 Implementation of the International Health Regulations (2005)¹

The Sixty-fourth World Health Assembly,

Recognizing the establishment of a Review Committee as provided for in Chapter III of Part IX of the International Health Regulations (2005), and the remit to review the functioning of the International Health Regulations (2005) as well as the response to pandemic (H1N1) 2009, in accordance with the objectives, scope, methodology and timeline accepted by the Executive Board at its 126th session;²

Commending the successful conclusion of the work of the Review Committee on the Functioning of the International Health Regulations (2005) in relation to Pandemic (H1N1) 2009, the leadership of its Chair, the dedication of its distinguished members, and the submission of its final report to the Director-General for transmittal to the Sixty-fourth World Health Assembly;

Having considered the final report of the Review Committee on the Functioning of the International Health Regulations (2005) in relation to Pandemic (H1N1) 2009,³

1. URGES 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
2. REQUESTS the Director-General:
 - (1) to present an update to the Sixty-sixth World Health Assembly, through the Executive Board, on progress made in taking forward the recommendations of the Review Committee on the Functioning of the International Health Regulations (2005) in relation to Pandemic (H1N1) 2009;
 - (2) to provide technical support to Member States in implementing the recommendations of the Review Committee on the Functioning of the International Health Regulations (2005) in relation to Pandemic (H1N1) 2009.

(Ninth plenary meeting, 20 May 2011 –
Committee A, first report)

¹ See Annex 6 for the financial and administrative implications for the Secretariat of this resolution.

² See document EB126/2010/REC/2, summary record of the second meeting, section 2.

³ See document A64/10.

⁴ See Annex 1 for the recommendations made by the Review Committee on the Functioning of the International Health Regulations (2005) in relation to Pandemic (H1N1) 2009.

WHA64.2 WHO reform¹

The Sixty-fourth World Health Assembly,

Having considered the report by the Director-General entitled World Health Organization: reforms for a healthy future,²

1. ENDORSES the agenda for reform as set out in the Director-General's report;
2. URGES Member States to support the implementation of the reform programme;
3. REQUESTS the Executive Board to establish an appropriate process to examine the issues related to WHO's governance identified in the report;
4. REQUESTS the Director-General:
 - (1) to present a detailed concept paper for the November 2012 World Health Forum, setting out objectives, numbers of participants, format and costs, to the Executive Board at its 130th session in January 2012;
 - (2) in consultation with Member States, to develop an approach to independent evaluation, and to present a first report on the independent evaluation of the work of WHO to the Sixty-fifth World Health Assembly in May 2012;
 - (3) to present an update of progress to the Sixty-fifth World Health Assembly, through the Executive Board.

(Ninth plenary meeting, 20 May 2011 –
Committee A, second report)

WHA64.3 Appropriation resolution for the financial period 2012–2013

The Sixty-fourth World Health Assembly,

1. WELCOMES the total effective budget³ under all sources of funds, that is, assessed and voluntary contributions, of US\$ 3 958 979 000, presented in three segments:

Programme budget segment	US\$
Base programmes	2 626 762 000
Special programmes and collaborative arrangements	863 533 000
Outbreak and crisis response	468 684 000
Total effective budget	3 958 979 000

¹ See Annex 6 for the financial and administrative implications for the Secretariat of this resolution.

² Documents A64/4 and A64/INF.DOC./5.

³ See documents A64/7, A64/7 Add.1 and A64/47.

2. RESOLVES to appropriate for the financial period 2012–2013 an amount of US\$ 1 038 840 000, financed by net assessments on Members of US\$ 928 840 000, estimated Member States' non-assessed income of US\$ 15 000 000 if available, and transfer to the Tax Equalization Fund of US\$ 95 000 000, as shown below:

Appropriation section	Purpose of appropriation	Appropriations financed by net assessments and Member States' non-assessed income (US\$)
1	To reduce the health, social and economic burden of communicable diseases	79 186 000
2	To combat HIV/AIDS, tuberculosis and malaria	45 634 000
3	To prevent and reduce disease, disability and premature death from chronic noncommunicable diseases, mental disorders, violence and injuries and visual impairment	44 809 000
4	To reduce morbidity and mortality and improve health during key stages of life, including pregnancy, childbirth, the neonatal period, childhood and adolescence, and improve sexual and reproductive health and promote active and healthy ageing for all individuals	55 754 000
5	To reduce the health consequences of emergencies, disasters, crises and conflicts, and minimize their social and economic impact	18 568 000
6	To promote health and development, and prevent or reduce risk factors for health conditions associated with use of tobacco, alcohol, drugs and other psychoactive substances, unhealthy diets, physical inactivity and unsafe sex	37 731 000
7	To address the underlying social and economic determinants of health through policies and programmes that enhance health equity and integrate pro-poor, gender-responsive, and human rights-based approaches	18 753 000
8	To promote a healthier environment, intensify primary prevention and influence public policies in all sectors so as to address the root causes of environmental threats to health	32 507 000
9	To improve nutrition, food safety and food security, throughout the life-course, and in support of public health and sustainable development	22 359 000
10	To improve health services through better governance, financing, staffing and management, informed by reliable and accessible evidence and research	145 421 000
11	To ensure improved access, quality and use of medical products and technologies	30 751 000

12	To provide leadership, strengthen governance and foster partnership and collaboration with countries, the United Nations system, and other stakeholders in order to fulfil the mandate of WHO in advancing the global health agenda as set out in the Eleventh General Programme of Work	202 410 000
13	To develop and sustain WHO as a flexible, learning organization, enabling it to carry out its mandate more efficiently and effectively	209 957 000
	Subtotal	943 840 000
	Transfer to Tax Equalization Fund	95 000 000
	Total	1 038 840 000

3. FURTHER RESOLVES that:

(1) notwithstanding the provisions of Financial Regulation 4.3, the Director-General is authorized to make transfers between the appropriation sections up to an amount not exceeding 10% of the amount appropriated for the section from which the transfer is made; the expenditure resulting from any such transfers shall be reported in the financial report for the financial period 2012–2013;

(2) amounts not exceeding the appropriations voted under paragraph 2 shall be available for the payment of commitments incurred during the financial period 1 January 2012 to 31 December 2013 in accordance with the provisions of the Financial Regulations; notwithstanding the provisions of the present paragraph, the Director-General shall limit the commitments to be incurred during the financial period 2012–2013 to sections 1 to 13;

(3) the amount of the contribution to be paid by individual Members shall be reduced by the sum standing to their credit in the Tax Equalization Fund; that reduction shall be adjusted in the case of those Members that require staff members to pay income taxes on their WHO emoluments, taxes which the Organization reimburses to said staff members; the amount of such tax reimbursements is estimated at US\$ 20 578 300, resulting in a total assessment on Members of US\$ 949 218 300;

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

5. RECOGNIZES that the voluntary contributions required to meet the portion of the effective working budget not financed through net assessments on Members are US\$ 3 015 139 000.

(Ninth plenary meeting, 20 May 2011 –
Committee A, second report)

WHA64.4 Health conditions in the occupied Palestinian territory, including east Jerusalem, and in the occupied Syrian Golan¹

The Sixty-fourth 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 Arab occupied territories;

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

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

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

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

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

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

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

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

¹ See Annex 6 for the financial and administrative implications for the Secretariat of this resolution.

² Document WHA64/27.

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 Palestinian Ministry of Health 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;

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

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, and comply in this regard with the provisions of the Israeli Palestinian Agreement on Movement and Access of November 2005;

(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 and medical staff to the Palestinian health institutions in occupied east Jerusalem and abroad;

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

(6) improve the living and medical conditions of Palestinian detainees, particularly children, women and patients, and provide the necessary medical treatment to the detainees, whose serious medical conditions are worsening every day;

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

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

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

(10) respect and facilitate the mandate and work of UNRWA and other international organizations, and ensure the free movement of their staff and aid 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 (1949), which 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 urges 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 their 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 submit a fact-finding report on the health and economic situation in the occupied Palestinian territory, including east Jerusalem, and in the occupied Syrian Golan;
- (3) to support the establishment of medical facilities and provide health-related technical assistance to the Syrian population in the occupied Syrian Golan;
- (4) to continue providing necessary technical assistance in order to meet the health needs of the Palestinian people, including the handicapped and injured;
- (5) to also provide support to the Palestinian health and veterinary services in preparing for unusual emergencies;
- (6) to support the development of the health system in the occupied Palestinian territory, including development of human resources;
- (7) to make available the detailed report prepared by the specialized health mission to the Gaza Strip;
- (8) to report on implementation of this resolution to the Sixty-fifth World Health Assembly.

(Ninth plenary meeting, 20 May 2011 –
Committee B, first report)

WHA64.5 Pandemic influenza preparedness: sharing of influenza viruses and access to vaccines and other benefits¹

The Sixty-fourth World Health Assembly,

Having considered the report of the Open-Ended Working Group of Member States on Pandemic Influenza Preparedness: sharing of influenza viruses and access to vaccines and other benefits;²

Acknowledging the work of the Co-Chairs and the Bureau of the Open-Ended Working Group;

Welcoming the outcome of the Open-Ended Working Group of Member States on Pandemic Influenza Preparedness: sharing of influenza viruses and access to vaccines and other benefits in elaborating the Pandemic Influenza Preparedness Framework for sharing of influenza viruses and access to vaccines and other benefits (the “Pandemic Influenza Preparedness Framework”);

Recognizing the role of industry as an important contributor to technology innovation and transfer in addressing the challenges of pandemic influenza preparedness and response,

¹ See Annex 6 for the financial and administrative implications for the Secretariat of this resolution.

² See documents A64/8 and A64/8 Corr.1.

1. ADOPTS, in accordance with Article 23 of the WHO Constitution, the Pandemic Influenza Preparedness Framework, including its annexes;¹
2. URGES Member States:²
 - (1) to implement the Pandemic Influenza Preparedness Framework;
 - (2) to support actively the wide implementation of the Pandemic Influenza Preparedness Framework, and to consider providing adequate resources for its implementation;
3. CALLS UPON relevant stakeholders to give priority to implementing the Pandemic Influenza Preparedness Framework;
4. REQUESTS the Director-General, in consultation with the Advisory Group:
 - (1) to implement the Pandemic Influenza Preparedness Framework;
 - (2) to monitor and review the operation of the Pandemic Influenza Preparedness Framework and all of its components, in accordance with its provisions;
 - (3) to report, on a biennial basis, to the World Health Assembly, through the Executive Board, on progress in the implementation of this resolution.

(Tenth plenary meeting, 24 May 2011 –
Committee A, third report)

WHA64.6 Health workforce strengthening³

The Sixty-fourth World Health Assembly,

Having considered the reports on health system strengthening;⁴

Recalling resolution WHA57.19 on challenges posed by the international migration of health personnel, which, inter alia, urged Member States to develop strategies to mitigate the adverse effects of migration of health personnel and minimize its negative impact on health systems, and to frame and implement policies that could enhance effective retention of health personnel;

Recalling also resolution WHA59.23 on rapid scaling up of health workforce production, which, inter alia, recognized that shortages of health workers are interfering with efforts to achieve the internationally agreed health-related development goals, including those contained in the Millennium Declaration, and those of WHO's priority programmes;

Taking note of the WHO Global Code of Practice on the International Recruitment of Health Personnel,⁵ which, inter alia, recognized that an adequate and accessible health workforce is

¹ See Annex 2 for the Pandemic Influenza Preparedness Framework.

² And where applicable, regional economic integration organizations.

³ See Annex 6 for the financial and administrative implications for the Secretariat of this resolution.

⁴ Documents A64/12 and A64/13.

⁵ Adopted in resolution WHA63.16.

fundamental to an integrated and effective health system and for the provision of health services, and that Member States should take measures to meet their own needs with respect to health personnel, namely, to educate, retain and sustain a health workforce that is appropriate for the specific conditions of each country;

Acknowledging the ongoing development of the WHO policy guidelines on the transformative scale-up of health professional education, which is related to the equitable and efficient increase in quantity, quality and relevance of the skill-mix of the health workforce;

Recognizing that quantity, quality and relevance are prerequisites for the sustainable transformative scaling up of teachers in health professional training institutions;

Recognizing that recruiters and employers are key stakeholders who may contribute to success in the implementation of the WHO Global Code of Practice on the International Recruitment of Health Personnel;

Noting with approval recent international calls to action regarding the importance of ensuring scale-up and an equitable distribution of the health workforce globally, regionally and within countries;¹

Recognizing the centrality of human resources for health to the effective operation of health systems, as highlighted in *The world health report 2006*,² and that the health workforce shortages and inefficiencies are also seriously hampering effective implementation of primary health care, as stated in *The world health report 2008*,³ and expansion of health service coverage, as described in *The world health report 2010*;⁴

Deeply concerned that shortages and inadequate distribution of appropriately trained and motivated health workers, and inefficiencies in the ways in which the health workforce is managed and used, remain major impediments to the effective functioning of health systems and constitute one of the main bottlenecks to achieving the health-related Millennium Development Goals;

Realizing that increased production and improved retention of health workers, in particular in rural areas, rely on various factors including a sufficient and sustainable health financing system, which is to some extent determined by decisions made outside the confines of the health sector, including in international organizations;

Observing that insufficient evidence of the effectiveness of health workforce policies and a lack of comprehensive, reliable and up-to-date data, including analytical tools, constitute significant challenges for Member States trying to achieve or maintain a sufficient, sustainable and effective health workforce;

¹ Including, but not limited to, the *Kampala Declaration and Agenda for Global Action of March 2008*, the G8 Communiqué of July 2008; *Closing the gap in a generation: health equity through action on the social determinants of health: Final Report of the Commission on Social Determinants of Health*. Geneva, World Health Organization, 2008; the High-level Taskforce on Innovative International Financing for Health Systems, 2009; and the *Venice concluding statement on maximizing positive synergies between health systems and global health initiatives*, 2009.

² *The world health report 2006. Working together for health*. Geneva, World Health Organization, 2006.

³ *The world health report 2008. Primary health care: now more than ever*. Geneva, World Health Organization, 2008.

⁴ *The world health report 2010. Health systems financing: the path to universal coverage*. Geneva, World Health Organization, 2010.

Concerned that many Member States, particularly those with critical shortages or imbalances of health workers, also lack the governance, technical and managerial capacity to design and implement efficient and effective policy interventions related to scaling up and retaining the health workforce;

Realizing that a sufficient, efficient and sustainable health workforce is at the heart of robust health systems and a prerequisite for sustainable health improvement;

Recognizing the division of health responsibilities between national and subnational levels of government that is unique to federated States,

1. URGES Member States:¹

(1) to implement the voluntary WHO Global Code of Practice on the International Recruitment of Health Personnel in order that both source and destination countries may derive benefits from the international migration of health personnel and in order to mitigate the negative effects of health worker migration on health systems, particularly in countries with critical health worker shortages;

(2) to prioritize, in the context of global economic conditions, public sector spending on health, as appropriate, to ensure that sufficient financial resources are available for the implementation of policies and strategies to scale up and retain the health workforce, particularly in developing countries, and to recognize it as an investment in the health of the population that contributes to social and economic development;

(3) to consider developing or maintaining a national health workforce plan as an integral part of a validated national health plan, in accordance with national and subnational responsibilities with increased efforts towards effective implementation and monitoring, as appropriate in the national context;

(4) to use and implement evidence-based findings and strategies, including those from the Global Health Workforce Alliance Taskforce on Scaling Up Education and Training, for the successful scaling up of health worker education and training;

(5) to participate actively in the ongoing work on the WHO policy guidelines on transformative scale-up of health professional education in order to increase the workforce numbers and relevant skill-mix in response to country health needs and health systems context;

(6) to expand, strengthen and orient health professional training institutions, in terms of quantity, quality and skill-mix, to be relevant to the implementation of the transformative scaling up of health professionals;

(7) to develop strategies and policies to increase the availability of motivated and skilled health workers in remote and rural areas, with reference to WHO global policy recommendations on increasing access to health workers in remote and rural areas through improved retention of the health workforce;

(8) to implement the relevant recommendations for increased retention of health workers in rural areas, including: improved living conditions; safe and supportive working environments;

¹ And, where applicable, regional economic integration organizations.

outreach support; career development and advancement programmes; supporting professional networks; and social recognition of dedicated health personnel;

(9) to develop or strengthen in-country capacity for health workforce information systems in order to guide, accelerate and improve country action including the collection, processing and dissemination of information on their health workforce, covering, but not limited to, stock, education and training capacity, distribution, migration and expenditures;

(10) to work with other sectors to generate evidence and introduce effective policy interventions in order to address other factors that affect the availability of health workers in rural or remote areas, such as socioeconomic deprivation, geographical barriers and distance, transport and the acceptability of services;

2. URGES nongovernmental organizations, international organizations, international donor agencies, financial and development institutions and other relevant organizations working in developing countries:

(1) to align and harmonize, in line with the Paris Declaration on Aid Effectiveness and the Accra Agenda for Action, their education, training, recruitment and employment practices with those of the countries in which they are based, in particular national health plans, where available, in order to create coherence and coordination and support Member States' efforts in building a sustainable health workforce, strengthening health systems and improving health outcomes;

(2) to support national long-term strategies and interventions to build and sustain a sufficient and efficient health workforce, including investment in the future health workforce;

3. REQUESTS the Director-General:

(1) to continue the implementation of the WHO Global Code of Practice on the International Recruitment of Health Personnel, including, upon request, provision of technical support to Member States in implementing the Global Code;

(2) to provide leadership at global and regional levels by generating evidence and recommending effective interventions to address factors that hinder access to health workers; to work closely with partner agencies in the multilateral system on appropriate measures to support Member States' efforts to maintain or achieve a sufficient, sustainable and effective workforce; and to advocate for this topic to be placed high on global development and research agendas;

(3) to provide technical support to Member States, upon request, for their efforts to scale up education and training and improve the retention of the health workforce; including the identification of efficient and effective health workforce policies and the development and implementation of national health workforce plans;

(4) to support Member States, upon request, in strengthening their capacity for coordination on health workforce issues between ministries of health, other ministries and other relevant stakeholders;

(5) to encourage and support Member States in developing and maintaining a framework for health workforce information systems, in order to accommodate the collection, processing and dissemination of information on their health workforce, including stock, migration, education and training capacity, skill-mix, distribution, expenditures, positions and determinants of change;

(6) to encourage Member States to support the ongoing development of the WHO policy guidelines on transformative scale-up of health professional education in order to increase the quantity, quality and relevance of the health workforce, and towards addressing shortages in human resources for health in an equitable and efficient manner;

(7) to promote research relevant for both developing and developed countries on efficient and effective policies and interventions to improve scale-up and retention of the health workforce, with the aim of establishing and maintaining an accessible global evidence base for best practice, and efficient and effective health workforce policies and interventions, including supporting the strengthening of knowledge centres with the purpose of accommodating translation of evidence and best practice into context-specific policy solutions;

(8) to strengthen capacity within the Secretariat with the purpose of giving sufficient priority to relevant tasks related to the Organization's wider efforts in addressing the global health workforce crisis;

(9) to report on progress in implementing this resolution to the World Health Assembly, through the Executive Board, in a manner integrated with the reporting on resolution WHA63.16 on the WHO Global Code of Practice on the International Recruitment of Health Personnel.

(Tenth plenary meeting, 24 May 2011 –
Committee A, fourth report)

WHA64.7 Strengthening nursing and midwifery¹

The Sixty-fourth World Health Assembly,

Having considered the reports on health system strengthening;²

Recognizing the need to build sustainable national health systems and to strengthen national capacities to achieve the goal of reduced health inequities;

Recognizing the crucial contribution of the nursing and midwifery professions to strengthening health systems, to increasing access to comprehensive health services for the people they serve, and to the efforts to achieve the internationally agreed health-related development goals, including the Millennium Development Goals and those of the World Health Organization's programmes;

Concerned at the continuing shortage and maldistribution of nurses and midwives in many countries and the impact of this on health care and more widely;

Acknowledging resolution WHA62.12 on primary health care, including health system strengthening, which called, inter alia, for the renewal and strengthening of primary health care, as well as urging Member States to train and retain adequate numbers of health workers, with appropriate skill-mix, including primary care nurses and midwives, in order to redress current shortages of health workers to respond effectively to people's health needs;

¹ See Annex 6 for the financial and administrative implications for the Secretariat of this resolution.

² Documents A64/12 and A64/13.

Acknowledging the ongoing WHO initiatives on the scaling up of transformative health professional education and training in order to increase the workforce numbers and the relevant skill-mix in response to the country health needs and health systems context;

Recognizing the global policy recommendations by WHO on increasing access to health workers in remote and rural areas through improved retention¹ as an evidence platform for developing effective country policies for rural retention of nursing and midwifery personnel;

Taking note of the WHO Global Code of Practice on the International Recruitment of Health Personnel;²

Reaffirming the call for governments and civil society to strengthen capacity to address the urgent need for skilled health workers, particularly midwives, made in the WHO UNFPA UNICEF World Bank Joint Statement on Maternal and Newborn Health;

Noting the importance of multidisciplinary involvement, including that of nurses and midwives, in high-quality research that grounds health and health systems policy in the best scientific knowledge and evidence, as elaborated in WHO's strategy on research for health, endorsed in resolution WHA63.21;

Noting that nurses and midwives form the majority of the workforce in many countries' health systems, and recognizing that the provision of knowledge-based and skilled health services maximizes the physical, psychological, emotional and social well-being of individuals, families and societies;

Recognizing the fragmentation of health systems, the shortage of human resources for health and the need to improve collaboration in education and practice, and primary health care services;

Having considered the reports on progress in the implementation of resolution WHA59.27 on strengthening nursing and midwifery;³

Mindful of previous resolutions to strengthen nursing and midwifery (WHA42.27, WHA45.5, WHA47.9, WHA48.8, WHA49.1, WHA54.12 and WHA59.27) and the new strategic directions for nursing and midwifery services in place for the period 2011–2015;⁴

Recognizing the need to improve the education of nurses and midwives,

1. URGES Member States to translate into action their commitment to strengthening nursing and midwifery by:

(1) developing targets and action plans for the development of nursing and midwifery, as an integral part of national or subnational health plans, that are reviewed regularly in order to respond to population-health needs and health system priorities as appropriate;

¹ *Increasing access to health workers in remote and rural areas through improved retention: global policy recommendations*. Geneva, World Health Organization, 2010.

² Adopted in resolution WHA63.16.

³ See documents A61/17 and A63/27.

⁴ Document WHO/HRH/HPN/10.1.

- (2) forging strong, interdisciplinary health teams to address health and health system priorities, recognizing the distinct contribution made by the knowledge and expertise of nurses and midwives;
- (3) participating in the ongoing work of WHO's initiatives on scaling up transformative education and training in nursing and midwifery in order to increase the workforce numbers and the mix of skills that respond to the country's health needs and are appropriate to the health system context;
- (4) collaborating within their regions and with the nursing and midwifery professions in the strengthening of national or subnational legislation and regulatory processes that govern those professions, including the development of competencies for the educational and technical preparation of nurses and midwives, and systems for sustaining those competencies; and giving consideration to the development of the education continuum that is necessary for attaining the required level of expertise of nursing and midwifery researchers, educators and administrators;
- (5) strengthening the dataset on nurses and midwives as an integral part of national and subnational health workforce information systems, and maximizing use of this information for evidence-based policy decisions;
- (6) harnessing the knowledge and expertise of nursing and midwifery researchers in order to contribute evidence for health system innovation and effectiveness;
- (7) engaging actively the expertise of nurses and midwives in the planning, development, implementation and evaluation of health and health system policy and programming;
- (8) implementing strategies for enhancement of interprofessional education and collaborative practice including community health nursing services as part of people-centred care;
- (9) including nurses and midwives in the development and planning of human resource programmes that support incentives for recruitment and retention, and strategies for improving workforce issues, such as remuneration, conditions of employment, career development and advancement, and development of positive work environments;
- (10) promoting the establishment of national and subnational mechanisms in order to develop and support the effective interventions proposed in the global policy recommendations on increasing access to health workers in remote and rural areas through improved retention;¹
- (11) implementing the WHO Global Code of Practice on the International Recruitment of Health Personnel, given the national impact of the loss of trained nursing staff, at national and local level as appropriate;

2. REQUESTS the Director-General:

- (1) to strengthen WHO's capacity for development and implementation of effective nursing and midwifery policies and programmes through continued investment and appointment of professional nurses and midwives to specialist posts in the Secretariat both at headquarters and in regions;

¹ *Increasing access to health workers in remote and rural areas through improved retention: global policy recommendations*. Geneva, World Health Organization, 2010.

- (2) to engage actively the knowledge and expertise of the Global Advisory Group on Nursing and Midwifery in key policies and programmes that pertain to health systems, the social determinants of health, human resources for health and the Millennium Development Goals;
- (3) to provide technical support and evidence for the development and implementation of policies, strategies and programmes on interprofessional education and collaborative practice, and on community health nursing services;
- (4) to provide support to Member States in optimizing the contributions of nursing and midwifery to implementing national health policies and achieving the internationally agreed health-related development goals, including those contained in the United Nations Millennium Declaration;
- (5) to encourage the involvement of nurses and midwives in the integrated planning of human resources for health, particularly with respect to strategies for maintaining adequate numbers of competent nurses and midwives;
- (6) to report on progress in implementing this resolution to the World Health Assembly, through the Executive Board, in a manner integrated with the reporting on resolution WHA63.16 on the WHO Global Code of Practice on the International Recruitment of Health Personnel.

(Tenth plenary meeting, 24 May 2011 –
Committee A, fourth report)

WHA64.8 Strengthening national policy dialogue to build more robust health policies, strategies and plans¹

The Sixty-fourth World Health Assembly,

Having considered the report on health system strengthening: improving support to policy dialogue around national health policies, strategies and plans;²

Having also considered the importance of policy directions suggested by the world health reports for 2008 and 2010;³ resolution WHA62.12 on primary health care, including health system strengthening; resolution EUR/RC60/R5 on addressing key public health and health policy challenges in Europe: moving forwards in the quest for better health in the WHO European Region; resolution WPR/RC61.R2 on the Western Pacific Regional Strategy for health systems based on the values of primary health care; resolution AFR/RC60/R1 on a strategy for addressing key determinants of health in the African Region; document AFR/RC60/7 on health systems strengthening: improving district health service delivery, and community ownership and participation; and document SEA/RC63/9 on the development of national health plans and strategies;

¹ See Annex 6 for the financial and administrative implications for the Secretariat of this resolution.

² Document A64/12.

³ *The world health report 2008. Primary health care: now more than ever.* Geneva, World Health Organization, 2008. *The world health report 2010. Health systems financing: the path to universal coverage.* Geneva, World Health Organization, 2010.

Recognizing that robust and realistic national health policies, strategies and plans are essential for strengthening health systems based on primary health care;

Underlining the importance of coherent and balanced policies, strategies and plans under ministries of health with respect to efforts to achieve the Millennium Development Goals;

Acknowledging that many Member States have made efforts to ensure that their national health policies, strategies and plans respond better to growing expectations for improved health and better services;

Noting that an inclusive policy dialogue with a comprehensive range of stakeholders, within and beyond government, including civil society organizations, the private sector, and health professionals and academics, within the health and other sectors, is critical to increasing the likelihood that national policies, strategies and plans will be appropriately designed and implemented and will yield the expected results,

1. URGES Member States:¹

(1) to show effective leadership and ownership of the process of establishing robust national or subnational health policies and strategies, basing that process on broad and continuous consultation and engagement of all relevant stakeholders;

(2) to base their national or subnational health policies, strategies and plans on the overarching goals of universal coverage, people-centred primary care and health in all policies, as well as on a comprehensive, balanced and evidence-based assessment of the country's health and its health system challenges;

(3) to ensure that national or subnational health policies, strategies and plans are ambitious but realistic with respect to available resources and the capacities of staff and institutions, and that they address the entire health sector, public as well as private, and the social determinants of health;

(4) to ensure that national health policies, strategies and plans are integrated with subnational operational plans, disease or life-cycle programmes, and are linked to the country's overall development and political agenda;

(5) to regularly monitor, review and adjust their national or subnational health policies, strategies and plans with a view to developing evidence-based responses to evolving challenges and opportunities, and to involve all relevant stakeholders;

(6) to strengthen their institutional capacity, as appropriate, in harmonizing and aligning donor programmes with national policies, strategies, priorities and plans;

(7) to promote the engagement and empowerment of all stakeholders, including civil society and communities, the private sector, health professionals and academics, in order that they participate actively and efficiently in policy dialogue concerning the performance of national policies, strategies and plans;

¹ And, where applicable, regional economic integration organizations.

2. CALLS upon development agencies and other partners to strengthen adherence to the principles of the Paris Declaration on Aid Effectiveness, of ownership, alignment, harmonization, results, and mutual accountability, encouraging efforts through mechanisms such as the International Health Partnership;
3. REQUESTS the Director-General:
- (1) to renew the Organization's role at country level as a facilitator of inclusive policy dialogue around national health policies, strategies and plans, to reflect this across the Organization's workplans and operations, and to provide technical input to the conduct of the planning process, as appropriate;
 - (2) to promote the principles of the Paris Declaration on Aid Effectiveness, of ownership, alignment, harmonization, results, and mutual accountability, based on priorities set out in the national health policies, strategies and plans;
 - (3) to support Member States in their efforts to ensure the ownership, quality and coordination of the technical support they receive, and to foster cross-country and regional learning and cooperation;
 - (4) to strengthen the Organization's capacity at all levels for enhanced and integrated support to national policy dialogue around national health policies, strategies and plans;
 - (5) to report to the Sixty-fifth World Health Assembly, through the Executive Board, on progress made, obstacles faced and results obtained in enhancing support provided to Member States for national policy dialogue around national health policies, strategies and plans.

(Tenth plenary meeting, 24 May 2011 –
Committee A, fourth report)

WHA64.9 Sustainable health financing structures and universal coverage¹

The Sixty-fourth World Health Assembly,

Having considered the reports on health system strengthening;²

Having also considered *The world health report 2010*,³ which received strong support from the International Ministerial Conference on Health Systems Financing – Key to Universal Coverage (Berlin, November 2010);

Recalling resolution WHA58.33 on sustainable health financing, universal coverage and social health insurance;

¹ See Annex 6 for the financial and administrative implications for the Secretariat of this resolution.

² Documents A64/12 and A64/13.

³ *The world health report 2010. Health systems financing: the path to universal coverage*. Geneva, World Health Organization, 2010.

Recalling also Article 25.1 of the Universal Declaration of Human Rights, which states that everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control;

Recognizing that effective health systems delivering comprehensive health services, including preventive services, are of utmost importance for health, economic development and well-being and that these systems need to be based on equitable and sustainable financing as mentioned in the Tallinn Charter: Health Systems for Health and Wealth (2008);

Underlining the valuable contribution made by fair and sustainable financing structures towards achieving health-related Millennium Development Goal 4 (Reduce child mortality), Goal 5 (Improve maternal health), and Goal 6 (Combat HIV/AIDS, malaria and other diseases), as well as Goal 1 (Eradicate extreme poverty and hunger);

Having considered *The world health report 2008*¹ and resolution WHA62.12, that highlighted universal coverage as one of the four key pillars of primary health care and services through patient-centred care, inclusive leadership and health in all policies;

Noting that health-financing structures in many countries need to be further developed and supported in order to expand access to necessary health care and services for all, while preventing and providing protection against disastrous financial risks;

Accepting that, irrespective of the source of financing for the health system selected, equitable prepayment and pooling at population level, and the avoidance, at the point of delivery, of direct payments that result in financial catastrophe and impoverishment, are basic principles for achieving universal health coverage;

Considering that the choice of a health-financing system should be made within the particular context of each country, and that it is important to regulate and maintain the core functions of risk pooling, purchasing, and delivery of basic services;

Acknowledging that a number of Member States are pursuing health-financing reforms that may involve a mix of public and private approaches, and a financing mix of contribution-based and tax-funded inputs;

Recognizing the important role of State legislative and executive bodies, with the support of civil society, in further reform of health-financing systems with a view to achieving universal coverage,

1. URGES Member States:²

- (1) to ensure that health-financing systems evolve so as to avoid significant direct payments at the point of delivery and include a method for prepayment of financial contributions for health care and services as well as a mechanism to pool risks among the population in order to avoid catastrophic health-care expenditure and impoverishment of individuals as a result of seeking the care needed;

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

² And, where applicable, regional economic integration organizations.

(2) to aim for affordable universal coverage and access for all citizens on the basis of equity and solidarity, so as to provide an adequate scope of health care and services and level of costs covered, as well as comprehensive and affordable preventive services through strengthening of equitable and sustainable financial resource budgeting;

(3) to continue, as appropriate, to invest in and strengthen the health-delivery systems, in particular primary health care and services, and adequate human resources for health and health information systems, in order to ensure that all citizens have equitable access to health care and services;

(4) to ensure that external funds for specific health interventions do not distort the attention given to health priorities in the country, that those funds increasingly implement the principles of aid effectiveness, and that they contribute in a predictable way to the sustainability of financing;

(5) to plan the transition of their health systems to universal coverage, while continuing to safeguard the quality of services and to meet the needs of the population in order to reduce poverty and to attain internationally agreed development goals, including the Millennium Development Goals;

(6) to recognize that, when managing the transition of the health system to universal coverage, each option will need to be developed within the particular epidemiological, macroeconomic, sociocultural and political context of each country;

(7) to take advantage, where appropriate, of opportunities that exist for collaboration between public and private providers and health-financing organizations, under strong overall government-inclusive stewardship;

(8) to promote the efficiency, transparency and accountability of health-financing governance systems;

(9) to ensure that overall resource allocation strikes an appropriate balance between health promotion, disease prevention, rehabilitation and health-care provision;

(10) to share experiences and important lessons learnt at the international level for encouraging country efforts, supporting decision-makers, and boosting reform processes;

(11) to establish and strengthen institutional capacity in order to generate country-level evidence and effective, evidence-based policy decision-making on the design of universal health coverage systems, including tracking the flows of health expenditures through the application of standard accounting frameworks;

2. REQUESTS the Director-General:

(1) to convey to the United Nations Secretary-General the importance of universal health coverage for discussion by the United Nations General Assembly at a forthcoming session;

(2) to provide a report on measures taken and progress made in the implementation of resolution WHA58.33, especially in regard to equitable and sustainable health financing and social protection of health in Member States;

- (3) to work closely with other United Nations organizations, international development partners, foundations, academia and civil society organizations, in fostering efforts towards achieving universal coverage;
- (4) to prepare a plan of action for the Secretariat to support Member States in realizing universal coverage, as envisaged in resolution WHA62.12 and *The world health report 2010*;¹
- (5) to prepare an estimate of the number of people covered by a basic health insurance that provides access to basic health care and services, that estimate being broken down by country and region;
- (6) to provide, in response to requests from Member States, technical support for strengthening capacities and expertise in the development of health-financing systems, particularly equitable prepayment schemes, with a view to achieving universal coverage by providing comprehensive health care and services for all, including strengthening capacity in tracking resource flows through the application of standard accounting frameworks;
- (7) to facilitate within existing forums the continuous sharing of experiences and lessons learnt on social health protection and universal coverage;
- (8) to report to the Sixty-fifth World Health Assembly and thereafter every three years, through the Executive Board, on the implementation of this resolution, including on outstanding issues raised by Member States during the Sixty-fourth World Health Assembly.

(Tenth plenary meeting, 24 May 2011 –
Committee A, fourth report)

WHA64.10 Strengthening national health emergency and disaster management capacities and the resilience of health systems²

The Sixty-fourth World Health Assembly,

Having considered the reports on health system strengthening;³

Recalling resolutions WHA58.1 on health action in relation to crises and disasters, and WHA59.22 on emergency preparedness and response, resolution WHA61.19 on climate change and health, and other World Health Assembly and Regional Committee resolutions and action plans, inter alia, on health security and the International Health Regulations (2005), as well as on pandemic preparedness, safe hospitals and other matters related to emergencies and disasters at local, subnational and national levels;

Recalling also United Nations General Assembly resolution 60/195, which endorsed the Hyogo Declaration and the Hyogo Framework for Action 2005–2015: Building the Resilience of Nations and Communities to Disasters, as well as resolutions 61/198, 62/192, 63/216, 64/200 and 64/251, which,

¹ *The world health report 2010. Health systems financing: the path to universal coverage*, Geneva, World Health Organization, 2010.

² See Annex 6 for the financial and administrative implications for the Secretariat of this resolution.

³ Documents A64/12 and A64/13.

inter alia, called upon Member States to increase efforts to implement the Hyogo Framework, to strengthen risk-reduction and emergency preparedness measures at all levels, and to encourage the international community and relevant United Nations entities to support national efforts aimed at strengthening capacity to prepare for and respond to disasters;

Reaffirming that countries should ensure the protection of the health, safety and welfare of their people and should ensure 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;

Regretting the tragic and enormous loss of life, as well as the injuries, disease and disabilities resulting from emergencies, disasters and crises of all descriptions;

Mindful that emergencies and disasters also result in the damage and destruction of hospitals and other parts of the health infrastructure, the weakened ability of health systems to deliver health services; and setbacks for health development and the achievement of the Millennium Development Goals;

Expressing deep concern that continuing poverty, increasing urbanization, and climate change are expected to increase the health risks and impact of emergencies and disasters on many countries and communities;

Acknowledging that most actions to manage the risks to health from natural, biological, technological and societal hazards, including immediate emergency response, are provided by local- and country-level actors across all health disciplines, including mass casualty management, mental health and noncommunicable diseases, communicable diseases, environmental health, maternal and newborn health, reproductive health, and nutrition and other cross-cutting health issues;

Recognizing the contribution of other sectors and disciplines to the health and well-being of people at risk from emergencies and disasters, including local government, planners, architects, engineers, emergency services and civil protection, and academia;

Concerned that country and community capacities to manage major emergencies and disasters are often overwhelmed, and that coordination, communications and logistics are often revealed as the weakest aspects of health emergency management;

Appreciating that some countries, including those with low-income or emerging country development status, have reduced mortality and morbidity in disaster situations through their investment in emergency and disaster risk-reduction measures, with the support of local, regional and global partners;

Recognizing also that WHO plays an important role as a member of the United Nations International Strategy for Disaster Reduction system and as the health cluster lead in the framework of humanitarian reform, and works closely with other members of the international community, such as the United Nations Secretariat of the International Strategy for Disaster Reduction, UNDP, UNICEF, the United Nations Office for the Coordination of Humanitarian Affairs, the International Red Cross and Red Crescent Movement, and other nongovernmental organizations, on supporting country capacity development and developing institutional capacities for multisectoral emergency and disaster risk-management, which includes disaster risk-reduction;

Building on the International Strategy for Disaster Reduction, the 2008–2009 World Disaster Reduction Campaign on Hospitals Safe from Disasters, the 2010–2011 Campaign on Disaster Resilient Cities, World Health Day 2008 on Climate Change and Health, World Health Day 2009 on

Hospitals Safe in Emergencies, and World Health Day 2010 on Urban Health Matters, which have resulted in local, subnational, national and global actions on reducing risks to health from emergencies and disasters;

Recognizing further that improved health outcomes from emergencies and disasters require urgent additional action at country, regional and global levels to ensure that the local, subnational and national health risk-reduction and overall response in emergencies and disasters are timely and effective and that health services remain operational when they are most needed, in this respect bearing in mind that emergencies and disasters affect men and women differently,

1. URGES Member States:¹

(1) to strengthen all-hazards health emergency and disaster risk-management programmes (including disaster risk-reduction, emergency preparedness and response)² as part of national and subnational health systems, supported by, and with effective enforcement of, legislation, regulations and other measures, to improve health outcomes, reduce mortality and morbidity, protect health infrastructure and strengthen the resilience of the health system and society at large, and mainstream a gender perspective into all phases of such programmes;

(2) to integrate all-hazards health emergency and disaster risk-management programmes (including disaster risk-reduction) into national or subnational health plans and institutionalize capacities for coordinated health and multisectoral action to assess risks, proactively reduce risks, and prepare for, respond to, and recover from, emergencies, disasters and other crises;

(3) to facilitate access by concerned government and other related agencies to information on types and quantities of hazardous materials stored, used or transported, in order to support effective health emergency and disaster risk-management;

(4) to develop programmes on safe and prepared hospitals that ensure: that new hospitals and health facilities are located and built safely so as to withstand local hazards; that the safety of existing facilities is assessed and remedial action is taken; and that all health facilities are prepared to respond to internal and external emergencies;

(5) to establish, promote and foster regional and subregional collaboration, as well as interregional cooperation within WHO, including sharing of experience and expertise for capacity development in risk-reduction, response and recovery;

(6) to strengthen the role of the local health workforce in the health emergency management system, to provide local leadership and health services, through enhanced planning, training for all health-care workers and access to other resources;

2. CALLS UPON Member States, donors and development cooperation partners to allocate sufficient resources for health emergency and disaster risk-management programmes and partners through international cooperation for development, humanitarian appeals, and support for WHO's role in health emergency and disaster risk-management matters;

¹ And, where applicable, regional economic integration organizations.

² Health emergency and disaster risk-management includes all measures to assess risks, proactively reduce risks, prepare for, respond to, and recover from, emergencies, disasters and other crises.

3. REQUESTS the Director-General:

- (1) to ensure that WHO at all levels has enhanced capacity and resources, and optimizes its expertise across all disciplines in the Organization, in order to provide the necessary technical guidance and support to Member States and partners for developing health emergency and disaster risk-management programmes at national, subnational and local levels;
- (2) to strengthen collaboration with and ensure coherence and complementarity of actions with those of relevant entities, including those in the public, private, nongovernmental and academic sectors, in order to support country and community health emergency and disaster risk-management, which includes disaster risk-reduction, as well as ongoing efforts by Member States to implement the International Health Regulations (2005);
- (3) to strengthen the evidence base for health emergency and disaster risk-management, including operational research and economic assessments;
- (4) to support national and subnational assessments of risks and capacities for health emergency and disaster risk-management, as a basis for catalysing action and strengthening national and subnational health emergency and disaster risk-management capacities, including disaster risk-reduction;
- (5) to report to the Sixty-sixth World Health Assembly through the Executive Board at its 132nd session, on progress made in implementing this resolution;
- (6) to consider, as appropriate, providing support to regional and subregional networks, as well as interregional cooperation with WHO, in order to strengthen their collaboration on health emergency and disaster risk management.

(Tenth plenary meeting, 24 May 2011 –
Committee A, fourth report

WHA64.11 Preparations for the High-level Meeting of the United Nations General Assembly on the Prevention and Control of Non-communicable Diseases, following the Moscow Conference^{1,2}

The Sixty-fourth World Health Assembly,

Having considered the report on WHO's role in the preparation, implementation and follow-up to the High-level Meeting of the United Nations General Assembly on the Prevention and Control of Non-communicable Diseases;³

Deeply concerned that the global burden and threat of noncommunicable diseases continue to grow, in particular in developing countries, and convinced that global action is necessary and urgent

¹ First Global Ministerial Conference on Healthy Lifestyles and Noncommunicable Disease Control (Moscow, Russian Federation, 28–29 April 2011).

² See Annex 6 for the financial and administrative implications for the Secretariat of this resolution.

³ Document A64/21.

response is needed, including by effectively addressing the key risk factors for noncommunicable diseases;

Reaffirming its commitment to the aim of the global strategy for the prevention and control of noncommunicable diseases to reduce premature mortality and improve quality of life;¹

Further recalling United Nations General Assembly resolution 64/265 in which the General Assembly decided to convene a high-level meeting of the General Assembly in September 2011, with the participation of Heads of State and Government, on the prevention and control of noncommunicable diseases, as well as resolution 65/238 on the scope, modalities, format and organization of the high-level meeting;

Recognizing the leading role of the World Health Organization as the primary specialized agency for health, and reaffirming the leadership role of WHO in promoting global action against noncommunicable diseases;

Noting with appreciation the first *WHO Global status report on noncommunicable diseases* launched on 27 April 2011, which may serve as an input into the preparatory process for the high-level meeting;

Noting also the outcomes of the regional consultations which were held by WHO in collaboration with Member States, with the support of relevant United Nations agencies and entities, which will serve to provide inputs to the preparations for the high-level meeting, as well as to the meeting itself;

Welcoming the outcome of the First Global Ministerial Conference on Healthy Lifestyles and Noncommunicable Disease Control, which was organized by the Russian Federation and WHO from 28 to 29 April 2011 in Moscow,

1. ENDORSES the Moscow Declaration,² including as a key input for the preparations leading to the high-level meeting;

2. URGES Member States:³

(1) to continue to support the preparations at national, regional and international levels for the high-level meeting, including, where feasible and relevant, a situation analysis of noncommunicable diseases and their risk factors, as well as an assessment of national capacity and health system response to address noncommunicable diseases;

(2) to be represented at the level of Heads of State and Government at the high-level meeting and to call for action through a concise action-oriented outcome document;

(3) to consider, as appropriate and where relevant, including in their national delegations to the high-level meeting, parliamentarians, and representatives of civil society, including nongovernmental organizations, academia and networks working on the control and prevention of noncommunicable diseases;

¹ See resolution WHA53.17.

² See Annex 3.

³ And, where applicable, regional economic integration organizations.

3. REQUESTS the Director-General:

(1) to continue exercising the leading role of WHO as the primary specialized agency for health, working together in a coordinated way with the United Nations, its specialized agencies, funds and programmes, and other relevant intergovernmental organizations and international financial institutions, in supporting Member States, including:

(i) in undertaking concerted action and a coordinated response in order to address promptly and appropriately the challenges posed by noncommunicable diseases, including further building on available situation analyses on noncommunicable diseases and risk factors; and

(ii) in highlighting the social and economic impact of noncommunicable diseases, including financial challenges, in particular in developing countries;

(2) to take into account the outcomes from the Moscow Conference in the preparations for the high-level meeting;

(3) to ensure that the Secretariat has adequate financial and human resources to prepare for the high-level meeting and to respond swiftly to its recommendations;

(4) to report to the Sixty-fifth World Health Assembly, through the Executive Board, on the outcomes of the first Global Ministerial Conference on Healthy Lifestyles and Noncommunicable Disease Control and the high-level meeting, and to develop, together with relevant United Nations agencies and entities, an implementation and follow-up plan for the outcomes, including its financial implications, for submission to the Sixty-sixth World Health Assembly, through the Executive Board.

(Tenth plenary meeting, 24 May 2011 –
Committee A, fifth report)

WHA64.12 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)¹

The Sixty-fourth World Health Assembly,

Having considered the reports on the health-related Millennium Development Goals;²

Recalling resolutions WHA63.15 and WHA61.18 on monitoring of the achievement of the health-related Millennium Development Goals, and WHA63.24 on accelerated progress towards achievement of Millennium Development Goal 4 to reduce child mortality: prevention and treatment of pneumonia;

Expressing deep concern at the slow pace of progress in achieving Millennium Development Goals 4 and 5 on reducing child mortality and on improving maternal health;

¹ See Annex 6 for the financial and administrative implications for the Secretariat of this resolution.

² Documents A64/11 and A64/11 Add.1.

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;

Recognizing that adequate antenatal care reduces the risks of maternal mortality, prematurity and other complications of pregnancy and delivery that can result in poor health outcomes for mothers and neonates;

Recognizing also the need to work towards greater transparency and accountability in international development cooperation regarding health, in both donor and developing countries, focusing on adequate and predictable financial resources as well as their improved quality and targeting;

Welcoming the United Nations Secretary-General's Global Strategy for Women's and Children's Health launched at the United Nations High-level Plenary Meeting of the General Assembly on the Millennium Development Goals (New York, September 2010), and acknowledging the strong political and financial commitment by Member States to follow up and implement the strategy;

Noting the United Nations Secretary-General's request that WHO lead a process to determine the most effective international institutional arrangements for global reporting, oversight and accountability on women's and children's health, including through the United Nations system;

Stressing that the monitoring of resource flows and results is a vital requirement for improving the accountability and responsiveness by governments and international development partners in addressing health issues;

Welcoming also the establishment of the Commission on Information and Accountability for Women's and Children's Health, which consists of high-level representatives;

Stressing also that concerns related to health equity and rights should also be addressed in efforts to achieve the Millennium Development Goals;

Stressing further that the Commission should take into account relevant existing data collections and existing performance indicators;

Welcoming further the final report of the Commission and its set of recommendations for strengthening accountability for resources and results in women and children's health,

1. URGES Member States¹ 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;
2. REQUESTS the Executive Board to review progress on the implementation of the recommendations of the Commission, starting at its 130th session, January 2012;

¹ And, where applicable, regional economic integration organizations.

3. REQUESTS the Director-General:

(1) to ensure the effective engagement of all stakeholders in the follow-up to the work of the Commission;

(2) to report annually until 2015 to the World Health Assembly on progress achieved in connection with the agenda item concerning the Millennium Development Goals.

(Tenth plenary meeting, 24 May 2011 –
Committee A, fifth report)

WHA64.13 Working towards the reduction of perinatal and neonatal mortality¹

The Sixty-fourth World Health Assembly,

Having considered the reports on the health-related Millennium Development Goals;²

Recalling resolution WHA58.31 advocating universal coverage of maternal, newborn and child health interventions;

Recalling also Millennium Development Goals 4 and 5, with their respective targets to reduce under-five mortality by two-thirds and maternal mortality by three-quarters, between 1990 and 2015;

Recognizing the importance of the Global Strategy for Women's and Children's Health launched in September 2010 by the Secretary-General of the United Nations and welcoming the report of the Commission on Information and Accountability for Women's and Children's Health;

Recognizing also the Partnership for Maternal, Newborn and Child Health, which reflects the growing international interest in and attention to this issue, and whose objective is to coordinate and intensify national, regional and global activities along the continuum of care for maternal and child health to achieve the Millennium Development Goals;

Taking into account the request by Member States to implement the WHO regional strategies;

Aware that WHO Member States have undertaken a number of actions and programmes to reduce perinatal and neonatal morbidity and mortality and meet the targets set by the Millennium Development Goals, developing their respective *National Plans for the Accelerated Reduction of Maternal and Child Mortality*, to improve equitable access, timeliness, continuity and quality of health care for women of childbearing age and newborn infants;

Noting the conclusion of the World Health Assembly that there has been insufficient and uneven progress towards achieving Millennium Development Goal 5 and an increase in the maternal mortality ratio in a number of countries, and that, while there has been progress towards achieving Millennium Development Goal 4 in terms of the reduction of child mortality, progress has stagnated in relation to the reduction of perinatal and neonatal mortality;

¹ See Annex 6 for the financial and administrative implications for the Secretariat of this resolution.

² Documents A64/11 and A64/11 Add.1.

Concerned by the limited resources for disease prevention and treatment of newborn infants in developing countries, which contribute to high perinatal and neonatal mortality rates;

Recognizing further the evidence that early and exclusive breastfeeding significantly reduces perinatal and neonatal mortality and recalling, in this regard, the importance of the implementation of the global strategy for infant and young child feeding and resolution WHA63.23 and other related resolutions;

Recognizing in addition that perinatal and neonatal mortality is a significant social and economic burden that seriously affects countries and in particular developing countries, that rates should be reduced both by preventing the most common problems such as prematurity, sepsis and respiratory conditions, and also by implementing basic, high-impact and low-cost interventions founded on solid scientific evidence;

Recognizing also that universal access to cost-effective perinatal and neonatal health interventions, including through the application of outreach, family, community and facility-based prevention, promotion and treatment services, significantly reduces a huge proportion of perinatal and neonatal deaths worldwide;

Aware that meeting the targets of Millennium Development Goals 4 and 5 will require intense health and intersectoral efforts with a high level of political commitment,

1. URGES Member States:

(1) to ensure that health authorities in countries with high perinatal and neonatal mortality rates use their stewardship and leadership to involve other institutions and sectors, to strengthen capacity to achieve a greater reduction in avoidable neonatal and perinatal mortality in the context of improving the continuum of maternal and child health;

(2) to further promote political commitment for effective implementation of the existing national, regional and/or global plans with the application of evidence-based strategies and interventions, including the Baby-Friendly Hospital Initiative, to improve perinatal and neonatal health and increase equitable access to quality maternal, newborn and child health services;

(3) to advance perinatal and neonatal care as a priority and develop, as appropriate, plans for universal access to cost-effective interventions, including actions to address sepsis and nosocomial infections, information and behaviour change communication, skilled birth attendants and early postnatal care, and early and exclusive breastfeeding;

(4) to strengthen the perinatal and neonatal mortality surveillance system, including data and vital statistics collection as well as monitoring and reporting mechanisms;

2. REQUESTS the Director-General:

(1) to continue to raise awareness within the international community about the global burden of perinatal and neonatal mortality and promote, based on current best practices, targeted plans to increase access to high quality and safe health services that prevent and treat perinatal and neonatal conditions within an integrated mother and child health package, including reproductive health;

(2) to strengthen regional and country-level institutional capacity and human resources, including skilled birth attendants and essential newborn care, such as the Baby-Friendly Hospital Initiative, to identify innovative solutions, and promote research to address the main

causes of perinatal and neonatal mortality such as prematurity, sepsis, respiratory conditions and infections, in particular of nosocomial origin;

(3) to support coordination of actions with relevant WHO entities and United Nations agencies and other stakeholders, and strengthen or build partnerships to promote intra- and inter-regional collaboration in order to enhance effectiveness of action in this specific area;

(4) to provide Member States with the necessary assistance and technical advice to develop and implement national policies, plans and strategies for the prevention and reduction of perinatal and neonatal mortality, and related maternal morbidity and mortality;

(5) to report to the Sixty-fifth World Health Assembly on progress achieved in connection with the agenda item concerning the Millennium Development Goals.

(Tenth plenary meeting, 24 May 2011 –
Committee A, sixth report)

WHA64.14 Global health sector strategy on HIV/AIDS, 2011–2015¹

The Sixty-fourth World Health Assembly,

Recalling resolution WHA63.19 in which the Director-General was requested, *inter alia*, to develop a WHO HIV/AIDS strategy for 2011–2015 that builds on previous WHO HIV/AIDS strategies and plans endorsed by several Health Assemblies, including resolutions WHA53.14, WHA56.30, WHA59.12 and WHA59.19;

Having considered the draft WHO HIV strategy 2011–2015,²

1. ENDORSES the global health sector strategy on HIV/AIDS, 2011–2015;³
2. AFFIRMS the vision and strategic directions of the global health sector strategy on HIV/AIDS, 2011–2015 and that the global strategy aims to guide the health sector's response to HIV/AIDS, including recommended actions at country and global levels, as well as contributions to be made by WHO;
3. WELCOMES the alignment of the global health sector strategy on HIV/AIDS, 2011–2015 with other strategies addressing related public health issues, including the UNAIDS strategy 2011–2015;⁴
4. URGES Member States:
 - (1) to adopt the global health sector strategy on HIV/AIDS, 2011–2015;
 - (2) to implement the strategy according to the four strategic directions to guide national responses as described in the strategy;

¹ See Annex 6 for the financial and administrative implications for the Secretariat of this resolution.

² Document A64/15.

³ See Annex 4 for the global health sector strategy on HIV/AIDS, 2011–2015.

⁴ *Getting to zero: UNAIDS strategy 2011–2015*. Geneva, UNAIDS, 2010.

5. REQUESTS the Director-General:

(1) to give adequate support to implementation of the global health sector strategy on HIV/AIDS, 2011–2015, including provision of support to Member States for country implementation and reporting on progress on the health sector response to HIV/AIDS;

(2) to monitor and evaluate progress in implementing the global health sector strategy on HIV/AIDS, 2011–2015, and to report on that progress, aligned with the reporting of other United Nations agencies, through the Executive Board, to the Sixty-fifth, Sixty-seventh and Sixty-ninth World Health Assemblies.

(Tenth plenary meeting, 24 May 2011 –
Committee A, sixth report)

WHA64.15 Cholera: mechanism for control and prevention¹

The Sixty-fourth World Health Assembly,

Having considered the report on cholera;²

Recalling resolution WHA44.6 on cholera, which led to the establishment of the Global Task Force on Cholera Control with the aim of providing support to Member States in reducing morbidity and mortality associated with the disease and in diminishing its social and economic consequences;

Recognizing that cholera is not being sufficiently addressed despite its prevalence in epidemic form in both endemic and non-endemic areas, causing suffering to millions, particularly among vulnerable populations, with a disease burden estimated to be 3–5 million cases and 100 000–130 000 deaths per year;³

Reiterating that the spread of cholera is a consequence of natural disasters, the lack of an adequate supply of safe potable water, deficient sanitation, poor hygiene, contamination of food, unplanned human settlement, especially in urban areas, the absence of effective health systems, inadequate health care, and poverty;

Acknowledging that effective public health interventions, such as proper and timely case management, improved environmental management, improved hygiene and sanitation behaviour, and access to and appropriate use of cholera vaccines, all depend on a solid system of surveillance and health-care delivery and a coordinated programmatic and multisectoral approach that includes access to appropriate health care, clean water and adequate sanitation, community involvement, open and transparent sharing of epidemiological information, and sustained policy dialogue;

Recognizing also the importance of emergency preparedness planning, surveillance strengthening, early response, and meeting relevant standards defined by the work of the Sphere Project in emergencies;

¹ See Annex 6 for the financial and administrative implications for the Secretariat of this resolution.

² Document A64/18.

³ Weekly epidemiological record, 2010, **85**(13): 117–128.

Noting that, in emergency health crises, and in emergencies where the situation threatens sanitary conditions, WHO's work as the humanitarian health cluster lead necessitates close cooperation with UNICEF's responsibilities as the lead of the WASH (water, sanitation and hygiene) cluster;

Affirming that progress in achieving the health-related Millennium Development Goals, and particularly access to safe drinking-water and sanitation under Goal 7 (Ensure environmental sustainability), would decrease the occurrence and spread of cholera, and that improving prevention and control of cholera will have a positive effect on other diarrhoeal diseases;

Recognizing further that control of cholera is entering a new phase with the development of safe, effective and potentially affordable oral cholera vaccines, and that this approach is complementary to, and should not substitute for, the existing effective prevention and control measures that are based on improved access to potable water, sanitation and hygiene,

1. URGES all Member States:¹

(1) to consider health, hygiene, water, sanitation and environmental issues as integral and interrelated parts of development policies and plans, and accordingly to allocate resources and undertake action, including health and hygiene education and public information, in order to prevent the risks of cholera epidemics occurring or to diminish such risks, giving due attention to the situation and needs of population groups most at risk;

(2) to strengthen surveillance and reporting of cholera in accordance with the International Health Regulations (2005), and to integrate the surveillance of cholera effectively into overall surveillance systems by building local capacities for data collection and analysis and encompassing information on crucial determinants such as water sources, sanitation coverage, environmental conditions and cultural practices;

(3) to work towards mobilizing sufficient technical and financial resources for coordinated and multisectoral measures for preparation, prevention and control of cholera, as well as other diarrhoeal diseases, in both endemic and epidemic situations, within the framework of health system strengthening and sector-wide approaches, and in the spirit of international solidarity;

(4) to involve the community and to scale up advocacy measures in view of the intersectoral nature of the disease;

(5) to refrain from imposing on affected or at-risk countries any trade or travel restrictions that cannot be justified on the grounds of public health concerns, in line with Article 43 of the International Health Regulations (2005);

(6) to undertake planning for and give consideration to the administration of vaccines, where appropriate, in conjunction with other recommended prevention and control methods and not as a substitute for such methods;

¹ And, where applicable, regional economic integration organizations.

2. REQUESTS the Director-General:

- (1) to strengthen and enhance measures to ensure that the Organization continues to respond expeditiously and effectively to the needs of the countries affected by or at risk of outbreaks of cholera;
- (2) to revitalize the Global Task Force on Cholera Control and to strengthen WHO's work in this area, including improved collaboration and coordination among relevant WHO departments and other relevant stakeholders;
- (3) to strengthen the coordination of international assistance during cholera epidemics in terms of equipment and human and financial resources, in order to ensure an effective and quick response, and to prioritize close collaboration with other clusters including, but not limited to, the WASH cluster and logistics, in order to maximize the effectiveness of the overall multilateral humanitarian response;
- (4) to provide technical support to countries for building their capacity to undertake effective control and prevention measures, including surveillance, early warning and response, laboratory capacity, risk assessment, case management, data collection and monitoring, and effective vaccine deployment;
- (5) to further promote research, and encourage surveillance, on the emergence of altered variants and drug-resistant strains of *Vibrio cholerae*, as well as to consider safe and effective innovations in oral rehydration therapy that can provide additional benefit in terms of the treatment outcome;
- (6) to promote ongoing interventions to change behaviour and food and water safety measures, including training and advocacy programmes, in order to improve sanitary and hygienic practices as critical components of cholera prevention and control;
- (7) to continue to support further research on safe, efficacious and affordable cholera vaccines, and to promote transfer of relevant vaccine manufacturing technologies to countries affected by or at risk of cholera, in order to build capacity for the local production of cholera vaccines;
- (8) to develop updated and practical evidence-based policy guidelines, including on the feasibility and assessment of the appropriate and cost-effective use of oral cholera vaccines in low-income countries and on the definition of target groups;
- (9) to liaise with relevant international funding agencies on possible support for introducing effective cholera vaccines in low-income countries;
- (10) to report to the Sixty-fifth World Health Assembly, through the Executive Board, on the global cholera situation and to evaluate efforts made in cholera prevention methods and control.

(Tenth plenary meeting, 24 May 2011 –
Committee A, sixth report)

WHA64.16 Eradication of dracunculiasis¹

The Sixty-fourth World Health Assembly,

Having considered the report on dracunculiasis;²

Recalling resolutions WHA39.21 and WHA42.29 on elimination of dracunculiasis and WHA44.5, WHA50.35 and WHA57.9 on eradication of dracunculiasis;

Recalling also that health ministers of countries endemic for dracunculiasis in 2004 signed, during the Fifty-seventh World Health Assembly, the Geneva Declaration for the Eradication of Dracunculiasis by 2009;

Noting the resolutions on the eradication of dracunculiasis adopted by the Regional Committee for Africa;³

Noting also with satisfaction the excellent results achieved by the countries where dracunculiasis is endemic in decreasing the number of cases from an estimated 3.5 million in 1986 to 3190 reported cases in 2009 and less than 1800 reported cases in 2010;

Encouraged that only four countries remained endemic for dracunculiasis at the end of 2009, all in sub-Saharan Africa, and that 187 countries and territories have been certified free of dracunculiasis transmission;

Congratulating all parties concerned, particularly UNICEF and The Carter Center, for increasing the availability of safe drinking-water, improving surveillance case detection and case containment, strengthening other interventions and expanding public awareness of the disease,

1. ENDORSES the strategy of intensified surveillance, case containment, use of cloth and pipe filters, vector control, access to safe drinking-water, health education and community mobilization;
2. CALLS ON the remaining Member States where dracunculiasis is endemic to intensify their eradication efforts, including active surveillance in villages where the disease is endemic and surveillance in dracunculiasis-free areas, prevention measures and political support at the highest levels;
3. CALLS ON Member States that have already been certified as being free from dracunculiasis and those that are in the pre-certification stage to intensify surveillance for the disease and report the results regularly, and to notify WHO within 24 hours of any case detected and the alleged country of origin of the case;
4. URGES Member States, UNICEF, The Carter Center and other appropriate partners to support the remaining countries where dracunculiasis is endemic in their efforts to stop its transmission as soon as possible, with, inter alia, provision of adequate resources for interrupting transmission and eventual certification of eradication of the disease;

¹ See Annex 6 for the financial and administrative implications for the Secretariat of this resolution.

² Document A64/20.

³ Resolutions AFR/RC38/R13, AFR/RC41/R2, AFR/RC43/R9, AFR/RC44/R8, and AFR/RC45/R8.

5. REQUESTS the Director-General:

- (1) to garner support for the remaining countries where dracunculiasis is endemic in their efforts to stop its transmission as soon as possible, with, inter alia, provision of adequate resources for interrupting transmission and certification of eradication of the disease;
- (2) to support surveillance in dracunculiasis-free areas and countries until global certification of eradication has been achieved;
- (3) to monitor closely the implementation of this resolution and report progress, through the Executive Board, to the Health Assembly every year until eradication of dracunculiasis has been certified.

(Tenth plenary meeting, 24 May 2011 –
Committee A, sixth report)

WHA64.17 Malaria¹

The Sixty-fourth World Health Assembly,

Having considered the report on malaria;²

Recalling resolutions WHA58.2 on malaria control and WHA60.18 that established World Malaria Day;

Recognizing that increased global and national investments in malaria control have yielded significant results in decreasing the burden of malaria in many countries, and that some countries are moving towards elimination of malaria;

Aware that recent successes in prevention and control are fragile and can only be maintained with sufficient investment to fund global malaria control efforts fully;

Realizing that current approaches to malaria prevention and control, when fully implemented in an integrated manner, are highly effective, rapidly make an impact, and contribute to stronger health systems and the achievement of the health-related Millennium Development Goals;

Acknowledging that full expansion of malaria control and prevention activities will need adequately-resourced national programmes functioning within effective health systems that provide for an uninterrupted supply of quality-assured commodities and services;

Conscious that many countries continue to have unacceptably high burdens of malaria and must rapidly increase prevention and control efforts in order to reach the targets set by the Health Assembly and the internationally agreed health-related goals contained in the United Nations Millennium Declaration;

Cognizant that strategies need to be reoriented in countries that have reduced their disease burden due to malaria in order to sustain those gains;

¹ See Annex 6 for the financial and administrative implications for the Secretariat of this resolution.

² Document A64/19.

Recognizing also that artemisinin based fixed-dose combinations are highly preferable to loose individual medicines that are co-blistered or co-dispensed;

Mindful that antimalarial prevention and control rely heavily on medicines and insecticides whose utility is continuously threatened by the development of resistance of plasmodia to antimalarial agents and of mosquitoes to insecticides;

Stressing that WHO and relevant technical partners should identify and address obstacles that impede manufacturers of artemisinin-based combination therapy in malaria-endemic countries from achieving prequalification;

Recognizing further the resolution adopted at the 18th Roll Back Malaria Board Meeting on artemisinin-based combination therapy manufacturing in malaria-endemic countries,¹

1. URGES Member States:

(1) to keep malaria high on the political and development agendas, to advocate strongly for adequate and predictable long-term financing for malaria control, and to sustain national financial commitments for malaria control in order to accelerate implementation of the policies and strategies recommended by WHO, thereby achieving Target 6.C of Millennium Development Goal 6, and contributing to Millennium Development Goals 4 and 5 as well as other targets set by the Health Assembly in resolution WHA58.2;

(2) to undertake comprehensive reviews of malaria programmes as an essential step in developing strategic and operational plans for achieving and maintaining universal access to and coverage of malaria interventions, notably:

(a) recommended vector-control operations for all people at risk, and maintenance of effective coverage particularly through (i) replacement and continuous provision of long-lasting insecticide-treated bednets, and targeted communication about their usage, and/or (ii) regular application of indoor residual spraying with insecticides, in accordance with WHO recommendations;

(b) prompt diagnostic testing of all suspected cases of malaria and effective treatment with artemisinin-based combination therapy of patients with confirmed falciparum malaria in both the public and private sectors at all levels of the health system, including the community level, and to use the expansion of diagnostic services as an opportunity to strengthen malaria surveillance;

(3) in order to sustain the advances in malaria control, to take immediate action to combat the major threats, namely:

(a) resistance to artemisinin-based medicines, by strengthening regulatory services in the public and private sectors, working to halt the use of oral artemisinin-based monotherapies and substandard medicines not meeting WHO prequalification standards or strict national regulatory authority standards, introducing quality-assurance mechanisms, and improving supply-chain management for all malaria commodities and services;

¹ Resolution RBM/BOM/2010/RES.129.

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- (b) resistance to insecticides, by adopting best practices such as: rotation of insecticides used for indoor residual spraying, and using insecticides approved for indoor residual spraying from insecticide classes other than pyrethroids (and compounds sharing cross-resistance with pyrethroids) when technically appropriate alternatives are available, in areas where usage of insecticide-treated bednets is high;
 - (4) to use the expansion of interventions for malaria prevention and control as an entry point for strengthening health systems, including laboratory services, maternal and child health services at peripheral health facilities, integrated management of illnesses at the community level, and timely and accurate surveillance;
 - (5) to maintain core national competencies for malaria control by sustaining a strong cadre of malaria experts, including entomologists, at all levels of the health-care system, where appropriate;
 - (6) to comply with existing commitments and international regulations on the use of pesticides, in particular the Stockholm Convention on Persistent Organic Pollutants (Stockholm, 2004);
 - (7) to increase funding for research and development in malaria prevention, control and treatment;
 - (8) to promote the scaling up of artemisinin-based combination therapy, where appropriate, either as fixed-dose combinations or co-administration of two separate drugs, with a system to ensure a high level of adherence to treatment, taking into account the local evidence on effectiveness, cost-effectiveness, availability and affordability, regulatory capacity, budget burden, feasibility and long-term sustainability;
2. CALLS upon the international partners, including international organizations, financing bodies, research institutions, civil society, and the private sector:
- (1) to ensure adequate and predictable global funding so that the global malaria targets for 2015 can be met and malaria-control efforts can be sustained in order to contribute to attaining the health-related Millennium Development Goals;
 - (2) to harmonize the provision of support to countries for implementing WHO-recommended policies and strategies based on local endemicity of malaria, using commodities that meet WHO prequalification standards or strict national regulatory authority standards, in order to secure universal access to vector-control and other prevention measures, diagnostic testing of suspected cases of malaria, and rational treatment of patients with confirmed malaria, as well as timely malaria surveillance systems;
 - (3) to support initiatives for the discovery and development of new medicines and insecticides to replace those whose usefulness is being lost through resistance, and to support both basic research on innovative tools for control and elimination of malaria (including vaccines) and operational research to overcome constraints limiting the expansion and practical effectiveness of existing interventions;
 - (4) to collaborate with WHO in order to support countries in accomplishing malaria goals and to progress to malaria's elimination;
 - (5) to focus on particularly vulnerable populations in high-burden countries, people in fragile situations, and tribal people threatened by forest malaria;

(6) to work together to support infrastructure development and the training of the pharmaceutical manufacturers from countries endemic for malaria in order to increase access to cost-competitive artemisinin-based combination therapies that meet international quality standards, provided such assistance is made available in accordance with clear and transparent protocols for the selection of manufacturers to receive this assistance, and that such assistance is provided in a strategic, prioritized and transparent way;

3. REQUESTS the Director-General:

(1) to support the development and updating of evidence-based norms, standards, policies, guidelines and strategies for malaria prevention, control and elimination in order to chart a course for reaching the 2015 malaria-related targets set by the Health Assembly and in the Millennium Development Goals, and for responding to the rapidly declining burden of malaria;

(2) to monitor global progress in the control and elimination of malaria and provide support to Member States in their efforts to collect, validate and analyse data from malaria surveillance systems;

(3) to provide support to countries in defining their human resource needs and strengthening human resource capacity for malaria and vector control at national, district and community levels by revitalizing international training courses and subregional training networks and promoting adequate systems of supervision, mentoring and continuing education;

(4) to provide support to Member States in identifying new opportunities for malaria control, as well as combating major threats, notably plasmodial resistance to antimalarial agents and mosquito resistance to insecticides, through the development and implementation of the Global Plan for Artemisinin Resistance Containment and a global plan for the prevention and management of insecticide resistance;

(5) to promote the transfer of technology to manufacturers of artemisinin-based combination therapies in malaria-endemic countries and to strengthen their capacity to meet WHO prequalification standards, provided such assistance is made available in accordance with clear and transparent protocols for the selection of manufacturers to receive this assistance, and that such assistance is provided in a strategic, prioritized and transparent way;

(6) to provide support, upon request, to national regulatory authorities to strengthen their capacity in terms of monitoring compliance with good manufacturing practices and WHO prequalification standards;

(7) to support Member States to continually monitor the progress of accessibility, affordability and use of artemisinin-based combination therapy;

(8) to report to the Sixty-sixth and Sixty-eighth World Health Assemblies, through the Executive Board, on implementation of this resolution.

(Tenth plenary meeting, 24 May 2011 –
Committee A, seventh report)

WHA64.18 Unaudited interim financial report on the accounts of WHO for the year 2010

The Sixty-fourth World Health Assembly,

Having examined the unaudited interim financial report on the accounts of WHO for the year 2010;¹

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

ACCEPTS the Director-General's unaudited interim financial report for the year 2010.

(Tenth plenary meeting, 24 May 2011 –
Committee B, second report)

WHA64.19 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-fourth World Health Assembly,

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

Noting that, at the time of opening of the Sixty-fourth World Health Assembly, the voting rights of Central African Republic, Comoros, Dominica, Guinea-Bissau, Somalia and Tajikistan were suspended, and such suspension was to continue until the arrears of the Member States concerned had 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 Grenada, Guinea and Kyrgyzstan were in arrears at the time of the opening of the Sixty-fourth 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 Kyrgyzstan at the opening of the Sixty-fourth World Health Assembly, and for the remaining two Member States at the opening of the Sixty-fifth 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-fifth World Health Assembly, Grenada and Guinea were still to be 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

¹ See documents A64/29 and A64/29 Add.1.

² See documents A64/49 and A64/49 Corr.1.

³ See document A64/31.

opening; and in accordance with resolution WHA61.8 if, by the time of the opening of the Sixty-fourth World Health Assembly, Kyrgyzstan were still to be in arrears in the payment of its rescheduled assessments, its voting privileges shall be suspended automatically;

(2) that any suspension that takes effect as set out in paragraph (1) above shall continue at the Sixty-sixth World Health Assembly and subsequent Health Assemblies, until the arrears of Grenada, Guinea and Kyrgyzstan 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, 24 May 2011 –
Committee B, second report)

WHA64.20 Special arrangements for settlement of arrears

The Sixty-fourth World Health Assembly,

Having considered the report by the Secretariat on the Status of collection of assessed contributions;¹

Noting that Ukraine has outstanding contributions;

Considering the request of Ukraine to reschedule the remaining balance of arrears under the special arrangements for settlement of arrears;²

1. DECIDES to allow Ukraine to keep its voting privileges at the Sixty-fourth World Health Assembly on the following conditions:

Ukraine shall pay its outstanding arrears of assessed contributions, totalling US\$ 26 395 036, over 10 years from 2013 to 2022, as set out below, in addition to payment of its annual assessment for the current year;

Year	US\$
2013	2 639 504
2014	2 639 504
2015	2 639 504
2016	2 639 504
2017	2 639 504
2018	2 639 504
2019	2 639 504
2020	2 639 504

¹ See documents A64/31 and A64/51.

² See document A64/32.

Year	US\$
2021	2 639 504
2022	2 639 500
Total	26 395 036

2. DECIDES that, in accordance with Article 7 of the Constitution, voting privileges shall be automatically suspended if Ukraine does not meet the requirements laid down in paragraph 1 above;
3. REQUESTS the Director-General to report to the Sixty-fifth World Health Assembly on the prevailing situation;
4. REQUESTS the Director-General to communicate this resolution to the Government of Ukraine.

(Tenth plenary meeting, 24 May 2011 –
Committee B, second report)

WHA64.21 Scale of assessments for 2012–2013

The Sixty-fourth World Health Assembly,

Having considered the report on the scale of assessments for 2012–2013,¹

ADOPTS the scale of assessments of Members and Associate Members for the biennium 2012–2013 as set out below:

Members and Associate Members	WHO scale for 2012–2013 %
Afghanistan	0.0040
Albania	0.0100
Algeria	0.1280
Andorra	0.0070
Angola	0.0100
Antigua and Barbuda	0.0020
Argentina	0.2870
Armenia	0.0050
Australia	1.9331
Austria	0.8511
Azerbaijan	0.0150
Bahamas	0.0180
Bahrain	0.0390
Bangladesh	0.0100
Barbados	0.0080
Belarus	0.0420
Belgium	1.0751
Belize	0.0010

¹ Document A64/33.

Members and Associate Members	WHO scale for 2012–2013 %
Benin	0.0030
Bhutan	0.0010
Bolivia (Plurinational State of)	0.0070
Bosnia and Herzegovina	0.0140
Botswana	0.0180
Brazil	1.6111
Brunei Darussalam	0.0280
Bulgaria	0.0380
Burkina Faso	0.0030
Burundi	0.0010
Cambodia	0.0030
Cameroon	0.0110
Canada	3.2072
Cape Verde	0.0010
Central African Republic	0.0010
Chad	0.0020
Chile	0.2360
China	3.1892
Colombia	0.1440
Comoros	0.0010
Congo	0.0030
Cook Islands	0.0010
Costa Rica	0.0340
Côte d'Ivoire	0.0100
Croatia	0.0970
Cuba	0.0710
Cyprus	0.0460
Czech Republic	0.3490
Democratic People's Republic of Korea	0.0070
Democratic Republic of the Congo	0.0030
Denmark	0.7361
Djibouti	0.0010
Dominica	0.0010
Dominican Republic	0.0420
Ecuador	0.0400
Egypt	0.0940
El Salvador	0.0190
Equatorial Guinea	0.0080
Eritrea	0.0010
Estonia	0.0400
Ethiopia	0.0080
Fiji	0.0040
Finland	0.5660
France	6.1234
Gabon	0.0140
Gambia	0.0010
Georgia	0.0060
Germany	8.0186
Ghana	0.0060

Members and Associate Members	WHO scale for 2012–2013 %
Greece	0.6910
Grenada	0.0010
Guatemala	0.0280
Guinea	0.0020
Guinea-Bissau	0.0010
Guyana	0.0010
Haiti	0.0030
Honduras	0.0080
Hungary	0.2910
Iceland	0.0420
India	0.5340
Indonesia	0.2380
Iran (Islamic Republic of)	0.2330
Iraq	0.0200
Ireland	0.4980
Israel	0.3840
Italy	4.9994
Jamaica	0.0140
Japan	12.5309
Jordan	0.0140
Kazakhstan	0.0760
Kenya	0.0120
Kiribati	0.0010
Kuwait	0.2630
Kyrgyzstan	0.0010
Lao People's Democratic Republic	0.0010
Latvia	0.0380
Lebanon	0.0330
Lesotho	0.0010
Liberia	0.0010
Libyan Arab Jamahiriya	0.1290
Lithuania	0.0650
Luxembourg	0.0900
Madagascar	0.0030
Malawi	0.0010
Malaysia	0.2530
Maldives	0.0010
Mali	0.0030
Malta	0.0170
Marshall Islands	0.0010
Mauritania	0.0010
Mauritius	0.0110
Mexico	2.3562
Micronesia (Federated States of)	0.0010
Monaco	0.0030
Mongolia	0.0020
Montenegro	0.0040
Morocco	0.0580
Mozambique	0.0030
Myanmar	0.0060

Members and Associate Members	WHO scale for 2012–2013 %
Namibia	0.0080
Nauru	0.0010
Nepal	0.0060
Netherlands	1.8551
New Zealand	0.2730
Nicaragua	0.0030
Niger	0.0020
Nigeria	0.0780
Niue	0.0010
Norway	0.8711
Oman	0.0860
Pakistan	0.0820
Palau	0.0010
Panama	0.0220
Papua New Guinea	0.0020
Paraguay	0.0070
Peru	0.0900
Philippines	0.0900
Poland	0.8281
Portugal	0.5110
Puerto Rico	0.0010
Qatar	0.1350
Republic of Korea	2.2602
Republic of Moldova	0.0020
Romania	0.1770
Russian Federation	1.6021
Rwanda	0.0010
Saint Kitts and Nevis	0.0010
Saint Lucia	0.0010
Saint Vincent and the Grenadines	0.0010
Samoa	0.0010
San Marino	0.0030
Sao Tome and Principe	0.0010
Saudi Arabia	0.8301
Senegal	0.0060
Serbia	0.0370
Seychelles	0.0020
Sierra Leone	0.0010
Singapore	0.3350
Slovakia	0.1420
Slovenia	0.1030
Solomon Islands	0.0010
Somalia	0.0010
South Africa	0.3850
Spain	3.1772
Sri Lanka	0.0190
Sudan	0.0100
Suriname	0.0030
Swaziland	0.0030
Sweden	1.0641

Members and Associate Members	WHO scale for 2012–2013 %
Switzerland	1.1301
Syrian Arab Republic	0.0250
Tajikistan	0.0020
Thailand	0.2090
The former Yugoslav Republic of Macedonia	0.0070
Timor-Leste	0.0010
Togo	0.0010
Tokelau	0.0010
Tonga	0.0010
Trinidad and Tobago	0.0440
Tunisia	0.0300
Turkey	0.6170
Turkmenistan	0.0260
Tuvalu	0.0010
Uganda	0.0060
Ukraine	0.0870
United Arab Emirates	0.3910
United Kingdom of Great Britain and Northern Ireland	6.6045
United Republic of Tanzania	0.0080
United States of America	22.0000
Uruguay	0.0270
Uzbekistan	0.0100
Vanuatu	0.0010
Venezuela (Bolivarian Republic of)	0.3140
Viet Nam	0.0330
Yemen	0.0100
Zambia	0.0040
Zimbabwe	0.0030
Total	100.0000

(Tenth plenary meeting, 24 May 2011 –
Committee B, second report)

WHA64.22 Amendments to the Financial Regulations¹

The Sixty-fourth World Health Assembly,

Having considered the report on amendments to the Financial Regulations;²

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

¹ See Annex 6 for the financial and administrative implications for the Secretariat of this resolution.

² Document A64/34.

ADOPTS the amendments to Financial Regulations 14.1, 14.8 and 14.9 to be effective as from 1 January 2012.¹

(Tenth plenary meeting, 24 May 2011 –
Committee B, second report)

WHA64.23 Appointment of the External Auditor

The Sixty-fourth World Health Assembly,

Having considered the report on the appointment of the External Auditor;²

1. RESOLVES that the Chairperson of the Commission on Audit of the Philippines be appointed External Auditor of the accounts of the World Health Organization as well as the non-consolidated affiliated entities and partnerships for the period 2012–2015, and that the Chairperson audits in accordance with the principles incorporated in Regulation XIV of the Financial Regulations and the Appendix to the Financial Regulations, provided that, should the necessity arise, the Chairperson may designate a representative to act in the Chairperson's absence;
2. EXPRESSES its thanks to the Comptroller and Auditor-General of India for the work performed for the Organization in the audit of the accounts for the financial periods 2008–2009 and 2010–2011.
3. FURTHER REQUESTS the Director-General to establish contractual terms and conditions between the Organization and the appointed External Auditor to cover the modalities of the External Auditor's work in fulfilling its mandate, with particular reference to the additional requirements posed by the introduction of the International Public Sector Accounting Standards as of 2012.

(Tenth plenary meeting, 24 May 2011 –
Committee B, second report)

WHA64.24 Drinking-water, sanitation and health³

The Sixty-fourth World Health Assembly,

Having considered the report on strategies for the safe management of drinking-water for human consumption;⁴

Recalling the Declaration of Alma-Ata on Primary Health Care and the various resolutions that stress the role of improving safe drinking-water, sanitation facilities and hygiene practices in primary health care, environmental health, prevention of waterborne diseases, protection of high-risk communities, infant and young child nutrition, including resolutions WHA39.20, WHA42.25, WHA44.28, WHA45.31, WHA35.17, WHA51.28 and WHA63.23, as well as resolution WHA64.15

¹ See Annex 5 for the amended Financial Regulations.

² Documents A64/35 and A64/35 Corr.1.

³ See Annex 6 for the financial and administrative implications for the Secretariat of this resolution.

⁴ Document A64/24.

on cholera: mechanisms for control and prevention, and resolution WHA64.16 on eradication of dracunculiasis;

Recalling further Target C of Goal 7 (Ensure environmental sustainability) of the Millennium Development Goals, which calls for halving by 2015, the proportion of the population without sustainable access to safe drinking-water and basic sanitation; and the importance of this target for the achievement of other goals, particularly Goals 4 (Reduce child mortality), 5 (Improve maternal health) and 6 (Combat HIV/AIDS, malaria and other diseases);¹

Recognizing that between 1990 and 2008 an estimated 1770 million people gained access to improved sources of drinking-water and 1260 million gained access to improved sanitation, but deeply concerned that by the end of 2008, 884 million people still lacked access to improved water sources and over 2600 million people did not have access to improved sanitation;

Noting the multiple health benefits and economic advantages of a broad public health approach through the expansion of access to safe drinking-water and sanitation, integrating household interventions, a more effective use of resources and the early incorporation of health considerations in the planning and design of water resources development, and recognizing the importance of pursuing these issues for the achievement of strategic objective 8 of the Medium-term strategic plan 2008–2013;

Recalling the International Decade for Action, “Water for Life” 2005–2015, proclaimed by the United Nations General Assembly in resolution 58/217; the International Year of Sanitation, 2008, declared in resolution 61/192; as well as the follow-up resolution 65/153, which called upon all Member States to support the global effort to realize “Sustainable sanitation: the five-year-drive to 2015”; and also recalling that water quality was the theme of the United Nations World Water Day 2010;

Recalling further United Nations General Assembly resolution 64/292, which recognized the right to safe and clean drinking-water and sanitation as a human right that is essential for the full enjoyment of life and all human rights, and Human Rights Council resolution A/HRC/RES/15/9, which affirmed that the human right to safe drinking-water and sanitation is derived from the right to an adequate standard of living and inextricably related to the right to the highest attainable standard of physical and mental health, as well as the right to life and human dignity;

Noting with interest the efforts made to improve access to safe drinking-water, basic sanitation and to promote good personal and domestic hygiene practices that contribute to a sustainable approach to fight sanitation- and water-related diseases such as cholera and diarrhoea, which claimed the lives of 2.5 million people in 2008, among whom were 1.3 million children under the age of five years;

Also noting the water, sanitation and hygiene components in the seven-point strategy agreed by WHO and UNICEF for comprehensive diarrhoea control, which include the promotion of hand washing with soap, household water treatment and safe storage and community-wide sanitation promotion;

Noting that millions of people are exposed to dangerous levels of biological contaminants and chemical pollutants in their drinking-water, partly due to the inadequate management of urban, industrial or agricultural wastewater;

¹ See United Nations General Assembly resolution 65/1.

Recognizing WHO's major normative role in issues of water and health, its key role in monitoring progress regarding water supply and sanitation as well as its promotional and capacity-building roles for water safety plans, sanitation safety plans, water and sanitation in health care, schools and other public buildings and settings, and safe management of medical waste;

Noting that global driving forces, including population growth, urbanization and climate change, are expected to affect significantly the availability and quality of access to water and sanitation services and of freshwater resources and the need for water resources development for other purposes, which in themselves carry potential health risks, and noting that a response to these trends requires an intersectoral approach mainstreaming health and environmental issues in national sectoral policies through integrated water resources management and strengthened institutional arrangements to prevent and reduce the incidence of sanitation- and water-related diseases;

Noting that over the last decade almost 2000 million people were victims of natural disasters, including floods and droughts, that act as key contributors to sanitation- and water-related diseases;

Recognizing also the need, in emergency situations, to develop prevention tools and specific actions for supplying drinking-water and sanitation as well as the leading role of both WHO in the health cluster and UNICEF in the nutrition and WASH (water, sanitation and hygiene) clusters in emergency operations,

1. URGES Member States:

- (1) to develop and strengthen, with all stakeholders, national public health strategies, so that they highlight the importance of safe drinking-water, sanitation and hygiene as the basis for primary prevention, based on an integrated approach of sectoral planning processes, policies, programmes and projects regarding water and sanitation, guided by an effective interministerial coordination mechanism at appropriate level, designating clear responsibilities across relevant ministries and institutions;
- (2) to promote new approaches to community education, empowerment, participation and awareness creation involving actively their leaders and civil society, with a view to having a specific impact, particularly on women, children, youth, indigenous people and vulnerable and the poorest people, acknowledging and encouraging good practices;
- (3) to ensure that national health strategies contribute to the realization of water- and sanitation-related Millennium Development Goals, and support the progressive realization of the human right to water and sanitation that entitles everyone, without discrimination, to water and sanitation that is sufficient, safe, acceptable, physically accessible and affordable for personal and domestic uses;
- (4) to strengthen the intersectoral policy frameworks and institutional mechanisms for integrated management of water- and sanitation-related health hazards and risks, including health impact assessment, strategic extension of drinking-water and sanitation systems and services, and environmental management to protect health in water resources and wastewater management projects;
- (5) to mobilize their efforts, in consultation with bilateral and multilateral partners and in close coordination with responsible local authorities, to prioritize and implement the reduction of disparities that exist between urban, periurban and rural areas as regards: access to drinking-water at home as well as from other improved sources; improved sanitation facilities; and hygiene;

(6) to offer appropriate facilities for access to safe drinking-water, sanitation and hand washing with soap in health-care establishments, schools and other public buildings and settings, as well as advocacy and training tools on safe water, sanitation and hygiene practices for those who operate and use these establishments;

(7) to improve cooperation between the appropriate authorities and stakeholders, including in transboundary settings, to establish, implement and maintain efficient systems for assessing water quality, regularly communicating relevant, easily accessible information and responding to water quality issues;

(8) to ensure, in particular, the sustainability of comprehensive and harmonized national and/or local water and sanitation-related monitoring systems and early warning tools in order to prevent and control sanitation- and water-related diseases as well as to develop emergency preparedness and action plans, particularly in the case of natural disasters and humanitarian emergencies;

(9) to work to strengthen, as necessary, the establishment, implementation and quality control of water safety plans and contribute to the development of sanitation safety plans, in collaboration with the WHO collaborating centres, WHO-hosted networks (drinking-water regulators, operation and maintenance, household water treatment and safe storage, management of small-community water supplies) and associations in official relations with WHO;

2. REQUESTS the Director-General:

(1) to continue calling the attention of the international community and decision-makers to the importance of primary prevention as a key goal, and the major impact of safe drinking-water, sanitation and hygiene on global public health, national economies, and the achievement of the Millennium Development Goals;

(2) to formulate a new, integrated WHO strategy for water, sanitation and health including a specific focus on water quality and monitoring issues, and on the promotion of a change in sanitation and hygiene behaviour, taking into account context-specific requirements with a view to encouraging the establishment of preventive measures, as well as rapid analysis techniques to guarantee the quality of drinking-water and avoid the adverse health impacts of water resources development;

(3) to strengthen WHO's collaboration with all relevant UN-Water members and partners, as well as with other relevant organizations promoting access to safe drinking-water, sanitation and hygiene services, so as to set an example of effective intersectoral action in the context of WHO's involvement in the United Nations Delivering as One initiative, and WHO's cooperation with the United Nations Special Rapporteur on the human right to safe drinking-water and sanitation, with a view to improving the realization of that human right;

(4) to strengthen the WHO/UNICEF Joint Monitoring Programme capacities to fulfil its mandate of monitoring progress towards the international drinking-water and sanitation development goals, and to serve as a platform for the generation of new sanitation and water indicators, including water quality and other relevant parameters at appropriate levels;

(5) to continue to support existing regional initiatives such as the United Nations Economic Commission for Europe Protocol on Water and Health, which is an instrument of reference for safe water management and the protection of human health, and to encourage the creation of similar instruments dedicated to sustainable water management and the reduction of sanitation-

and water-related diseases in other regions, as well as continue to encourage relevant regional initiatives such as the WHO/UNEP Libreville Declaration on Health and Environment (2010) or the WHO Parma Declaration on Environment and Health (2010);

(6) to develop, in coordination with bilateral and multilateral partners, Member States' capacities by providing guidelines and technical support to develop, implement, monitor and evaluate national action plans for the sustainable management, operation and maintenance of safe drinking-water supply and sanitation systems and services;

(7) to further support Member States' capacities in building and maintaining adapted information and monitoring systems in order to facilitate appropriate and streamlined reporting to relevant global monitoring mechanisms including the World Health Statistics, the WHO/UNICEF Joint Monitoring Programme for Water Supply and Sanitation and the UN-Water Global Analysis and Assessment of Sanitation and Drinking-Water;

(8) to increase technical assistance to countries by facilitating training and adult learning programmes for staff in charge of maintaining catchments, treatment and distribution facilities, and water and sanitation networks, as well as for staff and laboratories in charge of water quality monitoring, while encouraging the dissemination of best practices for household water treatment, especially where central water treatment or water supplies are deficient or not available;

(9) to promote partnerships for risk reduction in drinking-water installations and safe supply of drinking-water and methods to gather and disseminate the best practices and experiences in increasing access to safe drinking-water, sanitation and personal and domestic hygiene, in particular for the poorest populations, in health emergencies or during natural disasters;

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

(Tenth plenary meeting, 24 May 2011 –
Committee B, third report)

WHA64.25 Salaries of staff in ungraded posts and of the Director-General

The Sixty-fourth World Health Assembly,

Having considered the reports on the amendments to the Staff Regulations and Staff Rules;¹

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

1. ESTABLISHES the salaries of Assistant Directors-General and Regional Directors at US\$ 185 809 gross per annum before staff assessment, resulting in a modified net salary of US\$ 133 776 (dependency rate) or US\$ 121 140 (single rate);
2. ESTABLISHES the salary of the Deputy Director-General at US\$ 204 391 gross per annum before staff assessment, resulting in a modified net salary of US\$ 145 854 (dependency rate) or US\$ 131 261 (single rate);

¹ Document A64/38.

3. ESTABLISHES the salary of the Director-General at US\$ 251 188 gross per annum before staff assessment, resulting in a modified net salary of US\$ 176 272 (dependency rate) or US\$ 156 760 (single rate);
4. DECIDES that those adjustments in remuneration shall take effect on 1 January 2011.

(Tenth plenary meeting, 24 May 2011 –
Committee B, third report)

WHA64.26 International Agency for Research on Cancer: amendments to Statute

The Sixty-fourth World Health Assembly,

Having considered the report on the International Agency for Research on Cancer: amendments to Statute;¹

Considering the amendment to Article VIII of the Statute of the International Agency for Research on Cancer adopted by the Governing Council at its Fifty-third session;

Considering the provisions of Article X of the Statute of the Agency,

ACCEPTS the following amendment to the Statute of the Agency, which shall enter into force forthwith:

Article VIII – Finance

[Paragraphs (1) through (7), inclusive, of Article VIII are unchanged.]

(8) The funds and assets of the Agency shall be accounted for separately from the funds and assets of the World Health Organization and administered in accordance with the financial regulations adopted by the Governing Council.

(Tenth plenary meeting, 24 May 2011 –
Committee B, third report)

WHA64.27 Child injury prevention²

The Sixty-fourth World Health Assembly,

Having considered the report on child injury prevention;³

Recalling resolution WHA57.10 on road safety and health, which affirmed that road traffic injuries constitute a major public health problem that required coordinated international efforts;

¹ Document A64/43.

² See Annex 6 for the financial and administrative implications for the Secretariat of this resolution.

³ Document A64/23.

Recalling also that the Health Assembly in resolution WHA57.10 accepted the invitation by the United Nations General Assembly for WHO to act as a coordinator on road safety issues within the United Nations system, working in close collaboration with the United Nations regional commissions;

Further recalling resolution WHA60.22 on health systems: emergency-care systems, which recognized that improved organization and planning for provision of trauma and emergency care is an essential part of integrated health-care delivery, and resolution WHA58.23 on disability, including prevention, management and rehabilitation, which urged Member States to take all necessary steps for the reduction of risk factors contributing to disabilities in childhood;

Acknowledging the responsibilities to ensure safety in the care and protection of children affirmed in the Convention on the Rights of the Child (1989), in the International Labour Organization Convention 182 (1999) and in the International Labour Organization Convention 138 (1973), and further acknowledging the responsibilities to protect persons with disabilities set out in the Convention on the Rights of Persons with Disabilities (2006) particularly in developing, low- and middle-income countries where there exists a significant burden of child injuries;

Recognizing that child injuries are a major threat to child survival and health, that they are a neglected public health problem with significant consequences in terms of mortality, morbidity, quality of life, and social and economic costs, and that in the absence of urgent action this problem will hamper attainment of the Millennium Development Goals, particularly in developing, low- and middle-income countries, where there exists a significant burden of child injuries;

Recognizing that the leading causes of child death from unintentional injury include road traffic injury, drowning, fire-related burns, falls and poisoning. In some regions of the world, drowning is responsible for about half of the total number of child injury deaths; context-specific preventive measures including safe environment, safety products, safety management and awareness raising are crucial;

Further recognizing that multisectoral approaches to preventing child injuries and limiting their consequences through implementation of evidence-based interventions have resulted in dramatic and sustained reductions in child injury in countries that have made concerted efforts;

Welcoming the joint WHO/UNICEF *World report on child injury prevention*¹ and its recommendations for public health policy and programming;

Considering that existing programmes on child survival and child health and development should introduce child injury prevention strategies, ensuring these are an integrated part of child health services, and that the success of child health programmes should not only be gauged by the use of traditional measures of infectious disease mortality but also by indicators of fatal and non-fatal injury,

1. URGES Member States:

- (1) to prioritize the prevention of child injury among child issues and ensure that intersectoral coordination mechanisms necessary to prevent child injury are established or strengthened;
- (2) to continue and, if necessary, to strengthen the fulfilment of their obligations under the Convention on the Rights of the Child (1989) to respect, protect and fulfil the rights of children

¹ *World report on child injury prevention*, Geneva, World Health Organization, and New York, United Nations Children's Fund, 2008.

to the highest attainable standard of health and to take all appropriate legislative, administrative, social and educational measures to protect children from injury;

(3) to ensure that funding mechanisms for relevant programmes, including health programmes, cover child injury and prevention, emergency care, pre-hospital care, treatment and rehabilitation services;

(4) to implement, as appropriate, the recommendations of the WHO/UNICEF *World report on child injury prevention*, including, if not already in place, the assignation of a leadership role to a government agency or unit for child injury prevention and the appointment of a focal person for injury prevention, ensuring that such leadership facilitates collaboration between relevant sectors of government, communities and civil society; and, according to national needs, the key strategies identified in the *World report* as effective interventions for preventing child injury; and to monitor and evaluate the impact of these interventions;

(5) to integrate child injury prevention in national child development programmes and in other relevant programmes, and to establish multisectoral coordination and collaboration mechanisms, in particular ensuring that prevention of child injury is accorded appropriate importance within programmes for child survival and health;

(6) to ensure that national data collection across relevant sectors or surveillance systems quantifies the demographic, socioeconomic and epidemiological profile of the burden of, risk factors for, and costs of child injury, and to ensure that the resources available are commensurate with the extent of the problem;

(7) to develop and implement a multisectoral policy and plan of action, where necessary, that contain realistic targets for child injury prevention and include promotion of standards and codes on the prevention of child labour, as well as on legal adolescent employment, product safety, school and play spaces, transportation, construction regulations and laws, and that either stand alone, or are incorporated within the national child health policy or plan;

(8) to enforce and, if necessary, strengthen the existing laws and regulations relevant to the prevention of child injury;

(9) to strengthen emergency and rehabilitation services and capacities, including first-response teams, acute pre-hospital care, management at health facilities, and suitable rehabilitation programmes for injured or disabled children;

(10) to define priorities for research, taking into consideration the WHO/UNICEF *World report on child injury prevention*, and working closely with research and development communities, including relevant manufacturers and distributors of safety products;

(11) to raise awareness and health literacy, in particular on child safety, among parents, children, employers and relevant professional groups, as well as among all members of society, about risk factors for child injury, especially transport, including the use of “cell” phones and other such mobile devices while driving, workplace hazards, water and fire hazards, and lack of child supervision and protection of children, and to advocate dedicated child injury prevention programmes;

2. REQUESTS the Director-General:

- (1) to collaborate with Member States in improving data collection and analysis systems for child injuries and in establishing science-based public health policies and programmes for preventing and mitigating the consequences of child injury;
- (2) to collaborate with organizations of the United Nations system, international development partners and nongovernmental organizations to establish a network to ensure effective coordination and implementation of activities for child injury prevention in low- and middle-income countries;
- (3) to encourage research that expands the evidence base for interventions to prevent child injuries and mitigate their consequences, and that evaluates the effectiveness of such interventions through collaborating centres and other partners, including translation into affordable safety products, policy interventions and effective implementation;
- (4) to facilitate the adaptation and transfer of knowledge on measures and instruments to prevent child injury, from developed to developing settings;
- (5) to support Member States in developing and implementing child injury prevention measures;
- (6) to provide additional support to national injury prevention focal persons by organizing regular global and regional meetings and providing technical assistance;
- (7) to provide technical support for strengthening systems and capacities for emergency and rehabilitation services;
- (8) to collaborate with Member States, organizations in the United Nations system, and international development partners and nongovernmental organizations in order to mobilize resources and to augment the capacities needed to prevent child injury and undertake related rehabilitation programmes; to organize advocacy activities for governments of Member States; and to raise awareness that, in the absence of urgent action, this problem will hamper attainment of the Millennium Development Goals, particularly in developing, low- and middle-income countries where there exists a significant burden of child injuries;
- (9) to invest more in building institutional and individual capacities among Member States so that they are able to develop cost-effective interventions at national and subnational levels;
- (10) to report progress made in implementing this resolution, through the Executive Board, to the Sixty-seventh World Health Assembly.

(Tenth plenary meeting, 24 May 2011 –
Committee B, fourth report)

WHA64.28 Youth and health risks¹

The Sixty-fourth World Health Assembly,

Having considered the report on youth² and health risks, which highlights the immediate and long-term effects of health risks on young people;³

Recalling the resolutions that directly address issues concerning young people: WHA38.22 on maturity before childbearing and promotion of responsible parenthood; WHA42.41 on the health of youth; WHA56.21 on the strategy for child and adolescent health and development, WPR/RC39.R12 Rev.1 on adolescent health; EM/RC43/R.11 on health education of adolescents; AFR/RC51/R3 on adolescent health: a strategy for the African Region; EUR/RC55/R6 on the European strategy for child and adolescent health and development; and CD48.R5 on the Pan American regional strategy for improving adolescent and youth health;

Recalling also the right of everyone, including adolescents and youth, to the enjoyment of the highest attainable standard of physical and mental health, also recalling the International Covenant on Economic, Social and Cultural Rights, the United Nations Convention on the Rights of the Child, the United Nations Convention on the Elimination of All Forms of Discrimination against Women and other international and regional human rights instruments, and emphasizing the need to promote the equality of young women and men and respect for diversity;

Recognizing that health is not only the absence of disease or infirmity, but a state of complete physical, mental and social well-being as articulated in the Constitution of the World Health Organization;

Acknowledging the fact that the 1800 million young people globally – one quarter of all people living in the world are between the ages of 10 and 24 years – make up the largest cohort in history, thereby representing an extraordinary opportunity to shape the world's social, economic and health futures;

Recognizing also that the 2.6 million annual deaths among young people are generally preventable and that their current health behaviours and conditions can compromise both their existing and future health as well as the health of future generations;

Mindful also that heterogeneity of the youth population and their circumstances renders some young people, for example adolescent girls, more vulnerable than others to negative health outcomes;

Emphasizing the importance of promoting healthy lifestyles, such as participation in physical activity and sport, a healthy diet, and physical education, for young people;

Acknowledging also the attention given to young people in resolutions dealing with the population at large: resolution WHA56.1 on the WHO Framework Convention on Tobacco Control; resolution WHA63.13 on the Global strategy to reduce the harmful use of alcohol; resolution WHA57.17 on the Global strategy on diet, physical activity and health; resolution WHA63.14 which

¹ See Annex 6 for the financial and administrative implications for the Secretariat of this resolution.

² WHO defines adolescents as between 10 and 19 years and young people as 10–24 years of age. The United Nations defines youth as those persons between 15 and 24 years.

³ Document A64/25.

endorsed the recommendations on the marketing of foods and non-alcoholic beverages to children; resolution WHA61.14 on the implementation of the global strategy for the prevention and control of noncommunicable diseases; resolution WHA57.12 on the strategy on reproductive health; the UNAIDS strategy 2011–2015; resolution WHA59.19 on the global strategy for the prevention and control of sexually transmitted infections; resolution WHA64.14 on the global health sector strategy on HIV/AIDS, 2011–2015; the United Nations Decade of Action for Road Safety, 2011–2020; resolution WHA60.22 on health systems: emergency-care systems; and the recommendations contained in the *World report on violence and health* that were taken note of in resolution WHA56.24;

Recognizing further the roles of the organizations and programmes in the United Nations system, such as ILO, UNESCO, UNICEF, UNHCR, UNFPA and UNAIDS, as well as the International Organization for Migration, to address youth health risks and in influencing the determinants of youth health;

Taking note of the importance of addressing social determinants of youth health, social protection mechanisms that ensure the social inclusion, education and employment of youth, and the Guanajuato Declaration, resulting from the World Youth Conference (Leon, Guanajuato, Mexico, 25–27 August 2010) and which called for increased investments in policies and programmes across sectors and national development plans, with the meaningful participation of young people, following the World Programme of Action for Youth to the Year 2000 and beyond;¹

Cognizant that the United Nations World Programme for Action on Youth to the Year 2000 and beyond¹ encourages governments to develop comprehensive sexual and reproductive health-care services and provide young people with age-appropriate access to those services including, inter alia, education and services in family planning as set out in the programmes of action from the International Conference on Population and Development (1994), the World Summit for Social Development (1995) and the Fourth World Conference on Women (1995); ensuring that adolescents have age-appropriate information about, access to and choice of, the widest possible range of safe, effective modern methods of family planning; and to provide adolescents with comprehensive education on human sexuality, on sexual and reproductive health and gender equality so as to enable them to deal in a positive and responsible way with their sexuality;

Mindful in addition that meeting the indicators and targets related to young people is crucial for attaining six of the eight Millennium Development Goals (Goals 1, 2, 3, 4, 5 and 6), and that paying specific attention to young people contributes to achieving the aims of recent global health initiatives such as the United Nations Secretary General's Global Strategy for Women's and Children's Health and UNAIDS' Universal access to HIV/AIDS prevention, treatment, care and support;

Recognizing also the opportunities to pay specific attention to the health needs of adolescents and youth during the forthcoming United Nations General Assembly high-level meetings on HIV/AIDS, on youth and on the prevention and control of noncommunicable diseases;

Acknowledging further the capacity of young people to participate and lead in health and development and the leadership they demonstrate in using and developing innovative technologies to meet global and local challenges to their health and development,

1. REAFFIRMS WHO's strategies that address the major health risks facing youth and include specific interventions for this age group;

¹ United Nations General Assembly resolution 50/81.

2. URGES Member States, in accordance with their national laws and regulations, to accelerate action, as appropriate, and develop policies and plans to address the main determinants of health affecting young people, including health-related behaviours and their impact on health at later stages in life by:

- (1) adopting national health policies and strategies that contain specific targets and indicators on relevant determinants including assets, and outcomes of youth health and well-being;
- (2) reviewing and revising policies in health and other areas with a view to including measures to protect young people from harm (e.g. early child-bearing, sexual exploitation and violence, use of illicit substances and tobacco, harmful use of alcohol, lack of physical activity, unhealthy diet and obesity, road traffic and other injuries, and mental health problems);
- (3) reviewing and revising policies in health and other areas to eliminate all forms of discrimination experienced by youth;
- (4) putting in place systems for health management information and vital registration that provide up-to-date age- and sex-specific data, given the existing gap in the data regarding young people's health;
- (5) promoting the responsiveness of the health system to adolescents' needs, including health workforce development and financing in order to remove barriers to access to youth-friendly health-care services;
- (6) providing access to contraception; reproductive health-care services; prevention, treatment and care of HIV/AIDS and sexually transmitted infections and associated support; mental health services; and trauma care;
- (7) promoting access to accurate information and evidence-based approaches that promote healthy behaviour, for example health information on sexual and reproductive health;
- (8) promoting collaboration across sectors at all levels on young people's health including aspects related to health in sectors such as education, social inclusion, social and physical environments, employment, and the media, and with civil society organizations and the private sector, as appropriate;
- (9) involving different actors, such as families, communities and youth themselves, in addressing determinants and health risks of young people, and mobilizing stakeholders in order to detect and help young people at risk or with a disadvantaged background;
- (10) supporting the role of young people, with special attention to youth organizations, with a view to facilitating young people's empowerment and participation in influencing their environments and shaping public policy;

3. ENCOURAGES multilateral and bilateral donors, international financial institutions and international development partners to support Member States to carry out these efforts, including through the provision of financial and technical support, as appropriate;

4. REQUESTS the Director-General:

- (1) to ensure that the appropriate priority is accorded within the Secretariat, as well as the necessary commitment, effective coordination and adequate resources in order to specify further

and expand the implementation of existing strategies as they apply to young people, and to regularly monitor the results of such action on adolescents' health;

(2) to address the health risks of adolescents and young people in the next Medium-term strategic plan across programmes and levels of the Secretariat in order to provide sufficient technical support to Member States;

(3) to identify knowledge gaps and facilitate research that will strengthen the evidence base needed to establish, deliver and monitor effective and age- and gender-appropriate programmes for adolescents and youth;

(4) to continue to collaborate, as appropriate, with organizations in the United Nations system, civil society, and the private sector, that have a bearing on young people's health;

(5) to strengthen the Secretariat's capacity to provide sufficient technical support on youth health to Member States, in particular health authorities, including strengthening the capacity of WHO centres such as the WHO Mediterranean Centre for Health Risk Reduction;

(6) to promote the participation and empowerment of young people as key stakeholders in health development, including in the work of the Organization;

(7) to periodically report on the health of young people and the implementation of this resolution, through the Executive Board, to the World Health Assembly, with the first report being to the Sixty-seventh World Health Assembly.

(Tenth plenary meeting, 24 May 2011 –
Committee B, fourth report)

WHA64(4) Establishment of the General Committee

The Sixty-fourth World Health Assembly elected the delegates of the following 17 countries as members of the General Committee: Albania, Botswana, China, Cuba, Egypt, Eritrea, Ethiopia, France, Gambia, Guinea, Hungary, India, Micronesia (Federated States of), Paraguay, Russian Federation, United Kingdom of Great Britain and Northern Ireland, and United States of America.

(First plenary meeting, 16 May 2011)

WHA64(5) Adoption of the agenda

The Sixty-fourth World Health Assembly adopted the provisional agenda prepared by the Executive Board at its 128th session, with the deletion of four items and the transfer of five items from Committee A to Committee B.

(Second plenary meeting, 16 May 2011)

WHA64(6) Verification of credentials

The Sixty-fourth 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; Dominican Republic; Ecuador; El Salvador; Equatorial Guinea; Eritrea; Estonia; Ethiopia; Fiji; Finland; France; Gabon; Gambia; Germany; Ghana; Greece; Guatemala; Guinea; Guinea-Bissau; Guyana; Haiti; Honduras; Hungary; Iceland; India; Indonesia; Iran (Islamic Republic of); Iraq; Ireland; Israel; Italy; Jamaica; Japan; Jordan; Kazakhstan; Kenya; Kiribati; Kuwait; Kyrgyzstan; Lao People's Democratic Republic; Latvia; Lebanon; Lesotho; Liberia; Lithuania; Luxembourg; Madagascar; Malawi; Malaysia; Maldives; Mali; Malta; 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; Sierra Leone; Singapore; Slovakia; Slovenia; Solomon Islands; Somalia; South Africa; Spain; Sri Lanka; Sudan; Swaziland; Sweden; Switzerland; Syrian Arab Republic; Thailand; Timor-Leste; Togo; Tonga; Trinidad and Tobago; Tunisia; Turkey; Turkmenistan; Tuvalu; Uganda; Ukraine; United Arab Emirates; United Kingdom of Great Britain and Northern Ireland; United Republic of Tanzania; United States of America; Uruguay; Uzbekistan; Vanuatu; Venezuela (Bolivarian Republic of); Viet Nam; Yemen; Zambia; and Zimbabwe.

(Seventh plenary meeting, 18 May 2011)

WHA64(7) Election of Members entitled to designate a person to serve on the Executive Board

The Sixty-fourth 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: Cameroon, Mexico, Myanmar, Nigeria, Papua New Guinea, Qatar, Senegal, Sierra Leone, Switzerland, Uzbekistan.

(Ninth plenary meeting, 20 May 2011)

WHA64(8) United Nations Joint Staff Pension Fund: appointment of representatives to the WHO Staff Pension Committee

The Sixty-fourth World Health Assembly nominated Dr Ebenezer Appiah-Denkyira of the delegation of Ghana as a member, and Mrs Palanitina Tupuimatagi Toelupe of the delegation of Samoa as an alternate member, of the WHO Staff Pension Committee for a three-year term until May 2014 as well as Dr Viroj Tangcharoensathien of the delegation of Thailand as a member of the WHO Staff Pension Committee for the remainder of the term of office of Dr A.A. Yoosuf of the delegation of Maldives, namely, until May 2013.

(Tenth plenary meeting, 24 May 2011)

WHA64(9) Selection of the country in which the Sixty-fifth World Health Assembly would be held

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

(Tenth plenary meeting, 24 May 2011)

WHA64(10) Substandard/spurious/falsely-labelled/falsified/counterfeit medical products

The Health Assembly considered the report of the Working Group of Member States on Substandard/Spurious/Falsely-Labelled/Falsified/Counterfeit Medical Products contained in document A64/16 and decided to accept the "Next steps" contained in the report. The Health Assembly specifically decided to extend the period set out in decision WHA63(10) in order to allow the Working Group to complete its work as soon as possible.

It was further decided that the Working Group should resume its work as soon as possible following the Sixty-fourth World Health Assembly and report on its work to the Sixty-fifth World Health Assembly through the Executive Board at its 130th session.

(Tenth plenary meeting, 24 May 2011)

WHA64(11) Smallpox eradication: destruction of variola virus stocks¹

The World Health Assembly decided to reaffirm strongly the decisions of previous Health Assemblies that the remaining stocks of variola virus should be destroyed.

The Health Assembly also reaffirmed the need to reach consensus on a proposed new date for the destruction for the variola virus stocks, when research outcomes crucial to an improved public health response to an outbreak so permit.

It also decided to include a substantive item “Smallpox eradication: destruction of variola virus stocks” on the provisional agenda of the Sixty-seventh World Health Assembly, through the Executive Board, following the Sixty-sixth World Health Assembly.

(Tenth plenary meeting, 24 May 2011)

¹ See Annex 6 for the financial and administrative implications for the Secretariat of this decision.

ANNEXES

ANNEX 1¹

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

[A64/10 – 5 May 2011]

Recommendation 1

Accelerate implementation of core capacities required by the International Health Regulations (2005). WHO and States Parties should refine and update their strategies for implementing the capacity-building requirements of the International Health Regulations (2005) (IHR), focusing first on those countries that will have difficulty meeting the 2012 deadline for core capacities. One possible way to support and accelerate implementation would be for WHO to mobilize appropriate agencies and organizations that would be willing to provide technical assistance to help interested countries assess their needs and make the business case for investment. Making the case for investment in IHR capacity building and subsequent resource mobilization would increase the likelihood that more States Parties could come into compliance with the IHR. Donor countries and organizations could take advantage of the IHR Annex 1A as a priority list for development support and also seize opportunities to share specialized resources, such as laboratories, across countries. WHO should also update the 2007 guidance on National Focal Point functions, and include examples of good practice to reinforce the value of the IHR.

Recommendation 2

Enhance the WHO Event Information Site. WHO should enhance its Event Information Site (EIS) to make it an authoritative resource for disseminating reliable, up-to-date and readily accessible international epidemic information. States Parties should be able to rely on the EIS as a primary source for information on epidemiological status, risk assessment, response measures and their rationales. The EIS could also be used to post WHO guidance before it is made public. Additional ways to enhance the EIS include:

- Using EIS for guidance and messages to NFPs.
- States Parties allowing WHO to share more information.
- Including more events and expanding information on each event. For instance, for each event there could be maps, expanded risk assessments and recommendations, and links to relevant WHO guidance and Collaborating Centres.
- Posting all temporary and standing recommendations issued under the IHR as well as information on Member States that institute additional measures and their rationales for these, and the status of WHO's request for such a rationale.

¹ See resolution WHA64.1.

Recommendation 3

Reinforce evidence-based decisions on international travel and trade. When States Parties implement health measures that significantly interfere with international traffic and are more stringent than those recommended by WHO, IHR Article 43 provides that the States Parties shall inform WHO of their actions. (As stated in Article 43, “significant interference generally means refusal of entry or departure of international travellers, baggage, cargo, containers, conveyances, goods and the like, or their delay, for more than 24 hours.”) In such circumstances, WHO should energetically seek to obtain the public-health rationale and relevant scientific information, share it with other States Parties, and, where appropriate, request reconsideration, as stipulated under Article 43. WHO should review and assess the effectiveness and impact of border measures taken during the pandemic to support evidence-based guidance for future events.

Recommendation 4

Ensure necessary authority and resources for all National IHR Focal Points. States Parties should ensure that designated National IHR Focal Points have the authority, resources, procedures, knowledge and training to communicate with all levels of their governments and on behalf of their governments as necessary.

Recommendation 5

Strengthen WHO’s internal capacity for sustained response. WHO should strengthen its internal capacity to respond to a sustained Public Health Emergency of International Concern, such as a pandemic, identifying the skills, resources and internal arrangements to support a response that extends beyond a few months. Among the internal arrangements that WHO should reinforce are:

- Identify the skills, resources and adjustments needed for WHO to carry out its role in coordination and global support.
- Establish an internal, trained, multidisciplinary group of staff who will be automatically released from their normal duties for an unspecified duration, with a relief rotation after a designated interval.
- Ensure a 24/7 capacity to meet the personal needs for accommodation, meals, transportation and childcare of WHO staff enlisted in a sustained emergency response.
- Establish an event management structure that could be maintained throughout a future pandemic or other sustained global public-health emergency.

Recommendation 6

Improve practices for appointment of an Emergency Committee. WHO should adopt policies, standards and procedures for the appointment and management of an Emergency Committee (EC), which assure an appropriate spectrum of expertise on the committee, inclusive consultation and transparency with respect to freedom from conflicts of interest.

- As provided in Article 48 of the IHR, WHO should appoint an Emergency Committee with the spectrum of expertise and geographical representation appropriate for each event. The Review Committee also concluded that a broader spectrum of expertise among EC members might have been useful, including in risk communication. The Review Committee

acknowledged that WHO must appoint an EC with a set of skills and expertise that is appropriate for and particular to each event for which it is constituted. For an influenza pandemic, this expertise would include virology, laboratory assessment, epidemiology, public-health field and leadership experience, veterinary science, risk assessment and risk communication and methodological expertise in systematic reviews of the scientific literature.

- To ensure that the full range of views is presented, WHO should invite all members of an Emergency Committee to participate in all of its major deliberations.
- WHO should clarify its standards and adopt more transparent procedures for the appointment of members of expert committees, such as an Emergency Committee, with respect to potential conflicts of interest. The identity and relevant background, experience and relationships of Emergency Committee members should be publicly disclosed at the time of their proposed appointment, with an opportunity for public comment during a period of initial, probationary service that would apply to all members. WHO should have clear standards for determining when a conflict of interest exists that warrants disqualifying an individual, and have clear procedures to determine when and on what basis exceptions may be made to obtain necessary expertise or balance. The Review Committee appreciates the need for expert consultations to be held in confidence so that the Director-General will have the benefit of candid discussion and advice. The desirability of confidential consultation heightens the burden of transparency on standards for appointment.
- As part of a more proactive and rigorous approach to managing conflicts of interest, WHO should appoint a designated ethics officer.

Recommendation 7

Revise pandemic preparedness guidance. WHO should revise its pandemic preparedness guidance in order to: simplify the phase structure (one possible paradigm would include only three phases – baseline, alert phase, pandemic); emphasize a risk-based approach to enable a more flexible response to different scenarios; rely on multisectoral participation; draw upon lessons learnt at a country, regional and global level; and include further guidance on risk assessment.

Recommendation 8

Develop and apply measures to assess severity. WHO should develop and apply measures that can be used to assess the severity of every influenza epidemic. By applying, evaluating and refining tools to measure severity every year, WHO and Member States can be better prepared to assess severity in the next pandemic. Assessing severity does not require altering the definition of a pandemic to depend on anything other than the degree of spread. Rather, while not part of the definition of a pandemic, measured and projected severity are key components of decision-making in the face of a pandemic.

The Committee recognizes that estimating severity is especially difficult in the early phase of an outbreak, that severity typically varies by place and over time, and that severity has multiple dimensions (deaths, hospitalizations and illness, with each varying by age and other attributes, such as pre-existing health conditions and access to care; burden on a health system and social and economic factors). Descriptive terms used to characterize severity, such as mild, moderate and severe, should be quantitatively defined in future WHO guidelines so that they may be used consistently by different observers and in different settings. The Committee urges consideration of adaptive measures that would move as rapidly as possible from early counts of cases, hospitalizations and deaths to population-based rates. Severity should be assessed as early as possible during a pandemic and

continually re-assessed as the pandemic evolves and new information becomes available. Severity might be assessed using a “basket of indicators” in a pre-agreed minimum data set (e.g. hospitalization rates, mortality data, identification of vulnerable populations and an assessment of the impact on health systems). Estimates of severity should be accompanied by expressions of confidence or uncertainty around the estimates.

Recommendation 9

Streamline management of guidance documents. WHO needs a strategy and document management system to cope with the development, clearance, translation and dissemination of guidance and other technical documents in a timely and consistent way during a public-health emergency. Interim guidance should be revised as data become available. When feasible, if the guidelines have potential policy implications, WHO should make every effort to consult with Member States and provide them with advance notice of impending publications. WHO should develop the capacity to assure consistency of guidelines across the Organization, recognizing that conditions in different regions and individual countries may vary.

Recommendation 10

Develop and implement a strategic, organization-wide communications policy. WHO should develop an organization-wide communications policy and a strategic approach to improve routine and emergency communications. A strategic approach entails matching the content, form and style of communication with the media, timing and frequency that will reach the intended audience and serve the intended purpose. WHO should be prepared to sustain active, long-term communications outreach when circumstances require, to acknowledge mistakes and to respond professionally and vigorously to unwarranted criticisms. Web publishing procedures should be clarified so that changes in web pages can be historically tracked and archived. WHO should invest in a robust social media presence for rapid communication to a wider, more diverse audience.

Recommendation 11

Encourage advance agreements for vaccine distribution and delivery. In concert with efforts by Member States, and building on existing vaccine distribution systems, WHO should encourage advance agreements with and among appropriate agencies and authorities in Member States, vaccine manufacturers and other relevant parties that would facilitate approval and delivery of pandemic vaccines to low-resource countries, to increase equity in supply and support advance planning for administration of vaccines.

Recommendation 12

Establish a more extensive global, public-health reserve workforce. Member States, in concert with WHO, should establish a more extensive global reserve workforce of experts and public-health professionals to be mobilized as part of a sustained response to a global health emergency and deployed for service in countries that request such assistance. The size, composition and governing rules for activating and deploying such an entity – the Global Health Emergency Workforce – should be developed through consultation and mutual agreement among the Member States and WHO. The number and particular skills of the experts deployed will depend on specific characteristics of the emergency to which the workforce is responding. This workforce would significantly expand the current Global Outbreak and Alert Response Network by strengthening its composition, resources and capacity, with a view towards better support for sustained responses to public-health emergencies.

At present, WHO's capacity to prepare and respond in a sustained way to any public-health emergency is severely limited by chronic funding shortfalls, compounded by restrictions on the use of funds from Member States, partners and other donors. Mindful of concerns about efficiency and accountability that motivate some of the restrictions, the Committee concludes that the establishment of a contingency fund outside of WHO, but available for deployment by WHO at the time of a public-health emergency, will be a prudent step to assure an immediate and effective global response.

Recommendation 13

Create a contingency fund for public-health emergencies. Member States should establish a public-health emergency fund of at least US\$ 100 million, to be held in trust in a location and form that would be readily accessible to WHO. The fund, which would support surge capacity, not the purchase of materials, would be released in part or whole during a declared Public Health Emergency of International Concern, based on approval of a plan for expenditures and accountability submitted by WHO. The precise conditions for use of the fund should be negotiated among the Member States in consultation with WHO.

The Review Committee commends the effort made by Member States to reach agreement on sharing of viruses and access to vaccines and other benefits. The Review Committee believes that success will depend on a mutual expectation of proportionate, balanced benefit and contribution by all stakeholders. An agreement that is one-sided or that expects contribution without benefit, or vice versa, will be neither acceptable nor sustainable. The Review Committee also believes that obligations and benefits not linked to a legal framework are unlikely to last.

Recommendation 14

Reach agreement on sharing of viruses and access to vaccines and other benefits. The Review Committee urges Member States and WHO to conclude negotiations under the Open-ended Working Group of Member States on Pandemic Influenza Preparedness: Sharing of Influenza Viruses and Access to Vaccines and Other Benefits. A successful conclusion to this negotiation will lead to wider availability of vaccines and other benefits and greater equity in the face of the next pandemic, as well as continued timely sharing of influenza viruses.

The Review Committee offers the following elements for consideration as part of an acceptable agreement.

Measures to expand global influenza vaccine production capacity:

- WHO should continue its practice of working with public-health laboratories to make seed vaccine virus strains widely available to all vaccine manufacturers.
- In so far as it is consistent with national priorities, risk assessments and resources, the Review Committee urges countries to immunize their high-risk populations yearly against seasonal influenza. This can reduce the burden of disease. In addition, this can increase experience with local production, distribution and delivery and encourage more global capacity for vaccine production. More generally, experience with comprehensive programmes during seasonal influenza (in such areas as surveillance, communication, professional and public education, health-protection measures and pharmaceuticals) provides valuable preparation in advance of a major pandemic.

- The Committee urges countries to strengthen their capacity to receive, store, distribute and administer vaccines. Technological advances that reduce reliance on a cold chain and otherwise simplify administration will streamline these processes.
- The Committee urges Member States, international organizations and industry to aid the transfer of technologies for vaccine and adjuvant production in parts of the world currently lacking this capacity, such as Africa, through established programmes such as the Global Action Plan to Increase Supply of Pandemic Influenza Vaccines (GAP).

Measures to increase access, affordability and deployment of pandemic vaccine:

- All vaccine manufacturers should commit to a contribution of 10% of pandemic influenza vaccine from each production run to a global redistribution pool. WHO should be responsible for managing allocations from this pool based on advice from a consultative committee.
- Increased access to vaccines and antiviral drugs can be achieved through advance agreements between industry, WHO and countries. These agreements should be negotiated without regard to virus subtype, for a specified period of time (e.g. three to five years) and should be regularly reviewed and renewed.
- Other measures that may promote greater and more equitable access to vaccine include differential pricing, direct economic aid to low-resource countries and additional donations of vaccine from purchasing countries or manufacturers.
- Countries that receive donated vaccine, as any purchaser of the vaccine, should adhere to the same practices of releasing and indemnifying manufacturers from certain legal liabilities.

Measures to detect and promptly identify potential pandemic influenza viruses:

- Every Member State should commit to share promptly, according to the principles of sharing of influenza viruses and access to vaccines and other benefits, any biological specimens and viral isolates that may be related to a new or emerging influenza virus in humans with WHO collaborating laboratories. Viruses isolated from animals should be promptly sent through the appropriate animal health system. The sharing of specimens and viral isolates should be accompanied by arrangements to share benefits, including access to vaccines.

The world's capacity to prevent and limit a severe pandemic is constrained by many factors: predominant reliance on vaccine production technology that has changed little in 60 years; the need to match vaccine to particular viral strains; the inability to predict which influenza viruses will be dangerous to human health; uncertainty about the effectiveness of many pharmaceutical and public-health measures; the lack of field-based, rapid, affordable, highly sensitive and specific diagnostic tests; and limitations of infrastructure, resources and capacities in many countries. Also needed are improved knowledge of and practical strategies for implementing public-health and personal-protective measures, such as handwashing, respiratory etiquette, isolation and social distancing.

Some of these limitations can be reduced over time through national and international research. Further, the results of research on personal and public-health protective measures may apply to any emerging public-health threat, especially when few or no drugs or vaccines exist. Because assessment of public-health measures typically must occur in real time in the midst of an outbreak, it is crucial to design and prepare research protocols and plans in advance. Beyond research advances, global resilience depends on host and environmental factors, so that improving health status, promoting

economic development and strengthening health systems can mitigate the impact of a future pandemic virus.

Recommendation 15

Pursue a comprehensive influenza research and evaluation programme. Member States, individually and in cooperation with one another, and WHO should pursue a comprehensive influenza research and evaluation programme. This should build on a thorough review of the evidence gained in all fields from the 2009 H1N1 pandemic. Key research goals include: strengthen surveillance technology and epidemiological and laboratory capacity to improve detection, characterization and monitoring of new viruses; identify viral and host determinants of transmissibility and virulence; develop rapid, accurate, inexpensive point-of-care diagnostic tests; enhance the accuracy and timeliness of modelling projections; create broader spectrum, highly effective, safe and longer-lasting vaccines; hasten vaccine production and increase throughput; devise more effective antiviral drugs and antimicrobials to treat bacterial complications; evaluate the effectiveness of drug, vaccine, personal protective equipment, personal hygiene and social interventions; assess the effectiveness and costs of border measures and enhance risk communication. Much of this research and evaluation can and should be carried out in the absence of a pandemic. However some studies can only be carried out during a global event such as a pandemic. For these it is essential that protocols be prepared and funding identified in advance so that research can begin without delay.

Table Lead responsibility and time frame to complete implementation of recommendations

	Short term (within 1 year)	Medium term (within 2 years)	Long term (beyond 2 years)
WHO led	<p>Enhance the WHO Event Information Site (Recommendation 2)</p> <p>Strengthen WHO's internal capacity for sustained response (Recommendation 5)</p> <p>Improve practices for appointment of an Emergency Committee (Recommendation 6)</p> <p>Streamline management of guidance documents (Recommendation 9)</p> <p>Develop and implement a strategic, organization-wide communications policy (Recommendation 10)</p>	<p>Revise pandemic preparedness guidance (Recommendation 7)</p> <p>Develop and apply measures to assess severity (Recommendation 8)</p>	<p>Reinforce evidence-based decisions on international travel and trade (Recommendation 3)</p>
Country led	<p>Reach agreement on the sharing of viruses and access to vaccines and other benefits (Recommendation 14)</p>	<p>Ensure necessary authority and resources for all National IHR Focal Points (Recommendation 4)</p>	<p>Accelerate implementation of core capacities required by the IHR (Recommendation 1)</p>

	Short term (within 1 year)	Medium term (within 2 years)	Long term (beyond 2 years)
Jointly led		Encourage advance agreements for vaccine distribution and delivery (Recommendation 11) Establish a more extensive global, public-health reserve workforce (Recommendation 12) Create a contingency fund for public-health emergencies (Recommendation 13)	Pursue a comprehensive influenza research and evaluation programme (Recommendation 15)

ANNEX 2

Pandemic Influenza Preparedness Framework for the sharing of influenza viruses and access to vaccines and other benefits

[A64/9, Attachment 2 – 5 May 2011]

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1. PRINCIPLES

In relation to pandemic influenza preparedness: sharing of influenza viruses and access to vaccines and other benefits, WHO Member States:

- (1) recall World Health Assembly resolution WHA60.28 on pandemic influenza preparedness: sharing of influenza viruses and access to vaccines and other benefits;
- (2) note the continuing risk of an influenza pandemic with potentially devastating health, economic and social impacts, particularly for developing countries, which suffer a higher disease burden and are more vulnerable;
- (3) recognize that Member States have a commitment to share on an equal footing H5N1 and other influenza viruses of human pandemic potential and the benefits, considering these as equally important parts of the collective action for global public health;
- (4) this Framework will be guided by the goal of its universal application for the protection of all people of the world from the international spread of disease;
- (5) recall the need for rapid, systematic and timely sharing of H5N1 and other influenza viruses with human pandemic potential with WHO Collaborating Centres on Influenza and WHO H5 Reference Laboratories as a contribution to assessment of pandemic risk, development of pandemic vaccines, updating of diagnostic reagents and test kits, and surveillance for resistance to antiviral medicines;
- (6) reaffirm obligations of States Parties under the International Health Regulations (2005);
- (7) recognize this Framework is to be implemented in a manner consistent with applicable national and international laws, regulations, and obligations;
- (8) recognize that the benefits arising from the sharing of H5N1 and other influenza viruses with human pandemic potential should be shared with all Member States based on public health risk and need;
- (9) recognize the need for a fair, transparent, equitable and efficient framework for the sharing of H5N1 and other influenza viruses with human pandemic potential and for the sharing of benefits, including access to and distribution of affordable diagnostics and treatments, including vaccines, to those in need, especially in developing countries, in a timely manner;
- (10) recognize also the WHO leadership and oversight functions over these issues and the need for collaboration with the United Nations System Influenza Coordinator and with relevant intergovernmental organizations;
- (11) recognize the sovereign right of States over their biological resources and the importance of collective action to mitigate public health risks;
- (12) recall the global strategy on public health, innovation and intellectual property, adopted in resolution WHA61.21;
- (13) recall that resolutions WHA60.28 and WHA61.21 recognize that “intellectual property rights do not and should not prevent Member States from taking measures to protect public health” and “that intellectual property rights are an important incentive in the development of new health care products.

However, this incentive alone does not meet the need for the development of new products to fight diseases where the potential paying market is small or uncertain”;

(14) recognize that the commitment to share on an equal footing H5N1 and other influenza viruses of human pandemic potential and the benefits enables WHO Member States and the Director-General to assess the global risk of an influenza pandemic and allows WHO Member States and the Director-General to take actions to reduce the risk of the emergence of a pandemic and to facilitate the development and production of vaccines, diagnostic materials and other pharmaceuticals that can assist in rapidly responding to and containing an emerging pandemic;

(15) acknowledge with serious concern that current global influenza vaccine production capacity remains insufficient to meet anticipated need in a pandemic;

(16) acknowledge with serious concern that the distribution of influenza vaccine manufacturing facilities is inadequate particularly in developing countries and that some Member States can neither develop, produce, afford nor access the vaccines and other benefits;

(17) note the WHO Global pandemic influenza action plan to increase vaccine supply (GAP)¹ and its goal of reducing the gap between potential vaccine demand and supply during an influenza pandemic, by expanding the global capacity to produce influenza vaccine, including in developing countries;

(18) recognize the importance of Member States, pharmaceutical manufacturers and other entities with access to relevant technologies in respect of influenza vaccine, diagnostics, and pharmaceuticals making specific efforts to transfer these technologies, skills, knowledge and know-how to countries, particularly developing countries, that do not currently have access to these technologies, skills, knowledge and know-how;

(19) recognize the need for financing mechanisms that would promote affordability and equitable access to quality influenza vaccines, medicines and technologies by developing countries.

2. OBJECTIVE

The objective of the Pandemic Influenza Preparedness Framework is to improve pandemic influenza preparedness and response, and strengthen the protection against the pandemic influenza by improving and strengthening the WHO global influenza surveillance and response system (“WHO GISRS”), with the objective of a fair, transparent, equitable, efficient, effective system for, on an equal footing:

- (i) the sharing of H5N1 and other influenza viruses with human pandemic potential; and
- (ii) access to vaccines and sharing of other benefits.

3. SCOPE

3.1 This Framework applies to the sharing of H5N1 and other influenza viruses with human pandemic potential and the sharing of benefits.

3.2 This Framework does not apply to seasonal influenza viruses or other non-influenza pathogens or biological substances that may be contained in clinical specimens shared under this Framework.

¹ Document WHO/CDS/EPR/GIP/2006.1.

4. DEFINITIONS AND USE OF TERMS

For the purpose of this Framework, the following terms have the meanings assigned to them below.

4.1 Pandemic influenza preparedness biological materials or PIP biological materials

“PIP biological materials”,¹ for the purposes of this Framework (and its appended Standard Material Transfer Agreements (SMTAs) and terms of reference (TORs)) and the Influenza Virus Tracking Mechanism (IVTM), includes human clinical specimens,² virus isolates of wild type human H5N1 and other influenza viruses with human pandemic potential; and modified viruses prepared from H5N1 and/or other influenza viruses with human pandemic potential developed by WHO GISRS laboratories, these being candidate vaccine viruses generated by reverse genetics and/or high growth re-assortment.

Also included in “PIP biological materials” are RNA extracted from wild-type H5N1 and other human influenza viruses with human pandemic potential and cDNA that encompass the entire coding region of one or more viral genes.¹

4.2 Other technical terms

“Genetic sequences” means the order of nucleotides found in a molecule of DNA or RNA. They contain the genetic information that determines the biological characteristics of an organism or a virus.

“Reference reagents” are biological or chemical substances or organisms and parts thereof used in diagnostic or surveillance activities. They are rigorously characterized and shown to be suitable for use as standards in order to compare and validate results of analyses obtained in different laboratories.

“Reference reagents for potency determination of vaccines/vaccine potency reagents” means reagents used by vaccine manufacturers and regulatory laboratories for the purpose of testing and standardizing the potency of vaccines against H5N1 and other influenza viruses with human pandemic potential.

“Influenza virus with human pandemic potential” designates any wild-type influenza virus that has been found to infect humans and that has a haemagglutinin antigen that is distinct from those in seasonal influenza viruses so as to indicate that the virus has potential to be associated with pandemic spread within human populations with reference to the International Health Regulations (2005) for defining characteristics.

“Pandemic influenza preparedness vaccine virus” or “PIP vaccine virus” connotes any high-growth reassortant virus or any influenza reference virus, WHO-recommended influenza virus for vaccine use or other influenza virus material generated, including by new and emerging technologies, from H5N1 or other influenza virus with human pandemic potential that is provided to influenza vaccine manufacturers for the purposes of developing a prototype pandemic, pre-pandemic, pandemic or other influenza vaccine.

¹ OPERATIONAL EXEMPTION: materials shared within the WHO GISRS or with other laboratories specifically for non-commercial public health uses including surveillance activities, diagnostic applications, and quality assurance, are not handled as PIP Biological Materials. Their onward transfer for purposes other than those specified in the terms of reference of National Influenza Centres, WHO Collaborating Centres, Essential Regulatory Laboratories and H5 Reference Laboratories is not allowed under this operational exemption.

² The definition for this term has been provided.

“Clinical specimens” means materials taken from humans or animals, in as far as the samples taken from animals are shared by originating countries/laboratories with the WHO GISRS. These include specimens collected from the respiratory tract (for example, swabs and aspirated fluid), and also blood, serum, plasma, faeces, and tissues, for diagnostic purposes, detection of pathogens and further characterization, study or analysis.

“High-growth reassortant influenza viruses” means hybrid influenza viruses, including recombinant viruses, that have been generated from two or more different influenza viruses and selected to grow better in eggs or tissue cultures for optimal influenza vaccine production.

“Influenza reference viruses” means wild-type influenza viruses of human or animal origin that WHO has selected as representative of important groups of influenza viruses on the basis of extensive antigenic and genetic studies and comparisons with influenza viruses from many countries. As the influenza viruses evolve in nature, new influenza reference viruses are selected.

“WHO-recommended influenza viruses for vaccine use” means wild-type influenza viruses that are recommended by WHO as the basis for an influenza vaccine.

“Wild-type influenza viruses or influenza virus isolates” means naturally occurring influenza viruses that have been detected by any means including molecular methodology and/or cultured either in eggs or cells (i.e. isolated) directly from clinical specimens or subsequent culture passages and have not been purposefully modified.

4.3 Institutions, organizations and entities

“Essential regulatory laboratories” means influenza laboratories designated by WHO located in, or associated with, national regulatory agencies and which have a critical role at the global level for developing, regulating and standardizing human influenza vaccines. Such laboratories participate in the WHO GISRS in accordance with their corresponding terms of reference.

“Influenza vaccine, diagnostic and pharmaceutical manufacturers” means public or private entities including academic institutions, government owned or government subsidized entities, nonprofit organizations or commercial entities that develop and/or produce human influenza vaccines and other products derived from or using H5N1 or other influenza viruses of human pandemic potential.

“National Influenza Centres” or “NICs” means influenza laboratories authorized and designated by the Member State and subsequently recognized by WHO to perform a number of functions including providing PIP biological materials to the WHO GISRS in accordance with the terms of reference.

“Other authorized laboratory” means influenza laboratories authorized by the Member State to provide PIP biological materials to the WHO GISRS. This term is intended to cover laboratories in those Member States which do not have a National Influenza Centre or Member States with NICs but which also have additional laboratories with certain roles usually performed by NICs.

“Public health researchers” means researchers in public health and/or basic sciences at public or private institutions outside of the WHO GISRS, universities and other academic research institutions with a primary research interest in public health.

“WHO Collaborating Centres on Influenza” or “WHO CCs” means influenza laboratories designated by WHO and supported by national authorities to perform certain roles within the WHO GISRS, and which have accepted formal terms of reference from WHO. In general, they differ from National Influenza Centres and WHO H5 Reference Laboratories in having global responsibilities and more extensive technical capacities.

“WHO H5 Reference Laboratories” means influenza laboratories that have been designated by WHO in order to strengthen national and regional capacity for reliably diagnosing H5 virus infection until this capacity is more widespread.

“WHO GISRS” means the international network of influenza laboratories, coordinated by WHO, that conduct year-round surveillance of influenza, assessing the risk of pandemic influenza and assisting in preparedness measures. The WHO GISRS comprises National Influenza Centres, WHO Collaborating Centres on Influenza, WHO H5 Reference Laboratories and Essential Regulatory Laboratories.

4.4 Other terms

“Advisory Group” means the Group referred to in section 7.2 of this Framework.

“Affected country” means countries with laboratory confirmed cases of H5N1, or other influenza viruses with human pandemic potential.

“Director-General” means the Director-General of the World Health Organization.

“Least-developed country” means those countries that are periodically classified as least-developed countries by the United Nations Committee for Development Policy.

“Originating laboratory” means a National Influenza Centre or other authorized laboratory that initially sends PIP biological materials/clinical specimens to other laboratories within the WHO GISRS and to other recipients.

“Originating Member State” means the Member State where the PIP biological materials/clinical specimens were first collected.

“Pandemic Influenza Preparedness Framework” means this Pandemic Influenza Preparedness Framework for the sharing of influenza viruses and access to vaccines and other benefits.

“Influenza Virus Traceability Mechanism” (“IVTM”) means an IT-based system for tracking the transfer and movement of PIP biological materials into, within and out of the WHO GISRS as defined in the Framework.

“WHO antivirals stockpile” means a reserved quantity of antiviral medicines and associated equipment for management of outbreaks of H5N1 and other influenza viruses with human pandemic potential, as specified in section 6.8 of this Framework.

“WHO Member States” means the States party to the WHO Constitution.

“WHO pandemic influenza preparedness vaccine stockpile” or “PIP vaccine stockpile” is the stockpile of vaccines for H5N1 or other influenza viruses with human pandemic potential referred to in section 6.9 of this Framework.

“WHO Secretariat” has the meaning assigned to it in the WHO Constitution.

5. PANDEMIC INFLUENZA PREPAREDNESS SYSTEM FOR SHARING OF H5N1 AND OTHER INFLUENZA VIRUSES WITH HUMAN PANDEMIC POTENTIAL

5.1 General

5.1.1 Member States, through their National Influenza Centres and Other authorized laboratories, should in a rapid, systematic and timely manner provide PIP biological materials from all cases of H5N1 and other influenza viruses with human pandemic potential, as feasible, to the WHO Collaborating Centre on Influenza or WHO H5 Reference Laboratory of the originating Member State's choice.

5.1.2 By providing PIP biological materials from National Influenza Centres and Other authorized laboratories to WHO Collaborating Centres on Influenza and WHO H5 Reference Laboratories as set out in section 5.1.1 above, Member States provide their consent for the onward transfer and use of PIP biological materials to institutions, organizations and entities, subject to provisions in the Standard Material Transfer Agreements.

5.1.3 National Influenza Centres and Other authorized laboratories will make, as feasible, efforts to ensure that PIP biological materials, from cases of H5N1 and other influenza viruses with human pandemic potential, that they provide to WHO Collaborating Centres on Influenza and WHO H5 Reference Laboratories:

- (i) contain viable material; and
- (ii) are accompanied by information as agreed in the Influenza Virus Traceability Mechanism and other clinical and epidemiological information needed for risk assessment.

5.1.4 Member States may also provide PIP biological materials directly to any other party or body on a bilateral basis provided that the same materials are provided on a priority basis to the WHO Collaborating Centres on Influenza and/or H5 Reference Laboratories under this Framework.

5.2 Genetic sequence data

5.2.1 Genetic sequence data, and analyses arising from that data, relating to H5N1 and other influenza viruses with human pandemic potential should be shared in a rapid, timely and systematic manner with the originating laboratory and among WHO GISRS laboratories.

5.2.2 Recognizing that greater transparency and access concerning influenza virus genetic sequence data is important to public health and there is a movement towards the use of public-domain or public-access databases such as Genbank and GISAID respectively; and

5.2.3 Recognizing that in some instances the publication of genetic sequence data has been considered sensitive by the country providing the virus;

5.2.4 Member States request the Director-General to consult the Advisory Group on the best process for further discussion and resolution of issues relating to the handling of genetic sequence data from H5N1 and other influenza viruses with pandemic potential as part of the Pandemic Influenza Preparedness Framework.

5.3 Traceability and reporting mechanisms

5.3.1 The Director-General, in consultation with the Advisory Group,¹ will put in place in a timely manner a transparent traceability mechanism that uses an electronic system in order to track in real time the movement of PIP biological materials into, within, and out of the WHO GISRS.

5.3.2 To ensure that rapid, systematic and timely feedback is provided to Originating laboratories and Member States, the Director-General will also include in the traceability mechanism and associated electronic reporting systems a request that WHO Collaborating Centres, H5 Reference Laboratories and Essential Regulatory Laboratories provide a summary report of laboratory analyses and on request any other available information required by the originating laboratory regarding PIP biological materials.

5.3.3 In order to ensure that the IVTM does not hinder the functioning of the WHO GISRS during pandemic influenza emergencies, as determined by the Director-General, the Director-General may temporarily modify the requirement to record all PIP biological materials. Such a modification must be limited to the pandemic virus strain or strains connected with the emergency.

5.3.4 The Director-General shall report on any such modification to Member States.

5.4 Standard Material Transfer Agreements

5.4.1 The Standard Material Transfer Agreement 1 (SMTA 1) in Appendix 1 will be used to cover all transfers of PIP biological materials within the WHO GISRS for the duration of its applicability.

5.4.2 The Director-General will, using the Standard Material Transfer Agreement 2 (SMTA 2) in Appendix 2, enter into agreements with entities outside the WHO GISRS. Such agreements will cover all transfers of PIP biological materials to recipients for their duration.

6. PANDEMIC INFLUENZA PREPAREDNESS BENEFIT SHARING SYSTEM

6.0 General

6.0.1 Member States should, working with the WHO Secretariat, contribute to a pandemic influenza benefit-sharing system and call upon relevant institutions, organizations, and entities, influenza vaccines, diagnostics and pharmaceutical manufacturers and public health researchers to also make appropriate contribution to this system.

6.0.2 The PIP Benefit Sharing System will operate to:

- (i) provide pandemic surveillance and risk assessment and early warning information and services to all countries;
- (ii) provide benefits, including, where appropriate, capacity building in pandemic surveillance, risk assessment, and early warning information and services to Member States.

¹ In November 2007 at the Intergovernmental Meeting on Pandemic Influenza Preparedness: sharing of influenza viruses and access to vaccines and other benefits, the term “advisory mechanism” was substituted for the term “oversight mechanism” used in resolution WHA60.28.

(iii) prioritize important benefits, such as and including antiviral medicines and vaccines against H5N1 and other influenza viruses with human pandemic potential as high priorities, to developing countries, particularly affected countries, according to public health risk and needs and particularly where those countries do not have their own capacity to produce or access influenza vaccines, diagnostics and pharmaceuticals. Prioritization will be based on assessment of public health risk and need, by experts with transparent guidelines;

(iv) build capacity in receiving countries over time for and through technical assistance and transfer of technology, skills and know-how and expanded influenza vaccine production, tailored to their public health risk and needs.

6.0.3 The pandemic influenza preparedness Benefit Sharing System will include the elements set out in the remainder of this part.

6.1 WHO coordination of pandemic influenza preparedness and response

WHO will coordinate influenza pandemic preparedness and response in accordance with applicable International Health Regulations (2005) provisions and this Framework. As regards the benefits outlined in this Framework, WHO should pay particular attention to policies and practices that promote the fair, equitable and transparent allocation of scarce medical resources (including, but not limited to, vaccines, antivirals and diagnostic materials) during pandemics based on public health risk and needs, including the epidemiology of the pandemic. During inter-pandemic periods, WHO will work with Member States and relevant stakeholders to prepare for the aforementioned role.

6.2 Pandemic risk assessment and risk response

6.2.1 WHO GISRS laboratories will make available to the WHO Secretariat and the originating Member State, in a rapid, systematic and timely manner, a summary report of laboratory analyses and on request any other available information required regarding PIP biological materials to enable the affected countries and in particular, developing countries, to make an effective and meaningful risk response.

6.2.2 WHO will provide information on risk response including, but not limited to, information on development of vaccines, candidate virus and effective antivirals to all affected countries and in particular, to developing countries, to enable an effective and meaningful risk response.

6.2.3 The WHO Secretariat will make available to all Member States, in a rapid, systematic and timely way, pandemic risk assessments and assist with risk response with all necessary supporting information.

6.2.4 WHO Collaborating Centres on Influenza and WHO H5 Reference Laboratories and the Director-General will actively continue to provide technical assistance to Member States to enhance research and surveillance capacity, including staff training, with the objective of improving national pandemic risk assessment and pandemic risk response.

6.3 Provision of PIP candidate vaccine viruses

6.3.1 The Director-General will ensure that WHO Collaborating Centres on Influenza/H5 Reference Labs and Essential Regulatory Laboratories, as agreed in the terms of reference, provide PIP candidate vaccine viruses upon request:

(i) to influenza vaccine manufacturers on a no preference basis;

- (ii) at the same time to the laboratories of originating and other Member States;
- (iii) to any other laboratory.

6.3.2 Any entity receiving PIP candidate vaccine viruses will meet appropriate biosafety guidelines (*WHO Laboratory Biosafety Manual*, 3rd edition) and employ laboratory protection best practices.

6.4 Provision of diagnostic reagents and test kits

6.4.1 WHO Collaborating Centres on Influenza, WHO H5 Reference Laboratories and Essential Regulatory Laboratories, working with the WHO Secretariat, will continue to make available to National Influenza Centres and Other authorized laboratories, without charge, supplies of noncommercial diagnostic reagents and test kits for the identification and characterization of clinical specimens of influenza.

6.4.2 Influenza diagnostic manufacturers receiving PIP biological materials are urged to make available to WHO GISRS laboratories, without charge or at concessional and/or preferential rates, supplies of diagnostic reagents and test kits for the identification and characterization of clinical specimens of influenza, if circumstances warrant.

6.5 Provision of reference reagents for potency determination of vaccines

6.5.1 Essential Regulatory Laboratories will continue to provide, upon request, reference reagents for potency determination of vaccines against H5N1 and other viruses of human pandemic potential to national regulatory laboratories and influenza vaccine manufacturers of all Member States.

6.5.2 Essential Regulatory Laboratories will continue to provide upon request, training in quality control of vaccines against H5N1 and other viruses of human pandemic potential to national regulatory laboratories of all Member States.

6.6 Laboratory and influenza surveillance capacity building

6.6.1 Upon request, Member States with advanced laboratory and influenza surveillance capacity are urged to continue to work with WHO and other Member States, particularly developing countries, to develop national laboratory and influenza surveillance capacity, including:

- (i) to conduct early detection, isolation and characterization of viruses;
- (ii) to participate in pandemic risk assessment and response;
- (iii) to develop research capacity related to influenza;
- (iv) to achieve technical qualifications for consideration of laboratories as National Influenza Centres, WHO H5 Reference Laboratories and WHO Collaborating Centres on Influenza.

6.7 Regulatory capacity building

6.7.1 Upon request, Member States with advanced regulatory capacity should improve and strengthen the work that has been undertaken by Member States with WHO, particularly in developing countries, to strengthen the capacity of regulatory authorities to carry out the necessary measures for the rapid approval of safe and effective human influenza vaccines, diagnostics and pharmaceutical products,

including products developed from the use of PIP biological materials, especially those derived from new sub-types of influenza viruses.

6.7.2 Member States should make publicly available information on the notification of health regulatory approval of vaccines, diagnostics and pharmaceutical products for H5N1 and other influenza viruses with human pandemic potential, including those developed from the use of PIP biological materials.

6.8 Antivirals stockpiles

6.8.1 The Director-General will continue to work with other multilateral agencies, donors, international philanthropic organizations/entities, private foundations, and other potential partners, including institutions, organizations and entities and in particular influenza vaccine, diagnostic and pharmaceutical manufacturers, to seek commitments for contributions, maintain and further develop a stockpile of antiviral medicines and associated equipment for use in containment of outbreaks of H5N1 and other influenza viruses with human pandemic potential.

6.8.2 The Director-General will continue to coordinate with Member States, institutions, organizations and other entities and encourage them to maintain and further develop stockpiles of antiviral medicines and associated equipment for use in containment of outbreaks of H5N1 and other influenza viruses with human pandemic potential.

6.8.3 The Director-General will continue to seek the guidance of expert advice in determining the size, composition, replenishment, operational use and deployment procedures for use of the WHO antivirals stockpile.

6.9 Pandemic influenza preparedness vaccine stockpile

6.9.1 The Director-General will establish and maintain a stockpile of vaccines for H5N1 and other influenza viruses with human pandemic potential and associated equipment, including syringes, needles and applicators, consistent with expert guidance.

6.9.2 The WHO stockpile will initially include 150 million doses of H5N1 vaccine for use in accordance with expert guidance including the Strategic Advisory Group of Experts on immunization (SAGE). Indicatively:

- (i) 50 million doses will be for use in affected countries, according to public health risk and need, to assist in containing the first outbreak or outbreaks of an emerging pandemic; and
- (ii) 100 million doses will be for distribution, once a pandemic begins, to developing countries that have no or inadequate access to H5N1 influenza vaccines, on a per capita basis, with use to be determined by those countries.

6.9.3 Member States should urge influenza vaccine manufacturers to prioritize and respond to the needs of the WHO PIP vaccine stockpile and to donate sufficient doses of vaccines for H5N1 to meet its initial target (see 6.9.1 above).

6.9.4 The Director-General will continue to seek the guidance of experts in determining the size, composition, replenishment and operational use of the vaccines in the WHO PIP vaccine stockpile for H5N1 and other influenza viruses with human pandemic potential.

6.9.5 If insufficient doses are donated, the Director-General will work with Member States to explore the use of sustainable financing mechanisms (see 6.14 below) to meet the requirements of the WHO PIP vaccine stockpile.

6.9.6 The Director-General will, with the guidance of experts, keep under review the potential for the pre-pandemic use of the WHO PIP vaccine stockpile in affected countries, including by supporting trials as appropriate.

6.9.7 The Director-General will work with relevant experts and Member States to develop and exercise operational plans for the deployment of the vaccines in the WHO PIP vaccine stockpile.

6.10 Access to vaccines in the inter-pandemic period for developing countries

6.10.1 Separately from measures to support the WHO PIP vaccine stockpile set out in section 6.9 above:

(i) Member States should urge influenza vaccine manufacturers to set aside a portion of each production cycle of vaccines for H5N1 and other influenza viruses with human pandemic potential for stockpiling and/or use, as appropriate, by developing countries; and

(ii) Member States should continue to work with each other, with the Director-General and with influenza vaccine manufacturers, with the aim of ensuring that adequate quantities of vaccines for H5N1 and other influenza viruses with human pandemic potential are made available to developing countries at the same time as to developed countries, on the basis of public health risk and needs and at tiered prices (see 6.12 below).

6.11 Access to pandemic influenza vaccines

6.11.1 Member States should urge vaccine manufacturers to set aside a portion of each production cycle of pandemic influenza vaccine for use by developing countries; and

6.11.2 The Director-General, consulting Member States and the Advisory Group, will convene an expert group to continue to develop international mechanisms, including existing ones, for the production and distribution of influenza vaccines on the basis of public health risk and needs during a pandemic, for consideration by the World Health Assembly in 2010.

6.12 Tiered pricing

As a measure to improve the affordability for developing countries of pandemic influenza vaccines and vaccines for H5N1 and other influenza viruses with human pandemic potential, and antivirals, Member States should urge influenza vaccine and antiviral manufacturers individually to implement tiered pricing for these vaccines and antivirals. As part of this approach, influenza vaccine and antiviral manufacturers individually should be urged to consider the income level of the country, and negotiate with the national authorities of the recipient country, in arriving at the price to be applied in the private and public markets of each country. In this context the vulnerability of the least developed countries should be taken into account.

6.13 Technology transfer

6.13.1 The Director-General will continue to work closely with Member States and influenza vaccine manufacturers to implement the WHO Global Pandemic Influenza Action Plan to Increase Vaccine

Supply, including its strategies to build new production facilities in developing and/or industrialized countries and through transfer of technology, skills and know-how.

6.13.2 Member States should urge influenza vaccine, diagnostic and pharmaceutical manufacturers to make specific efforts to transfer these technologies to other countries, particularly developing countries, as appropriate.

6.13.3 Technology transfer should be conducted in a manner consistent with applicable national laws and international laws and obligations, facilitated progressively over time, on mutually agreed terms, and be suitable to the capacity of recipient Member States, to empower developing countries to study and manufacture influenza vaccines, diagnostics and pharmaceuticals.

6.13.4 Influenza vaccine manufacturers who receive PIP biological materials may grant, subject to any existing licensing restrictions, on mutually agreed terms, a non-exclusive, royalty-free licence to any influenza vaccine manufacturer from a developing country, to use its intellectual property and other protected substances, products, technology, know-how, information and knowledge used in the process of influenza vaccine development and production, in particular for pre-pandemic and pandemic vaccines for use in agreed developing countries.

6.13.5 Member States seeking to receive technology to produce influenza vaccine should be encouraged to first conduct studies on the disease burden of seasonal influenza with related economic analysis in their country. Should the study warrant, Member States should be encouraged to consider incorporating seasonal influenza vaccination into their national immunization programme, which will enable sustainable functioning of the manufacturing facilities.

6.14 Sustainable and innovative financing mechanisms

6.14.1 With a view to ensuring the sustainable financing of the PIP Benefit Sharing System, particularly for developing countries; and

6.14.2 Having regard to the desirability of all Member States and recipients of PIP biological materials contributing to the PIP Benefit Sharing System, financially or in kind, according to their capacity and over time.

6.14.3 Influenza vaccine, diagnostic and pharmaceutical manufacturers, using the WHO GISRS, will make an annual partnership contribution to WHO for improving global pandemic influenza preparedness and response. It is decided that the sum of the annual contributions shall be equivalent to 50% of the running costs of the WHO GISRS.¹ Such contributions will commence in 2012. The distribution between companies is to be based on transparency and equity, based on their nature and capacities. The Director-General in consultation with the “Advisory Group” will further define the specific amounts to be contributed by each company as well as the mechanism for implementation (see section 6.14.5 below). In so doing, the Director-General and the “Advisory Group” will collaborate with industry. The Director-General will report annually on the outcome to the Executive Board.

¹ The running costs of the GISRS for 2010 were approximately US\$ 56.5 million. The running costs of the WHO GISRS are understood to be a reference index for the partnership contribution of 50%. Such running costs may change over time and the partnership contribution will change accordingly. Such running costs are not to include the partnership contributions themselves.

6.14.3.1 Member States and other stakeholders are encouraged to consider making donations and in-kind contributions to WHO for improving global pandemic influenza preparedness and response.

6.14.4 The contribution acquired under 6.14.3 shall be used for improving pandemic preparedness and response, *inter alia*, for conducting disease burden studies, strengthening laboratory and surveillance capacity, access and effective deployment of pandemic vaccines and antiviral medicines.

6.14.5 The Director-General will propose to the Executive Board which proportion of contributions should be used for inter-pandemic preparedness measures, and which proportion should be reserved for response activities in the event of a pandemic, based on the advice of the “Advisory Group”.

6.14.6 The Director-General, based on advice from the “Advisory Group”, will decide on the use of resources. The Director-General and the “Advisory Group” will interact with manufacturers and other stakeholders.

6.14.7 Member States are urged to continue to support the speedy and successful implementation of the WHO Global Pandemic Influenza Action Plan to Increase Vaccine Supply by 2015 by providing adequate financial support in accordance with Framework sections 6.13.1 and 6.13.2.

6.14.8 Member States are urged to support the availability and rapid expansion of the safe use of adjuvant technology through WHO as appropriate while at the same time strengthening the monitoring of vaccine safety.

6.14.9 Member States are urged to continue and increase their support to strengthen laboratory and surveillance capacity particularly in developing countries by providing adequate financial and technical support in accordance with Framework section 6.6.

7. GOVERNANCE AND REVIEW

7.1 General

7.1.1 The implementation of this Framework will be overseen by the World Health Assembly with advice from the Director-General.

7.1.2 An oversight mechanism is hereby established, which includes the World Health Assembly, the Director-General and the independent “Advisory Group”, established in connection with the Interim Statement of November 2007, and composed of international experts serving the Organization exclusively. Respectively, their function will be as follows:

(i) The Health Assembly, consistent with the Organization’s Constitutional function to act as the “directing and co-ordinating” authority on international health work, as set forth in Article 2(a) of the WHO Constitution, will oversee implementation of the Framework.

(ii) The Director-General, consistent with her role and responsibilities, particularly in connection with collaborating institutions and other mechanisms of collaboration, *inter alia*, will promote implementation of the Framework within WHO and among relevant WHO-related entities.

(iii) In order that the Health Assembly and Director-General have appropriate expert monitoring and evaluation processes to support these functions, the Advisory Group, as provided for in this section, will provide evidence-based reporting, assessment and recommendations regarding the functioning of the Framework. The Advisory Group, consistent

with WHO practice regarding such independent expert bodies, will advise the Director-General but will not itself engage in administrative functions, such as the recognition, or withdrawal of recognition, of technical institutions, nor will it have a public role, except as authorized.

7.2 Advisory Group

7.2.1 The Director-General will maintain the Advisory Group, referenced in section 7.1.2 above, to monitor and provide guidance to strengthen the functioning of the WHO GISRS and undertake necessary assessment of the trust-based system needed to protect public health and to help ensure implementation of this Framework.

7.2.2 The Director-General, in consultation with Member States, will continue to ensure that the Advisory Group is based on equitable representation of the WHO regions and of affected countries, taking into account balanced representation between developed and developing countries.

7.2.3 The Advisory Group will comprise 18 members drawn from three Member States in each WHO Region, with a skill mix of internationally recognized policy-makers, public health experts and technical experts in the field of influenza.

7.2.4 The Advisory Group will function to assist the Director-General in monitoring the implementation of this Framework, in accordance with the terms of reference for the Advisory Group in Appendix 3 of this Framework.

7.2.5 The Advisory Group will present an annual report to the Director-General on its evaluation of the implementation of this Framework. The report should cover the following:

- (i) necessary technical capacities of WHO GISRS;
- (ii) operational functioning of WHO GISRS;
- (iii) WHO GISRS influenza pandemic preparedness priorities, guidelines and best practices (e.g. vaccine stockpiles, capacity building);
- (iv) increasing and enhancing surveillance for H5N1 and other influenza viruses with human pandemic potential;
- (v) the Influenza Virus Tracking Mechanism;
- (vi) the sharing of influenza viruses and access to vaccines and other benefits;
- (vii) use of financial and non-financial contributions.

7.2.6 The Director-General will present a report on the work carried out by the Advisory Group, through the Executive Board, to the Sixty-fifth World Health Assembly in 2012 for its consideration including a decision on the Advisory Group's future mandate.

7.3 Governance and review of terms of reference for WHO global influenza surveillance and response system Laboratories

7.3.1 The terms of reference of the WHO Collaborating Centres on Influenza, WHO H5 Reference Laboratories, National Influenza Centres and Essential Regulatory Laboratories should be developed in accordance with the guiding principles outlined in Appendix 4 to this Framework.

7.3.2 The Director-General, in consultation with the Advisory Group and competent authorities in Member States, and the WHO Collaborating Centres, WHO H5 Reference Laboratories, National Influenza Centres, and Essential Regulatory Laboratories, will review periodically the terms of reference of the institutions and laboratories of the WHO GISRS and amend them when needed, to promote the principles provided by this Framework, and report thereon to the World Health Assembly.

7.3.3 Member States may bring to the attention of the Director-General allegations of non-compliance by institutions and laboratories of the WHO GISRS with their respective terms of reference or the Standard Material Transfer Agreements.

7.3.4 In the event of any alleged breaches of the terms of reference or the Standard Material Transfer Agreements by a WHO Collaborating Centre on Influenza, WHO H5 Reference Laboratories or National Influenza Centre, and Essential Regulatory Laboratories, the Director-General will review the circumstances and may discuss with the Advisory Group any appropriate action in response to those breaches. Where there has been a serious breach, the Director-General may consider suspending or revoking the WHO designation of the relevant laboratory.

7.4 Monitoring and review of the Pandemic Influenza Preparedness Framework

7.4.1 The Director-General shall on a biennial basis inform the World Health Assembly, through the Executive Board, on the status of, and progress on:

- (i) Laboratory and surveillance capacity (see Framework section 6.6);
- (ii) Global influenza vaccine production capacity (see Framework sections 6.13.1 and 6.13.2);
- (iii) Status of agreements entered into with industry, including information on access to vaccines, antivirals and other pandemic material (6.14.3 and 6.14.4);
- (iv) Financial report on the use of the partnership contribution (6.14.5);
- (v) The experience arising from the use of the definition of PIP biological materials in section 4.1.

7.4.2 The Framework and its Appendices will be reviewed by 2016 with a view to proposing revisions reflecting developments as appropriate, to the World Health Assembly in 2017, through the Executive Board.

APPENDIX 1

Standard Material Transfer Agreement 1 (SMTA 1)

Standard Material Transfer Agreement within the WHO global influenza surveillance and response system (GISRS)

In furtherance of the Pandemic Influenza Preparedness Framework for the sharing of influenza viruses and access to vaccines and other benefits (the “Framework”), this Standard Material Transfer Agreement (“Agreement” or “SMTA 1”) has been developed.

Article 1. Parties to the Agreement

1.1 Parties to SMTA 1 are limited to influenza laboratories that have been designated or recognized by WHO and have accepted to work under agreed WHO terms of reference. In this Agreement:

The Provider is the laboratory sending Materials, as herein defined,

(name and address of the provider or providing institution, designation of the laboratory (i.e. whether NIC/WHO CC/H5RL/ERL/other authorized laboratory), name of authorized official, contact information for authorized official) (hereinafter referred to as “the Provider”)¹

and

The Recipient is the laboratory receiving Materials, as herein defined,

(name and address of the recipient or recipient institution, designation of the laboratory (i.e. whether NIC/WHO CC/H5RL/ERL/other authorized laboratory), name of authorized official, contact information for authorized official) (hereinafter referred to as “the Recipient”)¹

1.2 Provider and Recipient are hereafter collectively referred to as “Parties”.

Article 2. Subject matter of the Agreement

PIP biological materials as defined in Section 4.1 of the Framework (hereinafter “Materials”) transferred from the Provider to the Recipient are subject to the provisions of this Agreement.

Article 3. General provisions

The Provider or recipient will consider support to the strengthening of the laboratory and surveillance capacity of the networks of developing countries.

¹ To be completed if signature is required pursuant to Article 11 below.

Article 4. Rights and obligations of the Provider

4.1 The Provider undertakes the following with respect to the Materials:

4.1.1. To comply with its respective WHO global influenza surveillance and response system (GISRS) terms of reference.

4.1.2. To ensure that the Materials are handled in accordance with applicable WHO guidelines and national bio-safety standards.¹

4.2. The Provider agrees to the onward transfer and use of the Materials, to all members of the WHO GISRS, on the same terms and conditions as those provided in the Standard Material Transfer Agreement within the WHO GISRS (SMTA 1).

4.3 The Provider consents to the onward transfer and use of the Materials to entities outside the WHO GISRS on the condition that the prospective recipient has concluded a Standard Material Transfer Agreement outside the WHO GISRS (SMTA 2).

4.4. The Provider shall inform the WHO of shipments of Materials to entities inside/outside the WHO GISRS by recording in the Influenza Virus Tracking Mechanism (IVTM).

Article 5. Rights and obligations of the Recipient

5.1 The Recipient undertakes the following with respect to the Materials:

5.1.1 To comply with its respective WHO GISRS terms of reference.

5.1.2. To ensure that the Materials are handled in accordance with applicable WHO guidelines and national bio-safety standards.

5.1.3. To inform WHO of shipments of Materials to entities inside/outside the WHO GISRS by recording in the IVTM.

5.1.4 In the event of further transfers within the WHO GISRS, to do so in accordance with SMTA 1.

5.2. The Recipient shall actively seek the participation of scientists to the fullest extent possible from originating laboratories and other authorized laboratories, especially those from developing countries, in scientific projects associated with research on clinical specimens and/or influenza virus from their countries and actively engage them in preparation of manuscripts for presentation and publication.

5.3. The Recipient shall appropriately acknowledge in presentations and publications, the contributions of collaborators, including laboratories/countries providing clinical specimens or influenza virus with pandemic potential or reagents, using existing scientific guidelines.

¹ “WHO Guidance on Regulations for the Transport of Infectious Substances”. Document WHO/CDS/EPR/2007.2. Geneva, World Health Organization 2007 and “WHO Guidelines for the collection of human specimens for laboratory diagnosis of avian influenza infection”.

Article 6. Intellectual property rights

6.1 Neither the Provider nor the Recipient should seek to obtain any intellectual property rights (IPRs) on the Materials.

6.2 The Provider and the Recipient acknowledge that any IPRs on the Materials obtained before the date of adoption of the Framework by the World Health Assembly will not be affected by SMTA 1.

6.3 The Provider under SMTA 1 may have used technology protected by IPRs for the generation and/or modification of the Materials. Any recipient of such Materials acknowledges that such IPRs shall be respected.

Article 7. Dispute resolution

7.1. In the event of a dispute under SMTA 1, Parties concerned shall seek in the first instance to settle the dispute through negotiation or any other amicable means of their own choice. Failure to reach agreement shall not absolve the parties to the dispute from the responsibility of continuing to seek to resolve it.

7.2. In the event that the dispute is not settled by the means described under paragraph 1 of this Article, one of the Parties concerned may refer the dispute to the Director-General, who may seek advice of the Advisory Group with a view to settling it. The Director-General may make recommendations to the Parties regarding its resolution and shall report to the World Health Assembly on any such matters.

7.3. The Parties also acknowledge the role of the Director-General under the Framework, in particular under section 7.3.4.

Article 8. Warranty

The Provider makes no warranties as to the safety of the Materials, or as to the accuracy or correctness of any data provided with them. Likewise, the provider does not make any warranties as to the quality, viability, or purity (genetic or mechanical) of the Materials being furnished. The Provider and the Recipient assume full responsibility for complying with their respective national biosecurity and biosafety regulations and rules as to import, export or release of biological materials.

Article 9. Duration of Agreement

This contractual agreement shall remain in force until December 31, 2021 and shall be automatically renewed until December 31, 2031 unless the World Health Assembly decides otherwise.

Article 10. Acceptance and Applicability

10.1. Recipients or Providers in the WHO GISRS at the time of the adoption of the Framework by the World Health Assembly: Acceptance by such laboratories of their WHO terms of reference, as contained in the Framework, constitutes acceptance of SMTA 1.

10.2 Recipients or Providers that join the WHO GISRS after adoption of the Framework by the World Health Assembly: Acceptance of designation or recognition by WHO to become a WHO GISRS laboratory will constitute acceptance of SMTA 1.

10.3. Applicability: SMTA 1 shall cease to be applicable only upon suspension or revocation of designation or recognition by WHO or upon formal withdrawal by the laboratory of its participation in the WHO GISRS or upon mutual agreement of the WHO and the laboratory. Such a suspension, revocation or withdrawal shall not relieve a laboratory of pre-existing obligations under SMTA 1.

Article 11. Signature

Further to Article 10 above entitled “Acceptance and Applicability”, unless either party requires this Agreement to be executed by signature of a printed document, no further evidence of acceptance is required.

APPENDIX 2

Standard Material Transfer Agreement 2 (SMTA 2)

Standard Material Transfer Agreement outside the WHO global influenza surveillance and response system (GISRS)

Article 1. Parties to the Agreement

WHO and Recipient.¹

Article 2. Subject matter of the Agreement

PIP biological materials as defined in Section 4.1 of the Framework (hereinafter “Materials”) transferred to the Recipient are subject to the provisions of this Agreement.

Article 2. bis Definitions

- (a) As provided for in Section 4 of the Pandemic Influenza Preparedness Framework for the sharing of influenza viruses and access to vaccines and other benefits.
- (b) Other terms as agreed by the parties.

Article 3. Obligations of the Provider

To be agreed by the parties.

Article 4. Obligations of the Recipient

4.1 The recipient agrees to comply with the commitments selected below, in accordance with the terms set out in the Annex to this agreement.

4.1.1 The recipient shall comply with the commitments selected on a timetable determined by WHO in consultation with the Advisory Group established by the PIP Framework and in coordination with the recipient, based on optimal pandemic preparedness and response considerations.

A. For manufacturers of vaccines and/or antivirals, the recipient shall commit to at least two of the following options:

- A1. Donate at least 10%² of real time pandemic vaccine production to WHO.

¹ Recipients are all entities that receive “PIP Biological Materials” from the WHO global influenza surveillance and response system (GISRS), such as influenza vaccine, diagnostic and pharmaceutical manufacturers, as well as biotechnology firms, research institutions and academic institutions. Each recipient shall select options based on its nature and capacities.

² Recognizing that flexibility is important in negotiating with all manufacturers, in a range of 5–20%.

A2. Reserve at least 10%¹ of real time pandemic vaccine production at affordable prices to WHO.

A3. Donate at least X treatment courses of needed antiviral medicine for the pandemic to WHO.

A4. Reserve at least X treatment courses of needed antiviral medicine for the pandemic at affordable prices.

A5. Grant to manufacturers in developing countries licenses on mutually agreed terms that should be fair and reasonable including in respect of affordable royalties, taking into account development levels in the country of end use of the products, on technology, know-how, products and processes for which it holds IPR for the production of (i) influenza vaccines, (ii) adjuvants, (iii) antivirals and/or (iv) diagnostics.

A6. Grant royalty-free licenses to manufacturers in developing countries or grant to WHO royalty-free, non-exclusive licenses on IPR, which can be sublicensed, for the production of pandemic influenza vaccines, adjuvants, antivirals products and diagnostics needed in a pandemic. WHO may sublicense these licenses to manufacturers in developing countries on appropriate terms and conditions and in accordance with sound public health principles.

Where Option 5 or 6 is selected, the Recipient shall regularly provide to WHO information on granted licenses and the status of implementation of the licensing agreement. WHO shall provide such information to the Advisory Group.

B. Manufacturers of products relevant to pandemic influenza preparedness and response, that are not manufacturing vaccines or antivirals, shall commit to one of the following options: A5, A6, B1, B2, B3, B4.

B1. Donate to WHO at least X² diagnostic kits needed for pandemics.

B2. Reserve for WHO at least X² diagnostic kits needed for pandemics, at affordable prices.

B3. Support, in coordination with WHO, the strengthening of influenza specific laboratory and surveillance capacity in developing countries.

B4. Support, in coordination with WHO, transfer of technology, know-how and/or processes for pandemic influenza preparedness and response in developing countries.

C. The recipient shall, in addition to the commitments selected under A or B above, consider contributing to the measures listed below, as appropriate:

- Donations of vaccines;
- Donations of pre-pandemic vaccines;
- Donations of antivirals;
- Donations of medical devices;

¹ Recognizing that flexibility is important in negotiating with all manufacturers, in a range of 5–20%.

² Recognizing that flexibility is important in negotiating with all manufacturers.

- Donations of diagnostic kits;
- Affordable pricing;
- Transfer of technology and processes;
- Granting of sublicenses to WHO;
- Laboratory and surveillance capacity building.

4.2 The Recipient shall ensure that the PIP biological materials are handled in accordance with applicable WHO guidelines and national bio-safety standards.

4.3 If applicable, the Recipient shall appropriately acknowledge in presentations and publications, the contributions of WHO laboratories providing the materials identified in Article 2, using existing scientific guidelines.

4.4 The recipient shall only further transfer the PIP biological materials if the prospective recipient has concluded an SMTA with the World Health Organization. Any such further transfer shall be reported to the World Health Organization. The Director-General may, under exceptional circumstances, allow the PIP biological materials to be transferred to a prospective recipient while requesting this aforementioned recipient to enter into an SMTA, and report to the “Advisory Group” accordingly.

4.5 The recipient may exchange PIP biological materials with any other holder of an SMTA concluded with the World Health Organization.

Article 5. Dispute resolution

If a dispute cannot be resolved through negotiations or other non-binding means of the parties’ choice, disputes shall be subject to binding arbitration on conditions that are mutually agreed by the parties.

Article 6. Liability and indemnity

To be agreed by the parties.

Article 7. Privileges and immunity

Nothing in or relating to these clauses shall imply the obligation of WHO to submit to any national legislation or jurisdiction, or be deemed a waiver of any of the privileges and immunities of WHO in conformity with the Convention on the Privileges and Immunities of the Specialized Agencies approved by the General Assembly of the United Nations on November 21, 1947 or otherwise under any national or international law, convention or agreement.

Article 8. Name and Emblem

To be agreed by the parties.

Article 9. Warranties

To be agreed by the parties.

Article 10. Duration of Agreement

To be agreed by the parties.

Article 11. Termination

To be agreed by the parties.

Article 12. Force Majeure

To be agreed by the parties.

Article 13. Governing law

To be agreed by the parties.

Article 14. Signature and Acceptance

In WITNESS Whereof, this Agreement has been duly executed by the parties.

SIGNED for and on behalf of WHO

SIGNED for and on behalf of Recipient

Signature

Signature

Name

Name

Title

Title

Annex*

To be agreed by the parties.

* Editor's note: the annex is to be developed, as necessary, by the parties.

APPENDIX 3

ADVISORY GROUP TERMS OF REFERENCE

(Adopted by the Intergovernmental Meeting at its resumed session in December 2008, as amended by the Open-Ended Working Group of Member States on Pandemic Influenza Preparedness: sharing of influenza viruses and access to vaccines and other benefits in April 2011.)

1. Background and mandate of the Advisory Group

1.1 The Interim Statement adopted by WHO Member States attending the session of the Intergovernmental Meeting on Pandemic Influenza Preparedness, 20–23 November 2007, urged action to develop fair, transparent, and equitable international mechanisms on virus sharing and benefit sharing. Member States called on the Director-General to establish an Advisory Mechanism to monitor, provide guidance to strengthen the functioning of the trust-based system needed to protect public health and undertake necessary assessment of that system. To carry this out, Member States specified that an Advisory Group will be appointed by the Director-General in consultation with Member States, based on equitable representation of the WHO regions and of affected countries.

1.2 The trust-based system is now referred to as the “Pandemic Influenza Preparedness Framework for the sharing of influenza viruses and access to vaccines and other benefits” (hereinafter “the Framework”). The scope of the Advisory Group is to monitor, assess and report on the system for sharing H5N1 influenza viruses and other influenza viruses with human pandemic potential as well as access to vaccines and other benefits of the Framework. The institutional components of the Framework to be monitored by the Advisory Group are National Influenza Centres, Other authorized laboratories, WHO Collaborating Centres, H5 Reference Laboratories, and Essential Regulatory Laboratories, as defined in Section 4 of the Framework. The pharmaceutical industry, although not included, can be consulted by the Advisory Group.

2. Functions of the Advisory Group

2.1 To monitor, assess and report on how the different functions of the Framework are implemented by its components. The information to conduct these tasks should be provided by the WHO Secretariat and other independent sources, if available. Monitoring by the Advisory Group will enable ongoing assessment of the functioning of the Framework and should include at least:

- (a) the rapid, systematic and timely sharing of H5N1 and other influenza viruses with human pandemic potential with the WHO global influenza surveillance and response system (GISRS);
- (b) the Influenza Virus Traceability Mechanism;
- (c) the global improvement of laboratory capacity, particularly in developing countries, to enhance pandemic influenza preparedness;
- (d) the fair and equitable sharing of benefits;
- (e) the use of financial and non-financial contributions.

2.2 To carry out the necessary assessment of the Framework according to quantitative and qualitative indicators developed from information provided by the WHO Secretariat and other independent sources, if necessary.

2.3 To provide guidance to strengthen the functioning of the Framework to the Director-General.

2.4 To make recommendations to the Director-General on the use of financial and non-financial contributions.

2.5 Recommendations and reports of the Advisory Group shall be evidence based.

2.6 To present an annual report to the Director-General on its evaluation of the implementation of this Framework. The report should cover the following:

- (a) necessary technical capacities of WHO GISRS;
- (b) operational functioning of WHO GISRS;
- (c) WHO GISRS influenza pandemic preparedness priorities, guidelines and best practices (e.g. vaccine stockpiles, capacity building);
- (d) increasing and enhancing surveillance for H5N1 and other influenza viruses with human pandemic potential;
- (e) the Influenza Virus Tracking Mechanism;
- (f) the sharing of influenza viruses and access to vaccines and other benefits;
- (g) use of financial and non-financial contributions.

3. Nomination of members

3.1 The Advisory Group will comprise 18 members drawn from three Member States in each WHO region, with a skill mix of internationally recognized policy-makers, public health experts and technical experts in the field of influenza. In the exercise of their functions the Members shall act as international experts serving WHO exclusively.

3.2 Each member will serve for three years. The duration of appointment of each member will be three years with a renewal of one third of the members every year; replacements must maintain the equitable representation of the six WHO regions and affected countries; all members will be eligible for two appointments. In the event of resignation or incapacity of a member for any reason, the Director-General will appoint a replacement member with a view to maintaining the equitable representation of the six WHO regions and affected countries. The replacement will complete the term of the previous member. The Group will select from among its members, a Chairperson and a Vice-Chairperson. The Chairperson and Vice-Chairperson will serve for two years after which another Chairperson and Vice-Chairperson will be selected by the Group members.

3.3 The Director-General will regularly accept nominations of representatives and will draw from this list to replace outgoing members with a view to maintaining the equitable representation of the six WHO regions and affected countries.

4. Working procedures

4.1 The Director-General will apply to this Advisory Group working procedures consistent with WHO's practices and procedures.

4.2 The Regulations for Expert Advisory Panels and Committees will apply to the Advisory Group, including with respect to the private nature of meetings. Furthermore, members of the Advisory Group will not make public statements, individually or on behalf of the Group, on the work of the Advisory Group, except as authorized in connection with reporting requirements or by the Director-General.

5. Resources for implementation

The Director-General will make available the necessary human and financial resources to support the work of the Advisory Group.

APPENDIX 4

GUIDING PRINCIPLES FOR THE DEVELOPMENT OF TERMS OF REFERENCE FOR CURRENT AND POTENTIAL FUTURE WHO GLOBAL INFLUENZA SURVEILLANCE AND RESPONSE SYSTEM (GISRS) LABORATORIES FOR H5N1 AND OTHER HUMAN PANDEMIC INFLUENZA VIRUSES

The specific roles, responsibilities and activities conducted by the different WHO global influenza surveillance and response system (GISRS) laboratories can differ depending on whether they are a National Influenza Centre, a WHO Collaborating Centre, an H5 Reference Laboratory or an essential regulatory laboratory. However, in the context of pandemic influenza preparedness and their work with H5N1 and other viruses of human pandemic potential, the development of the terms of reference for each group of WHO GISRS laboratories shall comply with the following core guiding principles.

1. All activities conducted by WHO GISRS laboratories under their WHO terms of reference will be consistent with the Framework and the Standard Material Transfer Agreement.*
2. The WHO GISRS laboratories will be coordinated by, and provide support to, WHO.
3. The WHO GISRS laboratories will provide a timely summary report of laboratory analyses and on request any other available information on tests conducted, test results and associated risk assessment and risk response as is specified in their terms of reference.
4. The WHO GISRS laboratories will share experience and provide capacity-strengthening support to WHO Member States within their resources where necessary.
5. The WHO GISRS laboratories will provide support as specified in their terms of reference for the development of potential pandemic vaccine, pandemic vaccine, diagnostic test materials and pharmaceuticals.
6. If WHO GISRS laboratories conduct research on influenza viruses received for public health surveillance purposes, they will do so in a manner that includes participation of scientists, to the fullest extent possible, from the submitting National Influenza Centre or Other authorized laboratory, especially those from developing countries, including through the publication process.
7. The WHO GISRS laboratories will support global public health preparedness and response, especially for urgent situations including international outbreaks and epidemics.
8. The WHO GISRS laboratories will share in a rapid, systematic and timely manner PIP biological materials, using the Influenza Virus Traceability Mechanism as appropriate, including distribution to other qualified laboratories, to facilitate public health risk assessment, risk response activities and scientific research in accordance with the Standard Material Transfer Agreement.*

* Editor's note: the reference to "Standard Material Transfer Agreement" is understood to mean "Standard Material Transfer Agreement 1".

* Editor's note: the reference to "Standard Material Transfer Agreement" is understood to mean "Standard Material Transfer Agreement 1".

9. The WHO GISRS laboratories will submit genetic sequences data to GISAID and Genbank or similar databases in a timely manner consistent with the Standard Material Transfer Agreement.*
10. The originating laboratories which provide the PIP biological materials received by the WHO GISRS laboratories will be given due credit and recognition.

APPENDIX 5

WHO COLLABORATING CENTRES FOR INFLUENZA

**TERMS OF REFERENCE RELATED TO WORK WITH PANDEMIC
INFLUENZA PREPAREDNESS BIOLOGICAL MATERIALS**

BACKGROUND

The WHO global influenza surveillance and response system (GISRS) serves as a global alert mechanism for the emergence of influenza viruses with important features, including those with pandemic potential. For activities related to pandemic influenza, the WHO GISRS includes four complementary categories of institutions and laboratories: National Influenza Centres, WHO Collaborating Centres, WHO H5 Reference Laboratories and Essential Regulatory Laboratories. The WHO GISRS is coordinated by the WHO Global Influenza Programme. Within each category all institutions and laboratories perform functions defined by core terms of reference. The core terms of reference for WHO Collaborating Centres are the minimum requirements that must be met by each WHO Collaborating Centre and the capacity to fulfil these is a prerequisite to designation as a WHO Collaborating Centre. Each laboratory or institution that is formally recognized or designated as a part of WHO GISRS by WHO has accepted to be bound by the core terms of reference applicable to its category. The following are the core terms of reference applicable to the WHO Collaborating Centres.

In addition, individual WHO Collaborating Centres within the WHO GISRS may have additional specific terms of reference, where appropriate. The specific terms of reference recognize that there are differences in expertise, capacities and interests among the WHO Collaborating Centres and provide for individual WHO Collaborating Centres to perform additional functions related to pandemic risk assessment and response. Specific terms of reference will be discussed with and agreed upon between the WHO Collaborating Centre and the WHO Global Influenza Programme before the WHO Collaborating Centre's designation and redesignation.

In general, the WHO Collaborating Centres conduct influenza pandemic risk assessment on an ongoing basis and provide advice, expertise and support to Member States and the Secretariat to facilitate activities in response to influenza risks. The WHO Collaborating Centres support outbreak investigation, conduct comprehensive virus analyses, and select and develop candidate influenza vaccine viruses with pandemic potential. The efficient implementation of pandemic influenza risk assessment and risk response is based on the collective efforts of all WHO GISRS members and through the rapid sharing of biological materials, reference reagents, epidemiologic data and other information.

It is understood that the Guiding Principles, as agreed by the Intergovernmental Meeting and reproduced below, will guide all activities, specific terms of reference or associated functions of the WHO GISRS laboratories when they act in their capacity as a WHO GISRS laboratory. The terms of reference for all WHO GISRS laboratories have been developed under the following overarching Guiding Principles:

Guiding Principles for the development of terms of reference for current and potential future WHO global influenza surveillance and response system (GISRS) laboratories for H5N1 and other human pandemic influenza viruses

1. All activities conducted by WHO GISRS laboratories under their WHO terms of reference will be consistent with the Framework and the Standard Material Transfer Agreement.*
2. The WHO GISRS laboratories will be coordinated by, and provide support to, WHO.
3. The WHO GISRS laboratories will provide a timely summary report of laboratory analyses and on request any other available information on tests conducted, test results and associated risk assessment and risk response as is specified in their terms of reference.
4. The WHO GISRS laboratories will share experience and provide capacity strengthening support to WHO Member States within their resources where necessary.
5. The WHO GISRS laboratories will provide support as specified in their terms of reference for the development of potential pandemic vaccine, pandemic vaccine, diagnostic test materials and pharmaceuticals.
6. If WHO GISRS laboratories conduct research on influenza viruses received for public health surveillance purposes, they will do so in a manner that includes participation of scientists, to the fullest extent possible, from the submitting National Influenza Centre or other authorized laboratory, especially those from developing countries, including through the publication process.
7. The WHO GISRS laboratories will support global public health preparedness and response, especially for urgent situations including international outbreaks and epidemics.
8. The WHO GISRS laboratories will share in a rapid, systematic and timely manner biological materials related to pandemic influenza preparedness, using the Influenza Virus Traceability Mechanism as appropriate, including distribution to other qualified laboratories, to facilitate public health risk assessment, risk response activities and scientific research in accordance with the Standard Material Transfer Agreement.*
9. The WHO GISRS laboratories will submit genetic sequences data to GISAID and Genbank or similar databases in a timely manner consistent with the Standard Material Transfer Agreement.*
10. The originating laboratories which provide the PIP biological materials received by the WHO GISRS laboratories will be given due credit and recognition.

* Editor's note: the reference to "Standard Material Transfer Agreement" is understood to mean "Standard Material Transfer Agreement 1".

Core terms of reference

WHO Collaborating Centres for Influenza are centres of excellence on influenza which are designated by WHO and which agree to the following:

A. General conditions and activities

WHO Collaborating Centres for Influenza:

1. work under the coordination of the WHO Global Influenza Programme, and provide support to WHO (Guiding Principles 2, 7);
2. fulfil the core terms of reference and specific terms of reference using financial support provided only by governmental and/or other non-commercial sources;
3. use the WHO Influenza Virus Traceability Mechanism to record the receipt and transfer of PIP biological materials (Guiding Principle 8);
4. comply with the Standard Material Transfer Agreement* of the Pandemic Influenza Preparedness Framework for sharing of influenza viruses and access to vaccines and other benefits (Guiding Principle 1);
5. maintain the capacity to exchange materials and information on a regular and timely basis with other WHO Collaborating Centres (Guiding Principles 3, 8);
6. have full and unrestricted access to biosafety level 3 laboratory facilities that meet recognized international and national standards. The Provider assumes full responsibility for complying with their respective national biosecurity and biosafety regulations on the understanding that such regulations and rules shall, at a minimum, meet the relevant and current WHO standards;
7. serve as a technical resource to WHO for any other urgent issues related to pandemic influenza or influenza outbreaks with pandemic potential (Guiding Principles 2, 5);
8. appropriately acknowledge the originating laboratories providing clinical specimens and/or influenza viruses with pandemic potential (Guiding Principles 8, 10);
9. maintain and strengthen active communication and collaboration with National Influenza Centres¹ and WHO to ensure that up-to-date information and findings of public health significance are rapidly exchanged (Guiding Principles 3, 4, 7, 8);
10. alert WHO and the country from which clinical specimens and/or viruses with pandemic potential were provided, on unusual findings related to pandemic influenza risk assessment (Guiding Principles 3, 7);

* Editor's note: the reference to "Standard Material Transfer Agreement" is understood to mean "Standard Material Transfer Agreement 1".

¹ WHO-designated National Influenza Centres.

11. provide expertise and laboratory support when requested by WHO, to assist Member States, and in particular developing countries, in responding to outbreaks of influenza viruses with pandemic potential and risk assessment (Guiding Principles 2, 3, 4, 7);
12. provide training and laboratory support to National Influenza Centres, especially those in developing countries, on laboratory techniques and skills, including diagnosis, data analyses, risk assessment and other critical capacities (Guiding Principle 4);
13. assist WHO in improving global surveillance for influenza viruses with pandemic potential (Guiding Principles 2, 7) including the development of standards, recommendations and policies as well as improving associated outbreak response and pandemic preparedness (Guiding Principles 2, 3, 4, 7);
14. provide regular and timely surveillance data and results of virus characterization to originating laboratories and to WHO (Guiding Principle 3, 7);
15. advise the WHO GISRS on laboratory methods for diagnosis of influenza viruses with pandemic potential, including the adoption of new diagnostic approaches, the improvement of laboratory practices and other operational needs (Guiding Principles 2, 3, 5).

B. Laboratory analyses and related activities

WHO Collaborating Centres for Influenza:

1. conduct accurate laboratory diagnosis, typing and subtyping, and confirmation of influenza A(H5) and other influenza viruses with pandemic potential for specimens received (Guiding Principles 2, 3, 7);
2. conduct isolation of influenza viruses with pandemic potential in embryonated eggs and cell culture;
3. conduct detailed antigenic and genetic analyses of influenza viruses with pandemic potential and make the results available to WHO and the originating laboratories in a timely manner (Guiding Principles 2, 3, 4, 7);
4. share available haemagglutinin, neuraminidase and other gene sequences of A(H5) and other influenza viruses with pandemic potential immediately with the originating laboratory, WHO Collaborating Centres and H5 Reference Laboratories (Guiding Principle 3);
5. upload available haemagglutinin, neuraminidase and other gene sequences of A(H5) and other influenza viruses with pandemic potential to a publicly accessible database in a timely manner but no later than three months after sequencing is completed, unless otherwise instructed by the laboratory or country providing the clinical specimens and/or viruses (Guiding Principle 9);
6. produce and distribute ferret antisera against influenza viruses with pandemic potential to WHO laboratories involved in influenza vaccine virus selection and development (Guiding Principle 5);
7. conduct analyses, provide data and advice to WHO and participate in meetings and teleconferences concerning the selection, development and timely availability of candidate vaccine viruses for H5N1 and other influenza viruses with pandemic potential (Guiding Principles 2, 5, 7);

8. participate in the development of candidate influenza vaccine viruses for pandemic influenza preparedness and response (Guiding Principles 5, 7);
9. conduct antiviral susceptibility testing of H5N1 and other influenza viruses with pandemic potential and provide timely reports to the originating laboratories and WHO (Guiding Principle 3);
10. select, maintain and update a group of reference influenza viruses with pandemic potential, including H5N1, and corresponding antisera if available and update the availability of candidate influenza vaccine viruses and corresponding antisera, if any, to WHO (Guiding Principles 2, 3, 5, 7);
11. develop, update and produce laboratory diagnostic reagents for influenza H5N1 and other viruses with pandemic potential directly or through contracted entities, and distribute them to National Influenza Centres subject to the availability of resources (Guiding Principle 5);
12. share in a timely manner clinical specimens and influenza viruses with pandemic potential in accordance with the Standard Material Transfer Agreement* with laboratories working in coordination and collaboration with the WHO Global Influenza Programme, including:
 - (i) other WHO Collaborating Centres (Guiding Principles 1, 8);
 - (ii) essential regulatory laboratories that are involved in the WHO process of candidate influenza vaccine virus selection and development, as well as vaccine potency reagent development (Guiding Principles 1, 8);
 - (iii) other laboratories involved in WHO coordinated specialized activities (e.g. the WHO External quality assessment project for the detection of subtype influenza A viruses using polymerase chain reaction; the WHO influenza polymerase chain reaction primer updating), and other activities whose purpose is to strengthen global influenza surveillance and other risk assessment and risk response; as well as capacity building (Guiding Principles 1, 4, 8);
13. select candidate influenza vaccine viruses under the coordination of WHO, for development and production of vaccines against influenza viruses with pandemic potential. Depending on the vaccine production process, the candidate influenza vaccine viruses can include wild type viruses and high-growth reassortant viruses, including those prepared by reverse genetics. Distribute candidate influenza vaccine viruses to appropriate recipients with appropriate biosafety level capacity on request, including influenza vaccine manufacturers, diagnostic companies, research institutes and others interested in receiving influenza vaccine viruses (Guiding Principles 5, 8);
14. select, maintain and update reference A(H5N1) and other influenza viruses with pandemic potential as antigenically and genetically representative of important groups of viruses. Subject to the availability of resources, distribute both reference viruses and corresponding antisera, on request, to National Influenza Centres and other institutes for non-commercial activities including surveillance, and reference and research (Guiding Principle 10);

* Editor's note: the reference to "Standard Material Transfer Agreement" is understood to mean "Standard Material Transfer Agreement 1".

C. Research and scientific presentations and publications

WHO Collaborating Centres for Influenza:

1. actively seek the participation of scientists from originating laboratories/countries in scientific projects associated with research on clinical specimens and/or influenza viruses from their countries and actively engage them in preparation of manuscripts for presentation and publication (Guiding Principle 6);
2. appropriately acknowledge in presentations and publications, the contributions of collaborators, including laboratories/countries providing clinical specimens or influenza viruses with pandemic potential or reagents, using guidelines such as those outlined by the International Committee of Medical Journal Editors¹ (Guiding Principle 6).

Specific terms of reference

These are additional functions attributed to an individual WHO Collaborating Centre in the light of its specific expertise in the field of influenza.

¹ See <http://www.icmje.org/>.

NATIONAL INFLUENZA CENTRES

TERMS OF REFERENCE RELATED TO WORK WITH PANDEMIC INFLUENZA PREPAREDNESS BIOLOGICAL MATERIALS

BACKGROUND

The WHO global influenza surveillance and response system (GISRS) serves as a global alert mechanism for the emergence of influenza viruses with important features, including those with pandemic potential. For activities related to pandemic influenza, the WHO GISRS includes four complementary categories of institutions and laboratories: National Influenza Centres, WHO Collaborating Centres, WHO H5 Reference Laboratories and Essential Regulatory Laboratories. The WHO GISRS is coordinated by the WHO Global Influenza Programme. Within each category all institutions and laboratories perform functions defined by core terms of reference. Each laboratory or institution that is formally recognized or designated as a part of the WHO GISRS by WHO has accepted to be bound by the core terms of reference applicable to its category. The following are the core terms of reference applicable to the National Influenza Centres.

National Influenza Centres play a key role in pandemic influenza risk assessment by alerting WHO immediately to outbreaks of H5N1 or other influenza viruses with pandemic potential. National Influenza Centres collect specimens from suspected cases of H5N1 or other unusual influenza viral infection, perform laboratory diagnosis and analysis, and ship in a timely manner, such specimens or viruses isolated from them, to a WHO Collaborating Centre or H5 Reference Laboratory for advanced virological analysis. Efficient pandemic influenza risk assessment and risk response are based on collective efforts from all WHO GISRS members through rapid exchange of biological materials, reference reagents, epidemiologic data and other information.

It is understood that the Guiding Principles, as agreed by the Intergovernmental Meeting and reproduced below, will guide all activities, specific terms of reference or associated functions of the WHO GISRS laboratories when they act in their capacity as a WHO GISRS laboratory. The terms of reference for all WHO GISRS laboratories have been developed under the following overarching Guiding Principles:

Guiding Principles for the development of terms of reference for current and potential future WHO global influenza surveillance and response system (GISRS) laboratories for H5N1 and other human pandemic influenza viruses

1. All activities conducted by WHO GISRS laboratories under their WHO terms of reference will be consistent with the Framework and the Standard Material Transfer Agreement.*
2. The WHO GISRS laboratories will be coordinated by, and provide support to, WHO.
3. The WHO GISRS laboratories will provide a timely summary report of laboratory analyses and on request any other available information on tests conducted, test results and associated risk assessment and risk response as is specified in their terms of reference.

* Editor's note: the reference to "Standard Material Transfer Agreement" is understood to mean "Standard Material Transfer Agreement 1".

4. The WHO GISRS laboratories will share experience and provide capacity strengthening support to WHO Member States within their resources where necessary.
5. The WHO GISRS laboratories will provide support as specified in their terms of reference for the development of potential pandemic vaccine, pandemic vaccine, diagnostic test materials and pharmaceuticals.
6. If WHO GISRS laboratories conduct research on influenza viruses received for public health surveillance purposes, they will do so in a manner that includes participation of scientists, to the fullest extent possible, from the submitting National Influenza Centre or other authorized laboratory, especially those from developing countries, including through the publication process.
7. The WHO GISRS laboratories will support global public health preparedness and response, especially for urgent situations including international outbreaks and epidemics.
8. The WHO GISRS laboratories will share in a rapid, systematic and timely manner PIP biological materials, using the Influenza Virus Traceability Mechanism as appropriate, including distribution to other qualified laboratories, to facilitate public health risk assessment, risk response activities and scientific research in accordance with the Standard Material Transfer Agreement.*
9. The WHO GISRS laboratories will submit genetic sequences data to GISAID and Genbank or similar databases in a timely manner consistent with the Standard Material Transfer Agreement.*
10. The originating laboratories which provide the PIP biological materials received by the WHO GISRS laboratories will be given due credit and recognition.

Core terms of reference

National Influenza Centres are laboratories that fulfil the terms of reference listed below. A National Influenza Centre is formally designated by the health ministry of the country concerned and is recognized by WHO. A National Influenza Centre may have additional obligations under the authority of its ministry of health.

A. General conditions and activities

National Influenza Centres:

1. work under the coordination of the WHO Global Influenza Programme and provide support to WHO (Guiding Principles 2, 7);
2. use the WHO Influenza Virus Traceability Mechanism to record the receipt and transfer of PIP biological materials (Guiding Principle 8);

* Editor's note: the reference to "Standard Material Transfer Agreement" is understood to mean "Standard Material Transfer Agreement 1".

3. comply with the Standard Material Transfer Agreement* of the Pandemic Influenza Preparedness Framework for sharing of influenza viruses and access to vaccines and other benefits (Guiding Principle 1);
4. serve as a key point of contact between WHO and the country of the National Influenza Centre on issues related to surveillance, laboratory diagnosis, and sharing of clinical specimens and/or influenza viruses with pandemic potential, as well as sharing of important related clinical or epidemiological information, when available, with WHO (Guiding Principles 2, 3, 4, 7, 8);
5. participate actively in WHO pandemic influenza surveillance activities and maintain active communication and collaboration with other members of the WHO GISRS (Guiding Principles 4, 7, 8).

B. Laboratory and related activities

National Influenza Centres:

1. collect or process as appropriate clinical specimens from patients suspected to be infected with H5N1 and other influenza viruses with pandemic potential (Guiding Principle 7);
2. act as a collection point for virus isolates of suspected pandemic influenza from laboratories within the country;
3. conduct testing of clinical specimens for influenza viruses and detect influenza viruses that cannot be readily identified with diagnostic reagents provided through the WHO GISRS;
4. ship, within one week, clinical specimens and/or viruses that cannot be readily identified with diagnostic reagents provided through the WHO GISRS to a WHO Collaborating Centre or H5 Reference Laboratory of their choice and include the date the specimen was collected and relevant geographical, epidemiological and clinical information (Guiding Principles 2, 3, 5, 7, 8);
5. attend laboratory training courses provided by the WHO Collaborating Centres in an effort to establish and maintain capacity to recognize influenza viruses that cannot be readily identified (Guiding Principle 4);
6. review, maintain and strengthen influenza surveillance in the country (Guiding Principle 2);
7. provide technical advice and support to other influenza laboratories in the country on specimen collection and shipment logistics, laboratory biosafety and other operational procedures related to influenza surveillance (Guiding Principles 2, 7).

C. Information and communication

National Influenza Centres:

1. alert WHO immediately when influenza viruses are detected that cannot be readily identified with diagnostic reagents provided through the WHO GISRS or when unusual outbreaks of non-seasonal influenza or influenza-like illness emerge;

* Editor's note: the reference to "Standard Material Transfer Agreement" is understood to mean "Standard Material Transfer Agreement 1".

2. provide national authorities and the general public with information on H5N1 and other influenza viruses with pandemic potential circulating in the country in a timely manner.

D. Research, scientific presentations and publications

National Influenza Centres:

1. actively seek the participation of scientists from originating laboratories/countries in scientific projects associated with research on clinical specimens and/or influenza viruses from their countries and actively engage them in preparation of manuscripts for presentation and publication (Guiding Principle 6);
2. appropriately acknowledge in presentations and publications, the contributions of collaborators, including laboratories/countries providing clinical specimens or influenza viruses with pandemic potential or reagents, using guidelines such as those outlined by the International Committee of Medical Journal Editors¹ (Guiding Principle 6).

¹ See <http://www.icmje.org/>.

WHO H5 REFERENCE LABORATORIES

TERMS OF REFERENCE RELATED TO WORK WITH PANDEMIC INFLUENZA PREPAREDNESS BIOLOGICAL MATERIALS

BACKGROUND

The WHO global influenza surveillance and response system (GISRS) serves as a global alert mechanism for the emergence of influenza viruses with important features, including those with pandemic potential. For activities related to pandemic influenza, the WHO GISRS includes four complementary categories of institutions and laboratories: National Influenza Centres, WHO Collaborating Centres, WHO H5 Reference Laboratories and Essential Regulatory Laboratories. The WHO GISRS is coordinated by the WHO Global Influenza Programme. Within each category all institutions and laboratories perform functions defined by core terms of reference. The core terms of reference for WHO H5 Reference Laboratories are the minimum requirements that must be met by each WHO H5 Reference Laboratory and the capacity to fulfil these is a prerequisite to designation as a WHO H5 Reference Laboratory. Each laboratory or institution that is formally recognized or designated as a part of the WHO GISRS by WHO has accepted to be bound by the core terms of reference applicable to its category. The following are the core terms of reference applicable to the WHO H5 Reference Laboratories.

WHO H5 Reference Laboratories are laboratories that were designated by WHO on an ad hoc basis commencing in 2005, to support the WHO GISRS in response to the emergence and spread of highly pathogenic avian influenza H5N1. These laboratories conduct influenza risk assessment and response by providing reliable laboratory diagnosis of influenza infection in humans, especially those suspected of being associated with avian influenza A(H5) viruses or other influenza viruses with pandemic potential. Efficient influenza risk assessment and risk response are based on collective efforts from all WHO GISRS members through rapid exchange of biological materials, reference reagents, epidemiologic data and other information.

It is understood that the Guiding Principles, as agreed by the Intergovernmental Meeting and reproduced below, will guide all activities, specific terms of reference or associated functions of the WHO GISRS laboratories when they act in their capacity as a WHO GISRS laboratory. The terms of reference for all WHO GISRS laboratories have been developed under the following overarching Guiding Principles:

Guiding Principles for the development of terms of reference for current and potential future WHO global influenza surveillance and response system (GISRS) laboratories for H5N1 and other human pandemic influenza viruses

1. All activities conducted by WHO GISRS laboratories under their WHO terms of reference will be consistent with the Framework and the Standard Material Transfer Agreement.*
2. The WHO GISRS laboratories will be coordinated by, and provide support to, WHO.

* Editor's note: the reference to "Standard Material Transfer Agreement" is understood to mean "Standard Material Transfer Agreement 1".

3. The WHO GISRS laboratories will provide a timely summary report of laboratory analyses and on request any other available information on tests conducted, test results and associated risk assessment and risk response as is specified in their terms of reference.
4. The WHO GISRS laboratories will share experience and provide capacity strengthening support to WHO Member States within their resources where necessary.
5. The WHO GISRS laboratories will provide support as specified in their terms of reference for the development of potential pandemic vaccine, pandemic vaccine, diagnostic test materials and pharmaceuticals.
6. If WHO GISRS laboratories conduct research on influenza viruses received for public health surveillance purposes, they will do so in a manner that includes participation of scientists, to the fullest extent possible, from the submitting National Influenza Centre or other authorized laboratory, especially those from developing countries, including through the publication process.
7. The WHO GISRS laboratories will support global public health preparedness and response, especially for urgent situations including international outbreaks and epidemics.
8. The WHO GISRS laboratories will share in a rapid, systematic and timely manner PIP biological materials, using the Influenza Virus Traceability Mechanism as appropriate, including distribution to other qualified laboratories, to facilitate public health risk assessment, risk response activities and scientific research in accordance with the Standard Material Transfer Agreement.^{1*}
9. The WHO GISRS laboratories will submit genetic sequences data to GISAID and Genbank or similar databases in a timely manner consistent with the Standard Material Transfer Agreement.*
10. The originating laboratories which provide the PIP biological materials received by the WHO GISRS laboratories will be given due credit and recognition.

Core terms of reference

WHO H5 Reference Laboratories are laboratories which are designated through a defined WHO process, on an ad hoc basis, and which meet the core terms of reference listed below.

A. General conditions and activities

WHO H5 Reference Laboratories:

1. work under the coordination of the WHO Global Influenza Programme; and provide support to WHO (Guiding Principle 2);
2. meet the WHO criteria for accepting positive results of H5 infection in humans;¹
3. use the WHO Influenza Virus Traceability Mechanism to record the receipt and transfer of PIP biological materials (Guiding Principle 8);

* Editor's note: the reference to "Standard Material Transfer Agreement" is understood to mean "Standard Material Transfer Agreement 1".

¹ WHO web site.

4. comply with the Standard Material Transfer Agreement* of the Pandemic Influenza Preparedness Framework for sharing of influenza viruses and access to vaccines and other benefits. (Guiding Principle 1);
5. provide laboratory services to its own country and other countries when needed for diagnosis of influenza A(H5) and other influenza viruses with pandemic potential (Guiding Principles 3, 7);
6. alert WHO and the country that provided clinical specimens and/or viruses with pandemic potential about unusual findings related to pandemic influenza risk assessment (Guiding Principles 3, 7);
7. provide feedback to WHO on the use of WHO recommended diagnostic protocols and primers to assist WHO in updating laboratory diagnostic recommendations (Guiding Principles 2, 3, 4, 5).

B. Laboratory and other activities

WHO H5 Reference Laboratories:

1. provide advice to clinics, hospitals and other specimen collection sites on safe and appropriate clinical specimen collection, storage, packaging and shipping (Guiding Principle 7);
2. conduct accurate laboratory diagnosis, typing and subtyping and confirmation of influenza A(H5) and other influenza viruses with pandemic potential for specimens received and make the results available to WHO Collaborating Centres and the originating laboratories in a timely manner (Guiding Principles 2, 3, 4, 7);
3. provide expertise and laboratory support in response to outbreaks of A(H5) and other influenza viruses with pandemic potential (Guiding Principles 2, 3, 4, 5, 7);
4. routinely share clinical specimens and/or virus isolates from A(H5) and other influenza viruses with pandemic potential with WHO Collaborating Centres for further characterization in accordance with the Standard Material Transfer Agreement* (Guiding Principles 1, 8, 10);
5. share available haemagglutinin, neuraminidase and other gene sequences of A(H5) and other influenza viruses with pandemic potential immediately with the originating laboratory, WHO Collaborating Centres and H5 Reference Laboratories (Guiding Principle 3);
6. upload available haemagglutinin, neuraminidase and other gene sequences of A(H5) and other influenza viruses with pandemic potential to a publicly accessible database in a timely manner, but no later than three months after sequencing is completed, unless otherwise instructed by the laboratory or country providing the clinical specimens and/or viruses (Guiding Principle 9);
7. appropriately acknowledge the originating laboratories providing clinical specimens and/or influenza viruses with pandemic potential (Guiding Principles 8, 10).

* Editor's note: the reference to "Standard Material Transfer Agreement" is understood to mean "Standard Material Transfer Agreement 1".

C. Research, scientific presentations and publications

WHO H5 Reference Laboratories:

1. actively seek the participation of scientists from originating laboratories/countries in scientific projects associated with research on clinical specimens and/or influenza viruses from their countries and actively engage them in preparation of manuscripts for presentation and publication (Guiding Principle 6);
2. appropriately acknowledge in presentations and publications, the contributions of collaborators, including laboratories/countries providing clinical specimens or influenza viruses with pandemic potential or reagents, using guidelines such as those outlined by the International Committee of Medical Journal Editors¹ (Guiding Principle 6).

¹ See <http://www.icmje.org/>.

ESSENTIAL REGULATORY LABORATORIES

TERMS OF REFERENCE RELATED TO WORK WITH PANDEMIC INFLUENZA PREPAREDNESS BIOLOGICAL MATERIALS

BACKGROUND

The WHO global influenza surveillance and response system (GISRS) serves as a global alert mechanism for the emergence of influenza viruses with important features, including those with pandemic potential. For activities related to pandemic influenza, the WHO GISRS includes four complementary categories of institutions and laboratories: National Influenza Centres, WHO Collaborating Centres, WHO H5 Reference Laboratories and Essential Regulatory Laboratories. The WHO GISRS is coordinated by the WHO Global Influenza Programme. Within each category all institutions and laboratories perform functions defined by core terms of reference. The core terms of reference for Essential Regulatory Laboratories are the minimum requirements that must be met by each Essential Regulatory Laboratory and the capacity to fulfil these is a prerequisite to designation as an Essential Regulatory Laboratory. Each laboratory or institution that is formally recognized or designated as a part of the WHO GISRS by WHO has accepted to be bound by the core terms of reference applicable to its category. The following are the core terms of reference applicable to the Essential Regulatory Laboratories.

Essential Regulatory Laboratories are formally associated with national regulatory agencies, and have a critical role in developing, regulating and standardizing influenza vaccines. They have performed this role for nearly four decades within the WHO GISRS, and have thereby contributed to the production of safe and effective influenza vaccines through the selection and development of candidate vaccine viruses. While they previously had no formal terms of reference with WHO, in practice, they worked closely with both WHO and the influenza vaccine manufacturers. Currently there are four Essential Regulatory Laboratories: the Center for Biologics Evaluation and Research, United States of America; the National Institute for Biological Standards and Control, United Kingdom of Great Britain and Northern Ireland; the National Institute for Infectious Diseases, Japan, and the Therapeutic Goods Administration, Australia.

The core terms of reference are the minimum requirements that must be met by each Essential Regulatory Laboratory, either individually or as a group. Specific terms of reference may be discussed with and agreed upon by the Essential Regulatory Laboratory, the WHO Global Influenza Programme and, in some cases, industry before recognition.

It is understood that the Guiding Principles, as agreed by the Intergovernmental Meeting and reproduced below, will guide all activities, specific terms of reference or associated functions of the WHO GISRS laboratories when they act in their capacity as a WHO GISRS laboratory. The terms of reference for all WHO GISRS laboratories have been developed under the following overarching Guiding Principles:

Guiding Principles for the development of terms of reference for current and potential future WHO GISRS laboratories for H5N1 and other human pandemic influenza viruses

1. All activities conducted by WHO GISRS laboratories under their WHO terms of reference will be consistent with the Framework and the Standard Material Transfer Agreement.*
2. The WHO GISRS laboratories will be coordinated by, and provide support to, WHO.
3. The WHO GISRS laboratories will provide a timely summary report of laboratory analyses and on request any other available information on tests conducted, test results and associated risk assessment and risk response as is specified in their terms of reference.
4. The WHO GISRS laboratories will share experience and provide capacity strengthening support to WHO Member States within their resources where necessary.
5. The WHO GISRS laboratories will provide support as specified in their terms of reference for the development of potential pandemic vaccine, pandemic vaccine, diagnostic test materials and pharmaceuticals.
6. If WHO GISRS laboratories conduct research on influenza viruses received for public health surveillance purposes, they will do so in a manner that includes participation of scientists, to the fullest extent possible, from the submitting National Influenza Centre or other authorized laboratory, especially those from developing countries, including through the publication process.
7. The WHO GISRS laboratories will support global public health preparedness and response, especially for urgent situations including international outbreaks and epidemics.
8. The WHO GISRS laboratories will share in a rapid, systematic and timely manner PIP biological materials, using the Influenza Virus Traceability Mechanism as appropriate, including distribution to other qualified laboratories, to facilitate public health risk assessment, risk response activities and scientific research in accordance with the Standard Material Transfer Agreement.*
9. The WHO GISRS laboratories will submit genetic sequences data to GISAID and Genbank or similar databases in a timely manner consistent with the Standard Material Transfer Agreement.*
10. The originating laboratories which provide the PIP biological materials received by the WHO GISRS laboratories will be given due credit and recognition.

Core terms of reference

Essential Regulatory Laboratories meet the following core terms of reference listed below, either individually or as a group:

* Editor's note: the reference to "Standard Material Transfer Agreement" is understood to mean "Standard Material Transfer Agreement 1".

A. General conditions and activities

Essential Regulatory Laboratories:

1. advise WHO on the selection of H5N1 and other influenza viruses with pandemic potential for use in influenza vaccines (Guiding Principles 2, 3, 5);
2. assist WHO and Member States in developing vaccine-related aspects of preparedness and response plans for pandemic influenza (Guiding Principles 2, 3, 4, 7);
3. advise WHO on relevant regulatory and development aspects of vaccines for H5N1 and other influenza viruses with pandemic potential (Guiding Principles 2, 3, 5);
4. when requested, inform and advise WHO on work programmes and new technologies aimed at improving development and standardization of vaccines for H5N1 and other influenza viruses with pandemic potential (Guiding Principles 2, 3, 4, 5);
5. use the WHO Influenza Virus Traceability Mechanism to record the receipt and transfer of PIP biological materials (Guiding Principles 8);
6. comply with the Standard Material Transfer Agreement* of the Pandemic Influenza Preparedness Framework for sharing of influenza viruses and access to vaccines and other benefits (Guiding Principle 1).

B. Laboratory and related activities

Essential Regulatory Laboratories:

1. store, and, if required, amplify representative H5N1 and other influenza viruses with pandemic potential obtained from the WHO GISRS for the purpose of developing influenza vaccine viruses (Guiding Principles 1, 2);
2. on request by WHO, develop candidate H5N1 and other influenza vaccine viruses with pandemic potential and characterize them using agreed standards (Guiding Principles 1, 2, 3, 5, 6);
3. store, and, if required, amplify candidate H5N1 and other influenza vaccine viruses with pandemic potential obtained from the WHO GISRS (Guiding Principles 1, 2, 3, 5);
4. prepare and calibrate reference reagents for standardization of candidate influenza vaccine viruses for H5N1 and other influenza viruses with pandemic potential in conjunction with other Essential Regulatory Laboratories (Guiding Principles 1, 2, 5);
5. distribute, subject to the Standard Material Transfer Agreement,* candidate influenza vaccine viruses for H5N1 and other influenza viruses with pandemic potential to interested laboratories, including laboratories within the WHO GISRS and influenza vaccine manufacturers (Guiding Principles 1, 2, 5);

* Editor's note: the reference to "Standard Material Transfer Agreement" is understood to mean "Standard Material Transfer Agreement 1".

6. directly or through contractors, supply reference reagents for standardization of H5N1 and other potential pandemic influenza vaccines to laboratories, such as laboratories within the WHO GISRS, national regulatory laboratories and influenza vaccine manufacturers (Guiding Principles 1, 2, 5);

7. analyse, provide data and advice to WHO and participate in meetings and teleconferences concerning the selection, development and timely availability of candidate vaccine viruses for H5N1 and other influenza viruses with pandemic potential (Guiding Principles 2, 5, 7).

C. Research and scientific presentations and publications

Essential Regulatory Laboratories:

1. actively seek the participation of scientists from originating laboratories/countries in scientific projects associated with research on clinical specimens and/or influenza viruses from their countries and actively engage them in preparation of manuscripts for presentation and publication (Guiding Principle 6);

2. appropriately acknowledge in presentations and publications, the contributions of collaborators, including laboratories/countries providing clinical specimens or influenza viruses with pandemic potential or reagents, using guidelines such as those outlined by the International Committee of Medical Journal Editors¹ (Guiding Principle 6).

¹ See <http://www.icmje.org/>.

ANNEX 3

First Global Ministerial Conference on Healthy Lifestyles and Noncommunicable Disease Control Moscow, 28–29 April 2011

MOSCOW DECLARATION¹

PREAMBLE

We, the participants in the First Global Ministerial Conference on Healthy Lifestyles and Noncommunicable Disease (NCD) Control, gathered in Moscow on 28–29 April 2011.

I.

Express appreciation for the leading role of the World Health Organization and the Government of the Russian Federation in the preparation and holding of the Ministerial Conference.

II.

Recognize that the right of everyone to the enjoyment of the highest attainable standards of physical and mental health cannot be achieved without greater measures at global and national levels to prevent and control NCDs.

III.

Acknowledge the existence of significant inequities in the burden of NCDs and in access to NCD prevention and control, both between countries, as well as within countries.

IV.

Note that policies that address the behavioural, social, economic and environmental factors associated with NCDs should be rapidly and fully implemented to ensure the most effective responses to these diseases, while increasing the quality of life and health equity.

V.

Emphasize that prevention and control of NCDs requires leadership at all levels, and a wide range of multi-level, multi-sectoral measures aimed at the full spectrum of NCD determinants (from individual-level to structural) to create the necessary conditions for leading healthy lives. This includes promoting and supporting healthy lifestyles and choices, relevant legislation and policies; preventing and detecting disease at the earliest possible moment to minimize suffering and reduce costs; and providing patients with the best possible integrated health care throughout the life cycle including empowerment, rehabilitation and palliation.

¹ See resolution WHA64.11.

VI.

Recognize that a paradigm shift is imperative in dealing with NCD challenges, as NCDs are caused not only by biomedical factors, but also caused or strongly influenced by behavioural, environmental, social and economic factors.

VII.

Affirm our commitment to addressing the challenges posed by NCDs, including, as appropriate, strengthened and reoriented policies and programmes that emphasize multi-sectoral action on the behavioural, environmental, social and economic factors.

VIII.

Express our belief that NCDs should be considered in partnerships for health; that they should be integrated into health and other sectors' planning and programming in a coordinated manner, particularly in low- and middle-income countries; that they should be part of the global research agenda and that the impact and sustainability of approaches to prevent and control NCDs will be enhanced through health systems strengthening and strategic coordination with existing global health programs.

RATIONALE FOR ACTION

1. NCDs, principally cardiovascular diseases, diabetes, cancers and chronic respiratory diseases, are the leading causes of preventable morbidity and disability, and currently cause over 60% of global deaths, 80% of which occur in developing countries. By 2030, NCDs are estimated to contribute to 75% of global deaths.
2. In addition, other NCDs such as mental disorders also significantly contribute to the global disease burden.
3. NCDs have substantial negative impacts on human development and may impede progress towards the Millennium Development Goals (MDGs).
4. NCDs now impact significantly on all levels of health services, health care costs, and the health workforce, as well as national productivity in both emerging and established economies.
5. Worldwide, NCDs are important causes of premature death, striking hard among the most vulnerable and poorest populations. Globally they impact on the lives of billions of people and can have devastating financial impacts that impoverish individuals and their families, especially in low- and middle-income countries.
6. NCDs can affect women and men differently, hence prevention and control of NCDs should take gender into account.
7. Many countries are now facing extraordinary challenges from the double burden of disease: communicable diseases and noncommunicable diseases. This requires adapting health systems and health policies, and a shift from disease-centred to people-centred approaches and population health measures. Vertical initiatives are insufficient to meet complex population needs, so integrated solutions that engage a range of disciplines and sectors are needed. Strengthening health systems in this way results in improved capacity to respond to a range of diseases and conditions.

8. Evidence-based and cost-effective interventions exist to prevent and control NCDs at global, regional, national and local levels. These interventions could have profound health, social, and economic benefits throughout the world.
9. Examples of cost-effective interventions to reduce the risk of NCDs, which are affordable in low-income countries and could prevent millions of premature deaths every year, include measures to control tobacco use, reduce salt intake and reduce the harmful use of alcohol.
10. Particular attention should be paid to the promotion of healthy diets (low consumption of saturated fats, trans fats, salt and sugar, and high consumption of fruits and vegetables) and physical activity in all aspects of daily living.
11. Effective NCD prevention and control require leadership and concerted “whole of government” action at all levels (national, sub-national and local) and across a number of sectors, such as health, education, energy, agriculture, sports, transport and urban planning, environment, labour, industry and trade, finance and economic development.
12. Effective NCD prevention and control require the active and informed participation and leadership of individuals, families and communities, civil society organizations, private sector where appropriate, employers, health care providers and the international community.

COMMITMENT TO ACTION

We, therefore, commit to act by:

At the Whole of Government level:

1. Developing multi-sectoral public policies that create equitable health promoting environments that enable individuals, families and communities to make healthy choices and lead healthy lives;
2. Strengthening policy coherence to maximize positive and minimize negative impacts on NCD risk factors and the burden resulting from policies of other sectors;
3. Giving priority to NCD prevention and control according to need, ensuring complementarity with other health objectives and mainstreaming multi-sectoral policies to strengthen the engagement of other sectors;
4. Engaging civil society to harness its particular capacities for NCD prevention and control;
5. Engaging the private sector in order to strengthen its contribution to NCD prevention and control according to international and national NCD priorities;
6. Developing and strengthening the ability of health systems to coordinate, implement, monitor and evaluate national and sub-national strategies and programmes on NCDs;
7. Implementing population-wide health promotion and disease prevention strategies, complemented by individual interventions, according to national priorities. These should be equitable and sustainable and take into account gender, cultural and community perspectives in order to reduce health inequities;

8. Implementing cost-effective policies, such as fiscal policies, regulations and other measures to reduce common risk factors such as tobacco use, unhealthy diet, physical inactivity and the harmful use of alcohol;
9. Accelerating implementation by States Parties of the provisions of the WHO Framework Convention on Tobacco Control (WHO FCTC) and encouraging other countries to ratify the Convention;
10. Implementing effective policies for NCD prevention and control at national and global levels, including those relevant to achieving the goals of the 2008–2013 Action Plan for the Global Strategy for the Prevention and Control of Noncommunicable Diseases, the WHO Global Strategy to Reduce the Harmful Use of Alcohol and the Global Strategy on Diet, Physical Activity and Health;
11. Promoting recognition of the rising incidence and burden of NCDs on national as well as international development agendas, and encouraging countries and international development partners to consider the level of priority accorded to NCDs.

At Ministry of Health level:

1. Strengthening health information systems to monitor the evolving burden of NCDs, their risk factors, their determinants and the impact and effectiveness of health promotion, prevention and control policies and other interventions;
2. According to national priorities, strengthening public health systems at the country level to scale up evidence-based health promotion and NCD prevention strategies and actions;
3. Integrating NCD-related services into primary health care services through health systems strengthening, according to capacities and priorities;
4. Promoting access to comprehensive and cost-effective prevention, treatment and care for integrated management of NCDs, including access to affordable, safe, effective and high quality medicines based on needs and resource assessments;
5. According to country-led prioritization, ensuring the scaling-up of effective, evidence-based and cost-effective interventions that demonstrate the potential to treat individuals with NCDs, protect those at high risk of developing them and reduce risk across populations.
6. Promoting, translating and disseminating research to identify the causes of NCDs, effective approaches for NCD prevention and control, and strategies appropriate to distinct cultural and health care settings.

At the International level:

1. Calling upon the World Health Organization, as the lead UN specialized agency for health, and all other relevant UN system agencies, development banks, and other key international organizations to work together in a coordinated manner to address NCDs;
2. Working through WHO in consultation with other multilateral organizations, international nongovernmental organizations, the private sector and civil society stakeholders to strengthen normative guidance, pool technical expertise, coordinate policy to achieve the best possible results and capitalize on synergies among existing global health initiatives.

-
3. Strengthening international support for the full and effective implementation of the WHO FCTC, the Action Plan for the Global Strategy for the Prevention and Control of Noncommunicable Diseases, the WHO Global Strategy to Reduce the Harmful Use of Alcohol, the Global Strategy on Diet, Physical Activity and Health and other relevant international strategies to address NCDs.
 4. Investigating all possible means to identify and mobilize the necessary financial, human and technical resources in ways that do not undermine other health objectives.
 5. Supporting the WHO in developing a comprehensive global monitoring framework on NCDs.
 6. Examining possible means to continue facilitating the access of low- and middle-income countries to affordable, safe, effective and high quality medicines in this area consistent with the WHO Model Lists of Essential Medicines, based on needs and resource assessments, including by implementing the WHO Global Strategy and Plan of Action on Public Health, Innovation and Intellectual Property.

WAY FORWARD

With a view to securing an ambitious and sustainable outcome, we commit to actively engaging with all relevant sectors of Government, on the basis of this Moscow Declaration, in the preparation of and the follow-up to the United Nations General Assembly High-level Meeting on the Prevention and Control of Non-communicable Diseases in New York.

ANNEX 4

Global health sector strategy on HIV/AIDS, 2011–2015¹

[A64/15, Annex – 28 April 2011]

1. INTRODUCTION

1. The global health sector strategy on HIV/AIDS, 2011–2015 guides the health sector response to human immunodeficiency virus (HIV) epidemics in order to achieve universal access to HIV prevention, diagnosis, treatment, care and support.² The strategy:

- reaffirms **global goals and targets** for the health sector response to HIV
- identifies **four strategic directions to guide national responses**
- outlines **recommended country actions and WHO's contributions within each strategic direction.**

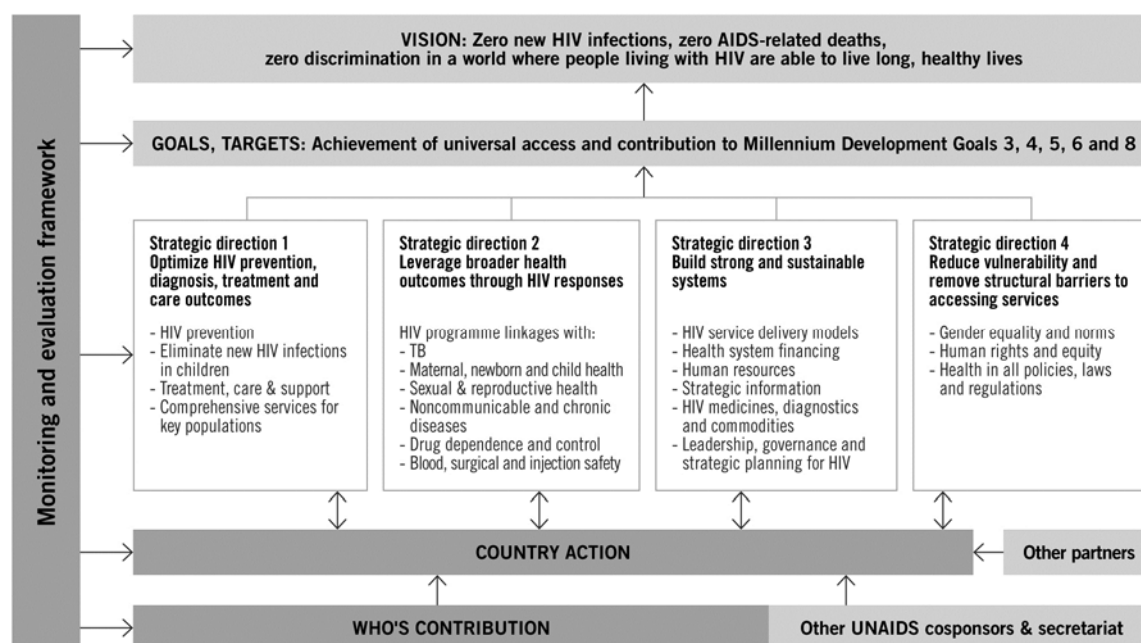
2. The strategy was elaborated in order to define the health sector's contribution to the broader, multisectoral response to HIV outlined in the UNAIDS strategy for 2011–2015.³ Implementation of the strategy will be supported by the WHO Secretariat, in collaboration with UNAIDS and other UNAIDS cosponsors. Collaboration in relevant policy and technical areas is identified, based on the division of labour proposed by UNAIDS.

3. The strategy promotes a long-term, sustainable HIV response through strengthening health and community systems, tackling the social determinants of health that both drive the epidemic and hinder the response, and protecting and promoting human rights and promoting gender equity as essential elements of the health sector response. It strengthens integration between HIV and other health services, improving both impact and efficiency. It calls on the world to build on the collaboration, innovation and investment that have forged hard-won progress to date, establishing the foundation for success over the next five years. Figure 1 depicts the elements of the strategy schematically.

¹ See resolution WHA64.14.

² The health sector encompasses organized public and private health services, health ministries, nongovernmental organizations, community groups and professional associations, as well as institutions that directly input into the health-care system.

³ *Getting to Zero: UNAIDS Strategy 2011–2015*, Geneva, UNAIDS, 2010.

Figure 1 Summary of the global health sector strategy on HIV/AIDS, 2011–2015

1.1 Context and rationale

4. The past 10 years have seen unprecedented commitments to global health and development, beginning in 2000 with the commitments in the United Nations Millennium Declaration that became known as the Millennium Development Goals with their corresponding set of time-bound targets. At the 2001 United Nations General Assembly Special Session on HIV/AIDS, United Nations Member States made pledges for a comprehensive response to HIV in the Declaration of Commitment on HIV/AIDS, and expanded those commitments in the Political Declaration on HIV/AIDS adopted in 2006, including a commitment to achieve universal access to HIV prevention, treatment, care and support for all in need. A rapid expansion in HIV services and dedicated AIDS financing paralleled these developments, with commitments rising from US\$ 1600 million in 2001 to US\$ 15 900 million in 2009, including substantial financing from the United States' President's Emergency Plan for AIDS Relief, the Global Fund to Fight AIDS, Tuberculosis and Malaria, and other bilateral, multilateral and domestic sources. The results have been remarkable:

- the number of new HIV infections globally declined 19% over the past decade. In 15 high burden countries HIV prevalence declined more than 25% among young people aged 15–24 years. These declines are largely attributable to expanded, improved HIV programmes
- access to antiretroviral therapy in low- and middle-income countries increased from only 400 000 people receiving such therapy in 2003 to 5.25 million by the end of 2009 (comprising 35% of those estimated to be in need)
- AIDS-related deaths dropped by 19% globally over the period 2004 to 2009 alone
- significant reductions in the price of first-line antiretroviral medicines mean that low-income countries can provide a year of antiretroviral therapy at a median cost of US\$ 137 per person
- 53% of pregnant women living with HIV had access to antiretroviral medicines to prevent transmission of HIV to their infants, up from 45% in 2008.

5. **Challenges for the global response to HIV.** This progress, however, is fragile and unevenly distributed. HIV incidence is increasing in some countries and regions, and too many new infections are still occurring: 2.6 million in 2009 alone, contributing to the current global prevalence of 33.3 million.¹ Although much reduced from their peak in 1999, new infections continue to outpace the number of people placed on treatment. Most people in need still do not have access to antiretroviral therapy, and demand is growing.

6. Sub-Saharan Africa accounts for 68% of the global prevalence of HIV, with diverse, generalized HIV epidemics that disproportionately affect women and young people (particularly young women). Women now account for almost 52% of global adult prevalence (60% of prevalence in sub-Saharan Africa), with gender inequity and harmful social norms helping drive transmission. This region will require intensified efforts in HIV prevention, treatment, care and support in order to reverse the spread of HIV and treat all those in need, with a stronger focus on the needs of women, girls and other vulnerable populations.² Even though young people (aged 15–24 years) are making important contributions to reducing HIV incidence, their access to priority HIV interventions, including sexual and reproductive health services and education during formative adolescent years, varies widely among countries.

7. HIV infection rates are increasing in several countries in eastern Europe and central Asia, which have expanding, concentrated epidemics, notably among people who inject drugs and their sexual networks.

8. National HIV responses are too often poorly targeted to the national epidemiological situation, and the HIV interventions delivered in many settings are of poor quality and do not adequately focus on vulnerable and most-at-risk populations³ in both generalized and concentrated epidemic settings. Although variations in prevalence and epidemiological patterns within countries and regions require different priorities and interventions, all national HIV plans should incorporate service delivery to these populations in order to ensure the effectiveness of national HIV responses. In addition those national plans need to incorporate measures to overcome structural barriers that undermine access to quality services.⁴

9. WHO's advocacy will emphasize the additional health sector investments required to achieve the Millennium Development Goals and targets and the goal of universal access. Although the current global economic climate is threatening both domestic and overseas development assistance, new directions and opportunities for attaining universal access are emerging: combination prevention; the Treatment 2.0 platform; eliminating new HIV infections among children; and the emerging scientific and programmatic evidence guiding the development of new, more effective approaches to HIV. The 2011 United Nations General Assembly High Level Meeting on AIDS (scheduled to be held in New York, 8–10 June 2011) will review progress made towards achieving global HIV goals and targets and will chart the future course of the HIV response. The strategy outlines the health sector

¹ *Global report: UNAIDS report on the global AIDS epidemic 2010*. Geneva, UNAIDS, 2010.

² Vulnerability to HIV is defined within the strategy as the extent to which individuals or specific populations are able to control their risk of acquiring HIV, such as agency in sexual decision-making, lack of knowledge about HIV, lack of access to male or female condoms, and other factors that affect HIV transmission.

³ Most-at-risk populations are defined within the strategy as men who have sex with men, transgender people, people who inject drugs, sex workers and prisoners.

⁴ Structural barriers are systemic barriers (social, cultural and legal) to access faced by key populations that deter them from accessing HIV services and reduce the effectiveness of services. Example of such structural barriers are police harassment and violence towards certain populations, and discriminatory policies, practices and attitudes in health services. Structural interventions aim to remove these barriers.

contribution to this response and is designed to be sufficiently flexible to incorporate decisions from that meeting.

10. ***The need for coordinated health sector action on HIV.*** Evidence and experience to date provide a compelling rationale for a new global health sector strategy on HIV. The WHO strategy is designed to meet the complex challenges of a dynamic epidemic in a rapidly evolving stage of global health actors. WHO's work on HIV has been guided by a series of broad-based strategies and initiatives, including the Global health-sector strategy on HIV/AIDS 2003–2007, the “3 by 5” initiative, and the WHO 2006–2010 plan for universal access. The evaluation of and experience from this work highlight the value of a strong WHO presence – and guiding framework – in supporting national efforts and building on progress made. This strategy builds on that work, outlining a robust, evidence-based guide for the health sector response to HIV from 2011 to 2015.

1.2 Contribution to the UNAIDS strategy for 2011–2015 and global health sector strategies

11. Ensuring alignment and coordination with the UNAIDS strategy for 2011–2015, *Getting to Zero*, is a cornerstone of WHO's strategy. The UNAIDS strategy provides the multisectoral framework for the response of the 10 cosponsors and secretariat to the HIV pandemic. Although the health sector is central to the HIV response, it must collaborate with other sectors in order to tackle the social, economic, cultural and environmental issues that shape the epidemic and access to health services. The WHO strategy outlines core components of WHO's contribution to UNAIDS' three strategic directions, namely:

- revolutionize HIV prevention (see Section 3.1 and 3.2)
- catalyse the next phase of treatment, care and support (see Section 3.3 and 3.4)
- advance human rights and gender equality for the HIV response (see Section 6.1 and 6.2).

12. In addition to setting the agenda for HIV programmes the WHO strategy aims to maximize the synergies between HIV and other health programmes in order to achieve the health-related Millennium Development Goals. It is closely aligned with other global health strategies and plans, including those for tuberculosis, reproductive health, sexually transmitted infections, maternal, newborn and child health, and public health and innovation (see Appendix); it also contributes to broader public health and development priorities, including health system strengthening and the social determinants of health. Recent progress indicates that universal access is achievable in a range of epidemiological and resource contexts. Continuing the momentum towards this goal is imperative, and the health sector has a central role in achieving success in the global response to HIV.

2. GLOBAL VISION, GOALS, TARGETS AND STRATEGIC DIRECTIONS

2.1 Global vision

13. Zero new HIV infections, zero AIDS-related deaths and zero discrimination in a world where people living with HIV are able to live long, healthy lives.

2.2 Global goals and targets

14. The two overarching goals of the strategy are:

- to achieve universal access to comprehensive HIV prevention, treatment and care

- to contribute to achieving Millennium Development Goal 6 (Combat HIV/AIDS, malaria and other diseases) and other health-related Goals (3, 4, 5 and 8) and associated targets.

15. The four targets for 2015, aimed at accelerating progress towards the strategy's goals, are:

- **reduce new infections:** reduce by 50% the percentage of young people aged 15–24 years who are infected (compared with a 2009 baseline)
- **eliminate new HIV infections in children:** reduce new HIV infections in children by 90% (compared with a 2009 baseline)
- **reduce HIV-related mortality:** reduce HIV-related deaths by 25% (compared with a 2009 baseline)
- **reduce tuberculosis-related mortality:** reduce tuberculosis deaths by 50% (compared with a 2004 baseline).

2.3 Strategic directions

16. The health sector response to HIV should follow four mutually-supportive strategic directions, outlined below with their objectives. These are aimed at achieving the above targets and goals over the five years of the strategy. Each content area is subdivided into recommended country action and WHO's contribution to support that action.

17. **Strategic direction 1: Optimize HIV prevention, diagnosis, treatment and care outcomes.** Integrate and improve the quality, effectiveness and coverage of HIV-specific interventions and approaches, and identify new HIV interventions as evidence emerges.

18. **Strategic direction 2: Leverage broader health outcomes through HIV responses.** Strengthen linkages and synergies between HIV and other related health programmes, notably for sexual and reproductive health, maternal, newborn and child health, tuberculosis, drug dependence and harm reduction, emergency and surgical care and nutrition.

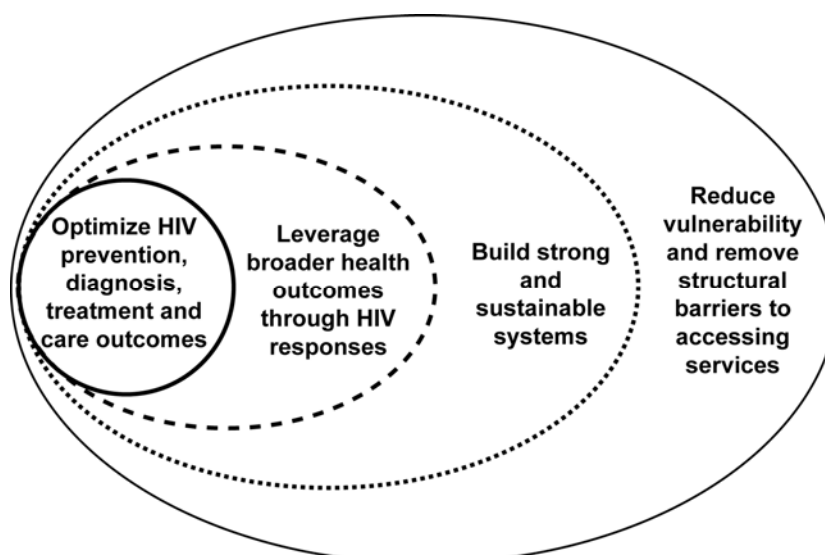
19. **Strategic direction 3: Build strong and sustainable systems.** Build effective, efficient and comprehensive health systems in which HIV and other essential services are available, accessible, affordable and sustainable.

20. **Strategic direction 4: Reduce vulnerability and remove structural barriers to accessing services.** The health sector must reduce risk and vulnerability by removing structural barriers to achieving equitable access to HIV services and protecting and promoting the human rights of key populations.¹

21. These four strategic directions are elaborated in detail in the following sections. Their relationship to each other is depicted in Figure 2. They are designed to collectively achieve the shared vision and goals of both the WHO and UNAIDS strategies on HIV/AIDS for 2011–2015.

¹ Key populations are defined within the strategy to include both vulnerable and most-at-risk populations. They are important to the dynamics of HIV transmission in a given setting and are essential partners in an effective response to the epidemic.

Figure 2 Relationship between the four strategic directions



2.4 “Know your epidemic, know your response”

22. **“Know your epidemic”.** Given the widely differing characteristics of the epidemics between countries and regions, national responses must be guided by the most current strategic information on the nature of the HIV epidemic and the country context. Knowing the epidemic thus includes understanding where, how and among whom new infections are occurring. It also requires identifying the social, legal and economic conditions that increase the risk of HIV transmission and limit access to HIV information and services. National responses must take into consideration:

- the preparedness, infrastructure and capacity of the health system or health systems
- whether the current response meets the needs of those most vulnerable to and at risk of HIV infection
- community and stakeholders’ contributions
- how to reach marginalized and remote populations and provide services in settings of humanitarian concern.

23. Even though surveillance systems have improved considerably since the start of the epidemic, it is clear that many countries still have weak health-information systems. Epidemiological information on populations at highest risk of HIV infection (for example, men who have sex with men, transgender people, sex workers, prisoners and people who inject drugs) is often limited or of poor quality. This problem is compounded by the absence of strong national health-information and vital-registration systems. Building stronger data collection systems for HIV surveillance and other health information is essential to understanding the epidemic and informing national HIV responses. Ensuring civil society’s participation in the development and implementation of these systems is crucial for ensuring that data gathering and analysis are robust and ethical.

24. **“Know your response”.** The national health sector response to HIV should be guided by a national strategic planning process that reviews, plans and prioritizes specific interventions and service delivery models that best meet national health needs. HIV programme information (including monitoring and evaluation data) must be linked to broader health-information systems in order to

ensure that robust, current and accurate information is gathered on national responses to HIV, including the populations accessing services, how services are delivered (for instance, through health facilities, community-based services or other delivery models) and HIV intervention availability and coverage for vulnerable and at-risk populations. WHO, UNICEF and UNAIDS have developed standardized tools to support country-level data collection, which is vital for establishing accurate information on national AIDS responses and global level reporting.

3. STRATEGIC DIRECTION 1: OPTIMIZE HIV PREVENTION, DIAGNOSIS, TREATMENT AND CARE OUTCOMES

25. Expanding coverage and improving the quality of HIV prevention, diagnosis, treatment and care interventions are required to achieve global goals and targets. HIV incidence is falling in many countries, but is increasing in others. National HIV responses must target high-quality, evidence-based HIV-specific prevention interventions to where transmission is actually occurring, and focus efforts on key populations underserved by current HIV programmes. Section 3.1 below on the prevention revolution outlines how the health sector can capitalize on recent advances in reducing infections through combining and targeting preventive interventions for maximum impact. Improved integration of HIV and non-HIV health services, radical decentralization of service delivery, and improvements in medicines, diagnostics and other components of HIV treatment and care will also be crucial for accelerating progress towards national and global targets.

26. Recent population-based health surveys suggest that less than 40% of people living with HIV know their HIV status. Providing accessible, quality-assured testing, counselling and referral services to relevant populations and removing HIV-related stigmatization and discrimination are essential for improving knowledge of serostatus.¹ Strategic direction 1 has four core elements:

- revolutionize HIV prevention
- eliminate HIV infections in children
- catalyse the next phase of diagnosis, treatment, care and support
- provide comprehensive, integrated services for key populations.

3.1 Revolutionize HIV prevention

27. Combining behavioural, biomedical and structural HIV preventive interventions, tailored to national epidemics, is the most effective approach to reducing new infections and improving service coverage among key populations. Such combined interventions tackle both behavioural and social drivers of the epidemics. Despite evidence of the effectiveness of this approach, few countries have extensively scaled up combined interventions. Combined approaches, such as behavioural change counselling (including that for couples), access to antiretroviral therapy and removing structural barriers to health services (such as stigmatization and discrimination), must be expanded more broadly and consistently.

¹ Testing and counselling must be voluntary, confidential and ensure that the human rights of clients are protected and promoted, regardless of setting or testing modality.

3.1.1 Recommended country action

28. **Prevent sexual transmission of HIV.** Interventions to reduce sexual transmission include behaviour change counselling, male and female condom programming, early initiation of antiretroviral therapy, safe male circumcision (in high HIV-prevalence settings), post-exposure prophylaxis, and quality-assured HIV testing and counselling of serodiscordant couples. Specific combination prevention packages for key populations are outlined in Section 3.3.

29. **Eliminate HIV transmission in health-care settings.** Health services should implement comprehensive infection-control strategies and procedures, including standard precautions, injection and surgical safety, blood safety, safe waste disposal and post-exposure prophylaxis for occupational exposure to HIV.

3.1.2 WHO's contribution

30. **Expand existing HIV prevention interventions.** WHO will develop an evidence-based HIV prevention package for the health sector and support its implementation at the national level. The design of the prevention package will reflect the findings of a review of behavioural interventions and advice on how they can best be combined with other interventions in a range of health settings. WHO will provide guidance on delivering combined prevention activities in generalized epidemics, including optimal approaches for key populations, such as women, girls and young people. It will also advocate the application of existing guidance in concentrated epidemics and update normative guidance as new evidence emerges.

31. **Drive the development of new HIV prevention interventions and approaches.** WHO will support the evaluation of potentially effective new interventions and approaches, including microbicides, pre-exposure prophylaxis and antiretroviral therapy as prevention, and provide guidance to countries on implementation as results become available. WHO will continue to support HIV vaccine development efforts through the WHO/UNAIDS HIV Vaccine Initiative. WHO will formulate guidance and associated operational advice on preventing HIV transmission in serodiscordant couples.

3.2 Eliminate new HIV infections in children

32. The number of HIV infections among children has fallen significantly as a result of expanded programmes to prevent mother-to-child transmission of HIV, from 500 000 in 2001 to 370 000 in 2009. As a result UNAIDS has called for the virtual elimination of new HIV infections in children by 2015, a feasible goal if comprehensive programmes to prevent such transmission are expanded and integrated with maternal, newborn and child health, sexual and reproductive health, and other health services, such as HIV treatment and care programmes.

3.2.1 Recommended country action

33. **Eliminate new HIV infections in children.** Expand comprehensive approaches to preventing mother-to-child transmission of HIV, including setting national targets to eliminate HIV in children using national prevention and treatment protocols. Key components include preventing HIV infection in women of child-bearing age, preventing unintended pregnancies among women living with HIV, reducing HIV transmission from women living with HIV to their infants, and providing appropriate early treatment and care for women living with HIV, their children and families.

3.2.2. WHO's contribution

34. **Work jointly with UNICEF to support eliminating new HIV infections in children.** This collaboration includes support for the United Nations Secretary-General's Global Strategy for Women's and Children's Health, and realizing WHO's strategic vision for prevention of mother-to-child transmission of HIV. WHO and UNICEF will provide technical guidance and support for the rapid expansion of integrated and comprehensive services for prevention of mother-to-child transmission of HIV and will monitor progress towards achieving a world free of new HIV infections in children. Core activities include:

- promoting provider-initiated HIV testing and counselling, re-testing, and counselling of couples in antenatal, maternal, newborn and child health services
- supporting the implementation and evaluation of WHO's guidelines issued in 2010 on: the use of antiretroviral medicines to treat pregnant women; the use of antiretroviral medicines to prevent HIV infection in infants; and HIV and infant feeding
- conducting evidence-based reviews to determine whether this guidance needs updating
- supporting an operational research agenda to guide more effective and efficient implementation of comprehensive programmes to eliminate new HIV infections in children.

3.3 Catalyse the next phase of HIV diagnosis, treatment, care and support

35. Global declines in HIV-related morbidity and mortality reflect the enormous progress made in HIV services over the past decade. Nevertheless, HIV prevalence and the demand on HIV diagnosis, treatment and care services continue to increase. Given the resource-constrained environment it will be more important than ever to select the appropriate interventions and service-delivery approach. Client-initiated and provider-initiated testing and counselling programmes that are quality assured must be extended in order to enable people to know their serostatus and to direct individuals to relevant prevention, care, treatment and support services.

36. Treatment 2.0 is the initiative launched by UNAIDS and WHO in order to catalyse the second phase of care and treatment scale-up. It aims to simplify high-quality treatment and improve the efficiency and effectiveness of treatment and care delivery, transforming the response of programmes from an emergency phase to long-term sustainability. WHO coordinates the work on HIV treatment and care and HIV/tuberculosis among UNAIDS' cosponsors, and will work with UNAIDS and global and country partners to implement the initiative.

3.3.1. Recommended country action

37. **Rapidly expand access to diversified HIV testing and counselling services.** HIV testing must be voluntary, confidential and accompanied by appropriate counselling, whether initiated by the client or the provider. Accelerated uptake of rights-based testing and counselling services for adults and children is required for prevention and early diagnosis and referral (as required) to care and treatment programmes and to support safe disclosure of HIV status. Tailoring counselling and testing services for specific populations at high risk of HIV infection may be needed in order to improve uptake and ensure retention in care.

38. **Expand and optimize HIV treatment and care for children, adolescents and adults.** Countries should update their national HIV treatment protocols on the basis of global guidelines and prepare implementation plans in order to ensure continuity of treatment between old and new treatment

regimens. Antiretroviral therapy should be started early (for everyone with CD4⁺ cell counts of $\leq 350/\text{mm}^3$) so as to reduce HIV-related morbidity and mortality and maximize the preventive impact on HIV and tuberculosis epidemics. Treatment should include the simplest, most tolerable and robust drug regimens recommended by WHO guidelines and simplified point-of-care and laboratory-based diagnostics and monitoring tools being developed through the Treatment 2.0 initiative. Nutritional care and support should be provided to enhance treatment effectiveness and adherence, retention in care and quality of life.

39. ***Reduce coinfections and co-morbidities among people living with HIV.*** Treatment and care programmes should include prophylaxis (including immunization), diagnosis and treatment of common opportunistic infections and co-morbidities. Particularly important is diagnosis and treatment of pneumonia, diarrhoea, malaria, viral hepatitis, malnutrition and other clinical conditions that are more serious for people living with HIV. HIV services should also screen for common malignancies, and assess, prevent and manage mental disorders. Attention should be given to addressing the needs of people living with HIV over the age of 50 years.

40. ***Decrease the burden of tuberculosis for people living with HIV.*** Countries should integrate “the Three I’s” into services for people living with HIV, namely: intensified case finding for active tuberculosis in people living with HIV; isoniazid preventive therapy in individuals with latent tuberculosis to prevent progression to active disease; and infection control in order to minimize transmission of tuberculosis.

41. ***Provide comprehensive care and support for people living with HIV.*** HIV-related palliative, community and home-based care should include a multidisciplinary approach to identify, assess and treat pain and meet other physical, psychosocial and spiritual needs of people living with HIV. Provision of opioid medicines, and training in their use, should be available in health facilities and in the community in order to manage pain and provide appropriate end-of-life care. Strengthening community-care systems, including the capacity of community and home-based carers, is essential for the delivery of integrated, decentralized services, expanding national HIV responses and improving health outcomes.

42. ***Make all components of “Positive health, dignity and prevention” available to people living with HIV.*** This resource¹ is designed to meet the specific health needs of people living with HIV. These include equitable access to clean water, sanitation and a full range of rights-based health promotion and health-care services, including sexual and reproductive health and HIV prevention counselling.

3.3.2. WHO’s contribution

43. ***Support improved uptake of HIV testing and counselling and linkages to care.*** WHO will assess the effectiveness of various HIV testing and counselling models and provide guidance on:

- training health-care workers to expand the delivery of diverse, rights-based HIV testing and counselling services, with a focus on improving linkages to other HIV services
- HIV testing and counselling of couples in order to reduce HIV transmission among serodiscordant couples

¹ UNAIDS, Global Network of People Living with HIV. *Positive health, dignity and prevention. Technical consultation report, 27–28 April 2009, Hammamet, Tunisia.* Amsterdam, The Netherlands, The Global Network of People Living with HIV (GNP+), 2009.

- the application of updated HIV testing algorithms and recommendations for selecting and using HIV diagnostics
- setting targets and improving the quality and coverage of HIV testing and counselling services.

44. ***Support expanded, optimized diagnosis, treatment and care through Treatment 2.0.*** WHO will support the implementation and monitoring of the Treatment 2.0 initiative, which includes the following five core areas of work:

- optimizing treatment regimens (including fixed-dose combinations, paediatric formulations and co-packaging of first- and second-line antiretroviral medicines)
- developing and making available standardized, quality-assured diagnostic and monitoring tools for use at the point of care
- delivering radically decentralized, integrated HIV services
- reducing costs
- mobilizing communities in the design and implementation of diagnosis, treatment and care programmes.

45. WHO will collaborate with UNAIDS to coordinate and monitor progress of the Treatment 2.0 initiative with global and country partners as the next phase of support to national HIV programmes. In addition to HIV diagnostics, Treatment 2.0 will include evaluating a package of affordable, accessible tuberculosis and viral hepatitis diagnostics for use in a range of health-care settings.

46. Pharmacovigilance will be incorporated as a standard of care into antiretroviral therapy programmes, along with standardized tools for monitoring and preventing drug resistance. WHO will also develop guidance on the choice of technology, their suitability in resource-constrained settings, and quality-control mechanisms.

47. ***Provide guidance and tools for diagnosis, treatment and care for children with HIV.*** WHO will provide guidance on early diagnosis of HIV infection in infants and rapid access to care and treatment, including nutritional support, of HIV-exposed infants, children and adolescents, focusing on provider-initiated testing and counselling in clinical settings. Guidance will be also be developed on ways to improve the quality of service delivery for children in order to ensure retention in care.

48. ***Strengthen tools to prevent and manage HIV/tuberculosis coinfection.*** WHO will promote expanded integration between HIV and tuberculosis services through the 12-point Interim policy on collaborative TB/HIV activities.¹ Key actions include:

- producing clinical guidelines and supporting implementation of operational tools for tuberculosis prevention and treatment within HIV health services, including application of “the Three I’s”
- promoting co-packaging, co-formulation and use of isoniazid/trimethoprim-sulfamethoxazole combinations to prevent tuberculosis in people living with HIV

¹ Document WHO/HTM/TB/2004.330.

- leading the development of a robust research agenda on HIV/tuberculosis coinfection, including improved surveillance of HIV and tuberculosis
- supporting joint reviews of HIV/tuberculosis planning and programmes.

49. ***Prevent, diagnose and manage other HIV-related coinfections and co-morbidities.*** WHO will develop new clinical guidelines to prevent, diagnose and manage the most serious HIV-related coinfections and co-morbidities in adults and children, including chronic viral hepatitis. WHO will promote non-discriminatory access to diagnostic and treatment services for hepatitis B and C, and advocate hepatitis B vaccination.

3.4 Provide comprehensive, integrated services for key populations

50. Recent country progress reports on key populations vulnerable to and at high risk of HIV infection indicate that many of these populations still have poor access to a comprehensive set of evidence-based HIV interventions, resulting in continued transmission of HIV. The available data from 2009 reveal that:

- young people (aged 15–24 years) account for 40% of new adult infections and need better, more consistent access to prevention, diagnosis and treatment services
- among young people living with HIV, about 80% live in sub-Saharan Africa and about two-thirds are female
- coverage of harm-reduction programmes is limited; out of 92 reporting countries, only 36 countries had needle and syringe programmes and 33 offered opioid substitution therapy
- a median of 57% of men who have sex with men were reached with prevention programmes, out of 21 reporting countries
- a median of 58% of sex workers had access to HIV prevention programmes, out of 38 reporting countries.

51. Expanding access to key populations will need integrating HIV services with other relevant health and social services, overcoming structural barriers to service access, such as stigmatization, discrimination and intimate partner violence, and tailoring HIV services to the needs of these populations.

3.4.1 Recommended country action

52. ***Implement a comprehensive package of interventions to meet the needs of vulnerable populations.*** Each country should identify populations vulnerable to HIV or underserved by current HIV programmes in both generalized and concentrated epidemics. The needs of young people and women should explicitly be addressed in national HIV responses. Particular attention should be given to expanding comprehensive combination HIV prevention programmes in communities with generalized epidemics. Policy-makers and programme managers should also consider the needs of migrant workers, refugees or displaced populations, street children, indigenous people, disabled people, prisoners, most-at-risk youth and people older than 50 years of age. Considerations of how best to deliver HIV interventions to these populations include cost, venue location and operating schedule, service-delivery methods and the structural interventions needed to reduce vulnerability.

53. **Ensure access to comprehensive services for sex workers, men who have sex with men and transgender people.** National HIV strategies, policies and programmes should meet the needs of sex workers, men who have sex with men and transgender people in both generalized and concentrated epidemics, including strategies to reduce stigmatization and discrimination in health-care settings and improve access to health services. Community-based organizations and peer networks should be involved in the planning and delivery of these services to improve the quality and effectiveness of HIV services.

54. **Provide harm-reduction services for people who use drugs.** National HIV strategies, policies and programmes in both concentrated and generalized epidemics should meet the needs of people who use drugs. A comprehensive package of services should be provided that – in addition to tailored HIV prevention, treatment and care interventions – includes: needle and syringe programmes; opioid substitution therapy and other drug-dependence treatment; prevention and treatment of sexually transmitted infections; condom programming; diagnosis and treatment of viral hepatitis and tuberculosis; and structural interventions to improve access to services.¹

55. **Reduce HIV risk and vulnerability in settings of humanitarian concern.** Contingency plans for essential HIV services should be part of national HIV plans in order to ensure continuity of HIV treatment and care in settings of humanitarian concern, including buffer stocks of essential medicines and commodities (including antiretroviral medicines, condoms, diagnostic assays, opioid analgesics and sterile injecting supplies). Training should be provided to essential emergency and health-service staff, based on the Inter-Agency Standing Committee Task Force on HIV/AIDS in Emergency Settings's Guidelines for HIV/AIDS interventions. Policies and interventions for reducing HIV-related stigmatization and discrimination within humanitarian health-care services should be implemented.

3.4.2 WHO's contribution

56. **Develop and promote combination prevention packages for key populations.** WHO will define health sector combination HIV prevention packages for key populations in different epidemic types and settings. WHO will collaborate with UNESCO, UNICEF and UNFPA to design a package for HIV prevention among young people. WHO will advocate evidence-based education on sex and sexuality for adolescents and their access to sexual and reproductive health services. It will collaborate with the United Nations Office on Drugs and Crime in elaborating a comprehensive health-sector package for prisoners and prison settings and, with UNHCR on implementing interventions in the Minimum Initial Service Package for Reproductive Health in Crisis Situations.

57. **Support expansion of services for sex workers and men who have sex with men.** WHO will work with UNDP and UNFPA and members of these at-risk populations to implement its guidance on intervention packages for sex workers, men who have sex with men and transgender people. Service packages will include promotion of male and female condoms, behavioural change interventions, diagnosis and treatment of sexually transmitted infections and HIV care and treatment. WHO will provide guidance to countries on setting targets for services tailored to these populations.

58. **Promote a comprehensive harm-reduction package for people who use drugs.** WHO, in collaboration with the United Nations Office on Drugs and Crime, will continue to support implementation of evidence-based harm-reduction interventions for people who inject drugs (including the needs of women who use drugs), and identify interventions and approaches for:

¹ WHO/UNODC/UNAIDS technical guide for countries to set targets for universal access to HIV prevention, treatment and care for injecting drug users, 2009.

- effectively preventing HIV infection in people who use amphetamine-type stimulants and cocaine and in non-injecting drug users
- reducing risk behaviours associated with alcohol use
- preventing and managing overdose.

4. STRATEGIC DIRECTION 2: LEVERAGE BROADER HEALTH OUTCOMES THROUGH HIV RESPONSES

59. Optimizing programme links between HIV and other key health areas is crucial for leveraging broader health outcomes. Such links are also important to ensure that HIV responses benefit from investments in other related health areas. HIV infection accounts for 6% of maternal mortality worldwide, with a recent study indicating that that figure may be as high as 18%. Globally, less than a third of children under 15 years of age in need are receiving antiretroviral therapy, reflecting a lack of integration between HIV services and maternal, newborn and child health services. HIV is closely linked with a wide range of other health issues, such as sexually transmitted infections, broader sexual and reproductive health, drug dependence, tuberculosis and blood safety. These links must be reflected in the delivery of health services in order to optimize investments in a range of health areas.

60. Early diagnosis and treatment of HIV in tuberculosis patients are compromised by low rates of HIV testing and counselling in tuberculosis services; in 2009, only 26% of notified tuberculosis cases knew their HIV status. Increasing numbers of drug users living with HIV are receiving antiretroviral therapy but dying of complications from hepatitis C or of drug overdoses. Young people must have access to education on sex and sexuality to ensure they have comprehensive, correct knowledge about HIV; currently it remains low. The safety of the blood supply remains a significant concern; only 48% of blood donations in low-income countries underwent quality-assured screening in 2009. HIV transmission in health-care settings will remain a major risk without adequate investment in blood-screening services, injection and surgical safety and other occupational health measures.

4.1 Strengthen links between HIV programmes and other health areas

61. Linking programmes and integrating HIV into other health services have the potential to improve the efficiency and effectiveness of both HIV-specific and broader health investments: expanded coverage of good antenatal care services supports efforts to reduce mother-to-child transmission of HIV, and effective HIV programmes reduce tuberculosis incidence and mortality.

62. Collaboration between HIV and other health programmes should facilitate programme coordination and align programme targets, ensure coherence across guidelines, and coordinate referral between services and managing human resources. Major health-system components should be aligned, including procurement and supply-management systems, laboratory services, and monitoring and evaluation.

4.1.1. Recommended country action

63. **Strengthen HIV/tuberculosis collaborative activities.** Countries should implement mechanisms for intensified collaboration and joint planning between HIV and tuberculosis programmes (outlined in Section 3.3). Joint policies, training programmes and standard operating procedures should be developed and put in place in order to prevent and manage HIV/tuberculosis coinfection. Surveillance of HIV infection among tuberculosis patients and tuberculosis prevalence among people living with HIV should be conducted, and monitoring and evaluation systems should be harmonized. Quality-assured HIV testing and counselling should be conducted among tuberculosis patients, and HIV

prophylaxis provided to presumptive tuberculosis cases as well as tuberculosis patients. Trimethoprim-sulfamethoxazole prophylaxis and antiretroviral therapy should be provided for tuberculosis patients living with HIV.

64. ***Strengthen linkages between HIV and maternal, newborn and child health services.*** HIV services should be integrated within a package of core interventions for maternal, newborn and child health that includes: high-quality antenatal, perinatal and postnatal services; prevention, screening and care for malaria and tuberculosis; syphilis screening and care; skilled birth attendance backed by emergency obstetric care; and newborn and child care, infant feeding support, immunization and family-centred nutritional care and support. HIV diagnostic and care services should be promoted for children within integrated packages such as WHO's Integrated Management of Childhood Illness.

65. ***Address sexual and reproductive health and rights.*** HIV prevention, testing and counselling services should be integrated into sexual and reproductive health services. Access to sexual and reproductive health services is essential for preventing unwanted pregnancies, primary HIV prevention and preventing HIV infections in children. Health services must pay particular attention to key populations and people living with HIV, including particular services for: prevention, diagnosis and treatment of sexually transmitted infections; family planning, including condom programming for dual protection and post-abortion care; cervical cancer screening and care; and survivors of sexual assault and gender-based violence, including emergency contraception, counselling and post-exposure prophylaxis. HIV-specific services should promote and deliver, as appropriate, family planning and broader sexual and reproductive health services, including the sexual and reproductive rights of people living with HIV.¹

66. ***Integrate HIV interventions into drug use prevention, treatment and control programmes.*** The nature, scope and consequences of drug use in the community should be assessed in order to guide the development and implementation of health services tailored for people who use drugs. A comprehensive package of harm-reduction services (see Strategic direction 1) should be integrated into drug prevention, treatment, rehabilitation, detoxification and control programmes, whether they be delivered by the health sector and by other sectors.

67. ***Strengthen the management of both HIV and noncommunicable and chronic diseases.*** Lessons learnt from HIV programme expansion should be applied in order to strengthen models of managing noncommunicable diseases, for example: mobilizing affected populations and the broader community in advocacy and service delivery; promoting multisectoral approaches to disease prevention, diagnosis and treatment; and decentralizing services. Noncommunicable disease programmes should cover common health complications of people living with HIV, including conditions associated with ageing, oral health, poor nutrition and sanitation, mental health disorders and long-term antiretroviral therapy. Access to potable water, sanitation and hygiene facilities are vital to the health of people living with HIV. Links between HIV and cancer programmes and services should be strengthened.

68. ***Link HIV and blood and injection safety programmes.*** Comprehensive programmes should be implemented to prevent HIV transmission in health-care settings. Programmes should promote improved blood and organ-donor selection, blood and tissue screening, voluntary non-remunerated blood donation, the rational use of blood and surgical procedures, and the implementation of safe injection practices. Counselling for blood donors and their families should be provided as an entry

¹ Sexual and reproductive health rights for people living with HIV are an essential component of Positive Health, Dignity and Prevention.

point for the treatment and care of donors who test positive for infections, thus minimizing further transmission. Safe blood transfusion for HIV-positive individuals should be ensured.

4.1.2. WHO's contribution

69. **Support strengthened collaboration between HIV and tuberculosis programmes.** WHO will advocate for more collaboration between HIV and tuberculosis programmes and the provision of integrated HIV and tuberculosis services. WHO will support implementation in countries of the 12 points of the Interim policy on collaborative TB/HIV activities with new or updated operational and clinical tools to guide management of tuberculosis and HIV coinfection. Guidance will be provided on the joint management of tuberculosis and HIV for specific populations and settings, including links with harm reduction and prison health programmes. WHO will support national HIV/tuberculosis programme reviews.

70. **Support the integration of HIV services with those for maternal, newborn and child health and sexual and reproductive health.** WHO will promote stronger linkages between HIV programmes and services and those for sexual and reproductive health and maternal and child health (including those outlined in Section 3.1.1), and develop (or update) the necessary guidance and tools. WHO will also develop and promote standardized and simplified operational tools for supporting decentralization and integration of these services at the primary care level, including community-based services.¹ WHO will support countries in assessing their policies, systems, and service delivery approaches related to integrating sexual and reproductive health and HIV, reviewing findings and drafting plans to strengthen these linkages and integrate them into national health and development plans.

71. **Support linkages between HIV programmes and services and those for drug control.** WHO will work closely with the United Nations Office on Drugs and Crime to strengthen collaboration between HIV programmes and those on drug dependence and drug control. Using public health evidence, WHO will advocate a rights-based approach to HIV prevention, diagnosis, treatment and care within drug prevention, treatment, rehabilitation and control programmes. HIV issues will be integrated into WHO's normative guidance and operational tools on preventing and managing drug dependence, as well as its guidance on the management of other health issues among people who use drugs, such as tuberculosis, mental health, viral hepatitis, sexually transmitted infections, overdose prevention, and maternal and child health.

72. **Promote linkages between HIV programmes and other priority health programmes.** WHO will advocate strengthening the links between HIV programmes and other priority health programmes relevant to HIV responses, including mental health, blood transfusion, emergency and surgical care, occupational health, water sanitation, cancer control and other noncommunicable diseases.

5. STRATEGIC DIRECTION 3: BUILD STRONG AND SUSTAINABLE SYSTEMS

73. HIV programmes have helped to strengthen national health systems by attracting new financing for health, building health system capacity (e.g. through improved monitoring and surveillance) and integrating chronic disease management in many resource-limited settings. However, more must be done to ensure that HIV-related investments translate into broad-based health systems and strengthening of community systems. An expanded HIV response must accelerate progress on building effective, efficient and comprehensive health systems in which HIV and other essential services are available, accessible and affordable, within which the increasingly vital role of community

¹ These tools include those for the Integrated Management of Pregnancy and Childbirth and Integrated Management of Childhood Illness.

based services is recognized and supported. Recent evidence demonstrates the consequences of weak health systems:

- 38% of low- and middle-income countries experienced stock-outs of antiretroviral medicines in health facilities at least once in 2009, highlighting weak procurement and supply management systems
- access to affordable HIV-related medicines may be hampered by failure to use the flexibilities built into the World Trade Organization Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS Agreement), limited availability of some generic medicines and formulations, weak price negotiation capacity in procurement systems, and high duties and taxes
- task-shifting approaches have helped to reduce the shortage of health workers in many countries, but ensuring quality, safety and motivation of those workers remains a challenge
- introducing new regimens for antiretroviral therapy, together with the need to monitor HIV drug resistance and toxicity, places additional demands on clinical and laboratory services.

5.1 Strengthen the six building blocks of health systems

74. National HIV responses can further strengthen the six building blocks of health systems:

- effective service delivery
- a well-trained, sufficiently-staffed workforce
- a robust health-information system
- access to essential medical products and technologies
- adequate health financing
- strong leadership and governance.

5.1.1. Recommended country action

75. The following elements are essential for ensuring synergies between national HIV programmes, strengthening each of the above health-system building blocks (including community-based components), and maximizing programme performance and related health outcomes.

76. **Adapt service delivery models.** Appropriate models of cost-effective service delivery that produce good health outcomes need to be selected (or adjusted) to meet the needs of populations at risk of HIV infection and people living with HIV (outlined in Section 3.1), with a strong focus on expanding access and improving the quality of HIV services through integrated, decentralized approaches. Community-based systems have a vital role to play in planning and implementing HIV services, particularly those for key populations. As national HIV responses shift significant services towards the community level, it is essential that community-based service-delivery providers be involved in planning so as to ensure strong links and coordination between formal and informal health-care settings. HIV services need to be quality assured through external and internal quality-management systems, irrespective of the health-delivery setting.

77. **Mobilize financing for health and strengthen social protection systems.** Mobilizing adequate financing from domestic or foreign donors for health, social protection and community systems will be the key to continuing the expansion of HIV services and keeping pace with increased demand. Funding should be channelled in ways that strengthen domestic means of health financing, based on national health priorities, and that ensure efficiency gains wherever possible. Health financing should minimize out-of-pocket expenditures, cover health services at the point of care, and reduce other financial barriers to accessing HIV services. Improving health equity in access to services can be supported by focusing on access in rural areas, and poor, vulnerable and most-at-risk populations.

78. **Strengthen human resources for health.** Training, recruitment and task-shifting strategies should be implemented to strengthen health workforce capacity. Countries should adhere to the WHO Global Code of Practice on the International Recruitment of Health Personnel¹ and ethical guidelines that minimize the migration of health workers from low-income to high-income countries, and from the public health sector to private and nongovernmental sectors.

79. In all settings, health workers must be competent to work with people living with HIV and affected populations by integrating HIV content into pre- and in-service training. The risk of health workers acquiring HIV in the workplace should be prevented with comprehensive occupational health and safety procedures (see Strategic direction 1), and guaranteed compensation for occupationally acquired illness. Policies and practices should be followed in order to ensure safe and supportive workplace environments for health-care workers and the ethical treatment of health-care workers living with HIV, including access to treatment and care. People living with HIV and community lay workers play vital roles in delivering HIV services and training health workers; their knowledge and skills can be supplemented through certification of skills in service delivery, and pay.

80. **Improve strategic health information systems.** Information systems in HIV programmes should be strengthened through integration and harmonization with broader national health information systems, including (to the extent possible) electronic information systems. Surveillance systems should provide routine, standardized data with consistent methods, tools and populations surveyed and move towards integration with the Country Health Systems Surveillance platform developed by WHO. National HIV programmes should collaborate with other stakeholders to design, implement and strengthen national monitoring and evaluation systems using WHO's guidance and tools. The monitoring and evaluation system should include:

- tools and processes for generating, analysing and reporting on interventions for HIV prevention, diagnosis, treatment and care, including outcome and impact measures that will enable progress made towards universal access goals and targets to be reported
- a national patient-monitoring system that supports the collection of core data such as patient retention and disease progression
- a national strategy for prevention and assessment of HIV drug resistance
- a national pharmacovigilance programme that includes antiretroviral medicines.

81. Support should be provided for operational research and greater collaboration between researchers and policy-makers to ensure that research findings are translated into practice. Research capacity can be increased through collaboration among national partners, donors, and between research organizations and networks.

¹ Resolution WHA63.16.

82. **Ensure access to medicines, diagnostics and other commodities.** Countries should secure continued access to affordable medicines, diagnostics and other commodities needed for the HIV response. National policies should be established to enable rapid regulatory approval of new and generic medicines and diagnostics and expedite their marketing approval. In order to contain costs, an open, competitive market should be fostered for these commodities, including (as needed) the use of the flexibilities available under the World Trade Organization Agreement on Trade-Related Aspects of Intellectual Property Rights, patent pooling and voluntary licence agreements between patent holders and generic manufacturers. The Medicines Patent Pool is a means to enhance availability and facilitate the development of new fixed-dose combinations and adapted formulations, such as paediatric formulations, through voluntary licence agreements. Supply-management systems for health commodities must be strengthened in order to improve the ability of those systems to distribute commodities to all service-delivery points.

83. Planning and coordination of the procurement, deployment, maintenance and quality assurance of point-of-care and laboratory-based technologies should be elements of national HIV responses. Laboratory systems must ensure reliability and accuracy in the technologies and platforms used to diagnose and monitor HIV infection and associated co-morbidities, monitor the immunological and virological aspects of HIV infection, monitor treatment including HIV drug resistance, and perform basic investigations for haematology and chemistry. Quality-management systems (including staff training tailored for laboratory and health workers based in formal or informal health settings) should be implemented.

84. **Strengthen leadership, governance and strategic planning.** Strategic partnerships should be forged among health sector service providers (including the public sector, civil society and the private sector) and with other sectors to develop and implement national HIV responses. Ensuring synergy and coherence between the HIV response, other health programmes and the multisectoral plan for HIV is crucial. Inclusive policy dialogue within and beyond the health sector should be fostered in order to ensure universal coverage, social justice and equity in national responses to HIV.

5.1.2 WHO's contribution

85. **Promote efficiencies in service delivery.** WHO will provide normative guidance on models of integrated, decentralized HIV service delivery for different epidemic types, based on review and evaluation of available evidence, including outlining the role of community-based health services. WHO will further streamline the integrated management tools in order to provide a simplified, efficient approach to service delivery.¹ It will support strengthening community systems which hold the key to improving the quality, efficiency and coverage of HIV services. It will strengthen civil society involvement in its policy development and implementation, such as Treatment 2.0 and the elimination of new HIV infections in children.

86. **Support efforts to finance the HIV response fully.** WHO will work with UNAIDS to estimate the investments needed to achieve global HIV goals. It will advocate a fully-funded response through domestic and foreign aid investments. WHO will develop and help to implement tools for costing national health sector plans and services. Support will be provided to develop national health-financing plans that incorporate HIV programmes, and for operational research on innovative, sustainable health-financing mechanisms. WHO will work with funding and development partners to improve development assistance and technical support. WHO will provide technical support to help

¹ These tools include the Integrated Management of Adolescent and Adult Illness, Integrated Management of Childhood Illness, Integrated Management of Pregnancy and Childbirth and Integrated Management for Emergency and Essential Surgical Care.

countries to mobilize and implement external funding, including financing from the Global Fund to Fight AIDS, Tuberculosis and Malaria.

87. ***Support efforts to strengthen health workforces.*** WHO will provide policy and technical guidance aimed at building an expanded, well-trained health workforce that incorporates community-based services to meet the health needs of communities. It will formulate, in partnership with countries and civil society organizations, evidence-based recommendations on expanding medical and nursing education and improving access to health workers (including community and lay workers) in underserved areas. Countries will be supported to build capacity for collecting and analysing data on the health workforce. Policy development will link to different sectors, including education, labour and finance, in order to ensure a coordinated, sustainable approach to strengthening the health workforce. WHO will draw on work to date with ILO, the United States' President's Emergency Plan for AIDS Relief and other partners to refine strategies on strengthening health workforce training, task-shifting, retention of health workers, and education.

88. ***Support improvements in strategic health information.*** WHO will provide guidance and support for improved collection, analysis and use of data in the health sector. WHO will support implementation of national longitudinal, interlinked patient-monitoring systems, including electronic formats, for HIV, HIV/tuberculosis coinfection, and other priority health sector interventions. Particular attention will be paid to supporting patient retention, data quality and quality of care. WHO will monitor and report annually on health sector progress towards universal access and the impact of HIV interventions on health-related Millennium Development Goals.

89. ***Shape the research agenda and stimulate the generation, translation and dissemination of knowledge.*** WHO will advocate adequate investment in HIV research and development and, with partners, set a global research agenda for the health sector response to HIV. It will promote the generation and application of new knowledge, with particular emphases on national ownership, improving the effectiveness of interventions and programmes, and promoting innovation. WHO will drive the research agenda on HIV treatment and preventive interventions based on antiretroviral medicines through the main work areas of the Treatment 2.0 platform (see Section 3.3.2).

90. ***Support increased access to affordable medicines, diagnostics and other commodities.*** WHO will support strategies for lower pricing and improved procurement of HIV-related medicines and commodities. Support will be provided to improve the procurement of HIV-related medicines, diagnostics and other commodities by disseminating information on medicines and diagnostics through the AIDS Medicines and Diagnostics Service, and promoting pooled procurement mechanisms and other measures to improve supply-chain management and reduce the risk of stocks running out of antiretroviral medicines and other health commodities. WHO will contribute to improved market transparency and a sustainable supply of HIV-related commodities by monitoring prices and forecasting demand. The selection for procurement of HIV-related commodities will be improved through prequalification and timely inclusion in the WHO Model List of Essential Medicines and the International Pharmacopoeia monographs. WHO will provide support to countries in delivering an uninterrupted supply of HIV-related commodities through technical assistance, capacity building and training in the effective use of tools for procurement and supply management.

91. WHO will also provide support and normative guidance on accessing simplified, quality-assured point-of-care and laboratory-based diagnostics and monitoring tools as part of the Treatment 2.0 initiative. Guidance and technical support will be provided to facilitate procurement and deployment of laboratory and point-of-care technologies and technical assistance to bolster national laboratory strategic planning, capacity building and implementation of quality assurance mechanisms. WHO will promote efforts for integrated and harmonized laboratory strengthening for HIV, tuberculosis, malaria and other important health issues, through such mechanisms as the Global Laboratory Initiative.

92. **Support national strategic planning and reviews.** WHO will collaborate with UNAIDS and the World Bank to ensure that the health sector is adequately resourced in multisectoral planning for the HIV response and that HIV is adequately included in other health sector planning. WHO will support reviews of national HIV plans, with particular attention to seeking synergy in the health system and to the efficient use of resources. WHO will further develop tools to guide national strategic planning processes and HIV programme reviews designed to improve health service management.

6. STRATEGIC DIRECTION 4: REDUCE VULNERABILITY AND REMOVE STRUCTURAL BARRIERS TO ACCESSING SERVICES

93. The health sector plays an essential role in reducing HIV vulnerability, reducing HIV-related stigmatization and discrimination, and removing structural barriers to accessing HIV services. The HIV response has been a public health trailblazer in promoting human rights, mobilizing communities, contributing to health equity and addressing social determinants of health. Removing gender-based health inequities and protecting the rights of people living with HIV and key populations are crucial steps to achieving universal access goals and health-related Millennium Development Goal targets. Gender-based health inequities and human rights protections for women, girls and key populations have not been adequately dealt with in national HIV responses to date. The most recent country progress reports indicate the following:

- less than half the countries have a budget for HIV-related programmes that aim at women and girls
- 67% of countries have laws, policies or regulations that posed obstacles to effective HIV service provision for key populations
- The People Living with HIV Stigma Index (results from 10 countries) indicates high rates of physical and verbal abuse experienced by people living with HIV, among which a significant proportion (from 12% to 88%) were denied access to health services.

94. Not only must specific interventions be implemented in the health sector, but policies and programmes in other sectors must be revised to reduce gender-based inequities and ensure human rights protections for key populations. The health sector also has an important role to play in providing evidence on the links between gender equity, human rights, the social determinants of health, and HIV. These elements should be covered in the design, implementation and monitoring of health sector interventions. Key elements are:

- promote gender equality and remove harmful gender norms
- advance human rights and promote health equity
- ensure health in all policies, laws and regulations.

6.1 Promote gender equality and remove harmful gender norms

95. National HIV responses can significantly reduce gender-based vulnerability to HIV infection in their communities (such as intimate partner violence) and gender-based inequities in access to health services. Health sector policies and programmes should empower women and girls to reduce their vulnerability to HIV, challenge harmful gender norms, and contribute to gender equality. Gender-based differential access to health interventions, such as antiretroviral therapy, should be addressed in HIV programming, and boys and men included in behavioural and structural interventions aimed at reducing gender inequality.

6.1.1 Recommended country action

96. **Collect gender-based health information.** Information systems for HIV and broader health aspects should collect and analyse sex- and age-disaggregated data in order to identify HIV transmission patterns, health-service inequities and programme impact among girls and boys, men and women.

97. **Include gender issues in the design, delivery and monitoring of health services.** A focused, integrated approach to removing gender-based health inequities will improve the quality, uptake and impact of health services. HIV programmes should promote equity between the sexes in sexual decision-making, including negotiation of safer sex and use of male and female condoms. Financial and human resources should be allocated to programmes aimed at overcoming gender-related barriers to accessing health services. Specific attention should be given to female carers so as to ensure that they have good, equitable working conditions, and are empowered to participate in leadership roles in health and community systems. Services relating to gender-based violence, including comprehensive services for survivors of rape and other sexual violence, should be introduced.

6.1.2 WHO's contribution

98. **Support improved gender equity and the generation of evidence related to gender-based health inequities.** WHO will support countries to identify and overcome gender-based barriers to access to services and related social inequalities. It will also provide support for advocacy and research on the relationship between HIV risk, gender-based violence and other human rights violations, and will provide guidance on the implementation of programmes addressing violence against women. WHO will include women (including women living with HIV) and community carers in developing policies and normative guidance aimed at ensuring that HIV services meet the needs of women.

6.2 Advance human rights and promote health equity

99. Legal and sociocultural barriers prevent people who use drugs, men who have sex with men, transgender people, prisoners and sex workers from accessing effective interventions and using health services. Laws and policies that criminalize possession of drug paraphernalia (such as clean needles to support safe injecting practices) should be removed in order to expand access to health services and improve their quality. Overcoming such structural barriers to access is crucial for improving uptake of health services and ensuring a consistent, equitable approach in national HIV responses.

6.2.1 Recommended country action

100. **Involve people living with HIV and key populations in the design, implementation and evaluation of national HIV responses.** National HIV responses should implement and monitor policies and practices aimed at eliminating stigmatization, discrimination and other human rights abuses in health service delivery. The impact of HIV-related stigmatization, discrimination and other human rights abuses on access to health services and health outcomes should be documented. Links should be established with broader accountability mechanisms (such as the high-level meetings of the United Nations General Assembly special session) that assess progress in protecting human rights, including the right to health.

6.2.2 WHO's contribution

101. **Promote the adoption of policies, practices and laws that protect human rights and eliminate discrimination in the health sector.** WHO will support evaluations of differential access to health services and health outcomes. It will develop guidance and tools to change discriminatory

attitudes among health-care workers towards people living with HIV and key populations. It will promote non-discriminatory standards of care in health services. It will also develop country tools to assess determinants of health risk and vulnerability, and to identify key populations and locations where HIV risk and transmission are elevated. WHO will promote disaggregation of data by sex, age and other stratifiers to support analyses of health equity, including differential access to health services and variances in health outcomes.

6.3 Ensure health in all policies, laws and regulations

102. The health sector has a unique role to play in ensuring that policies, laws and regulations in other sectors support national HIV responses, particularly in eliminating gender inequity and protecting and promoting the human rights of key populations.

6.3.1 Recommended country action

103. ***Use public health evidence to introduce pro-health action in other sectors.*** Health-related aspects of HIV should be considered in the development and review of policies, laws and regulations in other sectors so as to ensure that they do not increase HIV vulnerability, discriminate or in other ways impede access to services (e.g., in housing, social welfare, labour, immigration, defence, finance, education, foreign affairs and development). Laws should be reviewed and, if necessary, reformed in order to decrease HIV vulnerability, improve access to health services and protect human rights. Legislation should be enacted to uphold non-discrimination in all areas. Specific attention should be paid to: travel restrictions, employment, homophobia, sex work, drug control laws and criminalization of HIV transmission. A public-health approach to managing behaviours that put people at risk of HIV acquisition should be promoted as an alternate to criminalization. Sentencing alternatives to incarceration should be promoted as good public health practice.

6.3.2 WHO's contribution

104. ***Provide public health evidence to inform policies, laws and regulations in other sectors.*** WHO will bring increased attention to the health needs of key populations and help to define the role of other sectors in ensuring that these needs are met. WHO will support countries to draft or review health-related policies and legislation to ensure public health issues are adequately addressed. Public health evidence will be provided in order to influence strategies and plans in other sectors. WHO will work with partners at all levels to improve policy coherence, particularly with the main donor and development agencies and initiatives, including the Global Fund to Fight AIDS, Tuberculosis and Malaria, the United States' President's Plan for AIDS Relief and other bilateral programmes.

7. STRATEGY IMPLEMENTATION

105. The effective implementation of the strategy depends on concerted action by all stakeholders in the health sector response to HIV. Within the health sector, linkages across different disease-specific and cross-cutting programmes need to be established and strengthened. This section describes how the WHO Secretariat will organize itself to support implementation of the strategy. It also outlines how the health sector response dovetails with other sectoral responses and partners, and how the implementation of the strategy will be monitored and reported.

7.1 Optimizing WHO's HIV Programme

106. The Secretariat will strengthening alignment and harmonization among the many country, regional and global stakeholders. WHO's HIV Programme embraces action taken at all three levels of the Organization and across a wide range of departments and units. The Department of HIV in

headquarters is responsible for coordinating the overall Programme. Each of the six regional offices has a dedicated HIV unit. Many WHO country offices have staff working full-time or part-time on HIV. WHO will optimize its HIV Programme structure and operations through the following activities.

107. Implementing a clear division of labour across the three levels of the WHO Secretariat. Headquarters will focus on global policy and normative work and be responsible for global monitoring and reporting on the HIV pandemic and response. Global guidance will be streamlined so as to ensure timely communication of new recommendations and greater coherence. Regional offices will focus their efforts on coordination and facilitation of technical support to countries, including adaptation of global guidance at country level. Country offices will focus their efforts on providing strategic policy advice to health ministries and convening country partners around key issues.

108. Maximizing the synergies across other programme areas. The Secretariat's work on HIV links with a range of other high-priority areas within the Organization, including: health system strengthening; health-information systems; maternal, newborn and child health; sexual and reproductive health; tuberculosis and other infectious diseases; blood and injection safety; emergency and surgical care; nutrition; noncommunicable diseases and mental health; gender and women's health; vaccine development; access to essential medicines; innovation and intellectual property; social determinants of health; health law, human rights and ethics; and health in humanitarian crises. The strategy promotes strong linkages across these health programmes. Priority will be given to strengthening integration of HIV into the core work of these other programme areas. Mechanisms for joint planning and coordination across programmes will be enhanced. For example, WHO's support to the Elimination of New HIV Infections in Children initiative will be coordinated across units responsible for HIV, maternal and child health, sexual and reproductive health, and nutrition. WHO's contribution to Treatment 2.0 will be coordinated across units responsible for HIV, tuberculosis, essential medicines and diagnostics, child and adolescent health, and nutrition.

109. Leveraging the capacity of technical networks and partners. WHO depends on partners to implement its policies and guidance in countries. It will work with partners at all levels on improving policy coherence, particularly with major donor and development agencies and initiatives, including the Global Fund to Fight AIDS, Tuberculosis and Malaria, bilateral and multilateral programmes, private foundations and implementing partners. WHO will aim to strengthen national institutions, structures and systems for a sustainable response, working through knowledge hubs, WHO collaborating centres and technical networks. WHO plays an important convening role in promoting collaboration between civil society, the government and the private sector. Civil-society partners provide technical and programming support for WHO's work, including advocacy and development and implementation of policies, tools and guidelines. WHO's collaboration with civil society is particularly important in ensuring that essential services are delivered to populations not reached by state services and advocating for evidence-based policies, adequate resources, greater accountability and human rights protections for key populations.

110. Building the capacity of WHO staff. WHO will invest in developing the core competencies of its HIV Programme staff, focusing on the technical and policy areas required to deliver on the four strategic directions of the strategy. Management skills will be strengthened to ensure efficiency, effectiveness and the ability of the Organization to adapt to a changing environment.

111. Contributing to WHO and broader United Nations reform. Within the United Nations system, the HIV response has acted as a pathfinder for reform in a range of areas, including improved mechanisms for interagency collaboration, meaningful involvement of affected populations and broader civil society, multisectoral engagement, promotion of country ownership, increased accountability across all stakeholders and stimulation of innovative financing mechanisms. WHO will continue to promote the pathfinding role of the HIV Programme. WHO will actively participate in

country-level structures and processes that support national HIV and broader health plans and priorities, in accordance with the principles set out in the Paris Declaration on Aid Effectiveness.

7.2 WHO as a cosponsor of UNAIDS

112. WHO's collaboration within the United Nations system in the area of HIV is primarily managed through the mechanisms and structures of UNAIDS, including the Committee of Cosponsoring Organizations and the Programme Coordinating Board at the global level, meetings of the Regional Directors Group of UNAIDS Cosponsors at the regional level and United Nations Theme Groups on HIV/AIDS and Joint United Nations Teams on AIDS at country level.

113. The UNAIDS Division of Labour aims to coordinate roles, responsibilities and actions across its cosponsors and its own secretariat. Among the UNAIDS cosponsors, WHO leads the health-sector response to HIV, acts as the convening agency on the priority areas of HIV treatment and care and HIV/tuberculosis, and jointly coordinates with UNICEF work on prevention of mother-to-child transmission of HIV. Details on WHO's collaboration with other UNAIDS cosponsors and other partners are outlined in the Appendix.

7.3 Collaboration with other partners

114. WHO has an important convening role in bringing together different constituencies, sectors and organizations in support of a coordinated and coherent health sector response to HIV. In addition to its Member States and the other UNAIDS cosponsors and the UNAIDS secretariat, the WHO Secretariat works closely with other key partners, including bilateral donor and development agencies and initiatives, funds and foundations, civil society, technical institutions and networks, the commercial private sector and partnership networks.

7.4 Monitoring, evaluating and reporting

115. Implementation of the strategy will be monitored at four levels, using existing mechanisms.

7.4.1 Monitoring and reporting of progress towards global goals and targets

116. At the global level, regular reviews are planned to assess progress on the commitments and targets established in the United Nations Declaration of Commitment on HIV/AIDS, Political Declaration on HIV/AIDS and Millennium Development Goals. These reviews will build on the data received from countries through the reporting framework set by the United Nations General Assembly Special Session on HIV/AIDS and other monitoring and evaluation mechanisms.

117. Progress at global and regional levels in moving towards the targets set out in this strategy will be regularly assessed. Benchmarking – or comparisons between and within countries – will also be used to assess performance in reaching targets. The strategy is designed to be sufficiently flexible to incorporate additional priorities or fill gaps in the health sector response to HIV that may be identified at the High Level Meeting scheduled to be held in June 2011 or other meetings to review progress on global and national goals and targets.

118. To this end, WHO will continue to work with UNAIDS and other bodies to provide support to countries for the harmonized and standardized collection of core indicators, and in the preparation of global and regional reports. Annual reporting of the previous year's data is proposed, and UNAIDS will support a full review of universal access in June 2016.

7.4.2 Monitoring and evaluating the response at country level

119. Progress in implementing the health-sector response to HIV should be assessed with indicators on availability, coverage outcome and impact, taking into consideration recommendations by the United Nations General Assembly for monitoring implementation in its Declaration of Commitment on HIV/AIDS. Progress towards the HIV-related Millennium Development Goals will be tracked and reported. Numerous indicators are available to support country-level monitoring and reporting in the HIV Indicator Registry.

120. Indicators for monitoring the strengthening of health systems derive from a common platform for monitoring and evaluating national health strategies, known as the Country Health Systems Surveillance platform, coordinated by WHO. Instruments are also available for measuring progress in implementing policy, legal and structural measures for enhancing the HIV response, as recommended under strategic direction 4. These include the National Composite Policy Index, part of the reporting system on implementing the United Nations General Assembly's Declaration of Commitment on HIV/AIDS,¹ and The People Living with HIV Stigma Index, which involves a survey conducted by and for people living with HIV in order to document the extent and forms of stigmatization and discrimination in different countries, including those experienced in health services.

121. The table below lists core indicators for monitoring implementation of the Declaration of Commitment on HIV/AIDS and for tracking progress towards Millennium Development Goals that are proposed for consideration at country level. All indicators are to be sex- and age-disaggregated, as appropriate, and analyses should be conducted to determine whether the response adequately addresses key social determinants of HIV vulnerability and risk, including gender inequality, and takes the necessary steps to achieve equitable access to services. Working towards equity involves analyses of differences within and between groups, within and across countries, using a series of stratifiers and summary measures.

¹ United Nations General Assembly Special Session on HIV/AIDS. Monitoring the Declaration of Commitment on HIV/AIDS: guidelines on construction of core indicators: 2010 reporting. Geneva, UNAIDS, 2009.

Table Selected core indicators proposed for country consideration

<i>Strategic direction</i>	<i>Core indicators^a</i>
1. Optimize HIV prevention, diagnosis, treatment and care outcomes	1.1 <i>Percentage of young people aged 15–24 years who are HIV infected</i> 1.2 Number of deaths associated with HIV 1.3 Number of new HIV infections among children 0–4 years of age 1.4 <i>Percentage of men and women aged 15–49 years who received an HIV test in the previous 12 months and know their results</i> 1.5 Percentage of eligible adults and children with HIV infection who receive antiretroviral therapy 1.6 Number of HIV-positive individuals who receive trimethoprim-sulfamethoxazole prophylaxis according to national guidelines 1.7 <i>Percentage of estimated number of HIV-positive patients with incident tuberculosis who received treatment for HIV and tuberculosis</i> 1.8 Percentage of HIV-infected pregnant women who received antiretroviral medicines to reduce the risk of mother-to-child transmission of HIV
2. Leverage broader health outcomes through HIV responses	2.1 Unmet need for family planning 2.2 Maternal mortality ratio 2.3 All-cause mortality rate among children aged 0–4 years 2.4 Proportion of tuberculosis cases detected and cured under directly-observed treatment, short course
3. Build strong and sustainable systems	3.1 Recommended core indicators from the <i>Monitoring Health Systems Strengthening Handbook of Indicators and Related Measurement Strategies^b</i>
4. Reduce vulnerability and remove structural barriers to accessing services	4.1 <i>Completion of the National Composite Policy Index</i> 4.2 Completion of The People Living with HIV Stigma Index ^c 4.3 Availability of service-delivery points providing appropriate medical, psychological and legal support for women and men who have been raped or experienced incest

^a Indicators for monitoring implementation of the Declaration of Commitment on HIV/AIDS are in *italics*; indicators for tracking progress towards Millennium Development Goals are in **bold**.

^b For example, most countries will find it useful to track changes in availability of medicines at service delivery level, using the following core indicator: percentage of facilities that have all tracer medicines and commodities in stock, which is described in the WHO handbook (*Monitoring health systems strengthening: a handbook of indicators and related measurement strategies*. Geneva, World Health Organization, 2010).

^c This includes consideration of stigmatization and discrimination in the health services, as measured by the percentage of respondents who report that they were denied health services, including dental care, in the previous year because of their HIV status.

7.4.3 WHO's framework for results-based management

122. WHO's Medium-term strategic plan 2008–2013, which sets the Organization's strategic direction for that period, contains 13 strategic objectives. Much of WHO's HIV-related work comes under Strategic objective 2: To combat HIV/AIDS, tuberculosis and malaria, but there are significant HIV-related activities under six other strategic objectives (1, 4, 6, 7, 10 and 11). Each strategic objective has a set of organization-wide expected results with indicators, targets and resource requirements. Workplan implementation is monitored through a mid-term review at the end of the first year of each biennium and progress towards the achievement of the organization-wide expected results is reported at the end of each biennium.

7.4.4 UNAIDS' accountability framework

123. WHO's HIV work is reflected in UNAIDS' Unified Budget and Workplan, which sets a single biennial framework that promotes joint planning and budgeting across the 10 cosponsors and the UNAIDS secretariat, resulting in a combined two-year workplan. Each cosponsor is responsible for implementation of a set of broad activities related to their organizational mandate and the UNAIDS Technical Support Division of Labour. The Unified Budget and Workplan is accompanied by a performance-monitoring framework, which defines indicators against which progress in implementation of the budget and workplan is measured. Annual progress reports are submitted to the UNAIDS Programme Coordinating Board. The Unified Budget and Workplan will be replaced by an integrated unified budget and accountability framework for the period 2012–2015, the Unified Budget, Results and Accountability Framework, that includes a business plan, a results and accountability framework and a budget.

Appendix

WHO's collaboration with other UNAIDS cosponsors and the UNAIDS Secretariat

Cosponsor	Areas of collaboration
Office of the United Nations High Commissioner for Refugees	Implementing the Inter-Agency Standing Committee Guidelines for Addressing HIV in Humanitarian Settings; undertaking joint assessments and planning for HIV responses in countries affected by humanitarian crises; and adapting HIV guidelines and tools for settings of humanitarian crises, including for most-at-risk populations
United Nations Children's Fund	Prevention of mother-to-child transmission of HIV; treatment and care of infants and children; HIV prevention, treatment and care of young people; and strengthening of systems for procurement and supply-chain management
World Food Programme	Implementation of nutritional guidelines for HIV care and treatment in association with antiretroviral therapy and management of HIV and tuberculosis coinfection; and supporting operational research related to HIV treatment and care
United Nations Development Programme	Integrating HIV issues into national planning and legislative processes; countering stigmatization and discrimination in the health sector; formulating strategies for enabling trade, health and intellectual property legislation to increase affordability and access to HIV-related medicines; HIV prevention, treatment and care for men who have sex with men and transgendered people; training of community-based treatment supporters; and reducing gender inequity and dealing with gender-based violence
United Nations Population Fund	Condom programming, standards and quality assurance; linking sexual and reproductive health and HIV at the policy, systems and service delivery levels; preventing HIV infections in pregnant women, mothers and their children; sexual and reproductive health for people living with HIV including prevention of mother-to-child transmission of HIV; improving access of young people, women and sex workers to prevention, treatment and care services for HIV and sexually transmitted infections; eliminating gender-based violence; and promoting gender equality, empowerment of women and girls, and reproductive rights
United Nations Office on Drugs and Crime	HIV prevention and care for injecting and non-injecting drug users and in prison settings; advocacy of harm reduction and drug-dependence treatment and rehabilitation policies and programmes; and improving access to internationally controlled substances for the management of opioid dependence, pain control and palliative care
International Labour Organization	Integrating HIV issues into occupational safety and vocational training programmes; human resources for dealing with HIV; and providing policy guidance and practical measures to extend social protection

United Nations Educational, Scientific and Cultural Organization	HIV prevention and treatment and sexuality education in community and school settings
The World Bank	National HIV strategic planning; health system financing for HIV; and assessment of costs, cost-benefit and cost-effectiveness of HIV interventions
UNAIDS secretariat	Global advocacy and resource mobilization for major health sector initiatives; monitoring, evaluating and reporting on the HIV situation and response; supporting the assessment and development of new HIV prevention technologies, including HIV vaccines, microbicides and pre-exposure prophylaxis, and the introduction of proven new interventions, including male circumcision; facilitating discussions with industry to achieve price reductions of HIV-related medicines and commodities; coordinating and brokering technical assistance to countries, including for accessing and implementing grants from the Global Fund to Fight AIDS, Tuberculosis and Malaria; and strengthening country coordinating mechanisms, including the United Nations Theme Group on HIV/AIDS

ANNEX 5

Text of the amended Financial Regulations of the World Health Organization¹

[A64/34 – 17 March 2011]

Regulation XIV – External audit

14.1 External Auditor(s), each of whom shall be the Auditor-General (or officer holding equivalent title or status) of a Member government, shall be appointed by the Health Assembly. The term of office shall be four years, covering two budgetary periods, and can be renewed once for an additional term of four years. External Auditor(s) appointed may be removed only by the Assembly.

...

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

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

¹ Text amended in accordance with resolution WHA64.22.

5. Administrative implications

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

Most of the recommendations contained in the report will require additional activities at both the headquarters and regional office levels. By far the largest activity, and cost component, of the recommendations is the support required to accelerate the achievement of the national core capacities referred to in recommendation 1. There will be a particular need for actions at regional office level in order to implement this resolution.

(b) Can the resolution be implemented by existing staff? If not, please specify in (c) below.

No.

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

It is estimated that an additional 32 staff in the professional and higher categories will be needed; the staff in question will be deployed in roughly equal numbers between headquarters and the regional offices.

(d) Time frames (indicate broad time frames for implementation of activities).

The time frame for implementation is until end of 2015.

1. Resolution WHA64.2 WHO reform

2. Linkage to programme budget

Strategic objective:

Organization-wide expected result:

All strategic objectives.

All Organization-wide expected results.

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

The resolution relates to the agenda for reform of the whole Organization; as such, it is linked directly to all expected results, indicators, targets and baselines. The resolution only concerns the overall design of the programme of reform (and specific elements thereunder) and not its implementation; as such only the design activities are costed.

3. Budgetary implications

(a) Total estimated cost for implementation over the life-cycle of the Secretariat's activities requested in the resolution (estimated to the nearest US\$ 10 000, including staff and activities).

Activity 1

The Secretariat's work to prepare a detailed concept paper on the World Health Forum, to be held in 2012, is costed as follows:

100% of one full-time equivalent staff member at grade D.2 over 20 days (US\$ 20 000); 100% of one full-time equivalent staff member at grade P.2 over 20 days (US\$ 10 000).

Total cost: US\$ 30 000.

Activity 2

The cost of the Secretariat's work to develop an approach to independent evaluation (A.) and the cost of the independent evaluation (B.):

A. 100% of one full-time equivalent staff member at grade P.3 over 180 days (US\$ 90 000);

100% of one full-time equivalent staff member at grade G.4 over 180 days (US\$ 50 000).

Subtotal: US\$ 140 000

B. US\$ 500 000 for the independent evaluation group (consultant team).

Total cost: US\$ 640 000.

Activity 3

The development of the programme of reform by a competitively selected and contracted consulting firm (B.) in conjunction with the Secretariat (Project Team) (A.) is costed as follows:

A. 100% of one full-time equivalent staff member at grade P.2 over 180 days (US\$ 80 500); 100% of one full-time equivalent staff member at grade P.5 over 180 days (US\$ 131 100); 20% of one full-time equivalent staff member at grade D.2 over 180 days (US\$ 32 028); 40% of one full-time equivalent staff member at grade D.2 over 180 days (US\$ 64 055).

Subtotal: US\$ 310 000

B. US\$ 490 000 for the work of a competitively selected consulting firm.

Total cost: US\$ 800 000.

- (b) Estimated cost for the biennium 2010–2011 (estimated to the nearest US\$ 10 000 including staff and activities, and indicating at which levels of the Organization the costs will be incurred, identifying specific regions where relevant).**

Total of activities 1–3 outlined in (a) above: US\$ 1.47 million incurred at headquarters level.

- (c) Is the estimated cost noted in (b), included within the existing approved Programme budget for the biennium 2010–2011?**

Yes.

4. Financial implications

How will the estimated cost noted in 3(b) be financed (indicate potential sources of funds)?

Some financing has been secured from the Bill & Melinda Gates Foundation; some additional financing will also be requested from other sources.

5. Administrative implications

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

Headquarters.

- (b) Can the resolution be implemented by existing staff? If not, please specify in (c) below.**

Yes.

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

Not applicable.

- (d) Time frames (indicate broad time frames for implementation of activities).**

Activity 1: June – September 2011

Activity 2: June 2011 – February 2012

Activity 3: June – October 2011.

5. Administrative implications

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

The activities will be primarily implemented through the WHO Office in Jerusalem responsible for WHO's cooperation programme with the 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 in the areas of poliomyelitis eradication, emergency preparedness and response, and country focus, health security and environment.

(b) Can the resolution be implemented by existing staff? If not, please specify in (c) below.

It will be necessary to sustain beyond May 2011 the actual presence at country level of the national and international staff recruited to implement humanitarian health activities and interventions in the occupied Palestinian territory.

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

Not applicable.

(d) Time frames (indicate broad time frames for implementation of activities).

One year.

1. Resolution WHA64.5 Pandemic influenza preparedness: sharing of influenza viruses and access to vaccines and other benefits

2. Linkage to programme budget

Strategic objective:

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

Organization-wide expected result:

1.4 Policy and technical support provided to Member States in order to enhance their capacity to carry out surveillance and monitoring of all communicable diseases of public health importance.

1.7 Member States and the international community equipped to detect, assess, respond to and cope with major epidemic and pandemic-prone diseases (e.g. influenza, meningitis, yellow fever, haemorrhagic fevers, plague and smallpox) through the development and implementation of tools, methodologies, practices, networks and partnerships for prevention, detection, preparedness and intervention.

1.9 Effective operations and response by Member States and the international community to declared emergency situations due to epidemic and pandemic prone diseases.

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

Achievement of the Organization-wide expected results mentioned above, together with the targets of their indicators, will be given a major impetus through the following activities: conducting disease burden studies; expanding and building influenza vaccine production capacity; expanding the use of potent adjuvant technology; establishing stockpiles; building and strengthening laboratory and surveillance capacity; and creating National Influenza Centres and WHO Collaborating Centres for Influenza.

3. Budgetary implications

(a) Total estimated cost for implementation over the life-cycle of the Secretariat's activities requested in the resolution (estimated to the nearest US\$ 10 000, including staff and activities).

The total cost over the five-year plan of the resolution amounts to US\$ 287.0 million. The breakdown is as follows:

- activities for laboratory and disease surveillance capacity in countries (US\$ 105.8 million)
- activities for expanding global influenza vaccine production capacity in countries through disease burden studies, building and expanding country capacity, and expanding use of technology (US\$ 97.0 million)
- activities for establishing a stockpile of antiviral medicines (US\$ 67.0 million)
- activities and staffing of a Pandemic Influenza Preparedness Framework secretariat, including an Advisory Group, to manage the progress of the Framework (US\$ 17.2 million).

These budget estimates do not take into account costs associated with financial requirements stemming from the next pandemic.

(b) Estimated cost for the biennium 2010–2011 (estimated to the nearest US\$ 10 000 including staff and activities, and indicating at which levels of the Organization the costs will be incurred, identifying specific regions where relevant).

US\$ 2 million at headquarters for the period June to December 2011 (staff US\$ 1.49 million; activities US\$ 510 000).

This amount covers activities and staffing in order to: draft notifications on the Framework; establish membership of the Advisory Group; commence work on genetic sequences; establish an industry partnership contribution fund, and prepare a proposal on the fund's uses and management for consideration by the Executive Board at its session in May 2012; commence negotiations with companies and associations and other entities, and develop template legal agreements; and begin development of a communications strategy and plan.

(c) Is the estimated cost noted in (b), included within the existing approved Programme budget for the biennium 2010–2011?

No.

4. Financial implications

How will the estimated cost noted in 3(b) be financed (indicate potential sources of funds)?

Financing models for implementation of the resolution are being considered. An account expected to be funded by Member States, donors and industry is being proposed. Financing of the account will depend on new voluntary funding being identified.

5. Administrative implications

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

In 2011 the Framework secretariat at headquarters will commence work, coordinating with regional and country offices to set up the five-year plan of work for the resolution. As from 2012, much of the implementation will take place at country level with technical support from headquarters. Implementation will be coordinated by the Framework secretariat from headquarters.

(b) Can the resolution be implemented by existing staff? If not, please specify in (c) below.

No.

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

The following additional staff will be needed:

- three full-time equivalent staff in the professional and higher categories to design and develop training on the Influenza Virus Tracking Mechanism and to implement training courses across countries in support of the Global Influenza Surveillance and Response System;
- one 50% full-time equivalent staff member to lead genetic sequencing consultations;
- one full-time equivalent fund manager and one full-time equivalent finance assistant to manage the fund; and
- four full-time equivalent legal officers to negotiate with industry and to develop, among other things, contribution agreements, pre-purchase agreements and intellectual property licensing.

Additional contractual resources will be needed for the translation of documents and agreements (depending on the length of documents and language agreements). Additional support will also be needed for review of the Framework and annexes by 2016.

(d) Time frames (indicate broad time frames for implementation of activities).

Activities will commence immediately and will continue until the Framework and annexes are reviewed in 2016.

1. Resolution WHA64.6 Health workforce strengthening

2. Linkage to programme budget

Strategic objective:

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

Organization-wide expected result:

10.8 Health-workforce information and knowledge base strengthened, and country capacities for policy analysis, planning, implementation, information-sharing and research built up.

10.9 Technical support provided to Member States, with a focus on those facing severe health-workforce difficulties in order to improve the production, distribution, skill mix and retention of the health workforce.

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

WHO's activities in support of health workforce strengthening have links with strategic objective 10, specifically the two Organization-wide expected results mentioned above. The present resolution is also linked to the implementation of resolution WHA63.16, in which (inter alia) the WHO Global Code of Practice on the International Recruitment of Health Personnel was adopted.

3. Budgetary implications

(a) Total estimated cost for implementation over the life-cycle of the Secretariat's activities requested in the resolution (estimated to the nearest US\$ 10 000, including staff and activities).

US\$ 39.0 million over a period of six years, beginning 2011. This includes activities at headquarters and in the regions.

(b) Estimated cost for the biennium 2010–2011 (estimated to the nearest US\$ 10 000 including staff and activities, and indicating at which levels of the Organization the costs will be incurred, identifying specific regions where relevant).

US\$ 1.5 million at headquarters level and US\$ 4.5 million at regional level.

(c) Is the estimated cost noted in (b), included within the existing approved Programme budget for the biennium 2010–2011?

A total of US\$ 1.0 million is included for headquarters and the regions.

4. Financial implications**How will the estimated cost noted in 3(b) be financed (indicate potential sources of funds)?**

Costs will be met through income from core voluntary contributions from Member States and international partners. In line with the implementation strategy for the Code developed by the Secretariat, resource mobilization activities will be undertaken for this area with a particular focus on certain Member States and international partners, since this is a mission-critical activity. Indications of support have already been received from Japan, Norway, the United States of America and the European Union.

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

All levels of the Organization will be involved; however, implementation will particularly concern countries facing major challenges as a result of critical health workforce shortages.

(b) Can the resolution be implemented by existing staff? If not, please specify in (c) below.

No. Additional staff will be required at headquarters and in the regions.

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

Exact requirements will depend on the intensity of activities. Every effort will be made to make full use of secondments and the deployment of interns, in addition to employing short-term staff.

(d) Time frames (indicate broad time frames for implementation of activities).

An implementation strategy has already been developed by the Secretariat. Activities will be implemented according to this strategy, which covers the period 2011–2015.

1. Resolution WHA64.7 Strengthening nursing and midwifery**2. Linkage to programme budget**

Strategic objective:

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

Organization-wide expected result:

10.8 Health-workforce information and knowledge base strengthened, and country capacities for policy analysis, planning, implementation, information-sharing and research built up.

10.9 Technical support provided to Member States, with a focus on those facing severe health-workforce difficulties in order to improve the production, distribution, skill mix and retention of the health workforce.

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

WHO's activities in support of health workforce strengthening have links with strategic objective 10, specifically the two Organization-wide expected results mentioned above. Countries facing severe nursing and midwifery difficulties will be supported through WHO's activities to adopt relevant technical frameworks, tools and guidelines for strengthening nursing and midwifery practice.

3. Budgetary implications

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

A total of US\$ 4.0 million, covering the four-year period 2011–2014, will be required for the implementation of activities at all levels of WHO and the provision of support to Member States.

- (b) **Estimated cost for the biennium 2010–2011 (estimated to the nearest US\$ 10 000, including staff and activities, and indicating at which levels of the Organization the costs will be incurred, identifying specific regions where relevant).**

For the biennium, a total of US\$ 2.0 million will be incurred (US\$ 500 000 at headquarters level and US\$ 1.5 million at regional level).

- (c) **Is the estimated cost noted in (b), included within the existing approved Programme budget for the biennium 2010–2011?**

A total of US\$ 400 000 is included for headquarters and the regions.

4. Financial implications

How will the estimated cost noted in 3(b) be financed (indicate potential sources of funds)?

The cost will be met through a combination of voluntary and assessed contributions from Member States, together with contributions from international partners.

5. Administrative implications

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

All levels of the Organization will be involved; however, implementation will particularly concern countries facing major challenges as a result of critical health workforce shortages.

- (b) **Can the resolution be implemented by existing staff? If not, please specify in (c) below.**

No. Additional staff will be required at headquarters and in the regions.

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

Exact requirements will depend on the intensity of activities. Every effort will be made to make full use of secondments and the deployment of interns in addition to employing short-term staff.

- (d) **Time frames (indicate broad time frames for implementation of activities).**

The resolution requests the Director-General to report on progress to the Health Assembly in 2012 and 2014. Implementation of activities will be built into biennial workplans for 2010–2011, 2012–2013 and 2014–2015, as appropriate.

5. Administrative implications

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

All levels of the Organization will be involved.

- (b) **Can the resolution be implemented by existing staff? If not, please specify in (c) below.**

No.

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

Exact requirements will depend on the intensity of activities. Every effort will be made to make full use of secondments in addition to employing short-term staff.

- (d) **Time frames (indicate broad time frames for implementation of activities).**

The Secretariat is drawing up implementation plans.

1. Resolution WHA64.9 Sustainable health financing structures and universal coverage

2. Linkage to programme budget

Strategic objective:

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

Organization-wide expected result:

All the Organization-wide expected results under strategic objective 10, particularly:

10.10 Evidence-based policy and technical support provided to Member States in order to improve health-system financing in terms of the availability of funds, social and financial-risk protection, equity, access to services and efficiency of resource use.

10.11 Norms, standards and measurement tools developed for tracking resources, estimating the economic consequences of illness, and the costs and effects of interventions, financial catastrophe, impoverishment, and social exclusion, and their use supported and monitored.

10.12 Steps taken to advocate additional funds for health where necessary; to build capacity in framing of health-financing policy and interpretation and use of financial information; and to stimulate the generation and translation of knowledge to support policy development.

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

The resolution provides a framework that will contribute to the achievement of the expected results mentioned above and links to the relevant indicators, targets and baselines.

3. Budgetary implications

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

Implementation of the resolution will entail costs of US\$ 9.0 million over the next six years, in addition to the cost of US\$ 4.8 million estimated for implementation of resolution WHA62.12. This figure represents the cost of: scaling up technical and policy support to Member States in the

area of health financing for universal coverage; linking this effort with national health plans and strategies; and increasing capacity to share experiences across countries.

- (b) Estimated cost for the biennium 2010–2011 (estimated to the nearest US\$ 10 000 including staff and activities, and indicating at which levels of the Organization the costs will be incurred, identifying specific regions where relevant).**

All levels of the Organization are currently engaged in the provision of technical support to countries in relation to financing for universal coverage; they all facilitate the sharing of experiences across countries. The cost of scaling up these activities in order to meet the current demand from countries, as well as the need to share across countries information on what has worked and what has not worked, is estimated at US\$ 1.50 million during 2011 (US\$ 1.05 million for the regions and US\$ 450 000 for headquarters).

- (c) Is the estimated cost noted in (b), included within the existing approved Programme budget for the biennium 2010–2011?**

Some costs for technical support to countries and information sharing were included in the Programme budget 2010–2011. The costs outlined here are additional costs required to meet the growing demand for countries for this type of support partly in response to *The world health report 2010*.¹

4. Financial implications

How will the estimated cost noted in 3(b) be financed (indicate potential sources of funds)?

A strategy for mobilizing the additional resources required in a resource-constrained environment is being developed.

5. Administrative implications

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

All regions will engage in providing technical support to Member States. Headquarters will support this effort, helping to coordinate increased exchange of information as requested by the resolution – particularly since there is increasing demand for cross-regional exchanges. However, regional and country offices will also be heavily involved in information-exchange activities.

- (b) Can the resolution be implemented by existing staff? If not, please specify in (c) below.**

In order to meet the expected increase in demand from Member States for this type of support, new staff will be required or existing staff will need to be redeployed. Many regional and country offices do not have sufficient skills in health financing.

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

The costs mentioned above include additional staff in the professional category in the area of health financing policy (1.5 at headquarters and 3 in the regions).

- (d) Time frames (indicate broad time frames for implementation of activities).**

Health financing systems are always developing so requests for technical support will continue. The time frame for this costing is set at three bienniums (six years).

¹ *The world health report 2010. Health systems financing: the path to universal coverage*. Geneva, World Health Organization, 2010.

<p>1. Resolution WHA64.10 Strengthening national health emergency and disaster management capacities and the resilience of health systems</p>			
<p>2. Linkage to programme budget</p> <table border="0"> <tr> <td style="vertical-align: top;"> <p>Strategic objective:</p> <p>5. To reduce the health consequences of emergencies, disasters, crises and conflicts, and minimize their social and economic impact.</p> </td> <td style="vertical-align: top;"> <p>Organization-wide expected result:</p> <p>5.1 Norms and standards developed, capacity built and technical support provided to Member States for the development and strengthening of national emergency preparedness plans and programmes.</p> </td> </tr> </table> <p style="text-align: center;">(Briefly indicate the linkage with expected results, indicators, targets, baseline)</p> <p>The establishment and operation of a disaster risk-management and emergency-preparedness platform, together with a functional safe hospitals programme at national level will help significant progress to be made in the area of disaster risk-reduction, and emergency preparedness, response and recovery in countries at risk. The resolution will further strengthen the all-hazards health emergency and disaster risk-management programmes as part of national health systems in order to improve health outcomes, reduce mortality and morbidity, protect investment in health infrastructure and strengthen the resilience of the health system and society at large.</p>		<p>Strategic objective:</p> <p>5. To reduce the health consequences of emergencies, disasters, crises and conflicts, and minimize their social and economic impact.</p>	<p>Organization-wide expected result:</p> <p>5.1 Norms and standards developed, capacity built and technical support provided to Member States for the development and strengthening of national emergency preparedness plans and programmes.</p>
<p>Strategic objective:</p> <p>5. To reduce the health consequences of emergencies, disasters, crises and conflicts, and minimize their social and economic impact.</p>	<p>Organization-wide expected result:</p> <p>5.1 Norms and standards developed, capacity built and technical support provided to Member States for the development and strengthening of national emergency preparedness plans and programmes.</p>		
<p>3. Budgetary implications</p> <p>(a) Total estimated cost for implementation over the life-cycle of the Secretariat's activities requested in the resolution (estimated to the nearest US\$ 10 000, including staff and activities).</p> <p>The figures provided concern the period until the end of 2013.</p> <p>At headquarters level</p> <p>The total estimated cost is US\$ 7.44 million.</p> <p>For the provision of technical assistance (consultancies, including short-term contracts, Agreements for Performance of Work, scientific and technical advisory groups; travel; and training): US\$ 750 000.</p> <p>Staff costs (P.5 staff for two years, P.4 staff for two years and G.4 staff for two years): US\$ 1.65 million. This figure is based on the estimated cumulative time to be spent by a number of staff at different levels for this particular activity.</p> <p>The estimated total cost of strengthening the evidence base for health emergency and disaster risk-management, including operational research and economic assessments: US\$ 2.79 million.</p> <p>The estimated total cost of supporting national assessments of risks and capacities for health emergency and disaster risk-management, as a basis for catalysing action and strengthening national health emergency and disaster risk-management capacities: US\$ 2.25 million.</p> <p>At regional level</p> <p>The total estimated cost: US\$ 4.50 million (US\$ 750 000 per regional office).</p> <p>At country level</p> <p>The estimated minimum cost of provision of technical support by the Secretariat through the country offices to Member States implementing the resolution: US\$ 250 000 per country.</p> <p>(b) Estimated cost for the biennium 2010–2011 (estimated to the nearest US\$ 10 000 including staff and activities, and indicating at which levels of the Organization the costs will be incurred, identifying specific regions where relevant).</p> <p>At headquarters level</p> <p>For the provision of technical assistance (including consultancies involving short-term contracts and Agreements for Performance of Work, travel, training, scientific and technical advisory groups): US\$ 250 000.</p>			

For the strengthening of collaboration with relevant entities (including public, private and non-governmental bodies and academia) to support country and community health emergency and disaster risk-management, the estimated staff cost is: US\$ 550 000 (P.5 staff, US\$ 250 000; P.4 staff, US\$ 200 000; and G.4 staff, US\$ 100 000). This figure is based on the estimated cumulative time to be spent by a number of staff at different levels for this particular activity for a period of one year.

The estimated total cost of strengthening the evidence base for health emergency and disaster risk-management, including operational research and economic assessments: US\$ 930 000.

The estimated total cost of supporting national assessments of risks and capacities for health emergency and disaster risk-management, as a basis for catalysing action and strengthening national health emergency and disaster risk-management capacities: US\$ 750 000.

At regional level

The estimated total cost: US\$ 1.50 million (US\$ 250 000 per regional office).

At country level

The estimated minimum cost of provision by the Secretariat of technical support for implementation through country offices: US\$ 50 000 per country.

(c) Is the estimated cost noted in (b), included within the existing approved Programme budget for the biennium 2010–2011?

Yes, except at country level.

4. Financial implications

How will the estimated cost noted in 3(b) be financed (indicate potential sources of funds)?

Through fund-raising and voluntary contributions.

5. Administrative implications

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

Implementation will take place mainly in the country offices. Regional offices will provide support for training and capacity building and headquarters will be responsible for interagency coordination, overall planning and development of the evidence-based norms and guidelines necessary to develop and strengthen this area of work. The WHO Mediterranean Centre for Vulnerability Reduction in Tunis will provide technical assistance to all levels in areas of its expertise.

(b) Can the resolution be implemented by existing staff? If not, please specify in (c) below.

At the headquarters level, staffing is sufficient for the development component of this area and the staff cost is budgeted. At the regional and national levels, there is a need for additional expertise that could be recruited on a temporary basis (short-term contracts and Agreements for Performance of Work).

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

Not applicable.

(d) Time frames (indicate broad time frames for implementation of activities).

These activities are planned for the bienniums 2010–2011 and 2012–2013.

<p>1. Resolution WHA64.11 Preparations for the high-level meeting of the United Nations General Assembly on the prevention and control of non-communicable diseases, following the Moscow Conference¹</p>			
<p>2. Linkage to programme budget</p> <table border="0"> <tr> <td style="vertical-align: top;"> <p>Strategic objective:</p> <p>3. To prevent and reduce disease, disability and premature death from chronic noncommunicable diseases, mental disorders, violence and injuries and visual impairment.</p> <p>6. To promote health and development, and prevent or reduce risk factors for health conditions associated with use of tobacco, alcohol, drugs and other psychoactive substances, unhealthy diets, physical inactivity and unsafe sex.</p> </td> <td style="vertical-align: top;"> <p>Organization-wide expected result:</p> <p>3.1 Advocacy and support provided to increase political, financial and technical commitment in Member States in order to tackle chronic noncommunicable diseases, mental and behavioural disorders, violence, injuries and disabilities together with visual impairment, including blindness.</p> <p>3.2 Guidance and support provided to Member States for the development and implementation of policies, strategies and regulations in respect of chronic noncommunicable diseases, mental and neurological disorders, violence, injuries and disabilities together with visual impairment, including blindness.</p> <p>3.3 Improvements made in Member States' capacity to collect, analyse, disseminate and use data on the magnitude, causes and consequences of noncommunicable diseases, mental and neurological disorders, violence, injuries and disabilities together with visual impairment, including blindness.</p> <p>6.2 Guidance and support provided in order to strengthen national systems for surveillance of major risk factors through development and validation of frameworks, tools and operating procedures and their dissemination to Member States where a high or increasing burden of death and disability is attributable to these risk factors.</p> </td> </tr> </table> <p style="text-align: center;">(Briefly indicate the linkage with expected results, indicators, targets, baseline)</p> <p>It is envisaged that there will be an increase in the number of Member States: (i) with a unit in the ministry of health or equivalent national health authority, with dedicated staff and budget, for the prevention and control of noncommunicable diseases (indicator 3.1.4); (ii) that have adopted a multisectoral national policy on chronic noncommunicable diseases (indicator 3.2.3); (iii) with a national health reporting system and annual reports that include indicators on the four major noncommunicable diseases (indicator 3.3.4); (iv) with a functioning national surveillance system for monitoring major risk factors to health among adults based on the WHO STEPwise approach to surveillance (indicator 6.2.1).</p>		<p>Strategic objective:</p> <p>3. To prevent and reduce disease, disability and premature death from chronic noncommunicable diseases, mental disorders, violence and injuries and visual impairment.</p> <p>6. To promote health and development, and prevent or reduce risk factors for health conditions associated with use of tobacco, alcohol, drugs and other psychoactive substances, unhealthy diets, physical inactivity and unsafe sex.</p>	<p>Organization-wide expected result:</p> <p>3.1 Advocacy and support provided to increase political, financial and technical commitment in Member States in order to tackle chronic noncommunicable diseases, mental and behavioural disorders, violence, injuries and disabilities together with visual impairment, including blindness.</p> <p>3.2 Guidance and support provided to Member States for the development and implementation of policies, strategies and regulations in respect of chronic noncommunicable diseases, mental and neurological disorders, violence, injuries and disabilities together with visual impairment, including blindness.</p> <p>3.3 Improvements made in Member States' capacity to collect, analyse, disseminate and use data on the magnitude, causes and consequences of noncommunicable diseases, mental and neurological disorders, violence, injuries and disabilities together with visual impairment, including blindness.</p> <p>6.2 Guidance and support provided in order to strengthen national systems for surveillance of major risk factors through development and validation of frameworks, tools and operating procedures and their dissemination to Member States where a high or increasing burden of death and disability is attributable to these risk factors.</p>
<p>Strategic objective:</p> <p>3. To prevent and reduce disease, disability and premature death from chronic noncommunicable diseases, mental disorders, violence and injuries and visual impairment.</p> <p>6. To promote health and development, and prevent or reduce risk factors for health conditions associated with use of tobacco, alcohol, drugs and other psychoactive substances, unhealthy diets, physical inactivity and unsafe sex.</p>	<p>Organization-wide expected result:</p> <p>3.1 Advocacy and support provided to increase political, financial and technical commitment in Member States in order to tackle chronic noncommunicable diseases, mental and behavioural disorders, violence, injuries and disabilities together with visual impairment, including blindness.</p> <p>3.2 Guidance and support provided to Member States for the development and implementation of policies, strategies and regulations in respect of chronic noncommunicable diseases, mental and neurological disorders, violence, injuries and disabilities together with visual impairment, including blindness.</p> <p>3.3 Improvements made in Member States' capacity to collect, analyse, disseminate and use data on the magnitude, causes and consequences of noncommunicable diseases, mental and neurological disorders, violence, injuries and disabilities together with visual impairment, including blindness.</p> <p>6.2 Guidance and support provided in order to strengthen national systems for surveillance of major risk factors through development and validation of frameworks, tools and operating procedures and their dissemination to Member States where a high or increasing burden of death and disability is attributable to these risk factors.</p>		
<p>3. Budgetary implications</p> <p>(a) Total estimated cost for implementation over the life-cycle of the Secretariat's activities requested in the resolution (estimated to the nearest US\$ 10 000, including staff and activities).</p> <p>US\$ 4.5 million over a period of three years.</p>			

¹ First Global Ministerial Conference on Healthy Lifestyles and Noncommunicable Disease Control (Moscow, Russian Federation, 28–29 April 2011).

(b) Estimated cost for the biennium 2010–2011 (estimated to the nearest US\$ 10 000 including staff and activities, and indicating at which levels of the Organization the costs will be incurred, identifying specific regions where relevant).

US\$ 1.0 million at all levels of the Organization.

(c) Is the estimated cost noted in (b), included within the existing approved Programme budget for the biennium 2010–2011?

Yes.

4. Financial implications

How will the estimated cost noted in 3(b) be financed (indicate potential sources of funds)?

Costs will be met through income from voluntary contributions from Member States and contributions from international partners.

5. Administrative implications

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

All levels of the Organization.

(b) Can the resolution be implemented by existing staff? If not, please specify in (c) below.

No.

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

Every effort will be made to make full use of secondments from Member States, as well as employing short-term staff.

(d) Time frames (indicate broad time frames for implementation of activities).

Three years for all activities (the Secretariat is drawing up an implementation plan accordingly).

1. Resolution WHA64.12 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)

2. Linkage to programme budget

Strategic objective:

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

Organization-wide expected result:

10.4 Country health-information systems that provide and use high-quality and timely information for health planning and for monitoring progress towards national and major international goals strengthened.

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

10.11 Norms, standards and measurement tools developed for tracking resources, estimating the economic consequences of illness, and the costs and effects of interventions, financial catastrophe, impoverishment, and social exclusion, and their use supported and monitored.

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

The support to the work of the Commission on Information and Accountability for Women's and Children's Health is expected to:

- lead to better knowledge and evidence for health decision-making at country and global levels (expected result 10.5)
- contribute to strengthening of country health information systems (expected result 10.4)
- improved tracking of resources at country and global levels (expected result 10.11).

Using the current indicators, results of implementation can best be measured through the proportion of low- and middle-income countries with adequate monitoring of the health-related Millennium Development Goals that meet agreed standards (indicator 10.4.1). Currently, 40% of countries meet standards; the target is 60% by 2013.

3. Budgetary implications

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

US\$ 2.5 million for provision of technical and administrative support to the Commission.

- (b) Estimated cost for the biennium 2010–2011 (estimated to the nearest US\$ 10 000 including staff and activities, and indicating at which levels of the Organization the costs will be incurred, identifying specific regions where relevant).**

US\$ 2.5 million at headquarters.

- (c) Is the estimated cost noted in (b), included within the existing approved Programme budget for the biennium 2010–2011?**

No.

4. Financial implications

How will the estimated cost noted in 3(b) be financed (indicate potential sources of funds)?

Specified voluntary contributions provided by Member States for the work of the Commission.

5. Administrative implications

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

Headquarters level.

- (b) Can the resolution be implemented by existing staff? If not, please specify in (c) below.**

The resolution can be implemented by existing staff.

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

Not applicable.

- (d) Time frames (indicate broad time frames for implementation of activities).**

From January 2011 to September 2011.

1. Resolution WHA64.13 Working towards the reduction of perinatal and neonatal mortality

2. Linkage to programme budget

Strategic objective:

4. To reduce morbidity and mortality and improve health during key stages of life, including pregnancy, childbirth, the neonatal period, childhood and adolescence, and improve sexual and reproductive health and promote active and healthy ageing for all individuals.

Organization-wide expected result:

4.1 Support provided to Member States to formulate a comprehensive policy, plan and strategy for scaling up towards universal access to effective interventions in collaboration with other programmes, paying attention to reducing gender inequality and health inequities, providing a continuum of care throughout the life course, integrating service delivery across different levels of the health system and strengthening coordination with civil society and the private sector.

4.3 Guidelines, approaches and tools for improving maternal care applied at the country level, including technical support provided to Member States for intensified action to ensure skilled care for every pregnant woman and every newborn, through childbirth and the postpartum and postnatal periods, particularly for poor and disadvantaged populations, with progress monitored.

4.4 Guidelines, approaches and tools for improving neonatal survival and health applied at country level, with technical support provided to Member States for intensified action towards universal coverage, effective interventions and monitoring of progress.

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

The resolution links with indicators 4.1.1, 4.3.1 and 4.4.1; the targets for those indicators will measure progress in the implementation of the resolution.

3. Budgetary implications

(a) Total estimated cost for implementation over the life-cycle of the Secretariat's activities requested in the resolution (estimated to the nearest US\$ 10 000, including staff and activities).

It is estimated that implementation of the resolution will cover the five-year period 2011–2015. The estimated cost of implementation over this period at headquarters and in regional and country offices is US\$ 95.1 million.

(b) Estimated cost for the biennium 2010–2011 (estimated to the nearest US\$ 10 000 including staff and activities, and indicating at which levels of the Organization the costs will be incurred, identifying specific regions where relevant).

The estimated cost for the Secretariat at all levels during the remainder of the biennium would be US\$ 9.51 million.

(c) Is the estimated cost noted in (b), included within the existing approved Programme budget for the biennium 2010–2011?

Yes.

4. Financial implications**How will the estimated cost noted in 3(b) be financed (indicate potential sources of funds)?**

Existing extrabudgetary sources are not sufficient to support all these costs. It is estimated that US\$ 500 000 of additional funds will be needed. The Secretariat will seek to identify sufficient additional sources of funding to ensure that the resolution can be implemented.

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

Implementation in all regions and countries.

(b) Can the resolution be implemented by existing staff? If not, please specify in (c) below.

No.

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

Seven additional full-time equivalent staff members will be required – one at grade P.5 at headquarters and one at grade P.4 in each of the regions – to ensure the support for the implementation of the resolution in the regions.

(d) Time frames (indicate broad time frames for implementation of activities).

2011–2015.

1. Resolution WHA64.14 Global health sector strategy on HIV/AIDS, 2011–2015**2. Linkage to programme budget**

Strategic objective:

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

4. To reduce morbidity and mortality and improve health during key stages of life, including pregnancy, childbirth, the neonatal period, childhood and adolescence, and improve sexual and reproductive health and promote active and healthy ageing for all individuals.

The HIV strategy also links with strategic objectives 6, 7 and 11.

Organization-wide expected result:

All expected results.

All expected results.

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

The goals of the strategy are consistent with the UNAIDS Strategy 2011–2015 and reaffirm existing internationally agreed goals:

- to achieve universal access to comprehensive HIV prevention, treatment and care
- to contribute to achieving Millennium Development Goal 6 (Combat HIV/AIDS, malaria and other diseases) and other health-related Goals (3, 4, 5 and 8) and associated targets.

The HIV strategy's four targets for 2015 build on the indicators and targets of the Medium-term strategic plan 2008–2013. The targets are as follows:

- reduce new infections: reduce by 50% the percentage of young people aged 15–24 years who are infected (compared with a 2009 baseline)
- eliminate new HIV infections in children: reduce new HIV infections in children by 90% (compared with a 2009 baseline)
- reduce HIV-related mortality: reduce HIV-related deaths by 25% (compared with a 2009 baseline)
- reduce tuberculosis-related mortality: reduce tuberculosis deaths by 50% (compared with a 2004 baseline).

3. Budgetary implications

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

US\$ 515 million for the five-year period 2011–2015.

- (b) **Estimated cost for the biennium 2010–2011 (estimated to the nearest US\$ 10 000 including staff and activities, and indicating at which levels of the Organization the costs will be incurred, identifying specific regions where relevant)**

US\$ 73 million, of which more than two thirds is expected to be incurred at regional and country levels.

- (c) **Is the estimated cost noted in (b) included within the existing approved Programme budget for the biennium 2010–2011?**

Yes.

4. Financial implications

How will the estimated cost noted in 3 (b) be financed (indicate potential sources of funds)?

Funding sources include: assessed contributions; core voluntary contributions; core funding of the UNAIDS Unified Budget, Results and Accountability Framework; and direct voluntary contributions from Member States and foundations.

5. Administrative implications

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

The Secretariat will provide support to implementation of the strategy at all levels of the Organization and in all regions. A detailed draft operational plan for the next biennium has been developed, indicating specific outputs at each organizational level and for each region. Particular attention will be given to ensuring that the Organization has adequate capacity at country level to support strategy implementation.

- (b) **Can the resolution be implemented by existing staff? If not, please specify in (c) below.**

WHO's HIV programme is currently undergoing a realignment process that aims to identify the necessary competencies, skills and staffing structure for implementing the strategy. The realignment is focusing on improving efficiencies within the programme throughout the Secretariat, including defining a clear division of labour across the three levels of the Organization. The outcome of the realignment process should be implemented by July 2011 and it is anticipated that the staffing levels will be sufficient to support implementation of the strategy. It is anticipated that there may need to be some adjustments in staffing over the five-year period to meet changing demands.

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

Not applicable.

(d) **Time frames (indicate broad time frames for implementation of activities)**

The strategy will be implemented over a five-year time period. Detailed operational plans will be developed for each biennium.

1. Resolution WHA64.15 Cholera: mechanisms for control and prevention

2. Linkage to programme budget

Strategic objective:

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

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

8. To promote a healthier environment, intensify primary prevention and influence public policies in all sectors so as to address the root causes of environmental threats to health.

Organization-wide expected result:

1.3 Effective coordination and support provided to Member States in order to provide access for all populations to interventions for the prevention, control, elimination and eradication of neglected tropical diseases, including zoonotic diseases.

1.9 Effective operations and response by Member States and the international community to declared emergency situations due to epidemic and pandemic prone diseases.

5.4 Coordinated technical support provided to Member States for communicable disease control in natural disaster and conflict situations.

8.1 Evidence-based assessments made, and norms and standards formulated and updated on major environmental hazards to health (e.g. poor air quality, chemical substances, electromagnetic fields, radon, poor quality drinking-water and waste-water reuse).

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

The resolution is consistent with overall expected results, and with the specific elements noted below.

Baseline: ad hoc support provided to countries and regional offices according to expressed need.

Target: current biennium, develop a medium-term strategy 2011–2016 and a detailed plan of action and necessary tools; start implementation in three regions; biennium 2012–2013, implement plan in three regions with three countries in each; biennium 2014–2015, maintain and scale up activities in three regions and add the three remaining regions.

Indicators:

- (a) information and technical back-up provided to countries affected by outbreaks
- (b) support for each of the participating countries performed as follows:
 - national action plan revised and updated; cholera surveillance within integrated diseases surveillance reviewed in countries
 - “hot spots” and trends over time identified
 - specific needs for preparedness and prevention activities identified, control activities implemented and maintained over time (e.g. health education, food safety, water and sanitation, prepositioning of supplies)
 - assessment for vaccine use performed and, if pertinent, plan for introduction elaborated

- strategy undertaken for training of trainers, multiplication of national workshops and quality control of capacity-building activities (e.g. in the areas of case management and laboratory capacities)
 - monitoring of performances implemented according to indicators to be identified and developed
- (c) regular meetings with key stakeholders held to review progress and best practice on various topics
- (d) support provided to research activities in risk assessment, vaccine development, and other relevant issues.

3. Budgetary implications

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

Total for five years: US\$ 20.22 million for staff and activities (programme support costs not included).

- (b) **Estimated cost for the biennium 2010–2011 (estimated to the nearest US\$ 10 000 including staff and activities, and indicating at which levels of the Organization the costs will be incurred, identifying specific regions where relevant).**

Staffing: US\$ 874 000 at headquarters level and US\$ 606 000 at regional level (Regional offices for Africa, the Americas, and the Eastern Mediterranean).

Activities: US\$ 1.24 million, of which 57% will be incurred at regional level.

- (c) **Is the estimated cost noted in (b), included within the existing approved Programme budget for the biennium 2010–2011?**

The costs associated with outbreaks could to some degree be included in the existing figures for the approved Programme budget; the extent to which this can be done will depend mainly on the severity or regularity of outbreaks. It is not expected that the costs associated with preventive actions could be considered within the current budget ceilings of the strategic objectives mentioned above.

4. Financial implications

How will the estimated cost noted in 3(b) be financed (indicate potential sources of funds)?

A medium-term strategy will be developed and will be used for resource mobilization at international and country levels.

5. Administrative implications

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

Global coordination, backstopping and standard-setting at headquarters level; Global Task Force on Cholera Control functioning with participation from all relevant departments. Activities at regional and country levels involving a focus during the first biennium on the African Region, the Region of the Americas and the Eastern Mediterranean Region, scaling up to the South-East Asia, European and Western Pacific regions during successive bienniums.

- (b) **Can the resolution be implemented by existing staff? If not, please specify in (c) below.**

No.

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

Over a five-year period, four additional professional staff will be required at different levels; additional staff at the general service level will also be needed to support existing staff at headquarters. At the regional level, for each region a public health specialist or epidemiologist and a water and sanitation specialist at P.4 level would be required.

- (d) **Time frames (indicate broad time frames for implementation of activities).**

An initial phase of five years.

1. Resolution WHA64.16 Eradication of dracunculiasis	
2. Linkage to programme budget	
Strategic objective: 1. To reduce the health, social and economic burden of communicable diseases.	Organization-wide expected result: 1.3 Effective coordination and support provided to Member States in order to provide access for all populations to interventions for the prevention, control, elimination and eradication of neglected tropical diseases, including zoonotic diseases.
(Briefly indicate the linkage with expected results, indicators, targets, baseline)	
The resolution will provide the framework for increasing the number of countries and territories certified for eradication of dracunculiasis from 187 in 2010 to 193 by 2013.	
3. Budgetary implications	
(a) Total estimated cost for implementation over the life-cycle of the Secretariat's activities requested in the resolution (estimated to the nearest US\$ 10 000, including staff and activities).	
US\$ 30 million over the envisaged life-cycle of this resolution of five years (2011–2015).	
(b) Estimated cost for the biennium 2010–2011 (estimated to the nearest US\$ 10 000 including staff and activities, and indicating at which levels of the Organization the costs will be incurred, identifying specific regions where relevant).	
US\$ 12.74 million. The costs will be incurred at headquarters, the regional offices for Africa and for the Eastern Mediterranean and country offices.	
(c) Is the estimated cost noted in (b), included within the existing approved Programme budget for the biennium 2010–2011?	
Yes.	
4. Financial implications	
How will the estimated cost noted in 3(b) be financed (indicate potential sources of funds)?	
Existing extrabudgetary sources.	
5. Administrative implications	
(a) Implementation locales (indicate the levels of the Organization at which the work will be undertaken, identifying specific regions where relevant).	
Headquarters, the regional offices for Africa and for the Eastern Mediterranean and countries therein.	
(b) Can the resolution be implemented by existing staff? If not, please specify in (c) below.	
Yes.	
(c) Additional staffing requirements (indicate additional required staff – full-time equivalents – by levels of the Organization, identifying specific regions where relevant and noting necessary skills profile).	
None.	
(d) Time frames (indicate broad time frames for implementation of activities).	
2011–2015.	

1. Resolution WHA64.17 Malaria

2. Linkage to programme budget

Strategic objective:

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

Organization-wide expected result:

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

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

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

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

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

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

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

The resolution builds on the United Nations General Assembly resolution 55/284, which proclaimed the period 2001–2010 the Decade to Roll Back Malaria, particularly in Africa; and on resolutions WHA58.2 and WHA60.18, the latter of which resolved that World Malaria Day should be commemorated globally and annually. The resolution is taking forward the call by the United Nations Secretary-General for universal coverage with antimalarial interventions; it also provides the framework for achieving the array of malaria control-related expected results, targets and baseline figures for strategic objective 2 as outlined in the Medium-term strategic plan 2008–2013. Furthermore, these results, targets and baseline figures are aligned with the expected results and indicators included in the Roll Back Malaria Global Malaria Action Plan for the period 2008–2015.

3. Budgetary implications

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

The life-cycle of the resolution is 2011–2015. The estimated cost of the Secretariat's responsibility for coordinating full-scale implementation after 2012 is US\$ 500 000.

- (b) Estimated cost for the biennium 2010–2011 (estimated to the nearest US\$ 10 000 including staff and activities, and indicating at which levels of the Organization the costs will be incurred, identifying specific regions where relevant).**

A total of US\$ 250 000 is needed to enable the secretariat of the Global Malaria Programme to start working on the provision of support to implementation.

- (c) Is the estimated cost noted in (b) included within the existing approved Programme budget for the biennium 2010–2011?**

Eighty per cent of the estimated costs will be covered by the approved Programme budget.

4. Financial implications

How will the estimated cost noted in 3(b) be financed (indicate potential sources of funds)?

Extrabudgetary sources of funding will be mobilized.

5. Administrative implications

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

Malaria poses a major threat in all regions, and implementing the resolution will require action at headquarters, regional offices and in the country offices of the countries in which malaria is endemic.

- (b) Can the resolution be implemented by existing staff? If not, please specify in (c) below.**

No additional positions will need to be established to support implementation.

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

See point (b) above.

- (d) Time frames (indicate broad time frames for implementation of activities).**

The time frame of the resolution is five years.

1. Resolution WHA64.22 Amendments to the Financial Regulations	
2. Linkage to programme budget	
Strategic objective: 13. To develop and sustain WHO as a flexible, learning organization, enabling it to carry out its mandate more efficiently and effectively.	Organization-wide expected result: 13.5 Managerial and administrative support services ¹ necessary for the efficient functioning of the Organization provided in accordance with service-level agreements that emphasize quality and responsiveness.
(Briefly indicate the linkage with expected results, indicators, targets, baseline)	
The resolution links with the statutory External Audit of WHO and the certification of the Organization's accounts. The intended outcome is an unqualified audit opinion.	
3. Budgetary implications	
(a) Total estimated cost for implementation over the life-cycle of the Secretariat's activities requested in the resolution (estimated to the nearest US\$ 10 000, including staff and activities).	
The requirement for the External Auditor to issue a report on the audit of the annual financial statements is estimated to entail an additional cost of between US\$ 100 000 and US\$ 200 000 per biennium. The amount will be known when nominations are received for the post of External Auditor for the period of two bienniums 2012–2015 early in 2011, and once the External Auditor has been appointed by the Health Assembly in May 2011.	
(b) Estimated cost for the biennium 2010–2011 (estimated to the nearest US\$ 10 000, including staff and activities, and indicating at which levels of the Organization the costs will be incurred, identifying specific regions where relevant).	
None.	
(c) Is the estimated cost noted in (b) included within the existing approved Programme budget for the biennium 2010–2011?	
Not applicable.	
4. Financial implications	
How will the estimated cost noted in 3(b) be financed (indicate potential sources of funds)?	
Through the regular budget or administrative overheads (programme support costs on voluntary contributions or the post occupancy charge).	
5. Administrative implications	
(a) Implementation locales (indicate the levels of the Organization at which the work will be undertaken, identifying specific regions where relevant).	
Implementation activities will principally concern headquarters and the Global Service Centre; the administered entities – UNAIDS, IARC, the International Computing Centre and the International Drug Purchase Facility, UNITAID – will also require yearly certification audits of their accounts. The change in the Financial Regulations should not affect the frequency of regional audits.	
(b) Can the resolution be implemented by existing staff? If not, please specify in (c) below.	
No additional staff will be needed, although the External Auditor will require additional resources.	

¹ Includes services in the areas of information technology, human resources, financial resources, logistics and language services.

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

See 5(b) above.

(d) Time frames (indicate broad time frames for implementation).

The first annual certification audit will encompass WHO's financial statements for 2012.

1. Resolution WHA64.24 Drinking-water, sanitation and health

2. Linkage to programme budget

Strategic objective:

8. To promote a healthier environment, intensify primary prevention and influence public policies in all sectors so as to address the root causes of environmental threats to health.

Organization-wide expected result:

8.1 Evidence-based assessments made, and norms and standards formulated and updated on major environmental hazards to health (e.g., poor air quality, chemical substances, electromagnetic fields, radon, poor-quality drinking-water and wastewater reuse).

8.2 Technical support and guidance provided to Member States for the implementation of primary prevention interventions that reduce environmental hazards to health, enhance safety and promote public health, including in specific settings (e.g. workplaces, homes or urban settings) and among vulnerable population groups (e.g. children).

8.4 Guidance, tools and initiatives created in order to support the health sector in influencing policies in other sectors to allow policies that improve health, the environment and safety to be identified and adopted.

8.5 Health-sector leadership enhanced for creating a healthier environment and changing policies in all sectors so as to tackle the root causes of environmental threats to health, through means such as responding to emerging and re-emerging consequences of development on environmental health and altered patterns of consumption and production and to the damaging effect of evolving technologies.

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

Drinking-water, sanitation and health issues cut across the Organization-wide expected results for strategic objective 8, particularly 8.1 (risk assessment and management guidelines), 8.2 (primary prevention), 8.4 (intersectoral capacity-building) and 8.5 (monitoring). Strengthened work on the prevention of water- and sanitation-related disease is consistent with the expected results under the strategic objective, and implementation of the resolution would be reflected within the indicators and targets of expected results mentioned above.

3. Budgetary implications

(a) Total estimated cost for implementation over the life-cycle of the Secretariat's activities requested in the resolution (estimated to the nearest US\$ 10 000, including staff and activities).

In addition to the current programme, the estimated cost for the period 2012–2013 is US\$ 3.94 million. The estimated cost per biennium on a continuing basis thereafter is about US\$ 21.0 million.

- (b) Estimated cost for the biennium 2010–2011 (estimated to the nearest US\$ 10 000 including staff and activities, and indicating at which levels of the Organization the costs will be incurred, identifying specific regions where relevant).**

US\$ 985 000 (25% of US\$ 3.94 million for the last six months of the biennium).

Costs will be incurred at headquarters and at the regional office level in those offices currently lacking advisors who specialize in water, sanitation and health, namely, the regional offices for Africa, the Eastern Mediterranean and the Western Pacific.

- (c) Is the estimated cost noted in (b), included within the existing approved Programme budget for the biennium 2010–2011?**

No.

4. Financial implications

- How will the estimated cost noted in 3(b) be financed (indicate potential sources of funds)?**

Additional voluntary funds are being sought; a number of parties have indicated interest.

5. Administrative implications

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

Implementation will involve activities at global, regional and country levels. Headquarters will play a coordination and management role and provide guidance and standard-setting, and will support the implementation of activities.

The regional offices will support the work in monitoring, water-safety planning, capacity building and approaches in specific settings.

Projects with a strong country focus will require the involvement of country office staff for satisfactory implementation.

- (b) Can the resolution be implemented by existing staff? If not, please specify in (c) below.**

No.

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

The following additional staff will be required: a Monitoring Manager at grade P.5; a Technical Officer at grade P.3 to support UN-Water's Global Analysis and Assessment of Sanitation and Drinking-Water; two Technical Officers at grade P.4, one to deal specifically with wastewater activities, and the other to deal with national health strategies to influence realization of the basic human right to water and sanitation; and three Regional Advisors on water, sanitation and health at grade P.4 (one in each of the regional offices for Africa, the Eastern Mediterranean and the Western Pacific).

- (d) Time frames (indicate broad time frames for implementation of activities).**

2010–2011. Following a broad consultation on developing a new generation of targets and indicators for post-2015 water and sanitation monitoring, a number of working groups will be activated as of 1 July 2011, with an incremental increase of staff to meet additional work requirements.

2012–2013. The start-up phase and coordination of strategic work should be completed; thereafter implementation of activities will be on a continuing basis.

1. Resolution WHA64.27 Child injury prevention	
2. Linkage to programme budget	
Strategic objective:	Organization-wide expected result:
3. To prevent and reduce disease, disability and premature death from chronic noncommunicable diseases, mental disorders, violence and injuries and visual impairment.	3.1 Advocacy and support provided to increase political, financial and technical commitment in Member States in order to tackle chronic noncommunicable diseases, mental and behavioural disorders, violence, injuries and disabilities, together with visual impairment, including blindness. 3.2 Guidance and support provided to Member States for the development and implementation of policies, strategies and regulations in respect of chronic noncommunicable diseases, mental and neurological disorders, violence, injuries and disabilities, together with visual impairment, including blindness. 3.3 Improvements made in Member States' capacity to collect, analyse, disseminate and use data on the magnitude, causes and consequences of chronic noncommunicable diseases, mental and neurological disorders, violence, injuries and disabilities, together with visual impairment, including blindness. 3.5 Guidance and support provided to Member States for the preparation and implementation of multisectoral, population-wide programmes to promote mental health, and to prevent mental and behavioural disorders, violence and injuries, together with hearing and visual impairment, including blindness. 3.6 Guidance and support provided to Member States to improve the ability of their health and social systems to prevent and manage chronic noncommunicable diseases, mental and behavioural disorders, violence, injuries and disabilities, together with visual impairment, including blindness.
(Briefly indicate the linkage with expected results, indicators, targets, baseline)	
The resolution provides a framework that will contribute to the achievement of the expected results in terms of the planned indicators, targets and baseline.	
3. Budgetary implications	
(a) Total estimated cost for implementation over the life-cycle of the Secretariat's activities requested in the resolution (estimated to the nearest US\$ 10 000, including staff and activities).	
It is estimated that this resolution will have a life-cycle of 10 years (2011–2021). The estimated cost of the Secretariat's activities in support of implementation is US\$ 10 million.	
(b) Estimated cost for the biennium 2010–2011 (estimated to the nearest US\$ 10 000 including staff and activities, and indicating at which levels of the Organization the costs will be incurred, identifying specific regions where relevant).	
If the resolution is adopted by the Health Assembly in May 2011, the estimated cost during the biennium 2010–2011 of the relevant Secretariat activities would be US\$ 500 000. It would be incurred at all levels of the Organization.	
(c) Is the estimated cost noted in (b), included within the existing approved Programme budget for the biennium 2010–2011?	
Yes.	

4. Financial implications**How will the estimated cost noted in 3(b) be financed (indicate potential sources of funds)?**

Existing extrabudgetary sources are insufficient to support this cost fully. The Secretariat will investigate additional sources of funding.

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

All WHO regions and countries.

(b) Can the resolution be implemented by existing staff? If not, please specify in (c) below.

No.

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

At headquarters, an additional staff member would be required at P.4 level to coordinate follow-up activities.

(d) Time frames (indicate broad time frames for implementation of activities).

2011–2021.

1. Resolution WHA64.28 Youth and health risks**2. Linkage to programme budget**

Strategic objective:

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

3. To prevent and reduce disease, disability and premature death from chronic noncommunicable diseases, mental disorders, violence and injuries and visual impairment.

4. To reduce morbidity and mortality and improve health during key stages of life, including pregnancy, childbirth, the neonatal period, childhood and adolescence, and improve sexual and reproductive health and promote active and healthy ageing for all individuals.

6. To promote health and development, and prevent or reduce risk factors for health conditions associated with use of tobacco, alcohol, drugs and other psychoactive substances, unhealthy diets, physical inactivity and unsafe sex.

7. To address the underlying social and economic determinants of health through policies and programmes that enhance health equity and integrate pro-poor, gender-responsive, and human rights-based approaches.

Organization-wide expected result:

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

4.6. Technical support provided to Member States for the implementation of evidence-based policies and strategies on adolescent health and development, and for the scaling up of a package of prevention, treatment and care interventions in accordance with established standards.

9. To improve nutrition, food safety and food security, throughout the life-course, and in support of public health and sustainable development.

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

This resolution links directly to indicator 4.6.1. In addition, it links to several of the indicators and targets for strategic objectives as set out in the Medium-term strategic plan 2008–2013 (Amended (Draft)) (revised version, April 2009).¹ The following indicators and targets are concerned: strategic objective 2, second point; strategic objective 3, all three points; strategic objective 6, all three points; strategic objective 7, first point; and strategic objective 9, third point.

3. Budgetary implications

(a) Total estimated cost for implementation over the life-cycle of the Secretariat's activities requested in the resolution (estimated to the nearest US\$ 10 000, including staff and activities).

The lifetime of this resolution is estimated at 10 years (2011–2021). The estimated cost to the Secretariat for implementation of the resolution over this period at headquarters, the regional offices and country offices is US\$ 105.0 million.

(b) Estimated cost for the biennium 2010–2011 (estimated to the nearest US\$ 10 000 including staff and activities, and indicating at which levels of the Organization the costs will be incurred, identifying specific regions where relevant).

The estimated cost for the Secretariat at all levels during the remainder of the biennium would be US\$ 5.3 million.

(c) Is the estimated cost noted in (b), included within the existing approved Programme budget for the biennium 2010–2011?

Yes.

4. Financial implications

How will the estimated cost noted in 3(b) be financed (indicate potential sources of funds)?

Existing funds are insufficient to support all these costs. The estimated additional funds needed are US\$ 530 000. The Secretariat will identify alternative sources of funding, to ensure sufficient funding levels to implement the resolution.

5. Administrative implications

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

Implementation in all regions and countries.

(b) Can the resolution be implemented by existing staff? If not, please specify in (c) below.

No.

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

Two additional regional staff are required at grade P.4, one in each of the regional offices for Africa and the Western Pacific to ensure support for implementation of youth health in the region.

(d) Time frames (indicate broad time frames for implementation of activities).

2011–2021.

¹ Available online at http://apps.who.int/gb/ebwha/pdf_files/MTSP2009/MTSP3-en.pdf (accessed on 17 May 2011).

1. Decision WHA64(11) Smallpox eradication: destruction of variola virus stocks	
2. Linkage to programme budget	
Strategic objective:	Organization-wide expected result:
1. To reduce the health, social and economic burden of communicable diseases.	1.7 Member States and the international community equipped to detect, assess, respond to and cope with major epidemic and pandemic-prone diseases (e.g. influenza, meningitis, yellow fever, haemorrhagic fevers, plague and smallpox) through the development and implementation of tools, methodologies, practices, networks and partnerships for prevention, detection, preparedness and intervention.
(Briefly indicate the linkage with expected results, indicators, targets, baseline)	
In the decision, the Health Assembly reaffirms the need to reach consensus on a proposed new date for the destruction of the variola virus stocks, when research outcomes crucial to an improved public health response to an outbreak so permit. The decision is consistent with the expected result mentioned above and its indicator.	
3. Budgetary implications	
(a) Total estimated cost for implementation over the life-cycle of the Secretariat's activities requested in the decision (estimated to the nearest US\$ 10 000, including staff and activities)	
Estimated costs are US\$ 1.54 million per year over the lifespan of the decision, which calls for reporting to the Sixty-seventh World Health Assembly.	
(b) Estimated cost for the biennium 2010–2011 (estimated to the nearest US\$ 10 000 including staff and activities, and indicating at which levels of the Organization the costs will be incurred, identifying specific regions where relevant)	
US\$ 770 000 at headquarters.	
(c) Is the estimated cost noted in (b) included within the existing approved Programme budget for the biennium 2010–2011?	
A figure of US\$ 410 000 is already included.	
4. Financial implications	
How will the estimated cost noted in 3 (b) be financed (indicate potential sources of funds)?	
Additional voluntary funds will be sought.	
5. Administrative implications	
(a) Implementation locales (indicate the levels of the Organization at which the work will be undertaken, identifying specific regions where relevant)	
Headquarters in coordination with the regional offices for the Americas and Europe (repository inspection visits).	
(b) Can the decision be implemented by existing staff? If not, please specify in (c) below	
Although additional dedicated technical and specialized logistics expertise will be required, this can be generated through the redeployment of existing staff.	

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

Not applicable.

(d) Time frames (indicate broad time frames for implementation of activities)

Implementation should begin as soon as possible following adoption of the decision. The decision does not indicate a specific time for the programme to end.